LONDON BOROUGH OF CROYDON

REPORT:	**Health and Wellbeing Board**	
DATE OF DECISION	**Wednesday 24 January 2024**	
REPORT TITLE:	**Frontrunner programme update**	
CORPORATE DIRECTOR / DIRECTOR:	**Matthew Kershaw, Chief Executive, Croydon Health Services and Executive Place Based Leader for Health (SWL ICB, Croydon Place) Annette McPartland, Corporate Director, Adult, Social Care and Health, London Borough of Croydon**	
LEAD OFFICER:	**Hilary Williams, Interim Joint Director of Transformation and Commissioning, South West London Integrated Care Board (Croydon) and Croydon Health Services NHS Trust. Laura Jenner, Deputy Director, One Croydon Alliance Programme Management Office. Bianca Byrne, Director of Commissioning, Policy & Improvement, Adult Social Care & Health, London Borough of Croydon**	
LEAD MEMBER:	**Councillor Yvette Hopley**	
DECISION TAKER:	**Health and Wellbeing Board**	
AUTHORITY TO TAKE DECISION:	**Constitution of the London Borough of Croydon - Part 4.L It is a function of the Health and Wellbeing board to encourage, for the purpose of advancing the health and wellbeing of people in Croydon, persons who arrange for the provision of any health or social care services in Croydon.**	
KEY DECISION? [Insert Ref. Number if a Key Decision] ***Guidance**: A Key Decision reference number will be allocated upon submission of a forward plan entry to Democratic Services.*	**No**	**N/A**

CONTAINS EXEMPT INFORMATION? ***(* See guidance)***	**NO**	**Public**
WARDS AFFECTED:	**All**	

1 SUMMARY OF REPORT

1.1 The current and traditional methods of delivering healthcare in Croydon require significant transformation to better enhance the health and wellbeing of our community, moving from crisis orientated delivery to one where the focus is on proactive and preventative models.

1.2 In 2017, the One Croydon Alliance, a partnership involving the NHS in Croydon, Croydon Council, and the local Voluntary and Community Sector (VCS) was formed .to address the challenges posed by an ageing population and to integrate health and social care services for all age groups in the borough.

1.3 The One Croydon Alliance has successfully implemented innovative models of care, including the Living Independently for Everyone (LIFE) service and has also allowed Alliance partners to collaborate on core business functions.

1.4 The recognition of our achievements led us to become a Frontrunner site, one of six sites selected nationally to pioneer radical approaches to hospital discharge and intermediate care provision.

1.5 This report provides an update on the timeline, progress, risk and issues with the Frontrunner programme.

2 RECOMMENDATIONS

The Health and Wellbeing Board is recommended:

2.1 To note the progress made on the Frontrunner Programme to date

2.2 To note the risk and issues with the Frontrunner programme

3 REASONS FOR RECOMMENDATIONS

3.1 This Frontrunner programme is aligned to the strategic decision objectives of this Board, in that having robust integrated Discharge and Recovery services it will support the reduction in health inequalities among certain cohort of our citizens in Croydon

3.2 High Quality Care is optimised through the development of efficient partnerships to support the development of an integrated Discharge and Recovery service where staff to have clear reporting lines, responsibilities, and objectives.

3.3 A key aim of this programme is to maximise the impact of the 'Croydon pound' by treating people in the right setting, reducing the overprovision of care and having clarity on funding arrangements and budgets.

3.4 The structural changes to the Discharge Team, will enable staff to have clear reporting lines, responsibilities, and objectives.

3.5 Through this integrated model of care and service delivery Health and Care Leaders from across the system work will continue to work collaboratively together progress the Frontrunner programme implementation and make decisions collectively.

4 BACKGROUND AND DETAILS

4.1 The current and traditional methods of delivering healthcare in Croydon requires significant transformation to better enhance the health and wellbeing of our community.

4.2 The commitment is to transform the health and care landscape across Croydon from services which are crisis orientated to those with the emphasis is on collaborative, integrated, and proactive care that maintains wellness and independence within the community and prioritises proactive and preventative care.

4.3 In 2017, the One Croydon Alliance, a partnership involving the NHS in Croydon, Croydon Council, and the local Voluntary and Community Sector (VCS) was formed to address the challenges posed by an ageing population and to integrate health and social care services for all age groups in the borough.

4.4 The One Croydon Alliance has successfully implemented innovative models of care, including the Living Independently for Everyone (LIFE) service and has also allowed Alliance partners to collaborate on core business functions.

4.5 The LIFE service comprises an integrated, community-based team consisting of professionals from reablement, rehabilitation, intermediate care, health and social care, clinicians, and colleagues from relevant community organisations.

4.6 In recognition of these achievements, Croydon was selected to be a national Frontrunner site, one of six sites selected to pioneer radical approaches to hospital discharge and intermediate care provision.

4.7 As a Frontrunner site, the aim is to build on the "One team, One name, One resource" approach of the LIFE service

4.8 Reducing hospital occupancy and unnecessary patient length of stay in hospital by: Creating an effective and truly integrated discharge team Improving joint ways of working on the wards.

4.9 Reducing overprovision of ongoing care (placements/POCs) by delivering integrated intermediate care:

4.10 Introducing a 7 day home first service to holistically assess patients' needs following hospital discharge

4.11 Integrating existing reablement and therapy teams

4.12 Improving relationships with domiciliary care agencies to commission outcomes-based care

4.13 Providing effective bedded intermediate care

4.14 This will be achieved by:

4.14.1 Establishing fully integrated teams and roles spanning acute and community care, through the introduction of a Transfer of Care Hub with integrated health and social leadership and pioneering blended roles between social workers and health discharge coordinators, creating integrated, locality based reablement and therapy teams to improve people's independence

4.14.2 Improving discharge pathways to provide high quality and timely support for patients following an acute episode by establishing an integrated MDT-led Home-First team to provide holistic assessments to patients following discharge

4.14.3 Commissioning the optimum number of intermediate care beds to meet the needs of the population and drive excellent outcomes

4.14.4 Integrating IT systems across acute, community and social care through the introduction of Patienteer software

4.14.5 Ensuring alignment and coordination across the system by creating clear oversight, clinical responsibility, ownership and agreed funding approaches.

4.15 The slide pack accompanying this report provides comprehensive detail on the timeline, progress, risk and issues with the Frontrunner programme.

7. CONTRIBUTION TO COUNCIL PRIORITIES

7.1 Outcome 5: Living healthier independent lives,

7.2 We will harness all the skills and experience available to improve health and wellbeing in the borough, enable people to live independently for as long as possible, and keep adults who are at risk of abuse and neglect safe. We will also work to reduce health inequalities and foster a sense of community and civic life.

7.3 Outcome 1: Getting our finances right,

7.4 We will instil financial discipline, make services more efficient and seek to get value for money from every penny of taxpayers' money we spend. We will listen to, respect and work with partner organisations, Croydon's diverse communities, the voluntary sector, and develop our workforce.

8. IMPLICATIONS

8.1 FINANCIAL IMPLICATIONS

8.1.1 Financial implications are currently being developed via the Frontrunner business case with the potential of a £3.2 million saving each year being suggested. Fewer patients requiring ongoing packages of care due to improved intermediate care offer (reablement and therapy)

8.2 LEGAL IMPLICATIONS

8.2.1 To follow

8.3 EQUALITIES IMPLICATIONS

8.3.1 Reducing health inequalities is a key aim of the SWL Integrated Care Partnership Strategy and plans to deliver on this aim will be described in the NHS Joint Forward Plan. A full EQIA has been completed the headlines:

- The program recognises and values same-sex relationships, ensuring that individuals within the LGBTQ+ community receive equal and respectful treatment. Staff training progrmme with a focus on reablement planning and LGBTQ
- Several people accessing the service have Dementia. Therefore, specialist dementia friendly communication resources are being put in place to improve accessibility.
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9. APPENDICES

9.1 *A* ***Frontrunner: Delivering integrated care in Croydon (One Croydon Alliance)***