Overview of Integrated Community Care Team (ICCT)

Definition:

“Person centred coordinated care to achieve quality, efficiency, access and customer satisfaction”¹

Integrated community care teams (ICCT’s) aim to develop person centred care planning and support for eligible adults, particularly elderly people and those with long term conditions, complex needs or who are approaching the end of their life, ensuring that services

- Maximise wellbeing
- Maximise choice and control
- Maximise independence and functioning
- Minimise intervention, unnecessary hospital admission and premature admission to long term care
- The above will be achieved through the care co-ordinator role and effective care planning

Each ICCT is based around a cluster of GP practices with a combined patient population of 30000 to 50000. The Integrated Community Team (ICCT) is a multidisciplinary team consisting of the following:

<table>
<thead>
<tr>
<th>ICCT Core members:</th>
<th>Additional members as required</th>
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<tbody>
<tr>
<td>GP</td>
<td>Practice Nurse</td>
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<tr>
<td>Integrated Community Care Team</td>
<td>Adult Services Team Manager</td>
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<tr>
<td>Administrator*</td>
<td></td>
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<tr>
<td>Community matron/nursing team*</td>
<td>Specialist nurses</td>
</tr>
<tr>
<td>Physiotherapist*</td>
<td>Sensory services ICCT link worker</td>
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<tr>
<td>Occupational therapist*</td>
<td>Consultant of elderly medicine</td>
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<tr>
<td>Social worker*</td>
<td>South Coast Ambulance Service</td>
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<td></td>
<td>Out of Hours GP’s (if required for End of Life patients etc)</td>
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<tr>
<td>Older Persons Mental Health Practitioner*</td>
<td>Voluntary services/teams as appropriate</td>
</tr>
<tr>
<td>Palliative care nurses</td>
<td>Adult Mental Health Practitioner</td>
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<td></td>
<td>Learning Disability Practitioner</td>
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<td>Substance misuse service</td>
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* required to attend weekly ICCT meetings

ICCT Planned Work

- proactively identify patients/clients with the most complex health and social care needs.
- plan and co-ordinate care and support to meet those needs in a timely way.
- Patients may be identified proactively through a risk stratification tool

¹ National Voices: People Shaping Health and Social Care
ICCT Unplanned Work
The person has acute care needs that might be managed in the community. Their care needs are likely to require urgent assessment which can be performed by any appropriately trained member of the ICCT with capacity. They will then facilitate immediate necessary planning, involving all relevant agencies in order to prevent avoidable admission.

How to Access the ICCT
During office hours each ICCT will have one point of access via the ICCT administrator. Out of hours access will be defined locally.

Meeting Frequency
- There will be weekly cluster level meetings at which core integrated community care team members will be represented. The purpose of this meeting will be to ensure that the management of high risk patients is closely and regularly managed and monitored by the wider multi-disciplinary team. GP's will not necessarily form part of these discussions and the chairing of the meetings will be by the senior nurse or other senior practitioner.
- Practices are invited to continue to hold monthly meetings with the integrated community care team to discuss patients whose needs are being met by the team and who need close management. This meeting will not replace the usual frequent communication required between meetings to support the safe and proactive management of patients

Who is the Care Co-ordinator?
The care co-ordinator can be from any discipline in the team and will liaise with professional colleagues as appropriate:
- They are the primary link between the patient and the Integrated Community Care Team
- They will develop the care plan with input from the patient, family, carers, and other team members
- They will identify patients from their caseload that need multidisciplinary input, and discuss their care at Integrated Community Care Team meetings
- They will ensure all appropriate forms are in place, eg, Do Not Attempt Cardiopulmonary Resuscitation, Ambulance Anticipatory Care Plan, patient centred care plan, continuing health care assessments

Who is the Integrated Community Care Team Administrator?
- The key link for the GP, Care Co-ordinator and patient
- A single point of contact for referrals
- The central hub of information for the team
- Holds the database/dashboard of patients (there will be one per integrated community team)

Locally Driven Elements
- Mechanism of GP involvement with the integrated community care team meetings
- Chairing of meetings
- Local content on the Integrated Community Care team’s dashboard/database