Health and Care Plan Refresh

- **The health and care plan can be found here: https://www.croydonccg.nhs.uk/get-involved/croydon-health-and-care-plan/Documents/4326v14_NHS_One_Croydon_Heath_CarePlan.pdf**

The Original Plan on a page is shown on slide 2.
The Plans can be found in the appendices from page 30

- We are setting out our progress against plans – the early sight of this is presented in slides 4 &5
- We will refresh the plan by October 2021:
  - Identify draft priorities for your area of focus
  - Articulate draft priorities for your area of focus by 16th July
  - Take part in the engagement event on the 27th July
  - Sign off – October

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

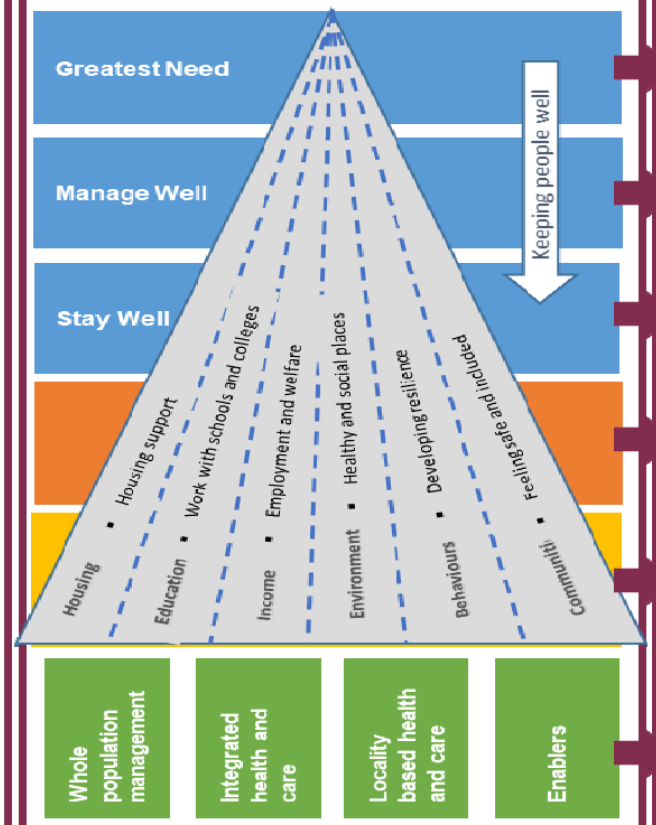
A sustainable health and care system
- Affordable models of care delivering improved outcomes

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)



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 One Croydon Health and Care Plan on a Page

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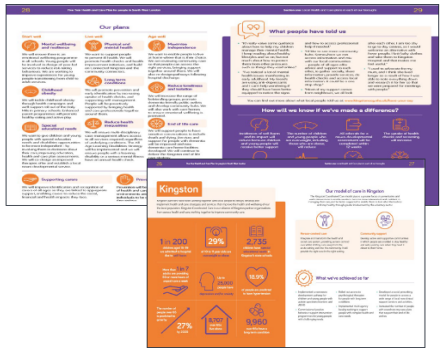
Refreshing the Plan

Developing refreshed Place based Local Health and Care Plans

- Two year plans were developed by all boroughs in Autumn 2019 following local health and care events.
- We have signalled to each Place based transition team that reviewing existing local health and care plans should be a key priority
- It is proposed that plans should be reviewed and refreshed by Place based transition teams over the next 6 months and finalised by the 1st October 2021
- We propose that revised Health and Care plans should cover the period 1st October 2021-31st March 2023
- We now propose to begin a dialogue with local transition teams about what they should cover and how they might be produced



Led by the Transition Team

Deadline 1st October

Cover period Oct 21-Mar 23

Address inequalities

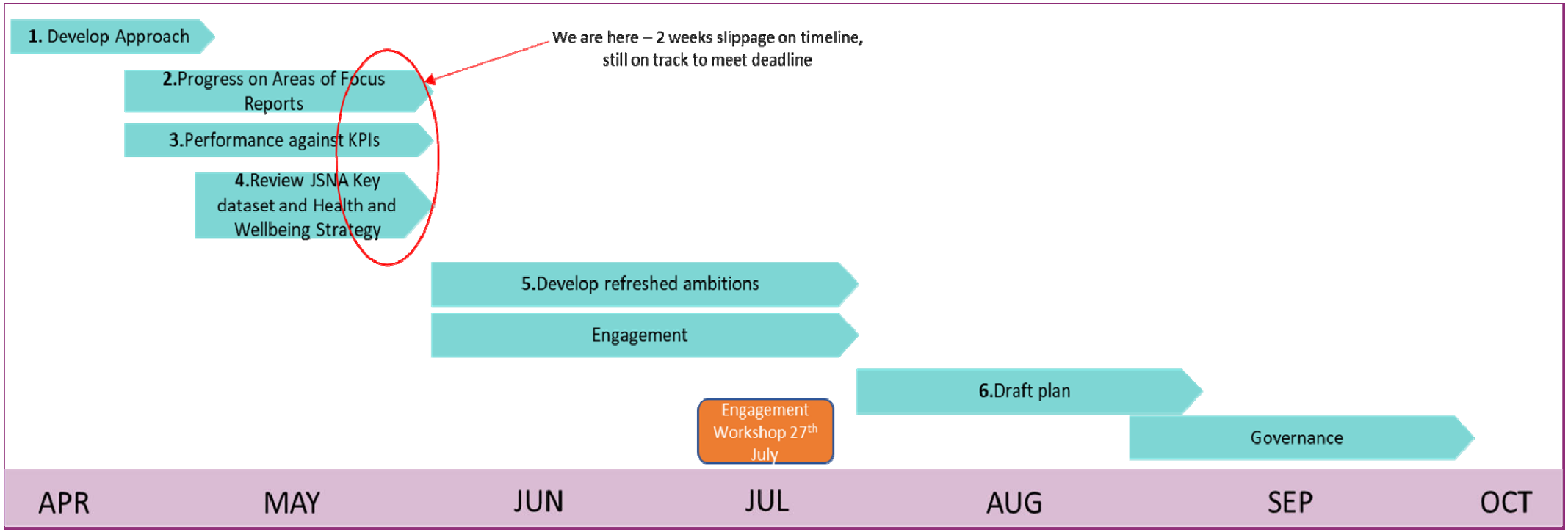
Progress over the last 12 months

Refreshed ambitions and local priorities

What might refreshed Local Health and Care plans cover ?

- ✓ What they have achieved over the last 12 months including an update against key indicators in the SWL five year strategy
- ✓ How they will meet their local population needs (as per JSNAs) and existing health and well-being strategies
- ✓ Refreshed ambitions for each place and setting out local priorities
- ✓ How their plans will address local health inequalities and steps they will take to support the South West London Equality, Diversity and Inclusion programmes objectives
- ✓ How they will deliver any emerging national must-do's (from any future operational planning guidance)
- ✓ How they will make a local contribution to health, social and economic development to prevent future risks to ill-health within different population groups
- ✓ Key risks for delivery, mitigations and resources required and how transformation will be measured against locally set performance measures

Timetable for Refresh



Highlights from Progress Reports

Area of Focus	Highlights
Localities develop locality based ICN+ and a proactive preventative approach approach	• The North East ICN+ site launched in July 2020 and has been operational for 10 months. • Following the success of the early adopter site in the North East Locality, the ICN+ model is being rolled out across the remaining five Localities in the borough in 2021. • One of the preventative interventions was the introduction of the Stay Steady, Stay Well clinic. • The ICN+ has been facilitating themed huddles focussing on certain conditions e.g., Diabetes and Respiratory.
Localities - GP /PCN	• CGPC Set up and run a Clinical Director Cabinet which is held monthly and provides space for CDs to discuss issues, concerns and plans on how to work collaboratively including paramedics, pharmacists and social prescribing in each PCN. • Provided the first mass vaccination site in Croydon for flu at Ikea and Crystal Palace Football Club. • Integrated all Enhances Access Service booking system so practices and out of hours service can see all appointments available across Croydon,. • During COVID CGPC supported Practices by getting laptops, webcams and set up Use Emis Enterprise to provide CCG with data on vaccine rollout. • Found an area that needed significant input which was the number of patients requiring SMI health check
Localities – Care Homes/Falls EoL	• Introduced a Telemedicine service in 75 of our care homes which has enabled prompt assessment of clinical needs and coordination of care when urgent, unplanned needs arise in care home residents. • A Care Home Liaison Coordinator has been introduced into the local hospital discharge team to reduce any unnecessary delays in transfer of care from hospital to a care home • Remote monitoring of vital sign in Care Homes using telehealth technology to be rolled out during 2021 • Community falls pilot showed positive results but on hold due COVID-19 staff redeployment; service to be relaunched with a focus on prevention and alignment with the ICN+ localities. • We have partnered with St Christopher's Hospice to work with community groups with the aim of helping everyone have a good death by encouraging local people to feel more comfortable about talking openly about death and dying and by recording their End Of Life Wishes
Localities – LIFE	• Due to the Pandemic, the Discharge to Assess (D2A) process was changed at the end of March 2020. The Council is the Single Point of Contact for all hospital discharges. The number of referrals to D2A increasing, as well as increased complexity of some of the patients discharged. This is tracked and a new D2A process is being designed taking into account new legislation in the White Paper on Discharge to Assess. • In 2019/20, at the end of reablement, in 47% of cases the client received no ongoing package of In a further 17% of cases the amount of care decreased due to reablement. compared to 34% and 20% in 20/21 respectively • The LIFE review paused during the pandemic, this has now been restarted and will look at more joined up ways to enables proactive case management to larger numbers of people across the different ICNs
Mental Health	• Implementation of the mental health community hub and spoke model Co-produced design phase complete and the pilot Mental Health Wellbeing Hub at the Whitgift Centre to be operational Q2 2021 • Crisis pathway improvements include the Recovery Space in Oct'20, Mental Health Crisis line expanded in Apr'20 and a Mental Health Clinical Assessment Unit at Emergency Dept • Greater Support in Primary Care through Mental Health Personal Independence Coordinators (MHPICs) and Reshaping of (SLaM) Community Mental Health Services • Improving Integrated housing is a Council led piece of work and was put on hold due to the pandemic. Work has restarted to develop a Temporary Accommodation Strategy • Autism Strategy nearing completion
Proactive and Preventative – Long Term Conditions	• 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 pro-active and preventative - Community outreach programme was developed and launched with BME forum and Asian Resource Centre • LTC pro-active and preventative – Expert Patient Programme was developed and launched with BME forum and Asian Resource Centre for Croydon
Proactive and Preventative – Local Voluntary Partnerships	• Talking Points - operational since December 2019. Over 280 residents have been referred or contacted. Resident needs have ranged from housing and benefits to social isolation and low-level mental illness. • Ten online 'Building Community Partnerships' events across all six localities have been held between November 2020 and May 2020. Events have been well-attended by an average of 30 VCS organisations and active citizens attending each one. • The prevention framework was signed off by representatives from all sectors in the partnership in December 2020; priorities include Falls (and frailty)Healthy weight,Immunisation take-up and Mental Health and Trauma • The Local Voluntary Partnership programme has supported the voluntary sector by awarding one-off and recurrent funding to small grass roots organisations; 69 funded initiatives. • Phase 1 Healthy Communities Together programme underway

Highlights from Progress Reports

Area of Focus	Highlights
COVID Resilient and Recovery – Public Health	• Upskilling community members to be able to offer initial support and signposting and increasing community awareness around mental health • In addition, a community trauma training programme is currently in development (working with the buying team) for implementation by September 2021 • Supporting children at risk of food poverty: school programmes include - food vouchers, breakfast club and schools grant • Public Health have commissioned 4 VCS organisations to deliver projects to vulnerable populations that aim to support residents to comply with infection control and isolation and improve vaccine uptake
Healthy Weight – Public Health	• Adult healthy behaviours programme now embedded in the localities. • New Child Weight Management service proposed and awaiting approval to commission. Implementation expected by beginning of October 2021. • Draft system weight action plan produced.
Modern Acute – Outpatients	• Optimise pathways - approximately 300 video consultations were taking place per week at CHS. Many services continue to use telephone and video appointments as a long term solution • Patient Initiated Follow Up (PIFU) pathways changes have been made within gastroenterology (IBD) • Proceeding with a patient portal solution that aligns with other providers in SWL.
Modern Acute - Urgent and Emergency Care	TBC
Better Start in Life and Maternity – Redesign the Urgent Care Paediatric pathway	• Paediatric Unit is still under development. The centre is looking to be open May 2022 • Completion and embedding of "Big 5" Advice & Guidance to improve consistency and quality of care • Asthma pathway & development plan • The Children and Young Persons Transformation Programme Board was re-launched in February 2021 • Improving data intelligence on urgent care pathway to support initiatives: CYP Urgent Care dashboard
Better Start in Life and Maternity	• Early help resources are deployed through three localities (North, Central and South) to provide better place-based services for the community • A new partnership Early Years Strategy is currently in development for 2021-2024 • Progressing assessment and actions to meet Ockenden recommendations – service user engagement from Maternity Voices Partnership (MVP) involved in peer review • CHS Maternity Services achieved 26.7% of women being booked onto a Continuity of Carer pathway at Match 2021 • Mental Health Investment Standard funding (MHIS) secured to deliver waiting time initiatives, increase CYP access to Emotional Wellbeing and Mental Health services and further develop digital services
All Age Disability	• In 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 • In April 2021, the disabilities service (18-65) moved to a localities model, enabling it to be comes aligned with the integrated community networks plus model • 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 aligned 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 • Autism Strategy Finalised and going through governance • Learning Disability and Mental Health Commissioning Boards established to develop the next 3 year commissioning strategy
Integration	• One Croydon formally agreed to include the ICN+ model of care in scope of the Alliance Agreement and contracted for this using the Integrated Delivery Agreement. ICN+ will be rolled out across the whole borough during 2021/2022 • During 2020 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 • Transition planning in place for ICS

Next Steps: Stage 4/5

1. Continue with stages as set out
    - Leads to commence engagement on progress priorities for their area
    - Review JSNA and local needs assessments
    - Analyse impact on outcomes framework
    - Organise engagement event (27th July)

2. Governance
    - Scrutiny briefing 22nd June: establish sign-off required for the refreshed plan