CLEAR
Empowering staff to innovate care

CLEAR Proactive Care 2022

Tyldesley, Atherton, Boothstown and Astley PCN

Personalised planned care for housebound and dementia patients

AT A GLANCE

CLEAR CHALLENGE

Variable care planning for dementia and housebound patients who had a higher than average number of GP visits and ED attendances

KEY CHANGES

A new dementia coordination service and better MDT working to improve collaboration and liaise with other services

FORECAST BENEFITS

Reduced health inequalities, improved patient care with better support for families and carers with productivity savings of £59,961

THE CHALLENGE

The PCN was keen to review its care for dementia patients as it had lower prevalence rates than the national average. Analysis of four years of data showed dementia and housebound patients had a significantly higher number of GP appointments and ED attendances than the general patient population - 29% had attended ED compared with 12.5% of patients over 65 without dementia. Care planning varied between practices and patients in more deprived areas had fewer annual reviews than those in less deprived areas.

WHAT THEY DID

The project team interviewed 20 frontline staff who were directly and indirectly involved in the care of dementia and housebound patients, working in a wide range of roles from receptionists and practice managers to heart failure and respiratory teams. Data for 50,431 PCN patients from January 2018 to January 2022 was analysed.

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CLEAR RECOMMENDATIONS

A dementia coordination service should be created to provide a single point of access for patients waiting for assessment and support those already diagnosed with dementia - ensuring all receive an annual care plan and medication reviews.

The team would comprise an advanced clinical practitioner specialising in dementia, three care coordinators, clinical pharmacist, trainee nurse or healthcare assistant, and a dedicated GP lead. Regular MDT meetings would be introduced to improve collaboration and liaise with wider health care services.

Patients at risk of developing dementia would be screened to enable earlier diagnosis.

Improving the quality of life of housebound and dementia patients with new dedicated service to reduce health inequalities and increased integrated and personalised care

FORECAST IMPACT

Health inequalities would be reduced and patient care improved with better support for families and carers.

It is projected that a new dementia coordination service would lead to a 50% reduction in GP appointments, 30% reduction in ED attendances and 30% reduction in emergency hospital admissions leading to productivity savings of £59,961.

A further £134,757 could be saved from better use of ARRS funding leading to a more resilient workforce better suited to meeting patients' needs. The PCN has started to implement the new model.