NAPC | National Association of Primary Care

PCH Characteristics in Practice

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Westongrove Primary Care Home

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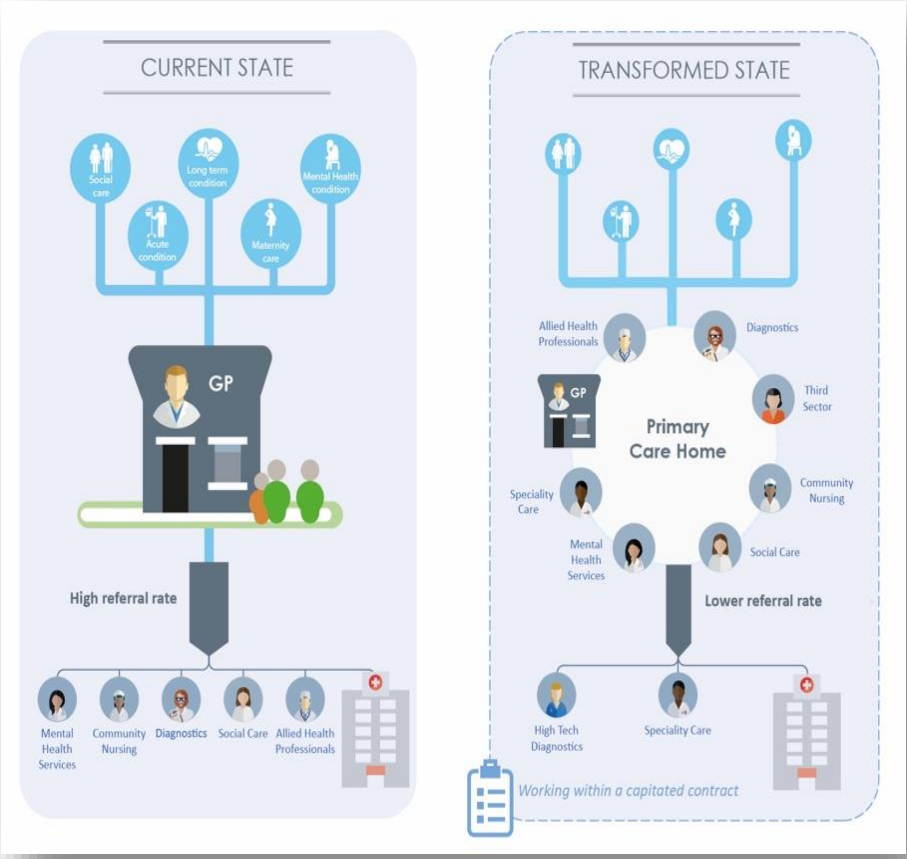
A PRIMARY CARE HOME NAPC

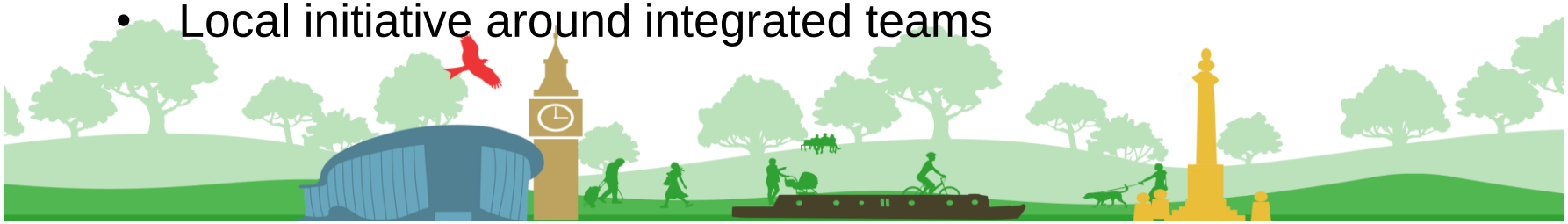
Primary Care Home Characteristics

1. The provision of care to a defined, registered population size of 30,000 to 50,000 people
2. Whole population health management approach
3. An integrated, multi-disciplinary workforce
4. Data, tools and resources aligned with the health needs of the whole population.



Westongrove Primary Care Home

- Established in 1998
- Population 28500 to 34000 in next 5 years
- Multi-disciplinary team
  - Admin/GP/PN/HCA/Dispensary/HV for elderly/Pharmacist
  - DN/HV/IAPT/Heart failure nurse/Palliative Care
  - Friends of WHC/Reservoir Walks
  - Local initiative around integrated teams



Characteristic: provision of care to a defined, registered population of 30,000 to 50,000

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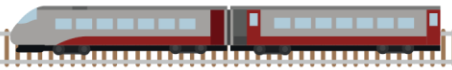
Quadruple Aim

- Improving the health of populations
- Improving the individual experience of care
- Reducing the per capita cost of care
- Improving the experience of providing care
  - Increasing joy and meaning for the workforce

Sikka et al (2015)BMJ Quality and Safety - http://qualitysafety.bmj.com/content/early/2015/06/02/bmjqs-2015-004160.full



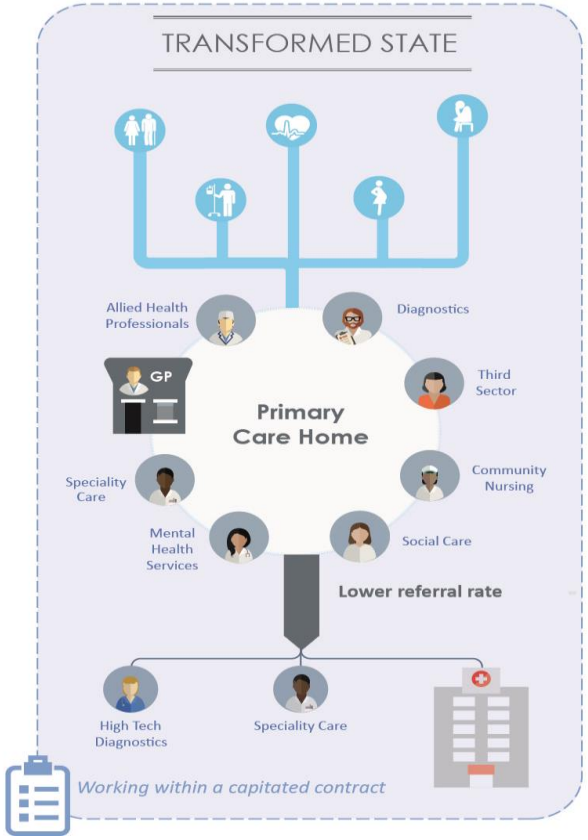
Population Health Need

- External data
- Stratifying populations
- Clinical team insight
- Patient stories & feedback
- Desired outcomes

Characteristic: focus on personalisation of care with improvements in population health outcomes

Skills matched to need

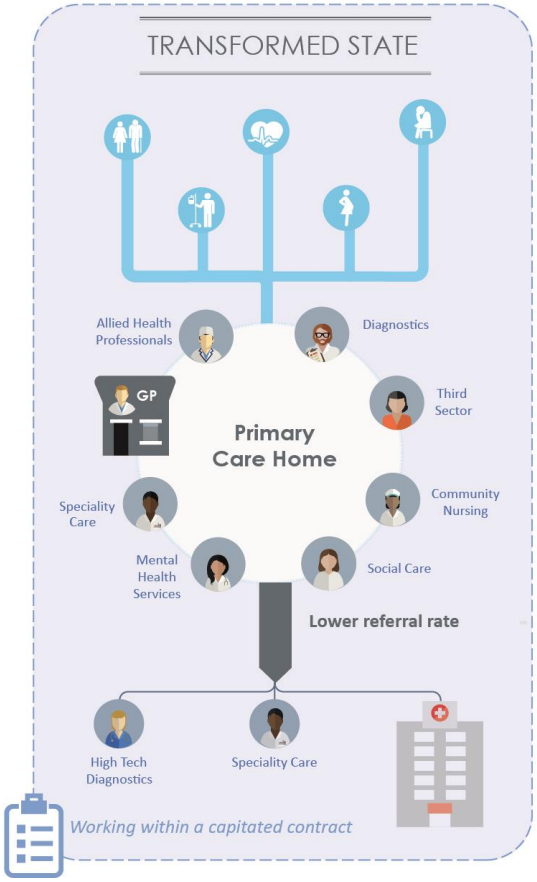
- Clinical leadership
- Nurses who
  - Work independently
  - High level clinical skills
  - Prescriber
  - Desire to learn and develop
- Admin Support
  - Communication & org skills
  - Knowledge of supporting services



Characteristic: an integrated workforce, with a strong focus on partnerships spanning health and care

Weston MDT

- Care Coordinator
- Nurse
- HCA
- Social Worker
- Dementia Alliance
- GP



Characteristic: an integrated workforce, with a strong focus on partnerships spanning health and care

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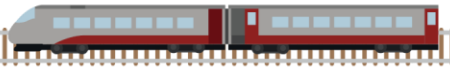
Resources

- Investment
- Social worker
- WG management time
- PHCT Support
- Dr Moreton - voluntary

Characteristic: aligned clinical & financial drivers; unified capitated budget; shared risks and rewards



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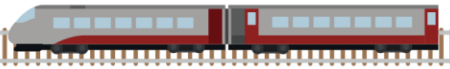
Outcomes

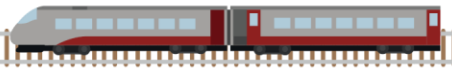
- ✓Improving the health of population
- ✓Improving the individual experience of care
- ✓Reducing the per capita cost of care
- ✓Improving the experience of providing care



PCH Learning

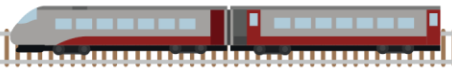
1. The provision of care to a defined, registered population size of 30,000 to 50,000 people
2. Whole population health management approach
3. An integrated, multi-disciplinary workforce
4. Data, tools and resources aligned with the health needs of the whole population.

1. Keep it manageable – focus on priority problem/opportunity and biggest gains
2. Complexity of patients more than expected – be prepared
3. Importance of clinical leadership and focus on skills
4. Use the assets around you – when you've identified them! Alignment of data and resources challenging!



Continuing our journey

- Advance Bucks Integrated Teams working
- New priorities – greater support with data
  - End of Life
  - Falls
  - Wound Management
- Workforce Development
  - Need – outcomes – care & support – skills - workforce
- Financial alignment???



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