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New Models of Care

Jeannie Harrop
Senior Integrated Commissioning Manager

Extensive Care – Overview

Consultant Led community based service

Seamless ‘step up / step down’ provision with Enhanced Primary care

Eligible patients referred by primary care and neighbourhood hubs

Referral criteria – patients with two LTC including frailty and dementia

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Integrated Neighbourhood Team

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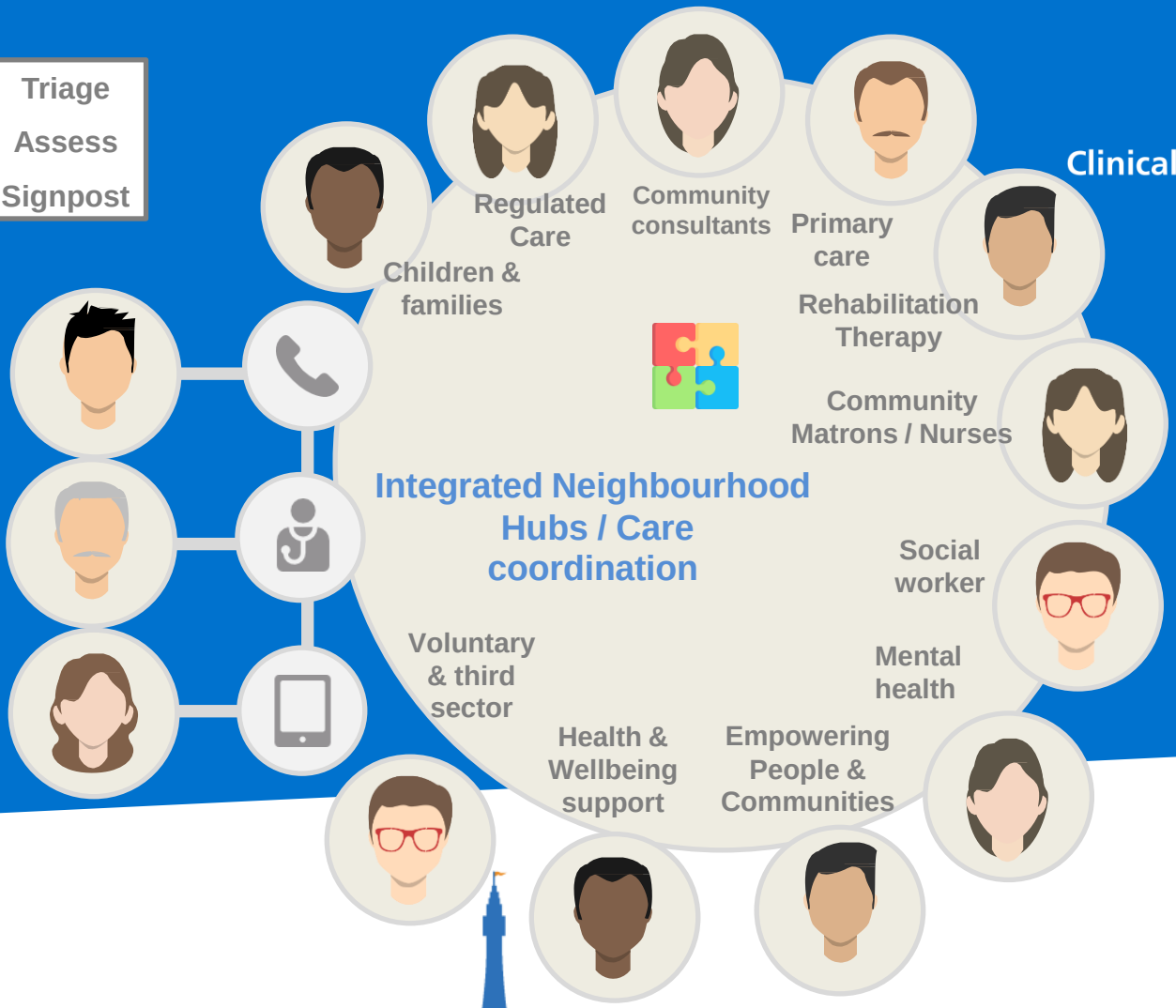
Triage
Assess
Signpost



Integrated pathways

- End of life care
- Intermediate Care
- Falls
- COPD
- Empowering people & Communities
- Drug and alcohol services
- Mental health

- Multi Disciplinary Team meetings
- Neighbourhood meetings
- Chronic Disease Management reviews
- Self referral
- Hospital discharge
- Processes

Blackpool Care Home model update

- All staff in post and integrated in the neighbourhood teams
- Completing planned chronic disease management reviews for all patients in care homes
- Responsive model in place in four neighbourhoods.
- The responsive model - all phones calls from care homes go via the hubs, not to primary care.
- The hubs are responsible for signposting and / or triaging for urgent patient issues either by phone, visits or via care home connect
- All care homes are using FCMS care coordination for out of hours to try and avoid an inappropriate admission.

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End of Life Care

Electronic Palliative Care Coordination System (EPaCCS)

- EPaCCS enables the recording and sharing of people's care preferences and key details about their care (at the end of life) with those delivering care. The system's support co-ordination of care and the delivery of the right care in the right place, by the right person, at the right time.
- EPaCCS template completed
- All templates will be logged with FCMS Care coordination service
- Now in place for primary care, neighbourhood hubs and Trinity Hospice.
- Yearly audit
- Further work is required with primary care and EPC to improve the % figures for EPaCCS

Empowering People and Communities

- Key focus for 2018/19 year.
- One of 15 areas receiving ‘intensive support’ from NHS England.
- Already implemented Patient Activation Measure locally in our Extensive Care service and continuing to roll-out further.
- In place across all six neighbourhoods
- Integration 20:20

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Ongoing Development of Enhanced Primary Care (including care home model)

It is now important that further integration with primary care becomes the focus for 2018/19 to ensure further continuity for patient care

A draft plan for the development of New Models of Care has been completed. Priorities for the plan include:-

- Allowing the EPC model to embed properly before further integration
- Communications to patients and carers
- Integration of the hubs with hospital discharge processes
- Further GP engagement and integration including the development of named GP leads in each neighbourhood and a Blackpool new models of care meeting
- To include care at home and learning disabilities in the model
- To review population sizes, practice boundaries and named GP practices for care homes to ensure they are still appropriate

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Ongoing Development of Enhanced Primary Care (including care home model)

- Self referral for patients and carers
- Development of Nexus
- Frequent caller model for primary care
- Mobile working
- Access to ‘Home’s Best’ - an offer of care and support might help them ‘get back on track’ in the short term; to provide intensive support to facilitate early supported discharges from hospital
- Fylde Coast approach via the Integrated Care Partnership – Integrated Primary and Community Care work stream