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Primary Care Home Case Study

Organisation:	Team BDP
Number of PCHs:	1
Population:	33,300
GP practices:	4 (with plans to form a single super-partnership)
Partnership:	East Cheshire GP practices, acute and community trusts, local ambulance service.
STP footprint:	Cheshire and Merseyside

The challenge

Team Bollington, Disley and Poyton (BDP) serves a semi-rural population across three villages with one of the oldest populations in the North West of England. There were significant variations in hospital admissions and length of stay, with lack of community coordination and social isolation regarded as major factors. Many services, particularly those for frail and diabetic patients, were uncoordinated, with little cooperation, staff support or multi-disciplinary team (MDT) leadership.

What they did

The practices teamed up with health and social care professionals from many different backgrounds to provide a truly co-ordinated service that is seamless, caring and compassionate. The PCH promotes independence, empowerment and healthy living to keep patients well and works closely with hospital services and other specialists to provide as much care within the home and local community as is safe and possible. Where needed, Team BDP provides continuity of care and named professionals to support patients. MDTs assess the most frail and complex patients, including those at risk of falling and people with long term conditions. The PCH has embraced the latest technology to promote remote working and consultation via telecare. A joint call and advice centre has been established to direct patients to the most appropriate service. There are plans to provide specialist and generalist clinics throughout the week. There will also be urgent child health and minor illness clinics 12 hours a day and an all-day advice, triage and signposting service provided by clinicians and social care professionals working together.

The impact

The practices have benefited from improved trust, confidence and cooperation. Better joined-up assessment of the most complex patients, with signposting to appropriate services, has given GPs more time to focus on people who most need them. This patient group now has lower than average rates of admission to hospital.

Lessons learnt

GPs don't like being left behind. Peer support has encouraged all other practices in Eastern Cheshire to form community hubs and consider further integration similar to multispeciality community providers (MCPs) and accountable care systems (ACSs). Forming one super-partnership will remove many of the current barriers to change.

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