

Whole Systems Integrated Care





Across NWL we are continuing to work together to be a Pioneer site for integrated care



















Clinical Commissioning Group

We have a 3 – 5 year vision for integration

Our shared vision of the WSIC programme ...

We want to improve the quality of care for individuals, carers and families, empowering and supporting people to maintain independence and to lead full lives as active participants in their community

77

... supported by 3 principles

People will be empowered to direct their care and support and to receive the care they need in their homes or local community

- GPs will be at the centre of organising and coordinating people's care
- 3 Our systems will enable and not hinder the provision of integrated care





Together we have described how care will be different

Providing care

- Health and social care professionals come together to form an Accountable Care Partnership (ACP), where they work in a coordinated and collaborative way
- The ACP listen to everyone's views and share objectives
- Decisions are made together within the ACP covering how best to deliver care, where to allocate budget and how to resource care
- When more specialised services are needed, the ACP can invite other providers to help deliver care
- The ACP is its own entity which works efficiently as one, supported by a joined up back office with shared managerial and administrative support
- When money is over or underspent, the ACP agrees together what to do



Organising care

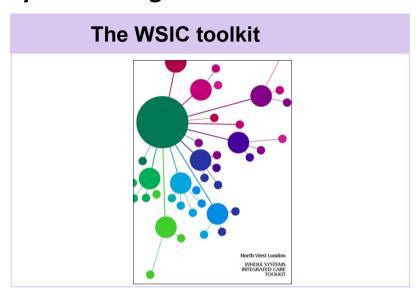
- Care is organised around groups of people with similar needs
- People are involved with their own care plan, with their own goals.
- They agree, with their care team, what happens when they become unwell and when they can return home
- Care plans include self care, community services and the voluntary sector
- People choose the services they want and have a say in how money is spent on them
- Health and social care staff work as one team, with the GP at the centre of people's health and wellbeing, finding people the right care in the right setting
- The team communicate frequently and keep each other up to date on patients' progress

Paying for care

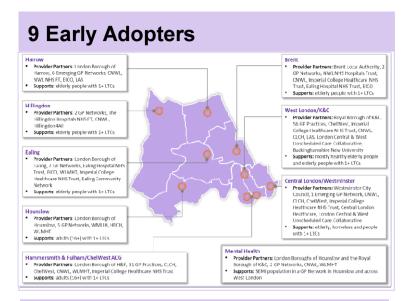
- Governance around co-commissioning agreed by LA, CCG and NHSE
- **Budgets** across social, mental health, acute, community and primary care are pooled for groups of people with similar needs who receive integrated care
- Contracts are in place to provide clarity over these arrangements which also define how risk is shared, for commissioners and ACPs
- These contracts set out targets that ACPs need to deliver against, including clinical, financial and outcomes

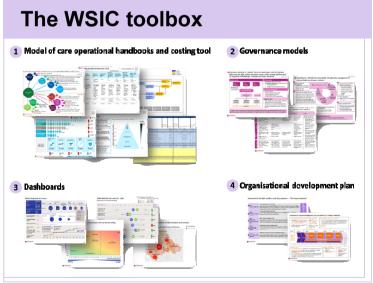


During 2014/15 we have worked hard to plan how we will implement Whole Systems Integrated Care









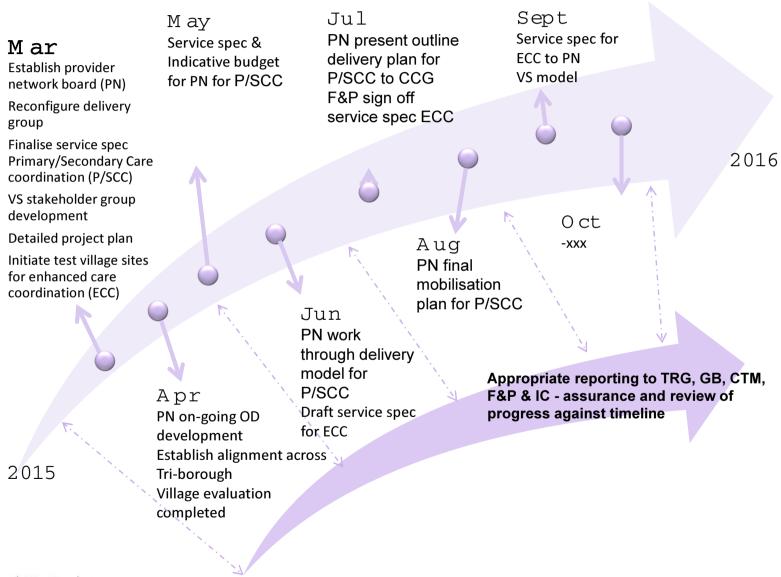


Summary description of model care

Central London CCG proposed model of care for residents, aged over 75 or with LTCs MDI Care plan 0 Everyone accesses care plan Whole Systems Integrated Care • Lists personal goals and how to R Care coordinator arranges achieve them Т diagnostics/home visit/team input to Shared services and support that can Planned care interventions MDT Н serve patients, service users and the MDT prepare for first plan Contingency plan for emergency Includes: Н Single IT System U Home care MDT В Rapid response Specialists (e.g., diabetologist, Multi-disciplinary team С cardiologist or geriatrician) Ε Every Village: Diagnostics MDI Care coordinator N Driver able to transport people to Community Matron Т hubs Community Nursing R Social care and Home Care Back office / operations team Social prescriptions provider Family MDT Third sector services coordinator Volunteers (expert and non) (organises social interventions on PCLN Mental Health Nursing behalf of MDT) Н Every Hub: Long term care coordinator (e.g., U MDT Physiotherapist liaison with home care provided В Environmental health officer (housing) beyond initial reablement or by Specialist Community Services agency outside MDT) Specialist i.e. Geriatrician S Hospital discharge coordination team MDT Podiatrist O (led by Geriatrician and able to Mental health expert One or U Clinical Pharmacist negotiate timely community discharge Т more Equipment via support at home) Н Team manager named MDI Out-of-hours Skype enabled switch Interpreters GP(s) Discharge Co-ordinator board, staffed by a GP Н **EOL Specialist** U В Operating base for each MDT Capabilities include: Central venue for: GP has more time and can: Home care visits Care appointments/diagnostics so Make home visits, including to care plan Rapid response (shift working to patients only travel to one place Offer longer, more regular appointments extend OOH cover within team) Services like patient education Direct MDT to provide care for people in line with Reablement Whole Systems services are hosted care plan Clinics in hubs across hubs Case conference with MDT



Whole Systems Integrated Care key milestones

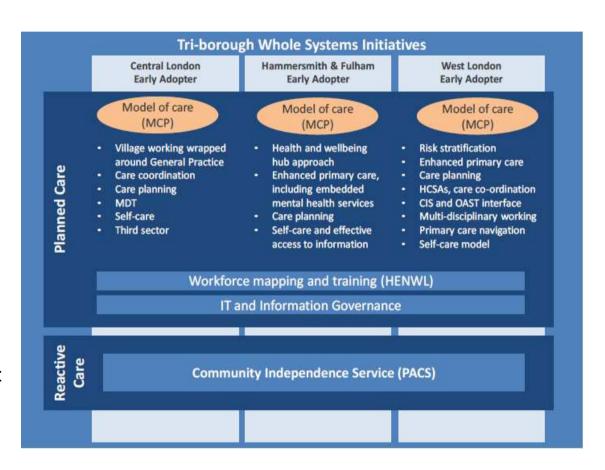




Planned and reactive models of care to support Whole Systems

As part of the North West London Whole Systems Pioneer Programme, Tri-borough partners are developing both planned and reactive models of care in support of the Whole Systems shared vision and principles:

- People will be empowered to direct their care and support and to receive the care they need in their homes or local community;
- GPs will be at the centre of organising and coordinating care so that it is accessible and provided in the most appropriate setting; and
- Our systems will enable and not hinder the provision of integrated care and ensure that funding flows to where it is needed most.





This will be supported by on-going enabling work across North West London

Model of Care (MoC) and Outcomes

- S Develop a common set of outcomes across NWL including embedding the outcomes in the way that Early Adopters performance manage and evaluate
- § Provide support and shared learning to developing Models of Care for existing and new population segments

Governance & Contracting

- § Support to develop the new capabilities and capacity required to move into a WSIC model
- § Support to make the necessary contracting changes that will support shifting from shadow to 'real' ways of working
- § Development of a consistent approach to assurance of new commissioning and provider models

Analytics and Informatics

- **S** Roll-out across NWL of the data warehouse and dashboards
- § Training and support to users as the dashboards get taken up across NWL
- § Consistent management of IG processes, stakeholder engagement and vendor management

Finance and capitation

- Move Early Adopters towards capitated budgets and pooled budgets from a technical and contractual
 perspective (development of a pricing methodology and principles)
- § Support Early Adopters with the changes that are required and provide, where appropriate, technical guidance in the implementation

New ways of working (Change Academy)

- § Roll-out the Change Academy to embed new ways of working for teams and their leaders
- § Run the Change Academy day-to-day including supporting participants, organising sessions, coordinating programmes

