Horizon PCN: Proactive & Personalised Care in our PCN

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Who we are

- Horizon PCN – located in Bury, Gtr Manchester
- 6 practices, c.87,000 registered patients (soon to be 7 practices, c.92,000 pts)
- Practice list size range from c.5,000 to c.47,000
- Not co-terminus – exist across 3 of the 5 neighbourhoods in locality
- Very distinct demographics in each neighbourhood, resulting in very different patient needs
- Large ARRS workforce already in place – H&WB Coaches with locality experience; dedicated Personalised Care CC

Community Initiatives

- Health Checks done in Community - support from H&WB Coaches
- Community Walks and Social Clubs
- LD Care Coordinators supporting increased uptake and quality of AHCs; developing community resources and linking in with wider system partners to inform development of support
- Support group for families/relatives with people involved in criminal justice
- ARRS – led MDT supporting care homes and residents medically and holistically
- NHS App uptake and support – digital support programme

High Intensity Service Use (HISU) Hubs

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Background

- Leadership for Empowered Communities & Personalised Care (LECPC) Programme
- Large ARRS workforce with a proactive/personalised care ‘focus’
- PCN involved in Proactive Care Development Programme, supported by GM ICB, 33N (CLEAR Programme) and Peak Health Coaching
- 3 cohorts available to work with and support – frailty, dementia and HISU
- HISU – identified as a consistent cohort across all 6 practices
- Cohort needed further refinement – too large initially

What's Our Plan?

- Cohort = >10 GP appts in previous 12-month period; coded with anxiety and/or depression; pre-identified CVD risks (high cholesterol – bloods already taken; increased gap in heart age/ actual age)
- 6-8 pts per hub
- Community locations (existing drop-ins)
- 3 'hubs' per month – 1 per neighbourhood
- 'Catch up' session every 2/12 – DNA's/ follow-up's/further support
- Proactive recruitment and follow-up from care coordinator
- Flexible/adaptable – ability to react to intelligence gathered

Proposed Model

- Pt attends – initial review with clinical pharmacist; bloods (POCT?)/medication review/height,weight,BMI etc (c.15-20 mins)
- Informal ‘meet and greet’ – cup of tea/biscuit etc
- Group session(s) – supporting well-being/ lower-level MH, lifestyle advice, exercise, healthy eating etc – SPLW/MH Wellbeing practitioner/H&WB coaches
- Option for 1:1 session with relevant staff member if further support required/requested
- Signposting to additional services/resources

Future Considerations

- Cohort – need to gauge size based on current criteria –manageable size; ensure no duplication with existing offers/models
- Outcome measures – qualitative/ quantitative
- Comms – practice/patient; personal approach from CC – how to encourage patients to attend?
- Translate model into different areas of care

Other Projects/ Initiatives

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- **Cancer screening promotion** - 456 unique conversations, 93 clients who had previously not considered completing screening have subsequently done so – 2 adverse findings to date (1 all clear, 1 receiving appropriate treatment); community outreach events targeting low-uptake cohorts (South Asian communities & Jewish ladies)
- **Wellness programme** – developed based on GP feedback; 8-week course covering healthy eating, stress management, CBT, exercise, smoking cessation, living with LTCs, heart health etc
- **SMI Health Checks** – pilot programme, mirroring model from other areas of GM – holistic support offer as part of SMI health check focusing on obesity, activity, CVD, diet, smoking, social factors, utilising POCT to facilitate AHC in community settings
- **Smoking Cessation for vape users** – Vape users no longer smoking cigarettes etc not eligible for smoking cessation support; now supporting vape users with cessation of vaping
- **Menopause Support Sessions** – lunchtimes, evenings and weekends, supported by colleagues from the wider system (i.e specialist pelvic health physio from local trust) – 423 attendees to date; 1-2-1 menopause support referrals also accepted; community-specific offers also developed

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- **Frailty programme** – utilising a proactive approach, identifying and working with patients with Rockwood score of 5
- 8-week intervention programme, providing graded strength and balance work followed by an education session, twice weekly for 8 weeks; following same ‘gold standard’ as cardiac & pulmonary rehab

	Day	Date	Time	Education
Session 1	Monday	4th March 2024	2.30pm-4pm	Welcome, Q&A for sessions, introduction, group orientation.
Session 2	Wednesday	6th March 2024	10.30-12pm	Benefits of exercise
Session 3	Monday	11th March 2024	2.30pm-4pm	Importance of hydration
Session 4	Wednesday	13th March 2024	10.30-12pm	Nutrition & Cholesterol
Session 5	Monday	18th March 2024	2.30pm-4pm	Medication reviews - guest speak Pharmacy
Session 6	Wednesday	20th March 2024	10.30-12pm	Mental health, stress management
Session 7	Monday	25th March 2024	2.30pm-4pm	How to keep your cardiovascular system strong & healthy
Session 8	Wednesday	27th March 2024	10.30-12pm	Goal setting / Exit Strategies - start to think about what happens next
Session 9	Monday	1st April BANK HOLS	NOT ON	Home work given :-)
Session 10	Wednesday	3rd April 2024	10.30-12pm	Community signposting - awareness of whats on near you
Session 11	Monday	8th April 2024	2.30-4pm	Smoking Cessation
Session 12	Wednesday	10th April 2024	10.30-12pm	Breathing exercises, adressing disordered breathing
Session 13	Monday	15th April 2024	2.30-4pm	leave free for a session requested by participants Q&A
Session 14	Wednesday	17th April 2024	10.30-12pm	How to improve sleep
Session 15	Monday	22nd April 2024	2.30-4pm	Exit stratgeies - reaffirm whats next
Session 16	Wednesday	24th April 2024	10.30-12pm	Re-do functional fitness, to show improvement from baseline

- Similar model of care has now been adopted by our locality ICB team as part of our Locally Commissioned Service contract

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