One Croydon

Your health and care partnership

One Croydon

Health and Care Plan Refresh

2022 to 2024

Welcome

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Croydon Health and Care Plan refresh

In 2019, our One Croydon partners launched our new five-year plan to help people in our community improve their health and wellbeing. Our ambition was – and still is – to deliver better care and support tailored to local needs, available closer to home within the neighbourhoods in which people live. We want to bring together the borough's NHS care for physical and mental health, along with GPs, social care and the voluntary sector, joining up services to provide more holistic care.

We started to deliver on our vision, with a greater collective focus on the prevention of ill health to help more people start well, live well and age well in Croydon. New initiatives to join up health and care in localities and new partnerships with the voluntary sector have started to bear fruit.

Then with the COVID-19 pandemic, and our collective focus had to change. Across the borough our teams came together to care for the many people affected by coronavirus and support our colleagues who have worked tirelessly as part of a coordinated response to the pandemic. Our partners across the NHS, local authority and voluntary organisations worked tirelessly to manage the impact of the pandemic, deliver the vaccine programme while continuing to provide essential services.

Other elements of our original plans have continued at pace as we continue to strive to make our Croydon Health and Care Plan a reality, aligned with the strategic aims of Croydon's Health and Wellbeing Strategy.

In this document – a refresh of our original Croydon Health and Care Plan - we want to tell you what we've done, what's changed and focus now together, on what we do next.

Within this document, you'll find a summary of what we've achieved to date and our refreshed and enhanced priorities that we have developed together over the last few months. In developing our plans we have built on the conversations we have had throughout our partnership in discussion with local families, patients, community groups, stakeholders and staff. We haven't stopped listening and we are committed to keeping this conversation going.

Thank you for your time and we look forward to continuing to work with you and all our partners to improve the health and wellbeing of people of Croydon.

Councillor Janet Campbell

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Section 1: Introduction and Context

Introduction

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The Croydon Health and Care Plan

In 2019, One Croydon launched a five-year Health and Care plan to help people in our community improve their health and wellbeing. Our ambition was to deliver integrated care and support tailored to local needs that is available closer to home within the neighbourhoods in which people live; bringing together the borough's NHS care for physical and mental health, along with GPs, social care and the voluntary sector.

We've come a long way to deliver on this ambition with multiple initiatives that join-up our health and care expertise to provide more coordinated services in our borough at the heart of communities; however, there are huge challenges ahead including uncertainty for jobs and economy, deterioration in residents' wellbeing, emerging unmet need and the Councils financial situation; we now need to need to build on what we've done and develop it further and at scale.

Why refresh? What's changed?

Croydon's health and care workforce, the Voluntary and Community Sector and wider community have achieved amazing things during the pandemic, and these demonstrate what we can do when we work closely together across the system with a common goal. Some of our plans had to change with COVID-19 as across the borough our teams came together to care for the many people affected by coronavirus and support our colleagues who have worked tirelessly as part of a coordinated response to the pandemic whilst others have continued at pace; this refreshed plan captures this learning and embeds it in the revised priorities and goals for 2021-2023.

Iin order to continue to make progress the refreshed plan has been developed to consider and support Croydon Council to implement its renewal plans (these will get council finances back on track and put the Council on a more sustainable footing) and implement the Health and Care Bill in a way that improves outcomes for the people of Croydon; the Bill builds on the NHS long term plan, captures learning from the Covid-19 pandemic and furthers integration of Health, Social Care and public health system

The Health and Care Bill was introduced to Parliament on the 6th July 2021 and confirmed the Government's intention to introduce Integrated Care Systems from April 2022. Part of the preparation to transition from to an ICS requires each of the six Places in South West London CCG to refresh their Health and Care Plans, focussing on what has been achieved, refreshing priorities, reducing inequalities and preventing future risks to ill-health.

Context: Integrated Care Systems

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Integrated care systems (ICSs) are partnerships of health and care organisations that come together to plan and deliver joined-up services and to improve the health of people who live and work in their area.

The ICS exist to achieve four aims:

- improve outcomes in population health and healthcare
- tackle inequalities in outcomes, experience and access
- enhance productivity and value for money
- help the NHS support broader social and economic development.

Place-based partnerships are collaborative arrangements formed by the organisations responsible for arranging and delivering health and care services; Croydon established a 'Place based partnership' back in 2017 through the One Croydon Alliance.
Within an ICS, Place-based partnerships will remain as the foundations of integrated care systems building on existing local arrangements and relationships. Place has four main roles, all of which One Croydon have been delivering since 2017:

- To support and develop primary care networks (PCNs) which join up primary and community services across local neighbourhoods.
- To simplify, modernise and join up health and care
- To understand and identify people and families at risk of being left behind and to organise proactive support for them; and
- To coordinate the local contribution to health, social and economic development to prevent future risks to ill-health within different population groups.

One Croydon is committed to supporting Croydon Health Services to build on its success as a member of the SWL Acute Provider Collaborative and further the success of the SWL APC by:

- Developing joint strategies for example elective care
- Providing further support to clinical networks to create innovative new pathways and tackle unwarranted variation
- Undertake even more joint workforce development and planning
- Maintaining the key features that have underpinned the APC's success including; a thin management layer, strong governance for delivery of agreed programmes and informal partnership governance rather than delegated authority

The Changes: a summary

The refresh has given One Croydon the opportunity to come together and assess our progress so far and what our priorities need to be in a fast-changing environment including emerging impact of the COVID-19 pandemic, the Health and Care Bill and the Local Authority financial position. The refresh includes:

- Additional Aims that include setting out our commitment to; support people to recover from the effects of the pandemic including resident engagement and active involvement, supporting our workforce, embedding population health management and tackling inequalities
- Refreshed Priorities and delivery plans for each Area of Focus
- A commitment to work together to ensure funding is based on need rather than historic spending patterns. We believe this is essential if we are to reduce inequalities in health across SWL
- Addressing health and wellbeing inequalities; acknowledging they existed before and have been exacerbated by COVID-19
- Developing robust metrics to measure the delivery and impact of our priorities
- Updated Outcomes Framework to better monitor impact on our long-term goals

Engaging with people and communities across Croydon

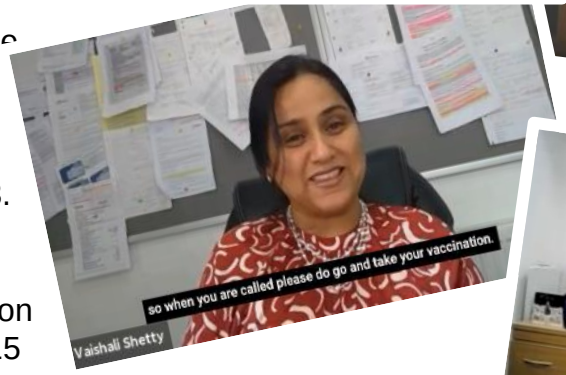
Since the Health and Care Plan was first published in 2019 health and care partners have continued to engage with local people to understand how we are meeting their needs and improving health and care outcomes, and how we can improve on these.

Programme and clinical leads for each programme led engagement on the specific areas of the plan including:

- Mental health community hub and spoke model co-design engagement
- All age disability hub
- Learning Disabilities and autism strategy
- One Croydon Service User Group
- Primary Care - integrating primary and secondary care
- Healthwatch led engagement on areas including urgent and emergency care, young people's experiences of
- mental health and ICN+
- Over 70 engagement events across the borough as part of the Covid-19 vaccination programme
- Building community partnership workshops held in each locality strengthening partnerships
- between One Croydon, our voluntary and community partners and Croydon residents

More detail about the **engagement delivered within each programme** can be found in section 3.

In addition to we undertook a stakeholder discussion exercise to test the draft priorities and gaining views from professionals and stakeholders from right across the Health and Care system on how we can improve outcomes for the people of Croydon. Overall, 123 people responded, from 15 different organisations including GPs.



Engaging with people and communities across Croydon

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Understanding what local people think of services is essential for us to improve them. We are committed to reaching out to local communities and supporting residents to have their say in the future of local services.

You said, we did….

"With so many different sources of information about COVID-19, some giving conflicting advice, it is difficult to know what to believe."

We held more than 65 events, reaching more than 4,000 people to engage them in the importance of protecting yourself against COVID-19, including testing and getting vaccinated during the pandemic. Joint working between One Croydon partners, Croydon BME Forum, Asian Resource Centre, Croydon Voluntary Action and other community groups has helped inform residents and raise awareness amongst our community on how to protect themselves. We have used social media to widen our reach and to signpost people to trusted sources of information, including our own single source of truth website which holds the latest information about vaccines and other COVID-19 related news at www.swlondonccg.nhs.uk

"Services and support is needed to help homeless people access and navigate health and care services. Particularly those who are not registered with a GP who can act as the gatekeepers of access."

A new integrated Home Pathways Team is being set up in Croydon Hospital to coordinate care for homeless people when they come to the hospital for specialist services, visiting A&E or when admitted to hospital. The team will support all homeless patients, taking time to understand their individual needs, to coordinate their care and link them with external agencies to offer continuing support after treatment.

"Better communication of waiting times: Patients understand they have to wait but would really welcome information on how long they will have to wait. This would make a big difference to their experience of waiting."

Croydon Health Services are working with healthcare systems experts at *Patienteer*, to provide real-time updates waiting times for urgent and emergency care, with digital screens and increased efforts to communicate clearly what our patients can expect from their visit.
3 people responded, from 15 different organisations including independent GPs.

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Section 2: Achievements against the plan

Original Aims: Achievements

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Focus on prevention and proactive care **by supporting local people before things become a problem and encouraging residents to be more proactive in their own health**

- Achievements include:
  - In Northeast Integrated Community Network + a total of 619 referrals have been received in the year of operation; outcomes show that 31% of people reported an increase in health and wellbeing and 25% reported an increase in movement, mobility and physical ability
  - Community Hubs (previously Talking Points) provided support around housing and benefits advice with n– 258 people receiving proactive advice and support in the first 8 months (Sep 20-Apr21)
  - Long Term Condition outreach programme delivered by BME Forum and Asian Resource Centre including community events, training community champions and delivering health checks People receiving support from Personal Independence coordinators achieved an average of a 2-point improvement in their wellbeing after 2 months (using the Short Warwick-Edinburgh Mental wellbeing scale)
- Many challenges remain to shift the dial to prevention, backlog of issues and unmet need post pandemic

Unlock the power of communities **by making the most of communities' assets and skills – the key to helping local people stay fit and healthy for longer is connecting them with their neighbours and communities and voluntary organisations**

- Local Voluntary Partnerships Programme grants have helped stimulate grassroots activity to add to the rich and diverse VCS we have in Croydon
- One Croydon is one of six groups across the country to bid successfully for the Healthy Communities Together Programme run by the King's Fund and National Lottery. The programme aims to maximize the potential of partnership between voluntary and statutory sectors, shifting resources and control to communities in order to reduce health inequalities.
- Voluntary and community sector came together with Croydon residents and partners in the statutory sector to support Croydon people through the pandemic and has continued to deliver a multitude of key services from Personal Independence Coordinators, to befriending and food banks.

Put services back into the heart of the community **by making sure local people have access to integrated services that are tailored to the needs of local communities**

- Achievements include:
  - Croydon as provider of choice
  - Localities ICN+ model: a successful early adopter in Northeast has led to the rollout across Croydon
  - Early Help provision delivered in Localities
  - Croydon Health and Wellbeing Space in the Whitgift Centre and Mental Health Personal Independence coordinators being recruited to

Additional Aims for 2021 to 2023

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Support Croydon people to recover from the effects of the pandemic, through the recovery programme and a focus on high quality care

- Continue to deliver the COVID-19 Vaccination programme and meet the needs of people with COVID-19 and its long-term effects
- Embed the core principles of resident and patient's engagement and active involvement to inform the decisions we make and the actions we take. Demonstrate this by regularly feeding back how people's views and experiences have influenced our work, "You said, we did"

Enable, develop and maintain the Croydon health and care workforce

- Build on the work undertaken through the SWL Recruitment Hub, Croydon Health Services People Plan and Localities work, adopting a strong programme to drive it forward for One Croydon

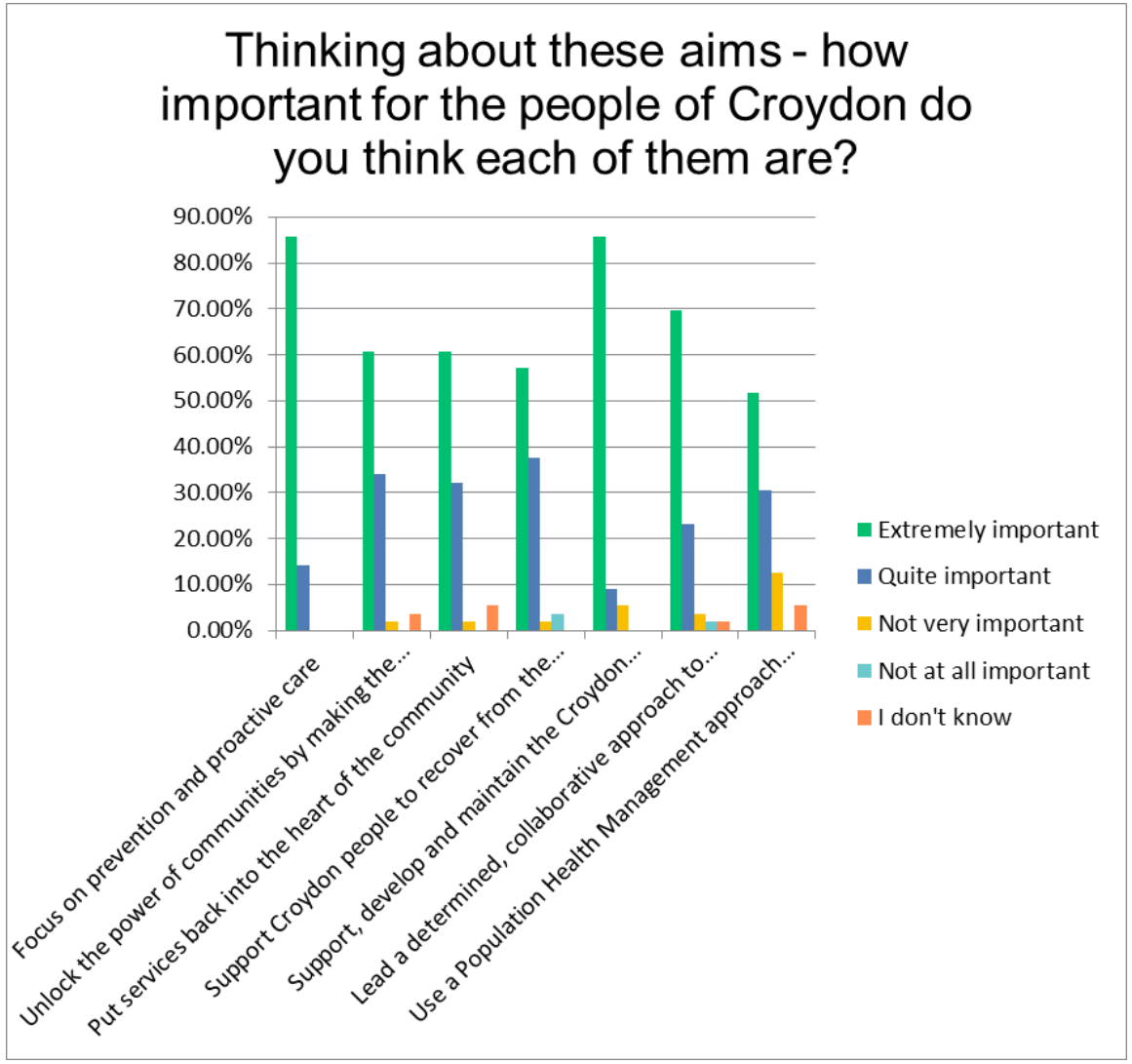
Lead a determined, collaborative approach to tackling inequalities

- Maintain focus on social need within ICN+ and work with VCS to deliver more proactive and preventative support around the wider determinants of health and wellbeing such as housing, debt, education and employment
- Build on Long term conditions work targeting most affected communities and deliver new programmes for example ethnicity in mental health
- Restart the work on social and economic development through the Anchor Institute programme

Embed a Population Health Management Approach

- Develop a strategic approach to PHM to tackle Health inequalities and improve the health & wellbeing of Croydon people
- Work collaboratively with SWL ICS to harness the maximum benefit from the SWL PHM and digital strategy
- Continued assessment to understand the impact of COVID as it emerges using local data, intelligence and people's experiences

Stakeholder feedback: Aims



Three of our aims were ranked as the most important to people and these were:

- Focus on prevention and proactive care
- Support, develop and maintain the Croydon health and care workforce
- Lead a determined, collaborative approach to tackling inequalities

2019 Health and Care Plan: Progress

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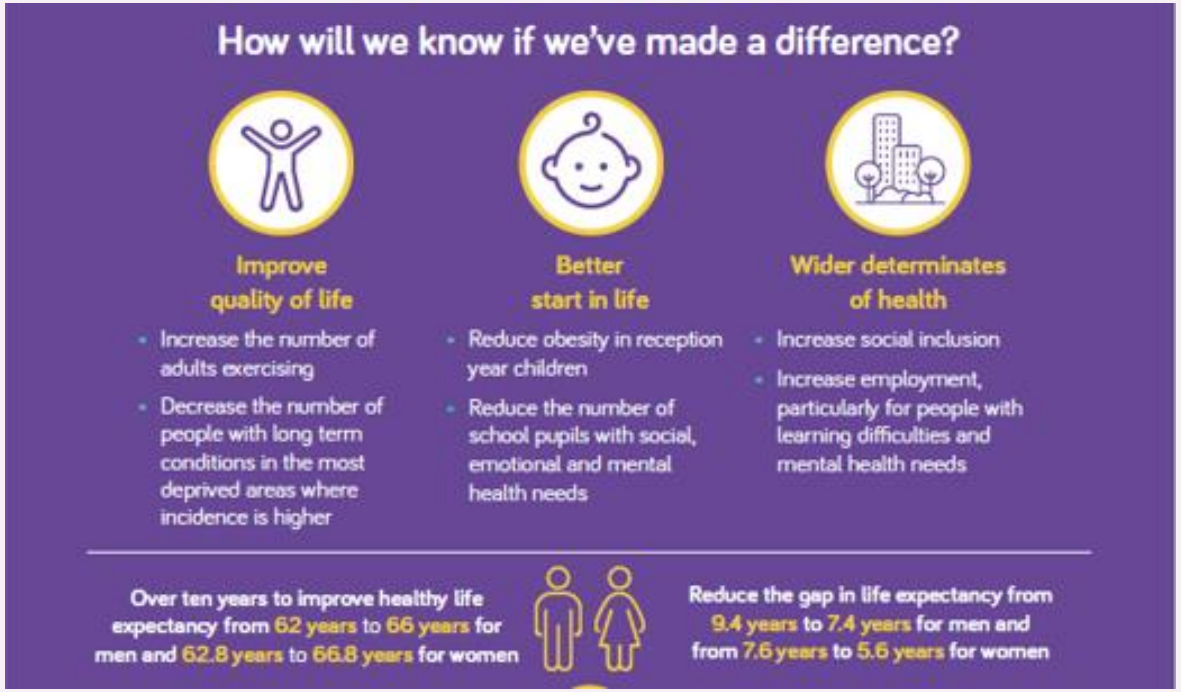
In the original Health and Care Plan we set out how we would know we have made a difference and measured progress using a set of nationally-available indicators in the Outcomes Framework. The table below shows progress against our long-term outcomes; the refreshed priorities include those areas in which progress has not been made. These long-term outcomes will be considerably impacted by the Covid pandemic; therefore, there will a focus on developing local measures to assess and monitor how we are making a difference to the health and wellbeing of People in Croydon and reducing Health Inequalities.



Measure	Baseline	Latest Performance
Increase the number of adults exercising	64.2%	62.2%
Decrease number of people with LTC in the highest deprived areas	Indicator not developed	
Reduce obesity in reception year children	21.9%	21.8%
Reduce number of pupils with social, emotional and mental health needs	2.5%	2.7%
Proportion of adult social care users who have as much social contact as they like	39.3	43.4
Adults in contact with secondary mental health services in paid employment	5.0%	6.0%
Adults with learning disabilities in paid employment	5.5	4.6
Improve health life expectancy in men	65	64.4
Improve health life expectancy in women	59.5	62.6

Outcomes Framework 2021-2023

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The Outcomes Framework has been updated to incorporate new measures that improve our ability to assess impact, as well as removing those for which national data is no longer collected. Regular reviews are undertaken by the Quality and Performance Group which includes subject matter experts, analysts and clinical leads, to ensure the most robust indicators are being used. In addition to these long-term goal indicators, each area of focus has a set of metrics to measure impact and delivery of our transformaiton programmes.

No.	Indicator	Priority / Project
Overarching and Wider Determinants		
1	Healthy life expectancy at birth (in years, males)	Inequalities
2	Healthy life expectancy at birth (in years, females)	Inequalities
3	Life expectancy at birth (in years, males)	Inequalities
4	Life expectancy at birth (in years, females)	Inequalities
5	Households in temporary accommodation (rate per 1,000 households)	Wider Determinants
6	Air pollution: fine particulate matter (mean micrograms per cubic metre)	Wider Determinants
7	Proportion of children in relative low income families (under 16)	Wider Determinants
8	Proportion of physically active adults (aged 19+)	Wider Determinants
9	Proportion of adults who are current smokers	Proactive and Preventative
10	Excess winter deaths (ratio %)	Whole Population Health
11	Unemployment rate	Wider Determinants

No.	Indicator	Priority / Project
Proactive and Preventative		
12	Proportion of adults who are overweight and obese	Healthy Weight
13	Proportion of people who report good life satisfaction (response score of 7 or higher)	Mental Health
14	Proportion of people who report good life worth (response score of 7 or higher)	Mental Health
15	People with type 2 diabetes who received all 8 care processes	Long-term conditions
16	Unplanned hospitalisations for chronic ambulatory care sensitive conditions (rate per 100,000 population)	Long-term conditions
17	Proportion of adult carers who have as much social contact as they like (survey conducted every 2 years)	Mental Health
18	Proportion of adult social care users who have as much social contact as they like	Mental Health
19	MMR for 2 doses at age 5	Immunisations
20	Flu vaccinations uptake in at risk groups	Immunisations
21	Emergency admissions due to falls in people aged 80+ (rate per 100,000)	Falls

No.	Indicator	Priority / Project
Localities		
22	Deaths which take place in hospitals - all ages	End of Life
23	People with long term conditions feel supported to manage their condition	Support the development of practices and primary care networks to join up primary care and community services
24	Estimated dementia diagnosis rate (aged 65+)	Dementia Care
25	People who use services who have control over daily lives	People having control / strengths based approach
26	Delayed transfers of care from hospital that are attributed to adult social care	LIFE
27	Proportion of people aged 65+ who were still at home 91 days after discharge from hospital into re-ablement/rehabilitation	LIFE

Cont. Outcomes Framework: 2021 to 2023

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No.	Indicator	Priority / Project
Enable a Better Start in Life and Maternity		
28	Low birth weight of term babies	Early Years
29	School readiness: good level of development at the end of reception year	Improving Mental Health and Wellbeing for Children and Young People
30	School pupils with social, emotional and mental health needs	Improving Mental Health and Wellbeing for Children and Young People
31	Rate of fixed-term exclusions in primary school (per 100 pupils)	Improving Mental Health and Wellbeing for Children and Young People
32	Rate of fixed-term exclusions in secondary school (per 100 pupils)	Improving Mental Health and Wellbeing for Children and Young People
33	16-17 year olds not in education, employment or training	
34	Excess weight among children in reception year	Improving Mental Health and Wellbeing for Children and Young People
35	Admissions for respiratory tract infections in infants aged 2, 3 and 4	Improving urgent care pathways and management of LTC
36	Unplanned hospital admissions for asthma for under 19s	Improving urgent care pathways and management of LTC
37	A&E attendances (aged 0-4, rate per 1,000)	Improving urgent care pathways and management of LTC
38	Hospital admissions for diabetes (aged <19, rate per 100,000)	Improving urgent care pathways and management of LTC

No.	Indicator	Priority / Project
Mental Health		
39	Adults in contact with secondary mental health services in paid employment	Partnership working
40	Gap in the employment rate between those in contact with secondary mental health services and the overall employment rate	Partnership working
41	Excess under 75 mortality rate in adults with serious mental illness	Improve the crisis MH pathway
42	IAPT Recovery Rate (at least 50% of people completing treatment with IAPT should recover)	Improve the community MH pathway
43	Adults in contact with secondary mental health services living in stable and appropriate accommodation	Partnership working

No.	Indicator	Priority / Project
Joining up Care for People with Disabilities		
44	Adults with learning disabilities in paid employment	Support people to live independently
45	Gap in the employment rate between those with a learning disability and the overall employment rate	Support people to live independently
46	Adults with a learning disability living in stable and appropriate accommodation	Support people to live independently
47	The proportion of people who use services who receive direct payments	Provide quality social care services
48	The number of people aged 18-64 whose long-term support needs were met by admission to residential and nursing care homes, per 100,000 population:	Provide quality social care services

No.	Indicator	Priority / Project
Modern Acute		
49	Responsiveness to inpatients' personal needs (within CHS)	Quality Improvement
50	Patient experience of hospital care (of CHS)	Quality Improvement
51	Patient safety incidents reported (within CHS, rate of all incidents per 1,000 bed days)	Quality Improvement
52	Outpatients - 25% virtual appointments	Outpatients Transformation
53	Theatre utilisation - 85%	Croydon Elective Centre
54	Bed Occupancy - 92%	Non-Elective

No.	Indicator	Priority / Project
Integrated Health and Social Care		
55	Health and care financial performance against plan	Shadow Health and Care Budget
56	Emergency readmissions within 30 days of discharge from hospital	ICN+
57	Emergency admissions for acute conditions that should not usually require hospital admission	ICN+

Achievements and gaps: closing the financial gap

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Financial Aims in the Health and Care Plan 2019:

- Better manage the financial gap (do nothing position of £100m gap in health and social care by 23/24)
- Shift balance of spend from reactive high-cost acute care to preventative and proactive out of hospital care

What have we done to progress these aims?

One Croydon has created a shadow health and care budget to remove organisational barriers and achieve:

- Greater flexibility in use and management of resources across the system
- Greater ability to shift resources for greatest impact, shifting from reactive to proactive and preventative care
- Outcomes based commissioning approach

The Impact of COVID-19 and current financial picture:

- Croydon Council financial position has significantly worsened with a section 114 notice being issued in December 2020. The Government has approved a capitalisation direction of £120m over the next two years to help Croydon Council achieve a balanced budget and this is conditional on the Council delivering its renewal plans at pace.

- The Joint Control total in the health system greatly improved the financial position. NHS investments since the start of the COVID-19 pandemic have been focused on pandemic response and recovery, alongside long-standing commitments on Mental Health and Primary Care. There is limited financial flexibility to fund other priorities. There is also a significant and increasing national requirement to make efficiencies.

- The transition to an ICS provides Croydon Place with an opportunity to continue having financial autonomy over its Health budget, this will enable the work on the Shadow Health and Care Budget and better use of resource across the system to continue.

- In addition, One Croydon partners are committed to work together to raise the issue of historic underfunding and the need to ensure that Croydon is allocated sufficient resources to meet the needs of the population.

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Section 3: Areas of Focus

Areas of focus

The Health and Care Plan described six areas of focus for the first two years – these were areas that One Croydon identified as requiring transformation and being key to achieving the aims of the plan:

1. Proactive and preventative care
2. Localities – joined up working in local communities
3. Modernising acute care
4. Adult mental health and well-being
5. Better start in life and maternity
6. Joining up care for people with disabilities

A subject Matter Expert is responsible for an Area of focus and a Clinical lead has been aligned to each one.

Both worked closely with a range of stakeholders to review the progress made since 2019, collate engagement and feedback that had been undertaken during this time, analyse the impact of COVID and using all this information to draft revised priorities for 2021 to 2023 which were then tested with stakeholders from across the system

Summary of progress for each area

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Localities - locality based ICN+	• North East ICN+ launched in July 2020 operational for 10 months • ICN+ model rolled out across remaining five Localities during 2021 • “Stay Steady, Stay Well clinic” introduced as prevention strategy • Themed “huddles” focussing on conditions including Diabetes and Respiratory
Localities - GP /PCN	• CGPC Clinical Director Cabinet held each month • First large flu vaccination clinics at Ikea and Selhurst Park, Crystal Palace • Integrated booking system allows GPs and out of hours service to see all available appointments • Laptops, webcams and Emis Enterprise provided to GP practices to support data reporting
Localities – Care Homes, Falls and End of Life	• Telemedicine service in 75 care homes helps assess clinical needs and coordination of care • Remote monitoring of vital sign in Care Homes using telehealth technology rolled out during 2021 • In partnership with St Christopher’s Hospice and community groups to help everyone have a good death by encouraging open conversations about dying and record ‘End Of Life’ wishes
Localities – LIFE	• Due to the Pandemic, Council named as Single Point of Contact for all hospital discharges resulting in an increase of patients being safely discharged from hospital • Due to the Pandemic, completion of the LIFE discharge to assess review was delayed, now restarted to look at more joined up ways to support more patients across the borough
Mental Health	• The mental health community hub and spoke model has been co-designed and the pilot Mental Health Wellbeing Hub at the Whitgift Centre is due to open during Q2 • Crisis pathway improvements include the Recovery Space, Mental Health Crisis line expansion and a Mental Health Clinical Assessment Unit at CHS Emergency Dept • Greater support in primary care through Mental Health Personal Independence Coordinators • Improving Integrated housing aims to develop a Temporary Accommodation Strategy
Proactive and Preventative – Long Term Conditions (LTC)	• The LTC care model was implemented in 2020 including; Atrial fibrillation systematic case finding service and Group consultations programme to support patients with diabetes and hypertension • LTC Community outreach programme was developed and launched with BME forum and Asian Resource Centre • LTC Expert Patient Programme was developed and launched with BME forum and Asian Resource Centre
Proactive and Preventative – Local Voluntary Partnerships (LVP)	• Over 280 residents have been to ‘Talking Points’ which opened in December 2019. Needs have ranged from housing and benefits to social isolation and low-level mental health • 12 online ‘Building Community Partnerships’ events well-attended by VCSE organisations • Prevention framework agreed by representatives from all sectors in Dec 2020: priorities include Falls and frailty, Healthy weight, Immunisation take-up, mental health and trauma • The LVP programme has supported the voluntary sector by awarding one-off and recurrent funding to small grass roots organisations; 69 funded initiatives

COVID Resilience and Recovery – Public Health	• Upskilling communities to offer initial support and signposting and increase mental health awareness • Community trauma training programme in development for implementation in September 21 • Supporting children at risk of food poverty: school programme includes food vouchers, breakfast club and school grants • Four VCS organisations commissioned to support residents around infection control, social isolation and vaccine uptake
Health Weight –Public Health	• Adult healthy behaviours programme now embedded in the localities • New Child Weight Management service proposed: implementation expected October 2021 • Draft system weight action plan produced
Modern Acute –Outpatients	• 300 video consultations taking place each week at Croydon University Hospital • Patient Initiated Follow Up pathway changes have been made within gastroenterology • Proceeding with a patient portal solution that aligns with other hospital providers in SWL
Modern Acute	• Croydon Elective Centre for elective surgery, planned procedures and cardiac care • Capacity increased in Croydon’s ITU from 15 to 22 beds • Expanding the Discharge Team building on learning from wave 1+2 and ‘perfect week’
Better Start in Life and Maternity	• Paediatric Unit under development due to open May 2022 • Completion and embedding of “Big 5” Advice & Guidance to improve consistency and quality of care • Asthma pathway and development plan • The Children and Young Persons Transformation Programme Board: February 2021 • Improving data intelligence on urgent care pathway support initiatives:
Better Start in Life and Maternity	• Early help resources deployed through three localities (North, Central and South) to provide better place-based services for the community • New partnership Early Years Strategy in development for 2021-2024 • CHS Maternity Services achieved 26.7% of women being booked onto a Continuity of Care pathway at March 2021 • Mental Health Investment Standard funding (MHIS) secured to deliver waiting time initiatives, increase CYP access to Emotional Wellbeing and Mental Health services
All Age Disability	• Independent Lives commissioned to train and develop new personal assistants, and provide advice and guidance to residents choosing to use a direct payment • In April 2021, the disabilities service (18-65) moved to a localities model, aligned with ICN+ model • Community led support model embedded in working practices of older adults and disabilities teams
Integration	• ICN+ and Mental HEalth MOdels formally bought into scope of the Alliance Agreement • One Croydon undertook a programme of work to develop a whole system pooled budget • Croydon Borough Cttee of SWL CCG and CHS have fully aligned governance and leadership

Proactive and Preventative Care

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What did we set out to do? This programme aims to increase the borough's focus on proactive and preventative care, to help people live and stay well and reduce the risks to health from long term conditions in our borough. Compared to the average Londoner, people in Croydon have a higher rate of diabetes and heart disease. More than 60% of adults in Croydon are overweight or obese and one in four older people have a life limiting long-term illness.

What progress have we made?

- In September 2020 we launched a long-term condition pro-active and preventative community outreach programmed in partnership with the Croydon BME forum and Asian Resource Centre for Croydon. More than 15 events involved more than 600 people in workshops to help reduce the risk diabetes and hypertension, which is more prevalent within Black, Asian and Minority Ethnic communities.
- Targeted out-reach work to raise awareness of long-term conditions and risk factors amongst harder to reach communities, have also encourage people to seek earlier intervention through their GP, regular NHS Health checks or contact with the borough's Live Well and Just Be programmes.
- All nine primary care networks have employed social prescribing link workers and are working to encourage collaboration with the voluntary sector. Both Croydon Social Prescribing and Croydon Voluntary Action are supporting and training the link workers to know where to sign people across the borough.
- A series of events called 'Building Community Partnerships' is up and running, where voluntary and community sector partner come together in geographic localities to discuss issues and challenges affecting their local neighbourhoods. These local partnerships provide the opportunity for organisations to build relationships with health professionals, and other statutory partners like social workers and housing workers.
- As One Croydon, we have developed a prevention framework that we will work in partnership across health, social care and our local voluntary and community groups to deliver. The framework explains the core principles of proactive and preventive care so that there is a shared understanding and action across the borough's health and care professionals. The aims to deliver a consistent approach across Croydon to reduce health inequalities in our borough.
- In the north-east of Croydon, our pilot of Integrated Community Networks plus (ICN+) have brought health and care teams together to connect residents with the support services around them. Last year, this helped more than 280 residents access help with housing, benefits, social isolation and mental health. The success of this model is now being rolled out across the borough.
- One Croydon Alliance created a Local Voluntary Partnership programme in 2019, supporting local grass roots organisations with funding (with grants of up to £5,000 each) to run initiatives that promote proactive and preventive health and wellbeing. Since the programme began, around 70 initiatives have been funded to connect residents to the neighbourhood groups and services around them. With initiatives ranging from gardening projects to community choirs, this is helping to reduce social isolation and to support people to live and stay well as an active part of our community
- More recently, we have also funded specific initiatives to improve access to mental health support in the voluntary sector, with a further eight community and voluntary organisations being awarded grants between £5,000-£50,000 to support Croydon people in projects for the next three years.
- One Croydon were selected by the Kings Fund and National Lottery Community Fund to participate in the 'Healthy Communities Together' programme, which seeks to strengthen partnership working between the voluntary and community sector, Health Services and the Local Authority. One of the key benefits of the programme has been to increase the 'voice' of the voluntary sector in the partnership, especially in terms of decision making, and the overarching ambition for this work is for the voluntary and community sector to be seen as an equal partner and to begin to shift more resources and spend into the Sector over time.

Proactive and Preventative Care

Your health and care partnership

What's changed with COVID-19?

Overnight the NHS and social care had to change the way it worked to respond to the COVID-19 pandemic. Services have had to take a more innovative approach to supporting their patients, by embracing technology, Croydon Health Services and the One Croydon Rapid response team can now monitor a patient's breathing, movement and heart rate safely from a patient's home and escalate their care, often before they realise they are becoming unwell, to keep people well and out of hospital. At the height of the second wave, this multidisciplinary team were caring for the equivalent of a virtual ward full of patients with COVID-19 safely in their own home, helping to increase capacity to care for people needing hospital treatment.

Throughout the lockdowns over the last 18 months, GPs and community teams remained open as usual to care for people in Croydon. To help people feel confident about coming forward for healthcare advice and treatment during the pandemic, appointments were delivered by telephone, online and video, with face-to-face appointments still available based on clinical need. Remote monitoring was rolled out to help Croydon GPs monitor patients with COVID-19 symptoms safely in their own home, helping healthcare teams to intervene early if someone's condition worsens and reduce the number of staff visits to limit potential exposure to coronavirus.

Since the Covid-19 vaccination programme began we have held more than 65 events reaching more than 4,000 people to engage them in the importance of getting vaccinated during the pandemic. This includes work with the Croydon BME Forum, Asian Resource Centre and other community groups, to help inform residents, tackle vaccine hesitancy and raise awareness amongst our community on how to protect themselves from COVID-19 and the response of local services to care for those affected.

During the COVID-19 pandemic, our Building Community Partnership events and the advice space in Thornton Heath were held virtually to help protect people from coronavirus. In a post-pandemic world, we want to consider how we can use the best of both online and face-to-face meetings to make it easier for people to access the care they need in the most convenient way for them.

One Croydon recognise the incredible contribution of the VCS in improving health outcomes, which we know goes well beyond the scope of funded or commissioned services. During the pandemic this was most acutely felt when the VCS provided support to individuals such as delivering food parcels, Befriending services, delivering medicines and escalating issues to statutory counterparts. 1000's of hours of high value volunteering have been undertaken.

One Croydon partners are working with leaders from across the VCS, from small grassroots organisations to larger providers to improve representation of the sector at all levels of decision making in the One Croydon Alliance. We expect that this will continue to raise the profile of the VCS sector as one of the main contributors to improving health and wellbeing outcomes to residents in Croydon. It also means that One Croydon partners will be able to capture evidence of success from the VCSE sector as a whole. The One Croydon Alliance is committed to recognising the voluntary and community sector as an equal partner in the Alliance.

Proactive and Preventative Care

How have we engaged with local people?

One Croydon
Your health and care partnership

Engagement highlights	Emerging themes	Impact	Next steps
There was considerable engagement and co-design with patients, the pubic and health, care and the voluntary sector partners to develop the long-term conditions (LTC) and diabetes models of care introduced in 2020.	• Care for people with long term conditions can feel fragmented rather than joined up • Specialist services are not always focused around the BAMER population where diabetes is high • Basic knowledge is widespread, but inconsistent. Many people are unclear about the benefits of treatment and lifestyle changes. • Cultural beliefs are cited as a reason for resisting medication. • Significant gaps between reported prevalence gaps for LTCs • In order to reduce the number of complications related to LTC, health and care services need to work with our communities to focus on prevention, early identification and embed knowledge and understanding of how to prevent and manage LTCs.	• A community outreach programme and the Expert Patient Programme (EPP) commenced in 2020, delivered by Croydon BME Forum and Asian Resource Centre Croydon. • 71 people completed the 9 EPP courses between March-October 2021. Feedback has been positive with many reporting sustained lifestyle changes. • Over 550 people attended 12 (virtual) LTC awareness raising events held between October 20 and July 21. 25 LTC community champions have been trained to date with a further 6 health check volunteers. By July, 54 people had their health check undertaken inclusive of pulse and blood pressure checked, followed by a diabetes risk assessment. • A systematic case finding service for of atrial fibrillation from Croydon GP practices. • A new integrated model of diabetes care was introduced in 2020, with the specialist team working across acute, community and primary care. • A new group consultations programme aimed at supporting patients with diabetes and /or hypertension to self-manage their condition more effectively and learn from peers is now commissioned from general practice.	• Continue to gather and respond to feedback and data on the EPP and Community outreach programme to maximise reach and impact. • Align community outreach programme with ICN+ model and building on joint working during Covid-29 pandemic with VCSE organisations to engage with specific communities to develop culturally specific materials and information. • Work with PCNs and VCSE organisations to deliver effective population health management strategies
One Croydon Alliance were selected to patriciate in The Healthy Communities Together programme, which has brought external investment into Croydon at moment of acute financial pressure. The programme seeks to strengthen partnership working between the voluntary and community sector, Health Services and the Local Authority	•The voluntary and community sector (VCS) have made recommendations to the partnership on how we can improve VCS representation in decision making •The VCS have contributed their time and expertise in developing the Croydon Locality Operating Model, using engagement events like Building Community Partnerships to seek out patient views on how services can be improved and more integrated •The Partnership have recognised that we can do more to recognise and value the contribution of the VCS for Croydon residents, in particular, ensuring that that the VCS is truly an equal partner in delivering the Health and Care Plan	•VCS contribution to improving health and wellbeing outcomes will be recognised more fully •Representation of the VCS in One Croydon governance boards and steering groups has been improved •Empowerment and Engagement activities relating to the integration of services in each locality has taken place, with input from local people, grassroots VCS organisations and medium to large VCS organisations, 12 events have taken place so far, with an average of 30 VCS organisations attending, over 100 organisations and groups not previously known to the partnership, and an average of 12 ‘active citizens’ as well as representation from all statutory partners in the Alliance •The partnership have agreed on a definition of what Community Empowerment means in Croydon, improving our shared understanding of how to engage with residents and communities •Commissioners across the partnership have been able to engage in honest and open dialogue with the VCS sector on how we might begin to shift more spend and resource into the VCS over time	• The work will continue in 2022 and beyond, we have developed a comprehensive implementation plan to ensure that we achieve all our objectives in strengthening the partnership further.

Proactive and Preventative Care

Your health and care partnership

What are our priorities now?

In 2021 to 2023, we will:

- Focus on prevention in everything we do – keeping people healthier for longer, especially focusing on the four key areas of:
  - Immunisations
  - mental health and trauma
  - healthy weight
  - falls and frailty

- Develop effective and sustainable partnerships between residents, the voluntary and community sector, the NHS and local authorities to improve health and wellbeing, reduce health inequalities and empower our communities.

- Refresh our commitment across all One Croydon partners to embed the core principles of resident and patient's engagement and active involvement to inform the decisions we make and the actions we take.

Localities - joined up work in local communities

One Croydon
Your health and care partnership

What did we set out to do?

We want to make it easier for people in Croydon to access the care and support they need stay healthy. Bringing health and care teams closer together to provide more coordinated care, we want to connect Croydon residents with the services around them, tailoring our care to local health needs to give people greater control of their health to build resilient and healthier neighbourhoods.

Localities - joined up work in local communities

What progress have we made?

• voluntary and community sector came together with Croydon residents and partners in the statutory sector to support Croydon people through the pandemic and has continued to deliver a multitude of key services from Personal Independence Coordinators, to befriending and food banks.

- We have developed a range of fully integrated locality based primary and community services, building on the success of our One Croydon Alliance.
- Our Living Independently for Everyone (LIFE) team brings together teams of social workers, community geriatricians, nurses and therapists to help people to regain their independence after illness and keep them well, and out of hospital where possible.
- A pioneering community hub is helping people to stay healthy on one of the most deprived areas of Croydon. The pilot Integrated Community Networks plus (ICN+) in Thornton Heath helps to connect health and care teams with residents, improving access to local support services. Local people now have access to a multidisciplinary team of GPs, social care workers, mental health specialists, physiotherapists, pharmacists and community groups, to connect residents with the support around them, including proactive care long-term conditions, help with healthy eating or access to benefits support.
- More than 3,000 Croydon residents have been supported by the ICN+ teams since the pilot was launched in 2020. Building on this success, the model will be rolled out across all or our localities in our borough in 2021. We have now begun joined up working in two of our other localities in the South West and South East of the borough and hope to begin in the remaining three localities over the coming weeks.
- We have begun to introduce the Stay Steady, Stay Well clinic to improve the health and well-being of older adults, to help people live independently for longer in their own homes.
- Personal Independence Co-ordinators (PICs) with Age UK Croydon are enabling older people to stay well and enjoy a better quality of life PICs work with each person to set and meet personal goals. Ranging from health changes, like joining a weight-loss programme, to socialising, or practical help with transport so they can make trips into the local area. PICs meet with community nurses, GPs, pharmacists and social workers to discuss the wellbeing of each person in their care.
- Telemedicine has been introduced in 75 care homes to give a direct line to the borough's experienced clinicians to help the prompt assessment of clinical needs and coordination of care when urgent, unplanned needs arise in care home residents.
- Care Home Liaison Coordinator introduced into the local hospital discharge team to reduce any unnecessary delays in transfer of care from hospital to a care home.
- To reduce the number of preventable falls for elderly care home residents, pilots have been introduced in partnership with Age UK Croydon, including 'Shimmer and Zimmer' which aims to build peoples' resilience when using walking aids.
- The Croydon GP Collaborative established a support framework for PCNs to help clinical directors deliver local services (Direct Enhanced Services, DES). The Collaborative has also set-up the Clinical Director Cabinet to support the development of PCNs.
- We now have nominated clinical directors in post to represent all of Croydon including mMental health, estates, social prescribing and the One Croydon Alliance. As part of this we have successfully worked together to roll out many pan-Croydon projects including paramedics, pharmacists and social prescribers for each of our PCNs, a cervical screening service run by CGPC and delivered by one practice on behalf of all of Croydon. This is now up for an award as we have seen 580% increase in uptake of cervical screening appointments across the borough.

Localities - joined up work in local communities

One Croydon
Your health and care partnership

What's changed with COVID-19?

Throughout the pandemic more people have worked together across professional and organisational boundaries to support and care for people in Croydon. ICN+ 'Talking points,' which were intended to be face-to-face drop-in clinics to connect with the community services, to tackle social isolation, improve access to mental health support or help people live and stay healthier, went online and were held virtually. Some elements of our pilot went on hold during the pandemic including the community falls pilot.

Many of our staff were working on the front-line of the pandemic and others were redeployed, for example, into the LIFE service helping to care for people safely at home and freeing up resources to care for people who need to be treated in hospital.

During the pandemic the VCS came together in Croydon and provided support to individuals such as delivering food parcels, Befriending services, delivering medicines and working closely with statutory services to support people who were shielding. Thousands of hours of high value volunteering have been undertaken by Croydon residents.

To keep patients and health and care staff safe during the pandemic, Personal Protective Equipment (PPE) was planned and coordinated across the borough, in line with national guidance. Our hospital experts also gave infection prevention and control guidance and training to Croydon's care homes to help protect residents from the spread of infections.

In December 2020, we began the largest vaccination programme ever delivered by the NHS. Alongside Croydon University Hospital, who were amongst the first in the country to begin to vaccinate local people, Croydon GPs worked together in Primary Care Networks at locality level to set up six GP-led vaccination centres across the borough and offer the covid-19 vaccine those most at risk of the virus. Vaccination centres at Selhurst Park and Centrale Shopping Centre and local Croydon pharmacists have since joined options for local people to be vaccinated and the vaccine has now been offered to all adults across the borough. We continue to encourage local people to take up the offer of the vaccine, and to make sure they also have their second dose.

Locally led GP vaccination teams delivered over 75% of the vaccines to those over 50 years old, and we are now working together to plan for the booster campaign for these groups in the autumn.

Localities - joined up work in local communities

One Croydon
Your health and care partnership

What are our priorities now... continued?

In 2021 to 2023, we will:

- **Complete and implement the review of the LIFE service – Living Independently for Everyone:** Implement a reviewed LIFE service that is sustainable building on continuing discharge to assess and A&E liaison which can help to reduce delays for adult patients who no longer need in-hospital treatment and provide at home care to help people recover and stay well in the comfort of their own homes. It will provide a community reablement service aimed at reducing hospital admissions, and work with people who are at risk of falls or a hospital admission to support them to stay healthy at home. Working to the Home First principle, the vision of LIFE is to be a compassionate, caring and effective multi-disciplinary, goal and outcome-based service that ensures every service user feels they are central to their journey to recovery and well-being.

- **Continue to roll out Integrated Care Networks Plus to connect health and care teams with residents, improving access to local support services:** Continue to develop the ICN+ model in all six of Croydon's localities and ensure they are supporting residents and expand the care available to include children and their families in Croydon. Work more closely with GPs to maximise the ICN+ offer to residents.

- **Supporting our workforce:** Maximising the resources and skills available within our workforce. Supporting our teams to work closer together across disciplines and services, including looking at pay and contractual differences. Focus on recruitment and retention and making Croydon a great place to work and lead on the development of new roles for our communities including community paramedics and training nurse associates. Continue to provide team development sessions focusing on training, organisational development and raising knowledge of community resources.

- **Increase patient and public engagement with residents:** Support patients to access the right service at the right time to improve their health and care. Engage with our residents, patients, carers and families and our local communities working closely with our voluntary and community partners. Utilise patient participation groups to listen and understand the experience of our current service users and build on our strengths to improve health and care services for the people we serve.

- **Support the development of practices and primary care networks to join up primary care and community services:** Develop local leadership forums where the voluntary sector, GP leaders and community services collaborate and work together to support our local populations and their unique health needs. Focus on health inequalities with an emphasis on equal access to services, long term conditions and learning disabilities.

Localities - joined up work in local communities

One Croydon
Your health and care partnership

What are our priorities now... continued?

- **Use data, IT and technology to improve the model of care and joint decision making for elderly care home residents:** Increasing the use of remote monitoring systems to help care home residents well and enable health and care teams to proactively monitor their condition. Ensuring care home staff have safe and secure online access to share clinical information with healthcare teams to aid the care of residents, and ensure all care homes in Croydon have good wi-fi connectivity and digital devices.

- **Enhanced Primary and Community Care support:** With weekly 'home rounds' or 'check ins' with residents in all care homes to monitor and coordinate care for residents. Embedding personalised care and support plans (PSCPs) to involve residents in decisions about their care and achieve better prescribing practice and delivery of care. Maximising the skills and experience within health and care teams in Croydon to improve support for care homes, including providing infection control training and support.

- **Developing a strategy for care homes to help prevent falls:** Coordinating reablement and rehabilitation services to help elderly residents regain their strength and mobility. Reviewing the Community Falls Service in line with the rollout of ICN+ localities.

- **Improved mental health support and dementia care:** Bringing health and social care teams closer together to enable residents to manage their own health and wellbeing and ensure improved experience and better quality of life.

- **Improving end of life care:** Ensuring care home residents are supported to make choices about their own care even at the end of life.

- **Building 'Compassionate Communities':** Helping elderly residents and families navigate the support available through local hospices, voluntary organisations and bereavement services. Providing awareness training to widen the support available from Compassion Neighbours and social prescribers to connect people with the services and community groups around them.

- **Expand the Localities approach to under 18s to create a Localities model for all ages:** Define and develop the Localities approach for Children's Services. Create strong links between Children's and Adult's Services resulting in an integrated, all age Localities offer to support residents.

Modernising acute care

One Croydon
Your health and care partnership

What did we set out to do?

Working together in the borough and as an integrated care system across South West London, we want to ensure people in Croydon have access to the highest quality care and outcomes to improve the health and wellbeing of our community. This programme covers the ongoing response and recovery of our services to the COVID-19 pandemic and the continued development of our integrated services to care for people in and out of hospital.

What progress have we made?

We have had to adapt many of our plans due to the pressures of COVID-19 but progress of modernising Croydon's Acute Care has continued at pace.

COVID recovery at Croydon Elective Care Centre

- Croydon was one of London's leading boroughs to restart planned treatment and surgery after the first wave of the pandemic. Croydon Health Services has created "hospital within a hospital" for non-COVID care. The Croydon Elective Centre (CEC) at Croydon University Hospital is COVID safe zone, with restricted access to other parts of the hospital, robust infection control and COVID screening of patients and staff. Dubbed a 'blueprint for the NHS' in the wake of a national health crisis, the CEC has provided planed care for almost 10,000 local people since July 2020, shortening waits for people that have had their treatment delayed because of COVID-19.
- To help clinical teams care for higher numbers of people needing hospital services, the Trust has also opened a dedicated emergency surgical centre and same day surgical assessment hub to protect the capacity needed to care for people needing emergency surgery and avoid unnecessary delays for people needing planned day case or overnight procedures.
- In June 2021, the Trust also opened a second elective centre at Purley War Memorial Hospital. Caring for patients that require only local anaesthetic, the Purley Elective Centre is increasing our capacity to treat people more quickly and free-up our main theatres at CUH for more complex cases to help clear the COVID backlogs.

Working together to clear the COVID backlogs

- By increasing our capacity we are reducing waits for Croydon patients needing planned surgery and treatment during the pandemic. We are also supporting our neighbouring trusts to clear the COVID backlogs as part of a coordinated response across South Sest London. Croydon Health Services has received more than 1,300 referrals to care for patients from nearby trusts in the past 12 months.

Modernising acute care

One Croydon
Your health and care partnership

Critical care expansion

- In line with NHS guidance, Croydon University Hospital increased its intensive care capacity from 15 to 22 beds to meet requirements during the height of the pandemic within safe staffing levels. Following the first wave of the pandemic, the Trust also increased its oxygen capacity on site to allow clinicians to provide non-invasive ventilation and Continuous Positive Airway Pressure (CPAP) oxygen for COVID-19 patients on designated wards – freeing-up capacity to care for the sickest patients in intensive care. The hospital can now flex its critical care capacity to meet surges in demand.
- Later this year, the Trust hopes to begin building to permanently double the intensive care space available to ensure patients can receive the highest standards of
- life-dependent care, close to where they live. Pending final approval, the major £14.7m redevelopment will create 22 intensive care and high dependency beds, with more en-suite facilities, quiet rooms and improved waiting areas to support families at some of the most difficult times in their lives. The project will also enable the Trust to enhance the facilities available for stroke and respiratory patients in hospital.

Digital first transforming outpatient care

- A large proportion of outpatient appointments are now offered by telephone or videoscreen to connect patients with hospital experts and avoid further delays for people's treatment because of COVID-19. Hospital consultants, will continue to see face-to-face where clinically required. During the height of the pandemic, around 300 video consultations were taking place each week at Croydon Health Services.
- To help ensure identified patients could still receive their medication during COVID-19, the 'Pharmacological Interventions Workstream' set up a medication delivery service with the Trust's non-urgent patient transport team. Patients who are unable to collect their prescription/medication following a video or telephone outpatient appointment are now able to get their medication delivered Monday, Wednesday or Friday.
- In April 2021, Croydon Health Services approved the use out of Patient Portal UK, which is a secure digital platform allowing two-way communication between patients and clinical services. Amongst other functions, the platform allows patients to view their letters digitally and manage their outpatient appointments. The new system will start being rolled out in late 2021.
- To support primary care in Croydon, Advice and Guidance allows GPs to seek expert advice from hospital consultants to review and agree the most appropriate care plans for their patients. Throughout the COVID pandemic, the Trust has continued to achieve performance above the 80% target for GP Advice and Guidance turnaround in two days.

Modernising acute care

One Croydon
Your health and care partnership

Enhancing our care for children in Croydon

- In August 2020, we were given the green light for the development of a £6 million new children's care unit at Croydon University Hospital. The new, integrated space includes the addition of a brand-new critical care unit and children's cancer unit, allowing the Trust to provide care closer to home for even more of the borough's sickest children. Alongside this, the state-of-the-art facility will house a medical ward, surgical ward and a short stay unit, for children and young people who need to be admitted to hospital, as well as providing improved facilities for patients and visitors, such as family spaces and relaxation rooms.
- This development will support our commitment to ensure our services reflect the needs of our patients, as we see the number of young people in the borough increase each year, making the project a vital part of our work, as we bring hospital and community services as well as local GPs, social care and the voluntary groups, to provide joined up care for the people of Croydon.
- The children's cancer unit is being supported by Chartwell Cancer Trust, who have joined forces with the NHS to raise £750,000 towards the new facility, transforming care for children, young people and their families who are dealing with cancer and the possibility of spending up to two years in treatment.

Urgent and Emergency Care Transformation Programme

- We have worked together to transform access and patient pathways for people seeking urgent and emergency care at Croydon Hospital emergency department. This has helped make sure those are admitted to hospital swiftly when they need to be and supported to be cared for at home when they no longer need inpatient care. Our urgent and emergency care transformation work has inlcuded Think 111 First, Same Day Emergency Care, Mental Health support in the emergency deparment and work to support those experiencing homelessness and inequalities.

Post COVID care

- Multidisciplinary support is now available for people suffering the long-term effects of COVID-19, to help Croydon residents recover without hospital care and stay well. At home care can now be provided by community nurses and therapists, with the support of GPs and hospital consultants where needed. This includes joined-up support for people suffering 'post COVID' symptoms, including chest pain, chronic fatigue and brain fog.

Modernising acute care

One Croydon
Your health and care partnership

What are our priorities now?

In 2021 to 2023, we will:

- **Maximizing our elective care**
  We will maximize our activity to treat people at Croydon and Purley Elective Centres to help recover the COVID backlogs to reduce the waits for patients who have had their planned care or treatment unavoidably delayed because of the pandemic including mutual aid to support those waiting for treatment in our neighbouring hospitals. Deliver our Outpatients Transformation Programme including through virtual appointments where appropriate.

- **Transforming urgent and emergency care**
- Making access to our services as simple and convenient as possible, acting on the feedback of our patients and harnessing our learning from COVID-19 to improve patient experience and reduce missed appointments. Reduce the length of stay in hospital for those patients who could be better treated at their homes or in the community to make sure only those who need to be are cared for in hospital.

- **In and out of hospital**
  Aligning health and care teams to provide more coordinated care and support for patient pathways including anti-coagulation, diabetes and dermatology to minimise delays when patients can be cared for at home or in the community and helping to ensure that only people that require acute care need to go to hospital. Develop ICN+ hubs across Croydon to increase the capacity for general practice and enable the integration of community and acute services in the community.

- **Transforming diagnostic services**
  Working collaboratively with the South West London Integrated Care System to explore opportunities for Community Diagnostic Hubs in Croydon to help diagnosis cancer and other health conditions earlier, in discussion with patients, staff and stakeholders in our borough.

- **Supporting our workforce**
  Supporting the health and wellbeing of our staff during once of the most challenging times in the health and care service as described in our People Plan. Making the most of the skills and expertise we have in the borough to retain our workforce and encourage more health and care professionals to join our teams in Croydon.

Adult mental health and well-being

One Croydon
Your health and care partnership

What did we set out to do?

- Work in partnership with schools and colleges to deliver a whole school approach to emotional health, well-being and mental health.
- Implement the mental health community hub and spoke model to put more clinicians out in the community to support people closer to home
- Develop a wider range of housing options for those with severe mental health problems to better support their needs
- Develop an improved mental health crisis pathway so that people in crisis have faster and easier access to specialist support

What changed during COVID-19?

The coronavirus pandemic continues to have an impact on the mental health of millions of people across the country including thousands of people in our Croydon communities. The impact of lockdown, loneliness and social isolation, the devastating impact of those who have died, their families, friends and communities, and the impact on jobs and incomes all play a part.

Croydon's unique population means we have high mental health needs including:

- Croydon's population is diverse with over 50% from Black, Asian and minority ethnic communities with this percentage predicted to increase over the next decade
- An estimated 10,000 people live in areas across Croydon considered to be within the most 10% most deprived in the country
- Mental health problems are 3x more common in children in households with the lowest 20% of income
- Half of all mental health problems begin by age 14 years
- Croydon has the highest number of unaccompanied asylum-seeking children

The immediate challenges to the NHS over the last 18 months has meant that the progress against our original plans has not been possible. For mental health services this has meant that we have not yet progressed as we would have hoped our mental health recovery spaces. However, we are working with key mental health providers as well as the community and voluntary sector to increase capacity and reduce waiting times in key services for example Counselling, to ensure timely support is available for our residents.

Adult mental health and well-being

One Croydon
Your health and care partnership

What progress have we made?

Over the last two years we are very proud of our close partnership working with key partners across the borough especially our voluntary sector partners including Croydon BME Forum, the Asian Resource Centre, Croydon Voluntary Action, MIND in Croydon, Imagine and Hear US to support our mental health transformation programme as well as throughout the pandemic and Covid-19 vaccination programme. Our delivery for Mental Health has included:

- **Recovery Space** we developed an alternative non-clinical space to the Emergency Department for those in mental health crisis. This centre opened in October 2020 and has supported over 400 individuals from October 2020 to end of June 2021 referred from both the Emergency Department and GPs across the borough.
- Preparation for the first of three **community mental health and wellbeing hubs** to be delivered across Croydon's six localities is underway with the intention of providing a "one stop" single point of access to deliver integrated mental health support for local people. Service Users have already named the first hub as the "Croydon Health & Wellbeing Space", which will be located at the WhitGift Centre.
- We are in the third phase (scaling up) of **reshaping secondary care community mental health services** having completed a pilot to simplify specialist mental health services to align them with our mental health and well-being hubs and six localities as they are implemented
- We now have six **Mental Health Personal Independence Co-ordinators** employed by the voluntary sector to provide practical support for people experiencing mental health issues across primary care
- Implemented an **Enhanced Shared Lives service** that enables an earlier discharge from hospital for mental health service users that no longer need hospital treatment. Or offering a short period of enhanced support rather than hospital admission, enabling people to return home.
- **Learning Disability annual health checks** building on improvements in previous years, despite COVID19 further improvement has been made in 2020-21. Over 1800 eligible people had received a check by the end of March 2021 since April 2020, an improvement of 292 more people when compared to the previous year. This means over 80% of people have managed to benefit from a health check and updated health action plans. People with LD are one of the prioritised groups for proactive care in post COVID recovery.

Improving outcomes for ethnic minority communities

- **The Croydon transformation** has established a Croydon Recovery Space and six Mental Health Personal Independent Coordinators hosted by the voluntary sector supporting over 60 people each month. These teams work closely with GPs and primary care colleagues integrating services for mental and physical health
- **Diversity has underpinned each step** Co-production of design, recruitment of staff with Croydon BME Forum in Partnership with Mind in Croydon.

Adult mental health and well-being

One Croydon
Your health and care partnership

How have we engaged with local people?

Engagement highlights	Emerging themes	Impact	Next steps
• Hear us forum – services users working with SLaM and the CCG as well as community and voluntary sector organisations. Meets monthly and engages with approximately 3,000 to 4,000 services users per year How Do We Ensure True Involvement? - Hear Us (hear-us.org) • 13 BME Grassroots events each attended by around 85-90 individuals and organisations with an interest in Mental Health led to formation strategic and operational Task and Finish group with both service users and carers • Mental Health Programme Board includes service user and carer representation	• Issues around trust – how do people know that services can and will help them? • Asking for help can be stigmatising and frightening, need to remove barriers • Challenges in accessing help – can feel like a barrier having to navigate through the system, especially when not in crisis. • Difficulties in understanding the terminology used • Mental health conditions can be isolating for the whole family/support network • People are turning to alternative support networks such as faith leaders and the VCSE when they need support	• Co-design and opening 'clinical health and wellbeing space' (named by service users) which offer culturally appropriate and timely support • Developed a robust feedback loop so learning from the first space informs opening of two more hubs and the service can iterate the way it supports residents • Service user/carer designed website sharing their own experiences and information • Decision to allow both open access and referrals from health professionals to the hub allowing people to access care directly	• Clinical health and wellbeing space in Whitgift opening imminently with a further hub in Thornton Heath • Hear Us, service users and Carers Forum stress testing different scenarios in the space/s • Identify key engagement priorities for next two years and develop engagement plan • Funding has been secured for a clinically-led partnership with a specific objective to reduce ethnic inequalities in access, experience and outcome of mental health care, linking to SLaMs Patient Carer Race Equality Framework (PCREF) development.

Adult mental health and well-being

One Croydon
Your health and care partnership

What are our priorities now?

In 2021 to 2023, we will:

- **Improve the Community Mental Health pathway**
  - Deliver four Mental Health Wellbeing Hubs for Croydon in Central, North, South-East and South-West Localities
  - Re-establish the Dementia Action Alliance
  - Strengthening Mental Health and Substance Misuse Pathways

- **Improve the Crisis Mental Health Pathway**
  - Establish a Mental Health Assessment Unit at Croydon University Hospital
  - Strengthen both the non-clinical and clinical provision and care pathways for those experiencing a mental health crisis

- **Continue developing greater Mental Health support in primary care**
  - Introduce new clinical & non-clinical roles focused on mental health
  - Strengthen the care pathways for mental health

- **Establish a clear pathway for people with a serious mental illness to more independent living**

- **Address the Health Inequalities for Mental Health across Croydon**
  - Implement the Ethnicity Mental Health Improvement Programme – Improving the access, experience and outcomes for ethnic minorities in Croydon especially for those groups significantly affected for example young black men.

- **Enhance Partnership Working**
  - Establish Mental Health and Learning Disability Joint Commissioning Boards to develop our commissioning plans, review current provision and market relations, and to ensure our collective resource is being used appropriately to support individuals with health and social care needs with a focus on prevention and early intervention

Better start in life and maternity

What did we set out to do?

Croydon has a young population with the highest number of 0- to 17-year-olds in London. To give children and young people the best start in life we set out to:

- Implement our healthy pregnancy programme to support mums-to-be immunisation rates, breastfeeding, parenting support and increase take-up of the borough's Live Well programme
- Improve mental health and emotional wellbeing for children and young people in Croydon through a borough-wide transformation plan
- Bring multidisciplinary health and care teams closer together to safeguard young people and reduce the number of the number of children in care through closer integrated working
- Improve access and reduce health inequalities for children and young people in Croydon.

Overall, Croydon's population is one of the most diverse in the capital, with over 50% from Black, Asian and minority ethnic communities with this percentage predicted to increase over the next decade. An estimated 10,000 people live in areas across Croydon considered to be within the most 10% most deprived in the country. Around 6,000 children are born in our borough every year.

What progress have we made?

Improving equality and outcomes in maternity

- The Trust's maternity services have launched the 'HEARD (Health Equity and Racial Disparity) campaign to improve the experience and outcomes during pregnancy for women from Black, Asian and Minority Ethnic backgrounds. This includes an education programme for staff and a recommended care pathway that incorporates early antenatal bookings, interpreting services at every appointment, and a personalised wellbeing assessment from a multi-disciplinary team of doctors, midwives and nursing teams to ensure joined up care for expectant mothers with a number of existing health conditions. Every woman will also have the opportunity to access a HEARD ambassador, ensuring respectful, equitable access to care for all.
- The Trust also offers additional support here in Croydon, through continuity of care teams and a dedicated team for mothers with diabetes, we are taking further action to tackle these issues and ensure we are providing every mother with the best care possible.

Better start in life and maternity

One Croydon
Your health and care partnership

Flu vaccinations in the community

- Croydon GPs and pharmacists played an active role in recording some of London's best public flu vaccination rates in 2020, with more than 149,803 (73.2%) GP-registered patients vaccinated

Continuity of Carer

- In line with national best standards, we have introduced Continuity of Carer in the borough's maternity services. Now, when pregnant women book with a continuity of care teams, they will be cared for by the same small team of midwives throughout their pregnancy. Especially for women with more complex health needs, this can help to deliver more personalised care and improve outcomes for women and their babies.

Caring for children close to home

Around £6 million is being invested at Croydon University Hospital to ensure some of the most poorly ill children can be cared for close to home. The new Paediatric Integrated Unit, opening in 2022, will include a new children's critical care unit and children's cancer unit, dedicated wards and comfortable family spaces and relaxation rooms. The multi-million development includes engagement with families and young people to ensure the design of the unit meets their needs, with continuing fundraising through the NHS and Chartwell Cancer Trust to raise £750,000 towards the facility.

Children's Hospital at Home

- This fantastic team celebrated its 25th birthday in May 2020 and is one of the borough's first truly integrated teams. Originally set up in 1995, the team of community nurses provides acute nursing care at home for children with long term conditions, including respiratory, cardiac and cancer. In 2020, we have strengthened the role of the 'Children's Hospital at Home' team for those children who come to A&E to avoid children having to be admitted to hospital unnecessarily. During the COVID-19 pandemic, members of the team were also drafted into the hospital to help the Trust's coronavirus response, including supporting the team in intensive care.

Children's asthma team

- Our children's asthma was praised by the Care Quality Commission during the last full inspection of the Trust's community services, noting the teams use of social media to inform and engage parents and proactively help children living with asthma. Continuing this approach, the team took part in the #AskAboutAsthma campaign with an 'ask the expert' online session with a parent chair to ask the questions gathered by children and young people. 'Nudge cards' have also been developed to help educate parents and ensure all children have a personalised asthma action plan (PAAP) to help manage the condition, with a Pilot of Asthma-Friendly Schools to promote safety and children and young people with asthma stay well with the support of local heath and care teams.

Better start in life and maternity

One Croydon
Your health and care partnership

What changed during COVID-19?

The immediate challenges of COVID-19 to the NHS has meant that the progress against our original plans has not been possible. In order to help keep vulnerable children and young people safe from coronavirus, many health checks and had to be held by telephone or video, with continuing at home visits where required with the use of Personal Protective Equipment (PPE) and robust infection prevention and control procedures.

Although Healthwatch Croydon conducted the 2019 Young People's Mental Health Survey before the pandemic, its findings are in line with the increase in demand for mental health services we are seeing in many London boroughs including Croydon which has seen rising demand for emotional wellbeing and mental health support, including increased anxiety, low mood and depression. The borough's NHS along with Croydon Voluntary Support, Healthwatch Croydon and local schools are considering a further survey to help target resources more effectively to provide greater care and support for mental health needs in the borough.

Through the legacy of Captain Sir Tom Moore and NHS Charities Together, and with the support of the Croydon Health Services Charitable Fund, more than £185,000 of this funding has been allocated to a number of system-wide partnership initiatives, including:

- A project to reduce the isolation felt by parents who care for disabled children
- Funding for counsellors to support young people between the ages of 16-24 and who are at risk of or currently homeless
- Development of a sensory room to be used for Dramatherapy, supporting young people in communities across the borough to process their grief in a healthy and safe way

Better start in life and maternity

One Croydon
Your health and care partnership

What are our priorities now?

In 2021 to 2023, we will:

- **Coordinated COVID-19 recovery:** Continuing to work in partnership to care for the wellbeing of children and young people affected by the pandemic. Identifying opportunities to intervene as early as possible to keep people safe and well and recover services to deliver face-to-face reviews for all mandatory of Croydon children aged 0-5 years other key contact points, in line with national standards

- **Early years:** Support the creation of an integrated early years strategy that incorporates the recommendations in Best start for life to act on the key priorities of national reviews, including strengthening continuity of care for all families (Better Start in Life 2021); achieving UNICEF Level 3 for Croydon to be breastfeeding friendly borough; implementing the findings of the HEARD review and improve pregnancy and birth outcomes for women from Black, Asian and Minority Ethnic backgrounds.

- **Maternity care:** Delivery of the long-term plan transformation ambitions, including the rollout Continuity of Carer more widely, for women from diverse or deprived areas and acting on the essential actions of the Ockenden Report.

- **Improving mental health and wellbeing for children and young people:** Ensuring access to the right emotional wellbeing and mental health services for children and young people in Croydon, increasing focus on prevention and early intervention, developing a comprehensive strategy for transitions for people aged 0-25, and reducing health inequalities for children and young people of African, Caribbean, Asian and other ethnic heritage.

- **Improving urgent care pathways for children:** To deliver against the priorities within the Children and Young Persons' Transformation Programme. Benefiting our community through the development of the new Paediatric Integrated Unit at Croydon University. Our priorities will also include help to manage long-term condition, such as asthma, epilepsy and diabetes, and improving waiting times to diagnose children with Autism Spectrum Disorder (ASD) or Attention Deficit Hyperactivity Disorder (ADHD)

- **Special Education Needs and Disabilities:** Ensuring health and care partners in Croydon meet statutory requirements and improve outcomes for children and young people with SEND.

- **Improving the health of Looked After Children:** Improving the health of Children Looked After, ensuring that this vulnerable cohort of children and young people supported within the partnership to manage their health and wellbeing needs, ensuring that they have the right support at the right time.

Joining up care for people with disabilities

One Croydon
Your health and care partnership

What did we set out to do?

- Give working age people flexible care that they can arrange themselves and have choice and control over
- Provide more joined up care for people with disabilities by implementing locality-based services and bringing multi-agency teams together
- Transform our practice for children with disabilities to provide consistent, high quality and proportionate support throughout their childhood and the transition to adulthood
- Provide digital solutions and assistive technology to support access and management of care for people.
- Have good conversations with people using community-led approaches, looking at what's strong, not what's wrong.

What progress have we made?

- Enhanced direct payment offer and personal assistant market.
- December 2019 Independent Lives were commissioned to train and develop new personal assistants, and provide advice and guidance to residents choosing to use a direct payment
- A new website was launched www.adultsupport.croydon.gov.uk, a comprehensive source of information advice and guidance on adult social care
- Re-developed day care model, Active Lives, in the community where appropriate, otherwise at our specialist and newly refurbished centre – Cherry Hub. This is to enable support to focus on the goals in the individuals care plan.
- In April 2021, the disabilities service (18-65) moved to a localities model, enabling it to align with the Integrated Community Networks plus model that was developed in the older people services (65+).
- In April 2021, the transitions service moved to adult social care. A programme will be built around the service to align it with the strengths-based model / good conversations and to the locality integrated community network model.
- A strategic review of assistive technology opportunities was developed, post COVID this review will need to be revisited at a system / borough level
- The community led support model is now fully embedded in the working practices of the older adults and disabilities locality teams.
- Learning and development has also been developed to ensure there is ongoing training for existing and new staff.
- Learning Disability annual health checks – we are building on improvements in previous years and despite COVID19 further improvement has been made in 2020-21. Over 1,800 eligible people had received a check by the end of March 2021 since April 2020, an improvement of 292 more people when compared to the previous year. This means over 80% of people have managed to benefit from a health check and updated health action plans. People with LD are one of the prioritised groups for proactive care in post COVID recovery.
- The Trust also offers additional support here in Croydon, through continuity of care teams and a dedicated team for mothers with diabetes, we are taking further action to tackle these issues and ensure we are providing every mother with the best care possible.

Joining up care for people with disabilities

One Croydon
Your health and care partnership

What changed during COVID-19?

The pandemic continues to cause uncertainty and stress to many people, and in particular for those with care and support needs, their carers, families and staff that support them. From the early stages of the crisis, many people with disabilities, their carers and families and will have been shielding, which may also have led to a loss of confidence and increased social isolation for some.

During the pandemic, our focus turned to ensuring our residents and staff were safe, so initially, many of our services were suspended and staff redeployed.

Our Active Lives services moved online, and we intend to continue these sessions which allow us to support more people. We will look at a hybrid model of both face to face and virtual sessions going forward.

Our Safeguarding work continued – individuals were visited and safeguarding processes followed if needed. We also continued with all Deprivation of Liberty (DoLS) work.

The Community LD Team (CLDT) developed a database to identify all vulnerable people living with LD with a particular focus on those with elderly carers.

There was impact on capacity and demand on the CLDT because the day care centres were closed and families were managing escalation of behaviors of concern

When LD patients were admitted to the acute Trust reasonable adjustments i.e family members staying were not always ensured.

There was increased oversight on inpatient service users with LD and/or ASD to ensure they were receiving the appropriate level of care and family still had access virtually throughout the pandemic.

Physical health needs for LD patients were left unmet due to changes to access primary care; although there was oversight of service users in community placements on a monthly basis virtually and by telephone.

Rapid Learning of Covid impacts from Life and Death Reviews of people with Learning Disabilities and Autism.

Joining up care for people with disabilities

One Croydon
Your health and care partnership

What are our priorities now?

A person-centred approach will run through all our priorities. In 2021 to 2023, we will:

- **Provide quality social care services**
- To provide the best quality social care services through maximising our resource allocation to keep our most vulnerable residents safe and healthy. We will focus on direct payment take up; and step up and step-down interventions having the right level of support that is flexible for individual's needs. Deliver a new reablement offer that maximises independence and transforms community care to reduce the reliance on impatient care.

- **Join up social, mental and physical health care**

  Address increasing activity across mental health, younger and older adult services, through demand management programmes including practice changes, improved information and advice for people at our front door. Diverting enquiries from transferring into statutory care by extending a 'digital' approach, improving information and advice to enable the maximum number of people to help themselves in the community through our ICN model; managing our placements spend, ensuring effective joint work and funding with the NHS for health needs and using direct payments as a first offer. We are also developing a new learning disability framework and service offer. Focussed on stronger service links between statutory and partner agencies, and with 'active citizens' at the core of shaping the offer.

- **Support people to live independently**

  Developing 3-year commissioning plans focused on maximising independence, to support people to live in the least restrictive environment and prevent and delay the need for long term care. A new supported living strategy and an options appraisal of our council provider services to optimise outcomes and reduce duplication.

- **Work in partnership with the voluntary and community sector**
- Developing an interdependent relationship with the voluntary, community and enterprise sector working in a multi-disciplinary, strengths-based way. Nurturing and establishing strategic partnerships and innovation.

- **Transform services for young people transitioning to adulthood**
- Transform our practice for young people transitioning to adulthood, to provide consistent, high quality and proportionate support. Planning early and listening and engaging with families and innovating to provide creative and independence strategies for our young people. Commissioning well and developing strategic relationships to provide cost effective improved outcomes. Continue to deliver high quality safeguarding assessments and interventions to better support younger people. Transform the transition pathway between children and young people and adult services.
- **Dementia friendly borough** to continue developing partnership working and service enabling Croydon to remain a Dementia friendly borough
- **Autism friendly borough** to enhance the borough's reputation as autism friendly, by delivering an action plan that delivers on the key partnership priorities within the autism strategy.
- **LeDeR - Learning from lives and deaths**

One Croydon
Your health and care partnership

Section 4: Socio-Economic Development

Anchor Institution

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Your health and care partnership

As Croydon's largest employers, the CCG (Croydon), Croydon Health Services and the Local Authority can have a huge impact on the socio-economic development of Croydon and, in turn, the health and wellbeing of its people. Over and above the delivery of front-line care, we have an enormous opportunity to use our scale and stability to benefit our staff and local people. With the impact of the COVID pandemic both on the economy and health and wellbeing the importance of taking up that opportunity is greater than ever.

What are the opportunities?

Employment and Skills
- Apprenticeships
- Sharing training opportunities
- Growing and targeting work experience

Supporting our staff
- Good Work Standard
  Debt/benefits advice?

Procurement
- Local market developmen
- Tender requirements

Sustainability
- Transport
- Biodiversity
- CO2

Engagement
- Engage local people and partners

Estates
- Free up for e.g. housing
- Host community orgs

Next Steps

- **Acknowledge and celebrate** the things we've already done and are already planning to do.
- **Focus on three priority areas,** The proposed priority areas are employment, estates/high street and procurement, because these are areas of significant need right now and where we can have a near-term impact.
- **Health and Local Authority to work in collaboration** to formulate a workplan.
- **Include measurement and quantifiable objectives** as part of the plan, to ensure real improvement and a focus on inequalities.
- **Develop a longer-term pipeline** through consultation with local people.
- **Continue to work at London and SWL levels.**

Anchor Institution: Progress in Priority Areas

One Croydon
Your health and care partnership

Employment and Enabling and Developing Our Workforce:

A significant challenge is ensuring we have the capacity and skilles in our workforce to meet the growing and changing needs of our populaiton; in addition, around 70% of our current workforce are Croydon Residents. Employing local people and enabling and developing our staff, particulalrly those from vulnerable communities that have been impacted the most by the COVID pandemic, will have significant soci-economic and wellbeing benefits for them and Croydon Place.

- One Croydon has introduced a workforce whole system group, looking at organisational development, joint services employment and staff wellbeing, and recruitment. The workforce group has designed and implemented a training and engagement programme to support integrated working and empower staff to lead on its development.
- Croydon Health Services have developed a Get in, Get on and Go further approach to career pathways maximising the ability to grow the future workforce through apprenticeship programmes
- There is a UK shortage of care workers in both home and residential care roles which mirrors shortages seen throughout the UK. Croydon council is working with Providers looking at their resilience strategies and running a campaign to drive a new generation of people to work in adult social care (ASC) and help fill the sector's vacancies
- There is significant work being undertaken across the One Croydon Partners workforce strategies and our ambition is to fully resource and develop this over the next 18 months.

Estates:

One Croydon has a dedicated Estates programme looking at council, community and NHS local estate assets, the ambition being to achieve our HEalth and Care Plan aim to deliver services closer to communitites, maximise efficient use and density of the Acute estate and support economic, social and environmental sustainability of our borough's high streets. Through this programme several exciting joint projects are being developed:

- A new Health and Wellbeing Centre (HWC), to be developed in New Addington. The HWC will provide front line services to the local population, as well as providing a base for the ICN+ team and services.
- A Primary Care Centre (PCC) in the Coulsdon area, to provide primary and community services to support an area of under-provision; this will also be a hub for the ICN+ team and Out of Hospital services.
- Several other ICN+ hubs are being explored using community space to enable service integration and ensuring services are closer to where people live.
- Community Diagnostic Centre, looking at estates options across One Croydon to develop the hub and spoke model to ensure services are closer to where people live.

One Croydon
Your health and care partnership

Section 5: Challenges to Delivery

Challenges to delivery

The environment in which the Health and Care Plan is being refreshed is rapidly changing, and it is hard to fully understand the impact of these changes. We are working together in One Croydon to be open and transparent about the challenges facing each individual organisation and using our solid partnership to come together and tackle these challenges together. Challenges to delivery of the health and Care Plan are listed below; each programme will be impacted differently, and the One Croydon partnership will ensure there is oversight of risk across the system to ensure we can effectively identify, address and mitigate them.

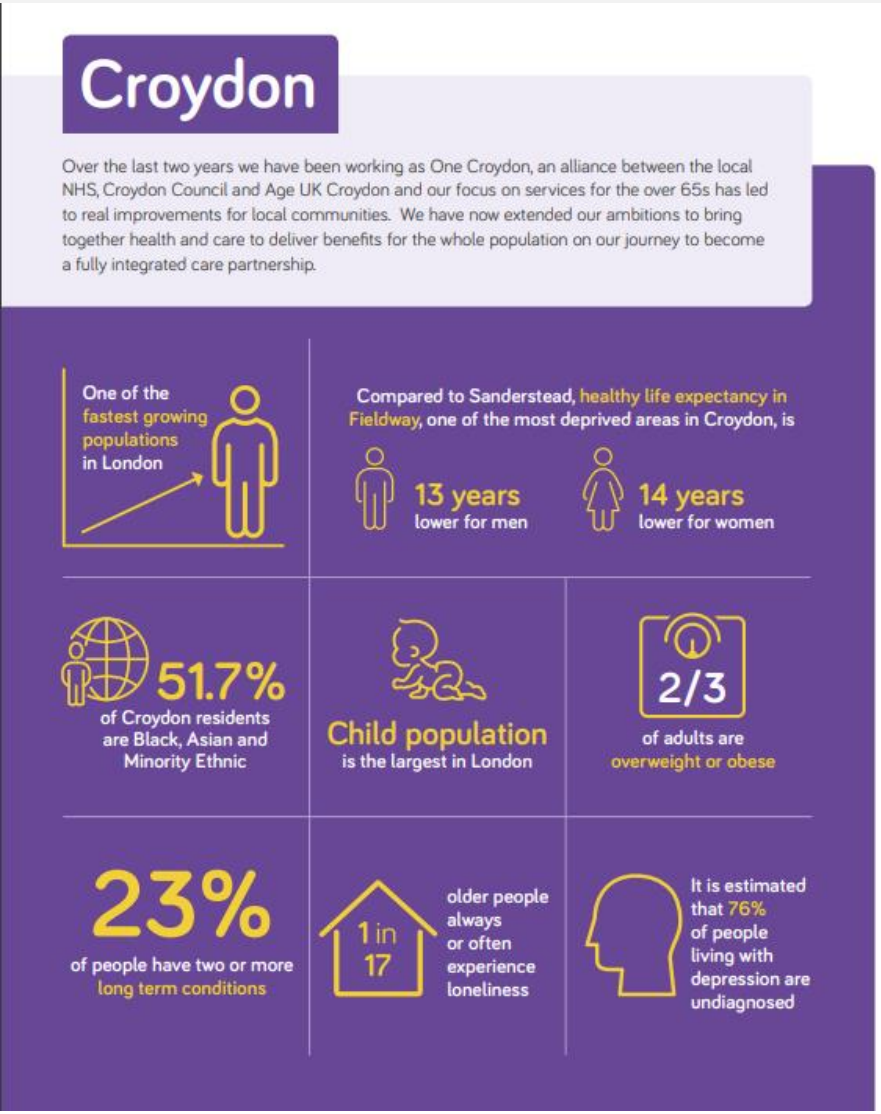
- COVID-19; delivering the vaccine programme and unknown impact of future waves
- Shortage of suitably trained staff
- ICS transition; ensuring that Croydon received maximum delegation in order to continue to deliver transformation at Place
- Operational pressures not allowing enough focus on transformation i.e., delivery of the vaccination programme and elective recovery
- Underdeveloped IT interoperability
- Underfunding of health by 4% (population based); consistent underfunding reduces our ability to deliver transformation as well as meeting changing/increasing needs of our people
- Requirement to bring costs of social care in Croydon in line with the London and/or National average. The impact felt and contribution to this transformation is required across the whole health and care economy
- Local Authority Financial pressures; impact is felt across the whole health and care economy
- Brexit; impact on products and workforce as well as supply chain issues.

One Croydon
Your health and care partnership

Appendices

Croydon Health and Care Plan summary 2019

One Croydon
Your health and care partnership



Read the full Croydon Health and Care Plan published in 2019 here

Croydon Health and Care Plan summary 2019

One Croydon
Your health and care partnership

Our plans for the next two years

Prevention and proactive care

- Increase coverage of social prescribing supported by Croydon's strong voluntary sector
- Further support to, and build the capacity of, the voluntary sector and communities to deliver preventative services
- Increase number of community health and wellbeing hubs providing integrated services
- Implement a new Long Term Conditions model of care prioritising diabetes, cardiovascular and respiratory disease and increase identification of those at risk of long term conditions
- Working age people will have flexible care that they can arrange themselves and have choice and control over, achieved through e-market places, personal budgets and direct payments

Better start in life

- Implement our children and young people's mental health transformation plan
- Implement the Healthy Pregnancy programme that will improve immunisation rates, breastfeeding rates, parenting support and take up of the Live Well programme
- Multidisciplinary approach to reduce the number of children in care through closer integrated working

Locality development

- Develop Integrated Community Networks Plus to bring together a complete clinical and health professional community, integrating GPs, mental health and community nurses, social care, pharmacy and the voluntary sector to proactively manage people with complex health and care needs at practice level
- Support GPs to implement Croydon's Primary Care Networks and to recruit Social Prescribers and Pharmacists for each one, establish local clinical cabinets and begin to manage, monitor and further improve quality
- Develop strengths-based approaches across disciplines through Community Led Support

All disabilities

- Give working age people flexible care that they can arrange themselves and have choice and control over
- Provide more joined up care for people with disabilities by implementing locality based services and bringing multi-agency teams together
- Transform our practice for children with disabilities to provide consistent, high quality and proportionate support throughout their childhood and the transition to adulthood

Mental health

- Work in partnership with schools and colleges to deliver a whole school approach to emotional health, wellbeing and mental health. Teams will work in schools and youth mental health first aid training will be provided.
- Implement the mental health community hub and spoke model to put more clinicians out in the community to support people closer to home
- Develop a wider range of housing options for those with severe mental health problems to better support their needs

Modern acute care

- Develop modern acute vision and strategies for physical and mental health
- Support our local Trust to become the provider of choice and optimise acute pathways through the pathway redesign programme and improve efficiency
- Redesign flows within the hospital to support delivery of the four-hour emergency department waiting times standard
- Reduce long lengths of stay by working with partners across the system including mental health and social care to support patients to get back home

What people have told us

- Services need to be more flexible and offer different levels of support to people in their own homes.
- Train people who visit isolated people in their homes so that they can alert services when their health starts to deteriorate
- We need to build resilience and confidence throughout our communities
- Residents need more help to stay well throughout their lives
- A lot of teachers lack confidence when it comes to addressing or talking about mental health issues with children and young people.
- We need more mental health services for those in crisis in the community.

You can find out more about what local people told us at: www.croydonccg.nhs.uk/get-involved

Our focus

1. Increase social prescribing
2. Voluntary sector delivering preventative services
3. Community health and well being hubs
4. Identification of those at risk of Long Term Conditions
5. Closing the financial gap

How will we know if we've made a difference?

Improve quality of life

- Increase the number of adults exercising
- Decrease the number of people with long term conditions in the most deprived areas where incidence is higher

Better start in life

- Reduce obesity in reception year children
- Reduce the number of school pupils with social, emotional and mental health needs

Wider determinates of health

- Increase social inclusion
- Increase employment, particularly for people with learning difficulties and mental health needs

Over ten years to improve healthy life expectancy from 62 years to 66 years for men and 62.8 years to 66.8 years for women

Reduce the gap in life expectancy from 9.4 years to 7.4 years for men and from 7.6 years to 5.6 years for women

This is a summary of the Croydon Health and Care Plan, you can read the full document at www.croydonccg.nhs.uk

Read the full Croydon Health and Care Plan published in 2019 here

Thank you

One Croydon
Your health and care partnership

- Any questions?
- Find out more here