national association of primary care

Healthy East Grinstead Partnership

Michelle Bull

Wed 28 June 2017

East Grinstead

- 41,500 registered population
- Population is older and more affluent than most

- History of innovation – the “guinea pig club”

- Higher levels of dementia (but that looks well managed)
- High chlamydia rates
- High Injury rates to under 5’s
- Higher respiratory deaths among the elderly

Healthy East Grinstead Partnership

Sussex Community NHS
NHS Foundation Trust

Queen Victoria Hospital NHS
NHS Foundation Trust

NHS
Horsham and Mid Sussex
Clinical Commissioning Group

Moatfield Surgery

Ship Street Surgery

Crawley Down Health Centre

Judges Close Surgery

ST CATHERINE'S HOSPICE
Care
Compassion
Understanding

Sussex Partnership NHS
NHS Foundation Trust

west sussex county council

East Grinstead & District ageUK

H&MSVA Horsham & Mid Sussex Voluntary Action

South East Coast Ambulance Service NHS
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" script 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**

HEGP Aims

Develop **sustainable** GP and community services with **improved access** for the local population

Improve the care of people who need both **GP care and specialist care for long term conditions** and for those who are **frail**

Help people to stay well by putting into place more localised health **prevention and wellbeing** services

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)

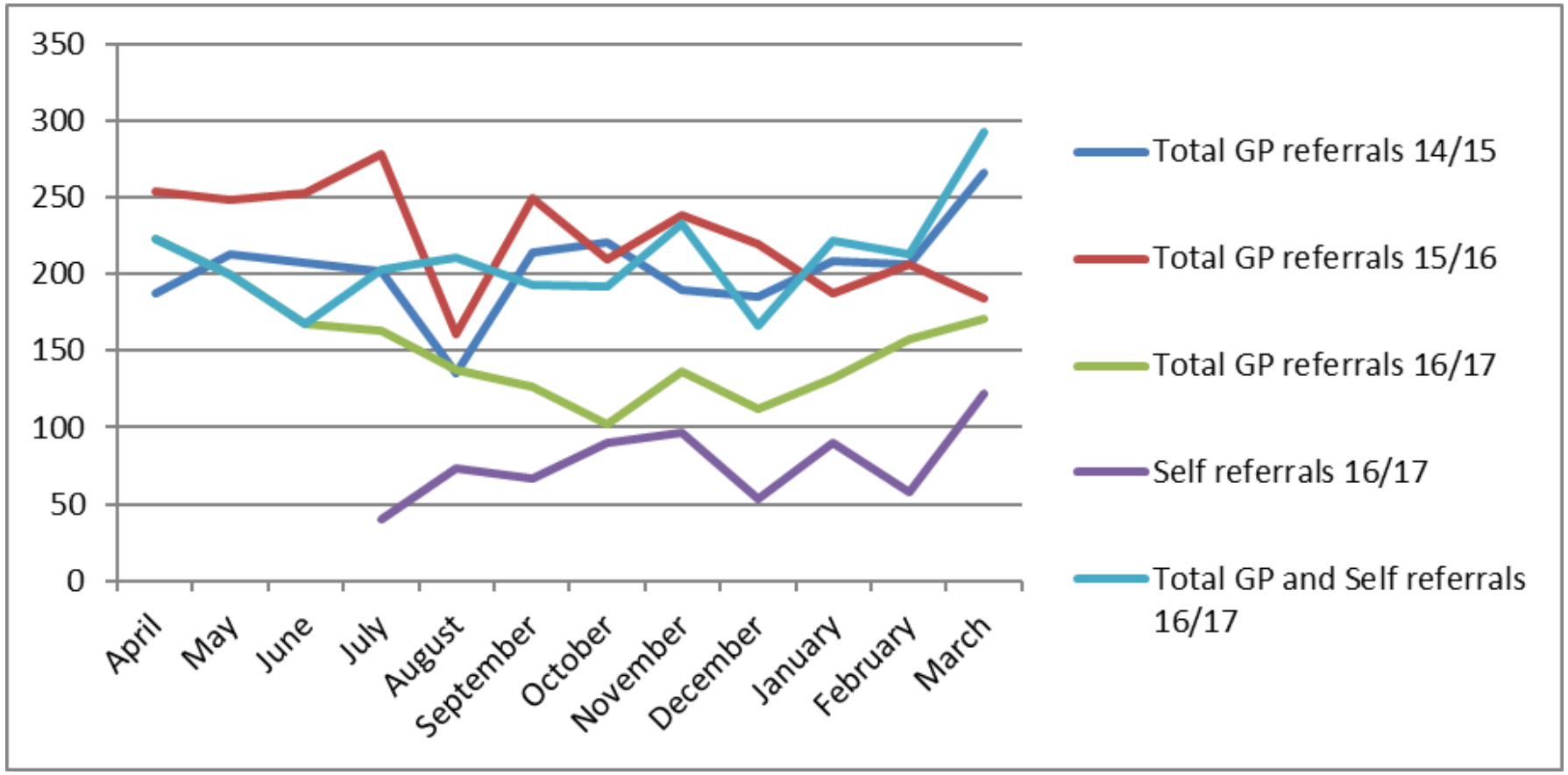
Self referral to musculoskeletal physiotherapy

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

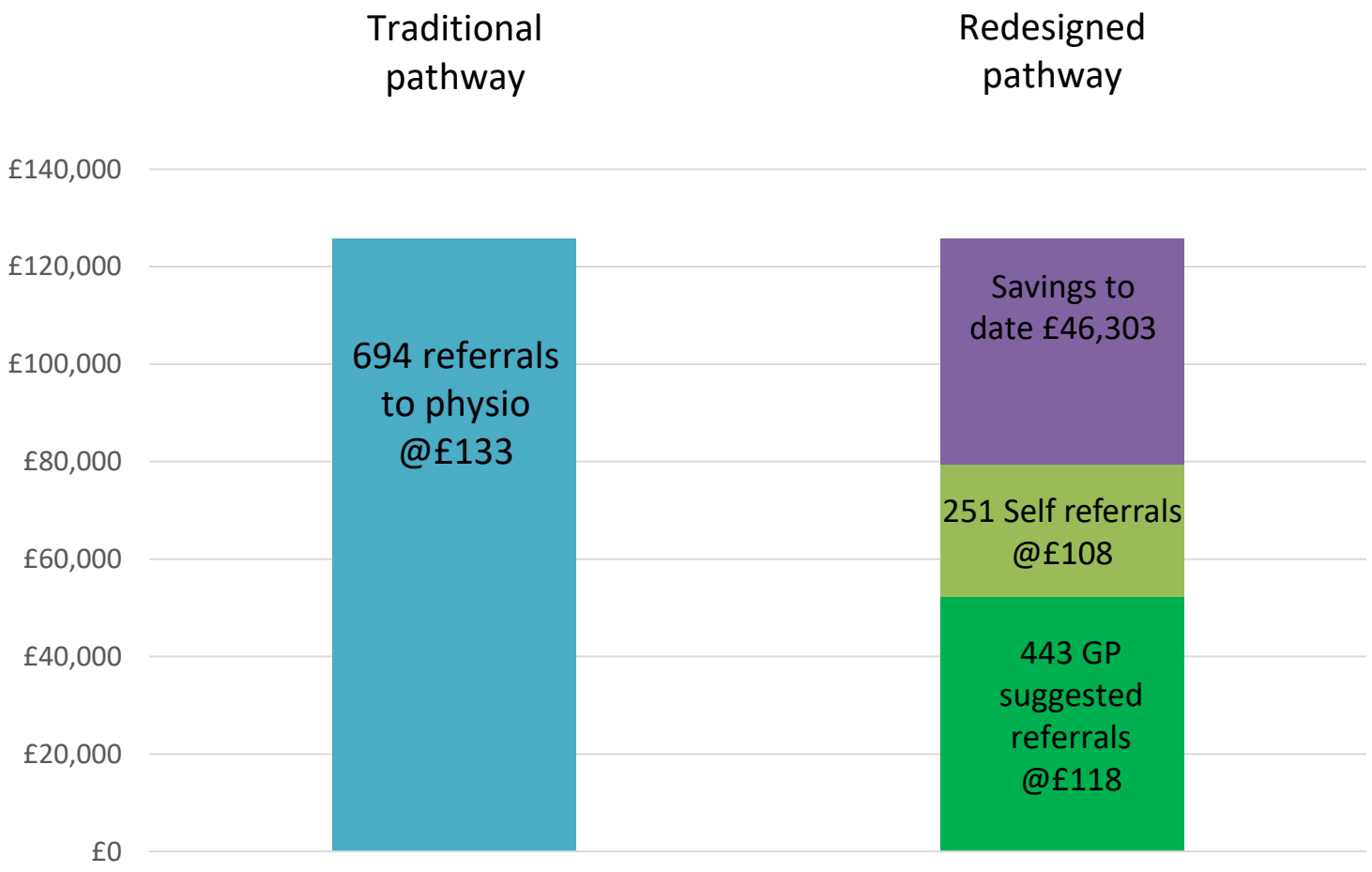
- Previously all referrals for physiotherapy had to come from a GP
- Now patient completes referral form which also includes self management advice
- Triaged by physiotherapy team at QVH
- Patient given appointment directly by QVH

- Removes need for GP appointment for referral
- Removes admin associated with referral for GP and practice staff

Number of referrals to MSK physiotherapy



Self referrals to MSK physiotherapy – Cost savings



Costs taken from the Chartered Society of Physiotherapy (2015) Physiotherapy Works for self-referral

NB where there was a self referral with no GP suggestion – this also released 251 additional appointments into primary care

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

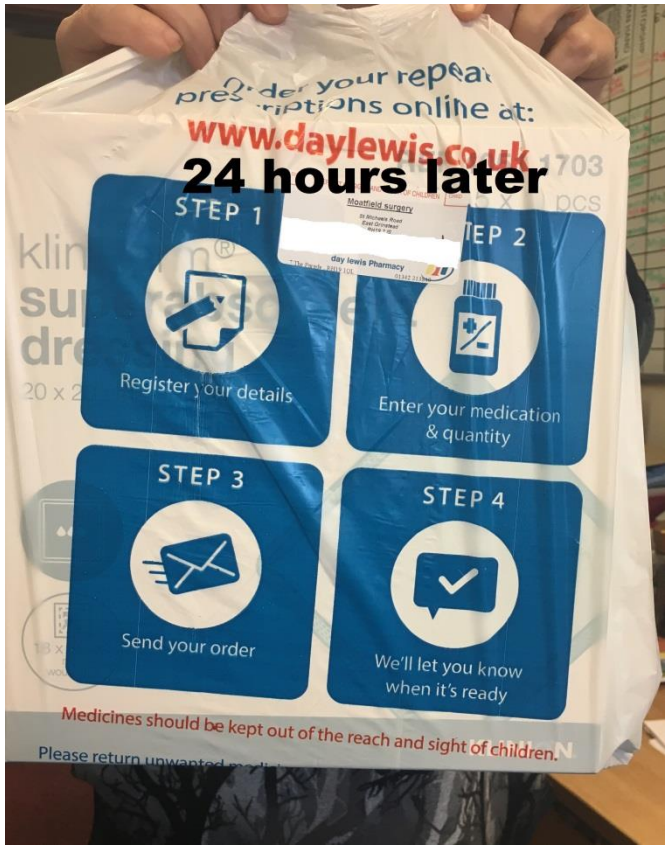
Dressings pathway previously

- 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
- Good for **GP and practice teams**
  - Releasing 3 hours of GP time per week/surgery
  - Plus associated admin time
- Good for the **health economy**
  - Increased staff efficiency (over 200 hours of nursing time back into the system so far since March)
- 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
  - Clinical lead

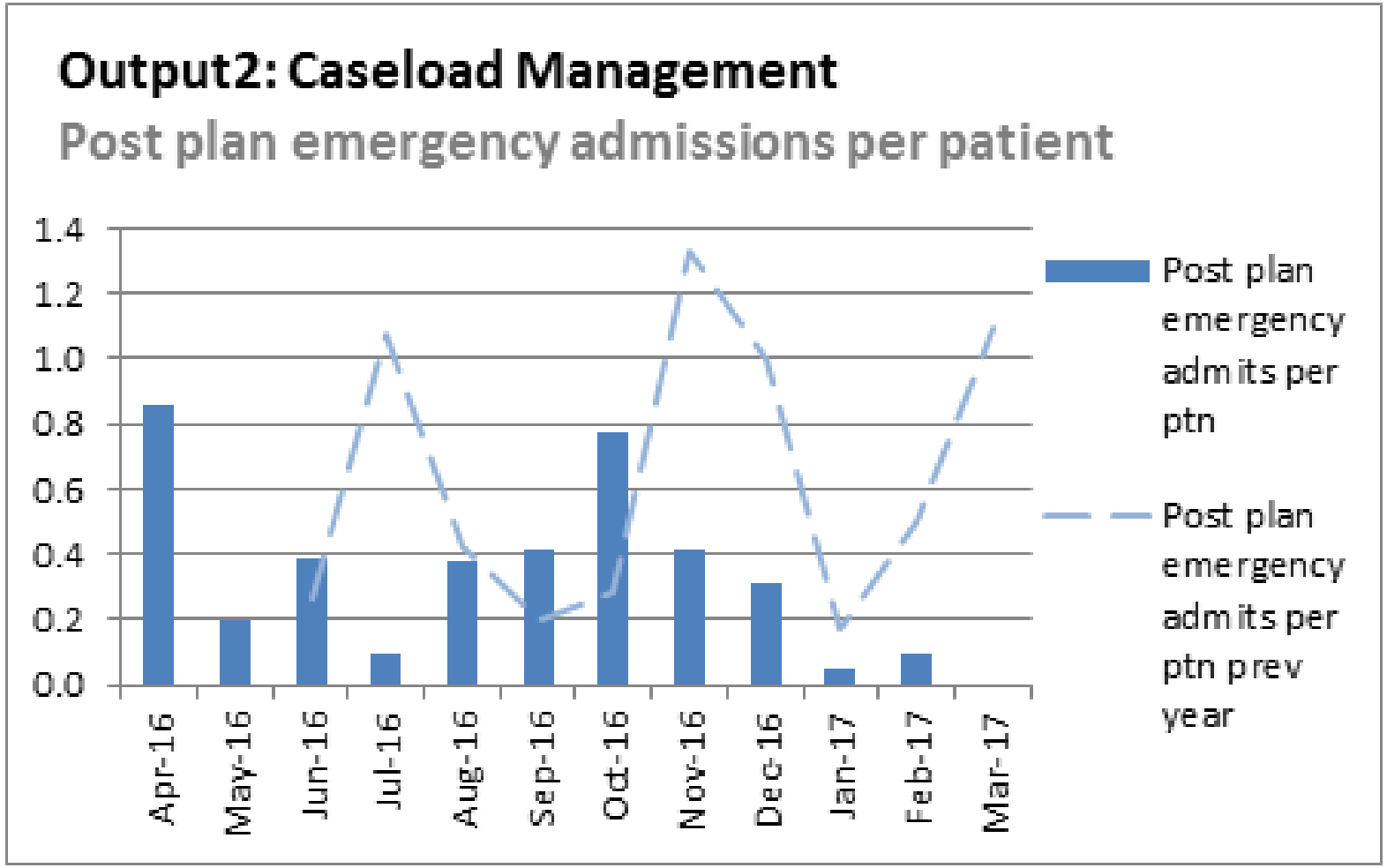
- Focused on those patients at highest risk of admission (greater than 75% risk of admission)

Targeting specific population segments

- Using our risk stratification tool (Docobo) to look at the registered populations of our four practices
- Targeted those at highest risk of admission: 154 patients
- Case management approach by our enhanced primary care team
- Targeted interventions
- Care plans developed and shared across our PCH

	Risk Category				
Measures	Lowest	Moderate	High	Very High	Total
Patients	38,173	1,335	382	154	40,044
% of population	95.3%	3.3%	1.0%	0.4%	100.0%
Total Cost	**9,564,080**	**2,714,246**	**1,092,354**	**741,378**	**14,112,058**

Those patients at highest risk of admission



Only 68 of the 154 remain in the very highest risk of admission group

Enhanced primary care team – what next?

- Expanding the team to include other community services (mental health liaison practitioners) and voluntary sector link workers
- Daily virtual huddles with GP practices
- Clinical Pharmacist focusing on those patients in nursing homes with polypharmacy
- Moving to focus on those 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?

- Prevention, wellbeing and self management
  - Health and wellbeing event in September
  - 46 dementia friends trained last week
- Town wide urgent on the day primary care service integrated with MIU
- Piloting integrated community based respiratory services for our 58 patients with COPD at high risk of admission
- Share learning and roll out with other localities
- Working with Social Finance and OptiMedis COBIC UK to investigate potential gains from a system integrator approach to population health across our PCH – working towards a unified budget

Contact details

Michelle Bull

Locality Manager

mbull@nhs.net

07798 575159

Want to know more about

Primary Care Home?

Visit us at

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

@NAPC_NHS #primarycarehome

national association of primary care