




Central London Community Healthcare 

NHS Trust

Barnet ■ Hammersmith and Fulham ■ Kensington and Chelsea ■ Westminster

Transforming Community Nursing Services Across Central London, West London and Hammersmith & Fulham CCGs

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Transformed Community Nursing Services Are Critical to the Success of Tri-borough CCGs Out-of-Hospital Strategies

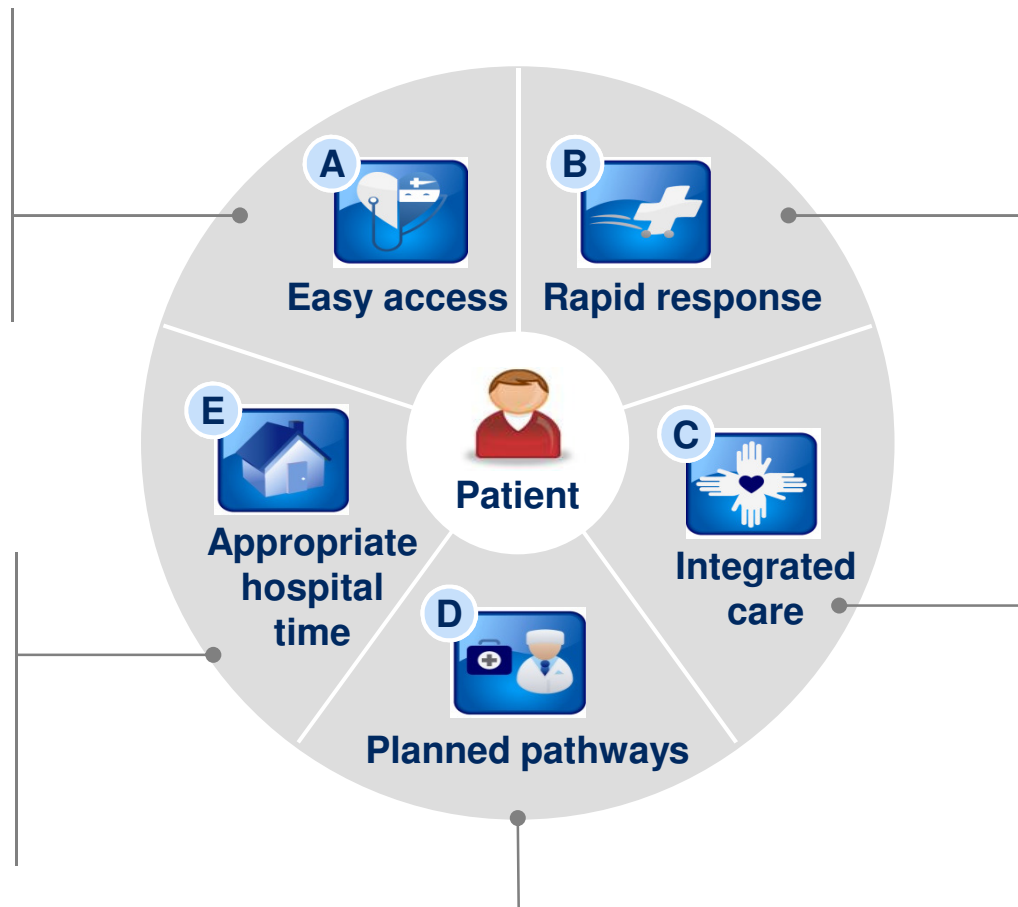
Out-of-Hospital Initiatives Across Tri-borough CCGs

Easy access to high quality, responsive primary care to make out-of-hospital care first point of call for people –

Information about housebound patients shared between community and primary care so GP can provide care first

Appropriate time in hospital when admitted, with **early supported discharge**

CLCH working closely with hospitals to support discharge and organise care in the community



Rapid response to urgent needs so that fewer patients need to access hospital emergency care

Rapid response teams provided by CLCH

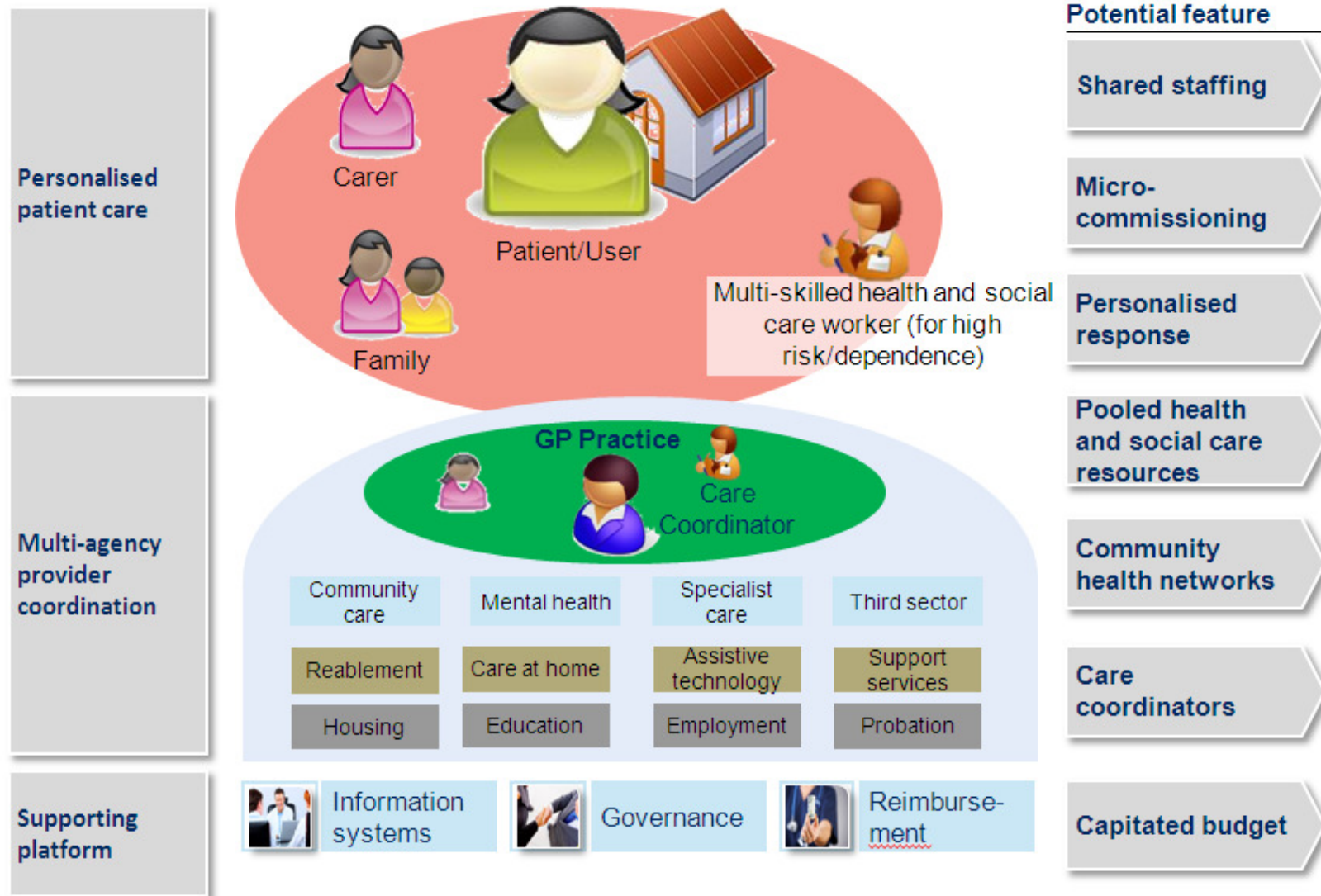
Providers (social and health) working together, with the patient at the center to proactively manage patients –

CLCH and tri-borough ASC working in joint teams

Simplified planned care pathways that ensure out-of-hospital care is not delivered in a hospital setting

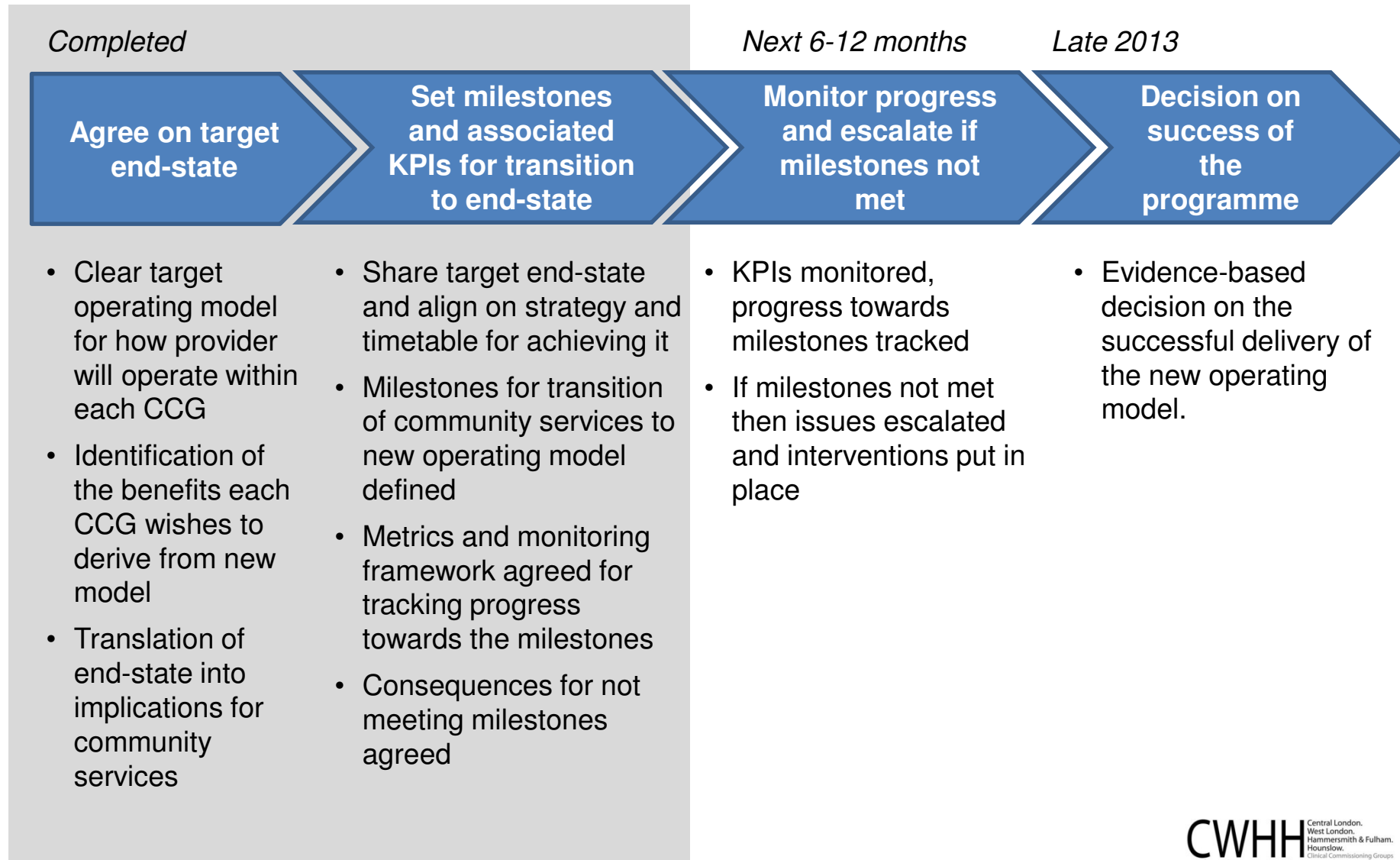
Case management services provided by CLCH and community matron participation in Integrated Care Pilot

CCGs Recognise that These Improvements Can Only Be Achieved Through Greater Integration of Health and Social Care at Network Level



Source: Whole Systems Integrated Care Programme

Service Development and Improvement (1)



Service Development and Improvement (2)

Service Development and Improvement Plan (SDIP)

Describes the set of activities and milestones that the Central London, West London and Hammersmith and Fulham CCGs have agreed with CLCH.

Timescale

01 May 2013 to 30 October 2013.

Themes

- Board approvals and joint programme governance;
- Data transparency;
- Target operating model new ways of working;
- Transition to the future operating model;
- Information systems, and;
- Workforce co-location.

Why

The CCGs and CLCH fundamentally believe that execution of the identified activities and milestones is essential in order to reshape and redesign the community services in a manner which will enable them to achieve their goal of better, more integrated, responsive and effective out of hospital care for patients.

Reporting and Monitoring

The proposed Tri-Borough Health and Social Care Integration Partnership Board will receive updates on the delivery of the plan for onward communication to HWBBs. Membership of the Board will include Lead Cabinet Members and CCG Chairs.



Example Milestones

Data Transparency

Implement a network/locality level dashboard - **August 2013**

Operating Model and New Ways of Working

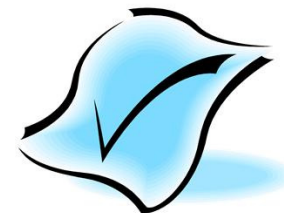
Complete outstanding operating model details with a focus on services to be transformed by September - **15 July 2013**

Transition to the New Operating Model

- Frontline Healthcare teams allocated by practice and organised around networks, and these arrangements communicated to respective practices - **Agreement of allocations June 2013, commencement of implementation July 2013**
- Recruit to new roles and embed new ways of working - 80% of new jobs / roles (to be employed by CLCH) recruited to and on-board - **30 August 2013**

Information Systems

- Move towards a single joint patient record and shared IT systems -Implementation of recommendations underway - **30 September 2013**



Conclusion

1. Clear plan with measurable milestones agreed between CCGs and CLCH.
2. The resulting operating model delivers a key element of the CCGs Out-of-Hospital Strategies and improvements for Patients and Service Users.
3. The new models support the agenda for the integration of health and social care and have been developed in collaboration with social care colleagues.