Enhancing primary care with faster access to services

Healthy East Grinstead Partnership Primary Care Home

The challenge
East Grinstead’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.

What was done
A primary care home (PCH) was established to improve the health of the population 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 the older population.

As a PCH, their objectives are to enhance primary care, improve access and bring specialist care to the community.

The biggest initiative so far 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) into an enhanced primary care team.

The team focus on patients at highest risk of admission to hospital and provide care to stop unnecessary admissions. Patients are receiving more joined-up care and are less likely to be admitted to hospital.

Pathways have been redesigned so that GPs are no longer involved in activities where they were adding no value, freeing them up for other work and improving access. Pregnant women can now self-refer to midwife services, people with musculoskeletal needs can go directly to a physiotherapist and community nurses order wound dressings online. Care coordinators have been introduced at all of the partnership’s four practices to signpost patients to any 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 and the primary care home is working closely with West Sussex Fire and Rescue Service to ensure housebound patients at risk of falls have their social and medical needs identified, as well as having fire prevention advice and information.
The results

In December 2016, there were 154 high-risk patients in East Grinstead but only 17 were on the caseload of the primary care home team. By the end of March 2017, more than 110 were on the caseload, with patients triaged, assessed and contingency plans developed.

These plans have been uploaded and shared across the health system. There has been a reduction in unplanned admissions from this group of patients as a result.

To improve access to primary care, pathways have been redesigned to free up GP capacity. More than 300 patients have self-referred to physiotherapy instead of going through their GP in the six months since the scheme went live in July 2016. Physiotherapists say the information they get from patients is better than through GPs and they are now able to triage patients and see urgent cases within five days, compared to all patients waiting six weeks to be seen.

The pathway for dressing prescriptions has been changed to allow community nursing teams to take ownership of the ordering of dressings. This has freed up three hours of GP time a week in each of the four surgeries, released 30 minutes of time for each nurse a week and has sped up the time taken to get dressings to their patients. Previously, over 55 per cent of nurses reported that it took over two weeks to get dressings to their patients, whereas now it is 48 hours.

There are around 400 births in the town each year. Pregnant mums no longer need a GP appointment before referral to the midwife. There are some 275-cataract operations carried out each year on patients from the town who no longer need to see their GP for follow-up prescriptions.

Overcoming barriers

There have been some challenges in sharing data across different health providers. To refer patients to the enhanced primary care team, each practice has had to contact patients to gain consent, which may have introduced some delay into the system. The need to agree effective information sharing across organisations is now a key priority.
Key learning

- It requires a collaborative mindset from all organisations and significant one-to-one engagement.
- Buy-in comes from explaining specific changes and benefits to individuals and teams.
- Establishing a successful primary care home requires a lot of time to be invested in developing relationships between participating organisations, to create buy-in to the collaboration, which is vital.
- Commitment from organisations for staff to work on PCH projects is essential to allow progress.

Takeaway tips

- It is important to identify benefits for each organisation to encourage joint working – these might be different for each organisation although moving to a collective aim.
- Allowing time for key members of staff to work on projects that may be slightly different to their usual role is important.
- It is important to invest time and effort into developing relationships at a one-to-one level – do not underestimate this!
Find out more

The Healthy East Grinstead Partnership was selected as a primary care home rapid test site in December 2015.

The PCH model was developed by the National Association of Primary Care (NAPC) and is an innovative approach to strengthening and redesigning primary care highlighted in Next Steps on the NHS Five Year Forward View. The model shares some of the features of the multispecialty community provider (MCP) bringing together a range of health and social care professionals as a complete care community to focus on local population needs and provide care closer to patients’ homes.

For more information on the primary care home model, visit www.napc.co.uk or contact napc@napc.co.uk

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