The vision

Defining features of the future 'House of Care':

- **Single point of entry -** via GP practice, patient (carer), integrated discharge team, other healthcare professional, care home etc
- **Co-located and integrated multidisciplinary teams** encompassing primary care, community health and social care providing **coordinated services** across local care networks configured and designed around patient (and carer) need, prevalence and geography[1]
- **Single assessment framework** across health & social care supported by trusted assessors (see scheme 3)
- **Single care planning tool** across health and social care
- **A single integrated patient record facilitated by EMIS** (see scheme 8)

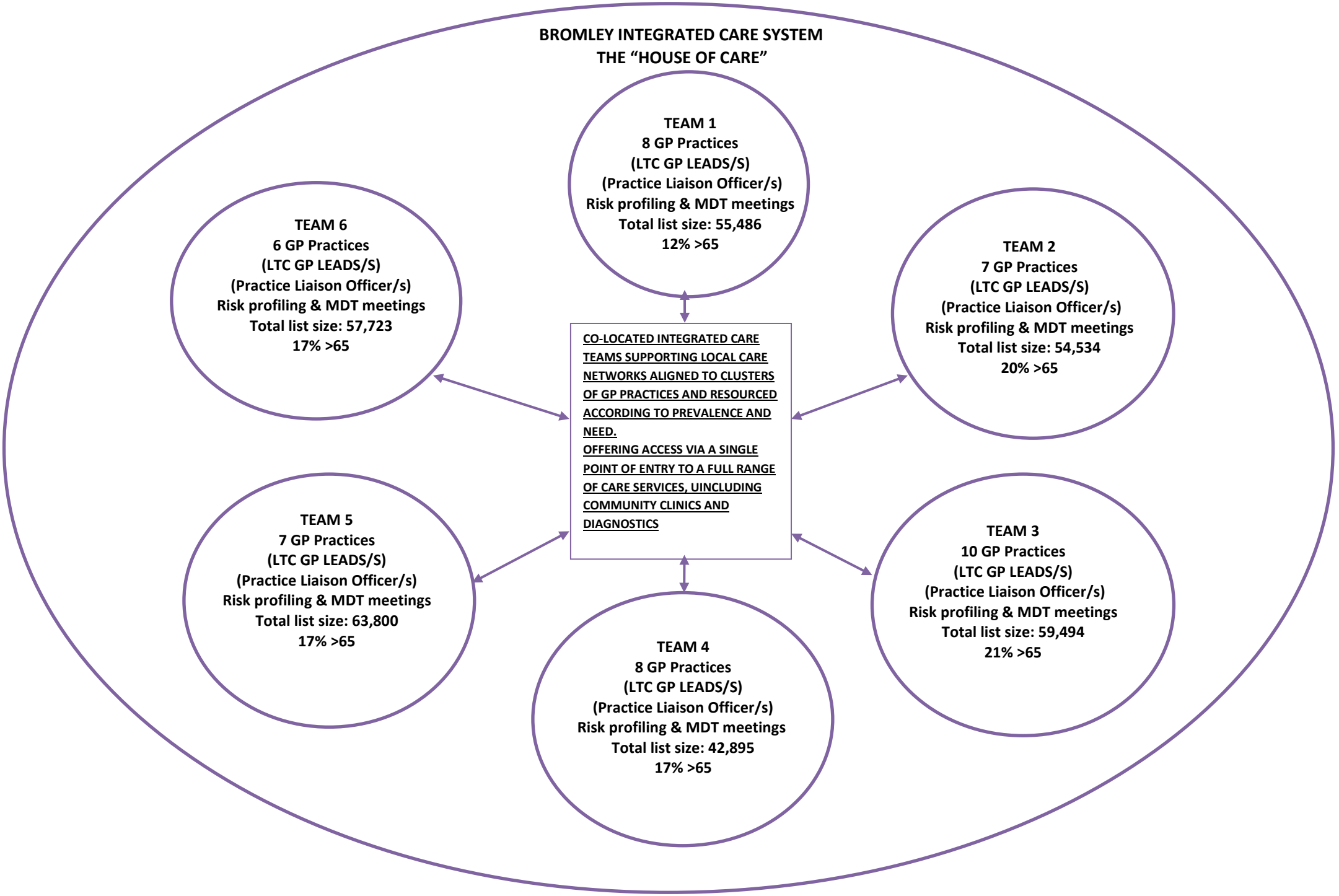
Co-located Integrated Care Team:

- Clinical team leader
- Team coordinator
- Community matron
- District nurse
- Physiotherapist
- Occupational therapist
- Nurse rehabilitation assistants
- Health care assistants
- Physiotherapy assistants
- Social Care Managers
- Community mental health (see scheme 4)
- Clinical Pharmacists

Other integrated services:
Specialists e.g. consultant geriatricians , diabetes and wound care nurses (offering advice, support and community clinics
Step-up and step-down (See scheme 1)
End of Life services (See scheme 3)
Voluntary sector advice, information and support (see scheme 5)
Carers support services (see scheme 6)
Falls (see scheme 3)

Community diagnostics and reporting
Community equipment (see scheme 7)

[1] The number of teams or local care networks is six currently, the configuration may change over time alongside primary care transformation and localised needs based commissioning and service provision


BROMLEY INTEGRATED CARE SYSTEM
THE "HOUSE OF CARE"
TEAM 1
8 GP Practices
(LTC GP LEADS/S)
(Practice Liaison Officer/s)
Risk profiling & MDT meetings
Total list size: 55,486
12% >65
TEAM 2
7 GP Practices
(LTC GP LEADS/S)
(Practice Liaison Officer/s)
Risk profiling & MDT meetings
Total list size: 54,534
20% >65
TEAM 3
10 GP Practices
(LTC GP LEADS/S)
(Practice Liaison Officer/s)
Risk profiling & MDT meetings
Total list size: 59,494
21% >65
TEAM 4
8 GP Practices
(LTC GP LEADS/S)
(Practice Liaison Officer/s)
Risk profiling & MDT meetings
Total list size: 42,895
17% >65
TEAM 5
7 GP Practices
(LTC GP LEADS/S)
(Practice Liaison Officer/s)
Risk profiling & MDT meetings
Total list size: 63,800
17% >65
TEAM 6
6 GP Practices
(LTC GP LEADS/S)
(Practice Liaison Officer/s)
Risk profiling & MDT meetings
Total list size: 57,723
17% >65
CO-LOCATED INTEGRATED CARE TEAMS SUPPORTING LOCAL CARE NETWORKS ALIGNED TO CLUSTERS OF GP PRACTICES AND RESOURCED ACCORDING TO PREVALENCE AND NEED.
OFFERING ACCESS VIA A SINGLE POINT OF ENTRY TO A FULL RANGE OF CARE SERVICES, UINCLUDING COMMUNITY CLINICS AND DIAGNOSTICS