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Primary Care Home Population Health Case Study

Organisation: Lewes Health Hub

The challenge

Three practices, which form the primary care home (PCH), successfully bid for funding from the Estates and Technology Transformation Fund (ETTF) to help develop new premises which will be built over the next two years as part of a 700-home development in Lewes. Preparations for their merger into a single practice, based in the same building, have involved looking at their different systems and processes and reviewing and adopting best practice. It became clear that, to improve patient care, they would need to take a population health management approach. This involves segmenting their local population - a process that analyses health data and identifies groups of people with similar health needs and risks with the aim of redesigning services tailored to the needs of each.

What they did

The practices have started this approach by segmenting their patients into three different groups – the generally well, people with chronic conditions and those with complex needs. This is being done in three ways – by questioning patients when they phone for appointments, using frailty index scores from data provided by their local commissioning support unit and analysing chronic disease information from the practices' own records.

The PCH has set up project development teams, consisting of doctors, nurses and receptionists who spend half a day a week for six weeks working on specific initiatives designed to improve services, aligning them more closely to the needs of each patient group. The teams have worked closely with patients from each of the three groups, conducting detailed interviews and recording their concerns and suggestions in a shared database. A telephone triage system has been introduced and receptionists are having training as care navigators. Acute care teams have been established in each practice and there are plans for them to join forces at the local minor injuries unit (MIU) where they will work with hospital staff as one urgent treatment centre, treating people with urgent medical problems as well as injuries. Over the next few months, they will start offering a seven-day service from 8am to 8pm. Each practice also has a continuous care team – a small group of four or five doctors who are available from 8.30am to 6.30pm each weekday to see patients with ongoing, recurring or multiple medical problems. When patients call to book appointments, they're asked about their condition and whether it's a new or ongoing medical problem. The receptionist then refers them to the most appropriate team.

The impact

Previously patients were seen on a first come, first served basis until the practices ran out of capacity. Now each patient is either seen or spoken to on the phone on the same day and this has helped reduce pressure on A&E and the out-of-hours service. Morale has improved among staff who feel a sense of ownership of the new systems and processes. Recruitment has been difficult in the past but now doctors are keen to work for the PCH impressed by the redesign of services and "whole system" approach to patient care.

Lessons learnt/success factors

Initially it was assumed that the workload of the continuous care teams would be substantially higher than that of the acute care teams but the volume of work is similar for both. Fragmented services result in more expensive, poor quality patient care.