Public Document Pack

Health & Wellbeing Board

To:
Councillor Yvette Hopley (Chair)
Councillor Margaret Bird (Vice-Chair)
Councillor Janet Campbell
Councillor Amy Foster
Councillor Maria Gatland
Councillor Tamar Nwafor
Annette McPartland, Interim Corporate Director Adult Social Care & Health (DASS)
Rachel Flowers, Director of Public Health - Non-voting
Edwina Morris, Healthwatch
Hilary Williams, South London and Maudsley NHS Foundation Trust
Michael Bell, Croydon Health Services NHS Trust - Non-voting
Steve Phaure, Croydon Voluntary Action - Non Voting
Matthew Kershaw, NHS Croydon Clinical Commissioning Group (CCG)
Debbie Jones, Corporate Director for Children, Young People and Education

A meeting of the **Health & Wellbeing Board** will be held on **Monday, 17 October 2022** at **2.00 pm** in **Council Chamber, Town Hall, Katharine Street, Croydon CR0 1NX**

Katherine Kerswell
Chief Executive
London Borough of Croydon
Bernard Weatherill House
8 Mint Walk, Croydon CR0 1EA

Michelle Ossei-Gerning
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7 October 2022

The agenda papers for all Council meetings are available on the Council website www.croydon.gov.uk/meetings

If you require any assistance, please contact Michelle Ossei-Gerning 020 8726 6000 x84246 as detailed above.

AGENDA – PART A

1. Apologies for Absence

To receive any apologies for absence from any members of the Committee.

2. Minutes of the Previous Meeting (Pages 5 - 10)

To approve the minutes of the meeting held on Wednesday 19 January 2022 as an accurate record.

3. Disclosure of Interests

Members and co-opted Members of the Council are reminded that, in accordance with the Council's Code of Conduct and the statutory provisions of the Localism Act, they are required to consider **in advance of each meeting** whether they have a disclosable pecuniary interest (DPI), an other registrable interest (ORI) or a non-registrable interest (NRI) in relation to any matter on the agenda. If advice is needed, Members should contact the Monitoring Officer **in good time before the meeting**.

If any Member or co-opted Member of the Council identifies a DPI or ORI which they have not already registered on the Council's register of interests or which requires updating, they should complete the disclosure form which can be obtained from Democratic Services at any time, copies of which will be available at the meeting for return to the Monitoring Officer.

Members and co-opted Members are required to disclose any DPIs and ORIs at the meeting.

- Where the matter relates to a DPI they may not participate in any discussion or vote on the matter and must not stay in the meeting unless granted a dispensation.
- Where the matter relates to an ORI they may not vote on the matter unless granted a dispensation.
- Where a Member or co-opted Member has an NRI which directly relates to their financial interest or wellbeing, or that of a relative or close associate, they must disclose the interest at the meeting, may not take part in any discussion or vote on the matter and must not stay in the meeting unless granted a dispensation. Where a matter affects the NRI of a Member or co-opted Member, section 9 of Appendix B of the Code of Conduct sets out the test which must be applied by the Member to decide whether disclosure is required.

The Chair will invite Members to make their disclosure orally at the commencement of Agenda item 3, to be recorded in the minutes.

4. Urgent Business (if any)

To receive notice of any business not on the agenda which in the opinion of the Chair, by reason of special circumstances, be considered as a matter of urgency.

5. Public Questions

Public Questions should be submitted before 12 noon on 12 October 2022 to democratic.services@croydon.gov.uk. Any questions should relate to items listed on the agenda. 15 minutes will be allocated at the meeting for all Public Questions that are being considered.

6. Better Care Fund End of Year 2021/22 submission to NHS England (Pages 11 - 30)

The Health and Wellbeing Board is asked to review and note the submission of the Better Care Fund end of year submission to NHS England.

7. Better Care Fund Plan 2022/23 submission to NHS England (Pages 31 - 106)

The Health and Wellbeing Board is asked to review and note the submission of the Better Care Fund 22/23 planning submission to NHS England.

8. Pharmaceutical Needs Assessment (Pages 107 - 112)

This paper provides a progress update on the process to produce and publish the 2022 PNA

9. Update on South West London Integrated Care System (Pages 113 - 134)

This paper gives provides an update on governance of SWL Integrated Care System and One Croydon Place, it also outlines health and care plan priorities and provides some examples of the delivery of the plan.

10. Exclusion of the Press and Public

The following motion is to be moved and seconded where it is proposed to exclude the press and public from the remainder of a meeting:

"That, under Section 100A(4) of the Local Government Act, 1972, the press and public be excluded from the meeting for the following items of business on the grounds that it involves the likely disclosure of exempt information falling within those paragraphs indicated in Part 1 of Schedule 12A of the Local Government Act 1972, as amended."

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Health & Wellbeing Board

Meeting of the Health and Wellbeing Board held on Wednesday, 19 January 2022 at 2.00pm.
This meeting was held remotely.

MINUTES

Present: Councillor Janet Campbell (Chair);
Dr Agnelo Fernandes (NHS Croydon Clinical Commissioning Group) (Vice-Chair);
Councillor Alisa Flemming
Councillor Jerry Fitzpatrick
Councillor Yvette Hopley
Councillor Margaret Bird
Annette McPartland, Interim Corporate Director Adult Social Care & Health (DASS)
Rachel Flowers, Director of Public Health - Non-voting
Edwina Morris, Healthwatch
Hilary Williams, South London and Maudsley NHS Foundation Trust
Michael Bell, Croydon Health Services NHS Trust - Non-voting
Matthew Kershaw, NHS Croydon Clinical Commissioning Group (CCG)

Also Present: Rachel Flagg (CAMHS - Integrated Delivery Manager)
Samantha Boyd (CAMHS - Associate Director of System Strategy)
Sarah Burns (CVA Live)
Andrew Brown (BME Forum)
Ima Miah (ARCC Ltd)
Katy Morteo (Metropolitan Police)
Yusuf Osman (Croydon Adult Social Service Users Panel Representative)
Sharon Hemley (Lead Commissioner for Early Years and Early Help)
Amina Diaz (BME Forum)
Richard Eyre (Head of Improvement)
Dr James Moore (Public Health Consultant)

Apologies: Councillors Stephen Mann, Councillor Mary Croos and Co-optee Member Steve Phaure

PART A

1/22 **Minutes of the Previous Meeting**

RESOLVED that the minutes of the meeting held on Wednesday 20 October 2021 were agreed as an accurate record with the following amendments:

- Paragraph 16/21 names Edwina Morris as the Healthwatch CEO throughout the minutes – this has been amended to the Chair of Healthwatch Croydon.

- Paragraph 16/21 names Hilary Williams as addressing the Board – this has been amended to Edwina Morris as addressing the Board.
- Paragraph 16/21 has the words “service users” which has been replaced with the word ‘volunteers’.

2/22 **Disclosure of Interests**

There were no disclosures at this meeting.

3/22 **Urgent Business (if any)**

The Chair was asked to approve a decision for the Better Care Fund Plan on December 16th 2021 and the report had been brought to the Panel for noting.

4/22 **Public Questions**

There was none.

5/22 **Director of Public Health annual report: The Magnificence of Croydon during the COVID-19 pandemic**

The Health and Wellbeing Board considered the Director of Public Health’s Annual Report which focused on the impact of Covid-19 on inequalities through the experience of Croydon residents.

The Board received a detailed presentation from the Director of Public Health, Rachel Flowers, who shared with the Board a video and supporting data which captured the inequalities the pandemic had caused. There were also importance messages of the five ways to wellbeing; and a further message of the importance of vaccinations and the opportunity to be vaccinated.

Members of the Board welcomed the report that illustrated the excellence of officers and health officers in addressing the pandemic at the height of its crisis; additionally also sharing the reflections of some of the people in Croydon via a video.

During the consideration of the recommendations, the Panel discussed the following:

- The effect of covid-19 for those of learning disability including autism was not represented, relating to the significance of deaths and other negative health aspect from that community. This needed to be flagged up as part of the structural discrimination of the autistic community, amongst other barriers in other groups. Inequalities preceded covid-19 and continue to be present. In response, the Director of Public Health recognised that from the large number of people who had died during

the pandemic, it was difficult to capture specific information as such for the Croydon borough.

- The elderly population was a great concern and recent statistics had shown that over 75% of people who had passed away during the pandemic were over 75 years old. Further, there were worrying concerns for people in residential care homes; and concerns with the homelessness, with more detail to be reviewed was requested around this.
- The Director of Public Health acknowledged the importance of listening to the voices of the people of Croydon, and the importance in communicating with different groups.

The Chair thanked the Director of Public Health for her report.

The Board **RESOLVED**: To note the content of the Director of Public Health's independent Annual Report.

6/22 **Health and Care Plan Refresh 2021-2023**

The Health and Wellbeing Board considered the Health and Care Plan Refresh 2021-2023 report, a refresh of the plan developed in 2019. This report highlighted the learned responses to the Covid-19 Pandemic; understanding the impact that the pandemic had on communities; and further to ensure there was a reduction on inequalities.

The Board received a detailed presentation from Matthew Kershaw (NHS Croydon Clinical Commissioning Group), Samantha Boyd (Associate Director of System Strategy) and Rachel Flagg (Integrated Delivery Manager, Adult Social Care Policy & Improvement), which reflected on the ambitions of the Health and Wellbeing strategy. Due to the pandemic, the refresh was necessary to embed, reiterate and refocus on the reduction of inequalities caused by the pandemic.

The Board Members thanked officers for the report presented which captured key learning and identified some significant changes, and further welcomed a whole range of changes relating to population and how the system worked together.

In response to queries raised by the Board, Matthew Kershaw, Rachel Flagg, Hillary Williams and Samantha Boyd clarified the following:

- Though the Autism strategy that was improved last year, Members wanted to learn more of the community engagement with the autistic community and a number of other priority issues identified in the strategy that was scarcely addressed as part of the recess. In response, the learning disability partnership board was to provide specifics of the delivery plan and input on the engagement process, which was an active participant process and it was noted that there was a lot of work to do within the autism adult diagnostic learning

disability pathway following gaps in provision particularly in primary care.

- In relation to vaccinations assistance particularly since the pandemic, the service had continued with the pop-up service within the community with communications on every platform available for more understanding around vaccinations and choice. Communications had further reached out within schools for young children who had questions about vaccinations to discuss further with their families. In addition, a small grant scheme provided a new campaign for community groups to deliver messaging around vaccinations, long-covid, employment and so much more within the borough. This was delivered through the long-term conditions project which was ran by the BME Forum and the Asian Resource Centre and partnership.

During the consideration of the recommendations, the Board discussed the following:

- It was proposed for this item to be heard again at the Board in the future, to hear of the outcomes identified within the appendices, how often were the frequency of the updates, and the outcome measures which related to the priorities of the Health and Wellbeing Board to look at the outcomes as a way of guidance for strategy moving forward.

The Board **RESOLVED**: To agree the refresh of the Health and Care Plan 2021-2023

7/22 **Pharmaceutical Needs Assessment**

The Health and Wellbeing Board considered the Pharmaceutical Needs Assessment report, which provided an update on the plans to produce and publish the 2022 Croydon Pharmaceutical Needs Assessment (PNA). The Board received an overview from the Public Health Consultant, Dr James Moore, who highlighted the statutory need for each local authority to publish and keep up to date a statement of the need for pharmaceutical services of its population within its area, which was referred to as a PNA.

With a statement to be published every three years, Croydon published their first in 2015 and their second in 2018. The next PNA was due in October 2022 as regulations was put in place for a delay due to the pandemic.

The proposal was to carry another competitive tender process ensuring the service specifications were tailored and limited to its statutory requirements. This project was to be funded by the Public Health budget.

The Board **RESOLVED**: To

1. Note the plans for procurement and development of the 2022 PNA for Croydon on behalf of the Health and Wellbeing Board and the proposed time line to meet the statutory deadline of publication by 1 October 2022.

2. Agree to the establishment of a PNA steering group with the terms of reference as outlined in the draft Terms of Reference in Appendix 1 to oversee the PNA process as recommended in the national PNA guidance

8/22 **Transforming Mental Health Services for Children, Young People (0-25) and their families across South West London - Local Transformation Plan Refresh 2021**

The Health and Wellbeing Board considered the Transforming Mental Health Services for Children, Young People (0-25) and their families across South West London - Local Transformation Plan Refresh 2021 report, which provided a refreshed Children and Young People's Emotional Wellbeing and Mental Health Local Transformation Plan for 2021. The Board received a detailed overview from Matthew Kershaw (Croydon Clinical Commissioning Group), and Rachel Flagg (Integrated Delivery Manager, Adult Social Care Policy & Improvement).

The Board learned that the South West (SW) London and the CCG was brought together a single plan that covered six boroughs and the key areas of system transformation. The SW London plan focused on resilience, prevention and early intervention. This aimed to address service boundaries and improve access to client's support system including the most vulnerable.

SW London successfully bid for extra funding in additional support to mental health teams in Croydon schools. The commitment in partnership was to improve services for children and young people with emotional wellbeing and mental health needs with the right level of investment for Croydon.

The Mental Health Alliance in Croydon had brought seventeen voluntary providers of mental health services which was to be included.

In response to queries raised by the Board, Rachel Flagg clarified the following:

- In relation to additional funding, there was a high level indication of SW London funding which was to translate across different portfolios within the borough, as such the service was awaiting further information on the borough level funding. It was also noted that the funding was non-recurrent.

During the consideration of the recommendations, the Board discussed the following:

- For the SEND Strategic Board to capture and provided information of the Croydon enhanced care register and the data which was to be shared with Education; further, to indicate how many children were subject to a care education and treatment reviews over the last twelve months.
- There was a lot of unmet needs in Croydon Schools with the scale unknown due to the pandemic with resources unable to keep up with the need, and thus there was a need to provide sufficient resources as more unmet needs would be identified and a more proactive care and prevention was desired. As such, it was necessary for services to identify the at-risk data to understand and address the emerging need and to include cohorts of at-risk young people in the population and health management priority work schemes.

The Board **RESOLVED**: To note and comment on the contents of the Local Transformation Plan refresh contained in the appendices.

9/22 **Exclusion of the Press and Public**

This was not required.

The meeting ended at 3.34 pm

Signed: .....

Date: .....

REPORT TO:	**HEALTH AND WELLBEING BOARD** 17 October 2022
SUBJECT:	**Better Care Fund end of year 2021/22 submission to NHS England**
BOARD SPONSOR:	**Annette McPartland** **Corporate Director** **Adult Social Care & Health Directorate** **Matthew Kershaw** **Chief Executive / Place Based Lead for Health** **Croydon Health Services NHS Trust**
PUBLIC/EXEMPT:	Public

SUMMARY OF REPORT

To ensure that both national and local governance is completed correctly, the Health and Wellbeing Board is asked to review and note the submission of the Better Care Fund end of year submission to NHS England.

BOARD PRIORITY/POLICY CONTEXT

Approving submission of the end of year report to NHS England sits within the legislative remit of the Health and Wellbeing Board. See section 4 of this report which sets out why for 2021/22 the Board is being asked to note, rather than approve the submission.

FINANCIAL IMPACT

This report confirms to NHS England that Croydon's 2021/22 Better Care Fund allocations were allocated and spent within the guidelines of the national Better Care Fund policy framework. It does not impact current budgets.

RECOMMENDATIONS

This report recommends that the Health and Wellbeing Board is asked to note the end of year 2021/22 outturn submission to NHS England.

1. BACKGROUND AND CONTEXT

1.1 The Better Care Fund (BCF) is one of the Government's national vehicles for driving health and social care integration. It requires Clinical Commissioning Groups (CCGs), now Integrated Care Board (ICBs), and local government to agree a joint plan, owned by the Health and Wellbeing Board (HWB). These plans enable using pooled budgets to support integration, governed by an agreement under section 75 of the NHS Act (2006).

1.2 Given the ongoing pressures in systems from COVID-19, there were minimal changes made to the BCF in 2021 to 2022. The 2021-22 Better Care Fund

policy framework built on progress during the COVID-19 pandemic, strengthening the integration of commissioning and delivery of services and delivering person-centred care, as well as continuing to support system recovery from the pandemic.

1.3 In Croydon, the Better Care Fund is delivered through the One Croydon Alliance. The Alliance is a health and care partnership created from a shared ambition to use Outcomes Based Commissioning and Population Health Management approaches to improve the lives of people in Croydon.

1.4 The Partners in this Alliance are Croydon Council, South West London ICB, formely CCG (Croydon Place), Croydon Health Service NHS Trust, The Croydon GP Collaborative, South London and Maudsley NHS Foundation Trust; and voluntary sector partners including Age UK Croydon.

2. APPROVING THE 2021/22 BCF PLAN

3.1 The 2021/22 plan was jointly created by Croydon's health and social care partners. It was signed-off by the One Croydon Senior Executive Group in November 2021.

2.1 2021/22 approval was sought from the Chair of the Health and Wellbeing Board on the 16 December 2021 and the Board ratified the plan at the next meeting on 19 January 2022.

3. SUBMITTING THE END OF YEAR 2021/22 REPORT TO NHS ENGLAND

3.1 The submission deadline for the end of year report was 27 May 2022. However, it was not possible for the Board to approve prior to submission, due to the cancellation of the June Board and the Terms of Reference not enabling delegation outside of the Board.

3.2 Having taken advice from Democratic Services, the only way to secure Board sign off for the submission, would be for NHS England to allow an extension to the deadline from 27 May until the next Board Meeting, or for NHS England to allow a temporary change to who can approve the report for submission.

3.3 The issue was escalated to the NHS England Better Care Fund regional lead on 17 May 2022. The response received confirmed, on this occasion, the Director Adult Social Services (DASS) and the Place Based Lead for Health would have permission to sign off the submission. Although a retrospective report would still need to go to the Health and Wellbeing Board to note the submission.

3.4 The report was duly signed off and submitted, meeting the national deadline of 27 May 2022. This report, once noted by the Board, concludes the second part of the amended submission guidance advised by NHS England.

4. KEY SUCCESS AND CHALLENGES NOTED IN THE SUBMISSION

4.1 The plan for 2021-22 was built upon established joint working in Croydon through the One Croydon Alliance and the delivery of the Croydon Health and Care Plan. This is a fully integrated programme of work between NHS

partners, the Voluntary Sector, Mental Health and social care. It outlines a vision for how health and social care will be delivered across the borough, particularly for those with the greatest need, to transform the health and wellbeing of local people.

4.2 The Better Care Fund and One Croydon programme delivering the funded schemes within it, are the strong foundations for integrated care in Croydon.

4.3 They help to deliver strategic commitments on the sustainability of Croydon's health and care services. These are to deliver care where the population needs it, encourage healthy lifestyles, as well as recognising the need for transformational work to reduce avoidable hospital admissions and hospital length of stay.

4.4 Most of the schemes in 2021-22 were rolled over from 2020-21 but the ethos shifted toward building on the integration work that Croydon has implemented since 2017.

4.5 2021/22 also built on previous plans to consider the increased emphasis on maximising independence and outcomes for people discharged from hospital via our integrated LIFE service.

4.6 It further included development of the Integrated Care Network Plus (ICN+) model of care in the 6 localities in Croydon. This is a major programme of transformation and integration that aims to improve outcomes for Croydon people through a proactive and preventative approach in each of the locality.

SUCCESSES

4.7 There is a joint organisational development working group. This aims to understand the learning and development needs across the system and increase awareness of and access to training and learning opportunities that are available across key partners.

4.8 There have been joint 'Localities Teams' Induction sessions, team manager meetings and relationship building workshops, including ongoing joined learning and development sessions for integrated teams in each of the six localities. Enabling team members to learn about each other's areas of work as well as about wider services available in the community.

4.9 Also commissioned has been systemic leadership development sessions for a cohort of 46 managers of operational teams to:

- Further build relationships with each other.
- Openly share opportunities and challenges they are facing.
- Raise awareness and understanding of different perspectives and capacities across the system.
- Develop new ways of working to better support the operational staff in each locality.

CHALLENGES

Population health management

4.10 The Croydon health and care system continues to face similar challenges as in previous years. Wider system pressures, including relatively high bed occupancy in hospital and sustained increased hospital discharges, impacted on the already challenging Council financial position, with additional costs on packages of care.

4.11 Croydon Council is the second largest of all the London boroughs in terms of population. And its population keeps growing. Around one in seven (13.8%) of our residents are aged 65 years or over. People are living longer, and our population is ageing with projections suggesting that the number of people aged over 85 will increase by two thirds in Croydon by 2029. This is an important trend because we know that older people generally have more health problems and are more likely to use health and care services.

4.12 The number of older people living on their own in Croydon is increasing, and a far greater proportions of older people living alone, aged 75 and over, are women.

4.13 Croydon faces significant challenges around deprivation and inequalities. 50% of the South West London Integrated Care System population are Croydon residents. They face barriers to improving health and wellbeing including income, health, education and housing. Over the last 4 quarters the number of households that were accepted as homeless has been more than 2,000 over the year.

4.14 Social isolation and loneliness can have a detrimental effect on health and wellbeing and people living on their own can be more at risk.

4.15 The difference in how these challenges are addressed, is in the shift towards more locality working via the ICN+ programme and more targeted population health management approach. Primary Care Networks (PCNs) are also addressing many issues around health inequalities using population health management.

4.16 One Croydon has also undertaken a series of actions that aimed to embed a strategic whole system approach through its Population Health Management (PHM) strategy, including:

- Participating in the NHS England place development programme.
- Selecting a key PHM challenge to test the Croydon approach.
- Setting up a PHM steering group.
- Developing a proactive and preventative framework.
- Working with PCNs to address local inequalities.
- Developing our PHM enablers (data, analysis, listening to our communities, leadership, evaluation).

Care homes

4.17 Croydon has a very high number of residential and nursing care homes in the borough (128). It admits a greater number of its residents to permanent

residential placement than it would like to, meaning that residents are not moved onto more suitable longer-term accommodation.

4.18 Despite the high number of homes in Croydon there is often still a need to find placements outside of the borough, resulting in the undesirable outcome of an individual being cared for outside of their local area.

4.19 The services provided by homes within the borough have not been developed fully this year in alignment with the requirements of our residents due to the pandemic; although we have seen positive engagement with providers in the period.

4.20 There is also the risk of provider failure, due to the rising costs of care, which the Council is committed to addressing locally via the Fair Cost of Care and its commitment to paying an appropriate unit cost.

5. CONSULTATION

5.1 This year's 21/ 22 plan was developed with input from the One Croydon Alliance partners and wider stakeholders in health and social care. The One Croydon Governance was used to agree and implement the schemes as planned.

6. EQUALITY IMPACT ASSESSMENT

This report has no impact or changes proposed that impact on people, budgets, processes, facilities or policies. An equality impact assessment was not required.

7. DATA PROTECTION IMPLICATIONS

7.1 **WILL THE SUBJECT OF THE REPORT INVOLVE THE PROCESSING OF 'PERSONAL DATA'?**

NO

CONTACT OFFICERS:

Annette McPartland
Corporate Director, Adult Social Care & Health Directorate

Matthew Kershaw
Chief Executive / Place Based Lead for Health, Croydon Health Services NHS Trust

APPENDICES TO THIS REPORT

Appendix 1 Better Care Fund end of year 2021/22 NHS England submission

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Better Care Fund 2021-22 Year-end Template

1. Guidance

Overview

The Better Care Fund (BCF) reporting requirements are set out in the BCF Planning Requirements document for 2021-22, which supports the aims of the BCF Policy Framework and the BCF programme; jointly led and developed by the national partners Department of Health (DHSC), Department for Levelling Up, Hosusing and Communities, NHS England (NHSE), Local Government Association (LGA), working with the Association of Directors of Adult Social

The key purposes of BCF reporting are:
1) To confirm the status of continued compliance against the requirements of the fund (BCF)
2) To confirm actual income and expenditure in BCF plans at the end of the financial year
3) To provide information from local areas on challenges, achievements and support needs in progressing the
4) To enable the use of this information for national partners to inform future direction and for local areas to inform

BCF quarterly reporting is likely to be used by local areas, alongside any other information to help inform HWBs on progress on integration and the BCF. It is also intended to inform BCF national partners as well as those responsible for delivering the BCF plans at a local level (including clinical commissioning groups, local authorities and service

BCF quarterly reports submitted by local areas are required to be signed off by HWBs as the accountable governance body for the BCF locally and these reports are therefore part of the official suite of HWB documents.

The BCF quarterly reports in aggregated form will be shared with local areas prior to publication in order to support the aforementioned purposes of BCF reporting. In relation to this, the BCF Team will make the aggregated BCF quarterly reporting information in entirety available to local areas in a closed forum on the Better Care Exchange

Note on entering information into this template

Throughout the template, cells which are open for input have a yellow background and those that are pre-populated have a grey background, as below:

Data needs inputting in the cell

Pre-populated cells

Note on viewing the sheets optimally

To more optimally view each of the sheets and in particular the drop down lists clearly on screen, please change the zoom level between 90% - 100%. Most drop downs are also available to view as lists within the relevant sheet or in

The details of each sheet within the template are outlined below.

Checklist (2. Cover)

1. This section helps identify the sheets that have not been completed. All fields that appear as incomplete should be complete before sending to the BCF Team.
2. The checker column, which can be found on the individual sheets, updates automatically as questions are completed. It will appear 'Red' and contain the word 'No' if the information has not been completed. Once completed the checker column will change to 'Green' and contain the word 'Yes'
3. The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.
4. Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will change
5. Please ensure that all boxes on the checklist are green before submission.

2. Cover

1. The cover sheet provides essential information on the area for which the template is being completed, contacts and
2. Question completion tracks the number of questions that have been completed; when all the questions in each section of the template have been completed the cell will turn green. Only when all cells are green should the template be sent to:
england.bettercaresupport@nhs.net
3. Please note that in line with fair processing of personal data we request email addresses for individuals completing the reporting template in order to communicate with and resolve any issues arising during the reporting cycle. We remove these addresses from the supplied templates when they are collated and delete them when they are no

3. National Conditions

This section requires the Health & Wellbeing Board to confirm whether the four national conditions detailed in the Better Care Fund planning requirements for 2021-22 (link below) continue to be met through the delivery of your
https://www.england.nhs.uk/publication/better-care-fund-planning-requirements-2021-22/

This sheet sets out the four conditions and requires the Health & Wellbeing Board to confirm 'Yes' or 'No' that these continue to be met. Should 'No' be selected, please provide an explanation as to why the condition was not met within the quarter and how this is being addressed. Please note that where a National Condition is not being met, the

In summary, the four national conditions are as below:
National condition 1: Plans to be jointly agreed
National condition 2: NHS contribution to adult social care is maintained in line with the uplift to CCG Minimum
National condition 3: Agreement to invest in NHS commissioned out-of-hospital services
National condition 4: Plan for improving outcomes for people being discharged from hospital

4. Metrics

The BCF plan includes the following metrics: Unplanned hospitalisation for chronic ambulatory care sensitive conditions, Proportion of hospital stays that are 14 days or over, Proportion of hospital stays that are 14 days or over, Proportion of discharges to a person's usual place of residence, Residential Admissions and Reablement. Plans for
This section captures a confidence assessment on achieving the plans for each of the BCF metrics.
A brief commentary is requested for each metric outlining the challenges faced in achieving the metric plans, any support needs and successes that have been achieved.
The BCF Team publish data from the Secondary Uses Service (SUS) dataset for Long length of stay (14 and 21 days) and Dischaege to usual place of residence at a local authority level to assist systems in understanding performance at

The metris worksheet seeks a best estimate of confidence on progress against the achievement of BCF metric plans and the related narrative information and it is advised that:
- In making the confidence assessment on progress, please utilise the available published metric data (which should be typically available for 2 of the 3 months) in conjunction with the interim/proxy metric information for the third month (which is eventually the source of the published data once agreed and validated) to provide a directional
- In providing the narrative on Challenges and Support needs, and Achievements, most areas have a sufficiently good perspective on these themes by the end of the quarter and the unavailability of published metric data for one of the three months of the quarter is not expected to hinder the ability to provide this useful information. Please also reflect on the metric performance trend when compared to the quarter from the previous year - emphasising any

Please note that the metrics themselves will be referenced (and reported as required) as per the standard national

5. Income and Expenditure

The Better Care Fund 2021-22 pool constitutes mandatory funding sources and any voluntary additional pooling from LAs (Local Authorities) and CCGs. The mandatory funding sources are the DFG (Disabled Facilities Grant), the improved Better Care Fund (iBCF) grant, and the minimum CCG contribution. A large proportion of areas also

Income section:

- Please confirm the total HWB level actual BCF pooled income for 2021-22 by reporting any changes to the planned additional contributions by LAs and CCGs as was reported on the BCF planning template.
- The template will automatically pre populate the planned expenditure in 2021-22 from BCF plans, including additional contributions.
- If the amount of additional pooled funding placed intothe area's section 75 agreement is different to the amount in the plan, you should select 'Yes'. You will then be able to enter a revised figure. Please enter the **actual income** from
- Please provide any comments that may be useful for local context for the reported actual income in 20121-22.

Expenditure section:

- Please select from the drop down box to indicate whether the actual expenditure in you BCF section 75 is different to the planned amount.
- If you select 'Yes', the boxes to record actual spend, and expanatory comments will unlock.
- You can then enter the total, HWB level, actual BCF expenditure for 2021-22 in the yellow box provided and also
- Please provide any comments that may be useful for local context for the reported actual expenditure in 2019/20.

6. Year End Feedback

This section provides an opportunity to provide feedback on delivering the BCF in 2021-22 through a set of survey questions

The purpose of this survey is to provide an opportunity for local areas to consider the impact of BCF and to provide the BCF national partners a view on the impact across the country. There are a total of 9 questions. These are set out

Part 1 - Delivery of the Better Care Fund

There are a total of 3 questions in this section. Each is set out as a statement, for which you are asked to select one

- Strongly Agree
- Agree
- Neither Agree Nor Disagree
- Disagree
- Strongly Disagree

The questions are:

1. The overall delivery of the BCF has improved joint working between health and social care in our locality
2. Our BCF schemes were implemented as planned in 2021-22
3. The delivery of our BCF plan in 2021-22 had a positive impact on the integration of health and social care in our

Part 2 - Successes and Challenges

This part of the survey utilises the SCIE (Social Care Institue for Excellence) Integration Logic Model published on this link below to capture two key challenges and successes against the 'Enablers for integration' expressed in the Logic

Please highlight:

8. Two key successes observed toward driving the enablers for integration (expressed in SCIE's logic model) in 2021-
9. Two key challenges observed toward driving the enablers for integration (expressed in SCIE's logic model) in 2021-

For each success and challenge, please select the most relevant enabler from the SCIE logic model and provide a narrative describing the issues, and how you have made progress locally.

SCIE - Integrated care Logic Model

1. Local contextual factors (e.g. financial health, funding arrangements, demographics, urban vs rurual factors)
2. Strong, system-wide governance and systems leadership
3. Integrated electronic records and sharing across the system with service users
4. Empowering users to have choice and control through an asset based approach, shared decision making and co-
5. Integrated workforce: joint approach to training and upskilling of workforce

6. Good quality and sustainable provider market that can meet demand
7. Joined-up regulatory approach
8. Pooled or aligned resources
9. Joint commissioning of health and social care

7. ASC fee rates

This section collects data on average fees paid by the local authority for social care.

Specific guidance on individual questions can be found on the relevant tab.

HM Government

NHS

Better Care Fund 2021-22 Year-end Template

2. Cover

Version 2.0

Please Note:

- The BCF end of year reports are categorised as 'Management Information' and data from them will published in an aggregated form on the NHSE website. Narrative sections of the reports will not be published. However as with all information collected and stored by public bodies, all BCF information including any narrative is subject to Freedom of Information requests.

- At a local level it is for the HWB to decide what information it needs to publish as part of wider local government reporting and transparency requirements. Until BCF information is published, recipients of BCF reporting information (including recipients who access any information placed on the BCE) are prohibited from making this information available on any public domain or providing this information for the purposes of journalism or research without prior consent from the HWB (where it concerns a single HWB) or the BCF national partners for the aggregated information.

- All information, including that provided on local authority fee rates, will be supplied to BCF partners to inform policy development.

- This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.

		Checklist: Complete:
Health and Wellbeing Board:	Croydon	Yes
Completed by:	Daniele Serdoz	Yes
E-mail:	daniele.serdoz@swlondon.nhs.uk	Yes
Contact number:	02039239524	Yes
Has this report been signed off by (or on behalf of) the HWB at the time of submission?	Yes	Yes
If no, please indicate when the report is expected to be signed off:	Wed 15/06/2022	Yes

Please indicate who is signing off the report for submission on behalf of the HWB (delegated authority is also accepted):

Job Title:	Director of Adult Social Care and Health	Yes
Name:	Annette McPartland	Yes

Question Completion - when all questions have been answered and the validation boxes below have turned green you should send the template to england.bettercarefundteam@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'

Complete	
	Complete:
2. Cover	Yes
3. National Conditions	Yes
4. Metrics	Yes
5. Income and Expenditure actual	Yes
6. Year-End Feedback	Yes
7. ASC fee rates	Yes

<< Link to the Guidance sheet

^^ Link back to top

Better Care Fund 2021-22 Year-end Template

3. National Conditions

Selected Health and Wellbeing Board: Croydon

Confirmation of Nation Conditions			Checklist
National Condition	**Confirmation**	**If the answer is "No" please provide an explanation as to why the condition was not met in 2021-22:**	Complete:
1) A Plan has been agreed for the Health and Wellbeing Board area that includes all mandatory funding and this is included in a pooled fund governed under section 75 of the NHS Act 2006? (This should include engagement with district councils on use of Disabled Facilities Grant in two tier areas)	Yes		Yes
2) Planned contribution to social care from the CCG minimum contribution is agreed in line with the BCF policy?	Yes		Yes
3) Agreement to invest in NHS commissioned out of hospital services?	Yes		Yes
4) Plan for improving outcomes for people being discharged from hospital	Yes		Yes

Better Care Fund 2021-22 Year-end Template

4. Metrics

Selected Health and Wellbeing Board: Croydon

National data may like be unavailable at the time of reporting. As such, please utilise data that may only be available system-wide and other local intelligence.

Challenges and Support Needs Please describe any challenges faced in meeting the planned target, and please highlight any support that may facilitate or ease the achievements of metric plans

Achievements Please describe any achievements, impact observed or lessons learnt when considering improvements being pursued for the respective metrics

Metric	Definition	For information - Your planned performance as reported in 2021-22 planning				Assessment of progress against the metric plan for the reporting period	Challenges and any Support Needs	Achievements	Checklist Complete:
Avoidable admissions	Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator 2.3i)	740.0				On track to meet target	There are a number of challenges that the local system is facing, including workforce shortages and exacerbation of long term conditions. We are aware these are national problems and not just for Croydon, but it is	The latest data (February 22) suggests we are on track to meet the target, with a rate of avoidable admissions per 100,000 population forecast at 677.8. Integrated Community Network teams are	Yes
Length of Stay	Proportion of inpatients resident for: i) 14 days or more ii) 21 days or more	**14 days or more (Q3)**	**14 days or more (Q4)**	**21 days or more (Q3)**	**21 days or more (Q4)**	Not on track to meet target	The latest data (February 22) suggests we are not on track to meet the target. More sick patients are attending hospital and needing admission, and they are having to stay longer because of their condition rather than delays	Since the middle of 20-21, our provision of Same Day Emergency Care (SDEC) has increased significantly and this level has been sustained over the winter period. Unlike in previous years we have not had to turn SDEC	Yes
		12.9%	13.4%	6.8%	7.4%				
Discharge to normal place of residence	Percentage of people who are discharged from acute hospital to their normal place of residence	93.4%				On track to meet target	The latest figure (February 2022) is 93.3% and local intelligence suggests we are on track to meet the target. There are still some challenges in gathering local data to understand the flow through the different	Croydon place has implemented a number of programmes in the last two years that have supported people to be discharged from hospital to their normal place of residence. These include Discharge to Assess, LIFE	Yes
Res Admissions*	Rate of permanent admissions to residential care per 100,000 population (65+)	484				On track to meet target	There have been a number of challenges around the covid-19 pandemic which included the higher acuity of discharges has led to more permenant places being made. The impact of outbreaks in care homes has	The performance indicator was based on projectedadmissions around that the pandemic would slow down in 21/22. There has been significant support provided to hospitals to aid prompt discharge and also	Yes
Reablement	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	87.7%				On track to meet target	There has been increased numbers of home care referrals with people having higher acuity. Whilst Croydon has a large home care market there has been issues over the last 12 months due to the pandemic where focus	Despite the challenges there has been success this year. Focus has been in place on hospital discharges and a dedicted programme around reablement and moving to a clear goals focus approach from	Yes

* In the absense of 2021-22 population estimates (due to the devolution of North Northamptonshire and West Northamptonshire), the denominator for the Residential Admissions metric is based on 2020-21 estimates

Better Care Fund 2021-22 Year-end Template

5. Income and Expenditure actual

Selected Health and Wellbeing Board: Croydon

Income

	2021-22	
Disabled Facilities Grant	£2,992,679	
Improved Better Care Fund	£9,684,754	
CCG Minimum Fund	£27,768,137	
Minimum Sub Total		£40,445,570

	Planned	
CCG Additional Funding	£1,292,000	
LA Additional Funding	£0	
Additional Sub Total		£1,292,000

Actual			
Do you wish to change your additional actual CCG funding?	No		
Do you wish to change your additional actual LA funding?	No		
			£1,292,000

	Planned 21-22	Actual 21-22
Total BCF Pooled Fund	£41,737,570	£41,737,570

Please provide any comments that may be useful for local context where there is a difference between planned and actual income for 2021-22	

Expenditure

	2021-22
Plan	£41,737,570

Do you wish to change your actual BCF expenditure?	No

Actual	

Please provide any comments that may be useful for local context where there is a difference between the planned and actual expenditure for 2021-22	

Checklist

Complete:

- Yes
- Yes
- Yes
- Yes
- Yes
- Yes

Better Care Fund 2021-22 Year-end Template

6. Year-End Feedback

The purpose of this survey is to provide an opportunity for local areas to consider and give feedback on the impact of the BCF. Covid-19 had a significant impact on services and schemes delivered on the ground which may have changed the context. However, national BCF partners would value and appreciate local area feedback to understand views and reflections of the progress and challenges faced during 2021-22
There is a total of 5 questions. These are set out below.

Selected Health and Wellbeing Board: Croydon

Part 1: Delivery of the Better Care Fund

Please use the below form to indicate to what extent you agree with the following statements and then detail any further supporting information in the corresponding comment boxes.

Statement:	Response:	Comments: Please detail any further supporting information for each response	Checklist Complete:
1. The overall delivery of the BCF has improved joint working between health and social care in our locality	Strongly Agree	Our plan for 2021-22 was built upon established joint working in Croydon through the One Croydon Alliance and the delivery of the Croydon Health and Care Plan. This is a fully integrated programme of work between NHS partners, the Voluntary Sector, Mental Health and social care which outlines a vision for how health and social care will be delivered across	Yes
2. Our BCF schemes were implemented as planned in 2021-22	Strongly Agree	This year's plan was developed with input from the One Croydon Alliance partners and wider stakeholders in health and social care. The One Croydon Governance was used to agree and implement the schemes as planned.	Yes
3. The delivery of our BCF plan in 2021-22 had a positive impact on the integration of health and social care in our locality	Strongly Agree	The BCF and One Croydon Programme are the strong foundations for integrated care in Croydon and help us deliver on our strategic commitments on the sustainability of Croydon's health and care services, delivering care where our population needs it and encouraging healthy lifestyles, as well as recognising the need within our transformational work to reduce	Yes

Part 2: Successes and Challenges

Please select two Enablers from the SCIE Logic model which you have observed demonstrable success in progressing and two Enablers which you have experienced a relatively greater degree of challenge in progressing.
Please provide a brief description alongside.

4. Outline two key successes observed toward driving the enablers for integration (expressed in SCIE's logical model) in 2021-22	SCIE Logic Model Enablers, Response category:	Response - Please detail your greatest successes	
Success 1	5. Integrated workforce: joint approach to training and upskilling of workforce	We are running a joined organisational development working group to understand the learning and development needs across the system and increase awareness of and access to training and learning opportunities that are available across key partners. We have run joint Localities Teams induction sessions, team manager meetings and relationship building workshops and introduced ongoing, joined learning and development sessions for integrated teams in each of the six localities for the team members to learn about each other's areas of work as well as about wider services available in the community. We have	Yes
Success 2	4. Empowering users to have choice and control through an asset based approach, shared decision making and co-production	We have introduced Community-led support across discharge teams. Staff have received training on the 'good conversation' tool. The training will enable them to offer community support and non-funded solutions at the point of options being discussed with patients and families. The Community Connect map will be used as a first point of contact and on triage to inform available alternative options at every conversation with the person. Key features of this approach are: •No decision about a patient's long term care needs should be taken in an acute setting	Yes

5. Outline two key challenges observed toward driving the enablers for integration (expressed in SCIE's logical model) in 2021-22	SCIE Logic Model Enablers, Response category:	Response - Please detail your greatest challenges

Challenge 1	6. Good quality and sustainable provider market that can meet demand	Croydon has a very high number of residential and nursing care homes in the borough (128). It admits a greater number of its residents to permanent residential placement than it would like to, meaning that residents are not moved onto more suitable longer-term accommodation. Despite the high number of homes in Croydon there is often still a need to find placements outside of the borough, resulting in the undesirable outcome of an individual being cared for outside of their local area. The services provided by homes within the borough have not been developed fully this year in alignment with the requirements of	Yes
Challenge 2	1. Local contextual factors (e.g. financial health, funding arrangements, demographics, urban vs rural factors)	Croydon Place continues to face similar challenges as in previous years. Wider system pressures, including relatively high bed occupnacy in hospital and sustained increased hospital discharges, impacted on the already challenging Council financial position, with additional costs on packages of care. Croydon Council is the second largest of all the London boroughs in terms of population. And its population keeps growing.	Yes

Footnotes:
Question 4 and 5 are should be assigned to one of the following categories:
1. Local contextual factors (e.g. financial health, funding arrangements, demographics, urban vs rural factors)
2. Strong, system-wide governance and systems leadership
3. Integrated electronic records and sharing across the system with service users
4. Empowering users to have choice and control through an asset based approach, shared decision making and co-production
5. Integrated workforce: joint approach to training and upskilling of workforce
6. Good quality and sustainable provider market that can meet demand
7. Joined-up regulatory approach
8. Pooled or aligned resources
9. Joint commissioning of health and social care
Other

Better Care Fund 2021-22 Year-end Template

7. ASC fee rates

Selected Health and Wellbeing Board: Croydon

The iBCF fee rate collection gives us better and more timely insight into the fee rates paid to external care providers, which is a key part of social care reform.

Given the introduction of the Market Sustainability and Fair Cost of Care Fund in 2022-23, we are exploring where best to collect this data in future, but have chosen to collect 2021-22 data through the iBCF for consistency with previous years.

These questions cover average fees paid by your local authority (gross of client contributions/user charges) to external care providers for your local authority's eligible clients. The averages will likely need to be calculated from records of payments paid to social care providers and the number of client weeks they relate to, unless you already have suitable management information.

We are interested ONLY in the average fees actually received by external care providers for your local authority's eligible supported clients (gross of client contributions/user charges), reflecting what your local authority is able to afford.

In 2020-21, areas were asked to provide actual average rates (excluding whole market support such as the Infection Control Fund but otherwise, including additional funding to cover cost pressures related to management of the COVID-19 pandemic), as well as a 'counterfactual' rate that would have been paid had the pandemic not occurred. This counterfactual calculation was intended to provide data on the long term costs of providing care to inform policymaking. In 2021-22, areas are only asked to provide the actual rate paid to providers (not the counterfactual), subject to than the exclusions set out below.

Specifically the averages SHOULD therefore:
- EXCLUDE/BE NET OF any amounts that you usually include in reported fee rates but are not paid to care providers e.g. your local authority's own staff costs in managing the commissioning of places.
- EXCLUDE/BE NET OF any amounts that are paid from sources other than eligible local authority funding and client contributions/user charges, i.e. you should EXCLUDE third party top-ups, NHS Funded Nursing Care and full cost paying clients.
- EXCLUDE/BE NET OF whole-market COVID-19 support such as Infection Control Fund payments.
- INCLUDE/BE GROSS OF client contributions /user charges.
- INCLUDE fees paid under spot and block contracts, fees paid under a dynamic purchasing system, payments for travel time in home care, any allowances for external provider staff training, fees directly commissioned by your local authority and fees commissioned by your local authority as part of a Managed Personal Budget.
- EXCLUDE care packages which are part funded by Continuing Health Care funding.

If you only have average fees at a more detailed breakdown level than the three service types of home care, 65+ residential and 65+ nursing requested below (e.g. you have the more detailed categories of 65+ residential without dementia, 65+ residential with dementia) **please calculate for each of the three service types an average weighted by the proportion of clients that receive each detailed category:** 1. Take the number of clients receiving the service for each detailed category.
2. Divide the number of clients receiving the service for each detailed category (e.g. age 65+ residential without dementia, age 65+ residential with dementia) by the total number of clients receiving the relevant service (e.g. age 65+ residential).
3. Multiply the resultant proportions from Step 2 by the corresponding fee paid for each detailed category.
4. For each service type, sum the resultant detailed category figures from Step 3.

Please leave any missing data cells as blank e.g. do not attempt to enter '0' or 'N/A'.

	For information - your 2020-21 fee as reported in 2020-21 end of year reporting *	Average 2020/21 fee. If you have newer/better data than End of year 2020/21, enter it below and explain why it differs in the comments. Otherwise enter the end of year 2020-21 value	What was your actual average fee rate per actual user for 2021/22?	Implied Uplift: Actual 2021/22 rates compared to 2020/21 rates	Checklist Complete:
1. Please provide the average amount that you paid to external providers for home care, calculated on a consistent basis. (£ per contact hour, following the exclusions as in the instructions above)	£17.50	£17.50	£18.75	7.1%	Yes
2. Please provide the average amount that you paid for external provider care homes without nursing for clients aged 65+, calculated on a consistent basis. (£ per client per week, following the exclusions as in the instructions above)	£771.23	£771.23	£895.25	16.1%	Yes
3. Please provide the average amount that you paid for external provider care homes with nursing for clients aged 65+, calculated on a consistent basis. (£ per client per week, following the exclusions in the instructions above)	£728.01	£728.01	£886.58	21.8%	Yes
4. Please provide additional commentary if your 2020-21 fee is different from that reported in your 2020-21 end of year report. Please do not use more than 250 characters.					Yes

Footnotes:

* ".." in the column C lookup means that no 2020-21 fee was reported by your council in the 2020-21 EoY report

** For column F, please calculate your fee rate as the expenditure during the year divided by the number of actual client weeks during the year. This will pick up any support that you have provided in terms of occupancy guarantees.
(Occupancy guarantees should result in a higher rate per actual user.)

*** Both North Northamptonshire & West Northamptonshire will pull the same last year figures as reported by the former Northamptonshire County Council.

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REPORT TO:	**HEALTH AND WELLBEING BOARD** 17 October 2022
SUBJECT:	**Better Care Fund plan 2022/23 submission to NHS England**
BOARD SPONSOR:	**Annette McPartland** **Corporate Director** **Adult Social Care & Health Directorate** **Matthew Kershaw** **Chief Executive / Place Based Lead for Health** **Croydon Health Services NHS Trust**
PUBLIC/EXEMPT:	Public

SUMMARY OF REPORT

To ensure that both national and local governance is completed correctly, the Health and Wellbeing Board is asked to review and note the submission of the Better Care Fund 22/23 planning submission to NHS England.

BOARD PRIORITY/POLICY CONTEXT

Approving submission of the plans to NHS England sits within the legislative remit of the Health and Wellbeing Board.

FINANCIAL IMPACT

This report confirms to NHS England that Croydon's 2022/23 Better Care Fund allocations have been allocated within the guidelines of the national Better Care Fund policy framework. It does not impact current budgets.

RECOMMENDATIONS:

This report recommends that the health and well board ratify the 2022/23 Better Care Fund planning submission to NHS England.

1. BACKGROUND AND CONTEXT

1.1 The Better Care Fund (BCF) is one of the Government's national vehicles for driving health and social care integration. It requires Place Based NHS ICB's and local government to agree a joint plan, owned by the Health and Wellbeing Board (HWB). These plans enable using pooled budgets to support integration, governed by an agreement under section 75 of the NHS Act (2006).

1.2 There were minor changes made to the BCF plans from 21/22 and the 22/23 plans build on progress of previous plans. The plans strengthening the integration of commissioning and delivery of services and delivering person-centred care.

1.3 In Croydon, the Better Care Fund is delivered through the One Croydon Alliance. The Alliance is a health and care partnership created from a shared ambition to use Outcomes Based Commissioning and Population Health Management approaches to improve the lives of people in Croydon.

1.4 The Partners in this Alliance are Croydon Council, South West London ICB (Croydon Place), Croydon Health Service NHS Trust, The Croydon GP Collaborative, South London and Maudsley NHS Foundation Trust; and voluntary sector partners including Age UK Croydon.

2. APPROVING THE 2022/23 BCF PLAN

2.1 The 2022/23 plan was jointly created by Croydon's health and social care partners. It was signed-off by the One Croydon Senior Executive Group in September 2022.

2.2 The submission deadline for the 22/23 plans was 26 September 2022. However, it was not possible for the Board to approve prior to submission, due to the date of the Board and the Terms of Reference not enabling delegation outside of the Board.

2.3 It has been agreed by NHS England that the plans on this occasion may be signed off by the Place Based Lead for Health and the Director Adult Social Services (DASS) and a retrospective report brought to the next Health and Well Being Board for ratification.

3. CHANGES TO THE 2022/23 BCF POLICY FRAMEWORK REQUIREMENTS

3.1 An additional national condition in 22/23 requires areas to agree an overarching approach to meeting the BCF policy objectives to:

-Enable people to stay well, safe and independent at home for longer
-Provide the right care in the right place at the right time

Croydon schemes support these policy objectives.

3.2 Local systems have been required to outline how they provide support to unpaid carers. In Croydon the Council commission the Carers Support Partnership to provide carer's assessment and other support services that aim to prevent, reduce and delay future needs for support. The BCF part funds these services. For End-of-Life Care, there are services to support unpaid carers, focussing on supporting people to have care within their home, if that is their place of choice.

3.3 For the first time local areas are required to submit an intermediate care Demand and Capacity template. The requirement encompasses community reablement, bed based intermediate care for both step up from the community

and hospital discharge. This element of the template does not require assurance.

4. KEY FEATURES OF THE PLANS

4.1 Better Care Fund- 2022/23 Income and Expenditure Summary

Funding Sources	Income	Expenditure
DFG	£2,992,679	£2,992,679
Minimum NHS Contribution	£29,339,813	£29,339,813
iBCF	£9,978,112	£9,978,112
Additional LA Contribution	£0	£0
Additional ICB Contribution	£1,315,000	£1,315,000
Total	**£43,625,604**	**£43,625,604**

NHS Commissioned Out of Hospital spend from the minimum ICB allocation

Minimum required spend	£8,337,543
Planned spend	£16,756,455

Adult Social Care services spend from the minimum ICB allocations

Minimum required spend	£11,213,755
Planned spend	£11,357,393

Scheme Types

Assistive Technologies and Equipment	£569,997
Care Act Implementation Related Duties	£658,000
Carers Services	£243,233
Community Based Schemes	£4,365,808
DFG Related Schemes	£2,992,679
Enablers for Integration	£0
High Impact Change Model for Managing Transfer of Care	£0
Home Care or Domiciliary Care	£5,183,879
Housing Related Schemes	£133,000
Integrated Care Planning and Navigation	£5,608,367
Bed based intermediate Care Services	£2,585,432
Reablement in a persons own home	£3,826,448
Personalised Budgeting and Commissioning	£880,802
Personalised Care at Home	£9,883,364
Prevention / Early Intervention	£85,000
Residential Placements	£6,609,595
Other	£0
Total	**£43,625,604**

The Croydon BCF plan for 2022-23:

4.2 Includes a contribution to adult social care from the NHS in line with the required minimum contribution. This is approximately £11.3M which is the minimum requirement.

4.3 Includes a large proportion of NHS commissioned schemes delivered out of hospital. Croydon's BCF investment in NHS commissioned out-of-hospital services will total approx. £16.7, in excess of the mandated minimum of £8.35M.

4.4 Makes a significant contribution to enabling people to stay well, safe and independent at home for longer, whilst also striving to provide the right care at the right time in the right place. This is through a programme of work centred around developing integrated localities team with a focus on neighbourhood and communities to be at the heart of people's care, underpinned by a proactive and preventative approach using population health management to tackle health inequalities and target people with the highest needs.

4.5 As such, our plan meets the BCF national conditions, which were set out in the Planning Requirements published on July 19th 2022.

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

5. CHANGES TO SCHEME EXPENDITURE FROM 2021/22

5.1 Most of the BCF schemes in 2022-23 have been rolled over from 2021-22.

5.2 Additional investment has been allocated to Discharge to Assess processes in Croydon, to enable this pathway to continue. In addition, extra social work staff are funded also in the acute wards to facilitate discharges from acute elderly ward and palliative care.

5.3 We are continuing to strengthen Frailty as a key area of work through BCF funding and ICN+, by developing a strategy that will join up acute frailty care with frailty care in the community, posts are funded in ED to support early identification of frailty or those at risk of frailty.

6.0 METRICS

6.1. Quarterly metric ambitions are required to be set in 4 areas for 22/23

Using methodology, based on our current trajectory we have set realistic but stretching ambitions for these metrics:

Avoidable Admissions, Discharge to the Usual Place of Residence. Residential Admissions and Reablement

8.0 NHSE ASSURANCE AND NEXT STEPS

8.1 **The Timetable for agreeing BCF Plans and assurance are set out below:**

Scrutiny of BCF plans by regional assurers, assurance panel meetings and regional moderation	26/9/2022- 24/10/2022
Regionally moderated assurance outcomes sent to BCF team	24/10/2022
Cross- regional calibration	01/11/2022
Approval letters issued giving formal permission to spend (NHS Minimum)	30/11/2022
All Section 75 agreements need to be signed and in place	31/12/2022

8.2 As with previous years plans, there will be ongoing continued monitoring and compliance and quarterly reports will be submitted following the governance processes.

9.0 CONSULTATION

9.1 This year's 22/ 23 plan was developed with input from the One Croydon Alliance partners and wider stakeholders in health and social care. The One Croydon Governance was used to agree and implement the schemes as planned.

10.0 HUMAN RESOURCES IMPACT

10.1 BCF funding streams will enable staff recruitment within the stakeholder organisations. There are no identified risks.

11.0 EQUALITIES IMPACT

There are no changes proposed in this report that affect people, policies, facilities, or processes. An equality impact assessment therefore has not been carried out.

12.0 DATA PROTECTION IMPLICATIONS

WILL THE SUBJECT OF THE REPORT INVOLVE THE PROCESSING OF 'PERSONAL DATA'?

NO

CONTACT OFFICERS:

Annette McPartland
Corporate Director, Adult Social Care & Health Directorate

Matthew Kershaw
Chief Executive / Place Based Lead for Health, Croydon Health Services NHS Trust

APPENDICES TO THIS REPORT

Appendix 1 Better Care Fund 2022/23 Main Planning Template NHS England submission
Appendix 2 Better Care Fund 2022/23 Planning Narrative
Appendix 3 Better Care Fund 2022/23 Intermediate Care Demand and Capacity Template

BCF Planning Template 2022-23

1. Guidance

Overview

Note on entering information into this template

Throughout the template, cells which are open for input have a yellow background and those that are pre-populated have a blue background, as below:

Data needs inputting in the cell

Pre-populated cells

Note on viewing the sheets optimally

For a more optimal view each of the sheets and in particular the drop down lists clearly on screen, please change the zoom level between 90% - 100%. Most drop downs are also available to view as lists within the relevant sheet or in the guidance sheet for readability if required.

The details of each sheet within the template are outlined below.

Checklist (click to go to Checklist, included in the Cover sheet)

1. This section helps identify the sheets that have not been completed. All fields that appear as incomplete should be completed before sending to the Better Care Fund Team.
2. The checker column, which can be found on the individual sheets, updates automatically as questions are completed. It will appear 'Red' and contain the word 'No' if the information has not been completed. Once completed the checker column will change to 'Green' and contain the word 'Yes'

3. The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.
4. Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will change to 'Template Complete'.
5. Please ensure that all boxes on the checklist are green before submission.

2. Cover (click to go to sheet)

1. The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off.
2. Question completion tracks the number of questions that have been completed; when all the questions in each section of the template have been completed the cell will turn green. Only when all cells are green should the template be sent to the Better Care Fund Team: england.bettercarefundteam@nhs.net (please also copy in your Better Care Manager).

4. Income (click to go to sheet)

1. This sheet should be used to specify all funding contributions to the Health and Wellbeing Board's (HWB) Better Care Fund (BCF) plan and pooled budget for 2022-23. It will be pre-populated with the minimum NHS contributions to the BCF, Disabled Facilities Grant (DFG) and improved Better Care Fund (iBCF). These cannot be edited.

2. Please select whether any additional contributions to the BCF pool are being made from local authorities or ICBs and enter the amounts in the fields highlighted in 'yellow'. These will appear as funding sources in sheet 5a when you planning expenditure.

3. Please use the comment boxes alongside to add any specific detail around this additional contribution.

4. If you are pooling any funding carried over from 2021-22 (**i.e. underspends from BCF mandatory contributions**) you should show these on a separate line to the other additional contributions and use the comments field to identify that these are underspends that have been rolled forward. All allocations are rounded to the nearest pound.

5. Allocations of the NHS minimum contribution (formerly CCG minimum) are shown as allocations from ICB to the HWB area in question. Mapping of the allocations from former CCGs to HWBs can be found in the BCF allocation spreadsheet on the BCF section of the NHS England Website.
6. For any questions regarding the BCF funding allocations, please contact england.bettercarefundteam@nhs.net (please also copy in your Better Care Manager).

5. Expenditure (click to go to sheet)

This sheet should be used to set out the detail of schemes that are funded via the BCF plan for the HWB, including amounts, type of activity and funding source. This information is then aggregated and used to analyse the BCF plans nationally and sets the basis for future reporting.

The information in the sheet is also used to calculate total contributions under National Conditions 2 and 3 and is used by assurers to ensure that these are met.

The table is set out to capture a range of information about how schemes are being funded and the types of services they are providing. There may be scenarios when several lines need to be completed in order to fully describe a single scheme or where a scheme is funded by multiple funding streams (eg: iBCF and NHS minimum). In this case please use a consistent scheme ID for each line to ensure integrity of aggregating and analysing schemes.

On this sheet please enter the following information:

1. Scheme ID:
- This field only permits numbers. Please enter a number to represent the Scheme ID for the scheme being entered. Please enter the same Scheme ID in this column for any schemes that are described across multiple rows.

2. Scheme Name:
- This is a free text field to aid identification during the planning process. Please use the scheme name consistently if the scheme is described across multiple lines in line with the scheme ID described above.

3. Brief Description of Scheme
- This is a free text field to include a brief headline description of the scheme being planned. The information in this field assists assurers in understanding how funding in the local BCF plan is supporting the objectives of the fund nationally and aims in your local plan.

4. Scheme Type and Sub Type:
- Please select the Scheme Type from the drop-down list that best represents the type of scheme being planned. A description of each scheme is available in tab 5b.
- Where the Scheme Types has further options to choose from, the Sub Type column alongside will be editable and turn "yellow". Please select the Sub Type from the drop down list that best describes the scheme being planned.
- Please note that the drop down list has a scroll bar to scroll through the list and all the options may not appear in one view.
- If the scheme is not adequately described by the available options, please choose 'Other' and add a free field description for the scheme type in the column alongside. Please try to use pre-populated scheme types and sub types where possible, as this data is important in assurance and to our understanding of how BCF funding is being used nationally.
- The template includes a field that will inform you when more than 5% of mandatory spend is classed as other.

5. Area of Spend:
- Please select the area of spend from the drop-down list by considering the area of the health and social care system which is most supported by investing in the scheme.
- Please note that where 'Social Care' is selected and the source of funding is "NHS minimum" then the planned spend would count towards National Condition 2.
- If the scheme is not adequately described by the available options, please choose 'Other' and add a free field description for the scheme type in the column alongside.
- We encourage areas to try to use the standard scheme types where possible.

6. Commissioner:
- Identify the commissioning body for the scheme based on who is responsible for commissioning the scheme from the provider.
- Please note this field is utilised in the calculations for meeting National Condition 3. Any spend that is from the funding source 'NHS minimum contribution', is commissioned by the ICB, and where the spend area is not 'acute care', will contribute to the total spend under National Condition 3. This will include expenditure that is ICB commissioned and classed as 'social care'.
- If the scheme is commissioned jointly, please select 'Joint'. Please estimate the proportion of the scheme being commissioned by the local authority and NHS and enter the respective percentages on the two columns.

7. Provider:
- Please select the type of provider commissioned to provide the scheme from the drop-down list.
- If the scheme is being provided by multiple providers, please split the scheme across multiple lines.

8. Source of Funding:
- Based on the funding sources for the BCF pool for the HWB, please select the source of funding for the scheme from the drop down list. This includes additional, voluntarily pooled contributions from either the ICB or Local authority
- If a scheme is funded from multiple sources of funding, please split the scheme across multiple lines, reflecting the financial contribution from each.

9. Expenditure (£) 2022-23:
- Please enter the planned spend for the scheme (or the scheme line, if the scheme is expressed across multiple lines)

10. New/Existing Scheme
- Please indicate whether the planned scheme is a new scheme for this year or an existing scheme being carried forward.

This is the only detailed information on BCF schemes being collected centrally for 2022-23 and will inform the understanding of planned spend for the iBCF grant and spend from BCF sources on discharge.

6. Metrics (click to go to sheet)

This sheet should be used to set out the HWB's ambitions (i.e. numerical trajectories) and performance plans for each of the BCF metrics in 2022-23. The BCF policy requires trajectories and plans agreed for the fund's metrics. Systems should review current performance and set realistic, but stretching ambitions for 2022-23.

A data pack showing more up to date breakdowns of data for the discharge to usual place of residence and unplanned admissions for ambulatory care sensitive conditions is available on the Better Care Exchange.

For each metric, areas should include narratives that describe:
- a rationale for the ambition set, based on current and recent data, planned activity and expected demand
- the local plan for improving performance on this metric and meeting the ambitions through the year. This should include changes to commissioned services, joint working and how BCF funded services will support this.

1. Unplanned admissions for chronic ambulatory care sensitive conditions:
- This section requires the area to input indirectly standardised rate (ISR) of admissions per 100,000 population by quarter in 2022-23. This will be based on NHS Outcomes Framework indicator 2.3i but using latest available population data.
- The indicator value is calculated using the indirectly standardised rate of admission per 100,000, standardised by age and gender to the national figures in reference year 2011. This is calculated by working out the SAR (observed admission/expected admissions*100) and multiplying by the crude rate for the reference year. The expected value is the observed rate during the reference year multiplied by the population of the breakdown of the year in question.
- The population data used is the latest available at the time of writing (2020)
- Actual performance for each quarter of 2021-22 are pre-populated in the template and will display once the local authority has been selected in the drop down box on the Cover sheet.
- Exact script used to pull pre-populated data can be found on the BCX along with the methodology used to produce the indicator value:
https://future.nhs.uk/bettercareexchange/viewdocument?docid=142269317&done=DOCCreated1&fid=21058704
- Technical definitions for the guidance can be found here:
https://digital.nhs.uk/data-and-information/publications/statistical/nhs-outcomes-framework/march-2022/domain-2---enhancing-quality-of-life-for-people-with-long-term-conditions-nof/2.3.i-unplanned-hospitalisation-for-chronic-ambulatory-care-sensitive-conditions

2. Discharge to normal place of residence.
- Areas should agree ambitions for the percentage of people who are discharged to their normal place of residence following an inpatient stay. In 2021-22, areas were asked to set a planned percentage of discharge to the person's usual place of residence for the year as a whole. In 2022-23 areas should agree a rate for each quarter.
- The ambition should be set for the health and wellbeing board area. The data for this metric is obtained from the Secondary Uses Service (SUS) database and is collected at hospital trust. A breakdown of data from SUS by local authority of residence has been made available on the Better Care Exchange to assist areas to set ambitions.
- Ambitions should be set as the percentage of all discharges where the destination of discharge is the person's usual place of residence.
- Actual performance for each quarter of 2021-22 are pre-populated in the template and will display once the local authority has been selected in the drop down box on the Cover sheet.

3. Residential Admissions (RES) planning:
- This section requires inputting the expected numerator of the measure only.
- Please enter the planned number of council-supported older people (aged 65 and over) whose long-term support needs will be met by a change of setting to residential and nursing care during the year (excluding transfers between residential and nursing care)
- Column H asks for an estimated actual performance against this metric in 2021-22. Data for this metric is not published until October, but local authorities will collect and submit this data as part of their salt returns in July. You should use this data to populate the estimated data in column H.
- The prepopulated denominator of the measure is the size of the older people population in the area (aged 65 and over) taken from Office for National Statistics (ONS) subnational population projections.
- The annual rate is then calculated and populated based on the entered information.

4. Reablement planning:
- This section requires inputting the information for the numerator and denominator of the measure.
- Please enter the planned denominator figure, which is the planned number of older people discharged from hospital to their own home for rehabilitation (or from hospital to a residential or nursing care home or extra care housing for rehabilitation, with a clear intention that they will move on/back to their own home).
- Please then enter the planned numerator figure, which is the expected number of older people discharged from hospital to their own home for rehabilitation (from within the denominator) that will still be at home 91 days after discharge.
- Column H asks for an estimated actual performance against this metric in 2021-22. Data for this metric is not published until October, but local authorities will collect and submit this data as part of their salt returns in July. You should use this data to populate the estimated data in column H.
- The annual proportion (%) Reablement measure will then be calculated and populated based on this information.

7. Planning Requirements (click to go to sheet)

This sheet requires the Health and Wellbeing Board to confirm whether the National Conditions and other Planning Requirements detailed in the BCF Policy Framework and the BCF Requirements document are met. Please refer to the BCF Policy Framework and BCF Planning Requirements documents for 2022-23 for further details.
The sheet also sets out where evidence for each Key Line of Enquiry (KLOE) will be taken from.
The KLOEs underpinning the Planning Requirements are also provided for reference as they will be utilised to assure plans by the regional assurance panel.

1. For each Planning Requirement please select 'Yes' or 'No' to confirm whether the requirement is met for the BCF Plan.
2. Where the confirmation selected is 'No', please use the comments boxes to include the actions in place towards meeting the requirement and the target timeframes.

Better Care Fund 2022-23 Template

2. Cover

HM Government

NHS

Version 1.0.0

Please Note:

- You are reminded that much of the data in this template, to which you have privileged access, is management information only and is not in the public domain. It is not to be shared more widely than is necessary to complete the return.

- Please prevent inappropriate use by treating this information as restricted, refrain from passing information on to others and use it only for the purposes for which it is provided. Any accidental or wrongful release should be reported immediately and may lead to an inquiry. Wrongful release includes indications of the content, including such descriptions as "favourable" or "unfavourable".

- Please note that national data for plans is intended for release in aggregate form once plans have been assured, agreed and baselined as per the due process outlined in the BCF Planning Requirements for 2022-23.

- This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.

- Where BCF plans are signed off under a delegated authority it must be reflected in the HWB's governance arrangements.

Health and Wellbeing Board:	Croydon	
Completed by:	Helen Mason and Daniele Serdoz	
E-mail:	one.croydon.alliance@croydon.gov.uk	
Contact number:	020 3923 9524	
Has this plan been signed off by the HWB (or delegated authority) at the time of submission?	No	
If no please indicate when the HWB is expected to sign off the plan:	Mon 17/10/2022	<< Please enter using the format, DD/MM/YYYY
If using a delegated authority, please state who is signing off the BCF plan:	N/A (No delegated authority)	

Please indicate who is signing off the plan for submission on behalf of the HWB (delegated authority is also accepted):

Job Title:	Corporate Director Adult Social Care & Health, Croydon Council; Ch
Name:	Annette McPartland; Matthew Kershaw

	Role:	Professional Title (e.g. Dr, Cllr, Prof)	First-name:	Surname:	E-mail:
***Area Assurance Contact Details:**	Health and Wellbeing Board Chair	Cllr	Yvette	Hopley	yvette.hopley@croydon.gov.uk
	Integrated Care Board Chief Executive or person to whom they have delegated sign-off	Mr	Matthew	Kershaw	matthew.kershaw1@nhs.net
	Additional ICB(s) contacts if relevant	Ms	Rachel	Flagg	rachel.flagg@swlondon.nhs.uk
	Local Authority Chief Executive	Ms	Katherine	Kerswell	Katherine.Kerswell@croydon.gov.uk

Local Authority Director of Adult Social Services (or equivalent)	Ms	Annette	McPartland	Annette.McPartland@croydon.gov.uk
Better Care Fund Lead Official	Mr	Daniele	Serdoz	Daniele.Serdoz@swlondon.nhs.uk
LA Section 151 Officer	Ms	Jane	West	Jane.West@croydon.gov.uk

Please add further area contacts that you would wish to be included in official correspondence e.g. housing or trusts that have been part of the process -->

Question Completion - When all questions have been answered and the validation boxes below have turned green, please send the template to the Better Care Fund Team england.bettercarefundteam@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'. Please also copy in your Better Care Manager.

Please see the Checklist below for further details on incomplete fields

	Complete:
2. Cover	Yes
4. Income	Yes
5a. Expenditure	Yes
6. Metrics	No
7. Planning Requirements	Yes

<< Link to the Guidance sheet

^^ Link back to top

Better Care Fund 2022-23 Template

3. Summary

Selected Health and Wellbeing Board: Croydon

Income & Expenditure

Income >>

Funding Sources	Income	Expenditure	Difference
DFG	£2,992,679	£2,992,679	£0
Minimum NHS Contribution	£29,339,813	£29,339,813	£0
iBCF	£9,978,112	£9,978,112	£0
Additional LA Contribution	£0	£0	£0
Additional ICB Contribution	£1,315,000	£1,315,000	£0
Total	**£43,625,604**	**£43,625,604**	**£0**

Expenditure >>

NHS Commissioned Out of Hospital spend from the minimum ICB allocation

Minimum required spend	£8,337,543
Planned spend	£16,756,455

Adult Social Care services spend from the minimum ICB allocations

Minimum required spend	£11,213,755
Planned spend	£11,357,393

Scheme Types

Assistive Technologies and Equipment	£569,997	(1.3%)
Care Act Implementation Related Duties	£658,000	(1.5%)
Carers Services	£243,233	(0.6%)

Community Based Schemes	£4,365,808	(10.0%)
DFG Related Schemes	£2,992,679	(6.9%)
Enablers for Integration	£0	(0.0%)
High Impact Change Model for Managing Transfer of C	£0	(0.0%)
Home Care or Domiciliary Care	£5,183,879	(11.9%)
Housing Related Schemes	£133,000	(0.3%)
Integrated Care Planning and Navigation	£5,608,367	(12.9%)
Bed based intermediate Care Services	£2,585,432	(5.9%)
Reablement in a persons own home	£3,826,448	(8.8%)
Personalised Budgeting and Commissioning	£880,802	(2.0%)
Personalised Care at Home	£9,883,364	(22.7%)
Prevention / Early Intervention	£85,000	(0.2%)
Residential Placements	£6,609,595	(15.2%)
Other	£0	(0.0%)
Total	**£43,625,604**	

Metrics >>

Avoidable admissions

	2022-23 Q1 Plan	2022-23 Q2 Plan	2022-23 Q3 Plan
Unplanned hospitalisation for chronic ambulatory care sensitive conditions (Rate per 100,000 population)			

Discharge to normal place of residence

	2022-23 Q1 Plan	2022-23 Q2 Plan	2022-23 Q3 Plan

Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence (SUS data - available on the Better Care Exchange)	93.4%	93.8%	93.5%

Residential Admissions

		2020-21 Actual	2022-23 Plan
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	130	290

Reablement

		2022-23 Plan
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	93.3%

Planning Requirements >>

Theme	Code	Response
NC1: Jointly agreed plan	**PR1**	No
	PR2	Yes

	PR3	Yes
NC2: Social Care Maintenance	**PR4**	Yes
NC3: NHS commissioned Out of Hospital Services	**PR5**	Yes
NC4: Implementing the BCF policy objectives	**PR6**	Yes
Agreed expenditure plan for all elements of the BCF	**PR7**	Yes
Metrics	**PR8**	Yes

Better Care Fund 2022-23 Template

4. Income

Selected Health and Wellbeing Board: Croydon

Local Authority Contribution	
Disabled Facilities Grant (DFG)	Gross Contribution
Croydon	£2,992,679
DFG breakdown for two-tier areas only (where applicable)	
Total Minimum LA Contribution (exc iBCF)	**£2,992,679**

iBCF Contribution	Contribution
Croydon	£9,978,112
Total iBCF Contribution	**£9,978,112**

Are any additional LA Contributions being made in 2022-23? If yes, please detail below	No

Local Authority Additional Contribution	Contribution	Comments - Please use this box clarify any specific uses or sources of funding
Total Additional Local Authority Contribution	**£0**	

NHS Minimum Contribution	Contribution
NHS South West London ICB	£29,339,813
Total NHS Minimum Contribution	**£29,339,813**

Are any additional ICB Contributions being made in 2022-23? If yes, please detail below	Yes

Additional ICB Contribution	Contribution	Comments - Please use this box clarify any specific uses or sources of funding
NHS South West London ICB	£151,552	Local Voluntary Partnership
NHS South West London ICB	£1,163,448	Life Additional

Total Additional NHS Contribution	**£1,315,000**	
Total NHS Contribution	**£30,654,813**	

	2021-22
Total BCF Pooled Budget	**£43,625,604**

Funding Contributions Comments Optional for any useful detail e.g. Carry over

Better Care Fund 2022-23 Template

5. Expenditure

Selected Health and Wellbeing Board: Croydon

<< Link to summary sheet

Running Balances	Income	Expenditure	Balance
DFG	£2,992,679	£2,992,679	£0
Minimum NHS Contribution	£29,339,813	£29,339,813	£0
iBCF	£9,978,112	£9,978,112	£0
Additional LA Contribution	£0	£0	£0
Additional NHS Contribution	£1,315,000	£1,315,000	£0
Total	**£43,625,604**	**£43,625,604**	**£0**

Required Spend

This is in relation to National Conditions 2 and 3 only. It does NOT make up the total Minimum CCG Contribution (on row 31 above).

	Minimum Required Spend	Planned Spend	Under Spend
NHS Commissioned Out of Hospital spend from the minimum ICB allocation	£8,337,543	£16,756,455	£0
Adult Social Care services spend from the minimum ICB allocations	£11,213,755	£11,357,393	£0

>> Link to further guidance

Checklist

Column complete:

Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

Sheet complete

						Planned Expenditure								
Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Sub Types	Please specify if 'Scheme Type' is 'Other'	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding	Expenditure (£)	New/ Existing Scheme
1	Edgecome Unit	Provision of rapid integrated care access to specialised clinical	Bed based intermediate Care Services	Rapid/Crisis Response		Acute		CCG			NHS Acute Provider	Minimum NHS Contribution	£1,225,965	Existing
2	Urgent Care/ Roving GP (Part of CUCA)	Roving GP for patients at risk of being admitted to hospital without primary	Personalised Care at Home	Physical health/wellbeing		Community Health		CCG			NHS Acute Provider	Minimum NHS Contribution	£501,428	Existing
3	Croydon Community SLA-TACS (BCF)	Community based services supporting out of hospital care provision	Community Based Schemes	Multidisciplinary teams that are supporting		Community Health		CCG			NHS Community Provider	Minimum NHS Contribution	£2,857,563	Existing
4	Croydon Community SLA - TACS Nusing	This service is an expansion of the Rapid Response unit with 3	Personalised Care at Home	Physical health/wellbeing		Community Health		CCG			NHS Community Provider	Minimum NHS Contribution	£237,065	Existing
5	Croydon Community SLA - ICN / LIFE	This service ensures that vulnerable/at risk patients are better	Community Based Schemes	Multidisciplinary teams that are supporting		Community Health		CCG			NHS Community Provider	Minimum NHS Contribution	£420,588	Existing
6	Croydon Community SLA - COPD (BCF)	Delivery of a whole system redesign of the COPD service including:	Personalised Care at Home	Physical health/wellbeing		Community Health		CCG			NHS Community Provider	Minimum NHS Contribution	£605,445	Existing
7	Croydon Community SLA - Falls (BCF)	The provision of an integrated falls service largely focusing on older	Community Based Schemes	Multidisciplinary teams that are supporting		Community Health		CCG			NHS Community Provider	Minimum NHS Contribution	£255,658	Existing

8	Croydon Community SLA - Enhanced Care	Expansion of case management capacity (additional Health Visitor	Community Based Schemes	Integrated neighbourhood services		Community Health		CCG			NHS Community Provider	Minimum NHS Contribution	£182,447	Existing
9	Diabetes Service (BCF)	The service aims to improve the outcomes for people with diabetes	Integrated Care Planning and Navigation	Care navigation and planning		Community Health		CCG			NHS Community Provider	Minimum NHS Contribution	£1,146,906	Existing
10	Intermediate Care - Beds (BCF)	Intermediate Care beds in nursing homes with community geriatrician	Bed based intermediate Care Services	Step down (discharge to assess pathway-2)		Community Health		CCG			NHS Community Provider	Minimum NHS Contribution	£782,467	Existing
11	St Christopher's Hospice - Palliative Care (BCF)	Provision of specialist palliative care from St Christopher's hospice,	Personalised Care at Home	Physical health/wellbeing		Community Health		CCG			Charity / Voluntary Sector	Minimum NHS Contribution	£2,018,485	Existing
12	EOL Respite	Provision of a respite service for carers of people on an EoL	Carers Services	Respite services		Community Health		CCG			Charity / Voluntary Sector	Minimum NHS Contribution	£79,233	Existing
13	End of Life Care GSF (ST CHRISTOPHER'S	Supporting the delivery of advanced care planning for end of life	Personalised Care at Home	Physical health/wellbeing		Community Health		CCG			Charity / Voluntary Sector	Minimum NHS Contribution	£201,947	Existing
14	Marie Curie (BCF)	Marie Curie service supporting people to die at home	Personalised Care at Home	Physical health/wellbeing		Community Health		CCG			Charity / Voluntary Sector	Minimum NHS Contribution	£110,000	Existing
15	Integrated Stroke Service (BCF)	Support stroke patients to achieve mutually agreed, realistic	Integrated Care Planning and Navigation	Care navigation and planning		Community Health		CCG			NHS Community Provider	Minimum NHS Contribution	£67,250	Existing
16	Age UK- Integrated Falls Service (BCF)	Age UK Croydon Personal Safety (Falls Prevention) Service	Personalised Care at Home	Physical health/wellbeing		Community Health		CCG			Charity / Voluntary Sector	Minimum NHS Contribution	£93,197	Existing
17	Age UK- PICS- OOH (BCF)	Implementation of Personnel Independence Coordinators service	Integrated Care Planning and Navigation	Care navigation and planning		Community Health		CCG			Charity / Voluntary Sector	Minimum NHS Contribution	£928,297	Existing
18	Medicines Management - OOH BCF	Domiciliary medicines review service preventing a hospital	Personalised Care at Home	Physical health/wellbeing		Primary Care		CCG			CCG	Minimum NHS Contribution	£127,628	Existing
19	Diabetes Locally Commissioned Services	A community service, reducing the number of patients being managed	Personalised Care at Home	Physical health/wellbeing		Primary Care		CCG			CCG	Minimum NHS Contribution	£217,611	Existing
20	Basket Locally Commissioned Services	Delivery within Primary Care additional services (such as complex leg	Personalised Care at Home	Physical health/wellbeing		Primary Care		CCG			CCG	Minimum NHS Contribution	£476,728	Existing
21	PDDS excluding Prescribing Scheme (BCF)	Practice Development and Delivery local scheme to engage	Personalised Care at Home	Physical health/wellbeing		Primary Care		CCG			CCG	Minimum NHS Contribution	£2,851,278	Existing
22	SLaM BCF Community Funding (BCF)	Home Treatment teams support secondary mental health services.	Personalised Care at Home	Mental health /wellbeing		Mental Health		CCG			NHS Mental Health Provider	Minimum NHS Contribution	£1,722,667	Existing
23	SLaM MHOA BCF Funding (BCF)	This service helps to keep people out of hospital as it provides	Personalised Care at Home	Mental health /wellbeing		Mental Health		CCG			NHS Mental Health Provider	Minimum NHS Contribution	£338,885	Existing
24	MHOA Dementia - Altzheimers (BCF)	Development of communication material e.g leaflet to support	Carers Services	Other	Dementia service to support carers	Mental Health		CCG			NHS Mental Health Provider	Minimum NHS Contribution	£164,000	Existing
25	Frailty Practioners (BCF)	posts in ED to support early identification of frailty or those at risk of	Integrated Care Planning and Navigation	Support for implementation of anticipatory care		Community Health		CCG			NHS Community Provider	Minimum NHS Contribution	£125,000	New

26	Step Down and Convalescence Beds	Procurement of step down beds for hospital discharge	Bed based intermediate Care Services	Step down (discharge to assess pathway-2)		Social Care		LA			Private Sector	Minimum NHS Contribution	£577,000	Existing
27	TACS - Social Work Input	Social workers assigned to GP clusters in Croydon who attend the weekly	Community Based Schemes	Integrated neighbourhood services		Social Care		LA			Local Authority	Minimum NHS Contribution	£498,000	Existing
28	Life Reablement - OOH	An integrated community based single team under one	Reablement in a persons own home	Reablement service accepting community and		Social Care		LA			Private Sector	Minimum NHS Contribution	£983,000	Existing
29	Mental Health Reablement	MH reablement service offering interventions that aim to restore life	Personalised Care at Home	Mental health /wellbeing		Social Care		LA			NHS Mental Health Provider	Minimum NHS Contribution	£205,000	Existing
30	Mental Health packages of care	Packages of care for adult MH due to increased LOS	Home Care or Domiciliary Care	Domiciliary care to support hospital discharge		Social Care		LA			Local Authority	Minimum NHS Contribution	£347,000	Existing
31	A&E Triage	Service to facilitate discharge from A&E (instead of admission to	Home Care or Domiciliary Care	Domiciliary care to support hospital discharge		Social Care		LA			Local Authority	Minimum NHS Contribution	£181,000	Existing
32	Hospital DIscharge	The team carry out assessments and arrange packages of care for	Home Care or Domiciliary Care	Domiciliary care to support hospital discharge		Social Care		LA			Charity / Voluntary Sector	Minimum NHS Contribution	£181,000	Existing
33	IAPT Long Term conditions pilot	The service is at primary care level, available to anyone with a Common	Personalised Care at Home	Mental health /wellbeing		Social Care		LA			NHS Mental Health Provider	Minimum NHS Contribution	£176,000	Existing
34	Early Intervention and reablement	This covers care for the first 6 weeks on discharge from hospital,	Reablement in a persons own home	Reablement to support discharge - step down		Social Care		LA			Private Sector	Minimum NHS Contribution	£1,172,000	Existing
35	Prevent return to acute/ Care Home	ongoing packages allowing service users to remain in their own	Home Care or Domiciliary Care	Domiciliary care packages		Social Care		LA			Private Sector	Minimum NHS Contribution	£549,000	Existing
36	Extended Staying Put	This service covers household tasks which are not adaptation, for	Housing Related Schemes			Social Care		LA			Local Authority	Minimum NHS Contribution	£133,000	Existing
37	Care Support Team Nurses	Service to strengthen the support/preventative measures provided to	Prevention / Early Intervention	Other	care homes support	Social Care		LA			NHS Community Provider	Minimum NHS Contribution	£85,000	Existing
38	Alcohol Diversion	The post co-ordinates multi agency care plans for a specific cohort who	Integrated Care Planning and Navigation	Assessment teams/joint assessment		Social Care		LA			Charity / Voluntary Sector	Minimum NHS Contribution	£66,000	Existing
39	Specialist Equipment eg Telehealth /	This scheme covers aspects of staff, licenses and equipment relating	Assistive Technologies and Equipment	Telecare		Social Care		LA			Local Authority	Minimum NHS Contribution	£205,000	Existing
40	Shared Lives - Assisted Housing (MH OBD LoS)	Expansion of the Shared Lives service delivered by Croydon Council. This	Residential Placements	Supported living		Social Care		LA			Local Authority	Minimum NHS Contribution	£43,000	Existing
41	Demographic pressures - package of care	This is a contribution to overall funding to packages of care,	Home Care or Domiciliary Care	Domiciliary care packages		Social Care		LA			Private Sector	Minimum NHS Contribution	£2,386,000	Existing
42	Care Act	Implementation of statutory duties to the Council arising from the	Care Act Implementation Related Duties	Carer advice and support		Social Care		LA			Local Authority	Minimum NHS Contribution	£658,000	Existing
43	Social care pressures	A contribution to the overall funding of packages of care,	Residential Placements	Care home		Social Care		LA			Private Sector	Minimum NHS Contribution	£1,273,000	Existing

44	Social Care (Careline)	Careline alarm is designed to help older, frail or disabled people	Assistive Technologies and Equipment	Telecare		Social Care		LA			Local Authority	Minimum NHS Contribution	£241,000	Existing
45	Drug & Alcohol - Out of Hospital BusineDss Case	Integrated substance misuse service to reable people in the community	Integrated Care Planning and Navigation	Assessment teams/joint assessment		Social Care		LA			Local Authority	Minimum NHS Contribution	£190,000	Existing
46	Packages of Care	Meeting social care needs and supporting people to be discharged	Home Care or Domiciliary Care	Domiciliary care packages		Social Care		LA			Private Sector	iBCF	£1,258,533	Existing
47	BCF Basline LIFE	Additional contribution to the LIFE service for increased packages of	Reablement in a persons own home	Reablement to support discharge - step down		Social Care		LA			Private Sector	Minimum NHS Contribution	£508,000	Existing
48	DFG	DFG schemes. (please refer to narrative)	DFG Related Schemes	Discretionary use of DFG - including small adaptations		Social Care		LA			Private Sector	DFG	£2,992,679	Existing
49	Discharge to Assess	To continue discharge to assess	Residential Placements	Care home		Social Care		LA			Private Sector	Minimum NHS Contribution	£79,929	Existing
50	LIFE Additional	Additional Contribution to the LIFE service	Reablement in a persons own home	Reablement to support discharge - step down		Social Care		LA			Local Authority	Additional NHS Contribution	£1,163,448	Existing
51	Local Voluntary Partnerhip	Local Voluntary Partnership	Community Based Schemes	Integrated neighbourhood services		Community Health		CCG			Charity / Voluntary Sector	Additional NHS Contribution	£151,552	Existing
52	LIFE enhanced	expansion of the LIFE schemes to further support discharge	Integrated Care Planning and Navigation	Care navigation and planning		Community Health		CCG			NHS Community Provider	Minimum NHS Contribution	£244,682	Existing
53	Social Workers	Additional social care staffing to support hospital discharge: 1 FTE	Integrated Care Planning and Navigation	Assessment teams/joint assessment		Social Care		LA			Local Authority	Minimum NHS Contribution	£96,600	New
54	Residential Placements	Meeting social care needs and supporting people to be discharged	Residential Placements	Care home		Social Care		LA			Private Sector	iBCF	£2,851,829	Existing
56	Residential Placements	Meeting social care needs and supporting people to be discharged	Residential Placements	Nursing home		Social Care		LA			Private Sector	iBCF	£1,192,440	Existing
57	Supported Living	Meeting social care needs	Residential Placements	Supported living		Social Care		LA			Private Sector	iBCF	£1,133,194	Existing
58	Direct Payments	Meeting social care needs	Personalised Budgeting and Commissioning			Social Care		LA			Private Sector	iBCF	£880,802	Existing
59	Social work staff	Meeting social care needs	Integrated Care Planning and Navigation	Assessment teams/joint assessment		Social Care		LA			Local Authority	iBCF	£2,661,314	Existing
60	Equipment for dishcarge to assess	Wheelchair and ancillary equipment	Assistive Technologies and Equipment	Community based equipment		Social Care		LA			Local Authority	Minimum NHS Contribution	£123,997	New
61	Staffing for discharge to assess	staffing to continue discharge to assess	Integrated Care Planning and Navigation	Assessment teams/joint assessment		Social Care		LA			Local Authority	Minimum NHS Contribution	£82,318	New
62	discharge to assess placements	To continue discharge to assess packages and placements	Residential Placements	Supported living		Social Care		LA			Private Sector	Minimum NHS Contribution	£14,788	New

63	discharge to assess placements	to continue discharge to assess packages and placements	Residential Placements	Nursing home		Social Care		LA			Private Sector	Minimum NHS Contribution	£21,415	New
64	DIscharge to Assess placements	To continue discharge to assess, packages and placements	Home Care or Domiciliary Care	Domiciliary care packages		Social Care		LA			Private Sector	Minimum NHS Contribution	£281,346	New

Further guidance for completing Expenditure sheet

National Conditions 2 & 3

Schemes tagged with the following will count towards the planned **Adult Social Care services spend** from the NHS min:

- **Area of spend** selected as 'Social Care'
- **Source of funding** selected as 'Minimum NHS Contribution'

Schemes tagged with the below will count towards the planned **Out of Hospital spend** from the NHS min:

- **Area of spend** selected with anything except 'Acute'
- **Commissioner** selected as 'ICB' (if 'Joint' is selected, only the NHS % will contribute)
- **Source of funding** selected as 'Minimum NHS Contribution'

2022-23 Revised Scheme types

Number	Scheme type/ services	Sub type	Description
1	Assistive Technologies and Equipment	1. Telecare 2. Wellness services 3. Digital participation services 4. Community based equipment 5. Other	Using technology in care processes to supportive self-management, maintenance of independence and more efficient and effective delivery of care. (eg. Telecare, Wellness services, Community based equipment, Digital participation services).
2	Care Act Implementation Related Duties	1. Carer advice and support 2. Independent Mental Health Advocacy 3. Safeguarding 4. Other	Funding planned towards the implementation of Care Act related duties. The specific scheme sub types reflect specific duties that are funded via the NHS minimum contribution to the BCF.
3	Carers Services	1. Respite Services 2. Other	Supporting people to sustain their role as carers and reduce the likelihood of crisis. This might include respite care/carers breaks, information, assessment, emotional and physical support, training, access to services to support wellbeing and improve independence.
4	Community Based Schemes	1. Integrated neighbourhood services 2. Multidisciplinary teams that are supporting independence, such as anticipatory care 3. Low level support for simple hospital discharges (Discharge to Assess pathway 0) 4. Other	Schemes that are based in the community and constitute a range of cross sector practitioners delivering collaborative services in the community typically at a neighbourhood/PCN level (eg: Integrated Neighbourhood Teams) Reablement services should be recorded under the specific scheme type 'Reablement in a person's own home'

5	DFG Related Schemes	1. Adaptations, including statutory DFG grants 2. Discretionary use of DFG - including small adaptations 3. Handyperson services 4. Other	The DFG is a means-tested capital grant to help meet the costs of adapting a property; supporting people to stay independent in their own homes. The grant can also be used to fund discretionary, capital spend to support people to remain independent in their own homes under a Regulatory Reform Order, if a published policy on doing so is in place. Schemes using this flexibility can be recorded under 'discretionary use of DFG' or 'handyperson services' as appropriate
6	Enablers for Integration	1. Data Integration 2. System IT Interoperability 3. Programme management 4. Research and evaluation 5. Workforce development 6. Community asset mapping 7. New governance arrangements 8. Voluntary Sector Business Development 9. Employment services 10. Joint commissioning infrastructure 11. Integrated models of provision 12. Other	Schemes that build and develop the enabling foundations of health, social care and housing integration, encompassing a wide range of potential areas including technology, workforce, market development (Voluntary Sector Business Development: Funding the business development and preparedness of local voluntary sector into provider Alliances/ Collaboratives) and programme management related schemes. Joint commissioning infrastructure includes any personnel or teams that enable joint commissioning. Schemes could be focused on Data Integration, System IT Interoperability, Programme management, Research and evaluation, Supporting the Care Market, Workforce development, Community asset mapping, New governance arrangements, Voluntary Sector Development, Employment services, Joint commissioning infrastructure amongst others.
7	High Impact Change Model for Managing Transfer of Care	1. Early Discharge Planning 2. Monitoring and responding to system demand and capacity 3. Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge 4. Home First/Discharge to Assess - process support/core costs 5. Flexible working patterns (including 7 day working) 6. Trusted Assessment 7. Engagement and Choice 8. Improved discharge to Care Homes 9. Housing and related services 10. Red Bag scheme 11. Other	The eight changes or approaches identified as having a high impact on supporting timely and effective discharge through joint working across the social and health system. The Hospital to Home Transfer Protocol or the 'Red Bag' scheme, while not in the HICM, is included in this section.
8	Home Care or Domiciliary Care	1. Domiciliary care packages 2. Domiciliary care to support hospital discharge (Discharge to Assess pathway 1) 3. Domiciliary care workforce development 4. Other	A range of services that aim to help people live in their own homes through the provision of domiciliary care including personal care, domestic tasks, shopping, home maintenance and social activities. Home care can link with other services in the community, such as supported housing, community health services and voluntary sector services.
9	Housing Related Schemes		This covers expenditure on housing and housing-related services other than adaptations; eg: supported housing units.

10	Integrated Care Planning and Navigation	1. Care navigation and planning 2. Assessment teams/joint assessment 3. Support for implementation of anticipatory care 4. Other	Care navigation services help people find their way to appropriate services and support and consequently support self-management. Also, the assistance offered to people in navigating through the complex health and social care systems (across primary care, community and voluntary services and social care) to overcome barriers in accessing the most appropriate care and support. Multi-agency teams typically provide these services which can be online or face to face care navigators for frail elderly, or dementia navigators etc. This includes approaches such as Anticipatory Care, which aims to provide holistic, co-ordinated care for complex individuals. Integrated care planning constitutes a co-ordinated, person centred and proactive case management approach to conduct joint assessments of care needs and develop integrated care plans typically carried out by professionals as part of a multi-disciplinary, multi-agency teams. Note: For Multi-Disciplinary Discharge Teams related specifically to discharge, please select HICM as scheme type and the relevant sub-type. Where the planned unit of care delivery and funding is in the form of Integrated care packages and needs to be expressed in such a manner, please select the appropriate sub-type alongside.
11	Bed based intermediate Care Services	1. Step down (discharge to assess pathway-2) 2. Step up 3. Rapid/Crisis Response 4. Other	Short-term intervention to preserve the independence of people who might otherwise face unnecessarily prolonged hospital stays or avoidable admission to hospital or residential care. The care is person-centred and often delivered by a combination of professional groups. Four service models of intermediate care are: bed-based intermediate care, crisis or rapid response (including falls), home-based intermediate care, and reablement or rehabilitation. Home-based intermediate care is covered in Scheme-A and the other three models are available on the sub-types.
12	Reablement in a persons own home	1. Preventing admissions to acute setting 2. Reablement to support discharge -step down (Discharge to Assess pathway 1) 3. Rapid/Crisis Response - step up (2 hr response) 4. Reablement service accepting community and discharge referrals 5. Other	Provides support in your own home to improve your confidence and ability to live as independently as possible
13	Personalised Budgeting and Commissioning		Various person centred approaches to commissioning and budgeting, including direct payments.
14	Personalised Care at Home	1. Mental health /wellbeing 2. Physical health/wellbeing 3. Other	Schemes specifically designed to ensure that a person can continue to live at home, through the provision of health related support at home often complemented with support for home care needs or mental health needs. This could include promoting self-management/expert patient, establishment of 'home ward' for intensive period or to deliver support over the longer term to maintain independence or offer end of life care for people. Intermediate care services provide shorter term support and care interventions as opposed to the ongoing support provided in this scheme type.
15	Prevention / Early Intervention	1. Social Prescribing 2. Risk Stratification 3. Choice Policy 4. Other	Services or schemes where the population or identified high-risk groups are empowered and activated to live well in the holistic sense thereby helping prevent people from entering the care system in the first place. These are essentially upstream prevention initiatives to promote independence and well being.

16	Residential Placements	1. Supported living 2. Supported accommodation 3. Learning disability 4. Extra care 5. Care home 6. Nursing home 7. Discharge from hospital (with reablement) to long term residential care (Discharge to Assess Pathway 3) 8. Other	Residential placements provide accommodation for people with learning or physical disabilities, mental health difficulties or with sight or hearing loss, who need more intensive or specialised support than can be provided at home.
18	Other		Where the scheme is not adequately represented by the above scheme types, please outline the objectives and services planned for the scheme in a short description in the comments column.

Better Care Fund 2022-23 Template

6. Metrics

Selected Health and Wellbeing Board: Croydon

8.1 Avoidable admissions

		2021-22 Q1 Actual	2021-22 Q2 Actual	2021-22 Q3 Actual	2021-22 Q4 Actual	Rationale for how ambition was set	Local plan to meet ambition
Indirectly standardised rate (ISR) of admissions per 100,000 population	Indicator value	187.2	160.4	178.3	152.9	Q2, Q3 and Q4 have been estimated as having the same quarterly incremental improvement as we saw in 21/22. To give an overall improved position on 21/22 Unknown variables that could impact on	Croydon has developed OOH integrated provision and AED avoidance schemes in the last few years. Inc: ICN+ teams in dentifying those high risk of admission, LIFE service with 2 hr response, also additional
		2022-23 Q1 Plan	2022-23 Q2 Plan	2022-23 Q3 Plan	2022-23 Q4 Plan		
(See Guidance)	Indicator value	157	134	150	128		

>> link to NHS Digital webpage (for more detailed guidance)

8.3 Discharge to usual place of residence

		2021-22 Q1 Actual	2021-22 Q2 Actual	2021-22 Q3 Actual	2021-22 Q4 Actual	Rationale for how ambition was set	Local plan to meet ambition
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence	Quarter (%)	94.0%	93.8%	93.0%	93.2%	Q2 and Q3 ambitions wer set following methodology of averaging the last 3 years for the same quarters. Q4 was estimated following the same incremental improvement from Q3 to Q4 in 21/22. Local plans and BCF investments are anticipated to have an impact from Q4 as there will be a lag as staff are recruited and embedded.	Croydon place has implemented a number of programmes in the last two years that has supported people to be discharged from hospital to their normal place of residence. These include Discharge to Assess, LIFE service, ICN+, Staying Put (housing and adaptations). These programmes have contributed to supporting people discharge back to their normal place of residence. It is anticipated
	Numerator	7,477	7,469	7,044	6,410		
	Denominator	7,954	7,965	7,578	6,876		
		2022-23 Q1 Plan	2022-23 Q2 Plan	2022-23 Q3 Plan	2022-23 Q4 Plan		
(SUS data - available on the Better Care Exchange)	Quarter (%)	93.4%	93.8%	93.5%	93.7%		
	Numerator	6,730	7,524	7,336	6,848		
	Denominator	7,208	8,023	7,847	7,308		

8.4 Residential Admissions

		2020-21 Actual	2021-22 Plan	2021-22 estimated	2022-23 Plan	Rationale for how ambition was set	Local plan to meet ambition
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	129.5	484.5	308.6	289.7	The demand for bed based care is still increasing and above 20/21 actuals. This is based on existing flow on pathway 2 and 3 but with a factor on ensuring that home first model is in place jointly between acute and adult social care. However it should be	Partners are following a home first policy before any admission into a residential based setting. Any referrals will be looked at in line with this policy and based on demand that is predicted for 22/23. There is a joint transformation programme to look
	Numerator	70	270	172	165		
	Denominator	54,048	55,731	55,731	56,960		

Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population (aged 65+) population projections are based on a calendar year using the 2018 based Sub-National Population Projections for Local Authorities in England:
https://www.ons.gov.uk/releases/subnationalpopulationprojectionsforengland2018based

8.5 Reablement

		2020-21 Actual	2021-22 Plan	2021-22 estimated	2022-23 Plan	Rationale for how ambition was set	Local plan to meet ambition
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	84.1%	87.7%	90.3%	93.3%	A steady improvement of 3% has been seen for the last 3 years, from improvements in the out of hospital reablement offer in Croydon. Demand is expected to increase. Hospital discharge and in the community step up services for reablement are being	The Home First Policy continues to be embedded with development of knowledge and skills for staff. A focused decision making panel is being implemented to further scrutinise all proposed residential home admissions to mandate all options
	Numerator	401	1,682	570	776		
	Denominator	477	1,918	631	832		

Please note that due to the demerging of Northamptonshire, information from previous years will not reflect the present geographies.

As such, the following adjustments have been made for the pre-populated figures above:
- 2020-21 actuals (for **Residential Admissions** and **Reablement**) for North Northamptonshire and West Northamptonshire are using the Northamptonshire combined figure;
- 2021-22 and 2022-23 population projections (i.e. the denominator for **Residential Admissions**) have been calculated from a ratio based on the 2020-21 estimates.

Better Care Fund 2022-23 Template

7. Confirmation of Planning Requirements

Selected Health and Wellbeing Board: Croydon

Theme	Code	Planning Requirement	Key considerations for meeting the planning requirement These are the Key Lines of Enquiry (KLOEs) underpinning the Planning Requirements (PR)	Confirmed through	Please confirm whether your BCF plan meets the Planning Requirement?	Please note any supporting documents referred to and relevant page numbers to assist the assurers	Where the Planning requirement is not met, please note the actions in place towards meeting the requirement	Where the Planning requirement is not met, please note the anticipated timeframe for meeting it
NC1: Jointly agreed plan	PR1	**A jointly developed and agreed plan that all parties sign up to**	Has a plan; jointly developed and agreed between ICB(s) and LA; been submitted? Has the HWB approved the plan/delegated approval? Have local partners, including providers, VCS representatives and local authority service leads (including housing and DFG leads) been involved in the development of the plan? Where the narrative section of the plan has been agreed across more than one HWB, have individual income, expenditure and metric sections of the plan been submitted for each HWB concerned?	Cover sheet Cover sheet Narrative plan Validation of submitted plans	No		The H&WBB meets on October 17th 2022, there is no delegated authority outside of the meeting. See page 6 of the narrative desribing governance changed in Croydon. Plans will be informally agreed prior to submission.	October 17th
	PR2	**A clear narrative for the integration of health and social care**	Is there a narrative plan for the HWB that describes the approach to delivering integrated health and social care that describes: • How the area will continue to implement a joined-up approach to integrated, person-centred services across health, care, housing and wider public services locally • The approach to collaborative commissioning • How the plan will contribute to reducing health inequalities and disparities for the local population, taking account of people with protected characteristics? This should include - How equality impacts of the local BCF plan have been considered - Changes to local priorities related to health inequality and equality, including as a result of the COVID 19 pandemic, and how activities in the document will address these. The area will need to also take into account Priorities and Operational Guidelines regarding health inequalities, as well as local authorities' priorities under the Equality Act and NHS actions in line with Core20PLUS5.	Narrative plan	Yes			
	PR3	**A strategic, joined up plan for Disabled Facilities Grant (DFG) spending**	Is there confirmation that use of DFG has been agreed with housing authorities? • Does the narrative set out a strategic approach to using housing support, including use of DFG funding that supports independence at home? • In two tier areas, has: - Agreement been reached on the amount of DFG funding to be passed to district councils to cover statutory DFG? or - The funding been passed in its entirety to district councils?	Narrative plan Confirmation sheet	Yes			
NC2: Social Care Maintenance	PR4	**A demonstration of how the area will maintain the level of spending on social care services from the NHS minimum contribution to the fund in line with the uplift in the overall contribution**	Does the total spend from the NHS minimum contribution on social care match or exceed the minimum required contribution (auto-validated on the planning template)?	Auto-validated on the planning template	Yes			
NC3: NHS commissioned Out of Hospital Services	PR5	**Has the area committed to spend at equal to or above the minimum allocation for NHS commissioned out of hospital services from the NHS minimum BCF contribution?**	Does the total spend from the NHS minimum contribution on non-acute, NHS commissioned care exceed the minimum ringfence (auto-validated on the planning template)?	Auto-validated on the planning template	Yes			
NC4: Implementing the BCF policy objectives	PR6	**Is there an agreed approach to implementing the BCF policy objectives, including a capacity and demand plan for intermediate care services?**	Does the plan include an agreed approach for meeting the two BCF policy objectives: - Enable people to stay well, safe and independent at home for longer and - Provide the right care in the right place at the right time? • Does the expenditure plan detail how expenditure from BCF funding sources supports this approach through the financial year? •Has the area submitted a Capacity and Demand Plan alongside their BCF plan, using the template provided? • Does the narrative plan confirm that the area has conducted a self-assessment of the area's implementation of the High Impact Change Model for managing transfers of care? • Does the plan include actions going forward to improve performance against the HICM?	Narrative plan Expenditure tab C&D template and narrative Narrative plan Narrative template	Yes			

Agreed expenditure plan for all elements of the BCF	**PR7**	**Is there a confirmation that the components of the Better Care Fund pool that are earmarked for a purpose are being planned to be used for that purpose?**	• Do expenditure plans for each element of the BCF pool match the funding inputs? (auto-validated) • Is there confirmation that the use of grant funding is in line with the relevant grant conditions? (see paragraphs 31 – 43 of Planning Requirements) (tick-box) • Has the area included a description of how BCF funding is being used to support unpaid carers? • Has funding for the following from the NHS contribution been identified for the area: - Implementation of Care Act duties? - Funding dedicated to carer-specific support? - Reablement?	Expenditure tab Expenditure plans and confirmation sheet Narrative plan Narrative plans, expenditure tab and confirmation sheet	Yes			
Metrics	**PR8**	**Does the plan set stretching metrics and are there clear and ambitious plans for delivering these?**	• Have stretching ambitions been agreed locally for all BCF metrics? • Is there a clear narrative for each metric setting out: - the rationale for the ambition set, and - the local plan to meet this ambition?	Metrics tab	Yes			

BCF narrative plan template

This is a template for local areas to use to submit narrative plans for the Better Care Fund (BCF). All local areas are expected to submit narrative BCF plans but use of this template for doing so is optional. Although the template is optional, we encourage BCF planning leads to ensure that narrative plans cover all headings and topics from this narrative template.

These plans should complement the agreed spending plans and ambitions for BCF national metrics in your area's BCF Planning Template (excel).

There are no word limits for narrative plans, but you should expect your local narrative plans to be no longer than 15-20 pages in length.

Although each Health and Wellbeing Board (HWB) will need to agree a separate excel planning template, a narrative plan covering more than one HWB can be submitted, where this reflects local arrangements for integrated working. Each HWB covered by the plan will need to agree the narrative as well as their excel planning template.

An example answers and top tips document is available on the Better Care Exchange to assist with filling out this template.

Cover

Health and Wellbeing Board(s)

Croydon

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

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

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

How have you gone about involving these stakeholders?

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

Executive summary

This should include:

- Priorities for 2022-23
- Key changes since previous BCF plan

This document sets out Croydon's Better Care Fund Plan for 2022/23. It complements the BCF Planning Template which will be submitted together with this narrative.

This BCF narrative document and the Planning template will show that Croydon BCF plan for 2022-23:

1- Has been jointly agreed between health and social care partners. This plan has been developed with input from the One Croydon Alliance partners and wider stakeholders in health and social care. As outline in the next section of this document the One Croydon Governance has been used to agree the plan, which will then be signed off by the Health and Wellbeing Board.
2- Includes a contribution to adult social care from the NHS in line with the required minimum contribution. This is approximately £11.3M which is the minimum requirement.
3- Includes a large proportion of NHS commissioned schemes delivered out of hospital. Croydon's BCF investment in NHS commissioned out-of-hospital services will total approx. £16.7, in excess of the mandated minimum of £8.35M.
4- Makes a significant contribution to enabling people to stay well, safe and independent at home for longer, whilst also striving to provide the right care at the right time in the right place. This is through a programme of work centred around developing integrated localities team with a focus on neighbourhood and communities to be at the heart of people's care, underpinned by a proactive and preventative approach using population health management to tackle health inequalities and target people whit the highest needs.
5- As such, our plan meets the BCF national conditions, which were set out in the Planning Requirements published on July 19th 2022.

Our joint priorities are outlined in section 3 ("Overall BCF approach to Integration"). Our plan for 2022-23 builds upon established joint working in Croydon through the One Croydon Alliance and the delivery of the Croydon Health and Care Plan. This is a fully integrated programme of work between NHS partners, the Voluntary Sector, Mental Health and Social Care which outlines a vision for how health and social care will be delivered across the borough, particularly for those with the greatest need, to transform the health and wellbeing of local people. The plan emphasises three clear priorities:

- Focus on prevention and proactive care: supporting people to stay well, manage their own health and maintain their wellbeing by making sure they can get help early.

- Unlock the power of communities: connecting people to their neighbours and communities, who can provide unique support to stay fit and healthy for longer.
- Develop services in the heart of the community: giving people easy access to joined up services that are tailored to the needs of their local community

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

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

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

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

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

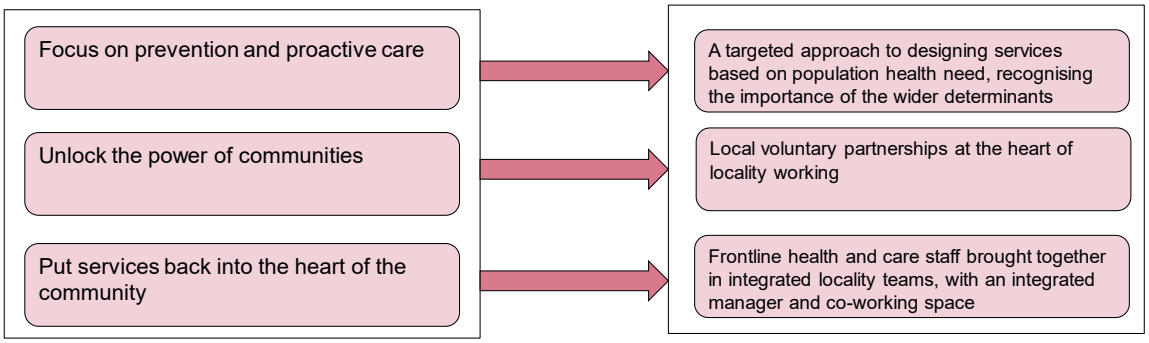
- Multi-Agency Huddles (including social workers) which are practice based
- LIFE service (Living Independently for Everyone)
- Community Diabetes Service
- Falls Service
- Community Based COPD Service

- Community Based Cardiology Service
- Accessible Mental Health Service
- Mental Health Reablement
- End-of-life care

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

Most of the BCF schemes in 2022-23 have been rolled over from 2021-22 but the ethos has shifted toward building on the integration work that Croydon has implemented since 2017 and feed into the Localities Programme of integration in Croydon.

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



We are continuing to strengthen Frailty as a key area of work through BCF funding and ICN+, by developing a strategy that will join up acute frailty care with frailty care in the community. Other key changes are the additional investment in Discharge to Assess processes in Croydon, to enable this to continue. Additional social work staff are funded also in the acute wards to facilitate discharges from acute elderly ward and palliative

Governance

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

On 1 July 2022, we launched South West London (SWL) Integrated Care System (ICS) as we take on health and care statutory responsibilities in line with the new legislation, outlined in the 2022 Health and Social Care Act. It is envisaged that the introduction of the SWL ICS will only strengthen the already established One Croydon partnership as well as further ensure that local people receive the best care.

In preparation for the migration to ICS One Croydon Alliance introduced a number of whole system groups, including that of the Commissioning and planning group. This addition has allowed One Croydon the opportunity to strengthen the BCF management and oversight. In order to maximise the opportunity new governance has been installed, that have made the below amendments to the BCF S75 as well as the appropriate Terms of Reference.

Health and Well Being Board

Croydon Council's constitution has changed from an Executive Leader and Cabinet Model, to a directly elected Mayor, and in May 2022 the residents voted in a new Mayor. The changes to these decision-making arrangements have had implications on other Boards creating some delays to some governance as the amendments to the constitution are made. During this time, the June 2022 Health and Well Being Board was cancelled, the next scheduled Board is in October 2022. There are no delegated powers outside of the Board, and as such this is the closest opportunity to sign off the 22/23 BCF plans in Croydon. However, proposals will be made at this Board meeting to amend the Terms of Reference to the Board to the BCF plans in future will be able to delegated to key decision makers and the plans brought the Board for ratification.

BCF Executive Group & SEG:

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

The role of the Commissioning, Planning and PHM:

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

Introduction of the BCF working group:

To facilitate the process of reviewing, planning and developing BCF spend options, a new BCF working group has been formed by commissioners and finance personal from health and social care. This group includes from across Croydon, Finance leads, Commissioners, Head of Improvement and Policy, One Croydon leads and the DFG lead. The groups report to the Commissioning, planning & PHM group quarterly with all reviews, options and proposed changes prior to any final submission.

Joint Priorities and the Croydon Health and Care Plan

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

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

In 2019, One Croydon launched a five-year Health and Care plan to help people in our community improve their health and wellbeing. Following 2020/21 and the COVID-19 pandemic a new refreshed plan was needed as a response from health and social care. This refresh has given One Croydon the opportunity to come together and assess our progress so far and what our priorities need to be in a fast-changing environment including emerging impact of the pandemic, the Health and Care Bill and the Local Authority financial position.

Overall BCF plan and approach to integration

Please outline your approach to embedding integrated, person centred health, social care and housing services including:

- Joint priorities for 2022-23
- Approaches to joint/collaborative commissioning
- describe any changes to the services you are commissioning through the BCF from 2022-23.
- How BCF funded services are supporting your approach to integration. Briefly

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

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

Approach to collaborative commissioning

In the last year, we have strengthened our commissioning partnerships with communities and the voluntary and community sector. A 'Healthy Communities Together Model' is in development, with 6 local areas, each area has a lead from the voluntary and community sector. The ambition, is to enable a stronger voice for all

voluntary sector organisations within Croydon, creating a shared leadership model with partners. As part of this, a locality-based commissioning model is being created, with the principle to shift spend and activity into the Voluntary community sector over time. This is to be informed by an evidence-based approach to improve outcomes, manage demand and better value. Scoping of potential contracts that can be delivered by the sector and a locality- based process for grants allocation are in development.

We have also strengthened our collaborative commissioning work between the Council and the ICB. For example, the recommissioning of the BCF funded End of Life Respite service. This is commissioned by the ICB. The aim of this service is to supports people to die at home if that is their preferred place of death whilst reducing the risk of A&E/Hospital admission if a carer enters a crisis.

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

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

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

Changes to previous BCF plans

Most of the BCF schemes funded in 22-23 have rolled over from 21-22. The ethos however has been to build on the integration work that Croydon has implemented since 2017 through the One Croydon Alliance of health and care. The schemes feed into, and enhance much of the ICN+ programme of integration and the six localities in Croydon. Much of the iBCF schemes have also refocused on packages of care to support reablement and Discharge to Assess.

All adults in Croydon (>18) are in scope for our initiatives.

Other changes to the plans are in relation to support the emerging Frailty Strategy, aligned with the ICN+ model. The strategic objectives are:

- Strategic objective 1: Clinical Frailty is recognised as a condition which needs to be addressed as part of a holistic approach to identifying and addressing people's wider needs.
- Strategic objective 2: People identified as living with frailty will experience improved outcomes through better access to appropriate interventions at the right time and in the right place.
- Strategic objective 3: Better use of resources by early identification, proactive intervention and improved care planning.
- Strategic objective 4: To always adopt a patient centred approach by engaging with people living with frailty and their carers, to understand what matters to them.
- Strategic objective 5: People are empowered to understand and influence their own care, through better communication, education and self-management.

As part of this work, and delivered through joint BCF and Aging Well (Anticipatory Care) funding, we are implementing additional capacity through two Advanced Frailty Practitioners to support the Acute Care of the Elderly (ACE) team to identify and review patients in ED, supporting transfer and care through a frailty SDEC and virtual ward (both currently under review and further development) and into the community as appropriate to avoid admissions wherever possible. The 'front door' focussed roles will work with the newly appointed ACE Interface Consultant who will focus on early support and intervention for older people in ED and SDEC.

In addition, changes to the current Complex Care Support Team are in progress to refine the current band 7 roles (3 WTE) and, including a further 3 additional WTE roles, to undertake locality based Frailty Practitioner roles. Thereby ensuring embedment in local neighbourhood teams as part of the ICN+ arrangements.

The additional frailty practitioner roles and advanced frailty practitioner roles are currently being finalised with the aim of recruitment being completed by December 2022. Full mapping of current services and the new roles is to be undertaken shortly to ensure clarity of roles and responsibility and enhanced joint working across primary care, community, ED and acute, and social care through the ICN+ MDTs.

Engagement on local frailty services is to be undertaken in September 2022, to inform how we deliver the strategy and support people in the best way to meet their goals for independent living, including reducing the exacerbation of frailty. This work also aligns with the development of community - based schemes through voluntary sector partners to support earlier identification of frailty, provide appropriate exercise classes and support, as well as basic health checks.

Additional funding has been allocated to existing Falls Prevention scheme delivered by Age UK Croydon to work with people at home to reduce the risk of falls. Referrals had become increasingly complex. The additional funding has enabled the service to be more sustainable and the services has good outcomes with reduced the call outs for LAS, A&E attendances, hospital admissions, and reablement packages.

Challenges to integration

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

- the ability for Health services and Council services to integrate IT systems to allow systems to communicate securely and allow for data interoperability
- Wider system pressures, including relatively high bed occupancy in hospital and sustained increased hospital discharges, with additional costs on packages of care
- Risks to the delivery of BCF plans due to the already challenging financial position of Croydon Council
- Workforce recruitment, retention and wellbeing. The pandemic has put sustained pressures on staff in health and care, compounded by shortages of qualified professionals
- Estates. There are many examples of integrated teams working together. However, there are issue in Croydon with where to put these teams. The pandemic has helped facilitating remote working but for effective team development having some shared spaces is important particularly for multi-agency working and relationship building.
- Covid-19 and winter pressures are expected to create extremely challenging conditions over the next few months. Many of our schemes have been very effective during the pandemic and demonstrated the power of collaborative working in getting through a crisis. However, we cannot underestimate the risk to delivery of our ambitions due to these significant pressures.

Implementing the BCF Policy Objectives (national condition four)

National condition four requires areas to agree an overarching approach to meeting the BCF policy objectives to:

- Enable people to stay well, safe and independent at home for longer
- Provide the right care in the right place at the right time

Please use this section to outline, for each objective:

- The approach to integrating care to deliver better outcomes, including how collaborative commissioning will support this and how primary, community and social care services are being delivered to support people to remain at home, or return home following an episode of inpatient hospital care
- How BCF funded services will support delivery of the objective

Plans for supporting people to remain independent at home for longer should reference

- steps to personalise care and deliver asset-based approaches
- implementing joined-up approaches to population health management, and preparing for delivery of anticipatory care, and how the schemes commissioned through the BCF will support these approaches
- multidisciplinary teams at place or neighbourhood level.

Plans for improving discharge and ensuring that people get the right care in the right place, should set out how ICB and social care commissioners will continue to:

- Support safe and timely discharge, including ongoing arrangements to embed a home first approach and ensure that more people are discharged to their usual place of residence with appropriate support.
- Carry out collaborative commissioning of discharge services to support this.

Discharge plans should include confirmation that your area has carried out a self-assessment of implementation of the High Impact Change Model for managing transfers of care and any agreed actions for improving future performance.

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

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

The key programme funded through BCF that Enable people to stay well, safe and independent at home for longer is the ICN+ programme

<u>ICN+</u>

The One Croydon flagship programme, the Integrated Community Network Plus Programme, has established an integrated community health and social care service that comprises of Adult Social Care, Croydon Health Services, Mental Health and the voluntary sector within each of the 6 localities that make up the borough of Croydon. The integrated teams enable information sharing, joint assessment and care management. The service model ensures a one name, one budget, one team approach, use of an agreed single eligibility assessment and review process, and increased entry pathways - all working to the same key outcomes.

Services under ICN+ localities are as follows:

- Community nursing
- Adult social care over 65s
- Adult social care under 65s
- Therapy services
- Age UK Personal Independence Coordinators (PICs)
- Mental Health PICs

- Named person for smaller community services e.g. Diabetes
- Link with Housing and other Council services

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

Furthermore, access to support can also be accessed via Community Hubs, formerly known as “Talking Points” in the community. Health, social care and voluntary sector staff attend the Community Hubs to provide the required support.

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

Community Led Support

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

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

Provide the right care in the right place at the right time

A significant proportion of the BCF funding is allocated to supporting hospital discharges via the LIFE service. The LIFE service is an integrated community-based team comprising staff drawn from across health, social care and the voluntary sector.

It provides intensive, proactive and goal-focused support for up to 6 weeks at times of high levels of need, when individuals require more clinical and social care interventions thereby preventing unnecessary hospital admissions or facilitating early supported discharge from a hospital ward, focussed on enabling the person back to the optimum state of wellbeing, functioning and independence (Reablement, Rehabilitation, Recovery).

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

The service consists of the following elements:

1. Single integrated multidisciplinary Team - A single LIFE Team that brings together existing community services into one integrated, intermediate care, multidisciplinary team.
2. D2A pathway which includes a Trusted Assessor model, where Social Care and Therapy staff undertaking a single integrated assessment covering elements of both health and social care. The D2A model is used for all hospital discharges when care and support is required.
3. The LIFE service operates 7 days a week, 365 days a year. To support discharges from hospitals, brokerage and social workers have moved to a 6-day coverage (Mon-Sat). This is based on the pattern of discharges during the week, which shows most discharges happening on a Friday. During the height of Covid, some of the social work capacity was moved to support D2A in the community.
4. Hospital-based social workers are part of the hospital discharge MDT meetings. There are also twice weekly morning calls attended by staff from the LIFE D2A team, recently extended to daily, where operational issues are discussed, and plans agreed. As per the national discharge guidance action cards, acute colleagues complete a D2A referral form (Part A) providing information on the type of support needed for discharge, as well as a limited functional assessment. This information is used to provide the resident with an interim care package to support safe discharge and settle the resident home. This is followed by a Part B assessment in the resident's place of residence; the Part B assessor assesses and co-ordinates the recovery care package, liaising with therapy/reablement and other care providers, as appropriate.
5. The LIFE Service will continue to work on developing stronger relationships with the locality ICN+ teams to ensure residents who need low level support, e.g., exercise, be-friending, etc, can access using existing community assets, to maintain their health and well-being and prevent readmission.

To support achievement of this ambition a few new schemes have been developed with the principal acute trust serving Croydon, Croydon Health Services NHS Trust (CHS) are currently being put in place locally or with existing schemes bolstered:

- the local discharge team has been reviewed and redesigned to ensure more timely and effective discharges from the wards.
- Out-of-hospital schemes supporting the targets include an increased focus on and support for reablement and Home First functions and the continued success of our Virtual Ward model led by Rapid response

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

- Supporting ward staff. Providing dedicated staff from the LA in supporting D2A from wards with home first principal and focusing on Pathway 0 where possible with support from partner agencies. Providing 3 staff per day working directly with ward teams.
- Increasing voluntary sector support to help discharge and prevent re-admission. Increase offer of voluntary sector such as Age UK and Red Cross in providing enhanced support for people when they return home to help them for 2 weeks to regain independence and prevent re-admissions.
- Using assistive technology and staff to prevent hospital admission. Using assistive technology to support this and provide crisis support for short term period.
- Emergency home care packages of care to prevent admission. 7 days funding for emergency cases to prevent hospital admission whilst long term support/care is provided. This may include waking night support if required.
- Using ICN+ to check on most vulnerable residents to prevent admission. ICN+ winter check on clients over 85 on what they have in place for winter. Ensuring everyone who is being discharged is discussed at a multi-agency GP huddle and reviewed by the ICN+ team.
- Supporting staff training to maximise independence of residents and prevent hospital admission. Training for the current staff on developing assessments and person-centred goal setting. Also supporting and enabling positive risk-taking to maximise independence.
- Educating and support residents. Campaign on educating more people on staying well and warm. Getting neighbours to look after each other.

A Hospital Only Discharge Programme has been established this year, to ensure appropriate focus is given to internal hospital arrangements for discharge. The workstreams include, medical leadership of flow, planning for discharge from admission such as ensuring all patients have an EDD set following 24hrs of admissions which is communicated to patient, family and carers and ensuring

functional and social status has been assessed within 24 hours of admission. There is work on optimising Board round/ Ward round and MDT processes and expanding and developing the Integrated discharge team. Other areas of focus are further embedding of 'Patienteer', workforce plans for therapy, medical and nurse staffing to develop role diversification and move to 7 day working. There are clear timescales and clear expected impact metrics such as reduction in bed occupancy, increase in frailty assessments, increase no of discharges by 1PM. Some of these areas of work are reflected it the High Impact Change Model summary below.

High Impact Change Model- Action Planning Template

Impact change	Where we are now	What we need to do
Change 1: Early discharge planning	**Established:** Integrated Discharge Teams (IDT) have been implemented in Croydon University Hospital (CUH). Discharge planning takes place much earlier and decision making based on the wards. Red bag scheme is used known and used confidently throughout wards. Full time red bag co-ordinator in post to develop/ improve/ embed the scheme.	Further develop the IDT team members- improving knowledge of discharge pathways, roles and responsibilities. In particular, on the wards. To move towards discussing discharge planning at the point of admission.
Change 2: Monitoring and responding to system demand and capacity	**Established:** Patienteer bed management technology is in implemented in CUH and is used routinely. Daily huddles of IDT, discuss long stay patients, discharge co-ordinators on the wards. Clear escalation points- flow chart guide.	Continue to improve usage as a traffic light system and to be used more strategically in reporting. Develop with staff to update the system more routinely in real time.
Change 3: Multi-disciplinary working	**Mature:** IDT implementation with full cross section of professions represented. Daily huddles of IDT. ICN and ICN+ in the community	Further develop the huddle arrangements and increased involvement with GP's

	continues to develop. Therapy staff engaged earlier on the wards.	
Change 4: Home first	**Mature:** D2A standardized policies and processes in place. Home First Policy is embedded.	To involve therapy earlier in process to support home first principles. To continue to develop consistent processes across SWL. Developed a pilot 'Placement in Principle Panel' – ad hoc panel called so every option is considered prior to long term placement agreed. Starts 5/9/22.
Change 5: Flexible working patterns	**Established:** Rapid Response, AED reablement hospital and community teams 7 day working. Assessments over weekends and discharges over weekend but less than in the week.	Role diversification for therapy and nurse programme to support 7 day working in the hospital. Primary Care Enhanced Access roll out in October 2022.
Change 6: Trusted assessment	**Established:** LIFE trusted assessor model is established- lower level equipment needs implemented to reduce therapy bottlenecks. Range of staff have accredited training	Monitoring process in place and outcomes. Discharge co-ordinators to support therapy D2A documentation.
Change 7: Engagement and choice	**Established:** Discharge policies clear, letter to patient/ family explaining and D2A, manage expectations. Red Cross support discharge	Developing ICN to use community assets and voluntary sector to support patients and reduce readmission
Change 8: Improved discharge to care homes	**Mature:** CH work well with discharge teams and facilitate discharge. Discharge teams and brokerage teams work closely effectively. CH are supported across	Monitor any failed discharges and identify areas of improvement across the system.

	the system, telemedicine 24/7, support from LIFE community teams.	Monitor Primary Care –Care Home DES of allocated GP's.
Change 9: Housing and related services	**Mature:** Homelessness team at CUH. SWL partnership worked at overcoming challenges with housing options. Toole developed with named contacts. Staying Put service has strong links with discharge team.	To further improve assessment on admission of housing status and work towards EDD.

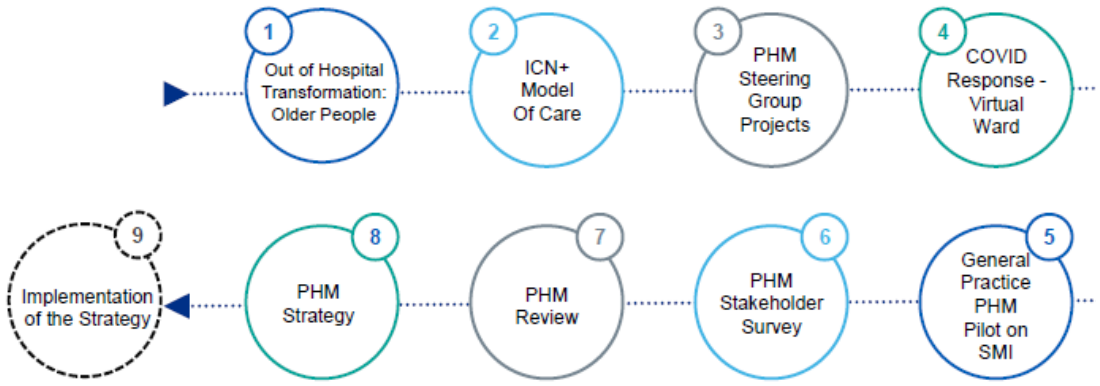
 # Plans for improving discharge and ensuring that people get the right care in the right place

Population Health Management

Several projects in Croydon have already taken place with a PHM approach including the Out of Hospital Transformation and Integrated Community Networks+ programmes as well as identifying ways in which we could help those most vulnerable during the COVID-19 pandemic.

During the refresh of Croydon's Health and Care Plan in 2021 a commitment was made to develop a Population Health Management strategy; the first step was to carry out a stakeholder management survey and a review into how we use our PHM resources. The review and survey enabled the development team to identify key challenges that must be overcome in order to enhance how we use a PHM approach, and how we can have a greater impact on improving outcomes for people.

Below shows the journey Croydon place has taken so far in creating a new PHM strategy.



Croydon's PHM strategy was approved in May of 2022 and is currently being implemented into current infrastructures. The strategy and subsequent implementation planning considers the unique diversity of the borough as well

as factor in the multiple areas of deprivation that have a significant negative impact on health and wellbeing of Croydon Place. Furthermore, significant consideration has and will need to consider NHSE CORE20 population (defined as 20% of most deprived) which identified that 50% of the SWL Core20 Population reside within Croydon Place.

To meet these challenges, a cultural shift is being undertaken that shifts Croydon Place to being data-informed, rather than data driven. The difference being that we use data to inform our decisions in parallel with people's lived experience and community intelligence gained through our strong relationships with the VCS and newly established Local Community Partnerships. All of which, will delay implementation of a fully integrated and neighbourhood effective PHM programme.

It is hoped that by Q1 23-24 we will start to see the first neighbourhood interventions that should start to generate benefits by the end of the same financial year. It is the belief of the implementation team that these benefits will include better health outcomes with reduced care gaps and real-time monitoring as well as:

- Improved quality of care while reducing costs;
- Improved care for patients with chronic and costly conditions;
- Real-time access and closed gaps in care along with patient-centric view; and
- Better clinical outcomes.

<u>Anticipatory Care</u>

The neighbourhood ICN+ MDT model is currently being reviewed and refined against the national requirements of the delivery of anticipatory care as well as local learning. However, given the ongoing focus on supporting people with multiple Long Term Conditions, frailty and high usage of unplanned care services, this alignment is already significantly in place. Roles funded by the BCF, including new frailty roles, as well as 2 ICN+ Network Manager roles are aimed at ensuring:

a. early identification of need,
b. early intervention through community -based services, including e.g., personal independence coordinators, social care support and wider voluntary sector services,
c. continuity of care through GP MDT huddles into community MDTs and wider support services

In line with the Anticipatory Care PCN DES Contract and the overall Operating Framework (both currently awaiting release), review of the ARRS role's function is in progress. This is with the aim of supporting the development of personalised care plans including e.g., social prescribing where appropriate. In addition, a pilot population health management (PHM) project is in progress; with the aim of roll out to locality level (including PCN involvement) to refine the identification of cohorts needing focussed support / services locally in line with the complex and significant health inequalities across Croydon. Discussions are in progress between the leads of the PHM and Anticipatory care programmes to ensure alignment, which will be driven through learning from the current PHM pilot

Supporting unpaid carers.

Please describe how BCF plans and BCF funded services are supporting unpaid carers, including how funding for carers breaks and implementation of Care Act duties in the NHS minimum contribution is being used to improve outcomes for unpaid carers.

Croydon Council commission the Carers Support Partnership to provide carer's assessment and other support services that aim to prevent, reduce and delay future needs for support. The Carers Support Partnership operates on a "hub and spoke" model in which Whitgift Foundation Carers Information Service runs the Carers Support Centre which is the "hub", and specialist services (Croydon Mencap and Mind in Croydon) are the "spokes".

The BCF contributes 21% (£109,000) to the overall contract value. Services in scope in the current contract include but are not limited to,

- The Carers Support Centre in central Croydon is the hub for carers' support that is easily accessible
- Information, Advice & Casework – through a range of methods such as telephone helpline, drop-in services, information packs and online directory services.
- Carers Assessment for adults (18+) – carers have the opportunity to talk about their caring role and get the right kind of support they need as a carer i.e. emergency planning, direct payments, respite etc.
- Allocation of carer's direct payment, accessed via the carer assessment
- Respite service – most carers who access this service do not make a financial contribution to their services and therefore the full cost of care would fall to social services. Carers have fed back that having an hour or two's break a week is something they can "hold onto" when their caring role becomes challenging.
- Health and wellbeing services such as the Carers Café, training and support groups, exercise classes and creative activities
- Counselling for young and adult carers
- Former carers support includes 1:1 bereavement counselling with a BACP registered counsellor and the Learning from Loss Programme

The performance of the contract is monitored and reviewed via regular contract monitoring reports and meetings with the service providers to ensure the service meets their targets and desired outcomes. Performance indicators include a combination of outputs (quantitative measures to assess the volume of activity) and outcomes (determinants of quality and the results achieved) indicators.

Key highlights in 2021/22:

1. Outputs
    - 690 adult carers assessments
    - 169 carers supported with home-based respite service
    - 213 carers received a one-off direct payment, amount ranging from £90-£1,250
    - 322 health and wellbeing sessions which were attended by over 2,100 carers
    - 1:1 counselling session to 137 carers

2. Outcomes (I statements)
    - 90% of carers felt better informed and supported.
    - 79% of carers felt better and able to cope with their caring roles
    - 89% of carers felt less isolated
    - 84% of carers felt their health and wellbeing have improved
    - 42% of carers agreed they had a break from caring (by attending the health and wellbeing sessions)

For End-of-Life Care, there are services to support unpaid carers, focussing on supporting people to have care within their home, if that is their place of choice:

- Marie Curie night sitting service – providing planned palliative care nursing covering a single patient in their usual place of residence who are in the end –o-f life stage of their illness. Cover is provided through short episodes of care delivered as appropriate to support the needs of patients and carers
- Carer Respite Service – provides a response support to the carers of patients (18+) of any diagnosis deemed to be within the last few months of life. The service complements the existing hospice at home services by providing their carers with practical, emotional, spiritual, social and bereavement support. This aims to reduce the risk of carers breakdown and crisis by providing a timely, responsive and reliable serviced to mee the changing needs of the carer and patient, as appropriate in the promotion of quality of life. Providing the carer with the peace of mind that their lived one is being properly cared for, while they benefit from time away from the care environment.

Croydon is committed to supporting carers by identifying carers at an early stage, assessing their needs and offering them appropriate support to prevent, reduce and delay future needs for support. The Carers Strategy 2018-2022 will be refreshed, and a review is underway to assess success, achievements, any further gaps to ensure it reflects the current landscape and needs of carers in Croydon. This strategy and will be used to inform future commissioning intentions.

Disabled Facilities Grant (DFG) and wider services

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

The Ministry for Housing, Communities and Local Government allocation for Croydon for 2022-23 is £2,992,679.00.

The DFG is a mandatory grant which is subject to a means test. The criteria for this grant are set out in statute. Based on the current average spend of £12,000 per adaptation, the original budget could potentially fund 249 adaptations.

Key outcomes are:

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

The DFG grant in Croydon is delivered under a Private Sector Housing Assistance Policy that is in place. The Policy was updated in July 2021 to reflect the government's guidance for the DFG process to be more flexible in its approach to providing adaptations.

As outlined above, in the key outcomes, The Policy is designed to assist 'owner occupiers' to keep homes in good repair, and enable older, vulnerable and people on low incomes to remain and live independently in their own homes. Our aim is to provide early interventions to prevent issues arising that would cost the ICS more money - invest to save. These include Adaptations and supporting Hospital Discharge.

Performance of the DFG feeds into BCF Governance Arrangements, the Joint Commissioning Executive and also imports into Croydon's Health and Wellbeing Board. The DFG is monitored monthly, with provision of activity, applications, approvals, timelines, completions and spend. These reports are overseen by the Head of Housing, the Capital Board and Executive Director of Housing.

There are long standing arrangements with the variety of Housing Associations, dependant on their size, on the contributions made to DFG in their properties, the

costs agreed in advance and then reimbursed by the Housing Associations, the links and the process works well.

As well as adults the DFG covers children with physical, mental and OR cognitive disabilities, which come via Health's Children's OT Service.

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

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

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

There is an increasing demand for adaptations from Housing Associations. Options are offered to the HA's to enable adaptations for their tenants. One option is to agree that the HIA will project manage the work, and the HA provides a contribution towards the cost of work, or secondly the HA will project manage themselves with funding from the DFG. In 99% of cases, they opt for the HIA to project manage the adaptation work, for which a fee is charged. The larger of the HA's provide 50% funding, or a set amount towards the adaptation.

The DFG and our enhanced reablement services are provided through the in house Staying Put Home Improvement Agency. Our strategy with the enhanced service is avoid hospital readmission, and to enable people to continue to remain living safely in their own homes, and to increase their independence. We achieve this by providing a range of measures which include fitting key safes, through our Handyperson Service, to enable care packages following discharge. This service also does minor adaptations i.e., grab rails, stair rails, lever taps, fits lockable medicine cabinets, as well as mitigating risks of trip hazards by removing trailing wires, taping torn carpet. We also do blitz cleans, furniture removal to allow micro living, tackle hoarding issues, etc. By providing one or a combination of these measures enables a safe discharge and independence to the person, and aims to avoid hospital readmission.

Equality and health inequalities

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

- Changes from previous BCF plan
- How these inequalities are being addressed through the BCF plan and BCF funded services
- Where data is available, how differential outcomes dependent on protected characteristics or for members of vulnerable groups in relation to BCF metrics have been considered
- Any actions moving forward that can contribute to reducing these differences in outcomes

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

The Core20plus5 approach has enabled detailed analytical research across SWL ICB to examine who are our Core20. In addition to the plus 5 clinical areas, maternity, severe mental illness, chronic respiratory disease, early cancer diagnosis and hypertension, SWL as identified Diabetes as an additional clinical area that requires accelerated improvement. In anticipation of additional funding from SWL ICB to address health inequalities in Croydon a call for bids was made to commissioners and a prioritisation process established by One Croydon. The prioritisation and scoring process, led by clinicians, sought alignment with Core20, our Health and Care Plans and the likely impact. The approval of the selected prioritised work streams is now being finalised.

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

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

Demographics

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

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

Future Demand for Services

People are living longer, and our population is ageing with projections suggesting that the number of people aged over 85 will increase by two thirds in Croydon by 2029. This is an important trend because we know that older people generally have more health

problems and are more likely to use health and care services. The number of older people living on their own in Croydon is increasing and a far greater proportions of older people living alone, aged 75 and over, are women. Social isolation and loneliness can have a detrimental effect on health and wellbeing and people living on their own can be more at risk.

Health and social care market

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

How inequalities are being addressed

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

Key features of the ICN+ model are:

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

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

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

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

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

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

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

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

management of diabetes, with the specialist team working across acute, community and primary care.

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

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

Examples of BCF funded schemes that specifically tackle health inequalities identified locally include, the LIFE team and the additional funding for the Local Voluntary Partnership. The Life team within the community, support vulnerable and at- risk patients out of hospital, with provision such as telehealth, 2 hour crisis response, hospital at home, therapy services, discharge to access and reablement. These services including ICN + are described above under 'Provide The Right Care In The Right Place At The Right Time'. The Local Voluntary Partnership, builds stronger communities, through hubs, with a preventative, strength based, outcome focused approach. Opportunities and sources of support are offered to residents preventing crisis, but fostering independence and mutual support.

There are a number of BCF funded programs that directly support the Health Inequalities specific conditions identified in CORE20 plus 6:

South London and Maudesley (SLAM) NHS mental health provider are funded to provide a service that helps keep people of out hospital, following a comprehensive assessment for those in the acute phase of mental illness. SLAM is also funded through BCF in a community provision in the home, with short intensive support to keep people at home and to facilitate earlier discharge.

There are 2 diabetes services (as Croydon has included diabetes as a local challenge). A community diabetes service reduces the number of patients being managed in an acute setting and house bound patients are seen. Structured diabetes education helps patients better manage their condition and reduce complications.

A community COPD service provides spirometry, pulmonary rehabilitation and evidence - based pathways. The Edgecome unit has a COPD assessment provision preventing admission.

Care Homes

Croydon has 128 registered care homes and the largest Care Home provision within London with over 3000 beds. Approximately half are Older People's homes and the rest are MD/LD homes. Given the scale of the challenge for Croydon in supporting this large number of care homes, access to services for Care Home residents has historically been variable as some services were not commissioned to cater for care home residents; whilst specialist services commissioned for care homes, especially LD and Mental Health, have always been extremely stretched. To address this inequity of access we are putting more investment into ICN+ so that residents in every care home can have the same level of access to locality services as any other

Croydon resident. We are also beefing up provisions for MH/Dementia and LD residents in care homes, whilst also working with the voluntary sector to put provisions in place to reach out to these cohorts of clients.

Inequality of outcomes linked to BCF metrics

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

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Better Care Fund 2022-23 Capacity & Demand Template

1.0 Guidance

Overview

The Better Care Fund (BCF) requirements for capacity and demand plans are set out in the BCF Planning Requirements document for 2022-23, which supports the aims of the BCF Policy Framework and the BCF programme. The programme is jointly led and developed by the national partners Department of Health (DHSC), Department for Levelling Up, Housing and Communities, NHS England (NHSE), Local Government Association (LGA), working with the Association of Directors of Adult Social Services (ADASS).

Appendix 4 of the Planning Requirements sets out guidance on how to develop Capacity and Demand Plans, useful

This template has been designed to collect information on expected capacity and demand for intermediate care. These plans should be agreed between Local Authority and Integrated Care Board partners and signed off by the

The template is split into three main sections.

Demand - used to enter the expected demand for short term, intermediate care services in the local authority (HWB) area from all referral sources from October 2022-March 2023. There are two worksheets to record demand

- Sheet 3.1 Hospital discharge - expected numbers of discharge requiring support, by Trust.
- Sheet 3.2 Community referrals (e.g. from Single points of Access, social work teams etc)

Intermediate care capacity - this is also split into two sheets (4.1 Capacity - Discharge and 4.2 Capacity - community). You should enter expected monthly capacity available for intermediate care services to support discharge and referrals from community sources. This is recorded based on service type.
2022-23 (October to March)

Spend data - this worksheet collects estimated spend across the local authority area on intermediate care for the whole year ie 2022-23. This should include all expenditure (NHS and LA funded) on intermediate care services as

Note on entering information into this template

Throughout the template, cells which are open for input have a yellow background and those that are pre-populated have a grey background, as below:

Data needs inputting in the cell

Pre-populated cells

Note on viewing the sheets optimally

To view each of the sheets and in particular the drop down lists clearly on screen, please change the zoom level to between 90% - 100%. Most drop downs are also available to view as lists in the relevant sheet or in the guidance tab

The details of each sheet in the template are outlined below.

2. Cover

1. The cover sheet provides essential information on the area for which the template is being completed, contacts and
section of the template have been completed the cell will turn green. Only when all cells are green should the template be sent to:
england.bettercarefundteam@nhs.net
(please also each copy in your respective Better Care Manager)
If you have any queries on the template then please direct these to the above email inbox or reach out via your BCM.

3. Please note that in line with fair processing of personal data we request email addresses for individuals completing the reporting template in order to communicate with and resolve any issues arising during the reporting cycle. We remove these addresses from the supplied templates when they are collated and delete them when they are no

3. Demand

This section requires the Health & Wellbeing Board to record expected monthly demand for supported discharge by discharge pathway (as set out in the Hospital Discharge Guidance avalable on Gov.uk)
Data can be entered for individual hospital trusts that care for inpatients from the area. Multiple Trusts can be selected from the drop down list in column F. You will then be able to enter the number of expected discharges from each trust by Pathway for each month. The template uses the pathways set out in the Hospital Discharge and
https://www.gov.uk/government/publications/hospital-discharge-and-community-support-guidance/hospital-dischar
We suggest that you enter data for individual trusts where they represent 10% or more of expected discharges in the area. Where a Trust represents only a small number of discharges (less than 10%), we recommend that you amalgamate the demand from these sources under the '**Other**' Trust option.
The table at the top of the screen will display total expected demand for the area by discharge pathway and by
Estimated levels of discharge should draw on:

- Estimated numbers of discharges by pathway at ICB level from NHS plans for 2022-23
- Data from the NHSE Discharge Pathways Model.

3.2 Demand - Community

This worksheet collects expected demand for intermediate care services from community sources, such as multi-disciplinary teams, single points of access or 111. The template does not collect referrals by source, and you should input an overall estimate each month for the number of people requiring intermediate care (non-discharge) each

Further detail on definitions is provided in Appendix 4 of the Planning Requirements. This includes the NICE Guidance definition of 'intermediate care' as used for the purposes of this exercise.

4.1 Capacity - discharge

This sheet collects expected capacity for services to support people being discharged from acute hospital. You should input the expected available capacity to support discharge across these different service types:

- Voluntary or Community Sector (VCS) services
- Urgent Community Response
- Reablement or reabilitation in a person's own home
- Bed-based intermediate care (step up or step down)
- Residential care that is expected to be long-term (collected for discharge only)

Please consider the below factors in determining the capacity calculation. Typically this will be (Caseload*days in month*max occupancy percentage)/average duration of service or length of stay
Caseload (No. of people who can be looked after at any given time)
Average stay (days) - The average length of time that a service is provided to people, or average length of stay in a
Please consider using median or mode for LoS where there are significant outliers
Peak Occupancy (percentage) - What was the highest level of occupany expressed as a percentage? This will usually apply to residential units, rather than care in a person's own home. For services in a person's own home then this would need to take into account how many people, on average, that can be provided with services at a given time.

4.2 Capacity - community

This sheet collects expected capacity for intermediate care services where a person has been referred from a community source. You should input the expected available capacity across the different service types.

You should include expected available capacity across these service types for eligible referrals from community sources. This should cover all service intermediate care services to support recovery, including Urgent Community Response and VCS support. The template is split into 5 types of service:

- VCS services to support someone to remain at home
- Urgent Community Response (2 hr response)

- Reablement or rehabilitation in a person's own home
- Bed-based intermediate care (step up)

5.0 Spend

This sheet collects top line spend figures on intermediate care which includes:
- Overall spend on intermediate care services - using the definitions in the planning requirements (BCF and non-BCF)
- Spend on intermediate care services in the BCF (including additional contributions).

These figures can be estimates, and should cover spend across the Health and Wellbeing Board (HWB). The figures do not need to be broken down in this template beyond these two categories.

HM Government

NHS

Better Care Fund 2022-23 Capacity & Demand Template

2.0 Cover

Version 1.0

Health and Wellbeing Board:	Croydon
Completed by:	Helen Mason & Paul Connolly
E-mail:	helen.mason@swlondon.nhs.uk
Contact number:	07828 673849
Has this report been signed off by (or on behalf of) the HWB at the time of submission?	No, subject to sign-off
If no, please indicate when the report is expected to be signed off:	17/10/2022 << Please enter using the format, DD/MM/YYYY

Please indicate who is signing off the report for submission on behalf of the HWB (delegated authority is also accepted):

Job Title:	Corporate Director Adult Social Care & Health, Croydon Council; C
Name:	Annette McPartland; Matthew Kershaw

How could this template be improved?	

Question Completion - Once all information has been entered please send the template to england.bettercarefundteam@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'

[<< Link to the Guidance sheet]

[^^ Link back to top]

Better Care Fund 2022-23 Capacity & Demand Template

3.1 Demand - Hospital Discharge

Selected Health and Wellbeing Board: Croydon

3. Demand

This section requires the Health & Wellbeing Board to record expected monthly demand for supported discharge by discharge pathway.

Data can be entered for individual hospital trusts that care for inpatients from the area. Multiple Trusts can be selected from the drop down list in column F. You will then be able to enter the number of expected discharges from each trust by Pathway for each month. The template uses the pathways set out in the Hospital Discharge and community support guidance - https://www.gov.uk/government/publications/hospital-discharge-and-community-support-guidance/hospital-discharge-and-community-support-guidance

If there are any 'fringe' trusts taking less than say 10% of patient flow then please consider using the '**Other**' Trust option.

The table at the top of the screen will display total expected demand for the area by discharge pathway and by month.

Estimated levels of discharge should draw on:

- Estimated numbers of discharges by pathway at ICB level from NHS plans for 2022-23
- Data from the NHSE Discharge Pathways Model.

Totals Summary (autopopulated)	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
0: Low level support for simple hospital discharges - e.g. Voluntary or Community Sector support - (D2A Pathway 0)	47	47	47	47	47	47
1: Reablement in a persons own home to support discharge (D2A Pathway 1)	296	368	390	333	354	362
2: Step down beds (D2A pathway 2)	25	25	25	25	25	25
3: Discharge from hospital (with reablement) to long term residential care (Discharge to assess pathway 3)	17	17	17	17	17	17

Any assumptions made:	Assumptions
	Pathway 0 (Voluntary and community sector) Contracted provider BRC has estimated average demand per month based on previous years data. There is expected to be fluctuations per month but level of detail in data is unable to predict which months will be the busiest. Estimated totals provided.

!!Click on the filter box below to select Trust first!!

Trust Referral Source (Select as many as you need)	Demand - Discharge Pathway	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
CROYDON HEALTH SERVICES NHS TRUST	0: Low level support for simple hospital discharges - e.g. Voluntary or Community Sector support - (D2A Pathway 0)	47	47	47	47	47	47
OTHER		0	0	0	0	0	0
CROYDON HEALTH SERVICES NHS TRUST	1: Reablement in a persons own home to support discharge (D2A Pathway 1)	214	259	284	231	237	274
OTHER		82	109	106	102	117	88
CROYDON HEALTH SERVICES NHS TRUST	2: Step down beds (D2A pathway 2)	23	23	23	23	23	23
OTHER		0	0	0	0	0	0

CROYDON HEALTH SERVICES NHS TRUST	3: Discharge from hospital (with reablement) to long term residential care (Discharge to assess pathway 3)	86	83	88	89	51	92
OTHER		12	11	12	12	7	13

Better Care Fund 2022-23 Capacity & Demand Template

3.0 Demand - Community

Selected Health and Wellbeing Board: Croydon

3.2 Demand - Community

This worksheet collects expected demand for intermediate care services from community sources, such as multi-disciplinary teams, single points of access or 111. The template does not collect referrals by source, and you should input an overall estimate each month for the number of people requiring intermediate care (non-discharge) each month, split by different type of intermediate care.

Further detail on definitions is provided in Appendix 4 of the Planning Requirements. This includes the NICE Guidance definition of 'intermediate care' as used for the purposes of this exercise.

Any assumptions made:	Voluntary or Community Sector Services Demand is based on previous years and the trend for the last 6 months. Urgent Community Response: The below numbers have been soley based on previous Rapid Response years with no other

Demand - Intermediate Care

Service Type	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Voluntary or Community Sector Services	280	290	303	259	268	297
Urgent community response	380	370	398	270	376	401
Reablement/support someone to remain at home	45	45	45	45	45	45
Bed based intermediate care (Step up)	23	23	23	23	23	23

Better Care Fund 2022-23 Capacity & Demand Template

4.0 Capacity - Discharge

Selected Health and Wellbeing Board: Croydon

4.1 Capacity - discharge

This sheet collects expected capacity for services to support people being discharged from acute hospital. You should input the expected available capacity to support discharge across these different service types:

- Voluntary or Community Sector (VCS) services
- Urgent Community Response
- Reablement or reabilitation in a person's own home
- Bed-based intermediate care (step down)
- Residential care that is expected to be long-term (collected for discharge only)

Please consider the below factors in determining the capacity calculation. Typically this will be (Caseload*days in month*max occupancy percentage)/average duration of service or length of stay

Caseload (No. of people who can be looked after at any given time)

Average stay (days) - The average length of time that a service is provided to people, or average length of stay in a bedded facility

Please consider using median or mode for LoS where there are significant outliers

Peak Occupancy (percentage) - What was the highest levels of occupany expressed as a percentage? This will usually apply to residential units, rather than care in a person's own home. For services in a person's own home then this would need to take into account how many people, on average, that can be provided with services.

Any assumptions made:	Bed based intermediate care (step down): Commissioning have confimed that there will be 14 commissioned intermediate beds until end of March 2023. Please note that these are the same the step up beds identified in 4.2 and not additional intermediate care beds. Pathway 1 capacity:

Capacity - Hospital Discharge

Service Area	Metric	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
VCS services to support discharge	Monthly capacity. Number of new clients.	50	50	50	50	50	50
Urgent Community Response (pathway 0)	Monthly capacity. Number of new clients.	380	372	398	269	376	401
Reablement or reabilitation in a person's own home (pathway 1)	Monthly capacity. Number of new clients.	238	238	238	238	238	238
Bed-based intermediate care (step down) (pathway 2)	Monthly capacity. Number of new clients.	14	14	14	14	14	14
Residential care that is expected to be long-term (discharge only)	Monthly capacity. Number of new clients.	17	17	17	18	17	17

Better Care Fund 2022-23 Capacity & Demand Template

4.2 Capacity - Community

Selected Health and Wellbeing Board: Croydon

4.2 Capacity - community

This sheet collects expected capacity for community services. You should input the expected available capacity across the different service types.

You should include expected available capacity across these service types for eligible referrals from community sources. This should cover all service intermediate care services to support recovery, including Urgent Community Response and VCS support. The template is split into 5 types of service:

- Voluntary or Community Sector (VCS) services
- Urgent Community Response
- Reablement or rehabilitation in a person's own home
- Bed-based intermediate care (step up)

Please consider the below factors in determining the capacity calculation. Typically this will be (Caseload*days in month*max occupancy percentage)/average duration of service or length of stay

Caseload (No. of people who can be looked after at any given time)

Average stay (days) - The average length of time that a service is provided to people, or average length of stay in a bedded facility

Please consider using median or mode for LoS where there are significant outliers

Peak Occupancy (percentage) - What was the highest levels of occupany expressed as a percentage? This will usually apply to residential units, rather than care in a person's own home. For services in a person's own home then this would need to take into account how many people, on average, that can be provided with services.

Any assumptions made:	Voluntary or community Sector Services The monthly capacity is based on the maximum caseload that a PIC can hold, taking into consideration fluctuations in staffing numbers, based on previous years. Bed based intermediate care (step up): Commissioning have confimed that there will be 14 commissioned

Capacity - Community

Service Area	Metric	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Voluntary or Community Sector Services	Monthly capacity. Number of new clients.	298	298	292	289	287	283
Urgent Community Response	Monthly capacity. Number of new clients.	380	372	398	269	376	401
Reablement or rehabilitation in a person's own home	Monthly capacity. Number of new clients.	30	30	32	30	30	30
Bed based intermediate care (step up)	Monthly capacity. Number of new clients.	14	14	14	14	14	14

REPORT TO:	**HEALTH AND WELLBEING BOARD** 17 October 2022
SUBJECT:	Pharmaceutical Needs Assessment
BOARD SPONSOR:	Rachel Flowers, Director of Public Health, Croydon Council
PUBLIC/EXEMPT:	

SUMMARY OF REPORT:

- To note progress and planned steps to publishing the 2022 Croydon Pharmaceutical Needs Assessment (PNA).

BOARD PRIORITY/POLICY CONTEXT:

Every Health and Wellbeing Board (HWB) in England has a statutory responsibility to publish and keep up to date a statement of the needs for pharmaceutical services of the population in its area, referred to as a Pharmaceutical Needs Assessment (PNA).

The purpose of the PNA is to plan for the commissioning of pharmaceutical services and to support the decision-making process in relation to new applications of change of premises of pharmacies.

FINANCIAL IMPACT:

No financial impact for Health and Wellbeing Board partners and the Council. The delivery of the Board is lead by the Council and costs are covered using the Public Health Grant funding.

RECOMMENDATIONS:

- To note progress and planned steps to publishing the 2022 Croydon Pharmaceutical Needs Assessment (PNA).
- the HWB agree to convene a meeting in November 2022 for the purpose of the HWB considering and if thought fit approving the revised PNA and the publication of same, in order to avoid any further delay in publishing the revised assessment beyond the statutory deadline of 1 October.

1. EXECUTIVE SUMMARY

1.1 This paper provides a progress update on the process to produce and publish the 2022 PNA.

1.2 Croydon Council commissioned PHAST CIC to develop the 2022 PNA on behalf of the HWB.

1.3 As part of the process, two surveys were conducted between May and July to gain views from Pharmacy Contractors and residents. A 60-days consultation is currently underway (from 31 August to 29 October).

1.4 Unforeseen challenges have impacted our ability to meet the statutory deadline of 1 October. The final report is expected to be ready for publication at the end of October 2022.

1.5 NHSE, the Mayor, the Chair of the HWBB, the Director of Public Health, the Steering Group, and Legal Services have been informed of the situation.

1.6 Advice from Legal Services has been sought to guide the process of approving and publishing the PNA after the statutory deadline.

2. DETAIL

PNA Development and Publication

2.1 In January 2022, Croydon Council commissioned PHAST CIC to produce the 2022 PNA on behalf of the HWB.

2.2 A steering group was established with representatives from the Croydon Council, South West London Integrated Care Board, Local Pharmaceutical Committee, Local Medical Committee, and Healthwatch Croydon. The function of the steering group is to oversee the production of the 2022 PNA for the London Borough of Croydon, reporting progress to the HWB.

2.3 As part of the PNA process, two surveys were conducted between May and July: (i) the Croydon Pharmacy Contractor survey was conducted to inform the PNA (80% response rate, or 58 of 73 pharmacies in Croydon.); and (ii) the Public PNA survey to gain views from residents about pharmacy services in Croydon (327 participants completed the survey, and more than 99% were Croydon residents).

2.4 The final phase requires a 60-days public consultation.

2.5 The launch of the 60-days public consultation was impacted due to a combination of delays in receiving stakeholders' feedback on the draft PNA and unforeseen logistics and technical challenges to go live. As a result, the consultation was launched on Wed 31 August, and it will run until the 29 October. This situation has impacted our ability to meet the statutory deadline to publishing the PNA (1 October). We endeavour to have the final 2022 PNA at the end of October 2022.

2.6 NHSE has been informed of this situation and an extension requested. However, NHSE do not have decision-making power and control over the statutory deadline.

2.7 The risk of publishing the PNA after the statutory deadline is perceived to be low. Whilst we finalise the 2022 PNA, NHSE has been advised they could use the 2018 PNA if any contractor approach them with any enquiry.

2.8 The Mayor, the Chair of the HWB, the Director of Public Health, and the Steering Group have been informed of the situation.

2.9 Legal Services has been informed of the situation and advice has been sought to guide the process of approving and publishing the PNA after the statutory deadline.

3. CONSULTATION

3.1 A 60-days public consultation on the draft PNA is currently underway (from 31 August to 29 October. The draft consultation can be found here: https://www.getinvolved.croydon.gov.uk/pharmacy

4. SERVICE INTEGRATION

4.1 PNAs provide a common structured framework within which commissioners and strategic planners can make decisions about pharmaceutical needs in a local area. They facilitate discussions between NHS England, local commissioners from the local authority and CCG, and local pharmacists around addressing local pharmaceutical needs, and provide a common framework for assessing activity and provision that should be in place to address these needs.

5. FINANCIAL AND RISK ASSESSMENT CONSIDERATIONS

5.1 There are no financial implications or risks that the board needs to consider. The PNA supports NHS England to make decisions about market entry. It has no direct cost implications to the Council or CCG.

5.2 The funding to undertake and develop the refreshed 2022 PNA has been identified as part of the public health ring-fenced grant and the funds have now been applied.

Approved by: Nish Popat - Interim Head of Corporate Finance, Croydon Clinical Commissioning Group

6. LEGAL CONSIDERATIONS

6.1 There is a statutory responsibility to produce a PNA. The Health and Wellbeing Board's review of the refreshed PNA will need to be supported by full legal clearance.

6.2 The Health and Social Care Act 2012 established Health and Wellbeing Boards and transferred to them (from the NHS Act 2006) the responsibility to publish and keep up to date a statement of the needs for pharmaceutical services of the population in its area, with effect from 1 April 2013. The requirements on how to

develop and update PNAs are set out in Regulations 3-9 Schedule 1 of the NHS (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013.

6.3 The 2012 Act also amended the Local Government and Public Involvement in Health Act 2007 to introduce duties and powers for Health and Wellbeing Boards in relation to Joint Strategic Needs Assessments (JSNAs). The preparation and consultation on the Pharmaceutical Needs Assessment should take account of the Joint Strategic Needs Assessment (and other relevant local strategies in order to prevent duplication of work and multiple consultations with health groups, patients and the public). The development of Pharmaceutical Needs Assessments is a separate duty to that of developing Joint Strategic Needs Assessments. As a separate statutory requirement, Pharmaceutical Needs Assessments cannot be subsumed as part of these other documents but can be annexed to them.

6.4 The Health and Social Care Act 2012 also transferred responsibility for using PNAs as the basis for determining market entry to a pharmaceutical list from PCTs to NHS England.

6.5 Sec 194 of the Health and Social Care Act 2012 provides that the HWB is a committee of the authority, and is to be treated as if it were a committee appointed under Sec 102 of the Local Government Act 1972, subject to modifications by regulation, and these modifications are contained in Regulations 3 and 4 of the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013. There is no provision in the Regulations for delegation to the Chair or to any other single member of the HWB. In addition, although the PNA is a function to be discharged by the Board other than by virtue of Sec 196(2) of the 2012 Act, the Board can only arrange for the discharge of that function by a sub-committee of the Board, unless the authority "otherwise directs", and Article 13.9 of the Constitution provides that the HWB is not permitted to establish or delegate functions to a sub-committee. Therefore, the only way in which the PNA can be approved and published before the next meeting of the HWB in January 2023 is for a further meeting of the HWB to be convened for this purpose.

6.6 Rule 6.1 of the Non-Executive Committee Procedure Rules provides "each Committee or Sub-Committee or the Council Solicitor in consultation with the relevant Chair may convene meetings on such other dates as they may agree in the light of business to be transacted".

6.5 Approved by Sandra Herbert, Head of Litigation and Corporate Law on behalf of the Director of Legal Services and Monitoring Officer

7. HUMAN RESOURCES IMPACT

7.1 There are no direct human resource impacts arising from the content of this report for Croydon Council employees or staff.

7.2 Approved by: Gillian Bevan, Head of HR, Resources and Assistant Chief Executives on behalf of the Chief People Officer.

8. EQUALITIES IMPACT

8.1 The Council has a statutory duty, when exercising its functions, to comply with the provisions set out in the Sec 149 Equality Act 2010. The Council must, in the performance of its functions, therefore have due regard to:

(a) eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;

(b) advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;

(c) foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

8.2 The purpose of any needs assessment, including the PNA, is to look at current and predicted future population needs for service provision or support. The PNA will identify the need for access to pharmaceutical services so that NHS England can approve or reject applications for additions to the pharmaceutical list. The PNA will also identify the need for locally commissioned services that local authority and CCG commissioners can respond to using relevant commissioning budgets.

8.3 As part of the PNA process, an “Equality Impact Assessment” (EIA) has been completed and signed off.

8.4 There are no negative impacts regarding groups with protected characteristics identified in the EQIA.

Approved By; Denise McCausland – Equality Programme Manager

CONTACT OFFICER:
Rachel Flowers, Director of Public Health
Rachel.flowers@croydon.gov.uk

REPORT TO:	**HEALTH AND WELLBEING BOARD** 17 October 2022
SUBJECT:	Update on SWL Integrated Care System
BOARD SPONSOR:	Matthew Kershaw
PUBLIC/EXEMPT:	Public

SUMMARY OF REPORT:

This paper provides an update on governance of SWL Integrated Care System and One Croydon Place, it also outlines health and care plan priorities and provides some examples of the delivery of the plan.

RECOMMENDATIONS:

The Board is asked to **note** the information in the paper for discussion at the Board.

1. DETAIL OF YOUR REPORT

On 1 July 2022, we launched the South West London Integrated Care System as we take on health and care statutory responsibilities.

The ICS has four purposes:

1. improving outcomes in population health and healthcare
2. tackling inequalities in outcomes, experience and access
3. enhancing productivity and value for money
4. supporting broader social and economic development

The South West London Integrated Care System brings our health and care partners closer together, to make sure local people receive the best care.
Legislation outlined in the 2022 Health and Social Care Act, makes it easier for GPs, hospitals, mental health, social care, community services, and the voluntary sector to work together more closely.

By working together, we can do more to:

- support people to live healthier and happier lives
- prevent ill-health; keep people independent for longer
- take action together to address the wider determinants of health (such as jobs, housing, education and our environment).

Place-based partnerships lead the detailed design and deliver of integrated services across their localities and neighbourhoods. In Croydon we have worked in this way through the One Croydon Alliance and our place-based partnership includes:

- Croydon Council
- Croydon Health Services NHS Trust
- Croydon Healthwatch
- South London and The Maudsley NHS Trust
- Croydon voluntary sector organisations
- NHS South West London

The paper outlines the role of Integrated Care Systems, the South West London Integrated Care System, One Croydon Alliance and our agreed priorities, updates the Board on delivery.

CONTACT OFFICER: Matthew Kershaw
Chief Executive and Place Based Leader for Health

Croydon
South West London Integrated Care System

South West London Integrated Care System update

Matthew Kershaw
Chief Executive and Place Based Leader for Health

Croydon is now part of the South West London Integrated Care System

On 1 July 2022, we launched the South West London Integrated Care System as we take on health and care statutory responsibilities

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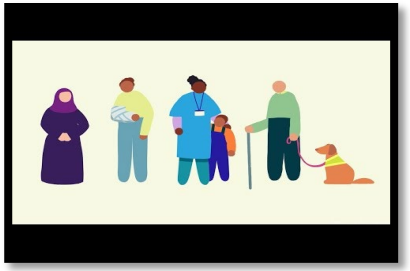
Legislation outlined in the 2022 Health and Social Care Act, makes it easier for GPs, hospitals, mental health, social care, community services, and the voluntary sector to work together more closely.

By working together, we can do more to: support people to live healthier and happier lives; prevent ill-health; keep people independent for longer; and take action together to address the wider-determinants of health. Examples of these wider-determinants of health are jobs, housing, education and our environment. We know these have a big impact on our health.

All over the country, in the poorest areas people have worse health and lower life expectancy than the people living in the richest areas. Our South West London ICS will focus on reducing these health inequalities or unfair differences in health in different groups within our six boroughs.

What is integrated care?

King's Fund animation: how the NHS works and how it is changing



NHS England: Strong Integrated Care Systems Everywhere

What are Integrated Care Systems?

Croydon South West London Integrated Care System

The Health and Care Act 2022 will establish 42 ICSs across England on a statutory basis.

Integrated Care Systems will be made up of two parts:

- **Integrated Care Boards** decide how the NHS budget for their area is spent and develop a plan to improve people's health, deliver higher quality care, and better value for money
- **an Integrated Care Partnerships** bring the NHS together with other key partners, like local authorities, to develop a strategy to enable the Integrated Care System to improve health and wellbeing in its area

Other important ICS features are:

- **Local authorities**, which are responsible for social care and public health functions as well as other vital services for local people and businesses.
- **Place-based partnerships** lead the detailed design and delivery of integrated services across their localities and neighbourhoods. Our place partnerships involve the NHS, local councils, community and voluntary organisations, local residents, people who use services, their carers and representatives and other community partners with a role in supporting the health and wellbeing of the local population.
- **Provider collaboratives** bring NHS providers together to achieve the benefits of working at scale across multiple places and one or more ICSs, to improve quality, efficiency and outcomes and address unwarranted variation and inequalities in access and experience across different providers.

Now **1.5million**

By 2031 **1.55million**

Resident population

£4.7 billion

NHS budget

6 London boroughs

Places

296 km²

Total area

21%

Now **13%**

By 2039 **17%**

Under 16 | Over 65

35%

Black, Asian and minority ethnic

21%

Long-term conditions

Average years **84**

Healthy years **65**

Average years **81**

Healthy years **66**

Life expectancy at birth

Richmond

Average years

86.3 82.6

Healthy years

68.1 71.4

Croydon

Average years

83.9 80.4

Healthy years

62.6 64.4

Range

Social care **36,000**

NHS **34,000**

Workforce

39

Primary care networks

180 + *

GP Practices

7

Acute and community providers

2

Mental health providers

* https://swlondonccg.nhs.uk/wp-content/uploads/2021/09/13996-SWLCCG-Annual-Report-and-Accounts-202021.pdf

South West London Integrated Care System

Our integrated care system will have two statutory committees:

NHS South West London Integrated Care Board decides how the NHS budget for their area is spent and develop a plan to improve people's health, deliver higher quality care, and better value for money

Our NHS Board is made up of:

- Our Chair
- 4 non-executive members
- Chief Executive
- 4 partner members NHS and Foundation Trusts
- Partner member Primary Medical Services
- Partner member Local Authorities
- Chief Finance Officer
- Medical Director
- Director of Nursing
- 6 Place Members
- Deputy Chief Executive Officer

South West London Integrated Care Partnerships bring the NHS together with other key partners, like local authorities, to develop a strategy to enable the Integrated Care System to improve health and wellbeing in its area

Our Partnerships Board is made up of:

- Co-Chairs – the ICB Chair and a Leader of a SWL Council
- Health members
  - ICB Chief Executive
  - ICB Population Health Management Director
  - ICB CFO
  - 5 NHS SWL Provider Chairs
  - Primary care representative
- Local Authority members
  - 6 Chairs of Health and Wellbeing Boards
  - Chief Executive representative
  - Director of Children Services representative
  - Director of Adult Services representative
  - Director of Public Health representative
  - Growth and economy representative
- 6 Place representatives
- SWL Clinical Senate co-chairs
- ICB Deputy Chief Executive Officer
- Healthwatch representative
- Voluntary sector representative

Both the ICB and the ICP meet in public throughout the year – more information about these meetings in public can be found at www.southwestlondonicb.nhs.uk

Working together – Acute Provider Collaborative

Croydon
South West London Integrated Care System

Bringing acute healthcare providers to improve quality and outcomes, including addressing unwarranted variation and inequalities in care

- A first meeting of the APC Board took place in September and included the Chairs and Chief Executives of Croydon Health Services NHS Trust, Kingston Hospital and St George's Epsom & St Helier Hospital Group.
- The team is looking at structural change across service areas to ensure maximum efficiency, transformation and capacity to ensure the delivery of national targets.
- Three major programmes of work sit within the APC:
    - Diagnostics
    - Outpatients
    - Elective recovery
- The APC had also formed a number of collaboratives hosted by individual trusts including:
    - SWL Recruitment Hub
    - Procurement
    - Pathology
    - South West London Orthopaedic Centre
- The APC has begun work on an elective strategy which will establish core principles for working together to reduce health inequalities and adopt a 'system first' approach to elective care. This will review demand and capacity in six high volume specialities to help assess current models of care
- Next steps: a scoping exercise to identify areas for further collaboration to support deliver of quality clinical outcomes.

Working together - Health and Wellbeing Boards (HWBs)

Croydon South West London Integrated Care System

- Guidance on Health and Wellbeing Boards (HWBs) had not been updated since 2013. The responsibilities outlined in the Health and Social Care Act 2012 are:
  - Assessing the health and wellbeing needs of their local population
  - Publishing a JSNA and joint local health and wellbeing strategy
  - Promoting greater integration and partnership working

- To align the role of HWB with the Health and Care Act 2022. in July 2022, ***Health and Wellbeing Boards draft Guidance for Engagement*** was published by The Department of Health and Social Care. The document focuses on:
  - The role of HWBs in enabling effective system and place-based working
  - Provides clarification about their role within systems

The guidance suggests five principles for Partners to adopt when developing relationships, including:

- Building from the bottom up
- Following their principles of subsidaiarity
- Have clear governance
- Collaborative leadership
- Avoiding duplication of existing governance mechanisms

The guidance recommends that systems build on the work of HWBs to ensure that action at a system-wide level adds value to what is being done at place. The DHSC asked a series of questions of HWBs and we now await final publication.

https://www.gov.uk/government/publications/health-and-wellbeing-boards-draft-guidance-for-engagement/health-and-wellbeing-boards-draft-guidance-for-engagement - questions-for-engagement

Working together – continuity

Croydon
South West London Integrated Care System

- ICB and ICP leaders within local systems, informed by the people in their local communities, need to build on the work of the HWB

- ICP should build on the existing work by HWB and other place based partnerships to integrate services

- The functions and duties that previously rested with CCGs have moved to ICBs.

- HWBs will continue the relationship and responsibility they had with the CCGs, this includes:
  - Forward plans (previously commissioning plans)
  - Annual reports
  - Performance assessments

Croydon 'Place'

Croydon South West London Integrated Care System

Croydon is one of South West London's six place partnerships alongside Merton, Kingston, Richmond, Sutton and Wandsworth.

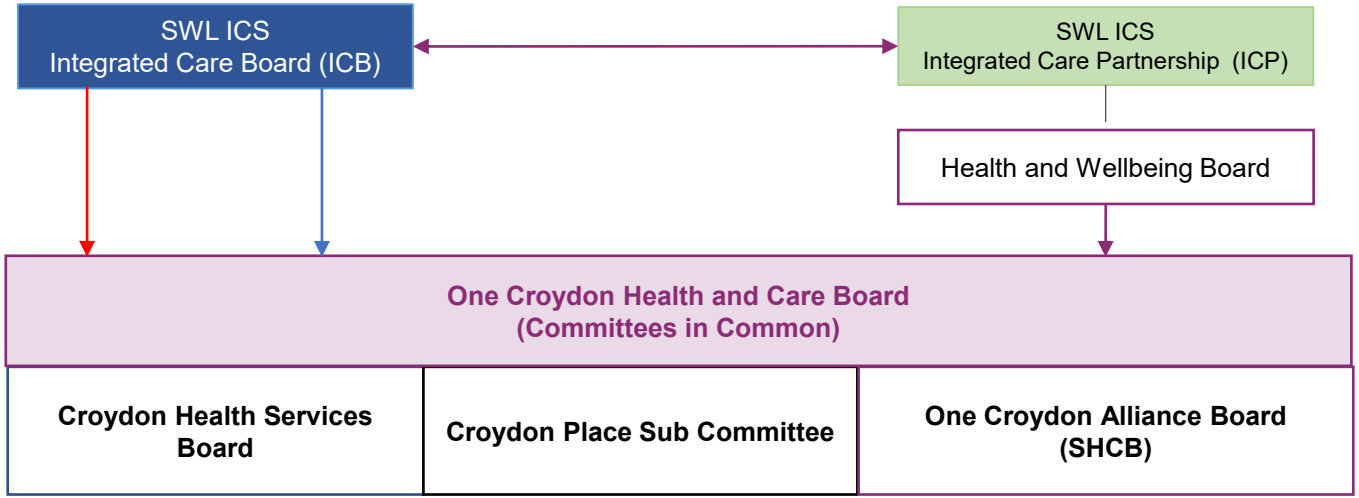
Place-based partnerships lead the detailed design and delivery of integrated services across their localities and neighbourhoods. Our place partnerships involve the NHS, local councils, community and voluntary organisations, local residents, people who use services, their carers and representatives and other community partners with a role in supporting the health and wellbeing of the local population.

In Croydon, our place-based partnership includes:

- Croydon Council
- Croydon Health Services NHS Trust
- Croydon Healthwatch
- South London and The Maudsley NHS Trust
- Croydon voluntary sector organisations
- NHS South West London

Croydon Place Structure

There is significant overlap between the Shadow Health and Care Board, Place Committee and Health Board resulting in the same people having similar discussions in three places. Partners agreed that bringing these boards together in a committee in common will rationalise decisions and discussion, and further builds on the alignment between the CHS Board and CCG Local Committee.



Financial delegation (scope TBC)

Health Decision/delegation

Wider Remit/whole place health and care

*Croydon Council will be changing from a Leader/Cabinet model to a Mayoral model in May 2022. The key difference being the Mayor is elected by the electorate every four years; decisions can still be delegated to the Cabinet.

Committee in Common: Membership

- The functions and membership of the Place committee are significantly similar to the Alliance Board (SHCB); therefore the aim was simplicity - to have the same membership for both.
- The list below shows membership for both the Place Committee and Alliance Board.
- The total number of members in the Committee in Common will be 28.

CHS Board Leadership	Place Committee/Alliance Board
Chairman of the Trust	Croydon Place Based Leader for Health (for CCG and CHS)
Chief Executive of the Trust (place Based Leader)	Chief Executive, Croydon Council
Joint Chief Financial Officer	**Chief Executive, Croydon GP Collaborative**
Joint Chief Nurse	Chief Executive, South London and Maudsley NHS Foundation Trust
Medical Director	Chair, Age UK Croydon
Non-Executive Director x7	A nominated Non-Executive Representative from each Alliance Member Organisation
Associate Non-Executive Director x1 (non voting)	VCS Infrastructure Organisation Chief Executive (on rotation basis)
Director of Human Resources and OD (non-voting)	Healthwatch Chief Executive
Director of Public Health, Croydon Council	Director of Public Health, Croydon Council
Chief Executive, Croydon Council	Director of Adult Social Services, Croydon Council
Healthwatch Chief Executive	Chair of Professional Cabinet
COO	Chair of Senior Executive Group
Director of Strategy Planning & Performance (non voting)	**NHSE Regulator open invite**

One Croydon: our place based partnership

Croydon was one of the first in London to appoint a Place Based Leader for Health, with responsibility for the borough's acute and community services and local primary care.

Our vision

Our vision remains the same – to deliver better care and support tailored to the needs of our communities and available closer to home. We will meet this ambition by bringing together the borough's NHS physical and mental health services, along with GPs, social care and the voluntary sector, joining up services to provide more holistic care.

We are committed to our original aims to:

- **Focus on prevention and proactive care:** preventing or identifying and tackling illness and ill-health at the earliest possible opportunity
- **Unlock the power of communities:** connecting local people with each other to help them stay fit, health and happier for longer
- **Put services back in the heart of the community:** providing easier access to local integrated services tailored to the needs of Croydon's communities.

Croydon Health and Care Plan

Croydon
South West London Integrated Care System

Following the impact of Covid-19, we have added new aims that set out to:

- **Support people to recover from the effects of the pandemic:** COVID-19 has identified and created new challenges for Croydon's health and care system to address working hand-in-hand with our communities
- **Support our health and care workforce:** recruit, retain and develop our health and care staff so we can provide the high-quality and resilient services our communities deserve
- **Embed a population health management approach:** use data, technology and public health expertise to put in place the right services, investment and approach for Croydon
- **Tackle inequalities:** to drive equality in health, we will also address equality in wider areas that impact health, like housing, employment and education

Croydon Clinical Leadership Priorities

Croydon South West London Integrated Care System

- Delivering Clinical / professional leadership which stems across Primary/ community and secondary care and drives through required pathway changes with all system partners
- Delivery against the Health and Care plan ambitions
- Making inroads into the significant backlog of care since March 2020, for example chronic disease management and case finding
- To meet growing epidemics including areas such as diabetes and hypertension
- Full implementation of the PCN DES with large changes around patient access and anticipatory care for 22/23, e.g. MDTs with care homes and community services
- Embedding digital transformation initiatives ranging from online consultations to patient access to medical records
- Reducing Health Inequalities and addressing the challenges within the CORE20 PLUS 6 for Croydon

Clinical/Professional Lead Portfolios

Programme of work	Clinical/ Professional lead	ICB Management lead
Population Health Management	Emily Symington	Laura Jenner
Quality & Prescribing	Khalid Khan	Helen Goodrum/ Louise Coughlan
Homelessness & Refugees	Nishal Velani	Meeta Kathoria
Digital / IT	Dinush Lankage	Laura Jenner/ Daniele Serdoz
Planned Care 1 General Surgery + ENT, Urology, Diagnostics, Haematology & Anti-coagulation	Farhhan Sami	Kama Balakrishnan
End of Life Care + Frailty	Nishal Velani	Karen Barkway
Personalisation / Social Prescribing	Emily Symington	Laura Jenner
Out of Hospital + Care Home	Anna Clarke	Daniele Serdoz
Long Term Conditions 1 Diabetes, Cardiovascular, Respiratory, Stroke, Dementia	Emily Symington	Meeta Kathoria
Adult Mental Health	Dev Malhotra	Wayland Lousley
Children and Young Persons Mental Health	Sharon Raymond	Shelley Prince
LD / Neurodevelopmental (Children & Adults)	Henk Parmentier	Jennifer Francis
Long Term Conditions (2) MSK/ Rheumatology/Pain, Trauma & Orthopaedics, Dermatology, Digestive Diseases	Bobby Abbott	Kamal Balakrishnan
Urgent Care + Primary Care Access	John French	Sarah Raheem
Children and Young Persons Physical Health	John French	Shelley Prince
Cancer	Jaimin Patel	Daniele Serdoz
Planned Care 2 Maternity/Gynaecology + Women's Health, Infectious Diseases, & Vaccination, Endocrinology, Renal, Neurology.	Judith Mbaire	Kamal Balakrishnan
Adult Mental Health 2	Sharon Raymond	Wayland Lousley
Localities (ICN+) Development	Khateja Malik	Laura Jenner
Safeguarding (Children)	Sharon Raymond	Sally Innes
Elected lead	Mike Simmonds	Matthew Kershaw
Primary Care Development Lead	Dipti Gandhi	Matthew Kershaw

SWL Acute Provider Collaborative

Another important feature of ICS working is SWL's Acute Provider Collaborative

Bringing NHS providers together to achieve the benefits of working at scale across multiple places and one or more ICSs

In SWL, the Acute Provider Collaborative comprises of us at CHS, alongside St George's, Epsom and St Helier, and Kingston Hospital NHS Foundation Trust

Working together to continuously improve quality, efficiency and outcomes, including proactively addressing unwarranted variation and inequalities in access and experience

The APC in South West London is helping to reduc duplication and increase efficiency, including sharing recruitment, procurement and pathology teams.

SWL recruitment hub

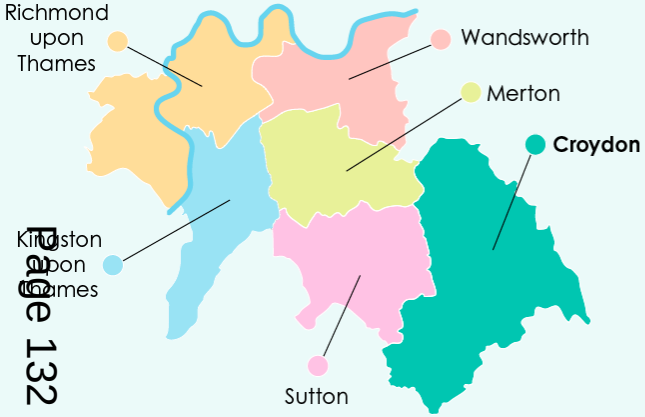
Time to recruit down in Croydon by 23% in six months, from almost 60 to 45 working days
Analysis of live activity compared to vacancy rates is undertaken for each Trust to ensure recruitment plans are targeted and adjusted as required.

Building on successes for 2022-23

SWL APC now has a vision to develop an elective strategy, maintaining our high performance and delivering a "system first" approach to elective care

Bringing the Croydon health and care plan to life

Croydon's practical solutions



Proud to be working together to create healthier communities

Partners involved

NHS South West London CCG
One Croydon's alliance of Voluntary and Community Sector organisations
Croydon Council

Find out more

Learn more about our work and get involved at www.swlondon.nhs.uk

How we're making a difference

Through the Healthy Communities Together programme, which was developed in partnership between The National Lottery Community Fund and The King's Fund, One Croydon was awarded £500,000 over 4 years to support local partnership working to improve the health and wellbeing of Croydon's local communities.

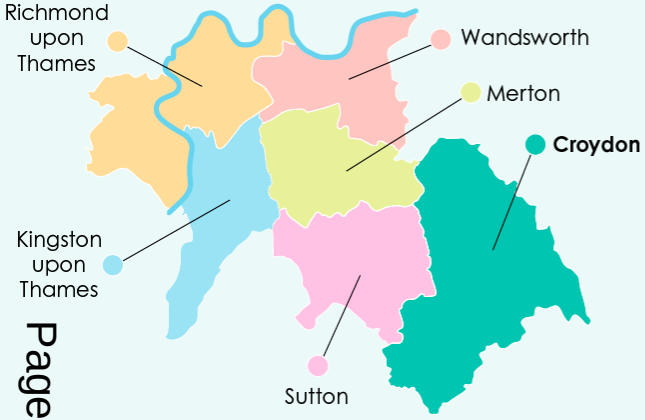
Six Local Community Partnerships (LCPs) have been implemented covering the whole of Croydon. Chairs from the local community are coming into post in each of these LCPs, bringing greater local ownership, collective voice and leadership.

The programme of LCP events gives the opportunity for local residents, community groups, local charities and health and social care teams to collaboratively develop community action plans

Locality partnership working has improved the connections between our clinical teams, our community assets and community organizations. It's empowered people to improve their quality of life.

Lynda Graham Social Prescribing Link Worker-Team Leader

Croydon's hospital in a hospital



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Croydon Health Services
Epsom and St Helier University Hospitals
St George's University Hospitals
Kingston Hospital

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How we're making a difference

To make sure that as many people as possible across South West London have their planned operation as soon as possible following the delays caused by the pandemic.

Over 18,500 patients have safely received planned care at the Croydon Elective Centre since it opened in July 2020, despite the pressures of the pandemic. The 'Covid-protected' hospital within a hospital has been dubbed a 'blueprint for the NHS', seeing around 300 patients from across South West London every week for routine surgery or planned care - more than a 10% increase since pre-lockdown levels. The Croydon Elective Centre has its own separate entrance, operating theatres, inpatient wards and a catheter lab, with strict infection prevention and control measures to keep it protected.

Around 2,000 patients have been referred to the centre from neighbouring trusts as part of a coordinate approach to tackle backlogs in South West London.

The Croydon Elective Centre is a great example of how clinically-led innovation can make a real difference to the lives of our patients and staff, as well as the wider health system.

Stella Vig, Consultant Surgeon and Clinical Director for COVID-19 Recovery, Croydon Health Services NHS Trust

Croydon
South West
London
Integrated
Care System

Thank you.

Any questions?