Cover

Health and Wellbeing Board(s):

CROYDON

Bodies involved in preparing the plan (including NHS Trusts, social care provider representatives, VCS organisations, district councils)

How have you gone about involving these stakeholders?

This plan has been developed with input from the One Croydon Alliance partners and wider stakeholders in health and social care.

Bodies involved include:

- SW London Clinical Commissioning Group (Croydon Borough)
- London Borough of Croydon
- Croydon Health Services
- Age UK Croydon
- South London and Maudsley NHS FT
- Croydon GP Collaborative.
- Local Care agencies, including care providers and care homes

Stakeholders have been involved via the One Croydon Alliance groups such as: the BCF working group, Localities Board, The Commissioning and Population health Management group and the Senior executive Group. This has included colleagues from Health, Social Care, Housing and DFG.

1.0 Executive Summary

This should include:

- *Priorities for 2021-22*
- *key changes since previous BCF plan*

This document sets out Croydon's Better Care Fund Plan for 2021-22. It complements the BCF Planning Template which will be submitted together with this narrative.

This BCF narrative document and the Planning template will show that Croydon BCF plan for 2021-22:

1- Has been jointly agreed between health and social care partners. This plan has been developed with input from the One Croydon Alliance partners and wider stakeholders in health and social care. As outline in the next section of this document the One Croydon Governance has been used to agree the plan.
2- Includes a contribution to adult social care from the NHS in line with the required minimum contribution. This is approximately £10.7M which is the minimum requirement.
3- Includes a large proportion of NHS commissioned schemes delivered out of hospital. Croydon's BCF investment in NHS commissioned out-of-hospital services will total approx. £15.9, this being well in excess of the mandated minimum of £7.89M.
4- Makes a significant contribution to support people achieving better outcomes following discharge from hospital. This is both through a programme of improvement of discharge processes from hospital and of Discharge to Assess in the community, which in Croydon has been established since 2017.

As such, our plan meets the BCF national conditions, which were set out in the Planning Requirements published on 30 September 2021.

Our joint priorities are outlined in section 3 ("Overall approach to Integration"). Our plan for 2021-22 builds upon established joint working in Croydon through the One Croydon Alliance and the delivery of the Croydon Health and Care Plan. This is a fully integrated programme of work between NHS partners, the Voluntary Sector, Mental Health and social care which outlines a 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 emphasises three clear priorities:

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

In Croydon, we are implementing this plan via the One Croydon Alliance, which is a health and care partnership created from a shared ambition to use Outcomes Based Commissioning to improve the lives of older people in Croydon. The Partners in this Alliance are: Croydon council, SW London CCG (Croydon Place), Croydon Health Service NHS Trust, The Croydon GP Collaborative, South London and Maudsley NHS Foundation Trust and Age UK Croydon.

In 2014, Croydon Council and Croydon Clinical Commissioning Group (now SW London CCG) recognised they faced a common challenge to improve services for older people in an environment where demand was increasing, and resources were reducing. They agreed to work together to establish an Outcome Based Commissioning (OBC) framework to develop services for people over 65.

In April 2017, local partners formed an Alliance and signed a 1-year transition plan (the Croydon Alliance Agreement) which was followed by a further 9-year extension signed in March 2018. Initially, the Alliance focused on older people and developed the Living Independently for Everyone (LIFE) service as well as setting up the GP Practice based Multi-Agency Huddles and Telemedicine in Care Homes. The Alliance has now extended its work to all adults and the direction of travel is that eventually the whole population will be in scope for Alliance working.

The Alliance vision is to support the people in Croydon to be independent and live longer, healthier and fulfilling lives and be able to access high quality care, in the right place and at the right time, thereby reducing health inequality in Croydon. The aim is to achieve this vision while realising financial sustainability in the system and maintaining improved outcomes.

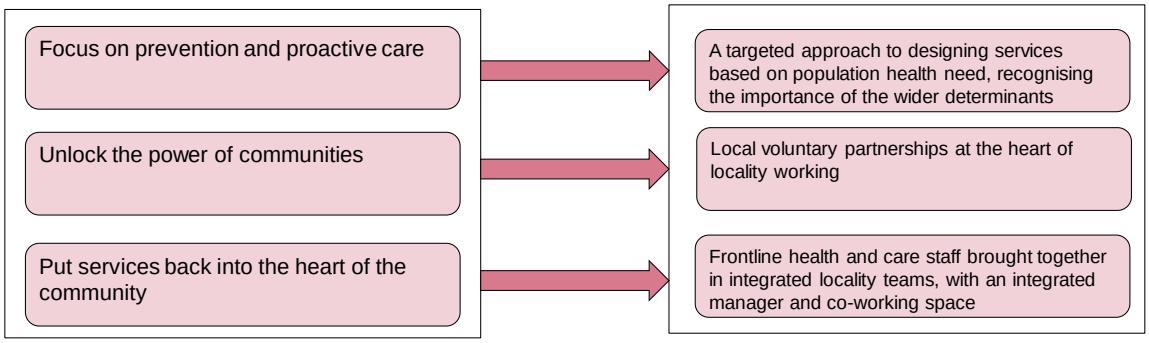
Previous BCF plans for Croydon focused on delivery of improved integrated community services that enabled people to receive the care they need at home or close to home. In so doing, reduce demand on acute health services and help maintain their independence and, as a consequence, reduce dependence on statutory services. These services included:

- Multi-Agency Huddles (including social workers) which are practice based
- LIFE service (Living Independently for Everyone)
- Community Diabetes Service
- Falls Service
- Community Based COPD Service
- Community Based Cardiology Service
- Accessible Mental Health Service
- Mental Health Reablement
- End-of-life care

All these service initiatives were supported through a range of other enabling projects including assistive technology, carer support, housing service, as well as additional social work support in working with the hospital to avoid admission to hospital through emergency care and facilitate timely and safe discharges.

Most of the BCF schemes in 2021-22 have been rolled over from 2020-21 but the ethos has shifted toward building on the integration work that Croydon has implemented since 2017 and feed into the Localities Programme of integration in Croydon.

We have built on previous plans to take into account the increased emphasis on maximising independence and outcomes for people discharged from hospital via our Croydon LIFE service. As well as the development of our Integrated Care Network Plus (ICN+) model of care in the 6 localities in Croydon. This is a major programme of transformation and integration that will improve outcomes for Croydon people through a proactive and preventative approach within each of the localities of the borough. One Croydon partners committed to a locality approach via ICN+ as a flagship initiative within our Croydon Health and Care Plan, which aims to deliver the three key objectives, as below.



We are also strengthening Frailty as a key area of work through BCF funding and ICN+, by developing a strategy that will join up acute frailty care with frailty care in the community.

The BCF and One Croydon Programme are the strong foundations for integrated care in Croydon and help us deliver on our strategic commitments on the sustainability of Croydon's health and care services, delivering care where our population needs it and encouraging healthy lifestyles, as well as recognising the need within our transformational work to reduce avoidable hospital admissions and hospital length of stay (see section called "Supporting Discharge").

2.0 Governance

Please briefly outline the governance for the BCF plan and its implementation in your area.

With the introduction of the One Croydon Alliance whole system groups, including that of the Commissioning, planning & PHM group, has allowed One Croydon the opportunity to strengthen the BCF management and oversight. In order to maximise the opportunity new governance has been installed, that have made the below amendments to the BCF S75 as well as the appropriate Terms of Reference.

BCF Executive Group & SEG:

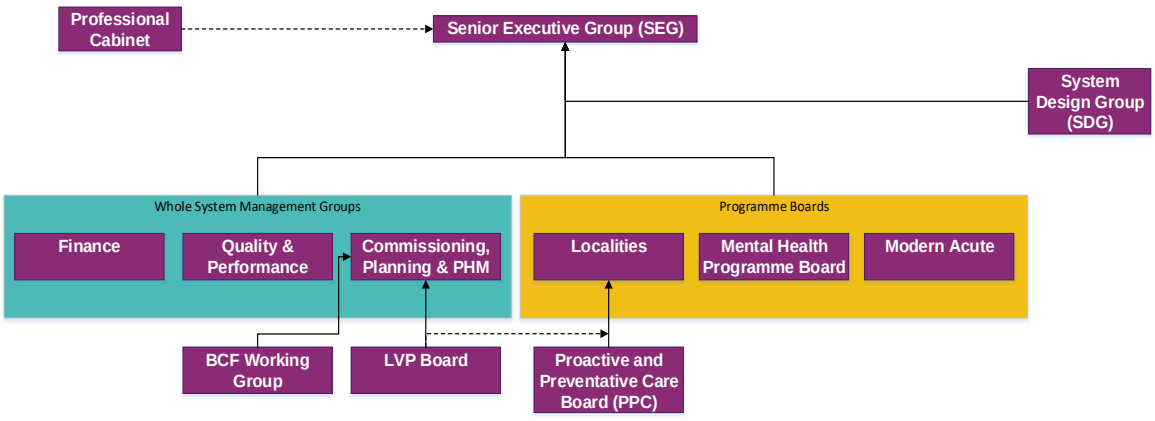
Under the previous S75 agreement, final BCF signoff was to be completed by the BCF executive board. However, as the key members of this executive board already sit within the Senior Executive Group (SEG), within the current one Croydon governance it was proposed and agreed that the BCF executive boards functions are subsumed into SEG. SEG reports into the Shadow Health and Care Board, which feeds into to the Croydon Health and Wellbeing Board.

The role of the Commissioning, Planning and PHM:

With the introduction of the Commissioning, planning & PHM group, there now exists a governing board that can apply oversight to BCF requests and Proposals prior to final agreement by SEG. Although not responsible for drafting proposals the group will now be responsible for discussing and approving proposals with all relevant One Croydon professionals.

Introduction of the BCF working group:

To facilitate the process of reviewing, planning and developing BCF spend options, a new BCF working group has been formed by commissioners and finance personal from health and social care. This group will report to the Commissioning, planning & PHM group quarterly with all reviews, options and proposed changes prior to any final submission.



This was approved by Senior Executive Group on the 5th October 2021.

3.0 Overall approach to integration

Brief outline of approach to embedding integrated, person centred health, social care and housing services including

- *Joint priorities for 2021-22*
- *Approaches to joint/collaborative commissioning*
- *Overarching approach to supporting people to remain independent at home, including strengths-based approaches and person-centred care.*
- *How BCF funded services are supporting your approach to integration.*

Briefly describe any changes to the services you are commissioning through the BCF from 2020-21

Joint Priorities and the Croydon Health and Care Plan

Croydon established a 'Place based partnership' back in 2017 through the One Croydon Alliance. Moving forward and with the introduction of the ICS, Place-based partnerships will remain as the foundations of integrated care systems building on existing local arrangements and relationships. Place has four main roles, all of which One Croydon has been delivering since 2017:

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

In 2019, One Croydon launched a five-year Health and Care plan to help people in our community improve their health and wellbeing. Following 2020/21 and the COVID-19 pandemic a new refreshed plan was needed as a response from health and social care. This 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 pandemic, the Health and Care Bill and the Local Authority financial position.

As such, additional aims for 2021 to 2023 have been included:

- Support Croydon people to recover from the effects of the pandemic, through the recovery programme and a focus on high quality care
- Support, develop and maintain the Croydon health and care workforce
- Lead a determined, collaborative approach to tackling inequalities
- Embed a Population Health Management Approach

Approach to collaborative commissioning

In the last year we have strengthened our collaborative commissioning work between the Council and the CCG.

One example is the recommissioning of the BCF funded End of Life Respite service. This is commissioned by the CCG. The aim of this service is to supports people to die at home if

that is their preferred place of death whilst reducing the risk of A&E/Hospital admission if a carer enters a crisis.

The contract ended on 30st September 2021. The CCG team in Croydon worked closely with the Council team to undertake a mini-tender for a new contract to begin on 1st October using the Council's Dynamic Purchasing System (DPS 1) to procure a new service. The evaluation panel was clinically led and involved 2 GPs, as well as colleagues from the Council, CCG and procurement team. The mini tender was successful, and a new provider identified. This was the first time the CCG used the Council's DPS for procuring a service collaboratively.

Placement is another area where there have been good opportunities for collaborative working. Croydon has 128 registered care homes and the largest Care Home provision within London with over 3000 beds. The Council and the CCG's CHC team are working in partnership to develop the Care Home market, especially Nursing Homes. A few examples of how we work collaboratively in commissioning include:

- Establishing a Care Home Strategy Group with key partners including Council, CHC, CCG and other health partners.
- CHC supporting and placing residents on D2A pathway 3 into Nursing Homes
- Looking at market trends for ongoing commissioning pathways
- Providing dedicated support and training to care homes through various mechanisms including dedicated webpages, webinars, training sessions, recruitment campaigns etc.
- Supporting around commissioning of intermediate care beds (BCF funded).

Approach to support people to remain independent at home

As in previous years and building on the work of the One Croydon Alliance to deliver the ambitions of the Croydon Health and Care Plan, we want people to continue to experience well-co-ordinated care and support in the most appropriate setting, which is truly person-centred and helps them to maintain their independence. The overarching approach to integration continues to be via the development of integrated care services that:

- help people to self-manage their condition and helps understand how, when and who to access care from when their condition deteriorates.
- help to keep people with one or multiple long term conditions and complex needs stable.
- allow people to get timely and high quality access to care when they are ill, delivered in the community where appropriate;
- support people who are in hospital to be discharged back home as soon as they no longer require hospital care, with appropriate plans in place for care to continue at home
- provide people who are discharged from hospital with the right level of support delivered at home or in the community to prevent readmission and promote independence
- support and provides education to both family and carers to ensure their health and well- being needs are met, and includes support to maintain finances and staying in work, where relevant
- help people requiring end of their life care to be supported to receive their care and to die in their preferred place.

There are two key programmes funded through BCF that deliver these ambitions.

ICN+

Our One Croydon flagship programme, the Integrated Community Network Plus Programme, has established an integrated community health and social care service comprising services from across Adult Social Care, Croydon Health Services, Mental Health and the voluntary sector within each locality. The integrated teams enable information sharing, joint assessment and care management. The service model ensures a one name, one budget one team approach, use of an agreed single eligibility assessment and review process, and increased entry pathways - all working to the same key outcomes.

Services under ICN+ localities are as follows:

- Community nursing
- Adult social care over 65s
- Adult social care under 65s
- Therapy services
- Age UK Personal Independence Coordinators (PICs)
- Mental Health PICs
- Named person for smaller community services e.g. Diabetes
- Link with Housing and other Council services

The ICN+ model aims to support people to stay well rather than treat them when they become sick. It focuses on preventing people developing long term conditions, such as diabetes or depression. If people have a condition, we work with them to stop it from becoming worse, thus reducing the number of avoidable hospital admissions. We recognise that physical health and mental health go hand in hand. Therefore, if we focus on preventing people from becoming lonely and social isolated, we will support them to stay independent and healthy.

Alongside rolling out the new team, access to support is also be available via Community Hubs, formerly known as “Talking Points” in the community. Health, social care and voluntary sector staff attend the Community Hubs to provide the required support.

The strength based, community-led support approach is adopted by all staff at the Community Hubs. Staff talk to people about what is important to them and explain what assets are available within local community to support them. The Community Hubs also provide advice about healthy living, housing and benefits. There is also access to a social prescriber and ongoing support from our well-established Personal Independence Service provided by Age UK croydon.

LIFE

The Croydon LIFE service established in 2017 continues to provide short term support to individuals to retain or regain their independence, at times of change and transition, which promotes the health, well-being, independence, dignity and social inclusion of the individuals who are referred to the Service. LIFE is the key service that delivers Discharge to Assess pathways in Croydon.

The service has established a highly responsive integrated intermediate care service across the borough, comprising of re-ablement, rehabilitation and other support services. The service brings together and develops the following existing services from Adult Social Care, Croydon Health Services Community Services and the Voluntary Sector:

- Community Re-ablement

- Re-ablement following hospital discharge
- Age UK Croydon Re-ablement support workers
- Rapid Response
- Community Intermediate Care Service, including home base and bedded step up/step down
- A&E Liaison
- Occupational Therapy
- Assistive technologies, comprising Telehealth and community equipment

The health and social care is delivered in a seamless, timely and holistic way in the community through an assessment of whether the service user has a physical, psychological or social need and whether the need is acute, long-term or a permanent change in function. The integrated service model uses an agreed single eligibility assessment and review process and increased entry pathways, all working to the same key outcomes. The service contributes to reductions in systems duplication, in non-elective hospital admissions and bed days.

Changes to previous BCF plans

Most of the BCF schemes funded in 21-22 have rolled over from 20-21. The ethos however has been to build on the integration work that Croydon has implemented since 2017 through the One Croydon Alliance of health and care. The schemes feed into, and enhance much of the ICN+ programme of integration and the six localities in Croydon. Much of the iBCF schemes have also refocused on packages of care to support reablement and Discharge to Assess.

All adults in Croydon (>18) are in scope for our initiatives. Frailty is an area of work that through BCF funding we are strengthening, by developing a joined up approach between acute and community frailty services.

Challenges to integration

Some of the key challenges we are facing for integration are:

- the ability for Health services and Council services to integrate IT systems to allow systems to communicate securely and allow for data interoperability
- Wider system pressures, including relatively high bed occupancy in hospital and sustained increased hospital discharges, with additional costs on packages of care
- Risks to the delivery of BCF plans due to the already challenging financial position of Croydon Council
- Workforce recruitment, retention and wellbeing. The pandemic has put sustained pressures on staff in health and care, compounded by shortages of qualified professionals
- Estates. There are many examples of integrated teams working together. However, there are issue in Croydon with where to put these teams. The pandemic has helped facilitating remote working but for effective team development having some shared spaces is important particularly for multi-agency working and relationship building.
- Covid-19 and winter pressures are expected to create extremely challenging conditions over the next few months. Many of our schemes have been very effective during the pandemic and demonstrated the power of collaborative working in getting

through a crisis. However, we cannot underestimate the risk to delivery of our ambitions due to these significant pressures.

4.0 Supporting Discharge (national condition four)

What is the approach in your area to improving outcomes for people being discharged from hospital?

How is BCF funded activity supporting safe, timely and effective discharge?

How BCF funding supports safe, timely and effective discharge

A significant proportion of the BCF funding is allocated to supporting hospital discharges via the LIFE service. As described in section 3 of this document, the LIFE service is an integrated community-based team comprising staff drawn from across health, social care and the voluntary sector. It provides intensive, proactive and goal-focused support for up to 6 weeks at times of high levels of need, when individuals require more clinical and social care interventions thereby preventing unnecessary hospital admissions or facilitating early supported discharge from a hospital ward, focussed on enabling the person back to the optimum state of wellbeing, functioning and independence (Reablement, Rehabilitation, Recovery).

As part of the One Croydon programme of work to review and improve the LIFE service, joint plans are discussed and agreed in relation to the discharge programme between CCG, LA and the local NHS Trust.

The service consists of the following elements:

1. Single integrated multidisciplinary Team - A single LIFE Team that brings together existing community services into one integrated, intermediate care, multidisciplinary team.
2. D2A pathway which includes a Trusted Assessor model, where Social Care and Therapy staff undertaking a single integrated assessment covering elements of both health and social care. The D2A model is used for all hospital discharges when care and support is required.
3. The LIFE service operates 7 days a week, 365 days a year. To support discharges from hospitals, brokerage and social workers have moved to a 6-day coverage (Mon-Sat). This is based on the pattern of discharges during the week, which shows most discharges happening on a Friday. During the height of Covid, some of the social work capacity was moved to support D2A in the community.
4. The additional hospital discharge fund has enabled Croydon to increase the capacity to assess and provide enhanced support to a larger number of discharges – in the last year, the borough has seen a two-fold increase in the number of discharges, many of which have also shown a rise in complexity.
5. Hospital-based social workers are part of the hospital discharge MDT meetings. There are also twice weekly morning calls attended by staff from the LIFE D2A team, recently extended to daily, where operational issues are discussed, and plans agreed. As per the national discharge guidance action cards, acute colleagues complete a D2A referral form (Part A) providing information on the type of support needed for discharge, as well as a limited functional assessment. This information is used to provide the resident with an interim care package to support safe discharge and settle the resident home. This is followed by a Part B assessment in the resident's place of residence; the Part B assessor assesses and co-ordinates the

recovery care package, liaising with therapy/reablement and other care providers, as appropriate.
A review of the LIFE service has found that Part A and Part B processes and communication between acute and community teams involved in discharge could be further improved to deliver a rehab/reablement focused approach. Proposed changes are currently being trialled to involve closer working with reablement providers.

6. The proposed changes will be complemented by opportunities to strengthen existing joint working arrangement with the hospital integrated discharge team
7. The LIFE Service will also work to develop a stronger relationship with the locality ICN+ teams to ensure residents who need low level support, e.g. exercise, be-briending, etc, can access using existing community assets, to maintain their health and well-being and prevent readmission.

The local hospital discharge team has also been reviewed and redesigned to ensure more timely and effective discharges from the wards. The new team will be implemented in Q3 and Q4 of 2021/22, depending on successful recruitment and embedding of changed processes and ways of working. As such, we are not expecting the impact of the new team to be fully embedded until the end of Q4.

Approach to improving outcomes for people discharged from hospital

We have introduced Community-led support across discharge teams. Staff have received training on the 'good conversation' tool. The training will enable them to offer community support and non-funded solutions at the point of options being discussed with patients and families. The Community Connect map will be used as a first point of contact and on triage to inform available alternative options at every conversation with the person. Key features of this approach are:

- No decision about a patient's long term care needs should be taken in an acute setting
- Follow up assessment and care should be timely and pro-active in the post-acute recovery phase with links to on-going community support
- Improved patient outcomes and experience at each part of the acute urgent care pathway and timely options for discharge with the appropriate assessment for "home" in the appropriate setting
- Care at home wherever possible with a view to enabling people to remain safe and independent in their own homes for as long as possible
- Review the emergency readmissions data over 50s to identify support within the integrated locality teams (ICN+) that could prevent readmissions
- Review the number of placements in the last 6 months to see if they could have gone home they had received night sitting

Over the next few months of winter some additional resources will be put in place to support safe, timely and effective discharge; improve the quality of discharges and avoid re-admission to hospital.

- Supporting ward staff. Providing dedicated staff from the LA in supporting D2A from wards with home first principal and focusing on Pathway 0 where possible with support from partner agencies. Providing 3 staff per day working directly with ward teams.
- Increasing voluntary sector support to help discharge and prevent re-admission. Increase offer of voluntary sector such as Age UK and Red Cross in providing

enhanced support for people when they return home to help them for 2 weeks to regain independence and prevent re-admissions.

- Using assistive technology and staff to prevent hospital admission. Using assistive technology to support this and provide crisis support for short term period.
- Emergency home care packages of care to prevent admission. 7 days funding for emergency cases to prevent hospital admission whilst long term support/care is provided. This may include waking night support if required.
- Using ICN+ to check on most vulnerable residents to prevent admission. ICN+ winter check on clients over 85 on what they have in place for winter. Ensuring everyone who is being discharged is discussed at a multi-agency GP huddle and reviewed by the ICN+ team.
- Supporting staff training to maximise independence of residents and prevent hospital admission. Training for the current staff on developing assessments and person-centred goal setting. Also supporting and enabling positive risk- taking to maximise independence.
- Educating and support residents. Campaign on educating more people on staying well and warm. Getting neighbours to look after each other.

5.0 Disabled Facilities Grant (DFG) and wider services

What is your approach to bringing together health, care and housing services together to support people to remain in their own home through adaptations and other activity to meet the housing needs of older and disabled people?

The Disabled Facilities Grant provides the source of funding for adaptations for owner occupiers, private and housing association tenants to facilitate major adaptations to their homes. Adaptations include provision of ramps, door widening for wheelchair access, level access showers, hoists, through-floor lifts, stair-lifts etc. Target group is clients with a disability of all ages, borough-wide, including paediatric clients/children. Assessments of need are carried out via Health OT's in adults and Children's services.

The Ministry for Housing, Communities and Local Government allocation for 2021-22 is £2,992,679.00.

The DFG is a mandatory grant which is subject to a means test. The criteria for this grant are set out in statute. Based on the current average spend of £11,000 per adaptation, the original budget could potentially fund 272 adaptations.

Key outcomes are:

- Provide access to suitable adaptations to help people to live as independently as possible in their own homes for longer.
- Allows people to self-manage long term condition(s) rather than rely on other forms of long-term support i.e. personal care using a level access shower rather than washed by care-workers.
- Prevent the need for costly residential placements, by provision of adaptations to help people use essential facilities within their home, move around the home and get into and out of the home.
- Improving safety of the home environment and prevents some unnecessary admissions to hospital or other clinical care settings because of lack of access to facilities in the home.
- People can stay living in their local communities for longer near to their support networks.

Performance of the DFG feeds into BCF Governance Arrangements, the Joint Commissioning Executive and also imports into Croydon's Health and Wellbeing Board.

The DFG covers children with physical, mental and OR cognitive disabilities, which come via Health's Children's OT Service.

For the provision of Assistive Technology, it is the OT's responsibility to assess the need of the client and they will make the referral to the Assistive Technology Team to provide the necessary equipment.

Croydon has recently updated its Private Sector Housing Assistance Policy, and now includes a range of discretionary measures under the DFG's to enable a more flexible approach to providing adaptations.

We have a fast-track grant, known as a 'Simple Adaptations Grant' for work up to £5k, whereby there is no means test and can provide such things as minor adaptations i.e. Ceiling Track Hoists, Stairlifts, Ramps. This can be turned around quickly to provide urgent adaptations as an early intervention, or to reduce the risk of hospital readmission.

We now have a Discretionary DFG, which can be given in addition to the mandatory DFG, totalling £60k. This facilitates major adaptations such as extensions to provide ground floor sleeping and washing facilities OR multiple adaptations through floor lift, Level Access Shower, Step Lift, Ceiling Track Hoists which exceed the current mandatory DFG limit of £30k.

The DFG and our enhanced reablement services are provided through the in house Staying Put Home Improvement Agency. During COVID-19 we saw an increase in referrals for our hospital discharge service. We maintained our service throughout this period, to ensure hospital beds were kept free for COVID-19 patients. We provided key safes through our Handyperson Service, blitz cleans, furniture removal to allow micro living, tackled hoarding issues, etc to enable independence and avoid hospital readmission.

The main aim of our service is to enable people to remain living safely in their own homes, and to increase their independence.

6.0 Equality and health inequalities

Briefly outline the priorities for addressing health inequalities and equality for people with protected characteristics under the Equality Act 2010 within integrated health and social care services. This should include:

- *Changes from previous BCF plan.*
- *How these inequalities are being addressed through the BCF plan and services funded through this.*
- *Inequality of outcomes related to the BCF national metrics.*

Croydon continues to face similar challenges as in previous years around health inequalities. The difference in how these challenges are addressed is in the shift towards more locality working via the ICN+ programme and more targeted Population health management approach. PCNs are also addressing many issues around health inequalities using population health manages and as part of the delivery of the PCN DES.

One Croydon has undertaken a series of actions that aimed to embed a strategic whole system approach to PHM, including: setting up a PHM steering group; developing a proactive and preventative framework; undertaking a BI review.

At a service level a PHM approach is routinely used in the development of new models of care and specific transformation projects i.e. ICN+, Diabetes. The ICN+ Model of Care is using a range of Localities Profiles maps which include health, social care and wider determinants data in order to understand the needs and health inequalities within localities so that resources can be targeted to address these. Further work is being done to pose specific questions for analysists to work on.

Demographics

Croydon's population is growing. The borough population recorded in Census 2001 was 330,587 and in the 2011 Census it had increased to 363,378. Based on ONS midyear estimates 2019, Croydon is home to 386,710 people and this is expected to increase to just under 500,000 by 2050. Croydon Council is the second largest of all the London boroughs in terms of population. Nearly a quarter of this figure (24.5%) is made up of young people aged 17 years or under. Around one in seven (13.8%) of our residents are aged 65 years or over. Croydon has the 4th largest proportion of young people in London which has implications on the types of services required to cater for the youth in Croydon. Like other London boroughs, Croydon has a higher proportion of residents from the BAME communities (especially Asian and Black communities) compared to the national average.

Croydon faces challenges around deprivation and inequalities in regard not only to income but other factors including health, education and housing. Over the last 4 quarters the number of households that were accepted as homeless has been over 2,000 over the year.

Future Demand for Services

People are living longer, and our population is ageing with projections suggesting that the number of people aged over 85 will increase by two thirds in Croydon by 2029. This is an important trend because we know that older people generally have more health problems and are more likely to use health and care services. The number of older people living on their own in Croydon is increasing and a far greater proportions of older people living alone, aged 75 and over, are women. Social isolation and loneliness can have a detrimental effect on health and wellbeing and people living on their own can be more at risk.

Health and social care market

Croydon has a very high number of residential and nursing care homes in the borough (128). It admits a greater number of its residents to permanent residential placement than it would like to, meaning that residents are not moved onto more suitable longer-term accommodation. Despite the high number of homes in Croydon there is often still a need to find placements outside of the borough, resulting in the undesirable outcome of an individual being cared for outside of their local area. The services provided by homes within the borough have not been developed in alignment with the requirements of our clients and therefore do not always meet their needs. There is also the growing risk of provider failure, due to the rising costs of care, which the Council is committed to addressing locally.

How inequalities are being addressed

The ICN+ programme addresses health inequalities across the borough by adopting a targeted, Locality approach based on person-centred care and using strength-based approaches. Data is analysed to understand the location and nature of health inequalities across the borough. The programme has undertaken a basic population segmentation of the borough, with understanding of key groups, their needs and their resource use. This has enabled the networks to introduce targeted preventative interventions which contribute to support people to remain independent at home.

Key features of the ICN+ model are:

- Health and Wellbeing: Recognising that people's needs may not just be physical health related, but may include Mental Health, social care needs, housing issues and other wider challenges
- Supporting people to stay well: Proactive health maintenance in a community setting, to reduce urgent and unplanned hospital visits and increase peoples' experience of good health. There will also be access to social prescribing through Personal Independence Co-ordinators (PICs)
- Long-term conditions (LTCs): Identifying those at risk of developing LTCs, and focusing on helping people with LTCs to self-manage their condition and prevent acute episodes
- Multidisciplinary: A tailored team to address the specific local needs of the population, including Mental Health services and support for Social Prescribing
- Accessible: Locally-based and locally-targeted care, Health, social care and voluntary sector staff will attend the Talking Points to provide drop-in support, focusing on a range of health and wellbeing needs
- Proactive / Population Health Management: Using a Systematic Case Finding Model to identify people who may need support, rather than waiting for them to self-present in crisis

Overall Croydon has a higher prevalence of chronic and long-term illness such as diabetes and cardiovascular conditions in BAME groups which require ongoing support from primary and community services. In addition, many BAME groups experience barriers in accessing primary care services which leads to delayed treatment, increase in A&E attendances and hospital admissions, and therefore higher costs to the health and social care system.

In order to address these and other identified issues the ICN+ programme and services funded through BCF schemes have used population health data, gathered on a locality basis, is being used to tailor the model for each local network. Different localities need a different offer and therefore need different levels of resource.

Croydon struggles with significant gaps between estimated and reported prevalence gaps for Long Term Conditions including type 2 diabetes and hypertension. To address this, we are rolling out a community outreach programme with delivery of health checks and community awareness events; aligned with ICN+ model and building on joint work during Covid-19 pandemic with public health and voluntary sector organisations to engage with specific communities and develop culturally specific materials and information.

Obesity prevalence is variable between ethnic groups with some groups (e.g. Indian and Pakistani) over 5 times more likely to develop obesity. Obesity is a risk factor in a wide range of diseases (e.g. stroke, diabetes, CHD, hypertension). Exacerbation of these conditions can result in a need for emergency care.

Atrial fibrillation is a heart condition that causes an irregular and often abnormally fast heart rate and can lead to an increased risk of stroke. There are circa 2000 estimated number of undiagnosed cases of atrial fibrillation in Croydon. To address this, we plan to roll out systematic case finding service for of atrial fibrillation through our GP practices.

Many Type 2 diabetes patients and patients with hypertension struggle to meet the nationally recommended treatment targets. To address this, we plan to:

- Roll out an innovative new group consultations programme aimed at supporting patients with diabetes and /or hypertension to self-manage their condition more effectively.
- Roll out of a self-management programme called the Expert Patient Programme.
- Work with PCNs to deliver effective population health management strategies to provide proactive care to meet the needs of people with long term conditions.
- Support general practice to deliver the weight management directed enhanced service, which encourages practices to develop a supportive environment for clinicians to engage with patients living with obesity and diabetes and/or hypertension about their weight; ensuring effective referral pathways into local weight management services.
- Work with General Practice to onboard a further 2000 Croydon residents with non-diabetic hypoglycaemia (pre-diabetes) onto the National Diabetes Prevention Programme
- Embed of new integrated model of diabetes care in Croydon aimed at reducing the number of complications related to diabetes by investing in specialist service which would move the focus to prevention, early identification and improved management of diabetes, with the specialist team working across acute, community and primary care.

Continue shift of care using virtual/remote monitoring for people with complex/multiple long-term conditions to be cared for at home rather than hospital using telehealth.

Work with ED and acute and community LTC specialist teams to develop and roll out new pathways for use of telehealth to avoid admission or facilitate earlier discharges.

Care Homes

Croydon has 128 registered care homes and the largest Care Home provision within London with over 3000 beds. Approximately half are Older People's homes and the rest are MD/LD homes. Given the scale of the challenge for Croydon in supporting this large number of care homes, access to services for Care Home residents has historically been variable as some services were not commissioned to cater for care home residents; whilst specialist services commissioned for care homes, especially LD and Mental Health, have always been

extremely stretched. To address this inequity of access we are putting more investment into ICN+ so that residents in every care home can have the same level of access to locality services as any other Croydon resident. We are also beefing up provisions for MH/Dementia and LD residents in care homes, whilst also working with the voluntary sector to put provisions in place to reach out to these cohorts of clients.

Inequality of outcomes linked to BCF metrics

BCF metrics are routinely monitored via our one Croydon system dashboard. Additionally, we have recently established a brand-new Croydon Population Health Management Group to look at a system-wide strategy for implementing population health management and addressing health inequalities across a spectrum of areas of work. We will ensure that BCF metrics are included to monitor any inequality of outcomes for the key BCF metrics.