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The Croydon Health and Care Plan 2022-2024:

Achievements and population outcomes

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What has been achieved through the Croydon Health and Care Plan 2022-2024 – Family Hubs

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The Croydon Health and Care plan was originally devised in 2019 to help people in our community improve their health and wellbeing. The plan was updated and ran from 2022-2024. Partners in Croydon have focused on taking a proactive and preventative approach to care, moving care closer to home and harnessing the power of the community.

As a result, there is closer joined up working between different services across the borough to make sure people get the right support when they need it. The plan for 2024-2029 will build on these achievements to go further towards prevention and support in the community.

Croydon's first Family Hub has opened in the south of the borough, offering access to 24 services.

CROYDON FAMILY HUB

Over 100 practitioners have had **Start for Life** training, to help give Croydon's children the best possible start.

Breastfeeding rates have increased across the borough; in December 2023 we reached 80.4% against a national average of 51%.

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What has been achieved through the Croydon Health and Care Plan 2022-2024 – Proactive and Preventative Care

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Six **Health Smart Hubs** have been set up across the borough.

- 5269 attendances at Health Hubs
- 284 exercise sessions
- conducted 1227 health checks

"I enjoy coming to the Health Hubs. It helps me keep fit and gives me lots of support to stay healthy at home."

People working in the community have built relationships to support health and wellbeing, particularly in communities who experience the greatest health inequalities. For example, through the **Long Term Conditions** programme during 2023/24, 450 people were given **health awareness** support and 850 given **health screening**, provided by the Voluntary and Community Sector, targeting health inequalities.

The **Expert Patient Programme** has provided support for up to 200 people a year with Long Term Conditions in local communities experiencing health inequalities. Residents showed significant improvement in confidence and coping strategies. For example, before taking the course, 63% of participants felt they were responsible for their own health. This rose to 90% afterwards.

"I have completed the 6-week expert patient programme and have found it to be very beneficial. The tutors have been kind, professional and at all times sympathetic. They were able to manage a large group of personalities with ease. In addition, the weekly email reminders were very helpful. I would recommend this course to others in my situation without hesitation."

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What has been achieved through the Croydon Health and Care Plan 2022-2024 – Healthy Communities Together

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- We have completed the Healthy Communities Together programme supported by the National Lottery and the Kings Fund to develop **partnerships with the voluntary and community sector**
- **Local community partnerships** have been established in the six localities, bringing together grassroots voluntary and community sector, enabling engagement to develop local plans to improve support to local communities.
- **Locality commissioning model** for the voluntary sector to respond to needs identified by the community at neighbourhood level
- **Community hubs** have been set up to support people with social issues that affect wellbeing and enable them to make connections in their communities

Over 3823 residents have accessed the four community hubs (period April 23 – Sept 24)

Of residents surveyed from April 24:

- ❑ 133 have connected with a new community led group or activity
- ❑ 44 residents have connected with a new person
- ❑ 433 have met with service providers present at the hubs
- ❑ 59 signposted to other providers
- ❑ Over 700 residents reported that would not have known where to go without the hub.

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What has been achieved through the Croydon Health and Care Plan 2022-2024 – Mental Health Transformation

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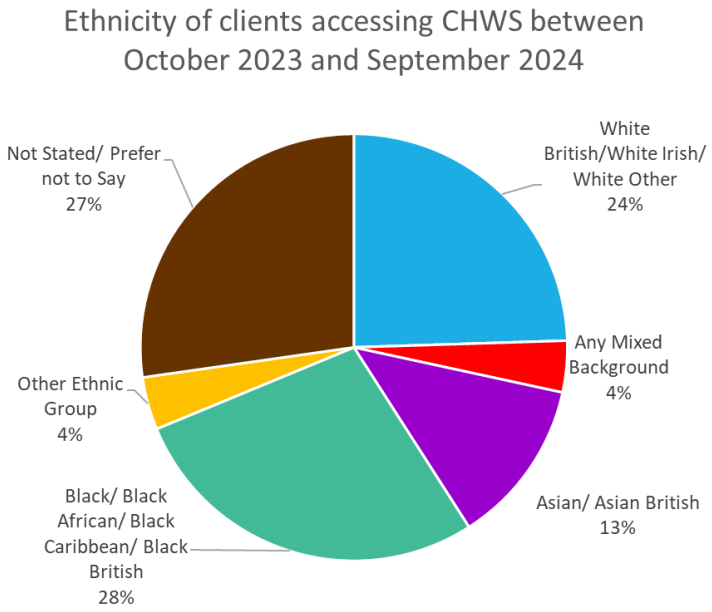
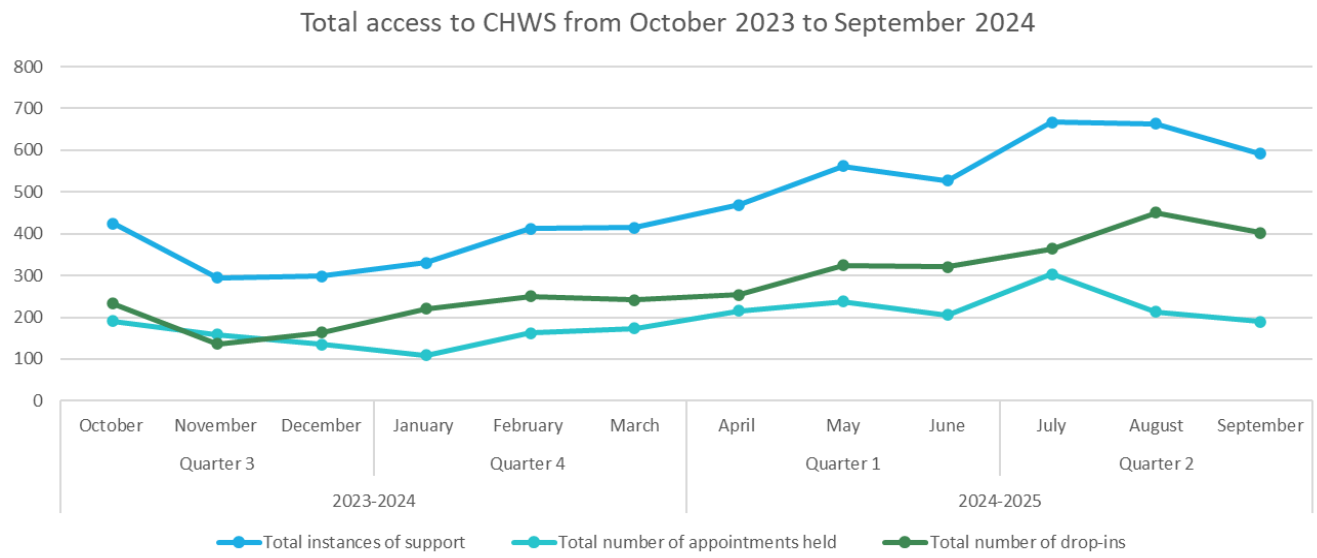
HEALTH AND WELLBEING SPACE

The partnership between Croydon BME Forum, Mind in Croydon and South London and the Maudsley have set up the **Croydon Health and Wellbeing Space (CHWS)** in the Whitgift shopping centre. The number of people coming to the CHWS to receive support has increased significantly, from around 300 a month in November 2023 to 600 a month in September 2024.





Through this partnership, new roles of Mental Health Personal Independence Coordinators have been working in the community to support people in a holistic way. There are also now Primary Care Network mental health support workers, linking into South London and the Maudsley.

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What has been achieved through the Croydon Health and Care Plan 2022-2024 – Supporting integration

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Health and care partners have continued to work together as **One Croydon** Alliance, with joined up governance to support integration. A two-year **Better Care Fund** plan was agreed between Integrated Care Board (ICB) and Croydon Council, reflecting joint priorities to support proactive care and hospital discharge.

Croydon has been an NHS England Frontrunner for **discharge and reablement** with the programme now in implementation phase to reduce length of stay and improve reablement, to support residents to regain as much independence as possible following a stay in hospital.

We have established a new Integrated Discharge Team (IDT) as part of the Transfer of Care Hub (TOCH) within the hospital, featuring blended roles and a dedicated housing officer to support effective discharges

The percentage of people still at home after 91 days after returning home following support from the reablement service (so they have not been readmitted or gone into a care home) has increased from 81% in June 2023 to 88% in June 2024. This is above the London average of 86%.

The Home First Living Independently for Everyone team now conducts daily multidisciplinary team (MDT) meetings with reablement care providers in Croydon. This ensures that residents discharged home are well-supported, preventing further hospital admissions and helping them regain independence.

4,653
Discharges from hospital supported[3]

3 with support from Adult Social Care

Adult Social Services have worked with partners, residents and the VCS to develop a new multi-agency Dementia Strategy and Carers Strategy achieved Dementia Friendly Borough status as part of the Croydon Dementia Action Alliance

Adult Social Care developed new supported living schemes for people with learning disabilities, increasing high quality provision which enables people to continue living within their own communities.

464
Carers supported by Adult Social Care and Health services

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What has been achieved through the Croydon Health and Care Plan 2022-2024 – Integrated Neighbourhood Teams

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- Building on our ICN+ Programme, we have continued to develop **Integrated Neighbourhood Teams** (INTs) in Croydon to support people in a joined up way in the community.
- We have **key roles** in place to support this way of working, including INT Managers for the North, Central and South networks, Network Facilitators to coordinate multi-disciplinary team working and Frailty Co-ordinators to support people at locality level.
- We have developed our Locally Commissioned Scheme for **Proactive Care** in Croydon, aligning it with national guidance as a key enabler for integrated working.

Integrated Neighbourhood Teams (INTs) (period Oct 22 – Sept 24)

Multi-disciplinary team huddles have worked together to proactively plan care for 3446 people, enabling 1,885 individuals to remain in their homes, avoiding unnecessary hospital admissions.

Croydon age UK

Age UK Croydon Personal Independence Co-ordinators (Period Oct 22 – Sept 24 (excludes ICN+ & Community Referrals)
450 referrals to support residents in their independence

mind in Croydon

Mental Health Personal Independence Co-ordinators (period March 22 – Sept 24)
385 Referrals to the service to support residents holistically with mental health and wellbeing.

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What has been achieved through the Croydon Health and Care Plan 2022-2024 – Primary Care

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Key elements of the South West London Primary Care Strategy have been progressed, with a focus on prevention, modern general practice and access improvement. All Primary Care Networks submitted and implemented improvement plans for primary care access.

2.23m GP appointments were provided in 2023/24 and from Oct – Mar these increased by 58k compared to the previous year.

In the latest GP Patient survey for Croydon, 60% stated that it was easy to get through to their GP practice by phone compared with 53% in South West London and 50% in England.

75% rated their GP as very good in the friends and family test

98% of Croydon's GP practices are rated as good by the Care Quality Commission

In Dec 2019, there were 225 GPs across 51 practices. In April 2024, there were 229 GPs across 45 practices. There are now 235 additional roles in GP practices. This number is due to increase to 244 by March 2025.

Support programmes with Primary Care Networks around diabetes recovery have delivered positive outcomes for patients above the national target.

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What has been achieved through the Croydon Health and Care Plan 2022-2024 – Croydon GP Collaborative

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Croydon GP Collaborative

Recruitment, Retention and Engagement (RRE) programme which aims to build up and support our Croydon workforce

Trainee Nursing Associate (TNA), subsequently re-titled Student Nursing Associate (SNA), aim to increase numbers of new SNAs into Croydon general practice through promoting the role to new and existing staff. So far there are 9 Student Nurse in post and one that has graduated as a Nurse Associate.

Ongoing support, training and mentorship for our GP colleagues

Investment and Impact (IIF) Dashboard to PCNs which highlights each practice's performance within the PCN and shows the performance of Practices against the Croydon average performance of Service Requirements as highlighted under the Network Contract DES.

Croydon had the lowest uptake of Annual Health Checks in SWL. Through the use of PCaS mobilised a service to see patients who had previously been hard to engage with. In July of this year CGPC were nominated as finalists in the HSJ patient safety award category for this service.

Publication and distribution of the GP Dashboard monitoring performance against local and national KPIs

CGPC ran a specialist smear service for patients for those who have additional needs such as learning disabilities or those who are particularly nervous and anxious.

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The opening of our first 'one stop shop' for NHS testing at Purley Community Diagnostic Centre, fast-tracking access to vital tests, such as x-rays, CT scans and cardiology screening to help detect serious illness sooner and to help patients manage their existing conditions more effectively – with another planned for New Addington in 2025

Over £1.5 million invested in improvements to sickle cell care, funding equipment that will allow over 300 patients to access a new a red cell apheresis service on site at Croydon University Hospital to and reduce waiting times and intervals between sessions and increasing the support we can offer locally to our diverse population.

Caring for thousands of Croydon's patients

Between 450-650 referrals into the service every month

Approx 250 patients monitored remotely since 2022

Over 23,000 hospital bed days saved in 2024 alone

The **Virtual Wards** Team has brought together community rapid response nurses, doctors and telehealth technicians, as well as support from therapy services such as Croydon's LIFE team within the community as well as a nursing-led hospital in-reach team to avoid unnecessary hospital admissions and support earlier discharge from hospital

30,758 referrals for our District Nursing service

46,000+ referrals to Croydon Health Services community services between Jan 2023 and Jan 2024

1985 referrals to the locality Pharmacy Service

Additional **dermatology** (skin) and **anticoagulation** services (reducing the risk of blood clots), in partnership with Croydon GP Collaborative.

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Measuring outcomes for the Croydon population

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Reporting on outcomes

The previous Health and Care Plan Outcomes Framework was set in 2019 and updated in 2021 to incorporate new measures, as well as removing those for which national data was no longer collected. The framework consists of 57 indicators.

It is worth noting that the framework spans the time of the covid pandemic and as a result some indicators are impacted by this, either due to direct effects of the pandemic, the disruption to programmes of activity or effects on reporting, as many data submissions were postponed during covid.

For some metrics, we are only able to report on data from halfway through the plan as more recent data has not yet been published.

With those caveats, of the 57 outcomes in the framework; 26 (46%) moved in the ‘right’ direction from baseline, 23 (40%) moved in the ‘wrong’ direction and the remaining 8 (14%) didn’t have a preferred direction of travel.

The next few pages summarise a selection of these indicators which reflect overarching population health, linked to the programmes of the Croydon Health & Care Plan, reflecting cross-partnership system working.

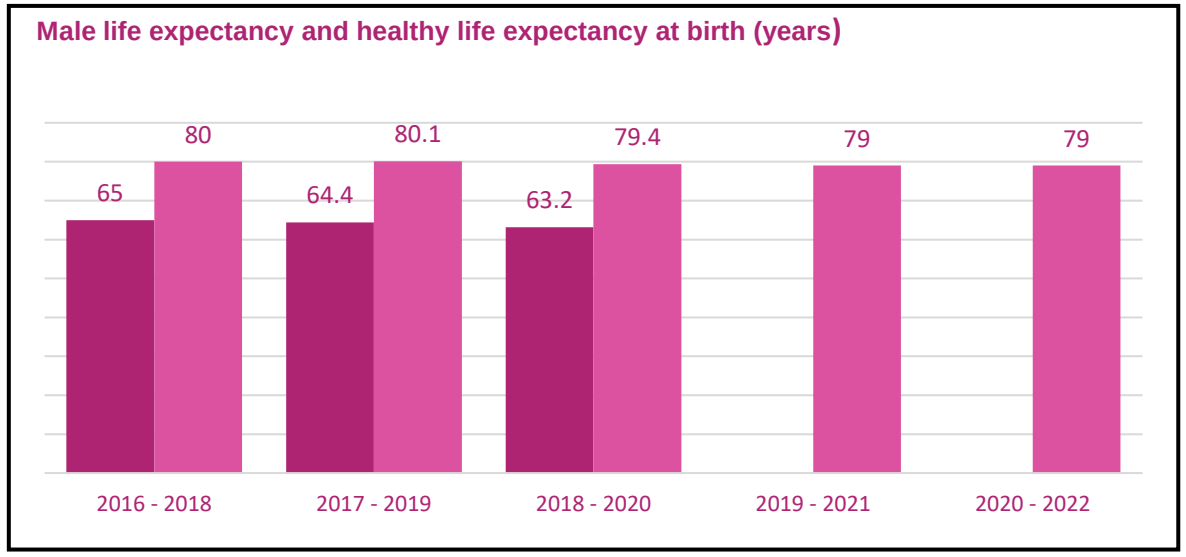
Outcomes Framework 2021-2023 – Life Expectancy

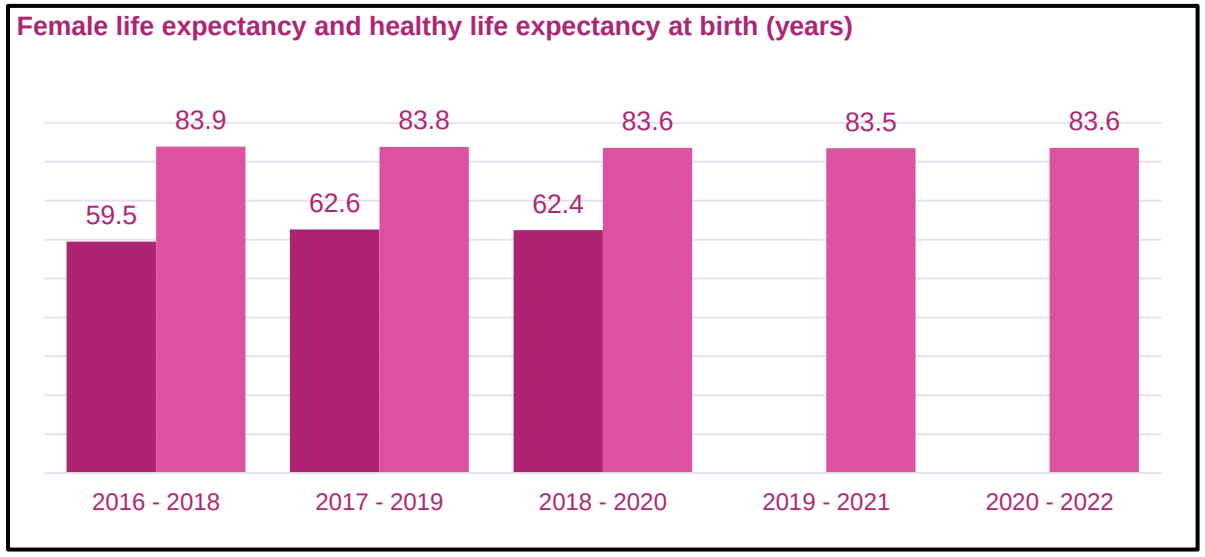
Life expectancy and healthy life expectancy is the overarching measure of population health; this has been affected by the covid pandemic and impacted by reporting delays.

The gender gap in Croydon in life expectancy at birth increased from 3.9 years in 2016-18 to 4.6 years in 2020-22.

Male life expectancy at birth in Croydon slightly decreased from 80 years to 79 years, similar to the London average of 79.1 years. The number of years lived in poor health increased from 15 years in 2016-18 to 16.2 years in 2018-20 and inequality based on deprivation increased from 8.2 years to 9.2 years in the same time-period – 9.2 years is the fifth largest inequality gap in London.

Female life expectancy at birth in Croydon stayed relatively steady from 83.9 years to 83.6 years, the same as the London average. The number of years lived in poor health decreased from 24.4 years in 2016-18 to 21.2 years in 2018-20 and inequality based on deprivation increased from 6.3 years to 6.5 years in the same time-period – 6.5 years is the seventh largest inequality gap in London.





■ Healthy life expectancy at birth
■ Life expectancy at birth

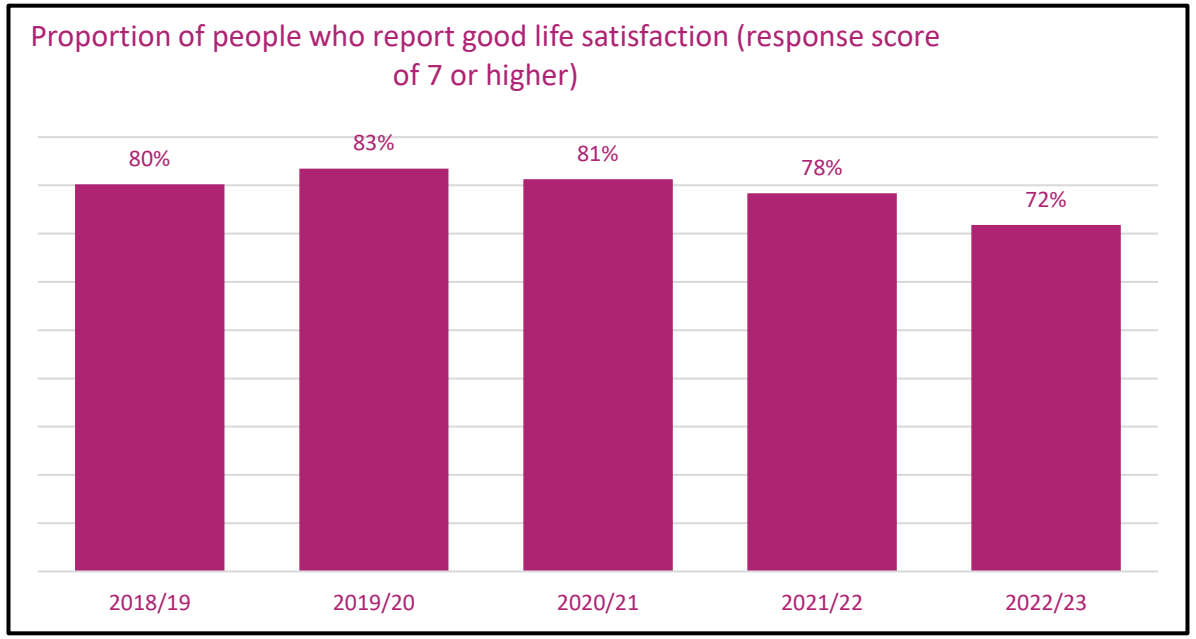
Outcomes Framework 2021-2023 – Population Wellbeing

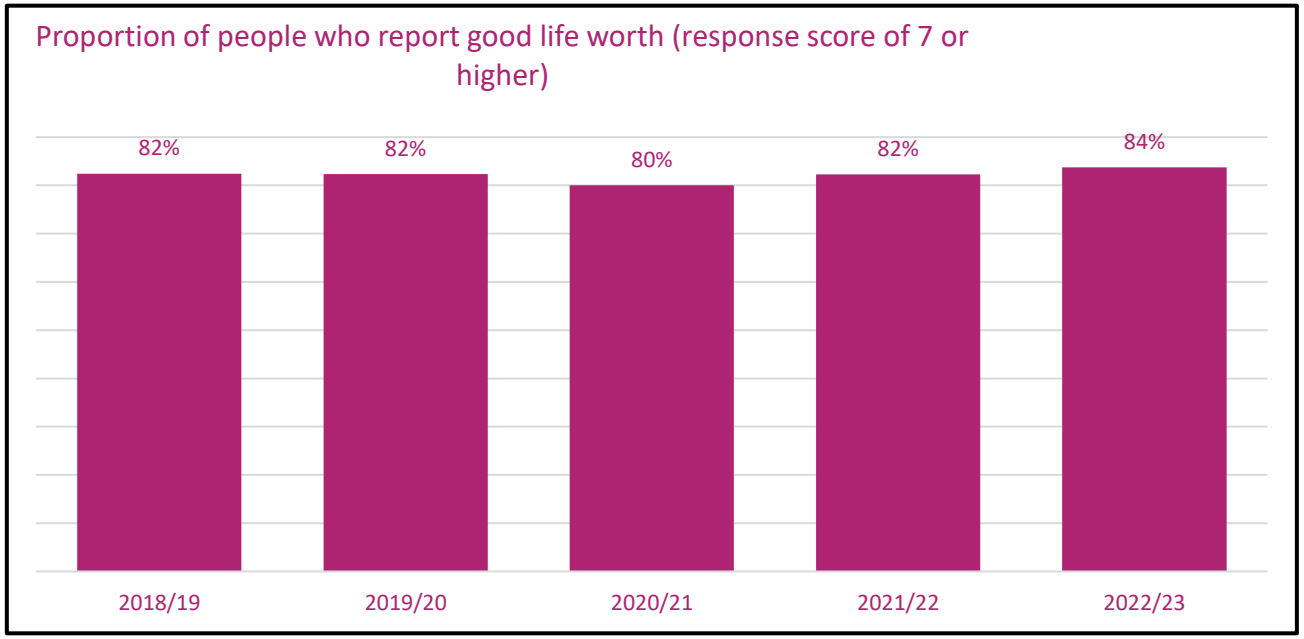
The national Annual Population Survey asks “Overall, how satisfied are you with your life nowadays” and “Overall, to what extent do you feel the things you do in your life are worthwhile?” – for both questions respondents are asked to give a score out of ten.

In Croydon, good life satisfaction has decreased over the past three years. In 2022/23 the average score was 6.97, lower than the London average of 7.35

Life worth in contrast has shown an increase in the last two years. In 2022/23 the average score was 7.64, similar to the London average of 7.60.

Its worth noting that sample sizes are small (240 in Croydon in 2022/23).

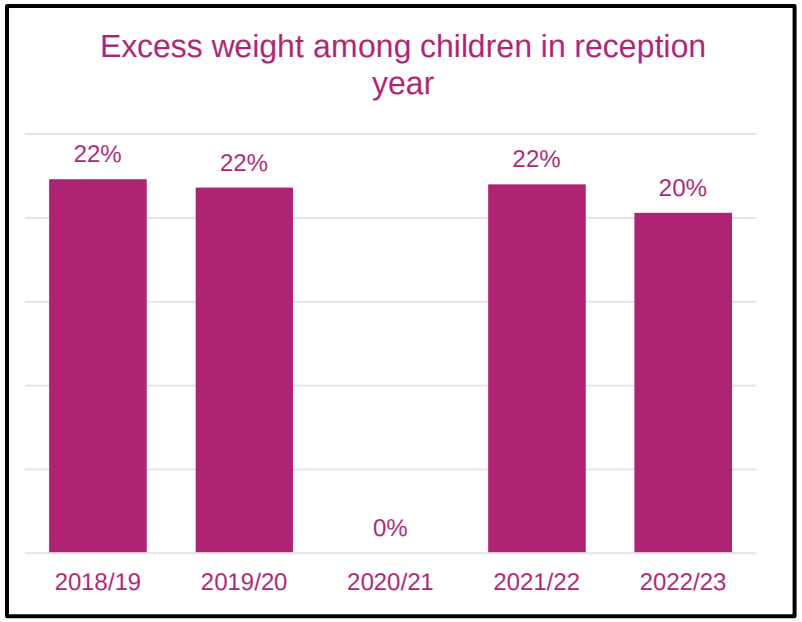


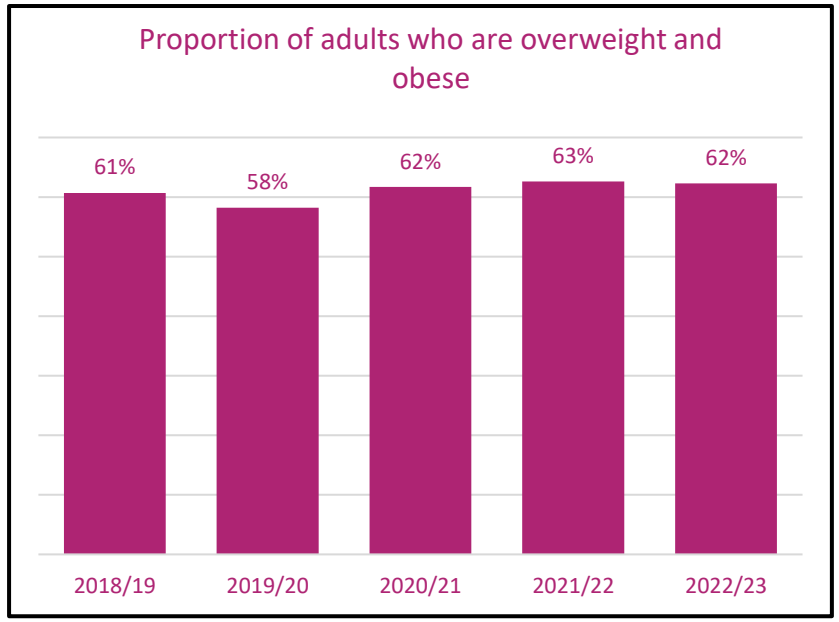


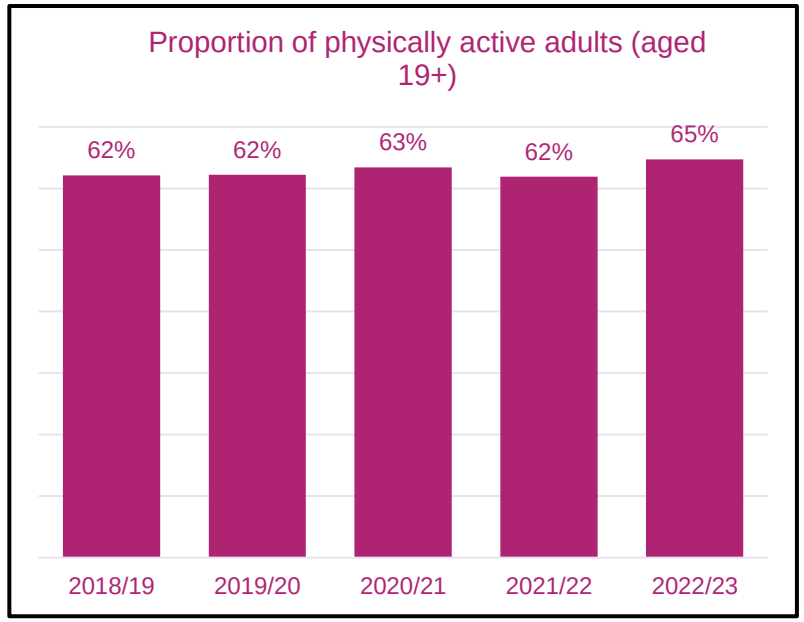
Outcomes Framework 2021-2023 – Physical activity and excess weight

The National Childhood Measurement Programme (NCMP) measures all children in reception year (aged 4-5). The programme was suspended in 2020/21 due to covid. Latest figures show 20.3% of Croydon children are overweight or obese, statistically similar to the London average (20%).

Sport England's Active Lives Survey provides details on BMI and activity in adults. The latest data shows that 62.3% of Croydon's adults were measured as overweight or obese, significantly higher than the London average (57.2%) and the 7th highest proportion in London. 64.7% were physically active (in-line with CMO guidelines), statistically similar to the London average (66.3%).







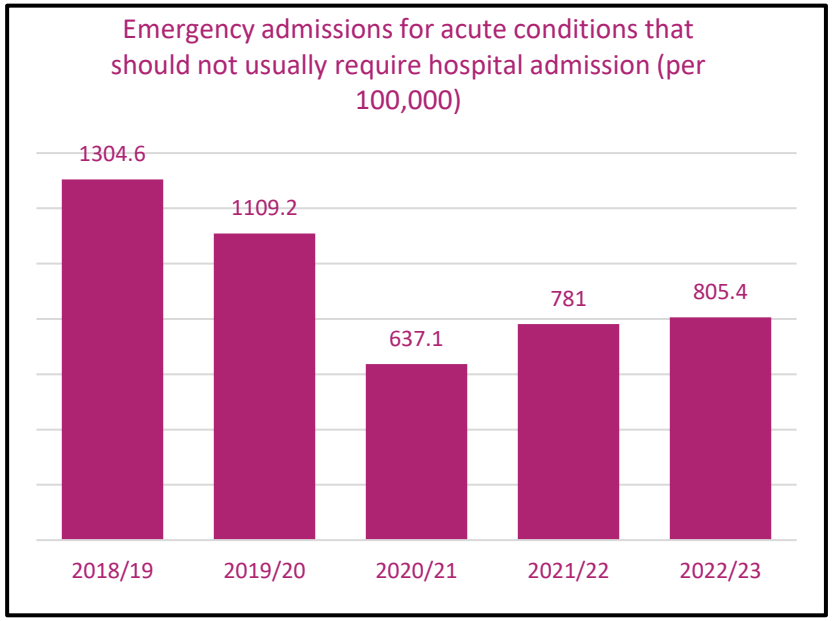
Outcomes Framework 2021-2023 – Hospital Admissions

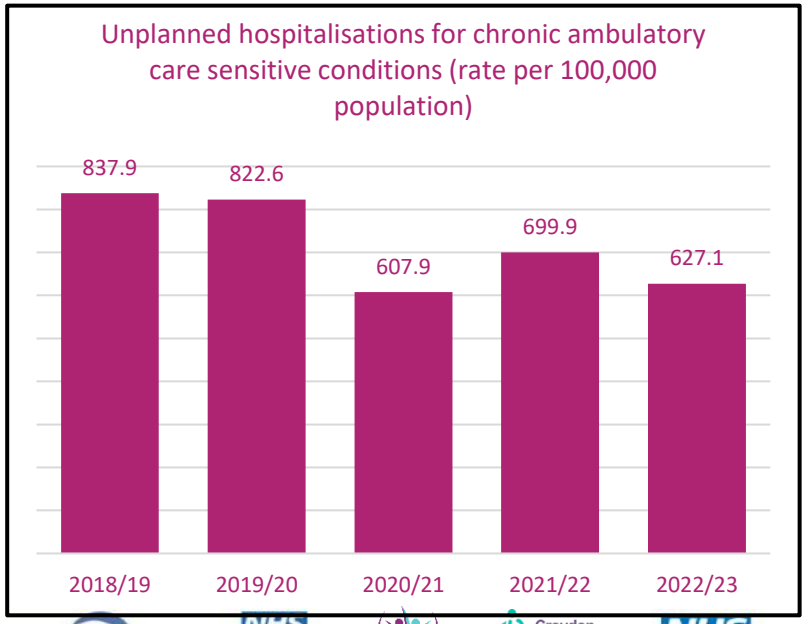
Improvement has been made over the last five years in reducing unnecessary hospital admissions.

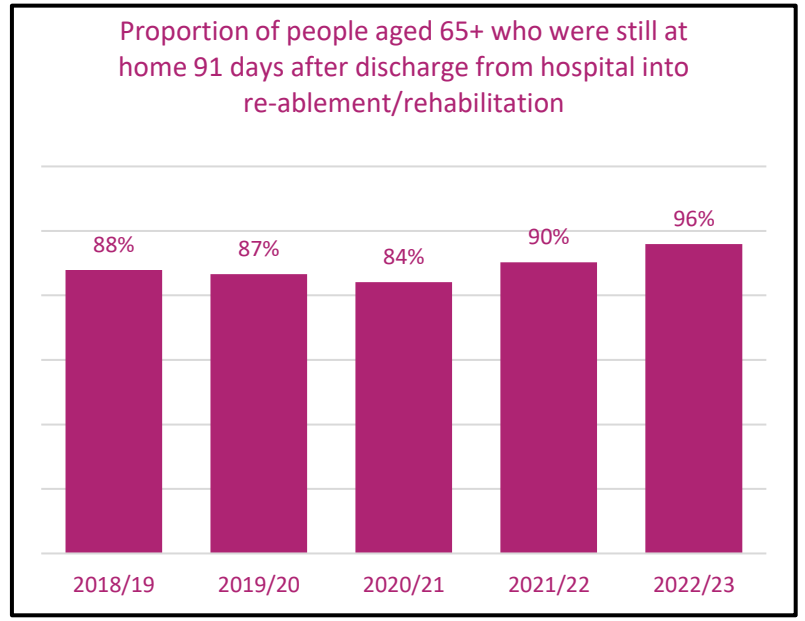
The rate of emergency admissions for acute conditions that do not usually require hospital admission (ear/nose/throat infections, kidney/urinary tract infections, angina, among others) has fallen from 1,304.6 per 100,000 to 805.4 per 100,000, this was lower than the London average of 891.2. Similarly, the rate of people with specific long-term conditions, which should not normally require hospitalization who are admitted to hospital in an emergency has also reduced from 837.9 per 100,000 to 627.1 per 100,000, statistically similar to the London average of 658.8. These conditions include, for example, diabetes, epilepsy and high blood pressure and are termed chronic ambulatory care sensitive conditions.

The proportion of older people discharged from hospital into for rehabilitation/reablement still at home 91 days after discharged has increased from 88% to 96%, higher than the London average of 86.2%.

National data for 2023/24 is not yet available, but local intelligence suggests that the trajectory is upward, following a drop during the pandemic although we expect the mist recent data to show avoidable admissions have not returned to pre-pandemic levels. This may be due in part to the introduction of Same Day Emergency Care (SDEC) at Croydon University Hospital.







Outcomes Framework 2021-2023 – Children & Young People and Long Term Conditions

The proportion of children aged five receiving both doses of MMR vaccination has increased to 70.3%. This is still below the national target of 90% (all London boroughs are below this target) and is also below the London average of 74%.

The proportion of school pupils with SEN with a primary type of need identified as social, emotional and mental health has been increasing each year. Latest data shows that 3.4% of pupils have this need identified, statistically similar to the London average of 2.8%.

The GP Patient Survey measures the directly standardised percentage of people who feel supported to manage their long-term condition, in Croydon this has stayed relatively steady at 54%, in 2021 this was higher than the London average of 51.3%.