COVER

Health and Wellbeing Board

Croydon

Bodies involved strategically and operationally 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 in Croydon.

Bodies involved include:

- SW London ICB (Croydon Borough)
- London Borough of Croydon
- Croydon Health Services
- Age UK Croydon and other VCS organisations
- South London and Maudsley NHS FT
- Croydon GP Collaborative.
- Local Care agencies, including care providers and care home

How have you gone about involving these stakeholders?

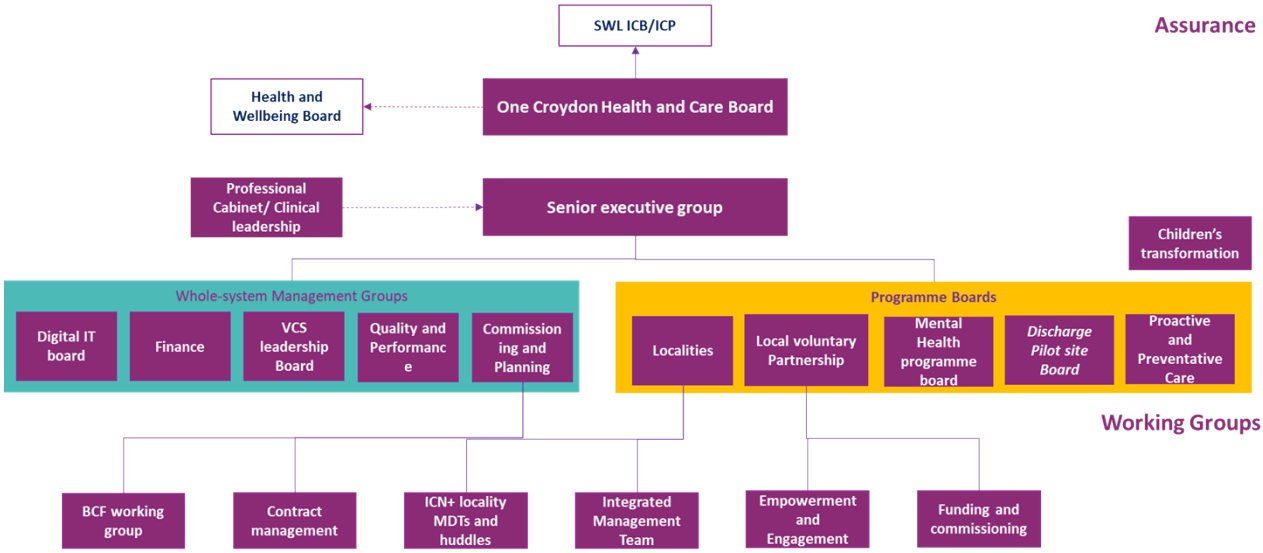
Stakeholders have been involved via the One Croydon Alliance groups such as: the BCF working group, Localities Board, the Senior executive Group. This has included colleagues from Health, Social Care and Housing who have engaged via the Council participation into the BCF working group as a starting point. This year we have also had significant further engagement through the Frontrunner governance, including the design groups and workshops undertaken to understand the challenges and design the new model with all system partners.

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. 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.

One Croydon Alliance introduced a number of whole system groups, which has allowed One Croydon the opportunity to fully embed the BCF management and oversight within the local governance. Amendments have been reflected in 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. Proposals have been made to amend the Terms of Reference of the Board to make provisions for delegated authority to key decision makers to sign-off BCF plans, with plans brought to the Board for ratification. We are anticipating the BCF plans will be signed off at the next Board meeting which will take place on the 28th of June 2023, the same day of the national submission.

BCF Executive Group & SEG

Historically, 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 in 2021 it was 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 and Planning Group

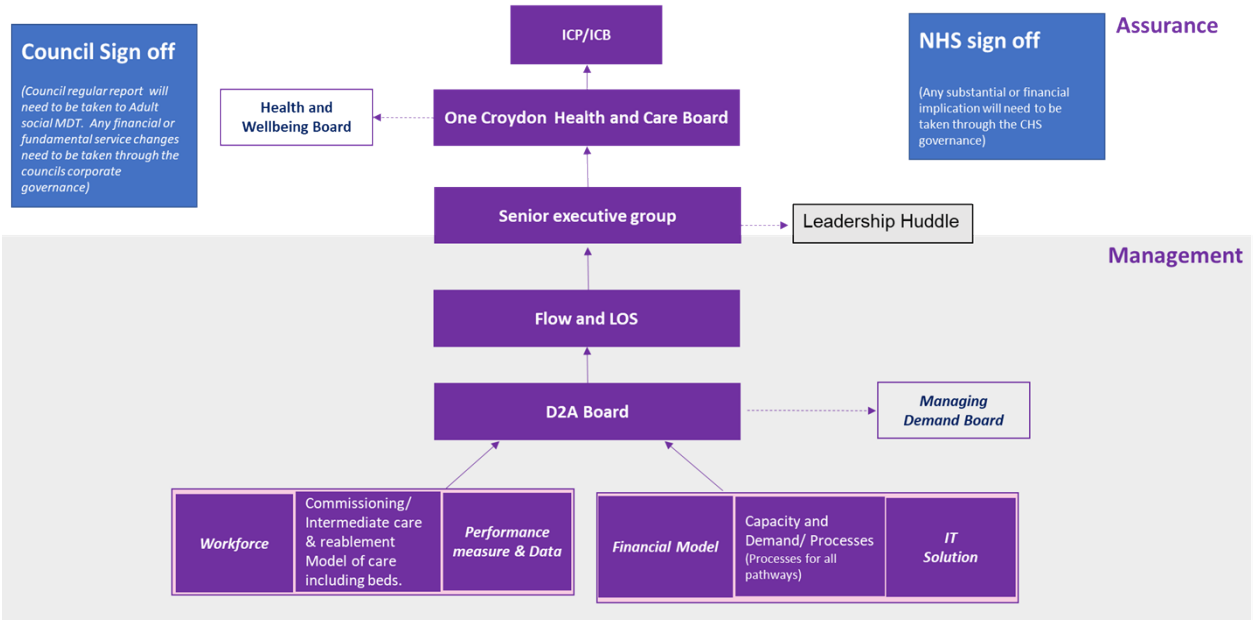
With the introduction of the Commissioning and planning group, there now exists a governing board that can apply oversight to BCF requests and proposals prior to final agreement by SEG. Although not responsible for drafting proposals the group is responsible for discussing and approving proposals with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

BCF working group

To facilitate the process of reviewing, planning and developing BCF spend options, a BCF working group was established by commissioners from health and social care in 2021. This group includes stakeholders from across Croydon, Finance leads, Commissioners, Head of Improvement and Policy, One Croydon leads and the DFG lead. The group takes all reviews, options and proposed changes to the Commissioning and Planning Group prior to any final submission to SEG for agreement.

New Discharge Transformation Governance

As part of the Frontrunner programme, Croydon is reviewing its model of care for supporting discharge from hospital and intermediate care offer. Many of the pathways and services to support discharges are funded through the BCF. Therefore, it was imperative to ensure that the two governance routes are aligned through the Senior Executive Group.



EXECUTIVE SUMMARY

This should include:

- Priorities for 2023-25
- Key Changes since previous BCF plans

This document sets out Croydon's Better Care Fund Plan for 2023/25. 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 2023-25:

- 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 previous 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 (National Condition 1).
- Includes a contribution to adult social care from the NHS in line with the required minimum contribution (National Condition 4)
- Makes a significant contribution to supporting people to remain independent for longer and, where possible, support them to remain in their own home (National Condition 2), whilst also striving to provide the right care at the right time in the right place (National Condition 3). This is through a programme of work centred around hospital discharge improvement and further developing integrated localities team with a focus on neighbourhood and communities to be at the heart of people's care.

Our joint priorities are outlined in the next section ("Overall BCF plan and approach to Integration"). Our plan for 2023-25 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 and address the significant level of health inequalities experienced by our local communities. 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

Key Changes since previous BCF plans

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:

- Proactive and personalised care through the implementation of multi-Agency Huddles (including social workers) which are GP practice based and locality MDTs (ICN+)
- LIFE service (Living Independently for Everyone) to deliver our Croydon Discharge to Assess model, including reablement/rehabilitation in the community

- Other integrated neighbourhood-based services for Diabetes, COPD and Cardiology, contributing to addressing health inequalities in core 20+5 populations in the Croydon localities
- Increased investment in Frailty, Falls and End of Life Service
- Community Mental Health offer to support early discharge as well as admission avoidance.

All these service initiatives were supported through a range of other enabling projects including assistive technology, carer support, housing service (such as Staying Put), 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.

Although many of the BCF schemes in 2023-25 will be rolled over from 2022-23, the ethos has shifted toward building on the integration work that Croydon has implemented since 2017 to take into account:

- the increased emphasis on providing the right care in the right place at the right time, and improving outcomes for people discharged from hospital via our Croydon LIFE service. As described later in the document, Croydon is one of the national Frontrunner sites and the objectives of the programme to transform hospital discharges, align strongly with the BCF objectives;
- the embedding of a neighbourhood approach with our Integrated Care Network Plus (ICN+) model of care in the 6 localities in Croydon working with PCNs to support Croydon people to maintain independence through a proactive and personalised care approach within each of the localities of the borough;
- the additional BCF funding available to support hospital discharges, which has provided the opportunity to increase and align intermediate care capacity in the system in line with the demand and capacity model developed through BCF planning;
- the strengthening of the Croydon frailty and end of life model of care through increased BCF funding and better alignment to ICN+, with acute frailty care strongly joined up with frailty care in the community.
- the significant level of health inequalities experienced in Croydon as highlighted in the Core20+5 analysis and the need to refocus many of the programmes to address inequalities as well as meeting statutory requirements from the Equality Act.

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.

Please note that there is also a SWL review of the Better Care Fund across all Boroughs. This review is expected to be completed in the Autumn and may inform some further changes for next year.

NATIONAL CONDITION 1: 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 2023-25**
- **Approaches to joint/collaborative commissioning**
- **How BCF funded services are supporting your approach to continued integration of health and social care. Briefly describe any changes to the services you are commissioning through BCF from 2023-25 and how they will support further improvement of outcomes for people with care and support needs.**

Joint Priorities for 2023-25

Local NHS, Croydon Council and Voluntary and Community Sector (VCS) partners have been collaborating as the One Croydon Alliance since 2017. One Croydon is an established place-based partnership responsible for setting the strategic direction for health and care in Croydon and for overseeing the embedding of an integrated, person-centred health, social care and housing programme of transformation.

Our vision is to deliver better care and support that is 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 general practice, council and the voluntary sector, joining up services to provide more holistic care. The BCF is a crucial enabler for achieving this vision.

Our Health and Care Plan is aligned to the broader Health and Wellbeing Strategy set by the Health and Wellbeing Board and outlines the Joint Priorities for the Croydon system over the next 2 years, as outlined below.

Live well – To give working age people the best support, we set out to:

1) Help them manage their Long-Term Conditions, aiming to work with general practices to identify those who would benefit from holistic assessment and personalised care planning and provide appropriate support across health and care system.
2) Reduce Health Inequalities, prioritising programmes that will identify and or look to reduce health inequalities within Croydon.
3) Improve Mental health & Wellbeing, focusing on prevention of admissions and facilitating early discharge, key BCF funded programmes such as the Home Treatment Team and MH Packages of Care will continue working proactively to support people with complex mental health needs accessing the new MH Step-down beds if required.

Age Well – To support our older residents the best we can, we set out to:

1) Continue to improve our Frailty and personalised care programmes, embedding an approach where consideration of frailty needs is 'everybody's business'
2) Help residents maintain their independence for as long as possible, delivering on the ambitions of the NHSE Discharge Integration Frontrunner programme, of which Croydon is one of six national sites.

3) Support people to live and die with dignity, embedding services to support early discharge from hospital of people on an end-of-life pathway, with continuity of care across community services including those provided by St Christophers Hospice via the Choose Home service.

Golden Threads

1) Integration and Neighbourhood development – bringing together primary and secondary social and health care services, along with local VCS partners, to provide more coordinated care and tailoring our local offer to give people greater control of their health and build resilient and healthier neighbourhoods.
2) Supporting carers – with a commitment to the development of a One Croydon Carers strategy and delivery plan that will look to ensure that the people who support are themselves supported appropriately.
3) Workforce - Strengthening the roles of social prescribers; community connectors, wellbeing coaches and other allied health professional roles and build a workforce able to make interventions to tackle social inequalities, help people improve their lifestyles and, hence, their health outcomes.
4) Proactive and Preventative care, helping people to stay well and reduce the risks to their health from long-term conditions.

Approach to collaborative commissioning

Healthy Communities Together

Our commissioning partnerships with local communities and the voluntary and community sector has been strengthened through the Healthy Communities Together programme, funded by the National Lottery, to build and strengthen Local Community Partnerships in each of Croydon's six ICN+ localities. As part of this, a locality-based commissioning model has been 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 address health inequalities, improve outcomes, manage demand whilst delivering better value. A locality-based process for grants allocation has been developed. The recommissioning of the BCF funded End of Life respite service is an example of this approach.

The Frontrunner Programme

Croydon has been selected as one of the six (6) NHSE Frontrunner sites. The high-level aim of the Discharge Integration Frontrunner programme is to develop an effective, integrated care provision across the One Croydon Alliance. One of the key outputs of the programme is to develop an integrated Transfer of Care Hub (TOCH) which will be a fully resourced team to include our reablement offer. Building on the successes of the integrated LIFE team launched in 2018, BCF funding will be used jointly by the NHS and the Local Authority to support the Frontrunner program in transforming care.

Developing an effective, integrated system (community and hospital discharge) will require a joint approach to commissioning services in particular our resources. It will also require us reviewing and redesigning our patient pathways to incorporate health, social and housing to ensure services are fully embedded, centred around the residents in Croydon and sustainable.

Other examples of collaborative commissioning

A few examples of how we work collaboratively in commissioning include:

- Working together to commission BCF funded intermediate care rehab bed provision through a joint commissioning approach for nursing home beds.
- Commission services collaboratively with the council using the recently introduced Adult Social Care Discharge funding; for example, commissioning Pathway 3 step up and Step-down beds as well as Mental health beds, to support hospital discharges and improve flow.
- Use of Section 75 agreements to pool funds or delegate commissioning responsibilities for services such as the community wheelchairs service and the community Equipment service - both provided by the Council's in-house Croydon Equipment service (CES).
- Collaborative commissioning of a falls pick-up service as part of the BCF funded, Council's Careline service.
- CHC supporting and placing residents on D2A pathway 3 into Nursing Homes
- 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 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 and recruitment campaigns.
- We have an Integrated Mental Health Placement Review team and approach to s117 aftercare needs with key partners SLP, SLaM, Council and SWL ICB.
- Supporting increased use of equipment/assistive technology in supporting hospital discharges through the pooled equipment budget.
- Looking at technology to join up IT systems to improve data flow and intelligence to speed up discharge planning.

Changes to previous BCF plans

Most of the BCF schemes funded in 22-23 will roll over into 23-24 and 24-25. 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. Some of the changes in this and next year's plan are briefly listed below.

- All schemes have been reviewed, funding redistributed and re-aligned to reflect current programs of transformation and integration of health and social care, such as the ICN+ and the LIFE programs, the Mental health Programs and the integrated Same Day Emergency Community offer.
- Some further investment in our offer to support people manage their long-term conditions in the heart of their communities, eg Asthma and COPD through a neighbourhood approach.
- More funding has been allocated to End of Life, Frailty and mental health initiatives, both from the NHS minimum contribution and the Discharge Funding as outlined later in this document. For example, Choose Home and Advanced Care Planning Practitioners, which support people on an end-of-life pathway to die in their preferred place.
- Much of the iBCF schemes have also refocused on packages of care to support reablement and Discharge to Assess.
- Expansion of the carer's support offer to expand the range of respite services, increasing the reach of emotional support services, linking with health and care services and modernising the digital support offer.

- New funding has been allocated by both the ICB and the Local Authority to support the Discharge Integration Frontrunner Programme as the new model of care is developed over the course of the programme. This is expected to be piloted in the second half of 2023-24 for full implementation in 2024-25. This will improve outcomes for people discharged from hospital.
- A Home from Hospital Service provided by the VCS is also being redesigned and funded through BCF. This is in addition to a Red Bag coordinator based in the hospital discharge team, supporting the hospital discharge pathway into care homes.
- The new ASC and ICB Discharge funding has also been agreed and allocated, with some schemes rolled over from 22-23 following an evaluation, and others newly implemented to create additional intermediate care capacity and support hospital discharges, as informed by an analysis of demand and capacity.

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

NATIONAL CONDITION 2

Use this section to describe how your area will meet BCF objective 1: Enabling people to stay well, safe and independent at home for longer.

Main schemes relating to NC2: Schemes 1,2,3,6,7,8,9,10,11-16,18,19,20,21,26,27,31,33,38

Please describe the approach in your area to integrating care to support people to remain independent at home including how collaborative commissioning will support this and how primary, intermediate, community and social care services are being delivered to help people to remain at home. This could be:

- **Steps to personalise care and deliver asset-based approaches**
- **Implementing joined up approaches to population health management, and proactive care, and how the schemes commissioned through the BCF will support these approaches**
- **MDTs at place or neighbourhood level, taking into account the vision set out in the Fuller Stocktake**
- **How work to support unpaid carers and deliver housing adaptations will support this objective**.

To enable people to stay well, safe and independent at home for longer, One Croydon partners committed to a Locality approach that aims to engage our local communities in co-producing services and activities and to deliver integrated, proactive care and support close to home by shifting power to local people and developing neighbourhood-based networks.

To deliver the above vision Croydon continues to develop and evolve the Integrated Community Networks Plus (ICN+) model of care in 6 Localities (aligned to PCNs), a flagship initiative within our Croydon Health and Care Plans.

Over the past year the model was reviewed and continues to be refined against the national requirements of proactive care, personalised care, the findings of the Fuller report as well as local learnings, with significant alignment already in place and improvement plans being articulated. There remains focus on people with multiple Long-Term Conditions, frailty and high usage of unplanned care services.

As such, the programme's current emphasis is to continue establishing effective ways of working that facilitate coordination and delivery of proactive and personalised care in the community via cross-system multidisciplinary teams (MDT) and by making every contact count, working toward health and social care integration of core community-based services.

In summary the two-year focus is on:

1. Supporting existing core community-based services to work in a holistic way and make every resident contact count, building professional networks with colleagues who support residents in the same geographical area (Locality aligned to PCNs)

2. Delivering effective and timely Neighbourhood Multidisciplinary team (MDT) working for residents identified in the community that would most benefit from coordination, care planning and proactive management via cross-system MDT Huddle discussions and joint working

3. Supporting best practice and quality improvement for the above via a Neighbourhood based coordination function that oversees all cases discussed and supported via MDTs as well as supports skills development and information sharing efforts between and beyond the core teams

To ensure strong asset-based and preventative focus six Local Community Partnerships (LCPs) were established by VCS partners to draft neighbourhood led Community Plans, ensuring greater local ownership, collective voice, and leadership. Each LCP is also developing Community Hubs to provide pathways for people into social support networks, community-led activities and specialist voluntary and statutory services, with preventative health and wellbeing programmes delivered from the hubs. There are currently three Community Hubs set up by the VCS in venues that are known and accessible to local residents. There are plans for at least one community hub in each of Croydon's six localities. The community facilitators are part of the MDTs in each of the six localities and ensure a strong link with the Hubs.

Roles and initiatives funded by the BCF, including ICN+ Teams, Proactive Care, Personal Independence Coordinators and Frailty Practitioners, are fundamental to progressing the development of the model and supporting operational development of the MDTs, and are aimed at:

- Undertaking early identification and providing oversight of cases put forward for MDTs, including being patient centred and ensuring a supportive assessment - building on intrinsic abilities of resident and support network
- Ensuring that validation, agreement and review of personalised plans at cross-system MDT meetings are solution focussed, including consideration of non-clinical needs – solving problems by working jointly and actioning appropriate interventions, ensuring streamlined access to wider support services, and only referring to other teams when there is a specific need
- Enabling increased joined up working and coordination of care in between MDT meetings via established professional networks
- Delivering timely intervention through community-based services, including e.g., personal independence coordinators, social care support and wider voluntary sector services - maximising independence and self-management
- Optimising use of health and social care services (reducing unnecessary interventions/ admissions).

In addition to the proactive care and MDT approach for all residents, the Croydon EOL steering group has been focussed on the development of services to maintain a personalised care approach, addressing health inequalities for those at end of life, and supporting people to die in their place of choice. In Croydon there is a significant variation in the completion of advance care plans based on ethnicity and health inequalities (the 'Core20' have a lower proportion of care plans and a higher average mortality risk). In addition, currently 50% of people at end of life die in hospital.

Population health management approach

The shift into Integrated Care Systems (ICS) presented an opportunity to create an aligned approach to improving population health across South West London (SWL) and use the increasingly rich data available to target those in our communities with the greatest need, to focus more on prevention and population health improvement, using a Population Health Management (PHM) approach.

During 2022 we worked with our health and care partners from across to develop and publish the South West London Population Health Management PHM Roadmap, which sets out the steps we need to take together in our six boroughs. to deliver a strong PHM approach in SWL.

In SWL we have developed Health Insights, a data/analytics platform which has been built using Microsoft Power BI and presents data from various sources using interactive dashboards; we also have a SWL BI/Analytics team who can provide more sophisticated data and analytics functions, as well as create bespoke dashboards to support our work programmes.

Working as a system, our health and care services can work together to design new proactive models of care which will improve health and wellbeing today as well as in the future. This means we can tailor better care and support for individuals, co-produce and design more joined-up and personalised care with our communities (patient segments or identified cohorts) and make better use of public resources for example the development of integrated multi-disciplinary neighbourhood teams (Fuller Stocktake).

Set out the rationale for your estimates of demand and capacity for intermediate care to support people in the community. This should include:

- **Learning from 2022-23**
    - **Where number of referrals did and did not meet expectations**
    - **Unmet demand**
    - **Patterns of referrals and impact of work to reduce demand on bedded services**
- **Approach to estimating demand, assumptions made and gaps in provision identified**
    - **Where have you estimated there will be a gap between demand and capacity**
    - **How have estimates of capacity and demand been taken on board and reflected in the wider BCF plans**

Our demand and capacity analysis suggests that our capacity for community referrals broadly matches demand. Referrals into intermediate care services from the community are relatively low as more focus is given to hospital discharges. One of the key aspects highlighted by this analysis is the flexible nature of our integrated LIFE service (scheme 4 and 28) for reablement and rehabilitation at home and in bedded settings. As the service takes both community and hospital discharge referrals, they are able to flex utilisation and cover gaps as much as possible. However, a few issues have been identified with the data, which is outlined below.

Social support (including VCS) demand and capacity

- Croydon has a very strong VCSE social care offer that is supported through the healthier communities together programme, VCS leadership board and the Localities Commissioning Model, however for the supplied information we have provided in the demand and capacity numbers are for the Personal Independent Coordinators and the Mental Health Personal Independent Coordinators as these are contracted services who supply accurate and timely information.
- The unmet demand for these services has not been able to be calculated for the 2022/23 financial year as the providers do not keep a waiting list and have not been recording instances or unmet demand, hence showing excess in capacity. However, we understand that the services are flexible enough to being able to accommodate variations in demand.
- The above-mentioned recording shortcomings will look to be addressed over the coming year allowing us to be more accurate without forecasting moving forward.

Urgent Community Response

- Reviewing the available data does indicate that demand for Urgent Community Response has steadily increased over the last 12 months. The provided demand and capacity numbers have not assumed that the trend will continue as we do not currently have enough data to test this assumption.
- We have assumed the same demand and capacity numbers, and this is due to the flexible and adaptive nature of the service. The service will move resources as needed to ensure daily demand is met however this may have a knock-on effect to other community teams (e.g. district nursing).

Pathway 1 Reablement and Rehabilitation demand and capacity:

- The Living Independently for Everyone (LIFE) service currently only receive on average 3-4 community cases per day however with the introduction of the Frontrunner programme, we are looking to double the referrals.
- The targeted programme to expand and encourage more uptake by the community teams can be seen in the provided projected numbers within the demand and capacity sheet.
- Currently the ‘additional demand’ in these lines is mitigated through the flexible working of the LIFE team in managing both hospital and community referrals as described above but also by the proactive work of the ICN+ teams (scheme 3) in the community and the new frailty practitioners (scheme 25), as outlined below (frailty).
- We are aware more rehab beds are needed and we have planned for more interim capacity (schemes 73, 77 and 78) this year through the Discharge fund. It has been challenging to commission bed rehab bed capacity due to the nature of the service and the resistance of the market. NHS and LA teams are working to mitigate this and

develop a local offer, but this is likely to be in place from next year. For now, we will have to rely on interim and spot purchased capacity.

Frailty

One of the key areas we continue to invest in through the BCF is around Frailty. The additional frailty practitioner roles and advanced frailty practitioner roles are now in place as of April 2023, following a significant delay due to challenges in recruitment. We therefore anticipate that there will be growing demand from diverting people attending A&E into the LIFE team.

Additional capacity will continue to be provided through Advanced Frailty Practitioners to support the Acute Care of the Elderly (ACE) team to identify and review patients in ED, supporting transfer of care through a frailty SDEC, a virtual ward and into the community as appropriate to avoid admissions wherever possible and support a neighbourhood approach to help frail people to remain as independent as 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.

Describe how BCF funded activity will support delivery of this objective, with particular reference to changes or new schemes for 2023-25 and how these services will impact on the following metrics:

- **Unplanned admissions to hospital for chronic ambulatory care sensitive conditions**
- **Emergency hospital admissions following a fall for people over the age of 65**
- **The number of people aged 65 and over whose long-term support needs were met by admission to residential and nursing care homes, per 100,000 population.**

How BCF funded activity will support delivery of this objective

The provision of proactive care through integrated health and care working (as described above) aims to deliver support to individuals with ambulatory care sensitive conditions (including frailty, falls and LTCs) through the delivery of personalised care plans focussed on:

1) Early identification of need based on risk stratification and clinical review of residents with multiple long-term conditions, experiencing health inequalities, frailty and high use of urgent and emergency care services.
2) Holistic assessment and development of personalised care plans to:
    - Support self-care and access to local community assets
    - Provide support to maintain and, where possible, improve health and wellbeing to reduce reliance on statutory services
    - Ensure plans are in place to support exacerbation of conditions through access to alternative services to urgent care
    - Supporting people to maintain their independence in their own home for as long as possible, reducing or delaying the need for long term care including admission in a care home
    - Supporting people at end of life to die in their place of choice – and at home where possible.
3) Streamlined care, minimising duplication of interventions through MDT working and coordination of care.

4) Review and updating of care plans with the individual at agreed timelines to ensure ongoing shared decision making and personalisation.
5) Better links to Housing and adaptations through the ICN+ MDT process in the neighbourhood model we are implementing.

Changes or new schemes for 2023-25 and impact on metrics

New updated services specifically funded through the BCF to support delivery of these ambitions are:

1. Integrated Community Network Plus MDTs in the community with a focus on developing integrated neighbourhood team approaches in line with the Fuller review (e.g. scheme 3).
2. Proactive Care LCS to be delivered by Primary care to deliver personalised care as part of the ICN+ model of care within neighbourhoods (scheme 21).
3. Frailty practitioners – community and acute (front door) based (scheme 25).
4. Supporting Independence in Croydon – through provision of Personal Independence Coordinators (scheme 10) and Personal Safety / Falls prevention service. (scheme 8) Also a collaborative approach to commission a falls pick-up service through the council's Careline service (scheme 44).
5. New services supporting End of Life patients (Schemes 11-16).
    - Croydon Choose Home provides specialist palliative care support in peoples home during the last days / weeks of life.
    - Advanced Care Plan Facilitator (to commence in June 2023) within the palliative care team, to ensure streamlined and consistent support acute and community settings.
    - Recommissioned End-of-Life night sitting service for 1 year.
    - Recommissioned EOL Carers Respite service from October 2023. This service provides personal care and support for people at end of life enabling carers to take time out from their caring duties. Development of this service specification has been undertaken with input from VCSOs enabling consideration of links with support for carers, and now includes an expectation of supporting carers to identify and access services which meet their needs.

These services will impact on the following metrics.

1) **Unplanned admissions to hospital for chronic ambulatory care sensitive conditions.**
   Croydon has seen an improvement of 12% in this avoidable admission metric from 21-22 to 22-23. As we continue to embed the work undertaken since the implementation of the localities model of care, we are expecting to sustain this performance and to improve it on the back of the new frailty model. As part of that business case, we are assuming a 6% improvement on the 22-23 performance.
2) **Emergency hospital admissions following a fall for people over the age of 65.**
   Croydon has seen an improvement of 6% in emergency admissions due to falls from 21/22 (1048) to 22/23 (985). And an improvement of 15% since 19/20 (1226). Local data suggest we are seeing 985 falls instead of the expected 864 for our population (121 more). As we continue to embed the work and services put in place with the implementation of the localities model of care, we expect performance to align with the expected number of falls on the back of the new frailty model, the services to support the EHCH framework implementation in care homes, and the falls pick up service as part of the UCR model. This will equate to a 12% improvement on the 22-23 performance.
3) **The number of people aged 65 and over whose long-term support needs were met by admission to residential and nursing care homes, per 100,000 population.**

Croydon has seen an increase in the last 18 months of residents who need long term support in care homes. This has mainly been driven through increased frailty and acuity of residents discharged from hospital through pathway 3. As part of the Frontrunner programme the pathway 3 will be revised with a focus on alternative step-down bedded offer with a focus on the resident returning to their usual place of residence coupled with re-enforcing our home first policy. The step-down bedded offer will include focus on complex social care issues, delirium and non-weight bearing residents. However, we will be seeing a projected increase in 23-24 even with the above measures.

NATIONAL CONDITION 3

Use this section to describe how your area will meet BCF objective 2: provide the right care in the right place at the right time.

Main schemes relating to NC3: Schemes 4, 5, 11, 16, 17, 28, 32, 34, 36, 49, 66, 67, 69, 70, 71, 73, 77, 76, 75, 79.

Please describe the approach to integrating care to support people to receive the right care in the right place at the right time, how collaborative commissioning will support this and how primary, intermediate, community and social care services are being delivered 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, in line with the Government's hospital discharge and community support guidance.**
- **How additional discharge funding is being used to deliver investment in social care and community capacity to support discharge and free up beds**
- **Implementing the ministerial priority to tackle immediate pressures in delayed discharges and bring about sustained improvements in outcomes for people discharged from hospital and wider system flow.**

Implementing the ministerial priority

This section describes in detail how in Croydon we will align our priorities for health and social care to the national priority to tackle immediate pressures in delayed discharges and demand for hospital attendances and admissions, bringing about sustained improvements in outcomes for people discharged from hospital, and wider system flow.

As this section describes, this will be achieved by embedding strong joint working between the NHS, the local authority and the voluntary, housing and independent sector providers. Over the course of 23-24 and 24-25, a key part of this will be through the delivery of the Frontrunner programme and funding from the hospital discharge fund will be a key enabler to the success of this programme.

Ongoing arrangements to embed a home first approach

A significant proportion of BCF funding is allocated to supporting hospital discharges via the LIFE service, 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).

The service consists of the following elements:

- Single integrated multidisciplinary Team - A single LIFE Team that brings together existing community services into one integrated, intermediate care, multidisciplinary team.
- 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.
- 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.

There is a Home from Hospital service with the Red Cross which supports people who have been discharged from hospital with lower-level care needs, they also offer support within the hospital to ensure all essential provision is in place prior to a home discharge.

Our staff also utilise our community pharmacists who support people at home with their medication following a hospital discharge. They support with any questions people may have regarding new medication prescribed and ensure people are comfortable with what they have been prescribed with support to enable them to be compliant and remain home.

Our LIFE service through the D2A model assesses individuals with a holistic approach collaboratively tapping into all the above-mentioned community services ensuring that patients discharged from hospital are efficiently monitored and onward referred into any of the community interventions.

Funding from the BCF will support the review of all the services ensuring our home first approach for our population is robust, joint up and working collaboratively to deliver more efficiently and cost effectively in the long term. This will include procuring interoperable, end-to-end IT infrastructure for the system.

Supporting a ‘Home First’ approach for people at End of Life

As part of addressing the high proportion of people at end of life dying in hospital, and the overall extended length of stay and delayed discharges for these patients, a number of key services have been developed with the aim of enabling earlier discharge home with support to enable people to die in their place of choice. This includes ensuring that there is a visible and accessible Advance Care Plan (through the embedment of the London Universal Care Plan) which outlines the patients and families wishes and plans to manage exacerbation of needs and imminent end of life.

The aim of the end-of-life pathway for people who have had an acute admission is to:

1. Ensure early review of needs through development / update of advance care plans, completion of Fast Track applications and initiation of community-based support

(including equipment etc) coordinated by an acute Advance Care Plan (ACP) Facilitator (due to commence June 2023)

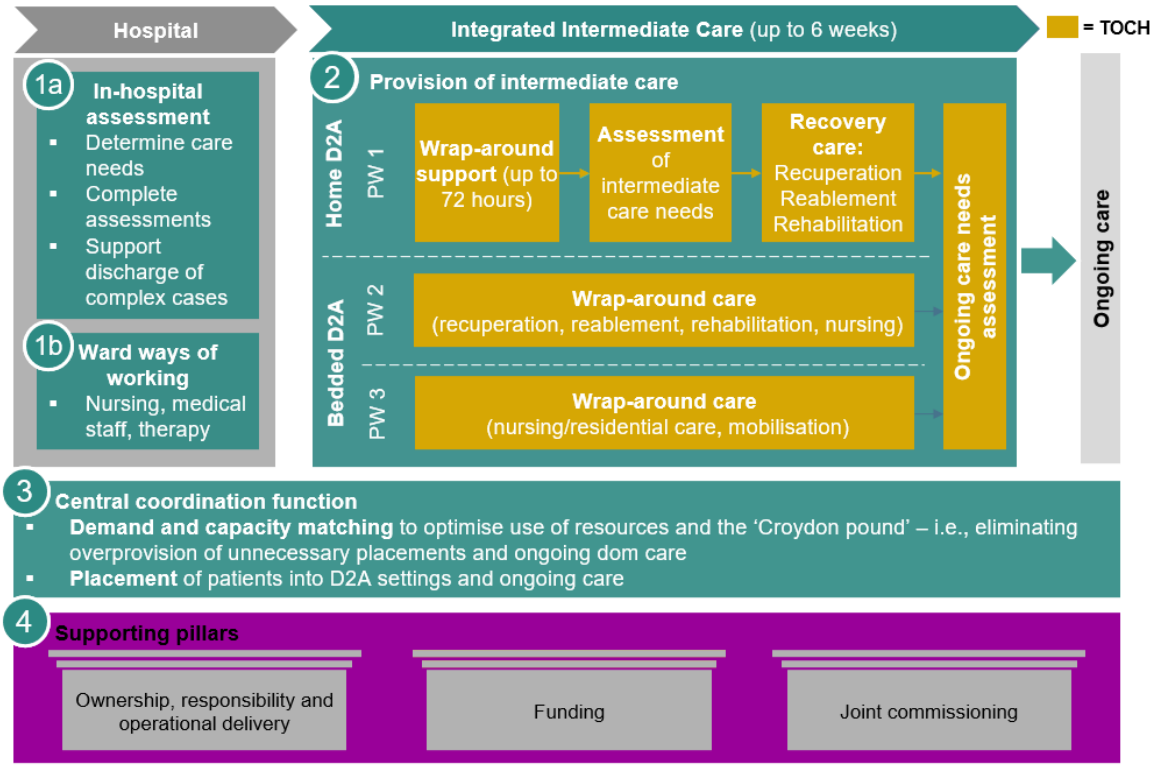
2. provide continuity of seamless care across the acute and community pathways via joint working between the ACP Facilitator and Community Nursing / Hospice / Primary Care / CHC Teams (including through the evolving community integrated model of care and MDT approach)
3. consideration of the need for key services and swift transfer of care to e.g., Choose Home, EOL Night Sitting, EOL Carer Respite, EOL Doula; as well as understanding the non-statutory / Voluntary and Community Sector Services available to provide personalised support which meets the cultural needs of the individual and their carers / family.

How additional discharge funding is being used to deliver capacity to support discharge and free up beds

The additional hospital discharge fund has enabled Croydon to increase the capacity to assess and provide enhanced support to a larger number of discharges – many of which have also shown a rise in complexity.

Discharge funding has increased the capacity in intermediate care provision, enhancing the function in our LIFE team to deliver assessments in the community as well as wrap-around care to keep people safe after discharge. It has also funded addition interim beds (Pathway 3) as well as mental health beds, to ensure people who cannot return immediately home, can be cared for in the community and not in a hospital ward.

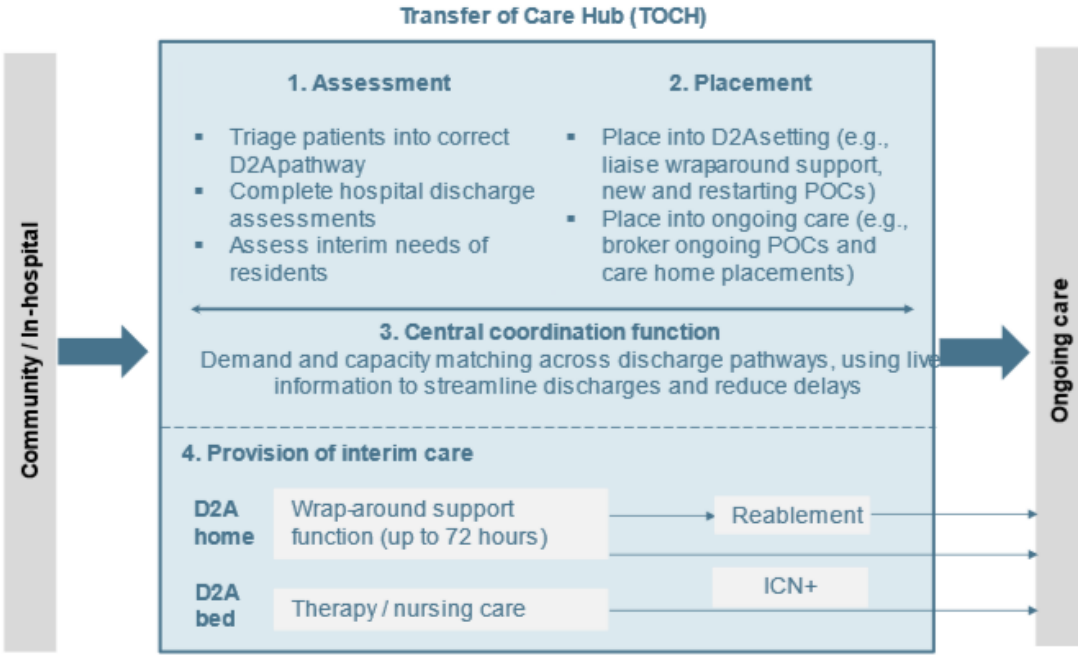
Funding has also been directed to improve local discharge processes, especially around pharmacy support, and for complex discharges of homeless people, which is a significant challenge in Croydon.



Croydon has been selected as one of the six (6) NHSE Frontrunner sites. The high-level aim of the programme is to develop an effective, integrated care provision across the One Croydon Alliance, a collaborative approach across the system. To develop an integrated approach in Croydon, the programme has undertaken a deep dive/ evaluation on all discharge pathways, reablement and Intermediate care offer. This exercise has been done across the system and the key output of the deep dive is to develop an integrated Transfer of Care Hub (TOCH) which will be a fully resourced to include our reablement and rehab offer.

The model will include the following functions:

1. Develop and implement a Transfer of Care Hub (TOCH) One Team, One Budget, One Name - improved interlinks with Primary Care/ ICN+
2. Introducing new blended roles and a flexible budget, this allows the service to use the voluntary sector when required
3. Integrated recovery team that is clinically led, made up of therapy, Health and Wellbeing advisers, reablement workers, pharmacist, personal independence coordinators. (Everyone needing support will get 72 hours of support, before there agreed pathway/ service is decided). The recovery team members will also be a part of the ICN+ GP huddles to ensure complete joint up between primary and secondary care.
4. An integrated commissioning model with joint budget overseen by the joint manager and commissioner.
5. Integrated leadership model to support both strategic and operational development of this new partnership arrangement.



The evaluation also highlighted several areas requiring investment:

- Better IT infrastructure to support information flow between organisations, we are planning to introduce a new integrated platform which will reduce admin time and allow assessment and information to be shared across our IT systems

- All staff both inhouse and external will need to be on the same parr to deliver structured reablement programmes / interventions to ensure effective support for all residents.
- Additional Health and Wellbeing advisors to support the additional daily referral and reduce the LoS
- Additional hours for home care reablement will be required to support the additional referral from hospital and community.

Funding provided via the BCF and the discharge fund will help recruit more inhouse reablement resources, upskill health and wellbeing assessors and support in the procurement of a robust collaborative IT infrastructure that will help with our discharge processes.

Set out the rationale for your estimates of demand and capacity for intermediate care to support people discharged from hospital. This should include:

- **Learning from 2022-23**
    - **Where number of referrals did and did not meet expectations**
    - **Unmet demand**
    - **Patterns of referrals and impact of work to reduce demand on bedded services**
- **Approach to estimating demand, assumptions made and gaps in provision identified**
    - **Where have you estimated there will be a gap between demand and capacity**
    - **How have estimates of capacity and demand been taken on board and reflected in the wider BCF plans**

We have undertaken a deep dive to review our hospital discharge data as part of the Frontrunner programme. This exercise looked at all the discharge pathways, including reablement and intermediate care and were reflected in the demand and capacity analysis and mitigations.

- The system could discharge five (5) more people on to Pathway 1 than what it is currently discharging (10 people)
- Croydon University Hospital ALOS has steadily risen since April 2021, increasing by 16% when compared to pre-pandemic
- Pathway 1 referrals have decreased by 34% since April 2022 – with referrals from the community falling the most
- Of those who start a Package of Care (POC), around 30% are classified as ‘fully re-abled’
- 25% of people referred to pathway 1 come of the service after one week
- A large proportion of LOA is due to delays for people being discharged via Pathway 1&3
- Our Assessment and Triaging function needs transforming in order to help reduce the LOS and ensure our residents are being discharged via the correct pathway.

We aim to move from ten (10) referrals to fifteen (15) discharges on pathway 1, and also aim to reduce the Length of Stay (LoS) for people on pathway three by 5 days. This

transformation will be done through the Transfer of Care Hub (TOCH) which we have designed with mobilisation and implementation due to follow in the summer of 2023. Through the extensive work we have been doing on improving hospital flow and discharge, we will be introducing new blended roles, reducing admin tasks freeing up time to support earlier discharges. We are also introducing a new IT platform connecting the hospital system with the local authority system improving communications and reducing the length of time to organise the discharge arrangements.

All the above has been reflected in the BCF plans (e.g. scheme 75 and 76). A few issues have been identified in the demand and capacity analysis, outlined below.

Social support (including VCS) demand and capacity

Similarly, to the section around community:

- The unmet demand for services has not been able to be quantified for the 2022/23 financial year as the providers do not keep a waiting list and have not been recording instances or unmet demand. Hence the apparent excess capacity. However, we understand that the services are flexible enough to be able to accommodate variations in demand.
- The above-mentioned recording shortcomings will look to be addressed over the coming year allowing us to be more accurate without forecasting moving forward.

Pathway 1 Reablement and Rehabilitation demand and capacity:

- Due to the way the Living Independently for Everyone (LIFE) service is structured and as there is a significant crossover of work taking place within the LIFE team, we are unable to confidently assess the reablement and rehabilitation demand, as the teams work in an integrated way and there are shortcomings in the way referrals are recorded. The two lines should therefore be seen as one service.
- When examining the 22/23 discharge data we can see that there have been an average 15.3 discharges per week, which sets our current demand baseline.
- With the introduction of the Frontrunner programme, we are predicting an increase in both demand and capacity, specifically from Croydon University hospital and mainly through pathway 1, starting from October 2023. This increase in demand and capacity, which can be seen in the predicted numbers, will be the result of additional capacity created via the programme's specific interventions as outlined in this document as well as a predicted decrease in pathway 1 LOS from 17 to 9.7.

Rehab beds (pathway 2)

- We are aware more rehab beds are needed and we have planned for more interim capacity (schemes 73, 77 and 78) this year through the Discharge fund, mostly seasonal. It has been challenging to commission rehab bed capacity due to the nature of the service and the resistance of the market. NHS and LA teams are working to mitigate this and develop a local offer, but this is likely to be in place from next year. For now, we rely on interim and spot purchased capacity as well as additional support for people at home.

Reablement in a bedded setting & Other Short-term social care capacity and demand from the community:

- Croydon place does not have any designated physical reablement beds within a residential or nursing homes, rather these are designated rehabilitation where some reablement may occur.
- Due to the challenges of fitting mental health discharges into the established pathways (SLAM is unable to provide a breakdown by pathway type), it was agreed that the discharges from South London and Maudsley NHS foundation trust into placements would all be recorded as Reablement in a bedded setting. All pathway 3 placements would be considered short term reablement / rehabilitative in nature, and the vast majority of pathway 2 placements are made into new supported living facilities.

Set out how BCF funded activity will support delivery of this objective, with particular reference to changes or new schemes for 2023-25 and how these services will impact on the following metrics:

- **Discharge to usual place of residence**

How BCF funded activity will support delivery of this objective

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 service, ICN+, Staying Put (housing and adaptations). These programmes will continue to contribute to supporting people discharged back to their normal place of residence.

Enhanced intermediate care capacity has also been created through the Discharge funding and this plan outlines the key areas where this capacity has been created. We are currently reviewing our model for discharges through the Frontrunner programme and one of the key objectives is to increase the number of discharges through pathway 1 by 5 a day.

As part of our reablement development we intend to have a joint commissioned approach with both in-house and external providers. This is likely to be on an agreed process / criteria with all partners e.g., complexity of reablement need to determine the pathway for a person's delivery of the care needed. Further details can be found in the previous sections of this narrative document.

Changes or new schemes for 2023-25 and impact on metrics

Local data is indicating that the percentage of people discharged to their usual place of residence in Croydon has remained approximately stable in 21/22 (93.5%) and 22/23 (93.2%), with only a small deterioration.

A deep dive into our discharge model has shown that we could discharge 5 more people a day, which equates to 390 a quarter and 1560 a year. We also have an additional 156 new people potentially discharged in interim pathway 3 beds in a year.

The high-level aim of the Discharge Integration Frontrunner programme is to develop an effective, integrated care provision across the One Croydon Alliance, a collaborative approach across the system. To develop an integrated approach in Croydon, the programme has undertaken a deep dive on all discharge pathways, reablement and Intermediate care offer. This exercise has been done across the system and the key output of the deep dive is

to develop aa integrated Transfer of Care Hub (TOCH) which will be a fully resourced to include our reablement offer.

The impact of the frontrunner programme will not be felt in full until 24/25, however we can forecast for 23/24 that with seasonality based on the last 2 years the expected discharges and discharges to usual place of residence, take into account the additional activity through the Discharge fund schemes highlighted above and assume a 0.2-0.3% overall improvement to bring us back to the 21/22 performance.

Set out progress in implementing the High Impact change Model for managing transfers of care, any areas for improvement identified and planned work to address these.

Impact change	Where are you now?	What do you need to do?
Change 1: Early discharge planning	We have undertaken a deep dive baseline across the system which has identified a lack of proactive discharge planning on wards, partly driven by poor communication at MDTs and unclear discharge roles and responsibilities We are carrying out a pilot on our hospital wards to test new ways of working and a blended model of care approach, based on principles of increased collaboration and communication between teams.	We need to embed the identified changes from the pilot programme as standard operating procedures across all CUH wards and the integrated discharge team We also need a communications strategy which will include our out-of-borough directory of services to help improve comms across our discharge pathways We need to create a training portfolio as well as our competency framework across all pathways to upskill our resources. This is particularly critical for the new 'blended' roles across the system
Change 2: System demand and capacity	Carried out work on our systemwide demand and capacity analysis to ascertain where the gaps are relating to monitoring and meeting demand We have improved our One Croydon system dashboard which highlights demand and capacity for discharge	Need to create a seamless approach to managing the demand through using our current IT systems in enabling us to better monitor the demand to ensure we have the capacity to deliver The development of the TOCH blueprint will require analysis of required capacity within our Transfer of Care Hub
Change 3: Multi-disciplinary working	Carried out a pilot introducing a blended role model of care working alongside the ward-based MDT. This includes Consultants, nurses, therapists, pharmacists, social workers and managers	We need to implement this approach within the hospital and community settings We need to provide the necessary training and competency to upskill our resources and build their confidence We also need to build in our communications strategy to fit in with our wider discharge pathways
Change 4: Home first	System fully signed up to Home First principles. We have introduced a panel who regularly discuss issues relating to complex case	We must intensify our communications of the principles with all various groups and stakeholders who provide care to the people of Croydon Through the Frontrunner programme we are building on our integrated reablement/

	We have created a communications strategy that supports the socialising of the home first principles widely in our system We are also identifying complex patient early in the process to enable effective discharge	intermediate care team to ensure we have the capacity to support more people via D2A The TOCH will have a 'triage' function that will identify the right pathway for patients and will utilise D2A settings (at home and bedded) to assess patients ongoing needs thoroughly in the community. The priority will be to send patients home rather than utilising bedded settings
Change 5: Flexible working patterns	From an Adult Social Care perspective, we have a hybrid working policy which encourages flexible working	We need to ensure we continue to work within the policy and ensure there is a work life balance for all staff
Change 6: Trusted assessment	Majority of our staff e.g., in the LIFE service are trusted assessors in the delivery of equipment, minor adaptations and creating reablement plans We are testing Trusted assessment in the new TOCH being developed – through blended assessors in the integrated discharge team and by reviewing our placement process for nursing/residential homes	Systemwide, we need to be embedding the trusted assessor model through efficient training and development We also need to set up a competency framework for effective delivery for all our residents in Croydon
Change 7: Engagement and choice	We have identified a cohort of people who we need to engage with to provide feedback / experience derived from using our pathways to help with the implementation process We are in the process of identifying stakeholders and community representatives to be part of our programme as a whole Healthwatch are currently conducting a survey to engage with our residents who have been discharged on a D2A pathway 1 to better understand their experiences to help reshape our services going forward	Continue with what we are doing and review the Healthwatch survey findings once completed to support shape the transformation process Device a systemwide Frontrunner communications and engagement strategy to support our mobilisation and implementation We need to continue to engage with all our stakeholders about the benefits of the overall programme – Primary care, carers, staff, residents etc.
Change 8: Improved discharge to care homes	We are currently investigating the gaps / barriers to more timely discharge to care homes from hospital and /or the community We are scoping the potential to have D2A bedded settings (building on the 'winter beds' pilot) that would enable patients to be assessed in the community	We need to be working closely with our commissioners and providers in Croydon to develop our Standard Operating Plans (SOPs) in relation to effective discharge of people into care homes or otherwise
Change 9: Housing and related services	We are seeing a delay in the transfer of care for people with a housing need and related issues	We need to have greater awareness of what is available from a housing perspective and what resources are available for individuals of all ages been discharged from hospital We need to create a SOP for what is available from Croydon council and the wider social housing perspective and how to access this –

		application process, how it is accessed, funding, commissioning arrangements, the pathway for people with Mental Health needs etc.

Please describe how you have used BCF funding, including the iBCF and ASC discharge Fund to ensure the duties under the care act are being delivered.

The Council and health partners fully engaged in deliverable outcomes in 22/23 for the ASCDF and put in various schemes to support flow. These included:

BCF Descriptor	**Work done by Croydon Council with the BCF**
Increasing workforce capacity within the community to allow discharge	BCF in Croydon is used to support posts in A&E, in hospital as well as to support community posts connected to hospital discharge (post discharge assessments). BCF is also used to support a specialist palliative post in Croydon University Hospital.
Increased capacity with home care providers to speed up discharge	Significant use of the BCF in reablement (in Croydon known as the "LIFE" service) to provide reablement packages of care to keep people home, help avoid readmission and help people step down from care altogether over a six-week period.
Increased capacity and costs for support services such as equipment, blitz cleans, keys safes etc.	We use funds from BCF to support our "Staying Put" which helps clients to return home and stay home by facilitating: • Key safes • Deep cleans • Plumbing and electrical work • Repairs (general) • Heating • Furniture moves • Home moves BCF is also used to support specialist telecare which can be for standard items such as falls sensors, but also for more specialist provisions.
Pathway 3 temporary step down beds for residents with complex social care needs	We will be funding beds to support pathway 3 discharge routes and allow clients to recover in a step-down environment.

Mental health step down beds/accommodation	BCF is used to provide POCs and Supported living arrangements which both help to step clients down from acute settings to more independent living.
Discharge hub within the hospital to move residents earlier out of acute beds	This will increasingly become a feature in 23/24. However, we have 1 post dedicated to A&E assessment to help prevent admission and to support people home with a level of support
Supporting SWLICB schemes on step down beds	LBC stepped up several interim winter beds in order to help facilitate faster discharge in winter.

The funding has been announced for 23/24 which must cover the whole of the financial year rather than four months compared to 22/23. The above schemes are in the process of being fully evaluated but from the initial evaluation the following schemes have been identified that have started in the beginning of 23/24 and will be expanded/changed to meet relevant winter pressures:

- Increasing workforce capacity within the community to allow discharge
- Increased capacity with home care providers to speed up discharge
- Pathway 3 temporary step down beds for residents with complex social care needs
- Mental health step down beds/accommodation
- Discharge hub within the hospital to move residents earlier out of acute beds

These schemes will support and complement the work on the transformational hospital discharge ‘Frontrunner Programme’. As detailed within this document the fund where required will support the transformational work in line with the high impact change model.

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".

Young carers	537	<15		
	1783	16-24		
			2320	Young Carers
Adult carers	3475	25-34		
	7656	35-49		
	10344	50-64		
	5035	>65		
			26510	Adult Carers >25
	28830	Total all carers		

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 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

We do also have a young person's carers service, but not funded through BCF.

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.

Given the reliance on unpaid carers to enable people at end of life to die at home, and support maintenance of dignity and quality of life, Croydon has had an EOL Carer Respite service (funded through the BCF) in place for some time. This service aims to provide personal care and support to the individual at end of life, which would normally be provided by an unpaid carer. This enables the carer to take a break from their caring duties for up to 8 hours per week.

We are currently reprocuring a revised service to commence on 1st October 2023. The revised service specification has been developed based on feedback received, and now includes requirement for an assessment of the need of the carer and signposting to relevant local services. This approach aims to ensure awareness of the range of groups / services available which can provide support to manage the caring duties, provide respite and support to the needs of the carer themselves, but also provide carer / family support after death of a loved one and during bereavement. The adds a personalised approach for the carer based on their needs, as well as those for the person at end of life.

DISABLED FACILITIES GRANT (DFG) AND WIDER SERVICES

What is your strategic approach to using housing support, including DFG funding, that supports independence at home.

The Ministry for Housing, Communities and Local Government allocation for Croydon for 2023-24 is £2,992,679.00. The amount for 2024-25 has not been published yet.

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 £13,208.84 per adaptation, the original budget could potentially fund 226 adaptations.

Key outcomes are:

- Provide access to suitable adaptations to help people to live as independently as possible in their own homes for longer.
- Allow 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 income to remain and live independently in their own homes. Our aim is also 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.

This is in line with the BCF ambitions and is strongly aligned with the strategic work One Croydon is delivering under both the Integrated Community Network Plus programme and more recently that of the Frontrunner programme. It is envisaged that housing for example will be fully embedded with the Transfer of Care Hub we are designing.

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. The split between adults/children is as follows:

- in 2021/2022, 15 cases of disabled occupant 17 years old or less; 67 cases of disabled occupant 18 – 65; 64 cases of disabled occupant 66+
- In 2022/2023, 10 cases of disabled occupant 17 years old or less; 65 cases of disabled occupant 18 – 65; 53 cases of disabled occupant 66+.

We do not currently hold data on the split between physical, mental and cognitive but we are looking at ways this could be recorded in the future.

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 Housing Associations 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 to 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 whilst aiming to avoid hospital readmission.

ADDITIONAL INFORMATION NON-ASSURED

Have you made use of the Regulatory Reform (Housing Assistance) Order 2002 (RRO) to use a portion of DFG funding for discretionary services? (Y/N)

YES

If so, what is the amount that is allocated for these discretionary uses and how many districts use this funding?

There is no set amount allocated for discretionary use, as the mandatory DFG limit is £30k a large proportion of the adaptations carried out exceed this amount and require us to use discretion to 'top up' these grants. This is in part due to the general increase in the cost of materials and equipment and labour costs.

Following approval of the Discretionary measures approved in the PSHA Policy in 2021, we are currently awaiting Cabinet approval to amend the Discretionary Disabled Loan Conditions.

This will assist disabled households where there is a working adult, who under the current means test for Mandatory DFG would not be eligible for any assistance with adaptations.

We undertake a preliminary financial assessment at an early stage, to determine grant eligibility, to avoid people being on a waiting list unnecessarily, who would not get any grant assistance with adaptations. Our records show that there is an increasing number of people who fall into this category, who we could potentially assist.to enable independence at home. OBJ

EQUALITY AND HEALTH INEQUALITIES

How will the plan contribute to reducing health inequalities and disparities for the local population, taking account of people with protected characteristics? This should include:

- **Changes from previous BCF plan**
- **How equality impacts of the local BCF plans have been considered**
- **How these inequalities are being addressed through the BCF plan and BCF funded services**
- **Changes to local priorities related to health inequality and equality and how activities in the document will address these**
- **Any actions moving forward that can contribute to reducing these differences in Outcomes**
- **How priorities and operational guidelines regarding health inequalities as well as local authorities' priorities under the Equality Act and NHS actions in line with the Core 20Plus5.**

Changes from previous BCF plan

One Croydon and the residents we serve experience unique challenges. As a community, we also share many strengths that contribute to our success. Croydon has the largest population of all London boroughs, with approximately 390,800 residents (ONS Census

2021). We are incredibly diverse—both geographically and in terms of socioeconomic make up.

- 50% of the South West London's Core20 population live in Croydon. Croydon, patients categorised as Core20+5 actually represent 40% of our population.
- Of the more than 33,000 carers in Croydon, 65% provide up to 19 hours of unpaid care a week; 20% provide 50 hours or more. This is being address through the development of a carer's strategy and commitment to support unpaid carers.
- There are over 2,000 homeless households in Croydon per quarter—a number that has remained consistent for many years. Individuals who identify as Black are represented at a much higher proportion within this demographic than those from other communities. This is being address through the implementation of a homeless discharge pathway.
- Excess weight in primary school pupils remains a national concern; 38% of Croydon pupils in Year 6 have excess weight (rolling three-year average to 2019/2020). This is being address through the implementation of weight management programmes.
- A significant number of people with Diabetes and CVD, a large proportion of people with hypertension who are undiagnosed, and inequality of access to respiratory diagnostics for Asthma and COPD. These are being addressed through funding services to support diagnosis and management of these LTC.

Croydon continues to face similar challenges as in previous years around health inequalities. The difference is how these challenges are addressed, through embedding on tackling health inequalities in every programme. The Core20+5 approach has enabled detailed analytical research across South West London Integrated Care System to examine our patient demographic. Primary Care Networks are also addressing many issues around health inequalities using population health management and as part of the delivery of the PCN DES.

These priorities regarding health inequalities are in line with the Core 20+5, as outlined in the sections below.

How equality impacts of the local BCF plans have been considered

For new services, Equality Impact Assessments will be carried out to assess impacts on protected groups.

A Health Inequalities Outcomes Framework (HIOF) is currently being developed in partnership with Croydon Public Health Team to enable the monitoring of health inequalities at a local level. The HIOF will use the following key outcomes:

- Gaps in life expectancy
- Gaps in healthy life expectancy
- Gaps in the top two conditions contributing to early death in Croydon (cancer and cardiovascular disease)
- Gaps in the top two conditions responsible for ill health in Croydon (mental illness and musculoskeletal disease)

Indicators related to these four key outcomes will be selected from the evidence base around the key factors across the life course that contribute to health inequalities observed in these outcomes. Where data permit, the Framework will aim to monitor gaps by different equalities groups including age, sex, ethnicity as well as locality and area-level deprivation.

The HIOF will aim to support:

- Identification of key risk factors that contribute to health inequalities in different stages of life including childhood and adulthood.
- Early and appropriate action across the life course to protect and promote health.

It is envisaged that the HIOF will:

- Inform long-term strategic planning and decision making for One Croydon's most senior decision makers
- Support local delivery plans so that they can better target health inequalities within certain groups or geographies

Changes to local priorities related to health inequality and equality and how activities in the document will address these

Health Inequality Funding

In September 2022, SWL informed place partnerships that funding could be made available towards each place Health Inequalities strategy to address the CORE20+5 focus areas as part of the wider SWL Health Inequalities framework. The following projects were selected and are being implemented:

- Healthier Lifestyles Health Hubs
- Children and Young People Tier 3 Weight Management
- Adult Tier 3 Weight Management
- Expert Patients Programme Expansion
- EMHIP – Mobile Mental Health and Wellbeing Hub
- Health Innovation Projects to support in tackling inequalities

How these inequalities are being addressed through the BCF plan and BCF funded services

Croydon have enhanced community services in place across Long Term Conditions to tackle and address Health Inequalities. Below are a few examples of programmes that will be funded through the Better Care Fund either in full or in part. Areas include Diabetes, Homelessness and other key CORE20+5 groups. It is worth noting that given the significant level of health inequalities experienced in Croydon as highlighted in the Core20+5 analysis most programmes have been refocused to support addressing inequalities, monitoring impact on the Core20+5 populations, as well as meeting statutory requirements from the Equality Act.

1) Homeless and Rough sleepers' pathway to tackle Health Inequalities (BCF funded)

Croydon, is seeing an increase in the number of rough-sleepers at 3x the rate compared to the rest of London. Homeless communities have complex needs which results in a bleak health inequity as is reflected in the average age of death amongst people who are homeless - 43y (female) and 47y (male), versus 83y (female) and 79y (male) for the general population. Using Adult Social Care Discharge funding we are looking to implement a specialized hospital in reach service (called Pathway) for homeless community to improve outcomes for this vulnerable community. The aims of the local Homeless Pathway service include:

- Improved identification of homeless patients within the hospital
- Holistic health, care and discharge planning for homeless patients
- Safe and effective discharge from hospital for service users
- Improved collaborative working by hosting multidisciplinary team meetings (MDT).

2) Integrated Diabetes Service (BCF Funded)

26,000 adults registered with a Croydon GP now have diagnosed diabetes. The CORE20 population has higher rates of diabetes than the general population: The average CORE20 member in South West London is:

- 34/% more likely to be diagnosed with diabetes
- Are diagnosed on average 4 years younger (at the average age of 61)
- 10% less likely to be achieving their diabetes treatment targets (which lowers the risks of complications)

The principal aim of the Croydon diabetes model of care is to ensure that services become integrated across the system. The focus of the Integrated Diabetes Service is on the prevention or delay in the development of complications by Improving the management of diabetes within primary care and reducing variation through joint working and upskilling.

Any actions moving forward that can contribute to reducing these differences in Outcomes

1) Healthier Communities Together Programme

Now in its second year of delivery, the Healthy Communities Together programme is going from strength to strength as it harnesses the skills of local people to create preventative health and social care services for residents. Building on the work established by Croydon's voluntary and community groups and by harnessing their skills and local expertise, communities have been empowered to take an active role in their neighbourhood to develop solutions to meet some of the wellbeing needs in their area.

Understanding the importance of a need to transition towards a proactive and preventative care model and build on the strengths of local people, a Local Community Partnership (LCP) has been created in each locality to bring greater local ownership, a collective voice and leadership that is representative of the local area.

Seeing residents as assets with rich, local knowledge and inspirational creativity, residents attend locality-based meetings along with community groups, local charities and health and social care teams to co-develop practical action plans to address each locality's health inequalities through locally co-ordinated activities and services.

These open forums provide the opportunity for residents, community groups, local charities and health and social care teams to co-produce community action plans and work collaborative to put these into action.

Croydon have applied loads of resource and assets to support Health and Social Care partnerships in joining up some of the services where applicable, and utilising contacts and memberships across those services to ensure there is limited duplication.

2) Population Health Management – Optum Scheme

Croydon commissioned a population health management strategy to identify people with hypertension in the lowest areas of deprivation across the localities. The delivery plan is currently being implemented using insights and development of traditional and non-traditional methods to integrate the service with Primary Care Networks and VCSE organisations in Croydon.