The Primary Care Home Model

Dr Nav Chana & Michelle Bull
21 March 2017
The NAPC describes four core characteristics of a Primary Care Home.

**Current State**
- Social care
- Long term condition
- Mental Health condition
- Maternity care
- Acute condition

**Transformed State**
- Allied Health Professionals
- Diagnostics
- Third Sector
- Community Nursing
- Speciality Care
- Mental Health Services
- Social Care

High referral rate

Working within a capitated contract

Lower referral rate
The PCH model can deliver multiple benefits in Primary Care

1. Improved patient care: proactive and person centred care by focusing on the needs of the person rather than the needs of the service.

2. Increased staff fulfilment: The PCH provides the environment and conditions for workforce development and effective team working.

3. Improved utilisation of locals resources: care teams that do the work take responsibility for a whole population budget for that registered community.

4. Delivers improvements in General Practice: multi-disciplinary teams in primary care will release more time for GPs

5. Helps to stabilise Primary Care: makes it easier for local providers to engage with each other and disparate units of Primary Care to coalesce into more robust units
The PCH model has spread to 92 sites so far.
PCHs have been successful in releasing a range of benefits for patients, staff, practices and the wider system

<table>
<thead>
<tr>
<th>Pilot Site Example Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A&amp;E Attendances</strong></td>
</tr>
<tr>
<td><strong>A&amp;E Admissions</strong></td>
</tr>
<tr>
<td><strong>GP Referrals</strong></td>
</tr>
<tr>
<td><strong>Prescribing Costs</strong></td>
</tr>
<tr>
<td><strong>Staff Satisfaction</strong></td>
</tr>
<tr>
<td><strong>Utilisation</strong></td>
</tr>
<tr>
<td><strong>Staff Retention</strong></td>
</tr>
<tr>
<td><strong>Patient Experience</strong></td>
</tr>
<tr>
<td><strong>GP Waiting Time</strong></td>
</tr>
<tr>
<td><strong>Population Health</strong></td>
</tr>
<tr>
<td><strong>Length of Stay</strong></td>
</tr>
</tbody>
</table>
The characteristics of the PCH model and the environment that it creates enables rapid progress in addressing priorities for the local health economy

We have identified features that are important to enabling primary care transformation. These are aligned with the four characteristics that define the PCH model:

1. The PCH is developed, implemented and led by providers while being supported by commissioners

2. Providers release benefits by working at a the right level to effect change

3. The PCH model fosters collaboration throughout the system

4. Staff are activated to become the drivers of positive change
PCH and NCM models

**‘LOCAL PCH MODEL’**

- Larwood and Bawtry PCH
- Beacon PCH
- St Austell PCH

**‘CCG WIDE PCH MODEL’**

- South Cheshire and Vale Royal CCGs (Winsford PCH, Central Crewe Cluster PCH)
- Durham Dales, Easington and Sedgefield CCG (9 PCHs across three localities: Durham Dales, Easington and Sedgefield)
- North Devon CCG (Integrated care Exeter)

**‘MCP PROVIDER PCH MODEL’**

- Cannock Chase CCG (Stafford Primary Care Home, Rugeley PCH)
- Horsham and mid Sussex CCG (Horsham PCH, Burgess Hill and Villages PCH Haywards Heath PCH, Healthy East Grinstead PCH)
- Wolverhampton CCG (Wolverhampton Care Collaborative PCH, Wolverhampton Total Care PCH)
- Thanet CIC (Ramsgate PCH, Margate PCH, Quex PCH, Broadstairs PCH)
Want to know more about Primary Care Home?

Visit us at

www.napc.co.uk/primary-care-home

@NAPC_NHS #primarycarehome
Healthy East Grinstead Partnership
Healthy East Grinstead Partnership

Sussex Community
NHS Foundation Trust

Queen Victoria Hospital
NHS Foundation Trust

Horsham and Mid Sussex Clinical Commissioning Group

Moatfield Surgery

Ship Street Surgery

Crawley Down Health Centre

Judges Close Surgery

Sussex Partnership
NHS Foundation Trust

West Sussex County Council

East Grinstead & District
ageUK

H&MSVA Horsham & Mid Sussex Voluntary Action

South East Coast Ambulance Service
NHS Foundation Trust
What do people want?

• Good access to primary care,
• Keeping care local,
• Care that is well coordinated,
• Having the right information to support self-care and as much focus on wellbeing as on health.
• In addition, local people recommended expansion of the range of services based at Queen Victoria Hospital so these would be more integrated and accessible both for patients and also for family and carers.

(taken from Five Communities engagement report)
What do the GP’s want?

• Avoid contacts which are purely administrative transactions. **Develop “self-referral” models**

• **Better local focus** eg a Maternity and Child Health hub in the town.

• Address the “DN dressings” scrip issue.

• See more of **Community Team Members** who we recognise and with whom we can **develop a working relationship**.

• **Better access to specialists for advice**, support or help in managing long-term conditions – something between the acute admission and the 3-month outpatient appointment.

• Help in managing **the inexorable rise in both need and demand**.

• Make our area a **desirable place to live and work**
The Healthy East Grinstead Partnership

Aims
1) Develop **sustainable** GP and community services with **improved access** for the local population
2) Improve the care of people who need both **GP care and specialist care for long term conditions** and for those who are **frail**
3) Help people to stay well by putting into place more localised health **prevention and wellbeing** services
4) Make people's care feel more **joined up** by bringing together **most community services** under **one team** to remove fragmentation of services
Improving access to primary care

• Redesigning care pathways to free up GP capacity:
  – Self referral to musculoskeletal physiotherapy
  – Redesign of dressings pathway
  – Direct access to midwifery
    • (400 live births a year)
Self referral to musculoskeletal physiotherapy

- Good evidence from the Chartered Society of Physiotherapy regarding self referral
  - Up to 30% of GP workload could be MSK

- Previously all referrals for physiotherapy had to come from a GP
- Now patient completes referral form which also includes self management advice
- Triaged by physiotherapy team at QVH
- Patient given appointment directly by QVH

- Removes need for GP appointment for referral
- Removes admin associated with referral for GP and practice staff
Number of referrals to MSK physiotherapy
Dressings pathway redesign

• Had previously been highlighted as an issue by GPs in their practices but nothing had ever happened to progress change

• Regular meetings of HEGP Ops Group built relationships across organisations with a willingness to take on the issue

• Also developed understanding of issues in the pathway for other organisations
Dressings pathway previously

• Nurse reviewed patient and decided on appropriate dressings
• Nurse faxed request to surgery
• Surgery processed request and passed to GP to sign prescription
• GP signed and prescription was collected by either patient or community pharmacy
• Patient received dressing ready for visit from nurse
Dressings pathway previously

• GPs frustrated by pathway
  – 92% not satisfied with current system
  – 100% felt a nurse led system would be safe
  – “They are the dressings experts not us”

• Nurses reported:
  – 85% of them were spending 30 mins or more a week chasing prescriptions/dressings
  – 85% of them had waited over a week for dressings to arrive (55% more than two weeks)
New dressings pathway

• Community nurses and tissue viability nurses order stock as required from an agreed formulary

• Community pharmacy dispenses and delivers to nursing base

• Nurse takes to patient for wound dressing
Dressings redesigned

• Good for the patient
  – Dressing arrives faster
• Good for nursing teams
  – Increased autonomy
  – Could spend an hour a day sorting prescriptions as 70-80% of their work is wound management
• Good for GP and practice teams
  – Releasing 3 hours of GP time per week/surgery
  – Plus associated admin time
• Good for the health economy
  – Decreased waste
  – Increased staff efficiency
• Staff have now identified other areas that would also benefit from same approach
**Enhanced primary care team**

• Brought together our community nursing team and our proactive care team to form a MDT wrapped around GP practices

• Team currently consists of:
  – Community nurses and community matrons
  – Physiotherapist and occupational therapist
  – Community psychiatric nurse
  – Social worker (WSCC)
  – Co-ordinator

• Focused on those patients at highest risk of admission (greater than 75% risk of admission)
Targeting specific population segments

- Using our risk stratification tool (Docobo) to look at the registered populations of our four practices
Those patients at highest risk of admission

- 154 patients identified
- Case management approach by our enhanced primary care team
- Targeted interventions
- Care plans developed and shared
- Measuring emergency admissions and A&E attendances in this group to demonstrate impact
Enhanced primary care team - what next?

• Expanding the team to include other community services

• As well as focusing on those 382 patients at high risk of admission (50-74% risk) and those with rising risk of admission

• Continue to develop relationships between GP practices, the wider team and other health and prevention services
  – Fire and Rescue Service
  – Mid Sussex Wellbeing
Our PCH - what next?

• Refining our PCH dashboard to demonstrate impact
  – Looking to work with our AHSN on specific projects
• Prevention, wellbeing and self management
• Town wide on the day primary care service
• Integrated community based services for:
  – Children and young people
  – Patients with respiratory conditions
  – Our frail population
• Working with patient leaders and our voluntary sector to fully utilise our community assets and infrastructure
• Discussing town wide QIPP plans and budgets
• Share learning and roll out with other localities