One Croydon
Your Health and Care partnership

Integrated Community Networks

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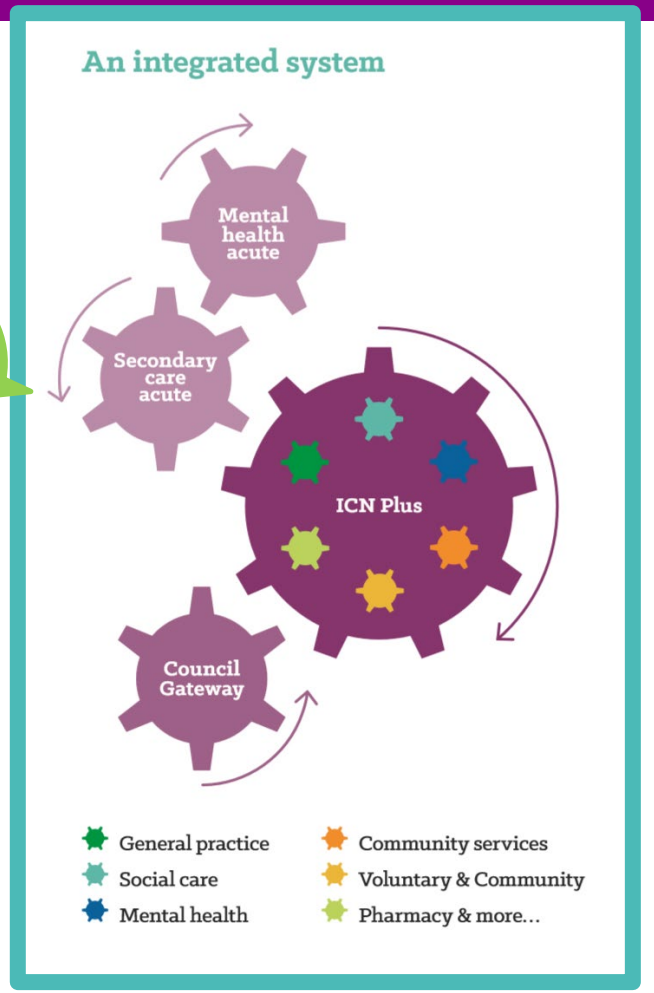
June 2021

Ambition



"Our ambition was to fundamentally change how our partners work together, using our combined resources wisely, to make sure we deliver the best health and care services for the people of Croydon. "

Dr Gaj Sivadhas, Chair and Medical Director, Croydon GP Collaborative

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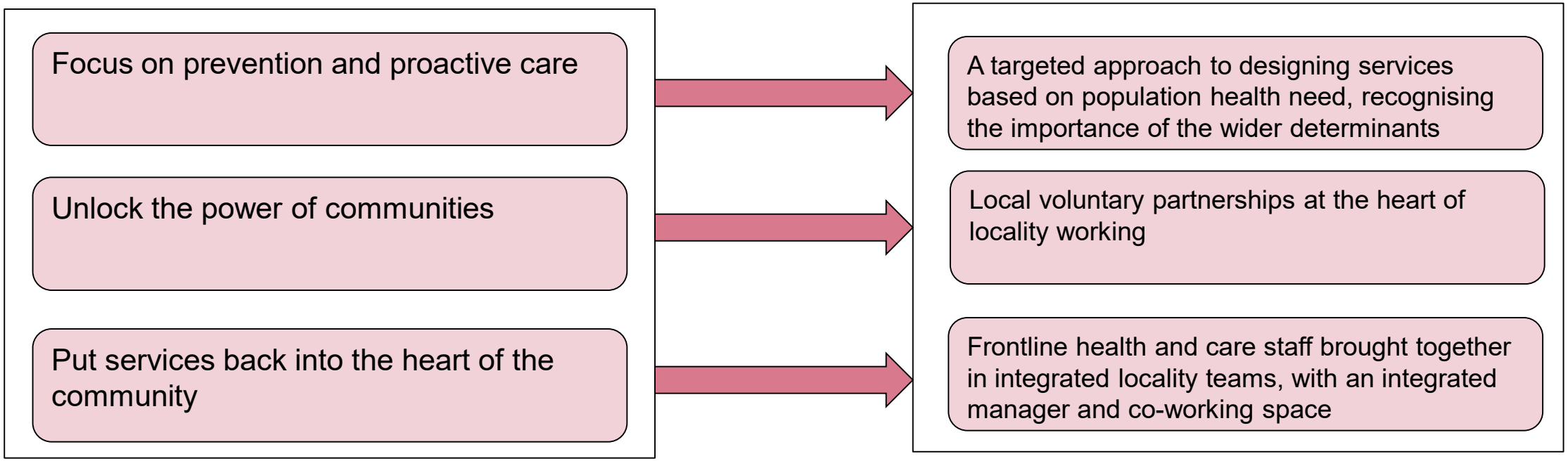
Introduction ICN+

Integrated Community Networks Plus (ICN+) is a major programme of transformation and integration that will improve outcomes for Croydon people through a proactive and preventative approach within each of the six localities of the borough. It is focused on all adults and aligned with services for children and families. The following should describe our whole model:

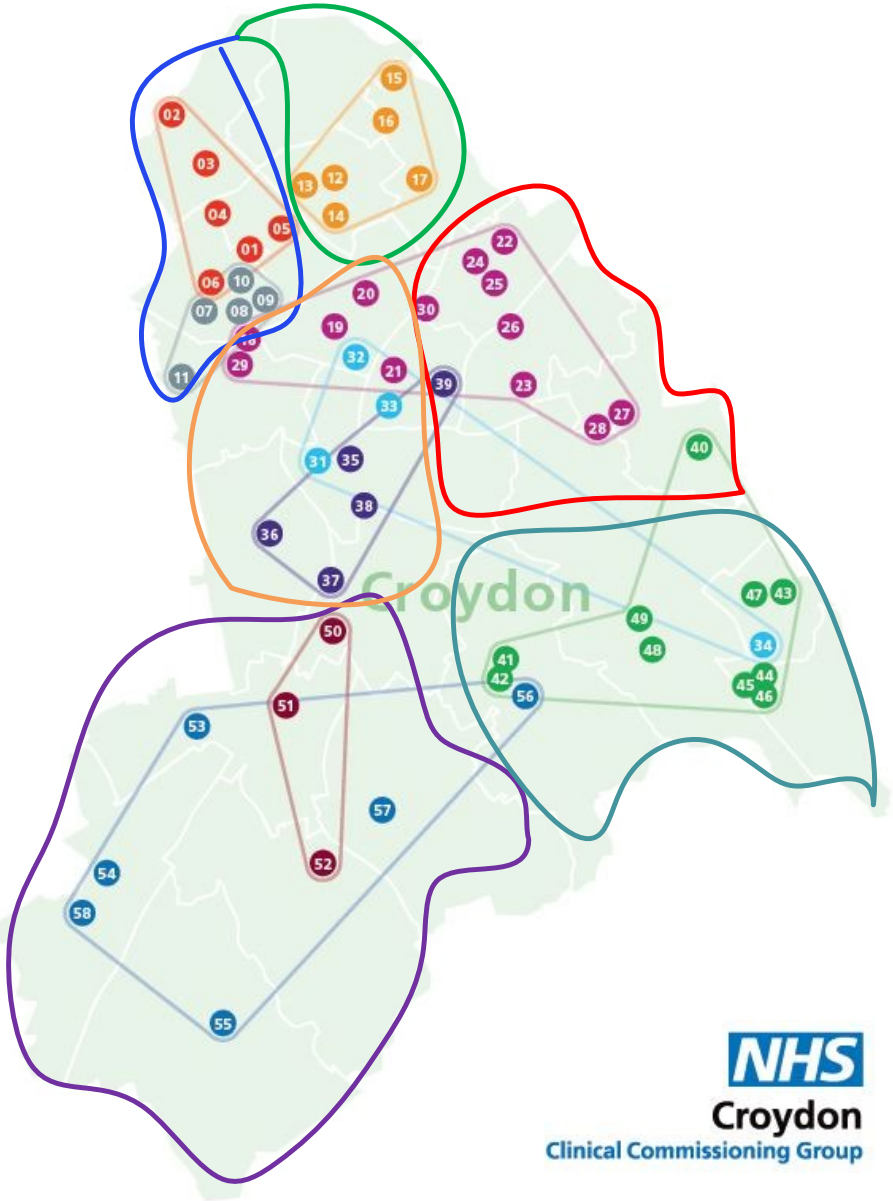
Our Localities vision is - "Total Place"
Our Operating Model is - ICN+ (straddling PCN's)
Our Practice Model is - Strengths Based Practice

One Croydon partners committed to a locality approach via ICN+ as a flagship initiative within our Croydon Health and Care Plan, which aims to deliver the three key objectives, as below.



The model of care has gone live in our early adopter site of Croydon North East (Thornton Heath) and we are now in the process of rollout the programme in the other 5 networks

ICN+ and PCNs



Geographical Locality Name	Numbers	PCNs Coverage
North West	01-11	Primary Care North Croydon, Mayday South
North East	12-17	One Thornton Heath
Central East	22-28, 39,40	Croydon GP Super Network, GPNET 5, Selnash PCN
Central West	18-21,29, 31-33,35-38	Croydon GP Super Network, GPNET 5, Croydon Central Network
South East	34, 41-49, 56	Selnash, Croydon Central Network
South West	50-55, 57,58	KMP Network, SPC Health PCN

The six ICNs straddle the nine PCNs as shown. Each ICN+ will be developed with the PCNs to support local need.

ICN+ model of Care

ICN+ core team

- **Physical space** in each locality for co-working and joint clinics
- **IT solutions** for virtual MDT meetings and flexible working
- Management of **locality health and care budget**

- Integrated manager
- Social workers
- Community Nursing
- Occupational Therapists
- Physiotherapists
- Pharmacist
- Network Facilitator
- Personal Independence Co-ordinators
- Talking Therapist
- Mental Health Assessment & Liaison officer

Under 65s has also moved into localities and working closely with the other services

Targeted support closer to home

- Group Consultations
- Diabetes service
- Joint over 50s clinic - frailty, healthy lifestyles, exercise
- Talking Therapy
- Podiatry
- Continence

Locality Voluntary Partnership

- Development of existing local collaboratives
- Relationships and pathways between voluntary and statutory sectors
- LVP grant funding devolved

TALKING POINT

- Access to VCS social activities
- Information and Advice
- Welfare Benefits
- Housing
- Health checks, healthy lifestyle
- PIC support
- Community connect

GP huddles

- Improved ways of working to be agreed with GPs in each locality to maximise benefits
- Proactive case finding
- Joint support plans

Links into specialist services

e.g. mental health drug and alcohol

Innovative approaches

e.g. Telehealth

What's worked well? (Benefits)

- Creating virtual space and co- location has improved relationships and communication, reducing bureaucracy and removing the need for long referral forms or complicated email chains.

- Training has allowed staff to develop a better awareness of other roles and develop their own skills. This has led to patient needs being identified by all staff members allowing for appropriate referrals to be made in a timelier manner.

- Networking with local voluntary groups to support assets based approach

- Virtual Talking Point has been a huge success, having supported **over 200** residents since June 2020, with connecting with the community, housing issues and benefits advice.

- Funding for 2 Community Network Facilitators in the voluntary sector to run the Talking Points.

- 6 new Mental Health PICs joining ICN+ teams to people with mental health issues

Case Study- Talking Point

Background

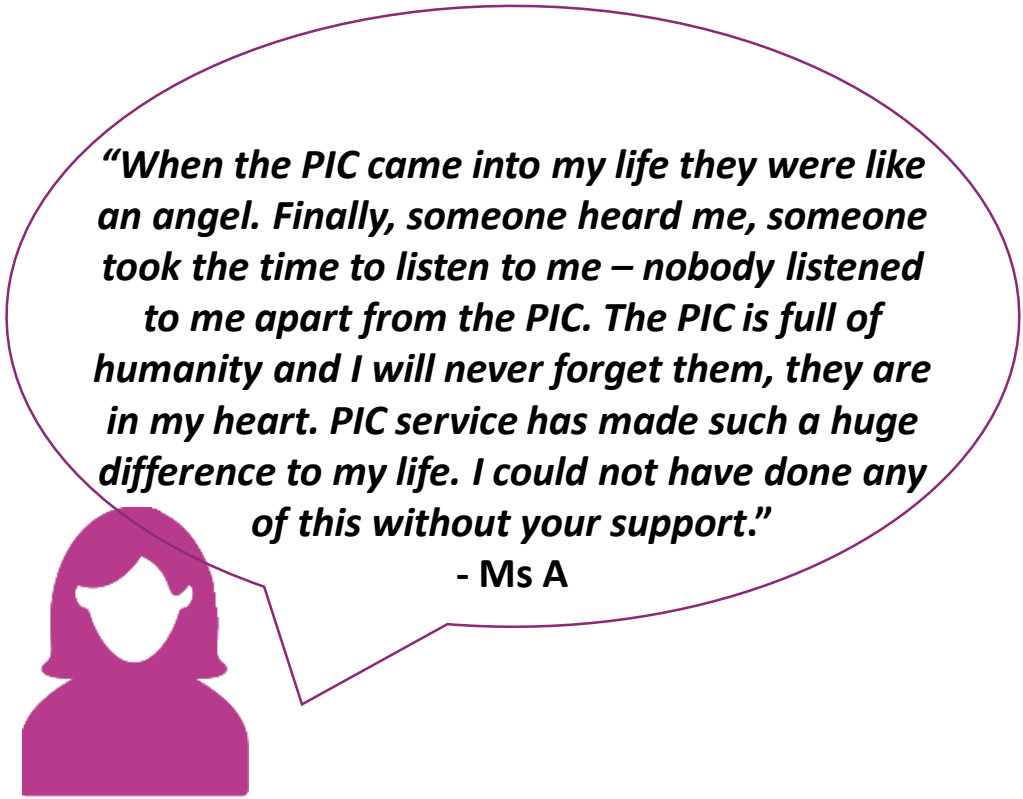
- Ms A is a 42 year-old Iranian lady who had fled domestic violence and been placed in Croydon with her teenage daughter. Ms A struggles with chronic pain, depression and other health conditions.
- Ms A was unable to leave her home as she could not manage the stairs leaving her feeling trapped and was sharing a bed with her daughter.
- Ms A was also struggling financially.

What did we do?

The PIC worked with Ms A to identify goals to improve her independence. Three main areas were identified – mobility, finances, and housing. The PIC assisted with each of these areas, contacting the relevant people e.g Housing, Benefits and Occupational Therapy teams to ensure the right support was in place for both Ms A and her daughter.

As a result of the ICN+ involvement Ms B is now…

- Living in accommodation much better suited to her needs. She has enough room to use the equipment provided by the OT service and no longer has to share a bed.
- Able to get outdoors without having to navigate several flights of stairs. This has improved her independence greatly as she can go for short walks by herself whilst her daughter is at school.
- Using her equipment provided by the OT team to mobilise around the house and is able to wash and prepare meals independently.
- Awaiting her medical assessment for Personal Independence Payment, which if successful will entitle her to a significant additional payment each month



Case Study- ICN+

Background

- Mr A is a 64 year old gentleman who lives alone
- Has prostate Cancer, COPD and high blood pressure
- Mr A was referred to the District Nurse (DN) Service via his GP for Catheter care.
- DN identified Mr A was not managing his catheter well, was unsteady on his feet and that he was not managing with getting or preparing food

What did we do?

Mr A was discussed at the daily ICN+ MDT where the DN requested a Social Worker contacted Mr A. Social Worker reported Mr A was known to adult social care and had declined Social Care involvement in the past.

Services Involved

- Falls Physiotherapist
- Reablement Officer
- PICs

As a result of the ICN+ involvement Mr A is now…

- Confident to walk to the local supermarket with a walking stick alone to get his own shopping on a daily basis.
- Confident to go into the community and stop and have a chat to those he knows on the high street
- Preparing his own meals and keeping his flat tidy
- Caring for his catheter independently with no District Nurse concerns
- Continuing with exercises alone
- Managing his finances appropriately

Local Voluntary Partnership

1. Leadership and Representation – this workstream group will create a shared leadership model with VCS partners, working with all voluntary groups and civil society in Croydon, improving connections with, across and between the sector. This group will ensure that the partnership has effective representation for the VCS across One Croydon governance and improved two way communication.

2. Local Empowerment and Engagement - this workstream group will develop an empowerment and engagement strategy with residents and the wider voluntary sector to help reduce health inequalities in Croydon by empowering local communities to co-produce the services they require.

3. Funding and Commissioning – this workstream group will review the totality of resource currently being spent in the voluntary sector and look at how this can be increased to support more people in the community without the need for statutory intervention. This may include the development of an investment strategy. The group will give consideration to current commissioned and grant-funded services with the voluntary sector such as those through the Community Fund and the Local Voluntary Partnership, floating support services, social prescribing and information and advice. The group is not responsible for making commissioning or funding decisions, but will make recommendations through the appropriate channels. This will include recommendations regarding best practice when commissioning with the voluntary sector, and reflect any changes to national policy and guidance regarding funding and/or commissioning with the voluntary sector.

Involvement

"We have been able to work together to deliver integrated care for our patients with complex health and social needs living with long term conditions. "
GP

"There is a real willingness to work together and learn from each other. The involvement of colleagues from both housing and benefits has been amazing and brings a perspective we wouldn't be able to bring ourselves."
Talking Point staff member

"Staff cared about what they were doing and wanted me to get as much benefit from them as I could."
Service user

"Working in the ICN+ has broken down the bureaucracy of sharing information, referring clients to a particular service and holistically assessing a client/patient situation, which has made it so much easier to meet a clients holistic support needs, inevitably promoting their wellbeing."
Social Worker

"I was down a very deep hole and couldn't see the way out but now I am near the top – you've made a huge difference to my life this year."
Service user

"Really made a difference to my Mum."
Carer

NHS

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High Level Implementation Timeline

ICN+ Key Milestones and Roll-out Plan

Aug-Sep 2020

- ICN+ Model Agreed
- ICN+ Business Case to Localities Board
- Reset PDG to oversee whole Programme
- ICN+ Business case to Shadow Health and Care Board

- **Work with Council to align processes for locality workforce planning**
- **Commence mapping of all the workforce and use the model to say how many staff in each locality**
- Development of Comms and Engagement strategy
- Link in with Modern acute for Joint clinics and Diagnostics Offer
- Estates options identified in each locality

Oct-Dec 2020

- Supporting and developing Locality Voluntary Partnerships
- Development of Budgets and contracting options
- Business case for Estates & IT for South East & South West
- Workforce mapping completed

- **Agree workforce and OD plan**
- Design of proactive and preventative offer for each network based on population health data
- Review and evaluate Early Adopter (NE) learnings
- Agree digital priorities and develop IT plan for ICN+ rollout
- Design schedule of teams' transitioning into virtual localities

Jan-Mar 2021

- Start transition into Localities
- Develop North West IT & Estates BC
- Develop central West IT & Estates BC
- Team building sessions completed in remaining 5 Localities

- Implementation of Comms and Engagement plan
- Targeted interventions starting
- Team building sessions for remaining 5 Localities
- First webinar 11th of February
- **Deliver workforce and OD plan across all Localities**
- Locality packs disseminated to staff

Apr-Jun 2021

- Develop IT& estate option for SW & CE
- South East & South West go-live
- Connect Your Care interface between Liquid Logic and EMIS
- Develop IT Primary care BC

- **South East and South West go-live 10th May 2021**
- Processes in place for all Localities
- Staff aligned from across partners into MDTs
- Second webinar held on 6th May 2021
- Coaching Circles & Creative Huddles in North East

Jul-Sept 2021

- Draft proposal for King's Fund
- Central East, Central West & North West go-live
- Mental Health PICs attending MDTs & Huddles
- Clinical Governance pathway agreed
- Team transition into localities complete

- Draft proposal for King's Fund
- Central East, Central West & North West go-live July
- Mental Health PICs attending MDTs & Huddles
- Clinical Governance pathway agreed
- Quality assurance guide
- Therapies integration

Oct-Dec 2021 and beyond

- Agree Management structure n
- Agree Population Health project
- Localities Dashboard agreed
- King's Fund model approved
- IT solution

- CQI Opportunities - Improve and Optimise
- Evaluation of integration so far
- Localities Dashboard developed and agreed
- King's Fund model approved
- IT solution agreed
- Integrated Management options presented