NHS
Southport and Formby
Clinical Commissioning Group

SFCCG Community Services Clinical model

Jan Leonard

November 2015

together
with you

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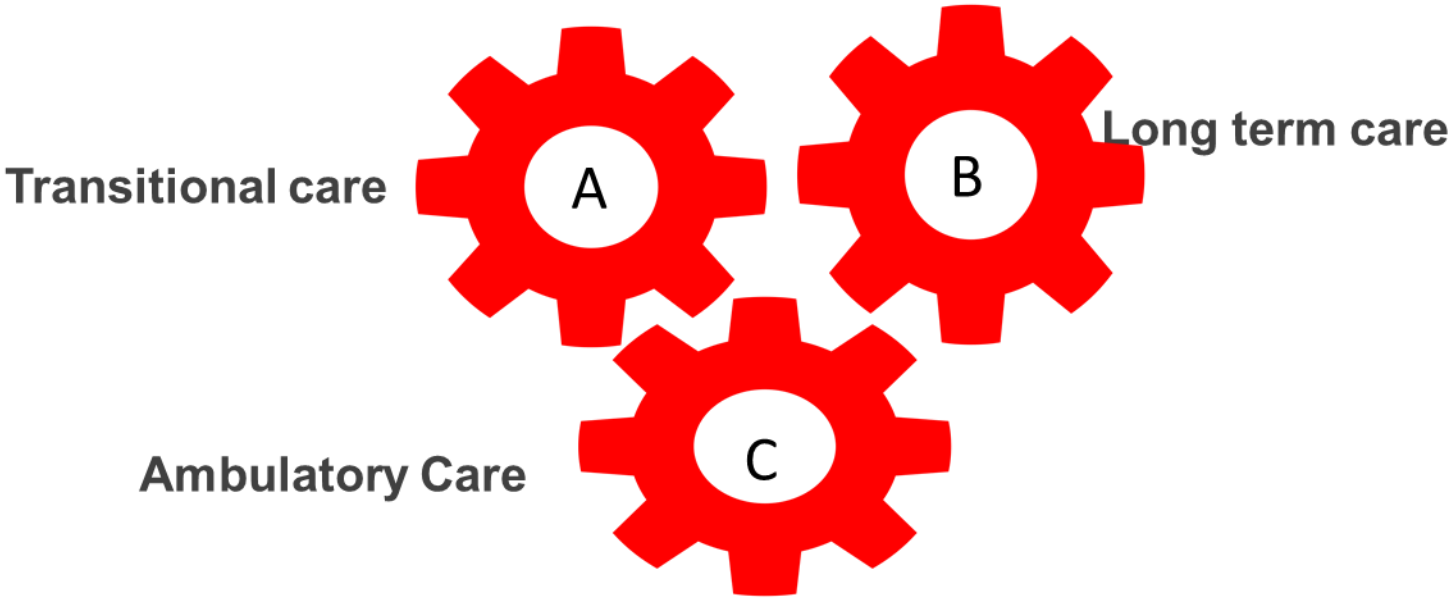
Community services model; Integrated care teams



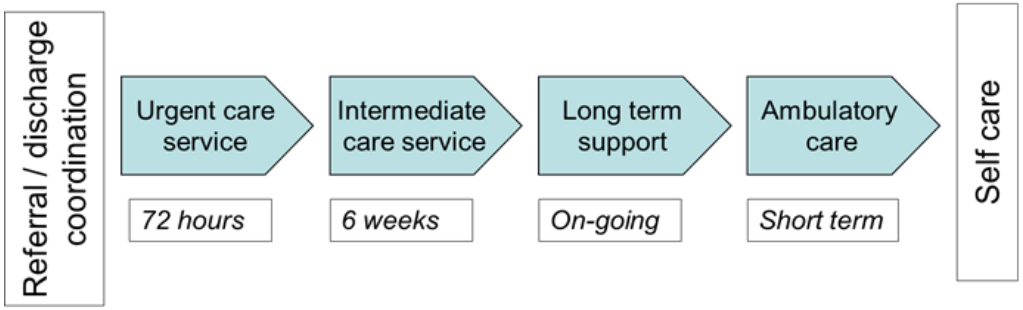
'Flow not Silo'

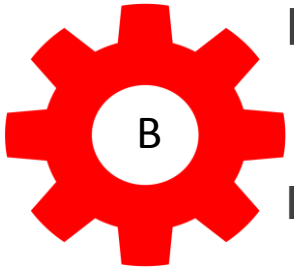
A

Transitional care

Dedicated transfer of care team: seamless transition to and from hospital, admission avoidance, transfer planning on admission

Urgent care team: safe alternatives to hospital admission, skilled staff to diagnose and prescribe where appropriate, 72 hours intensive support, access and support to alternatives such as intermediate care





Long term care Locality based

Nursing: housebound, complex LTC. Senior nurse leadership roles and case co-ordination, Specialist input

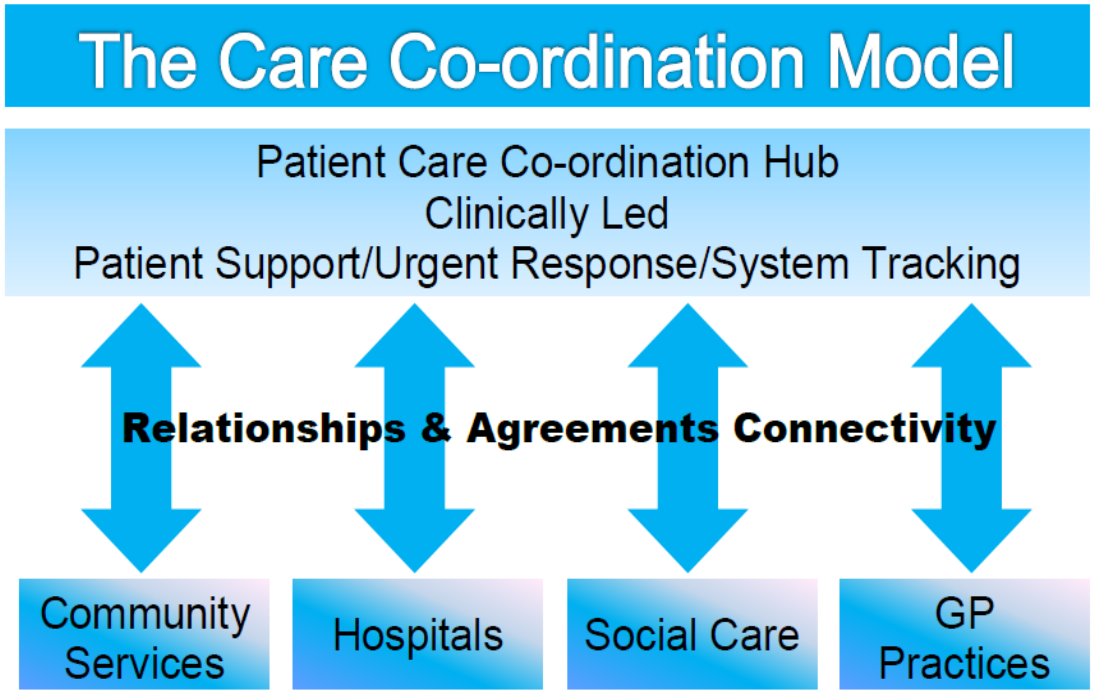
Care co-ordination: a clinical system not administration, case management in-reach, social care

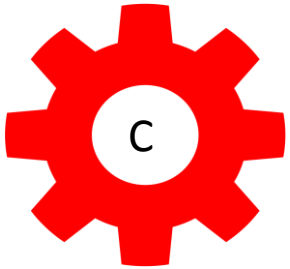
Integrated: seamless wraparound care, locality contact (SPA) attend MDTs, joint care management plans

Access to support: Health and wellbeing and voluntary sectors

B

Long-term care locality based



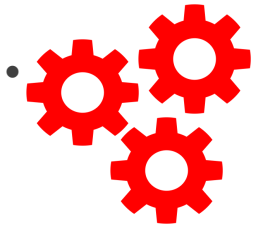


Ambulatory care

Clinics and treatment rooms: extended hours and extended roles, including minor injury

Ambulatory care sensitive conditions: Cardiac failure, diabetes, hypertension, respiratory disease, angina etc

Maintaining wellness and self care:
Joint working arrangements with councils, acute providers, VCF and CVS



What we expect:

- Multidisciplinary teams wrapped around General Practice
- Access to consultant opinion and diagnostics
- Data and information sharing
- Collective accountability for care and outcomes
- Community asset based approach
- Integration for populations
- Case management determined by risk
- Urgent response
- Targeted early intervention and enablement
- Care Co-ordination

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Thank You