NHS
Croydon
Clinical Commissioning Group

NHS
Croydon Health Services
NHS Trust

Croydon's Integration Journey To Date

January 2020

1.0. Introduction and Context

Croydon is one of London's fastest growing and most diverse boroughs with more than 380,000 residents. Like most regions across the UK, the Croydon health and care system is experiencing challenges. Notwithstanding this, we believe there are also real opportunities for the system to develop and improve for patients and staff.

There are significant health inequalities across Croydon – for example, life expectancy in the most deprived areas of the Borough is up to ten years lower than the least deprived. One in three patients treated in hospital are more suited to a community or home setting and large numbers of patients are currently leaving the Borough to receive elective care elsewhere. This is occurring at the same time as financial pressures across the local health and care system and national workforce shortages.

Croydon has been undertaking considerable collaborative work to address these challenges and take advantage of our opportunities over the last few years, through partnerships such as the One Croydon Alliance, which has resulted in a number of improvements in care to date.

However, to fully overcome these challenges, transformative change continues to be required and in May 2019 NHS Croydon Clinical Commissioning Group (CCG) and Croydon Health Services NHS Trust announced their intention to move towards greater alignment and integration to support the implementation of a 'place-based' model of care. This was seen as the next stage of our journey with further work on integration of health and care to follow.

This is in line with the NHS Long Term Plan and continues a journey of increasing collaboration which began in the Borough more than four years ago.

With the NHS, Councils and other organisations working together, 'place-based systems' have the collective aim of providing more coordinated services to look after the health and care of local people, with care available close to where people live and greater support to help residents live and stay well.

Croydon is in an ideal position for such models with a single provider of both acute and community services, a single co-terminus CCG and local authority and a commitment to integrated working at place level. Although this initial alignment is between two health organisations, this is one step towards further evolution to include other partners in the Borough, building on the success of the One Croydon Alliance. Greater alignment between the Trust and CCG also factors in Croydon's role in the broader South West London area as the six CCGs will become the single NHS South West London CCG and there is also the intent for the South West London Integrated Care System (ICS) to go live from 1 April 2020.

The ultimate goal of greater alignment is to:

- improve the health of the Croydon population;
- provide better quality care for patients;
- improve ways of working and initially return the NHS to sustainable financial balance;
- provide opportunities to combine staff focus on system transformation;
- create a greater range of roles to support recruitment and retention.

We will achieve this by working together to transform clinical services, but also improving organisational alignment and system performance in other areas, including shared functions and governance.

In a first for the NHS, from 1 October 2020 the two organisations share a single Chief Executive and Place Based Leader for Health, Matthew Kershaw who works alongside Sarah Blow, Interim Accountable Officer for NHS Croydon CCG, and also the Accountable Officer for the five other South West London CCGs.

Over time, the alignment of CHS and the CCG effectively see the two organisations operating in a single way across many of our core responsibilities. Key to this model is a single place-based leadership team which is now in place and full alignment across provider services, finance, clinical leadership and strategy and transformation, with executives having responsibilities spanning both organisations. Further work is underway to enhance and coordinate clinical leadership so that it is fully embedded in the future arrangements.

Responsibilities related to commissioning, procurement and contracting will remain a South West London CCG only function to manage any potential conflicts of interest.

As this is not a formal merger, the CCG Governing Body and the Trust Board will continue to exist and be held accountable for their respective statutory duties. However, all key decisions relating to strategy, transformation and finance will be taken at a 'committee in common' made up of executives, clinicians, non-executive input and other stakeholders.

2.0. Timetable

Over the past five years Croydon has worked to develop its integrated approach to health and care. There has been considerable progress over this period as set out below with key milestones identified. Going forward, the proposal is for a Croydon Health and Care Board to be established from April 2020. This will be the forum for health and care discussions and decisions and will start with managing the delegation from the SWL CCG of the Croydon health budget as well as the existing One Croydon Alliance financial agreements. The board will comprise of health and local authority leaders along with lay and patient representatives as per the Trust and CCG governance currently. It will initially be chaired by Dr Agnelo Fernandes and Mike Bell as Chairs of the CCG and Trust respectively and will deal with health business in the first instance, i.e. from April to September 2020. During this time, discussions will be also be progressed about expanding the remit of the committee to also pool social care and health budgets with the potential of a pilot from October 2020 and a phased go live from April 2021. There will also be a review of the board's function and operation so that we can learn from the experience which is largely unique across Health and Care in England.

Some of the key steps over this journey to date and our joint plans include:

- **April 2015** – Croydon Council and NHS Croydon CCG work together to jointly commission a 10 year 'outcomes based commissioning' contract for the over 65s;
- **June 2015** - A provider alliance is selected to deliver this vision consisting of Croydon Council Adult Social Care, Age UK Croydon, Croydon Health Services, South London and Maudsley NHS Foundation Trust, Croydon GP Collaborative;

- **January 2017** – commissioner and provider alliances decide to join forces;
- **April 2017** – One Croydon Alliance agreement first signed by all six partners: Croydon Council, NHS Croydon CCG, Croydon GP Collaborative, Croydon Health Services NHS Trust, the South London and Maudsley NHS Foundation Trust and Age UK Croydon. Initial year agreement to work together for a joined-up service for people over 65 needing health and social care support;
- **September 2017** - One Croydon Alliance launches living independently for everyone, LIFE, service to reduce the need for hospital stays among mainly over-65s with long-term conditions;
- **March 2018** – One Croydon Alliance agreement signed by all partners and renewed for further nine years;
- **October 2018** – Care Quality Commission rates the LIFE team's community reablement service as 'Good';
- **November 2018** – Over 160 members of the public, health and care front line staff, stakeholders and partners come together to shape a joint One Croydon Health and Care Plan;
- **April 2019** – go live with our joint control total and plan for the financial year as well as other changes such as the safeguarding team coming together and the Chief Pharmacist;
- **May 2019** – CHS and Croydon CCG publish partnership working proposal launched at a joint meeting in public opened by Cllr Tony Newman and with support and agreement from NHS England and the South West London Health and Care Partnership. Following sign off from Sir David Sloman for partnership working approach;
- **Summer / Autumn 2019** senior appointments made, work to complete the office of clinical leadership commenced;
- **October 2019** – One Croydon publish their joint Health and Care Plan for the Borough;
- **Winter 2019 / Spring 2020** – preparations to go live including discussions with Primary Care Networks and Local Medical Committee to ensure primary care input;
- **March 2020** – proposed go live for Thornton Heath ICN+ pilot;
- **April 2020** – go live with place based committee, linked to single South West London CCG which helps address any potential conflicts of interest, potential ICS go live and our next joint plan and control total;
- **September 2020** – review of board working to date and potential pilot for social care integration in terms of budget;
- **April 2021** – plan for integration to total place.

3.0. Outputs of the work to date

Based on our collaborative working in Croydon and the experience gathered from other integrated care work across the country and internationally, there are three key elements to integration to

deliver on a vision that is owned and supported by all partners. They are working relationships, new ways of delivering services and the underpinning governance arrangements.

3.1. Relationships

A fundamental element of integrated working is a set of strong and positive working relationships based on trust, honesty and openness. This is crucial as without this the challenges inherent in working across boundaries will undermine progress and prevent changes in services. One of the key steps to achieving this is the development of a single place-based leadership team, with full alignment across provider services, finance, clinical leadership and strategy and transformation, with executives having responsibilities spanning both organisations. It should be noted that some responsibilities will continue to be separate to manage any potential conflicts of interest.

An integrated leadership team has been appointed, this includes a joint Chief Executive & Place-Based Leader; Joint Chief Nurse; Joint Chief Finance Officer, Joint Director of Strategy and Transformation and a Joint Chief Operating Officer.

The Safeguarding team and the Pharmacy team across both organisations have aligned themselves, led by joint leaders, to provide greater combined expertise and strengthen services. Where appropriate, further teams will be aligned across the two organisations and/or joint CHS / CCG teams will be developed.

To build further on the integration work between the CCG and the Trust we have started a new approach to management team meetings. In essence, rather than run separately an Executive Management Board at the Trust and a Senior Management Team meeting at the CCG we will create a Health Management Board focussing on operational decision making, input to strategy and transformation, operational policy sign off (for appropriate issues locally) and overarching performance management and review for us in Croydon. Attendees at this meeting will be the system executives, Trust Clinical Directors, Dr Agnelo Fernandes as CCG Clinical Chair, Rachel Flowers as Director of Public Health supported by the communications leads at the Trust and CCG and Company Secretary. There will also be a quarterly Leadership Conference which will include a broader range of clinical and managerial leaders across the CCG and Trust demonstrating the expanded role of clinicians in discussing and leading change going forward.

Furthermore, a number of shared forums across assurance and decision making have also been developed. This includes a Quality Committee in Common and a Finance, Investment and Transformation Committee in Common (in common with the Borough Committee). The latest development is the People and Place Committee with the first meeting held in November 2019.

The vision for the Croydon system is: ***Working Together for a Healthier Croydon***. Arising from this is an Organisational Development and Engagement work stream focussed on developing a common vision and purpose at Board and executive level across both organisations. The King's Fund was engaged and has been working with the executive teams throughout 2019. They have supported them with:

- exploring the opportunities and risks associated with the integrated system and agreeing a collective strategy for an integrated system;
- developing greater alignment between the governing bodies, working towards an integrated approach to governance and an operational delivery plan;

- developing closer relationships and increasing collaboration and trust between system leaders;
- identifying and resolving the leadership challenges presented by the change;
- developing a collective narrative for change which is compelling and understood by stakeholders;
- identifying and promoting the values and behaviours driving integration

The Croydon vision, and the strategy to achieve it, now needs to be cascaded down to the next level of management within the CCG and CHS. Organisational barriers and silo working practices need to be broken down to remove conflicting priorities in the system so that staff are working with rather than against each other.

Ensuring that the next level of leaders within the organisations are clear about the vision, the strategy and how they can work in an integrated way should ensure that they can share accurate messages with their staff and there is consistency of messaging and approach.

Underpinning the above is the need to develop and embed a longer-term OD programme to support a joint CCG / CHS culture, agreed behaviours and ways of working. A draft OD plan is currently in development under the following headings:

- **Capacity** – right professional, right grade, right place: maximising new roles and new ways of work;
- **Capability** – competent and capable individual teams with the right values and behaviours;
- **Culture** – best in class leadership, people and change management.

The OD plan will be performance managed through the People and Place Committee.

Relationship building has also been a fundamental element of the One Croydon work and positive work across all partners has been evident since its inception. To build on this the Council and new integrated health team have arranged for a joint session to discuss how we work going forward and a wider workshop will follow to explore this in more detail. In addition, the Director of Commissioning from the Council is now an integral part of the health team working in a joint capacity across health and care. Similarly, work with the new Primary Care Networks, GP Collaborative and Local Medical Committee, is developing positively, reflecting the crucial nature of this input to the overall initiative. The formalisation of this and other work including with the voluntary sector as well as patients and the public as co-producers will be a focus going forward as a crucial element of our ongoing relationship building.

3.2. New ways of delivering services

In April 2018, One Croydon developed the Croydon Health and Care Plan to maximise the value of our partnership and work together to transform the way we deliver services. It outlines a fresh vision for how health and social care will be delivered across the Borough, particularly for those with the greatest need, to transform the health and wellbeing of local people. The plan, which covers the period from 2019/20 – 2024/25, emphasises three clear priorities:

(i) **Focus on prevention and proactive care**: supporting people to stay well, manage their own health and maintain their wellbeing by making sure they can get help early.

(ii) **Unlock the power of communities**: connecting people to their neighbours and communities, who can provide unique support to stay fit and healthy for longer.

(iii) **Develop services in the heart of the community**: giving people easy access to joined up services that are tailored to the needs of their local community

Our Programmes of Delivery

The delivery of our priorities is underpinned by several transformation programmes. These do not describe all the work happening in Croydon, they set out our vision for a joined-up approach to transforming services. These programmes can be split into two themes.

(i) **Settings of care focusing on the whole population:** The locality development programme is responsible for the co-ordinated development of integrated, locality-based care, designed around the needs of communities. The modern acute care – physical and mental health programmes aim to ensure high quality care as part of the wider integrate health and care system.

(ii) **Pathway programmes:** These focus on the customer journey for specific groups to ensure the integration of services delivers for the whole population including the preventative and proactive care programme, better start in life programme, better mental health and well-being, better life for people with disabilities programme, better outcomes for over 65s programme and better end of life care programmes.

The difference we are making

Over the past few years we have made many improvements. Working together has meant people have had greater opportunities to feel more connected to their communities whilst supporting their health and wellbeing by piloting and implementing social prescribing.

We have made available a Personal Independence Co-ordinator (PIC) for people needing individualised support to help develop 'My Life' Plans. Delivered with Age UK Croydon as part of our One Croydon Alliance, the PICS are enabling older people, to keep well and enjoy a better quality of life, with up to 16 weeks of dedicated support and visits. PICs work with each person to set and meet personal goals. These range from health changes, like joining a weight-loss programme, through to socialising more by attending a community group, or practical help with transport so they can make trips into the local area.

People have better access to improved health pathways of care, such as improved access through new use of technology and through integrating the GP and hospital musculoskeletal (MSK) services and more work across professionals to work proactively to reduce need. People have had better access to general practice by offering pre-bookable routine appointments at GP hubs.

Over the next two years we will focus on:

- **Preventing or delaying people developing long-term conditions**, such as vascular disease or diabetes, through screening and the management of those at risk. There will be integrated one-stop access points for mental health and wellbeing in Croydon where a person can drop in and chat to a team member in a café area. An expert navigator can help with a range of issues including helping people to access benefits and housing support.
- **Helping people to manage well,** such as developing social prescribing so all GPs, nurses and other primary care professionals will be able to prescribe to a range of local, non-clinical services, helping people to improve their quality of life and emotional, mental and general wellbeing, as well as levels of depression and anxiety.

- **When people do need acute care** they may be seen in the hospital or if appropriate in the community. Identifying alternative outpatient arrangements and technological solutions to improve elective care services and referral pathways will support the reduction of unnecessary outpatient appointments and increase their effectiveness. Improving access to elective care services, enabling shorter waits for planned care and ensuring patients receive diagnosis, treatment and care in the way that is most appropriate for them, first time, every time; and enhance clinical quality in elective care, leading to improvement in patient outcomes and improved quality and quantity of life.

- **Helping those with greatest need** by continue to develop the work of our Dementia Action Alliance to make Croydon a compassionate place to live and work for people with Dementia and their carers, extending this to those with Autism and disabilities.

- **Developing active and supportive communities.** There will be a community approach to social care, which will help people to use their own strengths and capabilities and consider what support might be available from their wider support network or within the community. Local Voluntary Partnerships will help to promote collaborative working among voluntary groups that provide support to local residents by promoting self-care, reducing social isolation and promoting independence.

- **Developing locality-based care, tailored to local needs.** Maximising the expertise and the resources available to look after the health and care of people within the neighbourhoods in which they live. Known as Integrated Care Networks+. The networks 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. There will be a range of health and care services in community spaces such as libraries and there will be new health and care wellbeing centres in New Addington, East Croydon and Coulsdon. We will have a number of hubs and networks of buildings and spaces bringing different professionals together to offer a range of services such as supporting children and families with their needs. (see 3.2.3 for more detail)

Working more closely with wider determinants of health. By working in a more joined up way as partner organisations and in particular with town planners, schools, colleges, transport, and businesses providing jobs we will be able to create a healthier Croydon that enables our citizens to lead healthier lives.

Six examples of real change

To demonstrate the range of initiatives now underway, the following sections focus in more detail on 6 areas where real change is starting to happen.

3.2.1. Urgent and Emergency Care with LIFE team

The Living Independently for Everyone LIFE service is a community-based team made up of staff drawn from across health and social care. The team work together to prevent the need for people to go into hospital, to support discharge from hospital after a stay is needed and to support people to get back on their feet afterwards.

The team includes Community Nurses, Physiotherapists, Occupational Therapists, Social Workers, Health and Wellbeing Assessors, Reablement Support Workers and the Voluntary sector. It provides intensive and proactive support for up to six weeks at times of high levels of need, focused on helping the person get back to the best possible state of wellbeing and independence. This is called reablement.

A discharge to assess process is in place which means that people can go home when they are ready, rather than waiting for an assessment for reablement support in a hospital bed.

The LIFE team will arrange for a care worker to visit as soon as possible after hospital discharge, usually within two hours of a patient arriving home, to help them settle in and ensure that there are no problems. Within 24 hours of arriving home, an assessor from the LIFE team will visit and agree a more detailed care plan. They will assess the potential for reablement and agree the goals the person wants to achieve over the next few weeks with the service. The team will make sure the home is as safe as possible and enables the person to become independent.

Within the hospital, the LIFE A&E Liaison team assess people who could go home with the appropriate care and support, rather than being admitted to hospital. The work of the A&E Liaison team avoided 992 hospital admissions between April and November 2019 and the LIFE service as a whole has already exceeded its admissions avoidance target for this financial year.

A review is underway to assess the positive outcome for Croydon residents and ensure the financially sustainability of this service.

3.2.2. Elective repatriation and transformation of elective pathways

The Elective Transformation programme was established following a benchmarking exercise to map patient activity and financial flows within the Croydon health system and in the surrounding areas. With strong performance in referral to treatment (RTT) at CHS, opportunities were identified to 'repatriate' Croydon patients who have historically chosen other providers for planned care services available within the Borough.

The aim of the elective transformation programme has been to enhance local service provision and support improvement in patient experience. The programme also aims to ensure access to care and associated information is swift and seamless for both patients and referrers to support our ambition to make CHS the provider of choice for Croydon people.

The key initiatives that were established to deliver this programme are summarised below:

- Set up of the Blue Button to support clinical requests and advice and guidance for GPs from hospital consultants;
- Establishment of the Call Centre which offers Patient and GP Helplines respectively;
- Hosting of an appointment booking service at CHS;
- Specialist Consultant-Led Clinical review;
- 48 hr electronic triaging;
- Contacting and booking patients into appropriate clinics/hospitals;
- Establishment Charter for Collaboration across primary and secondary care clinicians;
- Set up Clinical Ambassadors senate between primary and secondary care clinicians to work through challenges across clinical specialities;
- Working with other providers to facilitate swift access to care locally.

An interim joint system Deputy Director post across the CCG and CHS supported by dedicated primary and secondary care clinical leaders was established to provide programme leadership and ensure delivery of the objectives of the programme.

The following outcomes have been achieved by the programme:

- Blue Button available across 19 specialities;
- All 50 practices using the blue button – 95% referrals via the blue button;
- CHS market shared increased from 71% to 80%;

- 80% of calls are answered within 20 seconds;
- RTT performance across majority of the specialities is above 92%. CHS performs surpasses most of the London NHS providers.

Integrated Models of Care

New models of integrated care improve outcomes and offer improved efficiencies. A number of elective care integrated models of care have been designed and are at various stages of implementation.

Common principles upon which the planned care integrated models have been based are:

- Swifter triage and access to care for a range of hospital and community-based services across the Borough – delivered through a single point of access.
- Improved access to prompt expertise for primary care in the assessment and treatment of people.
- Improved communication between specialist clinicians and GPs and IT integration.
- Improved primary care education through effective clinical leadership.

The Integrated services commissioned to date are outlined in the table below.

Integrated Acute and Community Service	***Prime contractor***	***Sub-contractor***	***Implementation stage***
Dermatology (CroyDerm)	CHS	Croydon GP Collaborative (CGPC)	Launched April 2019
ENT (CINEAS)	CHS	Communitas	Launched May 2019
Anti-coagulation (CICAS)	CHS	CGPC	Launched 1 October 2019
Integrated ophthalmology service	Moorfields	Complete Ophthalmic Services	Launched 1 October 2019
Integrated diabetes service	CHS	NA	Launch scheduled for 1 July 2020

Qualitative feedback from both patients and staff members involved in integrated partnerships i.e. between CHS and CGPC and Communitas and Moorfields and COS is that the improved partnership working is helping to support a more seamless pathway for patients.

Friends and Family tests for over the last 6 months for both ENT and Dermatology indicate 98% and 92% satisfaction level respectively and work will continue to further improve this and other key metrics.

3.2.3. Integrated Community Networks Plus (ICN+)

In our Health and Care Plan, we set out how we will deliver preventative and proactive care for the whole population. Our approach centres around community services across health and social care, organised in six Croydon localities, supported by wider services like housing.

What's the problem being solved?

We have made great strides through our One Croydon approach, but too often, the focus remains on treating people when they become sick, rather than supporting them to stay well. We want to support people in the community so that they are as healthy as possible and reduce the need for people to go to hospital or become dependent on Adult Social Care services.

There are still barriers to fully integrated working and we want to develop seamless ways of working across health, social care and the voluntary sector.

What is our starting point?

We are building on the first phase of the One Croydon transformation programme when we introduced Integrated Community Networks in our six Croydon localities. These are:

- East Croydon
- Purley
- New Addington and Selsdon
- Mayday
- Thornton Heath
- Woodside and Shirley

Integrated Community Networks bring together multi-disciplinary teams in regular 'huddle' meetings in GP practices, supported by a Network Facilitator for each of the six areas.

The huddles work together to proactively plan care and support for people at risk of escalating health and care needs. Social work teams have reorganised to match the six networks and Personal Independence Co-ordinators (PICs) have been employed by Age UK Croydon as a key part of the huddle team. The PICs work with older people to help keep them independent and well at home, as well as linking them in with the local community and voluntary sector.

The first phase of Integrated Community Networks (ICN), along with our other projects like the Living Independently for Everyone (LIFE) service, helped to bring down emergency hospital admissions for adults by 18% between April 2017 and September 2018.

The next phase, Integrated Community Networks Plus (ICN+), goes further to encourage communities to support themselves and each other and to enable services in a locality to help people in a more holistic way, by professionals across health and social care working together more seamlessly.

What is ICN+?

Integrated Community Networks Plus is our way of delivering health and care in the community across Croydon's localities. It starts with the community and the assets that people can access around them - this is our Community Led Support approach.

We are helping to connect people in their communities through:

- setting up drop-in 'talking points' at community venues;
- supporting grassroots community activities through our Local Voluntary Partnerships programme; and
- social prescribing.

ICN+ also brings together teams of professionals across health and social care to focus on the particular needs of the community in a locality. This is a different way of working because staff from different disciplines will become one team. This will help staff to focus on people's individual needs in a more holistic way, rather than someone 'doing their bit' and handing them on to another team and will become for patients of all ages over time.

What is happening?

Thornton Heath is the first adopter in the phased implementation of ICN+ across the Borough. We used population health data to understand the specific needs of people living in this area, as well as setting up a community reference group to understand residents' views.

A 'Talking Point' has started running every Monday morning in Parchmore Community Centre, where the Food Stop is also held with access to discounted food. Residents can drop in without appointment to talk to Age UK, Adult Social Care, DWP and other partners. People can get healthy living support, housing and benefits advice and connections into community activities. We are testing the use of a case finding model to identify people who might benefit from being invited to come to a Talking Point.

We are recruiting an integrated manager to work across the ICN+ team, managing both health and social care staff. A comprehensive training and OD programme for the multi-disciplinary team is starting and the team's integrated operating procedure is being drafted so that staff from different disciplines are clear about how they work together.

MDT meetings of the ICN+ team will take place from February and a touchdown space in Thornton Heath is being set up with appropriate IT facilities, so that the team have a space to work collaboratively across disciplines, without the delay and bureaucracy of referrals and emails.

The plan is for the Thornton Heath work to go live from March and we will then reflect on and adjust the model of care, as we start to roll out this approach to the rest of the Borough during the next year.

What is the expected impact?

Through ICN+, we hope to achieve increased wellbeing, resilience and independence for people in Croydon and a reduction in health inequalities. We expect to see a reduction in hospital admissions and eventually, through the Community Led Support approach a reduction in demand on Adult Social Care services.

3.2.4. Joint Chief Pharmacist and a joint pharmacy team

The CCG's previous Chief Pharmacist retired in August 2017, and the CCG took the opportunity to review the medicines optimisation team structure in light of the aim to transform services and improve integration with Croydon Health Services where appropriate.

At the time there were no suitably graded internal candidates and there was also a question of whether recruitment for an external candidate would be successful.

There was already considerable joint working between the two teams at a senior level and joint representation on Croydon Prescribing Committee, and the both Chief Pharmacists shared a similar vision of how medicines optimisation services might be developed across the interface. It was therefore proposed that the Chief pharmacist role of both organisations be joined, underpinned by additional infrastructure in both departments.

Process

A paper agreeing finance, governance and role was submitted to executive committees at both organisations, and a memorandum of understanding drawn up to ensure responsibility, accountability was clear, and also included a process for conflict of interests, should there arise.

This model was also discussed with NHSE Senior Pharmacists and the Chief Pharmaceutical Officer for England and Wales and received favourable feedback.

Opportunities

Better patient experience/care relating to access of medication on transition between hospital, community and primary care.

Greater links between the pharmacy departments and therefore opportunity for joint working and expanding on the initiatives already in place.

Better understanding of medicines management across the two sectors and therefore potential for improvement.

Better understanding of GP requirements relating to medicines management in order to improve two-way communication between the sectors.

Potential increased opportunities for savings across the whole health economy.

Examples of success

Since the creation of the post, both pharmacy departments have begun to work more closely, relationships have been established that were either non-existent or remote. This has resulted in quicker resolution of interface issues that sometimes arise between primary and secondary care, thereby providing a better experience for patients.

We have also developed the Integrated Community Network (ICN) pharmacy team, who were originally employed by the CCG, and therefore service provision limited by the remit of being employed by a commissioning organisation. In Q1 of 2019/20 the ICN team of pharmacists contract moved to CHS, providing greater scope for service development. Since being employed by CHS, the team now have access to both electronic patient records in primary and secondary care, and functionality of EMIS community has been developed to better record the service interventions, overall resulting in more efficient and effective care for the patients they see. The team have the capacity to see over 100 domiciliary patients per month.

There has also been work undertaken to increase the visibility of workplans and strategy of both departments. The CCG employed practice based pharmacists have presented the annual workplan at hospital pharmacy team meetings to ensure our hospital pharmacist are aware of any changes to prescribing in primary care and thus be able to support any initiative that might be influenced by secondary care.

QIPP and CIP plans worked now integrated, and this has resulted in challenging targets being achieved (combined £2.3m achievement). The senior pharmacy teams across both organisations now meet regularly to monitor workplans and agree new schemes. The creation of a single joint control total for the medicines budget has removed some barriers and allowed for better pathway to allow patients access to medication, for example, subcutaneous methotrexate.

An unexpected advantage of the post across SWL was to provide interface between SWL CCGS and Trusts – the Joint Chief Pharmacist is frequently able to provide opinion or commentary to better inform the development of procedures and policy having gained insight into the working both commissioners and providers.

Further developments

Joint Control Total - there will be further investigation of opportunities of efficient use of medicines across both primary and secondary care e.g. stoma and incontinence products, dressings, oral nutritional supplements.

ICN Team – the role of pharmacy within community services with be developed, such as implementing role Blood Pressure monitoring using the ICN team, and researching the use of a pharmacy technician to administer medication whilst supporting patient to take over their own administration in order to release district nursing time. There is also the potential to train pharmacists as prescribers to support the developments within community services e.g. complex care, falls.

The Chief Pharmacist will also be looking at further integrated posts to help support the transition between secondary and primary care and preventing admissions as well as work with community pharmacists.

3.2.5 Joint safeguarding team

Croydon Health Services and NHS Croydon CCG safeguarding services came together under one management structure in the Spring of 2019 to form the Croydon Health Integrated Safeguarding Team (CHIST). CHIST provides a joined-up approach to safeguarding, maximising resources, with a focus on vulnerable adults and children, including pre-birth and children looked after (CLA).

This has created a service with a significant level of expertise and a vision to develop a highly effective and robust model of safeguarding.

There have been significant improvements and achievements since CHIST was introduced and include:

- Improvement of health outcomes for CLA through the increased oversight of CLA services, the development of new pathways, improvement in compliance with statutory requirements for health assessments, more understanding of the health needs of CLA and a more developed approach to collaborative working with partners.

- Continuous improvement in CHS compliance with the Mental Capacity Act (2005) requirements. This includes increased quality assurance support delivered to frontline staff from the adult safeguarding team. Work is under way to meet the requirements of Liberty Protects Safeguards (LPS) which will replace Deprivation of Liberty Safeguards (DoLS) later this year.

- Improvements in the safeguarding learning and development model, enabling staff to have more understanding of how best to support vulnerable and at risk clients and patients whilst also improving compliance with statutory requirements.

- Development of an integrated Quality Assurance and Performance Framework that additionally reflects the requirements of the NHS contract.

- Promotion of the 'think family' agenda including the launch of the safeguarding duty desk as a single point of contact for concerns relating to adults, children and maternity.

- The response to the CQC Children Looked After Safeguarding (CLAS) review which was completed in February 2019 and explored the effectiveness of children looked after and safeguarding arrangements. The collaborative response to the findings of this review demonstrated significant improvements with the CQC signing off the action plan in January 2020.

The development of the CHIST model has strengthened the arrangements for safeguarding embedding it further within its business as usual activities. However, recruitment and retention remain an issue with vacancies across the service. While posts are being successfully filled, this has caused some disruption to the stability of the workforce and the focus will now be on supporting the development of a stable and cohesive team.

3.2.6. Single Financial Control Total

Croydon Health Services (CHS) and Croydon Clinical Commissioning Group (CCCG) began working more closely together throughout 2018/19. The construct of the contract for 2019/20 allowed both organisations to move from transactional negotiations about money to transformational delivery of quality and service changes for the benefit of patients. This laid the foundations to agree for 2019/20 both an overarching block contract and joint control total, with appropriate sharing of risks.

This financial alignment has removed planning barriers for 2019/20, enabling more robust service planning. A statement of intent was developed together which informed the CCG's commissioning intentions and now QIPP and CIPs are being jointly developed.

Both the CCG and the Trust are planning together for 2020/21 with a joint control total of £2.3m deficit. Risks are being mitigated through:

- Integrated senior Management Team including joint CFO across both the Trust and the CCG;
- Rationalised meetings and governance structures including quality, a single PMO oversight for Croydon health system, as well as integrated delivery teams (e.g. planned care, emergency care);
- Joint governance for oversight of the CIP / QIPP savings programme - Cost & Quality Operational Board (CQOB);
- Increased transparency on risks, opportunities and barriers to progress;
- Joint month end accounting process;
- Integration of CCG Governing Body and Trust Board.

3.3. Governance

As described in the timetable section, 2.0. above, the governance of the integration in Croydon has developed over time and will continue to do so over the coming months. Starting with the One Croydon Alliance agreement in April 2017 and the Memorandum of Understanding signed by Croydon CCG and Croydon Health Services in May 2019, the governance has developed to reflect the needs of the work and the priorities at the time.

We have now introduced a joint executive team across the CCG and Trust and will by end of January 2020 introduce a more formal Health Management Board for joint executives and clinical leaders to meet and manage the work of the CCG and Trust on a monthly basis. In addition to this a Health Leadership Conference which will include much wider representation of Trust and CCG leaders and key staff from the wider system will commence in March 2020 to discuss strategic and developmental issues as we progress our work as an integrated team.

From April 2020, the new Health and Care Board will be established. Initially this will manage the delegation from the SWL CCG of the Croydon health budget as well as the existing One Croydon Alliance financial agreements. The board will comprise of health and local authority leaders along with lay and patient representatives as per the Trust and CCG governance currently. It will initially be chaired by Dr Agnelo Fernandes and Mike Bell as Chairs of the CCG and Trust respectively and will deal with health business in the first instance, i.e. from April to September 2020. During this time discussions will be also be progressed about expanding the remit of the committee to also pool social care and health budgets with the potential of a pilot from October 2020 and a phased go live from April 2021.

In addition to our local alignment, the CCG is also working with the other five CCGs in the area with a view to merging from 1 April 2020.

In October 2019, the GP memberships and Governing Bodies of the six South West London CCGs (Croydon, Kingston, Merton, Wandsworth, Richmond and Sutton), voted in favour of merging into a single CCG for South West London.

The single CCG will be known as NHS South West London CCG and following a formal application to NHS England, national approval for the merger was given on 18 October 2019.

In coming together, the aims of the six CCGs are to:

- Move from the purchaser/provider split into integrated care systems;
- Build on the successes that our working together has delivered for patients
- Reduce duplication to invest in frontline services;
- Ensure that care is planned and delivered locally, with strong clinical leadership;
- Invest in new primary care networks of GP practices and ensure that GPs receive the same level of support, or better.

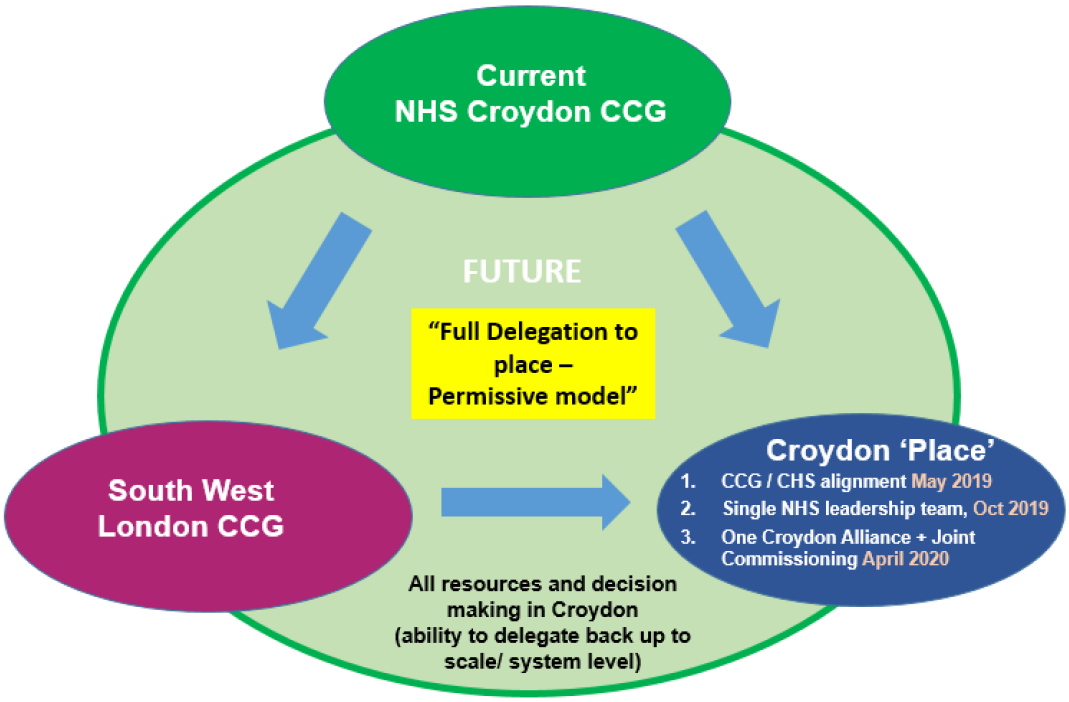
The SWL CCG Governing Body supports our work to establish a Croydon Borough Committee which we are designing locally as the Croydon Health and Care Board. The key elements of this Board are;

- Full delegation to Croydon Local Committee of the SWL CCG;
- GP clinical majority on local committee;
- Decisions relating to local care in Croydon will be made in Croydon with partners;
- Responsible for all resources and decisions;
- Freedom within SWL for Croydon to continue to innovate, integrate and improve patient outcomes and performance at a faster pace than the other boroughs/places;
- Delegate the 5 year allocations for Croydon population to Croydon Place;
- Local decision making on primary care;
- Croydon Place will be required to contribute financially to SWL wide initiatives, corporate costs, and risk pools which are yet to be determined;
- Ring-fencing primary care/PCN investment including recurrent and non-recurrent funding;
- Meeting the national requirement for mental health investment.

Phase One: Place Level Governance from 1 October 2019 to March 2020

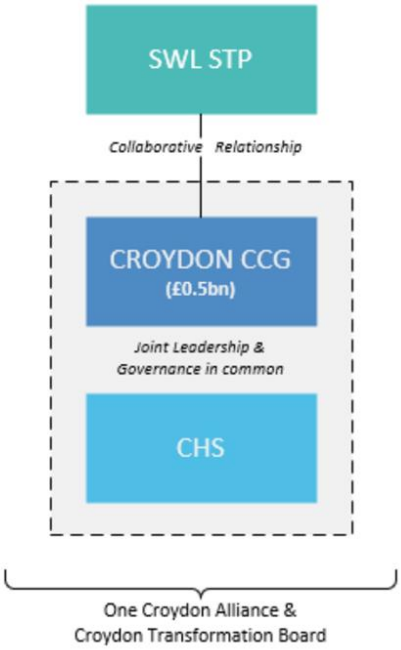
Our aligned work between the Trust and CCG Governing Body will manage the joint control, resources and decision making for both of our organisations.

Full delegation from South West London CCG to Croydon Place in accordance with SWL accountability agreement



These arrangements include:

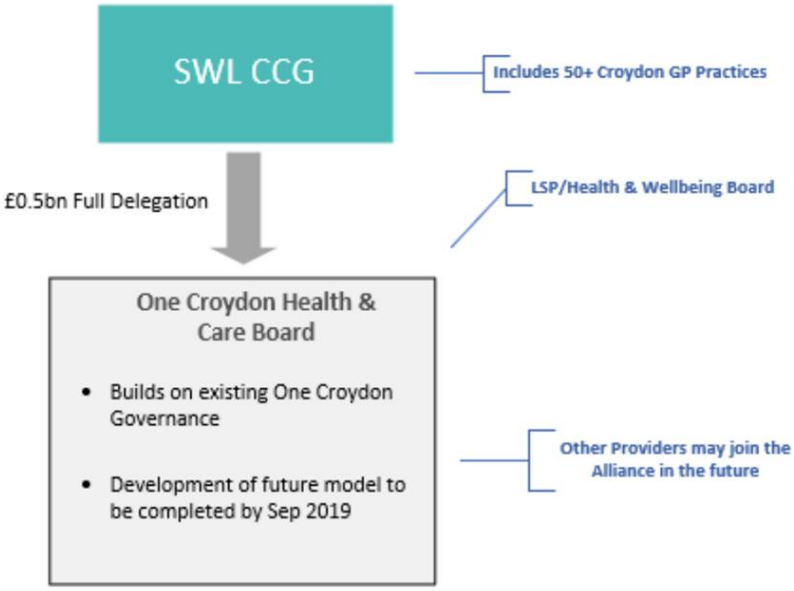
- CCG GB and CHS Board meeting in Common and Sub Committees in Common with joint financial and performance priorities
- A single place leader for health appointed
- Single executive team across the two organisations with joint responsibilities
- Responsibility for managing resources, strategy, planning and improvement
- Establishing aligned delivery structures
- Facilitates closer alignment as part of One Croydon's journey towards integrated health and care at a Place level



Phase 2: Place Level Governance from 1 April 2020

One Croydon Health & Care Board, which will build on the success of the Croydon Transformation Board, will manage the delegated health and care joint control total, resources and decision making. Croydon's governance arrangements will be:

- Delegated responsibility to make decisions on the agreed delegated budget
- Integrated budgets to include health, social care, public health, other trust income, mental health and primary care provision
- Governance arrangements to be co-designed with our partners



Within this model, SWL will retain the following accountabilities and responsibilities:

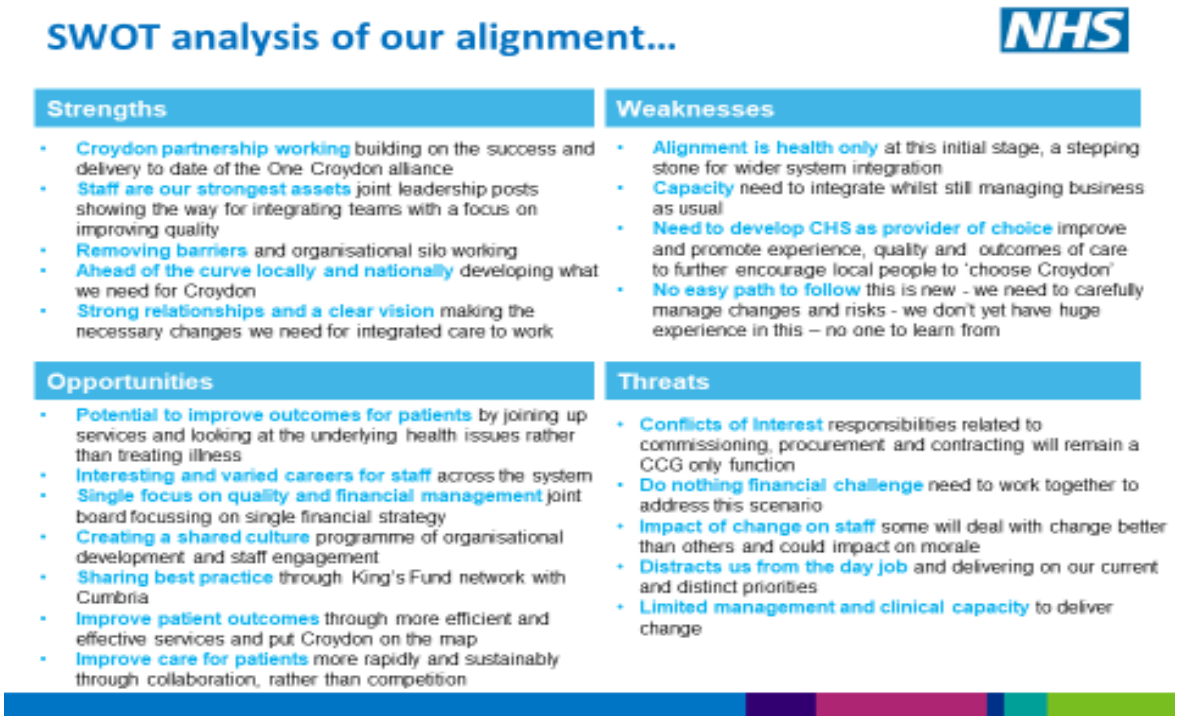
- CCG overall accountability and assurance;
- Support to manage Place conflicts of interest e.g. procurement;
- Tertiary and Most Specialist Care
- Working at scale – e.g. Digital, Estate, Workforce (which will also have a focus at place)

Phase 3: Total place arrangements

Commencing with a shadow approach, it is anticipated that the remit of the Health and Care Board will be expanded to include some pooling of social care and health budgets. If agreed a pilot would start in October 2020 and a phased go live from April 2021. This will be a key element of the work of the Health and Care Board when it goes live in April 2020.

4. Conclusion and next steps

Croydon as a place has already made significant progress with integrating its way of working and has started to change how some of our services work thereby driving improvements for patients, the public and staff. This is challenging work and there are strengths and weaknesses in what we have done and opportunities and threats in the future. Some of these are set out in the SWOT analysis below.



Going forward our focus will be on maximising the strengths and opportunities whilst mitigating the weaknesses and threats and this will be the focus of our work over the coming months.

In terms of content, progress with establishing the Health and Care Board with the necessary clinical and managerial relationships is crucial as is the work on transforming pathways of care. The Health and Care Plan highlights those areas where we believe we can have the biggest impact on by working together. Highlights from our plans within the 6 priority areas of the Health and Care Plan include:

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 multiagency 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.

By working together and building on the real progress made to date, we believe we can truly transform the health and care of Croydon