Croydon Health and Care Plan 2019/20 – 2024/25

FINAL DRAFT

"Working together to help you lead your life"

One of London's fastest growing and most diverse boroughs	A vibrant and energetic borough	The second greenest borough in the capital	Home to a thriving community, education, businesses, and the arts

Croydon Health and Care Transformation Plan

"It is not good enough to say that one organisation is responsible for this, the council for that, GPs or Croydon University Hospital for the other– the only way we can make meaningful and sustainable change and improvement is by working together." ***Councillor Louisa Woodley, Chair of the Croydon Health and Wellbeing Board.***

One Croydon is the partnership between the local NHS, Croydon Council and Age UK Croydon. Following our success focusing on the over 65s we have extended our partnership to the whole population. Together we continually review and assess the health and wellbeing needs in the borough of Croydon, along with existing services and facilities for meeting those needs. Where we find services that could be improved for our residents, it is our job to work together to integrate them and make improvements.

This document sets out our approach to improving health and wellbeing in Croydon together. This will take many years and this five-year plan sets out our journey and the improvements we expect to see on the way. This plan is concise so that people can clearly see how our long-term goals and outcomes link to our priorities and to our plans for delivery. We want front line staff and stakeholders to understand why we are changing the way we work and what that means for the people of Croydon. A summary will be developed to help the public understand our plans.

Over the past few years we have made many improvements, building on previous improvement. Working together has meant people have had greater opportunities to feel more connected to their communities whilst supporting their health and wellbeing by piloting and implementing social prescribing. We have made available a Personal Independence Co-ordinator (PIC) for people needing individualised support to help develop 'My Life' Plans. People have better access to improved health pathways of care, such as improved access through new use of technology and through integrating the GP and hospital musculoskeletal (MSK) services and more work across professionals to work proactively to reduce need. People have had better access to general practice by offering pre-bookable routine appointments at GP hubs.

However, in essence, current, traditional ways of working need to change if we want to improve the health and wellbeing of the people of Croydon. We need to see a fundamental change in how we do things and what we focus on. Too many of our services are focussed on supporting those in crisis or those with the most acute health and social care needs. We need to reset our operating model so that we work to support people to stay well for longer, and delay and avoid more people from becoming acutely unwell in the first place. We must do this by working more closely together and planning a united and holistic model of care for local people that is seamless at the point of use. We must have good conversations with people and use of Community Led approaches, looking at what's strong, not what's wrong. By working together we can align organisational priorities and we will:

- focus on prevention and proactive care – we want to support local people before things become a problem and encourage residents to be more proactive in their own health
- unlock the power of communities by making the most of communities' assets and skills – key to helping local people stay fit and healthy for longer is to connect them with their neighbours and communities
- put services back into the heart of the community - make sure local people have access to integrated services that are tailored to the needs of local communities – locality matters

One Croydon developed this health and care transformation plan to maximise the value of our partnership and work together to transform the way we deliver services.

The plan does not start from scratch but sets out for the first time an overview of the One Croydon plans in one document. It does not replace individual partner plans but builds upon them and on specific service strategies. It aligns with and supports the Health and Wellbeing Board's Strategy, the Croydon Local Strategic Partnership vision and will become a chapter alongside the health and care plans of the other boroughs in the South West London Health and Care Plan. The NHS Long Term Plan published in January 2019 reinforces the direction of travel set out in this plan. In addition, we await the publication of the Social Care Green Paper which will equally need to be reflected in our system planning. A summary of some of the engagement with stakeholders and the public that has influenced the shaping of this plan can be found on the CCG's website at INSERT LINK. The short film here gives a flavour of just one event held in November 2018.

This plan represents the next step in an exciting journey for Croydon's health and care partners. We know there is still more work to do, as set out in our next steps section and this plan will continue to evolve.

Jerry Cope
Croydon Transformation Board
Independent Chair

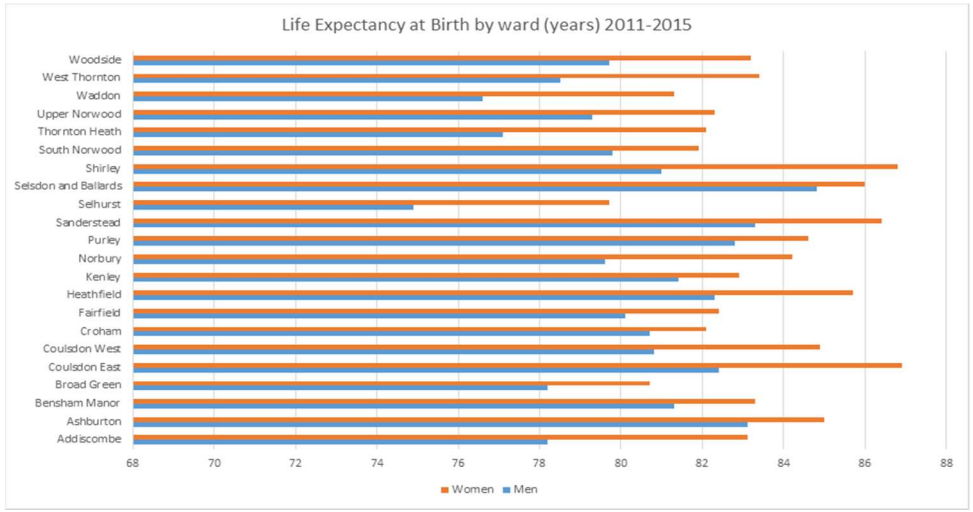
Our case for improvement

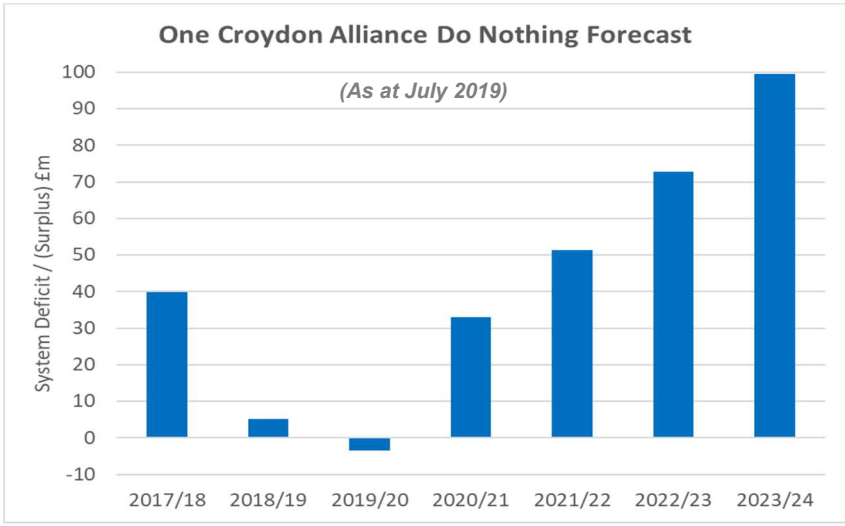
There are a number of challenges facing health and care services in Croydon that are preventing us from delivering **better outcomes for our population.**

Our current models of care are not **affordable** or **sustainable**. There are many opportunities to build on the strengths of local communities and integrate services for health and care that will lead to much improved models of care. We need to work together to change the way we support local people to improve their health and care. We must do this at a **scale** that will have the **biggest impact** and at a pace to keep up with the **growing demand**.

Some services are **fragmented and disjointed**. Teams do not work closely enough together across our organisations, which makes the user experience longer and more complicated than it needs to be. We must work to remove the unnecessary barriers between our services that are all working to support the same local people.

Too many of our services are focussed on supporting those in crisis or those with the most acute health and social care needs. We need to reset our **operating model** so that we work to **support people to stay well for longer**, and **delay and avoid** more people from becoming acutely unwell in the first place. We must do this by working more closely together and planning a united and holistic model of care for local people that is seamless at the point of use. If we do nothing there will continue to be significant inequalities in health between communities across the borough. The difference in Life Expectancy and Healthy Life Expectancy in Croydon and the decline in Healthy Life Expectancy means that people are spending more years in poor health. If we do nothing our system deficit will increase to such a scale, potentially leading to fewer services and a decline in quality.





Our health and care challenges and how they set our goals and priorities

There is significant inequality in health outcomes between communities

People in affluent areas are living significantly longer than people in poorer areas. This difference is even more extreme when we are looking at healthy life expectancy (HLE), life spent in good health and free from disability and disease. In Croydon, men living in Fieldway (HLE - 58.2) are expected to live 13 more years in poor health than those in Sanderstead (HLE - 71.3)

The improvements in raising life expectancy as well as healthy life expectancy has slowed down in recent years and people living in poorer areas experience an even slower rate of improvement. Some reasons for this decline are known such as deaths due to flu among older people, a slower rate of improvement for cardiovascular health, and a rise in obesity and dementia.

A key long term goal must be to:

- **Reduce inequalities**
- **Improve healthy life expectancy**

A key priority must be to:

- **Improve wider determinants of health and wellbeing**

Social, economic, and environmental circumstances have the biggest impact on health outcomes

Employment and adequate **housing** are key factors that determine physical and mental health and wellbeing. Almost a fifth (18.7%) of children under 16 in Croydon live in **low income families**. In Croydon, 234 people were seen sleeping rough in 2017 and 2450 people are living in **temporary accommodation**, including 864 families. Just under 25% of adults in Croydon are unemployed which is lower than the average for England. The **quality of the air** we breathe impacts on our health and can have a severe health impact on people with existing cardio-vascular or respiratory disease. In Croydon, air quality is variable with poor quality air correlating with some of the most deprived neighbourhoods. First time entrants to the **youth justice system** of the 10 - 17 olds was 537 per 100,000 year, the highest across the 33 London boroughs.

The first 1,000 days are crucial for the best start in life

- Croydon has the **largest child population** in London.
- Croydon has 4,351 **Children in Need**, and nearly one in four of all London's **unaccompanied asylum-seeking** children are in Croydon which is the second highest in the country.
- The level of **childhood obesity** is high. In 2016/17 almost one in four children (23.7%) aged four to five years are overweight or obese, increasing to more than one in three (27.7%) children aged 10 to 11 years.
- Admissions for **mental health conditions** for under 18s is higher in Croydon compared to London and national averages.
- **Childhood immunisation** uptake in Croydon is low compared to England and London. Immunisations protect children from disability and potentially fatal childhood illnesses.
- Croydon has one of the highest rates of **admission for asthma** among children and young people

A key priority must be to:

- **Enable a better start in life**

Our health and care challenges and how they set our goals and priorities

A number of risk factors for poor health are more prevalent in Croydon
We know there are a range of avoidable risk factors contributing to poor health outcomes and health inequalities. Around half of the difference in life expectancies between the least and most affluent parts of the borough can be linked to factors such as smoking, drinking more than the recommended amount of alcohol and having an unhealthy diet.

In Croydon, two thirds of adults are **overweight or obese**, one in eight adults **smoke** and there are high levels of sexually transmitted infections, particularly in areas of deprivation.

The proportion of the population with a long-term condition is increasing
Half of all adults registered with a GP report having a long-term condition. 23% (93,317) of the whole population of Croydon has two or more long term conditions (LTCs) and this is set to increase significantly over the next few years.

Mental Health issues are a leading cause of morbidity in the population
People with poor mental health often have worse physical health that is not adequately prevented or treated. In Croydon 6% of adults registered with a GP have a recorded diagnosis of depression. National estimates suggest that depression affects one in four adults so there is likely to be a significant proportion of the population in Croydon that have not been diagnosed.

Among young people, national reports estimate that one in eight five-19 year olds have at least one mental health disorder.
Too many people with mental ill-health are presenting at A&E and this has been increasing since 2017.

A key priority must be to:

- **Improve quality of life**

There are an estimated 1,300 people in Croydon with undiagnosed dementia
In 2017 there were an estimated 3,611 people aged 65+ living with dementia. However, in 2016/17, only 2,322 were formally diagnosed. Early diagnosis and treatment improves health outcomes and delays progression.

45% of people who use adult social care do not have as much social contact as they would like
In Croydon, there are an estimated 9,860 older people who are lonely and 5,423 older people who experience intense loneliness. There are also 17,227 people aged 18-64 who are socially isolated (annual public health report, 2016).

Our quality, workforce and finance challenges and how they set our goals and priorities

A key priority must be to:

- **Integrate health and social care**

Rising demand

The population of Croydon is growing. Overall life expectancy is increasing and we have an ageing population leading to greater demand on our services. Over the next few years, there will also be a particular increase in population around East Croydon station where there is a high concentration of new housing development.

Quality and Effectiveness of Care

The Care Quality Commission has rated **Croydon Health Services NHS Trust** as "requires improvement". **South London and Maudsley NHS Trust** was rated "Good" overall but "Requires Improvement" in one area.

Of the 50 **general practices** across the borough, one was rated as 'Inadequate' overall and three were rated as 'Requires Improvement' overall. The remaining were rated as good or outstanding. However there is a lot of variation in care given by GPs, including rates for diagnosis and referrals, which leads to varying outcomes for patients. Access to primary care is also challenging, with a high proportion of unregistered patients.

Croydon Council took immediate action to improve its **Children's Services** after an Ofsted inspection rated some areas of the service inadequate earlier this year. The council is addressing all the issues raised as a priority.

A key long term goal must be to have:

- **A sustainable health and care system**

Croydon Health Services as a provider of choice

44% of the budget spent on hospital care is on patients attending hospitals outside of Croydon. We believe that at least 17% of this could be repatriated to Croydon Health Services so that patients are treated closer to home and the local hospital trust can become more financially sustainable.

Workforce challenges

Croydon faces a number of workforce challenges that are affecting the health service nationally: the numbers of **nurses** (particularly in the community and mental health) and **GPs** have fallen and **social care** faces difficulty in recruiting to specialist roles for more complex work. The increase in demand means health and care professionals are overstretched. In addition there are difficulties in attracting staff to Croydon, despite it being a vibrant and energetic borough. Croydon can only offer outer London wage supplements which means it is hard to attract staff from neighbouring London boroughs.

Financial challenge

The health and care systems in Croydon face significant financial challenges. Working together we can better manage our collective financial gap, whilst delivering the health and care the people of Croydon deserve. If we do nothing, the collective deficit for the system by 2023/24 will be approximately £160 million.

What people have told us and how it sets our goals and priorities

"The feedback and ideas you have given us show us that you want to make Croydon health and care the very best they can be and we are all prepared to work to make that happen." **Councillor Louisa Woodley, Chair of the Croydon Health and Wellbeing Board**

Understanding what local people think of services is essential for us to improve them. We are committed to reaching out to local communities and supporting residents to have their say in the future of local services.

A key long-term goal must be to:

- **Help people meet their health and wellbeing aspirations**

You said, we did….

"Services need to be more flexible and offer different levels of support to people in their own homes."
Health and care professionals now work together in virtual multi-disciplinary teams to identify those people who need the most support and to provide those services when and where they need them.

"Train people who visit isolated people in their homes so that they can alert services when their health starts to deteriorate."
We ran a pilot to train meals on wheels' delivery workers to spot signs of deterioration in their customers and which services they should alert. Personal Independence Co-ordinators support people to feel confident enough to talk to vulnerable people about their concerns and needs.

"We need more mental health services for those in crisis in the community."
We will co-locate services to work together, using a hub and spoke model, to make sure they are accessible to existing community groups. We will develop an improved mental health crisis pathway so that people in crisis have faster and easier access to specialist support.

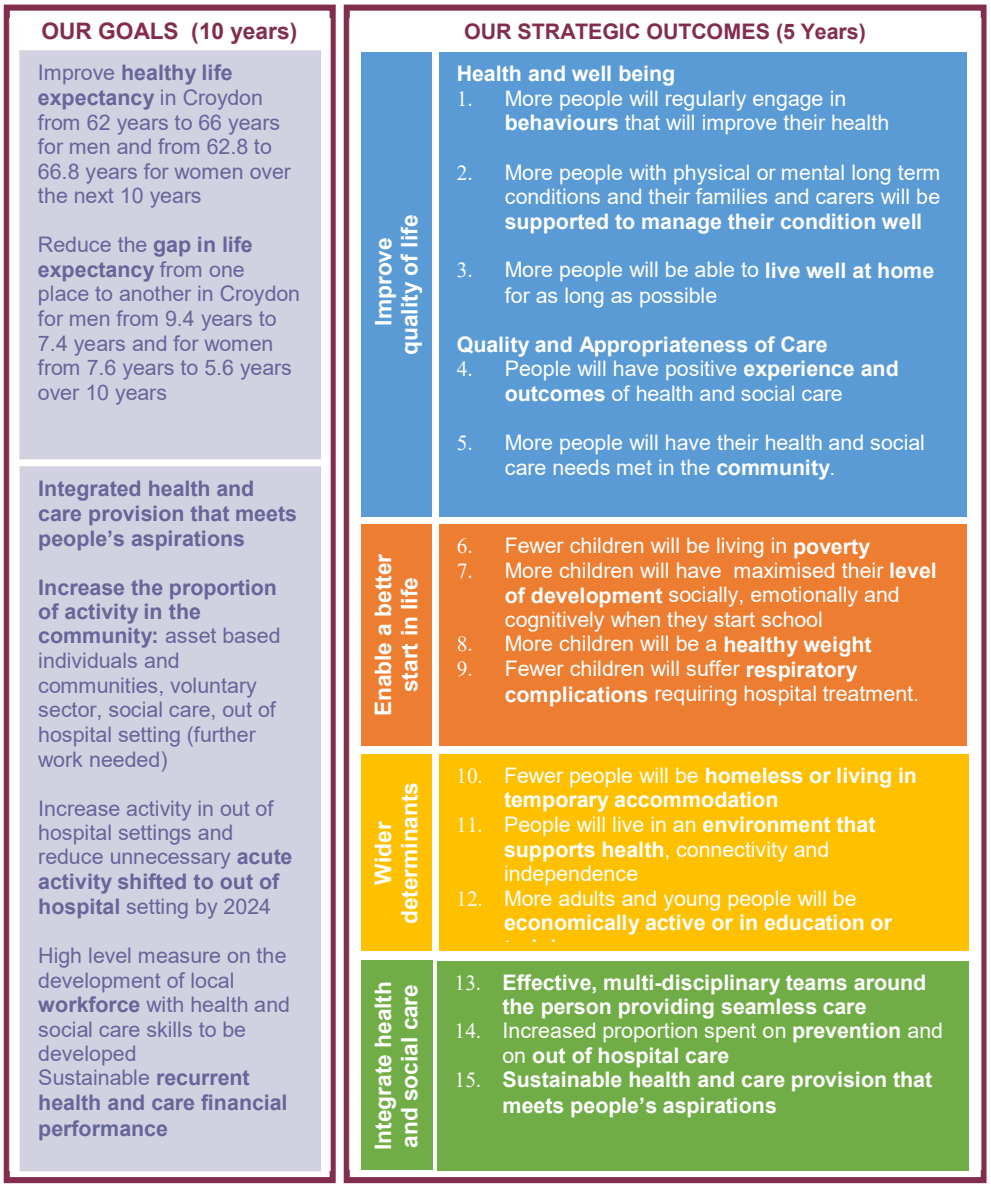
"A lot of teachers lack confidence when it comes to addressing or talking about mental health issues with children and young people."
Alongside our partners across south west London, we are running an engagement programme with children and young people at risk of self-harm. The engagement focusses on testing ideas, developed with young people, to see which may have the biggest impact on supporting young people who are at risk of self-harming.

What more we will do…

"You need to build resilience and confidence in our schools and throughout our communities"
Our Local Voluntary Partnership model will enable and promote collaborative working among local voluntary and community sectors to support residents and health and care providers to promote self-care, reduce social isolation and promote independence.

"Be nice to people. Why wouldn't people be nice?"
We will help develop a Compassionate Croydon Culture, where people can do little things that'll make a big difference to people's well-being. We will continue to develop the good work of our Dementia Action Alliance to make Croydon a compassionate place to live and work for people with Dementia and their carers, extending this to those with Autism and disabilities.

How we will know we have improved health and well-being



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

Our challenges have driven our long term (10 year) goals that will demonstrate the health and wellbeing improvements and the infrastructure changes that we need to see. We have considered the key factors that will have the greatest impact for the residents of Croydon on these goals and set (5 year) outcomes accordingly.

To ensure we are heading in the right direction we must keep track of the changes we expect to see annually. Appendix 1 sets out the annual **health and wellbeing indicators** and the system indicators.

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

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

Our goals over the next 10 years is to:

- Improve the healthy life expectancy in Croydon
- Reduce the gap in life expectancy in Croydon
- Integrate health and care provision that meets people's aspirations in Croydon

Croydon's health and care transformation plan on a page

"We need to have a real focus on prevention – stopping things becoming a problem where we can – and making sure our services are available where and when people need them." **Guy Van Dichele, Executive Director of Health, Well-being and Adults**

Working together to help you lead your life

The plan on a page (page 11) sets out a clear path from our long-term goals to our priorities and our plans for delivery. Our strategic approach to all that we do is to:

- **focus on prevention and proactive care** – we want to support local people before things become a problem and encourage residents to be more proactive in their own health. Our overall aim is to keep people well. We want people to stay well and we want to prevent things becoming a problem. If people do have a problem we want them to be able to manage well, and have access to support that will help them help themselves. For those that have the greatest need, we want them to have access to services in the right place, at the right time, first time.

- **unlock the power of communities by making the most of communities' assets and skills** – key to helping local people stay fit and healthy for longer is to connect them with their neighbours and communities. When people need care, we want a health and care system that can support them based on what matters to them. Personalising care will mean people have choice and control over the way their care is planned and delivered.

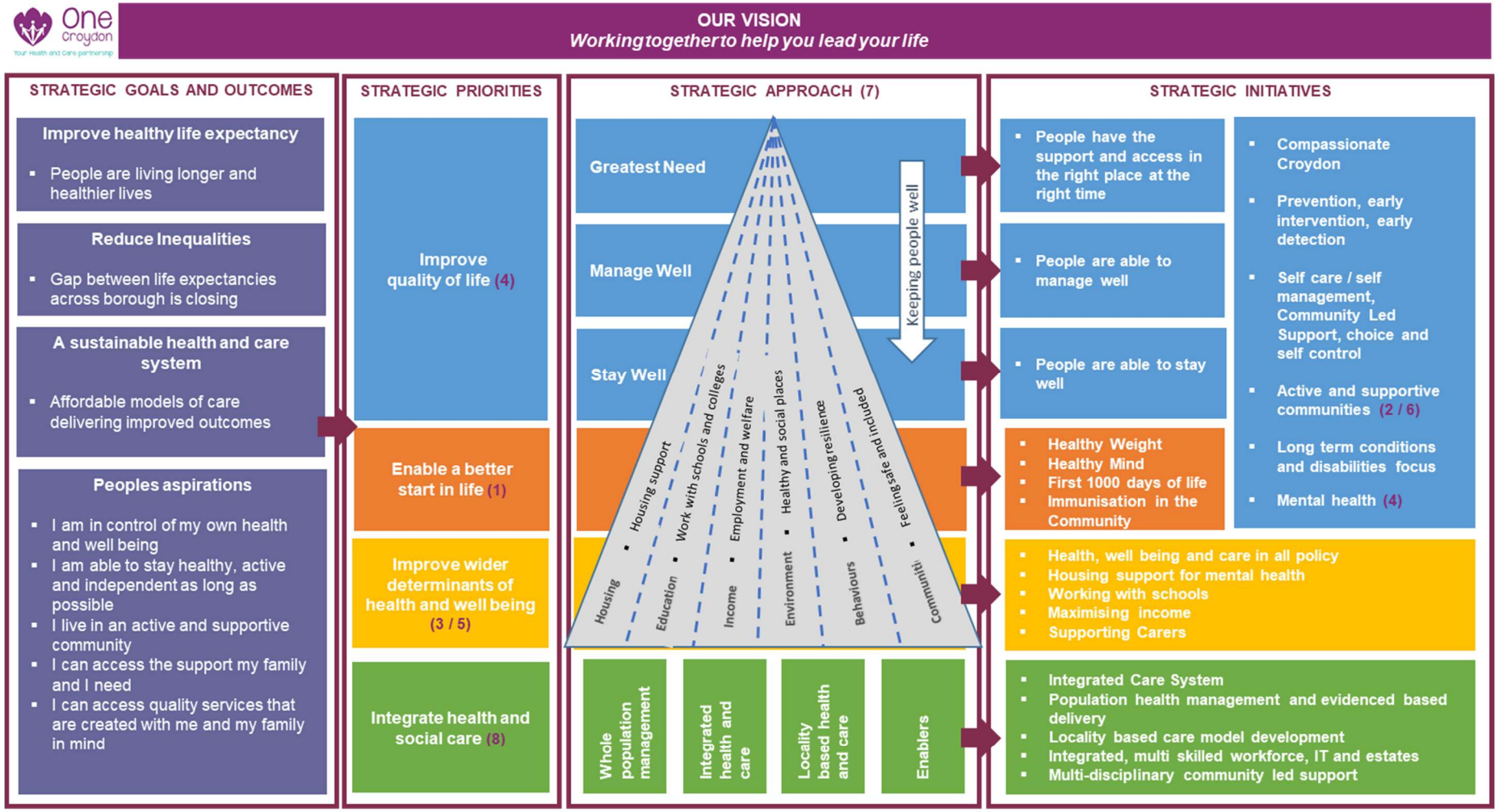
  There are many ways we will support people to do this: shared decision making, personalised care and support planning, social prescribing and community led support, support self-management, personalised health budgets and working with the strong voluntary sector in our borough to connect local people to be part of broader support networks so that they can take control of their own well-being.

  A new Voluntary Sector Strategy will support building capabilities with the voluntary sector as well as align where possible to support the delivery of this plan.

- **put services back into the heart of the community -** make sure local people have access to **integrated services that are tailored to the needs of local communities** – locality matters. We want to keep people well and out of hospital. Making sure local people and families have access to services, closer to home, wherever they live in the borough. Services must be accessible and responsive to their individual needs.

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

Croydon's health and care transformation plan on a page



(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

Integrated services that are tailored to the needs of local communities

This directional statement sets out One Croydon's focus for the next three years, to delivery an integrated care system in Croydon by 2021.

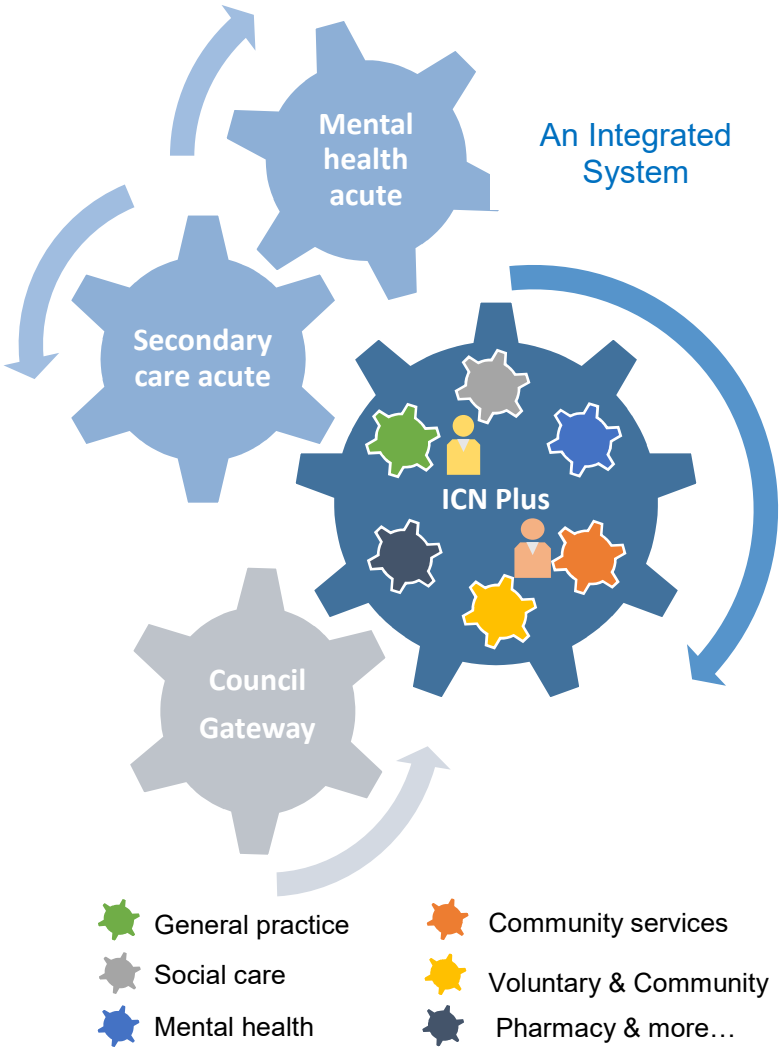
Working together we aim to improve the health of the people of Croydon, while also reducing inequalities both in life expectancy and healthy life expectancy. We began our journey focusing on the over 65's, our next step is to extend our scope to the whole population, aligning interventions and services to need, helping those that experience the worst health improve their health the fastest.

Our delivery model
To deliver preventative and proactive care for the whole population and to engage the community directly requires:

- **Community services to be organised around localities** – Building on our current Integrated Community Network model, ICN+ will develop wider health and care models of care around 6 GP networks, with wider council services delivered around 3 gateway localities. Health and care need, the responding models of care and affordability will determine whether interventions need to be delivered at locality level, across localities or borough wide.

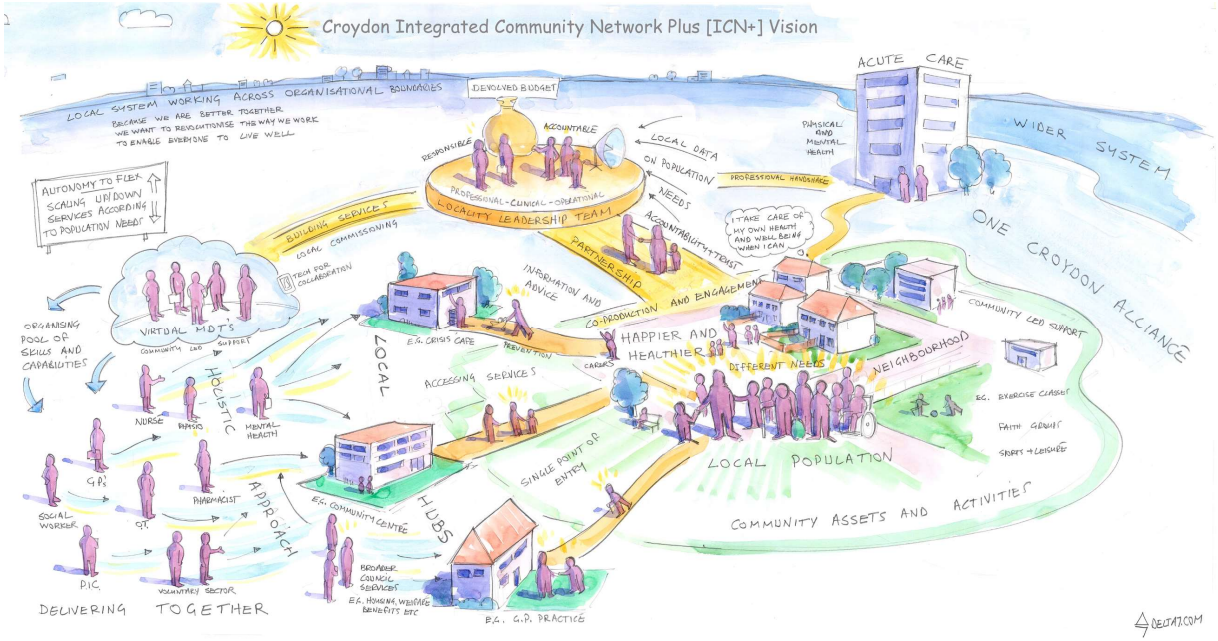
  Models of care will focus on a range of services that will go beyond working jointly but will work in an integrated way. That means the workforce will be multi-skilled to work across traditional but sometimes, artificial professional boundaries and also joint locality management teams.

- **Modern acute care** - both physical care and mental health care– models will ensure only those that need acute services go to hospital. Our local providers, by becoming the providers of choice will ensure acute provision responds at the point of need with a focus on good clinical outcomes enabling local integrated care.



Community Services Organised around localities

Integrated services that are tailored to the needs of local communities



Models of care will focus on a range of services that will not just be joined up but will work in a fully integrated way. The workforce will be multi-skilled to work across traditional but sometimes artificial professional boundaries and there will also be joint locality management teams.

ICN+ will create a ‘One team, One name, One budget’ approach to the delivery of these services, across different agencies, cultures and organisations. The programme will be delivered by establishing a leadership team in each network, establishing a multi-disciplinary service for each network with a focus on preventative and proactive intervention, co-designing and establishing methods of engagement between the local community and the leadership team, and developing a strong community network that supports local people’s health and wellbeing.

With Croydon’s nine new primary care networks at their heart, we will work with local GPs, health and care professionals, and their social prescribing link workers to begin to map existing voluntary and community groups in each area. We will engage with local residents in each area for them to help develop the integrated community network plus for their areas – so that it is local people who help decide what services should be prioritised in each network. This approach will help put communities at the heart of health and care to inform the development of services to meet local need, promote community ownership of not just the services they use but also of taking greater control of their own health and wellbeing.

How we will deliver transformational change

To deliver our ambitious goals we have developed a number of transformation programmes (appendix 1). These do not describe all the work happening in Croydon, they set out our vision for a joined-up approach to transforming services. These programmes can be split into two themes:

- Settings of care focusing on the whole population
- Pathway programmes focusing on the customer journey for specific groups to ensure the integration of services delivers for the whole population

Locality development	Developing integrated primary, community health and social care linking with other services such as housing and voluntary and community sector to provide localised services to support neighbourhoods of 30-50k population
Modern acute - physical health	Developing a strategy for the provision of physical health acute treatments in a hospital setting Developing models of care and enablers to support the strategy
Modern acute - mental health	Developing a strategy for the provision of mental health acute treatments in a hospital setting Developing models of care and enablers to support the strategy
Proactive care and preventative approaches	Developing proactive and preventative approaches including the development and implementation of a long term conditions strategy and holding programmes to account for building proactive and prevention models into their design
Better start in life	Developing a comprehensive Early Help and prevention offer focussing on addressing needs at the earliest point and providing effective support for children, young people and their families, developing models for care for children and
Better mental health and well being	Develop seamless and preventative support for mental health problems in primary care and the community and assessing options for better housing for those with severe mental health problems and support for carers
Better life for people with disabilities	Focus on more flexible, joined-up care for those with disabilities, including looking at digital solutions e.g. telecare for those with dementia and support for carers
Better outcomes for over 65s *	Focus on the pathways and integrated models that predominately support older people, such as discharge to assess, first phase ICN, reablement and residential and nursing placements
Better end of life care *	Focus on more integrated and improved end of life care in the most appropriate setting, considering support for carers and pathway improvements

* These programmes will be developed further.

Our focus for the next two years

"We believe in an approach that means our residents get the care, support and interventions they need without having to know who is doing it, or how – it just works." ***Dr Agnelo Fernandes, Vice Chair of the Croydon Health and Wellbeing Board, Clinical Chair of NHS Croydon***

Settings of care

The **Locality Development Programme** is responsible for the co-ordinated development of integrated, locality-based care, designed around the needs of local communities. This will include the implementation of Primary Care Networks, as well as specific locality-based out of hospital models of care. Our focus for the next two years is:

- Develop a range of fully integrate locality based primary and community services, building on our Integrated Community Networks and Living Independently for Everyone (LIFE) programmes
- Extend *proactive case management* through the scaling up of the LIFE/ICN programme and more joined up ways of identifying and working with those in need

The **Modern Acute Care Programme** aims to ensure that Croydon residents who need acute services will choose Croydon Health Services because it provides high quality care as part of the wider integrated health and care service. We cannot do this on our own and Croydon Health Services NHS Trust is working with hospitals across south west London to assess how they can collaborate more effectively. Our focus for the next two years is:

- Optimise acute pathways through the pathway redesign programme and improve efficiency so that CHS is the provider of choice for patients and GPs
- Continue to work with the south west London acute trusts to look at how to collectively improve the clinical and financial position
- Redesign flows within the hospital to support delivery of the four-hour emergency department waiting times standard

Pathway Programmes

The **Prevention and Proactive Care Programme** oversees the preventative agenda, leading on the implementation of many plans and ensuring all other programmes focus on preventative and proactive care. They will also lead on the development of vibrant communities. Our focus for the next two years is:

- Develop a new *long-term conditions model of care* that will provide support when intervention is needed, prioritising diabetes, cardiovascular disease and respiratory disease
- Build a *voluntary and community sector partnership* including the development of Local Voluntary Partnerships
- Develop our digital solutions to support people to access help and services quickly and easily

The **Better Start in Life** and the **Maternity Programmes** aim to ensure that children get the best possible **start in life** so that they have every chance to succeed and be happy. This includes promoting good emotional wellbeing and mental health for children and young people as well as ensuring mothers-to-be and their partners are supported throughout pregnancy. Our focus for the next two years is:

- Implement *children and young people's mental health transformation plan*
- Implement *Early Help Strategy* focusing on developing resilient families
- Redesign the *paediatric pathway* to ensure greater integration with primary care
- Implement the *Healthy Pregnancy programme* that will improve immunisation rates, breastfeeding rates, parenting support and Live Well programme uptake

The **Mental Health Programme** aims to prevent mental health problems and ensure early intervention for those with mental illness by improving access to services and providing care closer to home where appropriate. Our focus for the next two years is:

- Implement the mental health community hub and spoke model
- Improve the crisis pathway
- Provide greater support in primary care
- Improve *integrated housing* by development of a wider range of housing options for those with severe mental health problems

The **All Disabilities Programme** aims to support people with disabilities to remain at home as long as possible by providing quality services, timely and appropriate access, an effective journey and making more efficient use of resources. Our focus for the next two years is:

- 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
- Provide digital solutions and assistive technology to support access and management of care for people
- Have good conversations with people and use of Community Led approaches, looking at what's strong, not what's wrong.

A **locally, integrated health and care system** is a key ambition for One Croydon. It is key to ensure we can deliver sustainable integrated services. One Croydon is building on the success of the integrated services developed for over 65s and has extended the Croydon Alliance remit to the whole population. This plan underpins the next steps for the Alliance and its potential future partners. Our focus for the next two years is:

- Identify the next *models of care programmes to be developed through the Alliance* and implement them

- Implement *greater alignment* of resources across organisations where it will support the delivery of our plans. This will include aligning staff (both front line and back office staff), functions, budgets and other infrastructure such as IT and estates where appropriate
- Croydon CCG and Croydon Health Services will implement closer alignment of structures
- Develop a *population health management system* that will provide health and care information to support local teams to provide services tailored to the needs of their communities. It will also provide shared business intelligence so that the health and care system have 'one version of the truth'

We will develop our **infrastructure** to support the implementation of our programmes. Our focus for the next two years is:

- Develop and implement an integrated **workforce** plan supported by an Organisational Development programme
- Implement Phase 1 and 2 of the **IT interoperability programme**, sharing information between primary and secondary care, community, mental health and social care
- Implement the capital programmes to support development of the new health and wellbeing hubs as well as the improvement of the primary care **estates**
- Develop **communications campaigns** that help people develop their resilience and engage with local people to understand their experiences of new services and models of care
- Develop standardised **financial and contracting models**

What it will mean for people

Our strategic initiatives will be implemented over the next five years. The implementation plans are set out in appendix 2. These may change as we learn what works and what does not work and as we develop our thinking. Our commitment is that everything we do will be to help people lead their lives, by preventing health or care issues arising and if they do, supporting people to be as independent as possible.

Better Start in life
We are developing a comprehensive early help and prevention offer which focuses on addressing needs at the earliest point and providing effective support for children, young people and their families; the right help at the right time. This is based on the evidence that the earlier we get involved the better the outcomes are for children, young people and families. **Three locality-based teams have been established, who will be joined by partner agencies working in the relevant locality area.** The aim is to create a Partnership locally where children, young people and families receive the support they need in a coordinated way delivered by a multi-agency team of professionals. Locality working supports strong relationship between all key partners including the community and voluntary sector professionals helping them work in a much more coordinated way and as a team around the family.

Helping people stay well
We will focus on preventing or delaying people developing long-term conditions, such as vascular disease or diabetes, through screening and the management of those at risk. For those that do develop a condition supporting people to be activated in their own care (aka **patient activation)** will help people to develop the knowledge, skills and confidence to manage their own health and care, in partnership with health professionals.

There will be integrated **one-stop access points for mental health and wellbeing** in Croydon where a person can drop in and chat to a team member in a café area. An expert navigator can help with a range of issues including helping people to access benefits and housing support.

Helping people to manage well
Social prescribing - All GPs, nurses and other primary care professionals will be able to prescribe to a range of local, non-clinical services. This will help people to improve their quality of life and emotional, mental and general wellbeing, as well as levels of depression and anxiety. This is supported by developing vibrant partnerships in our local voluntary and community sector and investing in direct care from the sector (Local Voluntary Partnerships).

We will roll out **expert patient programmes** across Croydon to support people living with, or caring for someone with, one or more long-term health conditions. The course will give them a toolkit of techniques to manage their condition better on a daily basis, by increasing their confidence and quality of life.

Helping those with greatest need
We will continue to develop the good work of our **Dementia Action Alliance to make Croydon a compassionate place** to live and work for people with Dementia and their carers, extending this to those with **Autism and disabilities.** The work of our informal carers is valuable and we will work to co-produce support for them and increase choice and control for them and those they care for. We will work to ensure the right

accommodation is available with support for older people and those with disabilities, with a focus on supported living and people having their own front door and ensuring people have Active Lives and are supported into and to remain in work. We will reform our workforce into localities and develop our skill mix ensuring we make every contact count. Our integrated services for people who become unwell will work to avoid the need to go to hospital and provide joined up reablement, rehabilitation and intermediate care placements for people to support them while recovering. Following an unavoidable admission, we will support people as soon as they arrive home and provide the right rehabilitative care until they reach independence.

There is a real drive within Croydon to extend our dementia friendly community ambitions across the dementia pathway in both clinical terms and for families and carers.

To this end, all agencies across the pathway have recently come together to scrutinise where the pathway might work better together and an active task and finish group will focus on key areas. While the use of multi-disciplinary teams are enormously helpful to provide the best care, we are mindful of the need for someone to have an overview of the individual so they are considered as a whole person.

Likewise, there is also work underway ensuring the right kind of workforce training so the condition is properly understood across all providers in the borough.

Additionally, there is a carers training programme being rolled out across the borough to support carers understand the condition better and be more confident in dealing with it. We also are providing activities which allow people living with dementia and their carers/families to do 'normal' things, like going to the cinema, dances and singing.

Developing Active and Supportive Communities

There will be a **community approach to social care**, which will help people to use their own strengths and capabilities and consider what support might be available from their wider support network or within the community. This means social workers will look at a person's life holistically, considering their needs in the context of their skills, ambitions, and priorities.

We are already making a difference

Croydon Best Start was one of the first initiatives in the country to bring together midwifery and health visiting services with services for young children and families provided by Croydon Council and the voluntary sector. More than 5,500 families have now been visited at home following the birth of their baby by a member of our joined-up team. And in total the service has provided nearly 20,000 appointments at child health clinics across the borough

Social Prescribing in Croydon dramatically improves patients' health and wellbeing. In six months, there were over 28,000 attendances to community activities. A neighbouring borough found in a pilot they ran that patients needed 33% fewer GP appointments and it has cut hospital visits by 50% in the first year.

Personalised care at home in Croydon has delivered co-ordinated support for older people with long term conditions. Our 18 personalised independence coordinators aim to break the cycle of hospital admissions and this has resulted in fewer patients needing care packages for longer than six weeks after leaving hospital.

Medicines Management teams across Croydon Health Services and the Clinical Commissioning Group have improved patient care by facilitating better medicines management between the hospital, GPs and pharmacists.

Local Voluntary Partnerships will help to promote collaborative working among voluntary groups that provide support to local residents by promoting self-care, reducing social isolation and promoting independence.

Developing locality-based care, tailored to local needs

There will be a range of health and care **services in community spaces** such as libraries and there will be **new health and care wellbeing centres** in New Addington, East Croydon and Coulsdon. We will have a **number of hubs and networks of buildings and spaces** bringing different professionals together to offer a range of services such as supporting children and families with their needs.

Health and care services will be tailored to local community needs. **Primary Care at Home** will support this by building on the Integrated Care Networks. These networks bring together a complete clinical and health professional community, integrating GPs, mental health and community nurses, social care, pharmacy and the voluntary sector to proactively manage people with complex health and care needs at practice level.

Wider determinants of health

By working in a more joined up way as partner organisations and in particular with town planners, schools, colleges, transport, and businesses providing jobs we will be able to create a healthier Croydon that enables our citizens to lead healthier lives. There will be changes to the Croydon plan and other key policies will undergo **Health Impact Assessments** to review their potential impact on health and to identify opportunities to improve local living conditions.

Croydon's Integrated Care System

To deliver our ambitions we must work even more closely together not just at senior leadership level but at every level. Health and care professionals will work together alongside the voluntary sector, delivering a holistic approach for people.

The **One Croydon Alliance** focused initially on integrating services for over 65's. The Alliance makes partnerships more formal by having single budgets across organisations with agreed risk share arrangements, thereby removing some key organisational barriers. One Croydon is working towards developing a borough based integrated care system for 2021. We will seek to influence and engage with South West London to seek capability, capacity and investment for Croydon on key enablers to support transformation such as IT, estates and data/IG capacity. Croydon will maximise opportunities with the Mayor of London provided by London devolution.

A step on that journey is Croydon Health Services NHS Trust and NHS Croydon Clinical Commissioning Group plans to work more closely together to better plan and deliver health care in Croydon. Building on the success of the One Croydon Alliance, as well as the joint appointments of a Joint Chief Pharmacist and Joint Chief Nurse, the Trust and CCG are bringing together more common functions – removing duplication and freeing-up resources for the frontline and to support clinical staff. There will be a single Place Based Leader across both organisations.

For patients, the approach will ensure high quality joined-up care, wherever they seek treatment. For Trust and CCG staff, it will deliver greater opportunities to develop their careers, while increased alignment between the two organisations can also reinforce the financial future for health and care in Croydon.

Integrated commissioning, commercial structures and delivery models

The next step is to focus on the development of the integrated community network plus model for the whole population. At business case stage, we will consider the commercial structure, vehicles and delivery model options most appropriate. Sub Alliances may be required to take these forward, considering the partners required, which will be considered on a business case by business case basis but expected to cover all ages and areas, e.g mental health, children, etc. Joint strategic planning and integrated commissioning and pooling of budgets is required to ensure commissioning of the system to underpin the development of models of care as well as deliver efficiencies, effective contracting and procurement processes with a focus on quality. Integrated functions across the system such as quality and safeguarding and placement funding decisions to be explored as a priority.

Influencing the role of wider determinants

We know factors such as the housing and environment we live in, the education we receive and the relationships around us are major contributors to health, accounting for 80% of an individuals' health. This is why we will work further than just across health and social care. We must reach in towards all community partners to lever and influence change that will positively impact people's health and wellbeing, with the role of wider Local Government provision being central to this success.

Resourcing change management

To make this substantial multi-organisational change happen we will invest in the organisational development and workforce planning needed to support the creation of a One Croydon culture.

Financial Context

The health and care system faces significant financial challenges.

Over the years organisations have been making improvements internally as well as by working together.

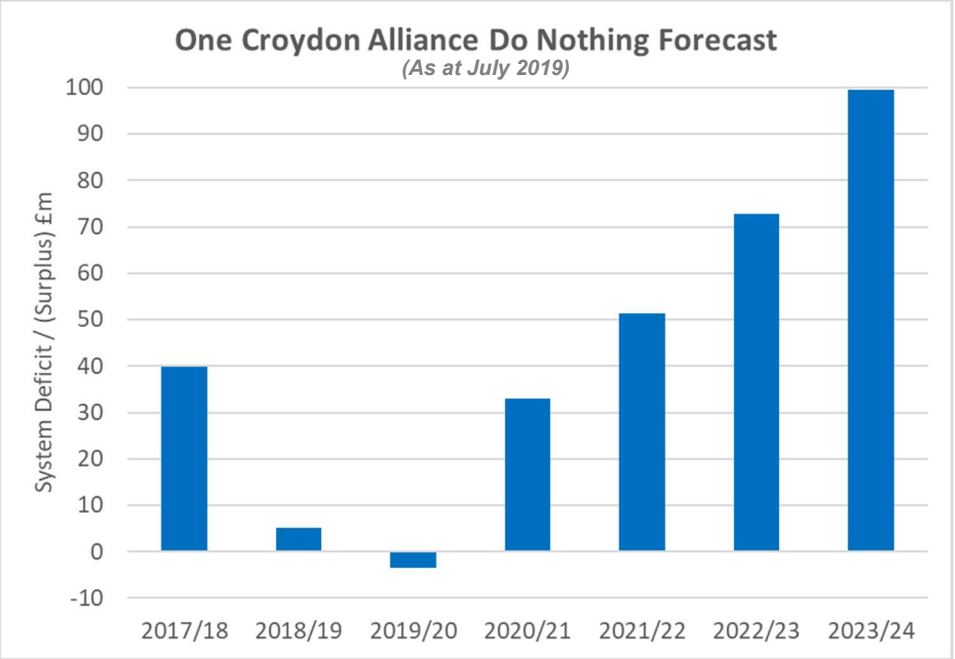
However with increasing demand from an ageing population, the need to improve quality and respond to rising patient expectations we must do more with the £890m (see Appendix 3) allocated to fund health and care in Croydon. It is therefore inevitable that the shape of services will have to change. To support our health and care plans we will shift the balance of our spend from reactive, high cost acute care to preventative, proactive out of hospital; care.

NHS England announced new 5-year population based allocations in January 2019. The Social Care green paper is awaited to clarify future funding for social care.

If we do nothing we will have approximately a £100m deficit by 2023/24. This is a similar challenge to that sized in previous strategies.

Clinically led working groups are developing patient focussed solutions to deliver care within the resources available. Further work will be undertaken to demonstrate how these plans will close the financial gap.

NOTE: This analysis requires updating for NHS 5-year planning assumption.

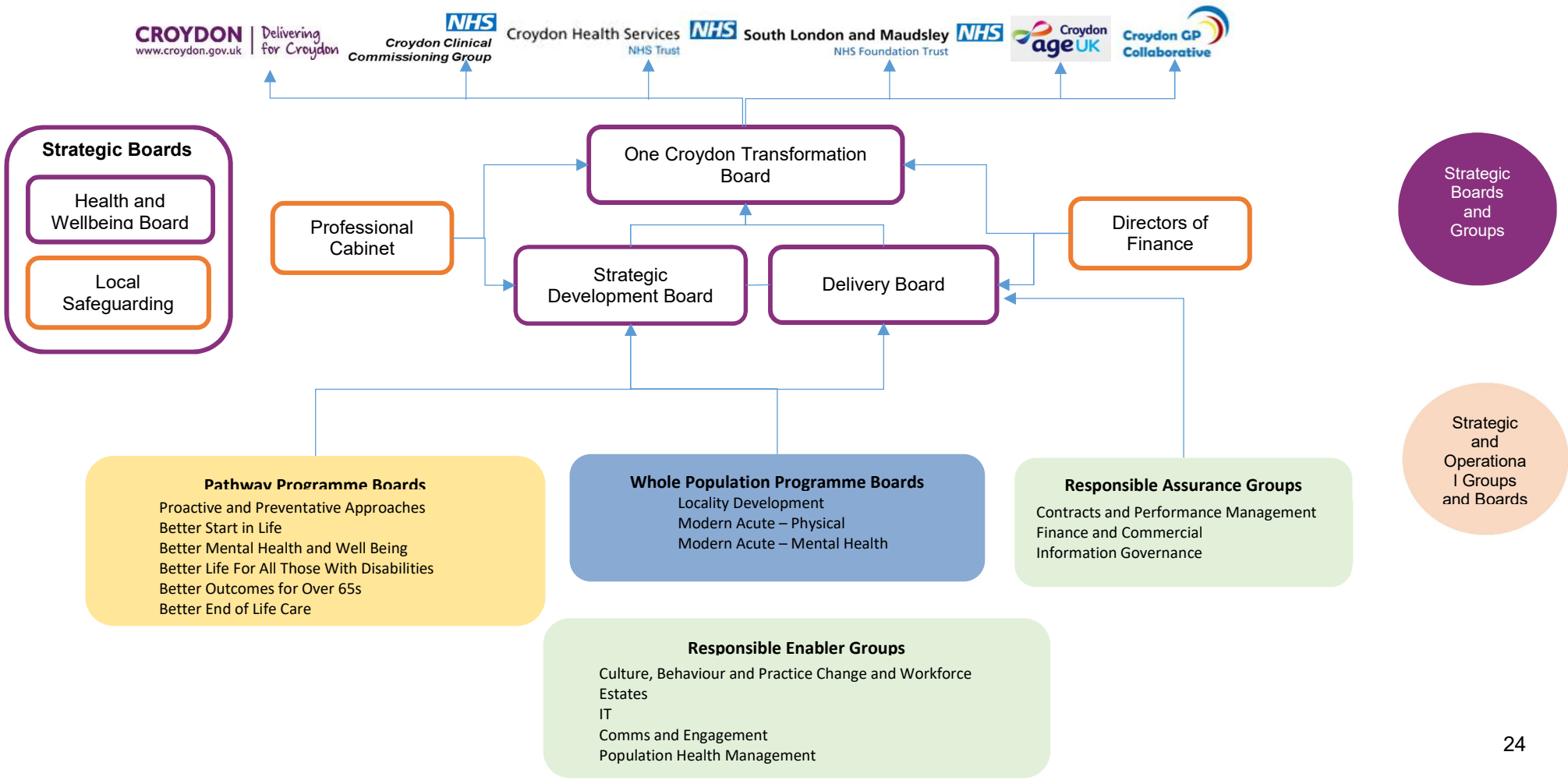


Do Nothing	Outturn	Outturn	Plan	Forecast	Forecast	Forecast	Forecast
	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24
	£m	£m	£m	£m	£m	£m	£m
CCG	-13.87	1.17	3.50	-6.53	-14.54	-25.57	-41.69
CHS	-22.20	1.50	0.00	-15.27	-21.76	-28.41	-35.23
LA	-3.80	-7.80	0.00	-10.20	-12.70	-15.30	-18.10
SLaM	0.00	0.00	0.00	-1.08	-2.25	-3.42	-4.45
	-39.87	-5.13	3.50	-33.08	-51.25	-72.70	-99.47

Our Governance

The Croydon Transformation Board is revising its governance to ensure it is able to deliver against the programmes identified. The Strategic Development Board and the Delivery Board will be responsible for strategy and delivery respectively. A number of programme boards will report to them. We will also establish a Pathway Programme Board for each specific group, focussing on the customer journey for that group so that we can ensure the integration of services delivers for the whole population. The Pathway Programme Boards will ensure that the care model designed for their group is locality focused and delivers good modern acute provision.

The governance structure below is currently in development:



Next steps

This plan represents an exciting journey that health and care partners are on together. To strengthen these plans and to continue the journey there are a number of other key pieces of work to complete. Over the next year we will working towards:

- **Showing how we are making a difference** – we recognise this plan sets out some significant challenges including a potential financial gap of approximately £160m by 2023/24 if we were to do nothing and continue to deliver services in the same way. We set out some ambitious plans to address those challenges however we recognise that we have not set out how our plans will meet those challenges. Work will continue to demonstrate how our plans meet the challenges and close the financial gap. Whilst we have set out our outcomes and indicators of success, each programme board will also set out their own specific outcomes.

- **Defining and refining our programmes** – this plan does not start from scratch. We have been able to take stock of the excellent work already being done across the borough and plan our next steps. Our programmes are therefore at different stages of development and the governance is under review in order to ensure it supports this ambitious plan effectively. We recognise that through this planning there were gaps in our programmes such a comprehensive **workforce and organisational development** plan. Work is underway to define this programme and to identify the resourcing needed to develop and support our staff. In addition there was a recognition whilst there was significant work being undertaken to support the **early years, children and families**, there were still potential opportunities to align work further.

- **Enabling our plans -** This plan does not focus on some of the key enablers that will support the delivery of our plans such as our workforce, IT and estates. Each of these areas are developing their own strategies to support this plan.

- **Continuous engagement** – This plan has been informed through engaging with our population including specific groups. This will continue as we develop the details of our plans. We will also be developing how we engage with local populations to be central to the Integrated Community Network Plus model.

- **Developing Annual Operating Plan** – this plan sets our challenging ambitions and plans for over the next two years. Health and care partners will strengthen their joint planning and develop annual implementation plans.

Appendix 1 Our annual measures

Appendix 2 Our programmes of delivery

KEY
- Current
- New

PROGRAMMES TO DELIVER OUR INITIATIVES	Stay Well	Manage Well	Greatest Need
Locality Development	▪ Develop our locality based, out of hospital care and proactive interventions model, including social care, housing, welfare and universal support ▪ Implement Gateway Locality Model to strengthen localities in three pilot areas ▪ Implement Primary Care Working at Scale and development of existing Integrated Community Networks ▪ Redesign outpatient care ▪ Improve ambulatory emergency care, redesign of the roving GP, increase 111 offering ▪ Improve integration between primary and secondary services, social care and housing ▪ Pathway redesign and process redesign		▪ Support Carers ▪ Extend proactive care management through extended ICNs, Develop LIFE at Scale, Community IV antibiotics and catheter mgmt. ▪ Care homes transformation and Assistive Technology ▪ Transform Falls & Frailty including falls response pilot ▪ Improve End of Life Care ▪ High intensity user programme
Modern Acute Hospital	▪ Transforming acute provision including community facing services ▪ Clinically sustainable hospital ▪ Optimising acute pathways and improving integration	▪ Supporting local integrated services through repatriation	▪ A&E transformation

Alignment with Strategic Priorities

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

Appendix 2 Our programmes of delivery

KEY
- Current
- New

PROGRAMMES TO DELIVER OUR INITIATIVES	Stay Well	Manage Well	Greatest Need
Prevention, and Proactive Care	**Prevention, Early Intervention, Early Detection** ▪ Develop consistent approach to preventing and proactive management of Long Term Conditions and support for people with disabilities ▪ Develop a prevention framework ▪ Review and develop Making Every Contact Count (MECC) ▪ Review and develop Just Be / Live Well ▪ Improve national diabetes prevention programme (Healthier You) ▪ Improve health screening including health checks **Self Care, Self Management and Personal Resilience** ▪ Expand Healthy pharmacy hub model to all areas of borough ▪ Create digital version of the Patient Activation Measure (PAM) ▪ Expand E-Market approach and align with social prescribing **Active and Supportive Communities** ▪ Build voluntary and community sector partnerships through the voluntary and community sector strategy to deliver whole system prevention ▪ Develop Local Voluntary partnerships (LVPs), including social prescribing, Asset Based Community Development (ABCD) ▪ Develop strengths based approaches across disciplines through community led support ▪ Maximise volunteering opportunities		
	Prevention, Early Intervention, Early Detection ▪ Develop proactive digital solutions including use and coverage of Health Help Now , service directory and e-market place ▪ Develop social prescribing at scale across the borough		**Self Care, Self Management & Personal Resilience** ▪ Multi-disciplinary community led support and strengths based approaches for our whole population ▪ "Nudge theory" to guide behaviour and activities ▪ Expand LIFE Proactive Community Referrals ▪ Proactive identification of people in greatest need
		Self Care and Self Management ▪ Systemise medication reviews for people ▪ Expand range of options for diabetes structured education (SE) **Shared Decision Making** ▪ Expand expert patients programme ▪ Expand group consultation at scale across settings and for all conditions ▪ Expand Health Help Now e.g. Push notices, Avatars – explain symptoms ▪ Develop the health champion role ▪ Roll out Shared Decision Making (SMD) toolkit	

Alignment with Strategic Priorities

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

Appendix 2 Our programmes of delivery

KEY
- Current
- New

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

Alignment with Strategic Priorities

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

Appendix 2 Our programmes of delivery

KEY
- Current
- New

PROGRAMMES TO DELIVER OUR INITIATIVES	Stay Well	Manage Well	Greatest Need
Better Life For Those With Disabilities	**All Age Disability and Adult Social Care Transformation (ADAPT)** • Working age people will have flexible care that they can arrange themselves and have choice and control over, achieved through e-market places, Personal budgets and direct payments • Transform our provision and workforce to implement locality based, multi agency working achieving seamless care for people with disabilities, with new front door ▪ Children with disabilities –Transforming our practice to provide consistent high quality and proportionate support through childhood and transition to adulthood ▪ People will have Active Lives, that are asset based and co-produced with them, ensuring coherent access and promotes inclusion and resilience for people and their carers ▪ Improve our housing offer to increase homes and housing options for people with complex health and social care needs ▪ Implement digital pathways		
	▪ Implement Compassionate Croydon ▪ Work and Health Programme ▪ Healthy Places including appropriate housing; accessibility; growth zone		
		▪ Supporting local integration and provision of services for our local population ▪ Community Led support with strength based approaches ▪ Improving housing options	
			▪ Neuro rehab development
Wider determinants of health and well being	▪ Implement Health, prevention and early intervention in all policies (housing, licensing, transport, planning) ▪ Implement Air Quality strategy ▪ Development of Growth Zone ▪ Implement Gateway locality model ▪ Implement Homelessness Strategy ▪ Implement School Superzones action plan		

Alignment with Strategic Priorities

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

Appendix 2 Our programmes of delivery

KEY
- Current
- New

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

Alignment with Strategic Priorities

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

Appendix 3 Integrated Financial Resources 2019/20 Plans

CONSOLIDATED NHS CROYDON POSITON	NHS Croydon Group Financial Position £m	Alliance Members Health Funding to Croydon Population £m	Total Croydon Health and Care Investment £m
FUNDING			
NHSE Funding - Croydon Population	594.3	594.3	745.3
NHSE Funding - Other Sources	59.0	49.0	37.1
DHSC Grant Funding to Local Authority	0.0	54.3	54.3
Other Revenue	28.9	36.8	36.8
Transitional Support (e.g. PSF, FRF, MRET)	13.2	13.2	13.2
Total Revenue	**695.4**	**747.6**	**886.7**
EXPENDITURE			
Pay	(216.7)	(276.4)	(276.4)
Non-Pay Other	(97.0)	(118.5)	(118.5)
Non-Pay - Drugs	(58.7)	(58.7)	(58.7)
Estates	(5.5)	(5.5)	(5.5)
Interest	(1.8)	(1.8)	(1.8)
Depreciation and amortisation	(8.4)	(8.4)	(8.4)
Capital Charges	(1.4)	(1.4)	(1.4)
Payments to Care Providers			
- Hospital Services	(190.6)	(141.9)	(261.0)
- Individual Placements	(26.7)	(53.5)	(53.5)
- Primary Care/Community Services	(69.9)	(69.9)	(89.9)
- Other	(15.3)	(8.2)	(8.2)
Total Expenditure	**(691.9)**	**(744.1)**	**(883.2)**
Net Financial Position	**3.5**	**3.5**	**3.5**
Croydon System Control Total (Target Deficit/Surplus)			
CCG	3.5	3.5	3.5
CHS	0.0	0.0	0.0
SLAM	0.0	0.0	0.0
NHSE	0.0	0.0	0.0
Local Authority	0.0	0.0	0.0
Total	**3.5**	**3.5**	**3.5**
Variance from Croydon System Control Total	0.0	0.0	(0.0)
Variance from Control Total Excl Trans Support	(13.2)	(13.2)	(13.2)