APPENDIX 2

DRAFT

Croydon's Health and Care Transformation Plan 2019/20 – 2024/25 Summary

Plan on a Page
Outcomes Framework
Programme Plans

Our plan on a page

Working together to help you lead your life

The plan on a page sets out a clear path from our long term goals to our priorities and our plans for delivery.

Our strategic approach to all that we do is to:

- **focus on prevention and proactive care** – we want to support local people before things become a problem

Our overall aim is to keep people well. We want people to stay well and we want to prevent things becoming a problem. If people do have a problem we want them to be able to manage well, and have access to support that will help them help themselves. For those that have the greatest need, we want them to have access to services in the right place, at the right time, first time.

- **unlock the power of communities** – key to helping local people stay fit and healthy for longer is to connect them with their neighbours and communities.

The key to helping local people stay fit and healthy for longer is to connect them with their neighbours and communities. Social prescribing is a way of supporting people to use all of the resources within their community. Working with the strong voluntary sector in our borough to connect local people to be part of broader support networks so that local people can take back control of their own well-being.

- make sure local people have access to **integrated services that are tailored to the needs of local communities** – locality matters

We want to keep people well and out of hospital. Making sure local people have access to services, closer to home, wherever they live in the borough. Services must be accessible and responsive to their individual needs.

Factors such as the environment we live in, the education we receive and the relationships around us are major contributors to health, accounting for 80% of an individual's health and wellbeing; whether that is to keep peoples well, help them manage well, our support those with the greatest need. We will work to improve the wider factors that contribute to the health of residents the most. Our strategic initiatives will ensure a whole system shift towards this preventative model of care, including self-care and self-management. We know in Croydon there are certain long term conditions that are more prevalent than others, such diabetes, cardiovascular disease and respiratory disease and we want to focus on trying to prevent further development of these conditions.

Croydon's health and care transformation plan on a page DRAFT v20

One Croydon
Your Health and Care partnership

OUR VISION
Working together to help you lead your life

STRATEGIC GOALS AND OUTCOMES

Improve healthy life expectancy

- People are living longer and healthier lives

Reduce Inequalities

- Gap between life expectancies across borough is closing

A sustainable health and care system

- Affordable models of care delivering improved outcomes

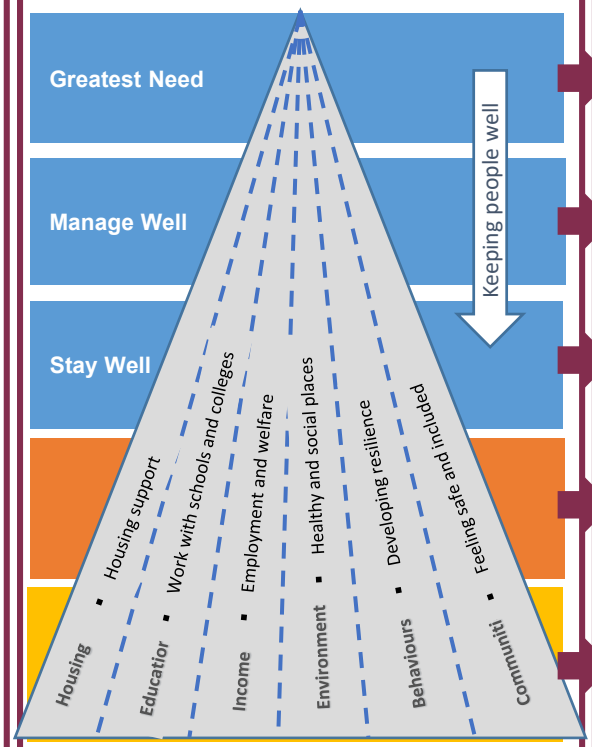
Peoples aspirations

- I am in control of my own health and well being
- I am able to stay healthy, active and independent as long as possible
- I live in an active and supportive community
- I can access the support my family and I need
- I can access quality services that are created with me and my family in mind

STRATEGIC PRIORITIES

- Improve quality of life (4)
- Enable a better start in life (1)
- Improve wider determinants of health and well being (3 / 5)
- Integrate health and social care (8)

STRATEGIC APPROACH (7)



- Whole population management
- Integrated health and care
- Locality based health and care
- Enablers

STRATEGIC INITIATIVES

- People have the support and access in the right place at the right time
- People are able to manage well
- People are able to stay well
- Healthy Weight
- Healthy Mind
- First 1000 days of life
- Immunisation in the Community
- Health, well being and care in all policy
- Housing support for mental health
- Working with schools
- Maximising income
- Supporting Carers
- Integrated Care System
- Population health management and evidenced based delivery
- Locality based care model development
- Integrated, multi skilled workforce, IT and estates
- Multi-disciplinary community led support

- Compassionate Croydon
- Prevention, early intervention, early detection
- Self care / self management, Community Led Support, choice and self control
- Active and supportive communities (2 / 6)
- Long term conditions and disabilities focus
- Mental health (4)

(No.) = Supports delivery of Health and Wellbeing Strategy priority areas
(1) A better start in life, (2) Strong, engaged, inclusive and well connected communities , (3) Housing and the environment enable all people of Croydon to be healthy (4) Mental wellbeing and good mental health are seen as a driver of health, (5) A strong local economy with quality, local jobs, (6) Get more people more active, more often, (7) A stronger focus on prevention (8) The right people, in the right place, at the right time

Our Outcomes

Measurement is a critical part of testing and implementing changes. We have developed an outcomes framework that has a balanced set of measures in order to monitor the changes we are making as well as whether they are actually leading to improvement where we need them.

Our challenges have driven our long term (10 year) goals that will demonstrate the health and wellbeing improvements and the infrastructure changes that we need to see.

We have considered the key factors that will have the greatest impact for the residents of Croydon these goals and set (5 year) outcomes accordingly.

To ensure we are heading in the right direction we must keep track of the changes we expect to see annually. We have set out the annual health and well being indicators and the system indicators.

However we cannot be driven solely by delivering these health and well being indicators as this will not lead to transforming the way we work together and deliver support and services across the health and care system.

We have therefore also set transformation indicators that will show we are delivering the health and care system change we need to see.

Measuring Success - Croydon's health and care transformation plan on a page DRAFT

OUR GOALS (10 years)

- Improve **healthy life expectancy** in Croydon from 62 years to 66 years for men and from 62.8 to 66.8 years for women over the next 10 years
- Reduce **premature mortality** from 317 (per 100,000) to 250 over the next 10 years

- Reduce the **gap in life expectancy** from one place to another in Croydon for men from 9.4 years to 7.4 years and for women from 7.6 years to 5.6 years over 10 years.

- **Integrated health and care provision that meets people's aspirations**
- **Increase the proportion of activity in the community:** asset based individuals and communities, voluntary sector, social care, out of hospital setting (further work needed)
- Increase activity in out of hospital settings and reduce unnecessary **acute activity shifted to out of hospital** setting by 2024
- High level measure on the development of local **workforce** with health and social care skills to be developed
- Sustainable **recurrent health and care financial performance**

OUR STRATEGIC OUTCOMES (5 Years)

Improve quality of life

Health and well being

1. More people will regularly engage in **behaviours** that will improve their health
2. More people with physical or mental long term conditions and their families and carers will be **supported to manage their condition well**
3. More people will be able to **live well at home** for as long as possible

Quality and Appropriateness of Care

4. People will have positive **experience and outcomes** of health and social care
5. More people will have their health and social care needs met in the **community**.

Health and well being
1a. Adults taking part in sports and physical activities
1b. Smoking prevalence
1c. Adult obesity
1d. Proportion of people who report good life satisfaction and worth.
2a Diabetes overall clinical care: people with T2DM that receive all 8 point process
2b Diabetes: estimated diagnosis rate of the estimated prevalence of diabetes
2c Dementia diagnosis rate
2d Number of emergency admissions for back, neck and musculoskeletal pain
2e Long term conditions prevalence gap by indices of multiple deprivation
3a Excess winter deaths
3b People who use social care who have control over their lives
3d ASCOF – social care measures. (tbc)
Quality and Appropriateness of Care
4a People with long term conditions feel able to manage their condition
4b Person experience and decision making (tbc)
5a Rate of unplanned hospitalisations aged 65+ for chronic ambulatory care sensitive conditions
5b Deaths which take place in hospital- all ages
5c Delayed transfer of care from hospital that are attributed to adult social care
5d Proportion of people aged 65 and over who were still at home 91 days after discharge from hospital into re-ablement/rehabilitation.
Increased number of community hubs and co-located services in local communities

Enable a better start in life

Increase families confidence in resilience & self care

6. Fewer children will be living in **poverty**
7. More children will have a maximised their **level of development** socially, emotionally and cognitively when they start school
8. More children will be a **healthy weight**
9. Fewer children will suffer **respiratory complications** requiring hospital treatment.

6a. Children in poverty (under 16)
6a. Low birth weight of term babies
7a .School readiness: maximised level of development at the end of reception year
7b. School pupils with social, emotional and mental health needs
7c. Rate of exclusions in primary and secondary school
8a. Excess weight among children in reception year
9a. Admissions for respiratory tract infections in infants aged 2,3 and 4
9b. Unplanned hospital admissions for asthma for under 19
9c. MMR for 2 doses
9d. Flu vaccinations uptake in at risk groups **(is this transformational?)**

Wider determinants

10. Fewer people will be **homeless or living in temporary accommodation**
11. People will live in an **environment that supports health**, connectivity and independence
12. More adults and young people will be **economically active or in education or training**.

10a. Households in temporary accommodation **or reduced homelessness?**
11a .Air quality indicators
11b. Access to healthy assets
12a. Unemployment rate, maximisation of income and reduction in poverty
12b. Employment of people with mental illness or learning disability
12c. 16-17 year old not in education, employment or training.
12d. Increased social inclusion

Integrate health and social care

13. Effective, multi disciplinary teams around the person providing seamless care

14. Increased proportion spent on **prevention** and on **out of hospital**

13. Sustainable health and care provision that meets people's aspirations

13a. Recurrent health and social care **financial balance**
13b 100% use of Croydon **integrated pathways**
13c Reduced spend on **private sector**
13d **Greater market share** of maternity and of planned care in Croydon
14a Reducing **readmission rates**
14b Reducing **length of stay**
14c Lower waste on **drugs**
14d Lower **Do Not Attend rates**
15a Increased **multi disciplinary teams**
15b Higher **productivity** of staff, clinics, theatres, beds, premises.
15c Reduced social isolation

Measuring Success - Croydon's health and care transformation plan on a page DRAFT

OUR TRANSFORMATIONAL CHANGE (Incremental increases annually)		OUR HEALTH AND CARE INDICATORS (Incremental increases annually)
Improve quality of life	Increased coverage of social prescribing Increased voluntary sector and communities in delivering preventative services Increased number **of community hubs and co-located services in local communities** Increased identification of those at risk of and those with a **long term condition** in order to proactively manage their condition	**Health and well being** 1a. Adults taking part in sports and physical activities 1b. Smoking prevalence 1c. Adult obesity 1d. Proportion of people who report good life satisfaction and worth. 2a Diabetes overall clinical care: people with T2DM that receive all 8 point process 2b Diabetes: estimated diagnosis rate of the estimated prevalence of diabetes 2c Dementia diagnosis rate 2d Number of emergency admissions for back, neck and musculoskeletal pain 2e Long term conditions prevalence gap by indices of multiple deprivation 3a Excess winter deaths 3b People who use social care who have control over their lives **3d ASCOF – social care measures. (tbc)** **Quality and Appropriateness of Care** 4a People with long term conditions feel able to manage their condition ***4b Person experience and decision making (to be developed*** 5a Rate of unplanned hospitalisations aged 65+ for chronic ambulatory care sensitive conditions 5b Deaths which take place in hospital- all ages 5c Delayed transfer of care from hospital that are attributed to adult social care 5d Proportion of people aged 65 and over who were still at home 91 days after discharge from hospital into re-ablement/rehabilitation.
Enable a better start in life		6a. Children in poverty (under 16) 6a. Low birth weight of term babies 7a .School readiness: maximised level of development at the end of reception year 7b. School pupils with social, emotional and mental health needs 7c. Rate of exclusions in primary and secondary school 8a. Excess weight among children in reception year 9a. Admissions for respiratory tract infections in infants aged 2,3 and 4 9b. Unplanned hospital admissions for asthma for under 19 9c. MMR for 2 doses 9d. Flu vaccinations uptake in at risk groups
Wider determinants	**Greater engagement** with the wider determinants of health partners Wider determinant partners demonstrably consider the **impact of policy and plans** on health and care	10a. Households in temporary accommodation 11a .Air quality indicators 11b. Access to healthy assets 12a. Unemployment rate, maximisation of income and reduction in poverty 12b. Employment of people with mental illness or learning disability 12c. 16-17 year old not in education, employment or training. **12d. Increased social inclusion**
Integrate health and social care	**Increased the organisational alignment of back office resources** **Increased market share** of maternity and of planned care in Croydon Increased **multi disciplinary teams**	13a. Recurrent health and social care **financial balance** 13b 100% use of Croydon **integrated pathways** 13c Reduced spend on **private sector** 14a Reducing **readmission rates** 14b Reducing **length of stay** 14c Lower waste on **drugs** 14d Lower **Do Not Attend rates** 15b Higher **productivity** of staff, clinics, theatres, beds, premises.

Our programmes of delivery

To deliver our ambitious goals we have developed a number of transformation programmes to lead the implementation of our plans . These do not describe all the work happening in Croydon. They set out our joined up approach to transforming services to achieve our vision. These programmes can be split into two themes:

- Models of care - the way health and care support and services are delivered. We will redesign preventative and proactive models of care that focus on the needs of local communities

- Infrastructure enablers – the way we work together to deliver our goals as well as the assets we have that will make it support delivery of our goals such as our workforce, IT and estates.

KEY
- Priority for 2019/20

PROGRAMMES TO DELIVER OUR INIAITIVES	Stay Well	Manage Well	Greatest Need
Together for Health and Care *Prevention, Early Intervention and Detection*	**Prevention, Early Intervention, Early Detection** ▪ Develop consistent approach to preventing and proactive management of Long Term Conditions and support for people with disabilities ▪ Develop a prevention framework ▪ Review and develop Making Every Contact Count (MECC) ▪ Review and develop Just Be / Live Well ▪ Improve national diabetes prevention programme (Healthier You) ▪ Improve health screening including health checks **Self Care, Self Management and Personal Resilience** ▪ Expand Healthy pharmacy hub model to all areas of borough ▪ Create digital version of the Patient Activation Measure (PAM) ▪ Expand E-Market approach and align with social prescribing **Active and Supportive Communities** ▪ Build voluntary and community sector partnerships through the voluntary and community sector strategy to deliver whole system prevention ▪ Develop Local Voluntary partnerships (LVPs), including social prescribing, Asset Based Community Development (ABCD) ▪ Develop strengths based approaches across disciplines through community led support ▪ Maximise volunteering opportunities		
	Prevention, Early Intervention, Early Detection ▪ Develop proactive digital solutions including use and coverage of Health Help Now , service directory and e-market place ▪ Develop social prescribing at scale across the borough	**Self Care and Self Management** ▪ Systemise medication reviews for people ▪ Expand range of options for diabetes structured education (SE) **Shared Decision Making** ▪ Expand expert patients programme ▪ Expand group consultation at scale across settings and for all conditions ▪ Develop the health champion role ▪ Roll out Shared Decision Making (SMD) toolkit	**Self Care, Self Management & Personal Resilience** ▪ Multi-disciplinary community led support and strengths based approaches for our whole population ▪ "Nudge theory" to guide behaviour and activities ▪ Expand LIFE Proactive Community Referrals ▪ Proactive identification of people in greatest need
Locality Development	▪ Develop our locality based, out of hospital care and proactive interventions model, including social care, housing, welfare and universal support ▪ Implement Gateway Locality Model to strengthen localities in three pilot areas ▪ Implement Primary Care Working at Scale and development of existing Integrated Community Networks ▪ Improve ambulatory emergency care, redesign of the roving GP, increase 111 offering ▪ Improve integration between primary and secondary services, social care and housing ▪ Pathway redesign and process redesign		▪ Support Carers ▪ Extend proactive care management through extended ICNs, Develop LIFE at Scale, Community IV antibiotics and catheter mgmt. ▪ Care homes transformation and Assistive Technology ▪ Transform Falls & Frailty including falls response pilot ▪ Improve End of Life Care ▪ High intensity user programme

Alignment with Strategic Priorities

Improve Quality of Life	Enable a better start in life	Improve wider determinants of health and well being	Integrate health and social care

KEY
- Priority for 2019/20

PROGRAMMES TO DELIVER OUR INIAITIVES	Stay Well	Manage Well	Greatest Need
Better Start in Life	▪ Implement Children and young people's mental health transformation plan ▪ Implement Early Help Strategy focusing developing resilient families ▪ Deliver the All Age Healthy Weight Strategy and pathway ▪ A focus on pre-conception health via Sexual health transformation and facilitating healthy behaviour ▪ Implement the School Superzones Programme ▪ First 1000 days of life ▪ Healthy Weight - healthy weight prevention and early intervention services ▪ Healthy Mind – develop and implement a screening tool ▪ Bringing Immunisation into the community	▪ Redesign paediatric pathway ▪ Expand pathway for A&E Frequent attenders ▪ Promote GP telephone advice line and asthma nursing service	▪ Develop community therapies strategy ▪ Redesign Children's community ASD diagnosis and care pathway
Maternity	▪ Personalised care and choice of place of birth – personalised care plans, increasing midwifery led care ▪ Continuity of care – named lead midwife and buddy throughout a women's maternity journey ▪ Safe care – Multi disciplinary team training on Saving Babies Life's Care Bundle ▪ Multi disciplinary working and working across boundaries ▪ Healthy Pregnancy - Immunisations, Breast feeding strategy, parenting support, live well programme ▪ A fairer payment system		▪ Postnatal care – proactive triage phone calls ▪ Perinatal mental health care - increasing opportunities for identification of those at risk
Adult Mental health	▪ Develop joint mental health strategy to promote good mental health problems and ensure early intervention ▪ Workplace wellbeing ▪ Provide the Live Well Croydon and Just Be services to improve mental wellbeing	Transforming community mental health provision for people with Serious Mental Illness to include: ▪ Enhance Primary Care – seamless service between primary & secondary care; improved support & rapid telephone advice for GPs; new primary care mental health support workers; address stigma of mental health. ▪ Community mental health hubs – common access to primary & secondary care; provision of wide range of services (clinical & social including benefits/housing/employment); link to ICNS. ▪ Improved integrated housing - develop wide range of housing support options (e.g. The Shared Lives Scheme) ▪ Connected communities – information, Local Voluntary Partnerships, including social prescribing directory of services galvanise communities, PIC support ▪ Self harm and suicide prevention strategy ▪ Talking Therapies – improve access to psychological therapies for people with common mental health problems. ▪ Dual diagnosis – substance misuse and physical health of people with mental ill health	▪ Dementia Friendly Croydon ▪ Improve crisis care pathway for people in mental health crisis. ▪ Improve services for women with mental health issues during the perinatal period through enhanced community multi-disciplinary teams. ▪ Reduce physical ill-health amongst SMI population. ▪ Improve training and employment opportunities for people with severe mental illness ▪ Addressing addictive behaviours

Alignment with Strategic Priorities

Improve Quality of Life | **Enable a better start in life** | **Improve wider determinants of health and well being** | **Integrate health and social care**

KEY
- Priority for 2019/20

PROGRAMMES TO DELIVER OUR INIAITIVES	Stay Well	Manage Well	Greatest Need
All Disabilities	**All Age Disability and Adult Social Care Transformation (ADAPT)** ▪ 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 ▪ Transform our provision and workforce to implement locality based, multi agency working achieving seamless care for people with disabilities, with new front door ▪ Children with disabilities –Transforming our practice to provide consistent high quality and proportionate support through childhood and transition to adulthood ▪ People will have Active Lives, that are asset based and co-produced with them, ensuring coherent access and promotes inclusion and resilience for people and their carers ▪ Improve our housing offer to increase homes and housing options for people with complex health and social care needs ▪ Implement digital pathways ▪ Implement Compassionate Croydon ▪ Work and Health Programme ▪ Healthy Places including appropriate housing; accessibility; growth zone	▪ Supporting local integration and provision of services for our local population ▪ Community Led support with strength based approaches ▪ Improving housing options	▪ Neuro rehab development
Wider determinants of health and well being	▪ Implement Health, prevention and early intervention in all policies (housing, licensing, transport, planning) ▪ Implement Air Quality strategy ▪ Development of Growth Zone ▪ Implement Gateway locality model ▪ Implement Homelessness Strategy ▪ Implement School Superzones action plan		
Modern Acute Hospital	▪ Optimising acute pathways and improving integration ▪ Redesign outpatient care ▪ Transforming acute provision including community facing services ▪ Clinically sustainable hospital	▪ Supporting local integrated services through repatriation	▪ A&E transformation

Alignment with Strategic Priorities

Improve Quality of Life	Enable a better start in life	Improve wider determinants of health and well being	Integrate health and social care

KEY
- Priority for 2019/20

PROGRAMMES TO DELIVER OUR INIAITIVES	Stay Well	Manage Well	Greatest Need
ENABLERS **A Croydon Integrated Care System**	▪ Development of an integrated care system design options ▪ Development and implementation of a population health management strategy and function ▪ Business cases for transformation and contracting developments, including shift to outcomes ▪ Integrated organisational functions such as placements, safeguarding and quality ▪ Organisational development ▪ Joint NHS control total and system financial risk share agreement ▪ Total resource sharing and matrix working		
ENABLERS **Others**	**Workforce and OD** ▪ Develop and implement a workforce plan and organisational development programme ▪ Whole system training solution ▪ Deliver culture change ▪ Workforce Well Being **IT and Digital** ▪ Interoperability Phase 1 and Phase 2 implementation – primary & secondary care, community and acute and mental health & social care ▪ IT infrastructure development ▪ Development of effective System IT Transformation Board and work programme **Estates** ▪ Support locality based development including New Addington Health Centre, East Croydon Growth Zone, Coulsdon Health Centre ▪ Improve GP estate ▪ Implement 'One Public Estate' **Communications and Engagement** ▪ Communicate and engage with public, staff and stakeholders that supports the One Croydon" approach ▪ Develop a method for understanind peoples satisfaction and experience of the transformation across the system ▪ Information and signposting ▪ Facilitate public consultations where necessary **Finance** ▪ Develop whole system financial approaches ▪ System Risk Share **Contracting & Procurement** ▪ Design and implement contracts and appropriate procurement processes to incentivise/support models of care		

Alignment with Strategic Priorities

Improve Quality of Life	Enable a better start in life	Improve wider determinants of health and well being	Integrate health and social care