

Integrated Self Management: The boiled egg approach



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Where we are in Lewisham

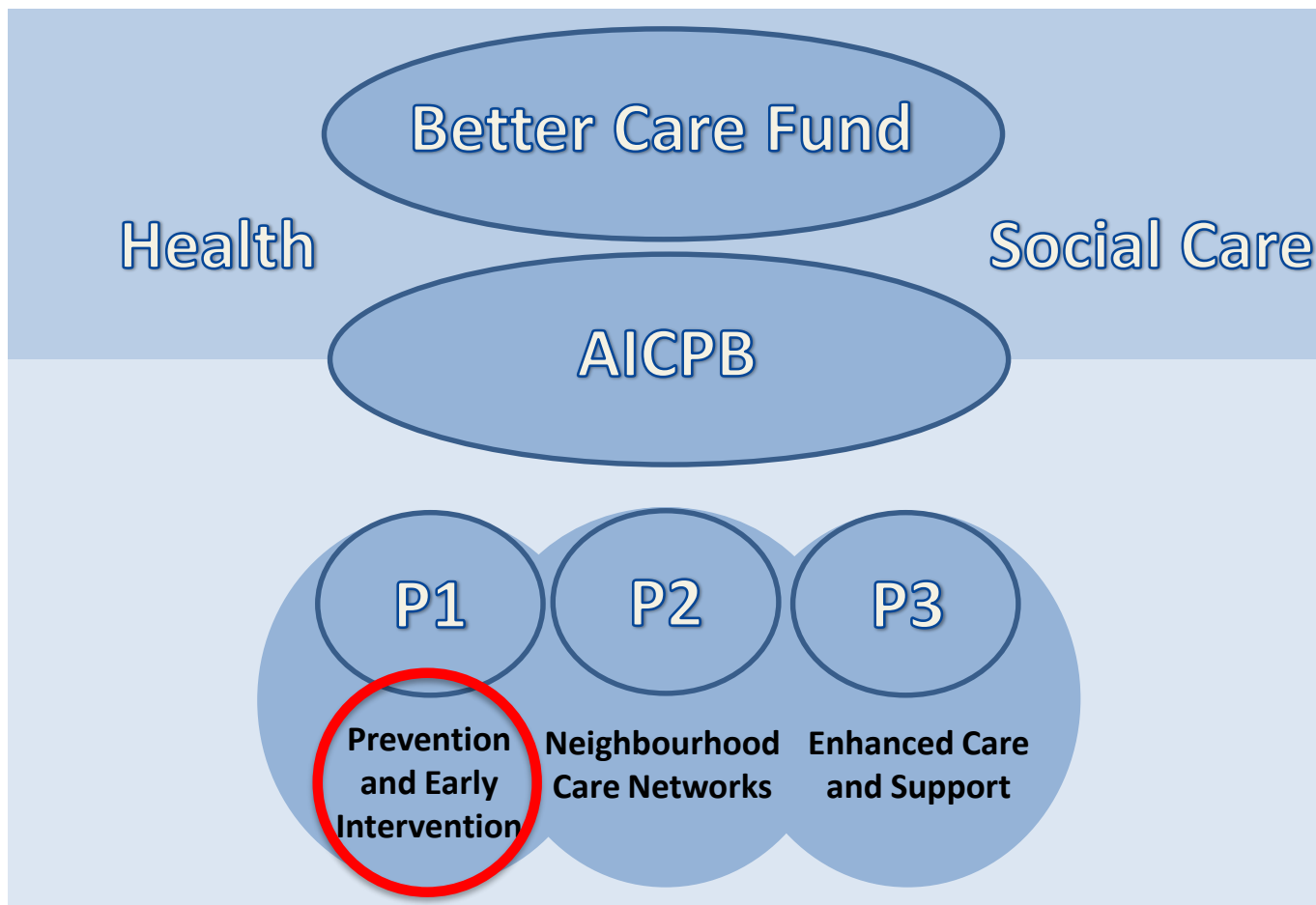
- Introductions
- The GP view
- Adult Integrated Care Programme
- Conceptual Framework for Self Management
- Road Map to Delivery
- Challenges



The General Practice Landscape

- **Business as usual** (not an option!)
- **Population** (Increasing numbers, aging population)
- **Complexity** (complexity MH/Multiple LTC/Housing)
- **Community based care** (change from hospital to community)
- **GP partnerships** (basic need for partners to work closer together. Work smarter)





Health vs. Social Care

“What's in a name??”

Self Care

Vs

**Self
Management**



Its Good to talk – What we found

- Disparate list of unrelated services and activities
- Variable activity and outcome reporting
- Contract monitoring
- Impact analysis
- What were we missing?



Recipe: How to make a model?

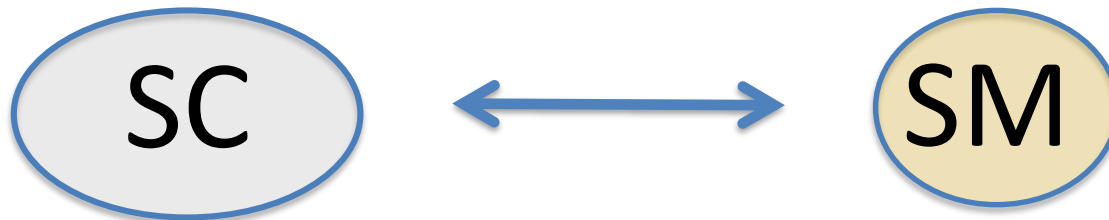
Ingredients & Method:

Step 1. Pick 20 ripe stakeholders

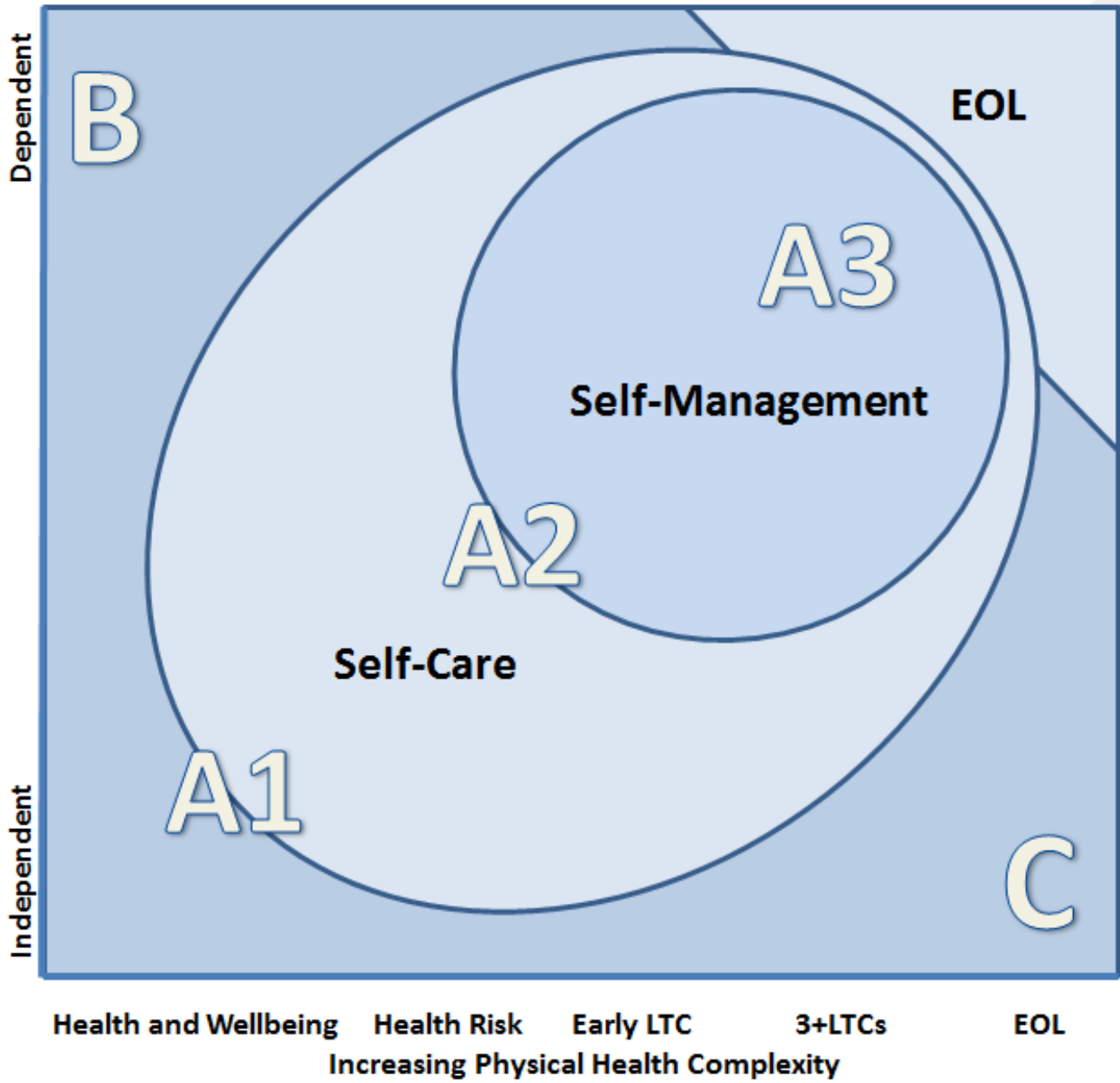
Step 2. Combine (vigorously)

Step 3. Add 'Whole Person'

Step 4. Add binding agent - Egg



Increasing Psychological and Social Complexity



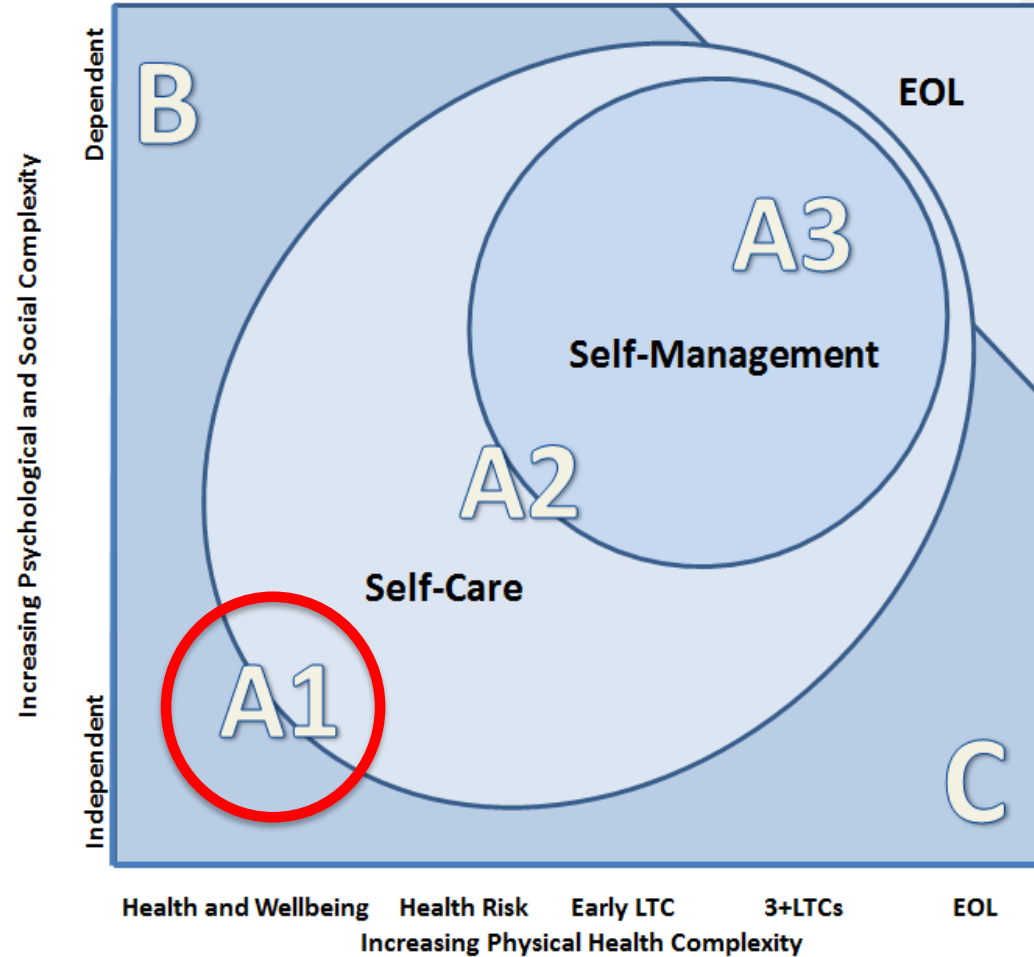
A1 Population Profile:

Ideally people would be able to access self-care services to help them manage their health

Model Description:

This is typically the prevention and early intervention stage where all is being done to support a healthy lifestyle.

People can move in and out of this stage if it is managed well



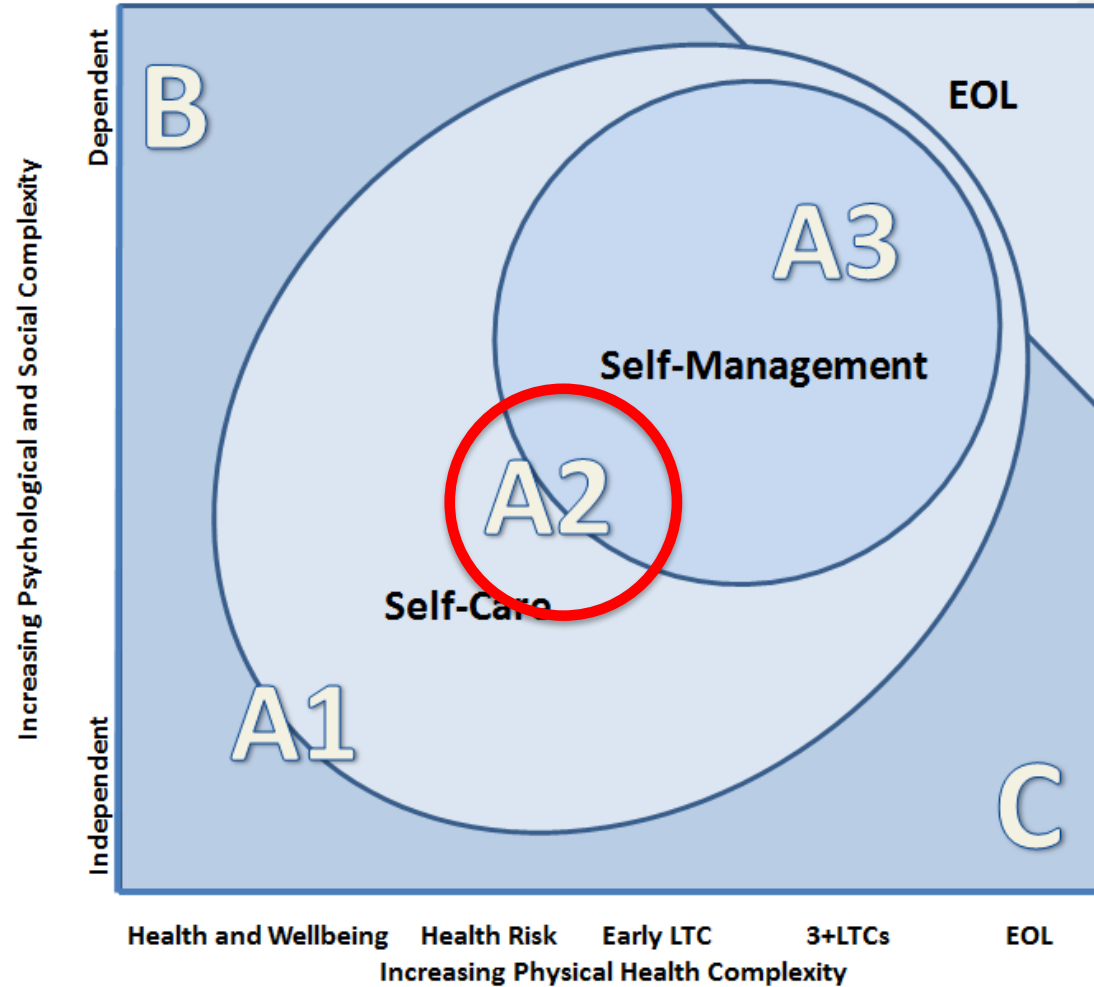
A2 Population Profile:

The person developing/diagnosed living with a LTC(s). Also the need to continue to both effectively self-manage and self-care

Model Description:

The transition self-management triggered by a LTC.

The idea would be to help maintain the person at A2 for as long as possible.

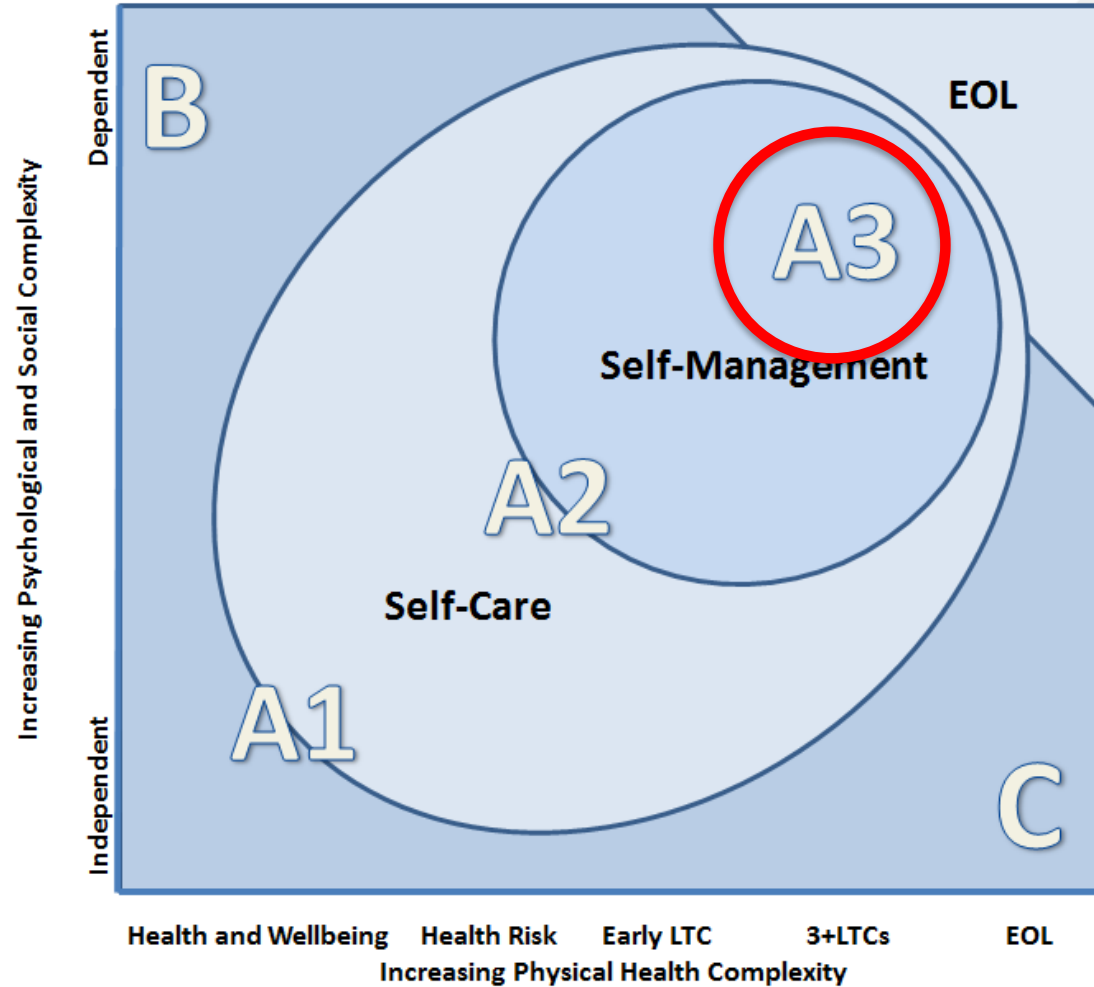


A3 Population Profile:

This person may be more dependent on many services as their health and wellbeing becomes more complex.

Model Description:

It is always possible to SC and SM at this point to some degree. Coordinated case management may be needed to ensure the person can remain as independent as possible.

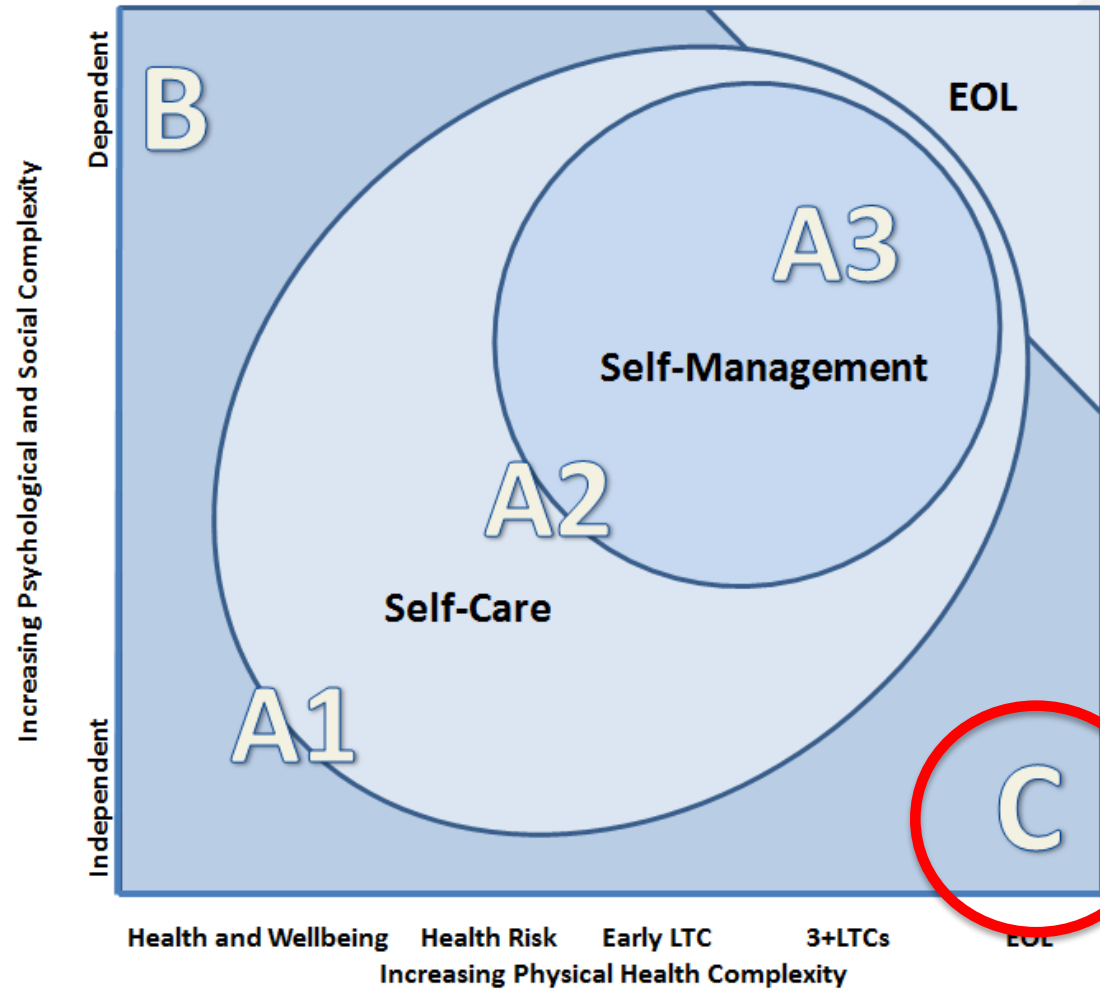


C Population Profile:

People that can have autonomy and capability to make choices but may not be engaging with self-care/self-management.

Model Description:

The idea is to reduce the size of this population by ensuring that SC/SM initiatives are population based, promotional, motivational and accessible across all communities. People may need specific navigation support to access SC/SM network.

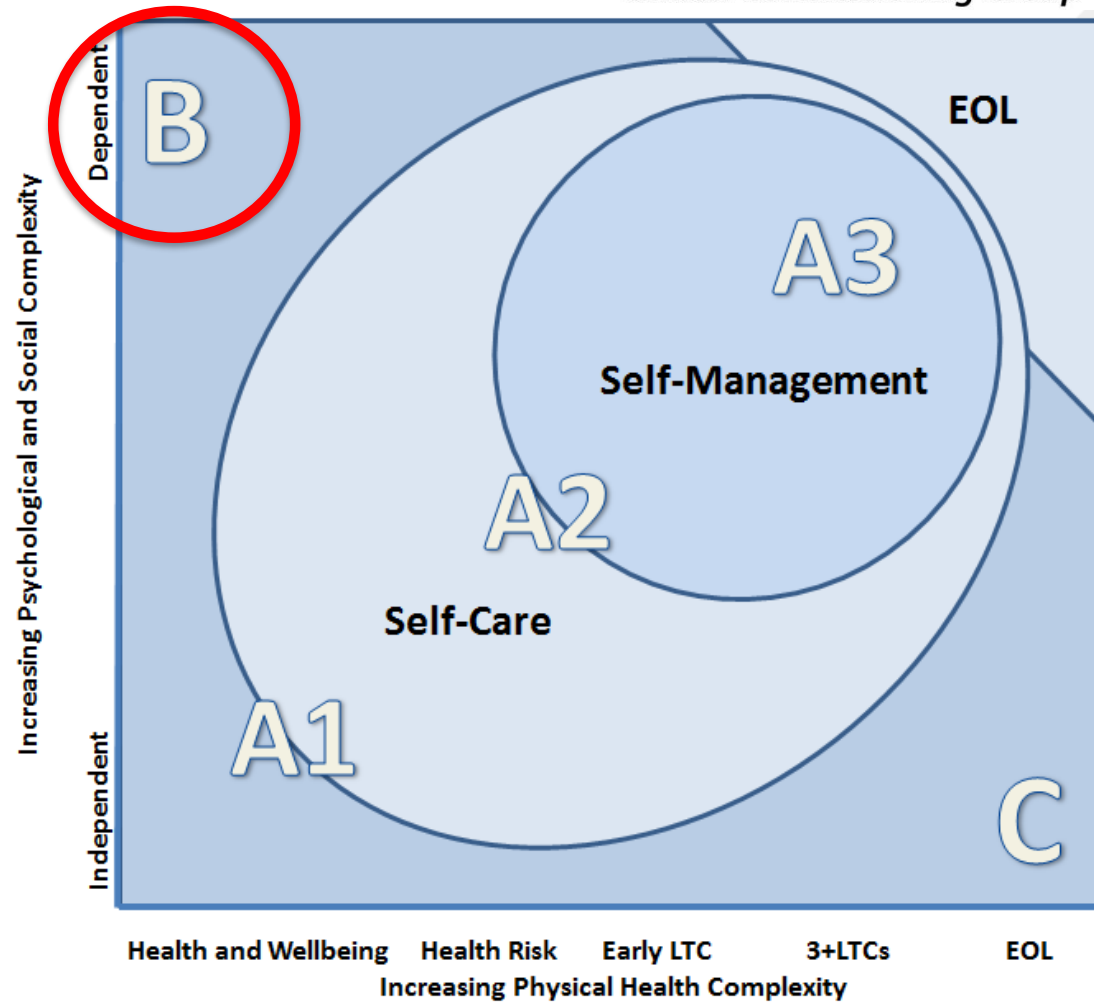


B Population Profile:

People that have complex health social care profiles that are more dependent on others/services to manage their own health or are unable to access services that can support them.

Model Description:

The aim would be to ensure this population are not excluded from SC/SM services because of their increasing levels of dependence on specialist service that may sit outside of the system



Road to delivery

- **Phase I** – Audit what we have against the model and its design principles
- **Phase II** – Align, Redesign and Commission against the model and design principles
- **Phase III** – Joint Commissioning and Provider framework



Challenges

- Culture shift
- Changing the way services are provided and commissioned (activity to outcomes)
- ‘Fortressing’ – Protecting own resources
- Capacity in the system
- Unplanned to planned



Conclusion – Long way to go

- Business as usual (not an option)
- Sustainable system
- More complexity
- Partnerships and Network
- People as experts



*“I went to a bookstore and asked the saleswoman, **'Where's the self-help section?'** She said if she told me, it would defeat the purpose”*

- George Carlin

Thank you Questions?

“The doctor of the future will give no medicines, but will interest his patients in the care of the human frame (body and mind), in diet, and in the causes and prevention of disease”

- Thomas Edison

