What are we trying to achieve?

Our vision for a 'Primary and Acute Care System' in Northumberland

Integrated health and social care supporting complex needs

Tools and information that support self management

Urgent and emergency care when you need it, in the right place

Financial stability

ACCOUNTABLE CARE ORGANISATION

NHS

Level of needs

Highest care needs

Ongoing care needs

Urgent care needs

Whole population

Proportion of the Population

One system, one team, one you

Out of Hospital Model

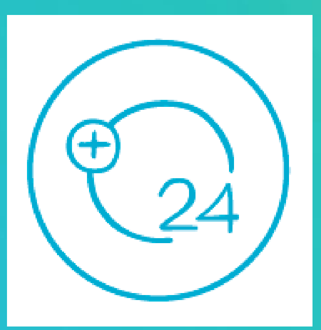
Locality based teams, working across organisational and professional boundaries

Better communication, joined-up systems and ONE shared health record

Proactively looking after and planning care for complex patients as well as rapid response

One system, one team, one you

New Ways of working



Developing services into planned and rapid response

Using the skill mix of teams, not just individuals

Developing specific roles
Eg. Clinical Pharmacists

Underpinned by a new model of planning and delivering care

A capitated budget for the population

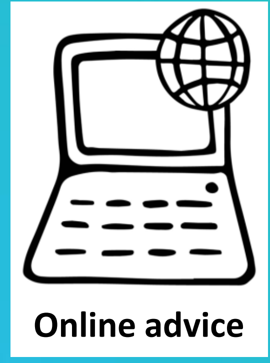
Mutual responsibility for the system

Sustainable services for the future

Tools and information that support self management

Healthy lifestyles

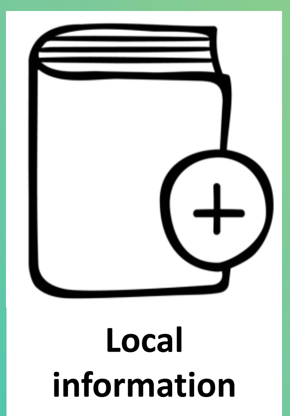
Resilient communities



Online advice

Good self - care

Positive wellbeing



Local information

One system, one team, one you

PROGRAMMES OF CARE

High Risk

Frail Elderly

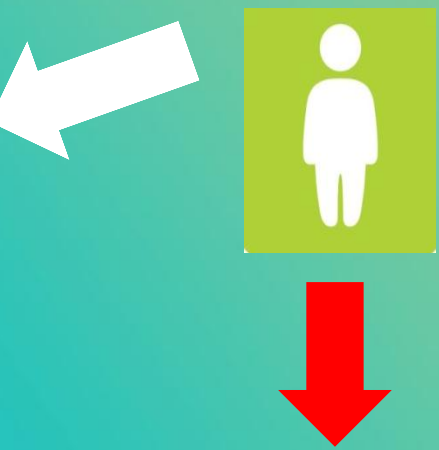
Nursing Homes

Mental Health

Palliative Care

Long Term Conditions

Programmes of Care



EMERGENCY CARE

MDT:
GP
Matron/DN
Pharmacist
OT Physio SW
Community Specialists

Unified record

Bespoke care plans including escalation decisions

PLANNED CARE

Acute GP or visiting Service

Single Point of Access

Urgent specialty access/ inpatients

URGENT CARE

Inpatient Bed

Hospital to Home

Hospital @ Home

INTERFACE CARE

Example: Nursing Home Programme- Planned care

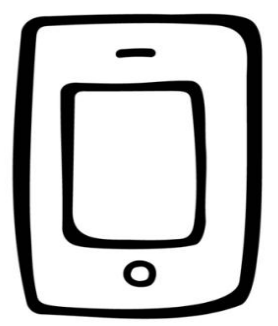
- All homes with an aligned matron, pharmacist and GP
- Matron: leads care with regular discussion and review with GP. Focus on education, clinical care and anticipatory planning
- GP: weekly round and case discussion, focus on anticipatory planning
- Pharmacist: systems and waste management, medicines reconciliation, acute interventions
- Care of Elderly Consultant: quarterly visit to home for case discussion and patient assessments
- Part of integrated clinical record; virtual assessments

Urgent and emergency care when you need it, in the right place

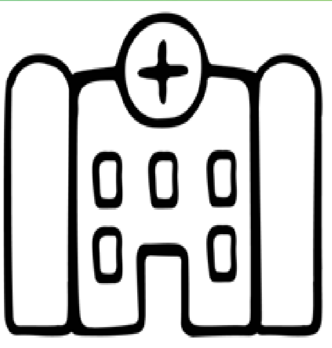
NHS

Local urgent care
-Capacity and demand exercise: increased GP urgent access
-Extended GP access

Acute visiting service
-triage of same day requests to GP, community nurse or pharmacist



Quick access
-to specialist telephone advice/ assessment
-single point of access



7 day emergency care – The Northumbria
-reduced admissions
-reduced length of stay

One system, one team, one you

Transition care

- **Hospital to Home team:**

  -early identification of patients with complex discharge needs

  -co-ordinated planning and follow through of patients to their home

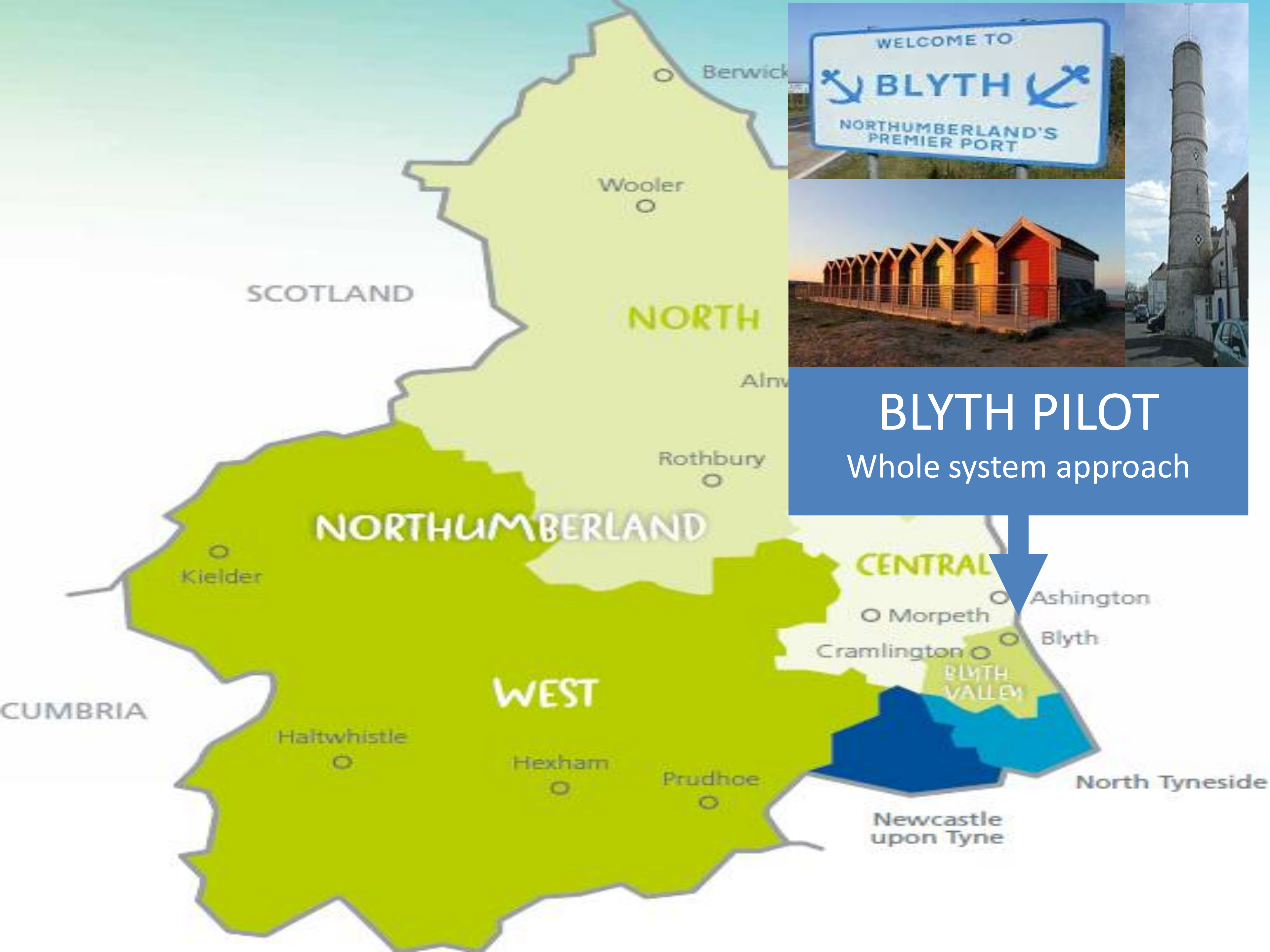
  -transfer of care when stable

- **Hospital at Home:**

  -virtual beds or step-down care

  -Respiratory, Care of Elderly, Palliative Care

Case study


WELCOME TO
BLYTH
NORTHUMBERLAND'S
PREMIER PORT
BLYTH PILOT
Whole system approach
SCOTLAND
NORTHUMBERLAND
NORTH
CENTRAL
WEST
CUMBRIA
Berwick
Wooler
Rothbury
Kielder
Ashington
Morpeth
Blyth
Cramlington
BLYTH
VALLEY
Haltwhistle
Hexham
Prudhoe
North Tyneside
Newcastle
upon Tyne

Blyth Planned care

- High risk/ frail elderly/ nursing home programmes of care
- Care led by matron, pharmacist and GP
- Involvement of community specialists as needed: Care of Elderly Consultant, Mental Health, Palliative Care
- Integrated clinical record
- Focus on maintaining health and anticipatory planning

Blyth planned care- MDT meetings

- Identification- A/E attendance/ high users, recent discharges, multiple medications, clinical opinion
- Streamlining of care, action plan
- Early warning indicators and escalation/ emergency anticipatory plans
- Review at next meeting of actions and results

Patient example

- Lady (72) with severe arthritis- pain and mobility problems
- Weekly GP attendances, weekly district nurse visits, monthly hospital clinic attendances
- MDT case review- struggling to manage care/ drifting
- Plan of action- specific request to rheumatology Consultant
- Result: streamlined care, education programme, forward plan including self management, community plan

BLYTH- urgent access

- 4 practices ~40,000, 3 models
- Model 1: Planned care delivered in surgery ; Urgent care is delivered through Blyth Acute Service in community hospital
- Model 2: NPC Central triage
- Model 3: Doctors Lists

BLYTH- acute visiting

- All patients are initially triaged by telephone
- Many are assessed and managed by telephone
- All patients who need to be seen are allocated to community matron, pharmacist, social care or GP depending on need-

    ~40% of visits do not need a GP

    ~25-30 hrs per month of GP time per 8,000 patients saved

- Link to frailty assessment service

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Blyth- initial results

- By changing the workforce model we can get to the sickest patients quicker with the right professional
- Targeting high risk patients more closely is trending to show fewer urgent contact requests (11% decrease)
- ~40% of visits are not being seen by a GP

  (~25-30 hrs per month of GP time saved for 8,000 patients)

BLYTH- initial results

- Individual patient level: seeing a reduction in multiple contacts (eg. 18 A/E Attendances in 6 months to 3 in 3 months)
- Social isolation is a major issue – referral to support planners previously not considered.
- Large amount of medications waste / polypharmacy (£15,000 savings in complex patients, £500 per month nursing homes)

How will we know if it is working?

Integrated health and social care supporting complex needs

Tools and information that support self management

Urgent and emergency care when you need it, in the right place

Financial stability

↓ Harm

↓ Population mortality rate

↓ A/E attendances

↓ Acute bed days

↓ Re-admission rate

↑ Patient experience

↑ Workforce satisfaction

One system, one team, one you

Challenges

- Variability
- Interfaces
- Real commitment/ shift to out of hospital model

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