Primary Care Home Case Study

Organisation:	Westongrove Partnership
Number of PCHs:	1
Population:	28,500
GP practices:	3
Partnership:	Three practices, integrated acute and community services provider, GP federation
STP footprint:	Buckinghamshire, Oxfordshire and Berkshire West (BOB)

The challenge

The partnership's patients include an above average percentage of frail, older people with complex health needs. Many are housebound or living in care homes. Hospital admission rates and GP appointments have been high among this group of patients with many saying they feel overwhelmed by multiple visits from different agencies.

What they did

An over-75s project team, the Weston Project, was set up bringing together a lead nurse, specialist nurse, therapist, healthcare assistant and two non-clinical care co-ordinators. The team takes a proactive approach to caring for up to 50 older patients at a time with complex needs. Care packages are developed for each patient who receives regular home visits from one of the team and phone calls from a care co-ordinator. The project has secured several "step-up" beds at a nursing home, enabling the early discharge of patients from hospital. Future priorities involve developing care around falls, wounds, frailty and end-of-life.

The impact

A 2016 patient survey showed 95 per cent felt their care at home was better because of the project. Hospital admissions, among patients on the complex needs caseload, are estimated to have fallen by up to 50% since the project's launch and GP feedback said the service had saved them time in 95% of cases. In the project's first year, 101 admissions were avoided and the average length of stay was nine days compared to the national average of 10. People have been able to live independently for longer at home, families and carers have received greater support and terminally ill patients have benefited from end-of-life care tailored to their needs. A social worker secondment led the team to finding out about the non-clinical resources in the community. Patients who once received several visits a day from different care agencies have a single point of contact. By visiting people's homes, the healthcare assistant has gained insight into problems such as cold, lack of food and trip hazards which may be affecting a person's health.

Lessons learnt/success factors

Relationships need to be developed between all agencies involved in a patient's care, so everyone understands what services, facilities and equipment are available and how to access them quickly and easily.

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