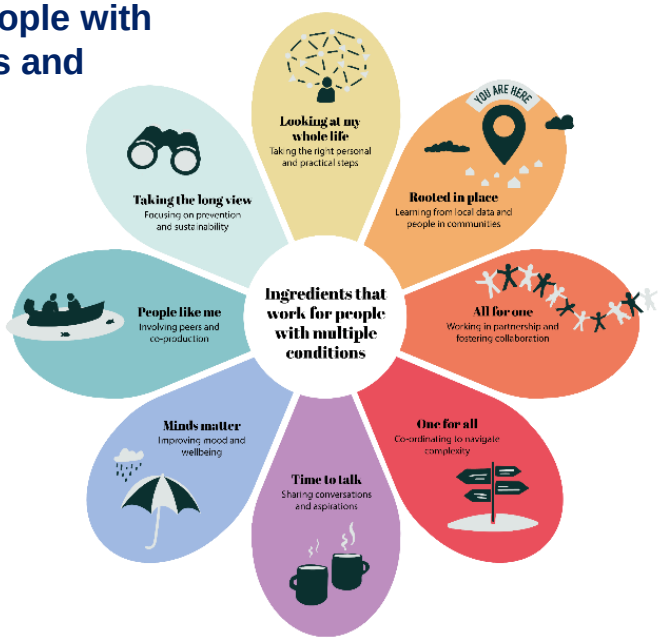
Resources for PCNs

Recovery journeys; what works for people with multiple conditions and how can PCNs and commissioners respond?

Improving care for people with multiple long-term conditions requires a model of health that is more balanced between the medical and social models, addressing the wider determinants of health, not just reacting to illness or promoting behaviour change. This requires a profound shift in how we think about and coordinate services around health.

Despite the need for listening and flexibility to take account of different personal and local circumstances, the Taskforce on Multiple Conditions offers eight commonly identified ingredients that work for people with multiple conditions that all frontline professionals can incorporate and that PCNs could support the adoption of.



Building services to support people's recovery journeys

The following are five 'features' of people's recovery journeys and some suggestions for how PCNs might respond

Recovery Journey – key features	What PCNs could do to embed the features
Access to 'trusted people and environments' so people feel able to open up about things they feel ashamed early on in their journey. Ideally, this 'trusted person' would be of a similar age and have some experience of what the individual is going through.	PCNs could work with community partners to provide access to empathetic 'peers' in congenial settings who can build trust with people, help them to face their truths and get to the bottom of what is troubling them.
People not having to repeat their story over and over again to different professionals. Recounting damaging experiences, coupled with the frustration of people not understanding, causes further damage and anger at a deep level;it reinforces negative feelings.	PCNs could develop 'information-sharing protocols' with partner organisations, to enable sharing of information with the individuals' consent. This would mean they only have to tell their story once.
To be seen as a person with talents and strengths (not just focusing on their problems) is very important in terms of confidence-building. People often need help to spot their own strengths and to find a place they can exercise them.	This is a key reason PCNs need to connect with community partners – because they can provide access to a whole range of possibilities to develop and employ/enjoy their talents.
Follow up ´did not attends´ (DNAs) because when people don't attend their appointment, it is often because they are struggling to hold onto all the strands of multiple services and other things going on in their lives.	PCNs need to work with GPs to change the way they respond to 'DNAs', so that people are followed up, perhaps by a social prescriber, especially when it happens often.
"Knowing what the map is…" because 'multiple vulnerabilities' occur when people are facing several problems at the same time and they feel out of control. One of the ways to start to get control back, making people feel better, is to be able to see a route through.	PCNs could support the development of a 'Support Map' that GPs, social prescribers, health coaches, care coordinator and others across primary care build up with people to help them to navigate their own care path.