One Croydon

Health and Care Plan Refresh

Health and Care Scrutiny Sub-Committee

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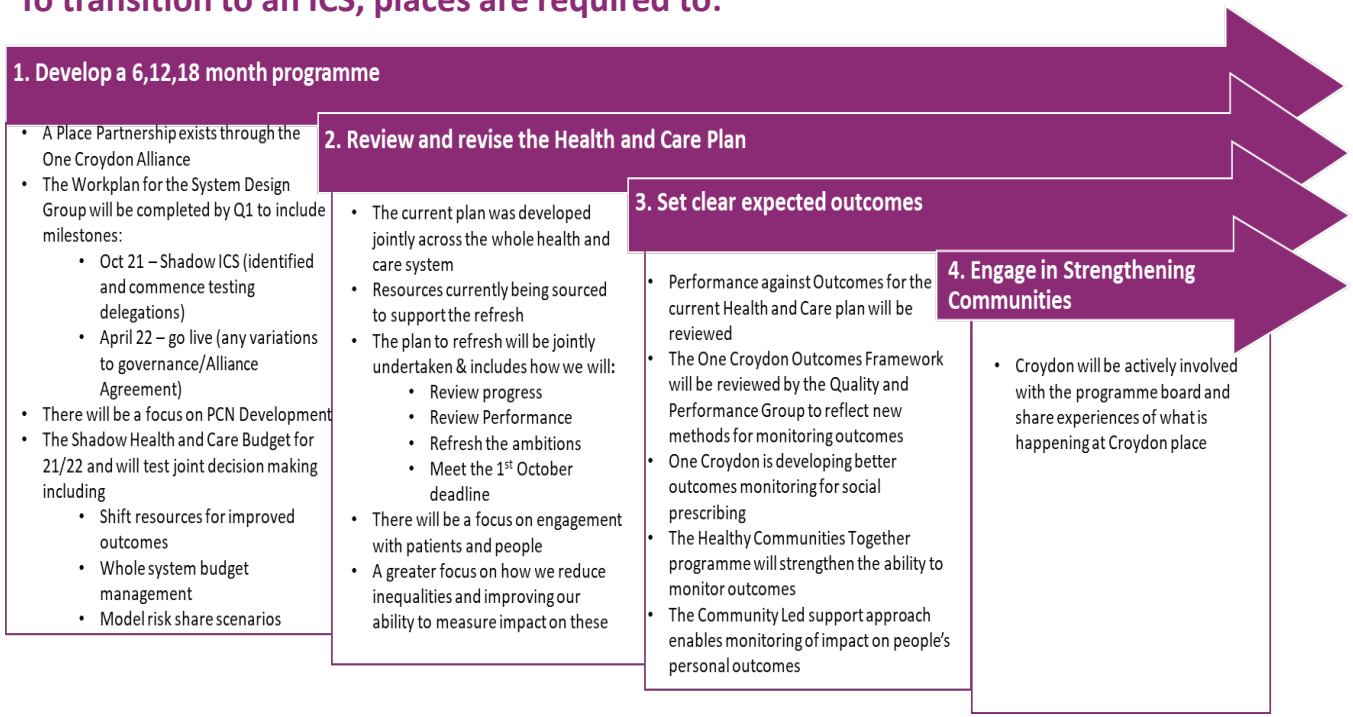
Context: Integrated Care Systems (ICS)

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

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

To transition to an ICS, places are required to:



Place-based partnerships are collaborative arrangements formed by the organisations responsible for arranging and delivering health and care services; Croydon established a 'Place based partnership' back in 2017 through the One Croydon Alliance.

Within an ICS, Place-based partnerships will remain as the foundations of integrated care systems as they are put on a statutory footing (subject to legislation), building on existing local arrangements and relationships

Place has four main roles:

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

Designing Croydon's Place Structure

One Croydon partners have been involved in workshops to **design our future and refresh our health and care plan**; partners agree that the transition to ICS can enable us to continue on our Journey to full integration and achieve even more, but that this is dependent on **maximising delegation to Croydon Place, as well as having a robust relationship with SWL ICS**.

Agreed Design Principles

Our design principle is to ***improve outcomes for the people of Croydon*** *and the best way to achieve our design principle is through the following criteria*:

1. Maximising delegation to place
2. Having sufficient resources and staff at place to deliver
3. Having a strong voice in SWL ICS to maximise benefits
4. Continuing with our ambition to formally pool Health and Social Care budgets
5. Equity amongst One Croydon Partners

Agreed Delegation Principles

1. Maintain whole pathway control at place
2. Delegation should not be a reduction in what Croydon currently has through the aligned CCG/CHS
3. Fair funding for Croydon: Croydon is a net importer of demand and is funded 4% below target
4. Delegate the things that are best done at place
5. Risk is shared across the ICS
6. Local referral to local services

Health and Care Plan: Why Refresh?

The Croydon Health and Care Plan

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

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

There are Some key areas that need greater focus, especially around enablers like workforce, estates and IT as well as Equalities, Diversity and Inclusion and Children and Young People.

The need to refresh

Health Priorities:

NHSE sets out how it will restore services, meet new demands and clear the backlog:

-Supporting the **health and wellbeing of staff** and taking action on recruitment and retention
-Accelerate the **restoration of elective and cancer care** and manage the increasing demand on **mental health services**

-**Expanding primary care capacity** to improve access and address health inequalities

-**Transforming community** and urgent and emergency care

- **Working collaboratively** across systems to deliver on these priorities.

- Ensure we have an **appropriate discharge** from hospital process

- **Reduce inequalities**

COVID-19 Pandemic:

Some of our plans had to change with COVID-19 as across the borough our teams came together to care for the many people affected by coronavirus and support our colleagues who have worked tirelessly as part of a coordinated response to the pandemic; **other plans have continued at pace** as we continue to strive to make our Croydon Health and Care Plan a reality.

The NHS has set out a clear priority to continue to **deliver the COVID-19 vaccination programme** as well as meeting the needs with COVID-19

Financial Position

Croydon Council is experiencing significant financial pressures and previously issued a now withdrawn **S114 notice**. The Council's renewal plan aims to bring spending for 18-64 years olds down to the London Average and for >65s down to the England average. The Health and Care Plan Refresh **priorities and programmes will support the Council to achieve financial stability.**

In addition, **Health in Croydon is historically underfunded** and One Croydon partners are working together to highlight the impact of this and resolve the position to ensure fairer funding.

The Changes

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

- Additional Aims setting out our commitment to; resident engagement and active involvement, supporting our workforce, embedding population health management and tackling inequalities
- A commitment to work together to raise the issue of underfunding for Croydon Health needs
- Addressing health and wellbeing inequalities; acknowledging they existed before and have been exacerbated by COVID-19
- Developing robust metrics to measure the delivery and impact of our priorities
- Updated Outcomes Framework to better monitor impact on our long-term goals

Some areas are underdeveloped and we will continue to work on these to ensure they are robust:

- Progress and priorities for Modern Acute Transformation and joining up care for people with Disabilities, in particular Learning Disabilities
- Working together on socio-economic development; bringing together the NHS Anchor Institute approach and Croydon Council Renewal Plans
- Acknowledgement of the risks to delivery and how we will work together as One Croydon to mitigate these

Challenges to delivery

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

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

Original Aims: Achievements and Gaps

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

- Achievements include; Huddles, 'Talking Points model', PICs, MH PICS, Expert Patient Programme and LTC outreach
- Many challenges remain to shift the dial to prevention, backlog of issues and unmet need post pandemic

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

- Achievements include; Social prescribing, LVP grants, new MH LVP grants, Healthy Communities Together
- Our communities came together during Covid in some ways, but isolation has deepened for others

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

- Achievements include; Croydon as provider of choice, ICN+ model in Thornton Heath, Wellness Centre, Localities programme
- Delays to the MH hub and the ICN+ rollout was slower than planned; there remains a big estates challenge

Proposed Additional Aims

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

- Continue to deliver the COVID-19 Vaccination programme and meet the needs of people with COVID-19 and its long-term effects
- Restart the work on social and economic development

Support, develop and maintain the Croydon health and care workforce

- Build on the work undertaken in the Croydon Health services and Localities programme through a strong programme to drive it forward for the Alliance

Lead a determined, collaborative approach to tackling inequalities

- embed the core principles of resident and patient's engagement and active involvement to inform the decisions we make and the actions we take.
- Maintain focus on social need within ICN+ and work with VCS to deliver more
- Build on LTC work targeting most affected communities and deliver new programmes e.g. Ethnicity in Mental Health

Population Health Management

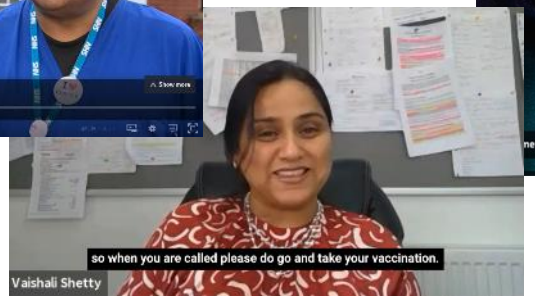
- Develop a strategic approach to PHM to tackle inequalities and improve the health & wellbeing of Croydon people
- Work collaboratively with SWL ICS to harness the most from the SWL PHM and digital strategy
- Continued assessment to understand the impact of COVID as it emerges

Engaging with people and communities across Croydon

Since the Health and Care Plan was first published in 2019 health and care partners have continued to engage with local people to understand how we are meeting their needs and improving health and care outcomes, and how we can improve on these. Programme Leads and commissioners have led engagement on the specific areas of the plan including:

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

In addition to this we are undertaking a stakeholder discussion exercise to test the draft priorities and gaining views from professionals and stakeholders from right across the Health and Care system on how we can improve outcomes for the people of Croydon.



Summary of progress for each area of focus

Localities - locality based ICN+ proactive and preventative	• North East ICN+ launched in July 2020 operational for 10 months • ICN+ model rolled out across remaining five Localities during 2021 • "Stay Steady, Stay Well clinic" introduced as prevention strategy • Themed "huddles" focussing on conditions including Diabetes and Respiratory
Localities - GP /PCN	• CGPC Clinical Director Cabinet held each month • First large flu vaccination clinics at Ikea and Selhurst Park, Crystal Palace • Integrated booking system allows GPs and out of hours service to see all available appointments • Laptops, webcams and Emis Enterprise provided to GP practices to support data reporting
Localities – Care Homes, Falls and End of Life	• Telemedicine service in 75 care homes helps assess clinical needs and coordination of care • Remote monitoring of vital sign in Care Homes using telehealth technology rolled out during 2021 • In partnership with St Christopher's Hospice and community groups to help everyone have a good death by encouraging open conversations about dying and record 'End Of Life' wishes
Localities – LIFE	• Due to the Pandemic, Council named as Single Point of Contact for all hospital discharges resulting in an increase of patients being safely discharged from hospital • Due to the Pandemic, completion of the LIFE discharge to assess review was delayed, now restarted to look at more joined up ways to support more patients across the borough
Mental Health	• The mental health community hub and spoke model has been co-designed and the pilot Mental Health Wellbeing Hub at the Whitgift Centre is due to open during Q2 • Crisis pathway improvements include the Recovery Space in Oct'20, Mental Health Crisis line expanded in Apr'20 and a Mental Health Clinical Assessment Unit at CHS Emergency Dept • Greater support in primary care through Mental Health Personal Independence Coordinators • Improving Integrated housing aims to develop a Temporary Accommodation Strategy
Proactive and Preventative – Long Term Conditions	• 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	• Over 280 residents have been referred or contacted to 'Talking Points' which opened in December 2019. Resident needs have ranged from housing and benefits to social isolation and low-level mental health • 10 online 'Building Community Partnerships' events across all six localities between November 2020 and May 2020 - well-attended by an average of 30 voluntary and community sector organisations • Prevention framework agreed by representatives from all sectors in the partnership in Dec 2020 priorities include Falls and frailty, Healthy weight, Immunisation take-up, 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

COVID Resilience and Recovery – Public Health	• Upskilling communities to offer initial support and signposting and increase mental health awareness • Community trauma training programme in development for implementation in September 2021 • Supporting children at risk of food poverty: school programme includes food vouchers, breakfast club and school grants • Four VCS organisations commissioned to support residents around infection control, social isolation and vaccine uptake
Health Weight – Public Health	• Adult healthy behaviours programme now embedded in the localities • New Child Weight Management service proposed with implementation expected October 2021 • Draft system weight action plan produced
Modern Acute – Outpatients	• 300 video consultations taking place each week at Croydon University Hospital • Patient Initiated Follow Up pathway changes have been made within gastroenterology • Proceeding with a patient portal solution that aligns with other hospital providers in SWL
Modern Acute	• Croydon Elective Centre protected zone for elective surgery, planned procedures and cardiac care • Capacity increased in Croydon's ITU from 15 to 22 beds • Expansion of the Integrated Discharge Team building on learning from wave 1+2 and 'perfect week'
Better Start in Life and Maternity – Redesign the Urgent Care Paediatric pathway	• Paediatric Unit under development due to open May 2022 • Completion and embedding of "Big 5" Advice & Guidance to improve consistency and quality of care • Asthma pathway and development plan • The Children and Young Persons Transformation Programme Board re-launched in February 2021 • Improving data intelligence on urgent care pathway support initiatives: CYP Urgent Care dashboard
Better Start in Life and Maternity	• Early help resources deployed through three localities (North, Central and South) to provide better place-based services for the community • New partnership Early Years Strategy in development for 2021-2024 • CHS Maternity Services achieved 26.7% of women being booked onto a Continuity of Carer pathway at March 2021 • Mental Health Investment Standard funding (MHIS) secured to deliver waiting time initiatives, increase CYP access to Emotional Wellbeing and Mental Health services and develop digital services
All Age Disability	• Independent Lives commissioned to train and develop new personal assistants, and provide advice and guidance to residents choosing to use a direct payment • In April 2021, the disabilities service (18-65) moved to a localities model, aligned with ICN+ model • Community led support model embedded in working practices of older adults and disabilities teams
Integration	• One Croydon formally agreed to include 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 202 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

Areas of Focus: Draft Priorities

The lead for each area of focus* in the health and care Plan has spent the last five months reviewing progress against original priorities and working with stakeholders to draft new priorities for the refresh; these are informed by needs assessments, engagement with people, the need to reduce inequalities exacerbated by COVID-19 and to support achievement of the overall health and care plan aims.

The document embedded here is a stakeholder discussion document that details progress and draft priorities for each of the areas of focus; stakeholders have an opportunity to comment until Thursday 23 September 2021 through an online survey **https://www.surveymonkey.co.uk/r/STT25J2**

Draft Priorities

*Areas of Focus Include: Proactive and Preventative care, Locality Development, Mental Health, Better Start in Life and Maternity, All Age Disabilities, Modern Acute Care

Health and Care Plan Outcomes

We set out our goals and outcomes for the long-term and developed an Outcomes Framework with a set of balances measures to monitor the changes we are making to the health and wellbeing of the population of Croydon.

The Outcomes Framework is updated quarterly and this refresh of the Health and Care Plan will include a full review of the measures used to ensure we use the most robust measures available.

In addition to the outcomes framework transformation programmes are continuing to develop robust ways of measuring the outcomes achieved for individuals, specifically in social prescribing, talking points and through the Healthy Communities Together Programme.

Our goals (10 years)

- Improve **average 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
- Improve the life expectancy of those living in the most deprived areas to 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
- 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 wellbeing** 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
Enable a better start in life	6. Fewer children will be living in poverty 7. More children will have 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
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
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 care 15. Sustainable health and care provision that meets people's aspirations

Outcomes Framework

The Outcomes Framework enables us to capture progress against our long-term goals; this framework is being updated to incorporate new measures that improve our ability assess impact as well as removing those that are no longer collected (at a national level). We are going to further develop our ability to assess impact of transformation programmes, and metrics will be developed by the performance and quality group during Q3; the focus being on how programmes are reducing inequalities and enable us to achieve the overall aims in the Health and Care plan.

Outcomes Framework Performance as at Q2 2021

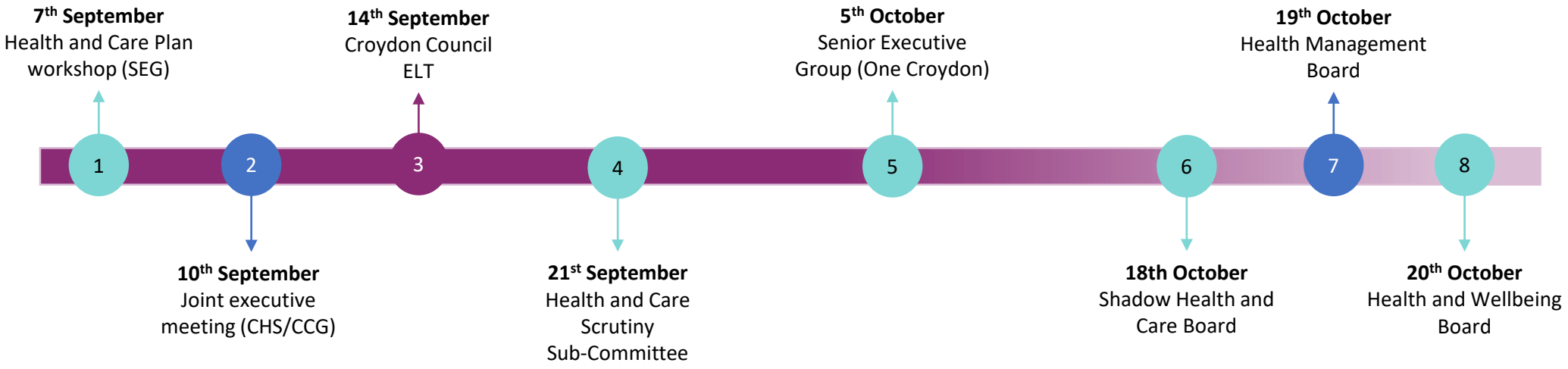
No.	Indicator	BASELINE Timeframe	BASELINE Croydon position	LATEST DATA Timeframe	LATEST DATA Croydon position	Change from baseline	Date Updated
Overarching							
	Healthy life expectancy (males)	2014 - 2016	62	2017 - 2019	64.4	↑	Feb-21
	Healthy life expectancy (females)	2014 - 2016	62.8	2017 - 2019	62.6	↓	Feb-21
Improve Quality of Life: Health & Wellbeing							
1a	Adults taking part in sports and physical activity	2016/17	64.2%	2019/20	62.2%	↓	May-21
1b	Smoking prevalence	2016/17	16.9%	2019/20	16.0%	↓	May-21
1c	Adults who are overweight and obese	2016/17	59.0%	2019/20	56.6%	↓	May-21
1d	Proportion of people who report good life satisfaction (response score of 7 or higher)	2017/18	77.0%	2018/19	83.5%	↑	Aug-20
1e	Proportion of people who report good life worth (response score of 7 or higher)	2017/18	77.6%	2018/19	82.4%	↑	Aug-20
2a	People with type 2 diabetes who received all 8 care processes	2016/17	40.1%	2018/19	60.2%	↑	Aug-20
2b	Estimated diabetes diagnosis rate	2017	65.8%	2018	66.4%	↑	Nov-19
2c	Estimated dementia diagnosis rate	2018	66.7%	2021	71.8%	↑	**Aug-21**
2d	Rate of emergency admissions for back, neck and musculoskeletal pains	2014/15	58.8	2017/18	93.9	↑	Nov-19
2e	**Long term conditions prevalence gap by IMD (to be developed)**	N/A, precise indicators still to be confirmed					
3a	Excess winter deaths	2016/17	19.8%	2018/19	8.8%	↓	Dec-20
3b	People who use services who have control over daily lives	2016/17	76.0%	2019/20	71.7%	↓	Dec-20
3d	**ASCOF social care measures (TBC)**	N/A, precise indicators still to be confirmed					
Improve Quality of Life: Quality and Appropriateness of Care							
4a	People with long term conditions feel supported to manage their condition	2017	59.0%	2019	54.8%	↓	Feb-21
4b	**Person experience and decision making (to be developed)**	N/A, precise indicators still to be confirmed					
5a	Rate of unplanned hospitalisations aged 65+ for chronic ambulatory care sensitive conditions	2017/18	899.1	2019/20	822.6	↓	Feb-21
5b	Deaths which take place in hospitals - all ages	2016	53.4%	2019	48.8%	↓	Dec-20
5c	Delayed transfers of care from hospital that are attributed to adult social care	2016/17	2.7	2019/20	1.8	↓	Dec-20
5d	Proportion of people aged 65+ who were still at home 91 days after discharge from hospital into re-ablement/rehabilitation	2016/17	91.3%	2019/20	86.6%	↓	Dec-20

No.	Indicator	BASELINE Timeframe	BASELINE Croydon position	LATEST DATA Timeframe	LATEST DATA Croydon position	Change from	Date Updated
Enable a Better Start in Life							
6a	Children in low income families (under 16)	2016/17	14.4%	2018/19	17.4%	↑	Dec-20
6b	Low birth weight of term babies	2017	3.3%	2019	3.1%	↓	May-21
7a	School readiness: good level of development at the end of reception year	2017/18	73.8%	2018/19	74.6%	↑	Feb-20
7b	School pupils with social, emotional and mental health needs	2018	2.5%	2020	2.7%	↑	Dec-20
7c	Rate of fixed-term exclusions in primary school	2016/17	1.2	2019/20	0.9	↓	**Aug-21**
7d	Rate of fixed-term exclusions in secondary school	2016/17	7.6	2019/20	6.9	↓	**Aug-21**
8a	Excess weight among children in reception year	2017/18	21.9%	2019/20	21.8%	↓	Dec-20
9a	Admissions for respiratory tract infections in infants aged 2, 3 and 4	2016/17	32.5	2019/20	23.9	↓	May-21
9b	Unplanned hospital admissions for asthma for under 19s	2016/17	342.1	2019/20	155.8	↓	May-21
9c	MMR for 2 doses at age 5	2017/18	67.0%	2019/20	70.9%	↑	Dec-20
9d	Flu vaccinations uptake in at risk groups	2017/18	42.3%	2020/21	43.7%	↑	**Aug-21**
Wider Determinants							
10a	Households in temporary accommodation	2017/18	12.6	2019/20	13.5	↑	Feb-21
11a	Air pollution: fine particulate matter	2016	11.4	2019	10.5	↓	May-21
11b	Access to Healthy Assets & Hazards index	2016	28.9%	2017	29.8%	↑	Nov-19
12a	Unemployment rate	2017	7.3%	2019	3.5%	↓	May-21
12b	Employment of people with mental illness	2018 Q1	17.0%	2021 Q1	59.2%	↑	**Aug-21**
12c	16-17 year olds not in education, employment or training	2016	10.5%	2020	5.4%	↓	**Aug-21**

One Croydon

Appendix

Governance Timeline



Croydon Health and Care Plan summary

Our plans for the next two years

Prevention and proactive care

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

Better start in life

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

Locality development

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

All disabilities

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

Mental health

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

Modern acute care

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

What people have told us

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

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

Our focus

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

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

Improve quality of life

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

Better start in life

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

Wider determinates of health

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

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

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

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

The Croydon Health and Care Plan and a summary document can be found here