



# Integrated Care Up-date- Health and Wellbeing Board 12th June



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# Delivery Plan: work programmes (themes)

Integrated Care Redesign  
Programme

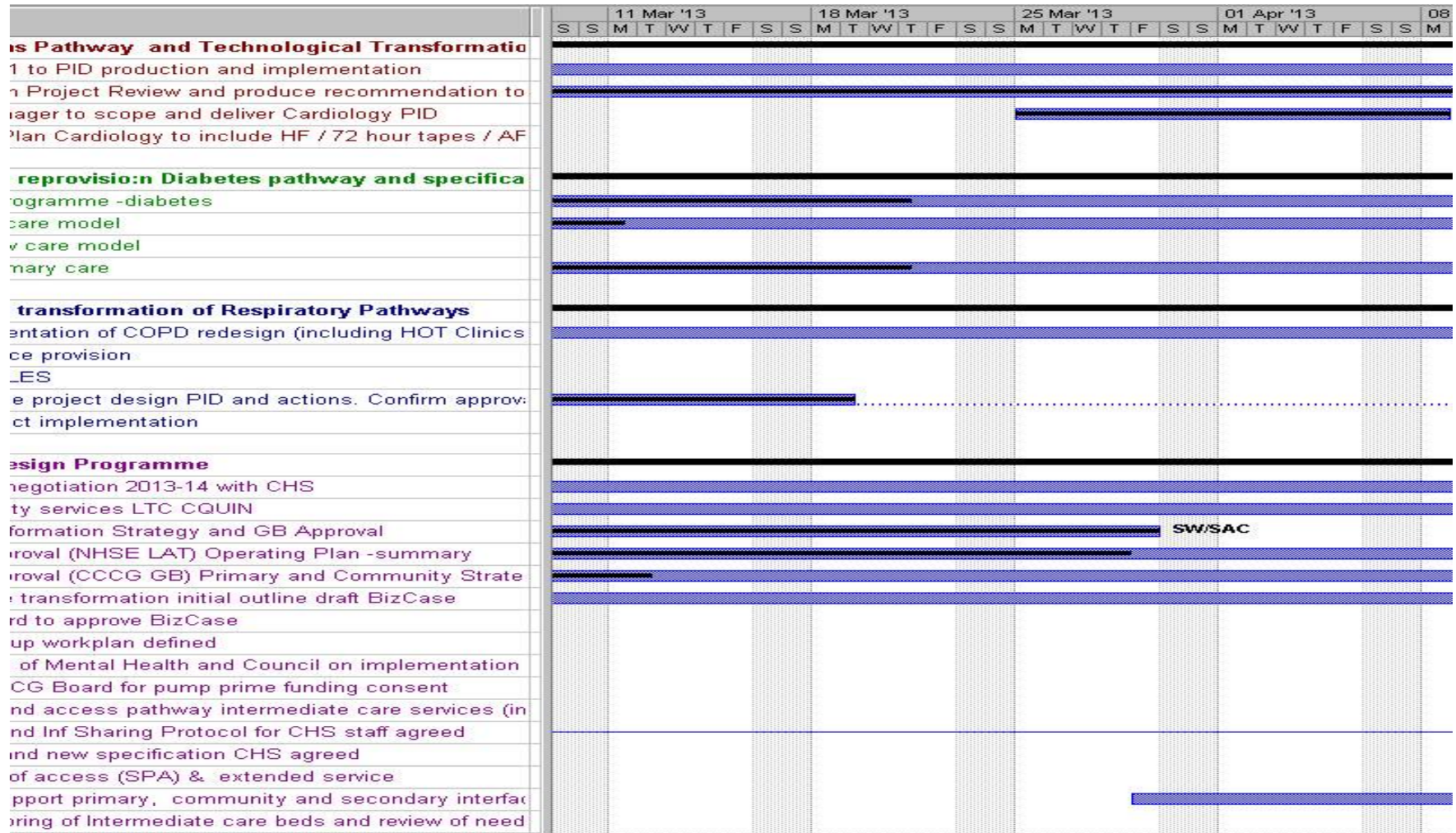
Primary Care

Structural  
Transformation  
Programme

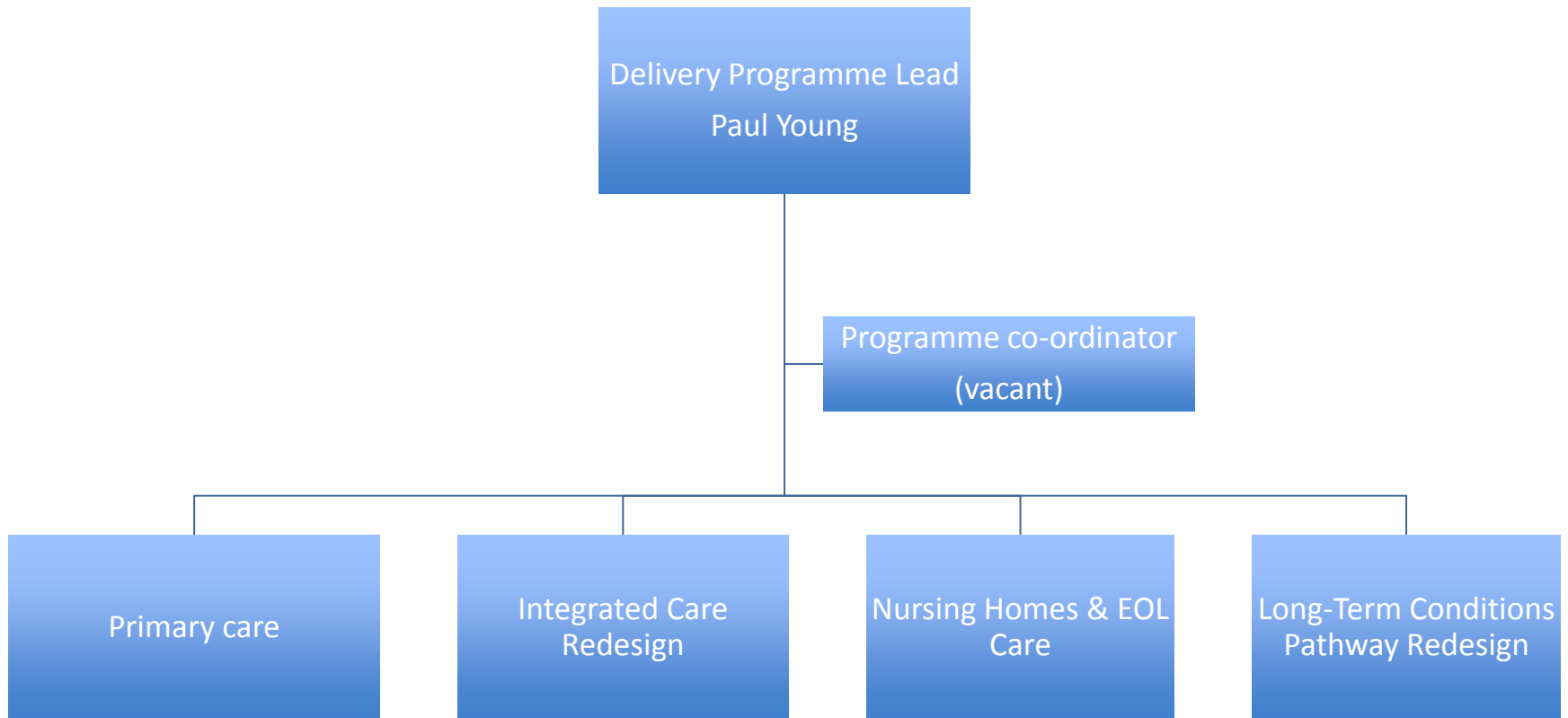
Long-Term Conditions  
Pathway Transformation

Nursing Homes & EOL Care  
Programme including  
telehealth

# Complexity of Delivery Plan



# Delivery Structure



# Inter-related and Interdependent whole system Change Programme

## Integrated Care Redesign Programme

Pump Prime Investment in Rapid/Appropriate Response Community Services

Single Point of Access/Assessment Service 24/7 for Intermediate care Services

Expansion of step-up and step down beds

Night and home sitting services

Investment in Social and Mental Health Practitioners aligned to Primary Care and Localities

Teams reflecting Locality Needs Assessment Profiles

### Primary care

Risk stratification LTC

#### Case finding

Case management

Transformational LES / DES

MDT support for complex needs

Coordination across Health, Social and Mental Health Services

Remote monitoring

Palliative Care and 3 Tiered approach to Long-term conditions

### Long- Term Conditions Pathway Transformation

Aligned to primary care

LTC Focus

Redesign across whole system:

Diabetes

Respiratory/COPD

Cardiology/Heart Failure

Falls

Nursing Homes / EOL Care / Telehealth

Prevention of admission by rapid proactive response

Upskilling staff

Standardise Offer

Rapid/Appropriate Response

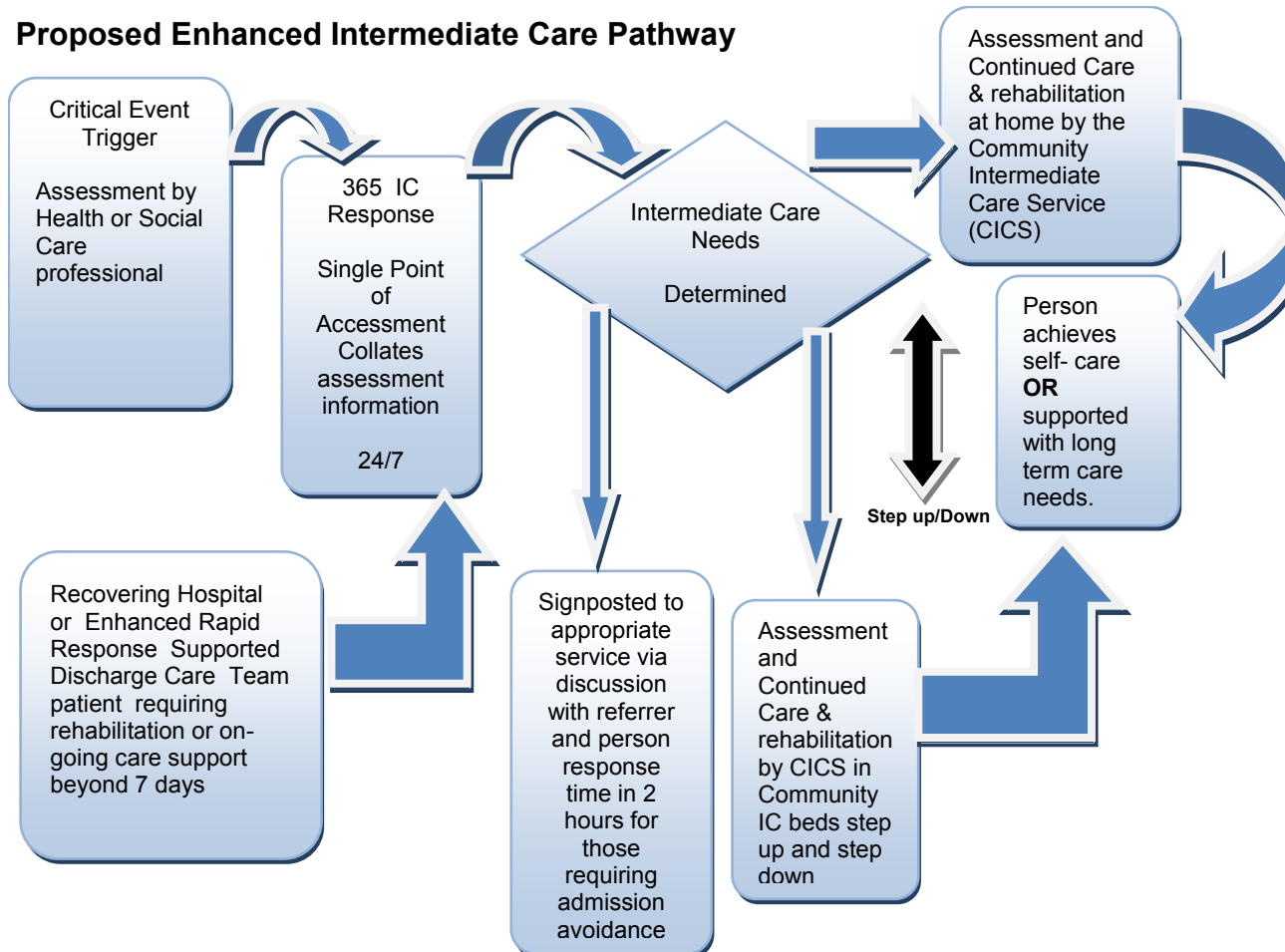
MDT

EOL Care coordination

Coordinate My Care

# Joint Vision

## Proposed Enhanced Intermediate Care Pathway

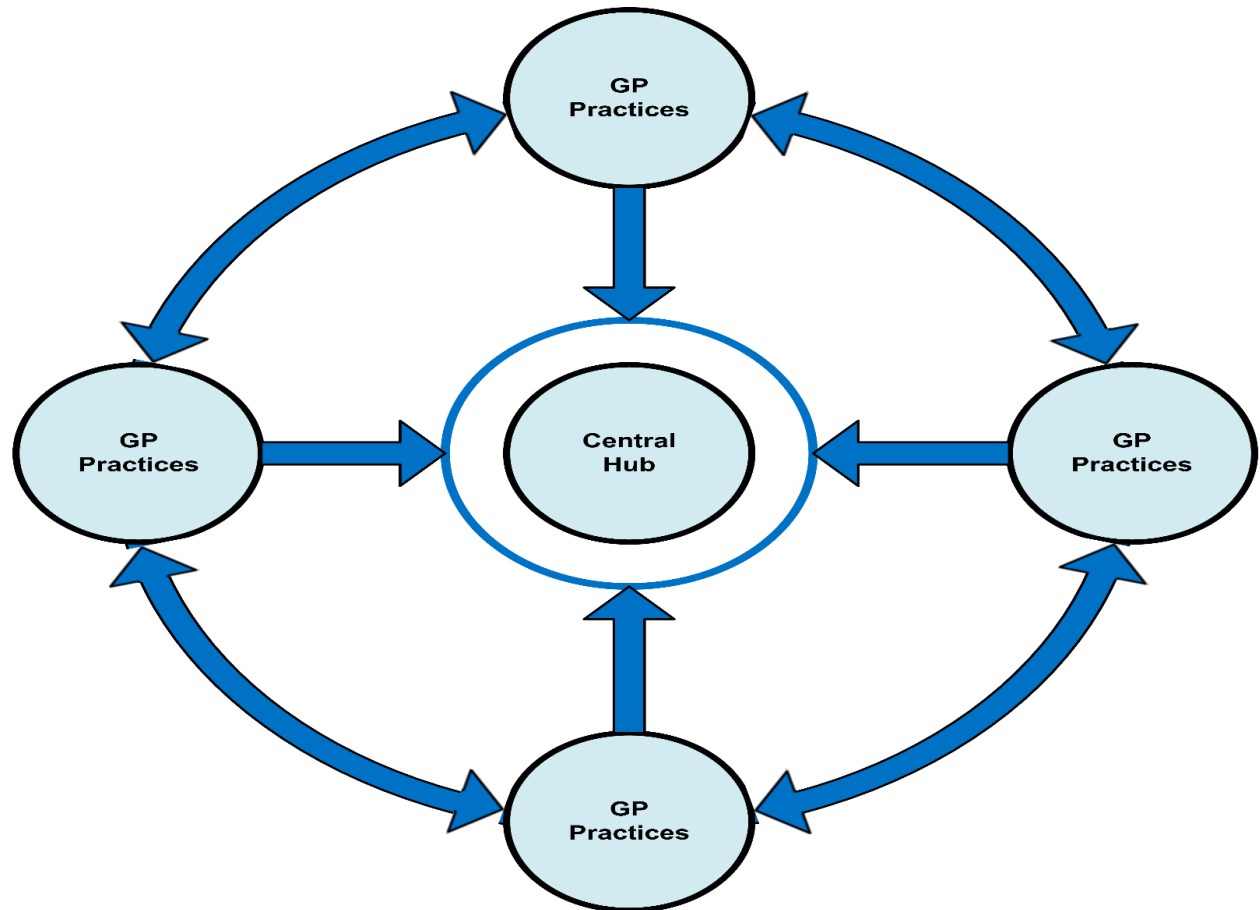


# Focus on Networks and Network Teams with a Hub and Spoke Model

## Geographical Network Hub & Spoke Model

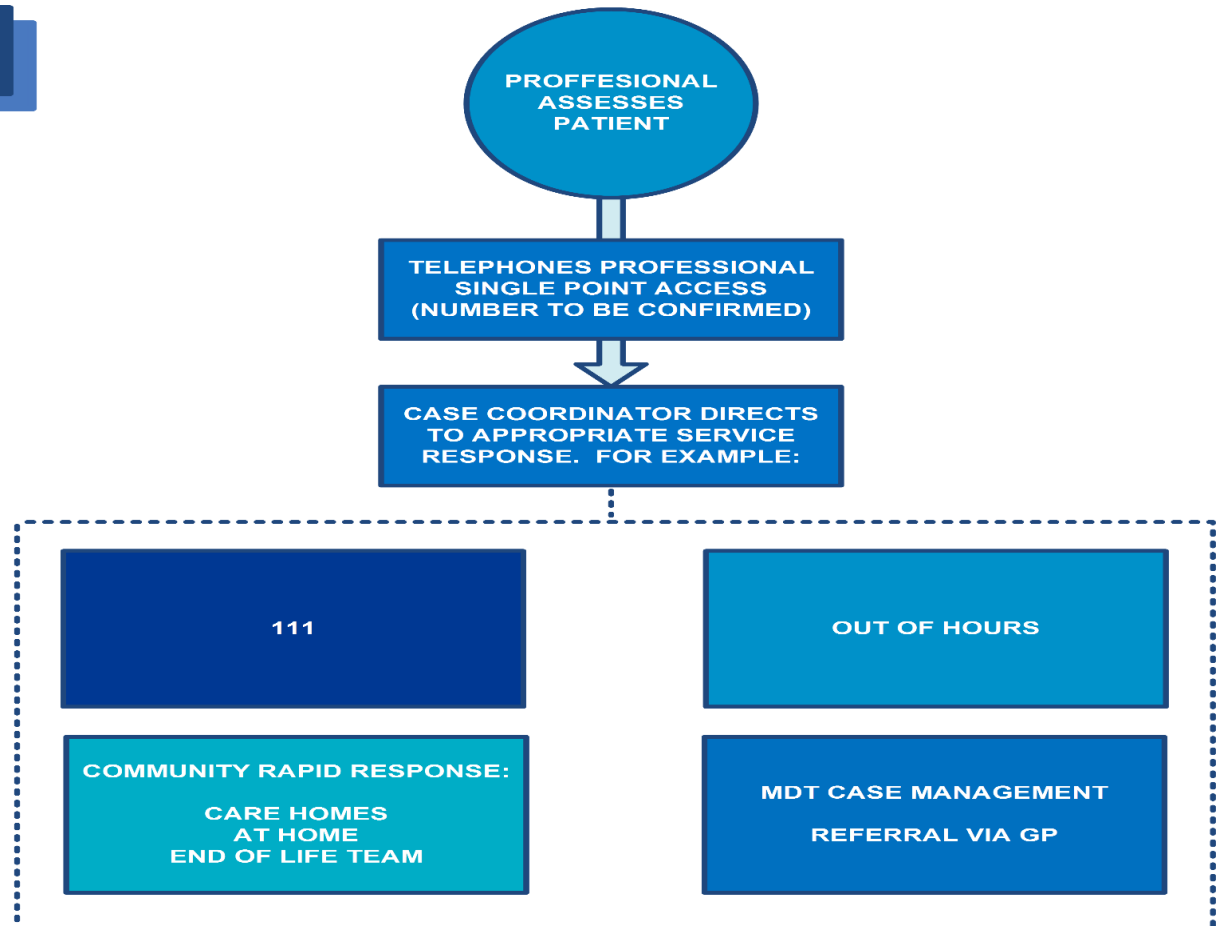
For each Geographical Network, a Hub and Spoke may be adopted with various GP Practices linking to the hub to provide equitable / specialist services to achieve economies of scale and / or to utilise skills effectively.

There are a variety of options for a Hub Building to be either in an existing GP Practice or another provider, e.g. Community Health Centre



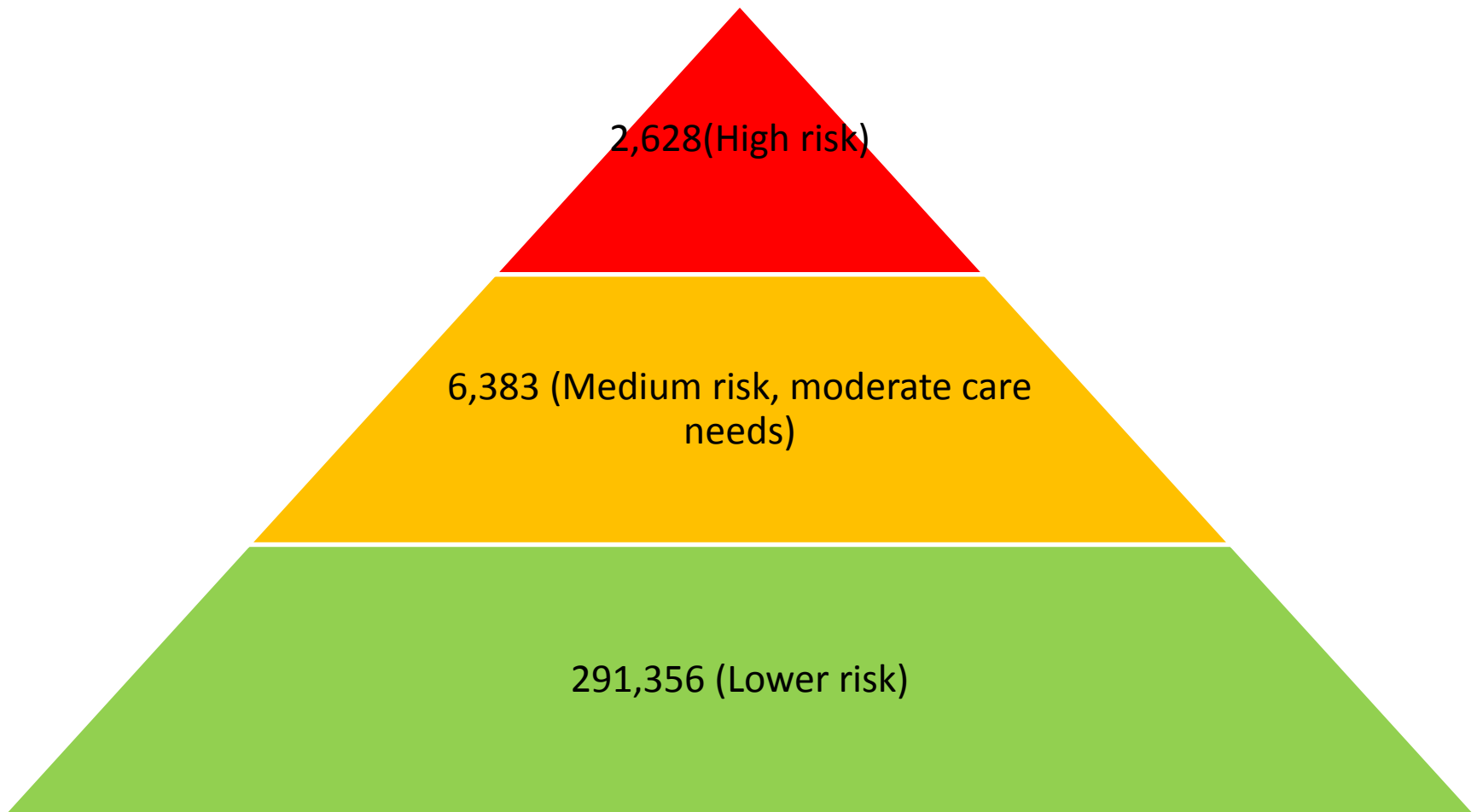
# Rapid Response in Connecting through a Single Point of Assessment to Network Teams

Single Point of Access For Professional Use to facilitate Community Rapid Response





# Pro-active Approach as well as Responsive Approach- Croydon Population with LTC Need



# How Identified?

Case Management Report (696 patients) [My Practice, Top 5% (Predicted Relative Cost Weight)] [Reset Filters](#)

As of - 28/02/2013

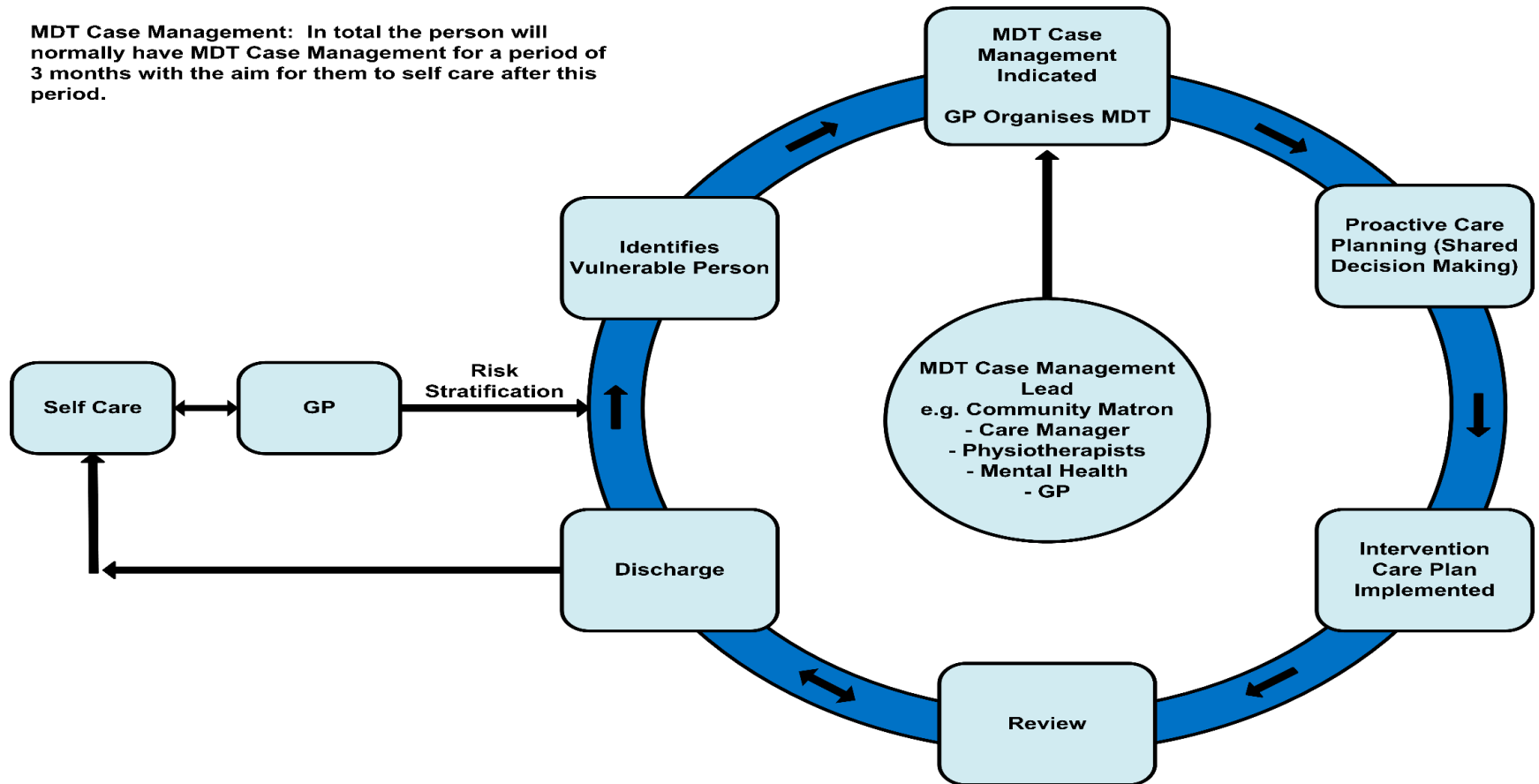
Show/Hide Demographic Columns   
  Show/Hide Risk Columns   
  Show/Hide Cost Columns  
 Show/Hide Condition Columns   
  Show/Hide Activities Columns   
  Show/Hide Review and Programmes Columns

Practice ID	Usual GP	NHS Number	Practice System ID	Age	Sex	Current Relative Cost Weight	Predicted Relative Cost Weight	Probability of High Total Cost	Difference Between Current & Predicted Cost Weights	Total Costs	Frailty Flag	Pharmacy cost	Predicted Relative Pharmacy Cost Weight	Probability of High Pharmacy Costs	RUB	Hospital Dominant Count	Chronic Condition Count
XXXXXX				56	M	25.33	32.85	0.95	7.51	£9,632	N	£1,187	7.42	0.78	5	4	
XXXXXX				81	M	25.33	30.85	0.95	5.51	£22,019	N	£1,671	9.14	0.82	5	3	
XXXXXX				63	F	18.49	27.42	0.95	8.93	£35,507	N	£13,594	37.38	0.99	5	4	
XXXXXX				66	M	25.33	26.45	0.95	1.12	£10,380	N	£882	8.90	0.82	5	4	
XXXXXX				51	M	25.33	23.30	0.95	-2.04	£27,152	Y	£396	4.22	0.30	5	6	
XXXXXX				75	F	25.33	22.37	0.95	-2.97	£31,342	N	£7,385	15.66	0.95	5	3	
XXXXXX				38	M	10.70	20.83	0.95	10.13	£21,597	N	£611	3.63	0.19	5	4	
XXXXXX				42	F	10.65	20.73	0.95	10.08	£21,342	N	£2,757	15.38	0.95	5	3	
XXXXXX				89	F	25.05	20.18	0.95	-4.87	£12,271	Y	£2,056	8.43	0.81	5	2	
XXXXXX				48	M	25.33	20.07	0.95	-5.26	£32,002	N	£1,317	12.44	0.92	5	5	
XXXXXX				79	F	18.49	19.12	0.95	0.62	£12,260	Y	£945	4.66	0.40	5	3	
XXXXXX				82	M	8.05	18.76	0.88	10.71	£12,940	N	£901	5.79	0.61	4	2	
XXXXXX				76	M	18.49	18.67	0.88	0.18	£18,252	N	£12,797	14.30	0.95	5	2	
XXXXXX				94	F	25.05	18.64	0.88	-6.41	£19,174	Y	£5,704	11.15	0.85	5	3	
XXXXXX				78	M	25.33	18.51	0.88	-6.83	£12,417	N	£2,154	12.03	0.90	5	4	
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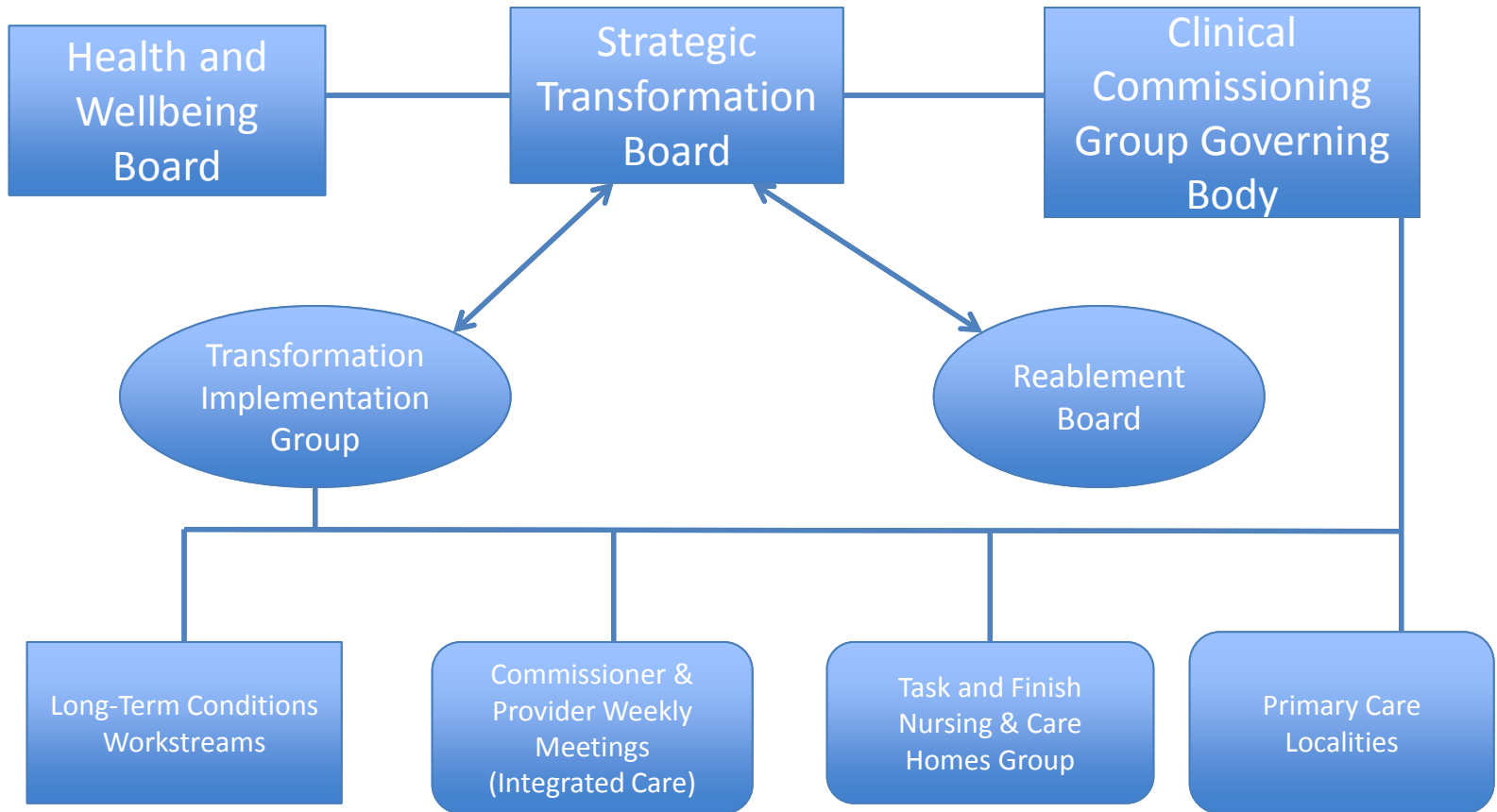
# MDT Case Management lead by Practices using Risk Stratification

## 3 Month Process from Identification to Discharge with Appropriate Care Plan

MDT Case Management: In total the person will normally have MDT Case Management for a period of 3 months with the aim for them to self care after this period.



# Governance Over-View



# Summary

- A whole system Transformational Implementation Plan
- Aligned to Transformation Strategy, Primary and community strategy, Reablement and Acute priorities
- Aligned to, but stretches the SW London BSBV Plan
- Programme delivery with named leads and single programme co-ordination (PY)
- Clear, costed and resourced, themed work programmes
- Programme overseen by Transformation Board: performance management, decision making within ToR, and unblock where necessary.
- Overall Responsibility of Croydon CCG Board / Health & Wellbeing Board and reporting to the Strategic Transformation Board