NHS
Croydon
Clinical Commissioning Group

Health and SocialCare

ScrutinyCommittee

Our fiveyear forwardsustainability and transformation plan for

SouthWestLondon

Croydon, Kingston, Merton, Richmond, Sutton and Wandsworth NHS Clinical Commissioning Groups and NHS England

'Working together to improve the quality of care in South West London'

Longer, healthier lives for
all the people in Croydon

About our five year forward plan

- Following the NHS Five Year Forward View, all regions of the NHS in England are required to produce five year Sustainability and Transformation Plans (STP)

- Our plan is the product of unprecedented collaboration between all NHS commissioners and providers in South West London, working with our six local authorities and GP federations

- A draft plan was submitted to NHS England on 30 June and revised version on the21 October- now undergoing assurance from NHS England

- The full draft STP will be shared following assurance and we will then discuss further with local people and stakeholders.

What is a sustainability and transformation plan?

- NHS shared planningguidance 2016/17 – 2020/21 sets out new approach to ensure health and care services are planned by place rather than around institutions

- A plan to improve the way that health care services are delivered to ensure that:
  - the quality of services meets national standards;
  - we address future challenges such as obesity and diabetes by delivering services in the right way;
  - inequalities are reduced across the area;
  - we work within the available budget

- Thisis an opportunity to build or strengthenrelationships - across health and localgovernment – but also with patients, communities, staff and the voluntarysector

Planning levels that contribute to thesustainability and transformation plan

Existing SWL workstreams, e.g. Urgent & Emergency Care	Develop condition/ pathway specific quality improvement, productivity enabling plans. Input commissioners and providers across SWL.
4 x sub-regional planning groups:	Responsible for the development of sub-regional out of hospitals plans.
6x CCGs working with local authorities	Responsible for the development of local cross partner preventions plans.

Foursub-regional planning footprints(boroughnot CCGcombined pops):

Richmond and Kingston Planning Group

Population:**363,543**

Croydon Planning Group

Population:**376,040**

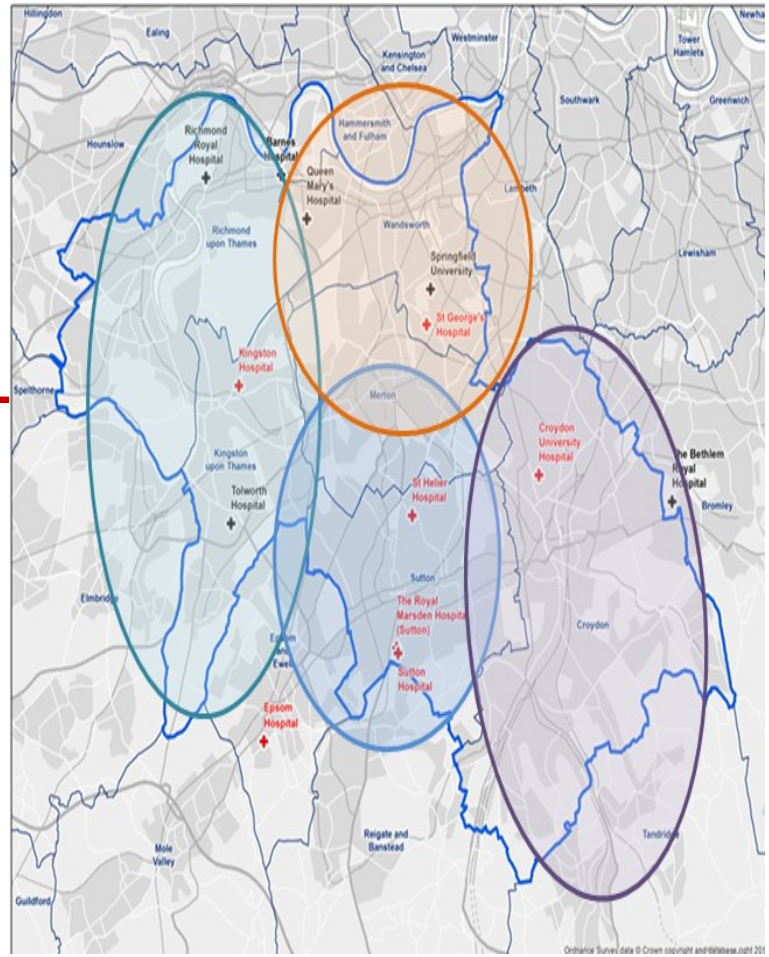
Wandsworth and Merton (*2/3) PlanningGroup

Population:**447,822**

Sutton and Merton (*1/3) PlanningGroup

Population:**265,972**

Plus patient flows to ESUH from Surrey Downs CCG



We are clear about the challenges we face

- We have a life expectancy gap of 9.4 years from the most affluent areas to the most deprived.
- Our population is growing and ageing, with increasingly complex mental and physical healthcare needs – we need to do more to help people live healthy, independent lives for as long as possible
- Services in South West London are not set up to achieve this. Too often people are admitted to hospital in an emergency or to inpatient mental health beds when they could have been treated earlier or elsewhere and not needed to be in hospital
- Quality of care varies enormously across south west London depending on where and when patients access services
- None of our acute hospitals meet all of the required standards for acute urgent and emergency care and we over-rely on agency staff to support acute services. Our best working hypothesis is that four acute sites is the optimum number.
- Changes to funding local councils and social care budgets have presented additional challenges to the NHS
- As a result of these pressures, the cost of providing care is rising far more quickly than inflation and the money we are allocated

Our principles

- If we do nothing, our services will not be sustainable – we need to act now to improve standards and outcomes for people in SouthWest London, while making sure services are clinically and financially sustainable

- Our draft plan sets out how we can work together across SouthWest London to support people to keep healthy and well – and to intervene early and deliver the right care in the best place to support them if they do become unwell

- To do this, we propose toshift more care from hospitals into the community,so we can provide care that is closer to home, tailored to people’s individual needs and supports them to stay as well as possible for as long as possible

- We will continue to work with local people and organisations across SouthWest London over the next few months to support the development of more detailed plans

The SWL Vision

Our Mission

To help South West London's residents to

Startwell,**live**well,**age**well

Our Vision

People live longer, healthier lives. They are supported to look after themselves and those they care for. They have access to high quality,joined-uphealth and care services when they needthem that deliver better health outcomes at a lower cost of provision to the system

Service Design Principles

1. Care is patient-centred and holistic

- Inclusive and recognises the role of family, friends, communities and voluntary organisations
- Joined-up and crosses organisational boundaries, encompassing people's physical, mental and social care needs
- Easy to navigate

2. Care is proactive and preventative

- Focused on enabling people to stay well and avoid the need to access healthcare services
- Prioritises early detection – people have access to early support mechanisms
- Promotes self management – people are encouraged to take responsibility for their own health

3. Care supports the quality of life and the outcomes people value

- People are supported to live life as fully as possible, for as long as possible
- People are aware of the choices available to them and have greater control

4. Care is financially sustainable

5. Our staff and care giversfeel supported and able to do their roles

Service DevelopmentPrinciples

1.We focus on**better health outcomes at lower cost of provision to the system**

- We work in partnership across all health and social care organisations ,including the third sector to design and deliver the solutions
- We make better use of resources, irrespective of the organisation
- We plan for a changing environment

2.We will rapidly adopt**evidence-based care**(where possible)

3.We maximise the use of**digital technology,**for the benefit of all stakeholders

The three big challenges we need to meet

Gap1: Improving health and wellbeing

- Growingand**ageing population**, but also an unusually**young population**.
- **Inequalities,**with pockets of deprivation that are linked to poorer health and wellbeing outcomes
- **Prevention in early years**could be improved (focus on childhood obesity)
- The number of**people living with dementia**is rising and embeddinghigh-qualitydementia care into servicesis key to improving care and clinical outcomes.

Developingcross-partnerprevention plans

The development of this plan has been welcomed as an opportunity to improve collaboration between the NHS and local authorities.

Gap2. Improving care and quality

Our care and quality base casedemonstrates that:

- We are failing to meet minimum standards for acute urgent and emergency care
- More could be done in the community to reduce the amount of care delivered in hospitals
- We can do more to improve the quality of general practice
- We are not consistently meeting the needs of people who have mental health needs ordementia

Underlyingfactors

Two main factors underpin these gaps in the quality of ourservices:

- Thelack of an available workforce to provide safe, effective care in the existing configuration of services
- Theprovision of preventative and proactive care, including primary care and services supporting earlier discharge from hospital, is inadequate.

Gap 3: Improving finance and efficiency

- Thecost of delivering services is rising much faster than inflation due to rapidly increasing demand; this is creating a financial gap which will make current services unaffordable by 2020/21 if we do not make changesnow.
- Ourinitial analysis suggested that if we do nothing, the financial gap in five years would be £900m.
- Webelieve that making changes to the way in which services are delivered can deliver changes that improve the quality of care as well as making services more cost-effective to the taxpayer.

Our health and well being challenge

South West London

- Inequalities with pocketsof**deprivation**across South West London
- **Behaviours**- Smoking, inactivity, poor diet and drinking too much
- **Growing and agingpopulation with diabetes**
- **Cancer**is a major cause of premature death
- High**hospital admissions for mental health conditionsfor under 18s**
- **Prevention in early years could be improved particularly childhood obesity**

Croydon

- Increasing**deprivation**with significant deprivation in north of the borough, Fieldway, New Addington and Shrublands
- **Smoking**: Smoking prevalence in Croydon is close to the national average. (est17.0% of adultssmoke)
- **Obesity**: One in four children aged four to five years are overweight or obese, and one in three children aged ten to eleven years are overweight or obese. An estimated 62.1% of adults are overweight orobese **Physicalactivity**levels arelower than the regional average
- There are 48,500**over 65s**in Croydon and they represent approximately 1 in 8 of Croydon's population at present and projected to grow.
- **Diabetes:**Croydon has a higher prevalence of people with diabetes than London or England
- **Circulatory diseases, cancers and respiratory diseases**remain the cause of themajority of excess**deathswhich contribute to the gap in life expectancy**
- Health Screening: Breast and cervical**cancer**screening rates are both significantly worse than the national average
- The**prevalence of severe mental illness**in Croydon is significantly higher than the national average, but similar to London.**Admissions for mental health conditions for under 18s**ishigher than London and national averages.

In addition Croydon faces a number of other health and well being challenges

- **Significantpopulation growth -**from 376,000 to400,000by 2022
- Over half of the population is from a**black,Asianand minority ethnic group**
- **Inequality in Life Expectancy**: Life expectancy is 9.1 years lower for men and 7.7 years lower for women in the most deprived areas of Croydon than in the least deprived areas
- **Employment**: Over a quarter of jobs in Croydon are estimated to pay below the London Living wage in 2014 and the proportion of people claiming Job Seekers Allowance is above the regional and national average
- **Housing**: Housing and homelessness represents a significant and growing challenge for Croydon in coming years. Homelessness has been increasing in Croydon over the past few years following a sustained decrease since 2003
- **Social Isolation**: Croydon has a lower rate of permanent admission into care homes, 421 per 100,000 over 65s compared to 465 per 100,000 in London and 651 per 100,000 in England. Only 44.3% of people have reported they have as much social contact as they would like, which is similar to the national average of 44.5%

Our care and quality challenge

South West London

- **Failing minimum standards**for urgent care and emergency care in our hospitalsincluding 7day working
- **Variationin how primary care**is co-ordinated for patients and perceived perceptions of accessibility
- **Increasein emergency admissions, non elective bed days and bedoccupancy**
- **13% of patients could have avoided admission and a further 42% could have benefit form early discharge**
- Poor**rate of admissions for people**

Croydon

- Ofthe 172 applicable**London Quality Standards,**Croydon HealthServices met99standards and didnot meet 61 standards(thereis insufficient evidence for 12 of thestandards)
- Number of**variations in primary care qualityandperformance**, including diagnosis, referrals, leading to varyingexperiences of care and outcomes forpeople
- Highest level of NEL Admissions in London
- 18%of patients could have avoided admission and a further39%could have benefit form early discharge

In addition Croydon faces a number of other care and quality challenges

Independence and independent living

- **Patients living at home**: The percentage of older people still at home 91 days after leaving hospital was 65.3% in 2012/13 compared with 81.4% for London overall
- **Social care-related quality of life:**People report quality of life in 2012/13 was 18.4 compared to 18.7 the previous year and the national average of 18.8
- **Control over daily life:**The percentage of people who use services who reported control of their daily life decreased to 68.8 in 2014/15 from 74 the previous year and remains below the national average of 75.1

Patient experience

- **Access to GP services:**patient experience has fallen to 71.4% from 73.4% from the previous year and remains below the national average of 73.3%
- **Communitymental health:**patient experience has fallen during 2014 from a score of 8.75 to 7 (out of 10)
- **Hospitalcare – inpatient**: patient experience has improved for 2014/15 to 70.5% from 67.1%. It is however below the national average 76.6%
- **Hospital care – outpatient**: patient experience has remained similar for 2014/15 at 74.4% however it remains below the national average 79.5%
- **Hospital care - A&E**: patient experience has remained similar for 2014/15 at 73% however remains below the national average 80.7%
- **Carer with social services**: satisfaction has fallen from the previous year to 25.5% from 29.9% and remains below the national average of 42.7%
- **People who use services with their carer and support:**satisfaction has improved to 59.9% in 2014/15 from 57.9% the previous year. It however remains below the national average 64.1%

Our plan will enable us to:

- Setup locality teams across South West London to provide care to defined populations of approximately 50,000 people. The teamswould alignwith GP practice localities and have the skills, resources and capacity to deliver preventative health and supportself-care
- Addressboth mental and physical needs in an integrated way, because we know this improves the wellbeing and life expectancy of people with severe mental illness and reduces the need for acute and primary care services for people withlong-term conditions
- Introducenew technologies to deliver better patient care (e.g. virtual clinics and apps)
- Useour workforce differently to give us enough capacity in community, social care and mental health services to bring care closer to home and reduce hospitaladmissions
- Makebest use of acutehospital staffthrough clinical networkingand/or consolidating activity on a smaller number of sites
- Reviewour acute hospitals to ensure that we meet the changing demands of ourpopulationsand to ensure that acute providers deliverhigh-quality, efficient care.

Summary ofsuggestedchanges

SouthWest London and Croydon

Croydon, Kingston, Merton, Richmond, Sutton and Wandsworth NHS Clinical Commissioning Groups and NHS England

'Working together to improve the quality of care in South West London'

Prevention and early intervention

- We need to better support people to live healthy, active and independent lives for as long as possible: this includes offering advice and support to stop people getting ill and to help patients to manage their long-term conditions
- Where people do get ill, we need to ensure they are diagnosed and supported at an early stage
- Mental and physical health issues must go hand in hand: support for people with long-term conditions like diabetes, medically unexplained symptoms and chronic pain should take into account mental as well as physical health needs
- We need to do more to identify people at risk of developing long-term conditions and use modern technology and a modernised workforce to develop proactive care to support them at home and in the community
- Much closer work between the NHS and local authorities, who provide social care, is critical to supporting the prevention agenda
- Modern technology can support the prevention agenda – e.g. online, apps and text-based services, Skype consultations

SWL Preventative and Proactive model of care

LONG TERM CONDITIONS

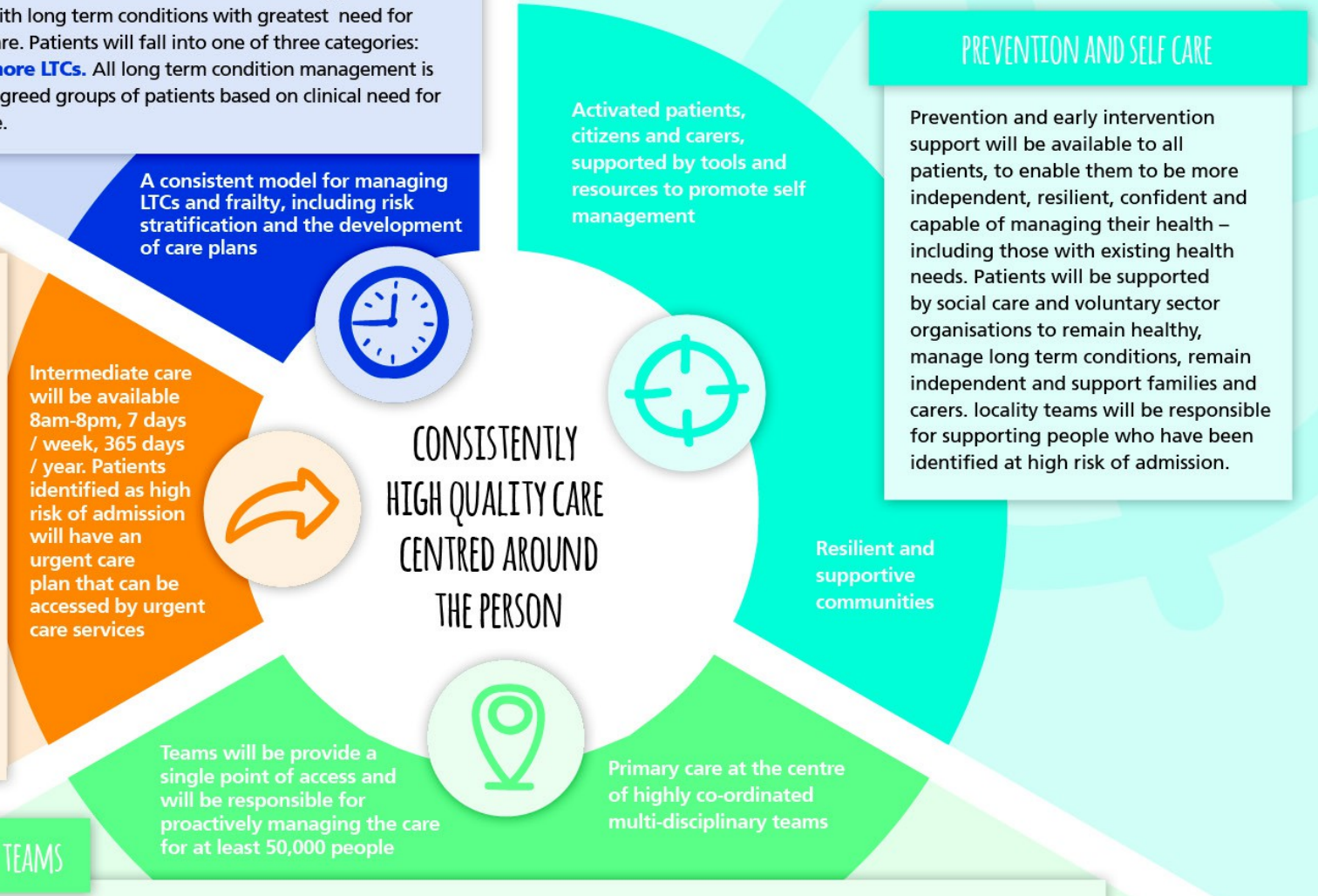
Risk stratification will be used to identify patients with long term conditions with greatest need for care. Patients will fall into one of three categories: **Mostly healthy • 1 LTC • 2 or more LTCs.** All long term condition management is community based other than for agreed groups of patients based on clinical need for hospital based acute/specialist care.

IMMEDIATE CARE

A community based system response to support someone in crisis to remain in the community, or support someone to be discharge back home from hospital. Home first principle but will have access to bedded facilities to support people who cannot safely be cared for at home.

There will be access to all health and care services in the community via a single point of access, including:

- Voluntary sector and community assets
- Locality
- Primary care (incl GP & OOH)
- Ambulance services
- Acute services



PREVENTION AND SELF CARE

Prevention and early intervention support will be available to all patients, to enable them to be more independent, resilient, confident and capable of managing their health – including those with existing health needs. Patients will be supported by social care and voluntary sector organisations to remain healthy, manage long term conditions, remain independent and support families and carers. locality teams will be responsible for supporting people who have been identified at high risk of admission.

LOCALITY TEAMS

Locality teams will be responsible for identifying patients at risk of a hospital admission, and will support patients to remain out of hospital. Patients will have access to step up / step down facilities to help avoid admissions, diagnostics within the community, and will support people to self- care and maintain a healthy lifestyle. Where patients are admitted to hospital, teams will work to ensure patients are discharged as timely as possible. All patients identified as at risk of hospital admission will benefit from MDTs, which will draw together social care, mental health, community services and care coordinator resources into a single team structure.

Croydon's sub regional plan

NHS Croydon Clinical Commissioning Group

Each sub region has developed plans across the priority areas to support prevention and early intervention and the delivery of care in the best place.

Appendix 1 provides the summary of Croydon's planned initiatives to deliver this.

In addition our sub regional plan sets out how what the SWL sustainability and transformation plan means for Croydon.

The scope of the Croydon sub-regional plan

Responding to theClinicalBoard'shypothesis about "delivering care in the best setting" including:

- Plansto avoid acute attendances and admissions
- Plans to enable earlier discharge from hospital
- Combining physical and mental health care elements
- Driving health and social care integration and connecting clinical with wider non-clinical support and assets in the community
- A particular focus on frailty and the development of locality teams

Plans cover all population groups; children and young people, adults and older people

Other elements within the sub-regional plans and are being addressed on a SWL-wide basis, drawing on plans/initiatives developed by individual CCGs and Boroughs.These include:

- Outpatientactivity
- Productivity within organisations; CIP and QIPP
- Public health and long term prevention plans
- Primary care; implementation of specifications and development of GPfederations

Transforming access to outpatients

- We want to deliver more consistent outpatients services acrossSouth WestLondon, stop patients having to attend unnecessary appointments and bring outpatient care closer to home

- We aim to stop unnecessary follow-up appointments by only providing annual reviews when clinically necessary, ideally in a primary care setting, stopping automatic follow-up appointments and making it easier to be re-referred

- We want to reduce variation between GP practices by expanding the use of referral management systems, setting up one-stop clinics and standardising protocols in our diagnostic services

- Better use of technology – e.g. Skype or telephone appointments, remote monitoring via smartphone apps, online services (e.g. for sexual health), better sharing of information between GPs and hospitals, text reminders for appointments

- More community-based clinics (e.g. musculoskeletal and dermatology), “upskilling” primary care work force to support community-based care, more ambulatory care in the community.

New models of care

- **Maternity**: Support women's choice of place of birth, increasing availability of home births and midwife-led care. Safe and sustainable hospital services for women who need obstetric-led care. More personalised antenatal and postnatal care, including reviewing consistency of carer and provision of perinatal mental health support.

- **Children's services:**Most children who are unwell should be treated in primary care and the community; better access to and availability of community-based care will reduce the need for hospital attendances. Children who need hospital care for a short period to be assessed, observed and treated in paediatric assessment units sitting alongside A&Es. Quick access to specialist inpatient care for the small number of children who need it. Increased networking between hospitals and between GPs/primary care and hospitals.

- **Urgent and emergency care**: An integrated service which achieves the core standards is a high priority. 24/7 integrated urgent care access, treatment and advice via an improved 111 service. Priorities include mental health crisis care, self-care support and 'see and treat' models for London Ambulance Service.

New models of care (2)

- **Ambulatory emergency care (AEC)**: Treatments such as deep-vein thrombosis or cellulitis are delivered in hospital but do not require hospital admission. AEC provides timely treatment and an improved experience for patients, avoiding unnecessary admissions. All six CCGs have signed up to further delivery of AEC. We also need to improve support outside hospital for people with mental health conditions, who are three times more likely to attend A&E at present. They could be better supported by ongoing support from services closer to home and earlier help when they start to become unwell.

- **Care for the frail elderly:**We want to improve care in the community for frail older people, building on existing work, for example in Croydon where acute hospitals work with other NHS and social care providers to support older people. We will consider converting parts of our acute sites to provide specialist elderly care. We know more older patients could be treated in the community, including dementia patients as well as those being treated in acute hospitals.

Primary care

- **Locality teams**to be set up acrossSouthWest London to support defined populations of approx. 50,000: role will be prevention/public health, early intervention, working closely with the voluntary and community sector, aligning with GP localities and supported by GP federations. There will be a single point of access for professionals.
- Commitment to**accessible, coordinated and proactive**primary care
- **Investment**in primary care will be higher than baseline core contract allocations, to cover cost of developing primary care hubs, continued federation development and increased workforce costs
- **Community Education Provider Networks**(CEPNs) to deliver a range of training to practice staff
- More**Care Navigator**roles; explore recruitment ofpractice-based clinical pharmacists, mental health therapists and others
- **Sutton Care Home Vanguard**rolled out acrossSouth West London
- **GP federations**: Six have been established and have formed a collaborative. Kingston and Wandsworth already have contracts in place (e.g. diabetes, ophthalmology, dermatology and musculoskeletal outpatients); Richmond has 8am-8pm GP access 7 days a week

Acute hospital services

- We must improve quality and optimise our workforce, in particular meeting the clinical standards required by the NHS Constitution. We need to make the best use of clinicians, increasing clinical networks across the trusts.

- We are considering a shared cancer centre, pooling the resources of St George's, Epsom, StHelier and Royal Marsden. We would only look to move routine cancer surgery from Kingston and Croydon to a new centre if this would deliver demonstrably better outcomes. An example of where this approach has worked well is the South West London & Epsom Orthopaedic centre – which is now renowned for its outcomes.

- Every hospital does not have to provide every service and we know from changes to London's stroke and trauma care that concentrating services can improve results. We will explore which services are provided on each site and how we might use clinical networks, get remote support from specialists or a lead site providing shared cover at quiet times.

- Demand islikely to increase by 2020/21. Moving more care into the community will offsetthis tosome degree: intermediate beds can be delivered in a range of ways in different places. Changes to specialised commissioning may potentially impact the numbers of bedsneeded in SWL. Allour hospitals have areas of estate that need improvement andinvestment and we are developing an Estates Strategy for south west London.

Acute hospital services (2): hospital configuration

Our best working hypothesis is that four acute sites is the optimum number.

- Evidence suggests that wecan meet the clinical standards acrossthree or four sites, while five looks more difficult, but we need to do further work and public engagement on this. We need to do more work, but four acute sites is our best working hypothesis on the grounds that it would be less expensive in terms of capital costs and more easy to deliver.

- Should we decide to reduce the number of acute sites, we would consider all options available. St George's Hospital is a fixed point as a provider of hyper-acute stroke and major trauma services. No changes would be made without public consultation and consideration of feedback from local people and organisations.

- Any changes to acute services would need to be seen in the context of our plans to improve community and primary care services, including better access to GPs and other clinicians, earlier support for those who need it and helping people to stay healthy and well wherever possible. This approach is likely to reduce the need for acute hospital care.

Acute hospital services (3): specialised commissioning

- NHS England has announced a review of specialised services in South London
- We will work with the South East London STP, NHSEnglandand allstakeholders across bothareas (providers trusts, CCGs, local councils and the public) as this develops
- South London has some similar services being provided in close proximity and we need to consider the long-term sustainability of specialised services at Guy's and St Thomas', King's College Hospital and St George's. Other providers like Epsom and StHelier will also be involved in the review.
- Four projects are in development: children's oncology, neuro-rehabilitation, HIV services and Tier 4 child and adolescent mental health services. Work is also underway to address local challenges in cardiovascular care and haematology. Cancerwas agreed to be"outofscope"as it was important to follow through on existingproposals
- Formalgovernancestructures arebeing developed for all specialised commissioning acrossLondon, including the creation of a Specialised Commissioning Planning Board
- Collaboration is expected between specialist mental health providers in South London(South London and Maudsley, Oxleas and SWLandSt George's)to transform adult secure services

Estates

- Fundamental change is needed in the way we manage south westLondonhealth and social care estate
- New models of care will increase primary care provision location of acute and mental health services in primary care/community settings
- There will be 20 multi-specialty ‘community hubs’ providing an integrated range of services – mainly through repurposing existing premises where possible, with small amount of new build
- Future acute estate will depend on bed audit/bed volumes, future configuration and review of specialised services
- We are working with local authorities and across the local NHS to develop anEstates Strategy for south west London

Workforce

- We need to develop our health and social care workforce across organisational and clinical boundaries, delivering integrated, patient-centred care that is high-quality and value for money

- There are 25,000 NHS staff and 32,000 in social care. Over 18,000 of NHS staff work min acute sector and only 2,500 in community settings. Without improved recruitment and retention, demand will outstrip supply

- National shortage of qualified staff such as GPs, nurses and paediatricians. Currently, we are over-reliant on agency staff. Some staff roles likely to change as services are delivered differently.

- There are four core priorities to develop our workforce:
  - Securing sustainable workforce and improving recruitment and retention
  - Capacity and skill mix
  - Working differently
  - A healthy workforce
- Education and training is a key enabler running across all priorities. We will work with local academic institutions/education providers to ensure sustainable workforce and right competencies.

Delivering an information revolution

- Technology is a critical enabler for many of the recommendations set out in our draft plan. It is critical that clinical information about patients follows them between different health and social care services
- **Self-care** for patients can be supported by digital technology, enabling patients to get information about their condition, or provide information such as their medical record, to help them make informed decisions about managing their health
- Technology such as **video conferencing** can help break down barriers between patients and clinicians and help clinicians get rapid specialist input when needed
- **Information sharing** that combines clinical, operational and financial data can help us take a 'whole system' approach to improve the way services are delivered
- **Digital technology** should be available to all clinicians and care professionals when they need it
- There are pockets of good practice already in south west London: these will need to be expanded significantly if we are to achieve our ambitions

Closing our financial gap

- By organising services better and delivering the initiatives set out in our plan, we can close our financial gap with no reduction in the quality of care
- An audit of acute hospital beds suggests that wecould substantially reducethe number of days people spend as inpatients by delivering improved models of care
- By changing outpatient services, we could reduce unnecessary appointments by 20%
- By reducing the use of procedures which have limited clinical effectiveness, we could reduce elective surgery by 13%
- Programmes to increase acute provider productivity by sharing non-clinical ‘back office’ functions are underway: areas being looked at by hospitals include procurement, a shared staff bank, reduction of corporate and administrative costs and more efficient management of our estates
- CCGs have also identified that they can make significant savings by working together more closely, including sharing ‘back office’ functions internally and with providers or councils.
- Pharmacy teams acrossSouth West Londonare working together to identify opportunities for medicines-related savings: for example by reducing use of medicines that are less clinically effective or significantly more expensive than alternatives

Involving local people

- We published an Issues Paper in 2014 which was widely distributed across south westLondonand discussed at large scale events with the public and stakeholders in each borough – feedback from these informed our five year forward plan
- In May 2016, we wrote to more than 1,600 local voluntary, community and campaigning organisations in south west London setting out our emerging thinking and asking for their views – these views were considered as our plan was being developed
- All feedback received to date and our response to it will be published shortly.We will produce regular ‘YouSaid,We Did’ reports summarising feedback received and ourresponse
- We plan further public events later in 2016/17, where we will discuss the content of our draft plan and seek people’s views
- We are running a large grassroots engagement programme with local Healthwatch organisations, leading to events in each borough for groups whose voices are seldom heard. There have been about 30 events so far, with many more planned. Feedback will continue to inform our thinking.
- Patients and the public are directly involved in each of our clinical workstreams and we have a Patient and Public Engagement Steering Group which oversees our public engagement

Our plan for the next six months

- Ourdraft STP was submitted to NHSE on 21st October 2016. Once national assurance is complete, the final plan will be published and further public engagement will take place
- We anticipate a series of public events in the next few months, which will help inform the development of our plan
- Should any proposals emerge that require public consultation we would envisage this would take place in late 2017
- A number of plans are already underway – for example plans to improve primary care, better preventative care, a more joined up approach between services and development of aSouth West LondonEstates Strategy.
- Further work, further information and further public engagement will be needed before we can finalise our plans.

Appendix

Overview of Current and Planned Croydon CCG & Local Authority Out of Hospital Initiatives

Key delivery principle	
Locality based teams, and Primary Care at the centre of highly coordinated multidisciplinary teams	

The following key priorities have been identified based on work at a SWL level, and additional work within the sub-region

Croydon Clinical Commissioning Group

Key delivery principle	Future planne		
Activated patients, citizens and carers, supported by tools and resources to promote self-management Resilient and supportive communities	• Expanded i manageme • Review and health care • Implement tools like F • Implement		

The requirements from key enablers have been identified for each initiative

Croydon Clinical Commissioning Group

Key initiative	Workforce	Estates	IT	Levers
Localityteams; primary care at the centre of MDTs Modelfor managing LTCs and frailty Resilient and supportive communities Activated patients,citizens and carers Single point of access	• Use of workforcemodelling tools to support more accurate assessments of need • New multi-professional models of Primary Care including e.g. Physician Associates, Pharmacists, and Care Navigators • Shifting of clinical resources from acute into community/primary care • Improved use of voluntarysector to support delivery of APA model of Care, and Together for Health programme • Improvedrecruitment and retention through e.g. Primary/Community cross training and development opportunities • Development of shared network/cluster based roles to support effective use of staff • Development of targeted training programmes with Croydon Community Education Provider Network (CDEPN) for clinical and non-clinical staff • Use of OutcomeBased Commissioning contractual levers to promote efficient use of resources	PriorityGP Primary Care investment areas identified: • East Croydon network-largest population, and most significant population growth of 12.4% • New Addington& Selsdon and Purley networks -premises shortfall of approximately 1,500sqm each by 2025 • High deprivation wards in East Croydon, New Addington & Selsdon, and Thornton Heath networks Capital funding principle-estate capital investmentdemonstrates: • Benefit for the greatest number of the population • Delivers overall Commissioning & Out-of-Hospital Strategies • Improvement in the quality of the estate where needed • Value for money (inc. affordability) To be delivered in a prioritised approach: 1. Develop hubs to support growth 2. Address practice improvements to support increasedprovision	Improved: • Interoperability between physical, social andmental care, and voluntary sector • Reduction in IM&T systems across primary and community care • Access to digital health records (clinicians and patients) buildingon existing portals such as Medical Information Gateway (MIG), Coordinate my Care (CMC) • Mobile working – devices, mobile solutions, wifi • E-consultations for patients • Videoand audio conferencing functionality • Patient messaging systems to improve e.g. update of screening, reducing missed appointments • Use of mobile apps to improve self-care and long term condition management • Improved commissioning and provider IM&T system infrastructure to improve resilience and reduction in overheads • Business informatics systems to support more targeted commissioning on need	• Primary Care PMS contracts • Croydon CCG Primary Care Local Incentive Schemes • Outcome based commissioning contract for over 65s

Key initiative	Next steps	Owner	By when
Single point of access Localityteams; primary care at the centre of MDTs Modelfor managing LTCs and frailty	***Integrated networks and care coordination:*** • Alignmentof Croydon CCG and Accountable Provider Alliance (APA) strategy and delivery groups to strengthen joint development and delivery of initiatives • Establishment of APA Model of Care (inc. implementation of Single Point of Access, Integrated Community Networks, Personal Independence Coordinators, My Life Plan) ***Improved access to support*** • Implementation of APA IntegratedIndependent Living Service (inc. rehabilitation/reablement, telecare, community and home support, rapid response and intermediate care beds) ***Improved Primary Care delivery*** • Further engagement with patients, GP Practices, and Croydon GP Federation to agree approach to delivery of population-based services in Croydon to support out of hospital care • PMS and GMS GP practices commissioned to provider agreed services as required ***Improved model for LTC management*** • Completed service reviews of LTC areas of focus and implementation of redesigned pathways	• CCG/ APA • CCG/ APA • CCG/APA • CCG • CCG • CCG	• 1st August 2016 • 1st April 2017 • 1st July 2017 • 1st September 2016 • 1st April 2017 • 1st April 2017
Resilient and supportive communities Activated patients,citizens and carers	• Joint reviewby Croydon CCG and APA to identify opportunities for improving engagement with communities, patients and carer's as part of APA Model of Care implementation • Completed assessmentofoutcomes for the3 priority areas being currently piloted (MSK, Respiratory and Diabetes) to shape future delivery of initiatives	• CCG/APA • CCG	• 1st August2016 • 1st April 2017

Key initiative	Next steps	Owner	By when
Shared responsibility and risk across the system, and involvement in proactive care (including hospitals)	***Outcome Based Commissioning (OBC)*** • Signoffof OBC contract ***Primary Care*** Engagement with GP Practices and GP Federation to develop primary care priorities and delivery approach	• CCG • CCG	• 1st October 2016 • 1st October 2016