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Primary Care Home Case Study

Organisation:	St Austell Healthcare
Number of PCHs:	1
Population:	31,800
GP practices:	1
Partnership:	The PCH involves community and mental health trusts, clinical commissioning group, county council, town council, public health, Eden project, voluntary sector and local employers.
STP footprint:	Cornwall and the Isles of Scilly

The challenge

St Austell has high levels of long-term unemployment, socioeconomic deprivation as well as a high prevalence of chronic disease and obesity. A large local practice closed in 2014 placing the remaining three practices under pressure. They have since merged and accepted patients from the failed practice. Primary care home offered a framework to redesign services to provide a sustainable future and offer new services with secondary and community care partners as well as the third sector.

What they did

The rapid test site has introduced social prescribing, integrated health and social care services and increased the skills of multidisciplinary teams. Many of the practice's patients are frail and elderly, physically inactive and often lonely. The practice worked with community providers, employing a social prescribing coordinator to see patients and refer them to resources ranging from walking groups to Zumba and canoeing to increase their physical activity, improve their diet and reduce social isolation.

Patients are receiving better coordinated care following the appointment of an integrated care manager to facilitate home visits (preventing duplication and inappropriate clinicians attending), improve hospital discharges and the treatment of complex/palliative-care patients. Community and district nurses are co-located at the practice's acute hub which sees people who need an urgent same day appointment.

The primary care home has concentrated on skills development for staff and expanding the multidisciplinary teams. A pharmacist is part of the practice team carrying out medication reviews and supporting patients with medication queries. There is a nurse-led minor illness team at the acute hub, and an acute visiting service using emergency care practitioners.

The impact

The social prescribing pilot resulted in 52 out of 150 patients completing 12 weeks of the programme, of those 94% saw an increase in their wellbeing score, 62% lost weight, 8% stayed the same, all would have increased weight without the programme.

Lessons learnt/success factors

It takes time to build trust and relationships between different organisations. Continued investment in relationships is needed. It is essential to have time to lead.