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Evidence and Potential Impact of Primary Care Homes and how to succeed [in the South West]

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A PRIMARY CARE HOME NAPC

Learning from history…

- Engagement of primary care clinicians vital
- Primary care and population size matters
- Incentives v overall management of population resources
- Clinical integration is important (primary and secondary)

Lewis R and Chana N (2018)"The primary care home: a new vehicle for the delivery of population health in England", Journal of Integrated Care, Vol. 26 Issue: 3, pp.219-230, https://doi.org/10.1108/JICA-04-2018-0032

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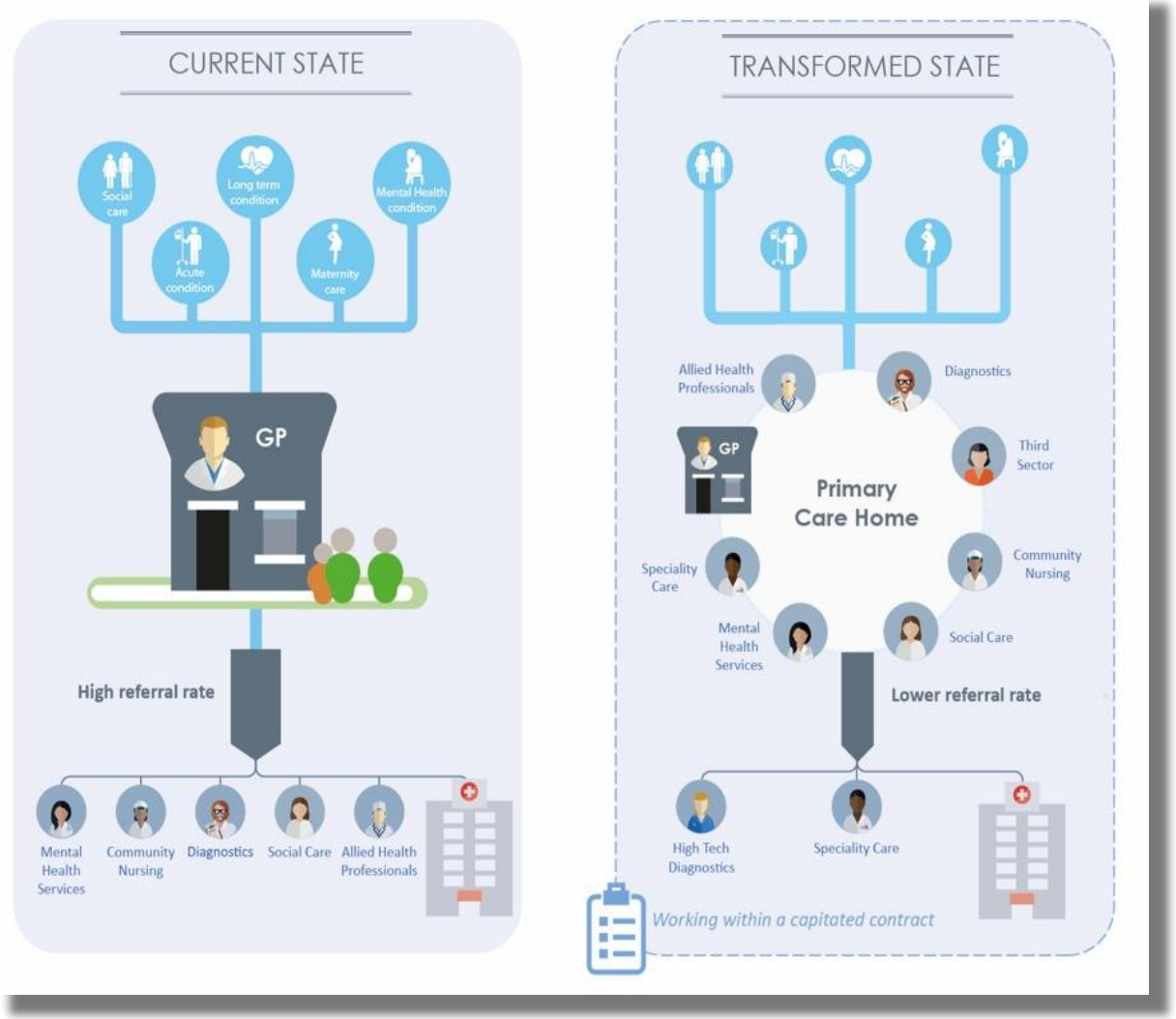
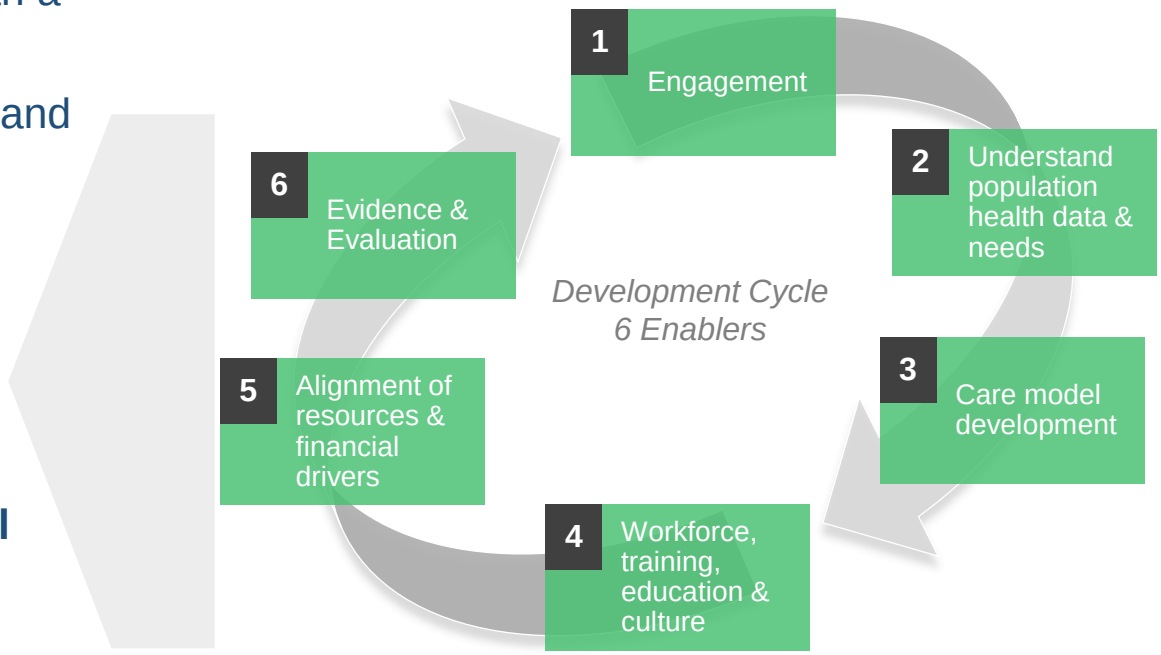
Primary Care Home (PCH): a form of Primary Care Network



Primary Care Home has four key characteristics and six key enablers

1. an **integrated workforce**, with a strong focus on partnerships spanning primary, secondary and social care;
2. a combined focus on **personalisation of care** with improvements in **population health outcomes**;
3. aligned **clinical and financial drivers**
4. provision of care to a defined, registered population of between **30,000 and 50,000**.



Building the energy, commitment and capability

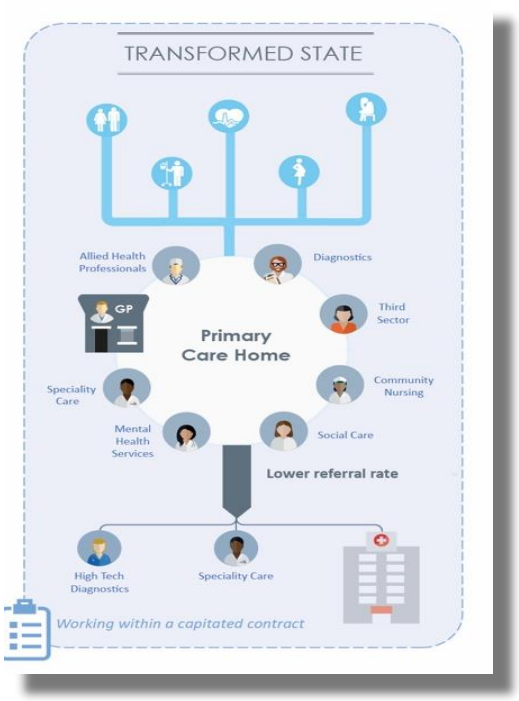
PCN Maturity Matrix

Foundation

Stage 1

Stage 2

Stage 3



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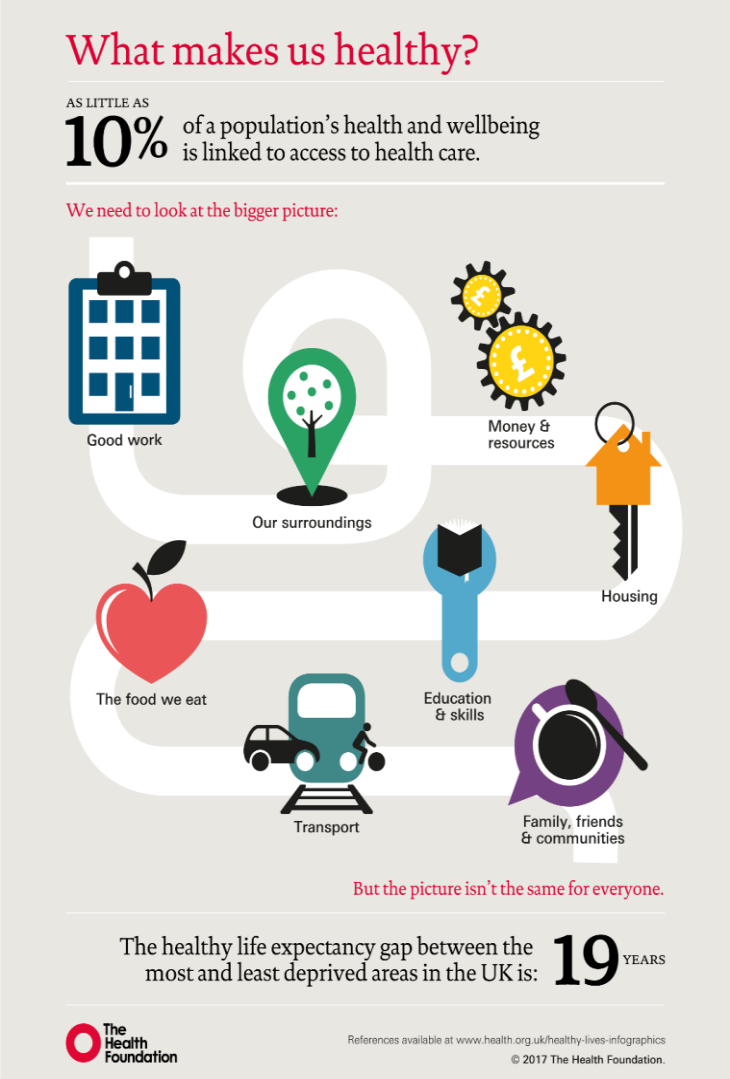
Our starting point….



The greatest influences on people's health and wellbeing come from outside direct healthcare provision

McGovern L, Miller G, Hughes-Cromwick P. Health Policy Brief: The relative contribution of multiple determinants to health outcomes. Health Affairs. 21 August 2014. Available from: http://healthaffairs.org/healthpolicybriefs/brief_pdfs/healthpolicybrief_123.pdf

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Multi-agency community provision

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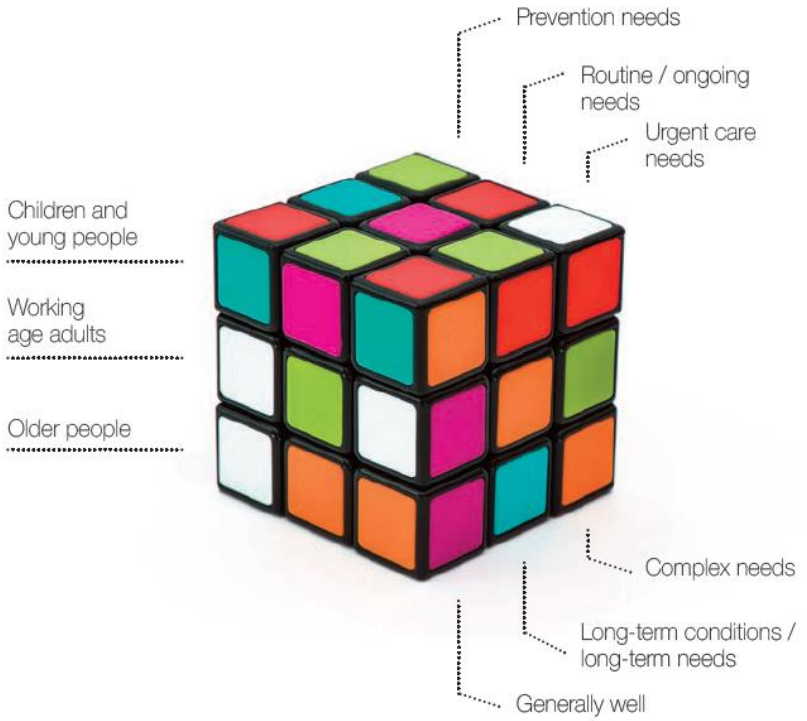
PCH based on '*whole*' population health management approach

	Generally well / good wellbeing	Long-term conditions / social needs	Complexity of LTC(s) / social needs and / or disability
Children and young people			
Working age adults			
Older people			



	Generally well		Long term conditions / Long term needs		Complexity of LTC(s) and/or disability	
	Low risk	High risk	Low risk	High risk	Low risk	High risk
Children and Young People						
Working Age Adults						
Older People						

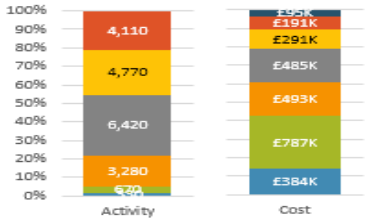
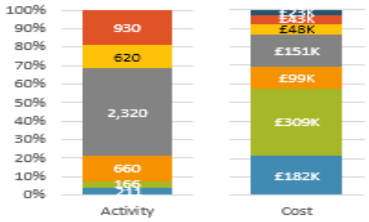
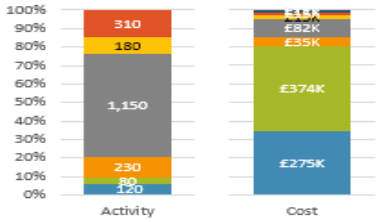
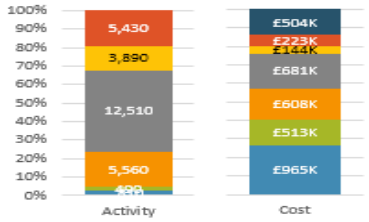
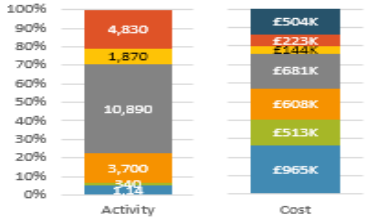
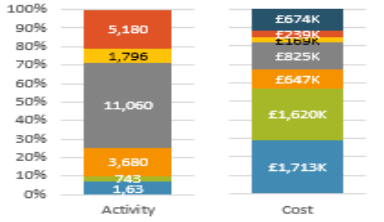
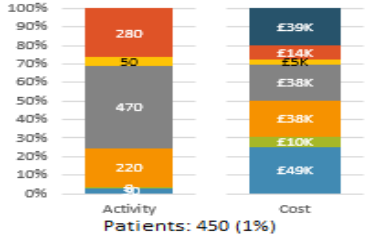
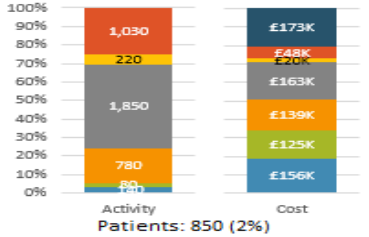
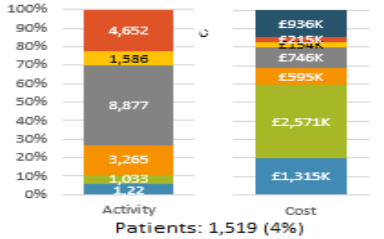
PCH List Size: 36, 890	Generally well 27439 (74%)		Long term conditions / Long term needs 5,935 (16%)		Complexity of LTC(s) and/or disability 3516 (10%)
	Low risk	High risk	Low risk	High risk	All
Children and Young People (11,942) (0- 25)	**9685**	**1515**	**397**	**288**	**57**
Working Age Adults (22,129) (26- 65)	**7395**	**8394**	**748**	**3652**	**1940**
Older People (2,819) (66 and over)	**203**	**247**	**85**	**765**	**1519**

East Merton PCH Segmentation Analysis

Activity and cost by segment

Key: Inpatient Elective | Emergency Admission | Outpatient First | Outpatient Follow-up | A&E | GP Visit | Pharmacy (Cost Only)

Note: Numbers have been suppressed from segments where patient count < 5

	Generally Well	Managing Long-term Conditions	Complex Patients
	Primary prevention, acute care, immunisation	Secondary prevention and care planning, managing LTCs better	Caring for people in a better way to minimise impact on health resources
0-24	 Patients: 11,200 (30%) Total Spend: £2,395,000 (10%) Spend per Patient: £1,322	 Patients: 685 (2%) Total Spend: £1,115,000 (5%) Spend per Patient: £13,980	 Patients: 57 (0%) Total Spend: £800,000 (3%) Spend per Patient: £28,286
25-69	 Patients: 15,789 (43%) Total Spend: £3,700,000 (15%) Spend per Patient: £992	 Patients: 4,400 (12%) Total Spend: £3,850,000 (16%) Spend per Patient: £2,872	 Patients: 1,940 (5%) Total Spend: £5,420,000 (22%) Spend per Patient: £8,446
70+	 Patients: 450 (1%) Total Spend: £185,000 (1%) Spend per Patient: £950	 Patients: 850 (2%) Total Spend: £860,000 (3%) Spend per Patient: £1,857	 Patients: 1,519 (4%) Total Spend: £6,371,218 (26%) Spend per Patient: £11,958

East Merton…

Acute response

Integrated nursing

Mental health (CYP and older age)

Specialist advice (including radiology)

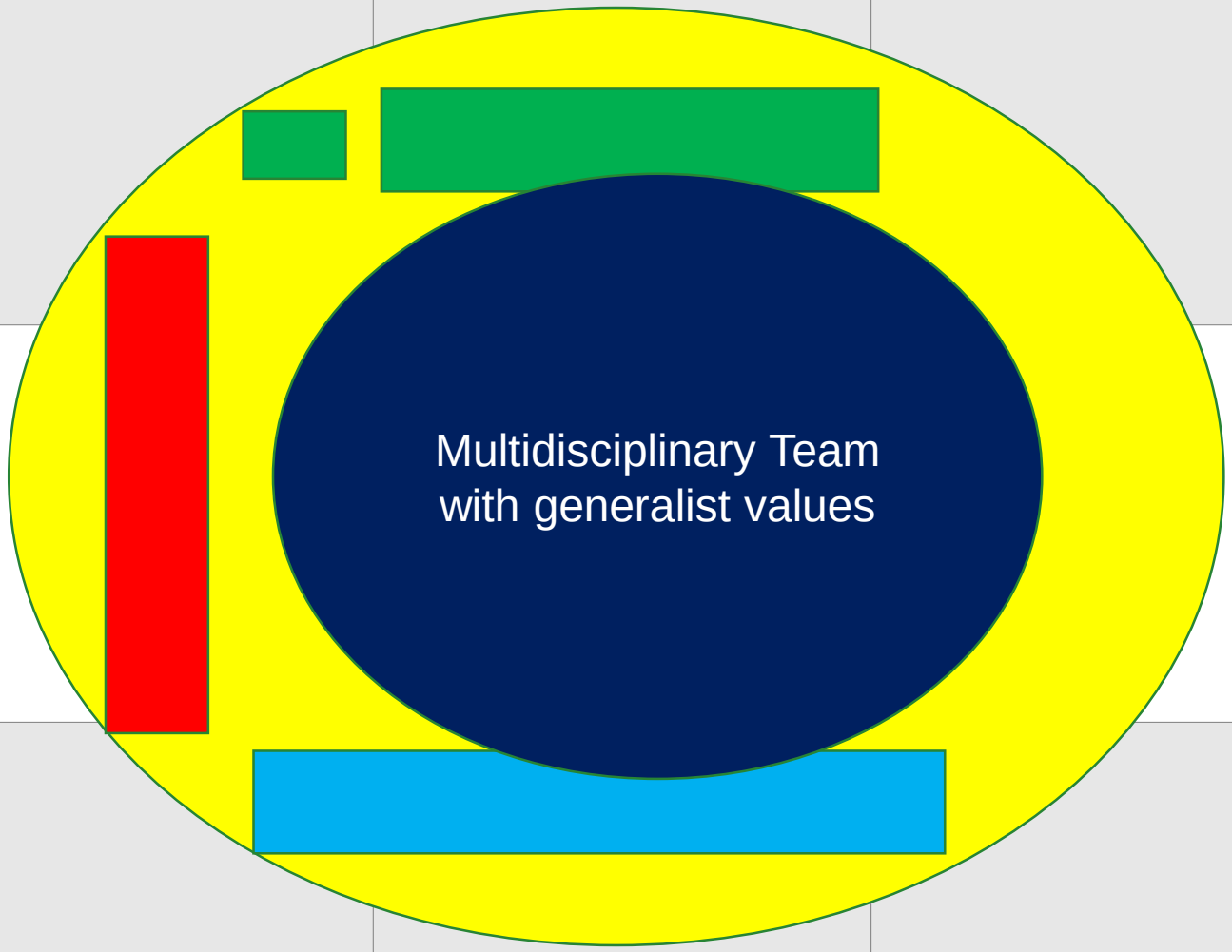
Care navigation and health coaching

Medicines Management

MSK and OT

Benefits, employment and housing advice

	Generally well/ good wellbeing	Long term condition(s)/ social needs	Complexity of LTC(s)/ social need and/or with disability
Children and young people			
Working age adults			
Older people			



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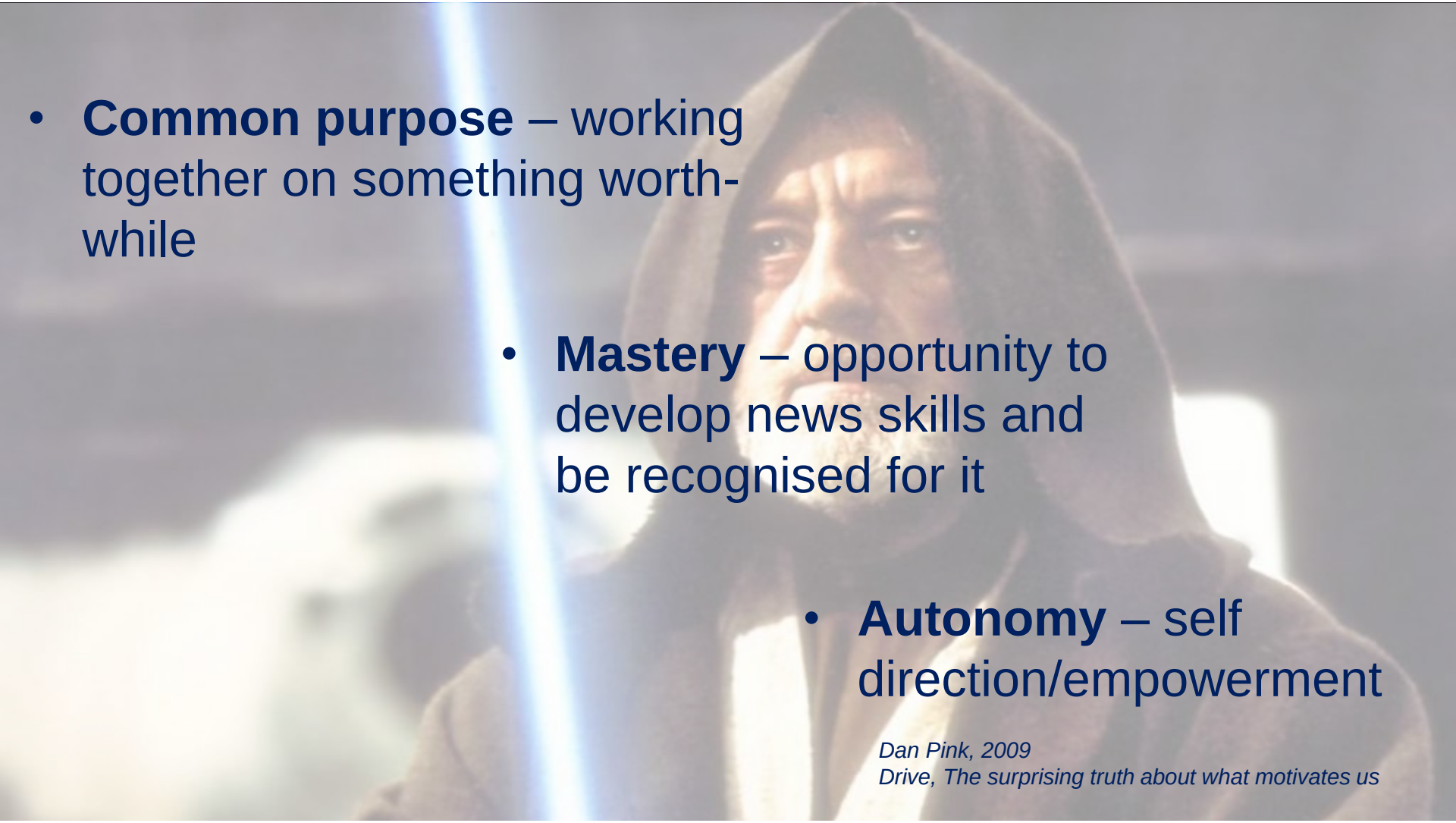
Only 4 things to do….

A different type of leadership is required

Robert K Greenleaf, "The Servant as a Leader" 1970

“Use the (Work) force, Luke” – Team Motivators



- **Common purpose** – working together on something worth-while
- **Mastery** – opportunity to develop news skills and be recognised for it
- **Autonomy** – self direction/empowerment

Dan Pink, 2009
Drive, The surprising truth about what motivates us

What are Primary Care Home sites doing?

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Analysis of **263** Initiatives

Collaboration

60%

of initiatives are engaging other local partners and **19%** are already working with agencies beyond the health system to address wider determinants of health.

Health Needs

24%

of initiatives are addressing mental health issues. Other common areas of focus include care of the elderly, LTCs, Wellness, Diabetes and MSK.

Care Models

38%

of initiatives include multidisciplinary case management. Other common interventions include social prescribing, specialist co-location, home care, early detection and health promotion.

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How are Primary Care Home sites performing?

Analysis of PCHs covering **10%** of Primary Care

Workforce

8%

more clinical non-GP staff compared to the national average. PCH sites employ proportionally fewer GPs and fewer non-clinical staff compared to the national average.

Population

2%

more people are very happy with their GP practice in PCH sites compared to the national average.

System

3%

lower A&E admission rate in PCH sites compared to the national average and a **9% lower A&E admission** rate when controlled for age. Also the growth in A&E admission is **33% lower in PCH sites.**

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Emerging themes from mature Primary Care Homes

1 Engagement

The most successful PCHs are those that are engaging acute, **social services** and the **voluntary sector**, but it's ok to start small with a shared vision.

2 Understand population health data & needs

It's ok to start on Population Health Management without access to linked data sets. **Just speaking** to your peers will reveal new insight, but look out for hard data too.

3 Care model development

Focus on the strength of multi-disciplinary teams and the **social determinants** of health when designing initiatives.

4 Workforce, training, education & culture

Develop **inter-disciplinary teams**, focused on collaboration across organisations and what services will be needed to support the health and care needs of the population group.

5 Alignment of resources & financial drivers

Ensure collaborative working arrangements are in place so what you start can be **sustained**.

6 Evidence & Evaluation

Don't let complexity get in the way. Start small and measure just **one thing** that you would like to change.

Learning from the Community of Practice

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Common Areas of Focus

Care of Elderly	**Care Homes:** Herne Bay & Larwood & Bawtry **Enhanced Frailty pathway:** Thanet
Mental Health	**Young:** Newport Pagnell and Team Winsford **Adult:** Fleetwood MH, alcohol & drug misuse North Halifax, Rugeley and East Cornwall
Diabetes	**Diabetic Hub:** South Westminster East Norfolk
Social Prescribing	**Pre-diabetic & CVD:** Newham St Austell lifestyle coach, Herefordshire
Dementia	**Healthy Memory clinic:** Lower Lea Valley
New roles	**Comm Pharmacist & GP:** COPD Fleetwood **HCA & Pharmacist:** Frailty Wolverhampton **Paramedic Home Visits:** East Grinstead