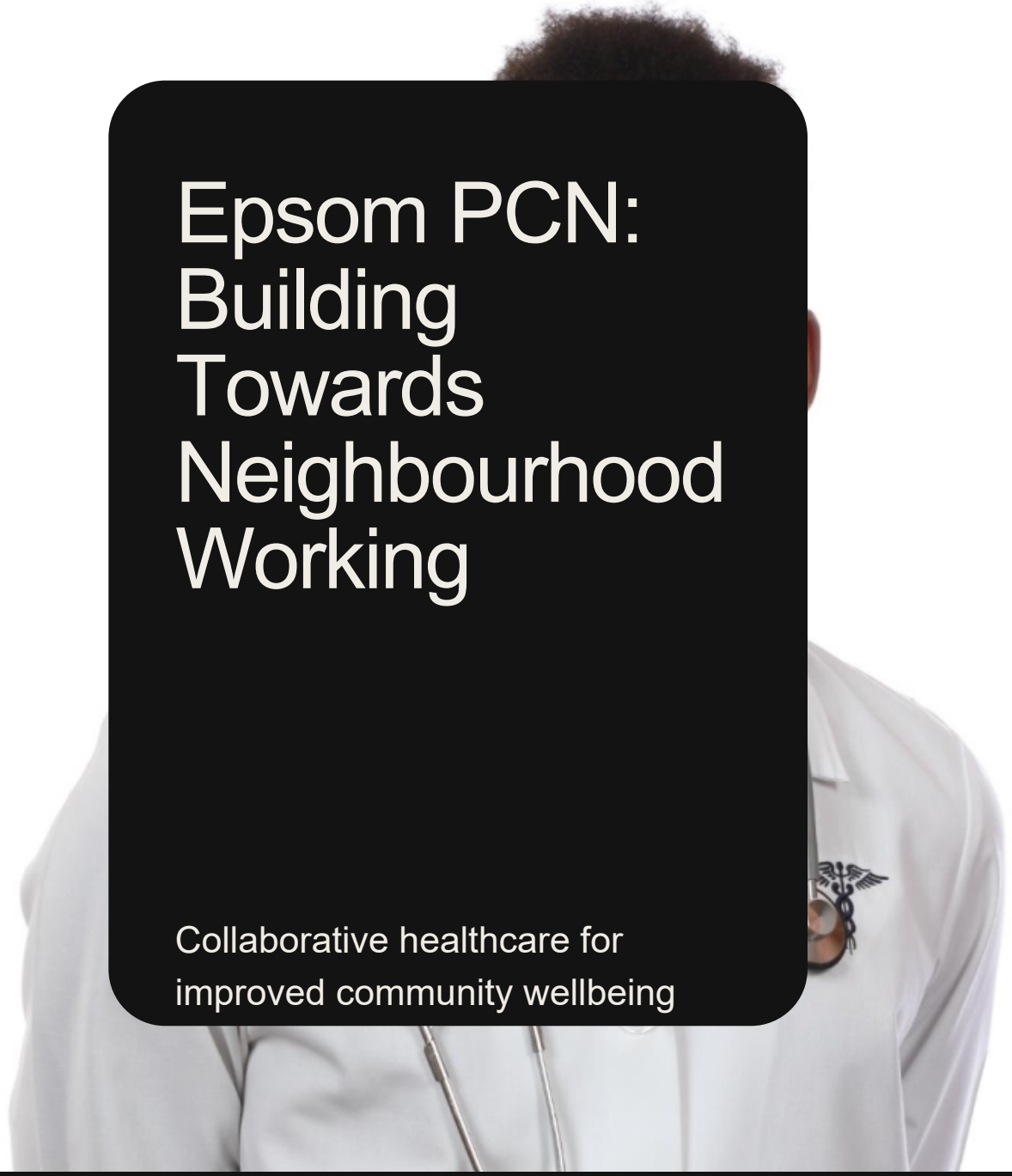
Epsom PCN: Building Towards Neighbourhood Working

Collaborative healthcare for improved community wellbeing



Foundations of Neighbourhood Working

Three Pillars of Left Shift in Health

1 ▢ Analogue → Digital

•Digitising processes
•Online access & remote consultation
•Better data sharing

2 ▢ Sickness → Prevention

•Early identification
•Self-management
•Reducing long-term demand

3 ▢ Hospital → Community

•Care closer to home
•Stronger MDTs
•Avoiding admissions

Continuity of Care Planning

Collaborative Personalised Care

Teams develop evolving personalised care plans aligning clinical and non-clinical inputs for complex patients.

Multi-disciplinary Coordination

PCN coordinates multi-disciplinary input and uses digital continuity markers to prioritise high-need patients.

Integrated Care Approach

Continuity planning connects workforce, pathways, and digital tools into a cohesive local care structure.

Community Partnerships

Extending Care Beyond Clinics

Community partnerships broaden care by addressing wellbeing outside traditional clinical settings. Advice café at St Barnabas Church and Library of Things at Bourne Hall Bungalow. Working with Active Surrey for patient and staff wellbeing. Close liaison with Good Company and Refer Net. OneYouSurrey on smoking cessation.

Role of Link Workers

Link workers connect healthcare practices with community assets ensuring referrals and follow-up support. Impact on GP appointments in 2024-25– 45% reduction in GP attendance post intervention.

Neighbourhood-Based Initiatives

Joint community initiatives like wellbeing hubs and outreach events target at-risk population groups effectively. Risk stratification tools enable us to layer clinical indices over deprivation indices etc. Contemplating event at Rainbow Centre or Bourne Hall – possibly to link in with flu clinics. Opportunistic health promotion to bring in Health MDT and VCSE.

Improving Health Equity

Partnerships strengthen resilience, equity, and preventative care within neighbourhoods over time.

Multidisciplinary Team Development

Diverse Clinical and Non-Clinical Roles

MDT includes GPs, community matrons, consultants, pharmacists, physiotherapists, mental health practitioners, paramedics, and health coaches supporting proactive patient care. Health & Wellbeing team deliver annual dementia reviews (approx. 95% completed) offering holistic care to patient and carers. Learning Disability annual reviews also covered by Health & Wellbeing team (around 95% completed).

Structured MDT Processes

Neighbourhood MDTs use structured huddles, case discussions, and joint patient reviews to ensure consistent, quality care.

Improved Patient Outcomes

Embedding MDT input in chronic condition pathways improves disease control and reduces unplanned care admissions. Current focus on in depth reviews for heart failure and COPD patients.

Risk Stratification

Patient Segmentation

Population health tools segment patients into high-risk, rising-risk, and stable long-term condition groups for targeted care. We can overlay clinical indices with deprivation indices to effectively target patient cohorts. We can also identify patient utilizing high number of appointments without apparent clinical indices present. Those patients can be best supported by Health & Wellbeing Team. We have evidence that 4% of our patient base takes around 20% of appointments. How can we work together to tackle this.

Predictive Analytics Use

Predictive analytics identify patients at risk of deterioration, enabling earlier intervention and personalized care plans.

Resource Prioritization

Risk stratification helps direct clinical and multidisciplinary team resources effectively to maximize impact.

At-Scale Working

Shared Workforce Resilience

Staff working across practices enhances resilience by filling gaps and meeting collective demand effectively. Estate space challenges can be overcome by working at scale.

Efficient Service Delivery

At-scale delivery of services like vaccination and proactive care maximises efficiency and reduces duplication.

System-wide Integration

Collaborating at scale aligns neighbourhood efforts with broader health system objectives for operational stability.