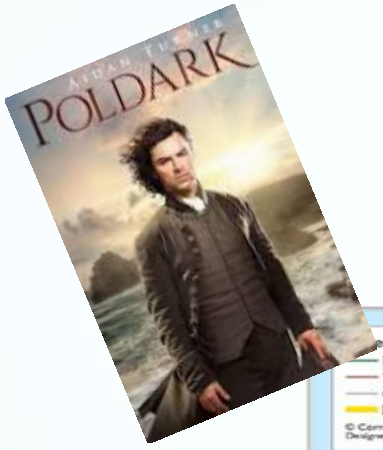
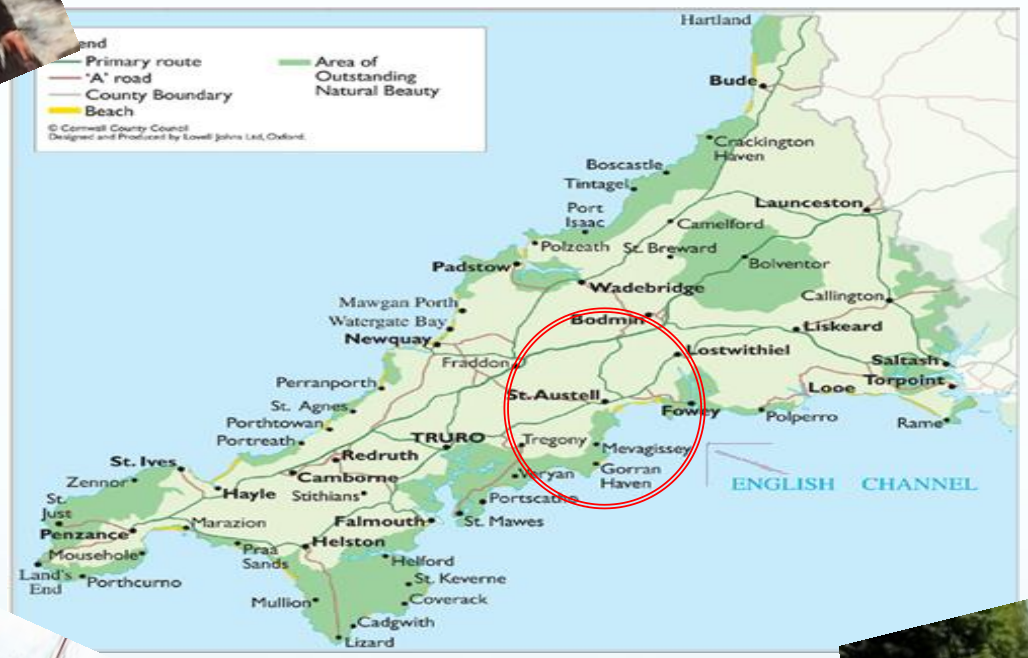
Primary Care Home:

General Practice and Public Health

Dr Stewart Smith

St Austell





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Background – primary care provision in St Austell (pre August 2014)

- Four GP Practices working in isolation (each with 6,000-11,000pts) Community hospital with MIU
- Difficulties recruiting and retaining
- St Austell (and Cornwall) has a high incidence of:
    - Chronic Disease
    - Economically inactive
    - Socio-economic deprivation

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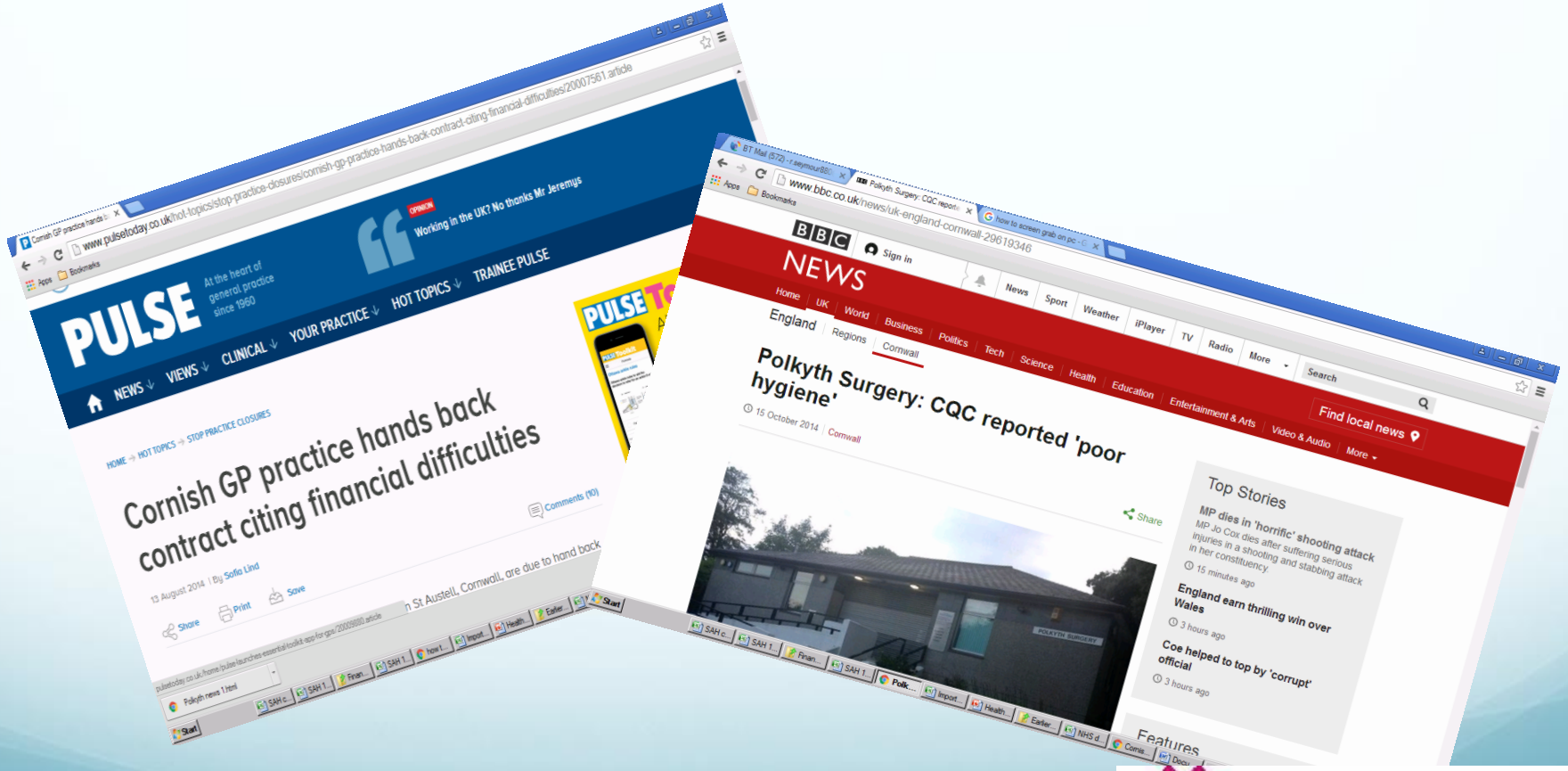
Polkyth practice failed in August 2014



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GP at Scale in St Austell

- Merger May 2015 – 32,000 Patients
- Separation of acute and planned care
- Central, acute hub 8-8 Monday to Friday (MDT and telephone triage-based)
- Work-force re-design and planning (3200 Patients/wte)
- Primary Care Home Rapid Test-Site December 2015
- Integration – CCG, community providers, Voluntary Sector etc
- Co-location with health promotion team since September 2016

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Four core characteristics of a Primary Care Home

1 **The provision of care to a registered population size of 30,000 to 50,000 people**

- We know that an 'optimum' size for a workforce100-150 (the 'Dunbar' number*)
- At this size the PCH is the "right size to scale" and the "right size to care".

**Dunbar, R. (2010). How Many Friends Does One Person Need? Dunbar's Number and Other Evolutionary Quirks. Faber & Faber.*

2 **A focus on personalisation of care with improvements in population health planning, provision and outcomes**

- Balancing the provision of personalised care, responsive to the needs of individuals with population health planning and provision
- Focus on the social determinants of health
- Focus on people who share characteristics within a population rather than a disease
- Proactive, preventative care,

Four core characteristics of a Primary Care Home

3 An integrated, multi-disciplinary workforce

- 100-150 people drawn from an existing workforce comprising:
  - healthcare workforce (e.g. primary, community, mental health, palliative care and appropriate specialist care teams)
  - social care workforce
  - voluntary and charitable workforce, patient groups and community assets.

4 Financial drivers aligned with the health needs of the whole population

- Aim to have responsibility for whole population budget built around the GP practices involved
- The scope of services provided is agreed through local commissioning arrangements
- The details of how the PCH will take on a whole population budget is being developed in conjunction with the NCM programme.

The Quadruple Aim

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

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

Primary Care home: Social Prescribing

- Aims: Improve Health and well-being and demedicalise Social and lifestyle issues
- Partnership working with public health and voluntary sector
- >250 patients so far.
- Simple referral via our facilitator
- Social Prescribing Facilitator providing bespoke lifestyle progrmme,motivational interviewing, follow-up and quality assurance
- Emphasis on group therapy, face to face communication and reduce duplication
- We can find physical activity (and other lifestyle help) for everyone
- Also: Support groups, nutrition, befriending, Arts, culture, carer support, voluntary sector mapping, mental health support etc.

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DELL

Social Prescribing 12 months

- >250 Patients have entered since August 2016
- 32% drop out rate (previous health promotion = 50%)
- 94% have had increased Wellbeing scores
- 68% of overweight patients have lost weight
- Community Integration and New Relationships
- Launch Event supported by NAPC

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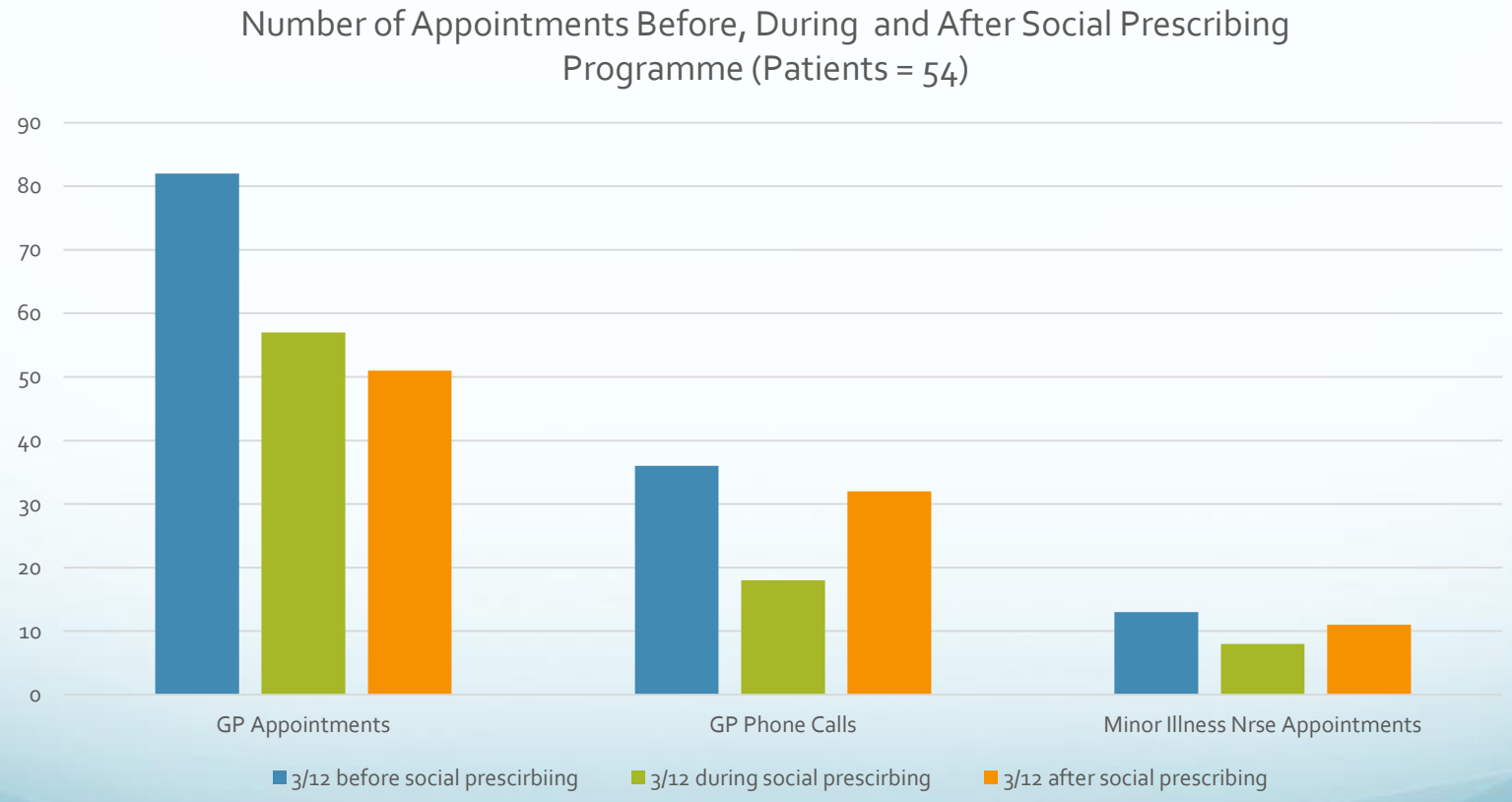
Appointments 3/12 Before, During and After Social Prescribing Programme



Health Promotion Team benefits

- Improved quality of referral
- Better targeting of hard to reach groups
- Reduced drop out rates
- New courses, relationships and facilities: gym classes, healthy eating, healthy cooking, more healthy weight classes, children's healthy weight, swimming for health and walking for health.
- Access to other community providers
- Happier team with less sick leave

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Enablers

- Time to lead and develop relationships
- Face to face communication and understanding each other's roles
- An appetite for change and courage to take the leap
- Function before form
- Focus on moving towards new populaton based healthcare
- Have fun!

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What Next?

- Developing a cross-sector, collaborative approach to social prescribing across Cornwall with Public Health Consultant
- Spread of this model across other PCH sites in Cornwall
- Working together to attract funding and scale this work
- Addition of Pharmacist medication review to 6 month Social Prescribing review
- More Impact Data
- More Fun!

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