



NAPC | National Association
of Primary Care

Primary Care Home December 2017



#primarycarehome



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Foreword

The Primary Care Home programme has gathered huge momentum since its inception in autumn 2015. From 15 original rapid test sites – we now have more than 200 sites across England, covering eight million patients – 15 per cent of the population.

Applications continue to come in – all are very welcome to join what has all the hallmarks of a social movement across integrated care. Its success, we believe, is because it is bringing about the change that clinicians know is right for their patients – something they've always wanted to do. Staff now feel empowered and excited, with the freedom to innovate and drive improvements. It is also about the human scale of the change where people feel they belong, own local challenges and can make a real difference working alongside their patients. Many have started with small changes that have led to early benefits and created a compelling case for further collaboration.

There are many more examples here of the difference primary care homes are beginning to make because of people coming together, seeking economies of scale and collaborating with others. These range from social prescribing and working with the voluntary sector and local government agencies, to more community-based specialised clinics, enhanced services for people with mental health problems and improving access. The primary care home has been endorsed in the NHS' latest delivery plan Next Steps on the NHS Five Year Forward View – a testimony to the success of sites which have already embarked on the primary care home journey. This is a journey that's joining up not only practices but all first contact providers – a true care community coming together to improve the health and wellbeing of their local population.

We look forward to supporting you and continuing that journey with you. The prize is worthwhile and the health and care systems are aligning to make our vision a reality.

John Pope CBE
Chief executive officer

Dr Nav Chana
Chairman

Dr James Kingsland OBE
President





About Primary Care Home

INTRODUCTION

Primary care home is an innovative approach to strengthening and redesigning primary care.

Developed by the NAPC, the model brings together a range of health and social care professionals to work together to provide enhanced personalised and preventative care for their local community.

Staff come together as a complete care community – drawn from GP surgeries, community, mental health and acute trusts, social care and the voluntary sector – to focus on local population needs and provide care closer to patients' homes.

Primary care home shares some of the features of the multispecialty community provider (MCP) – but it has four characteristics which form its distinctive identity. Its focus is on a smaller population enabling primary care transformation to happen at a fast pace, either on its own or as a foundation for larger models.

RAPID EXPANSION

NHS England Chief Executive Simon Stevens launched the primary care home programme in the autumn of 2015, with rapid test sites selected in December 2015.

Since then the programme has rapidly expanded – in 2016 more than 70 sites joined and this year in excess of 100 sites have successfully applied, bringing the

More than 200 sites
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total number of primary care home sites to 204 across England, serving eight million patients, 15 per cent of the population. Applications continue to come in.

All the sites are developing and testing the model as part of a community of practice.

PRIMARY CARE HOME PART OF LATEST NHS REFORMS

The primary care home model is featured in the Next Steps on the NHS Five Year Forward View and part of the practical delivery plans to transform primary care over the next two years to provide high quality services for patients and staff. Practices are encouraged to work together serving a combined patient population of between 30,000 – 50,000. This is the size that the NAPC believes is right – the right size for developing highly effective, unified, multi-professional teams – the right size to care – the right size to scale

and the right size to ultimately take budgetary responsibility together.

KEY FEATURES

There are four key characteristics that make up a primary care home:

- a combined focus on personalisation of care with improvements in population health outcomes
- an integrated workforce, with a strong focus on partnerships spanning primary, secondary and social care
- aligned clinical and financial drivers through a unified, capitated budget with appropriate shared risks and rewards
- provision of care to a defined, registered population of between 30,000 and 50,000.



STAGES OF PRIMARY CARE HOME

The development of a primary care home is a journey which begins with practices and other first contact care providers coming together, forming relationships and developing a sense of belonging among patients and staff.

The adoption of a whole population health management approach is critical to its success. This is a proactive approach to managing the health and well-being of a population. It incorporates the total care needs,

costs and outcomes of the population. A unified team is then built around the health needs of the population. Staff are given the freedom to act, encouraging innovation, improving staff satisfaction and in turn recruitment and retention.

Health is determined by a complex interaction between individual characteristics, lifestyle and the physical, social and economic environment. These broader determinants of health are considered more important than health care in ensuring a healthy population and need to be built into a PCH plan.



Staff are given the freedom to act



NAPC defines effective primary care as:

- A person's first point of contact with the health and social care system
- A person-centred (holistic) approach, rather than disease focused, to continuous lifetime care
- A comprehensive set of services, delivered by multi-professional teams, with a focus on population health needs
- The co-ordination and integration of care in partnership with patients and providers.



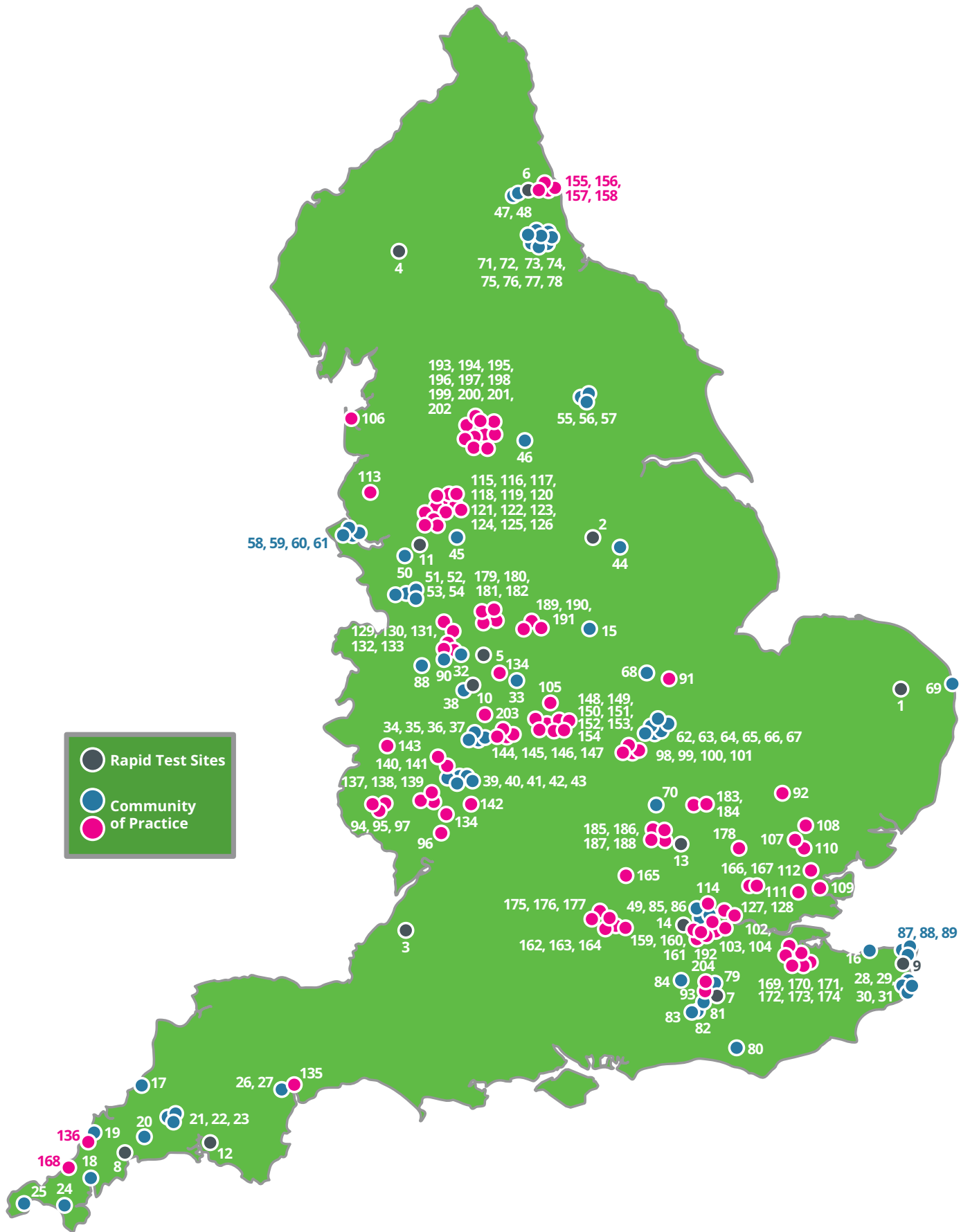
Rapid Test Sites

- 1 The Breckland Alliance
- 2 Larwood and Bawtry
- 3 South Bristol Primary Care Collaborative
- 4 Eden
- 5 Aspire Integrated Rugeley (AIR)
- 6 South Durham Health Community Interest Company (CIC)
- 7 The Healthy East Grinstead Partnership
- 8 St. Austell Healthcare
- 9 Thanet Health Community Interest Company (CIC)
- 10 Wolverhampton Total Health
- 11 Team Winsford
- 12 Beacon Medical Group
- 13 Luton Primary Care Cluster
- 14 Richmond

Community of Practice

- 15 Nottingham North and East Community Alliance
- 16 Heme Bay Health Care
- 17 North Cornwall
- 18 Truro Health Park (THP)
- 19 Perranporth and Penryn
- 20 Three Harbours Medical Group
- 21 22 23 East Cornwall Locality
- 24 South Kerrier Locality
- 25 Penwith
- 26 27 Integrated Care Exeter
- 28 29 30 31 South Kent Coast Integrated Accountable Care
- 32 Stafford Primary Care Alliance
- 33 Lichfield / Burntwood Network Partnership
- 34 35 36 37 Redditch and Bromsgrove Alliance
- 38 Wolverhampton Care Collaborative
- 39 40 41 42 43 Wyre Forest Alliance
- 44 Riverside Health Centre
- 45 Team BDP
- 46 OneLeeds
- 47 48 Derwentside Healthcare
- 49 Hammersmith and Fulham Partners
- 50 51 52 53 54 South Cheshire and Vale Royal Care Communities
- 55 56 57 Nimbus Care
- 58 59 60 61 Wirral GP Provider Federation
- 62 63 64 65 66 67 3Sixty Care
- 68 Rutland Healthcare
- 69 East Norfolk Medical Practice
- 70 Newport Pagnell Medical Centre and NPMC@Willen
- 71 72 73 74 75 76 77 78 Durham Dales, Easington and Sedgfield
- 79 Redhill and Merstham
- 80 Lewes Health Hub
- 81 Horsham
- 82 Burgess Hill and Villages
- 83 Haywards Heath
- 84 Dorking
- 85 South Camden Primary Care Neighbourhood
- 86 Hampstead Primary Care Neighbourhood
- 87 88 89 Ramsgate, Quex and Broadstairs
- 90 Newport District Neighbourhood Project
- 91 Lakeside Stamford
- 92 Granta and Shelford
- 93 Reigate and Horley Practice Network
- 94 95 96 97 Herefordshire Integrated Care Alliance
- 98 99 100 101 GP Alliance (Northampton)
- 102 103 104 Central Health Evolution
- 105 Millennium Federation
- 106 Fleetwood
- 107 108 109 110 111 112 Mid Essex
- 113 North West Health Alliance
- 114 Kentish Town
- 115 116 117 118 Manchester (Central)
- 119 120 121 122 Manchester (North)
- 123 124 125 126 Manchester (South)
- 127 128 Newham
- 129 130 131 132 133 134 South Staffordshire and Surrounds
- 135 Exeter Primary Care
- 136 Newquay and Petroc
- 137 138 139 140 141 142 143 South Worcestershire Alliance
- 144 145 146 147 148 149 150 151 152 153 154 Warwick North, Coventry and Rugby
- 155 156 157 158 North West North Tyneside
- 159 160 161 Surbiton, Chessington and Kingston
- 162 163 164 Wokingham North, West and East Clusters
- 165 Westongrove Partnership
- 166 167 Lower Lea Valley
- 168 North Kerrier Locality
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- 179 180 181 182 East Cheshire
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Rapid Test Sites



1

The Breckland Alliance

NO. OF PCHs: 1

NO. OF PRACTICES: 3

STP AREA:

Norfolk and Waveney

OVERVIEW

The Breckland Alliance has seen three GP practices in two small towns within a deprived, relatively isolated community come together to provide mutual support in an area which has struggled to recruit and retain GPs as well as cope with demand. The vision was to collaborate to develop a sustainable primary care service for their population ensuring the most challenged practice remained open and offer improved services closer to patients' homes where possible.

HOW THINGS ARE CHANGING

Shortly after creating a primary care home and a new structure, one of the alliance's practices hit a crisis. The response was to put a funding proposal to NHS England to stabilise the Watton Medical Practice. The practice had been forced previously to redefine its geographical boundaries and was in danger of closing. The PCH enabled the practices to support each other and plan for the delivery of primary care at scale.

Patients still have a surgery in Watton which would have otherwise closed. Staff are now collaborating and working across all three sites. Partners from the two Thetford practices have been covering clinical and

management sessions at the Watton practice to help stabilise it. A clinical board has been established to oversee its working, involving partners from all three practices. A clinical nurse manager works across the three sites and is working towards building one cohesive team across the PCH. To measure the impact, the primary care home is tracking patient satisfaction at Watton, which was previously very low, and the use of locums.

In the future, the alliance will enable the surgeries to invest in staff, improve back office services such as finance and IT and develop new services for patients. These are likely to include bringing hospital-based clinics into the

community, so reducing travelling time for members of the public, as well as developing health and wellbeing services to stop people becoming unwell in the first place. A focus is likely to be on the large number of elderly care homes in the area. It is hoped that more proactive care and routine medication reviews for residents will be delivered in the homes to improve health and wellbeing and optimise prescribing.

Lessons learnt have included the need to break down a culture of each practice working in isolation and make them more open to collaboration.

PARTNERS

Three GP practices, South Norfolk Clinical Commissioning Group, Norfolk and Suffolk NHS Foundation Trust, Norfolk and Norwich University Hospital NHS Foundation Trust, West Suffolk Hospitals NHS Foundation Trust, West Suffolk Clinical Commissioning Group, Norfolk Community Health and Care Trust, other local community providers and social services.



2 Larwood and Bawtry

NO. OF PCHs: 1
NO. OF PRACTICES: 2
STP AREA:
 South Yorkshire and
 Bassetlaw

OVERVIEW

Larwood and Bawtry Primary Care Home covers several villages in Nottinghamshire and South Yorkshire, some of which have high levels of deprivation and disease. Two practices wanted to build a new primary care team to care for their local populations and work in partnership with other organisations to ensure services improved and remained sustainable. The primary care home is improving the way the practices work together and bringing in new partners to improve services to

patients. It has three aims: to improve staff support and wellbeing so they can cope and stay well doing an increasingly difficult job, improve patient outcomes particularly by identifying issues before they become acute and find increasingly efficient ways of working.

HOW THINGS ARE CHANGING

The two GP surgeries have created integrated teams co-locating community and voluntary services in the practices. Community matrons and community nurses work with practice nurses in integrated neighbourhood teams. The practices provide administrative support to the community service staff, resulting in better exchange of information between GPs, practice nurses and the community teams.

Community advisors funded by the voluntary sector now work from the surgeries, running citizens advice clinics signposting patients to voluntary and non-medical services in the area. They provide a vital link to

services that can address some of the underlying causes of anxiety and depression including debt and unemployment. Close working with the district council has led to improved support in care homes and for people with housing needs. Social care clinics are held on site enabling patients to receive quicker needs assessments.

There's been a 5 per cent reduction in prescribing costs following the appointment of an in-house practice pharmacist who carried out medicine reviews for care home residents. Analysis over a seven-month period found a significant reduction in prescribing costs and projected

£229,000 annual savings, as well as reducing the risk of side-effects for patients. Emergency admissions dropped by 8 per cent over the same period with the clinical commissioning group estimating savings of £277,000.

Staff are working together better and find work more fulfilling (87 per cent of staff surveyed felt the PCH way of working had improved job satisfaction). Patient care has improved with better information among staff and care plans integrated across services.

Lessons learnt have included the need to engage staff and have a 'do and build' attitude.

PARTNERS

Two GP practices, Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust, Nottinghamshire Healthcare NHS Foundation Trust (community and mental health services provider), Nottinghamshire County Council (social services), Bassetlaw District Council, Bassetlaw Community and Voluntary Service and Bassetlaw Clinical Commissioning Group (CCG).



3

South Bristol Primary Care Collaborative

NO. OF PCHs: 1

NO. OF PRACTICES: 6

STP AREA:

Bristol, North Somerset and South Gloucestershire

OVERVIEW

Six practices in a deprived part of Bristol have come together with the city's community health services provider, Bristol Community Health, to develop new services to improve the health of the population. The area is one of the most deprived in the country, with high levels of health inequalities and disease.

The practices were concerned that on their own they would no longer be sustainable and wanted to collaborate to deliver

primary care differently. Becoming a primary care home gave them an opportunity to move away from struggling on their own and do things differently - together and with new partners. The vision is to create a multi-specialist team providing primary care services for their population, where the patient gets the right treatment at the right time. The primary care home is run by an executive committee with a memorandum of understanding between the six practices and Bristol Community Health. It has close links with the Bristol Clinical Commissioning Group and the public health department of Bristol City Council.

HOW THINGS ARE CHANGING

The collaborative has developed teams of nurses and paramedics who provide a rapid response to urgent calls for home visits from the frail elderly. Previously, GPs could only make home visits in the afternoon when it was often too late to intervene usefully with new medication, care arrangements or assessment at hospital. Now the teams attend quickly, early in the day, and make new arrangements for prescriptions, nursing, social support or hospital assessment. This means people who are frail, housebound and acutely unwell get appropriate care sooner. Doctors brief the practitioners before

the visit and there is a debrief with a doctor afterwards. The practitioners (two nurses and two paramedics), employed by Bristol Community Health, are funded by the Better Care Fund and the clinical commissioning group but their clinical workload is allocated by the practices, crossing cultural and organisational boundaries.

Integrated community dressing clinics have also been developed. Instead of patients going to see a GP or nurse for a wound dressing, or requiring a home visit from a district nurse, an offsite wound dressing clinic has been set up, once a week, in a local community

centre, in a semi-social setting. Bristol Ageing Better provides transport. This means people have a social as well as clinical experience, which reduces their isolation and improves their mental wellbeing. There is a large and active patient participation group with a patient champion who are engaged and helping to define the development of new services.

Lessons learnt have included the time it takes to build trust and relationships and the need to challenge a culture of 'silos' where people naturally focus on their own businesses. Challenges continue to be limited funding.

PARTNERS

Bristol Clinical Commissioning Group (CCG), Bristol City Council (BCC) and the Better Care Bristol Vision Governance Structure, Brisdoc (the GP out of hours service,) University Hospitals Bristol NHS Foundation Trust.



4 Eden

NO. OF PCHs: 1
NO. OF PRACTICES: 4
STP AREA:
 West, North and East
 Cumbria

OVERVIEW

The Eden Primary Care Home was created by local GPs from four practices struggling to recruit staff and sustain services who wanted to change the way they work to improve services for their isolated and older population in Cumbria. Developing a primary care home was seen as a way of creating sustainable, integrated services which better met the needs of the population and made their organisations more viable.

Their vision is to provide better care for patients, through an integrated service which avoids many different visits from different service providers and brings care closer to home avoiding the need for patients to travel miles to hospitals in Whitehaven, Carlisle and Penrith.

HOW THINGS ARE CHANGING

The primary care home has led to more integrated working between GP practices, and between district and practice nurses. It has enabled a number of specific projects including the introduction of new non-clinical services to meet patients needs and reduce the demand on GPs. Small local changes have been able to happen quickly while large scale plans as part of the Cumbria Success Regime and developing a Cumbria-wide integrated care community have been worked on.

Among the new services introduced has been Listening Ear, which provides confidential listening to people's problems and signposting to services which can address social and physical

isolation, ranging from coffee mornings to mindfulness classes, dancing and Tai Chi. This has eased the pressure on GPs from patients who have social rather than clinical needs. Dressing clinics have been moved out of surgeries into the community, for example, to village halls and churches to make them more sociable events where isolated people can socialise. The council's public health department has also employed health and wellbeing coaches to try to prevent childhood obesity and reduce the burden on health services.

Other projects include a review of patients receiving vitamin B12 injections, this found that only 20 of 66 people

receiving them needed to, reducing appointments and district nurse visits. For patients with chronic obstructive pulmonary disease (COPD), the primary care home is moving services into the community so people will no longer need to travel to Carlisle. The PCH has introduced new technology to enable self monitoring of blood clotting for people with chronic disease, putting them in charge of their care and reducing the need for district nurses to visit.

Lessons learnt include that it has been hard to take forward all the desired changes while wide-ranging reforms to the organisation of services are underway.

PARTNERS

Cumbria Clinical Commissioning Group, North Cumbria University Hospitals NHS Trust, Cumbria Partnership Foundation Trust, Cumbria County Council (social services and public health), Cumbria Council for Voluntary Service, and the Bishop of Cumbria.



5

Aspire Integrated Rugeley (AIR)

NO. OF PCHs: 1

NO. OF PRACTICES: 4

STP AREA:

Staffordshire

OVERVIEW

Rugeley is an old mining town which has a population with a higher than average prevalence of long-term conditions. There is a lot of respiratory disease in adults who worked in the mines and a fair amount of health inequality locally. Two of the four GP practices used to be one large practice and are now working together again as part of the primary care home. The vision is for out-of-hospital care to be delivered locally to avoid unnecessary hospital admissions, to improve whole population

health outcomes of the local community across all age groups and have a proactive, health and wellbeing agenda.

HOW THINGS ARE CHANGING

To cope with rising demand for urgent care, the primary care home has set up an overflow same-day appointment clinic with each of the four practices taking it in turns to host the afternoon clinics. As well as GPs, patients are being seen by advanced nurse practitioners, urgent care practitioners and physician associates. A community-based dressing clinic has been started to integrate community nurses into primary care and treat patients in a social setting where they meet others and receive falls prevention advice.

There is now a redesigned service with the community trust to support patients in a large care home, which had a historically high demand for GP

visits. Under the new pathway, there is leadership support for care home managers and the home contacts an advanced nurse practitioner initially to discuss any concerns. The nurse practitioner then pulls in additional support when needed. Early indications are that this is working well and requests are falling.

Patients with long-term stable conditions are being supported with telehealth. Teams of experts from hospital, community and primary care offer clinics to patients in surgeries. This expert approach has been shown to work with 19 out of 20 patients with respiratory conditions who would have normally required admission.

The primary care home is working with the acute hospital on a whole population health programme involving schools, universities, Tesco and other big employers. The programme aims to raise awareness of health and care careers and become ambassadors and promoters of a healthy body and mind.

Lessons learnt include that the primary care home seems to resonate with GPs, working as a bigger team and giving them a degree of resilience makes it feel like it will work. It is hoped it will lead to better patient outcomes, improved health for the local population and a reduction of stress and overwork for GPs.

PARTNERS

Four GP practices (Aelfgar Surgery, Brereton Surgery, Horsefear Practice and Sandy Lane Surgery), GP First Federation, Staffordshire and Stoke-on-Trent Partnership NHS Trust, Cannock Chase Clinical Commissioning Group, University Hospitals of North Midlands NHS Trust and patient representative.



6

South Durham Health Community Interest Company (CIC)

NO. OF PCHs: 1

NO. OF PRACTICES: 4

STP AREA:

Durham, Darlington, Teesside, Hambleton, Richmondshire and Whitby

OVERVIEW

Four practices have united with several providers around a new vision of care and are pioneering innovative new services for people with mental health, chronic pain and long term conditions. South Durham has high levels of unemployment, deprivation, mental illness and chronic disease. The primary care home offered a flexible model for the three large practices in Newton Aycliffe and a smaller practice in Shildon to collaborate with other partners to improve services and to work together better.

HOW THINGS ARE CHANGING

To address the high levels of adult male suicides and reduce the delays in accessing treatment, community psychiatric nurses (CPNs) are based in GP practices so patients with mental health needs can be directed to them immediately. Co-operation between the three Newton Aycliffe practices has meant the CPNs are treated as a shared resource and patients can be referred to whichever practice's CPN can see them first. Shildon was the first to pilot CPNs being based at the surgery, this was then rolled out to the other practices (and across the clinical commissioning group) following positive evaluation. The move has

generated positive feedback from patients and GPs.

Chronic pain had traditionally been treated in secondary care with medication. The primary care home has piloted an eight week course in mindfulness at its Shildon practice which is now being rolled out across the other practices.

The PCH has focussed 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 of activation of care, patients at the

lowest levels are being proactively referred to services that can support patients achieving lifestyle and behaviour change. Following a programme of tailored support, patients will be reassessed for a change in their activation measures. It is planned to incorporate the measure into patient annual reviews.

Lessons learnt include the need for everyone to be able to see they are having a positive impact. Staff need to feel welcomed as part of the practice team even if they only spend a limited amount of time there.

PARTNERS

Four practices, County Durham and Darlington NHS Foundation Trust (acute and community services), Durham County Council, Macmillan and other voluntary sector organisations.



7

The Healthy East Grinstead Partnership

NO. OF PCHs: 1

NO. OF PRACTICES: 4

STP AREA:

Sussex and East Surrey

OVERVIEW

The primary care home was established to improve the health of the population of East Grinstead and deliver a high quality local model of health and social care that is sustainable for future generations and works for children, families, people with increasing health needs and our older population. The town's four GP practices had been struggling to recruit and cope with demand treating a population that was living longer with long-term conditions. They wanted to build on the strength of

general practice. The PCH's objectives are to enhance primary care, improve access and bring specialist care to the community.

HOW THINGS ARE CHANGING

The biggest initiative has been to merge the community nursing team and an existing multidisciplinary proactive care team (consisting of occupational therapists, physiotherapists, community psychiatric nurses, community matrons, and social workers) to create an enhanced primary care team to focus on patients at highest risk of admission to hospital and to provide care to stop unnecessary admissions. Patients are receiving more joined up care and are less likely to be admitted to hospital.

GPs are no longer involved in activities

where they were adding no value, freeing them up for other work and improving access. These include the referral of pregnant women to midwife services (self-referral introduced), referral of people with musculoskeletal needs to a physiotherapist (self-referral introduced) and prescribing wound dressings (community nurses now order these online).

Care co-ordinators have been introduced at all four practices to signpost patients to non-clinical services they may need, ranging from food banks to social clubs. An additional urgent, on-the-day primary

care service is being developed across all four and the PCH is working closely with the Fire Service to ensure housebound patients at risk of falls have their social and medical needs identified.

Lessons learnt include that the PCH needs a collaborative mindset from all organisations and a lot of one-to-one engagement. Buy-in comes from explaining specific changes and benefits to individuals and teams.

PARTNERS

Four GP practices, Horsham and Mid-Sussex Clinical Commissioning Group, Queen Victoria Hospital NHS Foundation Trust, Sussex Community NHS Foundation Trust, Sussex Partnership NHS Foundation Trust, East Grinstead Town Council, West Sussex County Council, South East Coast Ambulance NHS Trust, Age UK East Grinstead and District, St Catherine's Hospice, Horsham and Mid-Sussex Voluntary Action, West Sussex Fire and Rescue Service.



8

St Austell Healthcare

NO. OF PCHs: 1

NO. OF PRACTICES: 1

STP AREA:

Cornwall and the Isles of Scilly

OVERVIEW

St Austell has high levels of long-term unemployment and socio-economic deprivation as well as a high prevalence of chronic disease and obesity. The primary care home model offered a framework for one large practice to redesign services and offer new ones in partnership with a wide range of statutory and voluntary sector organisations. Its vision is to provide sustainable services to its patients, meeting unmet needs and enabling people to access non-clinical solutions.

HOW THINGS ARE CHANGING

The primary care home has established integrated, multidisciplinary teams and opened up access to many non-clinical activities which can address the wider determinants of ill-health. It has focussed on three key workstreams: social prescribing, integration of health and social care and workforce development. The result is better and new services, less duplication and more skills development for staff.

Many of the practice's patients are the frail elderly who are physically inactive, often socially isolated and lonely. Poverty and unemployment are also major challenges. The practice engaged with community providers, employing a social prescribing facilitator who sees patients and refers them to resources

ranging from walking groups to Zumba, pilates classes and a canoe club, to increase their physical activity, improve their diet and reduce isolation. The pilot resulted in 52 out of 150 patients completing 12 weeks of the programme, of those 94% saw an increase in their wellbeing score and 62% had lost weight.

An integration manager role has been created to improve hospital discharges, the treatment of complex patients and palliative care. Home visits are being managed better and duplication has been reduced. GPs had been making 30 home visits a day but many patients were also being visited by district nurses, community matrons and the mental health team. Community nurses

and district nurses have also been co-located at the practice's acute hub which sees urgent same-day cases.

The PCH has concentrated on skills development for staff and diversifying the multidisciplinary team. A pharmacist is part of the practice team carrying out medication reviews. There is a nurse-led minor illness team, with the team internally trained and an acute visiting service using emergency care practitioners.

Lessons learnt: It takes time to build the relationships between organisations needed to make this work. Time to lead is essential.

PARTNERS

Kernow Clinical Commissioning Group, Cornwall Partnership Foundation NHS Trust (community and mental health trust), Cornwall County Council, St Austell Town Council, the Eden Project, Public Health England, Age UK, Pentreath (a mental health charity) and some big local employers including St Austell Brewery.



9

Thanet Health Community Interest Company (CIC)

NO. OF PCHs: 1 (plus 3 in COP, see nos. 89-91)

NO. OF PRACTICES: 3

STP AREA:

Kent and Medway

OVERVIEW

Demand for health services has historically been high in Thanet with an elderly population and deep pockets of deprivation. Forty per cent of the population is over 60 and many are frail in their 50s. At the same time, primary care has faced recruitment problems, with GP practices closing and those surviving struggling to cope with huge pressures on existing staff. With better prevention, there were indications that cardiovascular, respiratory disease and cancer could be diagnosed sooner.

HOW THINGS ARE CHANGING

There was a collective realisation that the status quo was unsustainable for patients and staff. Health and social care organisations realised that they needed to come together to pool resources on a voluntary basis to start building an integrated, accountable care organisation to improve care for frail elderly people and reduce demand. An integrated nursing team was established to provide an enhanced frailty pathway and an acute response team created to provide a range of treatment and personal care support to keep people out of hospital.

The team comprising a GP, nurses, health care assistants, physiotherapist, occupational therapist, voluntary care,

care agency work closely with social services. They assess patients and put a package of care in place to enable them to remain at home or be discharged. Health and social care coordinators were also brought in to GP surgeries to provide non-clinical support to patients and GP surgery hours extended to include weekends and Bank Holidays.

The frail elderly are receiving better care out of hospital and being admitted to hospital less frequently. Over a 10-week trial period in 2016/17, non-elective admissions fell by 155 compared to the same period last year, suggesting potential annual savings of almost £300,000.

Medication reviews have also brought down prescribing costs.

Factors contributing to its early success have been the commitment and buy-in from all organisations involved, effective staff engagement, commitment and leadership from the clinical commissioning group. Continuing funding of initiatives or an adequate capitated unified budget for the PCH will make it stick.

PARTNERS

Four practices, Kent Community Hospital Foundation Trust, East Kent Hospitals University Foundation Trust, Kent County Council (social care), Kent and Medway Partnership Trust (mental health), Ageless Thanet, voluntary sector organisations including Age UK and Crossroads, Local Pharmaceutical Committee, Local Dental Committee, Local Ophthalmic Committee, Thanet Hospice, South East Coast Ambulance Service.



10 Wolverhampton Total Health

NO. OF PCHs: 1 RTS,
2 PCHs – (see no. 38)

NO. OF PRACTICES: 8

STP AREA:
The Black Country

OVERVIEW

The primary care home has helped to stabilise and unite a group of eight GP practices struggling to deliver services in an area of high need, and develop new services focussing on the frail elderly, access and diabetics. Small GP practices were struggling with severe health inequalities together with an uneven distribution of frail elderly and diabetic populations which skewed demand. They were struggling to recruit staff and lacked the scale to bid for additional funding. It was clear

that greater integration was needed to create a sustainable basis for providing specialist multidisciplinary care which in turn would reduce demand on health and care services.

HOW THINGS ARE CHANGING

An integrated multidisciplinary team has been created to run severe frailty clinics focussing on care and prevention for the frail elderly. The team consists of a health care assistant and a senior clinical pharmacist. Each patient has a complete geriatric assessment covering mobility, exercise, hearing, vision, incontinence, medication review and lying and standing blood pressure (a good predictor of falls risk). The PCH has also linked up with the Fire Service who make 'safe and well' visits to people who have recently fallen.

A virtual diabetic clinic and an insulin initiation service have been launched, with support from pharmaceutical

companies, to speed up increased medication for poorly controlled diabetics and reduce the need to refer into the hospital clinics. Run by a specialist diabetic nurse and GP, the clinic offers advice while practitioners see patients in their surgeries.

The scale of the PCH has enabled it to bid for funds for additional services which individual surgeries were too small to bid for. Winter pressure money has been used to run additional surgeries over the Christmas bank holidays and Saturday mornings. These are held with the second primary care home in Wolverhampton with three practices acting as hubs in the city to cater for their combined 100,000 patients.

The EMIS IT systems from all practices have linked up enabling the hubs to access a patient's full records provided they give consent.

The PCH has been involved in running several pilots to help the clinical commissioning group (CCG) look at new services. In-house counsellors have been introduced following a bid for additional CCG money and social prescribing clinics funded by the city council. Both have proved successful.

Lessons learnt include that establishing a PCH takes much time and commitment – the GP lead is paid four hours a week to support it but spends two days a week on the PCH.

PARTNERS

Wolverhampton Total Health (eight practices: Newbridge Surgery, Whitmore Reans Health Centre, Fordhouse Medical Centre, Tudor Medical Practice, Church Street Surgery, Caerleon Surgery, East Park Practice, Keats Grove Surgery), Wolverhampton Clinical Commissioning Group, the local authority's public health team, Refugee and Migrant Centre, West Midlands Fire Service, Royal Wolverhampton NHS Trust.



11

Team Winsford

NO. OF PCHs: 1

NO. OF PRACTICES: 5

STP AREA:

Cheshire and Merseyside

OVERVIEW

Winsford, one of the most deprived areas in the country, has improved population outcomes with a town-based approach to health and wellbeing. When it applied to become a primary care home rapid test site, it had the worst one-year survival rates for cancer in the country. As a primary care home with a population size of 33,000, the group was able to focus on the whole town to improve both population health and clinical outcomes. It also gave practices the opportunity to be at the

heart of service redesign shaping the priorities and changes needed.

HOW THINGS ARE CHANGING

The PCH brought together everyone involved in the health and wellbeing of people in the Cheshire town of Winsford, where there are significant health inequalities, under the banner "Team Winsford". During the town's Wellbeing Week in February 2017, GPs, community staff and members of local voluntary organisations manned a stand promoting good lung health as part of the PCH's drive to improve cancer outcomes, with particular emphasis on lung cancer. This resulted in many people getting advice on respiratory health and being signposted to services including a new PCH led smoking cessation service and direct access to chest X-rays in the local hospital.

Five GPs came forward to be clinical champions in areas of special interest to them - diabetes, heart failure, cancer, dermatology and musculoskeletal conditions – with the aim of increasing access to local services and improving outcomes. A Winsford GP recently led the design and implementation of a primary care deep vein thrombosis service.

After identifying a need to focus on the health and wellbeing of children and young people, the PCH invested some money into a mental health and wellbeing support programme for teenagers and co-funded a primary school based exercise initiative. The local council plans to set up a Health

Hub in one of its under used buildings which people can use as a one stop centre for accessing both council and health and wellbeing services.

Winsford no longer has the lowest one-year cancer survival rates in the country and while this is not directly attributable to the PCH, it was the vehicle that enabled the focus to be placed on respiratory health, demonstrating that improving cancer outcomes is one of Winsford's key priorities.

The PCH model has now been adopted in four neighbouring urban areas, bringing the benefit of local focus to all 280,000 people living in Central Cheshire.

PARTNERS

Five practices, Vale Royal Clinical Commissioning Group, stakeholders and partners through the Connecting Care Provider board.



12 Beacon Medical Group

NO. OF PCHs: 1

NO. OF PRACTICES: 1

STP AREA:

Devon

OVERVIEW

The Beacon Medical Group in Plymouth – a very large practice across five sites - was frustrated with the fragmentation and dilution of local services and increasingly distant relationships with other health and care agents. It was also caring for patients with complex care needs in the face of a rising workload. There was high demand for appointments which didn't need GP expertise, staff were overworked and suboptimal working with other partners.

Taking on the mantle of a rapid test site enabled it to innovate in many ways, improve services to patients, address unmet needs and transform relationships with other providers. Its vision has been to create an integrated health and wellbeing service which meets its population's needs and inspired its staff.

HOW THINGS ARE CHANGING

Beacon Medical Group has cut the average waiting times for GP appointments by six days by expanding its urgent care teams across its sites. The teams comprising one or two GPs, a paramedic, nurse practitioners and pharmacists screen all patients seeking on-the-day appointments on the phone and invite those who need to be seen in. Over six months, the average waiting time for a GP appointment fell from 14 to eight days.

There is an enhanced service for the six largest care homes in their area. Each week a pharmacist and a GP carry out a 'ward round' at each care home visiting patients who are most at risk of hospital admission. They provide support to care home staff to help them support the patient better. The pharmacist conducts medication

reviews to reduce the complexity and cost of medication where appropriate. The PCH has also refocused its virtual ward, a monthly multidisciplinary team meeting involving the voluntary sector, physiotherapists, mental health staff and the community health team, who discuss patients they're concerned about, mainly the frail over-50s, create treatment plans and monitor progress.

Research into its most high-intensity patients, who had the most contact with GPs found that often they had mental health needs which were not being treated and they were going to A&E, sometimes with unexplained physical symptoms. A liaison psychiatrist from Devon Partnership Trust is now based in surgeries two days a week to see patients and offer advice to GPs.

More services have been started for vulnerable groups. For young people a 'takeover day' was held encouraging them to redesign services and counselling introduced in the evenings. There are many armed forces veterans in the area who are vulnerable to mental health issues, diabetes, tinnitus and musculoskeletal problems. By running a campaign, the PCH now knows of some 90 veterans locally and can offer them greater support.

Beacon are working with community pharmacists on marketing campaigns around flu jabs, using media and social media and messaging on prescriptions to target those most in need. Lessons learnt include a willingness to take risks and take on new initiatives without waiting for full funding to drive visible change.

PARTNERS

Beacon Medical Practice, Plymouth Hospitals NHS Trust, Devon Partnership NHS Trust (mental health), LiveWell SouthWest (community services), South Hams Community and Voluntary Services, Plymouth Octopus Project (support network for voluntary sector), Local Pharmaceutical Committee, New Devon CCG, Plymouth City Council.



13

Luton Primary Care Cluster

NO. OF PCHs: 2

NO. OF PRACTICES: 9

STP AREA:

Milton Keynes, Bedfordshire
and Luton

OVERVIEW

Cambridgeshire Community Services NHS Trust and two GP clusters came together to design and deliver services targeting groups in the community with significant needs. They focused on older people with multiple medications and patients with type 2 diabetes. The primary care home model was a flexible solution which enabled them to collaborate and deliver services in a way which met the needs of their patients and their organisations.

HOW THINGS ARE CHANGING

The rapid test site were aware of increased use of medications in the elderly population and concerned about the adverse outcomes, such as hospital admissions and falls which can be associated with polypharmacy. With limited resources, Medics United cluster looked at how they could work differently to support patients, particularly those over 75 years taking ten or more medications. Using funding as a rapid test site, they employed a clinical pharmacist for a 12-week pilot (September to December 2016) who visited surgeries and housebound patients, explaining and reviewing their medication in a one-hour consultation, reviewing their adherence to their medication and assessing their risk of developing an adverse drug reaction or admission to

hospital. Since the pilot, community pharmacy technicians have followed up with patients and monitored the impact of the reviews.

Luton's population has a high prevalence of diabetes. Many primary care colleagues had highlighted that their type 2 diabetes patients were not understanding fully the condition and this was leading to complications. Kingsway cluster targeted patients who were struggling to self-manage their condition with a HBA1C score of more than 80 (levels of glycated haemoglobin indicating average blood sugar levels) with repeated failures to attend GP, retinopathy or podiatry appointments. Patients were asked to attend specialist clinics for a one-hour consultation with the community

diabetes team (clinics in Urdu, Bengali and English). The team discussed with patients how they were managing their condition and used the Patient Activation Measure (PAMs) to tailor their approach to supporting and motivating them. After the appointment, patients can attend weekly group sessions for four weeks giving them an opportunity to share experiences and information, learn more about diabetes and living with a lifelong condition, support other attendees and make new friends. The rapid test site is in the process of piloting this pathway, so no evaluation is available.

Lessons learnt include that engagement with all stakeholders is key in the design, planning and implementation of the pilots.

PARTNERS

Nine practices (Barton Hills Medical Group, Bell House Medical Centre, Woodland Avenue Practice, Gardenia and Marsh Farm Practice, Kingsway Health Centre, Pastures Way Surgery, Conway Medical Centre, Medina Medical Centre and Wenlock Surgery), Cambridgeshire Community Services Trust, Luton Clinical Commissioning Group, patient groups, Healthwatch and LiveWell Luton.



14 Richmond

NO. OF PCHs: 1

NO. OF PRACTICES: 11

STP AREA:

South West London

OVERVIEW

Covering Twickenham and Whitton, Richmond Primary Care Home has a large population in a busy London borough. Its vision has been to work with front line staff to help identify the needs of the frail and elderly across Twickenham and Whitton and to work with multidisciplinary teams to strengthen best practice, identify gaps and introduce innovation.

It has brought together different workforces to care better for the frail and elderly, and listened to its local community, leading to frontline signposting training and engaging local college students in a mentorship training programme at a local care home.

HOW THINGS ARE CHANGING

Richmond held a series of learning workshops with multidisciplinary teams and spoke to all the practices, community pharmacies, community providers and therapists gathering best practice, areas for improvement and gaps in provision. These confirmed that carers were a vital part of health and social care and they needed better links into the health care system to both primary and community care. With an estimated 25 per cent of GP appointments not needing a GP, the PCH delivered level one signposting training to receptionists and pharmacy counter assistants to assess the type of help needed for people to stay well and maintain independence. This is being evaluated to help shape future training.

The PCH has launched a nursing home carer mentor scheme after raising awareness to health and social care students at Richmond College of Further Education about careers in the health and care sector and improve their prospects. Under the carer mentor scheme, students received an induction and then attended the nursing home once a week for six weeks working alongside staff for a full working day. Each student was allocated a mentor and they were able to gain experience of what the job entailed.

There are plans to roll out an emergency transfer scheme ('red bag') aimed at supporting accurate assessment and transfer to hospital

from care homes. The "red bag" keeps important information about a care home resident's health, including existing conditions and medication, in one place, easily accessible for ambulance and hospital staff. This means that ambulance and hospital staff can determine the treatment they need more effectively. This clearly identifies a patient as being a care home resident which means it may be possible for the patient to be discharged sooner.

Lessons learnt included that engaging and listening to front line staff and supporting them will increase the sustainability of this programme.

PARTNERS

Eleven practices, Hounslow and Richmond Community Healthcare, Richmond Clinical Commissioning Group, independent care homes, Richmond GP Alliance and the Richmond Local Pharmacy Committee, voluntary organisations.





Community of Practice

2nd wave – December 2016



15 Nottingham North and East Community Alliance

OVERVIEW

The Nottingham North and East Community Alliance (NNECA) Primary Care Home is made up of practices within the East of Nottingham. It serves a diverse population including areas of high deprivation as well as some of the most deprived areas in the UK. Across the PCH, there is significant variation in long term conditions and urgent care needs. The PCH vision is to develop a collaborative and strategic approach to addressing the health care needs of the combined patient population with their partners. Its aim is to develop a diversified workforce to enable patients to see the right person first time.

NO. OF PCHs: 1

NO. OF PRACTICES: 5

STP AREA: Nottinghamshire

HOW THINGS ARE CHANGING

Working together as members of the NNECA, practices have been able to come together to start to work collaboratively to improve the service they are able to provide and the health of their combined practice population.

The alliance has started work to develop a plan for a diversified workforce to enable patients to see the right person first time to address their health needs. One example has been to develop clinical pharmacists in general practice to improve patients' health and access to care. A pilot of a community pharmacist at one practice from 2015 to 2017 showed that diabetic patients achieving blood pressure targets increased by 28.3 per cent because of the programme. The pharmacist also improves access for patients by seeing urgent problems on the day.

As a PCH, it hopes to expand this approach throughout its member practices. Member practices have also begun to develop collaborative working looking at back office support and efficiency improvements as well as peer support to help develop a strategy for more strategic care and reducing unwarranted variation in referrals and urgent activity.

PARTNERS

Five practices (Apple Tree Medical Practice, Giltbrook Surgery, Peacock Healthcare, The Ivy Medical Group, Westdale Lane Surgery), Nottingham North and East Clinical Commissioning Group, Community Health Partnerships, Circle.

16 Herne Bay Healthcare

OVERVIEW

The primary care home's vision is to provide a resource for the community where primary and community care will work together to relieve pressure on the local health economy by providing a wide range of services closer to patients' homes. The partnership is in the process of setting up an Integrated Care Centre (ICC) at the local cottage hospital which will include a minor injury/illness facility together with catheter and deep vein thrombosis clinics and extended hours GP services. The ICC will be the first step towards the delivery of a patient-centred and integrated health and social care service driven by primary care and supported by the local community network.

NO. OF PCHs: 1

NO. OF PRACTICES: 4

STP AREA: Kent and Medway

HOW THINGS ARE CHANGING

Herne Bay Healthcare is in the process of mobilising the new Integrated Care Service and other services. These new services should be up and running by September 2017 and, once in place, are expected to result in a drop in unplanned admissions to secondary care, especially for patients with urological and respiratory problems. The primary care home also has plans for town-based multidisciplinary team meetings and closer liaison with more than 30 local residential and nursing homes which are expected to lead to a reduction in the number of elderly people admitted to hospital. There will also be joint working for the practice and community nursing teams, which should improve care for patients with long term conditions and an associated reduction in hospital admissions.

PARTNERS

NHS Canterbury and Coastal Clinical Commissioning Group, NHS Ashford Clinical Commissioning Group, East Kent Hospitals University NHS Foundation Trust, Kent Community Health NHS Foundation Trust, Kent and Medway NHS and Social Care Partnership Trust, South East Coast Ambulance Service, Kent County Council.



17 North Cornwall

OVERVIEW

North Cornwall applied to become part of the primary care home community of practice in 2016, since then there has been some changes in the management of the practices. This has resulted in reviews of partnership arrangements. The primary care home is looking to focus on smaller population groups and has identified three natural clusters.

HOW THINGS ARE CHANGING

While there are discussions around collaboration across practices in North Cornwall, some have made progress on integration. Working with other local primary care providers, some practices are developing new services delivered in a community setting.

PARTNERS

The original application involved nine practices: Bottreaux Surgery, Camelford Medical Centre, Carnewater Practice, Neetside Surgery, Port Isaac Surgery, Stillmoor House Surgery, Stratton Medical Centre, Wadebridge and Camel Estuary Practice.

NO. OF PCHs: 1

NO. OF PRACTICES: 9

STP AREA: Cornwall and the Isles of Scilly

18 Truro Health Park (THP)

OVERVIEW

Lander Medical Practice and Three Spires Practice in Truro are collaborating as a primary care home to develop their current services, become more patient-centred with increased community involvement and refresh staff involvement in their daily work.

HOW THINGS ARE CHANGING

The primary care home is aiming to develop new roles in information management, signposting patients to resources including social prescribing options, for example, exercise classes and other activities, with an emphasis on mapping the community assets to ensure they have an up-to-date record.

It is hoped that a physical activity lead will develop classes for different groups of patients and a café will be opened in the waiting room to encourage interaction and link into other resources including some for mental health and isolation.

They are looking at establishing a multimorbidity clinic with dedicated support from an Age UK worker and staff are learning from the ground-breaking surgery at Bromley-by-Bow.

The practices have a physiotherapy unit with gym, community nurses, acute care at home team, pharmacy and other services including podiatry and an eating disorders service. It is looking at ways of using the building space as efficiently as possible.

PARTNERS

Two practices (Lander Medical Practice and Three Spires Practice), Kernow Clinical Commissioning Group, Cornwall Health Out of Hours Service, Kernow Health Community Interest Company (CIC), Royal Cornwall Hospitals Trust (acute trust), Cornwall Partnership NHS Foundation Trust (mental health and community provider), Cornwall Council, two patient participation groups, Pentreath, Connect and other third sector providers, Age UK, Volunteer Cornwall, Cornwall and Isles of Scilly Education Provider Network, NHS England local team, Truro City Council.

NO. OF PCHs: 1

NO. OF PRACTICES: 9

STP AREA: Cornwall and the Isles of Scilly



19 Perranporth and Penryn

OVERVIEW

Perranporth and Penryn Surgeries are collaborating as a primary care home site to develop their services, streamline back office functions and develop innovative ways of facing the challenge of increasingly complex patient groups, from the frail elderly to a young student population.

HOW THINGS ARE CHANGING

The PCH has started a document management project designed to free up GP time. It has also secured funding to look at the feasibility of integrating a number of other surrounding practices to increase efficiency and provide a better service to patients in the local area. Patient participation groups are working on identifying voluntary resources that could be used to increase the range of services offered to patients.

PARTNERS

Two practices (The Perranporth Surgery and Penryn Surgery), Kernow Clinical Commissioning Group, Cornwall Health Out of Hours Service, Kernow Health Community Interest Company (CIC), Royal Cornwall Hospitals Trust, Cornwall Partnership NHS Foundation Trust.

NO. OF PCHs: 1

NO. OF PRACTICES: 2

STP AREA: Cornwall and the Isles of Scilly

20 Three Harbours Medical Group

OVERVIEW

The primary care home consists of three practices – Lostwithiel Medical Practice, Fowey River Practice and St Blazey Practice - representing the people of Fowey, Par, St Blazey, Lostwithiel, Polruan and the surrounding areas.

Two years ago these practices came together to discuss future proofing the three businesses and how to provide sustainable healthcare for the patients in each practice. A neighbouring practice had just handed back its General Medical Services (GMS) contract and it was felt that working together would help safeguard the future of all three practices.

The NHS Five Year Forward View reinforced a vision of working at scale and providing a better, more cost effective service for our patients. After attending a national meeting it was agreed that the primary care home model would be an ideal platform to develop local plans and ideas.

HOW THINGS ARE CHANGING

Since the initial meeting, staff from the three practices have met regularly as a cluster to identify key areas for joint working to deliver services.

The first priority was to look at IT arrangements. Through working with Microtest Health Solutions, the primary care home now has the ability to view patients' records across the three practices, which will enable it to provide weekend working in the future as well as being able to initiate working from an alternative practice should one of the sites become unusable because of a major incident or GP sickness.

The role of eldercare nurse coordinator has been developed and local funding has been secured for an 18-month trial. The post-holder will work across the patch, managing dementia and severely frail patients both in nursing homes and in their own homes. The nurse coordinator will help educate staff and carers alike, coordinate services and signpost to voluntary sector services, where appropriate, so preventing unnecessary hospital admissions.

The primary care home is working on providing secondary care clinics within the practices in a more cost effective manner, allowing patients to be seen in a familiar setting without having to travel to the nearest hospital in Truro. There are also plans to employ a pharmacist to work with the practices to provide safer, more cost effective medicines management.

PARTNERS

Three practices (Lostwithiel Medical Practice, Fowey River Practice and St Blazey Practice), NHS England Local Team, Age UK, Volunteer Cornwall, Kernow Clinical Commissioning Group, Cornwall Health Out of Hours (OOH) Service, Kernow Health Community Interest Company (CIC), Cornwall and Isles of Scilly Education Provider Network, Royal Cornwall Hospitals Trust (acute trust), Cornwall Partnership NHS Foundation Trust (mental health and community provider), Cornwall Council, Pentreath, Connect, two patient participation groups.

NO. OF PCHs: 1

NO. OF PRACTICES: 3

STP AREA: Cornwall and the Isles of Scilly



21 22 23 East Cornwall Locality

OVERVIEW

Ten practices have come together to develop three primary care homes in East Cornwall – a rural landscape with a higher than average population of elderly patients. Their vision comprises three key principles: resilience in general practice, integration across primary and community services and efficient models of care.

HOW THINGS ARE CHANGING

With a clear vision to move forward, six key priority areas have been developed which the locality is focussing on - the development of integrated care teams (further integration of community and primary care teams), long term condition management (de-layering of specialist care with more direct support to primary care), elective care (new models of care, better value for money to the NHS), non-elective care (increase use of existing community hospitals services, developing health population analytics), social prescribing (care navigation through increased working with voluntary and community sector) and practice workforce (the development of workforce skills and competencies and introduction of new workforce roles) eg. pharmacists, emergency care practitioners.

The locality is moving to delivering the priority areas and has additional management capacity to support the work. The development of the three primary care homes has already led to closer working across practices and more widely with community, acute and third sector partners.

PARTNERS

Ten GP practices in East Cornwall, Cornwall Partnership NHS Foundation Trust, Plymouth Hospitals NHS Trust, Kernow Health Community Interest Company, Kernow Clinical Commissioning Group, Volunteer Cornwall.

NO. OF PCHs: 3

NO. OF PRACTICES: 10

STP AREA: Cornwall and the Isles of Scilly

24 South Kerrier Locality

OVERVIEW

South Kerrier consists of a geographically distinct group of practices centred around the highly-valued Helston Community Hospital on The Lizard Peninsula. It covers a large geographical and remote area with poor transport links and many deprived, isolated and frail elderly people whose access to healthcare needs to be improved. The primary care home's work started with a networking meeting to enable community groups of therapy, primary care and discharge teams, and everyone to get to know each other. There were subsequent, more targeted, conversations around how to break down barriers and start working together more effectively together with the aim of providing better access and quality of healthcare at a local level.

HOW THINGS ARE CHANGING

A patient-centred frailty team has been established involving primary care doctors, therapists, the voluntary sector, mental health and social care teams, to optimise the coordination of services and improve communication between all of those involved in providing primary care on The Lizard. There is a weekend frailty clinic, hosted by one practice on behalf of all four, which proactively targets people at risk of hospital admission to support them at home. There are plans to introduce a leg dressing service with a social element, linking with community groups and activities. South Kerrier is applying for funding to start a local "Compassionate Communities" programme, based on the Frome model in Somerset. The programme will focus on tailoring clinician-led, rather than target-led, care at a local level. The emphasis will be on those areas which clinicians feel would most benefit from the programme's intervention and where results can be achieved in terms of an evidence-based reduction in non-elective admissions. It is a programme which has the enthusiastic support of all local surgeries and associated groups.

PARTNERS

Four practices and the Cornwall Partnership NHS Foundation Trust.

NO. OF PCHs: 1

NO. OF PRACTICES: 4

STP AREA: Cornwall and the Isles of Scilly



25

Penwith

OVERVIEW

Penwith is divided into two primary care home sites - East Penwith and West Penwith, each with a population of around 30,000. East Penwith comprises three GP practices, a community nursing and therapy team. West Penwith comprises six GP practices and a community base. The PCH teams are involved in deciding future priorities, one of which is a single point of coordination across health, social care and the voluntary sector.

HOW THINGS ARE CHANGING

The locality is currently exploring legal options for coming together as a single organisation, while retaining the integration of local services afforded by the two primary care homes at operational level. A number of bids to develop care coordinator roles have been submitted and the locality is working with the voluntary sector to develop a central, online resource of community assets. Several initiatives have been agreed with the aim of working at scale across all practices and in partnership with community providers including Cornwall Hospice Care. All of these initiatives underpin the overall aim of providing a proactive, responsive service to patients via integrated local resources. A leg dressing club with social activities has recently been established with the support of the voluntary sector. There are plans for “meet the team” events in both primary care homes to enable frontline practitioners to get a better understanding of each other’s roles.

PARTNERS

Nine practices, Kernow Health Community Interest Company (CIC), Cornwall Partnership NHS Foundation Trust, Cornwall Hospice Care, Age UK, Volunteer Cornwall and Changing Lives Community Interest Company.

NO. OF PCHs: 2

NO. OF PRACTICES: 9

STP AREA: Cornwall and the Isles of Scilly

26

27

Integrated Care Exeter

OVERVIEW

The PCH consists of seven practices working together as part of a wide, integrated care project on new models of prevention. It’s actively sharing lessons learnt with other GP practices across the city.

HOW THINGS ARE CHANGING

The PCH has developed a unique tool for identifying individuals and groups to target for prevention. Linking primary, acute and social care services, the tool is being used to identify those at high risk of developing serious health problems and to analyse the cost of different treatment options available to them. A social prescribing service, Wellbeing Exeter, has been introduced and is already showing promising results in terms of individual outcomes and a reduction in activity across the health and social care system. The PCH has set up a pilot pharmacy project in two practices with the aim of rolling it out to the other practices when the benefits have established. The project is as much about benefiting patients as it is about reducing prescription levels. Staff in the PCH practices are also working with community health and social care staff on improving joint working to improve services for some of the city’s most frail patients.

PARTNERS

Age UK Exeter, Devon Community Foundation, Devon County Council, Exeter City Council, Exeter Community Initiatives, Exeter CVS, Exeter Primary Care Ltd, New Devon Clinical Commissioning Group, Public Health (Devon County Council), Royal Devon and Exeter NHS Foundation Trust, South West Academic Health Science Network, Westbank.

NO. OF PCHs: 2

NO. OF PRACTICES: 7

STP AREA: Northern Eastern and West Devon CCG



28 29 30 31

South Kent Coast Integrated Accountable Care

OVERVIEW

The primary care home is developing a primary care access hub in each locality: Dover, Folkestone, Deal and Hythe/Romney Marsh. Each hub will cover holistic unscheduled care for the whole community from 8am to 8pm, seven days a week.

HOW THINGS ARE CHANGING

South Kent Coast is organising minor illness care into primary care access hubs. These are branch hubs for all practices in the locality, covering all patients on the GP's list as part of the General Medical Service. Its aim is to ensure patients see the right professional, first time on the same day, led by senior doctors from local practices and multi-professional teams to provide high quality care.

By transferring minor illness care into hubs, this will free up practices to provide holistic care for preventative medicine, long term conditions and chronic disease management. Patients will benefit with longer appointments and there will be continuity of care for frail, elderly and high risk patients to improve population health outcomes and prevent avoidable hospital admissions.

The PCH is implementing a home visiting service using nurses, health care assistants (HCAs) and paramedic practitioners across the whole population. It has also implemented interoperability and mobile working technology across all practices joining up care for all communities.

PARTNERS

Integrated Executive Provider Board for South Kent Coast Integrated Accountable Care Organisation, NHS South Kent Coast Clinical Commissioning Group, East Kent Hospitals University Foundation Trust, Kent and Medway NHS and Social Care Partnership Trust, Kent Community Health NHS Foundation Trust, South East Coast Ambulance NHS Trust.

NO. OF PCHs: 4
NO. OF PRACTICES: 30
STP AREA: Kent and Medway

32 Stafford Primary Care Alliance

OVERVIEW

The Stafford Primary Care Health Alliance aims to give member practices the opportunity to develop new services, improve efficiencies and ultimately, improve the quality of care provided to patients. The alliance will develop new ways of working that will use innovative approaches to health care delivery and work with local stakeholders to create a culture of wellbeing for its patients.

The practices have several joint work streams with the aim of making sustainable services for their community. They want to encourage wellbeing through healthy communities and are aiming to work more closely with local organisations.

HOW THINGS ARE CHANGING

The practices are jointly working together to reduce inappropriate admissions and condense the length of stay for frail and complex patients. They work as a collaborative with nursing homes to improve consistency of care.

The alliance uses an acute home visiting service, which provides access to a local GP who can carry out acute home visits on behalf of practices with the aim of reducing unnecessary attendances at A&E and possible admission. The service operates between 2.30pm to 7.00pm on weekdays.

One of the primary care home practices now provides Saturday morning nurse and doctor appointments giving patients extended access to general practice six days a week. Patients are also able to book appointments directly with a physiotherapist either as a face-to-face consultation or over the telephone assessment.

Wellbeing workers are carrying out social prescribing to assist patients with social needs, identifying and signposting them for support with finances, housing and relationship issues.

PARTNERS

The five practices are Castlefields Surgery, Holmcroft Surgery, Gnosall Surgery, Stafford Health and Wellbeing (SHaW) and Wolverhampton Road Surgery.

NO. OF PCHs: 1
NO. OF PRACTICES: 5
STP AREA: Staffordshire



33

Lichfield/Burntwood Network Partnership

OVERVIEW

The Lichfield and Burntwood Network Partnership has established itself as an alliance of GP practices in the region that collectively hold responsibility for the provision of primary care to the whole of Lichfield and Burntwood. The formation of the group was based on the Network Manifesto. This document highlighted the value to local GPs of working together to improve job satisfaction, reduce workload, increase primary care investment, improve patient care and fulfil contractual obligations in a better way.

NO. OF PCHs: 1

NO. OF PRACTICES: 6

STP AREA: Staffordshire

HOW THINGS ARE CHANGING

With the network acting as a central hub, several schemes have been identified under the following headings: care homes and the housebound, allied specialists, urgent care access hub, chronic diseases, medicine optimisation, holistic general practice, patient engagement, education and training.

Work is underway to set up a basis for these schemes with EMIS integration being the main project. This is nearing completion. Clinicians from each of the network practices will be able to access and record information directly to the patients' notes making consultations safer and more clinically effective.

Early pilots have taken place to test having specialists running direct clinics from practices, streaming patients that would originally have needed to see the GP prior to being referred straight to the specialist. This not only provides efficiencies in practice but also allows the patient to be seen earlier by the most appropriate specialist. This is being piloted with an musculoskeletal specialist clinic and mental health specialists.

PARTNERS

Six practices (Darwin Medical Practice, which was formerly Spires Practice and Fulfen Practice, Salters Meadow Health Centre, Boney Hay Surgery, Cloisters Medical Practice, Westgate Practice and Langton Medical Group).



34 35 36 37

Redditch and Bromsgrove Alliance

OVERVIEW

The Redditch and Bromsgrove Alliance is a partnership of local providers including health and social care operating across four primary care home sites. Their goal is to remove boundaries at the point that care is delivered, to create a system where patient interests come first and resources are collectively focussed on improving health outcomes, supporting people to stay well and to live independently for as long as possible.

The alliance has agreed four priority focus areas: improving access to care, integrating health and social care teams, integrating specialist support areas, promoting prevention and self management.

HOW THINGS ARE CHANGING

The Redditch and Bromsgrove Alliance is focussing on a range of projects, which support the priority focus areas. These include extending access to primary care and integration across local partners, supporting frailty, with a focus on care home support and integration across local partners, and introducing care navigation, with active signposting by primary care, supporting those with complex needs through multidisciplinary team meetings and expanding the local social prescribing offer.

The alliance has taken a snapshot of data to evidence their current state. This has enabled it to work with partners to agree what data is relevant and how all parties can collaborate on measuring outcomes for the total population.

An event has been held with representatives from all partner organisations including clinicians, patients, voluntary and community organisations to decide how they can best work together to support people to achieve better health and wellbeing.

With the neighbourhood teams established, it will be measuring the impact and benefits of the projects underway.

PARTNERS

All 22 general practices in Redditch and Bromsgrove, North Worcestershire Healthcare Ltd and Bromsgrove Primary Care Network, Worcestershire Health and Care NHS Trust (the county's main provider of community and mental health services), Worcestershire Acute Hospitals NHS Trust (the county's main provider of acute care), Worcestershire County Council (the county's provider of adult social care services), Redditch Borough and Bromsgrove District Councils, voluntary and community sector organisations, Redditch and Bromsgrove Clinical Commissioning Group.

NO. OF PCHs: 4

NO. OF PRACTICES: 22

STP AREA: Herefordshire and Worcestershire





38

Wolverhampton Care Collaborative

OVERVIEW

Wolverhampton Care Collaborative is a group of eight practices who have come together. It has followed the work carried out by Wolverhampton Total Health rapid test site and set its governance structure based on similar principles.

HOW THINGS ARE CHANGING

The primary care home started by looking at the ten high impact areas where they could make a difference and release GP capacity. This work has allowed them to work with their clinical commissioning group (CCG) to look at training their staff to become care navigators in their practices. It has also set up a practice manager group that has started skill mapping their staff and working together. The PCH is looking at establishing virtual hubs in Wolverhampton, in the north and south of the city.

As a collaborative, it has delivered urgent care at weekends and bank holidays over the winter pressure period. It has enabled it to streamline some of its work around patient information and marketing of its services. It has worked with NHS 111 to direct patients to its sites providing extra out-of-hours care. Work is ongoing to capture this data and to improve collaborative services.

In the future, the PCH intends to offer other services including psychological therapy and physiotherapy in the hub practice. Encouraged by work to date, it is working closely with its CCG to provide long term weekend access.

Since working closely, three practices have decided to merge into a single practice, to achieve scale in delivering services.

PARTNERS

Eight practices (Prestbury Medical Practice, Cannock Road Medical Practice, Woden Road Surgery, All Saints and Rosevillas Medical Practice, Grove Medical Centre, Ashfield Road Surgery, Bradley Medical Centre and Showell Park Health Centre), Wolverhampton Total Health, Wolverhampton Clinical Commissioning Group, Public Health, Royal Wolverhampton NHS Trust.

NO. OF PCHs: 1 (linked to RTS no. 10)

NO. OF PRACTICES: 8

STP AREA: The Black Country

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Wyre Forest Alliance

OVERVIEW

The Wyre Forest Alliance is a partnership between local providers of health and social care services. Its goal is to remove boundaries at the point that care is delivered, to create a system where patient interests come first and resources are collectively focused on improving health outcomes, supporting people to stay well and to live independently for as long as possible.

The alliance has agreed a common set of priority focus areas comprising improving access to care, integrating health and social care teams, integrating specialist support areas and promoting prevention and self-management.

HOW THINGS ARE CHANGING

The primary care homes are focussing on developing their neighbourhood teams. There will be five and fit within the PCH population size based around clustered GP lists. The Alliance Board has set a number of principles to allow the neighbourhood teams to design their own solutions to their local populations.

At all stages, the alliance has tested its thinking with staff, patients and carers to ensure it makes sense and will add value in the future. The approach adopted has been to do what makes most sense and build a resilient one-team approach adding competencies to the multidisciplinary teams as needs arise.

PARTNERS

All 12 general practices in Wyre Forest, Worcestershire Health and Care NHS Trust (the county's main provider of community and mental health services), Worcestershire Acute Hospitals NHS Trust (the county's main provider of acute care), Worcestershire County Council (the county's provider of adult social care services), Wyre Forest Clinical Commissioning Group and patient representation.

NO. OF PCHs: 5

NO. OF PRACTICES: 12

STP AREA: Herefordshire and Worcestershire



44 Riverside Health Centre

PARTNERS

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust, Nottinghamshire Healthcare NHS Foundation Trust, Bassetlaw Clinical Commissioning Group, Bassetlaw District Council, Healthwatch.

NO. OF PCHs: 1

NO. OF PRACTICES: 5

STP AREA: South Yorkshire and Bassetlaw

45 Team BDP

OVERVIEW

The aim is to ensure that patients, families and carers have access to care in their own homes by their local GP, nurses and community services.

HOW THINGS ARE CHANGING

The primary care home plans to co-ordinate services for frail and diabetic patients and offer both groups a response and support to keep patients out of A&E. The aim is to devise a 'one touch' approach to produce an easy and simple pathway for all patients within the informal partnership of GP practices in the Bollington, Disley, Poynton and Knutsford areas. With this co-ordinated approach, GP appointments will be freed up for the benefit of other groups of patients so ensuring equal and fair access for everyone who needs it. The primary care home has five practices with more planning to join.

NO. OF PCHs: 1

NO. OF PRACTICES: 4

STP AREA: Cheshire and Merseyside

PARTNERS

Vernova Healthcare Community Interest Company (CIC), East Cheshire NHS Trust, Cheshire East Council, Caring Together, Eastern Cheshire Clinical Commissioning Group, social services, community and mental health services, pharmacies, public health, local voluntary organisations including Age UK and British Red Cross, patients, carers and supporters.

46 OneLeeds

OVERVIEW

The primary care home is bringing together community health services, general practices and the voluntary sector with a shared goal of improving the quality of life and care for the most frail members of the local community.

HOW THINGS ARE CHANGING

The PCH is currently working with key stakeholders and GPs in and around the town of Wetherby to establish a community frailty service. The aim will be to reduce demand for GP home visits, 111 contacts and unplanned hospital admissions among this patient group.

This will be achieved by providing patients with better support and access to more appropriate assessment services in the community.

PARTNERS

Leeds North Clinical Commissioning Group, Leeds and York Partnership NHS Foundation Trust, Leeds Community Healthcare NHS Trust, Leeds Teaching Hospitals NHS Trust, NHS England, Leeds City Council, Connect Well (social prescribing service).

NO. OF PCHs: 1

NO. OF PRACTICES: 5

STP AREA: West Yorkshire



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48

Derwentside Healthcare

OVERVIEW

Derwentside Healthcare Ltd was established in 2015 and is starting to see real progress in terms of new ways of working. Members of the Board have demonstrated immense drive and enthusiasm in their determination to maintain the viability of general practices in Derwentside in difficult times for primary care. Co-operation among practices and a firm commitment to providing appropriate healthcare for local patients will be crucial to the primary care home's success.

HOW THINGS ARE CHANGING

There is a new service for patients with palliative care needs who are able to see a GP at weekends. Patients needing to be seen urgently can now see a GP during bank holiday weekends. A bid for funding to provide further extended hours – to see a GP, nurse practitioner, practice nurse or healthcare assistant – has been submitted.

The primary care home has designed and implemented a pilot diabetes programme, funded by NHS England and Durham County Council which is aimed at diagnosing patients and prevention. Over the course of the pilot, around 4.5% of the population (around 4,500 patients) were found to have non-diabetic hyperglycaemia (pre-diabetes) and there was a 14% increase in the percentage of recorded diabetes. The PCH has been involved in a new model of care with local community and acute trust providers to deliver services at scale to the majority of diabetic patients in the area.

PARTNERS

Derwentside Healthcare (federation of 14 practices), County Durham and Darlington NHS Foundation Trust, County Durham Council, NHS 111, North Durham Clinical Commissioning Group.

NO. OF PCHs: 2

NO. OF PRACTICES: 14

STP AREA: Northumberland, Tyne and Wear

49

Hammersmith and Fulham Partners

OVERVIEW

With one primary care home established, Hammersmith and Fulham Partners' ambition is to expand to four by the end of 2018. Three practices have merged to form the first with the ambition of providing comprehensive and personalised care to people who use its services, and creating a positive experience for those that work with or alongside them.

HOW THINGS ARE CHANGING

There are 30 practices across Hammersmith and Fulham, supported by the Hammersmith and Fulham GP Federation. Committed to delivering population-based health and improving outcomes for their registered population, they are working with key partners in the delivery of a more integrated approach to care.

Recently the three larger practices, which are part of the primary care home, merged: Brook Green Medical Centre, North End Medical Centre and Bush Doctors. There is now a single partnership comprising 17 partners and a total of 89 staff. They have established an Executive Board of six partners to guide the business.

A model of care across the sites is being finalised and will start to be implemented in May 2017. They are focussing on the following key areas: the clinical model, professional and organisational behaviours and cultures, location of care, equality of care, education and training and the patient voice.

The primary care home is working with local partner community providers to embed community nursing provision within this and create rotational posts across primary, acute and community care.

PARTNERS

The three practices (The Bush Doctors, Brook Green Medical Centre, North End Medical Centre), Central London Community Healthcare NHS Trust.

NO. OF PCHs: 1

NO. OF PRACTICES: 3

STP AREA: North West London



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South Cheshire and Vale Royal Care Communities

OVERVIEW

The primary care homes in South Cheshire and Vale Royal are locally referred to as care communities. A care community is an extended integrated support and care team built of local care services alongside secondary care professionals. Based around general practice at its core, this team works together to deliver new and existing services in a joined up way with the third sector, private sectors and the communities it services. It is delivered through shared values and ways of working, including virtual teams. It operates in a defined geographic area with the quality outcomes and performance measurement taking place at this level.

HOW THINGS ARE CHANGING

South Cheshire and Vale Royal Care Communities are influencing the way in which local services are being delivered. Winsford primary care home is one of the rapid test sites (see page 19).

Central to these plans are one transformation plan for community and primary care services, making each care community a reality. They are looking at integrated long term conditions management (diabetes, heart failure and musculoskeletal conditions), adopting a town approach to addressing local health and wellbeing needs - delivered in partnership with the local authority and town councillors, focussing on children and young people's mental health and wellbeing in partnership with local college and schools, implementing the RightCare community frailty pathway, increased patient access to primary care, promotion of personalised self-care and using technology to co-ordinate care. All are implementing the South Cheshire and Vale Royal Primary Care Charter, empowering practices to work with other providers to develop sustainability solutions, including implementation of the 10 High Impact Actions for Primary Care. Care Communities are early in their development but each have identified their local population priorities, whether this be disease specific or have an influencing role in how community-based services are being integrated within general practice. Other practical changes that are happening include consistency in clinical coding, extending federated ways of working, developing and implementing solutions that capture real time data around access, capacity and demand, flexible solutions to workforce and investment in primary care education programmes.

PARTNERS

All 18 practices supported by Mid Cheshire Hospitals NHS Foundation Trust, Cheshire and Wirral Partnership NHS Foundation Trust, South Cheshire and Vale Royal GP Alliance, Central Cheshire Integrated Care Partnership (NHS community services), Cheshire East Council, Cheshire West and Chester Council, voluntary sector organisations, NHS South Cheshire CCG Patient participation Federation, NHS Vale Royal (patient participation) Health Forum.

NO. OF PCHs: 5 (plus Winsford rapid test site)

NO. OF PRACTICES: 25

STP AREA: Cheshire and Merseyside





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Nimbus Care

OVERVIEW

Nimbus Care's three primary care homes north, south and west cover the populations of the Haxby Group, Unity Health, MyHealth and Priory Medical Group in York. They are aiming to provide coproduced, place-based integrated care determined by population needs. Unconstrained by traditional thinking, they are focussing on being pioneering and innovative with the aim of delivering high quality results and the best possible patient experience.

NO. OF PCHs: 3

NO. OF PRACTICES: 4

STP AREA: Humber Coast and Vale

HOW THINGS ARE CHANGING

The primary care homes are in the early stages of development – a steering group meets regularly and data is being collated in the three areas which will guide the projects and work streams.

Nimbus have developed and expanded a GP-led integrated care team that provides a service to all practices in York to avoid hospital admissions. This has locally stopped an increase in unplanned admissions, reduced length of stay and prevented excess bed days. The plans are to extend this to a frailty service to include complex, vulnerable and housebound people at home or in care homes.

The initial focus of the primary care homes is to encourage joint working and planning across practices with a project in each PCH. Nimbus Care West will be producing a service with the aim of improving health outcomes and reducing inequality. The North primary care home will be working across traditional practice boundaries to provide an urgent care solution to improve service provision of both routine and urgent care. Nimbus Care South will be focussing on mental health solutions at population level exploring options including emotional hygiene and café conversations.

PARTNERS

Four practices (Haxby Group Practice, Priory Medical Group, Unity Health and MyHealth), City of York Council, Public Health England, York Teaching Hospital NHS Foundation Trust, Healthwatch York and York CVS.

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Wirral GP Provider Federation

OVERVIEW

Wirral GP Provider (GPWFED) has 26 practices across three distinct geographical localities.

NO. OF PCHs: 4

NO. OF PRACTICES: 26

STP AREA: Cheshire and Merseyside

HOW THINGS ARE CHANGING

The primary care home has embarked on a number of improvements to services including extending GP access across three localities with seven hub sites. They hope to extend this to a further three locations.

It has introduced health screening for patients on anti-psychotic drugs and, in partnership with Broomwell Healthwatch have extended Tele-ECG to 15 practices and also provide it in three hub sites.

The PCH has participated in local initiatives for integrated care and influenced the adoption of primary care home as the preferred model in future discussions.

GPWFED has developed a robust constitution, an elected board, members council and patient forum. It has patient representatives engaged in all of their decision making and consultation process.

There are five projects under development: early intervention for frail and elderly, use of technology (e.g. TeleDerm, Teleconsultations), community specialist clinics, pre-op health checks and it is bidding for phlebotomy service and a health check programme.

PARTNERS

Wirral GP Provider (GPWFED), Primary Care Wirral, Wirral Clinical Commissioning Group, acute and community services, local authority.



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3Sixty Care

OVERVIEW

Our local vision embodies the characteristics of the primary care home model and is the guiding force behind our existing, whole-system transformation programme. This vision has been developed and shared with our shareholders during joint locality meetings and protected learning sessions.

3Sixty Care Partnership's vision is to develop a fully integrated primary and community service delivered through a network of five to seven primary care homes. Each will look after populations of 30-50,000 patients. Each PCH will deliver new models of care for complex care, urgent care, scheduled care, and prevention and wellbeing.

NO. OF PCHs: 6
NO. OF PRACTICES: 25
STP AREA: Northamptonshire

HOW THINGS ARE CHANGING

The 3Sixty Care Partnership aims to work within the primary care homes to introduce 'local same-day care hubs', staffed by a tailored health and care team with access to the resources needed to deliver high-quality, safer patient care, in the right place, at the right time, by the right person. This will be rolled out across all the primary care homes over the next three years with two sites going live during 2017.

In addition, a model for enhancing and coordinating support for patients with complex needs will be implemented across the primary care homes during 2017/18. This will target the most at risk groups of patients, including patients living in care homes, and will support people to live more independently and to manage their own health and wellbeing more effectively through a range of secondary prevention approaches e.g. health coaching, education classes and telehealth.

Our patients will have more control over their health and their treatments. They will be supported in their communities by high-quality, highly-motivated, primary, secondary and community care staff able to deliver, holistic, personalised, continuity of care.

PARTNERS

3Sixty Care Partnership are working collaboratively with Nene and Corby Clinical Commissioning Group, Kettering General Hospital FT, Northampton General Hospital, voluntary agencies, statutory organisations such as local Authority, Healthwatch and local groups with an interest in health.

68 Rutland Healthcare

OVERVIEW

Rutland Healthcare Primary Care Home is based around the four GP practices and is coterminous with the county council giving a unique opportunity for closer working with the unitary authority.

Their aim is to understand better local health needs and be part of the development of appropriate shared services, initially focussing on the frail elderly and those with chronic illnesses, but aiming to develop a whole health system approach to benefit all patients.

NO. OF PCHs: 1
NO. OF PRACTICES: 4
STP AREA: Leicester, Leicestershire and Rutland

HOW THINGS ARE CHANGING

The primary care home is in its infancy laying the foundations for future work.

Rutland County Council has been progressive in already developing working arrangements through the 'Rutland Experience' uniting community services and social care. It plans to continue developing closer working to speed access and assessment as well as avoid duplication. This is already demonstrating earlier discharges from hospital and admission avoidance. Initial meetings with the primary care home have taken place to establish a closer understanding of existing services and how future collaboration can develop. Involvement and participation from all members of the multidisciplinary teams has been encouraged. Work streams are being prepared to provide a clear understanding of the local health needs, key priorities and identify the resources needed. The PCH has led to improved inter-practice working. A review of services is being conducted with the local community and secondary care providers, who have expressed a keen interest in working collaboratively to achieve the PCH's goals. There is a clear local recognition of the need to change future working patterns and systems and the PCH model is seen as a way of helping achieve that.

PARTNERS

Four practices, Rutland County Council, East Leicestershire and Rutland CCG, Leicestershire Partnership Trust.



69

East Norfolk Medical Practice

OVERVIEW

The primary care home is facing a broad spectrum of health challenges – from high levels of deprivation, and the problems associated with it, in the seaside town of Great Yarmouth, to a frail, elderly population with complex needs in the east coast villages. There’s an eight-year life expectancy gap between those living in the poorest and most affluent areas. The practices have been struggling to cope with an ever-increasing demand for appointments from patients with non-clinical needs.

NO. OF PCHs: 1

NO. OF PRACTICES: 10

STP AREA: Norfolk and Waveney

HOW THINGS ARE CHANGING

The Lighthouse Medical Centre in Great Yarmouth has been piloting a social prescribing scheme, using a member of staff as a “connector” to help patients access support services in the local community. The service has proved so successful that the PCH has asked the local borough council to fund another three connectors. The patient participation group organised a networking event attended by more than 30 local care organisations, many of which were unknown to the GPs. A second event brought together over 100 voluntary and statutory bodies and a third was attended by several hundred members of the public. More targeted events focusing on support for patients with problems such as diabetes, chronic fatigue and gambling addiction are ongoing. The PCH has been referring patients to a free, community services run eight-week exercise programme which has been successful in helping patients tackle problems such as stopping smoking and losing weight. A “start my week here” get-together at the Lighthouse Medical Centre has enabled lonely and isolated patients to meet others in the same position and find out about local social groups to join. The PCH has worked with the local hospital to bring Hepatitis C clinics into the medical centre to improve attendance rates.

PARTNERS

10 practices, Great Yarmouth and Waveney Clinical Commissioning Group, Norfolk County Council Social Services, Norfolk and Suffolk NHS Foundation Trust, Great Yarmouth Borough Council.





70 Newport Pagnell Medical Centre and NPMC@Willen

OVERVIEW

Newport Pagnell's vision is to build on the existing successes of their integrated model of care by taking a holistic segmentation approach to population health. They are targeting care to each group through integrated working with colleagues across Milton Keynes, improving quality of care and meeting the needs of their patients.

The primary care home is aiming to provide holistic focused care to three groups: young people aged 11 and over with mental health needs, working age population with mental health needs and the frail elderly. Each group is further divided into the currently well with less complex health needs (the focus is on wellness rather than illness) and patients struggling with many layers of need that require care and support from the PCH's multidisciplinary team.

This is a growing practice, a second surgery opened in 2016 with capacity for another 6,000 patients.

HOW THINGS ARE CHANGING

The PCH is designing benefit and impact assessments from the start, working with key local stakeholders including acute and mental health.

Initiatives for young people aged 11 and over with mental health needs include gym courses to help confidence and social isolation, working with youth clubs and supporting the introduction of SMILE courses to help young people who are currently experiencing low level anxiety and depression and working with Compass Milton Keynes young people's drug and alcohol service which run children's drop in sessions during the summer holidays. This has prevented them being left without support, and increasing their addictions.

Initiatives for working age adults include working with their GP personal assistant (PA) team to develop primary care navigators and use social prescribing, and health and nutrition clinics. Milton Keynes' Improving Access to Psychological Therapy (IAPT) service is providing primary prevention and cognitive behavioural therapy (CBT) for the practice's patients. A pilot is underway for people with complex health needs who are frequent attenders in primary and secondary care, providing in-house therapy and support.

For the frail elderly, there is a single pathway for multiple long term conditions care. The primary care home is working with patients who have been admitted as an unplanned admission for respiratory/cardio problems to try and prevent readmission. They have also come together with secondary care to reduce emergency admissions in the community and supporting discharge. Another workstream is focussing on end-of-life care for diagnoses other than cancer.

PARTNERS

One practice (Newport Pagnell Medical Centre and NPMC@Willen), Milton Keynes Clinical Commissioning Group, Milton Keynes University Hospital NHS Foundation Trust, Milton Keynes Council, Milton Keynes Improving Access to Psychological Therapy (IAPT), Central and North West London NHS Foundation Trust (mental health), Newport Pagnell Town Council, Ousedale School, Places for People Leisure, The Brooklands Centre, Compass.

NO. OF PCHs: 1

NO. OF PRACTICES: 1 (2 surgeries)

STP AREA: Milton Keynes,
Bedfordshire and Luton





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Durham Dales, Easington and Sedgfield

OVERVIEW

In 2015 the Newton Aycliffe “Plan for Life” was one of the first primary care home rapid test sites. Learning from the site led to the development of 13 Teams Around Practices (TAP) countywide. These have been split into eight groups, each aligned to the eight primary care homes within County Durham. Their collective aim is to provide better outcomes for patients while alleviating the pressure on the system through smarter, more cohesive working arrangements across health and social care within their communities. The principle expected outcomes are: improved primary care access, enhanced prevention, enhanced independence and wellbeing through risk stratification, less A&E attendance, reduction in bed days and fewer people in residential and nursing care.

NO. OF PCHs: 8

NO. OF PRACTICES: 38

STP AREA: Durham, Darlington, Tees, Hambleton, Richmondshire and Whitby

HOW THINGS ARE CHANGING

A director of integration was appointed in January 2017. TAP implementation is a priority, team configurations have been proposed and work is underway with partners on staff alignment. There's been development work with early adopters of the TAP model around risk stratification, use of estate, interface and process. A communications and engagement plan is in place with existing patient engagement forums incorporated. The work is being overseen by a steering group with representation from all partner organisations. Workstreams are in place which include locality representatives to help shape work relating to referrals, work allocation, pathways, risk stratification and performance. A review is underway regarding the distribution of money in an effort to move away from the current focus on acute spend to a method based around “fair share” principles.

It is anticipated that the primary care home will launch on 25th May 2017, supported by the TAP model, with a view to extending it across the North Durham locality at a future date.

PARTNERS

GP Practices in Durham Dales, Easington, Sedgfield and North Durham, Durham County Council, County Durham and Darlington NHS Foundation Trust, Tees, Esk and Wear Valleys NHS Trust, North Durham Clinical Commissioning Group, Durham Dales, Easington and Sedgfield Clinical Commissioning Group, North of England Commissioning Services, County Durham Fire and Rescue Service, Durham Community Action, Voluntary Organisations Network North East, County Durham Carers Support, Derwentside Health Care Ltd, Chester-le-Street Health Ltd, Central Durham GP Providers Ltd, Durham Dales Health Federation, Intrahealth Ltd, South Durham Community Interest Company, Healthwatch Durham.



79 Redhill and Merstham

OVERVIEW

For Redhill and Merstham practices becoming a primary care home has formalised their collaboration and they have made huge strides over the past few months. They are working on two projects in partnership with East Surrey Clinical Commissioning Group and other community organisations. These are to improve the physical wellbeing for patients with severe mental illness working with Surrey and Borders older people mental health service, wellbeing advisors and GPs. They are also creating a local out of hospital diabetes service co-designing the pathway with public health, First Community Health and Care, a medicines management team, wellbeing advisors, consultant diabetologists and GP with a Special Interest (GPwSI).

NO. OF PCHs: 1
NO. OF PRACTICES: 5
STP AREA: Sussex and East Surrey

HOW THINGS ARE CHANGING

Practices have a long history of working close together. The primary care home has been conducting joint referral peer reviews, hosting regular multidisciplinary team meetings with partner community organisations including First Community Health and Care CIC, wellbeing advisors employed by Reigate and Banstead Borough Council, Surrey and Borders Partnership mental health for older adults, adult social care and South East Coast Ambulance Service.

The multidisciplinary meetings have started to help them break down those historic boundaries. Forming and developing relations has been key to developing a successful and sustainable out of hospital service for citizens. Through these meetings, it had become apparent how much duplication there was within the system which is being addressed.

After developing these relationships, they are now in a position to be able to help each other. One prototype involves improving the physical wellbeing of citizens with severe mental health problems, working with our partners. Diabetes care within East Surrey is fragmented and has been a huge burden on the acute sector for many years. The PCH is co-designing a robust community diabetes pathway which allows citizens to be treated closer to home within the network. It is confident this will reduce the rate of referrals into secondary care but at the same time increase the skills of community clinicians.

PARTNERS

Five practices (Greystone House Surgery, Moat House Surgery, Hawthornes Surgery, Holmhurst Surgery, Woodlands Surgery), First Community Health and Care Community Interest Company (CIC), Surrey County Council Adult Social Care, Surrey and Borders Partnership NHS Foundation Trust), Reigate and Banstead Local Authority, Public Health England.





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Lewes Health Hub

OVERVIEW

The three GP practices in the town of Lewes near Brighton serve a population of almost 30,000. A new development is due to bring a further 700 houses to the town centre. With increasing patient demand and decreasing staff morale, causing difficulties in staff recruitment, it was decided to use the potential for a new building as a catalyst to unite the three practices. Following the primary care home model, the practices are changing the way they care for patients by bringing together existing services to improve the movement of people, information and resources across health and social care and introducing new roles such as clinical pharmacists and patient navigators to guide people through the care system.

NO. OF PCHs: 1

NO. OF PRACTICES: 3

STP AREA: Sussex and East Surrey

HOW THINGS ARE CHANGING

The three GP practices of St Andrews, School Hill and Riverlodge have spent the last three years tentatively exploring how they could work together to create a better working environment and improve the quality of patient care at the same time as producing financial benefits. The alliance has been successful in its application to the Estates and Technology Transformation Fund which has recently provided financial support to look at new ways of working and designing a new building where the three practices can work together with community and voluntary services. This funding, combined with the support of High Weald Lewes Havens Clinical Commissioning Group, has enabled the alliance to make significant progress by taking time to focus on how patients experience their journey through the health and social care system. Whole practice meetings have been held, engaging all members of staff in exploring how the current system can cause frustration for patients and unnecessary contacts across primary and secondary care. Practice development teams, involving a cross section of all members of staff and local partners, are being developed to look at new ways of working to improve the experience of patients. The primary care home has come at the right time to help develop these ideas. This has produced engagement and enthusiasm from staff who are now developing a vision of the future.

PARTNERS

Three practices, Sussex Community NHS Foundation Trust, Sussex Community Development Association, Sussex Partnership NHS Foundation Trust.



81 Horsham

OVERVIEW

The practices have been working to develop a collaborative approach to delivering care in partnership with their clinical commissioning group, community services provider, mental health provider and West Sussex County Council. They are developing 'communities of practice' comprising local integrated primary care and community teams aligned with social care.

HOW THINGS ARE CHANGING

The primary care home is adopting initiatives that have been trialled by The Healthy East Grinstead Partnership rapid test site to help deliver their vision of the model. Building on shared learning, they have gone live with a redesigned pathway for ordering dressings which will increase GP capacity and are launching self-referral to musculoskeletal physiotherapy.

The practices meet monthly to underpin their collaborative approach. They've now brought together their community teams into one multidisciplinary team wrapped around their seven practices, focussing on patients most at risk of admission. All patients are assessed and have a contingency plan developed and shared with other providers across their health system. They've worked with West Sussex Fire and Rescue Service to carry out home safety checks on those most at risk.

Every practice has a care co-ordinator who works with patients with non-medical issues and helps them to access relevant support. They have also employed a voluntary sector link worker who is working with the care co-ordinators across the primary care home to help patients access local groups and services.

The patient participation groups are working collaboratively to improve access to health and wellbeing services through Horsham District Wellbeing for their practice populations.

PARTNERS

Seven GP practices (Village Surgery, Rudgwick Medical Centre, Holbrook Surgery, Park Surgery, Courtyard Surgery, Riverside Surgery, Orchard Surgery), Sussex Community Foundation NHS Trust, Sussex Partnership Foundation NHS Trust, Horsham and Mid Sussex Clinical Commissioning Group, West Sussex County Council, Horsham District Wellbeing, Horsham District Council, West Sussex Fire and Rescue Service, Horsham and Mid Sussex Voluntary Action, Age UK Horsham, voluntary sector and other statutory organisations services.

NO. OF PCHs: 1

NO. OF PRACTICES: 7

STP AREA: Sussex and East Surrey





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Burgess Hill and Villages

OVERVIEW

The practices have been working to develop a collaborative approach to delivering care in partnership with their clinical commissioning group, community services provider, mental health provider and West Sussex County Council. They are developing 'communities of practice' comprising local integrated primary care and community teams aligned with social care. The PCH is looking to improve capacity through adopting a locality approach to their paramedic visiting service.

NO. OF PCHs: 1

NO. OF PRACTICES: 5

STP AREA: Surrey and East Sussex

HOW THINGS ARE CHANGING

Meeting monthly to underpin their collaborative approach, the primary care home is adopting initiatives that have been trialled by The Healthy East Grinstead Partnership rapid test site to help deliver their vision of the model. Building on shared learning, they are launching a redesigned pathway for ordering dressings which will increase GP capacity. They are piloting self-referral to musculoskeletal physiotherapy with the aim of spreading it across the PCH.

The PCH has brought together their community teams into one multidisciplinary team wrapped around their seven practices, focussing on patients most at risk of admission. All patients are assessed and have a contingency plan developed which is shared with other providers across their health system.

Every practice has a care co-ordinator who works with patients with non-medical issues and helps them to access relevant support. They have also employed a voluntary sector link worker who is working with the care co-ordinators across the primary care home to help patients access local groups and services.

PARTNERS

Five practices (Park View Health Partnership, Silverdale, The Meadows, The Brow), Mid Sussex Healthcare, Sussex Community Foundation NHS Trust, Sussex Partnership Foundation NHS Trust, West Sussex County Council, Mid Sussex Wellbeing, Mid Sussex District Council, West Sussex Fire and Rescue Service, Horsham and Mid Sussex Voluntary Action, Age UK West Sussex, voluntary sector and other statutory organisations.



83 Haywards Heath

OVERVIEW

The practices have been working to develop a collaborative approach to delivering care in partnership with their clinical commissioning group, community services provider, mental health provider and West Sussex County Council. They are developing 'communities of practice' comprising local integrated primary care and community teams aligned with social care. The PCH is working collaboratively to improve primary care capacity through a locality approach to on-the-day demand.

NO. OF PCHs: 1

NO. OF PRACTICES: 7

STP AREA: Surrey and East Sussex

HOW THINGS ARE CHANGING

The PCH is learning from The Healthy East Grinstead Partnership rapid test site and adopting initiatives they have trialled. It is launching a redesigned pathway for ordering dressings to increase GP capacity and is planning to introduce self-referral for patients for musculoskeletal physiotherapy. Their community teams have been brought together into one multidisciplinary team wrapped around their seven practices, focussing on patients most at risk of admission. All patients are assessed and have a contingency plan developed which is shared with other providers across their health system.

Every practice has a care co-ordinator who works with patients with non-medical issues and helps them to access relevant support. They have also employed a voluntary sector link worker who is working with care co-ordinators across the PCH to help patients access local groups and services.

The practices meet monthly to underpin their collaborative approach. Plans for their patient participation groups to work collaboratively as part of the PCH are underway in partnership with the local council.

PARTNERS

Seven practices (Dolphins, Newtons, Northlands Wood, Lindfield, Cuckfield, Cowfold, Ouse Valley), Sussex Community Foundation NHS Trust, Sussex Partnership Foundation NHS Trust, West Sussex County Council, Mid Sussex Wellbeing, Mid Sussex District Council, West Sussex Fire and Rescue Service, Horsham and Mid Sussex Voluntary Action, Age UK West Sussex, voluntary sector and other statutory organisations.

84 Dorking

PARTNERS

Sussex Community NHS Foundation Trust, Sussex Community Development Association, Sussex Partnership NHS Foundation Trust.

NO. OF PCHs: 1

NO. OF PRACTICES: 5

STP AREA: Surrey Heartlands



85

South Camden Primary Care Neighbourhood

OVERVIEW

Camden has a diverse population with high levels of social deprivation and mental health problems and a large student body including potentially vulnerable international students, often lost to the healthcare system. Mental health is one of the key areas which the primary care home plans to prioritise.

HOW THINGS ARE CHANGING

The primary care home is examining local population needs and demographics and is working closely with the adjacent Hampstead and Kentish Town PCHs and neighbourhoods and Camden's Sustainable Insight Team. The team provides the data analysis which enables Camden Clinical Commissioning Group to measure performance, impact and value for money of its investment programmes and pilot schemes with the overall aim of improving health outcomes and value for the local population. The PCH is looking at more integrated ways of working and, having found a possible link between a neighbourhood frailty project and palliative care, is considering a potential pilot. Patient groups are increasingly involved in decision making as the PCH works towards expanding services tailored to the specific needs of local communities.

PARTNERS

Seven practices, Central North West London Healthcare NHS Foundation Trust, Royal Free London NHS Foundation Trust, University College Hospitals NHS Foundation Trust, Camden Council, Camden and Islington NHS Foundation Trust and Voluntary Action Camden.

NO. OF PCHs: 1

NO. OF PRACTICES: 7

STP AREA: North Central London

86

Hampstead Primary Care Neighbourhood

OVERVIEW

The practices around NW3, near the Royal Free Hospital, formally became a primary care home in December 2016 but have worked collaboratively for many years under the support of the wider Camden GP Federation (Haverstock Healthcare). The PCH has recently added to its list of practices in the group and now has seven, of differing sizes, covering around 50,000 patients.

HOW THINGS ARE CHANGING

Key activity within the neighbourhood has included running a four-week pilot using a "frailty duty doctor of the day". This was staffed by a few experienced doctors from the practices and run under the governance structure of the wider Haverstock Healthcare Federation. The scheme involved practices, community and hospital services being able to call a doctor with access to patient notes throughout the day. The aim was to target those patients at immediate risk of hospital admission. During the pilot, more than 80 patients were seen and emergency admission to hospital was avoided in nearly 50% of cases. In some of the more urgent cases, admission to hospital took place more quickly than it might otherwise have done. Close working relationships were developed with the hospital assessment unit as well as community and palliative care teams. There are now plans to reintroduce the service along with the neighbouring primary care home. Work has continued in developing a meeting structure involving all practices. The main focus has been on delivering the comprehensive "Universal Offer", commissioned by Camden Clinical Commissioning Group, which aims to deliver universal and equal access to enhanced services for local patients. The neighbourhood has been successful in its bid for a pharmacist and the recruitment process is underway.

PARTNERS

Seven practices, Central North West London Healthcare NHS Foundation Trust, Royal Free London NHS Foundation Trust, University College Hospitals NHS Foundation Trust, Camden Council, Camden and Islington NHS Foundation Trust, Voluntary Action Camden.

NO. OF PCHs: 1

NO. OF PRACTICES: 7

STP AREA: North Central London



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Ramsgate, Quex and Broadstairs

OVERVIEW

Thanet was chosen as one of the first primary care home rapid test sites and since then three more PCHs were launched in December 2015 to cover the whole of the district.

All are at varying stages of development but have a shared aim of providing tailored services that best meet the needs of patients. This will be realised using population health management methodologies and delivered through an integrated team with each PCH holding a capitated budget.

The primary care homes are the bedrock of the Integrated Accountable Care Organisation that is running in shadow form and will be fully functioning from April 2018. The overarching vision for Thanet is 'One Service, One Team, One Budget'.

HOW THINGS ARE CHANGING

With the three newer community of practice sites linked to Thanet's rapid test site, there's already been significant integration with all practices and community nursing combining to form one primary care nursing team. This is part of an integrated pathway around frailty.

Across all the PCHs, there is an acute response team providing care to patients in their own home for up to five days to avoid unnecessary hospital admissions.

Health and social care coordinators have been brought into every practice providing non-clinical support to patients.

The PCHs have led to the creation of new roles, based on competency, to meet the needs of patients as well as additional training opportunities. There's been a great deal of engagement work with staff, patients and the public involved in the design and stakeholders involved across health, social care and the voluntary sector.

PARTNERS

Ten practices, Kent Community Hospital Foundation Trust, East Kent Hospitals University Foundation Trust, Kent County Council (social care), Kent and Medway Partnership Trust (mental health), Ageless Thanet, voluntary sector organisations including Age UK and Crossroads, Local Pharmaceutical Committee, Local Dental Committee, Local Ophthalmic Committee, Thanet Hospice, South East Coast Ambulance Service.

NO. OF PCHs: 3 (plus rapid test site, see no. 9)

NO. OF PRACTICES: 10

STP AREA: Kent and Medway





90

Newport District Neighbourhood Project

OVERVIEW

Newport is a rural market town, on the edge of an urban clinical commissioning group. Although the cottage hospital closed in 1989, the population is used to services close to home. The primary care home's vision is to reintegrate local community and practice staff, rather than silo based working. It is looking to provide an overarching community service with the aim that no Newport patient should be seen at a district hospital unless absolutely necessary.

NO. OF PCHs: 1

NO. OF PRACTICES: 2

STP AREA: Shropshire and Staffordshire

HOW THINGS ARE CHANGING

Working with Telford and Wrekin Clinical Commissioning Group, its patient focus group and public health, the primary care home is piloting a social prescribing initiative based at the "hub". This allows GPs and reception staff (signposting training to come) to refer directly for advice to local authority services and community-run initiatives. This pilot scheme works in tandem with the local authority's healthy lifestyles team.

Working closely with their community trust, the PCH intends to start a wound care clinic, bringing patients from rural villages to access clinic-based care while accessing the "hub" at the same time so reducing feelings of isolation. This will reduce the general practice workload, allowing more time for long term conditions.

The partnership has been looking at the Buurtzorg way of working (founded in the Netherlands in 2006) and is planning to introduce pilot schemes in two local wards. There are plans to set up a local frailty service, identifying those most at risk for referral to a multidisciplinary team of professionals of GPs, mental health, local authority and community services staff.

Funding has been secured for a community phlebotomy service which will be based at the hub in future. A new population-based mental health scheme has been launched with the support of the community mental health memory team, Age UK coordinators, an Admiral Nurse (providing specialist support for dementia patients and their families) and the local authority. The musculoskeletal service is keen to use the hub's physiotherapy clinic space for multidisciplinary team working with on-site X-ray facilities. It's hoped that community medical clinics, for example those caring for patients with diabetes and respiratory problems, will use the hub's X-ray and outpatient facilities.

PARTNERS

Telford and Wrekin Clinical Commissioning Group, Shropshire Community NHS Trust, Telford and Wrekin Council, Telford and Wrekin Public Health, South Staffordshire and Shropshire Healthcare NHS Foundation Trust, Newport Cottage Care Centre.



Community of Practice

3rd wave – May/October 2017



91 Lakeside Stamford

OVERVIEW

Stamford has been working as a pilot site for the development of neighbouring teams in South Lincolnshire. The aim is to develop and embed the primary care home model initially within the Stamford locality through the development of a combined clinical system, providing enhanced patient care and reduced bureaucracy.

The practices are part of Lakeside Healthcare, a Multispecialty Community Provider (MCP) vanguard. The PCH model is part of the overall transformation plan that Lakeside Healthcare has developed for South Lincolnshire.

For the last two years, the practices in Stamford have been having weekly meetings with all providers developing a range of proposals including a co-located minor injuries unit, community step up beds and plans for home visiting, residential and nursing home teams.

PARTNERS

Three practices (Lakeside Healthcare at St Mary's Medical Centre, Lakeside Healthcare at Sheepmarket Surgery, Lakeside Healthcare at The Little Surgery), Lincolnshire County Council, Lincolnshire Partnership Foundation Trust (mental health), Lincolnshire Community Health Services, South West Lincolnshire Care Consortium, North West Anglia NHS Foundation Trust.

NO. OF PCHs: 1

NO. OF PRACTICES: 3

STP AREA: Lincolnshire

92 Granta and Shelford

OVERVIEW

The primary care home comprises Granta, a merged practice with sites in Sawston, Linton, Barley and Royston and Shelford a neighbouring practice.

The two practices' aspirations are aligned, focussing on multidisciplinary working. The Shelford/Granta boundary maps to the existing community team boundary. Discussions are at an advanced stage with Cambridge and Peterborough NHS Foundation Trust to second their community staff into the primary care home with a view to a full transfer in the future.

Among the plans are to pilot the acclaimed Buurtzorg model of community nursing which was founded in the Netherlands and is nurse-led.

It is also looking to move towards a John Lewis type model of ownership with all staff having a stake in the business, including the community staff moving across as well as any secondary care specialists who join.

Projects underway include the collaborative delivery of paediatrics, Ears, Nose and Throat (ENT) services and ophthalmology.

PARTNERS

Two practices (Granta Medical Practices and Shelford Medical Practice), Cambridgeshire and Peterborough Foundation Trust, Cambridgeshire Community Services, Cambridge University Hospitals NHS Foundation Trust.

NO. OF PCHs: 1

NO. OF PRACTICES: 2

STP AREA: Cambridgeshire and Peterborough



93 Reigate and Horley Practice Network

OVERVIEW

Alliance for Better Care, the GP federation for East Surrey, has been instrumental in creating four networks of practice. Redhill and Merstham (81) joined the community of practice in 2016. East Surrey Clinical Commissioning Group works closely with the federation and has made networks, the building blocks for their planned MCP in 2017 and 2018.

The federation is working with First Community Health and Care, the community healthcare provider, in each of the networks focussing on five key themes – social isolation, falls prevention, ‘a good death’, physical health for people with mental health problems and diabetes care in the community. All practices have ‘wellbeing advisors’ attached to their surgeries and there are plans to work together to reduce social isolation in the Reigate and Horley Practice Network.

NO. OF PCHs: 1
NO. OF PRACTICES: 5
STP AREA: Sussex and East Surrey

PARTNERS

Five practices (The Wall House Surgery, South Park Surgery, Birchwood Medical, Wayside Surgery, Smallfield Surgery), Alliance for Better Care, NHS East Surrey Clinical Commissioning Group, First Community Health and Care, Surrey and Borders Partnership NHS Trust, South East Coast Ambulance Reigate and Banstead social care.

94 95 96 97 Herefordshire Integrated Care Alliance

OVERVIEW

Taurus GP Federation is made up of all 24 GP practices in Herefordshire, who have collectively delivered the seven-day extended primary care access and other projects. Primary care at scale is being discussed between all practices to identify new ways of working, develop the workforce and raise standards within a unified primary care model.

At the same time, there has been the development of the Integrated Care Alliance with providers coming together committed to collaborative working to ensure care is delivered closer to patients’ homes. Herefordshire Clinical Commissioning Group have asked the alliance to redesign community services in a ‘GP wraparound model’. With four localities in Herefordshire, the proposal is to develop four primary care home models in the county.

The current provider of the majority of community services, Wye Valley NHS Trust has emphasised the commitment to transformation with the creation of a specific community division (integrated care division) with a local GP as associate medical director to provide leadership.

The alliance believes that the model will deliver care that will facilitate their shared ambition to place the patient at the heart of the service offering.

NO. OF PCHs: 4
NO. OF PRACTICES: 24
STP AREA: Hereford and Worcestershire

PARTNERS

Taurus GP Federation, Wye Valley NHS Trust, 2gether Mental Health Trust, Herefordshire Local Authority, Herefordshire Clinical Commissioning Group.



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GP Alliance (Northampton)

OVERVIEW

The GP Alliance is a federation of GPs in the borough of Northampton. It has plans to develop four primary care homes and is developing plans for further sites within its footprint. The federations were established in Northamptonshire in 2014. They were active participants in the development of the Northamptonshire Sustainability and Transformation Programme (STP) and have started to plan for the delivery of new care models.

The GP Alliance has been working with Northamptonshire Healthcare NHS Foundation Trust (NHFT) and is close to forming a joint venture agreement. Three practices have already teamed up to provide their 33,000 patients with a new way to access emergency, same-day appointments. The new pilot service was launched in response to patient feedback and the practices are working with NHFT to explore how access to community services support in the “emergency hub” on those days might enhance the offer.

NO. OF PCHs: 4

NO. OF PRACTICES: 12

STP AREA: Northamptonshire

PARTNERS

GP Alliance (12 practices), Northampton Healthcare NHS Foundation Trust, Nene Clinical Commissioning Group.

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Central Health Evolution

OVERVIEW

Central Health Evolution is a newly formed legal entity committed to sharing resources, policies and protocols and working for patients with immediate practices and local community services as per the primary home model. With Central Health Evolution, there are three emerging neighbourhoods.

The primary care homes have several workstreams focussed on integrating care locally. They are working with community nurses to geographically align with the neighbourhood populations. The PCHs are also providing a ‘GP at the front door’ model to their acute trust’s emergency department, and are working closely with them and the community team to develop this to a more sustainable integrated model. Work is underway on the enablers for this including estates, IT infrastructure and data sharing. Plans are to include the local mental health teams and local authority into the model in phase two.

NO. OF PCHs: 3

NO. OF PRACTICES: 11

STP AREA: North Central London

PARTNERS

Eleven practices, Central North West London (CNWL), Camden and Islington Foundation Trust, Camden Council, University College Hospital London.

105

Millennium Federation

OVERVIEW

Three practices from the Millennium Federation have agreed to work together to provide improved services to their population. Their aim is to improve the delivery of nursing services with integrated nursing within the primary care team.

All three practices are committed to sharing learning through regular meetings, building on relationships with partner organisations to deliver the model of care, evaluating and sharing experiences with each other and addressing any issues that they face to prevent recurring problems.

NO. OF PCHs: 1

NO. OF PRACTICES: 3

STP AREA: Leicester, Leicestershire and Rutland

PARTNERS

Three practices (Manor Park Medical Practice, Beaumont Lodge Medical Practice, Westcoates Medical Practice), Leicester City CCG, Leicestershire Partnership Trust, Mental Health Trust, Leicester City Council, Public Health, various voluntary organisations, patient participation groups, Demontfort University, Leicestershire Social Services.



106 Fleetwood

OVERVIEW

The Fleetwood Practices have a long tradition of working together, formally coming together as a federation as Fleetwood Community Care in 2014. It was successful in bidding against the Prime Ministers Challenge fund and has been providing seven-day access to primary care services for its community for the past two years.

Fleetwood Community Care directly employs clinical pharmacists who work in the practices. With support from Fylde and Wyre Clinical Commissioning Group, it has initiated the roll out of the IT system, EMIS Web, to community pharmacies and is developing an integrated approach to managing long term conditions such as chronic obstructive pulmonary disease (COPD) and hypertension between practices and community pharmacy.

The PCH has a Fleetwood multidisciplinary team for complex patients at risk of hospitalisation as well as a Fleetwood-wide home visiting service. The practices meet at least monthly to discuss neighbourhood priorities, services and issues. They also have a vibrant community engagement and activation group, 'Healthier Fleetwood'. This is a resident led community partnership. Partners include GP practices, other NHS providers, police, ambulance, fire and rescue, local authority, schools, voluntary sector, local sport clubs and associations. Its focus is on wellness and health creation.

PARTNERS

Three practices (Mount View, Broadway, The Fleetwood), Lancashire Care NHS Foundation Trust (mental Health), Blackpool Teaching Hospitals Foundation Trust (community nursing and therapy services), Fylde and Wyre Clinical Commissioning Group, Lancashire County Council, Wyre Borough Council, FCMS (out-of-hospital urgent care provider).

NO. OF PCHs: 1

NO. OF PRACTICES: 3

STP AREA: Lancashire and South Cumbria

107 108 109 110 111 112 Mid Essex

PARTNERS

Provide (Community Services Provider), Essex County Council (Social Services), North Essex Partnership Foundation Trust, District Council and Community Voluntary Service.

NO. OF PCHs: 6

NO. OF PRACTICES: 29

STP AREA:



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North West Health Alliance

OVERVIEW

The partnership arrangements are in place to develop this primary care home and the local clinical commissioning group is supportive. Joint bids for services have been drawn up, a business plan is in place and an integration manager has been appointed. The PCH has submitted a bid to West Lancashire Clinical Commissioning Group for the pain management service iHELP. In 2016/17, the alliance is looking at a range of projects including proactive care and nursing home work in Beacon and North Meols, women's services, over 75s frailty assessments and joint training. It has bids with NHS England to develop working at scale and has partnership arrangements in place to join practices administratively.

NO. OF PCHs: 1

NO. OF PRACTICES: 5

STP AREA: (Two) Cheshire and Merseyside, Lancashire and South Cumbria

PARTNERS

Five practices (Beacon Primary Care, North Meols Medical Centre, The Family Surgery, The Marshside Surgery and Viran Medical Centre), West Lancashire Clinical Commissioning Group, Southport and Formby Clinical Commissioning Group.

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Kentish Town

OVERVIEW

Kentish Town Primary Care Home is focussing on three areas to take this new model of integrated care to the next level: community mental health teams, social care and community and district nurses. The mental health burden in Camden is the second highest in the country so this is a key area for the PCH which is developing a primary care mental health team. This will bring a consultant and mental health specialist nurse into the group of practices. They will be involved in patient care planning, developing relationships across the practices and patient boundaries and, crucially, providing a bridge into the foundation trust.

The PCH is negotiating with the local authority to improve immediate access to carers and other social care provision, by expanding the current social care pilot within one of the practices. The pilot scheme has already shown great benefits in terms of improving integrated care for patients, particularly the frail elderly.

Kentish Town has long been aiming to close the gap between district/community nurses and practice based staff and care services. By fostering strong relationships with the local community trust, Camden Integrated Primary Care Service, the PCH is seeking to align its own services with those of the community nursing and rapid response admission avoidance teams to improve the joined-up care of frail and elderly patients.

PARTNERS

Camden Clinical Commissioning Group, Haverstock Healthcare, Camden and Islington NHS Foundation Trust, Central and North West London NHS Foundation Trust, Royal Free London NHS Foundation Trust, University College London Hospitals NHS Foundation Trust, Whittington Health NHS Trust, Age UK, Citizens Advice Bureau, Kentish Town Improvement Fund, The Tavistock and Portman NHS Foundation Trust, Camden Recovery Services and Health Education England.

NO. OF PCHs: 1

NO. OF PRACTICES: 6

STP AREA: North Central London



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Manchester (Central, North, South)

OVERVIEW

A great deal of progress has been made towards the PCH model locally although not carried out under that banner. GP clinical leads are now in place in all 12 neighbourhoods and some have been in post and active for about a year. Every neighbourhood has regular meetings involving all practices, health and social care partners and the voluntary sector.

Several grass roots initiatives have been identified and are being developed. Primary care is involved as an equal partner in citywide developments, represented through the three locality federations (north, central and south) and a citywide umbrella federation.

PARTNERS

Manchester City Council, Central Manchester Foundation Trust, the Greater Manchester Mental Health Trust and the voluntary sector represented via the city's infrastructure organisation MACC (Manchester Alliance for Community Care).

NO. OF PCHs: 12
NO. OF PRACTICES: 67
STP AREA: Greater Manchester

127 128 Newham

OVERVIEW

Newham Clinical Commissioning Group is developing an accountable care system (ACS), building on the Integrated Care partnership established as part of the Integrated Care Pioneer programme. The Primary Care Home is an enabler for the development of an ACS.

Newham has an existing model of cluster-based primary care. It has an ambitious vision for developing primary care to play a leadership role in the accountable care system and sees the PCH sites as a stepping stone to rolling out this model of care across the borough.

Examples of local services already commissioned to support the model include the diabetes pathway, with an extended role for primary care in managing all non-complex diabetes with patients having easy access to specialist advice. An extended hours access pilot scheme has been commissioned from the local GP federation, Newham Health Collaborative, and multidisciplinary teams have been established in GP clusters to support the co-ordinated care of patients with diabetes and those at high risk of hospital admission.

PARTNERS

Barts Health NHS Trust, East London Foundation NHS Trust, London Borough of Newham, and Stay Well Partnership (a third sector partnership).

NO. OF PCHs: 2
NO. OF PRACTICES: 18
STP AREA: North East London



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South Staffordshire and Surrounds

OVERVIEW

Nine localities have been created with most meeting on a regular basis as providers. Each locality is at different stages of development and has focused on the priorities that are most important to their area. These include network surgeries providing same day access, flu clinics and longer appointments for older people.

The primary care home is exploring new, more efficient ways of working, for example, by sharing the workforce and some backroom functions and focussing on strategic planning and integrated and multidisciplinary team working. It is also aligning its enhanced service contracts to deliver a collaborative approach by practices. It has developed a collaborative nursing home local enhanced service and has pump primed the project management in Stafford Town to enable practices to pool the funding and zone the practices to care home. It employs an advanced nurse practitioner to provide weekly visits to homes.

NO. OF PCHs: 6

NO. OF PRACTICES: TBC

STP AREA: Staffordshire

PARTNERS

Stafford and Surrounds Clinical Commissioning Group, Cannock Chase Clinical Commissioning Group, South East Staffordshire and Seisdon Peninsula Clinical Commissioning Group, Staffordshire and Stoke on Trent Partnership Trust, South Staffordshire and Shropshire Foundation Trust, Support Staffordshire, South Staffordshire Local Medical Committee and South Staffordshire District Council.

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Exeter Primary Care

OVERVIEW

The primary care home is working on an emerging vision. It is building on the foundations of Integrated Care Exeter PCH, which joined the community of practice in December 2016. Plans are to run them with similar programme design, each with three clusters working virtually. Ultimately, it is anticipated there will be three or more PCHs across Exeter, the exact footprint of these is not yet clear but will emerge with greater collaboration and GP involvement.

They will be looking at population segments, carrying out pilot schemes and learning to work together to provide better care focused on the needs of the individual. The size and make up of each will reflect the needs of local people, taking into account factors such as population growth, morbidities, frailty index and public health data. It has secured funding to develop primary care pilot projects.

NO. OF PCHs: 1

NO. OF PRACTICES: 9

STP AREA: Devon

PARTNERS

New Devon Clinical Commissioning Group, Royal Devon and Exeter NHS Foundation Trust, Westbank South West Academic Health Science Network, Exeter CVS and Devon Partnership Trust.



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Newquay and Petroc

OVERVIEW

The locality has a history of working well with its community teams and the voluntary sector. The Newquay pathfinder, which led to the Living Well experiment in Cornwall, showed to the practices, clinicians and patients the greater gains that could be realised by working differently together. The practices are keen to find ways to build on that experience.

One of the local practices provides medical cover for the local community hospital and all will need to be part of a wider discussion over the coming months about the role and function of community hospitals. The locality has a history of looking at different and new ways of working and sees the primary care home model as a way of bringing things together and moving onto the next stage.

PARTNERS

Three practices (Narrowcliff Surgery, Newquay Surgery, Petroc Surgery), Kernow Health Community Interest Company, Royal Cornwall Hospitals NHS Trust, Cornwall Partnership NHS Foundation Trust and Age UK.

NO. OF PCHs: 1

NO. OF PRACTICES: 3

STP AREA: Cornwall and the Isles of Scilly

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South Worcestershire Alliance

OVERVIEW

The goal of the South Worcestershire Alliance is to help people live well in supportive communities where care is joined up and delivered in the best place, by the most appropriate person and is underpinned by specialists.

The seven primary care homes aim to improve seven-day access to care by integrating primary and community teams with specialist support and promoting prevention and self care, especially among those most at risk.

They are determined to ensure that decisions are made based on the needs of the individual rather than the organisation. The alliance believes care should be provided at home wherever possible and GP practices should be at the heart of delivering that care.

The PCHs believe the depth of relationships and work to date will enable them to progress at pace, providing valuable learning and transferable design across their footprint.

The alliance has taken the learning from the new care model vanguards and international best practice to influence their vision and develop their principles. This has included Canterbury in New Zealand, the Burtzorg model in the Netherlands and the “best for Ester” approach from Sweden to ensure patients are at the centre of their design.

It is working closely with colleagues across Worcestershire who are already part of the primary care home community (Redditch and Bromsgrove Alliance, Wyre Forest Alliance). The alliance hope to strengthen and unite that approach formally across the county.

PARTNERS

Stay Well Healthcare (GP Federation), Worcestershire Health and Care NHS Trust, Worcestershire County Council, Worcestershire Acute Hospitals NHS Trust and South Worcestershire Clinical Commissioning Group.

NO. OF PCHs: 7

NO. OF PRACTICES: 32

STP AREA: Herefordshire and Worcestershire



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Warwick North, Coventry and Rugby

OVERVIEW

Both Warwickshire North and Coventry and Rugby Clinical Commissioning Groups are engaged in an STP-wide out of hospital design process which has included discussions with a range of partners, including acute providers, general practice, public and patients. This is looking at neighbourhood, place-based care around a footprint of GP practices covering a list size of 30-50,000 which fits well with the primary care home.

Warwickshire North, in common with the national picture, faces the challenge of managing the needs of an ageing population and the increasing prevalence of long term conditions and dementia which impact on the rising levels of frailty and dependence. The region provides care to around 188,000 people from 28 practices. The growing population has seen an increase in older, frail and vulnerable populations which has put pressure on services and housing needs. With planned developments of 25,400 additional properties across Warwickshire North, this pressure is likely to increase.

Practices have agreed to align into four geographic areas to develop interdisciplinary hubs. These are supported by South Warwickshire Foundation Trust's locality based community teams blending general community support with specialist nursing emergency response and intermediate care. The aim to build on this by developing the hubs so that they are also supported by social care and the third sector, tapping into the large range of community workers and social prescribing offers that already exist. The shared vision is to support the frail and vulnerable to maximise their independence and empower them to make choices that fit with their lives and deliver better outcomes for health and wellbeing.

There are 76 practices across Coventry and Rugby Clinical Commissioning Group. In Coventry, the group is developing integrated neighbourhood teams to achieve integrated working across all agencies to ensure the individual needs of frail and elderly patients can be met in the community. It is also looking to reduce avoidable, unplanned hospital admissions, minimise hospital stays and GP visits, maximise independence and support frail, elderly people to enable them to live well and independently for as long as possible in their own home. Other aims include ensuring that patients receive the appropriate level of care and reduce reliance on statutory agencies. The integrated neighbourhood teams are a different way of working that is all about collaboration and depends on information sharing between health and social care professionals.

PARTNERS

104 practices, Warwickshire North Clinical Commissioning Group, Coventry and Rugby Clinical Commissioning Group, Coventry and Warwickshire Partnership NHS Trust, Warwickshire Federation, public health, mental health, third sector.

NO. OF PCHs: 11

NO. OF PRACTICES: 104

STP AREA: Coventry and Warwickshire



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North West North Tyneside

OVERVIEW

North West North Tyneside consists of four locality groups of practices with registered populations of more than 45,000 each. The 29 practices have a long history of working in locality groups, and are migrating these groups into four primary care homes – Whitley Bay, North Shields, Wallsend and North West Tyneside – to cover the whole population.

North West North Tyneside faces problems common to much of the North East, including recruitment challenges, increased morbidity and elderly and frail people with no family nearby, and the perennial challenge of getting different ICT systems to communicate with each other.

The primary care homes are developing to address this. Recruitment can be managed on a PCH or federation basis, allowing new staff to choose a portfolio role or work in a single practice. The portfolio opportunities so far include frailty specialists for the frailty service in each PCH and clinical lead roles in health checks, cardiovascular disease (CVD) and gynaecology.

New community care pathways (deep vein thrombosis and menorrhagia) care for patients closer to home, through inter-practice referrals within PCH areas. Primary care navigators in each practice further reinforce the sense of community.

Each PCH is developing a model for extended hours and same day access, with a steering group of local practice representatives, and with setup, project management, governance, employment, registrations and contract management supplied by the GP Federation (TyneHealth).

The PCHs, via the GP Federation, coordinate nursing student placements and apprenticeships, and primary care research, which they hope will make North West North Tyneside even more attractive to clinical staff and a healthier place for people to live.

PARTNERS

Twenty-nine GP practices (five Care Quality Commission, CQC, Outstanding, 24 CQC Good); Northumbria Healthcare NHS Foundation Trust; Newcastle upon Tyne Hospitals NHS Foundation Trust; Northumberland, Tyne and Wear NHS Foundation Trust; North Tyneside Council's adult social care, children's social care, public health including health visitors and school nurses; voluntary sector: VODA (Voluntary Organisations Development Agency); Age UK North Tyneside; TyneHealth (GP Federation for all 29 practices) and NHS North Tyneside Clinical Commissioning Group.

NO. OF PCHs: 4

NO. OF PRACTICES: 31

STP AREA: Northumberland, Tyne and Wear



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Surbiton, Chessington and Kingston

OVERVIEW

Although the primary care home sites are very much in their infancy, mostly handling weekend and extended access facilities, they have a clear vision for the future.

Commissioners and providers are developing plans to roll out the new model of care with the aim of full implementation in spring 2017. Providers will then work together, initially in one locality, using the principles and model of care developed by the design team.

The PCHs are working on developing a number of services essential to the new model of care including home care to build the confidence and enhance the capability of home care workers to provide the care and support that people need, with emphasis on maintaining good community links and avoiding being drawn into the health system.

There are plans for a single occupational therapy team to avoid multiple assessments and hand-overs, duplication, fragmentation and delays. The PCHs are also focussing on improving community access to hospital specialists.

Providers are working together in four localities, covering the whole of Kingston. These new systems will ensure that people in Kingston are being listened to and will lead to the seamless provision of services across primary and secondary care. Learning groups will be established within and between the four hubs.

The ethos of multispecialty care will become the norm during 2017/2018 when the new model of care is fully commissioned.

PARTNERS

Kingston GP Chambers (a Kingston GP Federation and part of the South West London GP Federation), Your Healthcare (providing community services), adult social care, Staywell (Age Concern Kingston), Kingston Hospital, South West London and St George's Mental Health NHS Trust.

NO. OF PCHs: 3

NO. OF PRACTICES: 7

STP AREA: South West London

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Wokingham North, West and East Clusters

OVERVIEW

In Wokingham a cluster-based model has been in development within the locality for three years. More recently, all 13 practices in Wokingham have come together in an alliance structure, to be underpinned by a memorandum of understanding and run by an executive board.

Several early work streams have been identified including shared clinical pharmacist roles, piloting emergency care practitioner-led home visiting, reviewing the deep vein thrombosis pathway, providing pre-operative assessments in primary care and working with the broader adult community services on redesigning outpatients and managing high intensity users differently. Development of a full business plan is underway.

It is envisaged that in time the alliance will be part of a virtually-integrated Multispecialty Community Provider (MCP) arrangement also involving Berkshire Healthcare NHS Foundation Trust (BHFT) and Wokingham Borough Council.

Community health and social care builds upon the already established Wokingham Integrated Social Care and Health Team (WISH), an integrated service for short-term re-ablement. Clusters of Wokingham practices have successfully bid for funding through the national clinical pharmacists scheme.

PARTNERS

Wokingham GP Alliance (includes 13 practices), Wokingham Clinical Commissioning Group, Berkshire Healthcare NHS Foundation Trust, the Royal Berkshire NHS Foundation Trust, Wokingham Borough Council and the voluntary sector.

NO. OF PCHs: 3

NO. OF PRACTICES: 13

STP AREA: Buckinghamshire, Oxfordshire and Berkshire West



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Westongrove Partnership

OVERVIEW

The Westongrove Partnership launched an over 75s project team (The Weston Project) in January 2015 as part of the local clinical commissioning group (CCG) pilot scheme to focus on care of the elderly, many of whom are housebound or live in care homes, are frail and have complex health needs. The team consists of a lead nurse, further specialist nurse, a therapist/healthcare coordinator and two non-clinical care coordinators. They have the input of a retired GP and CCG lead for over 75s integrated working.

During the winter months of 2016/17 a social worker worked within the team. The project has shown how a multidisciplinary team focussing on a group of patients can work together to deliver more personalised care. This has resulted in keeping people out of hospital, reducing length of stay, enabling people to live independently longer at home, providing support to families and carers and the delivery of specific end of life care. A manual audit of patients showed that in 2016 the total number of hospital admissions prevented was 110.

The Weston Project has also secured several step-up beds at a local nursing home that have proved invaluable in re-enabling patients who may otherwise have been admitted into hospital or have had to stay in hospital longer. The project's nurses have been able to work closely with the nursing home team and other over 75s team locally, sharing expertise which has led to a positive impact on patients.

In 2016, the Weston Project was awarded the Bucks County Council Dignity and Care Award. Patient and carer feedback regarding the project, the team and the support they offer has been hugely positive. Results from a survey of patients showed that 95 per cent felt that their care at home was better since involvement. The GP referrer feedback showed that GPs felt their patients had benefitted from the service in 95 per cent of cases, the estimate of prevention of hospital admission was put at a minimum of 30 per cent and probably nearer to 50 per cent. The service had saved GP time in 95 per cent of cases.

The partnership's plans are being developed as an integral part of the local operating plan delivering the Sustainability and Transformation Plan. Westongrove plans to continue to develop its primary care home model, focussing on frail over 75s while improving the objective measures by which it can monitor future successes.

The key aims of the partnership are to improve the health of the local population, enhance the patient's experience of care, reduce the per capita cost of healthcare and improve the experience of providing care within the team. FedBucks, the local GP Federation, is working on an engagement process with local practices to support the formation of local integrated care clusters. As a FedBucks member, Westongrove will continue to work with them, the CCG and other partners, around its primary care home model.

PARTNERS

Westongrove (three practices), Buckinghamshire Healthcare NHS Trust (BHT), FedBucks, Aylesbury Vale and Chiltern Clinical Commissioning Group (CCG).

NO. OF PCHs: 1

NO. OF PRACTICES: 3

STP AREA: Buckinghamshire, Oxfordshire and Berkshire West

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Lower Lea Valley

OVERVIEW

Lower Lea Valley has developed the principles and draft model for an integrated community out-of-hospital services model. The model is expected to be launched from March 2018.

The community of practice has already pooled all the data from health and social care locally (primary care, community, mental health, acute and social care) into one platform, MedeAnalytics. It is working to develop an IT strategy for how best to use this rich data to meet the needs of the population.

PARTNERS

Eight practices (Abbey Road Surgery, Cromwell and Wormley Medical Centre, High Street Surgery, The Maples, Stanhope Surgery, Cuffley Village and Valley View Medical Centre, Stockwell Lodge Medical Centre, Warden Lodge Medical Practice), Hertfordshire Community NHS Trust, Hertfordshire Partnership University NHS Foundation Trust, Hertfordshire Care Services (county council), Royal Free London NHS Foundation Trust, Cheshunt Minor Injuries Unit (Haverstock Health), Carers in Hertfordshire and Crossroads.

NO. OF PCHs: 2

NO. OF PRACTICES: 8

STP AREA: Hertfordshire and West Essex



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North Kerrier Locality

OVERVIEW

The integration of community and primary care services is seen as a key driver in the transformation of the local NHS.

North Kerrier Locality is keen to develop Camborne Redruth Community Hospital as a central hub for extended access to primary care and out of hours services, while developing community-based social prescribing, starting with a leg dressing clinic which will include social activities. The community nursing and therapy team is already an integrated service based at the hospital and will shortly have a single referral and access process. This, together with the locality's increasing desire and proven ability to work at scale to find local solutions, is the basis of a strong PCH model which will provide the framework to formalise these working relationships and further integrate local services.

NO. OF PCHs: 1

NO. OF PRACTICES: 8

STP AREA: Cornwall and The Isles of Scilly

PARTNERS

Kernow Health Community Interest Company (GP Federation), Cornwall Partnership Foundation Trust and Royal Cornwall Hospitals Trust.

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Medway

OVERVIEW

Medway consists of 36 practices in six primary care homes covering Lerswood, Chatham, Gillingham, Rainham, Strood and Rochester. The practices have already been working together as local care teams (LCTs) within their own geographical areas for more than a year. These LCTs have endorsed the primary care home model as a vehicle to support and develop the services they deliver. They view regular interaction with other members of the 'community of practice' and participation in wider learning events as a key advantage to the programme. The ability to pool their resources, experience and tools, while working within a community with the same sense of purpose and identity, is seen as an enabler to speeding up change and improving delivery and performance. The teams look forward to developing their knowledge and experience and sharing their learning with a wider community. Medway Clinical Commissioning Group sees the primary care home model as the perfect vehicle through which general practice and wider primary care partners can be supported to provide the clinical leadership which is vital for the effective delivery of new models of care.

NO. OF PCHs: 6

NO. OF PRACTICES: 36

STP AREA: Kent and Medway

PARTNERS

36 GP practices, Medway Community Healthcare, Kent and Medway NHS and Social Care Partnership Trust, Medway Foundation Trust and Medway Council.



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South Reading Alliance

OVERVIEW

The South Reading Alliance is a newly formed and developing GP federation. It includes 16 practices across Reading which are geographically aligned via three primary care homes.

The alliance is in discussion with key stakeholders across the local health economy around the reconfiguration of services, including the deployment of community nurses, the development of social prescribing - with the voluntary sector and Reading Voluntary Action - and the bringing together of children's services commissioned by the local authority. The alliance has recruited a business manager who is developing these work-streams in greater detail.

The practices have been working collectively to provide extra clinics for patients as part of the clinical commissioning group's extended hours enhanced service (CES). The collaboration enables practices to work at scale in areas where delivering services is a challenge because of the small list sizes of some local surgeries. Work on interoperable IT systems is underway.

Each of the primary care homes has been carrying out reviews of patients with the highest impact on A&E services. Several practices are sharing clinical pharmacists and management of staff, skill mixing to deliver care that meets patients' needs. The three primary care homes are planning to integrate their back-office functions, which will gain momentum with the new business manager in post.

PARTNERS

16 practices, Berkshire Healthcare NHS Foundation Trust, Royal Berkshire NHS Foundation Trust, Reading Borough Council and the voluntary sector.

NO. OF PCHs: 3

NO. OF PRACTICES: 16

STP AREA: Buckinghamshire, Oxfordshire and Berkshire West



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Stort Valley and villages

OVERVIEW

The nature and scale of need is changing radically in Stort Valley and Villages. Most local people want enhanced access to care and many, especially those with long-term conditions, want improved continuity of care. They want more consistent and proactive services that support them to manage their conditions and achieve their goals. Their needs, both mental and physical, change and they expect local services to adapt accordingly. Some patients, notably the frail, those with multiple chronic conditions and those nearing the end of life, want better coordinated care. They want the services that are supporting them to work closely together, integrating - rather than duplicating - care closer to home and improving the experience of it.

To meet their needs, health and care providers in Stort Valley and Villages have set up an Integrated Care Board and developed a five-year vision, to improve access, continuity and coordination across the system. The primary care home's ambition is to support local people in managing their health and wellbeing in the place where they live, to give them help and guidance when needed and to promote independence throughout. It's envisaged that professionals in primary care, community services, hospital, mental health and social care will be able to work differently and closer together by organising care around the needs and preferences of patients. The PCH model will be tested initially by focusing on services for the frail elderly and those with long-term conditions.

The priorities for the first year include establishing a baseline for the locality so that any shift in outcomes and performance can be monitored and reported on effectively. The care of patients with long term conditions will be coordinated via a single care plan, managed by the most appropriate professional and documented on a shared IT platform. The locality is in the process of pooling system data from all local providers into a single platform (MedeAnalytics) and is working on an IT strategy to ensure this data is effectively used to meet the needs of the local population. A data analyst has been appointed to help with this work.

The role of the integrated community team will be expanded and developed along with clear pathways between different local community services. The PCH will work alongside the district council to develop a community model of social prescribing, ensuring effective use of local resources including those provided by voluntary organisations. An integrated workforce plan will be developed and a communications strategy put in place to ensure the PCH vision is pursued in partnership with professionals and the local population. The alliance will ensure its voice is heard regarding the development of Herts and Essex Hospital so that its vision for care pathways, both planned and unplanned, can be achieved.

PARTNERS

Five GP practices, Hertfordshire Community NHS Trust, Hertfordshire Partnership University NHS Foundation Trust, Hertfordshire County Council's Health and Community Services, Princess Alexandra Hospital NHS Trust, Hertfordshire Community NHS Trust (Herts and Essex Hospital Minor Injury Unit), Age Concern, East Hertfordshire District Council.

NO. OF PCHs: 1

NO. OF PRACTICES: 5

STP AREA: Hertfordshire and West Essex



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East Cheshire

OVERVIEW

Eastern Cheshire Clinical Commissioning Group has been instrumental in driving forward the Caring Together programme, which aims to deliver a new system of health and social care that joins up local services for the benefit of patients. The goals of Caring Together are essentially the same as those of the primary care home programme and locally the PCH model is seen as a means of achieving this aim. Eighteen practices have joined forces to develop four PCHs covering the localities of Chelford, Handforth, Alderley Edge and Wilmslow (Team Chaw), Congleton and Holmes Chapel (Team Choc), Knutsford (Team Knutsford) and Macclesfield (Team Macc).

In June 2017 the three Knutsford practices came together to form a prototype hub offering integrated working between the GP surgeries, community services, local authority, social care, voluntary sectors and patient groups. The team is looking at 90 day projects that will enhance services and care for patients. These projects are led by a lead clinician from each practice together with support from community matrons, district nurses and a wider area team. In Macclesfield, six practices have moved into new, purpose-built premises allowing for shared working and provision of services. The community nursing team is co-located in the same building and has proved invaluable to patient care. There is a central phlebotomy service and much sharing behind the scenes for purchasing and joint staff contracts.

In Team Choc, there are plans to bid for a clinical pharmacist. Team Chaw has been holding multidisciplinary peer group meetings - involving social services, GPs and the mental health team - when problems and issues across the group, as well as within individual practices, are discussed and addressed.

PARTNERS

Eighteen practices, Vernova Healthcare Community Interest Company (a social enterprise GP federation and provider of out-of-hospital services owned by all GP practices in Eastern Cheshire), East Cheshire NHS Trust, Cheshire and Wirral Partnership NHS Foundation Trust, Cheshire East Council (social care), Age UK Cheshire East and North West Ambulance Service NHS Trust.

NO. OF PCHs: 4

NO. OF PRACTICES: 18

STP AREA: Cheshire and Merseyside



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Bedfordshire, Luton and Milton Keynes

OVERVIEW

The six primary care homes in Bedfordshire, Luton and Milton Keynes cover the localities of Chiltern Valley, Ivel Valley, Leighton Buzzard and West Mid Bedfordshire.

In Chiltern Valley, nine practices have a history of collaborative working which includes the development of a practice matrons' service and the Caring Together multidisciplinary team (MDT) project which involves fortnightly reviews of patients with multiple needs. Each MDT consists of a broad range of health and social care professions and is aligned to a GP cluster of practices. The aims are to provide better integrated care for these patients and reduce hospital admission rates. Standard policies and procedures across all the practices have also been developed.

Ivel Valley's nine practices have also been working collaboratively, for example in running an out of hours service, M-Doc, which was operational until April 2017 when a new Clinical Commissioning Group provider was appointed. In Leighton Buzzard the three practices support each other when GPs are unavailable or urgent circumstances arise. All the practices' maternity services are on one site with people receiving antenatal care and ultrasound scans, regardless of which practice they are registered with. Plans are underway for a locality based stoma clinic with a nurse from Luton and Dunstable Hospital.

The six practices in the West Mid Bedfordshire locality have a long history of working together to identify service gaps and find solutions. They are currently working to develop a common website with the aim of enabling patients to access routine, face-to-face consultations in different ways.

Bedfordshire, Luton and Milton Keynes has been selected by NHS England for development as one of eight national Accountable Care Systems. The primary care home model provides a key opportunity for practices to commit to the shared learning of the community and also to share the enhanced learning of all the emerging Accountable Care Systems. The development of the model is also a core objective of all the clinical commissioning groups and partners, as part of the delivery of the Bedfordshire, Luton and Milton Keynes Sustainability and Transformation Plan.

PARTNERS

The 27 practices, Bedfordshire Clinical Commissioning Group, Central Bedfordshire Council, Essex Partnership University NHS Foundation Trust, Central and North West London NHS Foundation Trust, East London NHS Foundation Trust, Bedford Hospital NHS Trust, Milton Keynes University Hospital NHS Foundation Trust and Luton and Dunstable NHS Foundation Trust.

NO. OF PCHs: 6

NO. OF PRACTICES: 27

STP AREA: Bedfordshire, Luton and Milton Keynes



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Newcastle-under-Lyme

OVERVIEW

The Newcastle-under-Lyme population of 130,000 is covered by 20 GP practices ranging in list size from just over 2,000 to more than 13,000. The practices decided the time had come to strengthen their position by working together to future proof primary care provision across the town and make them resilient and ready for the changes ahead. This also allowed them to plan strategically together as practices and also with community partners.

Elderly care presents the biggest challenge for the local health economy.

Within the three localities, there are around 25,000 patients over the age of 65 with more than 3,000 patients over the age of 85. This was identified as a key area where the practices could make an impact on the quality of care and the experience of patients, with a reduction in unplanned hospital admissions to ease the burden on the acute sector. Several clinicians were developing different aspects of care for the frail elderly. The primary care homes plan to bring this work together and develop a coherent, clear and consistent approach to the community management of elderly care across three hubs.

Over the coming months, there will be a series of workshops to develop plans for an “extensive care” service to support the highest risk elderly patients with the most complex needs. Each of these patients will have a geriatric assessment and a clear management and hospital admission avoidance plan, overseen by a named care coordinator and involving a multidisciplinary team of healthcare professionals. Similar avoidance plans will be put in place for patients who are acutely unwell but who don’t require immediate admission.

For lower risk elderly patients, an elderly care facilitator (ECF) service will be established. It will form the backbone of a whole population approach to elderly care combining a proactive approach to the early identification of frailty and other issues such as dementia, social isolation, alcohol problems and vaccination uptake. The service will deliver whole population screening of patients aged 75 above. An educational event is planned to enable practices which have already developed the ECF model to share their experience. The practices will work towards using a uniform approach to classifying all patients over the age of 65 to ensure they receive the most appropriate care.

PARTNERS

The 20 practices, Staffordshire and Stoke-on-Trent Partnership NHS Trust, North Staffordshire Combined Healthcare NHS Trust, University Hospitals of North Midlands NHS Trust, Staffordshire Healthwatch, Staffordshire Housing Association, the charity VAST and Staffordshire Doctors Urgent Care (out-of-hours provider).

NO. OF PCHs: 3

NO. OF PRACTICES: 20

STP AREA: Staffordshire and Stoke-on-Trent





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East Merton

OVERVIEW

The East Merton primary care home (PCH) comprises four local GP practices covering a population of around 40,000 patients. The PCH aims to rapidly progress the model and share learning across Merton.

A population health management approach is being developed, beginning with people with long term health conditions. There are plans to establish an integrated team of health, social care and voluntary sector professionals working together in a coordinated way to plan for and support the delivery of their care. A dedicated multi-professional team based approach is also being developed to support people in care homes.

Access to urgent and emergency care will be improved through the development of better call handling and an acute response team, enabling other clinicians to focus on planned and more proactive care. The PCH also aims to improve access to locality-based mental health services and communication with specialist services more generally.

Staff capacity and capability is being developed through a workforce plan which includes sharing staff across sites as well as the back office human resources, administrative and management functions to support an integrated workforce model.

The PCH is committed to supporting the health and well-being of the local population and is prioritising social prescribing schemes and other community partnership approaches. These schemes are designed to support people with a wide range of social, emotional and practical needs including mental health problems, vulnerable groups (including the frail), those with complex needs, people who are socially isolated and frequent users of health services.

The PCH has signed a memorandum of understanding with the Commonsides Community Development Trust, a voluntary sector organisation, with the aim of forming a social enterprise partnership to address the broader determinants of health for the local population.

PARTNERS

The four practices, Central London Community Healthcare NHS Trust, Community Mental Health Team and mIAPT (the Improving Access to Psychological Therapies Service for Merton), Merton Council and the Commonsides Community Development Trust.

NO. OF PCHs: 1

NO. OF PRACTICES: 4

STP AREA: South West London



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Bradford Care Alliance

OVERVIEW

Bradford’s population is one of the most diverse in the country with significant health inequalities across the city. Many people, especially women, live much of their lives in poor health and more than 33,000 children live in relative poverty.

The primary care home model will play a key role in the implementation of the local sustainability and transformation partnership’s plan which includes prevention and early intervention at the first point of contact with patients.

The focus will be on delivering population health outcomes and care centred around individuals. Services will be transformed to meet the physical, psychological and social needs of the population, so reducing inequalities, addressing the wider determinants of health and supporting people to remain healthy, happy and at home.

There will be a specific focus on children, obesity, type 2 diabetes, cardiovascular disease, cancer, respiratory problems and mental health. Self-care will be promoted by using local community resources to support patients and by training staff to empower people to become more independent. High quality, specialist mental health services will be provided for all ages along with early intervention support services. There are plans to develop a sustainable model for 24/7 urgent and emergency care services as well as planned care.

The PCH programme involves the establishment of locality and community integrated teams made up of a wide range of health professionals including advanced nurse practitioners, specialist nurses (for example for dementia and end-of-life patients), dietitians, speech and language therapists, occupational therapists, social prescribers, care navigators and physiotherapists. These teams will work closely with hospital consultants and discharge teams, intermediate care units and community outreach teams, GPs, district nurses, community pharmacists and the voluntary sector. The aim will be to reduce pressure on hospitals and provide a better-quality service to patients where they feel most comfortable.

Other potential projects, developed as part of the Bradford out-of-hospital programme, could include mindfulness courses for people with chronic pain and working with the fire service to support the frail elderly at risk of falling.

PARTNERS

Sixty-six practices, Bradford Care Alliance Community Interest Company, Bradford District Care NHS Foundation Trust, Bradford Teaching Hospitals NHS Foundation Trust, City of Bradford Metropolitan Council and Bradford Voluntary Care Sector Alliance, NHS Bradford City and NHS Bradford Districts Clinical Commissioning Groups.

NO. OF PCHs: 10

NO. OF PRACTICES: 66

STP AREA: Bradford and Craven





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Your Health Partnership

OVERVIEW

Your Health Partnership is a single “super partnership” formed by the merger of four GP practices with 46,000 patients in Sandwell and West Birmingham. It shares resources, skills and knowledge across all its sites and has centralised management, care navigation and admin teams. The partnership is committed to continuous service improvement, by analysing activity data and drawing on the experience of patients and colleagues. It has a multidisciplinary home visiting team and provides outpatient services in the community.

The primary care home has good links with its acute trust and provides medical cover for its intermediate care beds. The acute trust, which also provides community services, has chosen lead clinicians and admin staff to work with the PCH to develop improved, integrated services. The partnership also has a good relationship with its local mental health trust which has enabled it to develop specialist services and skills. Agewell, the leading local voluntary service for the over-50s, is working with the PCH to establish a community referral pathway to its services which include home and community-based exercise, befriending, support for carers and dementia patients and health promotion. In 2017 the charity started a weekly strength and balance class, based at the Regis Medical Practice, for patients at risk of falling.

PARTNERS

One practice, Sandwell and West Birmingham Hospitals NHS Trust, Sandwell Metropolitan Borough Council, Black Country Partnership NHS Foundation Trust and Agewell.

NO. OF PCHs: 1

NO. OF PRACTICES: 1

STP AREA: The Black Country

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South Tandridge Network Group

OVERVIEW

Increasing demand from a growing number of elderly people with complex needs and the deteriorating overall health of the population has been putting a strain on a hospital-based system which is unsustainable.

The East Surrey Clinical Commissioning Group's (CCG) operating plan for 2016/17 highlighted primary care as the cornerstone of the local health economy and focused on the establishment of networks of GP practices, clustered geographically, covering populations of 30,000 - 50,000.

The South Tandridge Network Group is part of Alliance for Better Care (ABC) – a federation of 17 East Surrey GP practices established in 2014. ABC has been working with First Community Health and Care, which provides community health services in East Surrey. The two organisations have signed a memorandum of understanding which commits them to sharing knowledge, resources and expertise and working together to co-design and change the primary, community, social and secondary care systems. They are focusing on maximising opportunities to integrate primary care and community health services, reducing hospital admissions and delivering an excellent standard of community healthcare via combined medical practices, clinics, the local community hospital and in patients' homes. The CCG and other stakeholders have supported the development of a place-based plan that promotes the multispecialty community provider (MCP) approach to the delivery of primary care. The plan's goals include empowering the local population to stay healthy, through prevention and education, so avoiding medical conditions developing in the long term. The care of patients with long term conditions will be moved away from hospital, closer to home, and there will be multidisciplinary, co-ordinated care for those who are frail and those with the most complex health and social needs. An effective network of urgent care, based on enhanced primary care services, will be developed to reduce unnecessary A&E attendances.

PARTNERS

Three practices, First Community Health and Care, Surrey County Council's adult social care service, Surrey and Borders Partnership NHS Foundation Trust.

NO. OF PCHs: 1

NO. OF PRACTICES: 3

STP AREA: Sussex and East Surrey



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