Appendix B

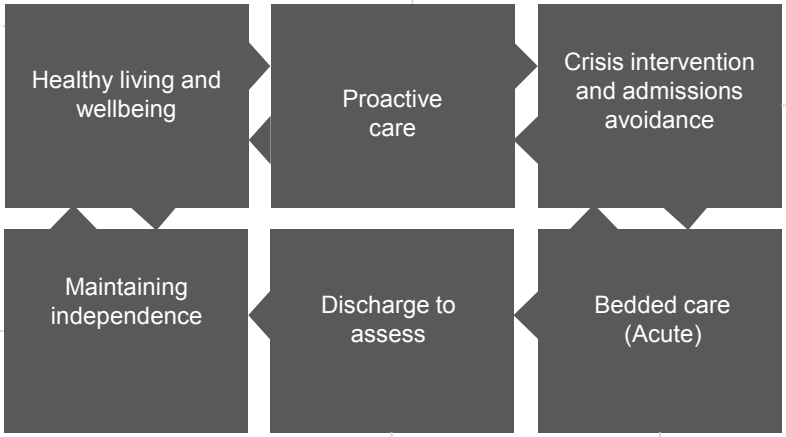
Enclosure 1b: A Proposed Model of Integrated Care in Croydon

For all partners (statutory, voluntary and community) to come together to provide high quality, safe, efficient, coordinated, seamless care to the people of Croydon and users that is proactive, focused on prevention and supports people to stay well and independent and is delivered as far as possible in the community.

- Promoting positive physical and mental health
- Asset Based Community Development
- Social prescribing
- Smoking/weight/alcohol programmes
- Falls prevention/strength and balance training
- Influenza and pneumococcal vaccination programmes
- Screening: Depression, Dementia LTC-DMT2, IHD, AF
- Home hazards risk assessment

- Risk stratification in Primary Care/MDT Integrated case management: physical and mental health
- LTC self care
- Advanced care planning
- End of life care
- Carer support
- Early Intervention Services MH/IAPT

- Longer term rehab/ reablement
- Equipment services
- Home adaptations
- 3rd Sector "Low level support" i.e. Social / Psychological /Physical
- Carer support
- Self management
- Personal budgets
- Promoting Recovery (Psychosis) Teams



- SPA and rapid assessment
- MH assessment and liaison teams
- GPs offering enhanced services
- Senior assessment (consultant/GP) of all frail/elderly in A+E and AMU
- Rapid response MDT team
- Outreach to community
- Inreach to A+E, AMU
- Comprehensive geriatric review
- Rapid access clinics
- Ambulatory service
- Step up beds in the community (care homes, community hospitals)
- Easy access to patient transport
- MH Crisis and Home Treatment Services/Crisis Line
- Support to nursing/care homes

- Coordinated discharge planning at the point of admission
- Early supported discharge before full recovery
- Geriatric follow-up in the community
- Community support teams
- Coordinated rehab/re-ablement in community setting
- Short term care packages
- Step down community beds (care home, comm hospital)
- Equipment services

- Elderly care specialists leading multidisciplinary teams
- Dementia awareness psychiatric liaison
- Proactive community teams in reach into hospital
- Information sharing with community teams
- Assertive community outreach/treatment