Croydon

Over the last two years we have been working as One Croydon, an alliance between the local NHS, Croydon Council and Age UK Croydon and our focus on services for the over 65s has led to real improvements for local communities. We have now extended our ambitions to bring together health and care to deliver benefits for the whole population on our journey to become a fully integrated care partnership.

One of the **fastest growing populations** in London

Compared to Sanderstead, **healthy life expectancy in Fieldway**, one of the most deprived areas in Croydon, is

13 years lower for men

14 years lower for women

51.7% of Croydon residents are Black, Asian and Minority Ethnic

Child population is the largest in London

of adults are **overweight or obese**

23% of people have two or more **long term conditions**

older people always or often experience loneliness

It is estimated that **76%** of people living with depression are undiagnosed

Our ambitions and aspirations

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

Our One Croydon Alliance partners are now working together to become a fully integrated care partnership. A step on that journey is the alignment between Croydon Health Services NHS Trust and NHS Croydon Clinical Commissioning Group. We are working on creating a single budget for health and care to help to better meet the needs and improve the experience and health outcomes of the people of Croydon as well as the opportunities for staff.

What we've achieved so far

Health and care professionals work together in virtual **multi-disciplinary teams** to identify people who need support and to provide those services when and where they need them. Reducing non elective admissions by 15% which means 3,000 fewer people were admitted to hospital last year.

Croydon's 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

Our Local Voluntary Partnership funds and supports local voluntary and community providers to work together to support residents to look after their own health, reduce social isolation and promote independence. Activities have included a cinema club for older people, a food growing club for newly-retired men and a tea party where people can also have a health check.

Social prescribing allows GPs and nurses to prescribe a range of non-clinical services – everything from Bollywood dancing to cooking lessons – to help improve people's emotional, mental and general wellbeing.

In six months, there were over 28,000 attendances across a range of activities and 37 of Croydon's 50 practices are now referring.

We launched our **Living Independently for Everyone (LIFE)** service. This supports people with long-term conditions mainly who are aged over 65 years old to stay at home and reduce their need to be admitted to hospital.

In its first year, the LIFE team got over 1,000 patients home sooner and helped 847 people avoid having to stay in hospital at all.

Our plans for the next two years

Locality development

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

Modern acute care

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

Prevention and proactive care

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

Mental health

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

All disabilities

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

Better start in life

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

What people have told us

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

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

Our focus

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

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

Improve quality of life

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

Better start in life

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

Wider determinates of health

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

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

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

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