HEALTH & WELL-BEING BOARD (CROYDON)

To: **Elected members of the council:**
Councillors Alisa FLEMMING, Yvette HOPLEY, Maggie MANSELL, Margaret MEAD, Louisa WOODLEY

Officers of the council:
Paul GREENHALGH (Executive Director of Children, Families & Learning)
Hannah MILLER (Executive Director of Adult Services, Health & Housing)
Dr Mike Robinson (Director of public health)

NHS commissioners:
Dr Agnelo FERNANDES (NHS Croydon Clinical Commissioning Group)
Dr Jane FRYER (NHS England)
Paula SWANN (NHS Croydon Clinical Commissioning Group)

Healthwatch Croydon
Vanessa HOSFORD (Healthwatch Croydon)

NHS service providers:
Steve DAVIDSON (South London & Maudsley NHS Foundation Trust)
John GOULSTON (Croydon Health Services NHS Trust)

Representing voluntary sector service providers:
Lynette PATTERSON (Croydon Voluntary Sector Alliance)
Steve PHAURE (Croydon Voluntary Action)
Nero UGHWUJABO (Croydon BME)

Representing patients, the public and users of health and care services:
Mark JUSTICE (Croydon Charity Services Delivery Group)
Karen STOTT (Croydon Voluntary Sector Alliance)

Non-voting members:
Ashtaq ARAIN (Faiths together in Croydon)
Rob ATKIN (Metropolitan Police)
David LINDRIDGE (London Fire Brigade)
Andrew McCOIG (Croydon Local Pharmaceutical Committee)
Lissa MOORE (London Probation Trust)
Annette ROBSON (Croydon College)

A meeting of the **HEALTH & WELL-BEING BOARD (CROYDON)** will be held on **Wednesday 16th July 2014** at **2:00pm**, in **The Council Chamber, The Town Hall, Katharine Street, Croydon CR0 1NX**.

JULIE BELVIR
Council Solicitor & Monitoring Officer,
Director of Democratic & Legal Services,
London Borough of Croydon
Bernard Weatherill House
8 Mint Walk
CR0 1EA

MARGOT ROHAN
Senior Members Services Manager
(Democratic Outreach)
(020) 8726 6000 Extn.62564
margot.rohan@croydon.gov.uk
www.croydon.gov.uk/agenda
8 July 2014

Members of the public have the opportunity to ask questions relating to items on this agenda of the Health & Wellbeing Board, either in advance or at the meeting, at the discretion of the chair.
Written questions should be addressed to:
Margot Rohan, Democratic Services & Scrutiny, Bernard Weatherill House, 4th Floor Zone G, 8 Mint Walk, Croydon CR0 1EA or email: margot.rohan@croydon.gov.uk
Questions should be of general interest, not personal issues. Written questions for raising at the meeting should be clearly marked.
Other written questions will receive a written response to the contact details provided (email or postal address) and will not be included in the minutes.
There will be a time limit for questions which will be stated at the meeting.
Responses to any outstanding questions at the meeting will be included in the minutes.

AGENDA - PART A

1. Appointment of Chair

2. Minutes of the meeting held on Wednesday 26th March 2014 (Page 1)

To approve the minutes as a true and correct record.

3. Apologies for absence

4. Disclosure of Interest

In accordance with the Council's Code of Conduct and the statutory provisions of the Localism Act, Members and co-opted Members of the Council are reminded that it is a requirement to register disclosable pecuniary interests (DPIs) and gifts and hospitality in excess of £50. In addition, Members and co-opted Members are reminded that unless their disclosable pecuniary interest is registered on the register of interests or is the subject of a pending notification to the Monitoring Officer, they are required to disclose those disclosable pecuniary interests at the meeting. This should be done by completing the Disclosure of Interest form and handing it to the Business Manager at the start of the meeting. The Chairman will then invite Members to make their disclosure orally at the commencement of Agenda item 3. Completed disclosure forms will be provided to the Monitoring Officer for inclusion on the Register of Members' Interests.

5. Urgent Business (if any)

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

6. Exempt Items

To confirm the allocation of business between Part A and Part B of the Agenda.

7. Annual report of the Director of Public Health (Page 7)

The report of the Director of Public Health for Croydon is attached.

8. Focus on outcomes: Pressure ulcers in the community (Page 13)

The report of the Chief Officer oif NHS Croydon Clinical Commissioning Group is attached.

9. JSNA 2013/14 healthy weight chapter final draft (Page 25)

The report of the Director of Public Health for Croydon, Croydon Council's Executive Directors of Adult Services, Health & Housing and Children, Families and Learning and the Chief Officer, Clinical Commissioning Group is attached.

10. JSNA 2014/15 key chapter topics (Page 31)

The report of the Director of Public Health for Croydon, Croydon Council's Executive Director of Children, Families & Learning and the Chief Officer, Clinical Commissioning Group is attached.

11. Joint mental health strategy (Page 41)

The report of the Chief Officer of NHS Croydon Clinical Commissioning Group and Croydon Council's Executive Director of Adult Services, Health & Housing is attached.

12. Children's Primary Prevention Plan (Page 47)

The report of the Executive Director of Children, Families and Learning is attached.

13. Public Questions

For members of the public to ask questions relating to the work of the Health & Wellbeing Board.

Questions should be of general interest, not personal issues.

There will be a time limit of 15 minutes for all questions. Anyone with outstanding questions may submit them in writing and hand them to the committee manager or email them to: Margot.Rohan@croydon.gov.uk, for a written response which will be included in the minutes.

14. Report of the Chair of the Executive Group (Page 75)

The report of the Executive Group is attached, covering the Work Programme, Performance report against health and wellbeing strategy indicators and Risk Register.

15. FOR INFORMATION ONLY (Page 143)

CCG Response to a request to update the Croydon Health and Wellbeing Board on the Joint SWL Collaborative Commissioning 5 Year Strategy - report and presentation attached.

16. Dates of future meetings in 2014

Thursday 11 September in the Town Hall, Katharine Street
Wednesday 22 October in the Conference Suite, Bernard Weatherill House, 8 Mint Walk
Wednesday 10 December in the Town Hall, Katharine Street
Time: 2pm

17. Camera Resolution

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

AGENDA - PART B

None

HEALTH & WELL-BEING BOARD (CROYDON)
Minutes of the meeting held on Wednesday 26th March 2014 at 2pm in Room F10, The Town Hall, Katharine Street, Croydon CR0 1NX

Present:

Elected members of the council:
Councillors Jane AVIS, Adam KELLETT, Margaret MEAD - chair

Officers of the council:
Jane DOYLE (Director of Community and Support Services)
Hannah MILLER (Executive Director of Adult Services, Health & Housing)
Dr Mike Robinson (Director of public health)

NHS commissioners:
Dr Agnelo FERNANDES (NHS Croydon Clinical Commissioning Group)
Paula SWANN (NHS Croydon Clinical Commissioning Group)

Healthwatch Croydon
Vanessa HOSFORD (Healthwatch Croydon)

NHS service providers:
Steve DAVIDSON (South London & Maudsley NHS Foundation Trust)
Karen BREEN (Croydon Health Services NHS Trust)

Representing voluntary sector service providers:
Sarah BURNS (Croydon Voluntary Action)

Representing patients, the public and users of health and care services:
Mark JUSTICE (Croydon Charity Services Delivery Group)
Karen STOTT (Croydon Voluntary Sector Alliance)

Non-voting members:
Ashtaq ARAIN (Faiths together in Croydon)
Beran PATEL (Croydon Local Pharmaceutical Committee)

Also present:
Solomon Agutu (head of democratic services & scrutiny), Bernadette Alves (Consultant in Public Health, Croydon Council), Fiona Assaly (Project co-ordinator, Public Health, Croydon Council), John Currie (Public Health principal, Croydon Council) , Alan Hiscutt (Head of Commissioning Vulnerable Adults & Supported Housing, Croydon Council) , Steve Morton (head of health & wellbeing, Croydon Council), Chris Forster (Director of Estates & Facilities, Croydon Healthcare Services NHS Trust) , Rachel Nicholson (Health Improvement Manager - Health Inequalities and Mental Wellbeing, Croydon Council) , Matt Phelan (Public Health interim principal, Croydon Council), Ellen Schwartz (Consultant in Public Health, Croydon Council) , Dwynwen Stepien (Head of Early Intervention and Family Support, Croydon Council), Amanda Tuke (Head of Partnerships & Business Development, Croydon Council) and Stephen Warren (Director of Commissioning Designate, CCG)

Committee Manager: Margot Rohan (senior members' services manager)

A12/14 INTRODUCTION

The Chair introduced new members - Vanessa Hosford (Healthwatch Croydon) - replacing Barbara Scott - and Karen Stott (Croydon Voluntary Sector Alliance) - replacing Charles Okech.

A13/14 MINUTES OF THE MEETING HELD ON WEDNESDAY 12TH FEBRUARY 2014

The Board **RESOLVED** that the minutes of the meeting of the Health & Wellbeing Board (Croydon) on 12 February 2014 be agreed as an accurate record.

A14/14 APOLOGIES

Apologies were received from Cllrs Tim Pollard and Maggie Mansell, John Goulston (Croydon Healthcare Services NHS Trust) - deputised by Karen Breen, Andrew McCoig (Croydon Local Pharmaceutical Committee) - deputised by Beran Patel, Paul Greenhalgh (Executive Director of Children, Families & Learning, LBC) - deputised by Jane Doyle (Director of Community and Support Services), Annette Robson (Croydon College) and Nero Ughwujabo (BME Forum).

A15/14 DISCLOSURE OF INTEREST

There were no disclosures of pecuniary interest at this meeting.

A16/14 URGENT BUSINESS (IF ANY)

South West London (SWL) Collaborative Commissioning - Five Year Strategic Plan
Paula Swann explained the reason for the urgency in that the SWL has to submit the Strategic Plan in June 2014 and the Health and Wellbeing Board is not meeting again until July 2014. The Board agreed to accept the report as an urgent item.

The presentation sets out a summary of the Strategic Plan, emphasising the need for change. The Board discussed the report and a number of questions were posed, including the location of the proposed Centre of Excellence and the challenge of getting the right mix of skills and numbers for staffing 24/7, in order to meet the London Quality standards.

The Health and Wellbeing Board **RESOLVED** to note the contents of the report.

A17/14 EXEMPT ITEMS

There were no exempt items.

A18/14 CHS EMERGENCY CARE DEPARTMENT BUSINESS CASE

Karen Breen (Deputy CEO & Chief Operating Officer, Croydon Health Services NHS Trust), supported by Chris Forster (Director of Estates & Facilities), presented this report. In so doing, they explained that Urgent care is provided through Virgin, not Assura Wandle, as stated in page 12 of the report. The key aspects of the Business Case were presented.

- The existing Emergency Department (ED) was designed in the 1980s and built for capacity of 70,000 patients per year but is now seeing 120,000 patients annually. As a result the department is poorly laid out, fragmented with poor sight lines, and the environment has inadequate ventilation and cramped facilities.
- During visits in July and September 2013, The Care Quality Commission (CQC) raised a number of concerns which this project will address.
- The patient Journey when attending the Emergency Department was described and how the design will enable far better patient experience.

In summary, the Strategic Outline Case (SOC) for the ED Redevelopment was approved in April 2013 by the Trust Development Authority (TDA), The outline case (OBC) will be issued to the TDA in April 2014. The Full Business Case (FBC) will be issued in August 2014. The planned main build start date is October 2014, with anticipated completion December 2015.

The Health and Wellbeing Board **RESOLVED**, having considered the public sector equality duty and the Joint Health and Wellbeing Strategy, to:

1. note the key objectives addressing the Trust's and CQC's issues as set out in the Outline Business Case (OBC) for the redevelopment of the ED, supports the case for change; and
2. endorse the proposals for redevelopment of the new ED.

A19/14 FINAL COMMISSIONING INTENTIONS 2014-15: CCG OPERATING PLAN 2014/15-2016/17

Stephen Warren (Director of Commissioning Designate, CCG) presented the report. The Operating Plan sets out the direction of travel for the next two years. The Plan addresses the significant challenges facing Croydon, particularly delivering care out of hospitals, the emergency service and Mental Health.

The discussion which followed established that this time next year the Board will be asked by NHS England to comment on CCG performance and the comments from the CCG will be based on this Plan. CCG officers stated that they will be reporting to their governing body on progress against the Operating Plan as a matter of course and would be happy to be assessed against it this time next year.

The Health & Wellbeing Board **RESOLVED** to receive and note the CCG operating plan.

A20/14 FINAL COMMISSIONING INTENTIONS 2014-15: CHILDREN AND FAMILIES PLAN

This was an information only report presented by Amanda Tuke (Head of Partnerships & Business Development, LBC) and Stephen Warren (Director of Commissioning Designate, CCG). They drew attention to the change that 10 priorities this year compared to 40 last year will make and that the 5 year CCG plan will need to reflect these.

The Board **RESOLVED** to receive the information.

A21/14 JSNA 2013-14 DOMESTIC VIOLENCE CHAPTER - FINAL DRAFT

Ellen Schwartz (Consultant in Public Health) presented the chapter. The aims of the chapter are:

- to provide overview around Domestic Violence and
- to enable target of services and resources better

The presentation was followed by a discussion, mostly on Female Genital Mutilation (FGM).

Having considered the domestic violence JSNA chapter, the Health and Wellbeing Board **RESOLVED** to:

1. approve the document in principle and delegate final approval of any further amendments to the responsible directors;
2. note the conclusions from the report.

A22/14 JSNA 2013-14 ALCOHOL CHAPTER - FINAL DRAFT

Bernadette Alves (Consultant in Public Health) gave a summary of the report. The presentation highlighted the high level of ambulance call outs and the fact that most drinking takes place in the home (especially women drinkers).

The presentation was followed by a discussion which covered licensing issues, express stores, binge drinking (mostly young

people) versus ordinary drinking and the impact of adult behaviour on children.

The Health and Wellbeing Board **RESOLVED** to:

1. consider the rapid JSNA alcohol chapter, approve the document in principle and delegate final approval of any further amendments to the responsible directors;
2. note the conclusions and recommendations;
3. endorse the recommendations of the rapid Alcohol JSNA.

A23/14 CHILDREN & YOUNG PEOPLE'S EMOTIONAL WELLBEING & MENTAL HEALTH STRATEGY

Stephen Warren (Director of Commissioning Designate, CCG) and Jane Doyle (Director of Community and Support Services) gave a summary of the report. They reported a real urgency to drive this work forward and the need for a separate strategy on the health of LAC, which would include their emotional needs.

The Health and Wellbeing Board **RESOLVED** to note the contents of the report and attached strategy Appendix 1 and to agree the action plan for 2014.

A24/14 PUBLIC QUESTIONS

Anne Milstead asked for clarification on her previously asked and unanswered questions:

1. What safeguards are there for the users of those services like care in the home under zero hours contracts?
2. What safeguards are there for whistleblowers when things start to go wrong when services are run by third parties?
3. Is there a place for public scrutiny and input of the procurement process BEFORE implementation?

For 1 & 2, what are the 'very stringent procedures' mentioned in the answer? Who does the monitoring? How do they do it?

A detailed verbal response was given at the meeting.

Appendix P&V was an attachment with the previous minutes and is attached again.

A25/14 REPORT OF THE CHAIR OF THE EXECUTIVE GROUP

Steve Morton drew attention to specific points in the report. (The Performance Report will be reviewed quarterly.)

The following issue was raised:

- CCG performance assessment should be added in

The Health and Wellbeing Board **RESOLVED** to agree proposed changes to the board work plan set out at paragraph 3.3 and to note risks identified at appendix 3.

A26/14 FOR INFORMATION ONLY

Pharmaceutical Needs Assessment (PNA) Update paper
Steve Morton explained that comments can be made on the PNA when it comes back to the Board at a later date.

A27/14 DATES OF FUTURE MEETINGS IN 2014

The next meeting of the Health and Wellbeing Board will be at 2pm on Wednesday 16 July in the Conference Suite in Bernard Weatherill House.

The meeting ended at 15:55pm

REPORT TO:	**HEALTH AND WELLBEING BOARD (CROYDON)** **16 July 2014**
AGENDA ITEM:	**7**
SUBJECT:	**2014 Annual Public Health Report**
BOARD SPONSOR:	**Dr Mike Robinson, Director of Public Health, Public Health Croydon, Croydon Borough Council**

CORPORATE PRIORITY/POLICY CONTEXT:

Production of an Annual Public Health Report is a statutory requirement of the Director of Public Health, hence this report is a priority for Public Health Croydon. By focusing on wards in areas of deprivation, New Addington and Fieldway, and by highlighting the community assets in this area, the report reflects national policy around reducing health inequalities as well as the national direction of travel in terms of identifying assets as well as needs.

Collectively, case studies in the report reinforce the Community Strategy by showing how individuals in New Addington and Fieldway are enterprising, creative, caring, and contribute to a learning, sustainable and above all connected Borough.

FINANCIAL IMPACT:

There are no financial implications of this report.

1. RECOMMENDATIONS

This report recommends that, having considered the public sector equality duty and the Joint Health and Wellbeing Strategy, the Health and Wellbeing Board endorse the Annual Public Health Report for 2014.

2. EXECUTIVE SUMMARY

2.1 The 2014 Annual Public Health Report focuses on New Addington and Fieldway. The report takes an asset based approach, highlighting some of the good work that has taken and is taking place in these areas, often led by communities themselves. The report is structured around the key factors that influence health and can be influenced (ie the economy, individual lifestyles and behaviours, social networks, health and social care services, housing and local neighbourhoods.) In this way it both demonstrates the breadth of public health and draws the spotlight on the many assets of these areas, including the people themselves.

2.2 One of the main goals of public health is to reduce health inequalities, defined as the unjust differences in health status that exist between population groups by factors such as deprivation. By focusing on two areas of high deprivation

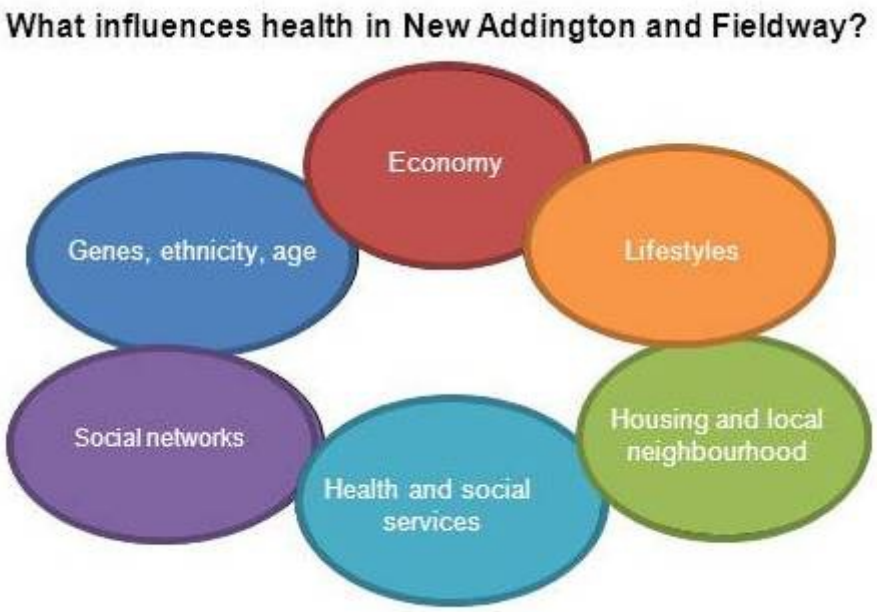
within Croydon, this public health report contributes to discussions around the proposed Fairness Commission. The report highlights projects and services that are making a real difference to people's lives. There may be lessons to be learnt from this piece of focused work on New Addington and Fieldway for targeted work in other parts of the Borough.

3. DETAIL

3.1 Background

This report was a collaborative effort, led by Public Health Croydon but produced in partnership with CVA and the CCG and with input from other sections of the Council.

The report is structured around the six broad areas which influence health[1] (see figure below). After an introduction defining and describing health inequalities, the report provides case studies of individuals, groups or organisations which are working hard to address these inequalities and improve health in these areas. A range of potential case studies was initially compiled by members of the APHR steering group. A shortlist was reached by prioritising those which were felt to be examples of inspirational work on key determinants of health such as economic hardship, food, weight, and smoking, which would nonetheless retain credibility with its audience.



The case studies that were selected and have been included in the report are summarised below.

SECTION THEME	CASE STUDIES

[1] This is an adapted, more user friendly version of 'The Determinants of Health' (Dahlgren and Whitehead, 1992).

1. Economy	Welfare Rights Team case study focusing on how the weekly income of a 90 year old woman in sheltered housing was increased; The Vine Foodbank showcases the work of the Salvation Army in providing a foodback for local residents Summary of Council response to benefit changes Job Club at the Octogon with appreciative comments from two male users; Focus on Cronx Brewery as an example of local people doing it for themselves – inspired by riots Library homework clubs, helping children get a good education, with a focus on one of the workers who started as a volunteer
2. Housing and local environment	Green spaces in New Addington and Fieldway Physical redesign of Central Parade and Business Improvement District Safer Neighbourhoods case study of improvements to Hares Bank Example from housing adaptations of the changes made for a wheelchair user.
3. Health and social services	Brenda Kirby Cancer Centre and case study of service user Mum2Mum peer support breastfeeding programme and case study with peer supporter who was herself supported Information on how to get involved in influencing health services locally.
4. Social networks	Family Centre case study including comments from a volunteer Over 50 Social club case study including comments from two users) Kingfisher Association (mental health user group) Addington Heights reablement centre 2Views Intergenerational project
5. Lifestyles	*Smoking* - Solutions4Health – three case studies of smokers/ex smokers who have successfully quit or still trying including a mental health worker *Healthy Weight* – inspirational case study of major weight loss from current Weight Watchers leader *Physical Activity* – case study of MiChange service user *Healthy Eating* – focus on Good Food Matters Community Food Learning Centre; Dunk the Junk project *Sexual health* – Croydon Drop in, Croydon Talkbus

Next steps

Following completion and electronic dissemination of the Public Health Report, the current plans are to produce a poster to be distributed locally. This will contain photos and brief quotes from a small number of the people included in the case studies, to generate local interest, along with a link to the wider report.

A short survey will be attached to the distribution list for the main report and the poster will contact contacts details for feedback. In addition, a focus group discussion will be carried out with those involved and ideally featured in the report.

4. CONSULTATION

4.1 Council leadership signed off the overall approach to the report in 2013.

4.2 A steering group was set up to guide the report's production, including representatives from Public Health, CVA, and the CCG.

4.3 The case studies featured in the report were pulled together by a combination of approaches involving local people, including direct approaches, and approaches via other organisations.

5. SERVICE INTEGRATION

5.1 Not applicable

6. FINANCIAL AND RISK ASSESSMENT CONSIDERATIONS

6.1 Not applicable

7. LEGAL CONSIDERATIONS

7.1 Not applicable

8. HUMAN RESOURCES IMPACT

8.1 Not applicable

9. EQUALITIES IMPACT

9.1 The Council has a statutory obligation to publish information annually on the steps that it is has taken in the exercise of its functions to address the Public Sector equality duty (PSED). This requires public bodies to ensure due regard to the need to advance equality of opportunity; foster good relations between people who share a "protected characteristic" and those who do not and take action to eliminate discrimination in the provision of services.

9.2 The annual public health report contains information on the actions that the Council has taken to address health inequality in two of the most deprived wards in Croydon – New Addington and Fieldway. It highlights some of the activities that the Council, working in partnership with local residents and community groups has used to understand and address the specific local health needs of the diverse community -including groups who share protected characteristics specifically in terms of age, ethnicity, gender and disability.

9.3 The case studies included in this report demonstrate that the focus of public

health activities is not just on providing services to treat ill health but on developing a preventative approach that enables the Council to understand and address the impact of causal factors such access to housing, employment and health services, ethnicity, age, access to social networks etc. that determine health-inequality.

9.4 (Approved by: Yasmin Ahmed, Equality Manager.)

10. ENVIRONMENTAL IMPACT

10.1 Not applicable

11. CRIME AND DISORDER REDUCTION IMPACT

11.1 None.

CONTACT OFFICER: Jenny Hacker, Consultant in Public Health, jenny.hacker@croydon.gov.uk; 0208 726 6000 x 61627

BACKGROUND DOCUMENTS Annual Public Health Report 2014

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REPORT TO:	**HEALTH AND WELLBEING BOARD (CROYDON)** **16 July 2014**
AGENDA ITEM:	**8**
SUBJECT:	**Achieving a reduction in Pressure Ulcers Across Croydon Health and Social Care Economy**
BOARD SPONSOR:	Paula Swann, Chief Officer, Croydon Clinical Commissioning Group

CORPORATE PRIORITY/POLICY CONTEXT:

It is a national priority to reduce the prevalence of pressure ulcers across the population. This is reflecting in the Department of Health's Quality, Innovation, Productivity, Prevention (QIPP) programme and a key area for the reduction of harm for patients or service users of health and social care settings.

FINANCIAL IMPACT:

At present the financial implications are not properly understood as the work to establish priorities for action is currently underway and is not due to report until the end of August 2014.

1. RECOMMENDATIONS

This report recommends that, having considered the public sector equality duty and the Joint Health and Wellbeing Strategy, the Health and Wellbeing Board:

1.1 **Discuss the content of this report**

1.2 It is recommended that the Health and Wellbeing Board extend the work initiated by Croydon Health Services by leading public awareness campaigns with the public, patients and carers including galvanising the support of voluntary sector organisations to assist in the focus of reducing the risk of pressure ulcers developing at home. This work cannot be delivered by one organisation and is therefore necessary to achieve a multi-agency approach.

2. EXECUTIVE SUMMARY

2.1. This report aims to raise the profile and issue of pressure ulcers acquired out of hospital settings and provides the background of the need to focus on the reduction of pressure ulcers to reduce harm but also to improve the health and wellbeing and tissue viability of both actual and potential users of health and social care services.

2.2. The treatment and prevention of pressure ulcers (PUs) is a critical part of providing holistic nursing care as pressure ulcers have a detrimental effect on patients' health, wellbeing, and experience of healthcare, as well as being a significant economic burden on the provision of healthcare within the NHS.

2.3. Patients with pressure ulcers experience pain and are at an increased risk of infection. This may severely impact on the ability to live independently at home.

2.4. The report highlights the national focus on the need to reduce pressure ulcers irrespective of where they occur and provides an update into the achievement of Croydon health Services since September 2013, where the organisation achieved a reduction in hospital acquired grade 2 pressure ulcers by 25% and all pressure ulcers by 31% through nurse education and monitoring. Croydon Health Services through the national Commissioning for Quality and innovation Scheme has been charged with the responsibility of leading work to reduce pressure ulcers irrespective of where they occur this is a wide and far-reaching responsibility and cannot be achieved without the full understanding and involvement of all stakeholders with the responsibility and interest in the health and wellbeing of Croydon's population.

2.5. Croydon's health and social care economy has a new challenge of addressing pressure ulcers that occur in patients at home and unknown to health or social care services. Table 1 below highlights that 45% of all pressure ulcers identified by Croydon Health Services occur in the patient's own home. This group of patients are not known to health services.

Table 1. Summary of Croydon Health Services DATIX reported Pressure Ulcers and their origin

Month 2013/14	Total Pressure Ulcers (Datix)	Trust Acquired PU,	Patients Home PU,	Nursing Home PU,	Other Location*
Total	**1402**	**320**	**632**	**223**	**117**
% of total	%	23%	45%	16%	8%

2.6. It is recommended that the Health and Wellbeing Board extend the work initiated by Croydon Health Services by contributing to raising the profile of the risks of developing pressure ulcers at home.

2.7. Croydon Health Services is seeking to address this issue through its listening into action programme and through targeted work on specific wards. The Health and Wellbeing Board and its partners will add value to the work of the trust by leading public awareness campaigns with carers and seeking the support of voluntary sector organisations.

3. Background

The purpose of this paper is to share the work that has been undertaken by Croydon Health Services (CHS) as part of the national Commissioning for Quality and Innovation Scheme initiated under the terms of the Department of Health National Standard Contract held with Croydon Clinical Commissioning Group (CCG)

A reduction in avoidable pressure ulcers became a key goal within the NHS following the Department of Health's Quality, Innovation, Productivity, Prevention (QIPP) programme, designed to improve health outcomes and quality care in four areas: pressure ulcers; falls; urinary tract infections and venous thrombosis[1].

Improvement goals on pressure ulcer prevalence for 2013/14 were set as a national CQUIN (Commissioning for Quality and Innovation), identifying that nationally pressure ulcers represent the highest burden of harm.

The treatment and prevention of pressure ulcers (PUs) is a critical part of providing holistic nursing care as pressure ulcers have a detrimental effect on patients' health, wellbeing, and experience of healthcare, as well as being a significant economic burden on the provision of healthcare within the NHS.

Croydon Health Services have managed a considerable reduction in the total prevalence of pressure ulcers across all services. Since September 2013, the organisation has reduced grade 2 pressure ulcers by 25% and all pressure ulcers by 31% through nurse education and monitoring.

However a large proportion of pressure ulcers in Croydon occur in patients who are not in receipt of health care services from CHS. This is also evident nationally; the current NHS Safety Thermometer results suggest that on average around 75% of patients with pressure ulcers are recorded as not being acquired whilst the patient was in the care of the current provider[2]. Whilst some pressure ulcers occur during an inpatient stay some pressure ulcers originate across and outside of the health and social care system and in Croydon 45% of patients with pressure ulcers were identified as pressure ulcers that were acquired at home, these patients were unknown to health services, as noted in table 1.

The Local Authority has employed a number of tissue viability nurses that support patients in nursing homes and it is expected that this positive intervention will contribute to the reduction of pressure ulcers acquired in nursing homes.

3.1. Pressure Ulcer Data

To reduce avoidable harm from pressure ulcers it is essential to ensure that accurate data is collected.

It is a requirement for hospitals to evaluate PU rates through the Safety Thermometer national reporting tool, which gives the point prevalence of PUs on one day in the month; and also via their internal incident reporting and management system, for example Datix software. It is important to note that these are different

measures and therefore numbers do not line up. i.e prevalence data reflects the level of pressure ulcers at a particular point in time whilst datix reports incidence the total number of pressure ulcers that have occurred throughout the year.

Importance has been placed on data collection to enable organisations to monitor and improve the reduction of pressure ulcers. It is also necessary to distinguish whether the PU was present on admission or acquired during an inpatient stay. If a pressure ulcer is identified when the patient has been within the trust's care for more than 72 hours (i.e. a deterioration of a pressure ulcer grade while an inpatient, or the patient has been within a community hospital setting or on a district nurse caseload) then the pressure ulcer is attributed to the trust, or is a "new" pressure ulcer. If the pressure ulcer is identified within 72 hours of the patient coming into the care of the trust then it is attributed to the organisation or home from which the patient came, and is recorded as "old".

3.2 Croydon Health Services Datix Trends

To manage collection of pressure ulcer incidence a Datix Incident form is completed by the trust for all pressure ulcers Grade 1 – 4, on first assessment of a pressure ulcer (if not already reported at the current grade) and when there is deterioration of pressure ulcer grade.

1 http://harmfreecare.org/wp-content/uploads/2012/06/NHS-ST-CQUIN-2012.pdf
2 http://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2013/09/CQUIN-Guidance-2014-15-PDF-751KB.pdf

Table 1 contains data obtained from Croydon Health Services Quality Reports. This demonstrates the relative proportion of reported pressure ulcers that are validated by the trust as being trust acquired, or developed in the patients home, nursing home, other hospital or residential home (for 2013/14). Between 18-28% of Datix reported pressure ulcers are trust acquired. The majority occur in patients who are not receiving services from a healthcare provider. This is in line with the national picture, with on average 25% of pressure ulcers being trust acquired and 75% not attributable to the trust[2].

It may be that the patients who are developing pressure ulcers while not under healthcare provision are visiting their GP or receiving social care packages or home help, and therefore it is possible that targeting both Public Health as well as these organisations will help with the prevention of pressure ulcers by raising awareness, such as through awareness and communications campaigns, while also increasing their identification and opportunity for treatment.

Table 2. Croydon Health Services DATIX reported Pressure Ulcers and their origin

Month 2013/14	Total Pressure Ulcers (Datix)	Trust Acquired, % of total in ()	Patients Home, % of total in ()	Nursing Home, % of total in ()	Other Location*	Sub-category of those listed
April	155	39 (25%)	67 (43%)	25	13	11
May	-	-	-	-	-	-
June	136	26 (19%)	55 (40%)	23 (17%)	18	14

July	127	32 (25%)	67 (53%)	22 (17%)	9	6
August	107	30 (28%)	47 (44%)	17 (16%)	8	5
September	117	23 (20%)	47 (40%)	13 (11%)	6	28
October	115	30 (26%)	58 (50%)	16 (14%)	6	5
November	116	21 (18%)	50 (43%)	22 (19%)	12	11
December	125	32 (26%)	53 (42%)	20 (16%)	15	5
January	129	27 (21%)	58 (45%)	27 (21%)	10	7
February	130	36 (28%)	58 (45%)	16 (12%)	10	10
March	145	24 (17%)	72 (50%)	22 (15%)	10	17

Data source: Croydon Health Services NHS Trust Quality Report to Trust Board, reports from July 2013 to June 2014[3]

* For example residential homes or another hospital

2.1. **Croydon Health Services Safety Thermometer Trends**

Information gathered via thematic review of grade 3+ pressure ulcers acquired between April and October 2012 was used to develop an action plan for 2013/14 which concentrated on

- Raising awareness and developing a culture where risks are identified, understood and managed;
- Equipment provided;
- Learning from incidents occur.

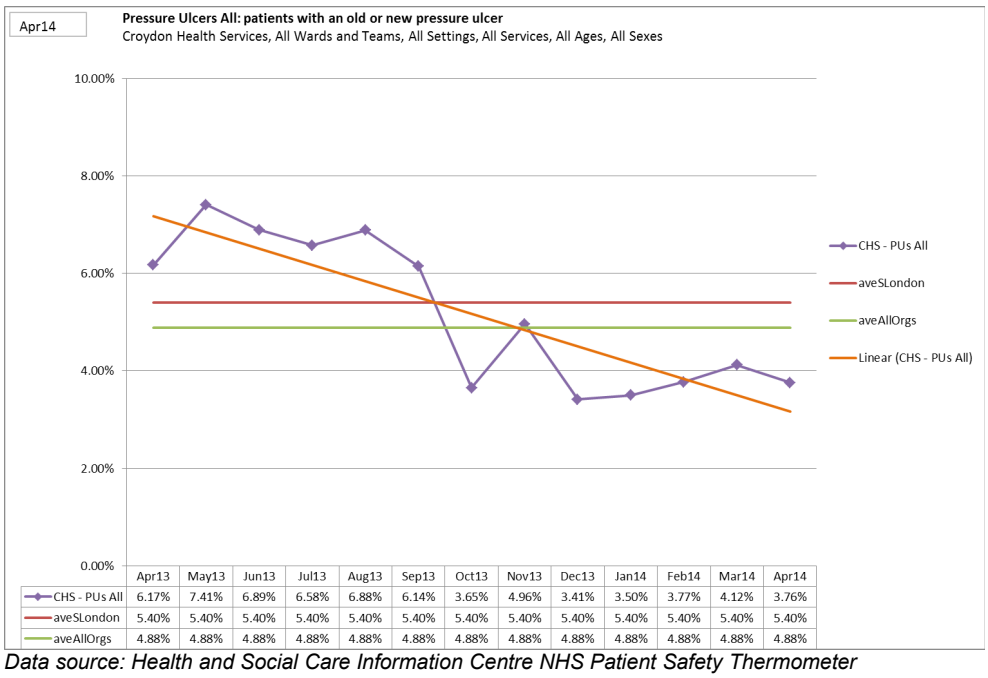
The action plan was monitored through 2013/14 by the Nursing and Midwifery Board, Clinical Quality Review meetings with commissioners and Patient Safety Committee.

During 2013/14 further work was implemented as new information was gathered. Compliance against pressure ulcer policy was checked using weekly audits. A trend analysis identified the common root causes for grade 3 pressure ulcers, relating to poor communication and lack of robust initial assessment of risk. These areas were then targeted. A pressure ulcer nurse was appointed on a 6 month secondment looking specifically at high reporting areas and areas that reported no pressure ulcers.

The action plan has had a good impact on the total prevalence of pressure ulcers identified in CHS acute and community services, but originating from any setting (Graph A). There is a clear reduction in clear reduction in numbers through the year, and CHS perform better than the average for both the South London subset and all organisations for the past 6 months.

3 http://www.croydonhealthservices.nhs.uk/about-us/Timetable-and-Papers.htm

Graph A. Total harms due to Old and New Pressure Ulcers, originating from all settings; detected in Croydon Health Services safety thermometer data, and comparison with average for South London and average for all organisations.



	Apr13	May13	Jun13	Jul13	Aug13	Sep13	Oct13	Nov13	Dec13	Jan14	Feb14	Mar14	Apr14
CHS - PUs All	6.17%	7.41%	6.89%	6.58%	6.88%	6.14%	3.65%	4.96%	3.41%	3.50%	3.77%	4.12%	3.76%
aveSLondon	5.40%	5.40%	5.40%	5.40%	5.40%	5.40%	5.40%	5.40%	5.40%	5.40%	5.40%	5.40%	5.40%
aveAllOrgs	4.88%	4.88%	4.88%	4.88%	4.88%	4.88%	4.88%	4.88%	4.88%	4.88%	4.88%	4.88%	4.88%

Data source: Health and Social Care Information Centre NHS Patient Safety Thermometer

3.4 StEIS Serious Incidents

Pressure ulcer grades 3 and 4 acquired under CHS care must be reported on the national Serious Incident database, StEIS, as an SI resulting in harm to a patient while under the care of the trust. Root Cause Analysis (RCA) is then initiated and local factors are identified that might have contributed to the development of the pressure ulcer (e.g. lack of staff attendance at study days, or late delivery of equipment). These factors are then highlighted and rectified.

Croydon Health Services reported 262 serious incidents in 2013/14, of which 152 were grade 3 or 4 pressure ulcers. Of these, 56 were de-escalated or closed as non-attributable to the trust, leaving a total of 96 for which investigations are either on-going or have been completed.

Of the 96 pressure ulcer investigations, 61 reports have been reviewed and the incidents closed, with action plans monitored by the trust and CCG. The remainder of reports (35) are currently either being critiqued by SLCSU clinical specialists or have been critiqued and questions have been raised prior to closure.

If a PU has occurred in a nursing/care home then the NHSE requirement is that this is closed on StEIS rather than de-escalated in order that there is a record on the system of the PU and to enable reporting and monitoring of these incidents.

Where a PU is acquired in a nursing home/care home then it will not be closed until there is confirmation that a safeguarding adult alert has been raised and information has been given as to where the PU originated. If it is a nursing or care home, then the SLCSU has developed a relationship with the Care Quality Committee, and a system is in place to ensure that they are made aware and can follow up any concerns.

Where the PU is attributable to another organisation then it is expected that the responsible organisation will report the pressure ulcer on StEIS and it will be de-escalated for the organisation who were not accountable for the pressure ulcer.

3.5. Actions

The emphasis of the national CQUIN Scheme is the Provider organisations need to work with their partners across their local health and social care system to address the causes of pressure ulcers and reduce their prevalence, regardless of source.

The CCG and CHS are aiming for a reduction of 15% pressure ulcer prevalence during 2014/15 this will mean reducing the median value to 30 from a median value of 35 this work is incentivised through the national CQUIN. The aim is to target improvements in the context of all relevant providers in a local health community, with a view to supporting joint working of organisations across a patient pathway. A working group has been established, led by the trust and with representation from the CCG, Public Health, Local Authority and Voluntary Sector stakeholders.

For 2014/15, the trust is developing an action plan with the emphasis on engaging with the whole health economy including GPs and nursing homes. Additionally, a pressure ulcer project has been included in wave 3 of the Listening into Action work. This forum will use stakeholder views to determine what the raft of issues are that impact on tissue viability across the health economy. The format of the Listening into Action Programme proposes ideas for action based on stakeholders considering 3 critical questions which will be developed by the Trust. The proposed date for this meeting is 20th August CHS are inviting stakeholders to attend. In addition to this the Head of Nursing for Patient Safety is meeting with Directorate leads to discuss trends in specific ward and community areas in order to further reduce the contribution of trust-acquired pressure ulcers to the total prevalence.

3.6. Recommendations

It is recommended that the Health and Wellbeing Board extend the work initiated by Croydon Health Services by leading public awareness campaigns with the public, patients and carers including galvanising the support of voluntary sector organisations to assist in the focus of reducing the risk of pressure ulcers developing at home. This work cannot be delivered by one organisation and is therefore necessary to achieve a multi-agency approach.

4. CONSULTATION

4.1. The consultation process is being led by Croydon Health Services through the listening into action work programme a stakeholder event is planned to take place 20th August,

5. SERVICE INTEGRATION

5.1. Not applicable at this stage but will need consideration as the recommendation

for actions are identified.

6. FINANCIAL AND RISK ASSESSMENT CONSIDERATIONS

6.1. To be considered as part of the development process the stakeholder event will help to shape this.

6.2. **Risks**

The risk of not supporting this patient focused priority will mean Croydon Health and Social Care economy are nationally identified as a system that has not taken steps to support the Provider in achieving a reduction in pressure ulcers and by doing so not supporting a reduction of harm.

6.3. **Options**

6.4. **Future savings/efficiencies**

6.5. (Approved by: Paul Heynes, Head of Departmental Finance, Adult Services, Housing and Health OR Mirella Green, Finance Manager on behalf of Head of Departmental Finance, Adult Services, Housing and Health)

7. LEGAL CONSIDERATIONS

7.1. This has not been considered at this stage

7.2. (Approved by: J Harris Baker, head of social care and education law on behalf of the Council Solicitor & Director of Democratic & Legal Services)

8. HUMAN RESOURCES IMPACT

8.1. None currently

8.2. (Approved by: Michael Pichamuthu, HR Business Partner, on behalf of the Director of Workforce, Equality & Community Relations)

9. EQUALITIES IMPACT

9.1. An Equality Impact assessment has been undertaken and it concludes that there are no adverse impacts on the protected groups.

9.2. (Approved by: *[Equalities Team senior officer]*)

10. ENVIRONMENTAL IMPACT

10.1. There are none

11. CRIME AND DISORDER REDUCTION IMPACT

11.1. There are none

CONTACT OFFICER: Michelle Rahman, Interim Director, Quality and Governance
Michelle.rahman@croydonccg.nhs.uk, 020 3668 1328

APPENDIX: Equality Analysis

South London
Commissioning Support Unit

Equality Analysis

Guidance and template and Equality Analysis Screening

Version 1.0 – 08.05.2014

NHS
Croydon Clinical Commissioning Group

Equality Analysis Screening Form

Date of Assessment	2nd July 2014
Assessor Name & Job Title	Michelle Rahman, Interim Director, Quality and Governance, Croydon CCG
Name of the strategy / policy / proposal / service function	Achieving a reduction in Pressure Ulcers Across Croydon Health and Social Care Economy
Aim/Purpose of Policy	The report aims to raise the profile and issue of pressure ulcers acquired out of hospital settings and provides the background of the need to focus on the reduction of pressure ulcers to reduce harm but also to improve the health and wellbeing and tissue viability of both actual and potential users of health and social care services. The treatment and prevention of pressure ulcers (PUs) is a critical part of providing holistic nursing care as pressure ulcers have a detrimental effect on patients' health, wellbeing, and experience of healthcare, as well as being a significant economic burden on the provision of healthcare within the NHS. The report highlights the national focus on the need to reduce pressure ulcers irrespective of where they occur and provides an update into the achievement of Croydon health Services since September 2013, where the organisation achieved a reduction in hospital acquired grade 2 pressure ulcers by 25% and all pressure ulcers by 31% through nurse education and monitoring. Croydon Health Services through the national Commissioning for Quality and innovation Scheme has been charged with the responsibility of leading work to reduce pressure ulcers irrespective of where they occur this is a wide and far-reaching responsibility and cannot be achieved without the full understanding and involvement of all stakeholders with the responsibility and interest in the health and wellbeing of Croydon's population.

1. Do you consider the strategy / policy / proposal / service function to have an **adverse equality impact** / **health inequality impact** on any of the protected groups*? Write either 'yes' or 'no' next to the appropriate group(s).

**As defined by the Equality Act 2010*

Protected Group	**Yes or No**	**Protected Group**	**Yes or No**	**Protected Group**	**Yes or No**
Age	no	Pregnancy/Maternity	N/A	Marriage/Civil Partnership (employment matters)	no
Disability	no	Race	no	Carers	no
Gender	no	Religion/Belief	no		
Gender Reassignment	no	Sexual Orientation	no		

2. If you answered 'yes' to any of the above, give your reasons why.

3. If you answered 'no' to any of the above, give your reasons why.

Gender Reassignment – There are no known impacts on gender re-assignment

Sexual Orientation – There are no known impacts on sexual orientation however, the services should comply with equality policies and deliver services to the same quality irrespective of sexual orientation.

Religion/Belief – There are no known impacts on religion or belief

Age – no as pressure ulcers are more prevalent in older people therefore the aim to reduce pressure ulcers irrespective of where they occur will present a positive impact for older people.

Gender – no for women as there are older women than men therefore the aim to reduce pressure ulcers irrespective of where they occur will present a positive impact for women.

Source: Office for National Statistics mid-2012 population estimates

Race – no - Croydon has a high percentage of BME groups. Over half of Croydon's population are from black Asian and minority ethnic groups who have a higher prevalence of diabetes certain cardiovascular diseases that are comorbid conditions associated with delayed wound healing. Therefore the aim to reduce pressure ulcers irrespective of where they occur will present a positive impact for BME groups.

Source: Croydon JSNA 2010/11 + cardiovascular disease
http://www.hopkinsmedicine.org/geriatric_medicine_gerontology/_downloads/readings/section8.pdf

Disability – no - Pressure sores affect people who are immobilised through sickness or disability. Therefore the aim to reduce pressure ulcers irrespective of where they occur will present a positive impact for this group of people.

Carers – no – improving a health condition may reduce the caring responsibilities of carers

Data collection - Providers should be asked to collect data on patient experience regarding as many of the protected characteristics as possible, as a minimum age, disability, race/ethnicity, gender and possibly extending to sexual orientation and religion/belief. This will enable us to assess the experience of all communities in Croydon.

4. Please indicate if a Full Equality Analysis is recommended.		NO	
Signature of Lead or Director	Date completed 02/07/2014		
Signature of Equality and Diversity Lead	Date reviewed 02/07/2014		

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REPORT TO:	**HEALTH AND WELLBEING BOARD (CROYDON)** **16th July 2014**
AGENDA ITEM:	**9**
SUBJECT:	**Rapid Healthy Weight Strategic Needs Assessment 2013/14**
BOARD SPONSOR:	**Dr Mike Robinson Director of Public Health** **Hannah Miller, Director of Adult Services, Health and Housing** **Paul Greenhalgh, Director of Children, Families and Learning** **Paula Swann, Chief Officer, Clinical Commissioning Group**

CORPORATE PRIORITY/POLICY CONTEXT:

Producing a local Joint Strategic Needs Assessment (JSNA) has been a statutory requirement since 2008. The Health and Social Care Act 2012 has reinforced the importance of JSNA in informing local commissioning decisions and given responsibility for the JSNA to health and wellbeing board members. Local authorities and Clinical Commissioning Groups are required to collaborate to produce a Joint Strategic Needs Assessment (JSNA).

FINANCIAL IMPACT:

Overweight and obesity and their associated health problems have a significant economic impact on the NHS.

In addition, obesity has a wider financial implication for educational attainment (general trend of rising obesity prevalence with decreasing level of education) and social care (obesity is associated with the development of long-term health conditions), placing demand on social care services.

The recommendations set out an approach to see a downward sustained trend in levels of obesity in children and adults.

1. RECOMMENDATIONS

This report recommends that the health and wellbeing board:

1. Consider the rapid Healthy Weight chapter, approve the document in principle and delegate final approval of any further amendments to the responsible directors.
2. Note the recommendations.

In addition, this report recommends that the health and wellbeing board:

3. Endorse the recommendations of the rapid Healthy Weight JSNA.

2. EXECUTIVE SUMMARY

2.1 The Rapid Healthy Joint Strategic Needs Assessment is one of 2 rapid needs assessments forming part of Croydon's 2013/14 JSNA.

2.2 The aim of the rapid JSNA healthy weight chapter is to provide an overall picture of the prevalence of overweight and obesity, and review commissioning activity to reduce rates of obesity.

2.3 The recommendations are set out in section 2 of the chapter. The key issues that will be of particular interest to the Health and Wellbeing board are:

2.4 **In Croydon, one in three children aged 10 to 11 are overweight or obese** (2012/13 National Child Management Programme (NCMP))[1] and for adults the situation is more serious as **over half of all adults are overweight or obese this equates to over 170,000 residents** (Croydon GP Data 2011/12 and Active People survey, 2012)[2] [3]. This means that children in Croydon are growing up in a borough where it is normal to be overweight.

2.5 Obesity is a health inequality issue. It is strongly related to social disadvantage among adults (Foresight 2007)[4] and children (NCMP 2011/12). Only 3% of overweight or obese children have parents who are not overweight or obese[5]. Studies have found that family environments have a strong influence on a child's development, their eating and activity habits, and predisposition to overweight.

2.6 An obese Londoner can expect to die eight to ten years earlier than their non-obese neighbour. Obesity causes cancer and heart disease, it limits life choices and increases early disability and costs London more than £4billion a year [6].

2.7 From 2007 to 2015, the estimated annual cost of obesity to the NHS in Croydon is predicted to rise significantly. During this period, the cost to the NHS is predicted to rise by 24% in Croydon[7] (£11.2 million).

2.8 A different approach is needed to tackle obesity, because after a decade of government and local intervention there are few signs of a significant reduction in obesity levels. Increasingly the evidence base notes that policies aimed solely at the individual are inadequate and by simply increasing the number or type of small-scale interventions are not sufficient to reverse the increasing trend in obesity[8]. Therefore significant effective action at a population level is required to prevent obesity.

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[1] Public Health England (2014) National Child Measurement Programme – England
[2] Croydon (2012) General Practice Data
[3] The Active People Survey (2012)
[4] Foresight (2007) Tackling Obesities Future Choices – Project Report. London: Department of Innovation Universities and Skills
[5] Healthy Weight Healthy Lives (2008) Cross Government Obesity Unit.
[6] Tackling Obesity: Future Choices (2007) Foresight
[7] National Institute for Health and Clinical Excellence. Obesity: Guidance on the prevention, identification, assessment and management of overweight and obesity in adults and children (CG 43). London: NICE, 2006.
[8] National Institute of Clinical Effectiveness. Public Health Guidance (42) Obesity: Working with local communities (2012)

2.9 Tackling obesity is complex and requires action at every level, from the individual to society, and across all sectors. Obesity cannot be effectively tackled by one discipline alone and local authorities are ideally placed to develop co-ordinated action to tackle obesity across its various departments, services and partner organisations. This approach is described as one which is a 'whole system' approach.

2.10 The recommendations are formulated from the review of current commissioning activity compared to the evidence base, and take this whole system approach.

3. DETAIL

3.1 The overall aim of the rapid Healthy Weight JSNA chapter is to improve outcomes for the people of Croydon through influencing commissioning by analysing information of current and future need.

3.2 The chapter identifies gaps in the current approach to the Healthy Weight agenda. Future priorities for improvement and development are made in the recommendations.

3.3 The chapter will be made available online on the Croydon Observatory website.

4. CONSULTATION

4.1 As this is a rapid JSNA no formal consultation was carried out.

4.2 The chapter was shared widely during the JSNA process. Input and direction have been obtained from a wide range of stakeholders across Croydon. A reference group guided the development of the chapter and included membership from across Croydon Council, Croydon Clinical Commissioning Group, and the Integrated Commissioning Unit.

Presentations of drafts of the chapter were given to:

- JSNA Steering group
- CCG SMT
- CCG Governing Body
- Council CLT

5. SERVICE INTEGRATION

5.1 One of the JSNA recommendations is to refresh the Healthy Weight strategy to create an action plan for the prevention and management of child and adult obesity, and take forward the recommendations from this JSNA for implementation. This will replace the Healthy Weight Healthy Lives (2009-2014) strategy.

6. FINANCIAL AND RISK ASSESSMENT CONSIDERATIONS

6.1 From 2007 to 2015, the estimated annual cost of obesity to the NHS in Croydon is predicted to rise significantly. During this period, the cost to the NHS is predicted to rise by 24% in Croydon[9] (£11.2 million).

6.2 As stated in the JSNA chapter there are evidence based cost effective interventions[10] which demonstrate that investment in child weight management intervention is a cost-saving intervention providing a return of investment of between 10 to 13 times on public investment.

6.3 The JSNA chapter set out recommendations. It is the responsibility of commissioners to agree how to make use of the financial resources available to address the recommendations set out.

7. LEGAL CONSIDERATIONS

7.1 Producing a local JSNA is a statutory requirement.

8. HUMAN RESOURCES IMPACT

8.1 There is a recommendation for frontline staff to be skilled-up to be able to assess and identify children at risk of obesity.

8.2 There could be an impact on releasing appropriate frontline staff across health and associated frontline professionals to undertake training.

9. EQUALITIES IMPACT

9.1 The JSNA Healthy Weight chapter has considered equality and diversity implications, by examining the impact of overweight and obesity on vulnerable groups in Croydon's population and considers needs for those people with protected characteristics (see data section 5).

9.2 Amongst women, the peak prevalence of obesity is seen in middle age, after which it declines slowly until early old age. In men, the peak prevalence also occurs in middle age, but the decline is much steeper, with the prevalence gap between men and women continuing to widen until age 75. By the age of 85+, the gap between men and women returns to that seen at age 15-19.

9.3 In Croydon, people with **learning disabilities** and those with **mental illness** are much more likely than the general population to be overweight or obese, particularly women. (Croydon's Adult Obesity Needs Assessment and Service Review, 2010).

[9] National Institute for Health and Clinical Excellence. Obesity: Guidance on the prevention, identification, assessment and management of overweight and obesity in adults and children (CG 43). London: NICE, 2006.

[10] New Economics Foundation

9.4 There is a varied distribution in Croydon by ethnic group. Black and mixed White and Black ethnic groups have the highest rates, while Asian and 'other' ethnic groups have the lowest.

9.5 The proportion of pregnant women in Croydon who are overweight has increased between 2011 and 2013, and recent data (CUH 2013 data) suggests that over half (53.5%) of these women who present at early pregnancy (12wks) are either overweight or obese.

10. ENVIRONMENTAL IMPACT

10.1 A reduction in car travel for short journeys will have a positive environmental impact, as there will be a decline in car emissions.

10.2 A change in planning policy to restrict the number of takeaways could have a positive environmental impact, to reduce litter.

11. CRIME AND DISORDER REDUCTION IMPACT

11.1 There is no specific crime and disorder reduction impact arising from this report.

CONTACT OFFICER: Anna Kitt, Health Improvement Principal, Public Health Croydon

Anna.Kitt@croydon.gov.uk Telephone: 020 8726 6000 ext.61842.

BACKGROUND DOCUMENTS
Key Topic 1: Rapid JSNA Healthy Weight Chapter 2013/14

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REPORT TO:	**HEALTH AND WELLBEING BOARD (CROYDON)** **July 2014**
AGENDA ITEM:	**10**
SUBJECT:	**2014-15 JSNA Key Topics**
BOARD SPONSOR:	**Dr Mike Robinson, Director of Public Health, Public Health Croydon, Croydon Borough Council** **Hannah Miller, Director of Adult Social Care** **Paul Greenhalgh, Director of Children, Families and Learning** **Paula Swann, Chief Officer, Clinical Commissioning Group**

CORPORATE PRIORITY/POLICY CONTEXT:

Local authorities and Clinical Commissioning Groups are required to collaborate to produce a Joint Strategic Needs Assessment (JSNA). Croydon's approach in recent years has been to combine production of an annual key dataset with a small number of chapters on key topic areas, with the latter guided by an agreed prioritisation process to rank proposals received from stakeholders each year.

FINANCIAL IMPACT:

Public health responsibilities transferred to Croydon Borough Council on 1st April 2013. A ring fenced budget transferred from the NHS on this date. There are no immediate financial issues arising from the production of JSNA reports such as key topic chapters. However, a key role for needs assessment is to identify evidence based interventions and identify gaps in service provision. As such, the needs assessments themselves are likely to contain recommendations for commissioners across health, social care and beyond relating to investment, and potentially disinvestment.

1. **RECOMMENDATIONS**

This item is for discussion and a decision. The report recommends that, having considered the public sector equality duty and the Joint Health and Wellbeing Strategy, the Health and Wellbeing Board agree to needs assessments taking place, as part of the annual JSNA cycle, on the following in 2014/15:

- Service provision for the over 65s
- Respiratory illness, children and young people
- Maternal health

2. EXECUTIVE SUMMARY

2.1 Croydon's approach to Joint Strategic Needs Assessment (JSNA) has been to combine a statistical analysis of Croydon's performance (the annual JSNA key dataset) with a small number of 'chapters' on key topic areas. This paper concerns the selection of the key topic areas for the 2014/15 JSNA.

2.2 To inform selection of key topics, a prioritisation process developed by the JSNA steering group was again utilised. As part of the process, proposals are invited from a range of stakeholders and then ranked against set criteria.[1] This year, a total of 19 key topic suggestions were made and scored as part of the JSNA prioritisation process. Those scoring highly were:

- Service provision for the over 65s
- Ethnicity and health
- Smoking – children and young people
- Maternal health
- People in mental health crisis
- Social isolation in older people
- Children with disabilities
- The care home community
- Female genital mutilation

2.3 The JSNA Governance group is recommending that the following key topics be considered for needs assessment as part of the 2014/15 JSNA.

- Service provision for the over 65s
- Respiratory illness, children and young people
- Maternal health

with ethnicity expected to form part of each chapter.

3. DETAIL

3.1 Joint Strategic Needs Assessment (JSNA) has been a statutory requirement of Directors of Public Health, Adult Social Care and Children's Services since 2008[2]. With the Health and Social Care Act of 2012, responsibility has transferred to the new Health and Wellbeing Board. JSNAs, along with Joint Health and Wellbeing Strategies, are intended to form the basis of CCG and local authority commissioning plans, across health, social care, public health and children's services. These are

1 Criteria used: scale of the problem locally, impact of the topic on individuals, value for money presented by tackling the issue, need to address performance locally, number and range of stakeholders for whom this is a priority, quality of evidence that the issue can be tackled, links with deprivation, and links to the equalities agenda.

2 Local Government and Public Involvement in Health Act, 2007

published (on Croydon Observatory website) as and when they are produced on a rolling basis.

Given the Health and Wellbeing Board's core functions of bringing together needs assessment in relation to health and social care, using assessment of need to agree joint priorities; promote integration and promote the involvement of the public in the commissioning process, the selection of JSNA key topic priorities is key business for the Health and Wellbeing Board.

3.2 Prioritisation process

Local approaches to fulfilling JSNA functions vary. Croydon has developed a transparent and systematic approach to informing annual needs assessment topics. Each year, a wide range of stakeholders are asked to submit suggestions for key topic areas. These are formally scored by members of the steering group against eight criteria. Scores reflect the suitability of the topic for needs assessment, rather than the quality of the proposal. To inform the scores, members of Public Health Croydon's Intelligence Team provide background information for each proposal regarding local prevalence, performance data, the strength of the evidence for addressing the problem and so on. Volunteer members[3] of the JSNA steering group then meet to discuss the evidence and agree scores for each of the proposals to enable these to be ranked and inform decision making. Where discussion does not produce consensus on scores for individual criteria, an overall score is achieved by a majority vote.

3.3 Results of prioritisation process 2014/15

A total of 19 key topic proposals were received by the JSNA Steering Group in 2014, from a range of sources (see Table 1).

Table 1: Sources of JSNA topic submissions, 2014

Source of proposal	Number of topic proposals
Public Health Children Families and Learning CCG (including one from a GP) HealthWatch	3 3 3 3
DASHH	2
Croydon Voluntary Action	1
Hear Us	1
South London and Maudsley Foundation Trust	1
Integrated Commissioning Unit	1
Community Rehabilitation Company (formerly London Probation Trust).	1

3 Representatives from Public Health, the CCG, Local Authority commissioning, CVA and HealthWatch.

Total	19

All nineteen proposals were taken to the first stage of the process to assess whether the proposals were suitable for needs assessment. At this stage, five proposals were eliminated. Reasons included that JSNA chapters had only recently been completed on similar topics, or that proposals were considered to be more suitable for research projects than needs assessments (see Appendix 1 for details). All proposers were notified.

The remaining 14 topic proposals entered stage 2 and were allocated scores against each of the eight criteria adopted by the JSNA Steering Group. The results of the scoring are shown in Table 2 below.

Table 2 Results of JSNA prioritization process June 2014

SUMMARY OF PROPOSAL	PROPOSING ORGANISATION	**TOTAL**
Service provision for over 65s	CCG	60
Ethnicity and health	Public Health	50
Smoking - children & young people	Public Health	48
Maternal health	Children and Families Partnership	42
People in mental health crisis	SLAM	40
Social isolation in older people	Public Health	38
Children with disabilities	Healthwatch	38
OIder people with mental health problems in care homes	DASHH	32
Female genital mutilation	CCG	30
Health of migrants and temporary overseas workers	CCG/GP	28
Adults with learning disabilities	ICU	28
Support to parents in risk groups	Children and Families Partnership	28
Long term conditions - children 0-19	Children and Families Partnership	26
Offender health in Croydon	Community Rehabilitation Company	24

The full results for each criteria are shown in Appendix 2.

The ranked results were taken to the JSNA Governance group at the end of June. Following Discussion with the JSNA Governance Group, it is proposed that the key topic areas for 2013/14 should consist of the following:

- Service provision for the over 65s
- Respiratory illness, children and young people (which would incorporate smoking)
- Maternal health

It is expected that ethnicity and health should be a key consideration in each chapter.

4. CONSULTATION

4.1 A wide range of stakeholders were invited to submit topic proposals as part of the JSNA prioritisation process. These include:

- Croydon Clinical Commissioning group
  - Clinical leads
  - Executive officers
  - Chair and deputy chair
  - Six GP networks
- Public Health Croydon
- Community pharmacists
- Directors of Adult Services, Housing and Health; Children Families and Learners, Development and Environment; Strategy, Commissioning, Procurement and Performance
- Local strategic partnerships:
- HWBB
- HWBB partnerships eg Addictive Behaviours Alliance
- Safer Croydon
- Children and Families
- Croydon Council managers and service leads
- Members of the JSNA Steering group
- Croydon Voluntary Action, for cascade through their member organisation
- Croydon HealthWatch, for cascade through its contacts

5. SERVICE INTEGRATION

5.1 There are no direct implications for service integration from the selection of topic areas for the JSNA.

6. FINANCIAL AND RISK ASSESSMENT CONSIDERATIONS

6.1 There are no direct financial considerations arising from this report. However, once completed, needs assessments are likely to raise areas where there may be a need for investment. Needs assessments should also look at disinvestment.

7. LEGAL CONSIDERATIONS

7.1 There are no legal issues arising for the purpose of this report.

8. HUMAN RESOURCES IMPACT

8.1 There are no specific human resource implications arising from this report.

9. EQUALITIES IMPACT

9.1 The JSNA prioritisation process includes an assessment of equality issues. Each topic that is proposed for a JSNA is scored against criteria that includes an assessment to ascertain the extent to which the topic will assess and consider the needs of groups that share a “protected characteristic” or are considered “vulnerable”.

Each JSNA chapter will have a section which looks at the equality and inclusion issues in relation to the main equality groups that share a “protected characteristics” for which data is available. This will also help us to identify equality groups where data is currently not available but may need to be considered.

The integration of equality and inclusion issues into the development of the JSNA will enable the Council to ensure that it meets the statutory obligation in the exercise of its functions to address the Public Sector equality duty (PSED). This requires public bodies to ensure due regard to the need to advance equality of opportunity; foster good relations between people who share a “protected characteristic” and those who do not and take action to eliminate the potential of discrimination in the provision of services.

9.2 Approved by: Yasmin Ahmed, Equalities Manager
Yasmin.ahmed@croydon.gov.uk; 0208 726 6000 x 63264

10. ENVIRONMENTAL IMPACT

10.1 Not applicable

11. CRIME AND DISORDER REDUCTION IMPACT

11.1 None.

CONTACT OFFICER: Jenny Hacker, Consultant in Public Health,
jenny.hacker@croydon.gov.uk; 0208 726 6000 x 61627

BACKGROUND DOCUMENTS None

Appendix 1: Proposals that did not reach stage 2 of the prioritisation process

1. '**Addiction services** in Croydon – are they good enough?'

   Proposed by: Mental Health Forum

   Reason: Addiction services in Croydon are in the process of being recommissioned, therefore it was not seen as a good use of resources to look at current services.

2. '**Community mental health services**.'

   Proposed by: Healthwatch

   Reason: 2012/13 JSNA focused on mental health and included consideration of community services.

3. 'Effect of **welfare reform** on mental health' *

   Proposed by: Hear Us

   Reason: this was seen as more suitable for a research project than a JSNA.

4. '**GP services'**

   Proposed by: Healthwatch

   Reason: Felt to be beyond the scope of a JSNA chapter.

5. '**Stroke pathways'**

   Proposed by: Steve Peddie

   Reason: this was considered to be part of pathway redesign rather than needs assessment. In addition there has been pan London work in this area.

* Submitted for the second time, from different organisations.

Appendix 2: Detailed results of JSNA prioritisation process (ranked high to low)

	A	B					C	D	SCORES			
PROPOSAL	**SCALE LOCALLY**		**IMPACT ON INDIVIDUALS**	**LINKS WITH DEPRIVATION**	**LEVEL OF EVIDENCE**	**LINKS T0 EQUALITIES**	**PRIORITIES/ TIMING**	**COMPARATIVE PERFORMANCE**	**VFM/ SAVINGS**	**SUB 1 A * B**	**SUB 2 C * D**	**TOTAL**
Service provision for over 65s	5		5	5	5	5	5	3	5	25	15	60
Ethnicity and health	5		5	3	3	5	5	3	3	25	9	50
Smoking - children & young people	3		5	5	5	3	5	3	5	15	15	48
Maternal health	3		5	5	5	3	5	3	3	15	9	42
People in mental health crisis	1		5	5	5	5	5	3	5	5	15	40
Social isolation in older people	3		5	3	3	5	3	3	3	15	9	38

Children with disabilities	3	5	3	3	5	3	3	3	15	9	38
The care home community	1	5	3	5	5	5	3	3	5	9	32
Female genital mutilation	1	5	3	3	5	5	3	3	5	9	30
Health of migrants and temporary overseas workers	1	3	5	3	5	3	3	3	3	9	28
Adults with learning disabilities	1	5	3	3	3	5	3	3	5	9	28
Support to parents in risk groups	1	5	5	3	3	3	3	3	5	9	28
Long term conditions - children 0-19	1	5	3	3	3	3	3	3	5	9	26
Offender health in Croydon	1	5	5	1	3	1	3	3	5	9	24

NB multipliers are applied to criteria A and B, and to criteria C and D, and the results added to the scores for the remaining criteria.

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REPORT TO:	**HEALTH AND WELLBEING BOARD (CROYDON)** **Wednesday, 16th July 2014**
AGENDA ITEM:	**11**
SUBJECT:	**Croydon Integrated Mental Health Strategy for Adults 2014-19**
BOARD SPONSOR:	**Paula Swann, Chief Officer, NHS Croydon CCG and Hannah Miller, Executive Director of Adult Services, Health and Housing**

CORPORATE PRIORITY/POLICY CONTEXT:

Producing a local Joint Strategic Needs Assessment (JSNA) has been a statutory requirement since 2008. The Health and Social Care Act 2012 has reinforced the importance of JSNA in informing local commissioning decisions and given responsibility for the JSNA to health and wellbeing board members. Local authorities and Clinical Commissioning Groups are required to collaborate to produce a Joint Strategic Needs Assessment (JSNA).

Croydon's 2012/13 Mental Health JSNA comprised of an overview chapter identifying common themes and further chapters focused on depression and schizophrenia, with a recommendation that a mental health strategy be developed.

The aim of the integrated mental health strategy is to create a shared transformational vision for mental health service provision in Croydon in the next 5 years. This Integrated Mental Health strategy for working age adults should be seen in close alignment to the strategy for children and young people's emotional well-being and mental health 2014-2016 and the work of the Mental Health for Older Adults (MHOA) service re-design project, which is taking forward recommendations from the Dementia Strategy and the current review of older adults mental health services in Croydon. There are also strong links with substance misuse services.

The strategy outlines the fact that mental ill-health has a number of socio-economic determinants including e.g:

- Worklessness
- How we are treated at work
- Debt
- Poverty
- Inadequate housing
- Immigration status

In turn we know that mental health has a broad impact across many aspect of society, not only health and social care services, but also on, education and employment and criminal justice including, police. The strategy covers the years 2014– 2019, in line with the Clinical Commissioning Group (CCG) 5 year strategy and the Council's forward plans for 2015-18.

1. RECOMMENDATIONS

The Health & Wellbeing Board is asked to discuss and comment on the draft Integrated Mental Health Strategy for adults including the proposed outcomes in each of the four key chapters

2. EXECUTIVE SUMMARY

2.1. This document sets out the Croydon integrated mental health strategy for adult mental health which is mainly focused on the needs of adults of working age. The strategy covers the financial years 2014 – 2019, in line with the CCG's 5 year strategy, and the Council's plans for 2015-18.

2.2 We are taking measures to cater for increased demand, ensuring timely access to the most appropriate services for patients and more robust pathways that are effective in delivering end to end care including prevention and social care needs.

2.3 Therefore the aim of the integrated mental health strategy is to create a shared transformational vision for mental health service provision in Croydon in the next 5 years. It is recognised that this strategy is been developed in the context of significant local and national challenges including:

- An increasing demand for mental health services (led in part by demographic changes and population growth), which has led to significant pressures on inpatient beds for Croydon's population.
- A challenging environment in terms of financial resources available to commissioners
- A service system that is imbalanced with a significant number of people in secondary care in the community that could be better managed in primary care, and an over reliance on inpatient provision.
- A low baseline for community services e.g. Improving Access to Psychological Therapies (IAPT) services.
- A need to develop further health and social care integration with the aim of promoting a whole person approach

2.4 By taking forward service re-design we plan not only to meet our financial challenge, but to raise the quality of the services we commission, and improve patient experience by ensuring that mental health problems are dealt with early and within non stigmatising environments.

2.5 For completeness and to understand the broader context in which people live their lives, it also references the strategic priorities for older adults with mental illness and with dementia. This adult's strategy should also be seen in close alignment to the strategy for children and young people's emotional well-being and mental health 2014 – 2016.

2.6 The draft document outlines:

- The national context for mental health and the vision for mental health services in Croydon.
- An overview of the local context including service provision.
- Local commissioning intentions
- The local financial context.
- How we intend to re-design services to make them more effective and efficient and the priority actions we will progress

3. DETAIL

3.1 Key messages and issues:

- A focus on building resilience in individuals and communities to support people with their own mental health and wellbeing
- Invest in more in prevention to prevent mental health problems occurring, or when they do to enable people to make a good recovery
- The need to address the wider determinants of mental health e.g., worklessness, debt, poverty, inadequate housing, immigration status
- The need for improved pathways in in primary and community care
- A need to reduce spend on acute inpatient services and to develop a wider range of community based options
- A need to improve access for BME groups and the range of services available
- Better support for people in community settings including strengthening the role of the voluntary sector

3.2 Mental health and wellbeing affects almost every part of a person's life. It has an impact on physical health, health behaviours, employment, education and quality of relationships with friends and family.

3.3 Mental health problems are common. One in four people will experience at least one mental health condition at some point in their life. They can affect anyone in Croydon, regardless of age, race, gender or social background, although some groups have a higher risk of mental disorder and lower levels of well-being. Mental ill health is the single largest source of disease burden, more than cancer and cardiovascular disease, and the costs extend well beyond health and social care.

3.4 One of the central priorities for the future is that primary care needs to be the main setting for supporting people with mental health problems. Evidence in Croydon suggests that currently a relatively high number of people with mental health problems are managed in secondary care, which is neither cost effective or in keeping with the vision to provide care in the least intensive setting. Services will need to ensure people are supported adequately at an earlier stage, reaching a 'crisis point' is avoided and people are supported to take a more active role in their own care.

3.5 Efforts to prevent mental health problems developing and to treat and support those with mental illness are enhanced through a focus on prevention and early intervention, through enabling our communities to develop resilience and through partnership working. The burden of mental ill health can be reduced through strong partnerships with agencies such as children's services, the

criminal justice system, services that help people to manage their long term physical health conditions, substance misuse services and in the statutory and voluntary sector.

3.6 It is essential that people with mental health problems are supported to manage mental health problems effectively, live a full life and work towards achieving their own goals and aspirations. Personalisation plays a key role in giving people greater choice and control, with all new packages of council-funded social care in Croydon's Integrated Adult Mental Health Services now being provided through Self-Directed Support, often with Direct Payments. Information, advice and support around wider issues such as housing concerns, employment and training issues and opportunities and the impact of welfare reform also contribute to helping people to maintain health and wellbeing and quality of life.

3.7 This document sets out the Croydon integrated mental health strategy for adult mental health which is mainly focused on the needs of adults of working age. The strategy is structured around the themes within the Department of Health (DoH) strategy 'Closing the GAP' and each section includes a summary of the priority outcomes for Croydon, main findings from the JSNA and key service user and stakeholder perspectives. A detailed workplan will also be developed to set out the work that Croydon CCG and social care commissioners will take forward.

4. CONSULTATION

4.1 Key stakeholders including service users and carers have been engaged comprehensively in the development of this strategy. Details of the specific meetings which have taken place, and the key themes emerging for the stakeholders, are set out in Appendix 2.

4.2 A workshop for members of the Mental Health Partnership also took place recently for them to feedback on progress for development of the strategy and to reconfirm that the CGG and Council would need their continuing support in terms of effective implementation.

5. SERVICE INTEGRATION

5.1 This strategy has been developed from the outset as an integrated strategy for Croydon, involving not just the CCG and the Council but the wider community of local stakeholders. In particular it has drawn on the experience of service users and family carers to ensure that their views on effective service integration have been taken into account in delivering good outcomes for individuals.

6. FINANCIAL AND RISK ASSESSMEENT CONSIDERATIONS

6.1 In 2013/14 the CCG and Croydon Council together spent around £60m directly on mental health service for adults of working age (detailed in the financial resources section £46.9 for the CCG and £12.3 for the council). The overall strategic aim is to strengthen prevention and early intervention services and to commission a broader range of services in the community. Investment in these types of services can be more cost effective with better outcomes for users of mental health services.

6.2 As is well known health and social care will have less money to spend on all service provision over the coming years, including on mental health. All this points to a need to do things differently. However the implementation of the strategy requires some significant service redesign and to support this the CCG has made significant investment to meet current service pressures and to redesign services to achieve improved outcomes for patients and associated service efficiencies.

7. LEGAL CONSIDERATIONS

7.1 Not applicable

8. HUMAN RESOURCES IMPACT

8.1 There are no staffing issues arising directly from this report.

9. EQUALITIES IMPACTS

9.1 An Equality Impact Analysis for the strategy is included as Appendix 5. A detailed workplan will be developed for implementation of the strategy and therefore the equality impact analysis will be reviewed and updated alongside this in order to ensure that any potential equality impacts are identified and responded to as appropriate.

10. ENVIRONMENTAL IMPACT

10.1 Not applicable

11. CRIME AND DISORDER REDUCTION IMPACT

11.1 Whilst there are no direct links the strategy does reference the Mental Health London Street Triage Service, an initiative that seeks to improve outcomes for people experiencing mental health problems through services working with a shared commitment to ensure the person in crisis gets the proper level of care in the right environment. Croydon Council will work with partners from SLaM, Police, London Ambulance Services and the voluntary sector ensure there is a local agreement to support this national policy

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CONTACT OFFICER: Tracy Stanley, Strategy and planning manager (acting) DASHH, Strategy, commissioning, procurement and performance, Croydon Council, tracy.stanley@croydon.gov.uk, 020 8726 6000 ext:61623

BACKGROUND DOCUMENTS: None

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REPORT TO:	**Health and Wellbeing Board** **16th July 2014**
AGENDA ITEM:	**12**
SUBJECT:	**Croydon Best Start:** developing a multi-agency model for improving universal and early intervention services for children from conception to aged five and their families
SPONSOR:	**Paul Greenhalgh Executive Director Children, Families and Learning**
CORPORATE PRIORITY/POLICY CONTEXT: Children and Families	
FINANCIAL IMPACT This report sets out plans to improve early intervention services for families with young children with the aim of reducing the call on later more costly interventions.	

1. RECOMMENDATIONS

1.1 The Board is asked to discuss the contents of the report with a view to recommending consultation and engagement on the development of a new integrated delivery model of services to children under five and their parents which will be designed around the needs of families ensuring a more effective service delivery.

2. EXECUTIVE SUMMARY

2.1 The proposal to develop the **Croydon Best Start** model of delivery is based on evidence of the importance of early experiences of babies and the influence on their future life chances. "*The early years are far and away the greatest period of growth in the human brain. It has been estimated that the connections or synapses in a baby's brain grow 20-fold, from having perhaps 10 trillion at birth to 200 trillion at age 3. For a baby, this is an explosive process of learning from the environment. The early years are a very sensitive period when it is much easier to help the developing social and emotional structure of the infant brain, and after which the basic architecture is formed for life. However, it is not impossible for the brain to develop later, but it becomes significantly harder, particularly in terms of emotional capabilities, which are largely set in the first 18 months of life." (Graham Allen Review, Early Intervention: the Next Steps 2013)*

2.2 The intention is that the model is co-designed by parents and communities so that they are at the heart of the system, not the 'recipients' but the co-constructors so that the system empowers communities and parents, developing their strengths and reducing dependencies on statutory services.

There is evidence about the positive and sustainable impact that full user engagement and peer to peer support has on improving the well-being of users and this is an opportunity to develop a model that has this at the centre of its design.

2.4 There are also a number of imperatives that underpin why it is crucial to consider developing a more effective model of support for families with babies and young children in Croydon. The Index of Multiple Deprivation (IMD) 2010 data shows that Croydon has become more deprived between 2004 and 2010. The population is estimated to increase by 10% by 2021 and 14% by 2031 due to increasing birth rates and inflow of people to Croydon. Approximately a quarter of children under 16 live in poverty but this is more concentrated within the youngest aged group. For example just over a third (35%) of children under five live in the 20% most disadvantaged super output areas as opposed to a fifth (20%) of young people aged 11-19. There are other factors that need to be built into projections of service demands. For example, in Croydon, 45% of the alcohol treatment population had children living with them in 2012/13, compared to 28% nationally. Levels of domestic abuse are also high in Croydon. Research by Women's Aid shows that 30% of domestic abuse occurs in pregnancy and therefore a significant proportion of our youngest children are at risk of the negative impact of violence within the home.

2.5 The costs of early intervention are far lower than those required for late intervention programmes, particularly for babies and children. For example the average cost of a family attending a parenting programme is in the region of £1,000 whereas the estimated cost of a child looked after in Croydon is £31,000 p.a. Research in the US found, on average, that early years education for 3- to 4-year-olds in low-income families had a benefit to cost ratio of 2.36 to 1 in the US. Based on current exchange rates, this corresponds to a net benefit of £6,000 per individual. The Wave Trust estimates a return of between £2.90 and £13 for every £1 invested in high quality early years interventions. There is a strong economic case why investment in the early years makes sense and, how further downstream, significant costs will be avoided. More importantly families and communities will be better able to support themselves, enjoy family life and prosper.

2.6 In Croydon, partners have started to work together on the early years so there is a good foundation for Croydon Best Start to build on. There is a strong network of children's centre collaborations and a Primary Prevention Plan (a plan for early help from conception to 5) that brings together health and children's centre services, close working with the voluntary sector as well as extensive engagement with parents and communities. This paper proposes that, with the commissioning of health visiting coming into the local authority in 2015, there is a unique opportunity to more fully integrate services including early learning and childcare, children's centre services, health visiting services, Family Nurse Partnership, family support and community services into one commissioning strategy which will be a more streamlined and effective way of managing significant resources. It may also be possible to explore improved integration with other specialist and health services including antenatal services. It is intended that the model will offer a more effective service and that the whole will be more than the sum of the parts. Management efficiencies can be made, most of which can be reinvested into meeting increasing demands.

2.7 The paper outlines the rationale for developing a new more radical model and proposes the key principles and co-design process. Discussions have taken place at the Children and Families Partnership and a paper for Cabinet is proposed for September with the fully designed model being ready for Cabinet decision in January 2015 for implementation in September 2015. An Expression of Interest has been made to the Department of Communities and Local Government (DCLG) for funding to support the transformation into a new integrated service model.

3. Current arrangements

3.1 Early Intervention Place

In 2013 Croydon was nominated by the Early Intervention Foundation as one of the first 20 Early Intervention Places in England. Working with the Early Intervention Foundation, the Council and its partners are committed to early help to tackle emerging problems for babies, children, young people and their families to prevent situations becoming more serious and to reduce the need for agencies to get involved. The Early Help Board (sub group of the Children and Families Partnership) has developed an Early Help Plan and guidance to promote early intervention across all service areas with the aim of shifting resources from late to early intervention. As part of this work there is a Primary Prevention Plan (a plan for early help from conception to 5) with 5 priorities for bringing together the work of all agencies into a more joined up approach. Building on the work of the strong partnership between Croydon Health Services, children's centres and Early Intervention Support Service, there is an opportunity to redesign the current service configuration into a single multi-agency model of delivery that is co-designed by the families who could benefit.

Research is clear that parenting is one of the most important drivers of reducing social inequalities in cognitive development before school; good parenting and early development can play a protective role for children growing up in disadvantaged environments. Recent research by the Sutton Trust has emphasised that the attachment and bond that children develop with their parents, particularly as babies and toddlers, is fundamental to their flourishing. Research also indicates the long lasting impact of good quality childcare on the learning outcomes for children, and also the strong influence of the home learning environment. A child's development score at just 22 months can serve as an accurate predictor of educational outcomes at 26 years.

3.2 Children's Centres and Family Engagement Partnerships in Croydon

The core purpose of Sure Start children's centres is to improve outcomes for young children and their families, with a particular focus on those in greatest need in order to reduce inequalities in:

- child development and school readiness
- parenting aspirations, self esteem and parenting skills; and
- child and family health and life chances.

The local authority has to a duty to ensure sufficient children's centres to meet local need and in making local arrangements to consider value for money and the ability to improve outcomes for all children and families especially families in greatest need.

3.3 **Early Learning and Development**

There are a total of 47 pre-schools; 99 day nurseries, 472 childminders, 6 nursery schools, 60 nursery classes and 124 reception classes. In Croydon 93% of three year olds access the funded 15 hours childcare across these early years settings.

The Early Years Foundation Stage (EYFS) sets the statutory standards that all early years providers must meet to ensure that children learn and develop well and are kept healthy and safe. It promotes learning and teaching to ensure children's 'school readiness' and underpins the development of a wide range of knowledge, experiences and skills to form the foundation of their learning. It also seeks to promote good partnership working between practitioners and parents, recognising the importance of the home learning environment.

There is a small central team that works with the Learning Communities, supports settings requiring improvement, delivers training, supports settings to track children's progress so that they can identify children's strengths and supports settings to identify and address areas of development. The team works in partnership with schools to implement the assessment of children's development as measured at the end of reception year (known as EYFS profile). The profile is used as an indicator for 'school readiness'. It describes each child's development against 17 early learning goals. Children are defined as having reached a 'Good Level of Development' (GLD) if they reach the expected levels in personal, social and emotional development; physical development; and communication and language and; mathematics and literacy.

Achievement at Early Years Foundation Stage of children by locality 2013

	North	South	East	West	Central	Croydon
Cohort	1331	1082	614	905	796	4728
Number achieving a GLD	619	517	259	355	383	2133
Percentage achieving a GLD	47%	48%	42%	39%	48%	45%

Nationally 52% of children achieved a good level of development. It is anticipated that children will achieve at least this level in 2014 in Croydon.

Croydon is developing sufficient childcare places for vulnerable two year olds (40% of all two year olds), with an estimated 2,000 places needed from September 2014. Currently the take up is slow with just over 600 places accessed in March, against a target of 1200 for the whole year. A publicity drive is planned to further promote available places and the benefits of accessing good quality childcare for children's development. Children's centres, health visiting and midwifery all play a role in ensuring that families understand the importance of good quality childcare but also in taking advantage of a whole family offer such as support for readiness for work or training, parenting courses etc.

3.4 **Health Services and the Healthy Child Programme (HCP)**

The HCP for children 0 – 5 is the early intervention and prevention public health programme that lies at the heart of a universal health visiting service for children and families. It is a programme of screening, immunisation, health and development reviews for children.

The HCP includes a universal service that is offered to all families, with additional services for those with specific needs and risks. Croydon Universal Services team of health visitors work closely with community partners to support families to access health information and services appropriate to their needs.

3.5 **Family Nurse Partnership**

Croydon Universal Services also delivers the Family Nurse Partnership (FNP) programme, a voluntary intensive home visiting programme for young mothers and fathers aged 19 or under. Specially trained nurses support young mums to have a healthy pregnancy, improve their child's development and health and to plan their own futures and achieve their aspirations. It is an evidence-based programme that has been extensively researched in the US over the last 30 years and has been shown to improve parent and child outcomes with significant economic returns on investment. Croydon's programme is already showing promising results and a large scale research project is underway in the UK which will report in 2014. In Croydon over 100 young mothers, fathers and their babies are being supported each year, many of whom have overcome multiple challenges in their lives leading to improvements in health outcomes, reduction in smoking, more children meeting age appropriate development and parents accessing schooling and university.

3.6 **Midwifery service**

The core purpose of the midwifery service, commissioned by the Croydon Clinical Commissioning Group and provided by Croydon Health Services, is to provide high quality, responsive maternity services in which women, their partners and families are supported to maintain and improve health and wellbeing throughout pregnancy, birth, the postnatal period and through the transition to parenthood. Croydon Health Services midwifery teams work in the hospital and community and enable women to give birth where they want and how they want. The new maternity centre provides midwife-led care in good quality accommodation with over 4,300 babies born in 2013/14 in the maternity unit and birth centre. The service aims to reduce maternal and child mortality rates and through antenatal and newborn screening programmes lead to early detection of abnormalities. Midwives run clinics in children's centres and work with health visitors and Family Engagement Partnerships.

3.7 Speech and language therapy, jointly commissioned by the local authority and Croydon Clinical Commissioning Group and delivered by Croydon Health Services is the provider of the speech and language therapy, is an essential service to support children. In addition to this generic service, additional communication, speech and language support is commissioned as part of Learning Communities and children's centre services.

3.8 The links with the early years services for children with disabilities are strong with good links with Portage and SEN services, many referrals coming through FEP. A range of group opportunities for children and their parents are provided through the children's centres including advice and information.

3.9 GP practices are more embedded within the Primary Prevention Plan than ever before and they are key to the Croydon Best Start model. Relationships with GP clusters is essential, and the option of wrapping Croydon Best Start

services around GP clusters would strengthen the whole system of support to families with young children. It would also help promote a 'think family' approach, enable GPs more easily to signpost families where they have concerns and better link up domestic abuse services with families seen by GPs.

3.10 Health outcomes for children is mixed in Croydon with significantly worse outcomes than the England average in terms of obesity, A & E attendances for under 5's, levels of immunisation and low birth weight. Breastfeeding and smoking status at time of delivery are particularly strong in Croydon with above regional and England averages. The Croydon Best Start model would be directly tackling health outcomes that are below average as well as continuing to improve on current successes.

3.11 **Parents in work and training**

The requirement to support parents to return to work and undertake training is a feature of children's centre core purpose. However the resources of Job Centre Plus have been stretched and this is an area that needs to be further addressed to promote opportunities for parents of young children to prepare for the world of work. However there are a range of volunteering programmes for parents which can lead to qualifications, as well as other learning opportunities, through Croydon Adult Learning. They also provide extensive family learning and links with children's centres are strong.

3.12 **Voluntary sector and commissioned services**

The voluntary sector in Croydon is extensive and varied with a range of key organisations delivering services for under 5's. Some specific examples include Family Navigators: a programme targeting harder to reach families to support them make independent decisions; Homestart working closely with Family Engagement Partnerships to support families with under 5's; other groups such as Fieldway Family Centre, Gingerbread, Family Lives, National Autistic Society etc all work with children's centres to support families. There is also a wider range of agencies that provide specific or whole family support providing a network of community based support for families across the borough. In addition the council has commissioned a number of evidence based parenting programmes including Incredible Years and EPEC (Empowering Parents Empowering Communities). Faith groups provide an extensive range of family support for their communities, and the Faiths Together in Croydon network provides a collective voice for all faith communities.

3.13 **Domestic Abuse and Sexual Violence**

The Family Justice Centre provides support to victims of domestic abuse from a multi-disciplinary team. The Centre provides a drop-in facility as well as telephone helpline and works in partnership with a wide range of agencies. With the increase in reported incidents of domestic abuse this is a key area of development as the service continues to develop, providing training and support for practitioners as well as working across all partners in Croydon. In addition the partnership approach has improved awareness and practice across all children and family services. With the high prevalence of domestic abuse within families with very young children, it will be crucial to consider domestic abuse support services as part of the Croydon Best Start model.

5. SERVICE INTEGRATION Croydon Best Start: designing the new model

5.1 The Croydon Best Start model will require a structured but flexible approach to help support the early development of babies, the transition of mothers and fathers to parenthood and enable both professionals and parents to identify and make well-informed decisions about the needs of the baby and the family.

Even with the potential efficiencies of integration of resources there is a question of whether this will be sufficient to meet increasing demands. There is a growing body of research that shows the cost effectiveness of user involvement in all stages in the delivery of a service. There is a need to avoid services unwittingly encouraging reliance rather than resilience and being designed around the perceived needs of professionals rather than users. In developing options for Croydon Best Start there is an opportunity to look at a service that not only involves parents in the design but also in the delivery, for example through peer to peer support.

5.2 Using what parents and communities have already told us, and a growing body of evidence that shows the effectiveness of users being involved in designing and delivering services produces better outcomes for less money, the new model will focus on designing a system that is based on strong and shared principles where parents are seen as equal partners and confident parents and communities and skilled practitioners, are able and willing to respond to the changing needs of families and communities in Croydon.

Peer support should be considered as an essential part of the new model. *It is a well-tested part of social care, mental health, physical health and, at an everyday level, it forms the basic structures of our families, friendships and communities, which practitioners and providers have long understood to be important to health and wellbeing.* (Innovation Unit: a not-for-profit social enterprise).

This approach shifts the focus onto the people and relationships involved in each health and care interaction, and away from institutions' services and processes. It is an asset based approach that recognises everyone's role and allows for people taking more control of their own lives, gaining confidence and self-respect through supporting others and building stronger social connections through friendships and mutual support. It is based on the belief that service models should be about a narrative of recovery, self-efficacy and hope rather than a more conventional deficit model. Croydon has developed a strong asset based approach and partners have already committed to Asset Based Community Development (ABCD) work across the borough.

5.3 In 2013 Croydon Children and Families Partnership and the Health and Wellbeing Board committed themselves to a Primary Prevention Plan (conception to 5). It is intended to promote and deliver the aim of ensuring that *every baby, child and young person is equipped with social and emotional skills and resilience to improve their life chances, enabling them to realise their potential.* The partnership working in this plan will provide a good foundation on which to build Croydon Best Start.

As part of developing the Primary Prevention Plan, partners have adopted the Family Partnership Model as their workforce development tool. This is a

challenging piece of work which, if successful, will deliver a sea-change in both the 'hearts and mind' of practitioners and in their everyday practice to ensure the needs of families are identified and met as early as possible through shared and robust assessment and action planning. Workforce development is critical to the success of Croydon Best Start.

5.4 An Integrated Governance Framework for commissioning health visiting between the council and NHS England will support the development of the new integrated model in the period before the council takes on commissioning responsibility for health visiting. The fact that Croydon already has an Integrated Commissioning Unit with Croydon Clinical Commissioning Group provides a strong platform through which to commission a redesigned integrated service.

5.5 **Croydon Best Start Design Principles**

It is proposed that there are four key principles

- designed and delivered in partnership with parents and communities
- builds on the work of partners through the Primary Prevention Plan
- commissioned in the context of an integrated outcomes framework for conception to 5
- builds on lessons learnt from previous consultation and engagement.

An integrated commissioning and outcomes framework will be developed that brings together the range of outcomes required across the various integrated services, it will also incorporate any key aspirations of parents and communities.

6. Engagement with families, communities and partners

6.1 A consultation with stakeholders on the Croydon Best Start is now proposed. This will also include the statutory duty to consult with local communities where changes are proposed in children's centres.

Building on earlier consultation regarding children's centre re-design and primary prevention principles our proposal is to undertake further consultation with parents, families, communities, practitioners, existing and potential partners, wider stakeholder groups and members and accountable leaders on the following aspects of a Best Start approach:

- the opportunity to re-design the current individual service configuration into an integrated service, and commissioning strategy;
- the re-design principles;
- the development of models that can be tested;
- the development of governance and leadership structures that enable parents to be an equal partner through all stages from design to delivery.

6.2 Governance for primary prevention lies with the Children and Families Partnership and Health and Well Being Board with partnership engagement and development led by the Early Help sub group Board of the Children and Families Partnership.

7 FINANCIAL AND RISK ASSESSMENT CONSIDERATIONS

7.1 In the table below the figures are provided for those services which the local authority and/or Integrated Commissioning Unit has currently within its portfolio or will have in 2015. Financial modelling will be outlined once the final Best Start service is designed.

Children's Centres	£3.5m
Health visiting	£4.5m
Family Nurse Partnership	£445k
Commissioned family support	tbc

7.2 Options

The first option is to keep the current services areas as they are currently individually commissioned e.g. children's centres, midwifery, family nurse partnership, health visiting, commissioned family support etc.

This paper proposes that a second option of developing a new integrated delivery model that will be more effective, improve value for money and make efficiency savings in management costs that can be reinvested in front line resources to address the increasing numbers of children and increasing complexity of needs in the borough.

There will be a cost-benefit analysis undertaken during the design phase so that the decision on which services are brought together into a single commissioning strategy is based on positive and substantive improvement in efficiencies.

If the savings options detailed above are not realised there will be the need to identify alternative savings to enable the targets to be delivered.

2 Future savings/efficiencies

The research is clear in the savings and efficiencies achieved by early intervention, particularly in the early years. The consensus from a wide range of published studies is a return on investment of between £1.37 and £9.20 for every pound invested in the early years.

8. COMMENTS OF THE COUNCIL SOLICITOR AND MONITORING OFFICER

8.1 The Solicitor to the Council comments that the amendments made by the Apprenticeship, Schools, Children and Learners Act 2009 inserted new sections into the Childcare Act 2006 ("the Act") which extend the requirement that as part of meeting their duties, local authorities must, so far as is reasonably practicable, include arrangements for sufficient provision of children centres to meet local need. This means local authorities are under a duty to secure sufficient children centres provision for their area.

The statutory requirements with regard to consultation in respect of changes to children centres contained within the Act stipulates a statutory duty to consult before opening, closing or significantly changing children centres.

In discharging their duty, a local authority must have regard to any guidance given from time to time by the Secretary of State.

DfE Statutory Guidance for Children's Centres, last issued in April 2013 provides detail on such matters as what changes should be consulted upon, the consultation process, whom should be consulted and what happens after consultation.

With regards to a minimum period for consultation, the guidance says it should be tailored to the scale of the potential change.

In respect of the Council's public sector equalities duty and when considering the proposals in this Report, the Cabinet must have 'due regard' to the protected characteristics and the specific needs of those within the relevant groups that may arise. Insofar as this decision may affect large numbers of vulnerable people, many of whom have one or more of the protected characteristics (in this case that would include age), the 'due regard' necessary is very high. Where this report and the EQIA identify any adverse impact, consideration will be given to measures to avoid that impact in developing the new delivery model.

9. HUMAN RESOURCES IMPACT

9.1 Full consultation will take place in conjunction with HR, Trade Unions and staff to consult on the proposals and mitigate the number of people adversely affected by the change.

10. EQUALITIES IMPACT

10.1 An Equalities Impact Assessment will include the likely impact of the proposed changes to the organisations themselves as well as the end service users. It will be updated with any relevant information that arises from the consultation exercise and it will be recorded where significant changes would have a disproportionate impact. It will also be necessary to consider whether it would be possible to mitigate any negative impacts and if so how. The EQIA presented to Cabinet along with the outcomes of consultation, before a final decision is made in November 2014.

11. CRIME AND DISORDER REDUCTION IMPACT

11.1 There is a long term positive impact as evidenced by the research on early intervention that well attached and healthy young children are less likely to be involved within the criminal justice system.

12. REASONS FOR RECOMMENDATIONS/PROPOSED DECISION

12.1 The need for reaching a growing population with increasing levels of poverty and disadvantage with a more integrated and effective service for under 5's.

13. OPTIONS CONSIDERED AND REJECTED

13.1 Consideration was given to a more significant reduction of the budget of children's centres and health visiting. This was considered to present too much risk in terms of meeting the statutory duty of children's centres and the healthy child programme, and would undermine the development Best Start and its ability to reach the increasing numbers of families.

CONTACT OFFICERS: Dwynwen Stepien, Head of Early Intervention Support Service, Children, Families and Learning

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Croydon Best Start

a multi-agency model for improving universal and early intervention services for children from conception to aged five and their families

so that

every baby, child and young person is equipped with social and emotional skills and resilience to improve their life chances, enabling them to realise their potential

Croydon Safeguarding Children Board (CSCB)
"Keeping Croydon Safe for Children"

Children's centres in Croydon

Local authority has a sufficiency duty to deliver children's centres

Core purpose:

- child development and school readiness
- parenting aspirations, self esteem and parenting skills
- child and family health and life chances

- 9 lead centres with network of centres/access points
- 12,000 families visit centres
- 1,000 referrals p.a. to Family Engagement

Croydon Safeguarding Children Board (CSCB)
"Keeping Croydon Safe for Children"

Health visiting and midwifery services in Croydon

Deliver the evidence based Healthy Child Programme supporting parents-to-be and parents through checks, advice and support at key stages of development

- 500 new births every month
- high level of safeguarding cases held
- Family Nurse Partnership > 100 young mums & dads
- all work as part of Family Engagement Partnership
- low immunisation rates
- high rates of obesity & A & E attendance <5's
- childhood asthma of concern

Croydon Safeguarding Children Board (CSCB)
"Keeping Croydon Safe for Children"

Early Years and wider community

Local authority has a childcare sufficiency duty for 40% 2 yr & 100% 3,4 yr olds

47 pre-schools; 99 day nurseries, 472 childminders, 6 nursery schools, 60 nursery classes and 124 reception classes.

- 48% of children attained a good level of development (52% nationally) at end of reception
- developing into Early Learning Communities to bring together and support providers to improve quality
- voluntary sector, community and faith groups offe significant resource – families/settings need

Croydon children & families partnership

Croydon Safeguarding Children Board (CSCB)
"Keeping Croydon Safe for Children"

Croydon as an Early Intervention Place

- nominated by Early Intervention Foundation as one of the first 20 Early Intervention Places in England
- committed to shift of resources from late reactive services to more positive capacity building early help
- evidence based programmes, practice and systems
- whole system, whole family and one workforce
- early years integration as one of our agreed

Croydon Safeguarding Children Board (CSCB)
"Keeping Croydon Safe for Children"

Evidence

- the bond that children develop with their parents, particularly as babies and toddlers, is fundamental to their flourishing, children without secure parental bonds are more likely to have behaviour and literacy problems
- a child's development score at 22 months is an accurate predictor of educational outcomes when they are 26
- evidence based programmes in the early years can offer a return between £2.90 and £13 for every £1 invested

The imperatives to developing a new model

- increasing population and increasing deprivation
- under 5's more deprived than 5-19 age group
- under 1's most vulnerable in terms of safeguarding
- 40% of 2 year olds in good quality childcare
- commissioning of health visiting coming into council
- synergy of <5's services –commissioning efficiencies
- motivated workforce attracted to work in Croydon
- build on GP clusters and early years networks
- efficiencies reinvested to meet unmet demand
- Ofsted demands of early years & children's centre
- the economic case of investing early

Croydon children & families partnership

Croydon Safeguarding Children Board (CSCB)
"Keeping Croydon Safe for Children"

Croydon Best Start Design Principles

- designed and delivered in partnership with parents and communities
- builds on the work of partners through the Primary Prevention Plan
- commissioned in the context of an integrated outcomes framework for conception to 5
- builds on lessons learnt from previous consultation and engagement

What is new in the Croydon Best Start model?

- Co-designed by parents – central to its development
- Co-delivered by parents through peer to peer and being part of the governance structure
- Driven by function not professional demarcation
- Single workforce – joint training, supervision
- Integrated outcomes framework

Developing an outcomes framework

i) parents-to-be, parents and the extended family network are confident that they can support themselves and access the services they need, when they need them

This would mean that:

- parents are co-designers with an engagement model in place that continues throughout the design and implementation period
- parents and communities are co-deliverers through peer to peer
- an asset based approach is used that builds the capacity of the community and moves away from a deficit model

ii) babies and children are thriving, learning and developing with good quality learning opportunities at home and outside and through accessing high quality childcare

This would mean that:

- parents are recognised as their child's first teacher, seen as equal partners by early years settings and supported to enjoy being involved in their children's learning
- children's learning is made visible at home, in the community and in settings

iii) parents-to-be and parents feel confident about their parenting and care for their baby and young children because there is a seamless service for children under five and their families

This would mean that:

- the model builds family capacity and prioritises early intervention and prevention
- a think family approach is taken to that the wider needs of siblings and adults

iv) parents-to-be and parents who need extra help get the services they need to overcome their problems as soon as problems emerge

This means that:

- the expertise of all practitioners is used appropriately so that activities are based on skills and expertise rather than professional status
- all services are considered contributors to Croydon Best Start
- evidence-based programme, practice and systems in place

v) practitioners across health, children's centres, the community and voluntary sector

Croydon Safeguarding Children Board (CSCB)
"Keeping Croydon Safe for Children"

Potential gains from a re-modelled service

- seamless service for parents that gives them a sense of control over their own lives
- single point of contact for families & more confidence in accessing wider range of services
- savings to be reinvested to improve frontline capacity
- reduction in take up of later statutory services
- cost benefit analysis to identify and improve efficiency and to evidence impact

July – October 2014

- Parent co-design groups set up
- engagement of wider stakeholders
- develop options and consult on best fit
- develop integrated outcomes framework

Subject to cabinet decision

November 2014 (post cabinet) - March 2015

- reshaping children's centre services & early years services
- commissioning of Early Years Teaching School (if agreed)
- voluntary sector and parent led service design panels continue

Croydon Safeguarding Children Board (CSCB)
"Keeping Croydon Safe for Children"

What is required next?

- open to a new model that delivers improved outcomes and efficiencies
- release of resources/time to the redesign
- commitment to parents as co-designers and co-producers
- engagement in modelling using Cost Benefit Analysis
- support in the development of an integrated outcomes framework
- officer time if successful DCLG expression of

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REPORT TO:	**HEALTH AND WELLBEING BOARD** **16 July 2014**
AGENDA ITEM:	**14**
SUBJECT:	**Report of the chair of the executive group: incorporating performance report, risk register and board work plan**
LEAD OFFICER:	**Hannah Miller, executive director of adults services, health and housing & deputy chief executive, Croydon Council**

CORPORATE PRIORITY/POLICY CONTEXT:

The Health and Social Care Act 2102 created statutory health and wellbeing boards as committees of the local authority. Their role is to improve the health and wellbeing of local people by promoting integration and partnership working between the NHS, social care, children's services, public health and other local services, and to improve democratic accountability in health.

FINANCIAL IMPACT:

None

1. RECOMMENDATIONS

The health and wellbeing board is asked to:

- Comment on performance against joint health and wellbeing strategy indicators at appendix 1. Areas of success and challenge identified by the performance report are set out in section 3.5 of this paper.
- Note risks identified at appendix 2
- Note changes to the board work plan set out in paragraphs 3.7 and 3.8

2. EXECUTIVE SUMMARY

2.1 The performance report at appendix 1 contains indicators to enable the board to track performance in delivery of the joint health and wellbeing strategy. A number of strategic risks were identified by the board at a seminar on 1 August 2013. The board agreed that the executive group would keep these risks under review. A summary of risks is at appendix 3. The health and wellbeing board agreed its work plan for 2013/14 at its meeting on 24 April 2013. The work plan is regularly reviewed by the executive group and the chair. This paper includes the most recent update of the board work plan at appendix 3.

3. DETAIL

3.1 The purpose of health and wellbeing boards as described in the Health and Social Care Act 2012 is to join up commissioning across the NHS, social care,

public health and other services that the board agrees are directly related to health and wellbeing, in order to secure better health and wellbeing outcomes for the whole population, better quality of care for all patients and care users, and better value for the taxpayer.

Work undertaken by the executive group

3.2 The board seminar on 1 August 2013 recommended that the chair of the executive group reported regularly to the board on the work undertaken by the executive group on behalf of the board. Key areas of work for the executive group between March and June 2014 are set out below:

- Review of the work plan including preparation of board agenda and topic prioritisation against the joint health and wellbeing strategy
- Discussion of proposals for the board away day planned for June 2014 (deferred).
- Consideration of future learning and development for board members including new board member induction, future board away days and learning events
- Liaison with other strategic partnerships including Croydon strategic partnership and children and families partnership
- Review of board strategic risk register
- Review of responses to public questions and general enquiries relating to the work of the board

Performance

3.3 Appendix 1 shows results for a selection of performance measures relating to joint health & wellbeing strategy priorities. The selection of performance indicators was agreed by the executive group. The report shows graphs for a selection of "good news" and potential challenge areas, and results for a wider suite of measures in tabular form.

3.3.1 For **improvement area 1: giving our children a good start in life**, breastfeeding prevalence is identified as an area of success. Two areas of challenge identified are teenage conception rate (although there has been significant improvement against this indicator) and MMR vaccination coverage.

3.3.2 For **improvement area 2: preventing illness and injury and helping people recover**, the proportion of households in fuel poverty is identified as an area of success. Areas of challenge include over 65s vaccinated against influenza, injuries due to falls, and people with HIV presenting at a late stage of infection.

3.3.3 For **improvement area 3: preventing premature death and long term health conditions** take up of NHS Health Checks is identified as an area of challenge.

3.3.4 For **improvement area 4: supporting people to be resilient and independent**, areas of success identified are the proportion of people

using social care who receive self-directed support and delayed transfers of care from hospital. Areas of challenge include the proportion of people using social care who receive direct payments, the proportion of adults with learning disabilities in paid employment and the proportion of people who use services who say that those services have made them feel safe and secure.

3.3.5 For **improvement area 5: providing integrated, safe, high quality services** and **improvement area 6 improving people's experience of care**, no focus areas are recommended at this stage

Risk

3.6 Risks identified by the board at the seminar on strategic risk held on 1 August 2013 are summarised at appendix 2. The executive group regularly review the board risk register. An additional risk relating to the production of the pharmaceutical needs assessment has been added to the risk register.

Board work plan

3.7 Changes to the board work plan from the version (9.0) agreed by the board on 26 March 2014 are summarised below. Changes were discussed by the executive group on 21 May 2014 and with the chair on 11 July 2014. This is version 10.0 of the work plan. The work plan is at appendix 3.

3.7.1 Addition of information item on the South West London collaborative commissioning strategy

3.8 A board away day was to have been held on 16 June 2014 to take forward the review and refreshing of the joint health and wellbeing strategy. This has now been deferred until the autumn (date to be confirmed). The board away day date of 1 October will now be used for a public engagement event.

4. CONSULTATION

4.1 A number of topics for board meetings have been proposed by board members. These have been added to a topics proposals list on the work plan. Board members were asked to indicate their priorities from this list through a short survey circulated at the beginning of September 2013. The executive group on 22 October 2013 asked the head of health and wellbeing to review topics covered at previous board and shadow board meetings and cross check against health and wellbeing board priorities to identify potential gaps. Recommendations were taken to the chair's meeting on 24 January 2014 and are reflected in the work plan.

5. SERVICE INTEGRATION

5.1 All board paper authors are asked to explicitly consider service integration issues for items in the work plan.

6 FINANCIAL AND RISK ASSESSMENT CONSIDERATIONS

6.1 Where there are financial or risk assessment considerations board paper

authors must complete this section and gain sign off from the relevant lead finance officer(s). Where there is joint funding in place or plans for joint funding then approval must be sought from the lead finance officer from both parties.

7. LEGAL CONSIDERATIONS

7.1 Advice from the council's legal department must be sought on proposals set out in board papers with legal sign off of the final paper.

8. HUMAN RESOURCES IMPACT

8.1 Any human resources impacts, including organisational development, training or staffing implications, should be set out for the board paper for an item in the work plan.

9. EQUALITIES IMPACT

9.1 The health and wellbeing board, as a committee of the council, has a statutory duty to comply with the provisions set out in the Equality Act 2010. The board must, in the exercise of all its functions, have due regard to the need to comply with the three arms or aims of the general equality duty. Case law has established that the potential effect on equality should be analysed at the initial stage in the development or review of a policy, thus informing policy design and final decision making.

9.2 Paper authors should carry out an equality analysis if the report proposes a big change to a service or a small change that affects a lot of people. The change could be to any aspect of the service – including policies, budgets, plans, facilities and processes. The equality analysis is a key part of the decision-making process and will be considered by board members when considering reports and making decisions. The equality analysis must be appended to the report and have been signed off by the relevant director.

9.3 Guidance on equality analysis can be obtained from the council's equalities team.

CONTACT OFFICER: Steve Morton, head of health and wellbeing, Croydon Council steve.morton@croydon.gov.uk, 020 8726 6000 ext. 61600

BACKGROUND DOCUMENTS

None

APPENDIX 1

Health & Wellbeing Board Performance Report

May 2014

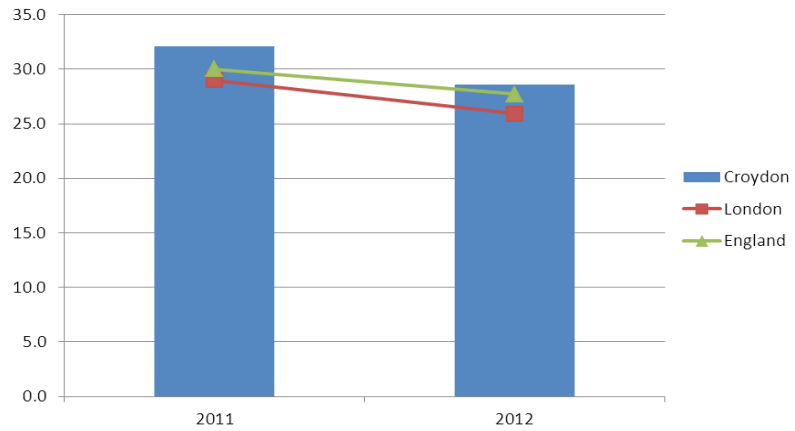
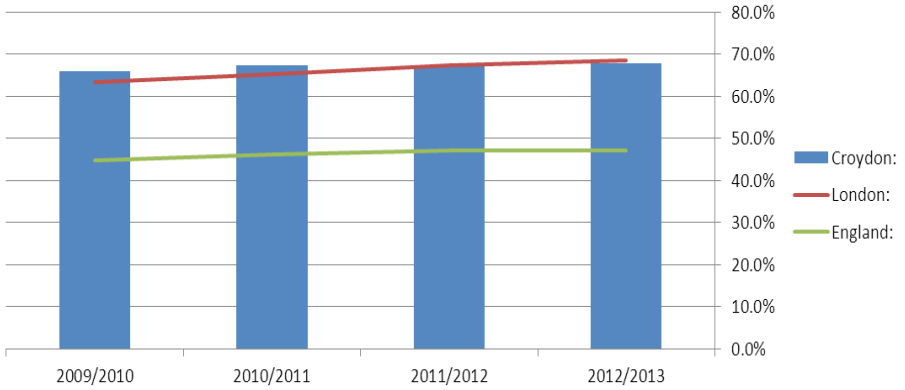
Strategy & Performance & Public Health Intelligence Team– Croydon Council
5/15/2014

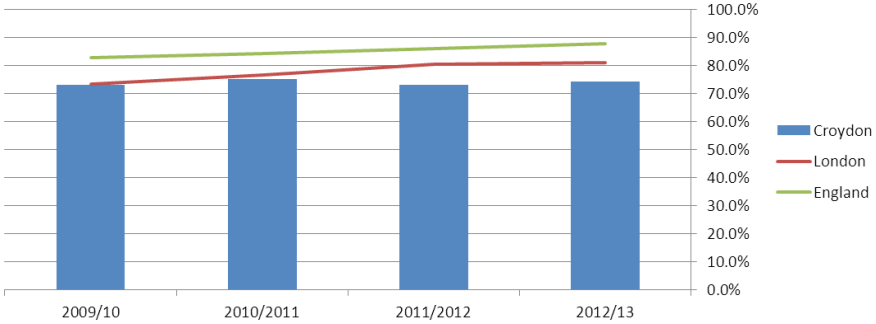
Contents

NOTE – the principal source of data within this report is the Croydon Key dataset developed by the Croydon Public Health Intelligence Team. Thanks to David Osborne (Senior Public Health Analyst) in particular for making this data source available and for his input into the selection of relevant performance measures.

Improvement area 1: giving our children a good start in life

Priorities
1.1 Reduce low birth weight
12. Increase breastfeeding initiation and prevalence
1.3 Improve the uptake of childhood immunisations
1.4 Reduce overweight and obesity in children
1.5 Improve children's emotional and mental wellbeing
1.6 Reduce the proportion of children living in poverty
1.7 Improve educational attainment in disadvantaged groups

Potential challenge areas	Areas of success
Conception rate per thousand women aged 15 to 17	**% breastfeeding prevalence at 6-8 week health check**
	
Croydon has been recognised for achieving a sustained and long-term decline in the rate of teenage conceptions. Falling more in line with the national average, the borough however remained above the London average for 2012	Breastfeeding prevalence at 6-8 weeks is significantly higher than the national average and remains in line with the London average
Potential challenge areas	
MMR vaccination coverage for two doses (5 years old)	

Potential challenge areas	Areas of success
Conception rate per thousand women aged 15 to 17	**% breastfeeding prevalence at 6-8 week health check**
 MMR vaccination coverage (2 doses for 5 yr-olds) has been showing a gradually increasing trend nationally and in London, whilst the latest available data (2012-13: 74.2) shows slight increase in comparison with the previous year (2011-12: 73.1) the indicator remains below the London and National average.	

Performance measures

Measure description	Source	Polarity (is a higher or lower number better?)	Most recent annual data	From	Previous year	London Average	England Average	Comparison with previous year	Comparison with London Average	Comparison with England Average
Conception rate per thousand women aged 15 to	Croydon key dataset	LOW	28.6	2012	32.10	24.4	26.3	BETTER	WORSE	ABOUT THE SAME

Measure description	Source	Polarity (is a higher or lower number better?)	Most recent annual data	From	Previous year	London Average	England Average	Comparison with previous year	Comparison with London Average	Comparison with England Average
17										
Breastfeeding initiation within 48 hours (% of mothers)	Croydon key dataset	HIGH	86	2012/13	87	86.8	73.8	ABOUT THE SAME	ABOUT THE SAME	BETTER
% breastfeeding prevalence at 6-8 week health check (infants totally or partially breastfed as a % of all subject to a health check)	Croydon key dataset	HIGH	67.9	2012/13	67.3	68.5	47.2	ABOUT THE SAME	ABOUT THE SAME	BETTER
Percentage of women who are smokers at the time of delivery	Croydon key dataset	LOW	7.6	2013/14 (Quarter 2 reporting period)	7.8	5	11.8	ABOUT THE SAME	WORSE	BETTER
Percentage of children aged 4-5 years with height and weight recorded who are either overweight	Croydon key dataset	LOW	23.7	2012/13	24.2	23.01	22.22	ABOUT THE SAME	ABOUT THE SAME	ABOUT THE SAME

Measure description	Source	Polarity (is a higher or lower number better?)	Most recent annual data	From	Previous year	London Average	England Average	Comparison with previous year	Comparison with London Average	Comparison with England Average
or obese										
Percentage of children aged 10-11 years with height and weight recorded who are either overweight or obese	Croydon key dataset	LOW	38.2	2012/13	38.3	37.5	33.9	ABOUT THE SAME	ABOUT THE SAME	WORSE
Percentage of live and still births under 2500 grams	Croydon key dataset	LOW	8.3	2011	8.8	8	7.4	BETTER	ABOUT THE SAME	WORSE
Immunisations - DTaP / IPV / Hib vaccination coverage (1 year old)	Croydon key dataset	HIGH	91.1	2012/13	91.3	91.1	94.7	ABOUT THE SAME	ABOUT THE SAME	WORSE
Immunisations - Hib / MenC booster vaccination coverage (2 years old)	Croydon key dataset	HIGH	86.6	2012/13	82.4	87.3	92.7	BETTER	ABOUT THE SAME	WORSE

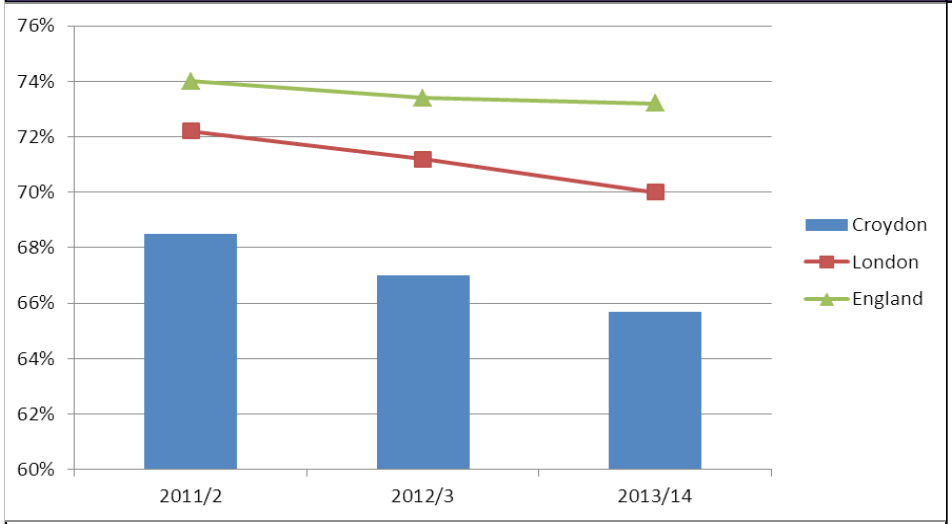
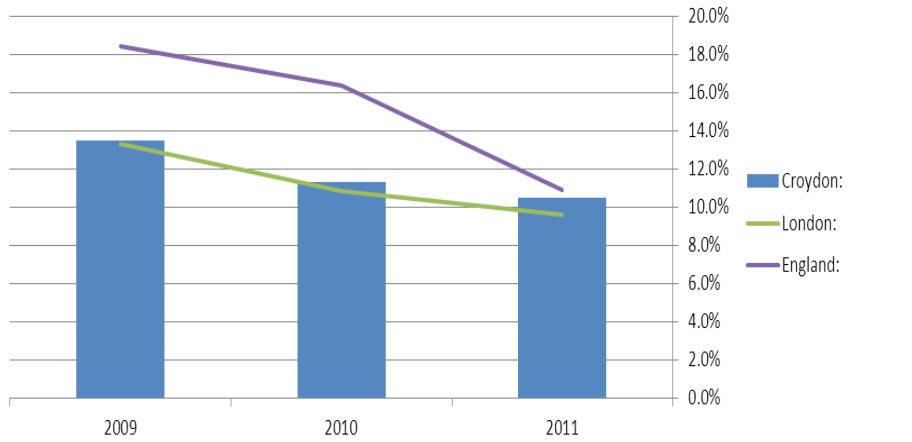
Measure description	Source	Polarity (is a higher or lower number better?)	Most recent annual data	From	Previous year	London Average	England Average	Comparison with previous year	Comparison with London Average	Comparison with England Average
Immunisations - PCV booster vaccination coverage (2 years old)	Croydon key dataset	HIGH	86.2	2012/13	82.4	86.6	92.5	BETTER	ABOUT THE SAME	WORSE
Immunisations - MMR vaccination coverage for one dose (2 years old)	Croydon key dataset	HIGH	86.5	2012/13	83.5	87.1	92.3	BETTER	ABOUT THE SAME	WORSE
Immunisations - DTaP / IPV vaccination coverage (5 years old)	Croydon key dataset	HIGH	92.7	2012/13	92.5	92.8	95.8	ABOUT THE SAME	ABOUT THE SAME	WORSE
Immunisations - MMR vaccination coverage for two doses (5 years old)	Croydon key dataset	HIGH	74.2	2012/13	73.1	80.8	87.7	ABOUT THE SAME	WORSE	WORSE
Tooth decay in children aged 5 (average number of teeth)	Croydon key dataset	LOW	1.05	2007/08	NA	1.31	1.11	UNKNOWN	BETTER	BETTER
Emotional wellbeing of	Croydon key	LOW	12.6	2011/12	11.5	13.5	14	ABOUT THE SAME	ABOUT THE SAME	WORSE

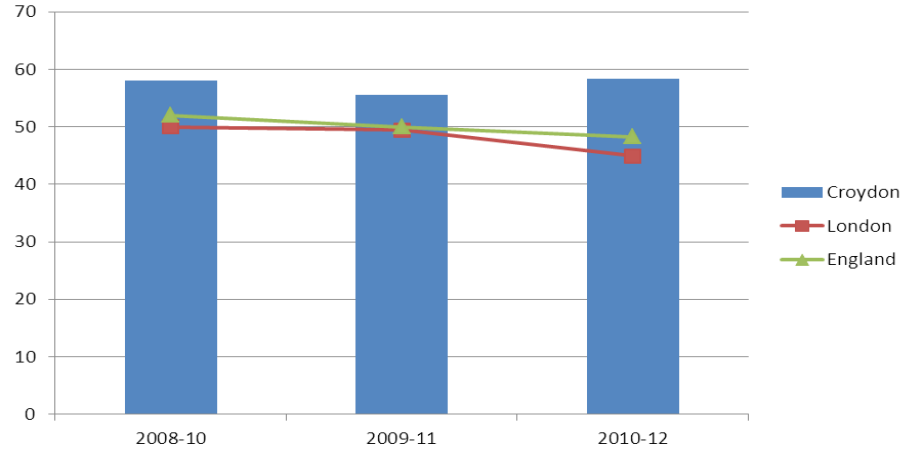
Measure description	Source	Polarity (is a higher or lower number better?)	Most recent annual data	From	Previous year	London Average	England Average	Comparison with previous year	Comparison with London Average	Comparison with England Average
looked-after children -	dataset									
Children living in poverty	Croydon key dataset	LOW	25.2	2011	25.7	26.5	20.6	ABOUT THE SAME	ABOUT THE SAME	WORSE

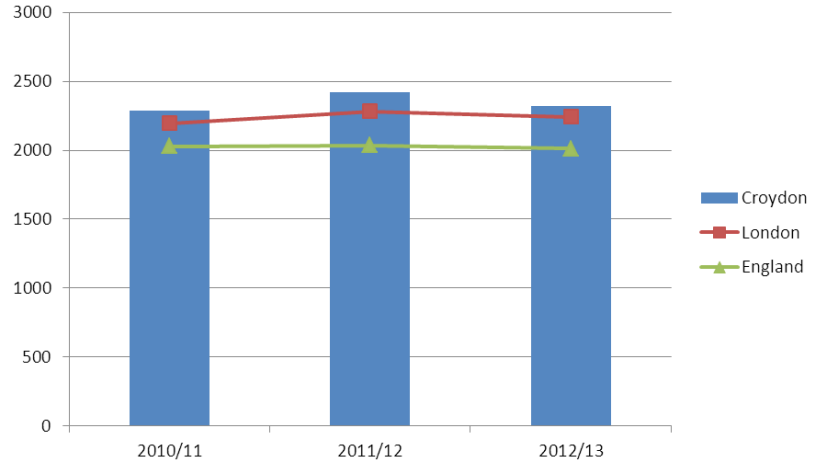
Improvement area 2: preventing illness and injury and helping people recover

Priorities
2.1 Reduce smoking prevalence 2.2 Reduce overweight and obesity in adults 2.3 Reduce the harm caused by alcohol misuse 2.4 Early diagnosis and treatment of sexually transmitted infections including HIV infection 2.5 Prevent illness and injury and promote recovery in the over 65s

Potential challenge areas	Areas of success
% of persons aged 65 and over immunised against influenza	**% Fuel poverty**

Potential challenge areas	Areas of success
	
The influenza immunisation rate for this age group in Croydon falls short of the national and London averages, although shows a similar rate of decline to the London average.	This indicator measures the percentage of households which are fuel poor, meaning they spend more than 10% of their income on fuel to maintain a "satisfactory heating regime" (usually 21 degrees for the main living area and 18 degrees for other occupied areas). The latest published data appears to show that this is improving in Croydon in line with the rest of London, however it should be noted that this measure has since been discontinued.
Persons presenting with HIV at a late stage of infection (% of new diagnoses of HIV)	

Potential challenge areas	Areas of success
 The proportion of late HIV diagnoses has increased, while London and England averages have continued to decline.	
Injuries due to falls (rate per 100,000 population aged over 65)	

Potential challenge areas	Areas of success
 While the rate of injuries fell in Croydon, it still remains above rates for both London and England.	

Performance measures

Measure description	Source	Polarity (is a higher or lower number better?)	Most recent annual data	From	Previous year	London Average	England Average	Comparison with previous year	Comparison with London Average	Comparison with England Average
% of persons aged 65 and over immunised against influenza	Croydon key dataset	HIGH	65.7	2013/14	67	70	73.2	**WORSE**	**WORSE**	**WORSE**

Measure description	Source	Polarity (is a higher or lower number better?)	Most recent annual data	From	Previous year	London Average	England Average	Comparison with previous year	Comparison with London Average	Comparison with England Average
Self-reported 4-week smoking quitters per 100,000 adult population aged 16+	Croydon key dataset	HIGH	793	2012/13	796	805	868	ABOUT THE SAME	ABOUT THE SAME	WORSE

Measure description	Source	Polarity (is a higher or lower number better?)	Most recent annual data	From	Previous year	London Average	England Average	Comparison with previous year	Comparison with London Average	Comparison with England Average
Smoking prevalence (% of adults aged over 18 who responded to survey)	Croydon key dataset	LOW	19.7	2011/12	19.4	18.9	20	ABOUT THE SAME	ABOUT THE SAME	ABOUT THE SAME

Measure description	Source	Polarity (is a higher or lower number better?)	Most recent annual data	From	Previous year	London Average	England Average	Comparison with previous year	Comparison with London Average	Comparison with England Average
Rate of hospital admissions with a primary or secondary diagnosis of obesity per 100,000 population	Public Health Outcomes	LOW	440	2012/13	307	462	551	WORSE	BETTER	BETTER

Measure description	Source	Polarity (is a higher or lower number better?)	Most recent annual data	From	Previous year	London Average	England Average	Comparison with previous year	Comparison with London Average	Comparison with England Average
	Framework									
Recorded crime attributable to alcohol: Persons, all ages, crude rate per 1000 population	Croydon key	LOW	9.22	2012/13	9.65	9.02	5.74	ABOUT THE SAME	ABOUT THE SAME	WORSE

Measure description	Source	Polarity (is a higher or lower number better?)	Most recent annual data	From	Previous year	London Average	England Average	Comparison with previous year	Comparison with London Average	Comparison with England Average
	dataset									
Percentage of patients on GP registers aged 17 and over diagnosed with diabetes	Croydon key dat	LOW	6.39	2012/13	6.1	5.82	6.01	ABOUT THE SAME	WORSE	WORSE

Measure description	Source	Polarity (is a higher or lower number better?)	Most recent annual data	From	Previous year	London Average	England Average	Comparison with previous year	Comparison with London Average	Comparison with England Average
	asset									
Adults achieving at least 150 minutes of physical activity per week (% of adults aged over 16)	Croydon key data base	HIGH	10.3	2012	NA	11	11.8	**UNKNOWN**	ABOUT THE SAME	ABOUT THE SAME

Measure description	Source	Polarity (is a higher or lower number better?)	Most recent annual data	From	Previous year	London Average	England Average	Comparison with previous year	Comparison with London Average	Comparison with England Average
	t									
Persons presenting with HIV at a late stage of infection (% of new diagnoses of HIV)	Croydon key data base	LOW	58.3	2010/12	55.5	44.9	48.3	WORSE	WORSE	WORSE

Measure description	Source	Polarity (is a higher or lower number better?)	Most recent annual data	From	Previous year	London Average	England Average	Comparison with previous year	Comparison with London Average	Comparison with England Average
	t									
Chlamydia diagnoses (ages 15-24) (rate per 100,000 population)	Croydon key data base	n/a	2511	2013/14 Quarter 3	2615	2075	1785	**UNKNOWN**	**UNKNOWN**	**UNKNOWN**

Measure description	Source	Polarity (is a higher or lower number better?)	Most recent annual data	From	Previous year	London Average	England Average	Comparison with previous year	Comparison with London Average	Comparison with England Average
	t									
Percentage of households identified as “fuel poor”	Croydon key data base	LOW	10.8	2011	11.3	9.6	10.9	BETTER	WORSE	ABOUT THE SAME

Measure description	Source	Polarity (is a higher or lower number better?)	Most recent annual data	From	Previous year	London Average	England Average	Comparison with previous year	Comparison with London Average	Comparison with England Average
	t									
Injuries due to falls (rate per 100,000 population aged over 65)	Croydon key data base	LOW	2318	2012/13	2418	2242	2011	ABOUT THE SAME	ABOUT THE SAME	WORSE

Measure description	Source	Polarity (is a higher or lower number better?)	Most recent annual data	From	Previous year	London Average	England Average	Comparison with previous year	Comparison with London Average	Comparison with England Average
	t									
Patient reported outcomes for elective procedures: Groin Hernia (EQ-5D-average health gain score out of 1)	NHS outcomes framework	HIGH	0.067	2011/2012	0.084	0.082	0.087	WORSE	WORSE	WORSE

Measure description	Source	Polarity (is a higher or lower number better?)	Most recent annual data	From	Previous year	London Average	England Average	Comparison with previous year	Comparison with London Average	Comparison with England Average
	work									
Patient reported outcomes for elective procedures: Hip Replacement (EQ-5D- average health gain score out of 1)	NHS outcomes fram	HIGH	0.381	2011/2012	0.366	0.397	0.416	**BETTER**	**ABOUT THE SAME**	**WORSE**

Measure description	Source	Polarity (is a higher or lower number better?)	Most recent annual data	From	Previous year	London Average	England Average	Comparison with previous year	Comparison with London Average	Comparison with England Average
	ework									
Patient reported outcomes for elective procedures: Knee Replacement (EQ-5D- average health gain score out of 1)	NHS outcomes fram	High	0.283	2011/2012	0.242	0.268	0.302	**BETTER**	**BETTER**	**WORSE**

Measure description	Source	Polarity (is a higher or lower number better?)	Most recent annual data	From	Previous year	London Average	England Average	Comparison with previous year	Comparison with London Average	Comparison with England Average
	ework									
Patient reported outcomes for elective procedures: Varicose Vein (EQ-5D- average health gain score out of 1)	NHS outcomes framework	High	Suppressed due to small sample	2011/2012	Suppressed due to small sample	0.076	0.095	**UNKNOWN**	**UNKNOWN**	**UNKNOWN**

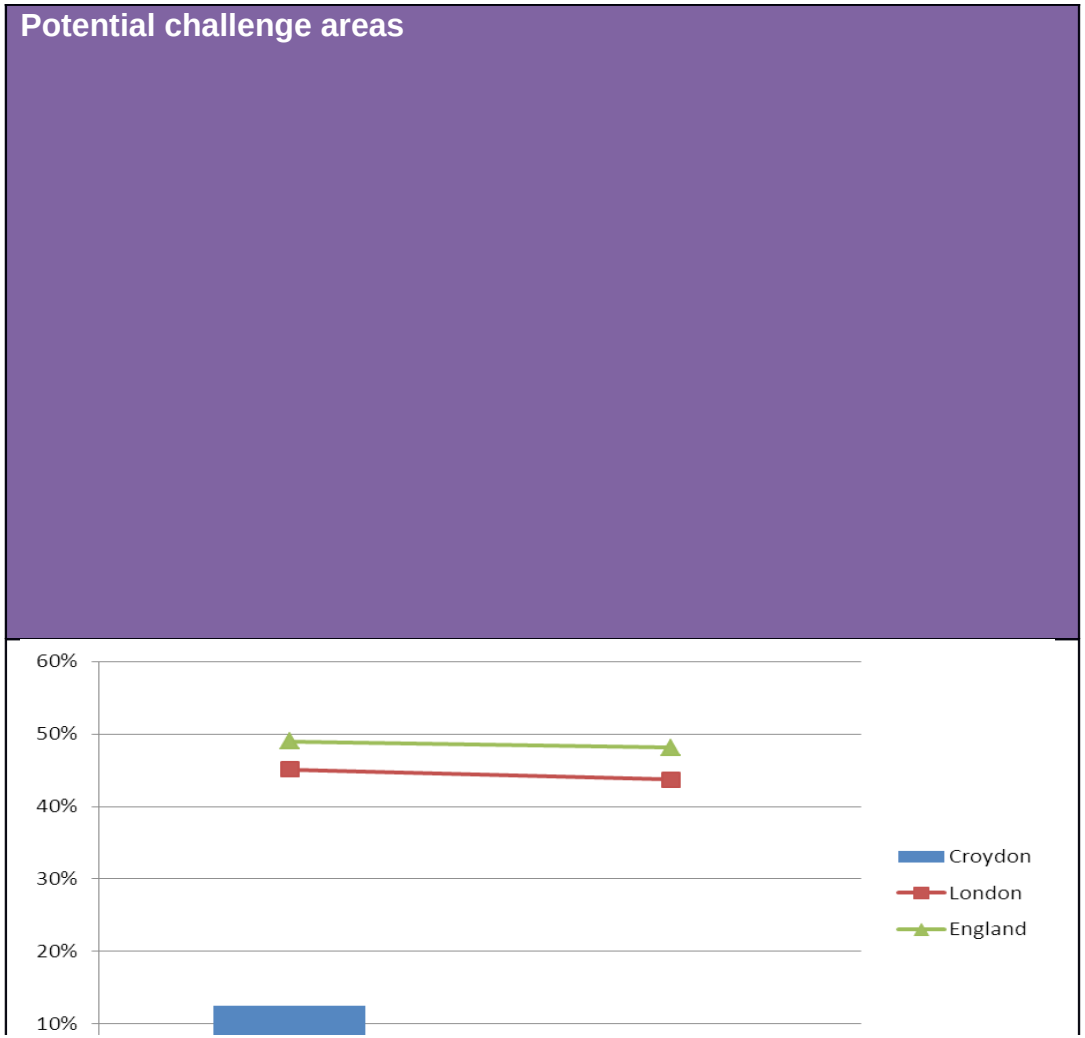
Measure description	Source	Polarity (is a higher or lower number better?)	Most recent annual data	From	Previous year	London Average	England Average	Comparison with previous year	Comparison with London Average	Comparison with England Average
	ework									

Improvement area 3: preventing premature death and long term health conditions

Priorities
3.1 Early detection and management of people at risk for cardiovascular diseases and diabetes 3.2 Early detection and treatment of cancers

Potential challenge areas

Take up of NHS health checks (% of people offered health checks)


Potential challenge areas
60%
50%
40%
30%
20%
10%
Croydon
London
England

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Performance measures

Measure description	Source	Polarity (is a higher or lower number better?)	Most recent annual data	From	Previous year	London Average	England Average	Comparison with previous year	Comparison with London Average	Comparison with England Average
Infant mortality - Rate per 1,000 live births,	Croydon key dataset	LOW	4.4	2009-11	4.8	4.4	4.4	BETTER	ABOUT THE SAME	ABOUT THE SAME
Life expectancy at age 75 (males) in years	Croydon key dataset	HIGH	11.5	2010-12	11.6	12	11.3	ABOUT THE SAME	ABOUT THE SAME	BETTER
Life expectancy at age 75 (females) in years	Croydon key dataset	HIGH	13.3	2010-12	13.1	13.9	13.	ABOUT THE SAME	WORSE	ABOUT THE SAME
Early deaths from cancer considered preventable (rate per 100,000 population aged under 75)	Croydon key dataset	LOW	79.6	2010-12	74.3	81.5	84.9	WORSE	ABOUT THE SAME	WORSE
Deaths from causes considered	Croydon key	LOW	179	2010-12	171	178.2	187.8	WORSE	ABOUT THE SAME	WORSE

Measure description	Source	Polarity (is a higher or lower number better?)	Most recent annual data	From	Previous year	London Average	England Average	Comparison with previous year	Comparison with London Average	Comparison with England Average
preventable (rate per 100,000 population)	dataset									
Early deaths from cardiovascular diseases considered preventable (rate per 100,000 population age<75)	Croydon key dataset	LOW	55.2	2010-12	56	52	53.5	ABOUT THE SAME	ABOUT THE SAME	ABOUT THE SAME
Early deaths from liver disease considered preventable (rate per 100,000 population age<75)	Croydon key dataset	LOW	14	2010-12	14.9	16.6	15.8	ABOUT THE SAME	BETTER	BETTER
Early deaths from respiratory diseases considered	Croydon key dataset	LOW	17.9	2010-12	15.4	17.1	17.6	WORSE	ABOUT THE SAME	ABOUT THE SAME

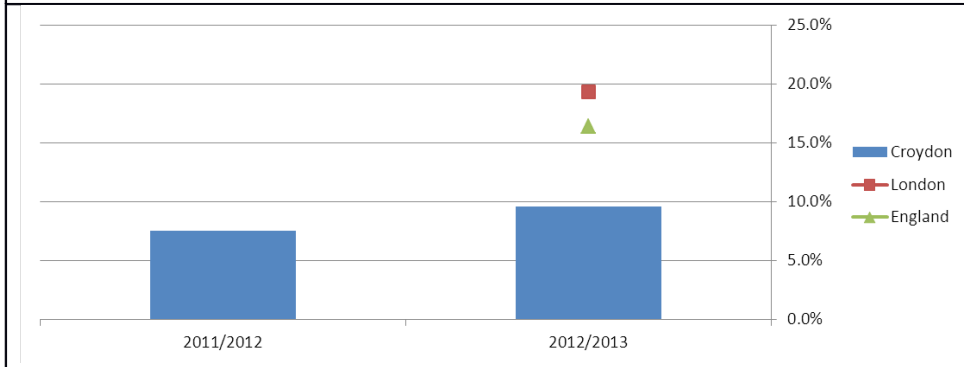
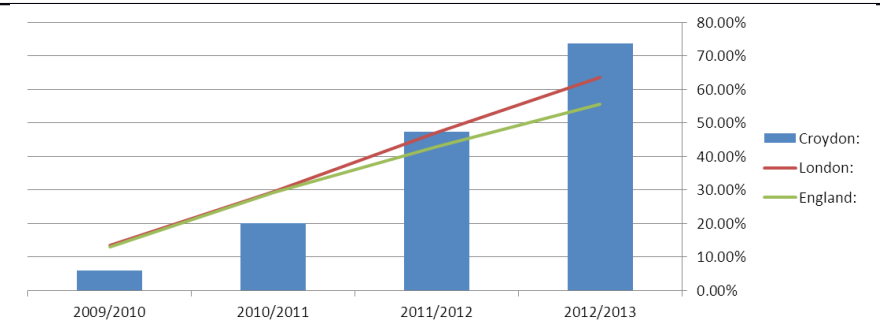
Measure description	Source	Polarity (is a higher or lower number better?)	Most recent annual data	From	Previous year	London Average	England Average	Comparison with previous year	Comparison with London Average	Comparison with England Average
preventable (rate per 100,000 population age<75)										
Offered an NHS health check (% of eligible people aged 40-74)	Croydon key dataset	HIGH	0.1[1]	2012/13	20	5.6	13.2	WORSE	WORSE	WORSE
Take up of NHS health checks (% of people offered health checks)	Croydon key dataset	HIGH	1.6	2013/14	12.5	43.7	48.10	WORSE	WORSE	WORSE
% of NHS health checks that identify patients to be at high risk	TBC	TBC	12.3	2012/13	10.2	Local indicator	local indicator	UNKNOWN	UNKNOWN	UNKNOWN
Breast screening rate (% of women	Croydon key	HIGH	69.2	2013	70.8	68.6	76.3	ABOUT THE	ABOUT THE SAME	WORSE

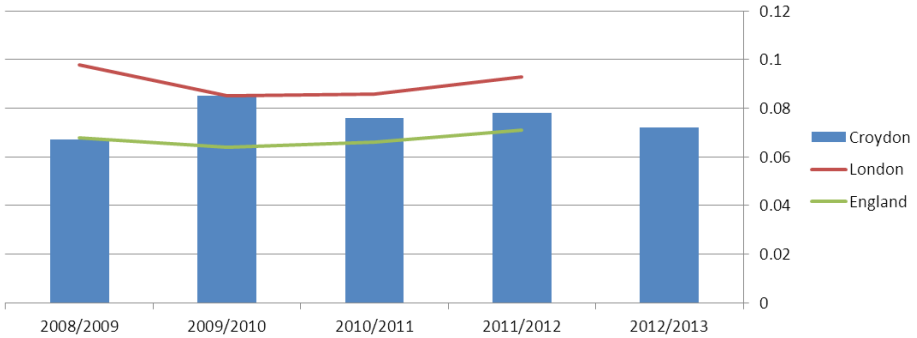
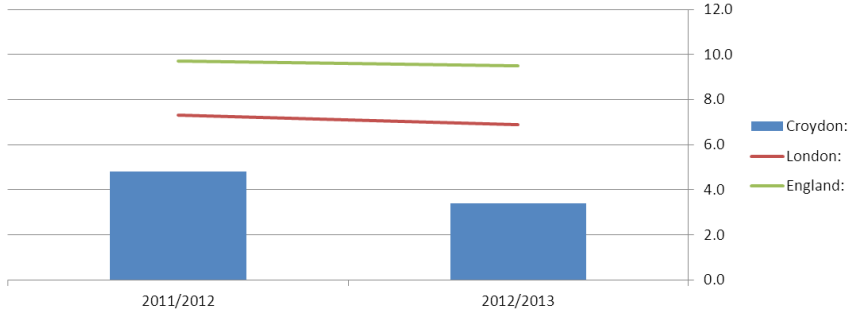
1 Revised, improved figures for health checks both offered and uptake have been submitted but are yet to be published. The figures presented here are those published.

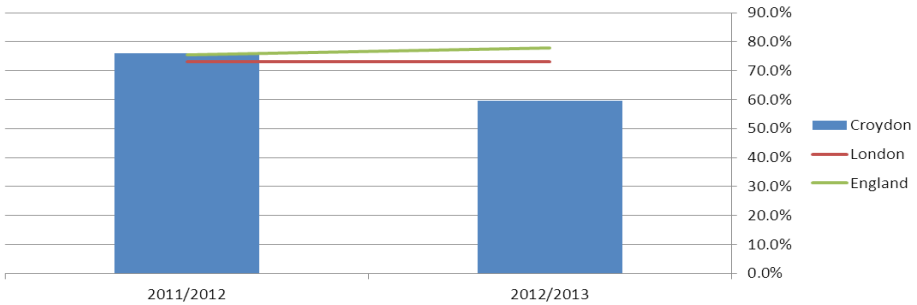
Measure description	Source	Polarity (is a higher or lower number better?)	Most recent annual data	From	Previous year	London Average	England Average	Comparison with previous year	Comparison with London Average	Comparison with England Average
aged 53-70)	dataset							SAME		
Cervical screening rate (% of eligible women aged 25-64)	Croydon key dataset	HIGH	71.7	2013	73.8	68.6	73.9	ABOUT THE SAME	BETTER	ABOUT THE SAME
Deaths from diabetes (rate per 100,000 population)	Croydon key dataset	LOW	5.64	2010-12	5.68	5.06	5.05	ABOUT THE SAME	ABOUT THE SAME	ABOUT THE SAME

Improvement area 4: supporting people to be resilient and independent

Priorities
4.1 Rehabilitation and reablement to prevent repeat admissions to hospital 4.2 Integrated care and support for people with long term conditions 4.3 Support and advice for carers 4.4 Reduce the number of households living in temporary accommodation 4.5 Reduce the number of people receiving job seekers allowance

Potential challenge areas	Areas of success
Proportion of people using social care who receive direct payments	**Proportion of people using social care who receive self-directed support**
	
	The proportion of people using self-directed support in

Potential challenge areas	Areas of success
Although increasing, the proportion of social care clients in receipt of direct payments appears to lag significantly behind London and national averages NB: Provisional figures for 2013/13 will be available in July 2014	Croydon has seen strong growth, outstripping the London and National averages. Croydon's figure for 2012/13 is one of the best in London. NB: Provisional figures for 2013/13 will be available in July 2014
Proportion of adults with learning disabilities in paid employment	**Delayed transfers of care from hospital per 100,000 population**
 The proportion of adults with LD in paid employment in Croydon does not show a particular trend and, whilst better than the England average, is short of performance across London. NB: Provisional figures for 2013/13 will be available in July 2014	 The frequency of delayed transfers of care from hospital is significantly lower in Croydon than London and National comparators. The same is also true for the accompanying indicator which shows only those delays attributable to social care services. NB: Provisional figures for 2013/13 will be available in July 2014

Potential challenge areas	Areas of success
Proportion of people who use services who say that those services have made them feel safe and secure	
 There appears to have been a significant decrease in the proportion of adult social care service users who feel that the service they receive makes them feel safe and secure. This shift is not replicated in London or national comparisons. NB: Provisional figures for 2013/13 will be available in July 2014	

Performance measures

Measure description	Source	Polarity (is a higher or lower number better?)	Most recent annual data	From	Previous year	London Average	England Average	Comparison with previous year	Comparison with London Average	Comparison with England Average
Survey Social care-related quality of life	ASCOF	HIGH	18.2	2012/1	18.2	18.2	18.8	ABOUT THE SAME	ABOUT THE SAME	ABOUT THE SAME

Measure description	Source	Polarity (is a higher or lower number better?)	Most recent annual data	From	Previous year	London Average	England Average	Comparison with previous year	Comparison with London Average	Comparison with England Average
				3						
Proportion of people who use services who have control over their daily life	ASCOF	HIGH	72.3%	2012/13	71.0%	70.7%	75.9%	ABOUT THE SAME	ABOUT THE SAME	ABOUT THE SAME
Proportion of people using social care who receive self-directed support	ASCOF	HIGH	73.8% 67.9% (provisional 2013-14)	2012/13	47.4%	63.5%	55.6%	BETTER	BETTER	BETTER
Proportion of people using social care who receive direct payments	ASCOF	HIGH	9.6% 7.4% (provisional 2013-14)	2012/13	7.5%	19.3%	16.4%	BETTER	WORSE	WORSE
Survey:Carer-reported quality of life	ASCOF	HIGH	7.7	2012/13		7.7	8.1	UNKNOWN	ABOUT THE SAME	WORSE

Measure description	Source	Polarity (is a higher or lower number better?)	Most recent annual data	From	Previous year	London Average	England Average	Comparison with previous year	Comparison with London Average	Comparison with England Average
Proportion of adults with learning disabilities in paid employment	ASCOF	HIGH	5.0% 6.3% (provisional 2013-14)	2012/13	7.8%	9.4%	7.2%	WORSE	WORSE	WORSE
Proportion of adults in contact with secondary mental health services in paid employment	ASCOF	HIGH	6.6% 7.5% (Quarter 3 2013-14)	2012/13	6.5%	6.1%	7.7%	BETTER	BETTER	WORSE
Proportion of adults with learning disabilities who live in their own home or with their family	ASCOF	HIGH	68.9% 66.2% (provisional 2013-14)	2012/13	72.9%	67.7%	73.3%	WORSE	ABOUT THE SAME	WORSE
Proportion of adults in contact with secondary mental health services living independently, with or without support	ASCOF	HIGH	78.2% 55.7% (Quarter 3 2013-14)	2012/13	72.9%	80.4%	59.3%	BETTER	ABOUT THE SAME	BETTER
Permanent admissions of younger	ASCOF	LOW	4.3	2012	44.2	10.8	14.9	BETTER	BETTER	BETTER

Measure description	Source	Polarity (is a higher or lower number better?)	Most recent annual data	From	Previous year	London Average	England Average	Comparison with previous year	Comparison with London Average	Comparison with England Average
adults (aged 18 to 64) to residential and nursing care homes, per 100,000 population				/13						
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	ASCOF	LOW	239.6	2012/13	566.6	493.7	708.8	BETTER	BETTER	BETTER
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/ rehabilitation services	ASCOF	HIGH	85.1%	2012/13	74.8%	85.9%	81.5%	BETTER	ABOUT THE SAME	ABOUT THE SAME
Delayed transfers of care from hospital per 100,000 population	ASCOF	LOW	3.4 5.1 (Mar-14)	2012/13	4.8	6.9	9.5	BETTER	BETTER	BETTER

Measure description	Source	Polarity (is a higher or lower number better?)	Most recent annual data	From	Previous year	London Average	England Average	Comparison with previous year	Comparison with London Average	Comparison with England Average
Delayed transfers of care from hospital which are attributable to adult social care per 100,000 population	ASCOF	LOW	1.1 1.2 (Mar-14)	2012/13	2.3	2.7	3.3	BETTER	BETTER	BETTER
Overall satisfaction of people who use services with their care and support	ASCOF	HIGH	54.2%	2012/13	53.9%	58.2%	63.7%	ABOUT THE SAME	WORSE	WORSE
Overall satisfaction of carers with social services	ASCOF	HIGH	29.2%	2012/13	Not available	35.2%	42.7%	UNKNOWN	WORSE	WORSE
Proportion of carers who report that they have been included or consulted in discussion about the person they care for	ASCOF	HIGH	63.4%	2012/13	Not available	65.9%	72.8%	UNKNOWN	ABOUT THE SAME	WORSE
Proportion of people who use services and carers who find it easy to find information about services	ASCOF	HIGH	66.8%	2012/13	70.9%	68.2%	71.5%	WORSE	ABOUT THE SAME	WORSE

Measure description	Source	Polarity (is a higher or lower number better?)	Most recent annual data	From	Previous year	London Average	England Average	Comparison with previous year	Comparison with London Average	Comparison with England Average
Proportion of people who use services who say that those services have made them feel safe and secure	ASCOF	HIGH	59.7%	2012/13	76.0%	73.1%	77.9%	WORSE	WORSE	WORSE

Improvement area 5: providing integrated, safe, high quality services

Priorities
5.1 Redesign of mental health pathways 5.2 Increased proportion of planned care delivered in community settings 5.3 Redesign of urgent care pathways 5.4 Improve the clinical quality and safety of health services 5.5 Improve early detection, treatment and quality of care for people with dementia

No focus areas recommended at this point

Measure description	Source	Polarity (is a higher or lower number better?)	Most recent annual data	From	Previous year	London Average	England Average	Comparison with previous year	Comparison with London Average	Comparison with England Average
All cause emergency hospital admissions (rate per 1,000 population)	Croydon key da	LOW	86.8%	2011/12	85.5%	80.9%	87.4%	ABOUT THE SAME	WORSE	ABOUT THE SAME

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Measure description	Source	Polarity (is a higher or lower number better?)	Most recent annual data	From	Previous year	London Average	England Average	Comparison with previous year	Comparison with London Average	Comparison with England Average
	taset									
Emergency readmissions within 30 days of discharge from hospital (%)	Croydon key dataset	LOW	12.2%	2010/11	12.0%	12.0%	11.8%	ABOUT THE SAME	ABOUT THE SAME	ABOUT THE SAME
Proportion of deaths from all causes that occur at usual place of residence	Croydon key dataset	NA	39.8	2012	38.1	35.8	43.7	**UNKNOWN**	**UNKNOWN**	**UNKNOWN**
Safety incidents	N	LOW	64	Oct 12- Mar 13	95	Not	Medium	**BETTER**	**UNKNOW**	**Medium**

Measure description	Source	Polarity (is a higher or lower number better?)	Most recent annual data	From	Previous year	London Average	England Average	Comparison with previous year	Comparison with London Average	Comparison with England Average
involving severe harm or death per 100 admissions	HS outcomes framework					available	Acute(Croydon's comparator group): 19		**N**	**Acute: WORSE**
Patient safety incidents reported rate per 100 admissions	NHS outcomes frame	LOW	6.6	Oct 12- Mar 13	7.5	Not available	Medium Acute(Croydon's comparator group): 6.2	**BETTER**	**UNKNOWN**	**Medium Acute: UNKNOWN**

Measure description	Source	Polarity (is a higher or lower number better?)	Most recent annual data	From	Previous year	London Average	England Average	Comparison with previous year	Comparison with London Average	Comparison with England Average
	work									
Incidence of avoidable harm: MRSA (crude count)	NHS outcomes framework	LOW	1 (YE 13/14, 4)	Oct-Dec 2013	1 (Jul-Sep13)	Not available	0.34	ABOUT THE SAME	UNKNOWN	WORSE
Incidence of avoidable harm: C.difficle (crude count)	NHS outcom	LOW	14 (YE 13/14, 51)	Oct-Dec 2013	14 (Jul-Sep 13)	Not available	5.2	ABOUT THE SAME	UNKNOWN	WORSE

Measure description	Source	Polarity (is a higher or lower number better?)	Most recent annual data	From	Previous year	London Average	England Average	Comparison with previous year	Comparison with London Average	Comparison with England Average
	esframework									

Improvement area 6: improving people's experience of care

Priorities
6.1 Improve end of life care 6.2 Improve patient and service user satisfaction with health and social care services

No focus areas recommended at this point

Measure description	Source	Polarity (is a higher or lower number better?)	Most recent annual data	From	Previous year	London Average	England Average	Comparison with previous year	Comparison with London Average	Comparison with England Average
Patient experience of primary care: GP Services	NHS outcomes framework	HIGH	84	2013	n/a	82	86.7	**UNKNOWN**	**BETTER**	**WORSE**
Patient experience of primary care: Out of Hours Services	NHS outcomes framework	HIGH	62	2013	59	62.9	70.2	**BETTER**	**ABOUT THE SAME**	**WORSE**
Patient experience of primary care: Dentistry	NHS outcomes framework	HIGH	82	2013	Not available	Not available	84	**UNKNOWN**	**UNKNOWN**	**ABOUT THE SAME**

Measure description	Source	Polarity (is a higher or lower number better?)	Most recent annual data	From	Previous year	London Average	England Average	Comparison with previous year	Comparison with London Average	Comparison with England Average
Patient experience of hospital care: Inpatient Overall Experience	NHS outcomes framework	HIGH	68	2012-13	67.7	Not available	76	ABOUT THE SAME	UNKNOWN	WORSE
Patient experience of hospital care: Outpatient Overall Experience	NHS outcomes framework	HIGH	74.4	2011	75.3	Not available	80	ABOUT THE SAME	UNKNOWN	WORSE
Patient experience of hospital care: Inpatient Responsiveness to Needs	NHS outcomes framework	HIGH	57.4	2011	58.6	Not available	68.1	ABOUT THE SAME	UNKNOWN	WORSE
Patient experience of hospital care: A&E Overall Experience	NHS outcomes framework	HIGH	75.5	2012	72.3	Not available	80	BETTER	UNKNOWN	WORSE
Access to NHS dental services	NHS outcomes framework	HIGH	90	Jul-Sep3013	Not available	90	93	UNKNOWN	ABOUT THE SAME	WORSE
Access to GP services	NHS outcomes framework	HIGH	74	2013	Not available	71	76.3	UNKNOWN	BETTER	ABOUT THE SAME

Measure description	Source	Polarity (is a higher or lower number better?)	Most recent annual data	From	Previous year	London Average	England Average	Comparison with previous year	Comparison with London Average	Comparison with England Average
Women's experience of maternity services: Intrapartum[2] (score between 1 -100)	NHS outcomes framework	High	70.5	2013	73.0	Not available	74.5	WORSE	UNKNOWN	WORSE
Patient experience of community mental health services[3] (score between 1-10)	NHS outcomes framework	HIGH	8.75	2013	8.5	Not available	85.8	BETTER	UNKNOWN	WORSE

2 Reliable data not available for pre and post natal components of this indicator. The indicator definition includes 6 questions across an antenatal survey (which Croydon did not submit), a Intrapartum survey- shown here and a Postnatal survey for which only one of the two questions is available in the Croydon report. As a result only the two questions c13 and c17 average from the Intrapartum results have been shown here.

3 Data is only available at SLAM (South London and Maudsley) level.

Appendix 2

31 May 2014

Risk Status

Risk Ref	Business Unit	Risk	Risk rating 01/14	Risk rating Future	Control measures Future	Existing	Total	% Implemented
LSPHC0002	Significant Partnership	Failure to ensure that the board's focus is balanced (for example, between statutory requirements / national guidance and local priorities; or health and wellbeing)	16	8	2	4	6	67%
LSPHC0008	Significant Partnership	Failure to successfully integrate commissioning or service provision due to inability or unwillingness to share data	20	15	3	2	5	60%
LSPHC0012	Significant Partnership	Failure to understand the community's expressed wants and choices and to ensure that ongoing engagement with the public is maintained and views	16	12	5	2	6	40%
LSPHC0015	Significant Partnership	Failure to clearly understand the purpose, boundaries and remit of the Board	16	4	2	2	3	67%
LSPHC0018	Significant Partnership	Board is not able to demonstrate improved outcomes for the population	16	12	4	4	4	60%
LSPHC0043	Significant Partnership	The Board fails to respond flexibly and effectively to changes in national policy or developing local issues	12	8	2	2	4	50%
LSPHC0044	Significant Partnership	Failure to ensure that the Board continuously develops and has the capacity and capability to operate effectively and efficiently.	16	12	3	2	3	67%
LSPHC0045	Significant Partnership	Limited or constrained financial allocations in health and social care which gives rise to the inability to balance reducing budgets with a rising demand	20	15	3	5	7	80%
LSPH0046	Significant Partnership	Failure to produce the pharmaceutical needs assessment	12	8	2	2	4	50%

Appendix 3 HWB work plan version 10.0

Date	Item	Purpose	Board sponsor	Lead officer / report author
16 July 2014	Board induction session			
16 July 2014	Appointment of chair	Decision	n/a	Solomon Agutu
	Annual report of the director of public health	Discussion	Mike Robinson	Jenny Hacker
	Focus on outcomes: Pressure ulcers in the community	Discussion	Paula Swann / Hannah Miller	Michelle Rahman / Kay Murray
	JSNA 2013/14 healthy weight chapter final draft	Decision	Mike Robinson	Sarah Nicholls / Anna Kitt
	JSNA 2014/15 key chapter topics	Decision	Mike Robinson	Jenny Hacker
	Final commissioning intentions 2014/15 • Adult services commissioning plans 2014/15	Information	Hannah Miller	Brenda Scanlan
	SW London collaborative commissioning strategy	Information	Paula Swann	Paula Swann
	Joint mental health strategy	Discussion	Paula Swann / Hannah Miller	Paula Swann /' Stephen Warren / Brenda Scanlan
	Children's primary prevention plan	Discussion	Paul Greenhalgh	Dwynwen Stepien
	Reform of services for children who will be subject to education, care and health plans	Information	Paul Greenhalgh	Linda Wright
	Report of the chair of the executive group • Work plan • Performance against health and wellbeing strategy indicators (quarterly standing item)	Discussion & decision	Hannah Miller	 Steve Morton Laura Gamble Steve Morton

Appendix 3 HWB work plan version 10.0

Date	Item	Purpose	Board sponsor	Lead officer / report author
	• Risk register			
25 July 2014	Board public engagement event: joint health and wellbeing strategy			
11 September 2014	Focus on outcomes: primary care : general practice	Discussion	Dr Jane Fryer	tba
	JSNA 2013/14 homeless households chapter final draft	Decision	Mike Robinson	Dave Morris
	Update on adults with learning disabilities (from April 2013)	Information	Hannah Miller	Alan Hiscutt
	Partnership groups report	Information	Hannah Miller	Steve Morton
	Report of the chair of the executive group • Work plan • Risk register	Discussion & decision	Hannah Miller	 Steve Morton Malcolm Davies
1 October 2014	Board public engagement event: joint health and wellbeing strategy review			
22 October 2014	Focus on outcomes: household income and health	Discussion	tba	tba
	Update on Heart Town • NHS Health Checks	Information	Mike Robinson	Steve Morton / Bevoly Fearon
	JSNA key dataset 2014/15	Discussion & decision	Mike Robinson	Jenny Hacker / David Osborne
	Partnership groups report	Information	Hannah Miller	Steve Morton
	Report of the chair of the executive group • Work plan	Discussion & decision	Hannah Miller	 Steve Morton

Appendix 3 HWB work plan version 10.0

Date	Item	Purpose	Board sponsor	Lead officer / report author
	• Performance against health and wellbeing strategy indicators (quarterly standing item) • Risk			Martin Ellender Malcolm Davies
	Update on dignity and safety	Information	Hannah Miller / Paula Swann	Kay Murray / Fouzia Harrington
	Safeguarding adults report	Information	Hannah Miller	Kay Murray
	Safeguarding children report	Information	Paul Greenhalgh	Jeneen Hatt
10 December 2014	Commissioning intentions 2015/16	Discussion	Paula Swann/Hannah Miller/Paul Greenhalgh/Mike Robinson/Jane Fryer	Stephen Warren / Brenda Scanlan / Jane Doyle/PH & NHS England leads tbc
	Health protection update • Immunisation & vaccination	Discussion	Mike Robinson	tba
	Partnership groups report	Information	Hannah Miller	Steve Morton
	Report of the chair of the executive group • Work plan • Risk	Discussion & decision	Hannah Miller	 Steve Morton Malcolm Davies
11 February 2015	Focus on outcomes: health and wellbeing of offenders & their families	Discussion	tba	tba
	Pharmaceutical needs assessment final draft for agreement	Decision	Mike Robinson	tbc
	Joint health and wellbeing strategy 2015-20	Decision	Hannah Miller /	tba

Appendix 3 HWB work plan version 10.0

Date	Item	Purpose	Board sponsor	Lead officer / report author
			Paula Swann / Paul Greenhalgh / Mike Robinson	
	JSNA 2014/15 chapter drafts	Decision	Mike Robinson	tba
	Report of the chair of the executive group • Work plan • Performance against health and wellbeing strategy indicators (quarterly standing item) • Risk	Discussion & decision	Hannah Miller	 Steve Morton Martin Ellender Malcolm Davies
25 March 2015	Focus on outcomes: topic to be agreed	Discussion	tba	tba
	Final commissioning intentions 2015/16	Information	Paula Swann/Hannah Miller/Paul Greenhalgh/Mike Robinson/Jane Fryer	Stephen Warren / Brenda Scanlan / Jane Doyle/PH & NHS England leads tbc
	Partnership groups report	Information	Hannah Miller	Steve Morton
	Report of the chair of the executive group • Work plan • Risk	Discussion & decision	Hannah Miller	 Steve Morton Malcolm Davies

Appendix 1b Summary record of topics covered at previous HWB meetings

n.b. minutes and papers of shadow health and wellbeing board meetings from 8 December 2011 to 13 February 2013 to can be found on the Council website by clicking on the following link: http://tinyurl.com/ShadowHWB.

Date	Items	Purpose	Board sponsor	Lead officer / report author
24 April 2013	Establishment of the health and wellbeing board	Decision	Councillor Margaret Mead	Solomon Agutu
	Focus on outcomes: adults with learning disabilities	Discussion	Geraldine O'Shea	Geraldine O'Shea / Mike Corrigan
	JSNA key data set 2012/13	Discussion	Mike Robinson	Jenny Hacker
	Heart Town proposal	Decision	Councillor Margaret Mead	Steve Morton / Bevoly Fearon
	Work plan (standing item)	Decision	Hannah Miller	Steve Morton
12 June 2013	Prevention, self-care and shared decision making	Discussion	Agnelo Fernandes	Daniel MacIntyre
	Better Services Better Value consultation	Discussion	Paula Swann / Agnelo Fernandes	Rachel Tyndall / Charlotte Joll
	Annual report of the director of public health	Information	Mike Robinson	Sara Corben
	Sign off JSNA deep dive chapters • Depression in adults • Schizophrenia	Decision	Mike Robinson	Bernadette Alves
	Update on integrated care (from September 2012)	Information	Agnelo Fernandes	Paul Young / Amanda Tuke / Brenda Scanlan
	Partnership groups proposal	Decision	Hannah Miller	Steve Morton

Appendix 1b Summary record of topics covered at previous HWB meetings

Date	Items	Purpose	Board sponsor	Lead officer / report author
	Work plan (standing item)	Decision	Hannah Miller	Steve Morton
18 July 2013	Board workshop on strategic risk			
11 September 2013	Improving outcomes for children with disabilities	Discussion and decision	Paul Greenhalgh	Linda Wright
	Reablement and hospital discharge programme – funding allocations 2013/14	Decision	Hannah Miller / Paula Swann	Andrew Maskell
	JSNA deep dive chapter • Emotional health and wellbeing of children	Decision	Mike Robinson	Kate Naish
	JSNA work plan 2013/14	Decision	Mike Robinson	Jenny Hacker
	Work plan (standing item)	Decision	Hannah Miller	Steve Morton
	Adult social care local account 2012	Information	Hannah Miller	Tracy Stanley
	Report from Croydon Congress health themed meeting 16 May 2013	Information	Mike Robinson	Sharon Godman
	Integrated commissioning unit for health and social care	Information	Hannah Miller / Paula Swann	Brenda Scanlan / Stephen Warren
	Integrated care pioneer status bid	Information	Hannah Miller / Paula Swann	Laura Jenner
23 October 2013	Focus on outcomes: homelessness, health and housing	Discussion	Hannah Miller	Peter Brown / Dave Morris
	Heart Town programme to prevent heart and	Discussion	Mike Robinson	Steve Morton

Appendix 1b Summary record of topics covered at previous HWB meetings

Date	Items	Purpose	Board sponsor	Lead officer / report author
	circulatory diseases			
	JSNA 2013/14 overview of health & social care needs	Discussion	Mike Robinson	Jenny Hacker
	Performance report (standing item)	Discussion	Hannah Miller/Paul Greenhalgh/Paula Swann	Martin Ellender
	Work plan (standing item)	Decision	Hannah Miller	Steve Morton
	Integration transformation fund	Information	Hannah Miller / Paula Swann	Andrew Maskell
	Safeguarding adults	Information	Hannah Miller	Kay Murray
	Safeguarding children	Information	Paul Greenhalgh	Jeneen Hatt
	Update on carers (from April 2012)	Information	Roger Oliver	Harsha Ganatra
	Update on children's primary prevention plan (from Feb 2013)	Information	Paul Greenhalgh	Dwynwen Stepien
4 December 2013	Commissioning intentions 2014/15	Discussion	Paula Swann/Hannah Miller/Paul Greenhalgh/Mike Robinson	Stephen Warren / Brenda Scanlan / Jane Doyle
	Substance misuse commissioning plans	Discussion	Hannah Miller	Alan Hiscutt
	Pharmaceutical needs assessment	Decision	Mike Robinson	Kate Woollcombe
	Work plan and report of the chair of the	Decision	Hannah Miller	Steve Morton

Appendix 1b Summary record of topics covered at previous HWB meetings

Date	Items	Purpose	Board sponsor	Lead officer / report author
	executive group (standing item)			
	Risk register (standing item)	Discussion	Hannah Miller	Steve Morton
5 December 2013	Board seminar – dignity and safety in care			
12 February 2014	Better Care Fund (formerly the integration transformation fund) 2014/15	Discussion & decision	Hannah Miller / Paula Swann	Andrew Maskell
	Dignity & safety in care seminar report	Discussion	Hannah Miller / Paula Swann	Kay Murray / Fouzia Harrington
	Report of the chair of the executive group • Work plan • Performance against health and wellbeing strategy indicators (quarterly standing item) • Risk	Discussion & decision	Hannah Miller	 Steve Morton Martin Ellender Malcolm Davies
	Local account 2012/13	Information	Hannah Miller	Tracey Stanley
	Heart Town update	Information	Mike Robinson	Steve Morton
26 March 2014	CHS emergency care department business case	Decision	John Goulston	Karen Breen
	South west London collaborative commissioning	Discussion	Paula Swann	Stephen Warren
	Final commissioning intentions 2014/15 • CCG Operating Plan 2014/15 – 2016/17	For information	Paula Swann/Hannah Miller/Paul	Stephen Warren / Brenda Scanlan / Jane Doyle

Appendix 1b Summary record of topics covered at previous HWB meetings

Date	Items	Purpose	Board sponsor	Lead officer / report author
	• Children and families' plan 2014/15		Greenhalgh	
	JSNA 2013/14 domestic violence chapter final draft	Decision	Mike Robinson	Ellen Schwartz
	JSNA 2013/14 alcohol chapter final draft	Decision	Mike Robinson	Bernadette Alves
	Children & young people's emotional wellbeing & mental health strategy	Discussion	Paul Greenhalgh / Paula Swann	Geraldine Bradbury / Stephen Warren
	Pharmaceutical needs assessment work plan 2014/15	Information	Mike Robinson	Matt Phelan
	Report of the chair of the executive group • Work plan • Risk register	Discussion & decision	Hannah Miller	 Steve Morton Malcolm Davies
27 March 2014	Board engagement event: review of progress against joint health and wellbeing strategy			

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REPORT TO:	**HEALTH AND WELLBEING BOARD (CROYDON)** **16th July 2014**
AGENDA ITEM:	**15**
SUBJECT:	**CCG Response to a request to update the Croydon Health and Wellbeing Board on the Joint SWL Collaborative Commissioning 5 Year Strategy**
BOARD SPONSOR:	**Paula Swann** **Chief Officer** **Croydon Clinical Commissioning Group**
CORPORATE PRIORITY/POLICY CONTEXT: This report is for information only	

1. RECOMMENDATIONS

1.1 The Health and Wellbeing Board is asked to note the contents of the report. Any questions should be directed to the report author outside of the meeting.

2. EXECUTIVE SUMMARY

2.1 The South West London 'Better Services Better Value 'BSBV': acute reconfiguration programme, which was launched in May 2011, was closed following the withdrawal of Surrey Downs CCG from the programme as their withdrawal meant that the proposals in that form were undeliverable.

2.2 There is still however a pressing need to address the issues raised by BSBV and the NHS England's 'call to action' which highlighted the clinical and financial challenges faced by the NHS nationally and called on CCGs to draw up local plans to address these challenges.

2.3 The six CCGs within South West London are working together in a 'Strategic Planning Group' as required by the 'call to action' to address the challenge, as individually we do not believe we can deliver the scale of change required.

2.4 There is a recognition that the NHS needs to change if we are to continue to provide high quality services to our local populations. It must adapt and change to meet the demands of growing populations with higher expectations and more complex needs. Existing services are fragmented and inconsistent, unable to meet the challenges of today.

2.5 The six CCGs have faced a dilemma of overseeing a continuous decline in our local health system followed by organisational failure and a need for external intervention or we work together with clinical colleagues and local people to agree a planned set of changes that deliver the care our residents deserve within the funding available to us in SW London. As the custodians of the health system and as local GPs, we believe the latter is the only acceptable way forward.

2.6 The six CCGs have approved and submitted a joint South West London 5 Year Strategic Plan which sets out our ambitions for transforming health services across the entire SWL health system, incorporating mental health, primary care, community services and local hospitals.

2.7 Drawing on previous work from the last two years and on more recent discussions with clinical colleagues across the health system, the initiatives are outlined across eight areas of work; Children's Services, Integrated Care, Maternity Care, Mental Health, Planned Care, Primary Care and Urgent and Emergency Care and Cancer Care.

2.8 The strategy does not include site-specific proposals; it focuses on standards of care and what commissioners expect. Delivery of these ambitions will require a collective approach, working with local providers, with local authorities and with NHS England as co-commissioners to ensure the transition happens in a way which is meticulously planned, sufficiently resourced and overseen by senior clinicians and health system leaders. Over the coming months, the CCGs will continue to work together with wider stakeholders to develop these initiatives into an overarching plan.

CONTACT OFFICER: Paula Swann, Chief Officer, Croydon Clinical Commissioning Group
Paula.swann@croydonccg.nhs.uk
02036687329

BACKGROUND DOCUMENTS: None

Our five year strategy

Paula Swann – Chief Officer
Croydon Clinical Commissioning Group

Croydon Health and Wellbeing Board
16th July 2014

BSBV

South West London Collaborative Commissioning

- *Better Services Better Value*: acute reconfiguration programme for south west London – launched May 2011
- Proposals twice developed for public consultation
- Withdrawal of Surrey Downs CCG meant proposals undeliverable
- CCGs agreed in March/April we should close the BSBV programme
- Need to address issues raised by BSBV and Call to Action: to do this the six CCGs and local providers need to work together

SWL Collaborative Commissioning

- The 6 CCGs and NHSE are working together in a Strategic Planning Group on developing and delivering a 5 year strategy
- Need to work together as challenges cross borough-boundaries and SWL healthcare is inter-dependent with established clinical networks
- Do not believe working in smaller groups could achieve scale of change needed, but we will also need to work closely with neighbouring CCGs
- All 6 CCGs support clinical case for change and will commission to London Quality Standards, 7 day working and Keogh Review recommendations
- Also want to set clear standards for mental health, community services, primary care
- CCGs want to be clear about the standards they expect for patients and to work with the local providers of care to determine the best way to achieve that change
- Local CCGs are decision-makers and each have agreed a joint SWL

Our vision for healthcare in south west London

“People in South West London can access the right health services when and where they need them. Care is delivered by a suitably trained and experienced workforce, in the most appropriate setting with a positive experience for patients. Services are patient centred and integrated with social care, focus on health promotion and encourage people to take ownership of their health. Services are high quality but also affordable.”

The case for change – 4 main drivers

- **Safety and quality standards.** Quality is variable across all services; none of our acute trusts meet all of London Quality Standards; we need to transform primary care and deliver highest standards in community and mental health services.

- **Financial gap.** The NHS budget is not expected to increase, but demand is increasing due to our rising and ageing population. Current analysis shows that if we continue as we are, the costs of commissioning will exceed CCG budgets by £210m by 2018/19. In addition, provider trusts have identified a financial gap of £360m

The case for change – 4 main drivers

- **Workforce gap.** There is a national shortage of specialist staff – for example, there are not enough consultants available to meet the London Quality Standards across all our hospitals. In addition, we need to ensure we have sufficient access to clinicians such as general practitioners and nurses in a community setting.

- **Rising demand for healthcare.** Our population is growing at one of the fastest rates in the country, meaning large increases in demand for maternity and paediatric care. Our ageing population, in which more people are living with long term illnesses like diabetes and heart disease, means there is a need to provide

Our five-year strategy: key messages

- **Standards matter**. The standards that we are asking of our providers are all about improving care and outcomes for patients – for example; ensuring consultant presence on hospital wards, which has been shown to improve patient and outcomes and in to save lives in emergencies.

- **We need to change the way we deliver health services** to meet the changing needs of an ageing population in which many more people live with long term conditions. This means we need to spend more money on services based in the community, keeping people out of hospital unless they really need to be there. (E.G.

Our five-year strategy: key messages

- **We will meet 100% of the London Quality Standards** (LQS) by 2018/19 and many of them before that. We will ensure seven-day services are delivered by 2015/16. This requires a collective approach across south west London.

- **Community-based services must meet the highest possible standards** and should be networked with each other and other health and social care services. All six CCGs have made huge progress on developing their plans to improve care outside hospital.

- **We need to transform primary care**, with networks of

Our five-year strategy: key messages

- **Mental health services need to be reshaped** so that they achieve the highest possible standards and are focused primarily in the community, working in an integrated way with physical health services, local authorities and the voluntary sector.

- **Most planned operations in south west London requiring an overnight stay will take place in a planned care centre** within five years, with urology services identified as a potential pilot.

- **Better information for patients** about where to access health services is critical to our success and that is why

Our five-year strategy: key messages

- **The five-year strategy sets out the direction of travel for the local NHS and the standards of care that we want for our patients.** Next step is work with provider trusts and Health and Wellbeing Boards on the detail of how we get there and what it means for each Trust.

- The strategy is to be implemented over a five-year period and ‘milestone’ plans are being agreed for each clinical area. The timescales for agreeing an implementation plan are under discussion.

- Working together across SWL is critical to achieving scale of change needed

Clinical Design Groups

The strategy sets out initiatives across eight areas of work:

- Children's services
- Integrated Care
- Maternity
- Mental Health
- Planned Care
- Primary Care Transformation
- Urgent and Emergency Care
- Cancer Care

These groups are drawn from local hospitals, community services, mental health services, GPs, pharmacists and patient reps.

Clinical Design Groups

- **Children's services** – we want to focus in the first two years on growing capacity in community services to care for more children closer to home and reduce unnecessary pressures on A&Es. There should then be a consolidation of acute services to meet minimum quality standards. The development of a SWL Children's network made up of experts across the system will oversee the transformation of services.
- **Integrated Care** – we will focus initially on the implementation of the Better Care Fund (BCF) plans alongside local authorities, with work in parallel to consider contracting, workforce and IT enablers for improving integration across SW London. Implementation of 7 day working in the community is targeted from 2016/17.
- **Maternity** – we will focus on increasing use of midwifery-led services for low risk pregnancies and birth. Also initiatives focus on improving continuity of carer and focus on women's experience of care, plus additional investment in midwifery and medical workforce. For women with more complex needs, and for those who develop complications in labour, all labour wards must have a consultant obstetrician present 14 hours per day by the end of 2014/15, with 24 hours per day achieved by 2018/19.

Clinical Design Groups

- **Mental Health** – we will commission a series of initiatives to develop capacity in community services, including developing a single point of access, increased access to psychological therapies and greater provision of home treatment, to be implemented between 2014/15 and 2016/17, with a view to providing better care and reducing acute in-patient admissions from 2017/18.
- **Planned Care** – we will co-create an implementation plan for a multi-speciality elective centre (MSEC), with urology services potentially deployed in a MSEC from 2016/17, one further specialty from 2017/18 and three more from 2018/19. Planning to include consideration of appropriate quality measures and approaches to contracting.
- **Primary Care Transformation** – we will work with NHS England to have a fully networked model of primary care by 2016/17, with implementation plans for estates improvements and workforce transformation to commence in the same year. There will be a greater emphasis placed on multi-disciplinary team working, prevention and supporting self-management, with GP surgeries working in networks.

Clinical Design Groups

- **Urgent and Emergency Care** – we will implement 7 day working across urgent and emergency care services in SW London by 2015/16, supported by an ambulatory (same day) emergency care model. We will commission to London Quality Standards across all emergency departments by 2016/17. Further improvements in efficiency and effectiveness, including greater connectivity with other settings, to be pursued through implementation of new IT systems.
- **Cancer Care** - we will focus on prevention of disease, early diagnosis and patient experience of treatment with an emphasis on patient choice and care provision in the community during active treatment, recovery, and, where necessary, the end of life phase. Every patient will be treated as an individual and offered the full support of the healthcare professionals involved.

Engagement

- Local NHS has been talking to local people for 3 years about the challenges – over 500 meetings as part of BSBV programme
- Each CCG carried out own local engagement programme on ‘Call to Action’
- A Stakeholder event was held on the 8th May to test the learning from previous engagement
- Further engagement will be key to the implementation phase
- Any proposals for major service change would require formal public consultation

Timescales

South West London Collaborative Commissioning

- Initial strategy drafted and shared with NHS England, local authorities and providers – April 2014
- Final draft strategy discussed by CCG Governing Bodies in public in early June and approved (published in last week of May 2014) and was submitted to NHS England on 20 June 2014
- Strategy does not include site-specific proposals – focus is on standards of care and what commissioners expect – detail of how to implement will be worked out with providers and Health & Wellbeing Boards
- Any major service change subject to public consultation
- Strategy to be implemented over next five years across SWL

Thank you

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