Case study: Greenwich – Co-ordinated care – a patient’s story

Tom, a 45 year old man from south east London, had been living with diabetes, chronic obstructive pulmonary disease (COPD), and a psychotic disorder for several years. He had gambling problems and lived in an overcrowded flat. This complex mix of issues resulted in him being the highest attender at A&E and a frequent visitor to his GP.

His GP referred him to Greenwich Coordinated Care who worked with him to develop the following I statements:

- My medication looked at
- To stop gambling
- Help with damp in bathroom
- To keep house tidy
- To do voluntary work
- To have more mental health team visits

His Greenwich Coordinated Care Navigator organised a multi-disciplinary team meeting to review his care in light of his I statements. This involved his GP, housing, Greenwich Action for Voluntary Services, community mental health team, carers centre, out of hours GP service, psychologist, and London Ambulance Services (LAS).

The care coordinator gathered the information and the multi-disciplinary team looked with fresh eyes working across boundaries. The psychologist learnt about the pattern of A&E from LAS and helped identify how his behaviours led to triggers ie boredom, gambling, anxiety.

The action plan they developed agreed:

- To refer to London fire brigade re hoarding
- Psychologist to support to increase confidence and help with anxiety and triggers
- Housing to look at flat and residence
- Medication to be reviewed and help to manage

This lead to the following outcomes:

- The GP, patient, psychologist further explored triggers for calling an ambulance and the calls reduced to only one a month in the last three months for appropriate physical needs
- His long-term medication management was reviewed with him
- Boredom, gambling and debt were tackled with the support of voluntary services
• Explored recovery through social inclusion
• Housing issue resolved (stepson who was stealing from him moved out after housing did an informal visit; safeguarding issues addressed)
• He attended GP appointments for diabetes more regularly

Contact: Jo Mant, Head of Stakeholder Engagement, Oxleas NHS Foundation Trust
Jo.mant@oxleas.nhs.uk