HEALTH & WELL-BEING BOARD (CROYDON)

To: **Elected members of the council:**
Councillors Margaret BIRD, Patricia HAY-JUSTICE, Yvette HOPLEY (Vice-Chair), Maggie MANSELL (Chair), Callton YOUNG

Officers of the council:
Barbara PEACOCK (Executive Director of People)
Rachel FLOWERS (Director of Public Health)

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

Healthwatch Croydon
Charlotte LADYMAN (Healthwatch Croydon)

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

Representing voluntary sector service providers:
Helen THOMPSON (Croydon Voluntary Sector Alliance)
Sara MILOCCO (Croydon Voluntary Action)
Nero UGHWUJABO (Croydon BME)

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

Non-voting members:
Ashtaq ARAIN (Faiths together in Croydon)
Sally CARTWRIGHT (London Fire Brigade)
Adam KERR (National Probation Service (London))
Andrew McCOIG (Croydon Local Pharmaceutical Committee)
Cassie NEWMAN (London Community Rehabilitation Company)
Claire ROBBINS (Metropolitan Police)

A meeting of the **HEALTH & WELL-BEING BOARD (CROYDON)** will be held on **Wednesday 14th September 2016** at **2:00pm**, in **The Council Chamber, The Town Hall, Katharine Street, Croydon CR0 1NX**.

JACQUELINE HARRIS-BAKER
Acting Council Solicitor and Acting Monitoring Officer
London Borough of Croydon
Bernard Weatherill House
8 Mint Walk, Croydon 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
5 September 2016

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. Minutes of the meeting held on Wednesday 8th June 2016 (Page 1)

To approve the minutes as a true and correct record.

2. Apologies for absence

3. 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.

4. 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.

5. Exempt Items

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

6. Strategic Items
Cancers - the early detection and treatment (Page 11)

The report of the Chief Officer of Croydon's Clinical Commissioning Group is attached.
A presentation is also attached.

7. JSNA key dataset 2016 (Page 77)

The presentation from Croydon's Director of Public Health is attached.

8. People's experience of using mental health day care services (Page 99)

The report of the Chief Officer of Croydon's Clinical Commissioning Group is/are attached.

9. Business items:
Tobacco control update (Page 111)

The report of the Croydon's Director of Public Health is attached.

10. Health Protection Forum update (Page 121)

The report of Croydon's Director of Public Health is attached.

11. Report of the chair of the executive group (Page 125)

The report of the Chair of the Executive Group is attached, covering the Work Programme and Risk Summary

12. FOR INFORMATION ONLY:
Healthwatch Croydon reports

Carers of over 65s - Experiences
Mental health – local perspective
Both reports can be accessed on the Healthwatch Croydon website here:
www.healthwatchcroydon.co.uk/impact

The Annual Report 2015-16 can be accessed here:
www.healthwatchcroydon.co.uk/annual-report-business-plan

13. Public Questions

For members of the public to ask questions relating to items on this agenda of the Health & Wellbeing Board meeting.

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.

AGENDA - PART B

None

Minutes of the meeting held on Wednesday 8th June 2016 in The Council Chamber, The Town Hall, Katharine Street, Croydon CR0 1NX

Present:

Elected members of the council:
Councillors Margaret BIRD, Patricia HAY-JUSTICE, Yvette HOPLEY (Vice-Chair), Maggie MANSELL (Chair), Callton YOUNG

Officers of the council:
Paul GREENHALGH (Executive Director of People)
Ellen SCHWARTZ (Consultant in Public Health)

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

Healthwatch Croydon
Charlotte LADYMAN (Healthwatch Croydon)

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

Representing voluntary sector service providers:
Helen THOMPSON (Croydon Voluntary Sector Alliance)
Sara BURNS (Croydon Voluntary Action)
Nero UGHWUJABO (Croydon BME)

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

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

Also present:

Councillors Maddie HENSON and Bernadette KHAN, Solomon AGUTU (Head of Democratic Services & Scrutiny), Steve MORTON (Head of Health & Wellbeing), Jo NEGRINI (Executive Director of Place), Pratima SOLANKI (director of Adult Social Care & All Age Disability Services), Ashley BROWN (Public Health Programme Manager), Jimmy BURKE (Public Health Principal), Dr Emily SYMINGTON (Public Health) and Dave MORRIS (SSC Strategy Manager)

Absent:

Rachel FLOWERS (Director of Public Health), Dr Jane FRYER (NHS England), Adam KERR (National Probation Service (London)). Dr Agnelo FERNANDES, Sharon KIRK (London

Probation Trust (Croydon)), Sara MILOCCO (Croydon Voluntary Action), Sally CARTWRIGHT (London Fire Brigade), Claire ROBBINS (Metropolitan Police)

Apologies: Rachel FLOWERS (Director of Public Health), Dr Jane FRYER (NHS England), Adam KERR (National Probation Service (London)), Dr Agnelo FERNANDES, Sharon KIRK (London Probation Trust (Croydon)), Sara MILOCCO (Croydon Voluntary Action), Claire ROBBINS (Metropolitan Police), Councillor Andrew RENDLE, Brenda SCANLAN (Director of Adult Care Commissioning)

A24/16 APPOINTMENT OF CHAIR AND VICE-CHAIRS AND CONSTITUTION OF THE HEALTH & WELLBEING BOARD

Councillor Maggie Mansell welcomed some new Members to the Board: Councillors Callton Young and Margaret Bird, Dr Ellen Schwartz (on behalf of Rachel Flowers, Director of Public Health). The Members of the Board then introduced themselves.

Solomon Agutu (Head of Democratic Services and Scrutiny) took the beginning of the meeting, to explain that this being the beginning of a new municipal year, the Board had to be reconstituted. He requested nominations for the Chair, to be elected by the Councillors and ex-officio statutory representatives on the Board. Solomon Agutu explained that the statutory members do not have to be elected:

- Councillor Maggie Mansell was proposed by: Cllr Callton Young and seconded by: Cllr Yvette Hopley

There were no other nominations, so she was duly elected and took the chair for the remaining appointments.

She explained that agreement to nominate a second Vice-Chair, representing the CCG, had been agreed at Council on 25 January 2016.

- Vice-Chair (CCG) – Dr Agnelo Fernandes was proposed by: Paul Swann and seconded by Cllr Maggie Mansell:

There were no other nominations, so he was duly elected.

- Vice-Chair - Councillor Yvette Hopley was proposed by: Paula Swann and seconded by: Cllr Callton Young

There were no other nominations, so she was duly elected.

Appointment of Other Voting Board Members, appointed by their organisations, proposed by Councillor Maggie Mansell:

- Croydon Healthcare NHS Trust – John Goulston, Chief Executive

- South London and Maudsley Hospital Trust – Zoe Reed, Service Director
- CVA – Sara Milocco, Head of Communities
- Croydon Charity Services Delivery Group – Stuart Routledge (Chief Executive, Age UK)
- Croydon Voluntary Sector Alliance (CSVA) (2 members) – Karen Stott (Director of Off the Record) and Helen Thompson (Carers Information Services)
- BME Forum - Nero Ughwujabo

Councillor Callton Young seconded the motion and the members were elected en bloc.

(FOR INFORMATION: Non-Voting Members, appointed by their organisations:

- Faiths Together in Croydon – Ashtaq Arain
- London Fire Brigade – Sally Cartwright, Borough Commander
- Metropolitan Police – Inspector Claire Robbins
- National Probation Service (London) – Adam Kerr, Assistant Chief Officer
- London Community Rehabilitation Company (LCRC) – Sharon Kirk, CRC Stakeholder and Partnership representative (replacing Lissa Anderson)
- Croydon Local Pharmaceutical Committee – Andrew McCoig, Chief Executive Officer
- Croydon College - no nomination confirmed)

Andrew McCoig suggested 2 of non-voting members be put forward as voting members.

A25/16 MINUTES OF THE MEETING HELD ON WEDNESDAY 13TH APRIL 2016

Strategic item P3 - Cllr Hay-Justice asked who is leading on the point about maternity services booklets only being printed in English. The BME Forum is leading? John Goulston ???

The minutes of the meeting held on 13 April were then agreed as an accurate record.

A26/16 DISCLOSURE OF INTEREST

There were none.

A27/16 URGENT BUSINESS (IF ANY)

There was no urgent business.

A28/16 EXEMPT ITEMS

There were no exempt items.

A29/16 STRATEGIC ITEMS:
'TOGETHER FOR HEALTH' - PREVENTION, SELF-CARE, SELF-MANAGEMENT AND SHARED DECISION MAKING

Jimmy Burke (Public Health Principal) and Dr Emily Symington gave a presentation (see attached):

- This shows the developments since a previous presentation brought to the Board in 2013
- NHS facing challenging times with major financial problems
- Ageing population and increasing burden of long term disease
- Need to ensure we are meeting the needs as they occur
- Encouraging communities to be more independent, to manage their own health with professionals
- Supporting communities to become involved in healthcare
- Large number of local projects under way
- 'Right care first place, first time'
- Working with other partner services to address societal issues affecting health

Cllr Mansell: Important to recognise where started with position of financial deficit. Three quarters of Trusts in financial deficit - not bad management but under funding. In public health, working to prevention agenda since Black report in 1980. Lot of actions taken, trying to educate people to live more healthily. Middle classes become healthier but others stayed where they are. Gap has widened. Very complicated issue - take away people ready to go home and fill with those who are ill, then needs increased. Cannot take average cost.

Charlie Ladyman gave a summary of the Healthwatch Croydon report:

- Findings of patient experience with regard to self-care and self-management
- Secondary patient experience data (evidence-base) is from internet sources, such as NHS Choices
- Generally residents still think GP when they could visit a pharmacy
- Approx. 20% of people who use A&E do not have a medical issue
- It is a big change going from paternalistic to self-managed

The Board then split into 4 groups, including members of the public, to debate the following:

"As part of promoting self-care in 'Together for Health', we encourage people to ask three questions when thinking about their health or care needs:

- What are my options?
- What are the pros and cons of these options?
- Where can I find information to decide which is the best option for me?"

Each table was asked to feed back the main issues arising from their discussions on the following:

1. Considering your knowledge of the health and care system in Croydon and personal experience, discuss the response to these questions for a Croydon resident.
2. How could services throughout Croydon work together better to empower residents to self-care?

Table 1:

- Education and information are important
- Patients should be used as a resource
- Services are under separate contracts which causes problems for joint working
- Learn lessons from the trailblazing 'Outcomes based Community Programme for the over 65s' and extend the approach

Table 2:

- Need to build a shared vision for Croydon
- Responsibility for keeping healthy must shift into the community
- Major cultural change from service dependency to self and community reliance
- Need to increase social connectedness with health workers working together to keep people well

Table 3:

- Communication is key - GP practices and pharmacies should have a care navigator who can signpost patients to the right place (NHS services, voluntary sector, health and fitness classes etc)
- Learn from others in carers groups who have gone through the same experience
- Major challenge as it is most effective to invest in prevention but initially it costs more

Table 4:

- Lack of consistency across the services
- Clearer framework needed to facilitate quality of access, with residents in contact with professionals
- Services need to be signposted better
- Services must work together **with** the community

The Board **NOTED** the presentation and report.

A30/16 COMMUNITY STRATEGY

Paul Greenhalgh introduced the report, which is an overarching strategy across all areas in the borough. It is the Council's most important strategic planning document and provides a framework for the work of all partner organisations within Croydon's Local Strategic Partnership (LSP) and the context for future strategies and plans in the borough.

Cllr Yvette Hopley: How well are we working within internal departments in the Council? We need a more joined up approach.
Cllr Maggie Mansell: That is what we are trying to do. Gateway service - helping people to deal with financial, housing, school, social care problems, rather than penalising them for not paying rent.
Paul Greenhalgh: 18 months ago the Council restructured into 3 departments, to ensure there is a much stronger join up between areas.

Nero Ughwujabo: Will someone look to see if the priorities of the Board are reflected?
Paul Greenhalgh: We are asking for approval to ensure alignment across the entire agenda and business and interests of HWB, as reflected in the HWB strategy.
Steve Morton: Ot is for the Board to think about the HWB strategy joining up with the Community Strategy - e.g. social isolation issues.

The Board **RESOLVED** to:

1. Approve the draft Community Strategy 2016-21, Appendix 1 to this report and recommend its adoption by Cabinet and Full Council
2. Agree that the Health and Wellbeing Board adopt the Community Strategy as approved by Full Council, for delivery over the period 2016-21
3. Agree that the Executive Director People and the Chief Officer of Croydon CCG are authorised to make minor factual or presentational amendments to the Community Strategy response to feedback from engagement detailed below prior to approval by Full Council.

A31/16 BUSINESS ITEMS:
SOUTH WEST LONDON SUSTAINABLE TRANSFORMATION PLAN

Paula Swann gave a presentation:

- The STP footprint is SW London.
- Priorities - 4 key areas of change
- Submission deadline is 30 June

Board members were asked to feedback their comments to Paula Swann before the end of June.

The following comments were raised at the meeting:

- Need clear focus to tackle challenges of deprivation in north of borough and New Addington and Fieldway. Solutions being put forward with significant challenges of financial constraints. Broader response rather than just a health response, which is struggling with resources.
- Significant amount of health issues local people face is about behaviour. There is significant opportunity if services work better together. Benchmark health services against others to see how efficient we are. On journey for last 3 years.
- £500,000 funding available to go to the best plan.
- Council has made vigorous representations to the Treasury about underfunding of local government and also Croydon health services

The Board **NOTED** the contents of the presentation.

A32/16 FOOD FLAGSHIP ANNUAL REPORT

Ashley Brown (Public Health Programme Manager) summarised the report.

Obesity is an increasing problem in Croydon, caused by a number of issues, including greater consumption of processed food, more sedentary lifestyles in both adults and children, and changes in employment and family norms. Obesity rates in Croydon children and adults are higher than the London average.

The national School Food Plan was published in 2013, with a recommendation that two London Boroughs be established as Food Flagship Programmes, with schools being the catalyst for change in a whole system transformation of the food landscape. After a competitive bidding process, Croydon and Lambeth were awarded food flagship status by the GLA (Greater London Council) in 2014.

The programme has achieved significant successes in the past 14 months with key funded projects achieving, and in some cases exceeding targets. There are 60 projects underway across the borough. One main aim is to ensure better provision in schools.

The following comments were made:

- Why has there not been a better take up in lower primary - are the portions not enough?
- Key Stage 2 - all eligible will get free lunches
- GLA funding £20,000 for 2 years
- Working with schools - trying to make changes where possible but not enough funding for **all** schools.
- Looking at things that work best
- How is success measured?
- Outcomes are ambitious - the national child development programme measures child obesity. An external evaluator is helping to assess the impact of having more access to good food.

The Board **RESOLVED** to:

- note the recent developments of the Food Flagship programme
- ratify the direction of travel for the future which is to embed system transformation across the council and its partners

A33/16 HEART TOWN ANNUAL REPORT

At its meeting on 23 October 2013 the Health and Wellbeing Board endorsed a strategic partnership approach to improving heart health in the borough and the extension of Croydon's Heart Town programme from two to five years. The report provides an update on Heart Town activity since the last report to the board on 10 June 2015.

Steve Morton highlighted the main points in the report:

- Since becoming a Heart Town, £30,000 has been raised to help fight heart disease
- There is a focus on smoking and people with mental illness
- Healthcheck programme from low uptake now seeing 500 people a month

The Board **NOTED** the report.

A34/16 REPORT OF THE CHAIR OF THE EXECUTIVE GROUP

Paul Greenhalgh gave a brief summary of the report.

The board risk register was developed by the board at a seminar on 1 August 2013. The board agreed that the executive group would keep these risks under review and update them as required. (see Appendix 1)

The work plan for 2016/17 at its meeting on 13 April 2016. 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 2.

The Board **RESOLVED** to:

- Note risks identified at appendix 1.
- Agree revisions to the board work plan for 2016/17 at appendix 2.

A35/16 PUBLIC QUESTIONS

There were no public questions.

The date of the next meeting is 14 September.

The meeting ended at 4:50pm

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REPORT TO:	**HEALTH AND WELLBEING BOARD (CROYDON)** **14 September 2016**
AGENDA ITEM:	**6**
SUBJECT:	**Improving the early detection and treatment of cancers in Croydon**
BOARD SPONSOR:	Paula Swann, Chief Officer – Croydon CCG

BOARD PRIORITY/POLICY CONTEXT:

Croydon Joint health and wellbeing strategy, 2013-2018

As part of its vision for longer healthier lives for everyone in Croydon, the Health and Wellbeing Board identifies as an ambition: increased healthy life expectancy and reduced differences in life expectancy between communities. The strategy identifies specific improvement areas relating to cancer that contribute to this ambition:

Improvement area 2: preventing illness and injury and helping people recover
2.1 Reduce smoking prevalence
2.2 Reduce overweight and obesity in adults
2.3 Reduce the harm caused by alcohol misuse

Improvement area 3: preventing premature death and long term health conditions
3.2 Early detection and treatment of cancers

Improvement area 5: providing integrated, safe, high quality services
5.4 Improve the clinical quality and safety of health services

Improvement area 6: improving people's experience of care
6.2 Improved patient and service user satisfaction with health and social care services

Croydon CCG's Vision, Objectives and operating plan commitments

Our vision is for longer healthier lives for all the people in Croydon. We will deliver this through an ambitious programme of innovation and by working together with the diverse communities of Croydon and with our partners. We will use resources wisely to transform healthcare to help people look after themselves, and when people do need care they will be able to access high quality services.

Our objectives are:
1.1 To commission high quality health care services that are accessible, provide good treatment and achieve good patient outcomes
2.1 To reduce the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital, for physical and mental health

3.1 To achieve sustainable financial balance by 2018/19 and NHS business rules of 1% surplus by 2020/21
4.1 To support local people and stakeholders to have a greater influence on services we commission and support individuals to manage their care
5.1 To have all Croydon GP practices actively involved in commissioning services and develop as a responsive and learning commissioning organisation

During 2016/17 we are working to:

- Ensure that all targets for cancer reporting are met, particularly with regards to the 62 day referral to treatment target, where there is poor performance across London and at a national level.
- We are achieving this through delivery of local action plans that are agreed with providers and which include the tracking of patient pathways to highlight issues that are causing delays.
- Adopt a collaborative approach across London on demand and capacity requirements for diagnostic services that are key in ensuring the delivery of the nationally set cancer targets. This involves establishing sufficient capacity within diagnostic services to ensure patients are seen and reported upon in a timely manner according to the agreed cancer pathways.
- Actively engage with clinicians in primary care to provide education and support in pathways for patients presenting with symptoms as per NICE guidance. This will improve on the percentage of patients who are detected and diagnosed at an earlier stage in their pathway and reduce levels of emergency activity.
- Implement the pan-London cancer pathways including direct access for GPs to diagnostics.

Achieving world-class cancer outcomes: A strategy for England 2015-2020
The Cancer Strategy for England was published in July 2015 by an Independent Cancer Taskforce. It set out the following six strategic priorities:
1. Prevention and public health
2. Earlier diagnosis
3. Patient experience
4. Living with and beyond cancer
5. Investing in modern, high quality services
6. Overhauling processes for commissioning, accountability and provision

NHS England's Five year Cancer commissioning Strategy for London, 2014
Clear themes emerged from engagement events held to develop the strategy. These themes were incorporated into it. They are:

- The importance of earlier detection
- The need to improve coverage and uptake of screening

- The need to support people living with and beyond cancer as a long term condition
- The importance of information and data as to the cost and performance of services
- The vital need for excellent communication

Five-year sustainability and transformation plan

New planning guidance published in December 2015 by NHS England instructs CCGs and their partners to establish 'place-based planning'. This means that alongside a one-year operational plan, a five-year sustainability and transformation plan (STP) must be developed. The final South-West London (SWL) STP will be delivered in October 2016. One of the national challenges each plan must address is the question '*How will you deliver a transformation in cancer prevention, diagnosis, treatment and aftercare in line with the cancer taskforce report?*' In response to this challenge, the cancer priorities of the SWL STP will be:

1. Screening and Early Diagnosis
2. Cancer waits and diagnostics
3. Reducing variation
4. Living with and Beyond Cancer

As part of its commissioning intentions, Croydon CCG will develop pathways to reflect these priorities alongside the priorities already identified in our local cancer strategy. Additionally, Croydon has been identified as the lead CCG for the SWL STP on prevention.

Croydon CCG Cancer Strategy 2014-19

In its Cancer Strategy 2014-19 Croydon CCG identifies its key challenges and areas for focus are:

- Prevention
- Improving early detection
- Reducing variation in care
- Improving breast screening rates for women and addressing an emerging issue of increased incidence of breast cancer[1]
- Addressing the increased incidence and emerging issue of increased deaths from prostate cancer
- Inequality in life expectancy between areas of deprivation
- Achievement of waiting time standards
- Improving patient experience

[1] Since the strategy was implemented the 1 year trend for incidence of breast cancer has shown some improvement

FINANCIAL IMPACT:

Success in addressing preventable cancer mortality and morbidity necessitates adequate investment in prevention, awareness, screening and services. The costs of cancer, both in in financial terms and in human terms, can be greatly reduced by early intervention. The earlier the intervention, the more impactful the investment will be. High quality prevention and awareness have the potential to deliver the greatest benefits.

1. RECOMMENDATIONS

The Board is asked to support and ensure stronger partnership working between local commissioners of cancer provision, in particular:

- Croydon Clinical Commissioning Group
- Croydon Council and its Public Health function

Working alongside national partners:

- Primary Care Commissioning - NHS England
- Public Health England
- NHS England - Specialised Commissioning

This will improve cancer outcomes for the people of Croydon and address health inequalities issues by tacking cancer all along the pathway, from prevention, awareness and screening to early diagnosis and treatment.

2. EXECUTIVE SUMMARY

2.1 Cancer causes one in four deaths in the UK and kills around 945 Croydon residents each year. Despite this toll, cancer care is improving significantly and currently around half of those diagnosed with the disease survive for 10 years or more. Incidence of cancer and cancer deaths are lower than England averages but Croydon does have challenges, in particular around breast and bowel screening.

2.2 There is evidence around serious health inequalities in cancer and work needs to take place locally to establish the scale and nature of health inequalities issues in the borough.

2.3 The financial and human costs of cancer are best addressed through ‘upstream’ interventions as many cases of cancer can be prevented though changes to lifestyles, such as quitting smoking or reducing excess weight. Smoking alone causes 28% of cancer deaths and this burden falls disproportionately on deprived communities.

2.4 Public health teams commission behaviour change service to deliver prevention and Croydon Council is implementing a new Livewell service to deliver this function during 2016-17. The council's NHS Healthchecks programme can support success in preventative interventions too. Other partners and stakeholders including Croydon CCG's Together for Health programme will need to join forces to be effective. The council is also able to use local regulation, such as licensing policy, to improve lifestyles.

2.5 Levels of awareness of cancer symptoms among the public are inconsistent and barriers exist to getting help when symptoms are discovered. Croydon can address this through promoting the national 'Be Clear on Cancer' campaigns as broadly as possible.

2.6 Similarly, there are issues around screening uptake, which the CCG is tackling through individual support for practices - in partnership with Cancer Research UK and Macmillan. This support includes improved cancer referral practice and 'safety-netting' to ensure patients do not fall through the cracks between services.

2.7 2015 NICE guidance has lowered the threshold of risk for symptoms suggestive of cancer, which triggers an urgent referral, to 3%. This will aid diagnosis of more cancers at an early stage - so called 'low risk but not no risk' cases. The CCG is also subject to a Quality Premium incentive scheme pushing for earlier stage diagnosis of cancer.

2.8 Despite improvements in cancer care, England performs poorly compared to some peer nations and so there is room for improvement in cancer survivorship. Survival is improved most profoundly through earlier diagnosis. A marker of late diagnosis (and hence a marker of survival) is the proportion of cancer cases that are discovered through emergency presentations at A&E. Croydon performs well against England in this respect, 17% against an England average of 20%.

2.9 Croydon CCG performs well against the range of cancer waiting time targets in the year to date, but the 62 day standard shows some underperformance and is a cause for concern. Plans to improve this performance issue are being implemented. It should be noted however, that Trusts report ever increasing pressures and there is a real risk that performance on waiting times may deteriorate.

2.10 For 2016-17 the CCG implemented a range of early diagnosis commissioning intentions within the acute care contract as local quality requirements.

2.11 In summary, the cancer pathway begins with sound, evidence-based behaviour change services, such as smoking cessation, weight management and physical

activity. Public awareness needs to be heightened through widely disseminated health promotion campaigns, such as *Be Clear on Cancer*.[2] Screening programs must be promoted and targeted to maximise uptake, for example, through the use of segmented social marketing approaches. Primary-care detection and referral must be optimised in line with best practice, and diagnostics must be accessible with prompt communication, both with primary care referrers and with patients.[3]

2.12 Only by a robust partnership approach can Croydon deliver the best possible cancer provision, increasing healthy life expectancy, reducing differences in life expectancy between communities and improving wellbeing and quality of life for all.

3. BACKGROUND

3.1 What is cancer?

Cancer is a disease associated with the abnormal and uncontrolled division of cells in the body. This can be in the skin or tissues surrounding organs (carcinomas); in the connective or supportive tissues such as bone, cartilage, fat, muscle, or blood vessels (sarcomas); in the blood forming tissue such as bone marrow (leukaemias); in the cells of the immune system (lymphoma and myeloma); or in the central nervous system (cancers of the brain and spinal cord). Some cancers can spread into other tissues over time – what is known as metastasis. This involves cancer cells being shed from a tumour and travelling to new sites within the body where they may begin to multiply.

3.2 Cancer mortality and morbidity

There are more than 200 different types of cancer and one in two people in the UK will get cancer in their lifetime.[4] Cancer causes 27% of global deaths[5] and in 2014 caused over 163,000 deaths (one in four of all deaths) in the UK alone.[6] The annual rate of cancer mortality in Croydon is 260 people per 100,000 population,[7] which means around 945 people die from cancer in the borough each year. However, advances in medicine mean that many people are cured and survival rates have improved with 50% of people diagnosed in England and Wales surviving their disease for ten years or more (2010-11).[8] Cancer survival is improving and has in fact doubled in the last 40 years in the UK. [9]

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[2] https://www.nhs.uk/be-clear-on-cancer#4Bq6gD5gWz9siiFO.97
[3] http://www.macmillan.org.uk/documents/aboutus/health_professionals/primarycare/improving-one-year-cancer-survival-2015.pdf
[4] Trends in the lifetime risk of developing cancer in Great Britain: comparison of risk for those born from 1930 to 1960. British Journal of Cancer (2015) **112**, 943–947. doi:10.1038/bjc.2014.606 www.bjcancer.com
[5] Global status report on noncommunicable diseases. World Health Organization, 2010.
[6] Cancer Research UK http://www.cancerresearchuk.org/health-professional/cancer-statistics Aug 2016
[7] https://www.cancerdata.nhs.uk/mortality/age_standardised_rates
[8] Cancer Research UK http://www.cancerresearchuk.org/health-professional/cancer-statistics/survival
[9] Cancer Research UK http://www.cancerresearchuk.org/health-professional/cancer-statistics/survival

3.3 Cancer incidence and mortality is lower in Croydon than the England average (see tables 3 and 4).[10] The local Joint Strategic Needs Assessment (JSNA) highlights where the borough varies from both the London and England averages around other cancer indicators. Our local JSNA for 2015-16 tells us that in some areas Croydon is performing well (table 1). For example, deaths from oesophageal cancer and colorectal cancer are significantly better than England and in the best 25% of local authorities/CCG's. The one-year and three-year trends consistently show improvement. Croydon performs favourably with regard to early deaths from cancer and incidence of bladder cancer; again significantly better than England and in the best quartile among local authorities/CCG's. The trends for these indicators appear stable.

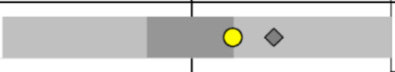
Indicator	Croydon	London	England	England Range	1 Year Trend	3 Year Trend	Time Period
177 Incidence of oesophageal cancer (rate per 100,000 population)	14.7	12.3	15.1		▶	—	2010 - 12
178 Deaths from oesophageal cancer (rate per 100,000 population)	9.0	10.5	13.3		▶	▶	2011 - 13
181 Incidence of colorectal cancer (rate per 100,000 population)	72.5	68.0	77.2		◀	▶	2010 - 12
182 Deaths from colorectal cancer (rate per 100,000 population)	24.5	26.6	28.8		▶	▶	2011 - 13
194 Incidence of bladder cancer (rate per 100,000 population)	16.0	18.2	19.3		◀	▶	2010 - 12
195 Deaths from bladder cancer (rate per 100,000 population)	7.3	8.2	9.0		▶	▶	2011 - 13

Table 1.

3.4 However Croydon is not without its challenges (table 2). The borough ranks low on financial expenditure on cancer and tumours. Another emerging issue for Croydon may be deaths from stomach cancer and, though current performance is not significantly worse than England, the one-year and three-year trends show deterioration. Breast screening rates for women aged 53-70 are also a cause for concern, with Croydon performing worse than both London and England. The worsening trend for this indicator is worrying. Likewise, the three-year trend for prostrate cancer deaths warrants attention.

[10] http://www.cancerresearchuk.org/cancer-info/cancerstats/local-cancer-statistics/?location-name-1=NHS%20Croydon%20CCG&location-1=07V

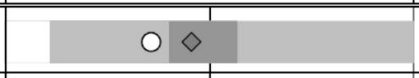
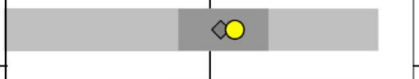
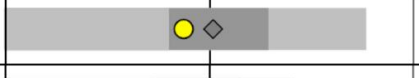
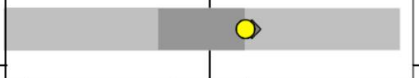
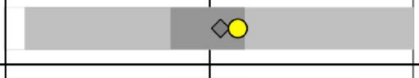
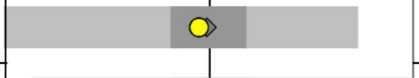
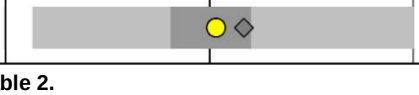
Indicator	Croydon	London	England	England Range	1 Year Trend	3 Year Trend	Time Period
169 CCG spend per head on cancers and tumours	£40	£47	£50		no data	no data	2013/14
179 Incidence of stomach cancer (rate per 100,000 population)	11.2	11.9	12.4		–	–	2010 - 12
180 Deaths from stomach cancer (rate per 100,000 population)	9.1	8.0	8.1		◄	◄	2011 - 13
187 Breast screening rate (% of women aged 53-70)	66.7%	68.9%	75.9%		◄	◄	2014
188 Incidence of breast cancer (rate per 100,000 population)	156	155	164		►	◄	2010 - 12
189 Deaths from breast cancer (rate per 100,000 population)	33.9	35.2	36.2		►	◄	2011 - 13
192 Incidence of prostate cancer (rate per 100,000 population)	178	175	174		►	►	2010 - 12
193 Deaths from prostate cancer (rate per 100,000 population)	48.3	45.0	49.1		►	◄	2011 - 13

Table 2.

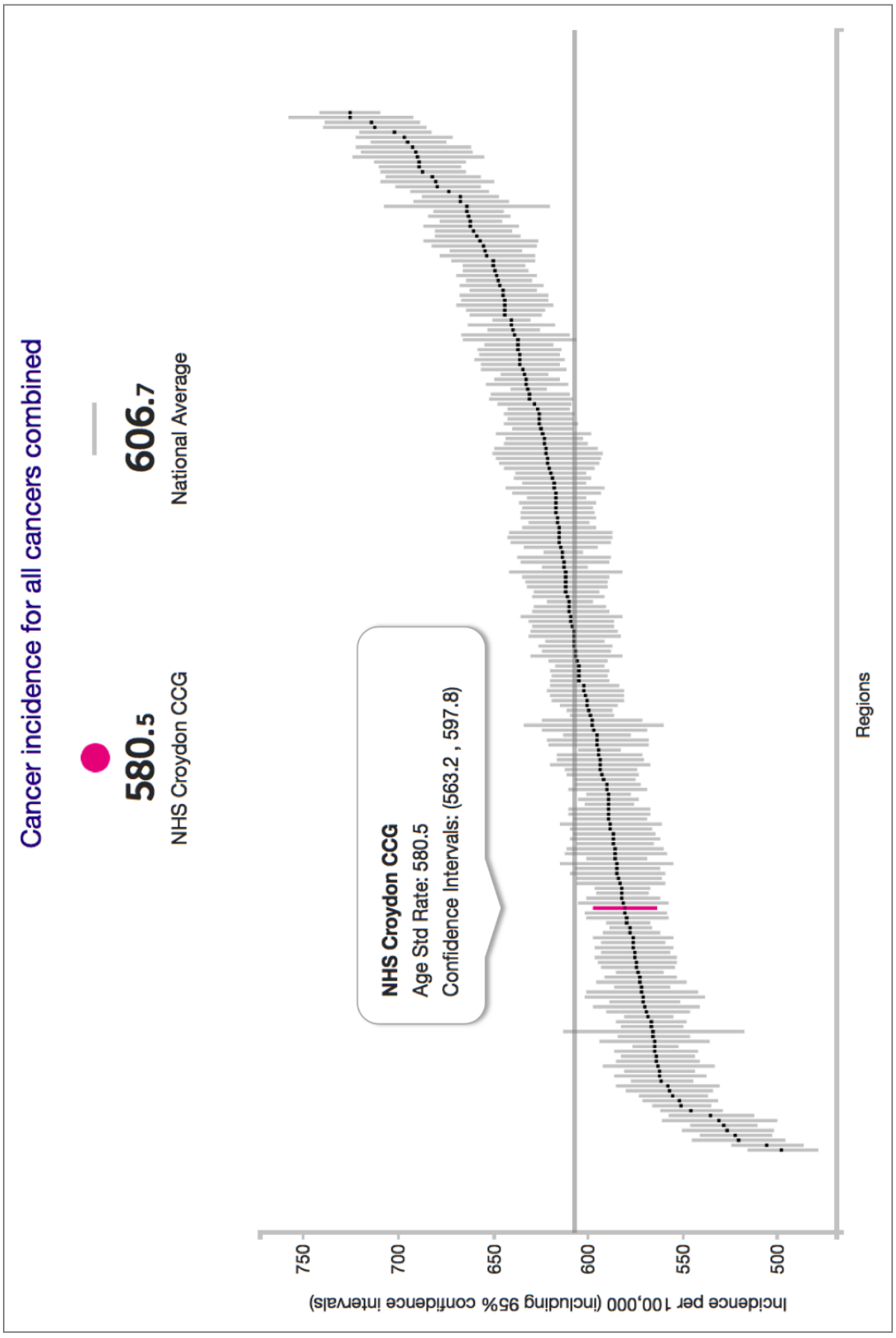

Cancer incidence for all cancers combined
580.5
NHS Croydon CCG
606.7
National Average
NHS Croydon CCG
Age Std Rate: 580.5
Confidence Intervals: (563.2 , 597.8)
Incidence per 100,000 (including 95% confidence intervals)
750
700
650
600
550
500
Regions

Table 3.

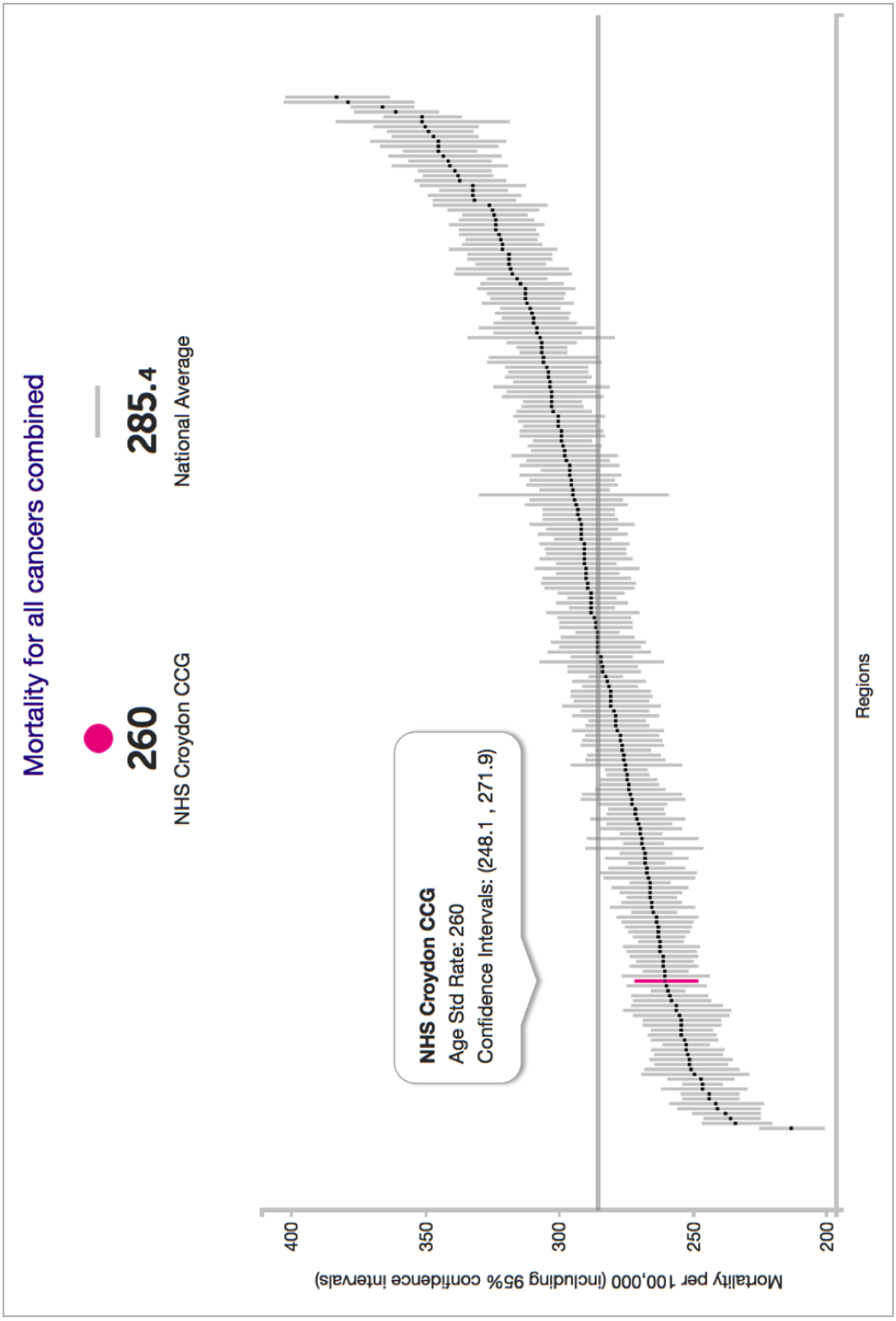

Mortality for all cancers combined
260
NHS Croydon CCG
285.4
National Average
NHS Croydon CCG
Age Std Rate: 260
Confidence Intervals: (248.1 , 271.9)
Mortality per 100,000 (including 95% confidence intervals)
400
350
300
250
200
Regions

Table 4.

3.5 **Health inequalities in cancer**

Health inequalities issues relating to cancer exist, associated particularly with deprived communities and Black and Minority Ethnic (BME) groups. These inequalities issues manifest themselves in the following areas:[11]

- **Cancer incidence, mortality and survival** – for example, African Caribbean men have three times the risk of being diagnosed with prostate cancer than do White men in the UK[12]
- **Lifestyle factors that predispose people to cancer**, such as obesity and smoking – for example, while 19% of the general smoke tobacco,[13] 32% of people with depression smoke[14] and up to 60% of people with psychosis smoke.[15] These groups also smoke more intensively than the general population[16]
- **Perceptions of cancer risk**, with more privileged groups tending to be more informed about risk factors – for example, in one survey, twice as many people from the least deprived group reported being aware of the link between fruit and vegetable consumption and cancer compared with the most deprived group[17]
- **Cancer symptom recognition**, with some evidence suggesting that some groups may have reduced awareness – for example, older women may have poor levels of breast cancer symptom recognition, even though their risk of developing breast cancer is higher than younger women[18]
- **Awareness of and use of health services**, with so-called 'harder to reach' groups having unmet needs around information, support and services – for example, participation in breast, cervical, and colorectal screening programmes is generally lower in minority ethnic groups than in the population as a whole[19]
- **Experience of cancer treatment** – for example, there is some evidence that indicates older people receive poorer cancer treatment than younger people[20]

3.6 The Equality Act 2006 makes it unlawful to discriminate on the grounds of race, age, gender, sexual orientation and religion in the provision of goods, facilities and services. Effective steps to address health inequalities in cancer are described in *Improving Outcomes: A Strategy for Cancer, 2011*. These include greater targeting and tailoring of interventions all along the cancer pathway;

[11] Cancer and health inequalities: An introduction to current evidence. Cancer Research, 2006
[12] Yoav Ben-Shlomo et al. The risk of prostate cancer amongst Black men in the United Kingdom: The PROCESS cohort study. European Urology 2008; 53 99-105
[13] 2014 Opinions and Lifestyle Survey Office for National Statistics, Feb. 2016
[14] 2007 Adult Psychiatric Morbidity Survey
[15] Adult psychiatric morbidity in England, 2007. Results of a household survey. The Health and Social Care Information Centre. http://www.esds.ac.uk/doc/6379/mrdoc/pdf/6379research_report.pdf
[16] The Royal College of Physicians. Smoking and mental health London, RCP, March 2013
[17] Reduce the Risk Survey (2004) Cancer Research UK
[18] Grunfield et al. (2002) *Women's knowledge and beliefs regarding breast cancer* British Journal of Cancer 86, 1373-1378
[19] Evidence to March 2010 on cancer inequalities in England www.ncin.org.uk/equalities
[20] Turner. NJ, Haward RA, Mulley. GP, Selby PJ. Cancer in old age - is it inadequately investigated and treated? BMJ.1999.319:309-12.

applying a ‘human rights’ approach to delivering personalised cancer care; and embedding equality in cancer services so it is not seen merely as an ‘add-on’.

Local areas can identify and address cancer related health inequalities by:

- Working with local authorities, public health teams and other partners to develop up-to-date intelligence, health inequalities mapping and health needs assessments. This will enable the provision of the most targeted solutions to meet the specific needs of different groups, thereby reducing health inequity.
- Providing targeted and tailored interventions at levels proportionate to identified need, in line with the principal of ‘proportionate universalism’, as advocated by the Marmot Review.[21]
- Undertaking detailed equalities impact assessments for all strategies, plans and provision.
- Understanding existing variations in disease prevalence, uptake of preventative interventions, and primary care and secondary care use that may reflect health inequality or differing needs. Develop plans to address these variations.
- Working with patients, the public and other stakeholders to develop outcomes-focused plans that meet identified needs in an equitable way. Strengthen this partnership approach to health and wellbeing with different communities.
- Focus investment ‘upstream’ to ensure health needs are met as early as possible for everyone.

4. PREVENTION

4.1 Need for cancer prevention in Croydon

Arguably, prevention of ill-health has never been higher on the agenda for health and social care in England. The NHS Five Year Forward View puts our present challenge in the starkest terms. It claims the future health of millions of children, the sustainability of the NHS, and the economic prosperity of Britain all now depend on a radical upgrade in prevention and public health.[22] Sadly, public health budgets are shrinking even as the need for strong public health measures becomes more pressing. This intensifies our present challenge.

4.2 The World Cancer Research Fund has estimated that 27-39% of the main types of cancers can be prevented by improving diet, physical activity and body composition.[23] Data from The World Health Organisation show that 40% of cancer cases could be prevented by lifestyle changes.[24] Healthier lifestyles,

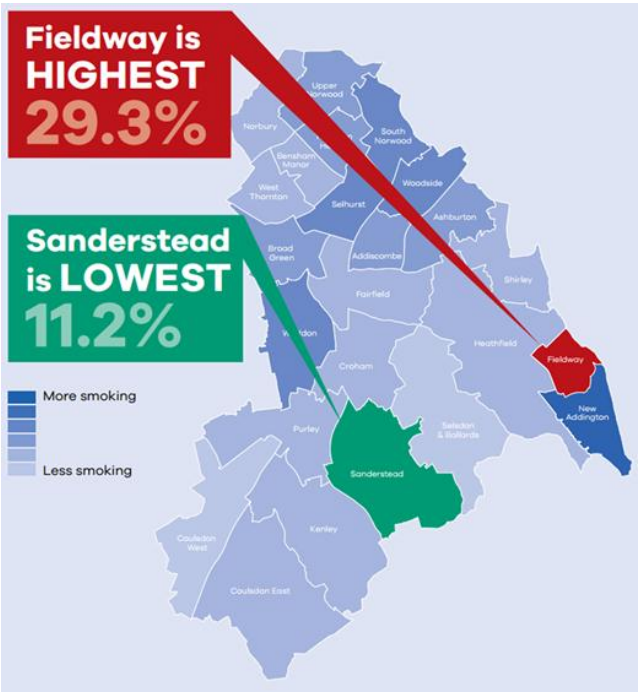
[21] Fair Society, Healthy Lives. The Marmot Review, 2010
[22] https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf
[23] Policy and action for cancer prevention. Food, nutrition, and physical activity: a global perspective. Washington, DC, World cancer research fund/american institute for cancer research, 2009.
[24] http://www.who.int/chp/chronic_disease_report/full_report.pdf

promoted through effective ill-health prevention, will lead to reduced incidence of cancers (table 5).[25]

Lifestyle factor	Cancer cases prevented	% of new cancer cases
Be Smokefree	64,500	19%
Keep a healthy weight	18,100	5%
Eating fruit and veg	15,100	5%
Drink less alcohol	12,800	4%
Be SunSmart	11,500	3%
Less processed and red meat	8,800	3%
Eat a high fibre diet	5,100	2%
Be active	3,400	1%
Eat less salt	1,700	1%
Other factors	**Cancer cases prevented**	**% of new cancer cases**
Minimise risks at work, such as asbestos	12,100	4%
Minimise certain infections, such as HPV	10,600	3%
Minimise radiation, such as unnecessary x-rays	6,100	2%
Breastfeed of possible	2,700	1%
Minimise any time spent on HRT	1,700	1%

Table 5.

4.3 Smoking is the biggest single cause of preventable cancers. Smoking causes more than one quarter (28%) of all cancer deaths in the UK.[26] More than eight out of ten lung cancers are caused by smoking.[27] According to the 2015 Annual Public Health Report for Croydon, locally one in five adults still smokes tobacco (58,000 people) and two thirds of these people started smoking before the age of 18, which is the legal age for purchasing tobacco products.



[25] Parkin DM, Boyd L, Walker LC. The fraction of cancer attributable to lifestyle and environmental factors in the UK in 2010. Summary and conclusions (link is external). Br J Cancer 2011;105 (S2):S77-S81.
[26] Parkin, DM. Tobacco-attributable cancer burden in the UK in 2010. Br J Cancer 2011; 105: S6-S13
[27] Cancer Research UK http://www.cancerresearchuk.org/health-professional/cancer-statistics/incidence

4.4 Smoking is the most significant cause of health inequalities.[28] Those who work in routine and manual occupations (low paid work) are twice as likely to smoke as the general population,[29] so smoking rates are higher in deprived areas. In Fieldway, one of Croydon's most deprived wards, 29% of adults smoke, whereas in Sanderstead, which is one of the most affluent, only 11% of adults smoke.[30] People with mental health problems also bear a disproportionate burden of smoking harms and smoking is the single largest contributor to the 10-20 year reduced life expectancy gap for this group. [31]

4.5 Alcohol use and obesity also contribute to ill-health including cancer. One in six adults in Croydon drinks at risky levels and two in three adults are overweight or obese (181,000 people)[32] predisposing them to a range of cancers. The links between economic deprivation, mental health problems and excessive use of alcohol are well established.[33] Raised Body Mass Index (BMI) increases the risk of cancers of the breast, colon/rectum, endometrium, kidney, oesophagus and pancreas.[34] [35] Conversely, moderate physical activity for 150 minutes each week is estimated to reduce the risk of breast and colon cancer by 21–25%.[36]

4.6 In line with national trends, Croydon's population is getting older and excess weight in the population is increasing.[37] This means that, without action, incidence of lifestyle-related cancers is likely to increase correspondingly.

4.7 Other factors associated with cancer can be addressed through communications campaigns around sun protection and interventions such as improving vaccination rates for HPV.

4.8 **Action on prevention in Croydon**

Public Health Teams based within local authorities lead on local preventative health, tying into regional and national campaigns as appropriate e.g. British Heart Foundation's National No Smoking day;[38] Alcohol Concern's Dry January;[39] and Public Health England's (PHE) Change 4 Life.[40]

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[28] Fair Society, Healthy Lives. The Marmot Review, 2010
[29] 2014 Opinions and Lifestyle Survey Office for National Statistics, Feb. 2016
[30] https://www.croydon.gov.uk/sites/default/files/articles/downloads/Annual%20Public%20Health%20Report%20for%202015.pdf
[31] Primary care guidance on smoking and mental disorders. Primary Care Mental Health Forum, 2014. http://www.rcpsych.ac.uk/pdf/PrimaryCareGuidanceonSmokingandMentalDisorders2014update.pdf
[32] https://www.croydon.gov.uk/sites/default/files/articles/downloads/Annual%20Public%20Health%20Report%20for%202015.pdf
[33] Clustering of unhealthy behaviours over time: Implications for policy and practice. King's Fund, 2012.
[34] Policy and action for cancer prevention. Food, nutrition, and physical activity: a global perspective. Washington, DC, World cancer research fund/american institute for cancer research, 2009.
[35] The world health report 2002: Reducing risks, promoting healthy life. Geneva, World Health Organization, 2002.
[36] Global health risks: mortality and burden of disease attributable to selected major risks. Geneva, World Health Organization, 2009.
[37] http://www.croydonobservatory.org/profiles/profile?profileId=47
[38] https://www.bhf.org.uk/health-at-work/blog/no-smoking-day
[39] http://www.dryjanuary.org.uk/

4.9 Public Health Teams also commission or provide behaviour change services and support to enable local residents to make healthy changes to their lifestyles. These services are evidence-based and provide good return on investment.[41] For example, it has been suggested that preventing a 1% increase in the number of people who are overweight or obese could save the NHS and Local Authorities around £97 million per annum.[42] A locally commissioned report in 2010, found that for every £1 invested in smoking cessation services, Croydon gained a return on investment of £5.36.[43]

4.10 Though local Public Health Teams have the key role, other council departments should support ill-health prevention, as should other public sector organisations, voluntary sector organisations and even local employers through workplace health initiatives, such as the Workplace Wellbeing charter,[44] which is supported by NHS England (NHSE) and PHE. Such workplace health initiatives could be supported by local public health teams and the NHS to raise the profile among employers. This represents a communications opportunity.

4.11 **The launch of Livewell**

Croydon Council's new Livewell programme will integrate the existing separate behaviour change services including smoking cessation, weight management and physical activity. The aim of Livewell is to help improve the health and wellbeing of the borough's residents by supporting healthy behaviour change.

4.12 One arm of the programme, known as 'Just Be', will promote behaviour change via an online platform providing information and practical advice on local health improvement services and assets. 'Just Be' will be complemented by the service currently known as MiChange, which is a 12-week, face-to-face motivational interviewing plan. MiChange has already delivered some success with past users. A broad marketing programme will be essential to achieving further success.

4.13 Livewell is due to roll out in quarters 3-4 of 2016-17. The implementation of the Livewell programme necessitates greater and continuing engagement with partners and stakeholders, in particular local healthcare services and local clinicians. The digital solution that comprises the main component of the council's behaviour change offer is heavily dependent on strong and consistent referral and signposting from local health, social care and voluntary sector professionals. Without this robust partnership, an online solution provided by a local authority is likely to experience difficulties in reaching potential users due

[40] http://www.nhs.uk/change4life/Pages/change-for-life.aspx
[41] https://www.nice.org.uk/about/what-we-do/into-practice/return-on-investment-tools
[42] https://www.nice.org.uk/news/press-and-media/nice-produces-interactive-tools-to-help-local-authorities-improve-peoples-health-and-save-money
[43] Croydon Smoking Costs. The Mackinnon Partnership, 2010.
[44] http://www.wellbeingcharter.org.uk/index.php

to being crowded out by gamut of high-quality, online alternatives already offering healthy lifestyle advice and support.

4.14 **NHS Healthchecks Programme**

Local authorities are also responsible for offering the National NHS Healthchecks Programme to their residents, which provides an opportunity to offer face-to-face, individualised health and wellbeing advice. The NHS Healthchecks programme aims to help people lower their risk of developing common but often preventable diseases. Croydon has struggled to achieve national targets for NHS Healthchecks in recent years. The JSNA key dataset for 2015-16 shows that there is work to do around offers of Healthchecks to residents, as well as delivery of Healthcheck interventions. A partnership approach is a useful way of increasing uptake, as will targeting the Healthchecks offer to local communities of higher risk.

Domain	Indicator	Croydon	London	England	England Range
NHS health checks	274 Offered an NHS health check (cumulative % of eligible people aged 40-74)	11.9%	44.6%	37.9%	
	275 Received an NHS health check (cumulative % of eligible people aged 40-74)	6.9%	21.5%	18.6%	

Table 6.

4.15 **Local policy and regulation**

The Local Authority also has powers to implement local policies that improve preventive health. For example, by legislating against shisha bars, the proliferation of unhealthy takeaways and restricting the availability of alcohol through licensing or mandatory pricing arrangements.

4.16 **NHS prevention initiatives**

The NHS increasingly plays a role in preventative health too. In particular this priority is promoted though Making Every Contact Count (MECC),[45] a partnership between PHE, NHSE and Health Education England as well as other organisations. MECC is an approach to behaviour change that uses the millions of day-to-day interactions that occur within the NHS, and other health and social care organisations, to support people in making positive changes to their physical and mental health and wellbeing.

4.17 A MECC interaction takes a matter of minutes and is not intended to add to the busy workloads of health, care and the wider workforce staff, rather it is structured to fit into and complement existing professional clinical, care and social engagement approaches. Evidence suggests that the broad adoption of the MECC approach by people and organisations across health and social care could potentially have a significant impact on the health of our population.[46] [47]

[45] https://www.gov.uk/government/publications/making-every-contact-count-mecc-practical-resources
[46] Making Every Contact Count (MECC): Consensus statement, Produced by Public Health England, NHS

4.18 Croydon CVA is a delivery partner for MECC, and receives grant funding from the CCG to deliver Asset Based Community Development and MECC in some of Croydon most deprived wards.

4.19 In addition, primary care are addressing cancer risk factors – for example, a majority of GP networks have chosen obesity as a priority for their Practice Development and Delivery Schemes (PDDS).

4.20 **Together for Health**

Croydon CCG is promoting and embedding prevention in its commissioning approaches through its Together for Health (TFH) programme. TFH seeks to improve patient outcomes and experience as well as creating conditions for a more financially sustainable local healthcare system. It achieves this through actively promoting, encouraging and embedding Prevention, Self-Care, Self-Management and Shared Decision Making (PSSSD) within the healthcare workforce and the wider population to increase independence, personal responsibility and personal ownership and around health and wellbeing. This will allow people to become informed and active participants in their health - in line with the strategic vision laid out in the NHS Five Year Forward View.

4.21 **Outcomes Based Commissioning through The Croydon Accountable Provider Alliance**

Outcomes Based Commissioning (OBC) is an innovative approach that promotes the integration of health and social care services in order to transform the way services are provided for older people in Croydon. The Croydon Accountable Provider Alliance (APA) will deliver OBC. The APA partners comprise Age UK, Croydon Council Adult Social Care, Croydon GP Collaborative, Croydon Health Services NHS Trust and South London & Maudsley NHS Foundation Trust. The APA's goal is to develop high-quality, person-centred, evidence-based, co-ordinated models of care for the over 65s in Croydon by engaging with stakeholders and the public. Due to a capitated budget arrangement, OBC will need to focus on prevention and early intervention as a fundamental principle of delivery. OBC is due to roll out in October 2016.

4.22 **The alignment of Local prevention programmes**

A workshop took place in July 2016 for the teams delivering Together for Health, Outcomes Based Commissioning and Public Health's Livewell programme. The purpose of this workshop was to discuss aligning these three local programmes, which all share ambitions around 'upstream' health and wellbeing in Croydon, and to establish what the benefits, risks and practical considerations would be for such a proposal. As they have common goals, it

England and Health Education England, et al. April 2016

[47] Global recommendations on physical activity for health. Geneva, World Health Organization, 2010.

has been proposed that the three programme teams should increase cooperation, collaboration and programme alignment through greater partnership working. A general consensus emerged from the workshop that further work should be undertaken to dovetail the programmes.

5. AWARENESS

5.1 Early diagnosis is vital in the fight to beat cancer. It has been estimated that if cancer survival rates in Great Britain matched the European average, then 6,000–7,000 deaths could be avoided each year. And if they matched the best, around 11,500 deaths could be avoided.[48] A key part of early diagnosis is public awareness of signs or symptoms of possible cancer. Awareness is worryingly low.

5.2 Delays in detection

There are three main barriers to early detection of cancer: public delay, GP delay and system delay. Tackling GP delay is addressed through addressing variation e.g. in rates of urgent referral, or in the provision of direct access diagnostics. System delay is addressed primarily through the waiting time standards framework. Patient delay relates to lack of knowledge, lack of awareness, attitudes to risk and even patient anxieties.

5.3 Patient delay

In a 2010 survey conducted by Cancer Research UK, more than three quarters of people asked to list possible warning signs and symptoms of cancer failed to mention pain, coughing or problems with bowels or bladder.

5.4 Even when people recognised signs they thought might be serious the survey found that nearly 40% said they might delay getting symptoms checked out because they would be worried about what the doctor might find and more than 25% might delay because they would be worried about wasting the doctor's time. [49]

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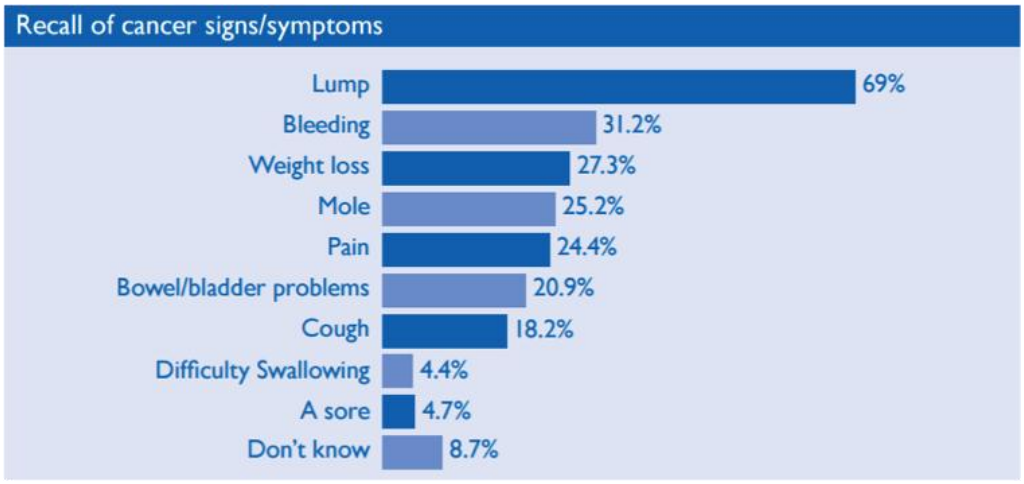
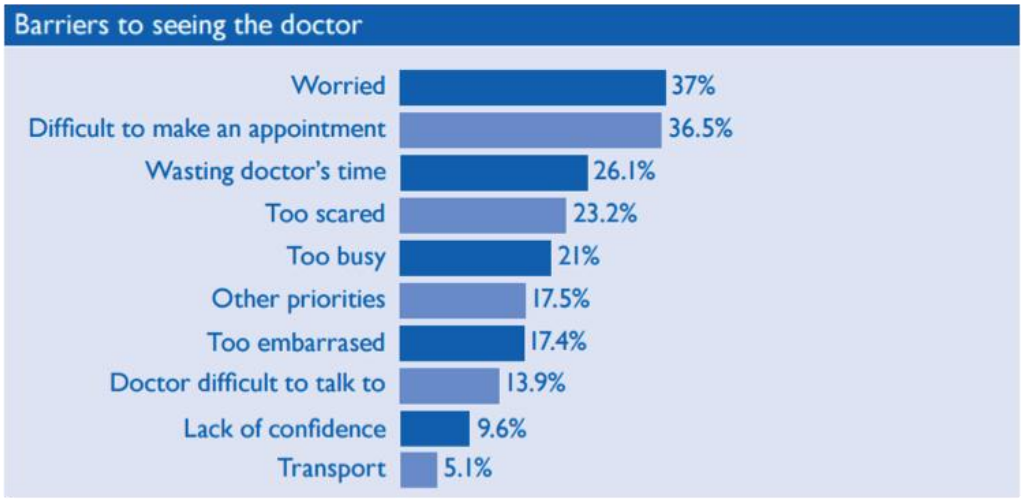
48 http://www.cancerresearchuk.org/prod_consump/groups/cr_common/@abt/@gen/documents/generalcontent/cr_085096.pdf

49 http://www.cancerresearchuk.org/prod_consump/groups/cr_common/@abt/@gen/documents/generalcontent/cr_085096.pdf

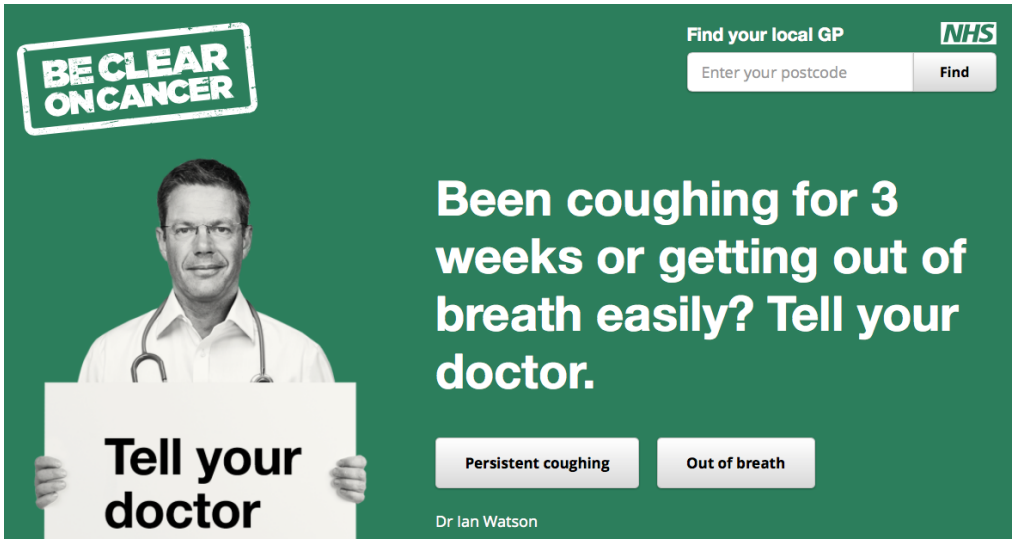


(Tables courtesy Cancer Research UK)



5.5 **Be Clear on Cancer**

Be Clear on Cancer is a series of national campaigns aiming to improve early diagnosis of cancer by raising public awareness of signs and/or symptoms of cancer, and to encourage people to see their GP without delay. The programme is led by PHE, working in partnership with the Department of Health, NHSE and Cancer Research UK. Each campaign is tested locally and then regionally, and then rolled out nationally if it proves to be effective.



5.6 Local partners should work together more closely to reinforce the impact of national campaigns through local channels. This would include information in local GP practices, secondary care, pharmacies, council services, through the voluntary sector and local awareness events led by public health. Efforts might be focused in areas where communities are particularly susceptible to certain cancers, or in pathways where a bottleneck of high-risk people might be found e.g. stop smoking services.

6. SCREENING

Cancer screening is an important way to detect cancer early. In the UK there are national screening programmes for breast, cervical and bowel cancer.

6.1 **Breast screening** is offered to women aged 50-70 in England. Women over 70 can still be screened, but will need to make their own appointment as they will not get an invitation. In England, this age range is gradually being extended to 47-73. **Cervical screening** is offered to women aged 25-64 in England. **Bowel screening** is offered to men and women aged 60-74 in England and a new test called Bowel Scope is starting to be offered to people at age 55.

6.2 In Croydon, six GP Networks exist – each comprising a number of local GP practices. Practices and their networks are profiled annually for a range of indicators around demography, disease prevalence, activity and quality of care - including cancer screening uptake. The networks are:

1. Mayday (MDY)
2. Thornton Heath (THN)
3. East Croydon (ECR)
4. Woodside/Shirley (WSS)
5. Purley (PRY)
6. New Addington/Selsdon (NAS)

6.3 The data in the network profiles highlights the areas where each network is significantly different from the Croydon average or where performance is well below target. As can be seen in table 7 below, there is variation around cancer prevalence as well as around cancer screening. Of especial concern are the low rates of bowel screening for 60-69 year olds within three GP networks. In the current year, practices have been given the opportunity to choose bowel screening as a practice priority within their mandatory Practice Development and Delivery Schemes (PDDS). This may help incentivise improved performance for this screening programme. Though it is not reflected at network level, Croydon poor performance around breast cancer screening has already been highlighted above.

5.6.1 Prevalence and incidence

Indicator	MDY	TNH	WSS	NAS	PRY	ECR	Cro	Lon	Eng	Target
Cancer diagnosed (since 1st April 2003) (all ages)	1.36%	1.56%	1.84%	2.06%	2.41%	1.42%	1.75%	1.54%	2.26%	
New cancer cases (incidence per 1,000)	2.84	3.57	3.66	4.45	4.61	3.32	3.70	3.38	5.08	

5.6.2 Cancer screening

The targets shown are the national targets for coverage.

Indicator	MDY	TNH	WSS	NAS	PRY	ECR	Cro	Lon	Eng	Target
Cervical screening coverage (last 5 yrs) (ages 25-64)	68.3%	74.1%	73.9%	75.0%	76.4%	68.1%	72.2%	68.4%	73.5%	80
Cervical screening coverage (excl. exceptions) (CS002)	79.5%	82.4%	82.2%	84.1%	85.8%	78.5%	81.8%	79.7%	81.8%	80
Breast screening coverage (last 3 years) (age 50-70)	57.9%	58.2%	66.3%	65.1%	69.0%	58.6%	62.9%	64.2%	72.2%	80
Bowel screening coverage (last 2.5 years) (age 60-69)	42.3%	43.4%	52.0%	53.8%	58.2%	44.2%	49.8%	48.8%	57.9%	

Table 7.

6.4 **Support to address variation in screening**

Practices are also receiving individual support visits to address variation against a number of cancer indicators. The CCGs own Variation Team provides the core support, across the whole range of care, helping practices eliminate variation, in line with best practice in local primary care.

6.5 In addition, Croydon has on-site practice support provided by our Macmillan GP, Dr Jaimin Patel, and our Cancer Research UK Health Professional Engagement Facilitator, Ekta Patel. Both work closely with individual practices to deliver a recognisable improvement across cancer care. Their work includes:

- Providing support and clinical advice to inform CCG strategies for cancer and end of life care
- Influencing GP peers to drive up standards of cancer care and ensure continuous improvement
- Facilitating and enabling education of primary health care teams
- Supporting practice nurses to take on a greater role for cancer, building on their skills used to support people with other long-term conditions
- Pathway and service redesign, including support to achieve quality and productivity targets

- Enhancing communication between primary, secondary and tertiary care

This support also involves assistance around other areas of cancer care, such as addressing variation in cancer urgent referrals (2 week waits); conversion rates for urgent referrals (positive diagnoses); 'safety netting' to ensure patients are not lost during referral; Significant Event Audits (SEA) to analyse cases where care doesn't go as planned and addressing health inequalities variation for BME groups, the elderly and the deprived.

Find a list of the practices visited in the past 12 months by our Macmillan GP and CRUK Engagement Facilitator below (table 8).

Practices visited in 12 months to date	Date:	Cancer Research UK	Macmillan
Portland medical centre	01/10/2015	x	x
Greenside Medical Practice	16/10/2015	x	
Mitchley Avenue Surgery	12/11/2015	x	
Downland Surgery	18/11/2015	x	
Old Coulsdon Medical Practice	25/11/2015	x	
Leander Road Primary Care Centre	30/11/2015	x	x
The Moorings Medical Practice	08/12/2015	x	
Parkside Practice	09/12/2015	x	x
The Coulsdon Medical Practice	09/12/2015	x	
Mersham Medical Centre	10/12/2015	x	
Selsdon Park	14/12/2015	x	
Woodcote Group	23/12/2015	x	
Keston	07/01/2016	x	
Brigstock Medical Practice	22/01/2016	x	x
Bramley Medical Practice	25/01/2016		x
Auckland	10/02/2016	x	
Violet Lane	12/02/2016	x	x
Norbury Medical Practice	07/03/2016	x	x
Thornton Heath	19/04/2016	x	x
Hartland Way Surgery	22/07/2016	x	x
Stovell House Surgery	01/08/2016	x	x

Table 8.

6.6 Croydon CCG has also used a Local Incentive Scheme (LIS) to deliver screening for prostate cancer in men – Prostate Specific Antigen (PSA). A range of additional practice visits took place in support of this LIS.

7. DIAGNOSIS

7.1 Cancer survivorship

Cancer survival is a key measure of the effectiveness of health-care systems. Persistent regional and international differences in survival represent many

avoidable deaths. Internationally, England is not among the best for cancer survivorship. During 1995–2007, survival for four cancers (breast, colorectal, lung and ovarian) improved in a number of comparable countries including England. However, survival was persistently higher in Australia, Canada, and Sweden, intermediate in Norway, and lower in Denmark, England, Northern Ireland, and Wales, particularly in the first year after diagnosis (table 9) and for patients aged 65 years and older.[50]

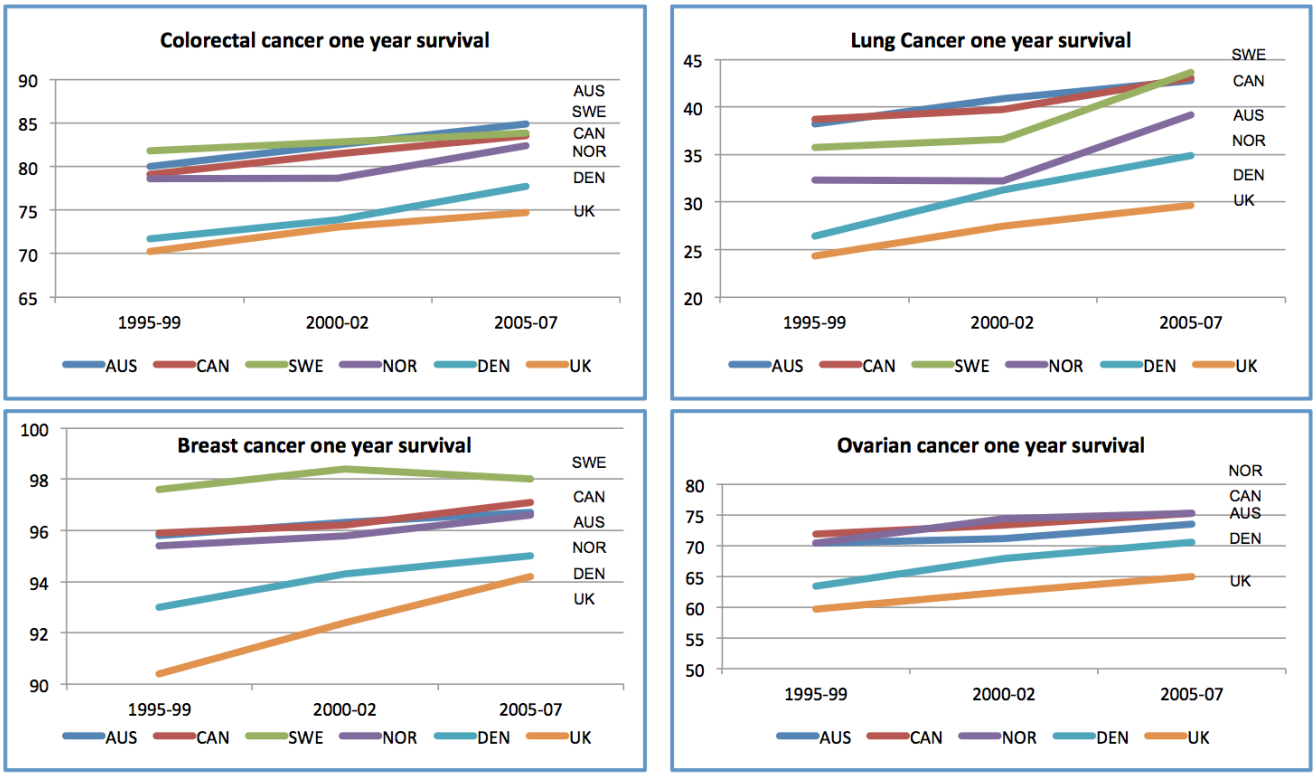


Table 9.

7.2 Evidence suggests that this variation in cancer survival is attributable to late diagnosis. In one study,[51] excess mortality in England was found to particularly pronounced in the first month and in the first year after diagnosis, and generally more marked in the oldest age groups. Survival was more comparable to better performing countries after the first year (see table 10). This suggests that cases are being diagnosed at later stages when cancer is less amenable to treatment.

[50] Cancer survival in Australia, Canada, Denmark, Norway, Sweden, and the UK, 1995–2007 (the International Cancer Benchmarking Partnership): an analysis of population-based cancer registry data. Coleman et al. 2010
[51] International Journal of Cancer. Volume 127, Issue 11, pages 2630-2638, 16 FEB 2010 DOI: 10.1002/ijc.25264 http://onlinelibrary.wiley.com/doi/10.1002/ijc.25264/full#fig4

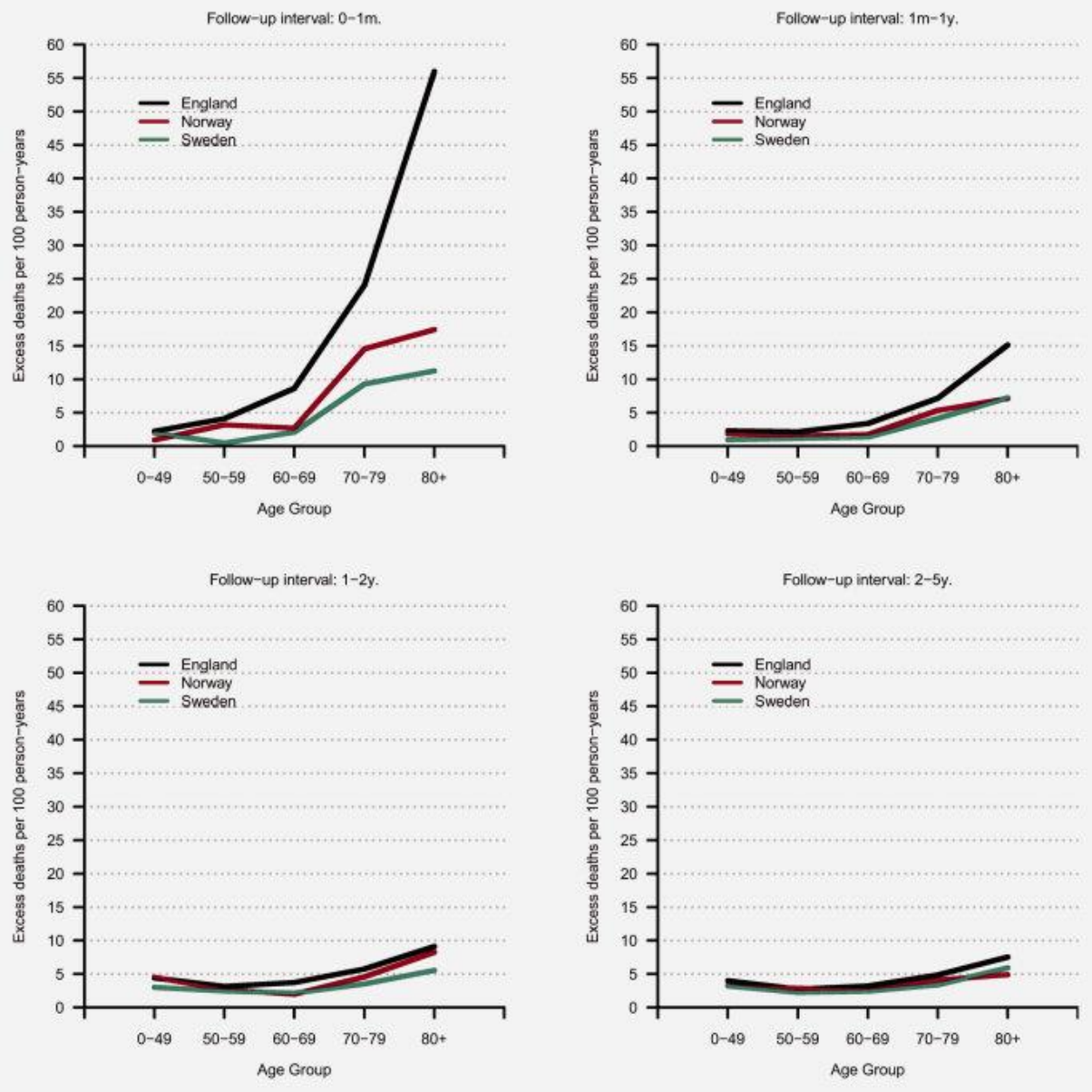
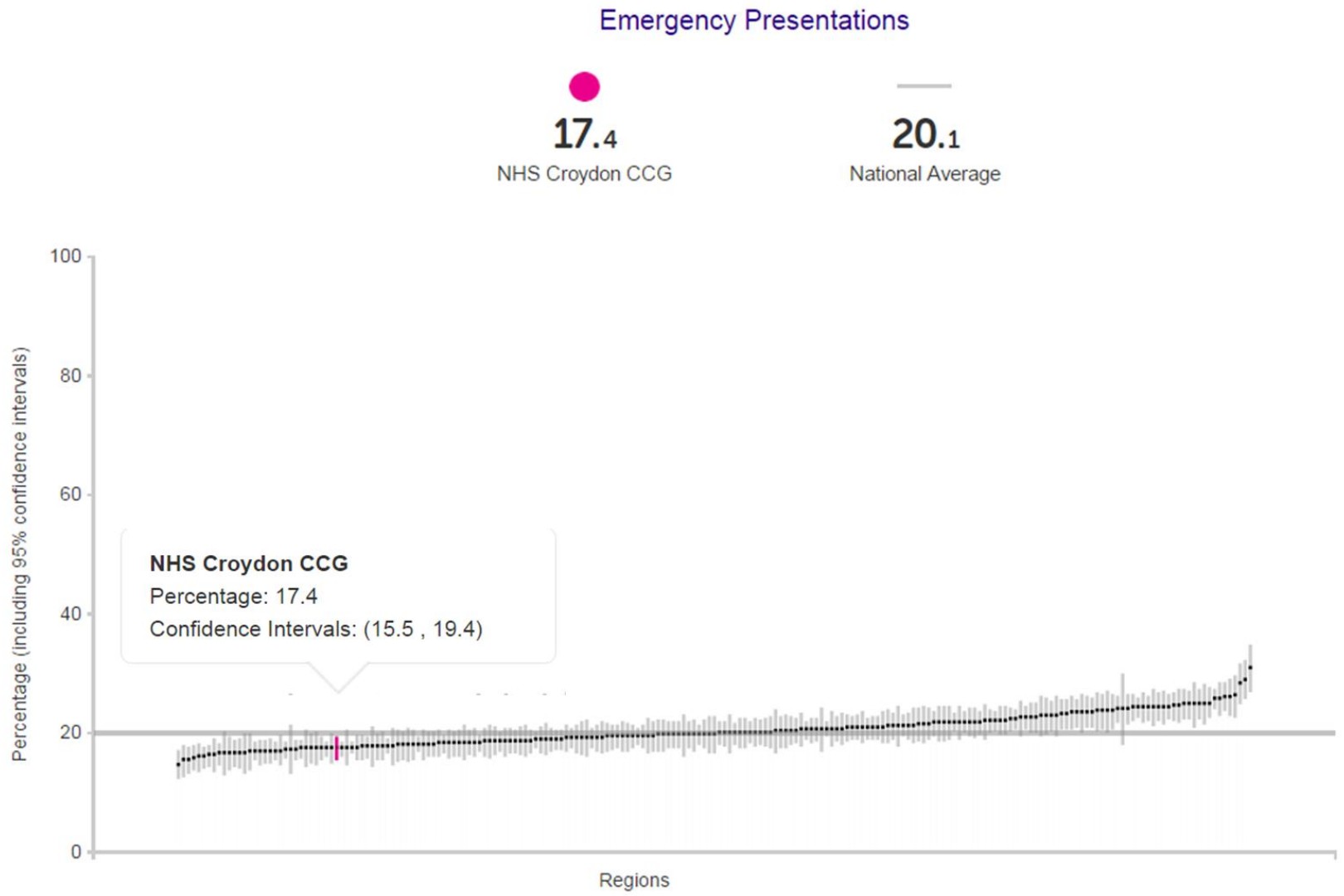


Table 10.

7.3 In London alone, more than a quarter of diagnoses are made in accident and emergency – which is very late. Croydon CCG's rate of diagnosis of cancer through emergency admission is 17.4% of cases, which is lower than the England average of 20.1% (see table 11). CCGs are now measured on one-year cancer survival as part of the *NHS England Assurance Framework* and improving cancer survival is one of the three key ambitions outline in *Achieving World-Class Cancer Outcomes.*[52]

[52] https://www.england.nhs.uk/wp-content/uploads/2016/05/cancer-strategy.pdf

Table 11.


Emergency Presentations
17.4
NHS Croydon CCG
20.1
National Average
100
80
60
40
20
0
Percentage (including 95% confidence intervals)
NHS Croydon CCG
Percentage: 17.4
Confidence Intervals: (15.5 , 19.4)
Regions

7.4 **What is cancer staging?**

Staging is a way of describing the size of a cancer and how far it has grown. Ideally cancer is diagnosed at the earliest stage possible when it is more treatable. When a cancer is first diagnosed, tests are carried out to establish how big the cancer is and whether it has spread into surrounding tissues. Checks will also be made to see whether it has spread to other parts of the body. Cancer staging systems may sometimes include grading of the cancer, which describes how similar a cancer cell is to a normal cell.

7.5 Staging is important because it helps determine appropriate treatment and it is strongly associated with survival: 1 year survival goes from 98% at stage 1 down to 46% for stage 4. The dominant staging model for commissioners uses four stages. A description of what the stages mean for most types of cancer is as follows:

Stage 1 usually means that a cancer is relatively small and contained within the organ where it started

Stage 2 usually means the cancer has not started to spread into surrounding tissue but the tumour is larger than in stage 1. Sometimes stage 2 means that cancer cells have spread into lymph nodes close to the tumour. This depends on the particular type of cancer

Stage 3 usually means the cancer is larger. It may have started to spread into surrounding tissues and there are cancer cells in the lymph nodes in the area

Stage 4 means the cancer has spread from where it started to another body organ. This is also called secondary or metastatic cancer

7.6 **Reducing late stage diagnosis**

Cancer survival rates in England have never been higher, but clearly we still lag behind the highest performing countries in the world. We know that the earlier cancer is diagnosed, the more likely it is to be successfully treated, and survival rates can be dramatically improved. Much of the early work that emphasised the importance of early diagnosis comes from the National Awareness and Early Diagnosis Initiative (NAEDI), a partnership between public and third sector organisations which was formed in 2008.[53] More recently, the independent cancer taskforce, in their report *Achieving World-Class Cancer Outcomes*, published in July 2015, set an ambition for the NHS that 62% of all cancers with known stage at diagnosis would be diagnosed at stages 1 and 2 by 2020. Achieving this target will requires every CCG to focus on and make significant improvement in early stage diagnoses.

7.7 Supporting clinicians to spot cancers earlier and allowing greater GP access to diagnostic and specialist advice were outlined in the NHS Five Year Forward View as key means of improving our diagnostic success. In addition, The

[53] http://www.cancerresearchuk.org/sites/default/files/health_professional_naedi_briefing_sheet.pdf

National Institute of Clinical Excellence (NICE) published new guidance on appropriate referral for suspected cancer in 2015, which lowered the threshold of risk for symptoms suggestive of cancer to trigger an urgent referral for suspected cancer to 3%, with the aim of diagnosing more cancers at an early stage.[54] So called 'low risk but not no risk' cases.

7.8 **Quality premium: Cancer Diagnosed at Early Stage**

The NHSE Quality Premium is a financial incentive intended to reward CCGs for improvements in the quality of the services that they commission and for associated improvements in health outcomes and reducing inequalities.

7.9 An indicator describing the proportion of cancers diagnosed at an early stage is clearly a useful measure for assessing improvement in early diagnosis and, ultimately, cancer survival. Thresholds have been set by NHSE based on levels of improvement previously seen amongst high-performing CCGs and thus felt to be achievable for the majority of CCGs.[55]

7.10 One limitation around the Quality Premium scheme in the current year (its first year) is a latency problem around staging data. Currently the most recent staging data is from the year 2013-14. In order to determine performance against the Quality Premium, access to accurate in-year data is necessary. The South West London Transforming Cancer Services Team (TCST) is working to address this problem by reducing the existing two-year lag in staging data. A solution is anticipated in quarter three of 2016-17.

7.11 **Cancer waiting times in Croydon**

The NHS has set maximum waiting time standards for access to healthcare. In England, those for cancer care fall under two headings: Individual patient right (as per the NHS Constitution) and waiting time standards to which the Department of Health holds both individual providers and commissioners to account.

Patients with suspected cancer have the right to:

- Access certain services commissioned by NHS bodies within maximum waiting times, or for the NHS to take all reasonable steps to offer a range of suitable alternative providers if this is not possible
- Be seen by a cancer specialist within a maximum of two weeks from urgent GP referral for suspected cancer

Government pledges on waiting times include:

- A maximum two-week wait (2WW) to see a specialist for all patients referred with suspected cancer

[54] https://www.nice.org.uk/guidance/conditions-and-diseases/cancer
[55] Quality Premium: 2015/16 Guidance for CCGs. NHSE, 2015

- A maximum 2WW to see a specialist for all patients referred for investigation of breast symptoms, even if cancer is not initially suspected
- A maximum one-month (31-day) wait from the date a decision to treat (DTT) is made to the first definitive treatment for all cancers
- A maximum 31-day wait for subsequent treatment where the treatment is surgery
- A maximum 31-day wait for subsequent treatment where the treatment is an anti- cancer drug regimen
- A maximum 31-day wait for subsequent treatment where the treatment is a course of radiotherapy
- A maximum two-month (62-day) wait from urgent referral for suspected cancer to the first definitive treatment for all cancers
- A maximum 62-day wait from referral from an NHS cancer screening service to the first definitive treatment for cancer
- A maximum 62-day wait from a consultant's decision to upgrade a patient's priority to the first definitive treatment for all cancers

7.12 **Croydon CCG performance on cancer waiting times**

As can be seen from table 12, to May 2016 Croydon is experiencing some success in meeting its waiting time targets, outperforming its SWL peers in many cases. The exception to this is the 62 day standard target, where some underperformance has been recorded. Plans to address and improve this performance issue are being implemented. It should be noted however, that Trusts report ever increasing pressures and there is a real risk that performance on waiting times may be in jeopardy going forward.

Cancer waits in Croydon - NHS Croydon CCG		Target	Performance YTD	Performance Month	Breaches	Latest Data	Previous Months			12M Trend
							Apr-16	Mar-16	Feb-16	
Cancer - 2 weeks	2 week wait	93%	96.4%	96.6%	39	May-16	96.2%	97.0%	97.4%	◀
	Breast symptoms 2 week wait	93%	92.7%	94.9%	6	May-16	90.4%	99.0%	100.0%	▲
Cancer - 31 days	31 day first definitive treatment	96%	97.5%	98.0%	2	May-16	97.1%	100.0%	98.4%	▲
	31 day subsequent treatment surgery	94%	96.9%	100.0%	0	May-16	93.8%	100.0%	100.0%	▲
	31 day subsequent treatment drug	98%	100.0%	100.0%	0	May-16	100.0%	100.0%	100.0%	◀
	31 day subsequent treatment radiotherapy	94%	97.8%	97.7%	1	May-16	97.9%	100.0%	100.0%	▲
Cancer - 62 days	62 day standard	85%	81.9%	77.0%	14	May-16	87.3%	85.1%	89.0%	▲
	62 day screening	90%	90.9%	100.0%	0	May-16	87.5%	100.0%	90.9%	▲
	62 day upgrade	90%	100.0%	100.0%	0	May-16	100.0%	87.5%	100.0%	◀
Quarterly Activity										
Cancer - 2 weeks	2 week wait (Quarterly)	93%	95.3%	96.6%	104	Mar-16			96.7%	◀
	Breast symptoms 2 week wait (Quarterly)	93%	95.3%	99.6%	1	Mar-16			96.9%	◀
Cancer - 31 days	31 day first definitive treatment (Quarterly)	96%	98.0%	96.7%	12	Mar-16			98.0%	▲
	31 day subsequent treatment surgery (Quarterly)	94%	96.1%	96.1%	2	Mar-16			93.3%	◀
	31 day subsequent treatment drug (Quarterly)	98%	99.8%	100.0%	0	Mar-16			100.0%	◀
	31 day subsequent treatment radiotherapy (Quarterly)	94%	98.0%	98.6%	2	Mar-16			97.5%	◀
Cancer - 62 days	62 day standard (Quarterly)	85%	82.4%	84.1%	32	Mar-16			88.7%	◀
	62 day screening (Quarterly)	90%	92.4%	95.8%	1	Mar-16			95.5%	◀
	62 day upgrade (Quarterly)	90%	87.1%	95.5%	1	Mar-16			80.0%	◀

Table 12.

7.13 **Croydon CCG commissioning intentions 2016-17**

In its commissioning intentions for the current year, the CCG committed to the following measures supporting earlier detection and treatment of cancers:

1. All GPs to have direct access to colonoscopy for low risk, not no risk of cancer via a diagnostic service
2. All GPs to have direct access to diagnostic services - flexible sigmoidoscopy for low risk, not no risk of cancer
3. All GPs to have direct access to diagnostic services - non-obstetric ultrasound for low risk, not no risk of cancer

3a. In order to promote the earlier diagnosis of ovarian cancer, services will be commissioned to support Ultrasound (US) and CA125 concurrently (CA 125 is a blood test to check for the cancer antigen which in itself is not a definite indicator for ovarian cancer which is why an ultra should also be undertaken)

4. All GPs to have direct access to same day chest x-ray for high risk of cancer and access for low risk, not no risk of cancer

4a. In order to support the reduction of the risk of delayed diagnosis, all commissioned services will be required to formally report A&E, Urgent Care Centres and inpatient chest x-rays

These standards have now been enshrined within the acute care contract as local quality requirements which will add extra impetus to their achievement.

8. CONCLUSION

8.1 **The importance of partnership working**

Good cancer care encompasses comprehensive prevention and awareness raising; targeted screening; early and accurate diagnosis through prompt and appropriate referral; high-quality, evidence-based treatment and aftercare; holistic support, including psychological support for patients and their families all along the pathway, including for those who are 'Living with and Beyond' (LWAB) cancer; effective palliative care; and care planning to meet individuals needs and desires at the end of life (EOL).

8.2 Responsibility for commissioning these varied elements of cancer provision is shared across multiple commissioners. Therefore all these commissioners must collaborate closely to deliver improved cancer outcomes and experience (figure 1).

8.3 If we are to improve cancer prevention, as well as **increasing early detection and treatment of cancers in Croydon**, a number of commissioning partners will need to come together. These partners are:

- Croydon CCG
- Primary Care Commissioning - NHS England
- Public Health England

- NHS England - Specialised Commissioning
- Croydon Council - Public Health

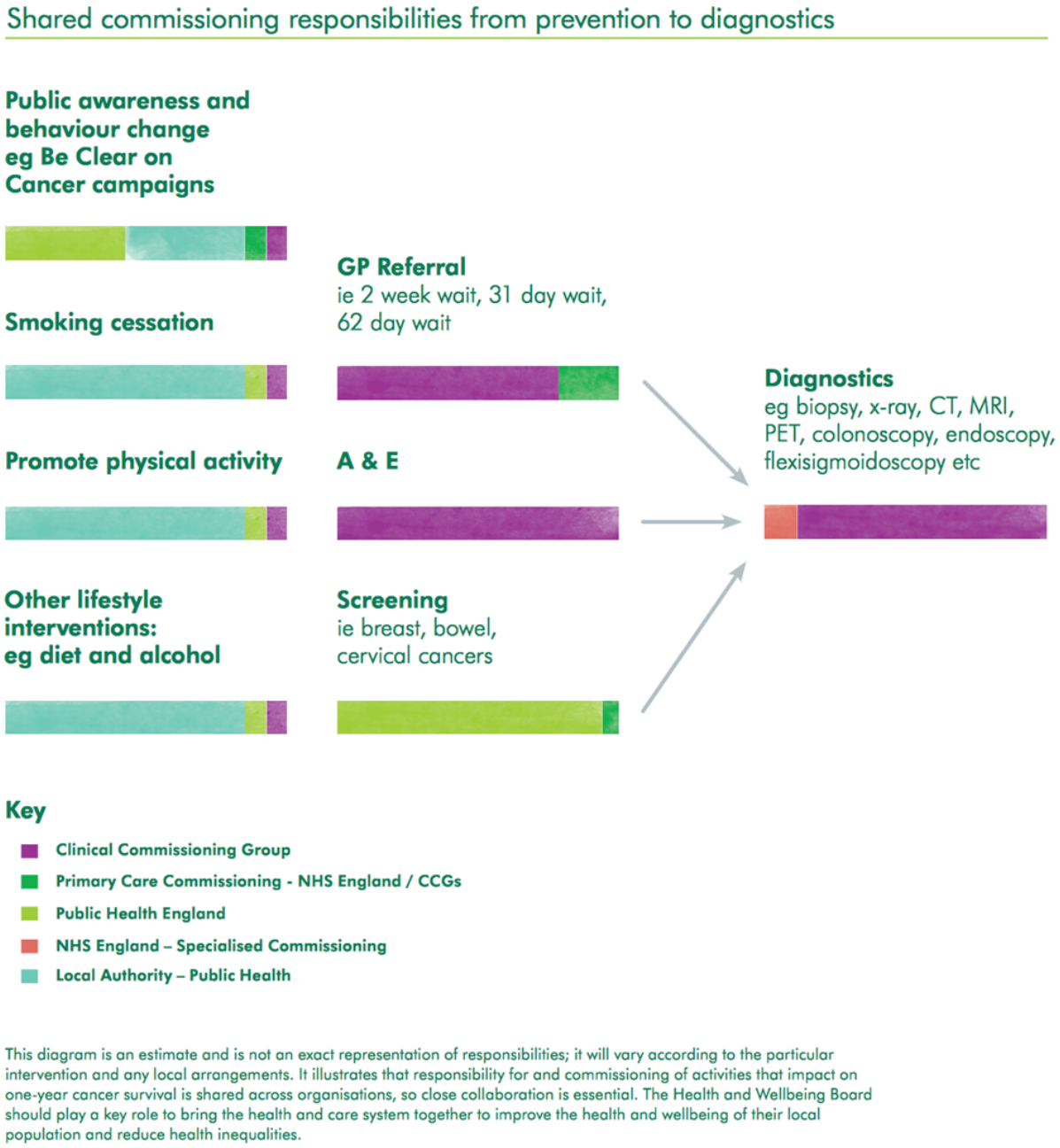


Figure 1.

8.4 Only through working together can local partners give patients and the public in Croydon the best possible cancer provision, increasing healthy life expectancy, reducing differences in life expectancy between communities and improving wellbeing and quality of life for all.

9. CONSULTATION
NOT APPLICABLE

10. SERVICE INTEGRATION
NOT APPLICABLE

11. FINANCIAL AND RISK ASSESSMENT CONSIDERATIONS
NOT APPLICABLE

12. LEGAL CONSIDERATIONS
NOT APPLICABLE

13. EQUALITIES IMPACT
NOT APPLICABLE

CONTACT OFFICER: Jimmy Burke, Senior Commissioning Programme Lead Croydon Clinical Commissioning Group

E-mail: Jimmy Burke@croydonccg.nhs.uk Tel: 0208 544 2268

NHS
Croydon
Clinical Commissioning Group

Improving the early detection and treatment of cancers in Croydon

Dr Tony Brzezicki

10 years GP with special interest – Breast Clinic CSH

GP Adviser to Transforming Cancer Services Team

Chair – London Early Diagnosis and Awareness Group (EDAG)

Clinical lead for Cancer – Healthy London Partnership

Co-Chair – Cancer Commissioning Board

Strategic context: HWBB

Croydon Joint health and wellbeing strategy, 2013-2018

The Health and Wellbeing Board identifies as an ambition: **increased healthy life expectancy and reduced differences in life expectancy between communities**. The strategy identifies specific improvement areas relating to cancer that contribute to this ambition:

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

2.1 Reduce smoking prevalence

2.2 Reduce overweight and obesity in adults

2.3 Reduce the harm caused by alcohol misuse

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

3.2 Early detection and treatment of cancers

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

5.4 Improve the clinical quality and safety of health services

Improvement area 6: improving people's experience of care

6.2 Improved patient and service user satisfaction with health and social care services

Strategic context: CCG

Our vision is for longer healthier lives for all the people in Croydon. We will deliver this through an ambitious programme of innovation and by working together with the diverse communities of Croydon and with our partners. We will use resources wisely to transform healthcare to help people look after themselves, and when people do need care they will be able to access high quality services.

CCG Operating Plan

During 2016/17 we are working to:

- Ensure that all targets for cancer reporting are met, particularly with regards to the 62 day referral to treatment target
- We are achieving this through delivery of local action plans that are agreed with providers and which include the tracking of patient pathways
- Adopt a collaborative approach across London on demand and capacity requirements for diagnostic services that are key in ensuring the delivery of the nationally set cancer targets
- Actively engage with clinicians in primary care to provide education and support in the pathways for patients presenting with symptoms as per NICE guidance and locally developed pathways
- Implement the pan-London cancer pathways - including direct access for GPs to diagnostics.

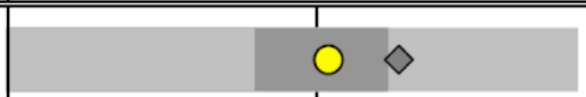
Strategic context: Cancer

- Achieving world-class cancer outcomes: A strategy for England 2015-2020
- NHS England's Five year Cancer commissioning Strategy for London, 2014
- Five-year sustainability and transformation plan
- Croydon CCG Cancer Strategy 2014-19

Burden of death and disease

- One in two people in the UK will get cancer in their lifetime
- Causes one in four of all deaths in the UK
- 945 people die from cancer in Croydon each year
- Survival rates have doubled with 50% of people diagnosed in England and Wales surviving their disease for ten years or more

Burden of death and disease

Indicator	Croydon	London	England	England Range	1 Year Trend	3 Year Trend	Time Period
177 Incidence of oesophageal cancer (rate per 100,000 population)	14.7	12.3	15.1		▶	–	2010 - 12
178 Deaths from oesophageal cancer (rate per 100,000 population)	9.0	10.5	13.3		▶	▶	2011 - 13
181 Incidence of colorectal cancer (rate per 100,000 population)	72.5	68.0	77.2		◀	▶	2010 - 12
182 Deaths from colorectal cancer (rate per 100,000 population)	24.5	26.6	28.8		▶	▶	2011 - 13
194 Incidence of bladder cancer (rate per 100,000 population)	16.0	18.2	19.3		◀	▶	2010 - 12
195 Deaths from bladder cancer (rate per 100,000 population)	7.3	8.2	9.0		▶	▶	2011 - 13

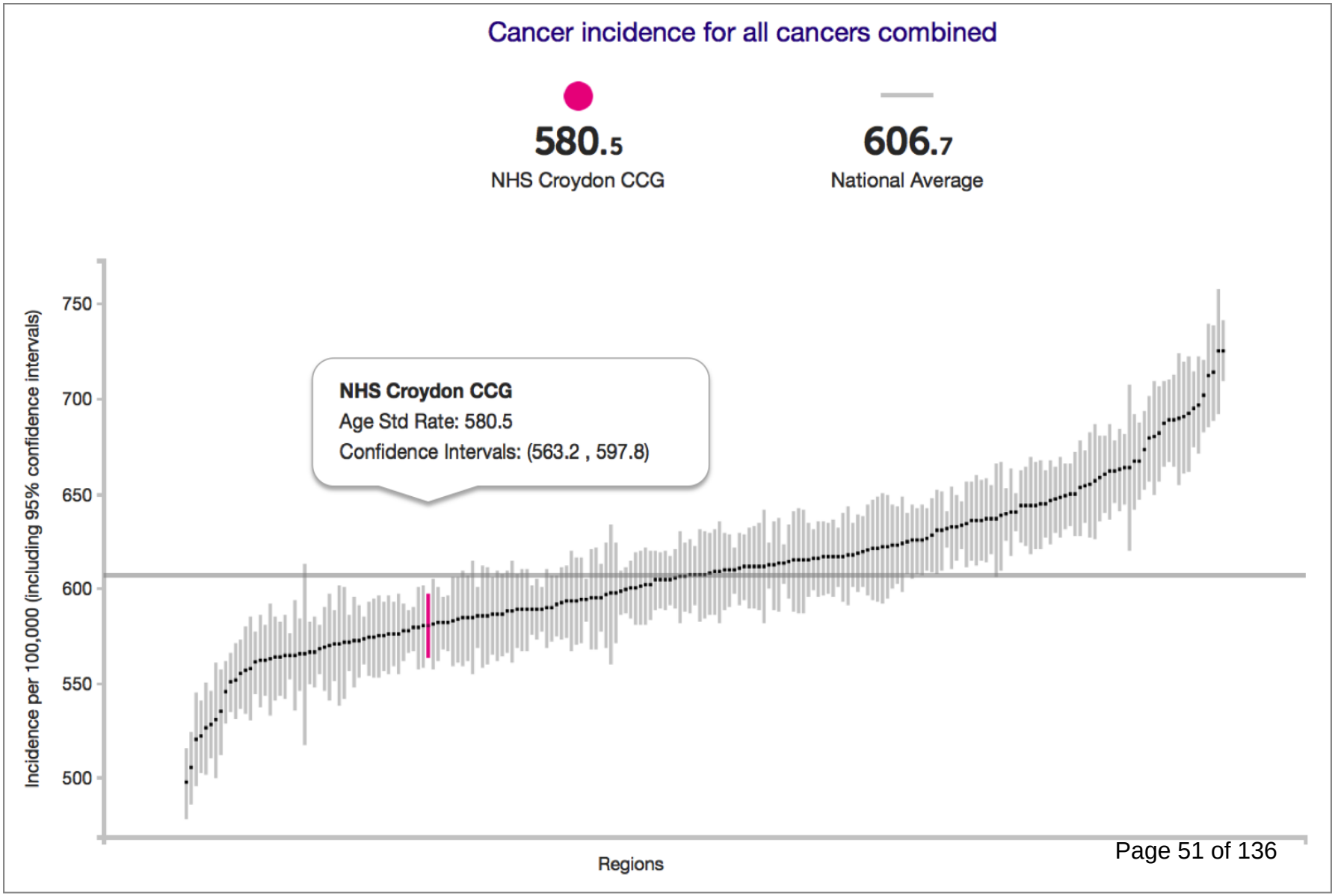
- Deaths from oesophageal cancer and colorectal cancer are **better** than England
- Early deaths from cancer and incidence of bladder cancer **better** than England

Burden of death and disease

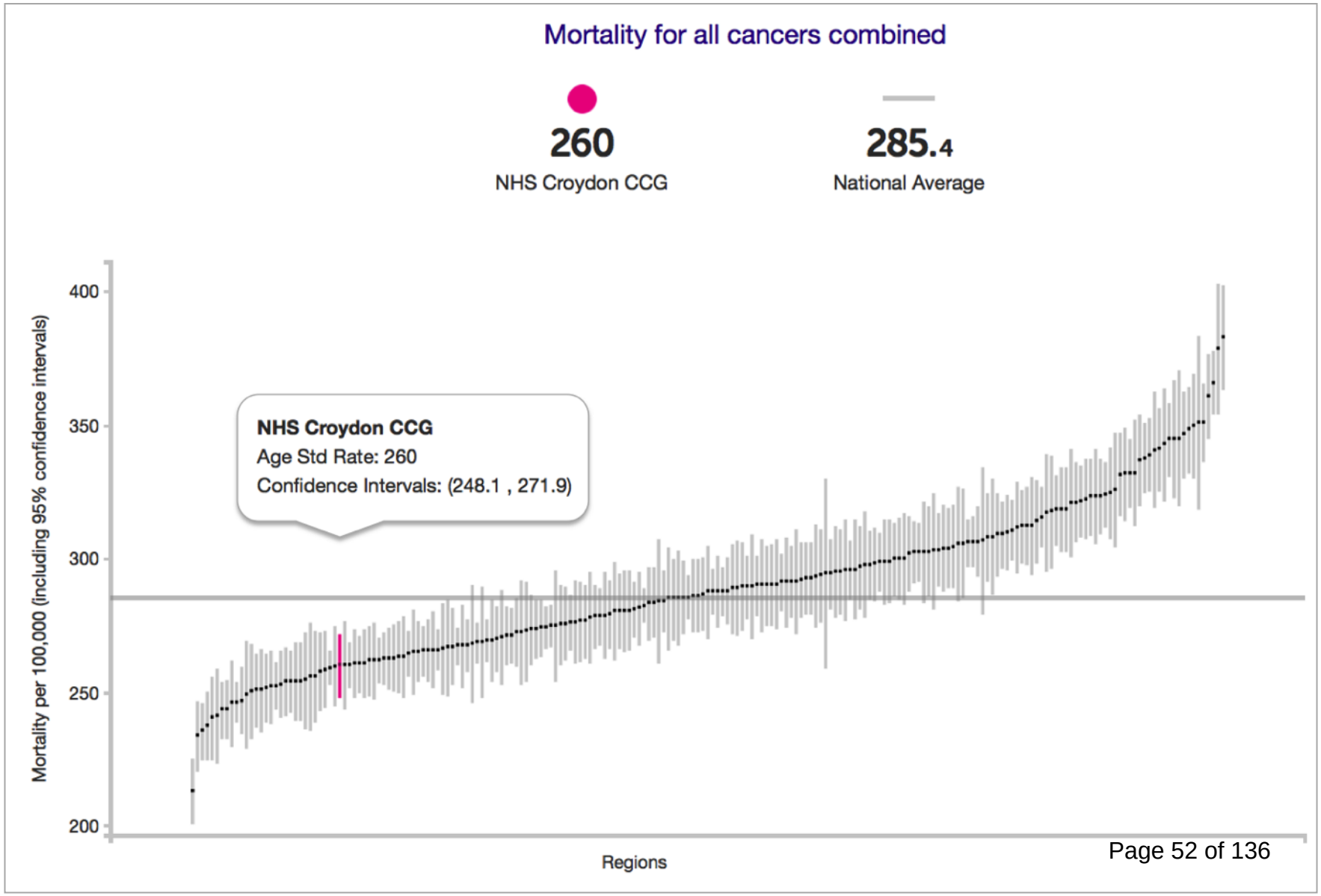
Indicator	Croydon	London	England	England Range	1 Year Trend	3 Year Trend	Time Period
169 CCG spend per head on cancers and tumours	£40	£47	£50		no data	no data	2013/14
179 Incidence of stomach cancer (rate per 100,000 population)	11.2	11.9	12.4		–	–	2010 - 12
180 Deaths from stomach cancer (rate per 100,000 population)	9.1	8.0	8.1		◄	◄	2011 - 13
187 Breast screening rate (% of women aged 53-70)	66.7%	68.9%	75.9%		◄	◄	2014
188 Incidence of breast cancer (rate per 100,000 population)	156	155	164		►	◄	2010 - 12
189 Deaths from breast cancer (rate per 100,000 population)	33.9	35.2	36.2		►	◄	2011 - 13
192 Incidence of prostate cancer (rate per 100,000 population)	178	175	174		►	►	2010 - 12
193 Deaths from prostate cancer (rate per 100,000 population)	48.3	45.0	49.1		►	◄	2011 - 13

- Croydon **ranks low** on financial expenditure on cancer
- **Emerging issue** of deaths from stomach cancer
- Breast screening rates for women aged 53-70 **worse** than England
- Three-year trend for prostrate cancer deaths is **of concern**

Burden of death and disease



Burden of death and disease



Health inequalities issues

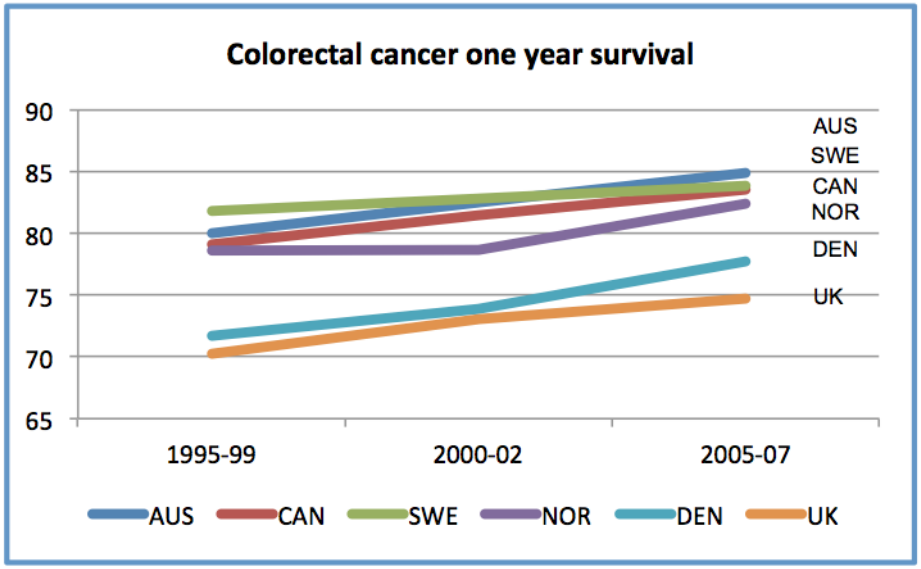
- Cancer incidence, mortality and survival
- Lifestyle factors that predispose people to cancer
- Perceptions of cancer risk
- Cancer symptom recognition
- Awareness of and use of health services
- Experience of cancer treatment

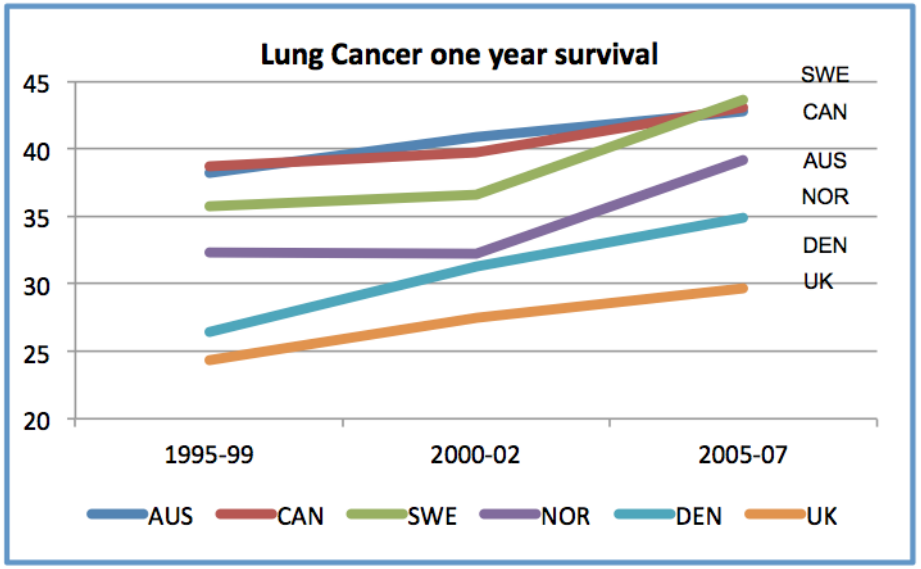
Addressing health inequalities issues

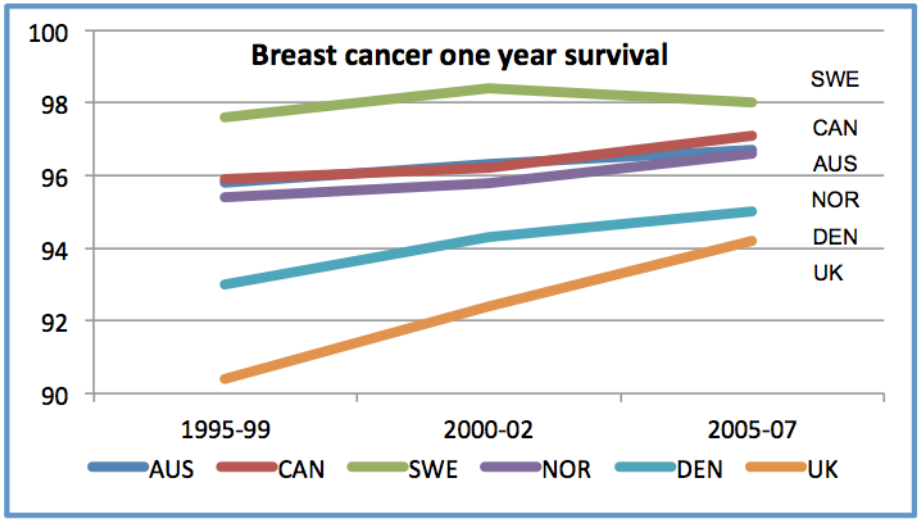
- Working with together to build intelligence and assess need
- Providing targeted and tailored interventions - ‘proportionate universalism’
- Detailed equalities impact assessments
- Understanding existing variations in cancer and developing plans to redress them
- Working with patients, the public and other stakeholders in partnership
- Focus investment ‘upstream’

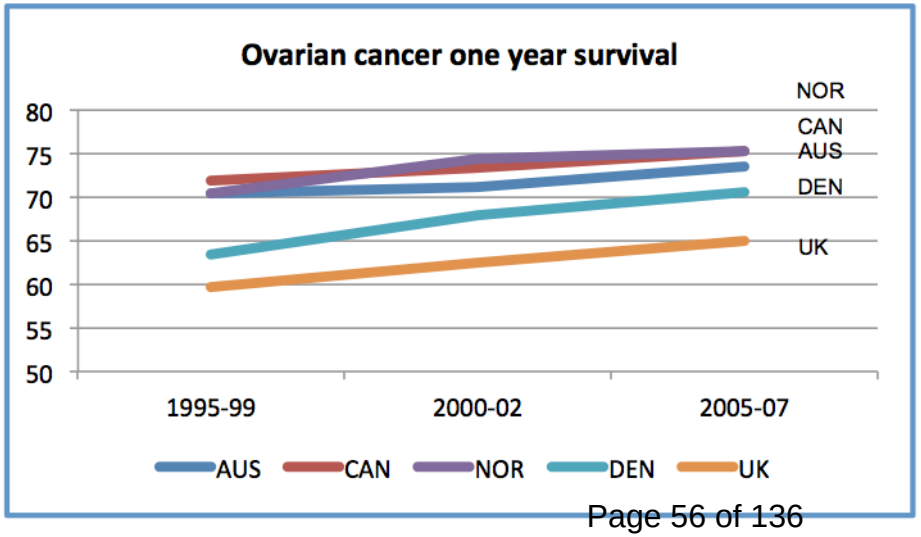
DIAGNOSIS

Survivorship

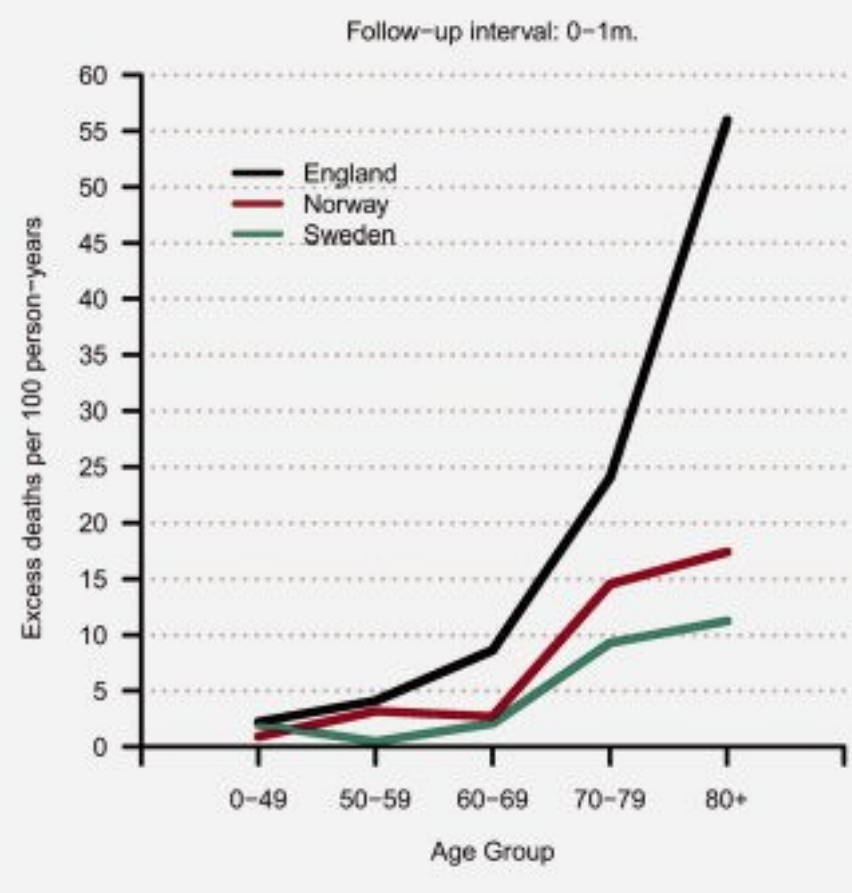


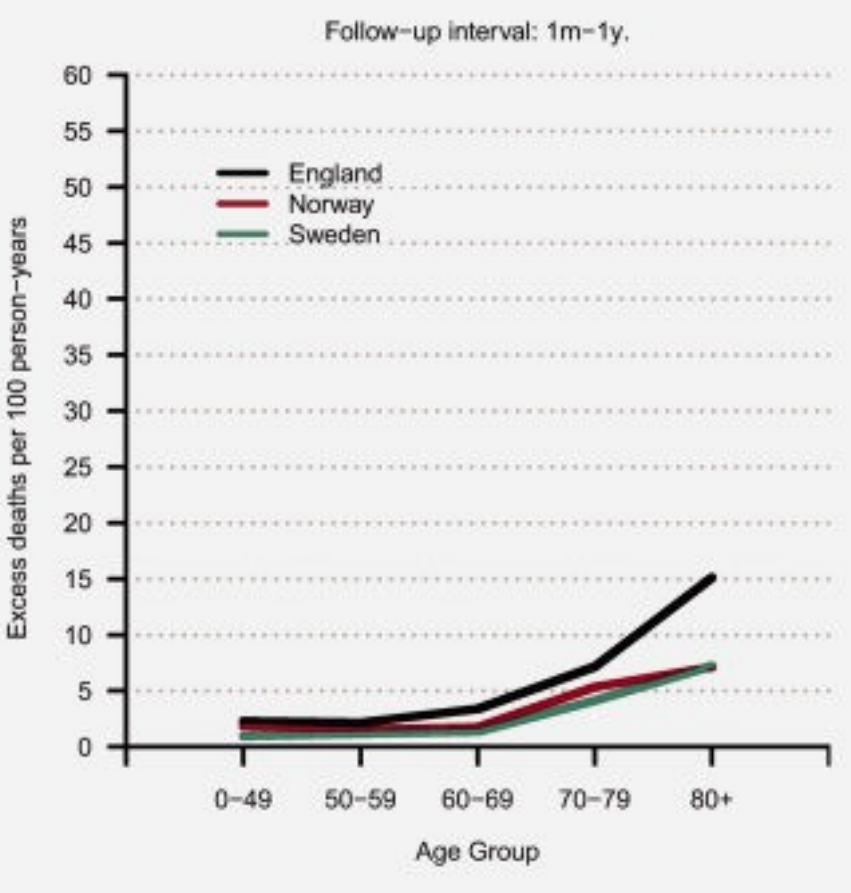






Breast cancer survival in England, Norway and Sweden: a population-based comparison

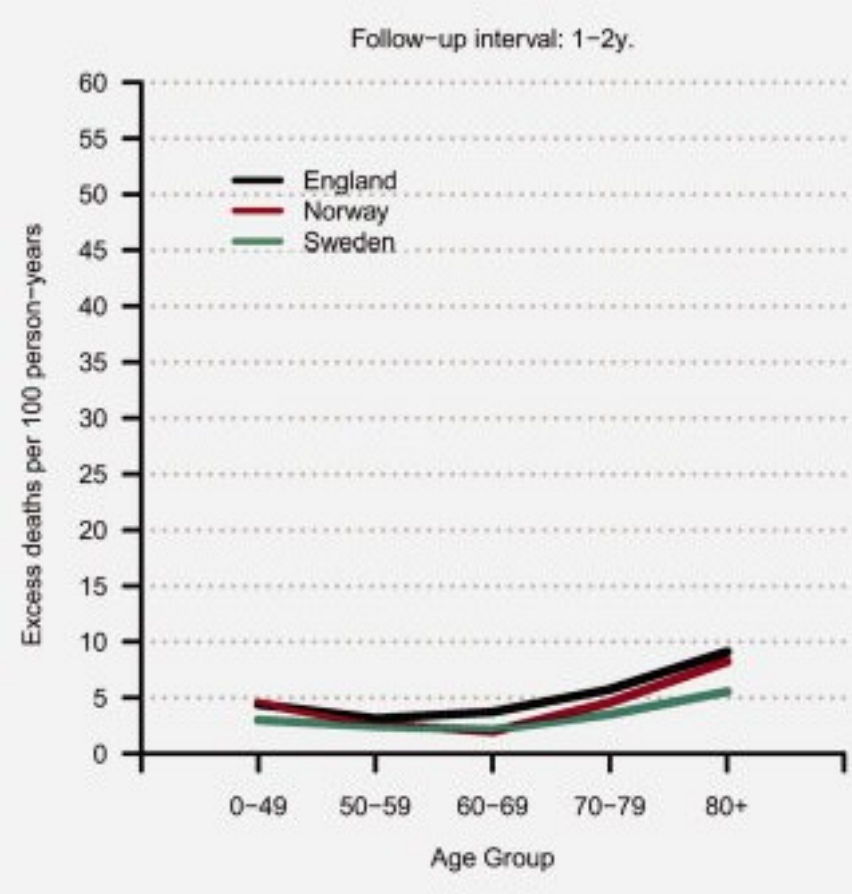




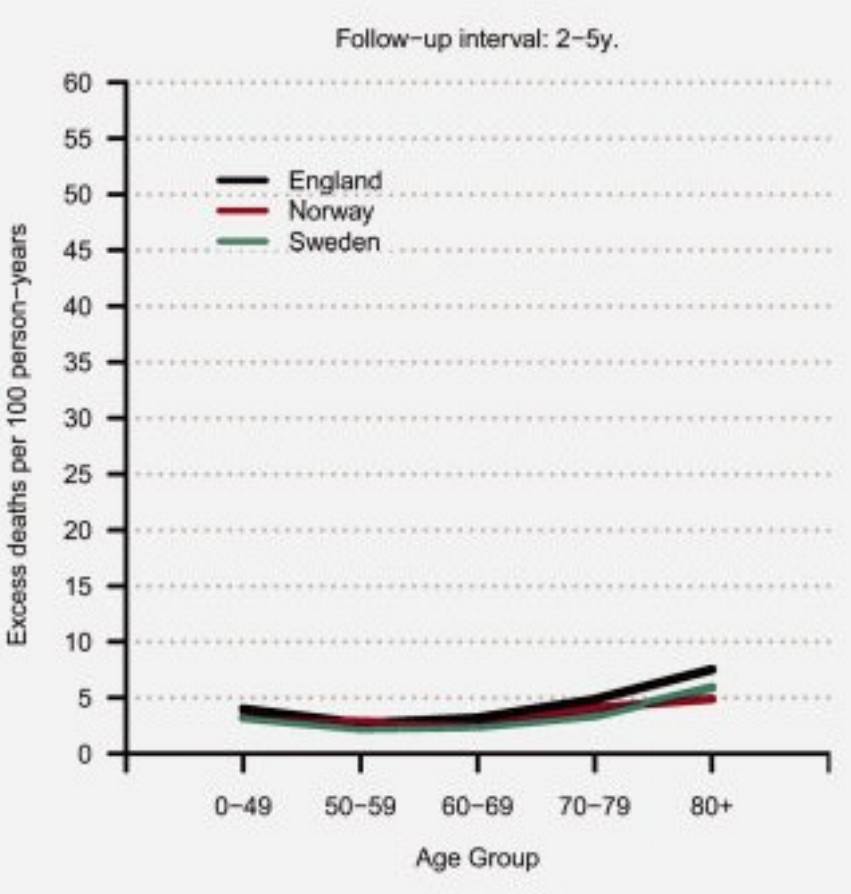
Follow-up interval
0-1 month

Follow-up interval
1 month – 1 year

Breast cancer survival in England, Norway and Sweden: a population-based comparison



Follow-up interval
1-2 year



Follow-up interval
2-5 year

Reducing late stage diagnosis

- *Achieving World-Class Cancer Outcomes*, July 2015 – ambition that 62% of all cancers diagnosed at stages 1 and 2 by 2020
- *NHS Five Year Forward View* - greater GP access to diagnostic and specialist advice
- New *NICE guidance* on appropriate referral for suspected cancer in 2015 - threshold for risk lowered to 3%
- *Quality premium: Cancer Diagnosed at Early Stage*

Reducing late stage diagnosis

Croydon CCG commissioning intentions 2016-17

1. All GPs to have direct access to colonoscopy
2. All GPs to have direct access to diagnostic services - flexible sigmoidoscopy
3. All GPs to have direct access to diagnostic services - non-obstetric ultrasound

3a. In order to promote the earlier diagnosis of ovarian cancer, services will be commissioned to support Ultrasound (US) and CA125 concurrently (CA 125 is a blood test to check for the cancer antigen which in itself is not a definite indicator for ovarian cancer which is why an ultra should also be undertaken

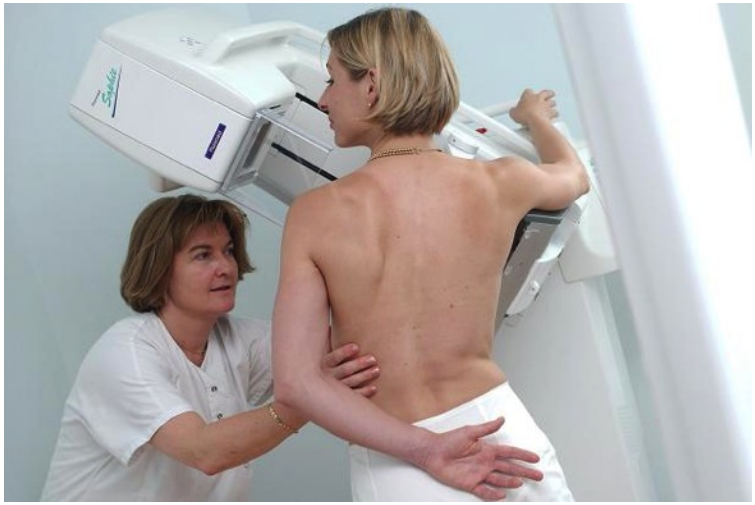
4. All GPs to have direct access to same day chest x-ray for high risk of cancer and access for low risk

4a. In order to support the reduction of the risk of delayed diagnosis, all commissioned services will be required to formally report A&E, Urgent Care Centres and inpatient chest x-rays

Now enshrined within the acute care contract as local quality requirements

Cancer waiting times – May 2016

Cancer waits in Croydon - NHS Croydon CCG		Target	Performance YTD	Performance Month	Breaches
Cancer - 2 weeks	2 week wait	93%	96.4%	96.6%	39
	Breast symptoms 2 week wait	93%	92.7%	94.9%	6
Cancer - 31 days	31 day first definitive treatment	96%	97.5%	98.0%	2
	31 day subsequent treatment surgery	94%	96.9%	100.0%	0
	31 day subsequent treatment drug	98%	100.0%	100.0%	0
	31 day subsequent treatment radiotherapy	94%	97.8%	97.7%	1
Cancer - 62 days	62 day standard	85%	81.9%	77.0%	14
	62 day screening	90%	90.9%	100.0%	0
	62 day upgrade	90%	100.0%	100.0%	0
Quarterly Activity					
Cancer - 2 weeks	2 week wait (Quarterly)	93%	95.3%	96.6%	104
	Breast symptoms 2 week wait (Quarterly)	93%	95.3%	99.6%	1
Cancer - 31 days	31 day first definitive treatment (Quarterly)	96%	98.0%	96.7%	12
	31 day subsequent treatment surgery (Quarterly)	94%	96.1%	96.1%	2
	31 day subsequent treatment drug (Quarterly)	98%	99.8%	100.0%	0
	31 day subsequent treatment radiotherapy (Quarterly)	94%	98.0%	98.6%	2
Cancer - 62 days	62 day standard (Quarterly)	85%	82.4%	84.1%	32
	62 day screening (Quarterly)	90%	92.4%	95.8%	1
	62 day upgrade (Quarterly)	90%	87.1%	95.5%	1



SCREENING

- **Breast screening** is offered to women aged 50-70 in England. In England, this age range is gradually being extended to 47-73.
- **Cervical screening** is offered to women aged 25-64 in England.
- **Bowel screening** is offered to men and women aged 60-74 in England and a new test called Bowel Scope is starting to be offered to people at age 55.

SCREENING IN CROYDON

5.6.1 Prevalence and incidence

Indicator	MDY	TNH	WSS	NAS	PRY	ECR	Cro	Lon	Eng	Target
Cancer diagnosed (since 1st April 2003) (all ages)	1.36%	1.56%	1.84%	2.06%	2.41%	1.42%	1.75%	1.54%	2.26%	
New cancer cases (incidence per 1,000)	2.84	3.57	3.66	4.45	4.61	3.32	3.70	3.38	5.08	

5.6.2 Cancer screening

The targets shown are the national targets for coverage.

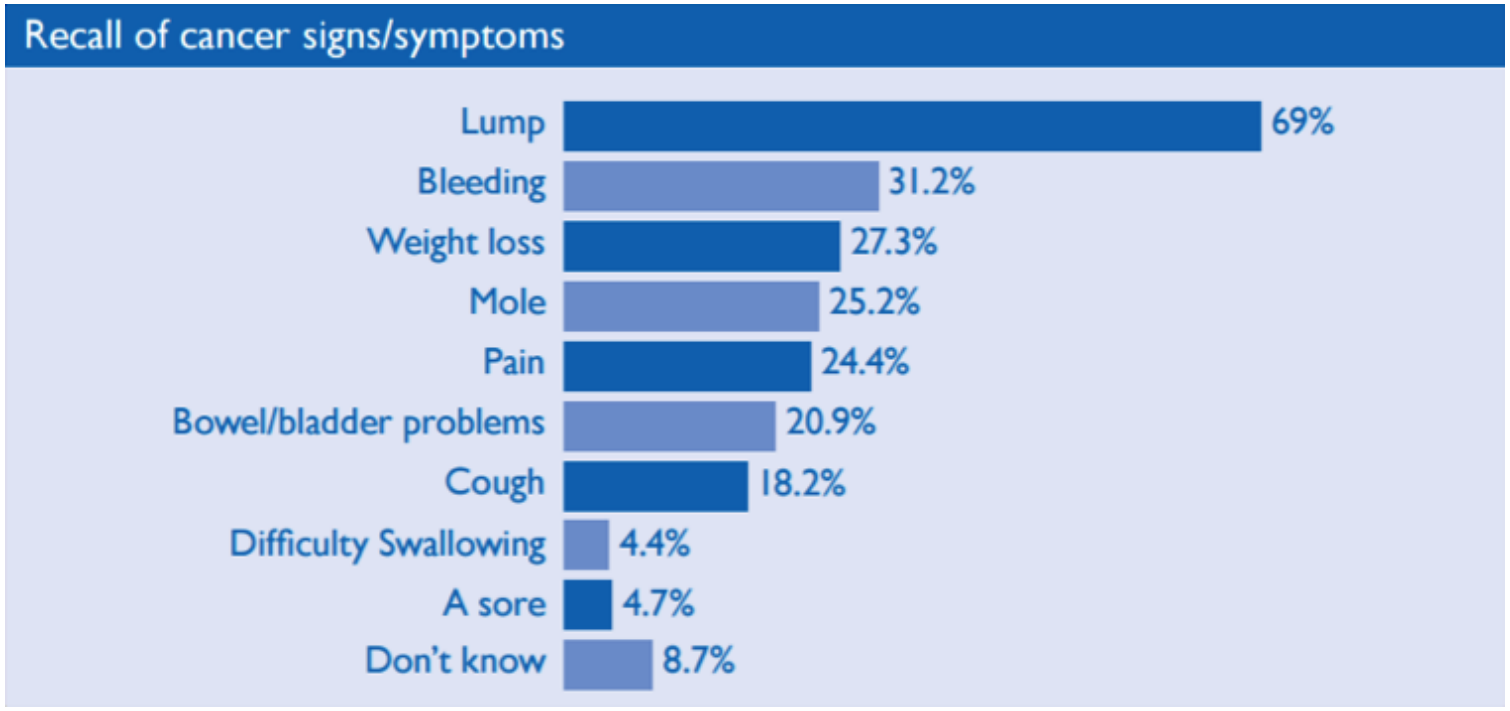
Indicator	MDY	TNH	WSS	NAS	PRY	ECR	Cro	Lon	Eng	Target
Cervical screening coverage (last 5 yrs) (ages 25-64)	68.3%	74.1%	73.9%	75.0%	76.4%	68.1%	72.2%	68.4%	73.5%	80
Cervical screening coverage (excl. exceptions) (CS002)	79.5%	82.4%	82.2%	84.1%	85.8%	78.5%	81.8%	79.7%	81.8%	80
Breast screening coverage (last 3 years) (age 50-70)	57.9%	58.2%	66.3%	65.1%	69.0%	58.6%	62.9%	64.2%	72.2%	80
Bowel screening coverage (last 2.5 years) (age 60-69)	42.3%	43.4%	52.0%	53.8%	58.2%	44.2%	49.8%	48.8%	57.9%	

- **Low rates of bowel screening for 60-69 year olds within three GP networks**
- **Though no significant underperformance among networks, breast screening a concern in Croydon**

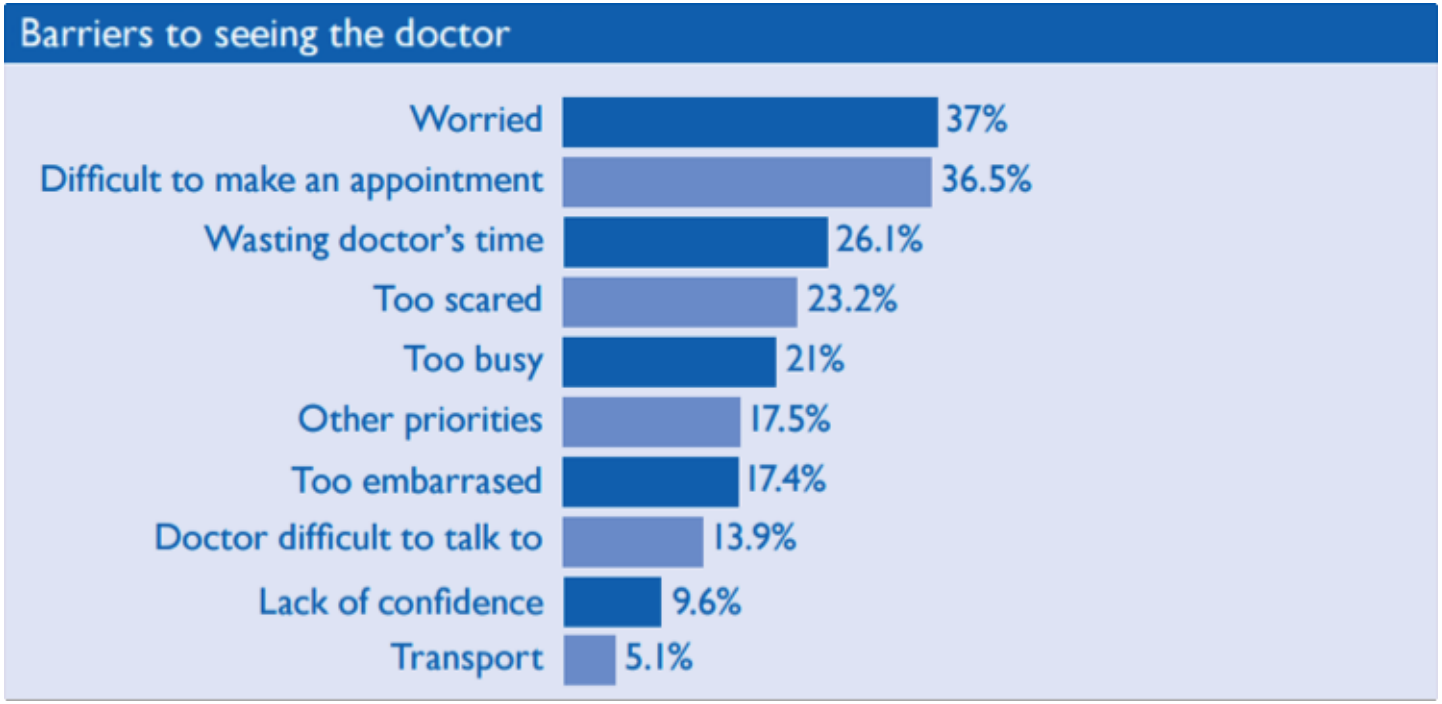
IMPROVING SCREENING IN CROYDON

Practices visited to date	Date:	Cancer Research UK	Macmillan
Portland medical centre	01/10/2015	x	x
Greenside Medical Practice	16/10/2015	x	
Mitchley Avenue Surgery	12/11/2015	x	
Downland Surgery	18/11/2015	x	
Old Coulsdon Medical Practice	25/11/2015	x	
Leadnder Roard Primary Care Centre	30/11/2015	x	x
The Moorings Medical Practice	08/12/2015	x	
Parkside Practice	09/12/2015	x	x
The Coulsdon Medical Practice	09/12/2015	x	
Mersham Medical Centre	10/12/2015	x	
Selsdon Park	14/12/2015	x	
Woodcote Group	23/12/2015	x	
Keston	07/01/2016	x	
Brigstock Medical Practice	22/01/2016	x	x
Bramley Medical Practice	25/01/2016		x
Auckland	10/02/2016	x	
Violet Lane	12/02/2016	x	x
Norbury Medical Practice	07/03/2016	x	x
Thornton Heath	19/04/2016	x	x
Hartland Way Surgery	22/07/2016	x	x
Stovell House Surgery	01/08/2016	x	x

AWARENESS


Recall of cancer signs/symptoms
Lump
69%
Bleeding
31.2%
Weight loss
27.3%
Mole
25.2%
Pain
24.4%
Bowel/bladder problems
20.9%
Cough
18.2%
Difficulty Swallowing
4.4%
A sore
4.7%
Don't know
8.7%

AWARENESS


Barriers to seeing the doctor
Worried
37%
Difficult to make an appointment
36.5%
Wasting doctor's time
26.1%
Too scared
23.2%
Too busy
21%
Other priorities
17.5%
Too embarrased
17.4%
Doctor difficult to talk to
13.9%
Lack of confidence
9.6%
Transport
5.1%

AWARENESS


BE CLEAR ON CANCER
Find your local GP
NHS
Enter your postcode
Find
Been coughing for 3 weeks or getting out of breath easily? Tell your doctor.
Tell your doctor
Persistent coughing
Out of breath
Dr Ian Watson

PREVENTION

The NHS Five Year Forward View:

*"The **future health of millions of children**,*

*the **sustainability of the NHS**,*

*and the **economic prosperity of Britain** all now depend on a*

***radical upgrade in prevention and public health**"*

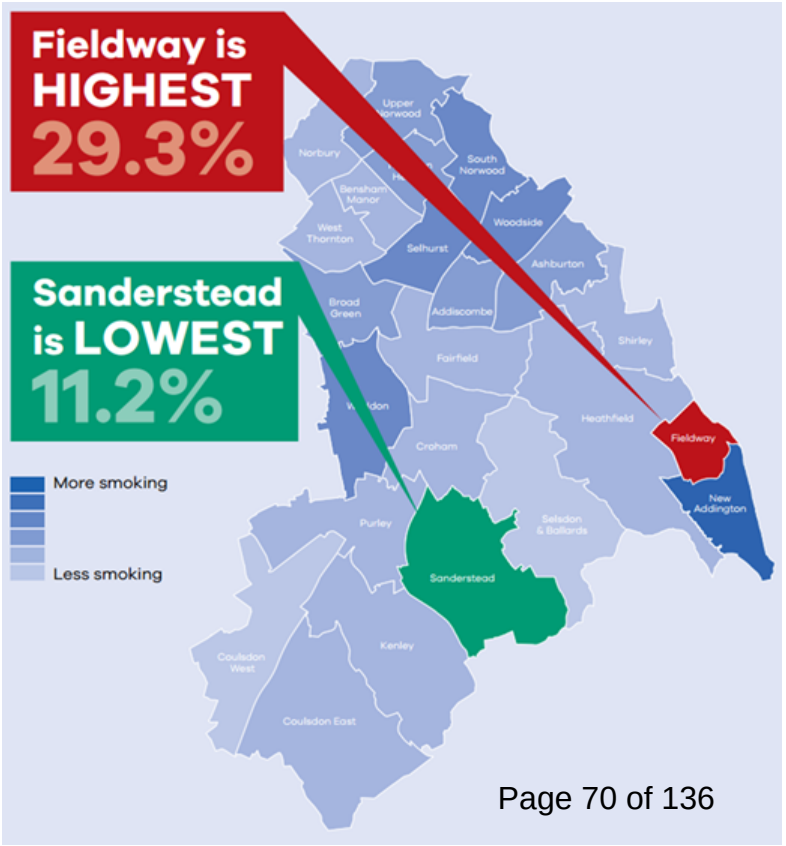
PREVENTION

Lifestyle factor	Cancer cases prevented	% of new cancer cases
Be Smokefree	64,500	19%
Keep a healthy weight	18,100	5%
Eating fruit and veg	15,100	5%
Drink less alcohol	12,800	4%
Be SunSmart	11,500	3%
Less processed and red meat	8,800	3%
Eat a high fibre diet	5,100	2%
Be active	3,400	1%
Eat less salt	1,700	1%
Other factors	**Cancer cases prevented**	**% of new cancer cases**
Minimise risks at work, such as asbestos	12,100	4%
Minimise certain infections, such as HPV	10,600	3%
Minimise radiation, such as unnecessary x-rays	6,100	2%
Breastfeed of possible	2,700	1%
Minimise any time spent on HRT	1,700	1%

PREVENTION

Smoking causes more than one quarter (28%) of all cancer deaths in the UK

58,000 people smoke in Croydon and two thirds of them started smoking before the age of 18



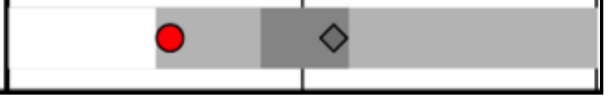
PREVENTION

- One in six adults in Croydon drink at risky levels
- Two in three adults are overweight or obese (181,000 people)
- Croydon's population is getting older and excess weight in the population is increasing
- **Without action, incidence of lifestyle-related cancers is likely to increase**

ACTION ON PREVENTION

COUNCIL PREVENTION:

- Public health
- Livewell
- NHS Healthchecks

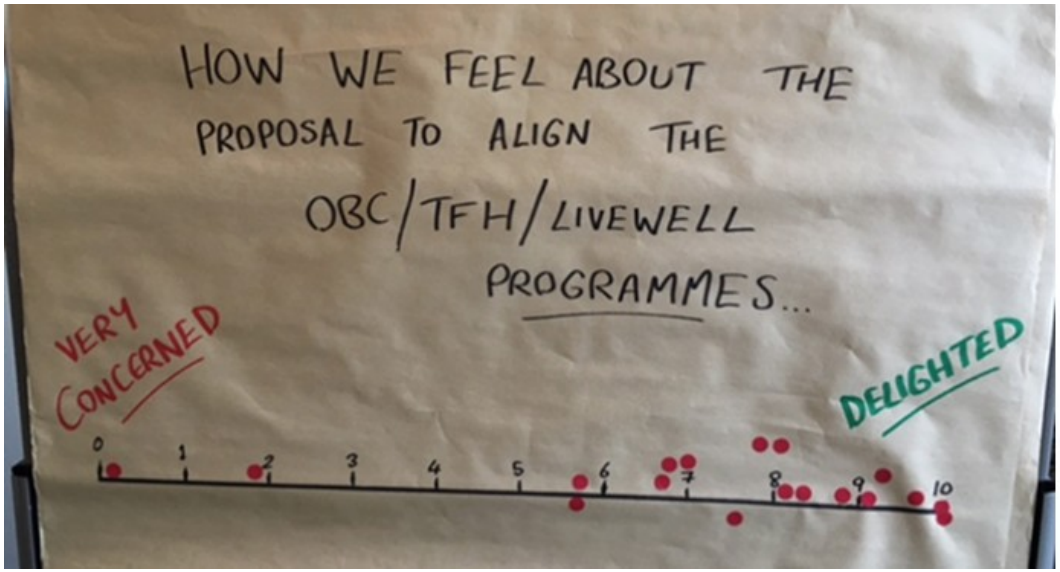
Domain	Indicator	Croydon	London	England	England Range
NHS health checks	274 Offered an NHS health check (cumulative % of eligible people aged 40-74)	11.9%	44.6%	37.9%	
	275 Received an NHS health check (cumulative % of eligible people aged 40-74)	6.9%	21.5%	18.6%	

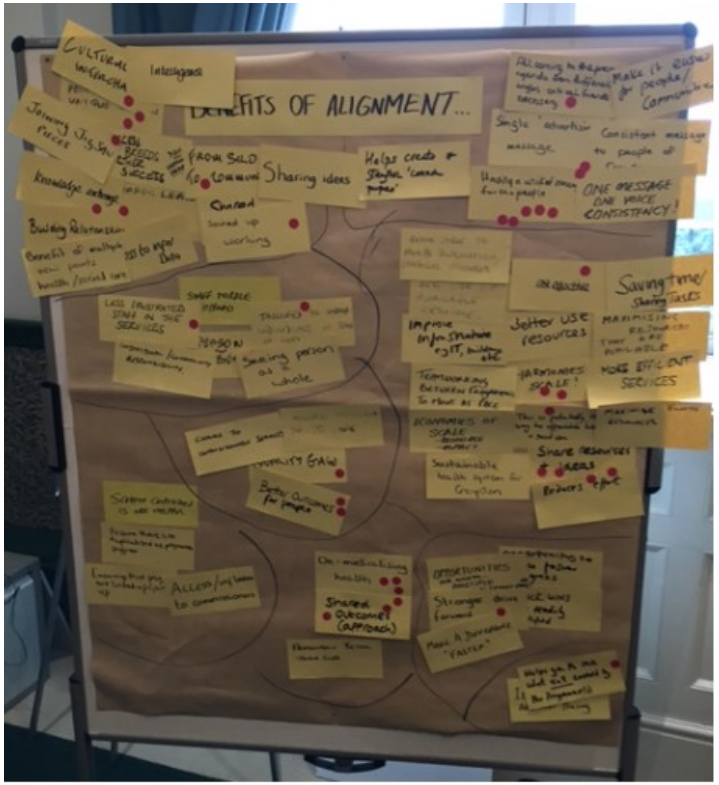
- Policy and Regulation

NHS PREVENTION:

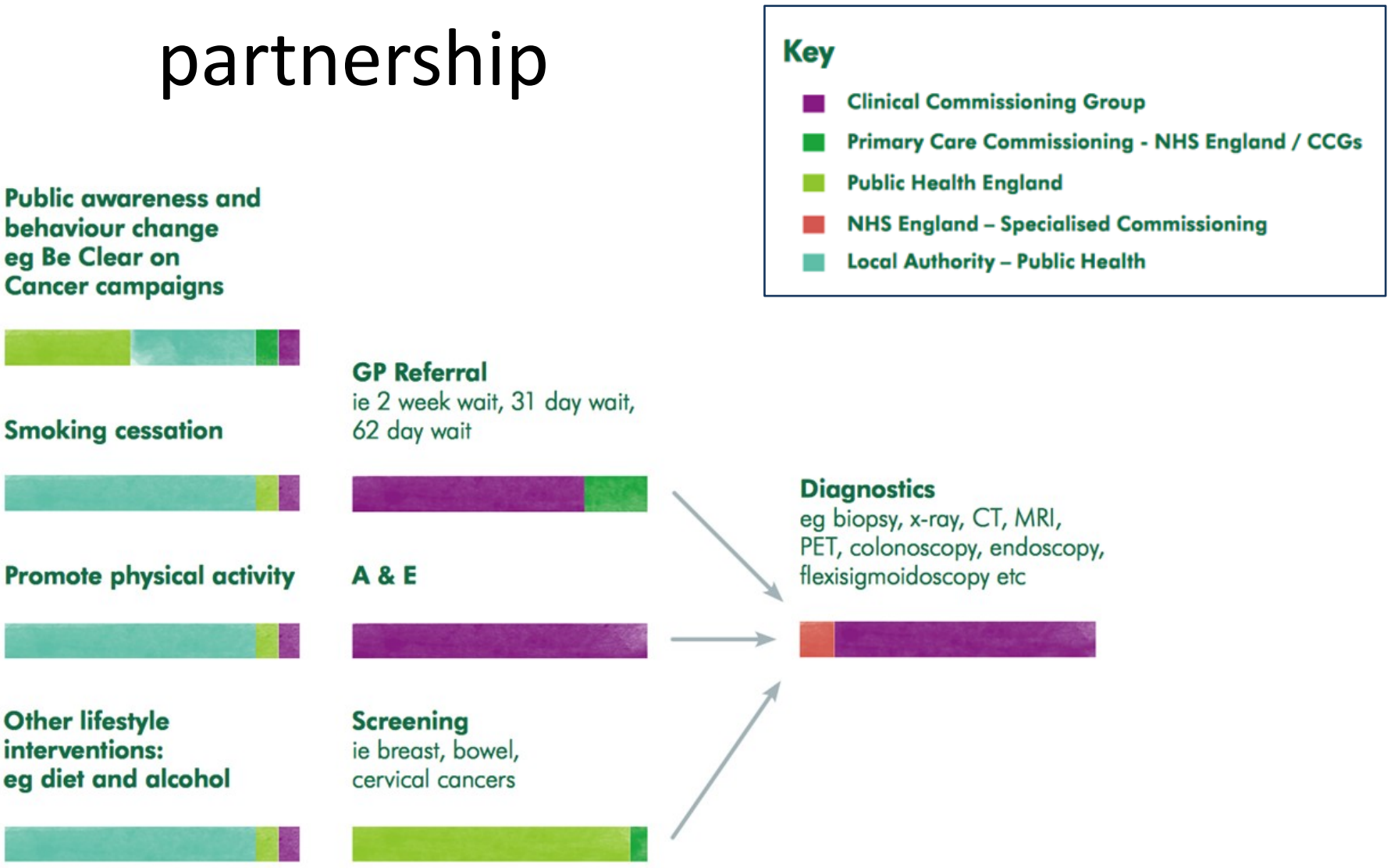
- Making Every Contact Count
- Together for Health
- Outcomes Based Commissioning

POTENTIAL FOR ALIGNMENT





The importance of partnership



Questions

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JSNA Key Dataset

Key Messages

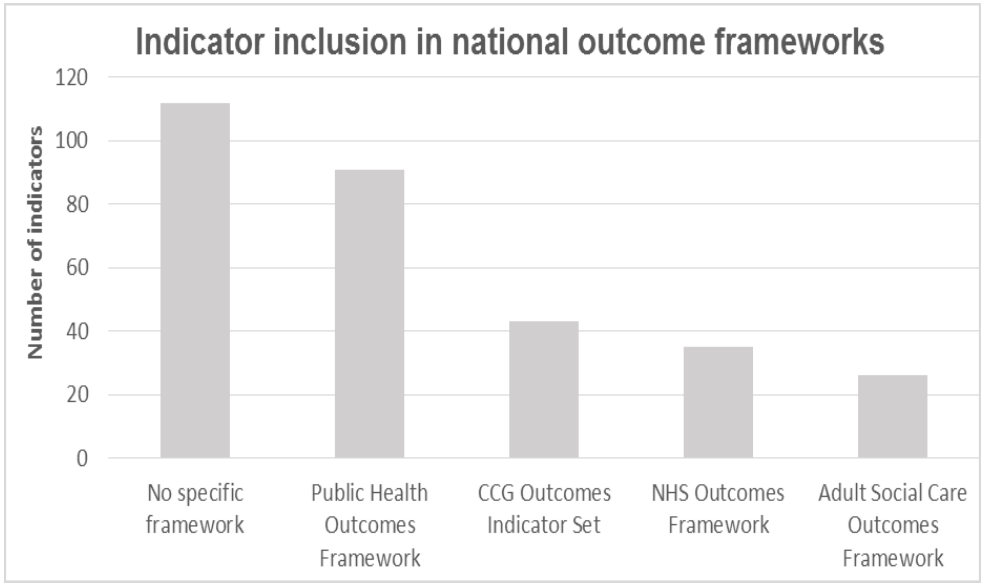
September 2016

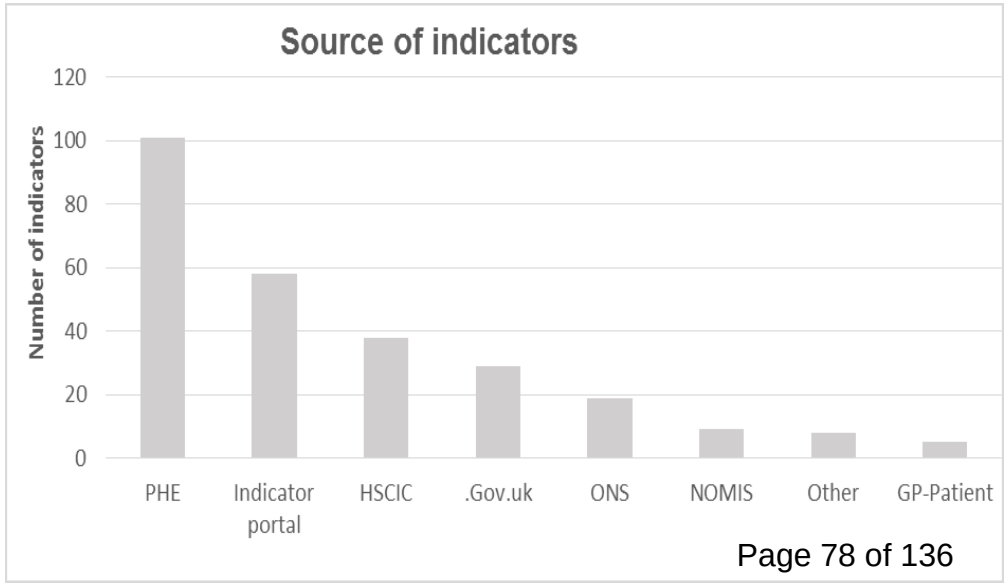
JSNA Key Dataset

The Croydon Key Dataset is a part of the local approach to Joint Strategic Needs Assessment (JSNA).

It is updated each year to show Croydon's relative position for a wealth of indicators of relevance to health and wellbeing.

This year, approximately 270 indicators have been included showing trends of Croydon's performance and levels of need and comparing these against the rest of the country.

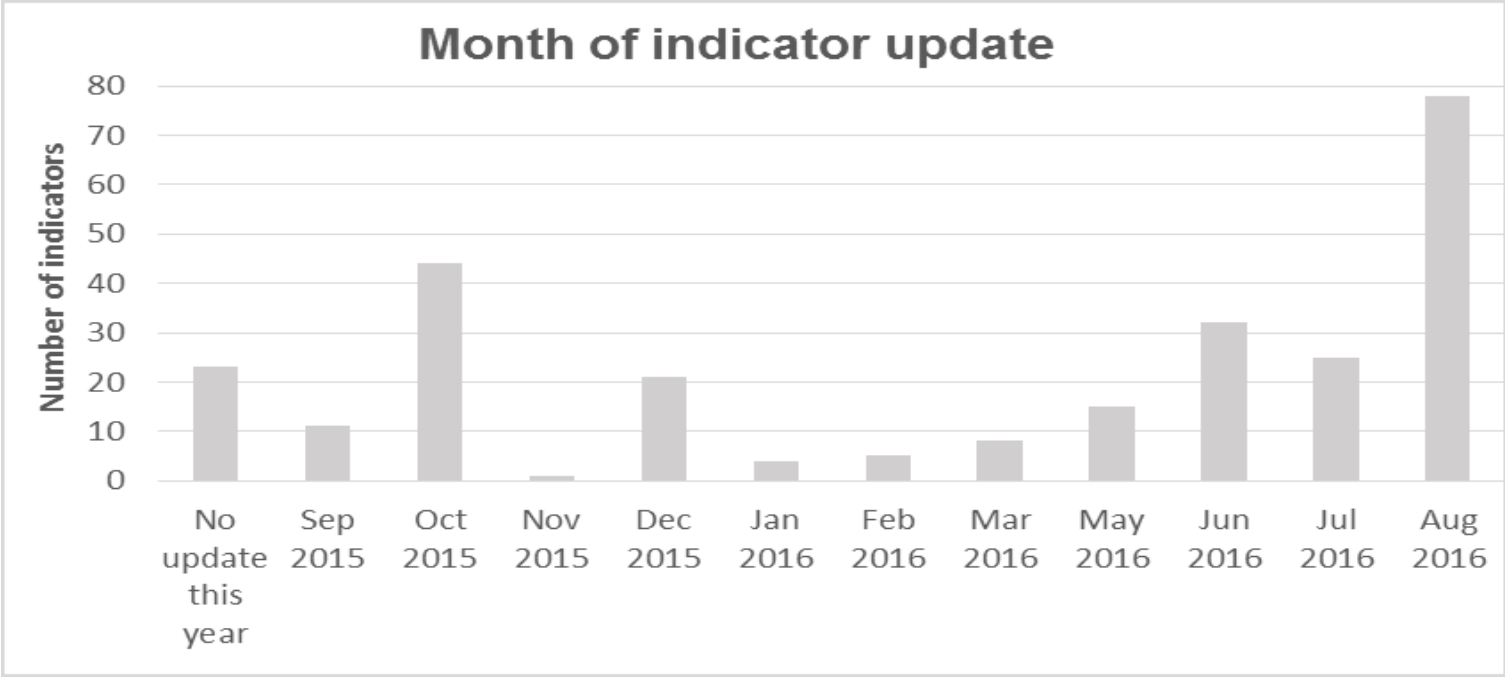




Limitations

The main limitation to any dataset of this kind is timeliness and while the most recent available data was used at the cut-off point for collection (12 August 2016), there is an inevitable time lag.

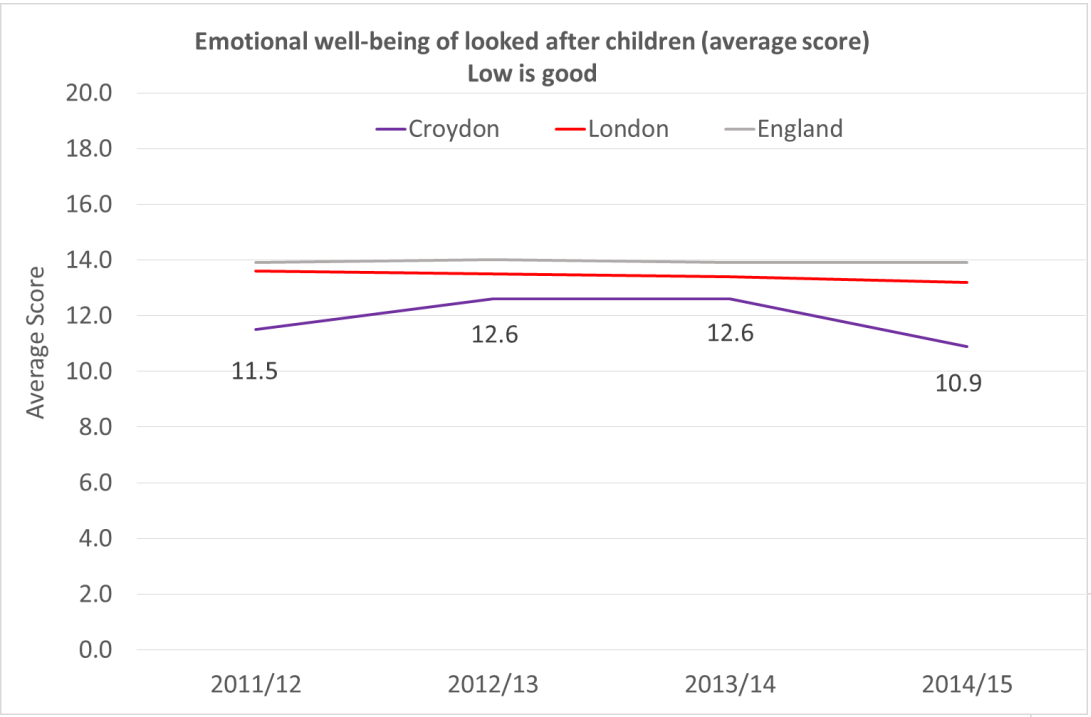
However, with a large number of indicators being sourced from the Public Health Outcomes Framework, early August is the when the majority of indicators are updated.



Good Performance

September 2016

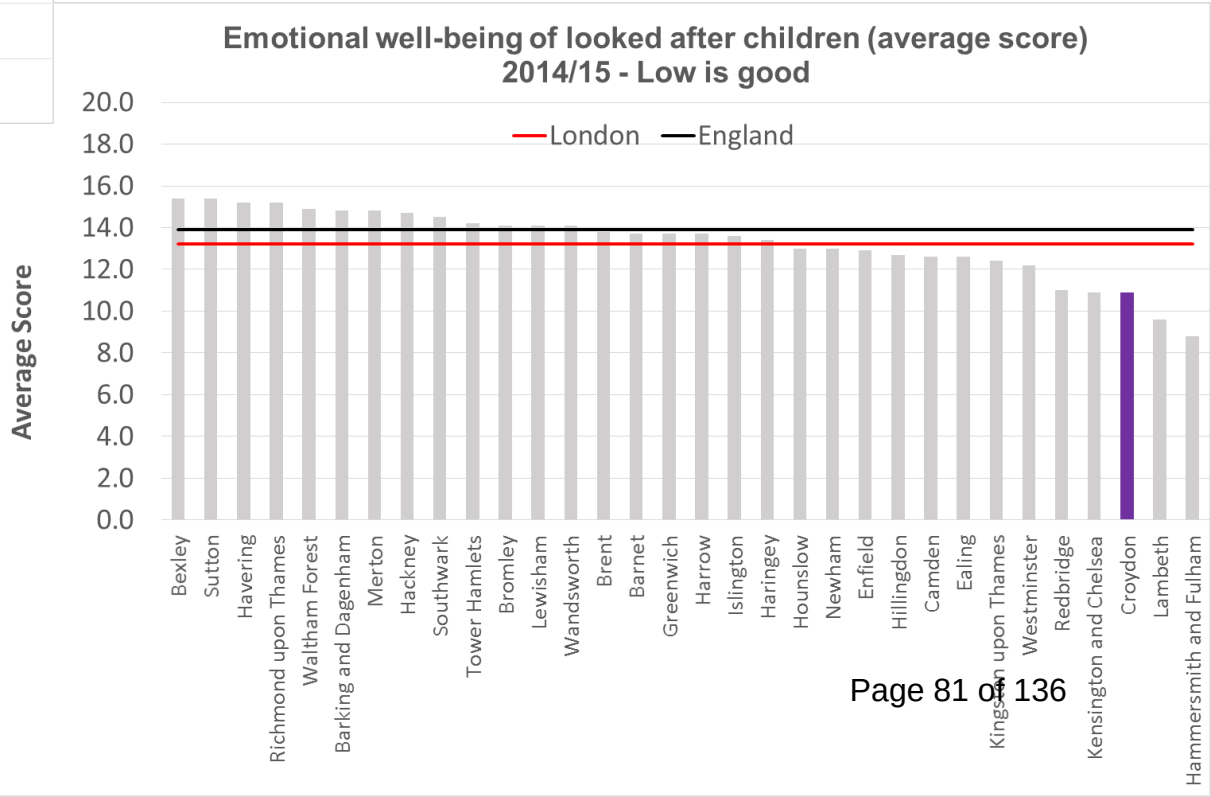
Emotional well-being of looked after children is improving (low score is good)



In 2014/15 Croydon is the

3rd highest performing LA in London

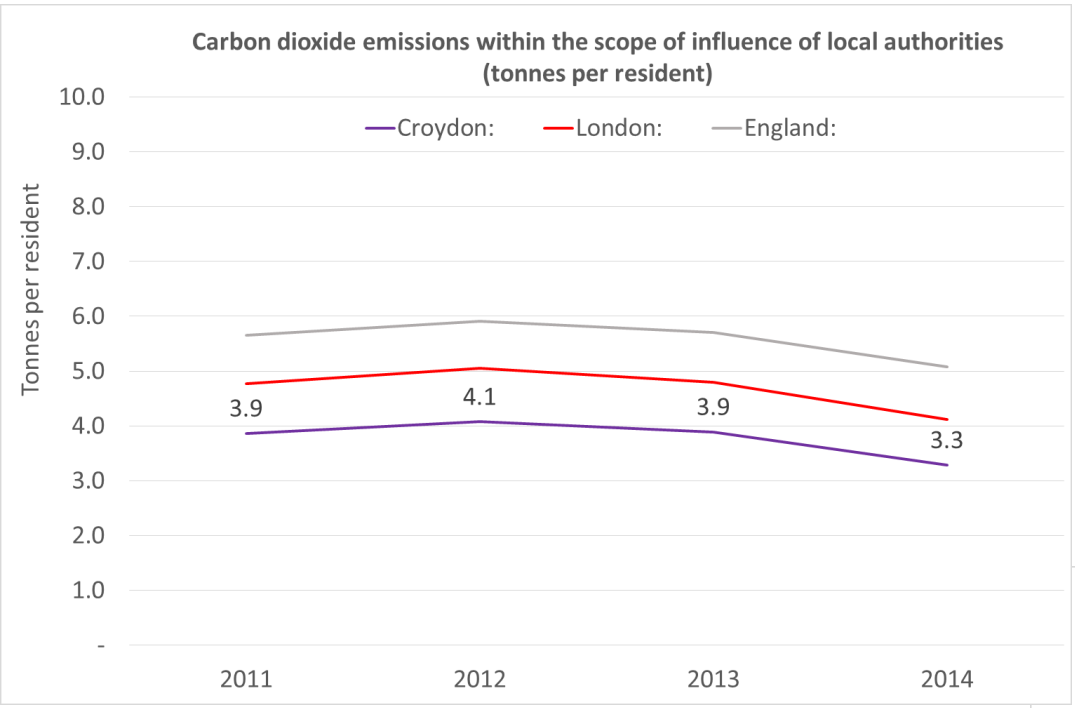
In 2013/14 Croydon was 7th



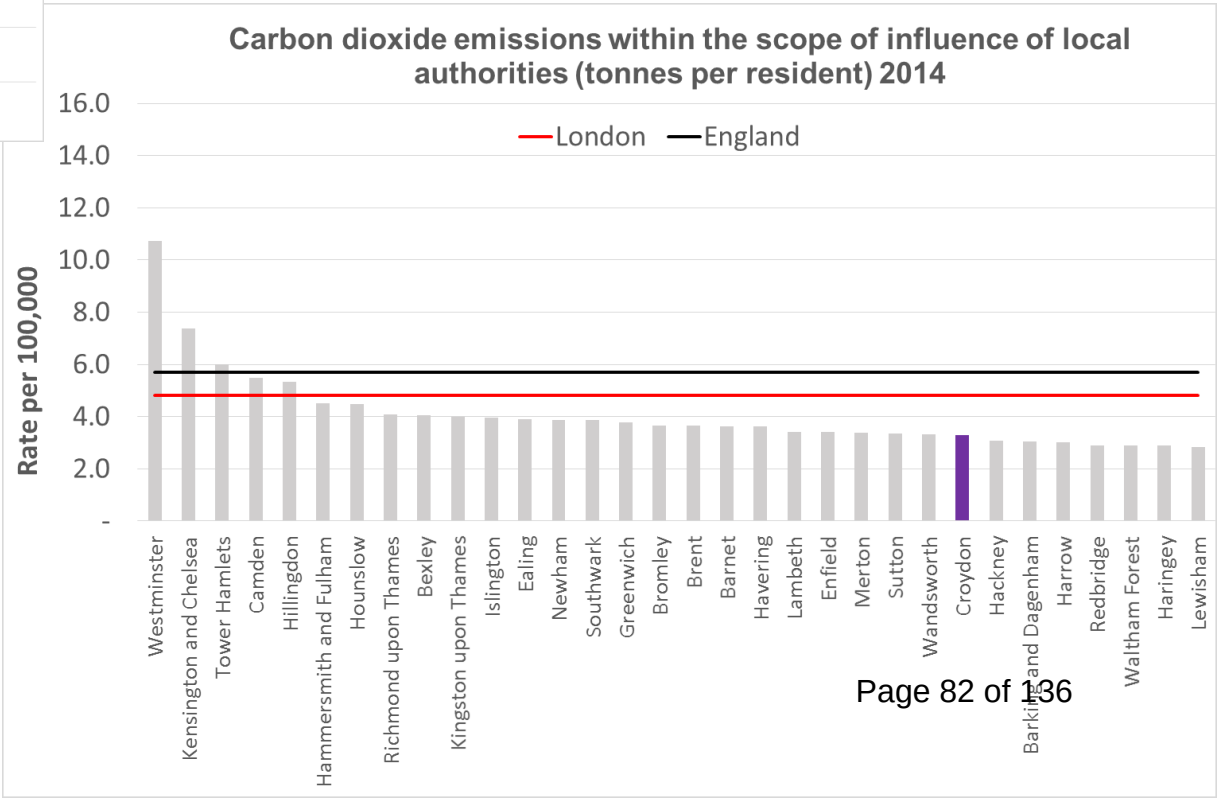
Methodology

Data is collected by local authorities through a strengths and difficulties questionnaire (SDQ) and a single summary figure for each child (the total difficulties score), ranging from 0 to 40, is submitted to the Department for Education through the looked after children return (SSDA903). A higher score indicates greater difficulties (a score of under 14 is considered normal, 14-16 is borderline cause for concern and 17 or over is a cause for concern).

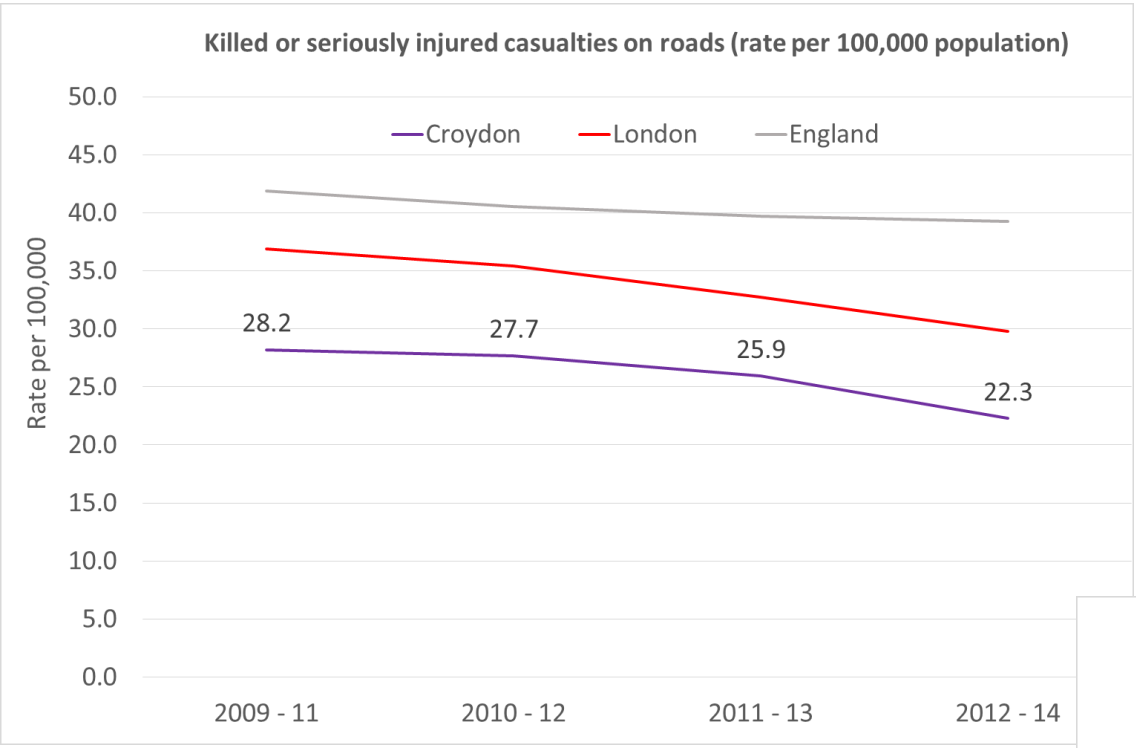
Carbon dioxide emissions within the scope of influence of local authorities down to 8th lowest in London (tonnes per resident)



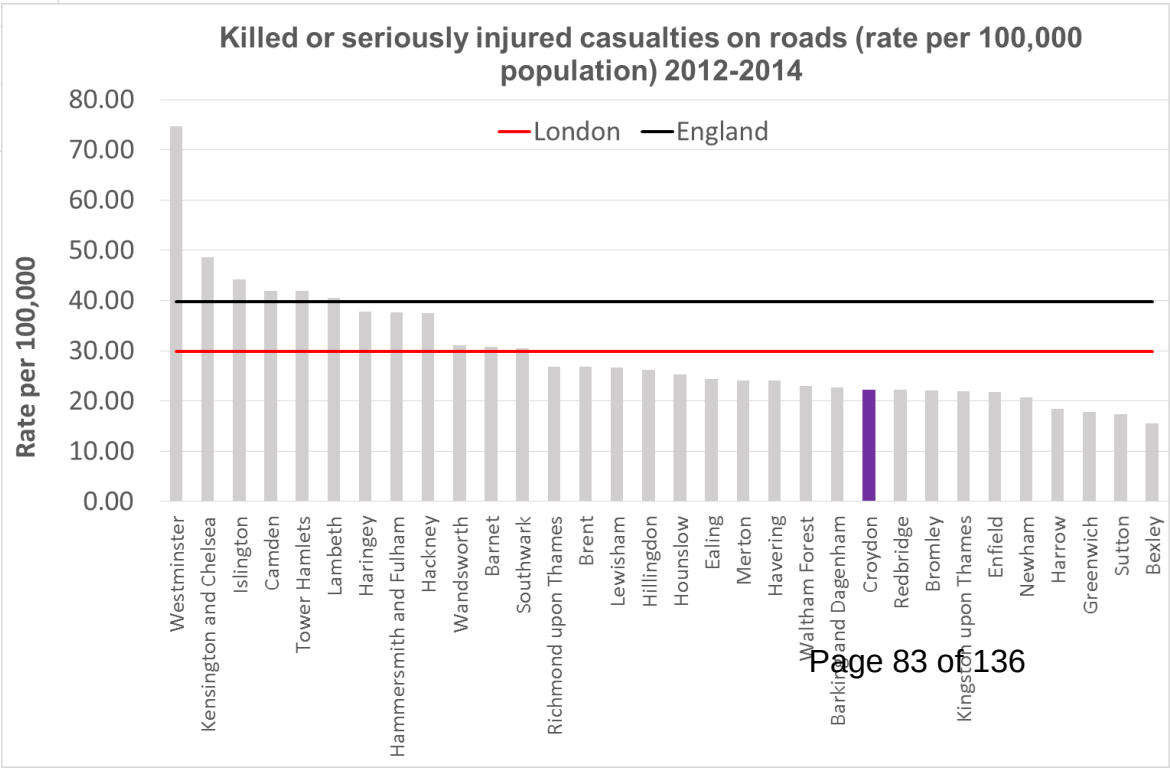
Croydon was 11th in 2007



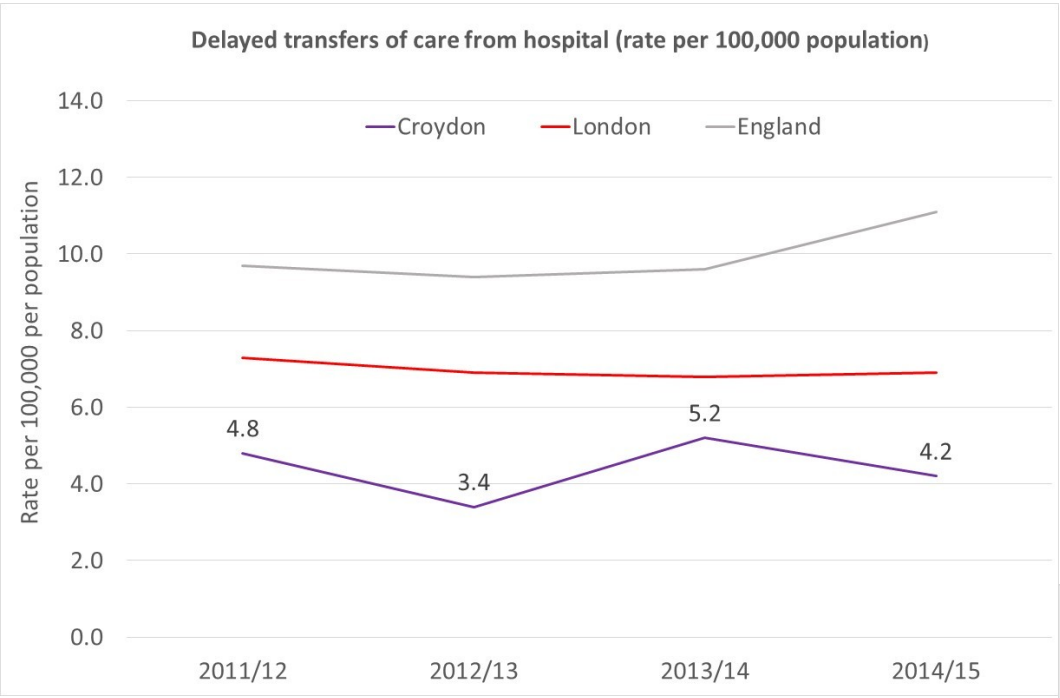
Killed or seriously injured casualties on roads rate down to 10th lowest in London (rate per 100,000 population)



Croydon was 15th lowest in in 2011-2013

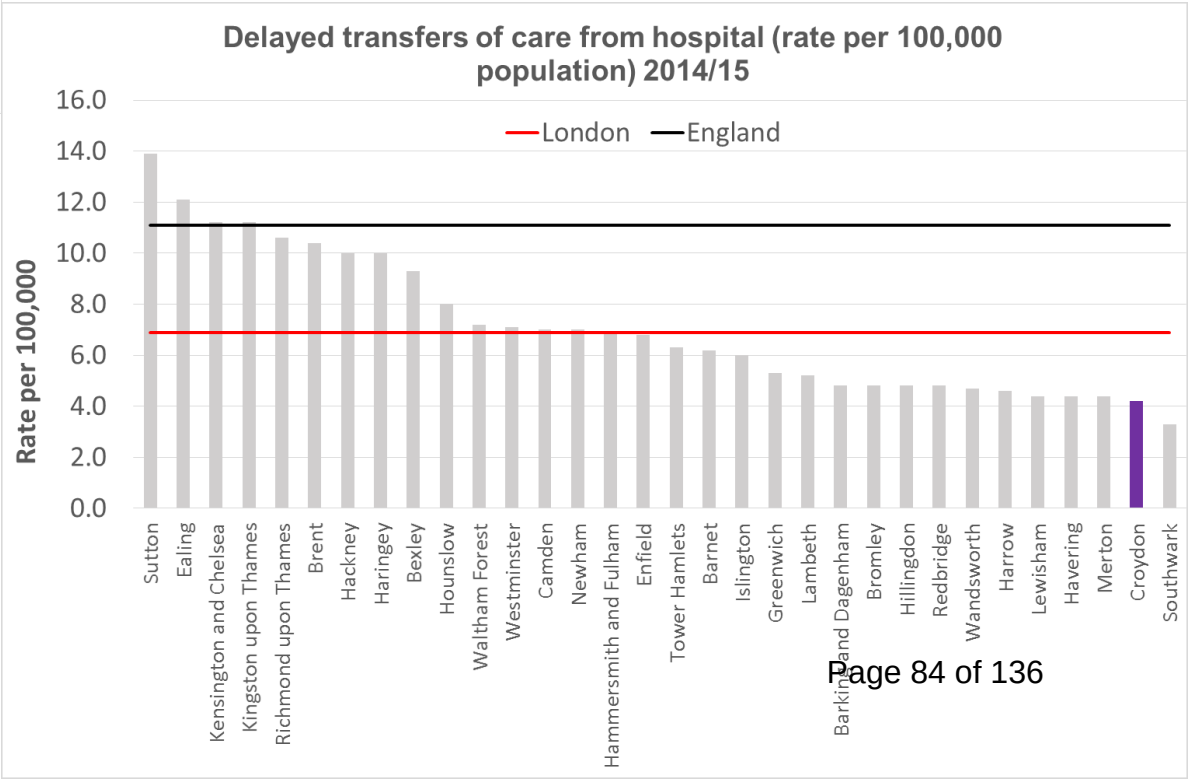


Delayed transfer of care from hospital rates second best performing in London

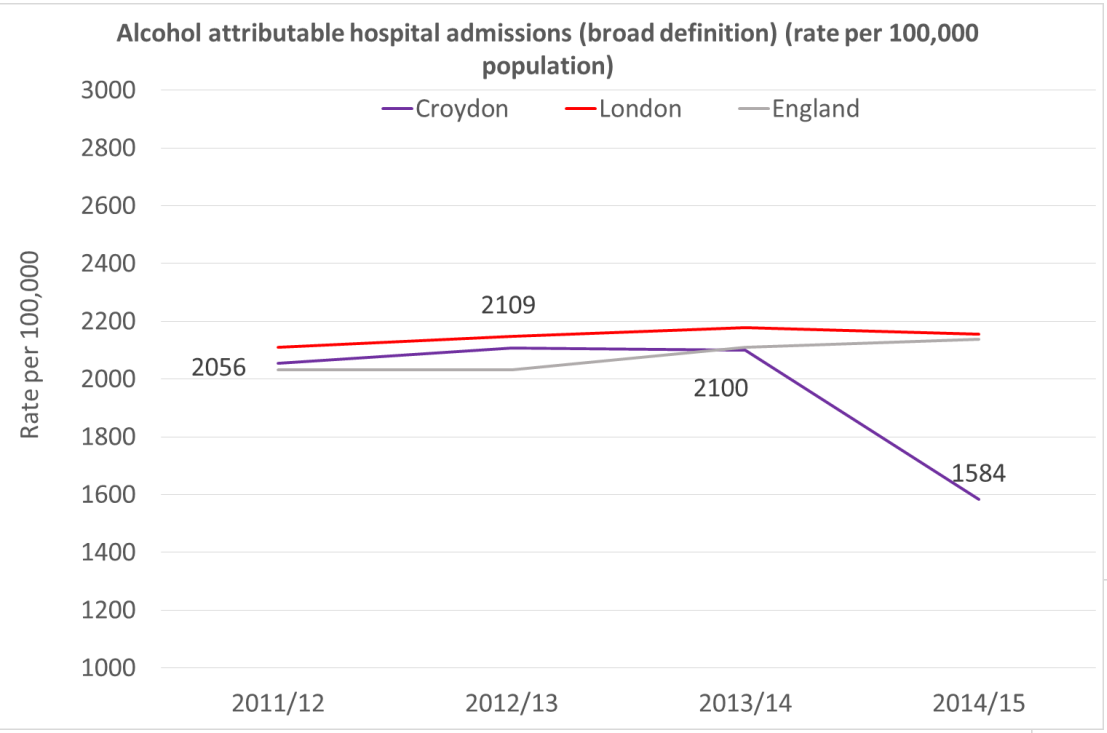


2nd lowest rate in London for delayed transfers of care from hospital

6th lowest rate in London for delayed transfers of care from hospital attributable to adult social care

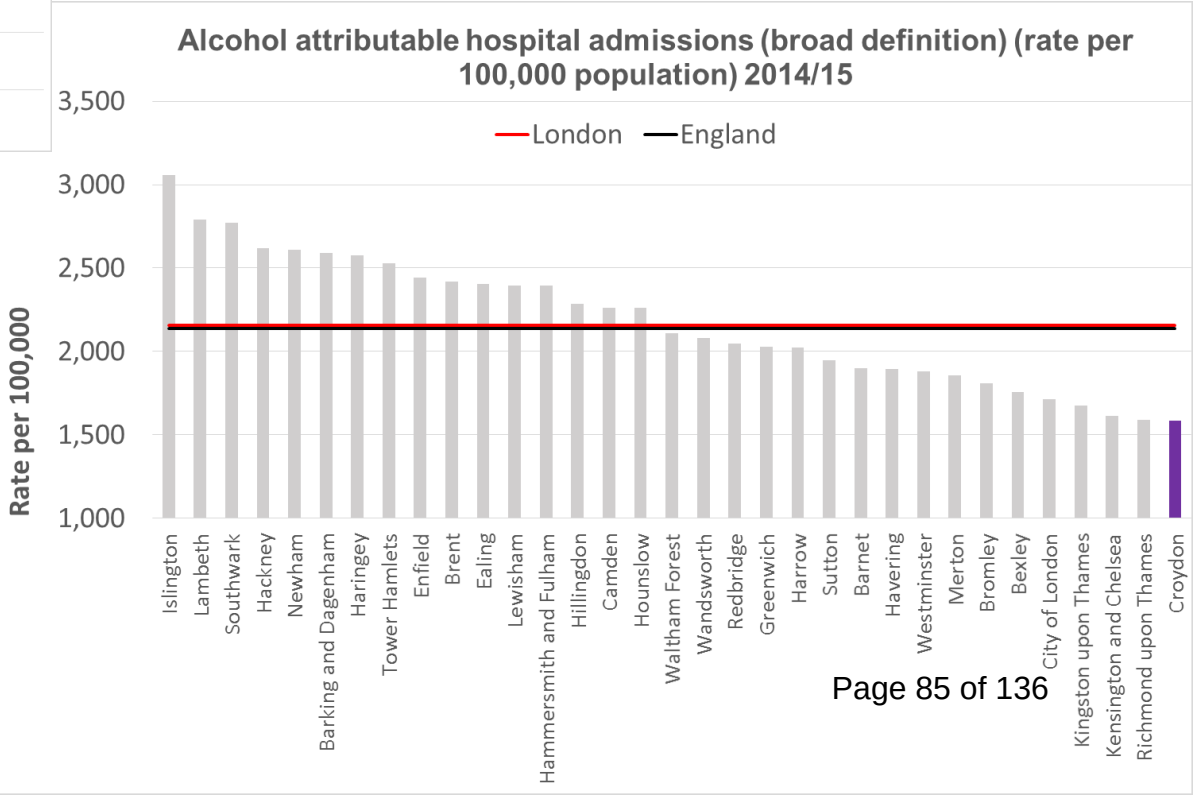


Huge decrease in alcohol attributable hospital admissions (broad definition)



Lowest in London for broad definition alcohol attributable hospital admissions

7th lowest in London for narrow definition alcohol attributable hospital admissions



Broad definition

Persons admitted to hospital where the primary diagnosis or any of the secondary diagnoses are an alcohol-attributable code.

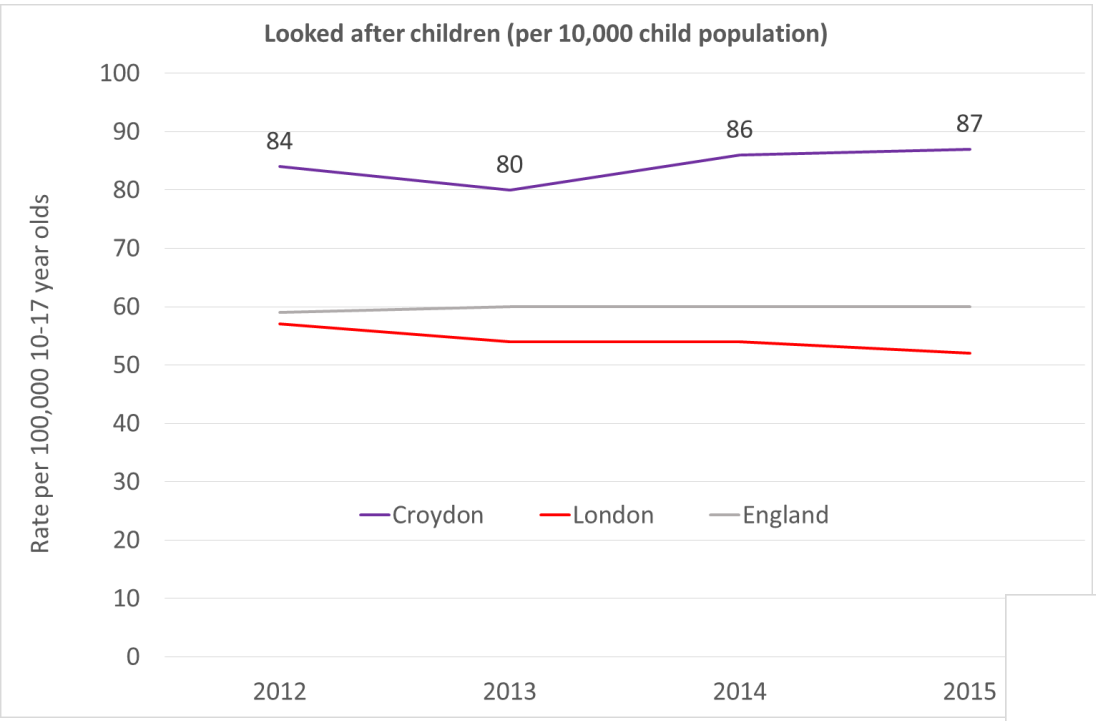
Narrow definition

Persons admitted to hospital where the primary diagnosis is an alcohol-attributable code.

Challenges

September 2016

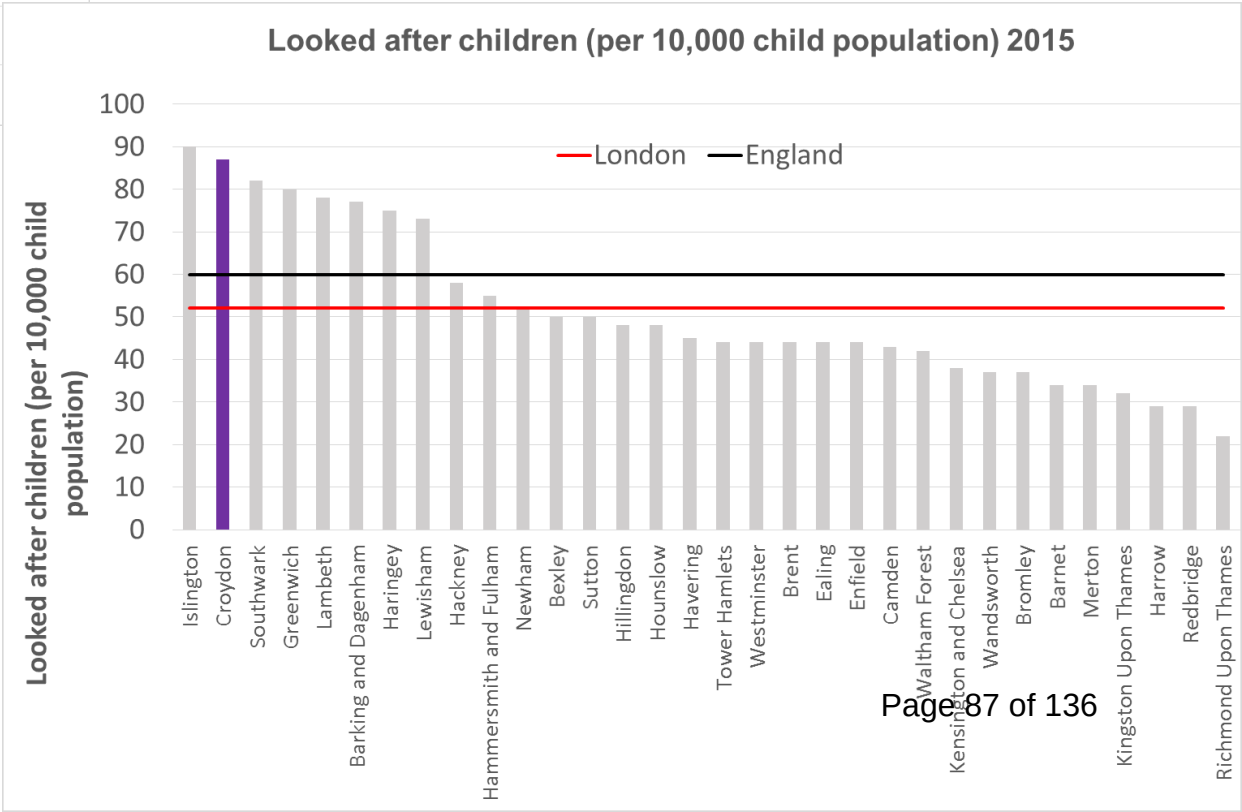
Looked after children (LAC) rate is increasing



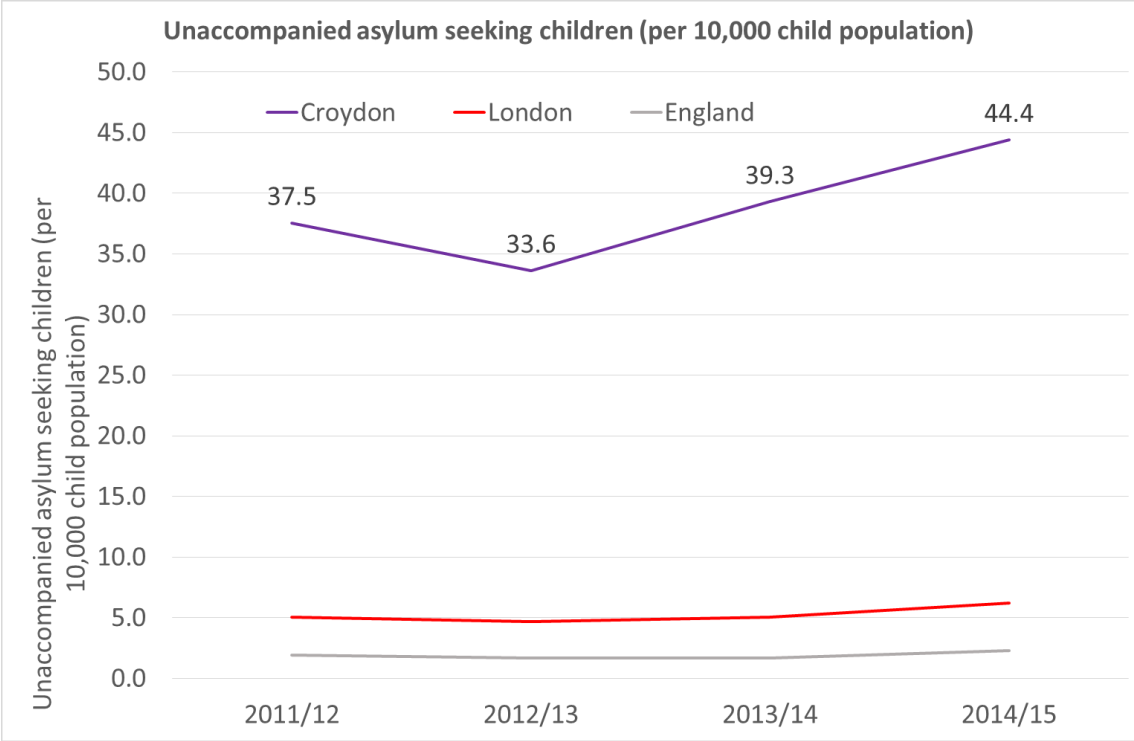
- In 2015, Croydon council is responsible for **810** looked after children.
- This is **87 per 10,000** children aged under 18

In 2015, Croydon has the **2nd highest rate in London**

In 2013, Croydon had the 6th highest LAC rate in London



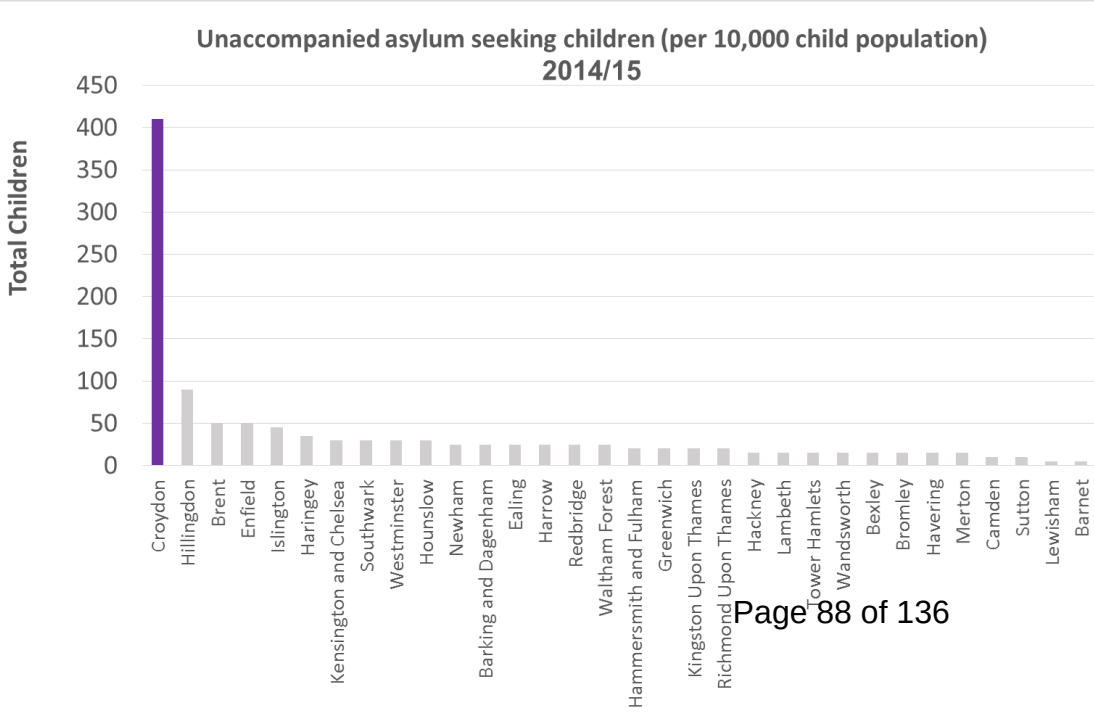
1 in 5 of all unaccompanied asylum seeking children in London are in Croydon



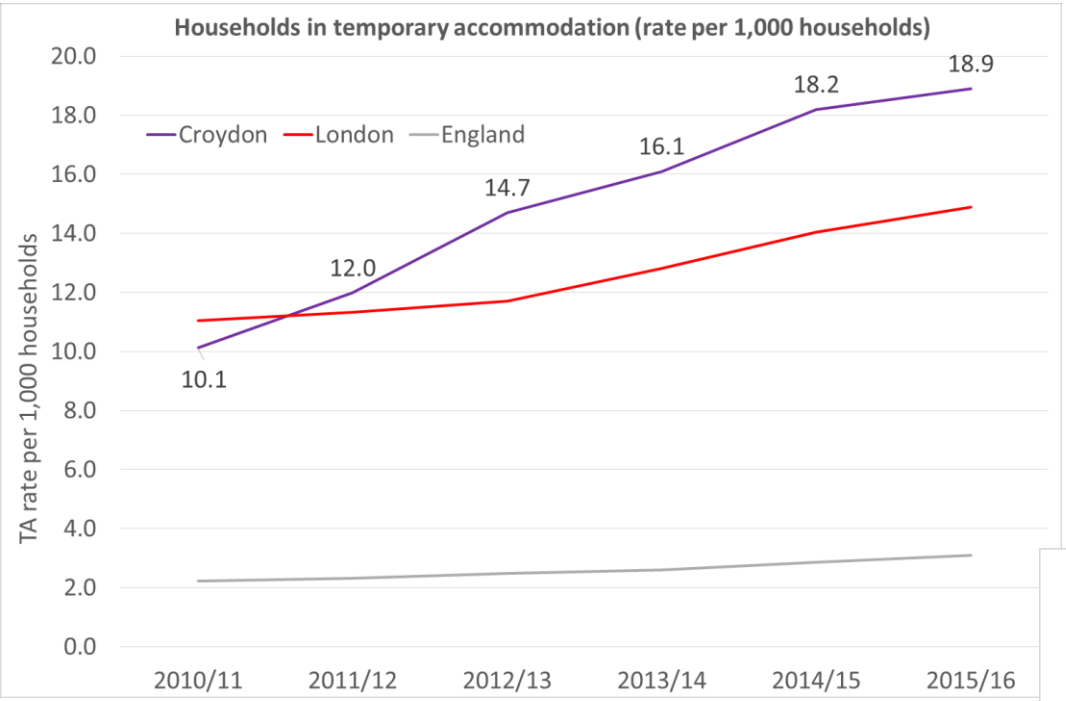
In 2014/15 there were **410** unaccompanied minors in Croydon

This is **44.4 per 10,000** of the child population

Lunar House, the headquarters of UK Visas and Immigration are in Croydon. This could explain the high numbers



Temporary Accommodation (TA) is rising higher than the London rate



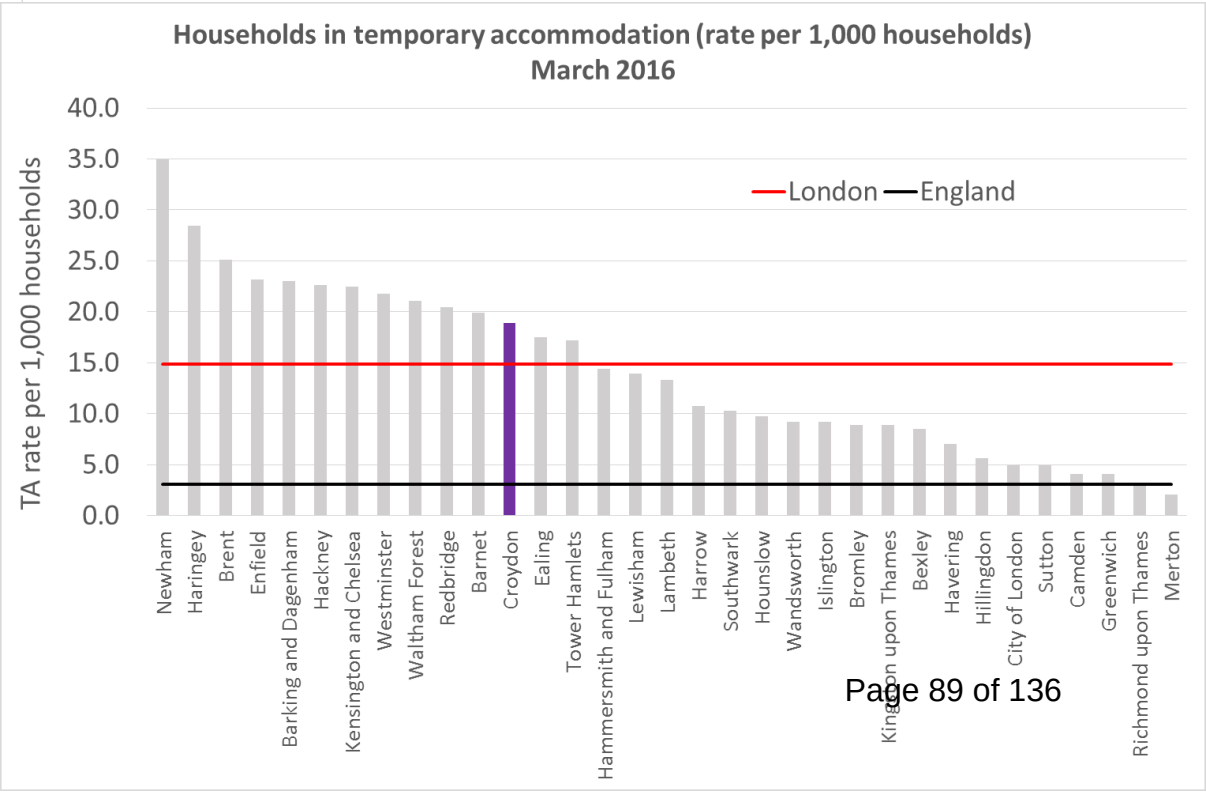
In March 2016 there were **2,918** households in TA.

This is 18.9 per 1,000 households and is the

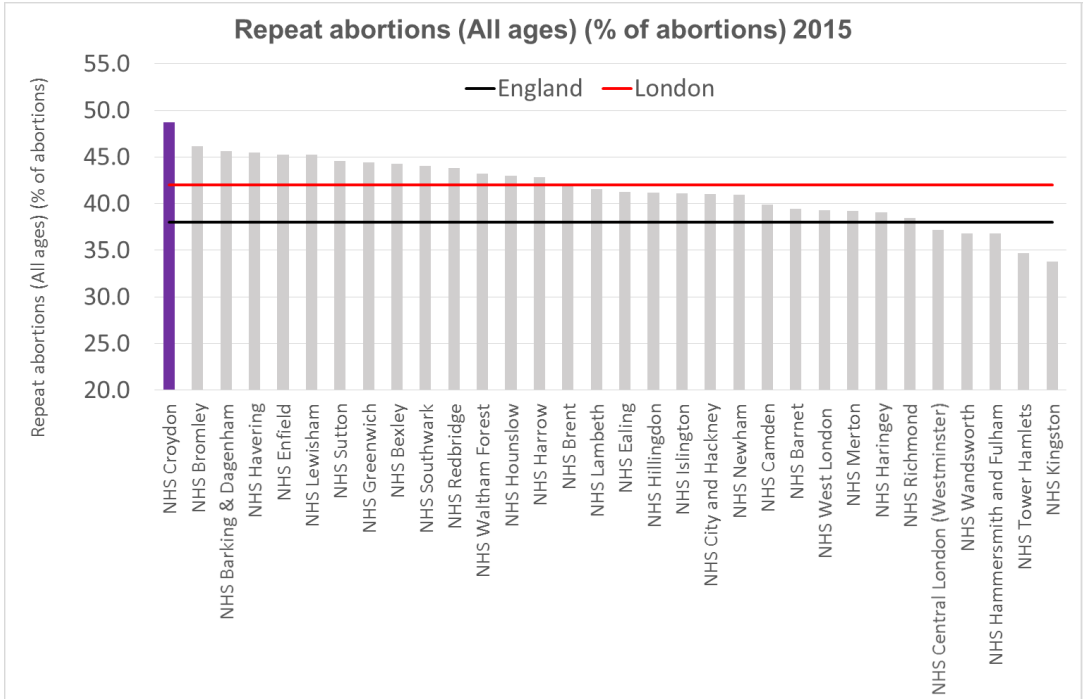
12th highest rate in London

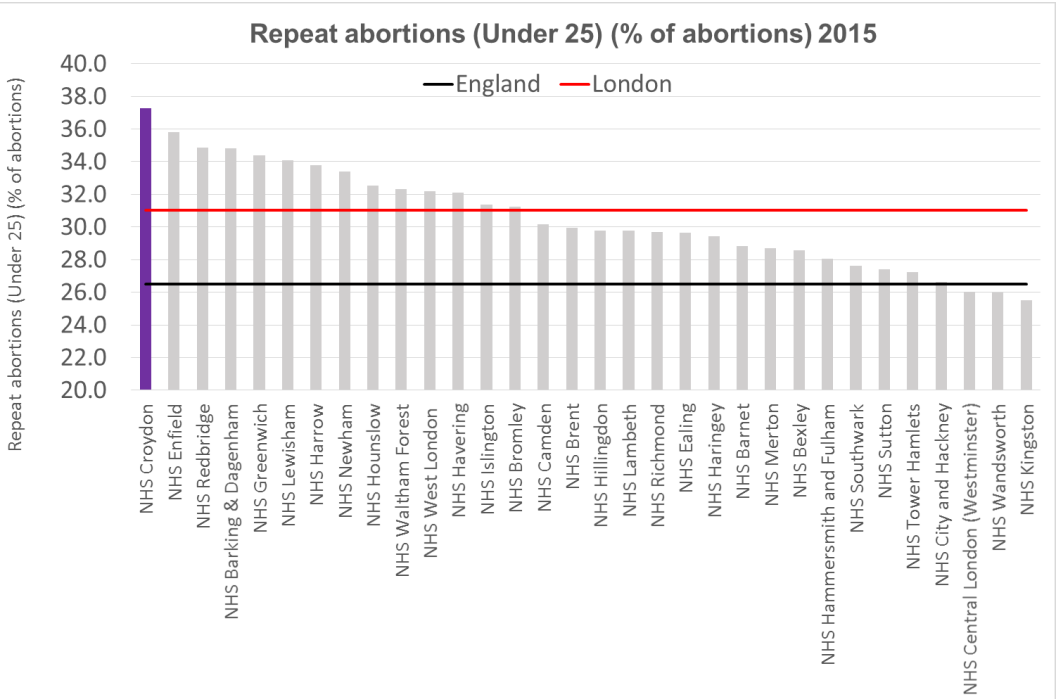
Neighbouring borough Merton only has 175 households in TA.

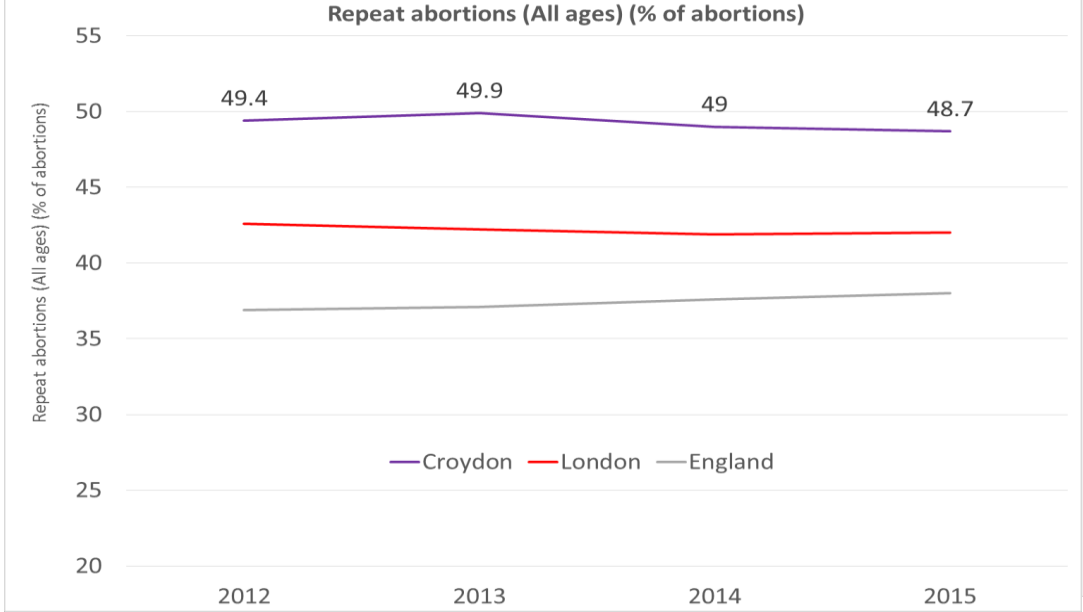
This is 2.1 per 1,000 households and is the lowest rate in London.

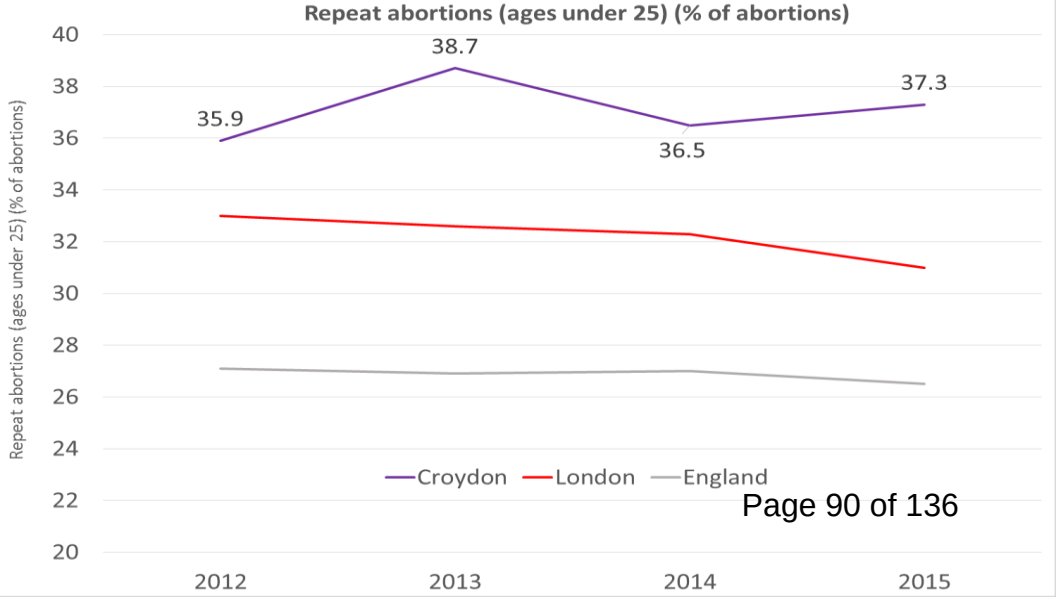


Repeat abortion rate is highest in London (for all ages and under 25s)

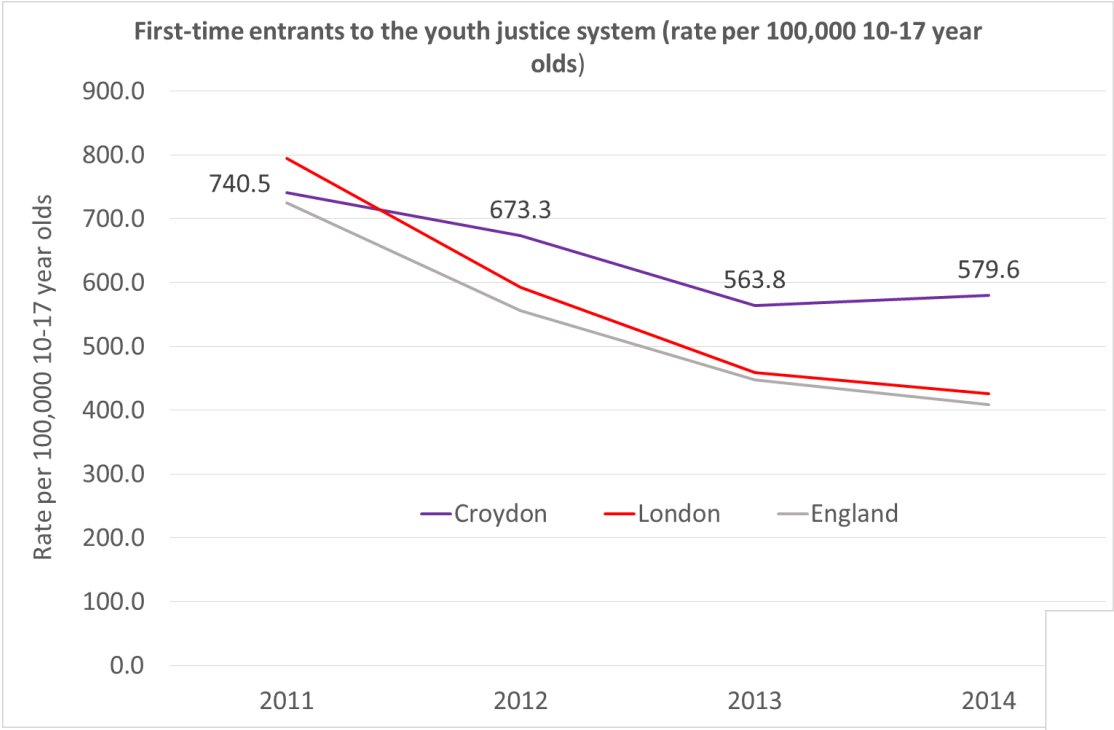








First time entrants to the youth justice system increasing compared to the London average

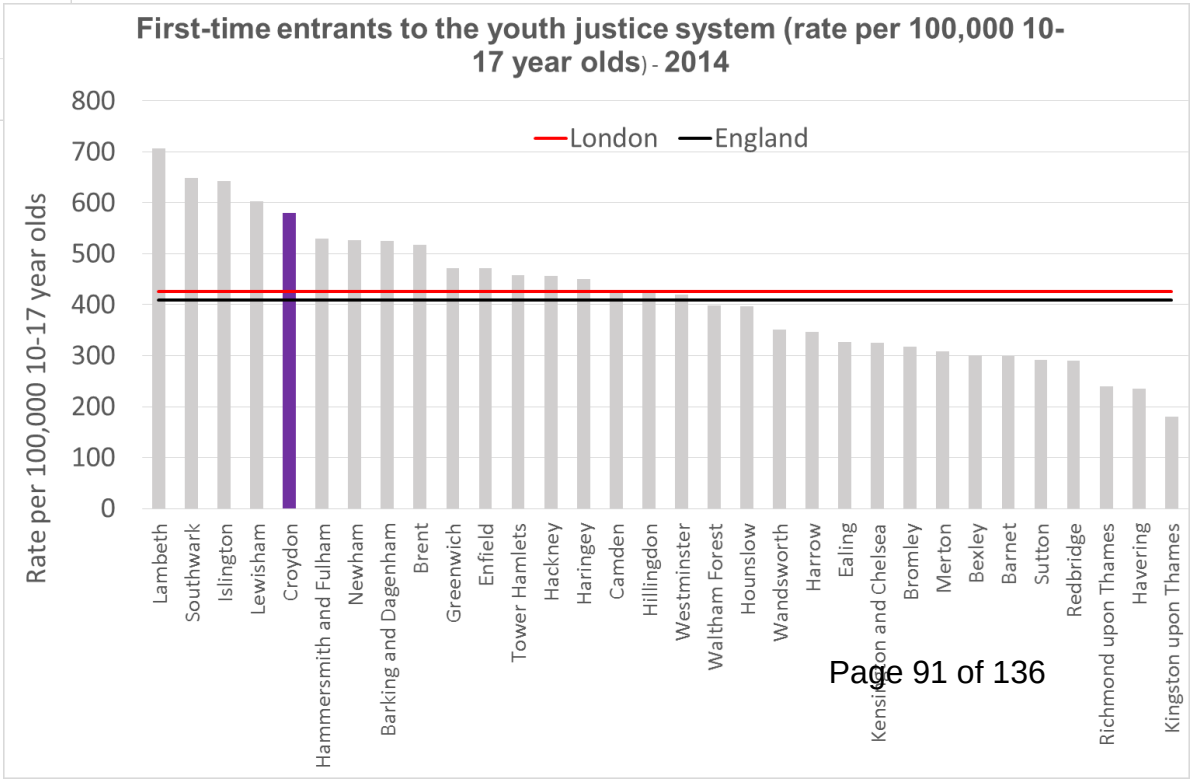


In 2011 the Croydon rate was lower than the London average

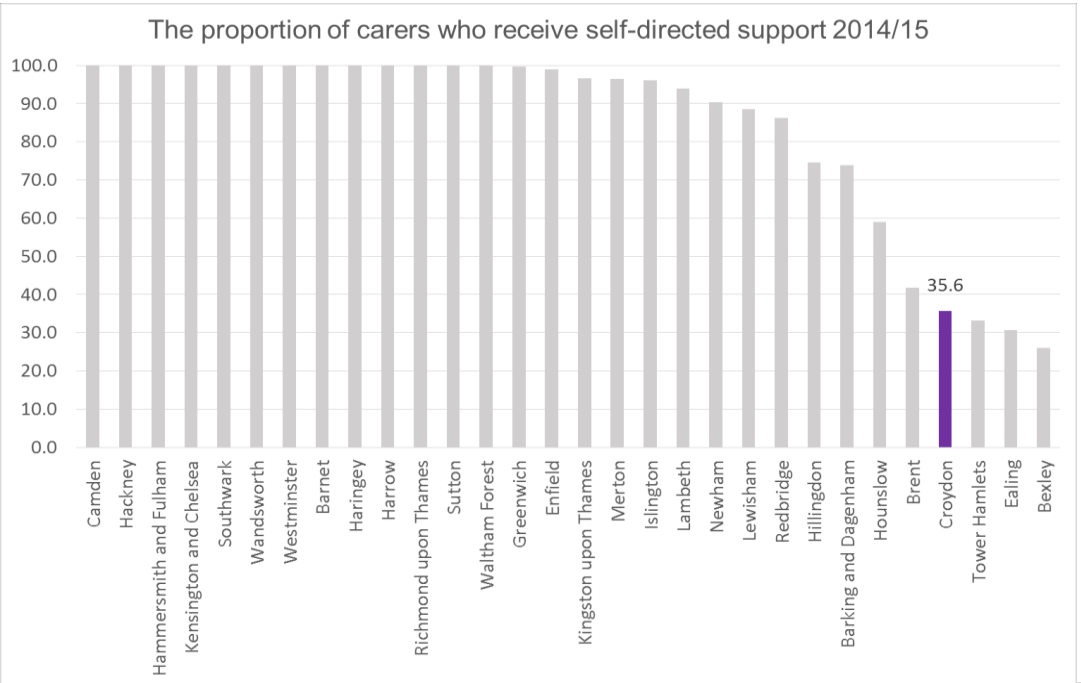
In 2014 Croydon has the

5th highest rate in London

Between 2013 and 2014 the Croydon rate increased when the London rate decreased



Poor performance for self directed support and proportion and directs payments (ASCOF measures)



Proportion of carers receiving self-directed support

4th lowest in London

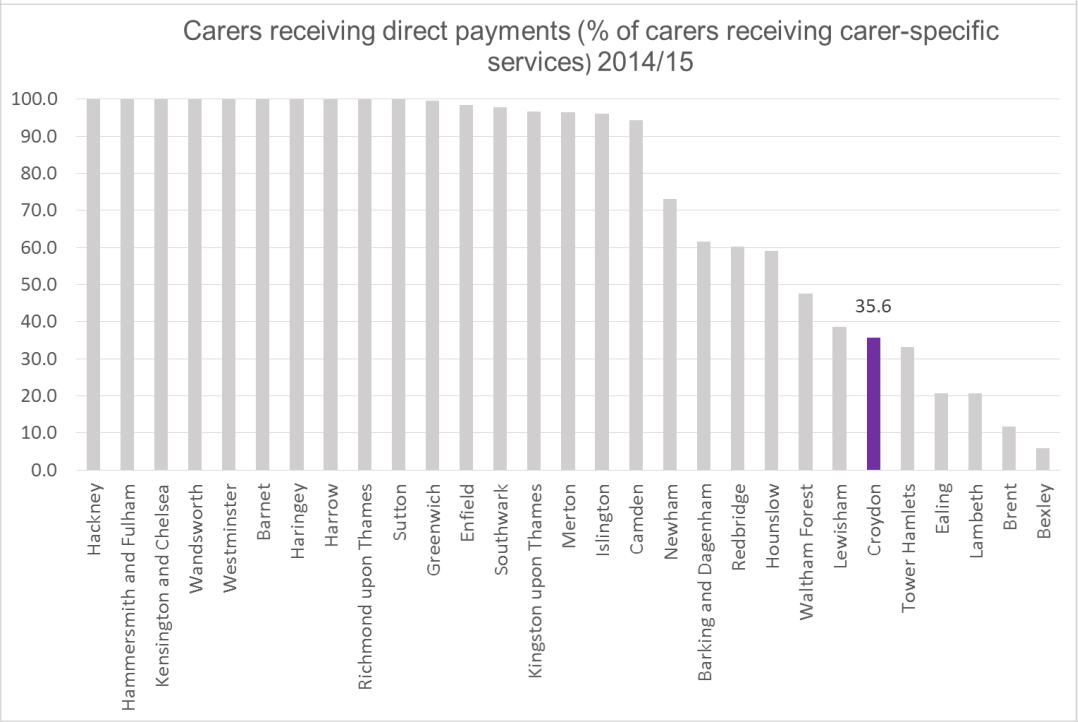
Proportion of carers receiving direct payments

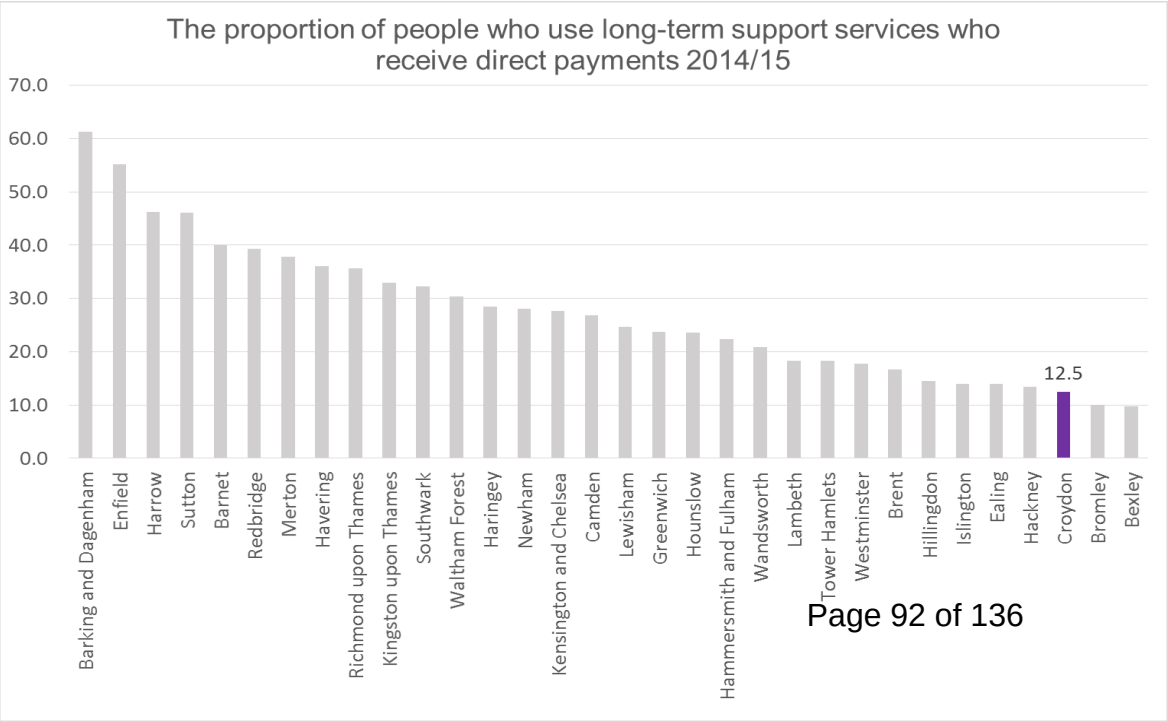
6th lowest in London

Proportion of people who use long-term support who receive direct payments

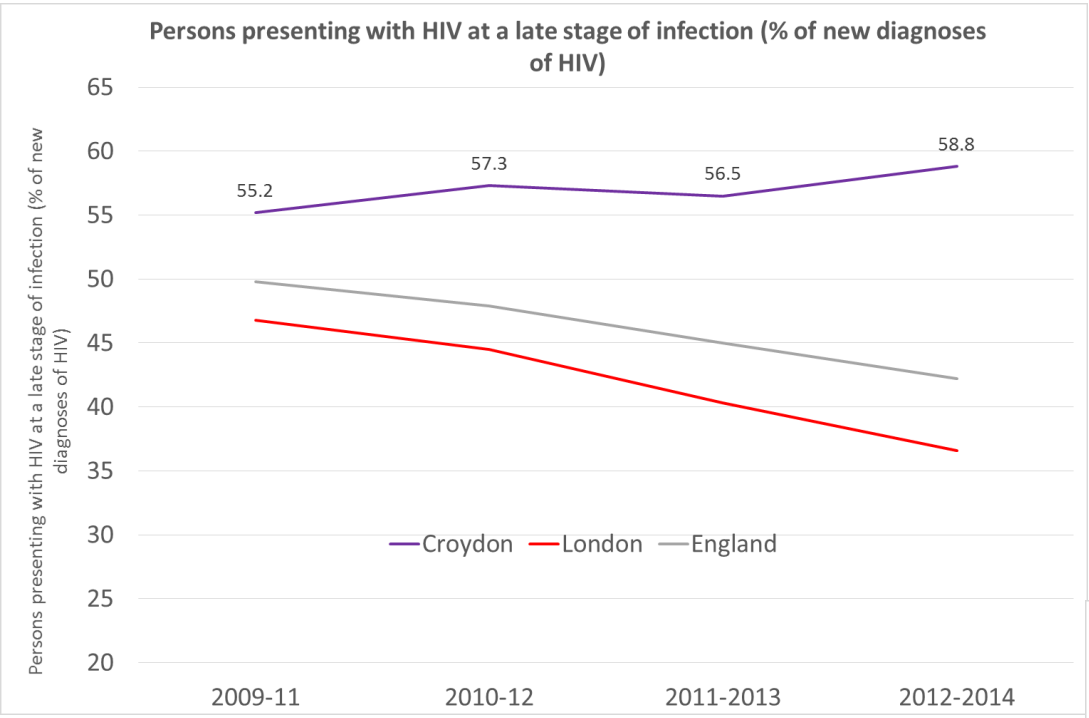
3rd lowest in London

Trend data not available for these measures

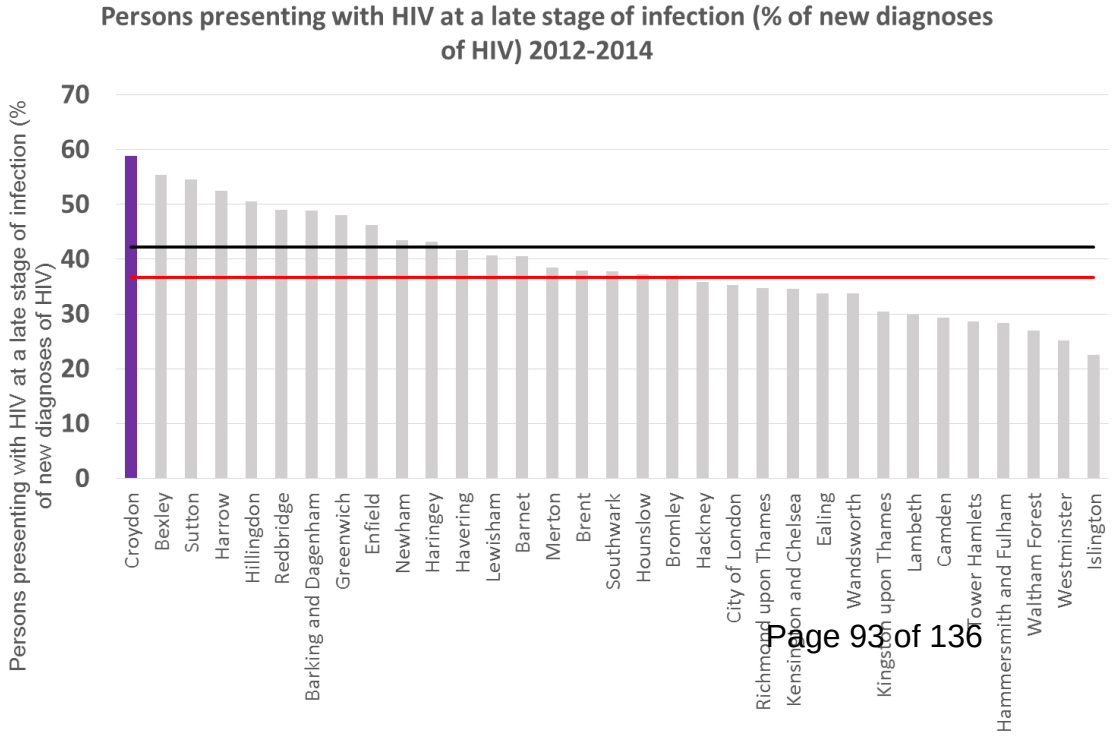




Persons presenting with HIV at a late stage of infection rate is increasing and is the highest rate in London



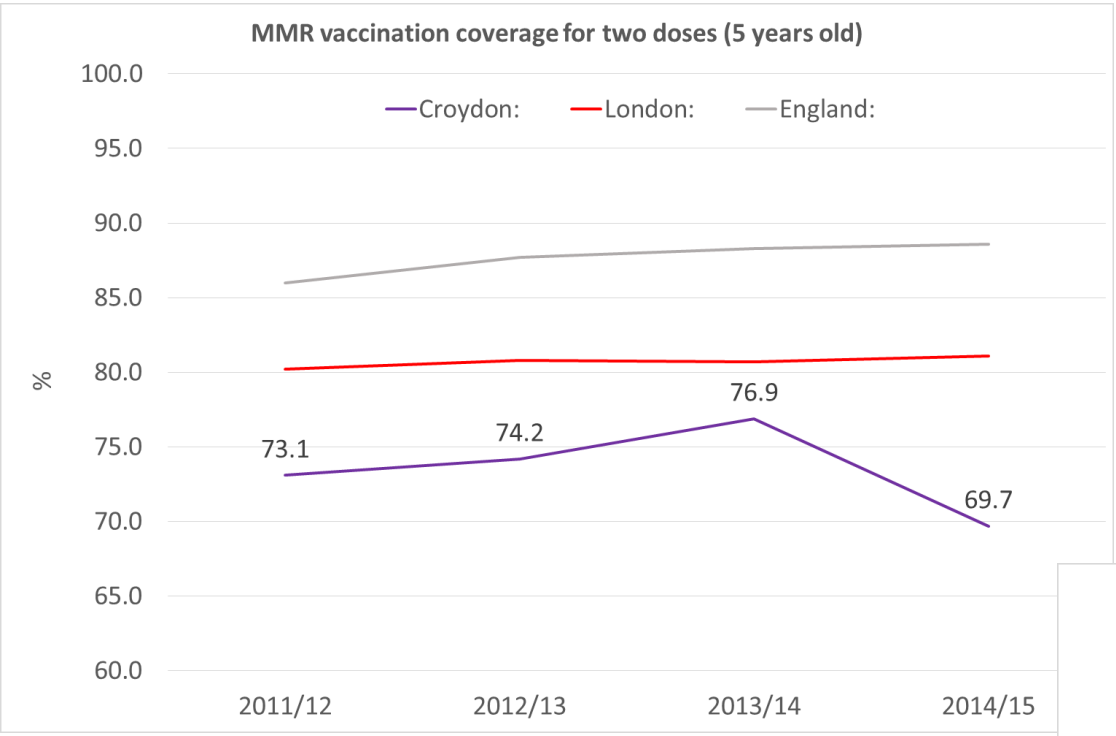
- Between 2012 and 2014 **58.8%** of all newly diagnosed HIV-infected adults in Croydon were at a late stage of infection
- This equates to **110** people



Definition

Percentage of newly diagnosed HIV-infected adults (aged 15 years or more) who have a CD4 count of less than 350 cells per mm3 within 91 days of HIV diagnosis

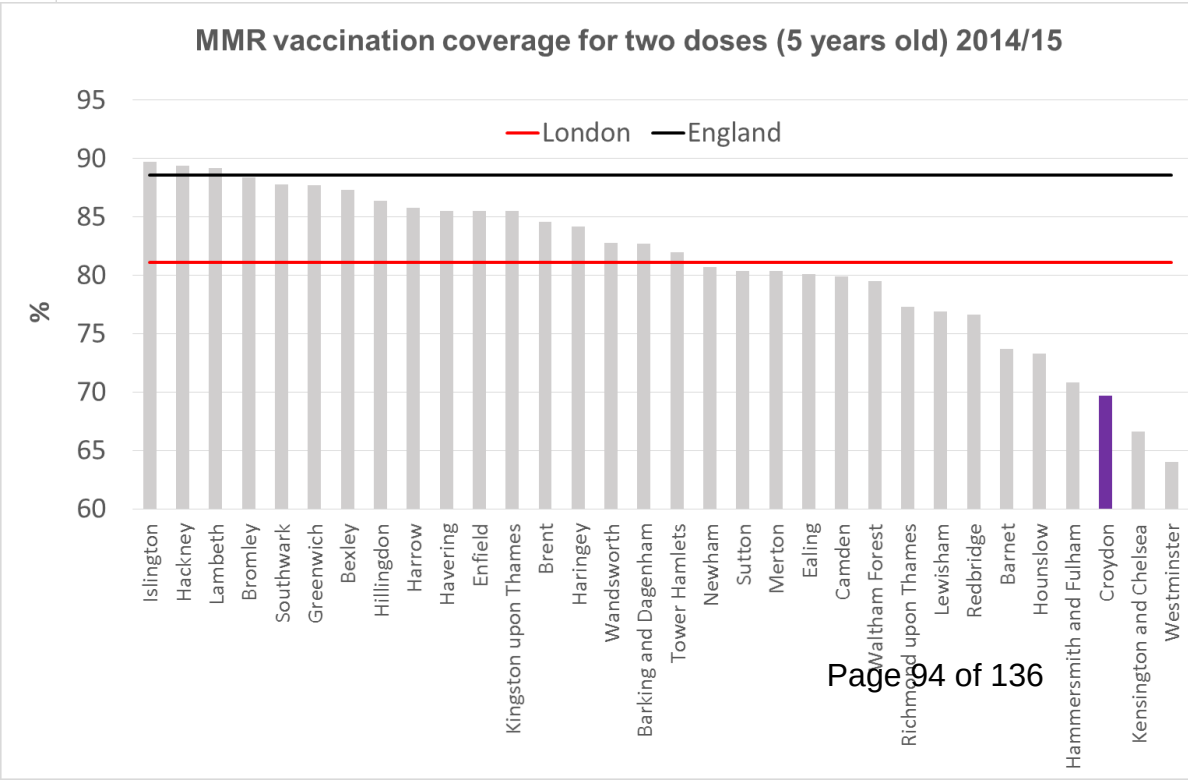
MMR vaccination coverage for two doses (5 years old) rate has decreased when the London rate has remained the same



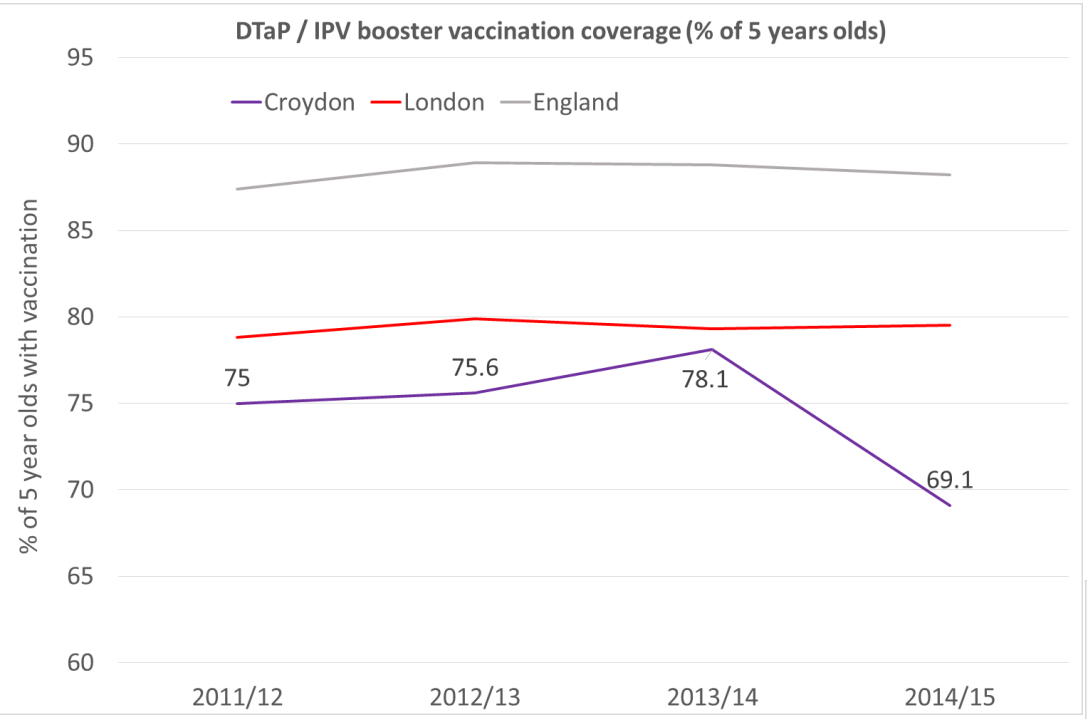
MMR vaccination rate for one dose (5 year olds) is 89.6%. This is the 9th lowest in London

MMR vaccination rate for two doses (5 year olds) is **69.7%**

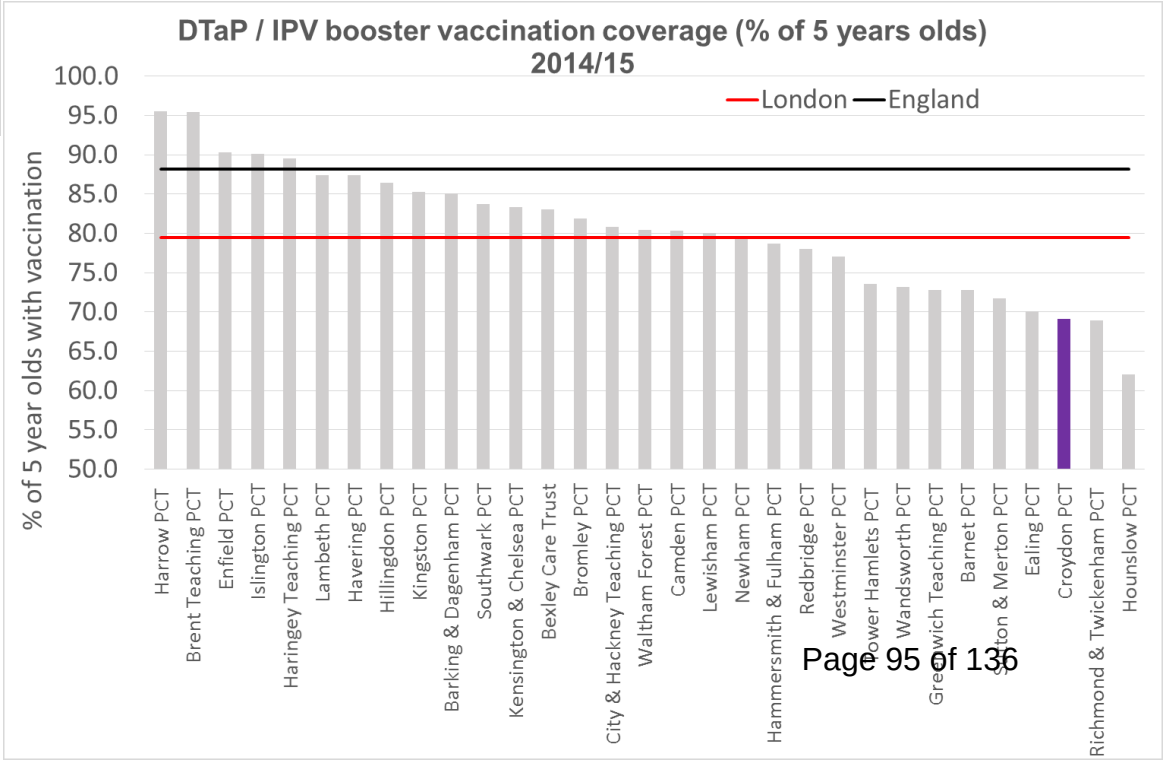
This is the **3rd lowest in London**



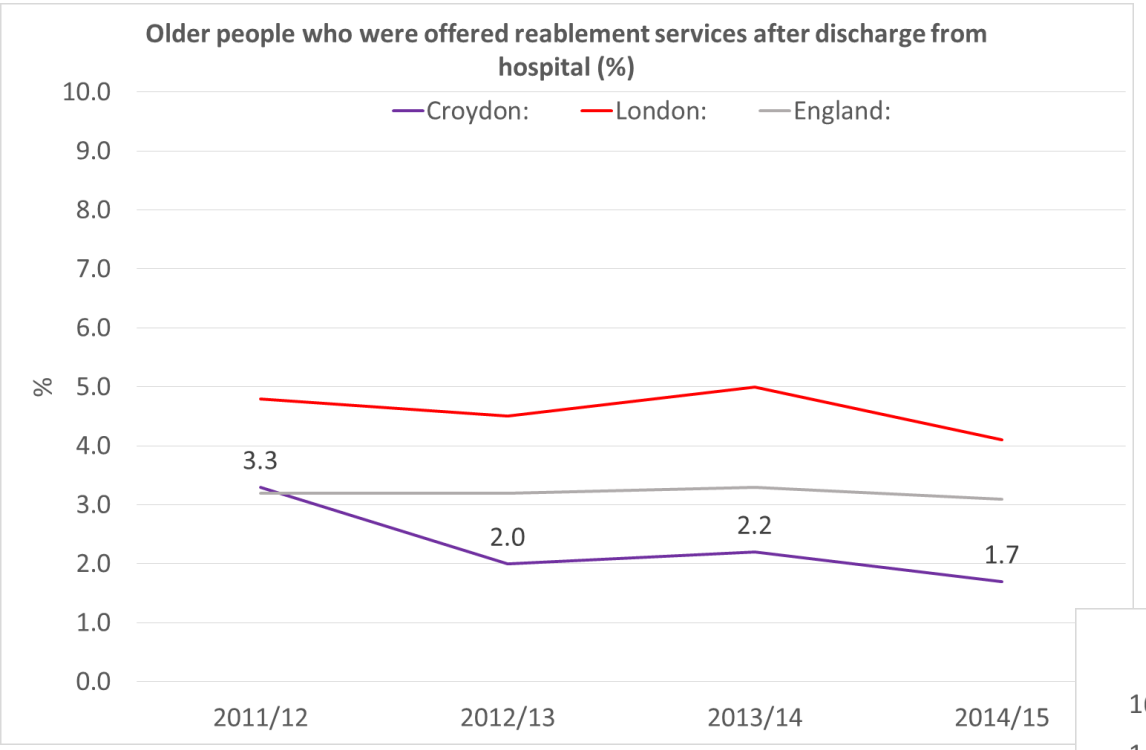
DTaP / IPV booster vaccination coverage for 5 years olds is decreasing and is now the 3rd lowest in London



Primary vaccination rate is 92.3% which is close to London average. However, booster vaccination rate drops to **69.1%**

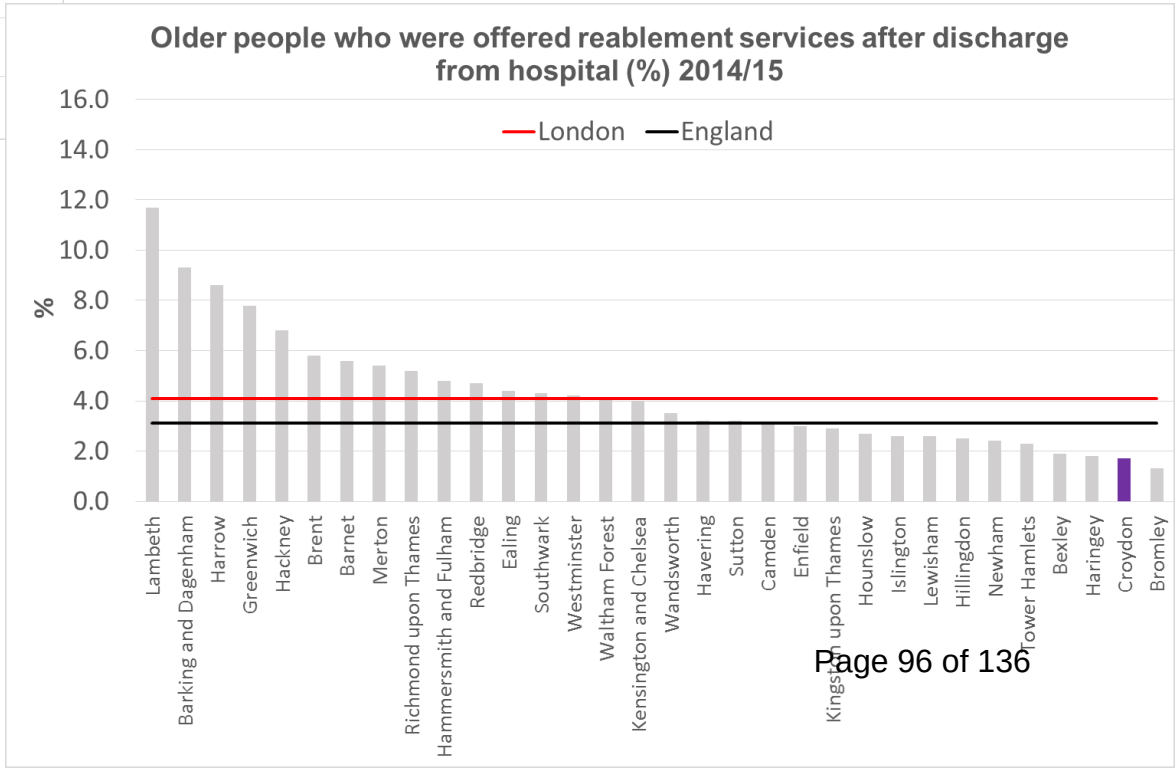


Older people who were offered reablement services after discharge from hospital proportion is the 2nd lowest in London



1.7% of older people were offered reablement services after being discharged from hospital

This is the **2nd lowest in London**



Desription

Number of older people (aged 65 and over) discharged alive from acute or community hospitals in England, who were discharged to their own home or to a residential or nursing care home or extra care housing for rehabilitation, with the clear intention that they will move on/back to their own home (including a place in extra care housing or an adult placement scheme setting). This includes all specialities and zero-length stays. When read along with the other measure of reablement (Older people still at home 91 days after discharge from hospital into reablement/rehabilitation services) this measure demonstrates the quality of reablement services available.

Going forward

The board is asked to give delegated authority to the director of Public Health, Director of People and Chief Officer of Croydon CCG to agree sign off of the full JSNA key dataset on behalf of the board.

Full dataset to be released on the Croydon Observatory mid-September

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REPORT TO:	**HEALTH AND WELLBEING BOARD (CROYDON)** **14 September 2016**
AGENDA ITEM:	**8**
SUBJECT:	**People's experience of using mental health day care services**
BOARD SPONSOR:	**Paula Swann, Chief Officer, Croydon Clinical Commissioning Group** **Barbara Peacock, Executive Director; People**

BOARD PRIORITY/POLICY CONTEXT:

The subject of the board paper intersects with a number NHS Croydon CCG & Croydon Council strategies. The provision of good quality day care services in the borough, that meet the needs of the population, will help to promote a positive experience of care and achieve positive outcomes. This will increase the resilience and independence of service users, that in turn will increase healthy life expectancy. Accessibility to the services is key, particularly for vulnerable adults, both in location and capacity. Efficient use of Voluntary and Community providers and integrated ways of working can all positively help to reduce inpatient admissions.

The strategic context includes the following:

- Joint Health & Wellbeing Strategy 2013-18

  Vision: Longer, healthier lives for everyone in Croydon.

  High level outcome measures:

  1) Increased healthy life expectancy and reduced differences in life expectancy between communities.

  2) Increased resilience and independence

  3) a positive experience of care.

- Mental Health Strategy 2014-2019

  1) Section 1: Increasing access to mental health services
  2) Section 2: Strengthening partnership working, and integrating physical and mental health care.
  3) Section 3: Starting early to promote mental wellbeing and prevent mental health problems.
  4) Section 4: Improving the quality of life of people with mental health problems.

- Community Strategy 2013-2018

  1) Goal two: Protect vulnerable people. Priority one: Good quality, accessible and joined-up services and information.
  2) Goal two: Protect vulnerable people. Priority two: Better prevention and early intervention for people who are vulnerable.
  3) Goal Three: Take responsibility. Priority two: Trust and confidence in local agencies.

- Operating Plan 2014-2016
    1) Reduce inpatient admissions by providing better care in community and primary care.

FINANCIAL IMPACT:

This report is for information only. There is no financial impact at this stage.

1. RECOMMENDATIONS

This report recommends that the health and wellbeing board:

1.1 Note the findings of the report and the next steps in reviewing the provision of mental health day services.

2. EXECUTIVE SUMMARY

2.1 This report updates on the provision of Mental Health day care services that were previously re-commissioned in 2009. The report provides an overview of the Voluntary & Community Sector (VACS) Services, specifically those that are currently jointly commissioned by NHS Croydon CCG & Croydon Council, and have an impact on social isolation.

2.2 Funding streams for these services are historic and reflected in the finance section (section 6).

2.3 There is a clear need to engage more with service users to determine people's views on service provision. Where service users surveys have been undertaken these are reflected in the report but the report has identified that improved monitoring is required of the commissioned service activity including more systematic collection of user experience. Current report templates do not systematically capture service user experience and feedback from all providers. Commissioners will therefore engage with providers to collect user feedback in a more structured way, which will be available for future reports.

2.4 The future strategic direction for mental health day services needs to be reviewed. Personalisation and personal budgets will be a key driver for the strategic direction going forward along with ensuring value for money.

2.5 A further report will be provided later in the year, following further engagement and the development of options for the strategic direction of mental health day care services.

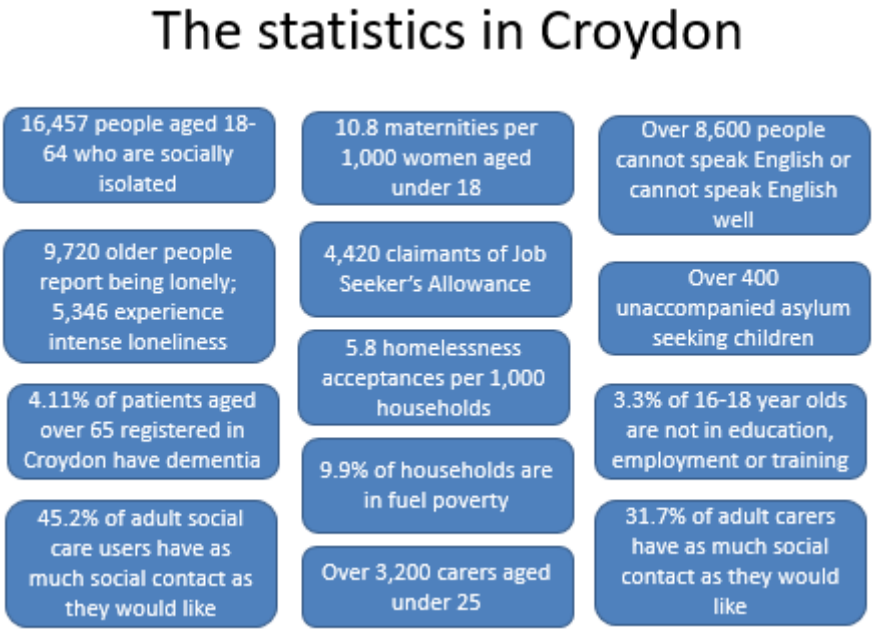
3. DETAIL

Evidence of Need

3.1 "One in four people will experience a mental illness in their lifetime. There are around 105,000 people in Croydon who suffer from depression and mood disorders and there are about 4,000 who have been diagnosed with severe mental illness. The World Health Organisation predicts that by the year 2030

there will be more people affected by depression than any other health problem. Those with a mental health problem are also more likely to have problems with their physical health, experience isolation, housing and financial problems. National data indicates that the life expectancy of someone with a severe mental illness is between 18 and 20 years less than average life expectancy."[1]

3.2 Social isolation is more prevalent in older people, but it can occur at any age. Disability and long term illness are also strongly linked with social isolation – conditions like depression can make it much more difficult to build relationships. Social isolation can be very detrimental to health, and is recognised by Public Health as having a potential impact in areas such as sexual health, educational attainment and debt.



Source: Director of Public Health presentation on social isolation at Croydon Congress, 2016

3.3 There are strong economic as well as social arguments for taking action to reduce and prevent social isolation and loneliness. A wide range of preventable health problems and wider social problems are known to arise out of loneliness:

- Increased visits to GPs and use of medication.
- Greater incidence of falls and need for long-term residential or nursing case.
- Use of accident and emergency services.
- Increased likelihood of youth offending, especially through membership of gangs and unemployment.
- Higher incidence of obesity, smoking, substance and alcohol abuse.
- More likely to develop mental health problems and depression and require hospital admissions; and
- Reduced social capital and cohesion, resulting in fragmentation of communities and reduced resilience.

[1] Croydon Health & Wellbeing Board – Joint health and wellbeing strategy 2013-2018 – page 29

Social Inclusion Service Overview

3.4 The attached document (**Appendix one**) provides an overview of the Voluntary & Community Sector services that are jointly commissioned by NHS Croydon CCG & Croydon Council, including a brief description of those services. The providers receive financial contributions from either one or both of the commissioning organisations. The document only represents the jointly commissioned services and is not representative of all Voluntary and Community Sector services available in the borough but does cover the key services. The Joint Mental Health Commissioning lead holds responsibility for performance management of the listed services against the contracted investments on behalf of the Council and the CCG. The Appendix shows a range of interlinked services provided in the borough that have an impact on reducing social isolation.

3.5 There are more comprehensive lists of services available in the borough. One such resource has been compiled by 'Hear Us - Croydon's Mental Health Service User Group'. In 2015, 'Hear Us' were funded by the Maudsley Charity to develop a guide to Croydon Mental Health and Wellbeing Services. This guide provides a robust overview of the services available in Croydon.[2]

3.6 In 2007 Croydon's mental health service commissioners undertook a review of Day Services and in 2009 commissioned a new set of Day Services that aimed to: improve the range of services available; ensure that there would be adequate services in place that are socially inclusive, assist users with their recovery; ensure that services were as accessible as possible for as many users as possible; and ensure that there is a range of interlinked services available that users can access.[3]

3.7 The 2007 Day Care proposals informed much of the strategy in relation to the jointly commissioned social inclusion services. In 2009, services were commissioned, re-launched or redesigned. Of those commissioned social inclusion services, the below listed remain commissioned to date. For a description of the service types, please see (**Appendix one**)

Service	**Service Type 1**	**Service Type 2**
Association for Pastoral Care (APCMH)	Social Inclusion – Drop-In	Slow Stream
Imagine – Drop-In	Social Inclusion – Drop-In	Slow Stream
Mind Welfare Benefits Advice	Social Inclusion – Income Generation	Slow Stream
Mind Employment	Social Inclusion – Employment Support	Fast Stream
Status Employment	Social Inclusion – Employment Support	Fast Stream
Mind Social Networks	Social Inclusion – Social Support	Fast Stream
Imagine Volunteering	Social Inclusion – Social Support	Fast Stream
Imagine Befriending	Social Inclusion – Social Support	Fast Stream

[2] http://www.hear-us.org/guide-2015

[3] Somewhere to go, Something to do – Feb 2014 – MIND in Croydon report – page 4

3.8 Providers operate to one of two types of service specification, “Fast Stream” and “Slow Stream”. The services were organised in this way with the goal of having clearly defined services, for referral at the ‘right place, right time’.

- Fast stream services were commissioned to provide structured person centred support to clients, based on goals identified by the service user, and delivered within a time limited context, generally within 2 years. It was decided that fast stream services should be made available to those with the greatest need. Need was defined by those clients engaged by secondary mental health services, whose care was managed through the Care Programme Approach (CPA).

- Slow stream services were commissioned to support service users to maintain or improve their recovery from mental illness, in a way that is not necessarily structured, goal oriented, or time limited. Services that fell into this sector were, for the most part, the drop-in services provided by the Association for Pastoral Care in Mental Health (APCMH) and Imagine. An exception to this is the Mind Welfare Benefits Advice service, which is open access and provides support to service users with complex welfare benefits claims.

3.9 Drop-in services are described as slow stream because it was recognised that some service users would benefit/need a slower pace of recovery, with gentle introductions to services, activities and opportunities beyond mental health services, to promote social inclusion. Drop-In services are open to anyone with a (self-identified) mental illness or need. These services are beneficial toward assisting clients to avoid the need for secondary mental health care. The drop-in services are universal social inclusion services, due to the open accessibility and range of services provided.

Review of Drop-in - Day care Providers

3.10 APCMH is funded to provide three adult mental health drop-ins per week, 52 weeks of the year, on fixed days and hours. The sites are in South Croydon, Addiscombe and Norbury. Staff support is provided to clients by the agency’s co-ordinator, and a number of volunteers. Whilst some service users are referred, the main method of referral is self-referral. The support provided by APCMH has a social focus. The drop-ins are a hub where clients can socialise, enjoy peer support, and the support of volunteers who staff the drop-ins. Whilst the drop-ins are mostly building focussed, there are also day-trips organised and activities. Case studies shared by the service have shown that service users can receive a high level of individual support.

3.11 One such study from 2015 reflected on the positive experiences of service users accessing activities via the drop-in service. The study describes the range of activities available; such as the women’s group and creative writing group. By having a safe-place to go, with activities that support development, and people to talk to, these service users have become more confident and independent. The study reflected that a major factor to these positive experiences was the fact the services aren’t time restricted. Service users are free to access the service and to engage at their own pace.

3.12 Imagine user led drop-in groups began in Croydon in October 2009. Imagine is funded to provide four adult mental health drop-in services, offering frequent sessions per week, Monday-Friday. The sites are in New Addington, West Croydon, Purley and Thornton Heath. The delivery method for these services is outreach focussed. Each drop-in is open access; anybody with a (self-identified) mental health problem is eligible for the service. The service arranges talks by representatives of external agencies to be delivered to clients attending drop-ins, with a view to helping service users broaden their horizons beyond Mental Health services and clients are assisted to engage with mainstream activities.

3.13 'Hear Us' completed a review of the Imagine drop-in services in 2014. The report reflected that one of the key strengths of the services was the ability to develop relationships and trust, owing to the regular contact these services can offer people. Feedback collected from users in this report showed that the drop-in services were a good 'safe place to go', good for 'activities' and good for 'social contact'. The report reflected on the strength of the day-care services in giving service users the opportunity to tackle their problems, but that there might also be a risk of creating dependency on the services, if users are not encouraged to take on new challenges and productive goals. Individual user feedback showed a preference for this drop-in service due to the range of activities available within relaxed settings.

3.14 There are a large number of user led community activities available; such as day-trips, social groups, music group, pool group and other social sessions. Service users are empowered to not only engage and socialise, but given the option to do so in varied and interesting ways. With service users empowered to lead the groups, this reduces the need for staffing and further promotes engagement. 2015/16 data showed that the average number of individual users per month, to attend user led-groups, were between 16 and 33, across the 4 sites.

Additional Day Care Providers

3.15 In addition to the jointly commissioned services, there are similar but also unique services in their own right, that positively impact social isolation. Two such services of note are:

Service	Description
Mind – Active Minds	Activities to stimulate new interest, promote a healthy lifestyle and improve confidence. Various courses, some of which do not require booking where service users can drop-in. [4]
Mind - Hub	The Hub at Fairfield is an extension to the aforementioned Social Networking Service, which offers support to people to understand and manage their mental and physical health issues. The Hub also provides a safe place for people who are lonely and isolated to meet and socialise with people and a place for them to receive practical help and advice.[5]

3.16 The Hub, run by MIND in Croydon, provides a friendly and supportive meeting place, with shared activities and help with problems. This can have a positive

[4] http://www.mindincroydon.org.uk/active-minds.asp
[5] http://www.mindincroydon.org.uk/the-hub.asp

impact on mental health, reduce social isolation, as well as the use of costly statutory services. The Hub was developed following the 'Somewhere to go, Something to do' report, Feb 2014, which collected the views from service users of what services they felt they needed to stay well. The Hub assists with:

- Form-filling
- Benefit issues
- Managing bills and debt
- Outreach support
- Community Issues (issues with neighbours e.t.c.)

The CCG funded a 1 year pilot of the HUB in 2014/15, from within the existing contract resource. MIND produced a pilot report in Nov 2015. 256 referrals were received during the pilot period. Most referrals (60%, 154 people) came from Secondary Mental Health Services. A fifth (20%, 49 people) were referred from GPs. 'Reducing isolation' was the most common reason for referral, with 85 of the 340 reasons being attributed to this. 'Socialising and meals' were a close second at 71. According to the 14/15 report, those users that engaged with the Hub make less of use of the statutory services. Of the 118 people reviewed, 80(67.8%) people visited their GP less. 68 (57.7%) used secondary services less.

MIND adopted the use of the Mental Health Recovery Star monitoring tool, which is a version of the "Outcomes Star", which both measures and supports progress for service users towards independence. The tool monitors a users knowledge or confidence in relation to 9 different categories, such as 'living skills' and 'Managing Mental health'. The hope is that the later assessments will reflect more positive results, to reflect the positive impact of the services. The tool was used with service users when joining the Hub and at 3, 6 and 12 month follow up. During the period of the review, 80 people completed their 4 reviews. MIND reported that there were 4 areas in particular where progress was made, which were 'Trust and hope in the future', 'Increase in Social Networks', 'Relationships' and 'Managing Mental Health'.

Strategic Direction & Commissioning Approach

3.17 The strategic direction of the jointly commissioned services needs to be reviewed for a number of reasons:

- Personal health budgets and the Community Fund process will impact on these services and need to be considered in respect of the current joint commissioning model, toward building a coordinated commissioning approach.
- Previous service reviews have raised an issue of accessibility of the 'fast stream' services, which are reserved for those with the greatest level of need recovering from mental illness. Those facing an escalating mental illness cannot access these services until they reach the point they are accepted by secondary care, due to requiring a CPA. This can result in access to the services being made available at potentially too late a stage in the pathway.
- The relationship between SLaM, Primary care and the Social inclusion services needs to be reviewed, to promote coordinated working and knowledge of services between providers. Previously there have been some

concerns regarding a lack of trust expressed from both sides: either the secondary service lacking trust in the expertise of social inclusion services, or the social inclusion services lacking faith in the secondary service working collaboratively with them.

- In previous years, the drop-in services have met the expectation of commissioners in terms of expected client numbers. Commissioners are currently reviewing 15/16 data for all jointly commissioned services for a clearer view on performance. However, it is noted that performance monitoring needs to be further developed to better assess the benefits and outcomes of these services to inform commissioning decisions and development.
- Improved engagement from commissioners with the providers will aid in this respect. Voluntary sector providers are uniquely placed and the experts with linking with the community and hard to reach groups.
- Current commissioned services are for working age adults, but there is an overlap with younger adult and older adult provision, which should be considered with future commissioning intentions.

3.18 In 2016, commissioners have committed to improve engagement with voluntary and community sector providers. Commissioners have scheduled a workshop in September 2016 to continue discussions with providers in relation to current provision and the future strategic direction. Further steering group engagement with providers focussing on the voluntary sector will be beneficial, along with consideration of the useful reviews and reports provided by the voluntary sector providers in recent years, which will help assess the effectiveness and gaps in the current service provision. Improved coordination between CCG and Croydon Council commissioners in relation to the strategic direction for community services is important, along with clarity on statutory funding responsibilities going forward, as well as the direction of the Community Fund services and Personal Budgets. There would also be benefit in coordinating work with the Outcomes Based Commissioning/Older Adults Mental Health services work stream, as social isolation is most prevalent for older people. Furthermore, it is important for the commissioners to be able to evidence the consideration of service users views in the commissioning of services, weighted by the evidence of service models that work most effectively and efficiently for achieving key outcomes.

Conclusion

3.19 This report provides an overview of the Voluntary & Community Sector services, jointly commissioned by NHS Croydon CCG & Croydon Council, with a focus on drop-in day care services that have an impact on social isolation and provides summaries of user experience surveys where these have been undertaken.

3.20 The strategic direction for the jointly commissioning social inclusion services has remained largely unchanged and has not been reviewed since the commissioning of the services in 2009. The range, frequency and varied locations of drop-in services provided show there are currently a number of options available in the borough. However, consideration needs to be given to future needs and the strategic direction for these services following more systematic user engagement.

3.21 Services should appear on a graded care pathway, to ensure service users access services at the right place and time, and to ensure the efficient use of scarce resource. There should be constructive cooperation between the various providers to ensure clients receive the right level of intervention in a timely fashion.

3.22 Improved reporting is needed with active management by commissioners toward achieving strategy goals. A reporting method to consider across all services is the recovery/monitoring star, utilised by MIND in Croydon for The Hub service. This tool is effective in monitoring service user experience, which can be invaluable toward developing more person centred care.

4. CONSULTATION

4.1 Public Health Croydon provided information in relation to Social Isolation, which is incorporated into this report.

4.2 The provider Mind has supplied monitoring information and reports in relation to The Hub. Information from these documents have been utilised in this report.

4.3 A voluntary sector workshop has been scheduled for September for further provider engagement and input regarding the strategic direction and to explore how service user feedback can be captured more systematically.

4.4 Further engagement with service users is needed in developing the strategic direction for day services going forward.

5. SERVICE INTEGRATION

5.1 Improved coordination between CCG and Croydon Council commissioners in relation to the strategic direction for community services is important, along with clarity on statutory funding responsibilities, as well as the interlinked work streams around the Community Fund and Personal Budgets. There would also be benefit in coordinating this work with the work around Outcomes Based Commissioning and services for Older Adults with Mental Health, as social isolation is most prevalent for older people.

6. FINANCIAL AND RISK ASSESSMENT CONSIDERATIONS

6.1 Current spend for NHS Croydon CCG & Croydon Council, for the jointly commissioned social inclusion services is as follows.

Service	**Service Type 1**	**Current Funding (annual value)**		
		CCG	Council	Total
Association for Pastoral Care (APCMH)	Social Inclusion – Drop-In	£0.00	£26,315.48	£26,315.48
Imagine – Drop-In	Social Inclusion – Drop-In	£35,000.00	£126,000.00	£161,000.00
Mind Welfare Benefits Advice	Social Inclusion – Income Generation	£71,453.00	£52,373.78	£123,826.78
Mind	Social Inclusion –	£35,539.05	£79,834.58	£115,373.63

Employment	Employment Support			
Status Employment	Social Inclusion – Employment Support	£61,979.33	£0.00	£61,979.33
Mind Social Networks	Social Inclusion – Social Support	£253,947.20	£88,961.12	£342,908.32
Imagine Volunteering	Social Inclusion – Social Support	£0.00	£60,000.00	£60,000.00
Imagine Befriending	Social Inclusion – Social Support	£0.00	£60,000.00	£60,000.00
			Grand Total	**£951,404**

7. LEGAL CONSIDERATIONS

7.1 None

8. EQUALITIES IMPACT

8.1 Any changes to services will need to be considered in relation to the impact on equalities. CCG Commissioners have met with the Equality & Diversity lead to begin this process. Future engagement needs to ensure that the needs of BME communities are adequately met.

CONTACT OFFICER: Tom Cox, Mental Health Commissioners, NHS Croydon CCG. E-mail: Tom.cox@croydonccg.nhs.uk , Tel: 020 3668 1988

BACKGROUND DOCUMENTS

See Appendix One

Appendix 1—NHS Croydon CCG & Croydon Council—Jointly Commissioned Voluntary & Community Sector (VACS) Services—

Drop-In

Three Drop In Services. Open access user run mental health service that provides a safe place to service users and broadens the outlook of service users to promote social inclusion.	Croydon APCMH
Open access user run mental health service that provides a safe place to service users and broadens the outlook of service users to promote social inclusion.	Imagine Drop In (Kingfisher)
	Imagine Drop In (Purley User Group)
	Imagine Drop In (Thornton Heath)
Open access user run mental health service that facilitates peer social inclusion and broadens the outlook of service users to promote social inclusion.	Imagine Drop In (New User)

Advocacy

Professional general advocacy service for mental health service users aged 18 to 65 years.	Mind Advocacy
Professional advocacy service concerned to meet the statutory requirement for advocacy under the Mental Health Act 1983 (amended 2007) for adult mental health service users of all ages.	Mind IMHA
Statutory advocacy service for clients lacking capacity and friends or relatives who can represent their best interests, required by the Mental Capacity Act 2005.	Voice Ability —IMCA

Primary Care Talking Therapies

Adult mental health counselling, or talking therapies service, primarily for people with common mental health problems (depression or anxiety).	Mind Counselling
Counselling service for people who have suffered bereavement, or loss.	Woodside Bereavement Service
	CRUSE in Croydon
Mental health counselling, or talking therapies service, for children and young adults (14-25 years of age), coping with common mental health problems (depression or anxiety).	Off the Record Youth Counselling
18. Adult mental health counselling, or talking therapies service primarily for people with common mental health problems (depression or anxiety).	CPF Counselling Croydon

Employment Support

CPA

Service for mental health service users subject to CPA at the time of referral. Prepares services for employment, and brokers employment with employers.	Mind Employment Support Service
	Status Employment

Information

Service provides telephone and in-person advice about mental health services, maintains an online service directory, and periodically prints a hard copy version of the online directory.	Mind Information

Social Support

CPA

Service for mental health service users subject to CPA at the time of referral. Brokers opportunities for service users outside of services within a structured programme (excluding employment services).	Mind Social Networks
Service for mental health service users subject to CPA at the time of referral. Brokers "friendship" relationships between mental health service users and volunteers to promote social inclusion.	Imagine (Befriending)
	Imagine (volunteering)

Income Generation

Welfare benefits and advice service for mental health service users with appeals and complex benefits cases.	Mind Welfare benefits
	Hear Us

Carers Support

Information and advice service for carers of adult mental health service users.	Rethink Carers Support Service

Involvement

Service that brings together stakeholder opinion to assist in the planning, design and monitoring of adult mental health services in Croydon.	CVA MH Forum
Service that brings together mental health service user opinion to assist in the planning, design and monitoring of adult mental health services in Croydon.	Hear Us Open Forum
Service that brings together stakeholder opinion to assist in the planning, design and monitoring of adult mental health services in Croydon to ensure equality of experience and outcome for people from BME communities.	Off the Record BME CDW
	Croydon BME Forum

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REPORT TO:	**HEALTH AND WELLBEING BOARD (CROYDON)** **14 September 2016**
AGENDA ITEM:	**9**
SUBJECT:	**Tobacco Control and stop smoking services**
BOARD SPONSOR:	**Rachel Flowers, director of public health, Croydon Council**

BOARD PRIORITY/POLICY CONTEXT:

Reducing the prevalence of smoking makes a significant contribution to the delivery of two of the six priorities of Croydon's joint health and wellbeing strategy:

- Preventing illness and injury and helping people recover.
- Preventing premature death and long term health conditions.

It also contributes to:

- Supporting people to be resilient and independent.
- Giving our children a good start in life

It supports the Council to meet the ambitions for Croydon of **growth, liveability** and **independence** through helping our residents to be as independent as possible.

And helps to deliver the NHS Five Year Forward View which calls for a "radical upgrade in prevention and public health"

Relevant national and international policy:

- Government's 'Healthy Lives, Healthy People: a tobacco control plan for England', 2011[1]
- Local Government Declaration on Tobacco Control[2]
- European Union Tobacco Products Directive[3]
- WHO Framework Convention on Tobacco Control[4]

RECOMMENDATIONS

1.1 This report recommends that the health and wellbeing board

- notes the transition of stop smoking services into the Live Well Programme
- supports the proposed wider tobacco control approach.

2. EXECUTIVE SUMMARY

1.1 This paper comprises a summary of the work being delivered to reduce the smoking prevalence in Croydon.

[1] https://www.gov.uk/government/publications/the-tobacco-control-plan-for-england
[2] http://www.smokefreeaction.org.uk/declaration/#Signatories
[3] http://ec.europa.eu/health/tobacco/docs/dir_201440_en.pdf
[4] http://apps.who.int/iris/bitstream/10665/42811/1/9241591013.pdf?ua=1

1.2 Tobacco control in Croydon has two main strands: a stop smoking service (SSS) that is commissioned by public health; and broader tobacco control activities that are undertaken by several services within the council.

1.3 By the end of 2016/17, Stop Smoking Services will be delivered through the Councils' Live Well Programme, an integrated, holistic, health behaviour change service that aims to help people to stop smoking, maintain a healthy weight, drink alcohol sensibly, be physically active and be happy.

1.4 One of the most significant developments in tobacco harm reduction in recent years has been the introduction of e-cigarettes which are 95% less harmful than combustible cigarettes. The Council is exploring the role of e-cigarettes not only in the Live Well Programme but also in the council's health and wellbeing policies for its workforce.

2.1 Smoking is the leading cause of ill health and premature death in Croydon and the single biggest cause of health inequalities. Stop smoking services deliver significant financial 'return on investment' benefits, with every £1 spent delivering an estimated £5.36 back to the local economy[5].

2.2 Some groups are particularly vulnerable to tobacco related harm and require extra support: children and young people (CYP), people with mental illness, pregnant women, and people with long term conditions (LTC). These groups will be supported in Live Well.

2.3 Across several measures of smoking prevalence, Croydon has higher need than in London and, in some cases, higher than England. In Croydon almost 18% of adults, and 7% of young people aged 15 are smokers. Almost 7% of pregnant women are smokers at the time of delivery.

2.4 In 2015/16, Croydon's SSS network of approximately 80 providers enabled almost 3,500 people to set a quit date. Service quality was high with over half (52%, 1,800 people) successful as 4 week quitters. Of these, 40% were still quit at 12 weeks.

2.5 A wider range of broader tobacco control measures were undertaken over the last year. Whilst there are areas of good practice, there needs to be a strategic tobacco control plan drawing these strands together.

2.6 Over the coming months, Croydon plans to focus on:

- The transition of the stop smoking services to the Live Well Programme.
- Delivery of an e-cigarette workforce pilot within the council staff
- Through the Live Well Alliance, developing a strategic tobacco control plan that reviews and prioritises wider tobacco control initiatives.

3. DETAIL

Introduction

3.1 This report aims to inform the board about the work undertaken over the last year to reduce smoking prevalence in Croydon and reduce the harms from tobacco.

3.2 Following papers on tobacco control presented to the HWBB in February and June 2015, Croydon Council renewed its strategic commitment to tobacco harm reduction through signing the Local Government Declaration on Tobacco Control.

[5] [5] Cost of smoking in Croydon, independent study by McKinnon Partnership, 2010

3.3 In recent months, Croydon participated in two systemic reviews of smoking and tobacco control: the London wide Sector Led Improvement programme and a CLeaR self-assessment. Recommendations included:

- Leadership - identify senior level champion from HWBB.
- Embed and see clear links across to key strategic plans.
- Commissioning - develop mental health, maternity, children and young people's service provision to have more impact on smoking prevalence.
- Tobacco Control Partnership - develop plan for organisation and involve key stakeholders.
- Communication – develop a standalone communication strategy for Tobacco Control.
- Innovation – identify innovative ways of using technology to increasing quit rate and delivering services.
- More focused prioritisation
- Stronger links with partners including regulatory services, schools, the healthy schools programme, other addiction and anti-social behaviour services, volunteers, students and young people.

3.4 Tobacco control in Croydon has two main strands: a stop smoking service (SSS) commissioned by public health; and broader tobacco control activities that are undertaken by several services within the council. The evidence-based SSS aims to provide support to residents aged over 12 years who want to quit smoking through 4 to 12 weeks of behavioural support and medication such as NRT (Nicotine Replacement Therapy). Wider tobacco control activities cover schools based work, local campaigns, enforcing licensing restrictions about under age sales and training of the wider workforce.

3.5 Over the last few months, the priority for the SSS has been delivering quits through the network of approximately 80 providers across the borough and preparing for the integration of the service into the Councils' Live Well Programme, an integrated, holistic, health behaviour change service that aims to help people to stop smoking, maintain a healthy weight, drink alcohol sensibly, be physically active and be happy.

3.6 The Live Well Programme has three parts:

- **Just Be….** A behaviour change website that will provide tailored information on healthy living, health assessments, podcasts, videos, apps, information about local services and advice on healthy behaviours
- **MI Change** – face to face interventions targeted at higher risk groups who need extra support to change one of more health behaviours.
- **Live Well Alliance** – a strategic borough wide partnership that will oversee lifestyle health promotion and behavioural change within communities.

Each part will provide elements that contribute to reducing the prevalence of smoking.

3.7 The budget for SSS and broader tobacco control is funded entirely from the ring-fenced public health budget. At the start of 2015/16, the budget was £1,053K however, in summer 2015, the government announced a mid-year cut of 6.2% to the national public health budget and Croydon, as for all councils in

the country, was required to identify mid-year savings. The SSS and tobacco control budget was therefore reduced by £200k. In 2016/17, the budget will be integrated into the wider Live Well budget.

4. E-cigarettes

4.1 One of the most significant developments in tobacco harm reduction in recent years has been the introduction of e-cigarettes. These battery powered devices deliver nicotine in a vapour rather than in smoke. Because the health harms in combustible cigarettes arise from the smoke, not from the nicotine content, vaping is safer than smoking and government bodies have estimated that vaping is 95% less harmful than smoking[6]. E-cigarette use has increased in recent years with an estimated 3m users in the UK. Although there are concerns that e-cigarettes could renormalize the act of smoking, thereby encouraging take up by young people, the evidence so far is that the vast majority of vapers, an estimated 98%, are smokers or ex-smokers.[7]

4.2 A recent report by the Royal College of Physicians recommended that in the interests of public health, the use of e-cigarettes, (as well as NRT and other non-tobacco nicotine products) should be promoted as widely as possible as a substitute for smoking[8]. Public Health England is providing leadership in this area, advising local areas to consider the potential of e-cigarettes as a harm reduction tool, and providing regular updates to the evidence base to support the development of national and local e-cigarette policies. PHE have recently developed guidance on the use of e-cigarettes within the workplace[9].

4.3 The Council is exploring the role of e-cigarettes not only in the Live Well Programme but also in the council's health and wellbeing policies for its workforce.

5. The harms and costs associated with smoking.

5.1 Smoking is the leading cause of ill health and premature death in Croydon and the single biggest cause of health inequalities. It is responsible for half the 9 year difference in life expectancy between the most and least deprived wards in the borough and causes almost 500 deaths each year[10].

5.2 Smoking costs Croydon between £84-£110 million per year and reducing smoking prevalence would reduce Croydon's smoking-related NHS Health care costs by an estimated £10m[11] and costs of smoking-related long term conditions by an estimated £3m to the local authority and £2.25m to self-funders. Smoking cessation delivers significant financial 'return on investment' benefits, with every £1 spent delivering an estimated £5.36 back to the local economy[12]. Stopping smoking can increase household incomes; in 2015, a 20-

[6] E-cigarettes: an evidence update. Public Health England (August 2015)
[7] Electronic Cigarettes. Parliamentary Office of Science and Technology. POSTNOTE number 533 August 2016
[8] Nicotine without Smoke: Tobacco Harm Reduction, Royal College of Physicians, 2016
[9] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/534586/PHE-advice-on-use-of-e-cigarettes-in-public-places-and-workplaces.PDF
[10] Quantifying the cost of Smoking in Croydon, The MacKinnon Partnership, June 2010
[11] ASH ready reckoner for DsPH 2014. www.ash.org.uk/localtoolkit/docs/Reckoner.xls
[12] Cost of smoking in Croydon, independent study by McKinnon Partnership, 2010

a-day smoker of a premium cigarette brand was estimated to spend about £3,000 a year on cigarettes[13].

5.3 Some groups are particularly vulnerable to tobacco related harm: children and young people (CYP), people with mental illness, pregnant women, and people with long term conditions (LTC). Currently, services are incentivized to target these populations.

5.4 **Children and Young.** Smoking is not an 'adult choice'. Two-thirds of adult smokers report that they took up smoking before the age of 18. The younger the age of uptake of smoking, the greater the harm because early uptake is associated with subsequent heavier smoking, higher levels of dependency, a lower chance of quitting, and higher mortality.[14]

5.5 **People with Severe Mental Illness**. People with mental illness have the highest smoking prevalence in society[15] and are up to four times more likely to smoke than the general population[16]. Whilst in the general population rates of smoking have diminishing over recent years, this reduction has not been replicated amongst people with severe mental illnesses (SMI) such as schizophrenia and bipolar disorder.[17] On average, people with these conditions die 15 to 20 years earlier than the general population, partly as a result of higher smoking rates.[18]

5.6 **Pregnancy.** Smoking during pregnancy increases the risk of complications such as miscarriage, a low birth weight baby, premature birth and infant deaths. In the UK, it causes up to 2,200 premature births, 5,000 miscarriages and 300 perinatal deaths every year[19,20]. Effects can be life-long with evidence that smoking in pregnancy may have a negative impact on long term physical growth and intellectual development of the child.[21]

5.7 **Long term conditions.** Many long-term conditions such as diabetes, cardiovascular disease and respiratory disease are caused or exacerbated by smoking. People who smoke have longer average stays in hospital, poorer outcomes from surgery and need social care support at a younger age[22].

6. Need in Croydon

6.1 Across several measures of smoking prevalence, Croydon has higher need than in London and, in some cases, higher than England:

- Smoking prevalence among adults is higher than the London average

[13] The economics of tobacco. ASH: 2015
[14] Young People and Smoking. ASH. July 2015
[15] ASH. Smoking and mental health. London: March 2016
[16] The Royal College of Physicians. Smoking and mental health London, RCP, March 2013
[17] Smoking and mental health. ASH: March 2016
[18] Smoking and mental health. ASH: March 2016
[19] Smoking Cessation at Pregnancy. A call to action. ASH: 2013
[20] Royal College of Physicians, Passive smoking and children, London, Royal College of Physicians, 2010.
[21] Smoking and reproduction. Ash 2013
[22] Smoking: Long term conditions. ASH

(17.9% vs 16.3%) and higher than in England (17.9% vs 16.9%)[23]. There are approximately 58,000 smokers living in Croydon. As is the case, nationally, smoking is more common in deprived wards with the prevalence of smoking in Fieldway (29.3%) almost three times higher than in Sanderstead (11.2%).[24]

- In Croydon, the percentage of pregnant mothers who are smokers at the time of delivery is higher than the London average (6.9% vs 4.9 %,) although lower than the England average (6.9% vs 11.4%).[25] This equates to approximately 351 women who still smoke at the time of delivery[26].
- In Croydon, smoking prevalence at age 15 is higher than in London (7.2% vs 6.1%), but lower than in England (7.2% vs 8.2%).
- Use of other tobacco products (including shisha) at age 15 (4.4%) is higher than both the London average (4.0%), and the England average (2.6%).[27]

7. Progress over the last 12 months

7.1 Croydon undertakes a range of measures to reduce the prevalence of smoking. In addition to the stop smoking services to support people who want to quit, the borough undertakes several activities: running local campaigns; training for the wider workforce so that they are able to raise awareness of the harms of smoking and in some cases, offer brief interventions; work within schools to prevent the update of smoking in young people; action taken against shisha and illicit tobacco. Croydon participates in London wide and national networks and learning sets to share best practice.

7.2 In 2015/16, Croydon's SSS was delivered by a network of approximately 300 advisors across 80 sites including Croydon Health Services, several outreach sites in deprived areas, general practices and pharmacies. The network enabled almost 3,500 people to set a quit date (SAQD). Service quality is good with over half (52%, 1,800 people) successful as 4 week quitters. Of these, 40% were still quit at 12 weeks. Overall, approximately 31% (i.e. 1,082) of people seen by the services were members of our target groups. Details of the services for targeted groups are shown in Table 1:

Table 1: Croydon Stop Smoking Service performance for targeted groups. 2015/16

Item	Activity	Performance
Pregnant Women	Specialist service provided at Croydon Health Services. Midwives trained to deliver smoking cessation. Two clinics in areas of higher deprivation	· Total pregnant women who SAQD: 117 · Total 4-week quitters: 61 (52%) · Total 12-week quitters: 38 (62% of 4-week quitters were successful at 12-week)

[23] Local Tobacco Control. Public Health England. On-line [Accessed 1/08/2016]
[24] Croydon JSNA 2015/16
[25] Croydon Joint Strategic Needs Assessment Croydon Key Dataset 2015/16. Croydon: 2016
[26] Public Health Outcome Framework [Accessed 18/08/2016]
[27] Croydon JSNA 2015/16

People with Mental Health	Innovative harm reduction pilot offering support through group sessions to helping people to cut down prior to stopping, or to reduce the amount they smoke until they are ready to set a quit date.	· Total people with mental health issues who SAQD: 48 · Total 4-week quitters: 16 (33%) · Total 12-week quitters: 9 (56% of 4-week quitters were successful at 12-week)
Long Term Conditions	Specialist service delivered mainly at CHS, and also through a network of providers across the borough.	· Total people with LTC who SAQD: 815 · Total 4-week quitters: 449 (55%) · Total 12-week quitters: 228 (51% of 4-week quitters were successful at 12-week)
People living in deprived areas	Outreach mobile bus located in various venues across the borough in areas of higher deprivation.	· Total people who SAQD: 389 · Total 4-week quitters: 211 (54%) · Total 12-week quitters: 116 (55% of 4-week quitters were successful at 12-week)
Young People	General service sees children aged 12 and over	· Total people aged under 25 who SAQD: 98 · Total 4-week quitters: 46 (47%) · Total 12-week quitters: 12 (27% of 4-week quitters were successful at 12-week)

Broader tobacco control measures are undertaken across the council and activity over the last year is summarized in Table 2. Whilst there are areas of good practice, a key recommendation from the sector led improvement and clear assessment is that Croydon develops a strategic tobacco control plan.

Table 2: broader tobacco control measures

Area	Aim	Achievements
Schools work	Led by Healthy Schools, aims to prevent young people from taking up smoking. Tobacco education which involves providing evidence of policies on drugs education, opportunities both within and outside the curriculum to support C&F Partnership priorities and PSHE curriculum.	· Over 50% of schools engaged in the scheme and offering a holistically education package underpinning the national curriculum and equipping CYP with skills to avoid risk behaviours and understand the health impact of drugs (including smoking).
Do you Pass training of retailers	Led by Trading Standards, ”Do You Pass” is a nationally accredited training programme for businesses covering the sale of all age restricted products including tobacco & nicotine inhaling devices. PHC and Trading Standards are the first to offer a combined free training session to SMEs in the Borough that includes not just the accredited training but also a unique PH introductory talk on the issues of young people and tobacco.	· Every shop selling age restricted products in the Borough has been personally visited by officers and offered the free training. · Over 300 people trained since the programme started in 2012, putting Croydon into the top three DYP trainers in the country.
Shisha bars	Led by Food and Safety Team, aims to improve compliance with the law.	· 14 Shisha bars have been identified as operating in Croydon. · Inspections were carried out by the Food and Safety Team: 4 premises were found to be not compliant with the legislation. · The Food and Safety Team are working with these businesses to provide guidance and ensure businesses comply with smoke free legislation and understand health risks around Shisha.

Campaigns	Led by PH, aims to raise awareness in Croydon residents of the harms of smoking and encourage engagement with stop smoking services	· Stoptober · No-Smoking day · Health Harm campaign/New Year resolution · Healthy workplace
Training	Led by PH, it aims to equip wider workforce with skills to discuss the benefits of stopping smoking with their customers and clients and, in some cases, offer brief interventions	Over 100 Staff trained in the following teams : · Croydon Gateway · Homeless Team · Access Croydon staff · Turnaround centre for young people · Midwives · MIND in Croydon · Primary Care · Voluntary sector · CHS Respiratory Team · CHS Junior Doctors
Illicit tobacco	Led by Regulatory services, aims to reduce the circulation of illicit tobacco.	· Croydon Trading Standards recently achieved a major success in raiding an illegal tobacco factory churning out hundreds of thousands of pounds-worth of fake branded rolling tobacco, making their largest seizure ever.

8. Future Direction

8.1 Over the coming months, Croydon intends to focus on:

- The transition of the stop smoking services to the Live Well Programme.
- Delivery of an e-cigarette workforce pilot within the council staff
- Through the Live Well Alliance, developing a strategic tobacco control plan that reviews and prioritises wider tobacco control initiatives.

Live Well Programme

8.2 Under the Live Well programme, there will be wider access to innovative digital support such as mobile phone apps, website tools, podcasts and videos that can support people living and working in Croydon to stop smoking. The face to face services will be targeted exclusively at groups with higher need: people living in deprived areas, pregnant women, people with a serious mental illness and those with long term conditions. The programme will explore the role of e-cigarettes in supporting quit attempts in line with evidence based guidance from the NCSCT (National Centre for Smoking Cessation and Training)[28].

E-cigarettes

8.3 Public Health have a joint lead role in the Council's workforce wellbeing agenda. In partnership with local colleagues, staff, Public Health England, and other local authorities, the team will commence a 6 month pilot to test approaches to vaping as an alternative to smoking cigarettes. The aim of the pilot is to reduce smoking prevalence in the council's workforce. The model is yet to be finalised, but the options being explored include:

- Restricted use of e-cigarettes (permission restricted to certain floors/areas/work-bases/staff groups)
- Permitted use of e-cigarettes in contained demarcated areas (outdoors or indoors; possibly with behavioural support)

[28] National Centre for Smoking Cessation and Training. [http://www.ncsct.co.uk/]

Wider tobacco control initiatives

8.4 The proposed Live Well Alliance will provide the strategic partnership that can oversee and support the development of a prioritised tobacco control action plan. This will draw on the recommendations made by the Sector Led Improvement programme and the CLeaR assessment.

9. CONSULTATION

9.1 As part of the SSS programme, consultations to improve the service have been carried out through a series of stakeholders' events involving the network of providers, and patient satisfaction surveys involving service users. The SSS GP champion regularly attends GP forums to discuss the program and provide feedback; and the LPC is involved through the Behavioural Change Alliance.

9.2 With the integration of Stop Smoking Services into the Live Well model, a market engagement exercise was carried out to determine if there was a market available to develop an integrated lifestyle service. This exercise showed that this was an emerging market place, so the decision was made to explore an internally provided service (Live Well).

10. SERVICE INTEGRATION

10.1 At the end of 2016/17, the SSS will be integrated and delivered through the Councils' Live Well Programme and the budget will be integrated into the wider Live Well budget.

10.2 The Live Well Programme will integrate current lifestyle services (Stop Smoking, Weight Management, Physical Activity and Alcohol prevention and early intervention) into a person-centred, holistic lifestyle service that will support people with multiple health behaviours and targeted at residents with the greatest needs. The Live Well Programme will interface with, and complement, other services, such as children and young people's services, drugs and alcohol treatment services, SLAM's 'recovery college' and others.

11. FINANCIAL AND RISK ASSESSMENT CONSIDERATIONS

11.1 There are no financial and risks implications arising from this report.

12. LEGAL CONSIDERATIONS

12.1 There are no legal considerations arising from this report.

13. EQUALITIES IMPACT

13.1 Stop Smoking service offered to the general population, however it prioritises specific target groups based on national policy and groups with greater needs and high risk. The following interventions have been developed based on national policy and local assessment of needs.

13.2 Specific training offered to address illegal underage sale to protect children and young people from effects of tobacco.

13.3 Tailored services developed and implemented to facilitate access to people with disabilities – particularly, people with severe mental health issues.

13.4 Specialised SSS services in place to support pregnant women throughout pregnancy and after childbirth, and to protect and assure children have the best start in life.

13.5 An initial Equalities Impact Assessment has been completed on the online platform of the Live Well model. A full equality analysis will be completed in line with the launch of the in-house behaviour change service.

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BACKGROUND DOCUMENTS none

REPORT TO:	**HEALTH AND WELLBEING BOARD (CROYDON)** **14 September 2016**
AGENDA ITEM:	**10**
SUBJECT:	**To provide a quarterly update to the board on the Croydon Health Protection Forum**
BOARD SPONSOR:	**Rachel Flowers, director of public health, Croydon Council**

BOARD PRIORITY/POLICY CONTEXT:

This report addresses the following local priorities set out in the Joint Health and Wellbeing Strategy:

- Increased healthy life expectancy and reduced differences in life expectancy between communities
- Local organisations will work together to address the factors that drive health problems amongst the poorest and most disadvantaged.
- Everyone's health will be protected from outbreaks of disease, injuries and major emergencies and remain resilient to harm.
- Earlier diagnosis and intervention means that people will be less dependent on intensive services.

FINANCIAL IMPACT:

No immediate financial implications.

1. RECOMMENDATIONS

1.1. This report is for information. The health and wellbeing board is asked to note the contents of the report.

2. EXECUTIVE SUMMARY

One of the four domains of public health practice is health protection, which includes infectious diseases, chemicals and poisons, radiation, emergency response and environmental health hazards.

The Croydon Health Protection Forum (HPF) was established in July 2015 with the purpose to have a strategic overview of health protection matters and with the aim to provide assurance to the Director of Public Health that arrangements

in place to protect the health of residents, are robust and implemented appropriately to local health needs. The health protection issues discussed at the Forum include adult and children immunisation programmes, and national screening programmes.

3. DETAIL

3.1 The Health Protection Forum meets quarterly bringing together various agencies including Croydon Council, Croydon Clinical Commissioning Group, Croydon University Hospital, NHS England, Public Health England, and other agencies relevant to the particular theme under discussion.

3.2 An annual work plan has been developed to understand and tackle local health protection issues and support planning of the meetings.

3.3 In 2015/2016, the meetings discussed and developed actions for the seasonal flu plan, tuberculosis in Croydon and the joint pandemic flu exercise. An overview of activities of the Forum in 2015/16 was reported to the HWBB in December 2015.

For 2016/2017 the work plan is:

May 2016	Childhood immunisations, overview of programmes and performance, universal neonatal BCG, maternal pertussis and flu, priorities for local action - MMR
September 2016	Local Screening programmes, overview of programmes and performance, local priorities and actions
December 2016	Potential topics: HIV, environmental hazards (air pollution)
March 2017	Review progress for the year

3.4 A local dashboard which will be reviewed at each meeting, is in the process of being compiled and will be agreed at the September meeting to give the Forum an overview of performance of local programmes e.g. immunisations, screening programmes, to highlight concerns and agree actions.

3.5 The January meeting focused on Tuberculosis (Tb) concentrating on screening, early diagnosis, vulnerable groups, treatment and contact tracing. Latent Tb screening is a service provided by Croydon GPs and is aimed at new entrants to the UK where they have been in the country less than 5 years. The plans and time line for the start of Neonatal Universal BCG screening were discussed.

3.5.1 Actions agreed at the meeting:

- To produce a briefing paper summarizing Tb services, programmes and who the commissioners are
- Discuss with sexual health commissioners about opportunistic testing
- To clarify universal provision of BCG vaccination in Croydon

3.6 The May meeting identified concerns about childhood immunisations. Data since 2013 shows that London has significantly lower uptake of childhood immunisations including MMR2 (Measles, Mumps and Rubella) and DTaP, [diphtheria, tetanus, and whooping cough (pertussis)], when compared to England. NHS England data for Croydon quarter 4 2015/2016 shows that by age 5 years, both the coverage of DTaP (69.6%) and MMR2 (68.9%) is significantly lower than the London average of 77.4% and 80.4% respectively. However, when compared with the same time period in 2014/2015, there is a significant increase in percentage of children aged 5 years whom have had the DTaP and MMR2 vaccinations. In quarter 4 of 2015/2016, of the South West London boroughs, Wandsworth had the highest coverage of MMR2 (87.3%) and Kingston of DTaP (81.3%).

3.6.1 Actions agreed at the meeting:

- To review the "call and recall" process of children for vaccination in Croydon.
- To review the NHS England Croydon Immunisation Action plan 2016/2017 which is underpinned by NHS England's immunisation strategic objectives to reduce inequalities, improve patient choice and increase immunisation uptake and coverage across London
- To convene a task and finish group to focus on improving MMR vaccinations

3.7 Measles Outbreak: Between February 2016 and 21 August 2016 there were 110 confirmed cases of measles in the South London Boroughs. Of these, 7 were in Croydon with Lambeth having the highest number (50) of cases. Over half of the 110 cases are in those aged 15 years and over. Of the 7 cases in Croydon, 4 are aged 0-14 years and 3 cases are in the 15-44 age group.

3.7.1 A press release from PHE England urged parents to have their children vaccinated. Locally, letters went out to all schools and colleges notifying them of the outbreak, highlighting the importance of vaccination and signposting where to access vaccinations.

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BACKGROUND DOCUMENTS: Nil

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REPORT TO:	**HEALTH AND WELLBEING BOARD** **14 September 2016**
AGENDA ITEM:	**11**
SUBJECT:	**Report of the chair of the executive group: incorporating risk register and board work plan**
LEAD OFFICER:	**Barbara Peacock, Executive Director, People, 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:

- Note the planned review of the local strategic partnership including the health and wellbeing board.
- Note risks identified at appendix 1.
- Agree revisions to the health and wellbeing board work plan for 2016/17 at appendix 2.

2. EXECUTIVE SUMMARY

2.1 This report summarises work undertaken by the health and wellbeing board executive group since the last meeting of the board on 8 June 2016.

2.2 The board risk register was developed by the board at a seminar on 1 August 2013. The board agreed that the executive group would keep these risks under review and update them as required. A summary of current risks and their ratings is at appendix 1.

2.3 The health and wellbeing board agreed its work plan for 2016/1 at its meeting on 13 April 2016. 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 2.

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 executive group met on 11 August 2016. Key areas of work for the executive group from June to August 2016 are set out below:

- Reviewed the board work plan including preparation of board meeting agenda and topic prioritisation against the joint health and wellbeing strategy.
- Liaised with other strategic partnerships including Croydon Local Strategic Partnership and the children and families partnership.
- The executive group agreed to take forward a board self-assessment as part of the planned review of the local strategic partnership. Proposals around changes to board governance, membership and functions will take into account the work already undertaken on the partnership groups which report to the board, the self-assessment exercise and the local strategic partnership review. A report to the health and wellbeing board has been schedule for the board meeting on 14 December 2016.
- The executive group also considered a proposal from Croydon Congress that the health and wellbeing board lead work to develop a social inclusion action plan. This follows a recommendation for work to assess the impact social isolation and loneliness by Croydon's Opportunity and Fairness Commission. The 2016 annual report of the director of public health will focus on social isolation and loneliness.
- Reviewed board strategic risk register.
- Considered responses to public questions and general enquiries relating to the work of the board.

Risk

3.3 Risks identified by the board are summarised at appendix 1. The executive group regularly review the board risk register. The risk register was reviewed by the executive group at its meeting on 11 August 2016, with existing controls updated and a number of new controls identified. There have been no changes to the risk ratings since the board meeting on 8 June 2016.

Board work plan

3.4 Proposed changes to the 2016/17 board work plan from the version agreed by the board on 8 June 2016 are summarised below. This is version 76 of the work plan. The work plan is at appendix 2.

3.4.1 Items on health as a social movement and asset based approaches to improving health scheduled for the board meeting on 19 October 2016.

3.4.2 The annual report of the director of public health moved to the meeting on 14 December 2016.

3.4.3 Item on partnership groups and HWB governance moved to 14 December 2016.

3.4.4 Item on outcomes based commissioning for over 65s move to the board meeting on 14 December 2016.

3.4.5 Item on primary care co-commissioning schedule for the board meeting on 8 February 2017.

3.4.6 Item on draft social inclusion action plan scheduled for 8 February 2016.

Appendices

Appendix 1 risk summary.
Appendix 2 board work plan.

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.

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.

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BACKGROUND DOCUMENTS
None

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14 September 2016

Risk Status

			Risk rating		Control measures			
Risk Ref	**Business Unit**	**Risk**	**Current**	**Future**	**Future**	**Existing**	**Total**	**% Impleme**
HWB5	HWB	Limited or constrained financial allocations in health and social care which gives rise to the inability to balance reducing budgets with a rising demand	25	20	4	5	9	70%
HWB6	HWB	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%
HWB8	HWB	Board is not able to demonstrate improved outcomes for the population	16	12	4	4	4	60%
HWB4	HWB	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%
HWB1	HWB	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%
HWB3	HWB	Failure to clearly understand the purpose, boundaries and remit of the Board	12	4	2	3	3	67%
HWB2	HWB	Failure to successfully integrate commissioning or service provision due to inability or unwillingness to share data	15	12	3	2	5	71%
HWB7	HWB	The Board fails to respond flexibly and effectively to changes in national policy or developing local issues	12	8	2	4	4	80%

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Topic proposed: date to be agreed
Mental health in the criminal justice system (proposed by Inspector Claire Robbins)

Date	Item	Purpose	JHWS priority	Board sponsor	Lead officer / report author
19 October 2016	**Strategic items**				
	Commissioning intentions 2016/17	The board has a duty to give an opinion on the alignment of the CCG's commissioning plan to the JHWS and the power to give its opinion to the council on whether the council is discharging its duty to have regard to the JSNA and JHWS.	Relates to a statutory function of the board	Paula Swann/Barbara Peacock	Stephen Warren / tbc
	Health as a social movement / Asset based approaches to improving health	To consider how individuals and communities can be supported to mobilise around health and wellbeing in Croydon	All	Barbara Peacock / Sarah Burns	Sarah Burns
	Business items				
	Joint commissioning executive report	To provide an overview of the work of the joint commissioning executive	All	Barbara Peacock / Paula Swann	Sarah Warman
	Safeguarding adults annual report	To inform the board of the work of the Safeguarding Adults Board	n/a	Barbara Peacock	Sean Olivier

Date	Item	Purpose	JHWS priority	Board sponsor	Lead officer / report author
	Safeguarding children annual report	To inform the board of the work of the Safeguarding Children Board	n/a	Barbara Peacock	Lorraine Burton
	Better Care Fund	To inform the board of progress on the work schedule of the Better Care Fund	n/a	Paula Swann / Barbara Peacock	Paul Young / Vanda Learey
	Healthwatch Croydon report	To report on relevant issues to the board	n/a	Charlie Ladyman	Darren Morgan
	Report of the chair of the executive group • Work plan • Risk	To inform the board of work undertaken by the executive group and consider the board risk register	n/a	Barbara Peacock	Steve Morton
14 December 2016	**Strategic items**				
	Annual report of the director of public health 2016	To discuss the content of the director of public health's annual report and agree any actions for the board arising from it	Statutory report	Rachel Flowers	Anita Brako
	Business items				
	Health protection update	To inform the board of key health protection issues for the borough including uptake of immunisations & vaccinations	Improve the uptake of childhood immunisations	Rachel Flowers	Ellen Schwartz

Date	Item	Purpose	JHWS priority	Board sponsor	Lead officer / report author
	Pharmaceutical needs assessment (PNA) update	To consider any changes to the PNA and agree process for full update	n/a	Rachel Flowers	Claire Mundle
	JSNA programme for 2017	To agree the JSNA programme for 2017	n/a	Rachel Flowers	Steve Morton
	Outcomes based commissioning for over 65s	To update the board on progress since the last report on 10/02/16	Prevent illness and injury and promote recovery in the over 65s	Paula Swann / Barbara Peacock	Martin Ellis
	Review of the local strategic partnership and health and wellbeing board (including partnership group review)	To consider proposed changes to board governance arising from the review of the LSP and HWB	n/a	Barbara Peacock	Brenda Scanlan / Steve Morton
	Healthwatch Croydon report	To report on relevant issues to the board	n/a	Charlie Ladyman	Darren Morgan
	Report of the chair of the executive group • Performance • Work plan • Risk	To inform the board of work undertaken by the executive group and consider the board risk register	n/a	Barbara Peacock	Steve Morton

Date	Item	Purpose	JHWS priority	Board sponsor	Lead officer / report author
8 February 2017	**Strategic items**				
	Primary care co-commissioning	To consider the development of primary care co-commissioning arrangements in Croydon	n/a	Paula Swann	tbc
	Social inclusion action plan	To agree draft social inclusion action plan	n/a	tbc	tbc
	Business items				
	Health and social care integration: Better Care Fund	To inform the board of progress on the work schedule of the Better Care Fund	n/a	Paula Swann / Barbara Peacock	Paul Young / Vanda Learey
	Healthwatch Croydon report	To report on relevant issues to the board	n/a	Charlie Ladyman	Darren Morgan
	Report of the chair of the executive group • Work plan • Risk	To inform the board of work undertaken by the executive group, to consider performance and review the board risk register	n/a	Barbara Peacock	Steve Morton

Date	Item	Purpose	JHWS priority	Board sponsor	Lead officer / report author
5 April 2017	**Strategic items**				
	Business items				
	CCG operating plan 2017/18	The board has a statutory duty to give an opinion on the alignment of the CCG's commissioning plan to the JHWS	n/a	Paula Swann	tbc
	Healthwatch Croydon report	To report on relevant issues to the board	n/a	Charlie Ladyman	Darren Morgan
	Report of the chair of the executive group • Performance report • Work plan • Risk	To inform the board of work undertaken by the executive group and consider the board risk register	n/a	Barbara Peacock	Steve Morton

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