PACT – Patient Aligned Community Team

Case study to support Mid and South Essex's HOSC Primary Care Update

December 2022

Please see a video on this case study @ Benfleet PCN Video FINAL.mp4 - Benfleet PCN Video FINAL.mp4 - Frame.ioBenfleet PCN Video FINAL.mp4 - Benfleet PCN Video FINAL.mp4 - Frame.io

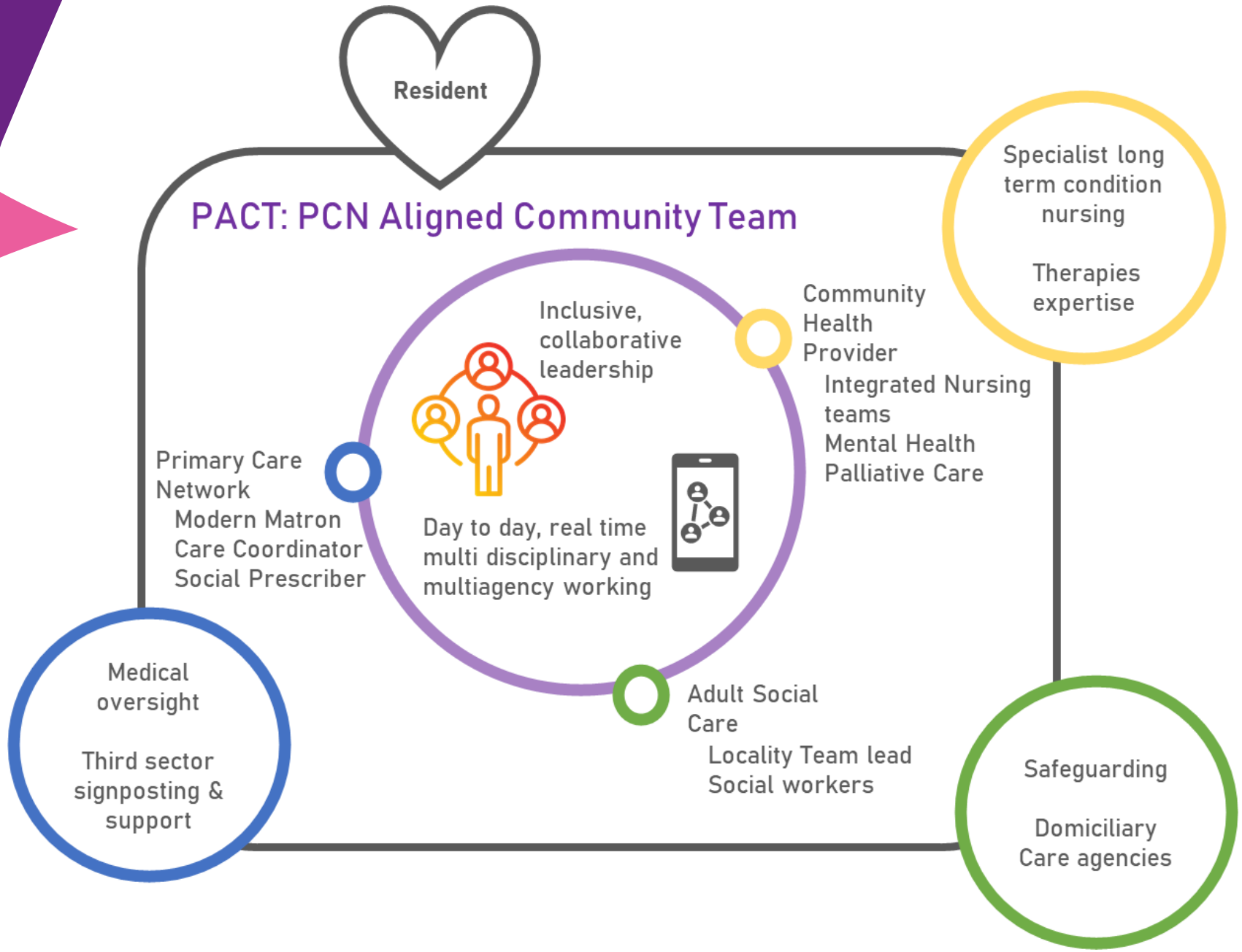
To be successful the PACT framework requires four elements:

The **resident at the heart** of the model

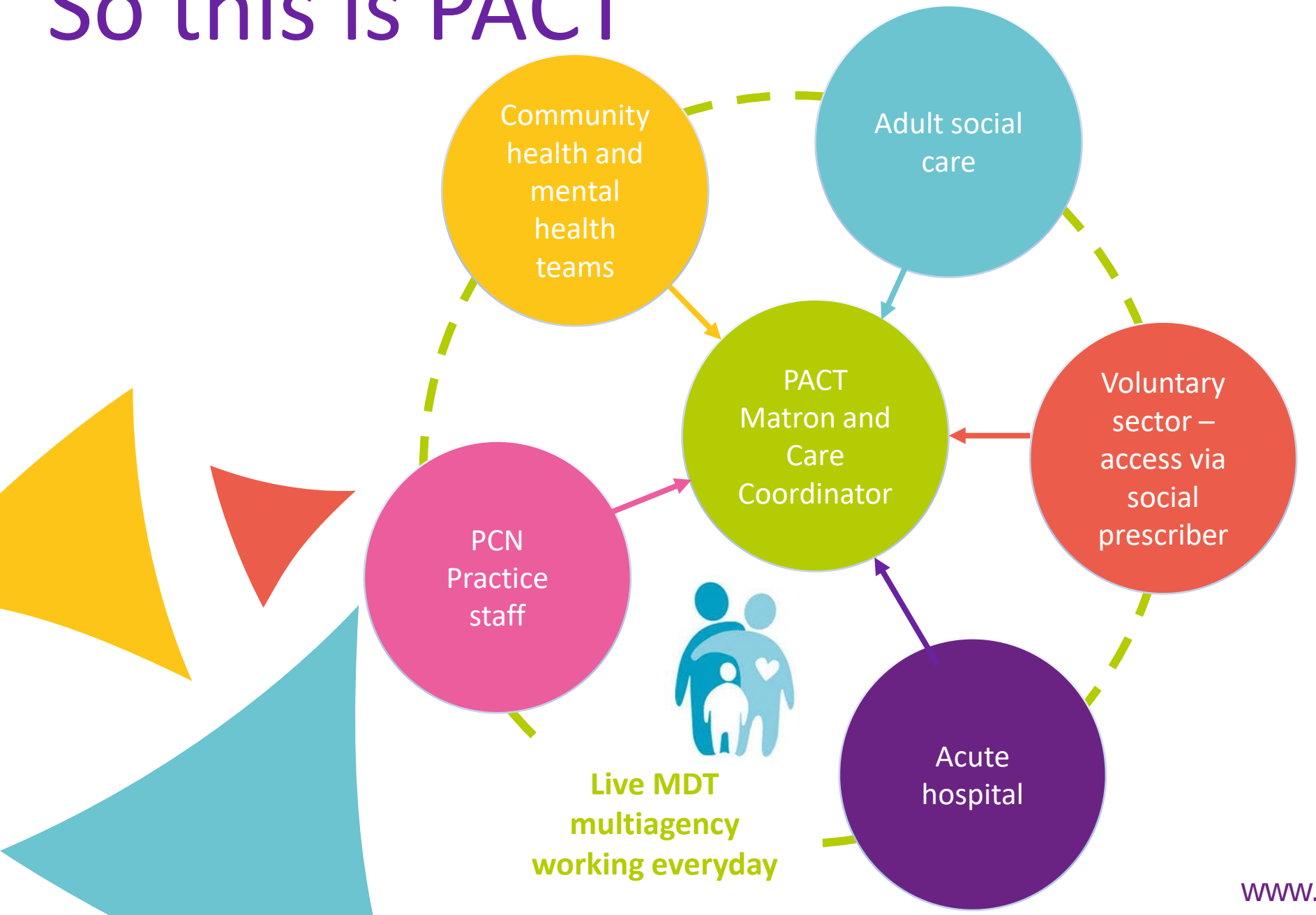
Positive and productive **multiagency, multidisciplinary relationships**

Easy and instant modes of **communication** for real time multiagency and multidisciplinary decision making

An inclusive, collaborative **leader**



So this is PACT



PACT is underpinned by:

The FRAIL+ framework

Digital tools and enablers – PCN SystmOne Hub links all practices.

Multiagency collaboration using FrEDA

Pro-active, anticipatory care to prevent crisis – and wrap around support in the event of crisis and hospital discharge

Live and efficient coordination and communication between all multi-agency professionals

Meet Rose* a real 91 year old, housebound, lives with daughter, several comorbidities, 11 regular medications, recently returned home from hospital after a fall

GP Home visit 1: Weak, swollen legs, short of breath. Start Diuretics. Refer to cardiology outpatients

GP Home visit 2: Rose deteriorates and falls. BP is 159/88 Medication increased to lower BP

GP Home visit 3: Mobility is worse, further falls. Blood tests show Rose is becoming unwell

GP Home visits 4,5 & 6 over the next fortnight: Rose is feeling increasingly worse and short of breath, mobility has steeply declined, and she is confused. Hypertension medication increased again

GP Home visit 7 Urgent admission to hospital. Condition worsens and Rose is discharged to a care home

* Names have been changed

Making things better for Rose

Rose's journey >250 hours

7 **urgent** primary care or community **home visits** in 5 weeks
4 GP phone calls to family in 3 weeks

2 unplanned, **crisis** admissions with **10 days in hospital** within 7 weeks

1 referral to **specialist cardiology** outpatients

None of these improved Rose's outcome - she just wanted to stay at home and be comfortable

Proactive FRAIL+ principles via PACT coordinate support around what matters to Rose

A better way <5 hours

FRAIL+ principles
- Find
- Refer
- Assess
- Intervene
- Listen

guide **30 minutes** of conversation and planning with Rose and family

Complete FrEDA and refer using internal links – **10 minutes**

Planned reviews shared between all PACT teams – **4 hours** over 10 months and **no hospital admissions**

Family say, "Thankyou for listening, great communication and team work to manage things in the way WE wanted"