Patient Co-design Workshop

Developing U&EC services together and agreeing a principle of co-design for London’s U&EC networks.
## Patient Co-Design Workshop

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<th>Examples of patient co-design of services in London</th>
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| Group discussions – Embedding co-design principles throughout U&EC networks | 20 mins |

| Summary of group discussions – describing pan London principles of co-design | 5 mins |
Involving patients and staff in Health 1000

Alan Steward - Barking and Dagenham, Havering and Redbridge CCGs
1: Traditional Commissioning

2: Year Of Care study
- Cost per patient
- Risk stratified
- Long term condition comorbidities
- Frequent flyers

3: The Health 1000 test

4: Future cohorts
- Redbridge
- Barking and Dagenham
- Havering
Patient Experience
The graphic below captures the experiences of two patients

Julius and Maurice as they transition from traditional services (Left) to Health 1000 (right)
Staff Experience
The graphic below captures the staff experiences
Hillingdon 4 All - A Health and Wellbeing Gateway for Hillingdon

Trevor Begg - Hillingdon CCG
A Health and Wellbeing Gateway for Hillingdon

Hillingdon 4 All
"Nothing about me, without me" - the patient and carer voice at the heart of all provision.

Integrated Care in Hillingdon Model of Care

- Specialist Resources (Ward Care Team)
- Consultant Geriatrician
- Social Worker
- Dedicated Core Care Team
- Proactive Review of Care Plan
- Weekly Reviews
- Monthly MDT Planning Reviews
- Monthly to Annually Review of Care Plan
- System Navigator / Care Coordinator
- My Care Plan: Co-produced, High Intensity, Dedicated Care Team, Key Worker
- GP Practice: Family Doctor, Community Pharmacist, Nursing Services
- Trigger event / Exacerbation
- Duly Huddles
- End of Life care pathway

Service Functions
- Health Coach and Education
- Telehealth and Telecare
- Domiciliary and Home Care
- Home Safe and Reablement
- Community Nursing (Inc. wound care)
- Community Phlebotomy
- Community Diagnostics
- Nutrition and Fluid Management
- I.V. Management
- Rapid Response
- Therapies (O/T, Physio)
- Equipment & Adaptations
- Non-clinical Advice & Support
- Community Mental Health
- Care’s Support
- Out of Hours
- Community Dietitian
- Befriending and other voluntary services
- Bereavement
- Night Sitting
- Supported leisure activities / centres
- Memory service
- Allied services (optician, dentist, podiatry)
- Speech and Language therapy

Supporting Healthy Independence
Gateway aims

- To provide a single point of access for all health professionals to the third sector ‘offer’
- To provide early intervention through a range of support and low-level preventative services
- To increase and maintain people’s wellbeing, motivation and ability to self-manage their own health needs
- To address issues such as loneliness, isolation and low level depression
- To promote appropriate use of primary care and reduce hospital admissions
Health and Wellbeing Gateway

“Make one call and we will do the rest”

Key features:

» One phone number to access our extensive preventative ‘offer’

» Structures co-terminus with GP Networks

» Use of Patient Activation Measure (PAM)

» Combined specialisms of five organisations

» Local knowledge and expertise
The process

» An initial screening assessment with a triage function

» Signposting to the relevant partner organisation and a course of action agreed

» Access to the Health and Wellbeing programme - a broad range of educational and preventative services that cover disability, mental health, age-specific provision, end of life and support for carers

» A PAM assessment, conducted as appropriate, and allocation of a designated support coordinator

» The development of a support plan to be included in GP-held integrated care plans

» Active case management for those with moderate needs who are identified as ‘at risk’ of deterioration

» 6 monthly review

» Ongoing social support and support for carers
Our approach

- Holistic health promotion
- Tackling loneliness and isolation
- Active case management
- Addressing social issues
- Support for carers
- Capacity-building and social capital
Our approach

Maslowe
Census 2011: Hillingdon residents aged over 65 - general health

Source: Census 2011
Why loneliness and isolation?

Evidence supporting the need to tackle social isolation

http://www.campaigntoendloneliness.org/blog/lonely-visits-to-the-gp/

In 2013, the National Campaign to End Loneliness polled a thousand GPs and asked how many older people they saw in the average day who they thought had come in mainly because they were lonely. The findings were shocking:

- Over three quarters of GPs were seeing between one and five lonely people a day
- One in ten doctors reported seeing between six and ten lonely patients a day
- A small minority (4%) said they saw more than 10 lonely people a day.
Loneliness: a threat to health

- The effect of loneliness and isolation on mortality exceeds the impact of well-known risk factors such as obesity and cigarette smoking (Holt-Lunstad, 2010)

- Loneliness increases the risk of high blood pressure (Hawkley et al, 2010)

- Lonely individuals are also at higher risk of the onset of disability (Lund et al, 2010)

- Loneliness puts individuals at greater risk of cognitive decline (James et al, 2011)

- Lonely people have a 64% increased chance of developing dementia (Holwerda et al, 2012)

- Lonely individuals are more prone to depression (Cacioppo et al, 2006)

- Loneliness and low social interaction are predictive of suicide in older age (O’Connell et al, 2004)
Empowered Patient Programme and Community Outreach

Radhika Howarth - Hillingdon CCG
radhika.howarth@nhs.net
Examples of co-designing services with patients

Empowered Patient Programme and Community Outreach

• Patient education and behaviour change programme that empowers patients and members of the local community to self-care and manage their health condition.

• Includes clinical and non-clinical information, education and self-management interventions based on needs identified through Equalities Impact Assessments and community outreach.

• The aim is to reduce follow up appointments that can be otherwise avoided or delivered in primary care, and reduce attendances to unscheduled care.

A number of different models of engagement and education have been developed:

• Workshop on basic first aid and managing minor ailments at home - British Red Cross

• Patient education on self-management of type 2 diabetes for English and non-English speakers – delivered by clinicians based on content co-designed by patients

• Winter Wellness workshops delivered by health connectors

• Healthy Heart workshops (Cardiology in collaboration with Public Health)
Examples of co-designing services with patients

EPP – Key features:

- Culturally sensitive approaches – building relationships and trust with local communities
- Community outreach and community education conducted by a team of bi-lingual health connectors
- Co-production – with patients, parents and communities in designing the interventions to ensure that the content is relevant, addressed their needs and encouraged a shared ownership of the work
- Collaboration and joint working: partnership with community groups, faith settings, voluntary sector, GPs, libraries, Public Health and other health professionals to broaden our project’s reach, share resources and expertise and make it accessible to all sections of the community

We have engaged with over 1,700 people from May-October 2015 and have already met the QIPP targets set for the year!
Examples of co-designing services with patients

Co-production in Action - Partnership project with a GP practice in Hayes:

- The aim of the project was to change dependency behaviour while improving parent’s ability to care for their children and families’ health and wellbeing, resulting in the ‘fully engaged patient’ who is confident about choosing ‘the right care at the right place at the right time’.

- Designed in collaboration with parents identified by the practice. The five week programme targeted parents with young children who were frequent attenders at A&E and GP practice.

- The programme consisted of five one hour workshops on different topics related to the physical, emotional and general wellbeing of the child.
Impact of co-designing with patients

Co-production in Action - Partnership project with a GP practice in Hayes:

The last time my baby had fever I got panicky and took her to the hospital. But now after these sessions I am realising the steps you can take when that happens. I won’t feel so panicky in the future. I will be a bit calmer and know how to deal with it.”

Parent with 13 month old baby
Examples of co-designing services with patients

Patient education self-management programme:

• The Diabetes QIPP programme (2014-2016) was based on the successful pilot which was undertaken in one locality to address the health inequalities that affected communities in the south of the borough.

• The workshop content was designed with patients to ensure it was culturally relevant and accessible.

• Peer to peer engagement: Patients and carers who participated in the workshops have become ambassadors for the programme.
Impact of co-designing with patients

Patient education self-management programme:

**Before:** “I knew a little bit about diabetes, but I did not know what I could do to manage my condition. I lost my husband last year, which made me depressed and de-motivated. I wasn’t bothered about my health.”

**After:** “I felt like a different person after I attended the course. I don’t know exactly what happened, but I came out feeling very motivated and determined to take control of my health. I saw other women like me in the same situation and that made me feel I wasn’t alone. The course gave me motivation. I said if you want to do it you can do it. I started making changes in my eating and drinking.”

“I don’t bother the GP any more. I feel so much happier and in control because my sugar is down. Even my doctor is very happy with me.”
Embedding co-design principles in U&EC networks

Group Discussion

The Five Year Forward View sets out expectations of Vanguards in terms of partnership with people and communities:

- Making care and support person-centred: personalised, coordinated, empowering. Achieved via:
  - Information, support and advocacy for patients, service users, carers and families
  - Personalised care, support planning and shared decision making as the default mode
  - Support for self management at scale, so people are informed, skilled and confident
  - Care is coordinated as set out in National Voices/Think Local Act Personal “I” statements

- Creating services in partnership with citizens and communities
- Focussing on equality and narrowing health inequalities
- Supporting carers; and using the voluntary, community and social enterprise sectors as key enablers.
Summary of group discussions

Describing pan London principles of co-design

• How do we ensure we use these principles when co-designing and producing services with other patient groups accessing urgent and emergency care? E.g. the “fit and well”

• How do we co design effectively across network boundaries? What do we need to do to balance between achieving locally determined priorities and ensuring consistency of services?

• What can be done once across London to support co-design locally? E.g. education and consistent messaging, changing patient behaviour