Belfast Integrated Care Partnerships
Regional Workshop
27th May 2015
Greetings from bonny Scotland

Overview of Belfast ICP Projects

What are our success factors

Objectives

Overview Frail Elderly Pathway

What is different for the patient
Success Factors

Better Patient Outcomes

Partnership

Integration

Shared Learning

Trust

Mixed Skill Base

AHP’s

Nurse

C+V

Social Worker

NIAS

Pharmacist

GPs

Service User and Carer
Belfast Integrated Care Partnerships

Working together to improve outcomes for Patients
Reduction in hospital admissions and length of stay
Better Self-Management and Knowledge of condition
Reduction in Incidence of COPD
Improved Quality of Life for COPD patients
Earlier Detection of COPD
Access to psychological services
GP review and assessment of COPD patients
Early Supported Discharge and 7 day enhanced community team
Smoking Cessation
Home Oxygen Assessment and Review
Pulmonary Rehabilitation
Respiratory
Structured Patient Education

Community Diabetes Team

Foot Protection Team

Reduction in hospital Admissions

Reduction in Amputations

Improvement in Education and Self Management

More Complex Patients Managed in the Community
Acute care at home pathway

Community services and pharmacy enabling self-care

Risk stratification LES – case finding and management

Patient becomes unwell – contacts GP or calls 999

GP visit or assessment

Acute care at home team: comprehensive multidisciplinary team assessment including community geriatrician/specialist GP/nursing/AHPs/social work

OPTIONS

Managed by Acute care at home team

Direct admission via BCH Direct

Referred to rehabilitation or reablement

Referred to core services