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Primary Care Home Case Study

Organisation:	South Durham Health Community Interest Company
Number of PCHs:	1
Population:	40,000
GP practices:	4
Partnership:	The PCH involves four practices, integrated care provideer (acute and community services), county council and the voluntary sector including Macmillan.
STP footprint:	Durham, Darlington, Teesside, Hambleton, Richmondshire and Whitby.

The challenge

South Durham is an area with high levels of adult male suicides and diabetes. Social deprivation, unemployment and disability claims are widespread and transport links are poor. There's been a history of high prescribing of pain relieving drugs.

What they did

To address the issue of high adult male suicides and reduce delays in accessing treatment, community psychiatric nurses (CPNs) have been based in GP practices so patients with mental health needs can be directed to them immediately. The CPNs are allocated to specific practices but can cross cover to manage peaks in demand. Chronic pain had traditionally been treated in secondary care with medication. The primary care home piloted an eight-week course in mindfulness as an alternative approach. The PCH also focused on improving self-care for patients with diabetes through the Insignia Patient Activation Measure (PAM). The measure is used to rank patients at one of four levels in terms of their knowledge, skills and confidence in managing their own health care. Patients at the lowest levels are proactively referred to services that can support them in achieving changes in their lifestyle and behaviour.

The impact

There was positive evaluation from the CPN pilot scheme and the clinical commissioning group (CCG) went on to commission a primary care mental health service across all the other practices in the CCG area. Feedback from the mindfulness course is awaited and will be shared with all practices in 2017. Building on this first PCH in Durham, "Teams Around Practices (TAP)" groups are being established, aligned to eight primary care homes in Durham Dales, Easington and Sedgefield Clinical Commissioning Group. The collective aim is to provide better outcomes for patients while reducing the pressure on the system through smarter, more cohesive working arrangements across health and social care within their communities.

Lessons learnt/success factors

The primary care home model has demonstrated how important it is for everyone to be able to see they are having a positive impact and that all staff need to feel welcomed as part of the team, even if they only spend a limited amount of time in the practice. For the new ways of working to be sustained, staff across all disciplines need to recognise that these positive changes are only possible as part of a larger organisation and could not have taken place at the individual practice level.