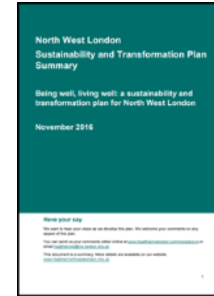
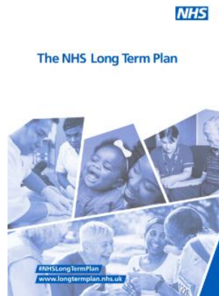
Central London
Clinical Commissioning Group

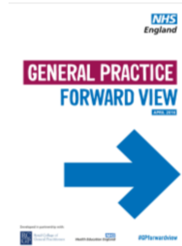
Integrated Community Team Pilot – ICT Regent's Canal and Paddington

Background



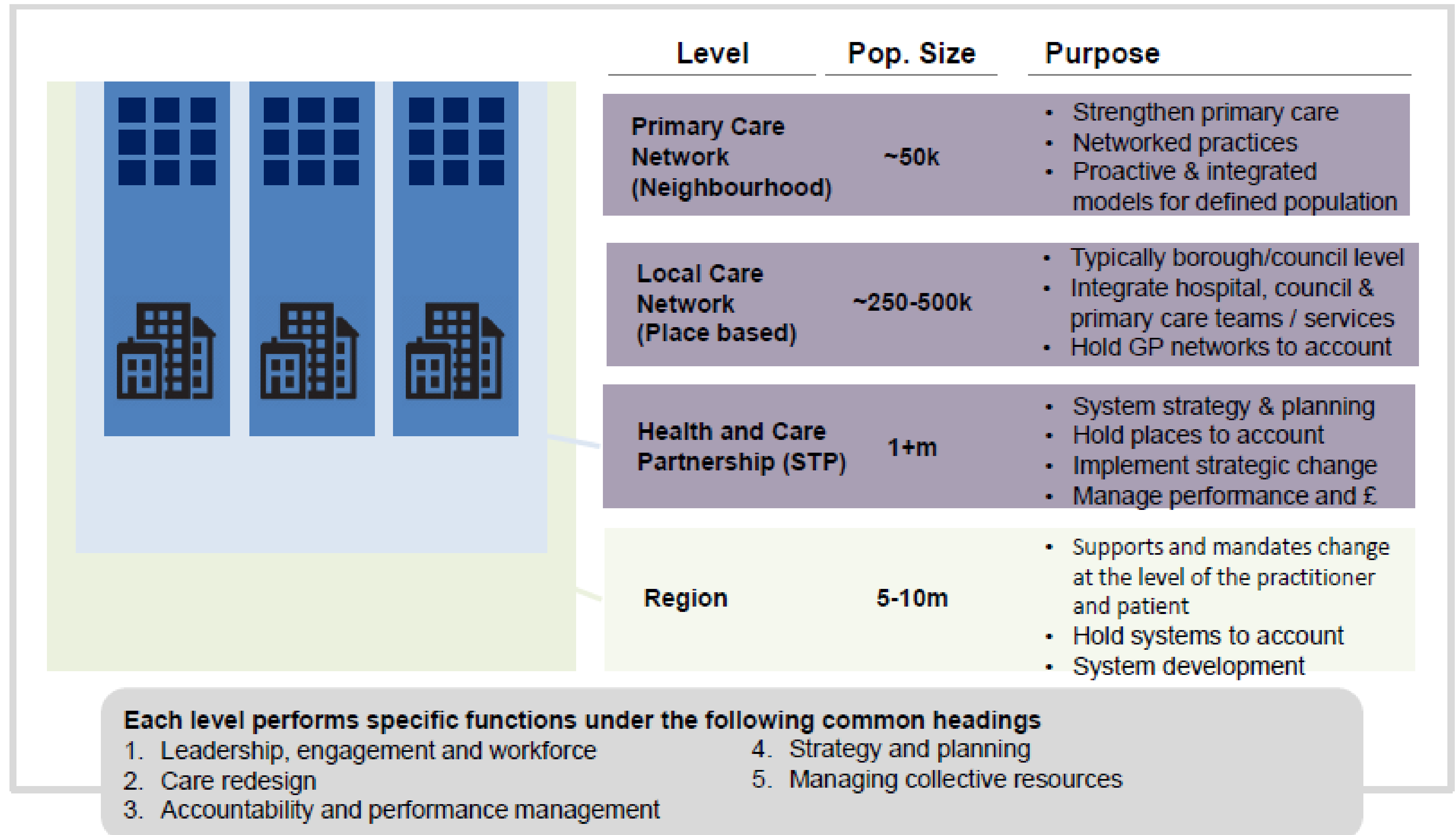
Integration
Working at Scale
New Models of Care
Primary Care Networks





Integrated care systems

Do different things at four different levels



New Models of Care Workstreams

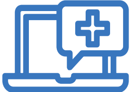
- Children
- Working age adults
- Mental Health
- Frailty and older adults

Delivering the Model of Care

Extended appointments for the PCH team to assess people with complex needs and to co-design care plans

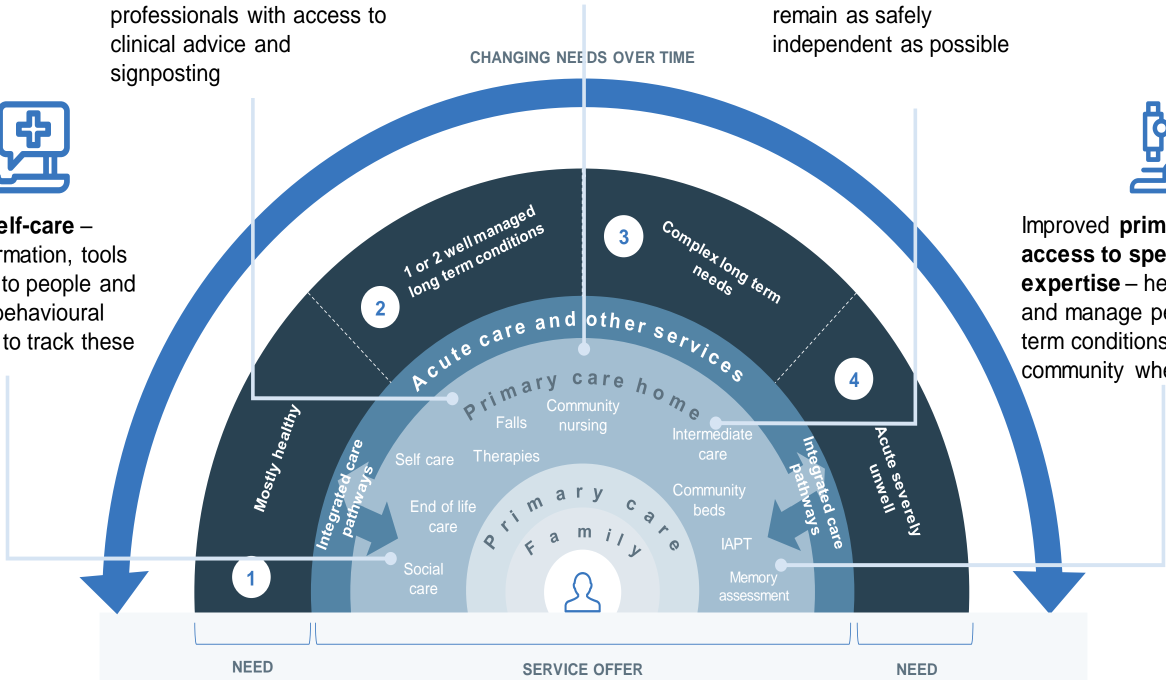
A **single point of access** providing people and professionals with access to clinical advice and signposting

A consistent **telehealthcare offer –** helping older people remain as safely independent as possible



A **focus on self-care** – providing information, tools and coaching to people and carers make behavioural changes; and to track these changes

Improved **primary care access to specialist expertise** – helping assess and manage people with long term conditions in the community where possible



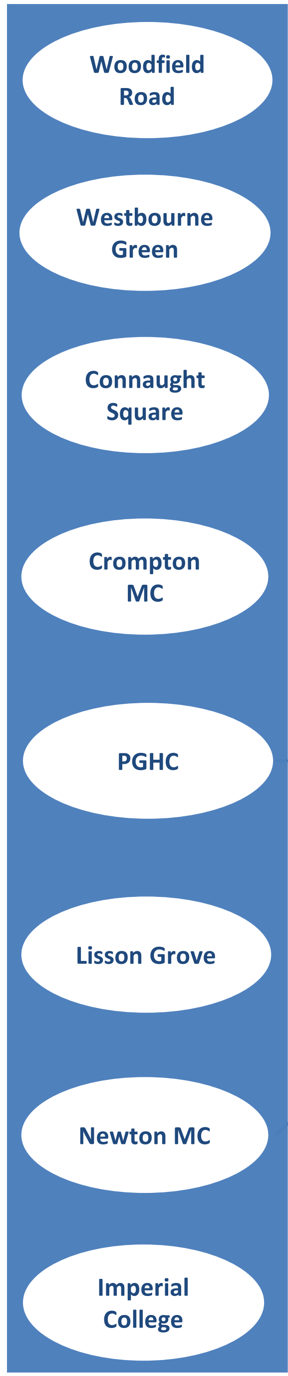
Workstream 1: Prevention and Early Identification

Workstream 2: Digital Opportunities

Workstream 3: Integrated Community Teams

Workstream 4: Integrated Community Response

PCN



Proactive Case Finding

ICT

SPA/SPOR/Tri-Borough Community SPA? (to be defined and agreed)

Social Worker

Voluntary Sector - to be defined

Consultant

MH Practitioner

Specialist Nurses

Care Navigator

RR Clinician

Physio

District Nurses

Community Matrons

OT

- **Single Care Plan**
- **Unified Assessment**
- **Virtual MDT**
- **Using S1 to ensure Communication & Continuity of Care**
- **Shared Management Structure**
- **Proactive Case Identification using WSIC**

Intended Benefits

- Improved outcomes for patients – measured using the agreed outcomes framework
- Increased opportunities for staff as they develop new skills and broaden their knowledge of other functions
- Opportunities to maximise efficiencies within the system
- Reduction in duplication between services/functions
- Full integration as staff across organisations work together seamlessly
- Enhanced preventative care
- Consistency in assessment and care

Prevention and Early Identification

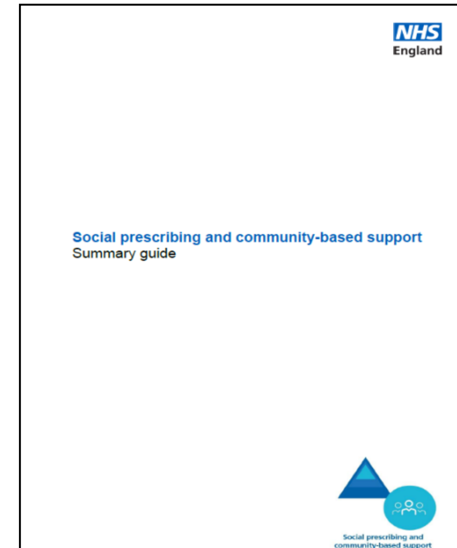
- Mapping out current options for people and families – including info available through local authorities, NHS websites, GPs, other health practitioners, and the Voluntary sector.

- Technology being rolled out or piloted across North West London:

  - Diabetes digital structured education (Type 2 Diabetes)
  - MyCOPD / MyHeart / MyAsthma
  - Skype for care homes – NHS 111
  - Health Help Now App
  - PAM
  - Sleepio
  - Migraine Buddy

Social Prescribing in Westminster

The CCG has engaged with a wide range of stakeholders – including One Westminster, GPs, social prescribing care navigators, local authority and other CCGs to set out the key elements of what makes a good social prescribing scheme and what needs to be in place locally.



Model for social prescribing:

Next Steps

- Finalise the model for the pilot
- Define the role of non commissioned services - social care and the voluntary sector
- Providers to develop MoU/Alliance Agreement/Governance Arrangements
- Commission the pilot for 2019/20
- Evaluate the pilot
- Roll-out CCG wide