Public Document Pack

Health & Wellbeing Board

To:
Councillor Janet Campbell (Chair)
Dr Agnelo Fernandes, NHS Croydon Clinical Commissioning Group (Vice-Chair)
Councillor Stephen Mann
Councillor Alisa Flemming
Councillor Jerry Fitzpatrick
Councillor Mary Croos
Councillor Yvette Hopley
Councillor Margaret Bird
Annette McPartland, Interim Corporate Director Adult Social Care & Health (DASS)
Rachel Flowers, Director of Public Health - Non-voting
Edwina Morris, Healthwatch
Hilary Williams, South London and Maudsley NHS Foundation Trust
Michael Bell, Croydon Health Services NHS Trust - Non-voting
Steve Phaure, Croydon Voluntary Action - Non Voting
Matthew Kershaw, NHS Croydon Clinical Commissioning Group (CCG)

A meeting of the **Health & Wellbeing Board** will be held on **Wednesday, 19 January 2022** at **2.00 pm**. **This meeting will be held remotely.**

Katherine Kerswell
Chief Executive
London Borough of Croydon
Bernard Weatherill House
8 Mint Walk, Croydon CR0 1EA

Michelle Ossei-Gerning
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PLEASE NOTE: Members of the public are welcome to remotely attend this meeting via the following web link: https://webcasting.croydon.gov.uk/

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If you require any assistance, please contact Michelle Ossei-Gerning
020 8726 6000 x84246 as detailed above.

AGENDA – PART A

1. Apologies for Absence

To receive any apologies for absence from any members of the Committee.

2. Minutes of the Previous Meeting (Pages 5 - 12)

To approve the minutes of the meeting held on 20 October 2021 as an accurate record.

3. Disclosure of Interests

Members and co-opted Members of the Council are reminded that, in accordance with the Council's Code of Conduct and the statutory provisions of the Localism Act, they are required to consider **in advance of each meeting** whether they have a disclosable pecuniary interest (DPI), an other registrable interest (ORI) or a non-registrable interest (NRI) in relation to any matter on the agenda. If advice is needed, Members should contact the Monitoring Officer **in good time before the meeting**.

If any Member or co-opted Member of the Council identifies a DPI or ORI which they have not already registered on the Council's register of interests or which requires updating, they should complete the disclosure form which can be obtained from Democratic Services at any time, copies of which will be available at the meeting for return to the Monitoring Officer.

Members and co-opted Members are required to disclose any DPIs and ORIs at the meeting.

- Where the matter relates to a DPI they may not participate in any discussion or vote on the matter and must not stay in the meeting unless granted a dispensation.
- Where the matter relates to an ORI they may not vote on the matter unless granted a dispensation.
- Where a Member or co-opted Member has an NRI which directly relates to their financial interest or wellbeing, or that of a relative or close associate, they must disclose the interest at the meeting, may not take part in any discussion or vote on the matter and must not stay in the meeting unless granted a dispensation. Where a matter affects the NRI of a Member or co-opted Member, section 9 of Appendix B of the Code of Conduct sets out the test which must be applied by the Member to decide whether disclosure is required.

The Chair will invite Members to make their disclosure orally at the commencement of Agenda item 3, to be recorded in the minutes.

4. Urgent Business (if any)

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

5. Public Questions

Public Questions should be submitted before 12 noon on 14 January 2022 to democratic.services@croydon.gov.uk. Any questions should relate to items listed on the agenda. 15 minutes will be allocated at the meeting for all Public Questions that are being considered.

6. Director of Public Health annual report: The Magnificence of Croydon during the COVID-19 pandemic (Pages 13 - 40)

The Director of Public Health has a statutory duty to produce an independent annual report to advise and make recommendations to professionals and the public, to improve population health. The Council also has a statutory responsibility to publish the Annual Report. Due to the unequivocal impact of COVID -19, the focus of this year's report is, the impact of COVID-19 on inequalities through the experience of Croydon residents, with recommendations on how we in Croydon can best protect ourselves, keep healthy and tackle inequalities together.

7. Health and Care Plan Refresh 2021-2023 (Pages 41 - 96)

The Five-year Croydon Health and Care Plan was developed in 2019 setting out how Croydon would deliver the Health and Care Strategy through its three aims: focusing on prevention and proactive care, unlocking the power of communities and putting services back in the heart of the community. The refresh allows us to learn from our response to the COVID-19 Pandemic, understand the impact the pandemic has had on our communities and ensure we reduce inequalities.

8. Pharmaceutical Needs Assessment (Pages 97 - 108)

This paper provides an update on the plans to produce and publish the 2022 Croydon Pharmaceutical Needs Assessment (PNA) and asks the Board to agree to the establishment of a PNA steering group.

9. Transforming Mental Health Services for Children, Young People (0-25) and their families across South West London - Local Transformation Plan Refresh 2021 (Pages 109 - 164)

This report provides members with the refreshed Children and Young People's Emotional Wellbeing and Mental Health Local Transformation Plan for 2021. The 2021 refreshed plan combines six local Children and Young People's Local Transformation Plans. The aim of this combined

refresh plan is to establish a more consistent strategic framework for improving mental health and emotional wellbeing services for children, young people and their families across South West London.

10. Exclusion of the Press and Public

The following motion is to be moved and seconded where it is proposed to exclude the press and public from the remainder of a meeting:

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

Health & Wellbeing Board

Meeting of held on Wednesday, 20 October 2021 at 2.00 pm.
This meeting was held remotely; to view the webcast, please click here.

MINUTES

Present: Councillor Janet Campbell (Chair);
Dr Agnelo Fernandes (NHS Croydon Clinical Commissioning Group) (Vice-Chair);
Councillor Mary Croos
Councillor Yvette Hopley
Councillor Margaret Bird
Rachel Flowers, Director of Public Health - Non-voting
Edwina Morris, Healthwatch
Hilary Williams, South London and Maudsley NHS Foundation Trust
Michael Bell, Croydon Health Services NHS Trust - Non-voting

Others present: Councillor Maddie Henson in substitute for Councillor Alisa Flemming
Sarah Burns, CVA Head of Communities in substitute for Steve Phaure
Neil Gouldbourne in substitute for Matthew Kershaw

Dr Kevin Vento, Croydon South London and Maudsley (SLaM)
Ima Miah, Asian Resource Centre
Andrew Brown, Croydon BME Forum
Yusuf Osman, Adult Social Service User Panel

Apologies: Councillor Alisa Flemming, Councillor Jerry Fitzpatrick, Steve Phaure, Debbie Jones, Annette McParland and Matthew Kershaw

PART A

10/21 Minutes of the Previous Meeting

RESOLVED that the minutes of the meetings held on 20 January 2021 and 17 June 2021 were agreed as a correct record.

11/21 Disclosure of Interests

Councillor Yvette Hopley declared that she was the Vice Chair of the South East Cancer Help Centre.

12/21 Urgent Business (if any)

There was none.

13/21 **Public Questions**

There were none.

14/21 **Health in Croydon's Black Community: A Tribute to Black History Month**

The Chair introduced the item and stated that there were two speakers. She firstly invited Dr Kevin Vento to address the Board.

Dr Kevin Vento stated that he was the psychosis lead for Croydon South London and Maudsley (SLaM) services for adult mental health and that he would be speaking on both the Croydon Health and Wellbeing Space, which was in the process of being launched, and black mental health. He detailed the following:

- A common misconception was the black people, particularly black men, did not benefit from mental health services. However there were challenges in engaging the black community with mental health services.
- It was known that black communities struggled engaging with primary care services, and the difficulty was in the first step in getting help where they were underrepresented, which needed to be improved. Black communities were overrepresented in secondary care services.
- A black person is almost three times more likely to be detained under the Mental Health Act, which as a statistic had not changed in the past 20 years.
- The NHS Long Term Plan included embedding services within the community and for community to work closer together. The Croydon Health and Wellbeing Space was a collaboration between Mind in Croydon, the Croydon BME Forum and SLaM.
- Dr Vento stated that he would be the clinical lead for the Space, which would be based at the Whitgift Centre, and he expressed his optimism for a true partnership going forward.
- The site would be open seven days a week and have an open door policy to maximise engagement and be an inviting venue. This initial engagement would then increase the access to secondary health services. As well as sign-posting, the Space would run in-house services and groups to support residents coping with traumas.
- The Space will be a service to fit the community and an accessible place, staffed by local people and link to local churches and other community groups.

The Chair thanked Dr Vento for his introduction and invited questions from the Board.

Councillor Yvette Hopley praised the idea and the model to provide services to people within the community, staffed by members of those communities the service users would feel comfortable to share their experiences with. She expected the Space to be a success story for Croydon and said the message needed to be shared with residents and associations that this site was operating and what services it provided.

Sarah Burns, CVA Head of Communities, welcomed the approach and stated that the ambition was positive. She said there were a few questions that needed to be considered in the early stages of development; firstly, in how the wider voluntary sector would be able to work with the BAME community, and secondly, how they would connect people struggling with mental health issues to the Health and Wellbeing Space. She said there were possible solutions to those, adding that one that should be considered was that the Mental Health Alliance. This Alliance would soon be launching which would be bringing together grassroots groups who had been working hard for years across Croydon to establish reputations and already worked with BAME communities. Another model to join up was the localities operating model within One Croydon.

In response, Dr Vento agreed that this provision should be inclusive of all other services and communities available in the borough. He stated that Croydon was a strikingly diverse borough, across heritage and religion with over 100 languages spoken, and the drive was to provide services that enabled residents to connect better and were fit for everyone.

Ima Miah, Asian Resource Centre CEO, agreed that the work should greater connect to the wider voluntary sector. Secondly, she raised concern over 'black' and 'BAME' being used interchangeably within this discussion – which risked excluding other communities, particular in light that Asian communities were also pressing for recognition of mental health. There were different understandings of mental health in different communities, where religion also was a factor; for instance in the Asian community a person may look to seek help from an Imam instead of a doctor, and different solutions may be discussed, such as marriage in some cases. In another example, it might be that Polish communities may not seek help from an advertising campaign that only presented black and brown service users. She reiterated the importance of the need to be inclusive of all communities to maximise engagement and outcomes.

Rachel Flowers, Director of Pubic Health, stated that it needed to be recognised that there were both operational and strategic considerations to address the deep seated inequalities around racism and discrimination in BAME communities, which captured a whole range of people and experiences. As a Board, they would not be able to solve the issues immediately, however the addition of this Space would be a welcome contribution to the large tapestry of services which have been developing and established within Croydon. She noted that there were a vast range of needs and types of engagement required around Croydon. She thanked Dr Vento for his presentation and commended his work.

Dr Agnelo Fernandez, Vice Chair, stated that the Space reflected great work in trying to address some of the issues previously highlighted. He agreed that there was a lot more to do across board, however particularly in underrepresented communities. It was clear that in relation to this piece of work, that specifically working with the black community around psychosis

was long past due, without excluding others. It was clearly important to act inclusively, but this work would also teach lessons in addressing similar issues in other communities to go forward effectively and utilise resources efficiently.

Dr Kevin Vento thanked the Board for their feedback and echoed the emphasis on inclusivity being key to the work. He stated that their approached would be transparent and accessible to ensure the service could be used by anyone.

The Chair thanked Dr Vento for his update to the Board, and next invited the colleagues from Croydon Health Services to speak on the item.

Leila Howe, Croydon Health Services, outlined the following:

- Speaking as part of the steering group which run alongside the Asian Minority Staff Network in Croydon, she thanked NHS colleagues for supporting their success as a network
- Messaging from staff within the network was that if you were BAME in Croydon, sometimes an experience would not be as good as white counterparts and that issues needed to be addressed
- When the aims and objectives of the network were drafted, they wanted to tackle issues as well as hosting cultural events, three being: bullying and harassment at work, lack of career progression and the recruitment process.

Andrew Brown, BME Forum, stated that by the end of the week over 40 BME events would have taken place in Croydon. He thanked everyone who had supported the Forum over this period.

15/21 **Integrated Care System (ICS) Update**

Neil Gouldbourne and Mike Bell, Croydon Health Services NHS Trust, introduced the ICS update, outlining the following:

- There was a national timetable to move away from Clinical Commissioning Groups (CCGs) to the new statutory bodies in the Integrated Care System (ICS), with duties transferred.
- There were several elements important to note of the South West (SW) London ICS in the context of Croydon:
  - There would be two Boards for the district: the Integrated Care Board, which would hold the NHS budgets, and an Integrated Care Partnership Board to focus on the wider detriments on health (which would include more collaboration from the council and the voluntary sector).
  - Discussions were taking place about how the Boards should relate to one another, their membership and remit.
  - There was understanding that Croydon was already working in an integrated and collaborative way that the upcoming changes were aimed to enable across the country, and Croydon would continue on its own journey in that context.

- A hallmark trait of CCGs was the prominent positions of GPs in the running and management of the health service, and in Croydon it was clear that had brought value. They intended to continue that strong voice for GPs in Croydon following the structure changes.
- With the dissolve of CCGs, it was important to investigate what GP leadership should look like going forward. A number of workshops took place to review what had worked well in Croydon and now there was a draft plan for the future arrangements of a GP leadership group within the Croydon structure and a position in the One Croydon Alliance.

- There were successful acute provider collaboratives in SW London, which run the SW London elective orthopaedic centre, SW London Pathology and a range or other initiatives. ICS was intended to further develop provider collaboratives and potentially provide a larger vehicle for the planning for the standardisation of clinical pathways procedures.
- The leadership of the ICS: the Chair had been confirmed as Millie Bannerjee and the process of appointing the induvial as the Chief Executive was underway.
- The staffing of the ICS: the ICS would inherit the CCG staff. There would be decisions to follow on how they would be deployed, given the move to a strategic commissioning model.

Dr Agnelo Fernandez, Vice Chair, stated the following:

- It was important to retain aspects of the clinical leadership in the new model. There would likely be only one representative at the ICS level for SW London.
- There was concern over the budgets going forward for clinical leadership, which were vital for its provision. Croydon was already currently underfunded. Croydon started the year with a deficit and ending in surplus due to efficiencies made and supported by good working relationship of the CCG and the integration agenda.

There would be risks and opportunities with the new model, however there was a history of Croydon of working together to achieve the best outcomes and working with communities that would put Crouton in a strong position in the future.

Councillor Yvette Hopley, Shadow Cabinet Member for Families, Health & Social Care, raised the following points of concern over:

- the process of funding and control moving away from Croydon;
- the separation of the GP voice in the new system and one representative SW London level seeming limited; and
- the politician's role in the new model. Currently there was an active role in the One Croydon Alliance and CCG of communication to residents that may be disassociated going forward in the new structures.

Edwina Morris, Healthwatch CEO, stated the following:

- Currently it felt that the views of residents and the work of Healthwatch was respected on a local level to Croydon. Going forward, working with

five other Healthwatch groups in SW London may be be difficult to maintain an affective voice to still speak on behalf of local residents and needs, before decisions were made.
- Healthwatch England had been lobbying to the Department for Health and Social Care, meeting with ICS Chairs to make the point that Healthwatch needed to remain effective at all ICS levels.

Mike Bell, Croydon Health Services NHS Trust representative, stated in response to the concerns raised, that many of the options discussed were not set in stone and there were still exercises taking place to take into account the ambitions and anxieties of all parties affected. Going forward, Croydon would seek maximum delegation streams (funding and ambitions) from the ICS to establish local priorities. Additionally, Croydon's ambition was to co-produce more with the public. He encouraged any partners involved to engage with the process of promoting Croydon's self determination within the ICS.

The Chair thanked everyone for their contributions.

16/21 **Healthwatch Croydon Annual Report 2020-21**

Hilary Williams, Healthwatch CEO, introduced the report and slides to the Board which summarised the work achieved by Healthwatch Croydon between 1 April 2020 and 31 March 2021.

Additionally invited to speak were services users James Kotai, Carole Hembest, Michael Hembest on their experiences and Healthwatch colleague Robyn Bone. Firstly, the service users described how they were involved in a project to improve signage for patients in hospitals and to ensure that signage was aligned to messaging to hospital letters. The project also involved designing a digital signposting system. Secondly, the Healthwatch colleague described the Croydon College placements in Healthwatch and how young people were engaging and influencing the services and the key skills and they gained. It was clear from the placements that the area of mental health particularly resonated with young people.

Councillor Yvette Hopley thanked Healthwatch for their valuable work for residents and stated that awareness of health systems were important, adding that even small changes helped patients. She asked if Healthwatch would be engaging in more Covid-19 specific work. The Healthwatch CEO responded that there was a live survey on long-Covid on the Healthwatch Croydon webpage which could be accessed on the following link: https://www.healthwatchcroydon.co.uk/take-part/projects/
Additionally, Healthwatch Croydon were involved in work on urgency and emergency care and looking at redesigning the pathways in Croydon and across SW London.

Councillor Margaret Bird congratulated the work of Healthwatch. She asked if there was any work, ongoing or planned, which focussed on diabetes services. She added that the Croydon contract for type two diabetes in the past moved to Bromley and had returned to Corydon. In response, the

Healthwatch CEO stated that they would note diabetes as a new stream of work to discuss.

Mike Bell, Croydon Health Services NHS Trust representative, echoed his thanks to Healthwatch for their work and excellent examples of co-production with residents, and on this occasion particularly in relation to the improvements to signage. He welcomed the upcoming work on emergency care pathways for Croydon.

Yusuf Osman, Adult Social Service User Panel, thanked Healthwatch for their work during the difficult time of the pandemic and successfully collating resident feedback. He asked if there were any plans in the upcoming year for Healthwatch Croydon to review the accessibility of information for the NHS in Croydon, particularly in relation to alternative formats for people who have disabilities. In response, Gordon Kay, Healthwatch Manager, stated that they had just been awarded a grant from Healthwatch England to carry out work on promoting accessibly beyond the current level, and for Croydon this will particularly focus on accessibly for residents and those of refugee status who speak little or no English. This work would then feed into the national accessibly of information standard.

RESOLVED: The Board agreed to note the recommendations as detailed in the report.

17/21 **An update on the Joint Strategic Needs Assessment (JSNA)**

Jack Bedeman, Public Health Consultant, introduced the report.

Yusuf Osman, Adult Social Service User Panel, asked if there was any data collected in relation to the number of residents living in Croydon with disabilities and whether this was sub-divided into separate impairments. He stated that type of data was important for planning local authority and NHS services. In response, Jack Bedeman stated that there was a limitation in what data was collected and that it was often stored disconnectedly across services, which resulted in Public Health's limitations to data access. Going forward, co-production was important in considering what data was required to build pictures of areas of interest and to retrieve the important data in a timely manner to understand what gaps needed to be filled and be outcome focussed.

Mike Bell stated that the statutory duty for Health and Wellbeing Boards to produce the JSNA continued under the new legislation. In the previous legislation, it was for CCGs to note the findings of the JSNA, however going forward he asked if there was a comparable duty for the ICS. Additionally, he asked if any discussion had taken place amongst the six SW London local authorities to aggregate some JSNAs for maximum impact of decisions taken at ICS level. In response, Jack Bedeman stated that there was not entirely clear steer yet on those positons.

Councillor Yvette Hopley asked what the role of the Board would be going forward and what sort of information would come to the board in the new strategic hierarchy. Secondly, she asked how data was picked up in the JSNA when local authorities provided for service users in other boroughs. In response, firstly, Jack Bedeman stated the JSNA was to provide baseline data which supported the development of the Health and Care Plan and the Health and Care Strategy, which both measured delivery and outcomes. The Board would benefit, in those terms, to have a clear forward plan and align that to the conclusions of those outcomes using a data driven approach - in relation to commissioning and and building bigger picture planning. Dr Agnelo Fernandez, Vice Chair, stated that the Croydon Public Health team in Croydon were national leaders of population health data, however going forward would be mined to a SW London level.

Mike Bell stated that in the move to the ICS system, it was critical for Croydon to retain the former CCG colleagues as a resource and analytical skill base. Councillor Yvette Hopley indicated the cross-party support of those intentions.

Edwina Morris and Jack Bedeman agreed there were opportunities for Healthwatch Croydon and Public Health to align and work together benefiting from strengths in combining the different types of data they handled.

RESOLVED: The Board agreed to note the recommendations as detailed in the report.

18/21 **Annual report of Health and Wellbeing Board 2020/2021**

Public Health Consultant, Jack Bedeman, introduced the report.

RESOLVED: The Board agreed to note the recommendations as detailed in the report.

19/21 **Exclusion of the Press and Public**

This item was not required.

The meeting ended at 4.13 pm

Signed:

Date:

REPORT TO:	HEALTH AND WELLBEING BOARD 19 January 2022
SUBJECT:	Director of Public Health annual report: The Magnificence of Croydon during the COVID-19 pandemic
BOARD SPONSOR:	Rachel Flowers – Director of Public Health
PUBLIC/EXEMPT:	Public

SUMMARY OF REPORT:

The Director of Public Health has a statutory duty to produce an annual independent report to advise professionals and the public and to improve population health and for the Council to publish this.

Due to the unequivocal impact of COVID -19, the focus of this year's report is the impact of COVID-19 on inequalities through the experience of Croydon residents. The report's recommendations will address how we in Croydon can best protect ourselves and keep healthy together.

Video has been chosen as the best medium for this report, it has closed captions to allow for translation to other languages and is accessible to British Sign Language signers. In addition, a data document sit alongside the video report and provides a background and recommendations to the themes explored within the video.

The report will be launched at the full Council meeting.

COUNCIL PRIORITIES 2020-2024

- This report will address opportunities to reduce inequalities within Croydon. It is for the public and will reflect the diverse range of residents within Croydon.
- Eighteen percent of Croydon's population live in areas identified as the 20% most deprived areas of the country and an estimated 43% of residents are within the Black or Asian ethnic group. The risk of severe outcomes and death from COVID is higher in those living in more deprived areas, and in Black, Asian and Minority Ethnic groups.
- The message of the video report will have a broad reach and will be accessible throughout the community. This will mitigate the risk that the public may overlook the learning of the last 20 months and become complacent in their health related decision making, potentially leading to further infections and COVID-related deaths.

This report also addresses the following joint health and wellbeing strategy priorities by:

- supporting strong, engaged, inclusive and well connected communities
- promoting good mental health

FINANCIAL IMPACT:

There is no direct financial impact of this report.

RECOMMENDATIONS:

The Health and Wellbeing Board is recommended to:

1.1 Note the content of the Director of Public Health's independent Annual Report.

2. EXECUTIVE SUMMARY

2.1 The Director of Public Health has a statutory duty to produce an independent annual report to advise and make recommendations to professionals and the public, to improve population health. The Council also has a statutory responsibility to publish the Annual Report. Due to the unequivocal impact of COVID -19, the focus of this year's report is, the impact of COVID-19 on inequalities through the experience of Croydon residents, with recommendations on how we in Croydon can best protect ourselves, keep healthy and tackle inequalities together.

2.2 This year's report is in video format and a data document which will allow for the widest reach, it is easily understandable, can be shared through multiple social media channels, and can be easily translated to support wider dissemination. The video report aligns with the Council's communications strategy to use a variety of communications and engagement channels and platforms to inform and reach out to as many people as possible about the health of our residents across the borough. The data document provides a background to themes explored within the video an overview of the resulting recommendations.

3. DETAIL OF THE REPORT

Covid-19 in Croydon

3.1 Over the last 18 months approximately 1 in every 8 Croydon residents have tested positive for COVID-19 (over 46,000 people). This figure is likely to be an underestimate. The most recent figures reveal that during this time Croydon has experienced over 1,000 COVID-related deaths; accounting for almost 1 in every 4 deaths in the borough.

3.2 The report is focused on Croydon's experience of the pandemic over the last 19 months based on the lived experiences of its residents. It looks at the impact of Covid-19, how residents were supported, how inequalities were impacted on and aims to highlight how Croydon can emerge fairer, more connected and more resilient from the pandemic.

Format of the Director of Public Health's report to the public

3.3 Video has been chosen as the best medium for this year's annual report. This is both pragmatic and because it best serves the purpose of the report. It is pragmatic as it means that it requires the least amount of input from the public health team, as our resources are stretched due to ongoing pressures in response to Covid, it is also quicker, cheaper and more straightforward than commissioning a written report.

3.4 Video also has the benefit of having the widest reach, is easily understandable, can be shared through social media channels, and easily translated to support wider dissemination. In July the Director of Public Health did a video message which was well received by residents with positive feedback saying how important people felt it was to be seeing the Director of Public Health speaking directly in this manner and the Council communicating openly. The use of video also allows us to ensure the report is accessible, as it is able to include British Sign Language (BSL), a language group which is unable to be catered for in a written report, and the audio focus means it is also more accessible to our residents with sight loss. In addition, the video will have closed captions which would allow those with hearing impairments who do not use BSL to access the video. This means we are demonstrating reasonable adjustments to allow access to these individuals who themselves are likely to suffer the impacts of widening health inequalities. Being a video with closed captions also increases the ability to translate the report into multiple languages.

3.5 The video has been produced in a manner to reflect the diversity of Croydon residents in a way which cannot be captured in a written report, allowing their experiences and stories to be used to augment all ongoing Covid communication over the next year, and depending on the content of the interviews will provide footage for wider ongoing health communication too.

In addition the data document captures the themes explored within the video and gives a background to the inequalities within Croydon and the recommendations made.

4. CONSULTATION

4.1 The Director of Public Health's annual report has being created with Croydon resident's voice throughout and is an independent report that others can then use to inform and shape any subsequent consultations. Voices from the Asian, Caribbean, African and European communities is reflected within the video report.

5 PRE-SCURTINY REPORT

This report has not yet been to scrutiny. The Director of Public Health will discuss the report and plans for scrutiny with Councillor Sean Fitzsimons and propose that this would come in early 2022.

6 FINANCIAL AND RISK ASSESSMENT CONSIDERATIONS

The cost of designing and producing the video report is funded through the COVID-19 Contain Outbreak Management Fund. Spend against the COVID-19 Contain Outbreak Management Fund grant is reported back to the Ministry of Housing, Communities and Local Government to ensure that it is used for the correct purposes, this is an appropriate use of this grant.

6.1 There are no direct financial implications arising from this report.

Approved by: Mirella Peters, Head of Finance

7. LEGAL CONSIDERATIONS

7.1 The Head of Litigation and Corporate Law comments on behalf of the interim Director of Law and Governance that under the Health and Social Care Act 2012 section 31(5) the Director of Public Health for a local authority must prepare an annual report on the health of the people in the area of the local authority which by section 31(6) the local authority is required to publish.

7.2 There are no additional legal considerations arising directly as a result of recommendations in this report.

Approved by Sandra Herbert, Head of Litigation and Corporate Law on behalf of the interim Director of Law and Governance & Deputy Monitoring Officer

8. HUMAN RESOURCES IMPACT

8.1 There are no immediate HR issues arising from this report for Croydon Council employees or staff.

Approved by: Gillian Bevan, Head of HR Resources, on behalf of the Director of Human Resources)

9. EQUALITIES IMPACT

9.1 The purpose of this report is to understand the impact of the pandemic on Croydon through the lived experiences of Croydon residents. The report will address the inequalities that exist and is aimed at supporting discussions and action to reduce this inequalities. This report will also highlight how Croydon can emerge as a more connected, fairer and resilient community.

Approved by: Denise McCausland; Equalities Manager on behalf of Director of Policy, Programmes and Performance

10. ENVIRONMENT AND CLIMATE CHANGE IMPACT

10.1 There are no environmental or climate change implications of this report.

11. CRIME AND DISORDER REDUCTION IMPACT

11.1 There are no implications of this report for the reduction or prevention of crime and disorder.

12. REASONS FOR RECOMMENDATIONS/PROPOSED DECISION

12.1 There is a statutory requirement for the Director of Public Health to produce an annual report which the Council is required to publish.

13. OPTIONS CONSIDERED AND REJECTED

13.1 The recommendations are required to meet statutory requirements.

14. DATA PROTECTION IMPLICATIONS

14.1 WILL THE SUBJECT OF THE REPORT INVOLVE THE PROCESSING OF 'PERSONAL DATA'?

NO - There is no personal identifiable data that has been used in the video or within the written addendum. Residents have told their stories however their personal identifiable information has not been used for the purpose of this report. All residents interviewed are over the age of 18 years and have signed the Council's media release form giving permission for their images captured to be used.

14.2 HAS A DATA PROTECTION IMPACT ASSESSMENT (DPIA) BEEN COMPLETED?

NO - There are no data protection implications in this report. Rachel Flowers will sign off the final video report.

All residents interviewed are over the age of 18 years and have signed the Council's media release form giving permission for their images captured to be used.

Approved by: Rachel Flowers, Director of Public Health

CONTACT OFFICER:

Denise Dixon, Public Health Principal

APPENDICES TO THIS REPORT

None.

THE MAGNIFICENCE OF CROYDON (AND THE INEQUALITIES)

THE NUMBERS BEHIND THE VIDEO

DIRECTOR OF PUBLIC HEALTH | ANNUAL REPORT 2021

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KEEP CROYDON SAFE

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INTRODUCTION

RACHEL FLOWERS - DIRECTOR OF PUBLIC HEALTH

In December 2019, I first read about a virus that had transferred from animals to humans, a public health marker that all Directors of Public Health are interested in.

From January 2020, there were memos across the NHS and local government about this "novel virus" and at the end of January 2020, I, along with all Directors of Public Health had a phone call with the four Chief Medical Officers of the four countries; England, Northern Ireland, Scotland and Wales.

In February we started seeing people going into hospitals and, sadly, start to die of what became known as COVID-19.

In March 2020, the World Health Organisation (WHO) declared an outbreak caused by coronavirus SARS-CoV-2 (COVID-19) a pandemic.

From February there were emergency processes put in place in Croydon Council and the local NHS to start to coordinate and try and reduce the transmission of this very infectious virus as part of an outbreak control plan. Croydon took advantage of pre-existing multi-agency partnerships and engaged with a wide range of stakeholders.

As a Director of Public Health, I have always been vocal about the impact of inequalities within Croydon and seeing COVID-19 disproportionately impact on those people and those communities already experiencing inequalities, the focus of this year's report is the impact of COVID- 19 on inequalities through the experience of Croydon residents.

This year's report takes the form of a video and a data document to the themes discussed in the video. The video report shows 'The magnificence of Croydon during the COVID-19 pandemic' highlighting the inequalities within Croydon and the impact of COVID-19 on the borough.

Through the voices of some of the people of Croydon we can remember the challenge that the start of a global pandemic brought, showing how communities came together in difficult and fast emerging circumstances providing an opportunity to acknowledge what we did as a community, while acknowledging that inequalities are there and are growing.

OUR POPULATION

Before the COVID –19 pandemic, the inequalities which existed within the borough were of great concern, as discussed in previous annual Director of Public Health reports.

The pandemic has highlighted and worsened those inequalities both nationally and within Croydon.

There are pockets of high deprivation within Croydon - with one small area ranking as the third most deprived area in London (out of 4,642 small areas) and approximately 10,000 residents of Croydon living in areas that are amongst the 10% most deprived areas of the country.

In England, there is a relationship between deprivation and life expectancy. In Croydon, females born in the most deprived areas have a life expectancy that is 6.2 years lower than those born in the least deprived areas.

For males, this gap increases to 8.4 years. Life expectancy for both men and women has dropped due to the pandemic.

An estimated 65% of Croydon's population have a non-White-British ethnic group. Compared to London as a whole, Croydon has a higher proportion of its population who are Black / Black British.

Croydon's non-White-British population are more likely to live in the more deprived areas of Croydon, with 48% of residents who are White British living in areas that are in the least deprived half of the country compared to just 26% of Croydon's non-White-British population.

According to the latest Indices of Multiple Deprivation, Croydon ranks 17 out of the 33 London boroughs in terms of deprivation – right in the middle.

> *Croydon, like sadly London and England, had inequalities before COVID and COVID has driven a great big wedge in the inequalities.*

Rachel Flowers, Director of public health

“We were more vulnerable in Croydon to COVID because of those inequalities.”

Rowenna, teacher in Croydon

9% of Croydon’s population are aged 70 and above, over 40,000 people. More than 5,000 babies were born to Croydon mothers during 2020. The impact of COVID-19 on the life chances of these children is yet to be determined.

The Care Quality Commission (CQC) reported in November 2021 that Croydon contains 128 nursing and residential homes – the largest number in London by some distance (the London borough with the second largest number of homes being Barnet containing 81 homes).

Many of our population both live and work within the borough and given the large number of care homes here employing over 3,000 staff and Croydon University Hospital employing over 3,600 staff, we know that there will have been many Croydon residents working in key people-facing roles throughout the pandemic.

Those working within care homes, hospitals and other front-line workers were more at risk of infection as they worked very closely with others and were unable to socially distance which increases the risk of exposure.

At its peak, there were almost 30,000 people living in Croydon regarded as ‘clinically extremely vulnerable’ who would have been particularly vulnerable to COVID-19.

Other factors already in place made isolating particularly difficult. 17% of households in Croydon do not have any private outdoor space and 10% of built-up area postcodes are not within 900m / 10-minutes walk of a park or public garden.

> *Lots of Deaf people didn’t know what was going on with COVID. How are we expected to get more information, and where would we get it from?*

Jotti - resident from the Deaf community

> *I was dealing with a residential home which obviously had people in it that were most at risk and most vulnerable.*

Jason, Care home owner

In 2019/20, more than 2,000 households in Croydon were in temporary accommodation and more than 2,500 households were owed a duty under the homelessness Reduction Act.

The Combined Homelessness and Information Network reported more than 300 rough sleepers in Croydon in the same year.

We know that there are over 3,000 people registered with the local sensory impairment team, approximately 51% being visually impaired and 49% hearing impaired. It can be difficult for this population to access services and information and some elements of the lockdown made this existing barrier more of a challenge.

ISSUES EXACERBATED BY COVID-19

The pandemic has caused financial inequalities to deepen with many of our residents losing income and relying on state-funded benefits to be able support themselves.

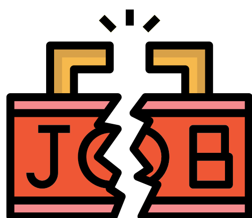
Research around the estimates of unemployment show that approximately 5% of the economically active population aged 16+ were unemployed in 2019/20, this increased to 7% in 2020/21. These increases were seen across London and England.

As would be expected, those living in more deprived areas of Croydon have higher proportions of their population claiming benefits and this gap has also increased during the pandemic.

> *The hard bit is the financial bit. That is the only thing I would actually worry about, that is the only worrying bit for me.*
>
> Donald - Owner, Yard Food

In addition to unemployment, up to the middle of September 2021, a total of 67,200 Croydon residents had been on furlough and 22,100 individual residents had claimed grants via the Self-Employment Income Support Scheme.

These financial difficulties facing the working age population has meant that the proportion of children eligible for free school meals has also increased during the pandemic, with more than a quarter of primary and secondary school pupils now eligible.



The percentage of working-age population claiming unemployment benefits (Universal Credit and JSA) increased significantly at the start of the pandemic and has remained higher than 2019 levels.

Prior to the pandemic, survey data tells us that 17% of Croydon adults felt lonely often, always or some of the time.

National studies into loneliness have shown that this increased during COVID-19, particularly during the January / February 2021 lockdown and that feelings of loneliness were higher amongst those from the least affluent populations, Black and Mixed ethnicities, disabled people and those with a long-term health condition and those aged 85+ or 16-24.

The number of domestic abuse offences increased sharply in Croydon during the first lockdown in 2020 and remains higher than 2019 levels.

The Combined Homelessness and Information Network reported an increase in the total number of rough sleepers in Croydon and across London in 2020/21 compared to 2019/20.

“Just before COVID, I had open heart surgery. I was quite concerned about the follow up.”

Priscilla - Volunteer

Since the COVID-19 pandemic there has been a greater demand for Mental Health services, particularly relating to anxiety, low mood, depression, suicide ideation and self-harm.

As such, the waiting lists for services have increased. To meet this demand there has been a significant increase in the number of virtual appointments while face to face appointments were maintained for the most vulnerable.

Similarly, there were interruptions to most of the health and wellbeing services, with some services such as Dentistry and Public Health Nursing being temporarily only accessible to those most in need and the most vulnerable.

... I had COVID too myself - I had to isolate by myself in one room separately from my family for two weeks - I had to be patient and endure this.

Jotti, Croydon resident

OUR COMMUNITY

The pandemic revealed two things about Croydon. One was the sheer scale and depth of the inequalities that are faced here. And second was the absolute amazing community spirit that we also have.

Rowenna, Teacher in Croydon

The Council's Gateway Discretionary Support team has financially supported 4,144 households for things such as food vouchers, emergency amenities and to move home.

The Education team has supported over 15,000 children eligible for free school meals across the pandemic by providing funding to local schools for food parcels and/or food vouchers and food and activity boxes throughout the holidays, as well as directly issuing vouchers and food parcels at the start of the pandemic when pupils were not in school.

In terms of financial support, 1,850 Test & Trace support payments were made between October 2020 and August 2021 to support those on low incomes required to self-isolate and by the middle of September 2021 22,100 individual residents had claimed grants via the Self-Employment Income Support Scheme.

We had already started pre-planning thinking we were going into a lockdown.

Markieu - Headteacher

Our faith says, we are reaching out to you and you know we are gonna get over this.

Petan - Christ Central Church

More than 2,500 devices , such as laptops, tablets etc, were issued by Croydon Council to help pupils continue their learning from home.

Croydon’s voluntary sector and the infrastructure organisations have greatly contributed to the voluntary community action during the pandemic.

For instance, managing the network of food banks and food distribution outlets, providing online support services, reaching out to communities and individuals who became isolated and fearful during the lockdown.

It is reported that there were over 3,000 Mutual Aid volunteers attached to local Mutual Aid groups.

> *And then I think it's just people... we step up, don't we?*
>
> Sandy - Volunteer

> .... was going there weekly to help sort the food donations from partners...
>
> Mary - Volunteer

The pandemic highlighted the diverse contribution of faith partners in Croydon by providing a tremendous opportunity to work more closely together around messages on infection prevention and control, COVID-19 misinformation, vaccine equity, access and uptake whilst providing their usual spiritual care in innovative ways.

This collaborative working has expanded to wider aspects of public health such as mental health e.g. 470 community members completed mental health first aid training sessions to support their community, including 53 faith leaders.

THE IMPACT OF COVID-19

At the time of writing this report, over 57,000 residents of Croydon have tested positive for COVID-19, approximately one in every seven residents. This is likely to be an underestimate of the total number of people who have actually had the virus.

There have been more than 1,000 COVID-19-related deaths and these account for approximately 23% of all deaths since 7 March 2020, meaning that almost one in every four deaths in the borough was COVID- 19 related.

The latest ONS analysis showed that certain occupation groups had higher rates of death involving COVID-19; elementary occupations (in males), process plant and machine operatives (in females) and caring, leisure and other service occupations (in both sexes).

In Croydon, the majority of our working population have professional occupations – these include health and education professionals such as doctors, nurses and teachers. Approximately a fifth work in those occupation groups with higher rates of death.

65% of Croydon adults have received both doses of the COVID-19 vaccination. 30% of those aged 12-17 have received their first dose and the booster programme is well underway.

"I don't know how a vaccine works but I want one because it's going to save my life."

James - Volunteer

"...we, as a global community, achieved something in 6-9 months that we had never been able to do before."

Nick - owner of Ludoquist

Across London, those living in the most deprived areas have experienced more than twice the amount of COVID-19-related deaths than those living in the least deprived areas.

Similarly, those with a Black / Black British or Asian / Asian British ethnic group have also seen almost twice the amount of COVID-19-related deaths than those with a White ethnic group.

Vaccination uptake in more deprived areas and those with a non-White British ethnic group is also lower across London when compared to those living in less deprived areas / those with a White British ethnic group.

When considering the effect of the COVID-19 pandemic on general and mental health, finances and employment, as well as missed education for children and young people, the true impact of COVID-19 will not be seen for many years.

"...It's been a time of awakening...."

Pastor Bola - His Grace Ministries

The pandemic has shone a light on structural racism, its impact on health and subsequent differences in health and health outcomes. Racial and ethnic differences in COVID- 19 diagnosis and death have persisted through the pandemic.

Racism has impacted ethnic minorities. Poor cultural sensitivity of national public health messaging contributed to the stigma, fear and lack of trust amongst some minority ethnic groups.

"Teenagers sharing beds with their parents; no internet connection available. Sometimes there are rat infestations; damp is pretty common. And if you say to someone or a family, not only do you have to live in those conditions, but now you must be locked down in those conditions for months."

Rowenna - Teacher in Croydon

RECOMMENDATIONS

The pandemic is not yet over, and it continues to impact our lives. In addition, we know that there are simple, effective things that we can do as part of our daily lives to improve our health and wellbeing.

This includes continuing to remember to adhere to hands, face and space COVID-19 measures.

These things apply on an individual level and a wider system level. They will help us to bounce back to be a fairer and more connected borough.

These are the Five Ways to Wellbeing:

CONNECT - We need to connect – as an individual making connections with others will enrich you. Croydon has an array of clubs and groups for people who share common interests - why not join one and connect. As a system continuing to maintain the brilliant partnerships formed over the last two years to reach out and serve the community in the most effective and efficient way.

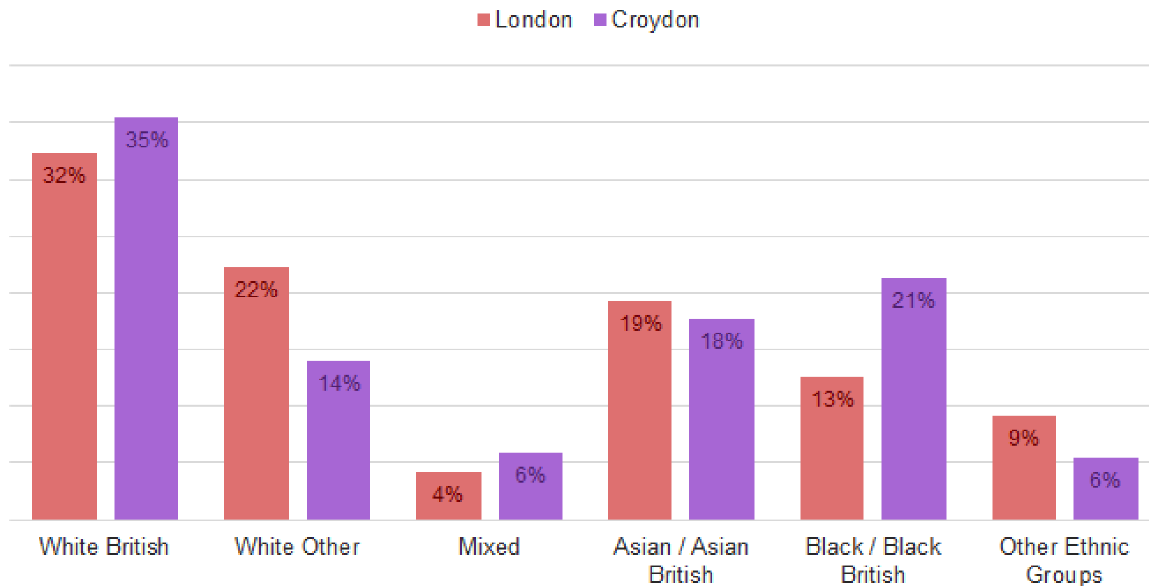
BE ACTIVE - We need to be active - being active and moving benefits both our physical health and mental health - play a game, think about how you get places, do gardening, discover a physical activity that you enjoy - there is so much to choose from in Croydon. As a nation a lot more people are working from home – let's think of innovative ways that we can all stay active even whilst working from home.

TAKE NOTICE - Take notice and be present in the here and now – being more aware of the present moment and reflecting on your previous experiences, will help you appreciate what matters most to you. Taking a moment to appreciate the little things, a smile, some fresh air, the hubbub of daily life. The pandemic has taught us that we cannot just do business as usual. We need to take notice of the world around us including inequalities that exist and prioritise opportunities to address these as a system.

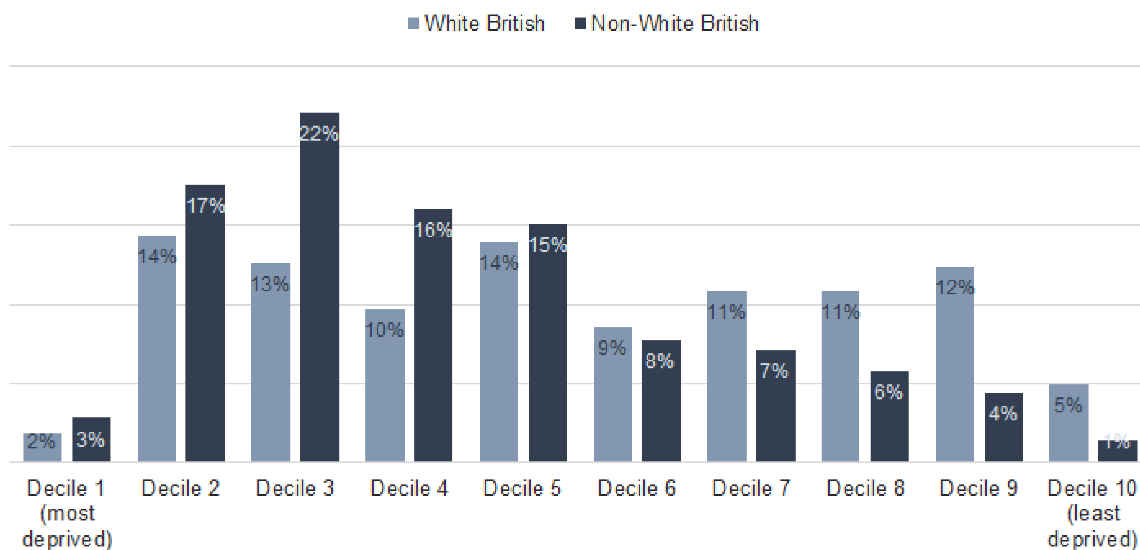
KEEP LEARNING - Learning can be fun and can help to make you more confident -let's not forget all that we have learnt over the pandemic and utilise this learning to implement the changes that will make a difference.

BEING GENEROUS – Doing small acts of kindness for other people whether that be through giving your time, with your words, or through your deeds- such as signing up for volunteering will support you to feel good. Despite current financial struggles, we must all work towards creative solutions to achieve better outcomes.

POPULATION STATISTICS

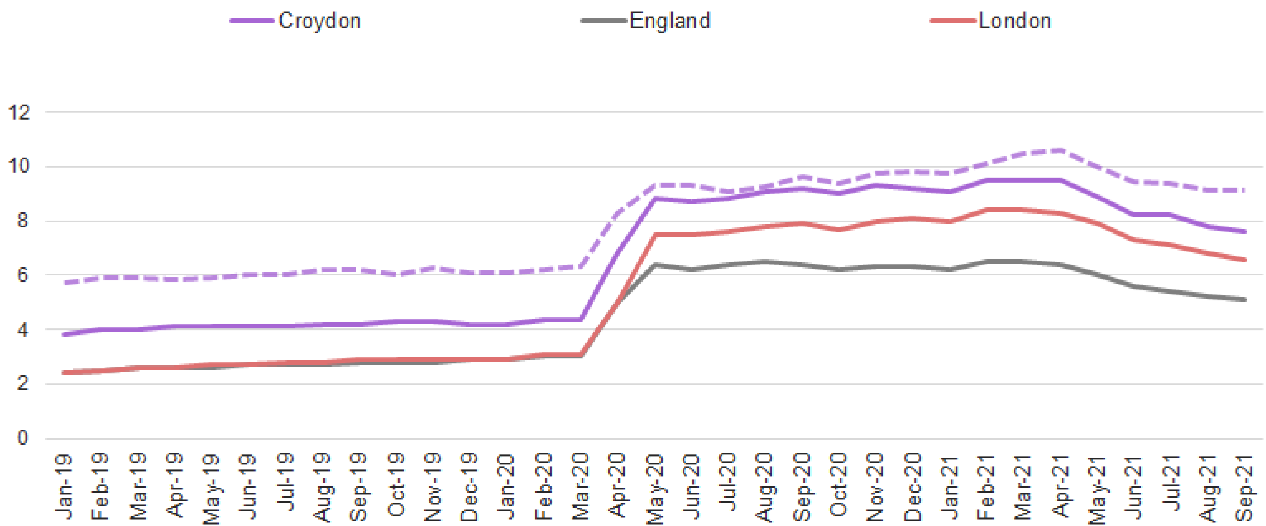


Source: National Immunisation Management Service, excludes those where ethnicity is recorded as Not Stated

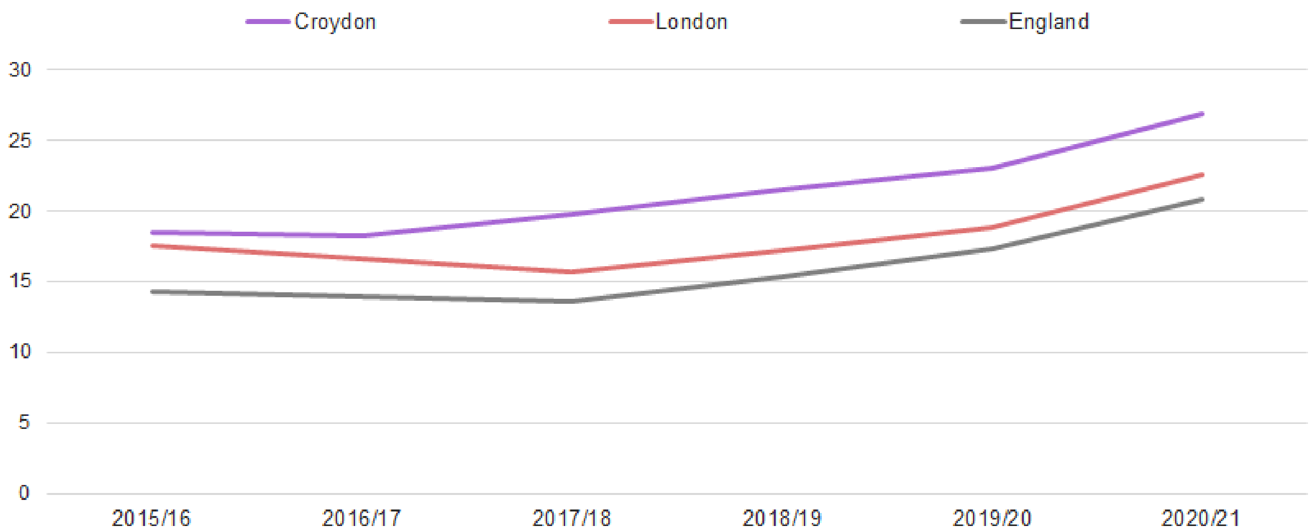


Source: National Immunisation Management Service, excludes those where ethnicity is recorded as Not Stated and Indices of Multiple Deprivation (2019)

Due to rounding, figures may not equal 100%

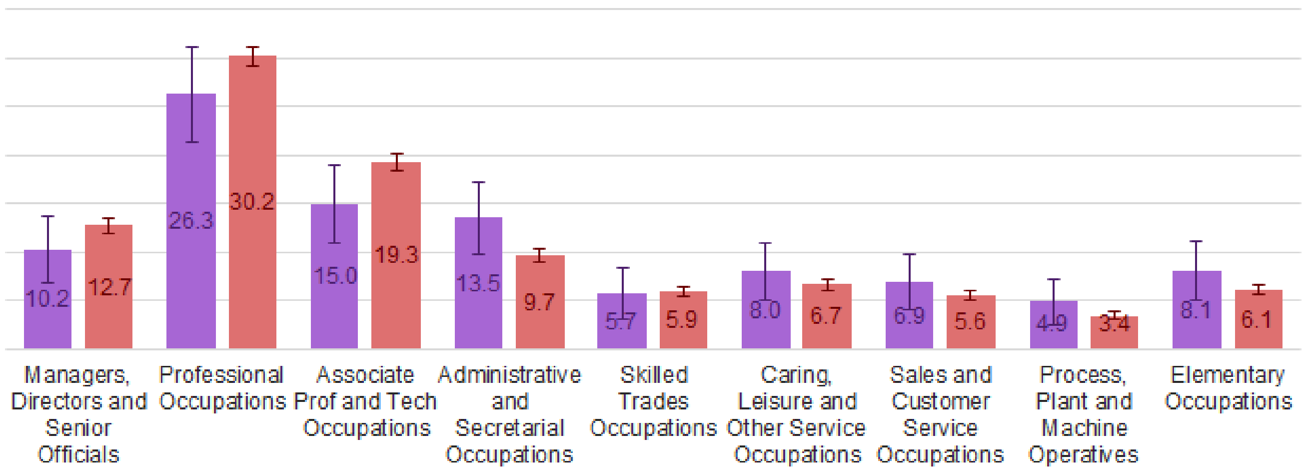


Source: Claimant Count, from NOMIS



Source: School pupils and their characteristics, Department for Education

Estimated proportion of employed population by broad occupation group, June 2020-July 2021



Source: Annual Population Survey, from NOMIS

REFERENCES

Further information regarding the health and wellbeing of Croydon's population can be found on the Croydon Observatory:

https://www.croydonobservatory.org/health-wellbeing/

Indices of Multiple Deprivation
https://www.gov.uk/government/statistics/english-indices-of-deprivation-2019

Population estimates - Taken from National Immunisation Management System. Restricted data provided by UKHSA

Life expectancy
https://fingertips.phe.org.uk/profile/public-health-outcomes-framework

Clinically extremely vulnerable Restricted data provided by NHS

Care homes
https://www.cqc.org.uk/files/cqc-care-directory-zip

Births
https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/livebirths/bulletins/birthsummarytablesenglandandwales/2020

Access to green space
https://www.ons.gov.uk/releases/accesstogardensandpublicgreenspaceingreatbritain

Housing
https://www.gov.uk/government/statistical-data-sets/live-tables-on-homelessness

Rough sleeping
https://data.london.gov.uk/dataset/chain-reports

Benefit Claimants
https://www.nomisweb.co.uk/datasets/ucjsa

Furlough
https://www.gov.uk/government/collections/hmrc-coronavirus-covid-19-statistics#coronavirus-job-retention-scheme

Self Employment Income Suport Scheme
https://www.gov.uk/government/collections/hmrc-coronavirus-covid-19-statistics#self-employment-income-support-scheme

Free school meals
https://explore-education-statistics.service.gov.uk/find-statistics/school-pupils-and-their-characteristics

Loneliness
https://fingertips.phe.org.uk/profile/public-health-outcomes-framework

https://sportengland-production-files.s3.eu-west-2.amazonaws.com/s3fs-public/2021-10/Active%20Lives%20Adult%20Survey%20May%202020-21%20Report.pdf?

COVID cases and vaccination
https://coronavirus.data.gov.uk/

COVID-related deaths
https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/causesofdeath/datasets/deathregistrationsandoccurrencesbylocalauthorityandhealthboard

Unemployment
https://www.nomisweb.co.uk/datasets/umb

Occupation
https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/causesofdeath/bulletins/coronaviruscovid19relateddeathsbyoccupationenglandandwales/deathsregisteredbetween9marchand28december2020#:~:text=elementary%20occupations%20(66.3%20deaths%20per,per%20100%2C000%20males%3B%20848%20deaths)

And -

https://www.nomisweb.co.uk/datasets/apsnew

COVID-19 mortality and vaccination
https://analytics.phe.gov.uk/apps/chime/

Domestic abuse
https://www.london.gov.uk/what-we-do/mayors-office-policing-and-crime-mopac/data-and-statistics/domestic-and-sexual-violence-dashboard

The cost of the video report is funded through the COVID-19 Contain Outbreak Management Fund.

Watch the Croydon video accompanying this data document on Croydon Council's YouTube channel:

www.youtube.com/user/croydoncouncil

My sincere thanks and gratitude to everyone who took part in the video who are named in the photos below, and to Rise Media.

Thanks also to colleagues in Croydon Council who contributed to compiling the video and data:

- Damian Brewer - Public Health Principal, who provided the British Sign Language support in the video
- Dr Jack Bedeman - Public Health Consultant
- Denise Dixon, Susan Mubiru and Bevoly Fearon - Public Health Principals
- Carol Lewis - Senior Public Health Intelligence Analyst
- Denise Malcolm - Senior Communications Officer
- Bethan Crowden - Communications Officer

Markieu

Rowenna

Donald

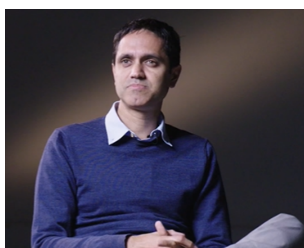
Priscilla

Pastor Bola

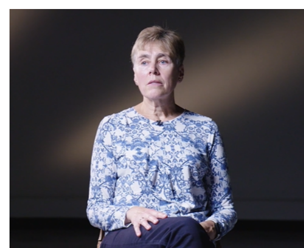
Nick

Jotti

James


Jason

Sandy


Mary

Petan

REPORT TO:	HEALTH AND WELLBEING BOARD 19 January 2022
SUBJECT:	Health and Care Plan Refresh 2021-2023
BOARD SPONSOR:	Matthew Kershaw
PUBLIC/EXEMPT:	Public

SUMMARY OF REPORT:

The Five-year Croydon Health and Care Plan was developed in 2019 setting out how Croydon would deliver the Health and Care Strategy ambition to *'Work together to make Croydon a great place to live, work and play for all its residents through creating rapid improvements in the health and wellbeing of our communities'* through its three aims: focusing on prevention and proactive care, unlocking the power of communities and putting services back in the heart of the community.

Progress has been made on delivering the aims of the Health and Care Plan with multiple initiatives that join-up health, care and the voluntary and community sector to provide more coordinated services in our borough at the heart of communities; however, there are huge challenges ahead including uncertainty for jobs and economy, deterioration in residents' wellbeing during the pandemic, emerging unmet need and financial pressures across health and social care.

The refresh allows us to learn from our response to the COVID-19 Pandemic, understand the impact the pandemic has had on our communities and ensure we reduce inequalities. There are some key areas that have greater focus in the refreshed plan, especially around enablers like workforce, estates and IT as well as Equalities, Diversity and Inclusion and Children and Young People.

The Health and Wellbeing Board reviewed the approach to refreshing the Health and Care Plan as well as initial progress reports in June 2021 where the Board noted that the plan would be finalised and approved by the Executive Director of Health Wellbeing and Adults following conclusion of the Stakeholder Consultation; subsequently the Plan was agreed by the Executive Director at the Shadow Health and Care Board on the 18th October 2021.

The refresh was reviewed by Health and Care Scrutiny Committee in September 2021.

BOARD PRIORITY/POLICY CONTEXT:

This report addresses the delivery of the Health and Wellbeing Strategy through the Health and Care Plan Refresh 2021-2023.

The Health and Care Plan Refresh priorities have been developed jointly by One Croydon Members and the wider VCSE sector.

FINANCIAL IMPACT:

The Health and Care Plan sets out priorities for the whole population of Croydon, detailing major transformation programmes across areas of focus. Where there is a need for financial investment or reallocation, the transformation or project in question will be subject to governance requirements for the funding source used and through a whole system business case where it crosses organisational boundaries.

RECOMMENDATIONS:

This report recommends that the Health and Wellbeing Board:

1. Agree the refresh of the Health and Care Plan 2021-2023.

1. Croydon Health and Care Plan Refresh 2021-2023

Croydon's health and care workforce, the Voluntary and Community Sector and wider community have achieved a great deal in very difficult circumstances during the pandemic, and this further demonstrates what we can do when we work closely together across the system with a common goal. Some of our plans had to change with COVID-19 as across the borough our teams came together to care for the many people affected by coronavirus and support our colleagues who have worked tirelessly as part of a coordinated response to the pandemic whilst other plans have continued at pace. This refreshed plan captures this learning and embeds it in the revised priorities and goals for 2021-2023.

In order to continue to make progress, the refreshed plan has been developed to consider and support Croydon Council to implement its renewal plans (these will get council finances back on track and put the Council on a more sustainable footing) and help us move towards greater integration of health and care.

The Health and Care Bill was introduced to Parliament on the 6th July 2021 and confirmed the Government's intention to introduce Integrated Care Systems from April 2022. Part of the preparation to transition to an ICS requires each of the six places in South West London CCG to refresh their Health and Care Plans, focussing on what has been achieved, refreshing priorities, reducing inequalities and preventing future risks to ill-health.

The refresh has given One Croydon the opportunity to come together and assess our progress so far and re-set our priorities. The refresh includes:

- Additional Aims setting out our commitment to; resident engagement and active involvement, supporting our workforce and embedding population health management

- Addressing health and wellbeing inequalities; acknowledging they existed before and have been exacerbated by COVID-19
- Developing robust metrics to measure the delivery and impact of our priorities
- Updated Outcomes Framework to better monitor impact on our long-term goals

A wide range of evidence and data was used to inform the refreshed aims and priorities including:

- The Joint Strategic Needs Assessment
- Healthwatch report
- COVID-19 impact reports (from various government and not-for-profit sources)
- Evidence base and data specific to each area of focus
- Stakeholder engagement
- NHS Planning Priorities
- Croydon Council Social Care Transformation plans

We are working together in One Croydon to be open and transparent about the challenges facing each individual organisation and using our solid partnership to come together and tackle these challenges. Each programme will be impacted differently, and the One Croydon partnership will ensure there is oversight of risk across the system to ensure we can effectively identify, address and mitigate them.

2. CONSULTATION

Engagement with people that have lived experience was undertaken for each area of focus including:

- Mental health community hub and spoke model co-design engagement
- All age disability hub
- Learning Disabilities and autism strategy
- One Croydon Service User Group
- Primary Care workshops
- Healthwatch led engagement on areas including urgent and emergency care,
- Young people’s experiences of mental health and ICN+
- Over 70 engagement events across the borough as part of the Covid-19 vaccination programme building community partnership workshops held in each locality strengthening partnerships between One Croydon, our voluntary and community partners and Croydon residents

In addition, we undertook a stakeholder discussion exercise to test the draft priorities and gain views from professionals and stakeholders from right across the Health and Care system on how we can improve outcomes for the

people of Croydon. Overall, 123 people responded, from 15 different organisations.

3. EQUALITIES IMPACT

The Health and Care Plan is focused on reducing health inequalities and the outcomes framework will measure the impact of this. Any areas of focus that deliver a service/policy change/transformation during the period of the Health and Care Plan will be required to undertake an Equality Impact Assessment in line with their own organisation's policies.

4. DATA PROTECTION IMPLICATIONS

4.1. WILL THE SUBJECT OF THE REPORT INVOLVE THE PROCESSING OF 'PERSONAL DATA'?

NO

4.2. HAS A DATA PROTECTION IMPACT ASSESSMENT (DPIA) BEEN COMPLETED?

NO - The Health and Care Plan does not involve processing or management of any data. All areas of focus that deliver a service/policy change/transformation during the period of the Health and Care Plan will be required to undertake a DPIA in line with their own organisation's DPIA policies.

CONTACT OFFICER:

Sam Boyd, Associate Director of System Strategy, Adult Social Care & Health

APPENDICES TO THIS REPORT:

Appendix 1 - One Croydon Health and Care Plan Refresh 2021-2023

One Croydon

Your health and care partnership

One Croydon

Health and Care Plan Refresh

2021 to 2023

Welcome

Croydon Health and Care Plan refresh

In 2019, our One Croydon partners launched our new five-year plan to help people in our community improve their health and wellbeing. Our ambition was – and still is – to deliver better care and support tailored to local needs, available closer to home within the neighbourhoods in which people live. We want to bring together the borough's NHS care for physical and mental health, along with GPs, social care and the voluntary sector, joining up services to provide more holistic care.

We started to deliver on our vision, with a greater collective focus on the prevention of ill health to help more people start well, live well and age well in Croydon. New initiatives to join up health and care in localities and new partnerships with the voluntary sector have started to bear fruit.

Then with the COVID-19 pandemic, and our collective focus had to change.   Across the borough our teams came together to care for the many people affected by coronavirus and support our colleagues who have worked tirelessly as part of a coordinated response to the pandemic. Our partners across the NHS, local authority and voluntary organisations worked tirelessly to manage the impact of the pandemic, deliver the vaccine programme while continuing to provide essential services.

Other elements of our original plans have continued at pace as we continue to strive to make our Croydon Health and Care Plan a reality, aligned with the strategic aims of Croydon's Health and Wellbeing Strategy.

In this document – a refresh of our original Croydon Health and Care Plan - we want to tell you what we've done, what's changed and focus now together, on what we do next.

Within this document, you'll find a summary of what we've achieved to date and our refreshed and enhanced priorities that we have developed together over the last few months. In developing our plans we have built on the conversations we have had throughout our partnership in discussion with local families, patients, community groups, stakeholders and staff. We haven't stopped listening and we are committed to keeping this conversation going.

Thank you for your time and we look forward to continuing to work with you and all our partners to improve the health and wellbeing of people of Croydon.

Councillor Janet Campbell

One Croydon

Your health and care partnership

Section 1: Introduction and Context

Introduction

One Croydon
Your health and care partnership

The Croydon Health and Care Plan

In 2019, One Croydon launched a five-year Health and Care plan to help people in our community improve their health and wellbeing. Our ambition was to deliver integrated care and support tailored to local needs that is available closer to home within the neighbourhoods in which people live; bringing together the borough's NHS care for physical and mental health, along with GPs, social care and the voluntary sector.

We've come a long way to deliver on this ambition with multiple initiatives that join-up our health and care expertise to provide more coordinated services in our borough at the heart of communities; however, there are huge challenges ahead including uncertainty for jobs and economy, deterioration in residents' wellbeing, emerging unmet need and the Councils financial situation; we now need to need to build on what we've done and develop it further and at scale.

Why refresh? What's changed?

Croydon's health and care workforce, the Voluntary and Community Sector and wider community have achieved amazing things during the pandemic, and these demonstrate what we can do when we work closely together across the system with a common goal. Some of our plans had to change with COVID-19 as across the borough our teams came together to care for the many people affected by coronavirus and support our colleagues who have worked tirelessly as part of a coordinated response to the pandemic whilst others have continued at pace; this refreshed plan captures this learning and embeds it in the revised priorities and goals for 2021-2023.

Iin order to continue to make progress the refreshed plan has been developed to consider and support Croydon Council to implement its renewal plans (these will get council finances back on track and put the Council on a more sustainable footing) and implement the Health and Care Bill in a way that improves outcomes for the people of Croydon; the Bill builds on the NHS long term plan, captures learning from the Covid-19 pandemic and furthers integration of Health, Social Care and public health system

The Health and Care Bill was introduced to Parliament on the 6th July 2021 and confirmed the Government's intention to introduce Integrated Care Systems from April 2022. Part of the preparation to transition from to an ICS requires each of the six Places in South West London CCG to refresh their Health and Care Plans, focussing on what has been achieved, refreshing priorities, reducing inequalities and preventing future risks to ill-health.

Context: Integrated Care Systems

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Integrated care systems (ICSs) are partnerships of health and care organisations that come together to plan and deliver joined-up services and to improve the health of people who live and work in their area.

The ICS exist to achieve four aims:

- improve outcomes in population health and healthcare
- tackle inequalities in outcomes, experience and access
- enhance productivity and value for money
- help the NHS support broader social and economic development.

Place-based partnerships arecollaborative arrangementsformed by the organisations responsible for arranging and delivering health and care services; Croydon established a 'Place based partnership' back in 2017 through the One Croydon Alliance.
Within an ICS, Place-based partnerships will remain as the foundations of integrated care systems building on existing local arrangements and relationships. Place has four main roles, all of which One Croydon have been delivering since 2017:

- To support and develop primary care networks (PCNs) which join up primary and community services across local neighbourhoods.
- To simplify, modernise and join up health and care
- To understand and identify people and families at risk of being left behind and to organise proactive support for them; and
- To coordinate the local contribution to health, social and economic development to prevent future risks to ill-health within different population groups.

One Croydon is committed to supporting Croydon Health Services to build on its success as a member of the SWL Acute Provider Collaborative and further the success of the SWL APC by:

- Developing joint strategies for example elective care
- Providing further support to clinical networks to create innovative new pathways and tackle unwarranted variation
- Undertake even more joint workforce development and planning
- Maintaining the key features that have underpinned the APC's success including; a thin management layer, strong governance for delivery of agreed programmes and informal partnership governance rather than delegated authority

The Changes: a summary

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The refresh has given One Croydon the opportunity to come together and assess our progress so far and what our priorities need to be in a fast-changing environment including emerging impact of the COVID-19 pandemic, the Health and Care Bill and the Local Authority financial position. The refresh includes:

- Additional Aims that include setting out our commitment to; support people to recover from the effects of the pandemic including resident engagement and active involvement, supporting our workforce, embedding population health management and tackling inequalities
- Refreshed Priorities and delivery plans for each Area of Focus
- A commitment to work together to ensure funding is based on need rather than historic spending patterns. We believe this is essential if we are to reduce inequalities in health across SWL
- Addressing health and wellbeing inequalities; acknowledging they existed before and have been exacerbated by COVID-19
- Developing robust metrics to measure the delivery and impact of our priorities
- Updated Outcomes Framework to better monitor impact on our long-term goals

Engaging with people and communities across Croydon

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Your health and care partnership

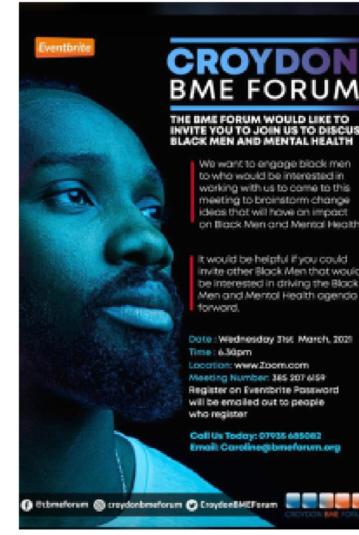
Since the Health and Care Plan was first published in 2019 health and care partners have continued to engage with local people to understand how we are meeting their needs and improving health and care outcomes, and how we can improve on these.

Programme and clinical leads for each programme led engagement on the specific areas of the plan including:

- Mental health community hub and spoke model co-design engagement
- All age disability hub
- Learning Disabilities and autism strategy
- One Croydon Service User Group
- Primary Care - integrating primary and secondary care
- Healthwatch led engagement on areas including urgent and emergency care, young people's experiences of
- mental health and ICN+
- Over 70 engagement events across the borough as part of the Covid-19 vaccination programme
- Building community partnership workshops held in each locality strengthening partnerships
- between One Croydon, our voluntary and community partners and Croydon residents

More detail about the **engagement delivered within each programme** can be found in section 3.

In addition to we undertook a stakeholder discussion exercise to test the draft priorities and gaining views from professionals and stakeholders from right across the Health and Care system on how we can improve outcomes for the people of Croydon. Overall, 123 people responded, from 15 different organisations including GPs.



Engaging with people and communities across Croydon

One Croydon
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Understanding what local people think of services is essential for us to improve them. We are committed to reaching out to local communities and supporting residents to have their say in the future of local services.

You said, we did….

"With so many different sources of information about COVID-19, some giving conflicting advice, it is difficult to know what to believe."

We held more than 65 events, reaching more than 4,000 people to engage them in the importance of protecting yourself against COVID-19, including testing and getting vaccinated during the pandemic. Joint working between One Croydon partners, Croydon BME Forum, Asian Resource Centre, Croydon Voluntary Action and other community groups has helped inform residents and raise awareness amongst our community on how to protect themselves. We have used social media to widen our reach and to signpost people to trusted sources of information, including our own single source of truth website which holds the latest information about vaccines and other COVID-19 related news at www.swlondonccg.nhs.uk

"Services and support is needed to help homeless people access and navigate health and care services. Particularly those who are not registered with a GP who can act as the gatekeepers of access."

A new integrated Home Pathways Team is being set up in Croydon Hospital to coordinate care for homeless people when they come to the hospital for specialist services, visiting A&E or when admitted to hospital. The team will support all homeless patients, taking time to understand their individual needs, to coordinate their care and link them with external agencies to offer continuing support after treatment.

"Better communication of waiting times: Patients understand they have to wait but would really welcome information on how long they will have to wait. This would make a big difference to their experience of waiting."

Croydon Health Services are working with healthcare systems experts at *Patienteer*, to provide real-time updates waiting times for urgent and emergency care, with digital screens and increased efforts to communicate clearly what our patients can expect from their visit.
3 people responded, from 15 different organisations including independent GPs.

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Section 2: Achievements against the plan

Original Aims: Achievements

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Focus on prevention and proactive care **by supporting local people before things become a problem and encouraging residents to be more proactive in their own health**

- Achievements include:
  - In Northeast Integrated Community Network + a total of 619 referrals have been received in the year of operation; outcomes show that 31% of people reported an increase in health and wellbeing and 25% reported an increase in movement, mobility and physical ability
  - Community Hubs (previously Talking Points) provided support around housing and benefits advice with n– 258 people receiving proactive advice and support in the first 8 months (Sep 20-Apr21)
  - Long Term Condition outreach programme delivered by BME Forum and Asian Resource Centre including community events, training community champions and delivering health checks People receiving support from Personal Independence coordinators achieved an average of a 2-point improvement in their wellbeing after 2 months (using the Short Warwick-Edinburgh Mental wellbeing scale)
- Many challenges remain to shift the dial to prevention, backlog of issues and unmet need post pandemic

Unlock the power of communities **by making the most of communities' assets and skills – the key to helping local people stay fit and healthy for longer is connecting them with their neighbours and communities and voluntary organisations**

- Local Voluntary Partnerships Programme grants have helped stimulate grassroots activity to add to the rich and diverse VCS we have in Croydon
- One Croydon is one of six groups across the country to bid successfully for the Healthy Communities Together Programme run by the King's Fund and National Lottery. The programme aims to maximize the potential of partnership between voluntary and statutory sectors, shifting resources and control to communities in order to reduce health inequalities.
- Voluntary and community sector came together with Croydon residents and partners in the statutory sector to support Croydon people through the pandemic and has continued to deliver a multitude of key services from Personal Independence Coordinators, to befriending and food banks.

Put services back into the heart of the community **by making sure local people have access to integrated services that are tailored to the needs of local communities**

- Achievements include:
  - Croydon as provider of choice
  - Localities ICN+ model: a successful early adopter in Northeast has led to the rollout across Croydon
  - Early Help provision delivered in Localities
  - Croydon Health and Wellbeing Space in the Whitgift Centre and Mental Health Personal Independence coordinators being recruited to

Additional Aims for 2021 to 2023

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Your health and care partnership

Support Croydon people to recover from the effects of the pandemic, through the recovery programme and a focus on high quality care

- Continue to deliver the COVID-19 Vaccination programme and meet the needs of people with COVID-19 and its long-term effects
- Embed the core principles of resident and patient's engagement and active involvement to inform the decisions we make and the actions we take. Demonstrate this by regularly feeding back how people's views and experiences have influenced our work, "You said, we did"

Enable, develop and maintain the Croydon health and care workforce

- Build on the work undertaken through the SWL Recruitment Hub, Croydon Health Services People Plan and Localities work, adopting a strong programme to drive it forward for One Croydon

Lead a determined, collaborative approach to tackling inequalities

- Maintain focus on social need within ICN+ and work with VCS to deliver more proactive and preventative support around the wider determinants of health and wellbeing such as housing, debt, education and employment
- Build on Long term conditions work targeting most affected communities and deliver new programmes for example ethnicity in mental health
- Restart the work on social and economic development through the Anchor Institute programme

Embed a Population Health Management Approach

- Develop a strategic approach to PHM to tackle Health inequalities and improve the health & wellbeing of Croydon people
- Work collaboratively with SWL ICS to harness the maximum benefit from the SWL PHM and digital strategy
- Continued assessment to understand the impact of COVID as it emerges using local data, intelligence and people's experiences

Stakeholder feedback: Aims

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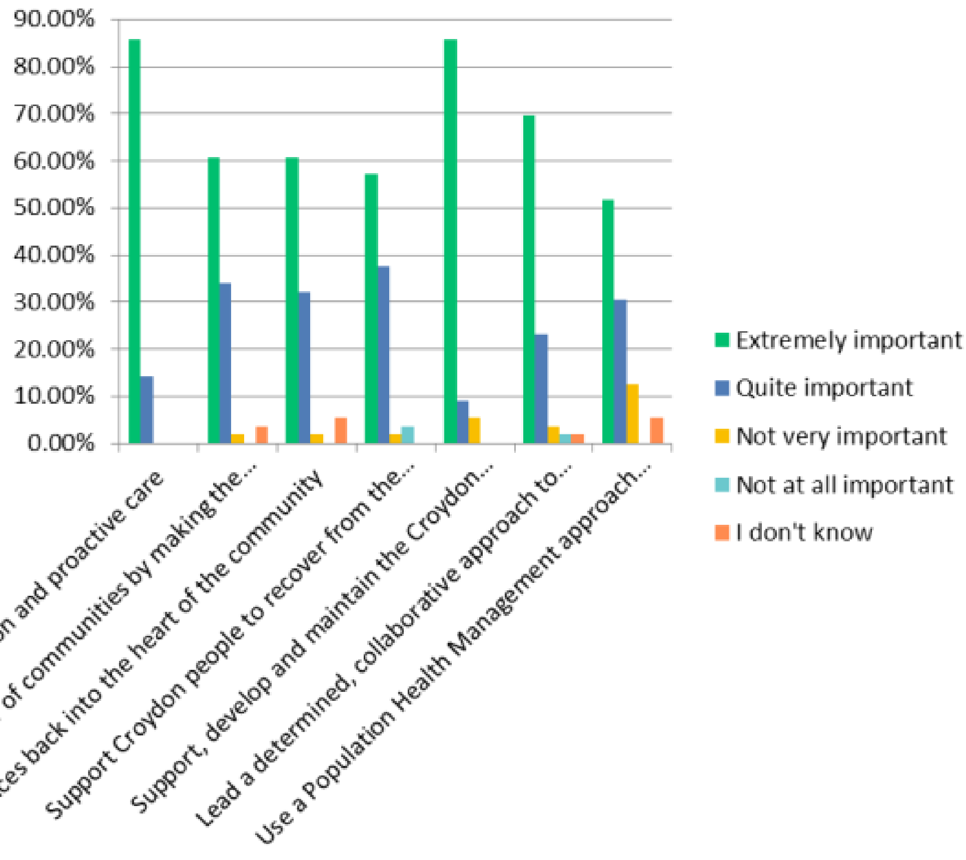

Three of our aims were ranked as the most important to people and these were:

- Focus on prevention and proactive care
- Support, develop and maintain the Croydon health and care workforce
- Lead a determined, collaborative approach to tackling inequalities

2019 Health and Care Plan: Progress

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In the original Health and Care Plan we set out how we would know we have made a difference and measured progress using a set of nationally-available indicators in the Outcomes Framework. The table below shows progress against our long-term outcomes; the refreshed priorities include those areas in which progress has not been made. These long-term outcomes will be considerably impacted by the Covid pandemic; therefore, there will a focus on developing local measures to assess and monitor how we are making a difference to the health and wellbeing of People in Croydon and reducing Health Inequalities.

How will we know if we've made a difference?

Improve quality of life

- Increase the number of adults exercising
- Decrease the number of people with long term conditions in the most deprived areas where incidence is higher

Better start in life

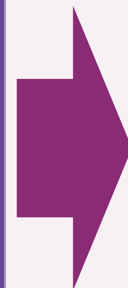
- Reduce obesity in reception year children
- Reduce the number of school pupils with social, emotional and mental health needs

Wider determinates of health

- Increase social inclusion
- Increase employment, particularly for people with learning difficulties and mental health needs

Over ten years to improve healthy life expectancy from 62 years to 66 years for men and 62.8 years to 66.8 years for women

Reduce the gap in life expectancy from 9.4 years to 7.4 years for men and from 7.6 years to 5.6 years for women



Measure	Baseline	Latest Performance
Increase the number of adults exercising	64.2%	62.2%
Decrease number of people with LTC in the highest deprived areas	Indicator not developed	
Reduce obesity in reception year children	21.9%	21.8%
Reduce number of pupils with social, emotional and mental health needs	2.5%	2.7%
Proportion of adult social care users who have as much social contact as they like	39.3	43.4
Adults in contact with secondary mental health services in paid employment	5.0%	6.0%
Adults with learning disabilities in paid employment	5.5	4.6
Improve health life expectancy in men	65	64.4
Improve health life expectancy in women	59.5	62.6

Outcomes Framework 2021-2023

The Outcomes Framework has been updated to incorporate new measures that improve our ability to assess impact, as well as removing those for which national data is no longer collected. Regular reviews are undertaken by the Quality and Performance Group which includes subject matter experts, analysts and clinical leads, to ensure the most robust indicators are being used. In addition to these long-term goal indicators, each area of focus has a set of metrics to measure impact and delivery of our transformaiton programmes.

No.	Indicator	Priority / Project
Overarching and Wider Determinants		
1	Healthy life expectancy at birth (in years, males)	Inequalities
2	Healthy life expectancy at birth (in years, females)	Inequalities
3	Life expectancy at birth (in years, males)	Inequalities
4	Life expectancy at birth (in years, females)	Inequalities
5	Households in temporary accommodation (rate per 1,000 households)	Wider Determinants
6	Air pollution: fine particulate matter (mean micrograms per cubic metre)	Wider Determinants
7	Proportion of children in relative low income families (under 16)	Wider Determinants
8	Proportion of physically active adults (aged 19+)	Wider Determinants
9	Proportion of adults who are current smokers	Proactive and Preventative
10	Excess winter deaths (ratio %)	Whole Population Health
11	Unemployment rate	Wider Determinants

No.	Indicator	Priority / Project
Proactive and Preventative		
12	Proportion of adults who are overweight and obese	Healthy Weight
13	Proportion of people who report good life satisfaction (response score of 7 or higher)	Mental Health
14	Proportion of people who report good life worth (response score of 7 or higher)	Mental Health
15	People with type 2 diabetes who received all 8 care processes	Long-term conditions
16	Unplanned hospitalisations for chronic ambulatory care sensitive conditions (rate per 100,000 population)	Long-term conditions
17	Proportion of adult carers who have as much social contact as they like (survey conducted every 2 years)	Mental Health
18	Proportion of adult social care users who have as much social contact as they like	Mental Health
19	MMR for 2 doses at age 5	Immunisations
20	Flu vaccinations uptake in at risk groups	Immunisations
21	Emergency admissions due to falls in people aged 80+ (rate per 100,000)	Falls

No.	Indicator	Priority / Project
Localities		
22	Deaths which take place in hospitals - all ages	End of Life
23	People with long term conditions feel supported to manage their condition	Support the development of practices and primary care networks to join up primary care and community services
24	Estimated dementia diagnosis rate (aged 65+)	Dementia Care
25	People who use services who have control over daily lives	People having control / strengths based approach
26	Delayed transfers of care from hospital that are attributed to adult social care	LIFE
27	Proportion of people aged 65+ who were still at home 91 days after discharge from hospital into re-ablement/rehabilitation	LIFE

Cont. Outcomes Framework: 2021 to 2023

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No.	Indicator	Priority / Project
Enable a Better Start in Life and Maternity		
28	Low birth weight of term babies	Early Years
29	School readiness: good level of development at the end of reception year	Improving Mental Health and Wellbeing for Children and Young People
30	School pupils with social, emotional and mental health needs	Improving Mental Health and Wellbeing for Children and Young People
31	Rate of fixed-term exclusions in primary school (per 100 pupils)	Improving Mental Health and Wellbeing for Children and Young People
32	Rate of fixed-term exclusions in secondary school (per 100 pupils)	Improving Mental Health and Wellbeing for Children and Young People
33	16-17 year olds not in education, employment or training	
34	Excess weight among children in reception year	Improving Mental Health and Wellbeing for Children and Young People
35	Admissions for respiratory tract infections in infants aged 2, 3 and 4	Improving urgent care pathways and management of LTC
36	Unplanned hospital admissions for asthma for under 19s	Improving urgent care pathways and management of LTC
37	A&E attendances (aged 0-4, rate per 1,000)	Improving urgent care pathways and management of LTC
38	Hospital admissions for diabetes (aged <19, rate per 100,000)	Improving urgent care pathways and management of LTC

No.	Indicator	Priority / Project
Mental Health		
39	Adults in contact with secondary mental health services in paid employment	Partnership working
40	Gap in the employment rate between those in contact with secondary mental health services and the overall employment rate	Partnership working
41	Excess under 75 mortality rate in adults with serious mental illness	Improve the crisis MH pathway
42	IAPT Recovery Rate (at least 50% of people completing treatment with IAPT should recover)	Improve the community MH pathway
43	Adults in contact with secondary mental health services living in stable and appropriate accommodation	Partnership working

No.	Indicator	Priority / Project
Joining up Care for People with Disabilities		
44	Adults with learning disabilities in paid employment	Support people to live independently
45	Gap in the employment rate between those with a learning disability and the overall employment rate	Support people to live independently
46	Adults with a learning disability living in stable and appropriate accommodation	Support people to live independently
47	The proportion of people who use services who receive direct payments	Provide quality social care services
48	The number of people aged 18-64 whose long-term support needs were met by admission to residential and nursing care homes, per 100,000 population:	Provide quality social care services

No.	Indicator	Priority / Project
Modern Acute		
49	Responsiveness to inpatients' personal needs (within CHS)	Quality Improvement
50	Patient experience of hospital care (of CHS)	Quality Improvement
51	Patient safety incidents reported (within CHS, rate of all incidents per 1,000 bed days)	Quality Improvement
52	Outpatients - 25% virtual appointments	Outpatients Transformation
53	Theatre utilisation - 85%	Croydon Elective Centre
54	Bed Occupancy - 92%	Non-Elective

No.	Indicator	Priority / Project
Integrated Health and Social Care		
55	Health and care financial performance against plan	Shadow Health and Care Budget
56	Emergency readmissions within 30 days of discharge from hospital	ICN+
57	Emergency admissions for acute conditions that should not usually require hospital admission	ICN+

Achievements and gaps: closing the financial gap

Financial Aims in the Health and Care Plan 2019:

- Better manage the financial gap (do nothing position of £100m gap in health and social care by 23/24)
- Shift balance of spend from reactive high-cost acute care to preventative and proactive out of hospital care

What have we done to progress these aims?

One Croydon has created a shadow health and care budget to remove organisational barriers and achieve:

- Greater flexibility in use and management of resources across the system
- Greater ability to shift resources for greatest impact, shifting from reactive to proactive and preventative care
- Outcomes based commissioning approach

The Impact of COVID-19 and current financial picture:

- Croydon Council financial position has significantly worsened with a section 114 notice being issued in December 2020. The Government has approved a capitalisation direction of £120m over the next two years to help Croydon Council achieve a balanced budget and this is conditional on the Council delivering its renewal plans at pace.

- The Joint Control total in the health system greatly improved the financial position. NHS investments since the start of the COVID-19 pandemic have been focused on pandemic response and recovery, alongside long-standing commitments on Mental Health and Primary Care. There is limited financial flexibility to fund other priorities. There is also a significant and increasing national requirement to make efficiencies.

- The transition to an ICS provides Croydon Place with an opportunity to continue having financial autonomy over its Health budget, this will enable the work on the Shadow Health and Care Budget and better use of resource across the system to continue.

- In addition, One Croydon partners are committed to work together to raise the issue of historic underfunding and the need to ensure that Croydon is allocated sufficient resources to meet the needs of the population.

One Croydon

Your health and care partnership

Section 3: Areas of Focus

Areas of focus

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The Health and Care Plan described six areas of focus for the first two years – these were areas that One Croydon identified as requiring transformation and being key to achieving the aims of the plan:

1. Proactive and preventative care
2. Localities – joined up working in local communities
3. Modernising acute care
4. Adult mental health and well-being
5. Better start in life and maternity
6. Joining up care for people with disabilities

A subject Matter Expert is responsible for an Area of focus and a Clinical lead has been aligned to each one.

Both worked closely with a range of stakeholders to review the progress made since 2019, collate engagement and feedback that had been undertaken during this time, analyse the impact of COVID and using all this information to draft revised priorities for 2021 to 2023 which were then tested with stakeholders from across the system

Summary of progress for each area

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Localities - locality based ICN+	• North East ICN+ launched in July 2020 operational for 10 months • ICN+ model rolled out across remaining five Localities during 2021 • “Stay Steady, Stay Well clinic” introduced as prevention strategy • Themed “huddles” focussing on conditions including Diabetes and Respiratory
Localities - GP /PCN	• CGPC Clinical Director Cabinet held each month • First large flu vaccination clinics at Ikea and Selhurst Park, Crystal Palace • Integrated booking system allows GPs and out of hours service to see all available appointments • Laptops, webcams and Emis Enterprise provided to GP practices to support data reporting
Localities – Care Homes, Falls and End of Life	• Telemedicine service in 75 care homes helps assess clinical needs and coordination of care • Remote monitoring of vital sign in Care Homes using telehealth technology rolled out during 2021 • In partnership with St Christopher’s Hospice and community groups to help everyone have a good death by encouraging open conversations about dying and record ‘End Of Life’ wishes
Localities – LIFE	• Due to the Pandemic, Council named as Single Point of Contact for all hospital discharges resulting in an increase of patients being safely discharged from hospital • Due to the Pandemic, completion of the LIFE discharge to assess review was delayed, now restarted to look at more joined up ways to support more patients across the borough
Mental Health	• The mental health community hub and spoke model has been co-designed and the pilot Mental Health Wellbeing Hub at the Whitgift Centre is due to open during Q2 • Crisis pathway improvements include the Recovery Space, Mental Health Crisis line expansion and a Mental Health Clinical Assessment Unit at CHS Emergency Dept • Greater support in primary care through Mental Health Personal Independence Coordinators • Improving Integrated housing aims to develop a Temporary Accommodation Strategy
Proactive and Preventative – Long Term Conditions (LTC)	• The LTC care model was implemented in 2020 including; Atrial fibrillation systematic case finding service and Group consultations programme to support patients with diabetes and hypertension • LTC Community outreach programme was developed and launched with BME forum and Asian Resource Centre • LTC Expert Patient Programme was developed and launched with BME forum and Asian Resource Centre
Proactive and Preventative – Local Voluntary Partnerships (LVP)	• Over 280 residents have been to ‘Talking Points’ which opened in December 2019. Needs have ranged from housing and benefits to social isolation and low-level mental health • 12 online ‘Building Community Partnerships’ events well-attended by VCSE organisations • Prevention framework agreed by representatives from all sectors in Dec 2020: priorities include Falls and frailty, Healthy weight, Immunisation take-up, mental health and trauma • The LVP programme has supported the voluntary sector by awarding one-off and recurrent funding to small grass roots organisations; 69 funded initiatives

COVID Resilience and Recovery – Public Health	• Upskilling communities to offer initial support and signposting and increase mental health awareness • Community trauma training programme in development for implementation in September 21 • Supporting children at risk of food poverty: school programme includes food vouchers, breakfast club and school grants • Four VCS organisations commissioned to support residents around infection control, social isolation and vaccine uptake
Health Weight –Public Health	• Adult healthy behaviours programme now embedded in the localities • New Child Weight Management service proposed: implementation expected October 2021 • Draft system weight action plan produced
Modern Acute –Outpatients	• 300 video consultations taking place each week at Croydon University Hospital • Patient Initiated Follow Up pathway changes have been made within gastroenterology • Proceeding with a patient portal solution that aligns with other hospital providers in SWL
Modern Acute	• Croydon Elective Centre for elective surgery, planned procedures and cardiac care • Capacity increased in Croydon’s ITU from 15 to 22 beds • Expanding the Discharge Team building on learning from wave 1+2 and ‘perfect week’
Better Start in Life and Maternity	• Paediatric Unit under development due to open May 2022 • Completion and embedding of “Big 5” Advice & Guidance to improve consistency and quality of care • Asthma pathway and development plan • The Children and Young Persons Transformation Programme Board: February 2021 • Improving data intelligence on urgent care pathway support initiatives:
Better Start in Life and Maternity	• Early help resources deployed through three localities (North, Central and South) to provide better place-based services for the community • New partnership Early Years Strategy in development for 2021-2024 • CHS Maternity Services achieved 26.7% of women being booked onto a Continuity of Care pathway at March 2021 • Mental Health Investment Standard funding (MHIS) secured to deliver waiting time initiatives, increase CYP access to Emotional Wellbeing and Mental Health services
All Age Disability	• Independent Lives commissioned to train and develop new personal assistants, and provide advice and guidance to residents choosing to use a direct payment • In April 2021, the disabilities service (18-65) moved to a localities model, aligned with ICN+ model • Community led support model embedded in working practices of older adults and disabilities teams
Integration	• ICN+ and Mental HEalth MOdels formally bought into scope of the Alliance Agreement • One Croydon undertook a programme of work to develop a whole system pooled budget • Croydon Borough Cttee of SWL CCG and CHS have fully aligned governance and leadership

Proactive and Preventative Care

One Croydon
Your health and care partnership

What did we set out to do? This programme aims to increase the borough's focus on proactive and preventative care, to help people live and stay well and reduce the risks to health from long term conditions in our borough. Compared to the average Londoner, people in Croydon have a higher rate of diabetes and heart disease. More than 60% of adults in Croydon are overweight or obese and one in four older people have a life limiting long-term illness.

What progress have we made?

- In September 2020 we launched a long-term condition pro-active and preventative community outreach programmed in partnership with the Croydon BME forum and Asian Resource Centre for Croydon. More than 15 events involved more than 600 people in workshops to help reduce the risk diabetes and hypertension, which is more prevalent within Black, Asian and Minority Ethnic communities.
- Targeted out-reach work to raise awareness of long-term conditions and risk factors amongst harder to reach communities, have also encourage people to seek earlier intervention through their GP, regular NHS Health checks or contact with the borough's Live Well and Just Be programmes.
- All nine primary care networks have employed social prescribing link workers and are working to encourage collaboration with the voluntary sector. Both Croydon Social Prescribing and Croydon Voluntary Action are supporting and training the link workers to know where to sign people across the borough.
- A series of events called 'Building Community Partnerships' is up and running, where voluntary and community sector partner come together in geographic localities to discuss issues and challenges affecting their local neighbourhoods. These local partnerships provide the opportunity for organisations to build relationships with health professionals, and other statutory partners like social workers and housing workers.
- As One Croydon, we have developed a prevention framework that we will work in partnership across health, social care and our local voluntary and community groups to deliver. The framework explains the core principles of proactive and preventive care so that there is a shared understanding and action across the borough's health and care professionals. The aims to deliver a consistent approach across Croydon to reduce health inequalities in our borough.
- In the north-east of Croydon, our pilot of Integrated Community Networks plus (ICN+) have brought health and care teams together to connect residents with the support services around them. Last year, this helped more than 280 residents access help with housing, benefits, social isolation and mental health. The success of this model is now being rolled out across the borough.
- One Croydon Alliance created a Local Voluntary Partnership programme in 2019, supporting local grass roots organisations with funding (with grants of up to £5,000 each) to run initiatives that promote proactive and preventive health and wellbeing. Since the programme began, around 70 initiatives have been funded to connect residents to the neighbourhood groups and services around them. With initiatives ranging from gardening projects to community choirs, this is helping to reduce social isolation and to support people to live and stay well as an active part of our community
- More recently, we have also funded specific initiatives to improve access to mental health support in the voluntary sector, with a further eight community and voluntary organisations being awarded grants between £5,000-£50,000 to support Croydon people in projects for the next three years.
- One Croydon were selected by the Kings Fund and National Lottery Community Fund to participate in the 'Healthy Communities Together' programme, which seeks to strengthen partnership working between the voluntary and community sector, Health Services and the Local Authority. One of the key benefits of the programme has been to increase the 'voice' of the voluntary sector in the partnership, especially in terms of decision making, and the overarching ambition for this work is for the voluntary and community sector to be seen as an equal partner and to begin to shift more resources and spend into the Sector over time.

Proactive and Preventative Care

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Your health and care partnership

What's changed with COVID-19?

Overnight the NHS and social care had to change the way it worked to respond to the COVID-19 pandemic. Services have had to take a more innovative approach to supporting their patients, by embracing technology, Croydon Health Services and the One Croydon Rapid response team can now monitor a patient's breathing, movement and heart rate safely from a patient's home and escalate their care, often before they realise they are becoming unwell, to keep people well and out of hospital. At the height of the second wave, this multidisciplinary team were caring for the equivalent of a virtual ward full of patients with COVID-19 safely in their own home, helping to increase capacity to care for people needing hospital treatment.

Throughout the lockdowns over the last 18 months, GPs and community teams remained open as usual to care for people in Croydon. To help people feel confident about coming forward for healthcare advice and treatment during the pandemic, appointments were delivered by telephone, online and video, with face-to-face appointments still available based on clinical need. Remote monitoring was rolled out to help Croydon GPs monitor patients with COVID-19 symptoms safely in their own home, helping healthcare teams to intervene early if someone's condition worsens and reduce the number of staff visits to limit potential exposure to coronavirus.

Since the Covid-19 vaccination programme began we have held more than 65 events reaching more than 4,000 people to engage them in the importance of getting vaccinated during the pandemic. This includes work with the Croydon BME Forum, Asian Resource Centre and other community groups, to help inform residents, tackle vaccine hesitancy and raise awareness amongst our community on how to protect themselves from COVID-19 and the response of local services to care for those affected.

During the COVID-19 pandemic, our Building Community Partnership events and the advice space in Thornton Heath were held virtually to help protect people from coronavirus. In a post-pandemic world, we want to consider how we can use the best of both online and face-to-face meetings to make it easier for people to access the care they need in the most convenient way for them.

One Croydon recognise the incredible contribution of the VCS in improving health outcomes, which we know goes well beyond the scope of funded or commissioned services. During the pandemic this was most acutely felt when the VCS provided support to individuals such as delivering food parcels, Befriending services, delivering medicines and escalating issues to statutory counterparts. 1000's of hours of high value volunteering have been undertaken.

One Croydon partners are working with leaders from across the VCS, from small grassroots organisations to larger providers to improve representation of the sector at all levels of decision making in the One Croydon Alliance. We expect that this will continue to raise the profile of the VCS sector as one of the main contributors to improving health and wellbeing outcomes to residents in Croydon. It also means that One Croydon partners will be able to capture evidence of success from the VCSE sector as a whole. The One Croydon Alliance is committed to recognising the voluntary and community sector as an equal partner in the Alliance.

Proactive and Preventative Care

How have we engaged with local people?

Engagement highlights	Emerging themes	Impact	Next steps
There was considerable engagement and co-design with patients, the pubic and health, care and the voluntary sector partners to develop the long-term conditions (LTC) and diabetes models of care introduced in 2020.	• Care for people with long term conditions can feel fragmented rather than joined up • Specialist services are not always focused around the BAMER population where diabetes is high • Basic knowledge is widespread, but inconsistent. Many people are unclear about the benefits of treatment and lifestyle changes. • Cultural beliefs are cited as a reason for resisting medication. • Significant gaps between reported prevalence gaps for LTCs • In order to reduce the number of complications related to LTC, health and care services need to work with our communities to focus on prevention, early identification and embed knowledge and understanding of how to prevent and manage LTCs.	• A community outreach programme and the Expert Patient Programme (EPP) commenced in 2020, delivered by Croydon BME Forum and Asian Resource Centre Croydon. • 71 people completed the 9 EPP courses between March-October 2021. Feedback has been positive with many reporting sustained lifestyle changes. • Over 550 people attended 12 (virtual) LTC awareness raising events held between October 20 and July 21. 25 LTC community champions have been trained to date with a further 6 health check volunteers. By July, 54 people had their health check undertaken inclusive of pulse and blood pressure checked, followed by a diabetes risk assessment. • A systematic case finding service for of atrial fibrillation from Croydon GP practices. • A new integrated model of diabetes care was introduced in 2020, with the specialist team working across acute, community and primary care. • A new group consultations programme aimed at supporting patients with diabetes and /or hypertension to self-manage their condition more effectively and learn from peers is now commissioned from general practice.	• Continue to gather and respond to feedback and data on the EPP and Community outreach programme to maximise reach and impact. • Align community outreach programme with ICN+ model and building on joint working during Covid-29 pandemic with VCSE organisations to engage with specific communities to develop culturally specific materials and information. • Work with PCNs and VCSE organisations to deliver effective population health management strategies
One Croydon Alliance were selected to patriciate in The Healthy Communities Together programme, which has brought external investment into Croydon at moment of acute financial pressure. The programme seeks to strengthen partnership working between the voluntary and community sector, Health Services and the Local Authority	•The voluntary and community sector (VCS) have made recommendations to the partnership on how we can improve VCS representation in decision making •The VCS have contributed their time and expertise in developing the Croydon Locality Operating Model, using engagement events like Building Community Partnerships to seek out patient views on how services can be improved and more integrated •The Partnership have recognised that we can do more to recognise and value the contribution of the VCS for Croydon residents, in particular, ensuring that that the VCS is truly an equal partner in delivering the Health and Care Plan	•VCS contribution to improving health and wellbeing outcomes will be recognised more fully •Representation of the VCS in One Croydon governance boards and steering groups has been improved •Empowerment and Engagement activities relating to the integration of services in each locality has taken place, with input from local people, grassroots VCS organisations and medium to large VCS organisations, 12 events have taken place so far, with an average of 30 VCS organisations attending, over 100 organisations and groups not previously known to the partnership, and an average of 12 'active citizens' as well as representation from all statutory partners in the Alliance •The partnership have agreed on a definition of what Community Empowerment means in Croydon, improving our shared understanding of how to engage with residents and communities •Commissioners across the partnership have been able to engage in honest and open dialogue with the VCS sector on how we might begin to shift more spend and resource into the VCS over time	• The work will continue in 2022 and beyond, we have developed a comprehensive implementation plan to ensure that we achieve all our objectives in strengthening the partnership further.

Proactive and Preventative Care

One Croydon
Your health and care partnership

What are our priorities now?

In 2021 to 2023, we will:

- Focus on prevention in everything we do – keeping people healthier for longer, especially focusing on the four key areas of:
  - Immunisations
  - mental health and trauma
  - healthy weight
  - falls and frailty
- Develop effective and sustainable partnerships between residents, the voluntary and community sector, the NHS and local authorities to improve health and wellbeing, reduce health inequalities and empower our communities.
- Refresh our commitment across all One Croydon partners to embed the core principles of resident and patient's engagement and active involvement to inform the decisions we make and the actions we take.

Localities - joined up work in local communities

One Croydon
Your health and care partnership

What did we set out to do?

We want to make it easier for people in Croydon to access the care and support they need stay healthy. Bringing health and care teams closer together to provide more coordinated care, we want to connect Croydon residents with the services around them, tailoring our care to local health needs to give people greater control of their health to build resilient and healthier neighbourhoods.

Localities - joined up work in local communities

One Croydon
Your health and care partnership

What progress have we made?

• voluntary and community sector came together with Croydon residents and partners in the statutory sector to support Croydon people through the pandemic and has continued to deliver a multitude of key services from Personal Independence Coordinators, to befriending and food banks.

- We have developed a range of fully integrated locality based primary and community services, building on the success of our One Croydon Alliance.
- Our Living Independently for Everyone (LIFE) team brings together teams of social workers, community geriatricians, nurses and therapists to help people to regain their independence after illness and keep them well, and out of hospital where possible.
- A pioneering community hub is helping people to stay healthy on one of the most deprived areas of Croydon. The pilot Integrated Community Networks plus (ICN+) in Thornton Heath helps to connect health and care teams with residents, improving access to local support services. Local people now have access to a multidisciplinary team of GPs, social care workers, mental health specialists, physiotherapists, pharmacists and community groups, to connect residents with the support around them, including proactive care long-term conditions, help with healthy eating or access to benefits support.
- More than 3,000 Croydon residents have been supported by the ICN+ teams since the pilot was launched in 2020. Building on this success, the model will be rolled out across all or our localities in our borough in 2021. We have now begun joined up working in two of our other localities in the South West and South East of the borough and hope to begin in the remaining three localities over the coming weeks.
- We have begun to introduce the Stay Steady, Stay Well clinic to improve the health and well-being of older adults, to help people live independently for longer in their own homes.
- Personal Independence Co-ordinators (PICs) with Age UK Croydon are enabling older people to stay well and enjoy a better quality of life PICs work with each person to set and meet personal goals. Ranging from health changes, like joining a weight-loss programme, to socialising, or practical help with transport so they can make trips into the local area. PICs meet with community nurses, GPs, pharmacists and social workers to discuss the wellbeing of each person in their care.
- Telemedicine has been introduced in 75 care homes to give a direct line to the borough's experienced clinicians to help the prompt assessment of clinical needs and coordination of care when urgent, unplanned needs arise in care home residents.
- Care Home Liaison Coordinator introduced into the local hospital discharge team to reduce any unnecessary delays in transfer of care from hospital to a care home.
- To reduce the number of preventable falls for elderly care home residents, pilots have been introduced in partnership with Age UK Croydon, including 'Shimmer and Zimmer' which aims to build peoples' resilience when using walking aids.
- The Croydon GP Collaborative established a support framework for PCNs to help clinical directors deliver local services (Direct Enhanced Services, DES). The Collaborative has also set-up the Clinical Director Cabinet to support the development of PCNs.
- We now have nominated clinical directors in post to represent all of Croydon including mMental health, estates, social prescribing and the One Croydon Alliance. As part of this we have successfully worked together to roll out many pan-Croydon projects including paramedics, pharmacists and social prescribers for each of our PCNs, a cervical screening service run by CGPC and delivered by one practice on behalf of all of Croydon. This is now up for an award as we have seen 580% increase in uptake of cervical screening appointments across the borough.

Localities - joined up work in local communities

One Croydon
Your health and care partnership

What's changed with COVID-19?

Throughout the pandemic more people have worked together across professional and organisational boundaries to support and care for people in Croydon. ICN+ 'Talking points,' which were intended to be face-to-face drop-in clinics to connect with the community services, to tackle social isolation, improve access to mental health support or help people live and stay healthier, went online and were held virtually. Some elements of our pilot went on hold during the pandemic including the community falls pilot.

Many of our staff were working on the front-line of the pandemic and others were redeployed, for example, into the LIFE service helping to care for people safely at home and freeing up resources to care for people who need to be treated in hospital.

During the pandemic the VCS came together in Croydon and provided support to individuals such as delivering food parcels, Befriending services, delivering medicines and working closely with statutory services to support people who were shielding. Thousands of hours of high value volunteering have been undertaken by Croydon residents.

To keep patients and health and care staff safe during the pandemic, Personal Protective Equipment (PPE) was planned and coordinated across the borough, in line with national guidance. Our hospital experts also gave infection prevention and control guidance and training to Croydon's care homes to help protect residents from the spread of infections.

In December 2020, we began the largest vaccination programme ever delivered by the NHS. Alongside Croydon University Hospital, who were amongst the first in the country to begin to vaccinate local people, Croydon GPs worked together in Primary Care Networks at locality level to set up six GP-led vaccination centres across the borough and offer the covid-19 vaccine those most at risk of the virus. Vaccination centres at Selhurst Park and Centrale Shopping Centre and local Croydon pharmacists have since joined options for local people to be vaccinated and the vaccine has now been offered to all adults across the borough. We continue to encourage local people to take up the offer of the vaccine, and to make sure they also have their second dose.

Locally led GP vaccination teams delivered over 75% of the vaccines to those over 50 years old, and we are now working together to plan for the booster campaign for these groups in the autumn.

Localities - joined up work in local communities

One Croydon
Your health and care partnership

What are our priorities now... continued?

In 2021 to 2023, we will:

- **Complete and implement the review of the LIFE service – Living Independently for Everyone:** Implement a reviewed LIFE service that is sustainable building on continuing discharge to assess and A&E liaison which can help to reduce delays for adult patients who no longer need in-hospital treatment and provide at home care to help people recover and stay well in the comfort of their own homes. It will provide a community reablement service aimed at reducing hospital admissions, and work with people who are at risk of falls or a hospital admission to support them to stay healthy at home. Working to the Home First principle, the vision of LIFE is to be a compassionate, caring and effective multi-disciplinary, goal and outcome-based service that ensures every service user feels they are central to their journey to recovery and well-being.

- **Continue to roll out Integrated Care Networks Plus to connect health and care teams with residents, improving access to local support services:** Continue to develop the ICN+ model in all six of Croydon's localities and ensure they are supporting residents and expand the care available to include children and their families in Croydon. Work more closely with GPs to maximise the ICN+ offer to residents.

- **Supporting our workforce:** Maximising the resources and skills available within our workforce. Supporting our teams to work closer together across disciplines and services, including looking at pay and contractual differences. Focus on recruitment and retention and making Croydon a great place to work and lead on the development of new roles for our communities including community paramedics and training nurse associates. Continue to provide team development sessions focusing on training, organisational development and raising knowledge of community resources.

- **Increase patient and public engagement with residents:** Support patients to access the right service at the right time to improve their health and care. Engage with our residents, patients, carers and families and our local communities working closely with our voluntary and community partners. Utilise patient participation groups to listen and understand the experience of our current service users and build on our strengths to improve health and care services for the people we serve.

- **Support the development of practices and primary care networks to join up primary care and community services:** Develop local leadership forums where the voluntary sector, GP leaders and community services collaborate and work together to support our local populations and their unique health needs. Focus on health inequalities with an emphasis on equal access to services, long term conditions and learning disabilities.

Localities - joined up work in local communities

One Croydon
Your health and care partnership

What are our priorities now... continued?

- **Use data, IT and technology to improve the model of care and joint decision making for elderly care home residents:** Increasing the use of remote monitoring systems to help care home residents well and enable health and care teams to proactively monitor their condition. Ensuring care home staff have safe and secure online access to share clinical information with healthcare teams to aid the care of residents, and ensure all care homes in Croydon have good wi-fi connectivity and digital devices.

- **Enhanced Primary and Community Care support:** With weekly 'home rounds' or 'check ins' with residents in all care homes to monitor and coordinate care for residents. Embedding personalised care and support plans (PSCPs) to involve residents in decisions about their care and achieve better prescribing practice and delivery of care. Maximising the skills and experience within health and care teams in Croydon to improve support for care homes, including providing infection control training and support.

- **Developing a strategy for care homes to help prevent falls:** Coordinating reablement and rehabilitation services to help elderly residents regain their strength and mobility. Reviewing the Community Falls Service in line with the rollout of ICN+ localities.

- **Improved mental health support and dementia care:** Bringing health and social care teams closer together to enable residents to manage their own health and wellbeing and ensure improved experience and better quality of life.

- **Improving end of life care:** Ensuring care home residents are supported to make choices about their own care even at the end of life.

- **Building 'Compassionate Communities':** Helping elderly residents and families navigate the support available through local hospices, voluntary organisations and bereavement services. Providing awareness training to widen the support available from Compassion Neighbours and social prescribers to connect people with the services and community groups around them.

- **Expand the Localities approach to under 18s to create a Localities model for all ages:** Define and develop the Localities approach for Children's Services. Create strong links between Children's and Adult's Services resulting in an integrated, all age Localities offer to support residents.

Modernising acute care

One Croydon
Your health and care partnership

What did we set out to do?

Working together in the borough and as an integrated care system across South West London, we want to ensure people in Croydon have access to the highest quality care and outcomes to improve the health and wellbeing of our community. This programme covers the ongoing response and recovery of our services to the COVID-19 pandemic and the continued development of our integrated services to care for people in and out of hospital.

What progress have we made?

We have had to adapt many of our plans due to the pressures of COVID-19 but progress of modernising Croydon's Acute Care has continued at pace.

COVID recovery at Croydon Elective Care Centre

- Croydon was one of London's leading boroughs to restart planned treatment and surgery after the first wave of the pandemic. Croydon Health Services has created "hospital within a hospital" for non-COVID care. The Croydon Elective Centre (CEC) at Croydon University Hospital is COVID safe zone, with restricted access to other parts of the hospital, robust infection control and COVID screening of patients and staff. Dubbed a 'blueprint for the NHS' in the wake of a national health crisis, the CEC has provided planed care for almost 10,000 local people since July 2020, shortening waits for people that have had their treatment delayed because of COVID-19.
- To help clinical teams care for higher numbers of people needing hospital services, the Trust has also opened a dedicated emergency surgical centre and same day surgical assessment hub to protect the capacity needed to care for people needing emergency surgery and avoid unnecessary delays for people needing planned day case or overnight procedures.
- In June 2021, the Trust also opened a second elective centre at Purley War Memorial Hospital. Caring for patients that require only local anaesthetic, the Purley Elective Centre is increasing our capacity to treat people more quickly and free-up our main theatres at CUH for more complex cases to help clear the COVID backlogs.

Working together to clear the COVID backlogs

- By increasing our capacity we are reducing waits for Croydon patients needing planned surgery and treatment during the pandemic. We are also supporting our neighbouring trusts to clear the COVID backlogs as part of a coordinated response across South Sest London. Croydon Health Services has received more than 1,300 referrals to care for patients from nearby trusts in the past 12 months.

Modernising acute care

One Croydon
Your health and care partnership

Critical care expansion

- In line with NHS guidance, Croydon University Hospital increased its intensive care capacity from 15 to 22 beds to meet requirements during the height of the pandemic within safe staffing levels. Following the first wave of the pandemic, the Trust also increased its oxygen capacity on site to allow clinicians to provide non-invasive ventilation and Continuous Positive Airway Pressure (CPAP) oxygen for COVID-19 patients on designated wards – freeing-up capacity to care for the sickest patients in intensive care. The hospital can now flex its critical care capacity to meet surges in demand.
- Later this year, the Trust hopes to begin building to permanently double the intensive care space available to ensure patients can receive the highest standards of life-dependent care, close to where they live. Pending final approval, the major £14.7m redevelopment will create 22 intensive care and high dependency beds, with more en-suite facilities, quiet rooms and improved waiting areas to support families at some of the most difficult times in their lives. The project will also enable the Trust to enhance the facilities available for stroke and respiratory patients in hospital.

Digital first transforming outpatient care

- A large proportion of outpatient appointments are now offered by telephone or videoscreen to connect patients with hospital experts and avoid further delays for people's treatment because of COVID-19. Hospital consultants, will continue to see face-to-face where clinically required. During the height of the pandemic, around 300 video consultations were taking place each week at Croydon Health Services.
- To help ensure identified patients could still receive their medication during COVID-19, the 'Pharmacological Interventions Workstream' set up a medication delivery service with the Trust's non-urgent patient transport team. Patients who are unable to collect their prescription/medication following a video or telephone outpatient appointment are now able to get their medication delivered Monday, Wednesday or Friday.
- In April 2021, Croydon Health Services approved the use out of Patient Portal UK, which is a secure digital platform allowing two-way communication between patients and clinical services. Amongst other functions, the platform allows patients to view their letters digitally and manage their outpatient appointments. The new system will start being rolled out in late 2021.
- To support primary care in Croydon, Advice and Guidance allows GPs to seek expert advice from hospital consultants to review and agree the most appropriate care plans for their patients. Throughout the COVID pandemic, the Trust has continued to achieve performance above the 80% target for GP Advice and Guidance turnaround in two days.

Modernising acute care

One Croydon
Your health and care partnership

Enhancing our care for children in Croydon

- In August 2020, we were given the green light for the development of a £6 million new children's care unit at Croydon University Hospital. The new, integrated space includes the addition of a brand-new critical care unit and children's cancer unit, allowing the Trust to provide care closer to home for even more of the borough's sickest children. Alongside this, the state-of-the-art facility will house a medical ward, surgical ward and a short stay unit, for children and young people who need to be admitted to hospital, as well as providing improved facilities for patients and visitors, such as family spaces and relaxation rooms.
- This development will support our commitment to ensure our services reflect the needs of our patients, as we see the number of young people in the borough increase each year, making the project a vital part of our work, as we bring hospital and community services as well as local GPs, social care and the voluntary groups, to provide joined up care for the people of Croydon.
- The children's cancer unit is being supported by Chartwell Cancer Trust, who have joined forces with the NHS to raise £750,000 towards the new facility, transforming care for children, young people and their families who are dealing with cancer and the possibility of spending up to two years in treatment.

Urgent and Emergency Care Transformation Programme

- We have worked together to transform access and patient pathways for people seeking urgent and emergency care at Croydon Hospital emergency department. This has helped make sure those are admitted to hospital swiftly when they need to be and supported to be cared for at home when they no longer need inpatient care. Our urgent and emergency care transformation work has inlcuded Think 111 First, Same Day Emergency Care, Mental Health support in the emergency deparment and work to support those experiencing homelessness and inequalities.

Post COVID care

- Multidisciplinary support is now available for people suffering the long-term effects of COVID-19, to help Croydon residents recover without hospital care and stay well. At home care can now be provided by community nurses and therapists, with the support of GPs and hospital consultants where needed. This includes joined-up support for people suffering 'post COVID' symptoms, including chest pain, chronic fatigue and brain fog.

Modernising acute care

One Croydon
Your health and care partnership

What are our priorities now?

In 2021 to 2023, we will:

- **Maximizing our elective care**
  We will maximize our activity to treat people at Croydon and Purley Elective Centres to help recover the COVID backlogs to reduce the waits for patients who have had their planned care or treatment unavoidably delayed because of the pandemic including mutual aid to support those waiting for treatment in our neighbouring hospitals. Deliver our Outpatients Transformation Programme including through virtual appointments where appropriate.

- **Transforming urgent and emergency care**
  Making access to our services as simple and convenient as possible, acting on the feedback of our patients and harnessing our learning from COVID-19 to improve patient experience and reduce missed appointments. Reduce the length of stay in hospital for those patients who could be better treated at their homes or in the community to make sure only those who need to be are cared for in hospital.

- **In and out of hospital**
  Aligning health and care teams to provide more coordinated care and support for patient pathways including anti-coagulation, diabetes and dermatology to minimise delays when patients can be cared for at home or in the community and helping to ensure that only people that require acute care need to go to hospital. Develop ICN+ hubs across Croydon to increase the capacity for general practice and enable the integration of community and acute services in the community.

- **Transforming diagnostic services**
  Working collaboratively with the South West London Integrated Care System to explore opportunities for Community Diagnostic Hubs in Croydon to help diagnosis cancer and other health conditions earlier, in discussion with patients, staff and stakeholders in our borough.

- **Supporting our workforce**
  Supporting the health and wellbeing of our staff during once of the most challenging times in the health and care service as described in our People Plan. Making the most of the skills and expertise we have in the borough to retain our workforce and encourage more health and care professionals to join our teams in Croydon.

Adult mental health and well-being

One Croydon
Your health and care partnership

What did we set out to do?

- Work in partnership with schools and colleges to deliver a whole school approach to emotional health, well-being and mental health.
- Implement the mental health community hub and spoke model to put more clinicians out in the community to support people closer to home
- Develop a wider range of housing options for those with severe mental health problems to better support their needs
- Develop an improved mental health crisis pathway so that people in crisis have faster and easier access to specialist support

What changed during COVID-19?

The coronavirus pandemic continues to have an impact on the mental health of millions of people across the country including thousands of people in our Croydon communities. The impact of lockdown, loneliness and social isolation, the devastating impact of those who have died, their families, friends and communities, and the impact on jobs and incomes all play a part.

Croydon's unique population means we have high mental health needs including:

- Croydon's population is diverse with over 50% from Black, Asian and minority ethnic communities with this percentage predicted to increase over the next decade
- An estimated 10,000 people live in areas across Croydon considered to be within the most 10% most deprived in the country
- Mental health problems are 3x more common in children in households with the lowest 20% of income
- Half of all mental health problems begin by age 14 years
- Croydon has the highest number of unaccompanied asylum-seeking children

The immediate challenges to the NHS over the last 18 months has meant that the progress against our original plans has not been possible. For mental health services this has meant that we have not yet progressed as we would have hoped our mental health recovery spaces. However, we are working with key mental health providers as well as the community and voluntary sector to increase capacity and reduce waiting times in key services for example Counselling, to ensure timely support is available for our residents.

Adult mental health and well-being

One Croydon
Your health and care partnership

What progress have we made?

Over the last two years we are very proud of our close partnership working with key partners across the borough especially our voluntary sector partners including Croydon BME Forum, the Asian Resource Centre, Croydon Voluntary Action, MIND in Croydon, Imagine and Hear US to support our mental health transformation programme as well as throughout the pandemic and Covid-19 vaccination programme. Our delivery for Mental Health has included:

- **Recovery Space** we developed an alternative non-clinical space to the Emergency Department for those in mental health crisis. This centre opened in October 2020 and has supported over 400 individuals from October 2020 to end of June 2021 referred from both the Emergency Department and GPs across the borough. Preparation for the first of three **community mental health and wellbeing hubs** to be delivered across Croydon's six localities is underway with the intention of providing a "one stop" single point of access to deliver integrated mental health support for local people. Service Users have already named the first hub as the "Croydon Health & Wellbeing Space", which will be located at the WhitGift Centre.
- We are in the third phase (scaling up) of **reshaping secondary care community mental health services** having completed a pilot to simplify specialist mental health services to align them with our mental health and well-being hubs and six localities as they are implemented
- We now have six **Mental Health Personal Independence Co-ordinators** employed by the voluntary sector to provide practical support for people experiencing mental health issues across primary care
- Implemented an **Enhanced Shared Lives service** that enables an earlier discharge from hospital for mental health service users that no longer need hospital treatment. Or offering a short period of enhanced support rather than hospital admission, enabling people to return home.
- **Learning Disability annual health checks** building on improvements in previous years, despite COVID19 further improvement has been made in 2020-21. Over 1800 eligible people had received a check by the end of March 2021 since April 2020, an improvement of 292 more people when compared to the previous year. This means over 80% of people have managed to benefit from a health check and updated health action plans. People with LD are one of the prioritised groups for proactive care in post COVID recovery.

Improving outcomes for ethnic minority communities

- **The Croydon transformation** has established a Croydon Recovery Space and six Mental Health Personal Independent Coordinators hosted by the voluntary sector supporting over 60 people each month. These teams work closely with GPs and primary care colleagues integrating services for mental and physical health
- **Diversity has underpinned each step** Co-production of design, recruitment of staff with Croydon BME Forum in Partnership with Mind in Croydon.

Adult mental health and well-being

One Croydon
Your health and care partnership

How have we engaged with local people?

Engagement highlights	Emerging themes	Impact	Next steps
• Hear us forum – services users working with SLaM and the CCG as well as community and voluntary sector organisations. Meets monthly and engages with approximately 3,000 to 4,000 services users per year How Do We Ensure True Involvement? - Hear Us (hear-us.org) • 13 BME Grassroots events each attended by around 85-90 individuals and organisations with an interest in Mental Health led to formation strategic and operational Task and Finish group with both service users and carers • Mental Health Programme Board includes service user and carer representation	• Issues around trust – how do people know that services can and will help them? • Asking for help can be stigmatising and frightening, need to remove barriers • Challenges in accessing help – can feel like a barrier having to navigate through the system, especially when not in crisis. • Difficulties in understanding the terminology used • Mental health conditions can be isolating for the whole family/support network • People are turning to alternative support networks such as faith leaders and the VCSE when they need support	• Co-design and opening 'clinical health and wellbeing space' (named by service users) which offer culturally appropriate and timely support • Developed a robust feedback loop so learning from the first space informs opening of two more hubs and the service can iterate the way it supports residents • Service user/carer designed website sharing their own experiences and information • Decision to allow both open access and referrals from health professionals to the hub allowing people to access care directly	• Clinical health and wellbeing space in Whitgift opening imminently with a further hub in Thornton Heath • Hear Us, service users and Carers Forum stress testing different scenarios in the space/s • Identify key engagement priorities for next two years and develop engagement plan • Funding has been secured for a clinically-led partnership with a specific objective to reduce ethnic inequalities in access, experience and outcome of mental health care, linking to SLaMs Patient Carer Race Equality Framework (PCREF) development.

Adult mental health and well-being

One Croydon
Your health and care partnership

What are our priorities now?

In 2021 to 2023, we will:

- **Improve the Community Mental Health pathway**
  - Deliver four Mental Health Wellbeing Hubs for Croydon in Central, North, South-East and South-West Localities
  - Re-establish the Dementia Action Alliance
  - Strengthening Mental Health and Substance Misuse Pathways

- **Improve the Crisis Mental Health Pathway**
  - Establish a Mental Health Assessment Unit at Croydon University Hospital
  - Strengthen both the non-clinical and clinical provision and care pathways for those experiencing a mental health crisis

- **Continue developing greater Mental Health support in primary care**
  - Introduce new clinical & non-clinical roles focused on mental health
  - Strengthen the care pathways for mental health

- **Establish a clear pathway for people with a serious mental illness to more independent living**

- **Address the Health Inequalities for Mental Health across Croydon**
  - Implement the Ethnicity Mental Health Improvement Programme – Improving the access, experience and outcomes for ethnic minorities in Croydon especially for those groups significantly affected for example young black men.

- **Enhance Partnership Working**
  - Establish Mental Health and Learning Disability Joint Commissioning Boards to develop our commissioning plans, review current provision and market relations, and to ensure our collective resource is being used appropriately to support individuals with health and social care needs with a focus on prevention and early intervention

Better start in life and maternity

One Croydon
Your health and care partnership

What did we set out to do?

Croydon has a young population with the highest number of 0- to 17-year-olds in London. To give children and young people the best start in life we set out to:

- Implement our healthy pregnancy programme to support mums-to-be immunisation rates, breastfeeding, parenting support and increase take-up of the borough's Live Well programme
- Improve mental health and emotional wellbeing for children and young people in Croydon through a borough-wide transformation plan
- Bring multidisciplinary health and care teams closer together to safeguard young people and reduce the number of the number of children in care through closer integrated working
- Improve access and reduce health inequalities for children and young people in Croydon.

Overall, Croydon's population is one of the most diverse in the capital, with over 50% from Black, Asian and minority ethnic communities with this percentage predicted to increase over the next decade. An estimated 10,000 people live in areas across Croydon considered to be within the most 10% most deprived in the country. Around 6,000 children are born in our borough every year.

What progress have we made?

Improving equality and outcomes in maternity

- The Trust's maternity services have launched the 'HEARD (Health Equity and Racial Disparity) campaign to improve the experience and outcomes during pregnancy for women from Black, Asian and Minority Ethnic backgrounds. This includes an education programme for staff and a recommended care pathway that incorporates early antenatal bookings, interpreting services at every appointment, and a personalised wellbeing assessment from a multi-disciplinary team of doctors, midwives and nursing teams to ensure joined up care for expectant mothers with a number of existing health conditions. Every woman will also have the opportunity to access a HEARD ambassador, ensuring respectful, equitable access to care for all.
- The Trust also offers additional support here in Croydon, through continuity of care teams and a dedicated team for mothers with diabetes, we are taking further action to tackle these issues and ensure we are providing every mother with the best care possible.

Better start in life and maternity

One Croydon
Your health and care partnership

Flu vaccinations in the community

- Croydon GPs and pharmacists played an active role in recording some of London's best public flu vaccination rates in 2020, with more than 149,803 (73.2%) GP-registered patients vaccinated

Continuity of Carer

- In line with national best standards, we have introduced Continuity of Carer in the borough's maternity services. Now, when pregnant women book with a continuity of care teams, they will be cared for by the same small team of midwives throughout their pregnancy. Especially for women with more complex health needs, this can help to deliver more personalised care and improve outcomes for women and their babies.

Caring for children close to home

Around £6 million is being invested at Croydon University Hospital to ensure some of the most poorly ill children can be cared for close to home. The new Paediatric Integrated Unit, opening in 2022, will include a new children's critical care unit and children's cancer unit, dedicated wards and comfortable family spaces and relaxation rooms. The multi-million development includes engagement with families and young people to ensure the design of the unit meets their needs, with continuing fundraising through the NHS and Chartwell Cancer Trust to raise £750,000 towards the facility.

Children's Hospital at Home

- This fantastic team celebrated its 25th birthday in May 2020 and is one of the borough's first truly integrated teams. Originally set up in 1995, the team of community nurses provides acute nursing care at home for children with long term conditions, including respiratory, cardiac and cancer. In 2020, we have strengthened the role of the 'Children's Hospital at Home' team for those children who come to A&E to avoid children having to be admitted to hospital unnecessarily. During the COVID-19 pandemic, members of the team were also drafted into the hospital to help the Trust's coronavirus response, including supporting the team in intensive care.

Children's asthma team

- Our children's asthma was praised by the Care Quality Commission during the last full inspection of the Trust's community services, noting the teams use of social media to inform and engage parents and proactively help children living with asthma. Continuing this approach, the team took part in the #AskAboutAsthma campaign with an 'ask the expert' online session with a parent chair to ask the questions gathered by children and young people. 'Nudge cards' have also been developed to help educate parents and ensure all children have a personalised asthma action plan (PAAP) to help manage the condition, with a Pilot of Asthma-Friendly Schools to promote safety and children and young people with asthma stay well with the support of local heath and care teams.

Better start in life and maternity

One Croydon
Your health and care partnership

What changed during COVID-19?

The immediate challenges of COVID-19 to the NHS has meant that the progress against our original plans has not been possible. In order to help keep vulnerable children and young people safe from coronavirus, many health checks and had to be held by telephone or video, with continuing at home visits where required with the use of Personal Protective Equipment (PPE) and robust infection prevention and control procedures.

Although Healthwatch Croydon conducted the 2019 Young People's Mental Health Survey before the pandemic, its findings are in line with the increase in demand for mental health services we are seeing in many London boroughs including Croydon which has seen rising demand for emotional wellbeing and mental health support, including increased anxiety, low mood and depression. The borough's NHS along with Croydon Voluntary Support, Healthwatch Croydon and local schools are considering a further survey to help target resources more effectively to provide greater care and support for mental health needs in the borough.

Through the legacy of Captain Sir Tom Moore and NHS Charities Together, and with the support of the Croydon Health Services Charitable Fund, more than £185,000 of this funding has been allocated to a number of system-wide partnership initiatives, including:

- A project to reduce the isolation felt by parents who care for disabled children
- Funding for counsellors to support young people between the ages of 16-24 and who are at risk of or currently homeless
- Development of a sensory room to be used for Dramatherapy, supporting young people in communities across the borough to process their grief in a healthy and safe way

Better start in life and maternity

One Croydon
Your health and care partnership

What are our priorities now?

In 2021 to 2023, we will:

- **Coordinated COVID-19 recovery:** Continuing to work in partnership to care for the wellbeing of children and young people affected by the pandemic. Identifying opportunities to intervene as early as possible to keep people safe and well and recover services to deliver face-to-face reviews for all mandatory of Croydon children aged 0-5 years other key contact points, in line with national standards

- **Early years:** Support the creation of an integrated early years strategy that incorporates the recommendations in Best start for life to act on the key priorities of national reviews, including strengthening continuity of care for all families (Better Start in Life 2021); achieving UNICEF Level 3 for Croydon to be breastfeeding friendly borough; implementing the findings of the HEARD review and improve pregnancy and birth outcomes for women from Black, Asian and Minority Ethnic backgrounds.
- **Maternity care:** Delivery of the long-term plan transformation ambitions, including the rollout Continuity of Carer more widely, for women from diverse or deprived areas and acting on the essential actions of the Ockenden Report.
- **Improving mental health and wellbeing for children and young people:** Ensuring access to the right emotional wellbeing and mental health services for children and young people in Croydon, increasing focus on prevention and early intervention, developing a comprehensive strategy for transitions for people aged 0-25, and reducing health inequalities for children and young people of African, Caribbean, Asian and other ethnic heritage.
- **Improving urgent care pathways for children:** To deliver against the priorities within the Children and Young Persons' Transformation Programme. Benefiting our community through the development of the new Paediatric Integrated Unit at Croydon University. Our priorities will also include help to manage long-term condition, such as asthma, epilepsy and diabetes, and improving waiting times to diagnose children with Autism Spectrum Disorder (ASD) or Attention Deficit Hyperactivity Disorder (ADHD)
- **Special Education Needs and Disabilities:** Ensuring health and care partners in Croydon meet statutory requirements and improve outcomes for children and young people with SEND.
- **Improving the health of Looked After Children:** Improving the health of Children Looked After, ensuring that this vulnerable cohort of children and young people supported within the partnership to manage their health and wellbeing needs, ensuring that they have the right support at the right time.

Joining up care for people with disabilities

One Croydon
Your health and care partnership

What did we set out to do?

- Give working age people flexible care that they can arrange themselves and have choice and control over
- Provide more joined up care for people with disabilities by implementing locality-based services and bringing multi-agency teams together
- Transform our practice for children with disabilities to provide consistent, high quality and proportionate support throughout their childhood and the transition to adulthood
- Provide digital solutions and assistive technology to support access and management of care for people.
- Have good conversations with people using community-led approaches, looking at what's strong, not what's wrong.

What progress have we made?

- Enhanced direct payment offer and personal assistant market.
- December 2019 Independent Lives were commissioned to train and develop new personal assistants, and provide advice and guidance to residents choosing to use a direct payment
- A new website was launched www.adultsupport.croydon.gov.uk, a comprehensive source of information advice and guidance on adult social care
- Re-developed day care model, Active Lives, in the community where appropriate, otherwise at our specialist and newly refurbished centre – Cherry Hub. This is to enable support to focus on the goals in the individuals care plan.
- In April 2021, the disabilities service (18-65) moved to a localities model, enabling it to align with the Integrated Community Networks plus model that was developed in the older people services (65+).
- In April 2021, the transitions service moved to adult social care. A programme will be built around the service to align it with the strengths-based model / good conversations and to the locality integrated community network model.
- A strategic review of assistive technology opportunities was developed, post COVID this review will need to be revisited at a system / borough level
- The community led support model is now fully embedded in the working practices of the older adults and disabilities locality teams.
- Learning and development has also been developed to ensure there is ongoing training for existing and new staff.
- Learning Disability annual health checks – we are building on improvements in previous years and despite COVID19 further improvement has been made in 2020-21. Over 1,800 eligible people had received a check by the end of March 2021 since April 2020, an improvement of 292 more people when compared to the previous year. This means over 80% of people have managed to benefit from a health check and updated health action plans. People with LD are one of the prioritised groups for proactive care in post COVID recovery.
- The Trust also offers additional support here in Croydon, through continuity of care teams and a dedicated team for mothers with diabetes, we are taking further action to tackle these issues and ensure we are providing every mother with the best care possible.

Joining up care for people with disabilities

One Croydon
Your health and care partnership

What changed during COVID-19?

The pandemic continues to cause uncertainty and stress to many people, and in particular for those with care and support needs, their carers, families and staff that support them. From the early stages of the crisis, many people with disabilities, their carers and families and will have been shielding, which may also have led to a loss of confidence and increased social isolation for some.

During the pandemic, our focus turned to ensuring our residents and staff were safe, so initially, many of our services were suspended and staff redeployed.

Our Active Lives services moved online, and we intend to continue these sessions which allow us to support more people. We will look at a hybrid model of both face to face and virtual sessions going forward.

Our Safeguarding work continued – individuals were visited and safeguarding processes followed if needed. We also continued with all Deprivation of Liberty (DoLS) work.

The Community LD Team (CLDT) developed a database to identify all vulnerable people living with LD with a particular focus on those with elderly carers.

There was impact on capacity and demand on the CLDT because the day care centres were closed and families were managing escalation of behaviors of concern

When LD patients were admitted to the acute Trust reasonable adjustments i.e family members staying were not always ensured.

There was increased oversight on inpatient service users with LD and/or ASD to ensure they were receiving the appropriate level of care and family still had access virtually throughout the pandemic.

Physical health needs for LD patients were left unmet due to changes to access primary care; although there was oversight of service users in community placements on a monthly basis virtually and by telephone.

Rapid Learning of Covid impacts from Life and Death Reviews of people with Learning Disabilities and Autism.

Joining up care for people with disabilities

One Croydon
Your health and care partnership

What are our priorities now?

A person-centred approach will run through all our priorities. In 2021 to 2023, we will:

- **Provide quality social care services**
- To provide the best quality social care services through maximising our resource allocation to keep our most vulnerable residents safe and healthy. We will focus on direct payment take up; and step up and step-down interventions having the right level of support that is flexible for individual's needs. Deliver a new reablement offer that maximises independence and transforms community care to reduce the reliance on impatient care.

- **Join up social, mental and physical health care**
  Address increasing activity across mental health, younger and older adult services, through demand management programmes including practice changes, improved information and advice for people at our front door. Diverting enquiries from transferring into statutory care by extending a 'digital' approach, improving information and advice to enable the maximum number of people to help themselves in the community through our ICN model; managing our placements spend, ensuring effective joint work and funding with the NHS for health needs and using direct payments as a first offer. We are also developing a new learning disability framework and service offer. Focussed on stronger service links between statutory and partner agencies, and with 'active citizens' at the core of shaping the offer.

- **Support people to live independently**
  Developing 3-year commissioning plans focused on maximising independence, to support people to live in the least restrictive environment and prevent and delay the need for long term care. A new supported living strategy and an options appraisal of our council provider services to optimise outcomes and reduce duplication.

- **Work in partnership with the voluntary and community sector**
- Developing an interdependent relationship with the voluntary, community and enterprise sector working in a multi-disciplinary, strengths-based way. Nurturing and establishing strategic partnerships and innovation.

- **Transform services for young people transitioning to adulthood**
- Transform our practice for young people transitioning to adulthood, to provide consistent, high quality and proportionate support. Planning early and listening and engaging with families and innovating to provide creative and independence strategies for our young people. Commissioning well and developing strategic relationships to provide cost effective improved outcomes. Continue to deliver high quality safeguarding assessments and interventions to better support younger people. Transform the transition pathway between children and young people and adult services.
- **Dementia friendly borough** to continue developing partnership working and service enabling Croydon to remain a Dementia friendly borough
- **Autism friendly borough** to enhance the borough's reputation as autism friendly, by delivering an action plan that delivers on the key partnership priorities within the autism strategy.
- **LeDeR - Learning from lives and deaths**

One Croydon
Your health and care partnership

Section 4: Socio-Economic Development

Anchor Institution

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Your health and care partnership

As Croydon's largest employers, the CCG (Croydon), Croydon Health Services and the Local Authority can have a huge impact on the socio-economic development of Croydon and, in turn, the health and wellbeing of its people. Over and above the delivery of front-line care, we have an enormous opportunity to use our scale and stability to benefit our staff and local people. With the impact of the COVID pandemic both on the economy and health and wellbeing the importance of taking up that opportunity is greater than ever.

What are the opportunities?

Employment and Skills
- Apprenticeships
- Sharing training opportunities
- Growing and targeting work experience

Supporting our staff
- Good Work Standard
  Debt/benefits advice?

Procurement
- Local market developmen
- Tender requirements

Sustainability
- Transport
- Biodiversity
- CO2

Engagement
- Engage local people and partners

Estates
- Free up for e.g. housing
- Host community orgs

Next Steps

- **Acknowledge and celebrate** the things we've already done and are already planning to do.
- **Focus on three priority areas,** The proposed priority areas are employment, estates/high street and procurement, because these are areas of significant need right now and where we can have a near-term impact.
- **Health and Local Authority to work in collaboration** to formulate a workplan.
- **Include measurement and quantifiable objectives** as part of the plan, to ensure real improvement and a focus on inequalities.
- **Develop a longer-term pipeline** through consultation with local people.
- **Continue to work at London and SWL levels.**

Anchor Institution: Progress in Priority Areas

One Croydon
Your health and care partnership

Employment and Enabling and Developing Our Workforce:

A significant challenge is ensuring we have the capacity and skilles in our workforce to meet the growing and changing needs of our populaiton; in addition, around 70% of our current workforce are Croydon Residents. Employing local people and enabling and developing our staff, particulalrly those from vulnerable communities that have been impacted the most by the COVID pandemic, will have significant soci-economic and wellbeing benefits for them and Croydon Place.

- One Croydon has introduced a workforce whole system group, looking at organisational development, joint services employment and staff wellbeing, and recruitment. The workforce group has designed and implemented a training and engagement programme to support integrated working and empower staff to lead on its development.
- Croydon Health Services have developed a Get in, Get on and Go further approach to career pathways maximising the ability to grow the future workforce through apprenticeship programmes
- There is a UK shortage of care workers in both home and residential care roles which mirrors shortages seen throughout the UK. Croydon council is working with Providers looking at their resilience strategies and running a campaign to drive a new generation of people to work in adult social care (ASC) and help fill the sector's vacancies
- There is significant work being undertaken across the One Croydon Partners workforce strategies and our ambition is to fully resource and develop this over the next 18 months.

Estates:

One Croydon has a dedicated Estates programme looking at council, community and NHS local estate assets, the ambition being to achieve our HEalth and Care Plan aim to deliver services closer to communitites, maximise efficient use and density of the Acute estate and support economic, social and environmental sustainability of our borough's high streets. Through this programme several exciting joint projects are being developed:

- A new Health and Wellbeing Centre (HWC), to be developed in New Addington. The HWC will provide front line services to the local population, as well as providing a base for the ICN+ team and services.
- A Primary Care Centre (PCC) in the Coulsdon area, to provide primary and community services to support an area of under-provision; this will also be a hub for the ICN+ team and Out of Hospital services.
- Several other ICN+ hubs are being explored using community space to enable service integration and ensuring services are closer to where people live.
- Community Diagnostic Centre, looking at estates options across One Croydon to develop the hub and spoke model to ensure services are closer to where people live.

One Croydon
Your health and care partnership

Section 5: Challenges to Delivery

Challenges to delivery

One Croydon
Your health and care partnership

The environment in which the Health and Care Plan is being refreshed is rapidly changing, and it is hard to fully understand the impact of these changes. We are working together in One Croydon to be open and transparent about the challenges facing each individual organisation and using our solid partnership to come together and tackle these challenges together. Challenges to delivery of the health and Care Plan are listed below; each programme will be impacted differently, and the One Croydon partnership will ensure there is oversight of risk across the system to ensure we can effectively identify, address and mitigate them.

- COVID-19; delivering the vaccine programme and unknown impact of future waves
- Shortage of suitably trained staff
- ICS transition; ensuring that Croydon received maximum delegation in order to continue to deliver transformation at Place
- Operational pressures not allowing enough focus on transformation i.e., delivery of the vaccination programme and elective recovery
- Underdeveloped IT interoperability
- Underfunding of health by 4% (population based); consistent underfunding reduces our ability to deliver transformation as well as meeting changing/increasing needs of our people
- Requirement to bring costs of social care in Croydon in line with the London and/or National average. The impact felt and contribution to this transformation is required across the whole health and care economy
- Local Authority Financial pressures; impact is felt across the whole health and care economy
- Brexit; impact on products and workforce as well as supply chain issues.

One Croydon

Your health and care partnership

Appendices

Croydon Health and Care Plan summary 2019

One Croydon
Your health and care partnership

Croydon

Over the last two years we have been working as One Croydon, an alliance between the local NHS, Croydon Council and Age UK Croydon and our focus on services for the over 65s has led to real improvements for local communities. We have now extended our ambitions to bring together health and care to deliver benefits for the whole population on our journey to become a fully integrated care partnership.

One of the fastest growing populations in London

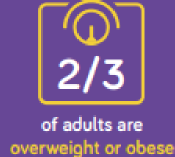
Compared to Sanderstead, healthy life expectancy in Fieldway, one of the most deprived areas in Croydon, is

13 years lower for men

14 years lower for women

51.7% of Croydon residents are Black, Asian and Minority Ethnic

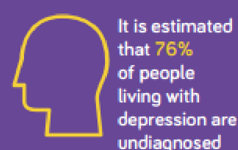
Child population is the largest in London



2/3 of adults are overweight or obese

23% of people have two or more long term conditions

1 in 17 older people always or often experience loneliness



It is estimated that 76% of people living with depression are undiagnosed

Our ambitions and aspirations

Focus on prevention and proactive care

We want to support local people before things become a problem and encourage residents to be more proactive in their own health

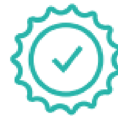
Unlock the power of communities

By making the most of communities' assets and skills – key to helping local people stay fit and healthy for longer is to connect them with their neighbours and communities

Put services back into the heart of the community

Make sure local people have access to integrated services that are tailored to the needs of local communities – locality matters

Our One Croydon Alliance partners are now working together to become a fully integrated care partnership. A step on that journey is the alignment between Croydon Health Services NHS Trust and NHS Croydon Clinical Commissioning Group. We are working on creating a single budget for health and care to help to better meet the needs and improve the experience and health outcomes of the people of Croydon as well as the opportunities for staff.



What we've achieved so far

Health and care professionals work together in virtual **multi-disciplinary teams** to identify people who need support and to provide those services when and where they need them. Reducing non elective admissions by 15% which means 3,000 fewer people were admitted to hospital last year.

Croydon's 18 **personalised independence coordinators** aim to break the cycle of hospital admissions and this has resulted in fewer patients needing care packages for longer than six weeks after leaving hospital

Our Local Voluntary Partnership funds and supports local voluntary and community providers to work together to support residents to look after their own health, reduce social isolation and promote independence. Activities have included a cinema club for older people, a food growing club for newly-retired men and a tea party where people can also have a health check.

Social prescribing allows GPs and nurses to prescribe a range of non-clinical services – everything from Bollywood dancing to cooking lessons – to help improve people's emotional, mental and general wellbeing.

In six months, there were over 28,000 attendances across a range of activities and 37 of Croydon's 50 practices are now referring.

We launched our **Living Independently for Everyone (LIFE)** service. This supports people with long-term conditions mainly who are aged over 65 years old to stay at home and reduce their need to be admitted to hospital.

In its first year, the LIFE team got over 1,000 patients home sooner and helped 847 people avoid having to stay in hospital at all.

Read the full Croydon Health and Care Plan published in 2019 here

Croydon Health and Care Plan summary 2019

One Croydon
Your health and care partnership

Our plans for the next two years

Prevention and proactive care

- Increase coverage of social prescribing supported by Croydon's strong voluntary sector
- Further support to, and build the capacity of, the voluntary sector and communities to deliver preventative services
- Increase number of community health and wellbeing hubs providing integrated services
- Implement a new Long Term Conditions model of care prioritising diabetes, cardiovascular and respiratory disease and increase identification of those at risk of long term conditions
- Working age people will have flexible care that they can arrange themselves and have choice and control over, achieved through e-market places, personal budgets and direct payments

Better start in life

- Implement our children and young people's mental health transformation plan
- Implement the Healthy Pregnancy programme that will improve immunisation rates, breastfeeding rates, parenting support and take up of the Live Well programme
- Multidisciplinary approach to reduce the number of children in care through closer integrated working

Locality development

- Develop Integrated Community Networks Plus to bring together a complete clinical and health professional community, integrating GPs, mental health and community nurses, social care, pharmacy and the voluntary sector to proactively manage people with complex health and care needs at practice level
- Support GPs to implement Croydon's Primary Care Networks and to recruit Social Prescribers and Pharmacists for each one, establish local clinical cabinets and begin to manage, monitor and further improve quality
- Develop strengths-based approaches across disciplines through Community Led Support

All disabilities

- Give working age people flexible care that they can arrange themselves and have choice and control over
- Provide more joined up care for people with disabilities by implementing locality based services and bringing multi-agency teams together
- Transform our practice for children with disabilities to provide consistent, high quality and proportionate support throughout their childhood and the transition to adulthood

Mental health

- Work in partnership with schools and colleges to deliver a whole school approach to emotional health, wellbeing and mental health. Teams will work in schools and youth mental health first aid training will be provided.
- Implement the mental health community hub and spoke model to put more clinicians out in the community to support people closer to home
- Develop a wider range of housing options for those with severe mental health problems to better support their needs

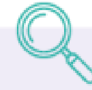
Modern acute care

- Develop modern acute vision and strategies for physical and mental health
- Support our local Trust to become the provider of choice and optimise acute pathways through the pathway redesign programme and improve efficiency
- Redesign flows within the hospital to support delivery of the four-hour emergency department waiting times standard
- Reduce long lengths of stay by working with partners across the system including mental health and social care to support patients to get back home

What people have told us

- Services need to be more flexible and offer different levels of support to people in their own homes.
- Train people who visit isolated people in their homes so that they can alert services when their health starts to deteriorate
- We need to build resilience and confidence throughout our communities
- Residents need more help to stay well throughout their lives
- A lot of teachers lack confidence when it comes to addressing or talking about mental health issues with children and young people.
- We need more mental health services for those in crisis in the community.

You can find out more about what local people told us at www.croydonccg.nhs.uk/get-involved



Our focus

1. Increase social prescribing
2. Voluntary sector delivering preventative services
3. Community health and well being hubs
4. Identification of those at risk of Long Term Conditions
5. Closing the financial gap

How will we know if we've made a difference?

Improve quality of life

- Increase the number of adults exercising
- Decrease the number of people with long term conditions in the most deprived areas where incidence is higher

Better start in life

- Reduce obesity in reception year children
- Reduce the number of school pupils with social, emotional and mental health needs

Wider determinates of health

- Increase social inclusion
- Increase employment, particularly for people with learning difficulties and mental health needs

Over ten years to improve healthy life expectancy from 62 years to 66 years for men and 62.8 years to 66.8 years for women

Reduce the gap in life expectancy from 9.4 years to 7.4 years for men and from 7.6 years to 5.6 years for women

This is a summary of the Croydon Health and Care Plan, you can read the full document at www.croydonccg.nhs.uk

Read the full Croydon Health and Care Plan published in 2019 here

Thank you

One Croydon
Your health and care partnership

- Any questions?
- Find out more here

REPORT TO:	HEALTH AND WELLBEING BOARD 19 January 2022
SUBJECT:	Pharmaceutical Needs Assessment (“PNA”)
BOARD SPONSOR:	Rachel Flowers, Director of Public Health, Croydon Council
PUBLIC/EXEMPT:	Public

SUMMARY OF REPORT:

- To note the procurement and development of the 2022 Croydon Pharmaceutical Needs Assessment.
- That the Board agrees to the establishment of a PNA steering group as outlined in the draft Terms of Reference in Appendix 1 to oversee the PNA process as outlined in the national PNA guidance

BOARD PRIORITY/POLICY CONTEXT:

From 1st April 2013, every Health and Wellbeing Board (HWB) in England has had a statutory responsibility to publish and keep up to date a statement of the needs for pharmaceutical services of the population in its area, referred to as a Pharmaceutical Needs Assessment (PNA).

The National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 (“the 2013 Regulations”) require each HWB to make a revised assessment as soon as is reasonably practicable after identifying changes to the need for pharmaceutical services which are of a significant extent.

Every area is required to publish a refreshed PNA document within 3 years. Croydon, in line with national regulations, published its first PNA in 2015 and the second in 2018. The third PNA is due to refresh and publish in October 2022.

Croydon Council outsourced the previous PNA for a total Contract Value of £37,703 through a competitive tender process. The proposed contract value has increased (to £40,000) to allow for inflation. The proposal is to carry out another competitive tender process via the Central Buying Team, ensuring the service specification is tailored and limited to the statutory requirements to ensure value for money. The project will be funded from the public health budget. The Public Health Ring-fenced grant is allocated by the Director of Public Health to improve population health and prevention and meet the nationally driven mandated requirements of the grant.

FINANCIAL IMPACT:

No financial impact for Health and Wellbeing Board partners.

RECOMMENDATIONS:

The Health and Wellbeing Board is recommended to :

1. Note the plans for procurement and development of the 2022 PNA for Croydon on behalf of the Health and Wellbeing Board and the proposed time line to meet the statutory deadline of publication by 1 October 2022.
2. Agree to the establishment of a PNA steering group with the terms of reference as outlined in the draft Terms of Reference in Appendix 1 to oversee the PNA process as recommended in the national PNA guidance

1. EXECUTIVE SUMMARY

1.1 This paper provides an update on the plans to produce and publish the 2022 Croydon Pharmaceutical Needs Assessment (PNA).

1.2 Croydon Council plan to outsource the development of the PNA on behalf of the HWB. This has been approved by the Spending Control Panel.

1.3 Croydon Council plan to carry out a competitive tender process via the Central Buying Team, ensuring the service specification is tailored and limited to the statutory requirements to ensure value for money.

1.4 The procurement process will be led by the Central Buying Team, and Public Health Commissioning and Public Health Teams.

1.5 The Procurement process started Friday 3 December 2022 and will run until 20 January 2022 after which a provider is expected to be appointed.

1.6 The Provider is expected to work and collaborate with the Public Health and proposed Steering Group to produce the PNA report.

1.7 The final report is proposed to be presented to the HWB for final sign off in September 2022 before publication.

2. DETAIL

Background

2.1 From 1st April 2013, every Health and Wellbeing Board in England has had a statutory responsibility to publish and keep up to date a statement of the needs for pharmaceutical services of the population in its area, referred to as a pharmaceutical needs assessment (PNA). Every area is required to publish a refreshed PNA document within 3 years. Croydon, in accordance with national regulations, published its first PNA by 1st April 2015 and the second in March 2018.

2.2 Regulation 6, which has prospective amendments introduced by the by National Health Service (Charges, Primary Medical Services and Pharmaceutical and Local Pharmaceutical Services) (Coronavirus) (Further Amendments) Regulations 2021/1346 Pt 2 reg.3(2)(b) which come into force on January 1, 2022, provides that in circumstances where a HWB has published its first or revised PNA before 1 April 2020, as is the case with Croydon, it must publish a

revised PNA before 1 October 2022. Therefore any revised PNA as is suggested by this report must be approved by HWB and published prior to that date.

2.3 The information to be contained in the Pharmaceutical Needs Assessment is set out in Schedule 1 of the National Health Service (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013. The PNA should include:

- A list of pharmacies in Croydon and the services they currently provide, including dispensing, health advice and promotion, flu vaccination, medicines reviews and local public health services, such as sexual health services.
- Relevant maps of providers of pharmaceutical services in the area.
- Services in neighbouring areas that might affect the need for pharmaceutical services in Croydon.
- Potential gaps in provision that could be met by providing more pharmacy services, or through opening more pharmacies, and likely future needs.

2.4 The Pharmaceutical Needs Assessment should also be aligned with the Joint Strategic Needs Assessment and Health and Wellbeing Board Strategy for Croydon.

2.5 PNAs enable health and care partners to identify unmet pharmaceutical needs. PNAs are used by NHS England to make decisions on applications to open new pharmacies and dispensing appliance contractor premises; or applications from current pharmaceutical providers to change their existing regulatory requirements. Applications to open new pharmacies can be keenly contested by applicants and existing NHS contractors and can be open to legal challenge if not handled properly. PNAs also support local authority and NHS commissioners to make decisions on the locally funded services need to be provided by local community pharmacies, and ensure that service provision is targeted in areas where there is population need for them.

2.6 Health and Wellbeing Boards need to ensure that the NHS England and its Area Teams have access to the local PNA, to support their decision-making and strategic planning processes. Croydon Council's Public Health team have ensured that NHS England know how to access and interpret the information provided in Croydon's current PNA. The current PNA is publicly accessible via the Croydon Observatory website: http://www.croydonobservatory.org/pna

2.7 A PNA should include information on local pharmacies and the services they already provide. These will include dispensing, providing advice on health, medicines reviews and local public health services, such as stop smoking, sexual health and support for drug users. It should look at other services, such as dispensing by GP surgeries, and services available in neighbouring areas that might affect the need for services in the local area. The PNA will take account of any changes to the commissioning of public health and CCG services in Croydon, and will also account for changes in NHS England commissioning arrangements.

2.8 The PNA should examine the demographics of the local population, across the area and in different localities, and their needs. It should look at whether there are gaps that could be met by providing more pharmacy services, or through opening more pharmacies. It should also take account of likely future needs. The PNA should also contain relevant maps relating to the area and its pharmacies. The PNA must be aligned with other plans for local health and social care, including the Joint Strategic Needs Assessment (JSNA) and the Joint Health and Wellbeing Strategy.

3. PNA Development and Publication

3.1 Tender process started Friday 3 December and will close Thursday 20 January when a provider is expected to be appointed to develop the 2022 PNA for Croydon on behalf of the Health and Wellbeing Board.

3.2 Utilising the Central Buying team to carry out a competitive tender process allow us to ensure value for money through limiting the service specification to the statutory requirements.

3.3 The project will be funded from the public health budget and has been approved by the Spending Control Panel.

3.4 The provider will work with the Steering group which is recommended to be established to support the PNA process. The Draft terms of reference are at Appendix 1 for Member's consideration and approval. The proposed membership of the Steering group is detailed at Appendix 1 and includes members representing: Croydon Council (including Public Health and Communications Teams), Croydon Clinical Commissioning Group, Local Pharmaceutical Committee, Local Medical Council, and Healthwatch Croydon. The provider will support the steering group but not be a member/decision maker on the Steering Group.

3.5 The Steering Group will oversee the production of the 2022 PNA for the London Borough of Croydon, reporting progress to the HWB.

3.6 Section 8 of the 2013 Regulations requires consultation with specific organisations and groups allowing them a minimum of 60 days for making their response to the consultation. A Consultation is planned to run in summer 2022 (June 2022 or sooner if possible). Reponses gathered from the consultation will be subsequently analysed and a PNA produced by September 2022.

3.7 The final report will be presented to the HWB in September 2022 to sign off before publication by 1 October 2022.

4. CONSULTATION

4.1 A first Consultation on the views of pharmacy services users is planned to be conducted in summer 2022 (expected June 2022 or sooner if possible). In the same period, commissioners and contractors will be also consulted using similar process. Results will be used to inform the PNA process and the development of the final draft.

5. SERVICE INTEGRATION

5.1 PNAs provide a common structured framework within which commissioners and strategic planners can make decisions about pharmaceutical needs in a local area. They facilitate discussions between NHS England, local commissioners from the local authority and CCG, and local pharmacists around addressing local pharmaceutical needs, and provide a common framework for assessing activity and provision that should be in place to address these needs.

6. FINANCIAL AND RISK ASSESSMENT CONSIDERATIONS

6.1 The PNA supports NHS England to make decisions about market entry.

6.2 The Department for Health and Social Care PNA Information pack for local authority and health and wellbeing boards 2021 states that "Due to the serious consequences of not following due process in developing the pharmaceutical needs assessment, it is recommended that the board includes production of the pharmaceutical needs assessment in the council's risk register"

6.3 The funding to undertake and develop the refreshed 2022 PNA has been identified as part of the public health ring-fenced grant.

6.4 The procurement of the 2022 PNA has been approved by the Central Buying Team, Spending Control Board, and the Director of Public Health. Due to the contract value, it was not required to present the project to the CCB.

The Director of Public Health informed the Chair of the Health and Wellbeing Board of the plans to produce and commission the PNA in December 2021 (this happened prior to launching the tender) and advised the Chair the case would be presented to the Board in January 2022.

Approved By Richard Ennis, Interim Corporate Director of Resources and Section 151.

7. LEGAL CONSIDERATIONS

7.1 The Head of Litigation and Corporate Law comments on behalf of the Director of Law and Governance that there is a statutory responsibility to produce a pharmaceutical needs assessment ("PNA").

7.2 The Health and Social Care Act 2012 established Health and Wellbeing Boards and transferred to them (from the NHS Act 2006) the responsibility to publish and keep up to date a statement of the needs for pharmaceutical services of the population in its area, with effect from 1 April 2013. The requirements on how to develop and update PNAs are set out in Regulations 3-9 and Schedule 1 of the National Health Service (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013 ("the 2013 regulations").

7.3 Regulation 6 of the 2013 regulation (which has prospective amendments introduced by the by National Health Service (Charges, Primary Medical Services and Pharmaceutical and Local Pharmaceutical Services) (Coronavirus) (Further Amendments) Regulations 2021/1346 Pt 2 regulation 3(2)(b) which come into force on January 1, 2022) provides that in circumstances where a HWB has published a PNA before 1 April 2020, as is the case with Croydon, it must publish a revised PNA by 1 October 2022. Therefore any revised PNA as is suggested by this report must be approved by HWB and published by that date to be in statutory compliance.

7.4 Failure to publish a PNA by the statutory deadline is challengeable by way of Judicial Review, as are the process followed in developing the PNA, including the consultation process and manner in which the consultation outcomes are considered and whether the PNA adheres to the minimum requirements set out in the 2013 Regulations.

Approved by: Sandra Herbert, Head of Litigation and Corporate Law on behalf of the Director of Law and Governance and Deputy Monitoring Officer.

8. EQUALITIES IMPACT

8.1 The purpose of any needs assessment, including the PNA, is to look at current and predicted future population needs for service provision or support. The PNA will identify the need for access to pharmaceutical services so that NHS England can approve or reject applications for additions to the pharmaceutical list. The PNA will also identify the need for locally commissioned services that local authority and CCG commissioners can respond to using relevant commissioning budgets.

8.2 As part of the PNA process, an "Equality Impact Assessment" (EIA) will be completed to identify if there would be any impact on any group with protected characteristics. The DPH and Equality Analysis Officer from Croydon Council will be responsible to sign off the EIA.

Approved by Denise McCausland – Equality Programme Manager.

9. DATA PROTECTION IMPLICATIONS

9.1 WILL THE SUBJECT OF THE REPORT INVOLVE THE PROCESSING OF 'PERSONAL DATA'?

YES - The PNA process involves data management, including a consultation. The Council will work with the Provider to ensure data is protected according to current legislation (e.g. Data Protection Act, GDPR) and all necessary assessment are completed (e.g. DPIA).

Data protection requirements have been included in the Service Specification and are part of the standard Council contracts.

To ensure all parties comply with regulations, the requirements, roles and responsibilities will be discussed and agreed with the Provider in the first contract meeting.

9.2 HAS A DATA PROTECTION IMPACT ASSESSMENT (DPIA) BEEN COMPLETED?

NO - As detailed above DPIA will be completed by the provider

9.3 "The Director of Public Health comments that the contract with the provider will support appropriate steps being taken for data protection.

Approved by: Rachel Flowers, Director of Public Health.

10. HUMAN RESOURCES IMPACT

10.1 There are no direct Human Resources implications arising from this report itself, which sets out the intention to outsource the development of the 2022 PNA for Croydon on behalf of the Health and Wellbeing Board.

10.2 However, the procurement exercise is likely to involve service provision changes which may invoke the effects of the Transfer of Undertakings (Protection of Employment) 2006 Legislation (amended 2014). The service will therefore need to ensure it works with the current contractors and their HR providers to ensure the appropriate policies and procedures are followed.

Approved by: Deborah Calliste, Head of HR for Adult Social Care & Health on behalf of the Director of Human Resources.

CONTACT OFFICER:

Rachel Flowers, Director of Public Health Rachel.flowers@croydon.gov.uk

APPENDICES TO THIS REPORT

Appendix 1 – Croydon 2022 PNA Steering Group Draft Terms of Reference

Croydon 2022 PNA Steering Group – Draft Terms of Reference

Purpose
Ensure the development of 2022 Croydon's Pharmaceutical Needs Assessment (PNA) so that Croydon Health and wellbeing Board meet its statutory responsibility for publishing the PNA in line with The National Health Service England (Pharmaceutical Services and Local Pharmaceutical Services) regulations.

Objectives
• To oversee the development of the pharmaceutical needs assessment in accordance with and ensure the Croydon PNA complies with the NHS Pharmaceutical Services and Local Pharmaceutical Services Regulations 2013.

• Ensure the PNA takes into account the local demography within Croydon Borough and ascertain whether there is sufficient choice and accessibility (e.g. physical access, language etc.) with regard to obtaining pharmaceutical services.

• Promote integration of the PNA with other strategies and plans including the Joint Strategic Needs Assessment, the Joint Health & Wellbeing Strategy, the CCGs' Commissioning Strategy Plans and other relevant strategies

• Ensure the consultation on the PNA meets the requirements of Regulation 8 of the 2013 Regulations. In particular, ensure that both patients and the public are involved in the development of the PNA.

• Ensure all appropriate stakeholders in Croydon are aware, engaged and involved in the development of the PNA.

• Present the PNA first and final draft to the Health and Wellbeing Board.

• Publish the PNA on the Council's website by October 2022.

• Develop a community pharmacy vision that is integrated across health and social care spectrum, ensuring direct link to the Health & Wellbeing vision for the borough

• Horizon scan for future policy direction and identify system decision makers to transform the vision into a reality for Croydon residents

• Ensure the vision paper has adequate and appropriate patient and public involvement along with the wider community pharmacies operating in Croydon

Governance
• The Health and Social Care Act 2012 transferred the statutory responsibility for PNAs from NHS Primary Care Trusts (PCTs) to Health and Wellbeing Boards (HWB), from 1 April 2013, with a requirement to publish a revised assessment at least every 3 years

• This Steering Group has been established to oversee the production of the 2022 PNA for the London Borough of Croydon, reporting progress and presenting the final report to the HWB on or before the September 2022 meeting.

• The Health and Wellbeing Board will be informed of progress towards the production of the PNA and relevant milestones through the HWB Programme Manager's quarterly updates.

• If a statement or decision from the Health and Wellbeing Board is needed in relation to the production of the draft PNA, a formal report will be prepared for the Health and Wellbeing Board's consideration.

• The steering group will report directly to the Director of Public Health and is accountable to Croydon Health and Wellbeing Board.

Frequency of meetings

Meetings will be arranged at key stages of the project plan. The Steering Group will meet in late summer 2022 to sign off the PNA 2022 for submission to the Health and Wellbeing Board.

Responsibilities

• Provide a clear and concise PNA process

• Review and validate information and data on population, demographics, pharmaceutical provision, and health needs

• To agree and sign off on the documentation for consultation purposes and to consult with the bodies stated in Regulation 8 of The NHS Regulations 2013:

  o Any Local Pharmaceutical Committee for its area

  o Any Local Medical Committee for its area

  o Any persons on the pharmaceutical lists and any dispensing doctors list for its area

  o Any LPS chemist in its area

  o Any Local HealthWatch organisation for its area

  o Any NHS trust or NHS foundation trust in its area

  o The NHSCB

  o Any neighbouring HWB

• • Ensure that due process is followed.Ensure that the draft and final PNA contains all the relevant statements required by legislation

• Review the responses to the consultation and agree its response to the points raised and agree what, if any, changes are to be made as a result of the consultation. This review will form part of the report on the outcome of the consultation and is included in the final version of the PNA.

• Agree the final version of the PNA for consideration and subsequent decision by the Health and Wellbeing Board.

• Report to Health & Wellbeing Board on both a Draft and Final PNA.

• Ensure that the Health and Wellbeing Board is able to publish a Final PNA by 1 October 2022.

Membership:

Delegate	Job title	Organisation
Mar Estupinan	Public Health Principal	Public Health Croydon, London Borough of Croydon
Jack Bedeman	Consultant in Public Health	Public Health Croydon, London Borough of Croydon
Denise Malcolm	Senior Communications Officer	London Borough of Croydon
Carol Lewis	Senior Public Health Intelligence analyst	Public Health Croydon, London Borough of Croydon
Edwina Morris	Chief Executive Officer	Healthwatch Croydon
Amit Patel	Chief Executive Officer	Croydon LPC
Louise Coughlan	Chief Pharmacist	Croydon Health Services
Lizzie Whetnall	Head of Communications and Engagement Croydon and South West London	South West London Health and Care Partnership
Karthiga Gengatharan	Medical Director	Surrey and Sussex LMCs

In attendance at meetings will be representatives of the provider who have been commissioned by London Borough of Croydon to support the development of the PNA. The *provider* is not to be a core member.

The meeting will be chaired by a representative of LBC Public Health, with the *provider* supporting.

Each core member has one vote. The Chair will have the casting vote, if required.

Core members may provide a deputy to meetings in their absence.

The Steering Group shall be quorate with five core Members in attendance, one of which must be a pharmacist member. Non-attending members are unable to cast a vote or participate in decision making. . To be included in decision-making, members' (or their nominated deputies) attendance is essential.

In attendance at meetings will be representatives of the *provider* who have been commissioned by London Borough of Croydon to support the development of the PNA.

REPORT TO:	HEALTH AND WELLBEING BOARD 19 January 2022
SUBJECT:	Transforming Mental Health Services for Children, Young People (0-25) and their families across South West London – Local Transformation Plan Refresh 2021
BOARD SPONSOR:	Matthew Kershaw - Chief Executive and Place Based Leader for Health Croydon Health Services NHS Trust
PUBLIC/EXEMPT:	Public

SUMMARY OF REPORT:

This report provides members with the refreshed Children and Young People's Emotional Wellbeing and Mental Health Local Transformation Plan for 2021. In previous years, 2015 to 2019, an annual refresh of a Croydon specific Local Transformation Plan was produced and submitted to NHS England for assurance.

The 2021 refreshed plan combines six local Children and Young People's Local Transformation Plans. The aim of this combined refresh plan is to establish a more consistent strategic framework for improving mental health and emotional wellbeing services for children, young people and their families across South West London.

BOARD PRIORITY/POLICY CONTEXT:

The NHS Five Year Forward View for Mental Health (FYFV) ended in March 2021 and covered the period from 2016-2021. The FYFV plan crossed over with the start of the new NHS Long Term Plan from 2019-2024.

The NHS Long Term Plan builds on the work set out in the FYFV plan for children and young people's mental health. This included the key ambitions for

- increasing access to NHS-funded community services
- expanding timely access to eating disorders services
- reducing inappropriate out of area placements
- improve transitioning between children's and adult mental health services
- and includes additional ambitions to deliver expanded crisis support.

The Plan describes the progress made against the Five Year Forward View for Mental Health and the NHS Long Term Plan vision, ambitions and targets for Child and Adolescent Mental Health Services (CAMHS). In addition, it supports the development and delivery of the transformation of mental health and emotional wellbeing services for children and young people.

The six South West London Clinical Commissioning Groups (CCG) merged into one South West London CCG in April 2020. SW London CCG continues to work with partners across health and social care to develop the Integrated Care Systems (ICS) framework and provider collaborative as set out in the government Health and Social Care white paper.

The move to an ICS represents the opportunity for joint working and collaboration across health and care, which will further benefit the transformation of children's and young people's mental health and emotional wellbeing services.

FINANCIAL IMPACT:

This report does not have any direct financial implications. It seeks to give an update on the delivery of work over the year as well as future plans and ambitions.

RECOMMENDATIONS:

The Board is asked to note and comment on the contents of the Local Transformation Plan refresh contained in the appendices.

1. BACKGROUND

1.1. This is the first South West London Clinical Commissioning Group's (SW London CCG) first joint transformation plan for children and young people's (CYP) mental health and emotional wellbeing. It brings together and builds on previous individual borough-based plans and refreshes ambitions, priorities, and proposals for the ongoing improvement of mental health services. Unlike in previous years, where the Local Transformation Plan refresh was submitted to NHS England for assurance, this combined refresh has been place level management led centrally by South West London Clinical Commissioning Group.

1.2. The SW London Local Transformation Plan (LTP) refresh describes progress against the Five Year Forward View for Mental Health and NHS Long Term Plan vision, ambitions and targets for Child and Adolescent Mental Health Services (CAMHS).

1.3. The plan acknowledges the significant and ongoing impact of the Covid-19 pandemic on the mental health of children, young people, and their families. Demand for services has increased and the CCG is working closely with providers across SW London to ensure services continue to meet the needs of children and young people.

1.4. Several key areas will be prioritised, including early support and prevention to further promote resilience and ensure children and young people can access early intervention services. There will be a move away from the tiered approach of service delivery with the implementation of the 'I -Thrive'

framework. This will ensure a stronger partnership approach with better flexible access to services.

1.5. The CCG will become an integrated care system during the lifespan of this plan. This will further support the approach to collaborative and joint working across health and care in SW London and ensure that the transformation of child and adolescent mental health services remains a top priority.

2. DELIVERY TO DATE

2.1. CAMHS Transformation Plans have helped to deliver Future in Mind and the Mental Health Five Year Forward View over the last five years.

2.2. The access target increase from 25% to 35% has been successfully achieved. The ambition is to go further with continued investment in preventive and early help services in schools, colleges and the community as well as expand core help to children and young people and crisis mental health services.

2.3. The Eating Disorders service has consistently met the national waiting time standards for urgent and routine referral up to March 2020, but the recent surge in demand has highlighted the need for additional investment in this specialist pathway.

2.4. The impact of COVID has dramatically changed the way services have been delivered. We saw the overnight move from face-to-face appointments to digital and online assessments and treatment for the majority of referrals.

2.5. A 24/7 all-age crisis pathway was established in April 2020 in response to COVID, offering telephone triage and face-to-face urgent assessments to avoid hospital admission. This also provided the possibility for a short admission without delay, where necessary for the safety of the children and young people’s mental health condition.

2.6. New mental health support team in schools programmes will continue to be rolled out in 2021/22 to further help children with mild to moderate mental health needs within schools and colleges.

2.7. Develop closer working relationships between the CCG and Local Authorities to support CYP with SEND/EHCPs with improved access to specialist LD CAMHS and integrated therapy offer, including psychology and positive behavioural support.

OUR FUTURE PLANS

2.8. Future priorities within the plan are:

- To use additional CAMHS investment to deliver Long Term Plan ambitions. This will include a more integrated 0-25 mental health service delivery model that works in close collaboration with partners in children and young adult services.

- Continue to transform access to services, including the digital offer, early help in schools and colleges to meet national targets.

- Deliver joined up specialist pathways that move away from tiers and age cut-offs. This will offer children and young people and families more choice when transitioning into adult services.

- Re-establish the intensive treatment option for children and young people with eating disorders to prevent the need for inpatient treatment

- Establish a fully integrated children and young people crisis service across SW London that includes timely self-harm and urgent crisis assessments. This will include capacity to deliver outreach and home treatment to children and young people and their families when they need it

3. CONSULTATION

3.1. The SW London Local Transformation Plan refresh has been written with children, young people, young adults (0-25) and their parents/families/carers in mind. Active engagement and participation in shaping and implementing the SW London Local Transformation Plan as well as borough-based priority projects is welcomed and encouraged from this key audience.

3.2. Feedback on the refreshed transformation plan is being sought after from Health and Well Being boards across the six boroughs along with the following forums taking place before the end of January:

- Health and Care Partnership Programme
- SWL CCG Quality & Performance Oversight Committee (QPOC)
- SWL Recovery and Transition Board
- SWL CCG Governing Body

4. FINANCIAL AND RISK ASSESSMENT CONSIDERATIONS

4.1. This report does not have any direct financial implications. It reports on the SW London Local Transformation Plan refresh and does not contain direct proposals.

Approved by: Philip Herd on behalf of the Head of Departmental Finance, Croydon Council

Approved by: Jonathan Robinson, Head of Finance – Croydon CCG on behalf of the Director of Finance, Croydon Clinical Commissioning Group

5. LEGAL CONSIDERATIONS

5.1. In 2015, the Children and Young People's Mental Health and Wellbeing Taskforce released their Future in Mind guidance outlining the aims for transforming the way Children and Adolescent Mental Health Services are delivered nationally. The refreshed Children and Young People's Emotional Wellbeing and Mental Health Local Transformation Plan for 2021 is in line with this and the NHS Long Term Plan published on 7th January 2019.

5.2. In addition, the following legal provisions should also be borne in mind:

5.3. The Children and Families Act 2014 provides a system of support across education health and social care to ensure that services are organised with the needs and preferences of the child and family, from birth, to the transition to adulthood. The support includes provision for children with long term health conditions, as well as and including mental health.

5.4. The Children and Families Act 2014 requires local authorities CCG's and NHS England, to establish joint commissioning arrangement to improve outcomes for children and young people.

5.5. Local Authorities have a duty under section 17 of the Children Act 1989 to safeguard and promote the welfare of 'children in need' in their area by providing appropriate services to them.

5.6. The Care Act 2014 applies to young people transitioning to adulthood. Under section 1(2)(b), Local authorities have a duty to promote the general wellbeing of individuals including their mental health.

Approved by: Doutimi Aseh, Interim Director of Legal Services & Interim Deputy Monitoring Officer.

6. HUMAN RESOURCES IMPACT

6.1. There are no human resources impacts from this report

6.2. No further comments from Human Resources. Happy to sign off.

Approved by Debbie Calliste, Head of Human Resources for Adult Social Care and Health and Children, Young People & Families on behalf of the Director of Human Resources.

7. EQUALITIES IMPACT

7.1. South West London Clinical Commissioning Group has health inequalities featured throughout its work and continues to commission services to address health inequalities experienced in emotional wellbeing and mental health by children and young people.

7.2. Reducing health inequalities is an overarching principle within Croydon and continues to be a key focus for both South West London Clinical Commissioning Group and the Health & Wellbeing Board.

7.3. Denise McCausland, Equality Programme Manager

7.4. Approved by Debbie Calliste, Head of Human Resources for Adult Social Care and Health and Children, Young People & Families on behalf of the Director of Human Resources.

8. DATA PROTECTION IMPLICATIONS

8.1. **WILL THE SUBJECT OF THE REPORT INVOLVE THE PROCESSING OF 'PERSONAL DATA'?**

NO

8.2. **HAS A DATA PROTECTION IMPACT ASSESSMENT (DPIA) BEEN COMPLETED?**

NO

8.3. Comments from Alison Tingle, IG Subject Matter Expert Manager:

I confirm that the South West London CCG Local Transformation Plan Refresh report has been reviewed and am satisfied that it does not contain any identifiable data. The completion of a DPIA is therefore not necessary in this circumstance, and I am content to sign this off from an IG perspective.

CONTACT OFFICER:

Connie Ikhifa, Senior Commissioning Manager. 020 3458 5525
Connie.ikhifa@swlondon.nhs.uk

APPENDICES TO THIS REPORT

Appendix 1 - Transforming Mental Health Services for Children, Young People (0-25) and their families across South West London 2021 - Transformation Plan.

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South West London
Clinical Commissioning Group

Transforming Mental Health Services for Children, Young People (0-25) and their families across South West London

2021

(Refresh of previous six local CAMHS Transformation Plans)

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Foreword

This is South West London Clinical Commissioning Group's (SW London CCG) first joint transformation plan for children and young people's (CYP) mental health and wellbeing. It builds upon the strengths of the previous borough-based plans and refreshes our ambitions, priorities, and proposals for the ongoing improvement of mental health services.

The plan acknowledges the significant and ongoing impact of the Covid-19 pandemic on the mental health of children, young people, and their families. Demand for services has increased and the CCG is working closely with providers across the SW London to ensure services continue to meet the needs of children and young people.

We will prioritise several areas over the coming year including early support and prevention to further promote resilience and ensure children and young people can access early intervention services. Also, we will move away from the tiered approach of service delivery and implement the 'I -Thrive' framework to ensure a strong partnership approach and more flexible access to services. New mental health support teams will continue to be rolled out in 2021/22 to help children with mild to moderate mental health needs within schools and colleges.

The CCG will become an integrated care system during the lifespan of this plan. This will further support the approach to collaboration and joint working across health and care within SW London and ensure that the transformation of child and adolescent mental health services remains a top priority.

Tonia Michaelides
Executive Locality Director & Joint Mental Health SRO

Dr Brinda Paramothayan
Clinical Lead – SW London Children's & Young People Mental Health Programme

Executive Summary

This SW London Local Transformation Plan (LTP) Refresh describes progress against the Five Year Forward View for Mental Health and NHS Long Term Plan vision, ambitions and targets for Child and Adolescent Mental Health Services (CAMHS). It considers the impact of Covid and recovery to date throughout the report. The refresh highlights positive developments and achievements as well as shared challenges across SW London and our plans to address these.

This document should be read alongside borough Health and Care Plans and the CCG's response to the Long Term Plan. It is not an overarching children's mental health strategy; it describes progress to date against historic ambitions and sets out our investments and plans for 2021/22 only. As we move to an ICS we will be engaging with partners, stakeholders and, of course, children and young people and their parents and carers to help us set our vision for the future of children's mental health in SW London.

There are many common themes and challenges across SW London that the plan seeks to address. These include:

- Demand for CYP mental health services continues to grow and acuity is more complex, particularly post Covid19, and some waits are long
- There are complex and sometimes fragmented commissioning arrangements for CAMHS/CYP provision across the six boroughs in SW London with multiple providers (both NHS and non-NHS), resulting in variability of service provision
- As the ICS develops, the steps to define and develop future CAMHS governance arrangements are still in progress and under consideration

With this SW London refresh we aim to establish a more consistent strategic framework for improving mental health services for CYP and their families across SW London.

The SW London LTP has been written with key audiences in mind:

- Children, young people, young adults (0-25) and their parents/families/carers, who are our current service users as well as those who need help in the future
- Professionals from Health, Education, Social Care and the Voluntary Sector working with CYP and their families
- NHS England requiring assurance on funding provided to SW London and its places

We are keen to increase our engagement and welcome active participation in shaping and implementing the SW London strategy as well as borough-based priority projects.

1. Context

March 2021 marked the end of the NHS Five Year Forward View for Mental Health (FYFV) that covered 2016-2021, crossing over with the start of the new NHS Long Term Plan, covering 2019-2024. The FYFV set out key ambitions for Children's Mental Health, including:

- Increasing access to NHS-funded community services
- Expanding timely access to eating disorders services
- Reducing inappropriate out of area placements

The NHS Long Term Plan builds on the work of the FYFV, continuing expansion of community and eating disorders services, and includes additional ambitions to deliver expanded crisis support and improved transition between children's and adult mental health services. The full set of LTP ambitions include:

- Nationally, 345,000 additional children and young people aged 0-25 accessing NHS funded services by 2023/24 (in addition to the FYFV commitment to have 70,000 additional children and young people accessing NHS Services by 2020/21)
- Achievement of 95% CYP Eating Disorder access and waiting times standard in 2020/21 and maintaining its delivery thereafter
- 100% coverage of 24/7 crisis provision for children and young people which combine crisis assessment, brief response, and intensive home treatment functions by 2023/24
- Comprehensive 0-25 support offer in all STPs/ICSs by 2023/24
- Mental Health Support Teams (MHSTs) to between a quarter and a fifth of the country by 2023/24

SW London was a Trailblazer in delivering Green Paper (2018) reforms of increasing access to 'whole school approach' and delivery of Mental Health Support Teams (MHST). We have delivered 13 MHSTs to date, with a further three MHSTs becoming operational in Wave 6 of the Programme in 2022.

SW London's six Clinical Commissioning Groups (CCG) merged into one South West London CCG in April 2020, following the national move towards Integrated Care Systems (ICS). SW London continues to work with partners across health and social care to develop our ICS framework and provider collaborative. The move to an ICS represents an opportunity for true collaboration and joint working across health and care, which will only further benefit children's mental health transformation.

This LTP refresh is focused on the whole SW London system, with opportunity for each of our six boroughs to highlight specific best practice or work that has contributed to transforming children's mental health services.

The Government identified an additional £500m for mental health services in 2021/22, with the aim of supporting post-Covid recovery and bringing forward some Long-Term Plan ambitions. In SW London, this additional funding includes:

- £1.2m for CYP community and crisis services.
- £363k for developing 18-25 services,
- £335k for eating disorder services, and
- £2.4m for supporting discharge from inpatient services across adults and CYP

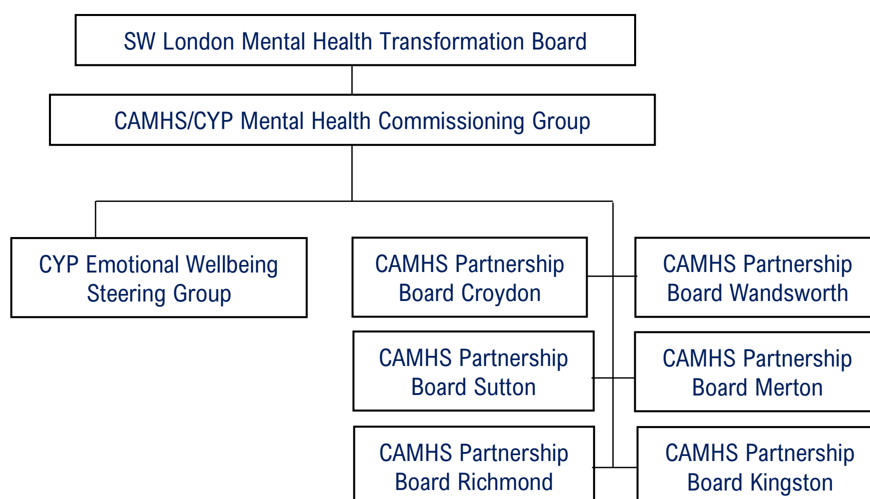
Further information on planned investment is set out in the 2021/22 Investment Plan, section 6.

2. Accountability, Transparency and Governance

Up to April 2020, SW London was made up of six Clinical Commissioning Groups (CCGs):

- Croydon
- Kingston
- Merton
- Richmond
- Sutton
- Wandsworth

On 1 April 2020, the six CCGs merged into one South West London CCG. The existing local CAMHS Partnership Boards in each borough have continued to oversee local transformation. As we transition to an ICS, governance arrangements are being reviewed across programmes. Currently, SW London CYP MH governance looks like:



The Mental Health Transformation Board is made up of partners from across adult and children's mental health including both Mental Health Trusts, GP Clinical Leads, Public Health, Healthwatch and voluntary sector organisations. It has representation from people with lived experience primarily in adult mental health. It oversees the whole of the SW London Mental Health Programme, including both adult and children's mental health.

The CAMHS Commissioning Group is a collaborative meeting of borough CAMHS Commissioners/ Managers, the Mental Health Trusts, SW London Mental Health Programme team and the GP Clinical Lead. Its aim is to share information and best practice, opportunities for collaboration and share some aspects of wider transformation work. Each borough representative brings their local system perspective, including input from local CAMHS Partnership Boards, made up of relevant local partners, stakeholders and people with lived experience.

As we move to an ICS and the provider collaborative develops, we will take the opportunity to refresh our governance and ensure it fits with the new ways of working.

This document marks the last annual refresh in the five-year requirement, thus presenting an opportunity to take a different approach. As such, this year we are combining the refresh into one SW London system document, with borough highlights and appendices.

Furthermore, the 2020 Coronavirus pandemic has significantly impacted upon the refresh process. Whereas it is normally produced in-year, with widespread engagement and consultation with local

partners and assurance provided by NHS England, the 2020/21 refresh has been delayed and will be assured differently.

Delays and the ongoing pandemic have reduced the opportunities to carry out wider engagement on this refresh. The CCG must satisfy itself that this document meets the national NHS England requirements and that it is published for anyone to read.

With this last refresh, we are setting out what we have achieved over the last five years and providing an opportunity to start a new conversation on what CYP MH transformation looks like in future. We have included high-level system plans for investment and transformation in 2021/22.

Below is a table of high-level CYP MH spend from 2020/21:

Category	2020/21 Outturn (£000s)
Children & Young People's Mental Health (excluding LD)	£23,115
Children & Young People's Eating Disorders	£1,559
Early Intervention in Psychosis (14-35)	£6,298
Learning Disabilities	£32,310

3. SW London Population/Local Need (prevalence) and health inequalities (0-25)

Population & Prevalence

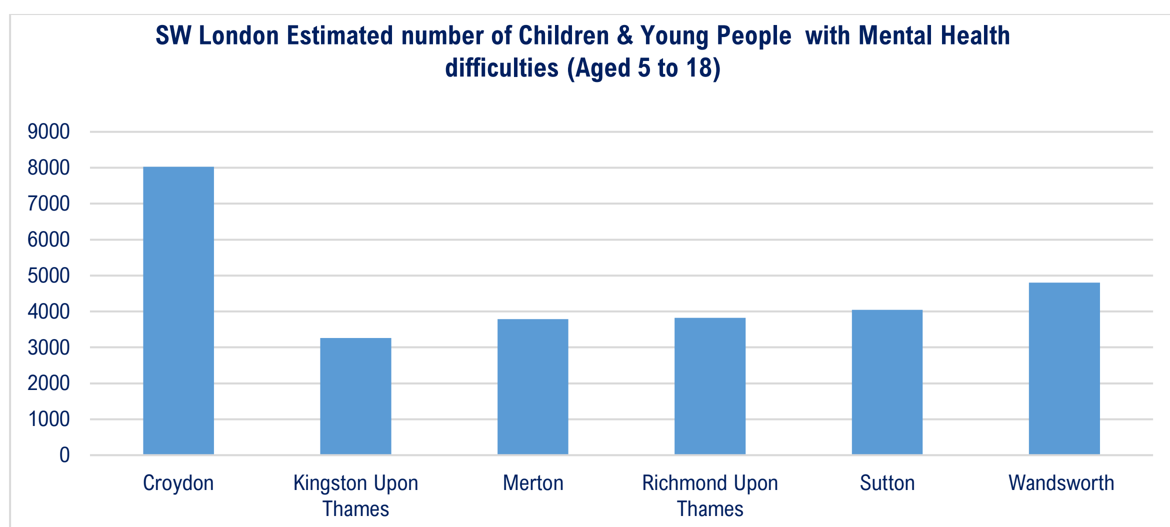
SW London has a population of around 1.5m with approximately 365,000 under-18s and approximately 120,000 18-25 year olds across the six SW London boroughs (see table below). This means that the 0-25 age groups make up around a third of the total SW London population, ranging from around 30% in Merton, Richmond, and Sutton to 33% in Croydon and Kingston.

	Croydon	Kingston	Merton	Richmond	Sutton	Wandsworth
Population	395,866	180,839	213,048	201,177	210,360	330,813
0-18	102,483	42,219	50,840	47,919	52,409	67,629
	(25.8%)	(23.3%)	(23.8%)	(23.8%)	(25%)	(20.4%)
0-25	131,582	59,598	66,252	59,860	66,048	97,005
	(33.2%)	(33%)	(31%)	(29.7%)	(31.3%)	(29.3%)

In terms of mental health prevalence, findings from the most recent national CYP Prevalence Study 2017 indicate that:

- One in eight (12.8%) 5-to-19-year-olds had at least one mental disorder when assessed in 2017
- Specific mental disorders were grouped into four broad categories: emotional, behavioural, hyperactivity and other less common disorders. Emotional disorders were the most prevalent type of disorder experienced by 5-to-9-year-olds in 2017
- Rates of mental disorders increased with age: 5.5% of 2-4-year-old children experienced a mental disorder, compared to 16.9% of 17-19-year-olds. Caution is needed, however, when comparing rates between age groups due to differences in data collection. For example, teacher reports were available only for 5–16-year-olds.
- Data from this survey series reveals a slight increase over time in the prevalence of mental disorder in 5-15-year-olds (the age-group covered on all surveys in this series). Rising from 9.7% in 1999 and 10.1% in 2004, to 11.2% in 2017
- Emotional disorders have become more common in 5–15-year-olds increasing from 4.3% in 1999 and 3.9% in 2004 to 5.8% in 2017.
- All other types of disorder, such as behavioural, hyperactivity and other less common disorders, have remained similar in prevalence for this age group since 1999.

The prevalence of mental health conditions in SW London CYP is set out below. These figures in the chart below are based on the results of the 2017 Mental Health of Children and Young People Survey.



Across our six boroughs we have approximately 222,000 children and young people in school. Our boroughs have mixed demographics characterised by some areas of high affluence and some areas have some of the poorest communities with high levels of index of multiple deprivation.

Table 1: Inequalities data for SW London

	Croydon	Merton	Kingston	Richmond	Sutton	Wandsworth	London	England
CYP School Population	57000	34000	26201	27826	39000	38000	14.4	14.4
% CYP not in education, Training or Employment (NEET) 2017	7.9	2.6	2.8	3.7	4.3	9.1	5	6
16-17 CYP accessing support for learning difficulties/disabilities (EHCP)	2693	1518	1042	1239	1588	1854	53975	319819
School children from Black, Asian, and Minority Ethnic (BAME) all school percent	43.3	33.9	22.1	10.7	29	39.4	40.9	16.7
First time entrants in criminal justice system 2017 rate per 100,000	586.2	282.6	222.2	184.9	265.6	379.3	292.5	380.3
Reoffending Rate % 2013	54%	25%	100%	0%	100%	71%	47.5%	42.6%
Looked after Children 2018 rates per 10,000	83	33	33	23	45	49	49	64
Secondary Fixed Term exclusions per 100 pupils 2016/17	7.6	7.8	3.3	7.2	4.4	5.2	7.5	9.4

Permanent Exclusion Rate (all schools 16/17)	0.07	0.06	0.06	0.05	0.05	0.09	0.09	0.1
Children in Need (all CIN as 31st March 2018 rate of episodes per 10,000)	873.4	458.9	344.2	326.4	580	867.2	681.4	635.2
Youth Victims of total notifiable offences 2018	5251	2013	1996	1814	2008	3819	4204	
Serious Youth Violence victims' rate per 100,000	440	116	96	96	155	201	252.1	
% of School CYP with social, emotional and mental health needs 2018	2.46	2.82	1.45	1.91	2.06	3.62	2.41	2.39
% Eligible and claiming for free school meals 2018	19.8	14.6	7.1	7.7	10.9	15.4	13.5	6
% of 11-15 year old CYP from low income families 2013	18.9	16.2	11	8.3	12.8	21.5	21.5	16
IMB average scores % 2015	23.6	14.9	11.1	10	14.6	18.3		21.8
Hospital admission as a result of self harm 10-14 year old rate per 100,000 2017-18	130.2	105.5	191.6	136.3	129	83.5	100.3	210.4
Hospital admission as a result of self harm 15-19 year old rate per 100,000 2017-18	431.9	364.1	470.9	500.3	539.7	485.2	341	648.6
Hospital admission episodes for alcohol specific conditions U18 per 100,000 2015=18	24.1	24.3	17.5	31.3	32	15	18	32.9

Table 1: Inequalities data for 2017 SW London (sources of data: Fingertips.phe.org.uk – child & maternal health data London, mayor of London – MOPAC, data and statistics. School population number – local authority school admissions data.

These variations within boroughs and across boroughs result in inequalities in heath including

- High numbers of CYP have special education needs and disability. The majority of these children have Education and Health Care Plans (EPHCP)
- The population of 16–17-year-olds Not in Education, Training or Employment (NEET) is above the England average in Croydon and Wandsworth
- There are pockets of high crime and first-time entrants to the criminal justice system, in Croydon (586/100,000) and Wandsworth (379/100,000) both of which are higher than the London rate.
- There are high levels of children in need in some areas of SW London, in particular Croydon (873/100,000) and Wandsworth (867/100,000)

- There are high levels of risky behaviour (particularly in areas of high affluence which is linked to poor emotional resilience). For example, in Kingston and Richmond, hospital admissions for under 18s for alcohol-specific conditions are 31 and 32 per 100,000, compared to a London average of 18 per 100,000. Self-harm rates are also high in Richmond and Sutton.

Addressing Health Inequalities in our most vulnerable children & young people
The overall high levels of affluence in parts of SW London are in stark contrast to the pockets of deprivation that highlight significant levels of inequalities within our geography. There are key vulnerable groups that are nationally recognised as being at risk of the effects of health inequalities and how they access services. The key groups include:

- Youth Justice system*
- Children Looked After (CLA)*
- Child Sexual Abuse (CSA)*
- Special Educational & Disabilities (SEND)
- Children and young people with autistic spectrum disorders and or learning disabilities
- Children Protection (CP) and Children in Need (CIN)
- Transforming Care Cohort/Care, Education & Treatment review (CETR)
- Children and young people with conduct disorders and/or ADHD

  * = Vulnerable groups who may access services differently.

Addressing Health Inequalities in CYP from ethnic minorities
The under-representation of CYP from ethnic minorities accessing support from a range of services including CAMHS is well documented, increasing their risk of vulnerability to poorer outcomes and conversely their over representation in other systems such as the Youth Justice System.

On average there are fewer CYP from ethnic minority backgrounds accessing Tier 2 (Getting Help) or Tier 3 services (Getting more help). There are ethnic disparities not only in access but also the experience and outcomes for CYP from ethnic minority backgrounds.

Our plans to address health inequalities are based on the data about health inequalities in relation to the local population outlined above; therefore, we will:

- Focus on ensuring there is a whole system response to supporting CYP with ASD and/or ADHD
- Continue to support young people in contact with the Youth Justice system to access earlier mental health support to prevent re-offending behaviour
- Ensure all Children Looked After having their mental health needs met regardless of where they live or go to school.
- Continue to consult young people and their families on priority areas for additional help
- Jointly commission services across Health and Social Care
- Deliver Mental Health Awareness training in partnership across Health, Social Care and Education in schools, academies and colleges.

SW London is currently supporting an innovative project in Wandsworth aimed at improving the outcomes of adults from ethnic minorities accessing adult mental health services, called the Ethnicity in Mental Health Improvement Programme (EMHIP). Key innovations include piloting Wellbeing Community Hubs with embedded mental health practitioners, increasing service options for people from ethnic minorities and ensuring services offer culturally appropriate support. Learning from this project and its various workstreams will likely be applicable across all SW London mental health services, including CYP. We fully expect to look at how we can replicate key elements of this work as we move forward.

In previous local CAMHS transformation plans, we only reported mental health prevalence findings up to the age of 18. However, as we aim to establish better integrated mental health help up to the age of

25, we wish to highlight key findings for young adults from mental health surveys and prevalence studies. There is also ongoing work to address changes in demand due to the pandemic.

1. **Around three quarters of adults with mental illness first experience symptoms before age 25**, with the prevalence and impact of many mental health problems peaking in the 18-25 age category. Young women aged 16-24 experience the highest rates of common mental disorders out of all age categories (Adult Psychiatric Morbidity Survey, 2014).
2. **Mental health issues are on the rise among young adults in the UK.** Common mental health issues like depression and anxiety are on the increase amongst 16-24s: 19% experienced them in 2014, compared to 15% in 1993. (Adult Psychiatric Morbidity Survey, 2014).
3. **The number of students disclosing mental health problems to their university is on the increase.** A recent Institute of Public Policy Research report found a fivefold increase in the number of first year students disclosing a mental health condition to their institution: 2% of first year students (15,395) in 2015/16, up from 0.4% in 2006/7.
4. **Young adults are less likely to receive treatment than other age groups.** 16-24s are less likely than any other age group to receive mental health treatment for common mental disorders, such as anxiety or depression, or following self-harm.

3.1. What have children and young people and their parents/carers told us?

We started our local CAMHS transformation programme by working with children and young people and their families in all SW London boroughs. Young people and their parents told us that:

- they need consistent and effective early intervention to support them
- they want to be able to access support in a range of ways, outside of medical settings, for example in one-to-one and group sessions in schools and online
- stigma is still an issue and confidentiality is important
- they want teachers and parents and carers to have support too
- they want to be involved in developing solutions and services that will work for them
- they don't want a start and stop approach
- they want confirmation of when treatment will commence
- they would like continued CAMHS input up to the age of 19 (up to the time they finish school or college
- they feel that current transition arrangements are not working, they feel like a cliff edge
- they don't want to be moved from one service to the next in the middle of treatment

4. SW London Response to Needs

SW London intends to move towards the national iThrive framework as recommended by the NHS Long Term Plan. This model distinguishes between support and treatment, and groups of children, young people and their families by type of input they require. The central group of 'thriving' focusses on broader population need that gets supported by public health interventions. The four outer groups distinguish between the need of individuals, the skill mix needed to meet these needs, the main terminology used to describe this need (e.g., wellbeing, ill health, or support), and resources needed to meet those needs. They do not distinguish between severity or type of problem.

This model will be used by SW London ICS to move CAMHS towards a need led model rather than insisting on a tiered model with a set of professionally defined criteria and thresholds. It will also be expanded to include 18–25-year-olds, as we aim to overcome current transition challenges between young people and young adult mental health services by implementing an integrated 0-25 mental health service model by 2023/24

Children's, Young People/Young Adult's (0-25) and their Families State of Being

Type of Input Needed

Croydon CAMHS, which is predominantly provided by SLAM, have already adopted the above framework in the names of core teams (for more info see also slam.nhs.uk - Croydon CAMHS)

- Croydon CAMHS Getting Advice Team
- Croydon CAMHS Getting Help Team
- Croydon CAMHS Getting More Help Team
- Croydon CAMHS Getting Support with Risk Team
- Croydon CAMHS Crisis Care Service

Further CAMHS Teams are

- Croydon CAMHS Learning Disabilities Team
- Croydon CAMHS Mental Health Support Team
- Croydon CAMHS Child Wellbeing Practitioner Team
- Support, Engagement and Delivery in Schools (SEaDS)

4.1. Promoting Resilience, Prevention & Early Intervention

This section focuses on 'thriving', promoting resilience, getting advice and early help.
The Thrive model is very much a systems and partnership approach to nurturing emotional wellbeing by offering self-help advice as well as timely access to early help

The Thrive model also applies a life span and 'think families' approach to prevention & early intervention. Consequently, our prevention and early intervention approach promotes close cooperation with the SW London Perinatal Mental Health Service from Adult Mental Health as well as partnership working with maternity and Health Visiting services, which are all focused on ensuring maternal (and paternal) wellbeing as well as a healthy start to life for all children.

The NHS Long Term Plan set out the national ambition of reaching 66,000 more women by 2023/24, The above target means for SW London that we will need to see at least 1,500 women each year from 20/21, rising to achieve 10% of ONS birth rate by 2023/24. This will require the expansion of our current teams to include more psychiatrists, specialist nurses, psychologists plus other support roles and peer support workers. In 2020/21, SW London perinatal services saw 1,215 women, which equated to a 5.7% access rate against the target of 7.1%.

SW London stated in its first response to the ambitions of the NHS Long Term Plan in 2019 to expand the SW London perinatal service and to establish stronger links between perinatal mental health and early help services for 0–5-year-old children and their parents.

All pregnant women, who have pre-existing mental health conditions or experience new mental health problems during pregnancy or following the birth of their child or children can access this multi-disciplinary service that is working with our Mother Baby Units (MBUs), GPs, Improving Access to Psychological Therapies (IAPT) services, Health Visitors, and voluntary sector to ensure women receive the right level of care for them, in the right place.

Expanding access

In addition to seeing more women, our service will need to adapt to delivering care for up to two years and assessing and signposting fathers/partners for support. Because most of our services are still quite new, we need to review our current staff skill mix and identify the demand and capacity needed to deliver this revised model of care. We will be reviewing our services in 2021/22 as we also develop our Maternal Mental Health Service model, ensuring the two services are appropriately linked to provide a seamless pathway for women who have experienced trauma during their maternity journey and/or have mental health needs appropriate for the perinatal service to support.

Promoting Resilience, Prevention and Early Intervention in Schools and Colleges (5-18): Progress with setting up new Mental Health Support Teams (MHSTs) for clusters of Primary and Secondary Schools and Further Education Colleges (FE)

In 2017, the Department of Health and Social Care (DHSC) and the Department for Education (DfE) published the 'Transforming Children and Young People's Mental Health' Green Paper, which set out proposals for improving the services and help available to CYP with mild to moderate mental health needs within education settings. The aims of these improvements included removing the requirement of a referral into a specialist mental health setting.

The proposals had three main elements:

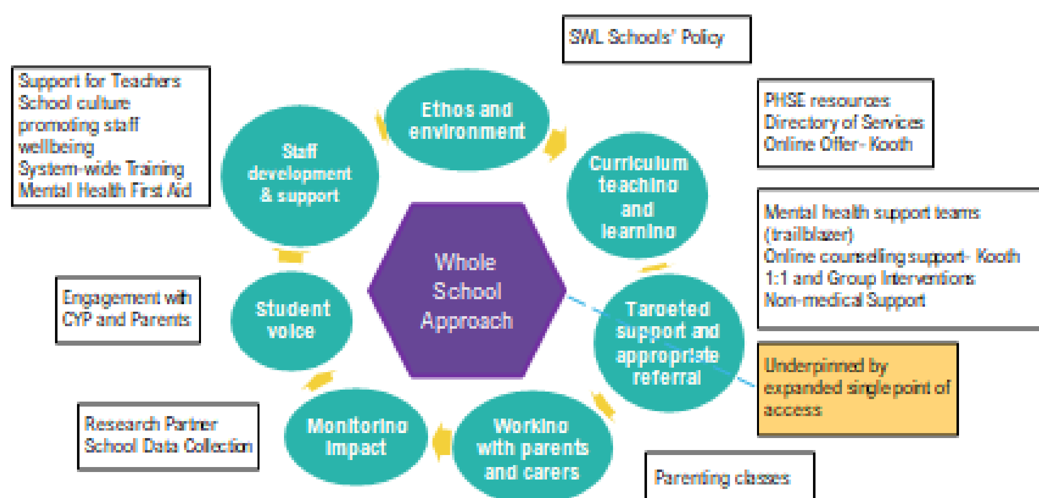
- A Designated Senior Lead (DSL) for Mental Health in each participating school/college to oversee the approach to mental health and wellbeing.
- To establish Mental Health Support Teams (MHSTs), providing specific extra capacity for early intervention for mild to moderate mental health problems and supporting the promotion of resilience and good mental health and wellbeing in an education setting
- To trial a four-week waiting time for access to specialist NHS led child and adolescent mental health services in selected areas (SW London was not a selected site to implement this proposal).

In 2018, the Government invited local health and care partnerships across the nation to bid for Trailblazer funding to set up MHSTs for clusters of Primary and Secondary School or clusters of FE Colleges. Each proposed cluster of schools should consist of around 8000 pupils/students.

The six local SW London CCGs submitted a SW London partnership bid consisting of the following prevention and early intervention pillars to deliver a whole school/college approach:

- Each participating Primary and Secondary School to have a named senior mental health lead and one Head Teacher to take on the overall Cluster Lead role
- Ongoing collaborative work with teachers, parents/carers and CYP to embed the whole school approach (see Whole School Approach depiction below)
- Each participating school develops an action plan at the beginning of the pilot project, which will be reviewed at regular intervals
- Each cluster of schools will have one MHST consisting of 7.5 Whole Time Equivalent (WTE) clinical staff and 0.5WTE administrative support (see below staff mix)
    - 0.5 WTE Senior Clinical Practitioner to provide clinical leadership, consultation, and supervision to the staff team,
    - 1WTE Specialist Practitioner
    - 2WTE talking or creative therapists
    - 4WTE Emotional Wellbeing Practitioners to deliver brief group and individual interventions for mild to moderate mental health problems
    - 0.5WTE Administrative Support.
- The Empowering Parents Empowering Communities (EPEC) peer parenting programme will be offered in each borough and aims to develop 'parental resilience.' The delivery of EPEC parenting groups is part of the core offer for Trailblazer Schools.
- Each cluster of schools will have access to online and/or digital counselling.
- MHST and school staff will participate in the ongoing evaluation of the Trailblazer Programme, i.e. data collection to monitor impact

Whole School Approach supporting children and young people, their parents/carers and teachers



Funding for Wave 1 of the national Trailblazer Programme was initially awarded for three MHSTs linked to one cluster of schools each in Merton, Sutton and Wandsworth (Southfields).

The Head Teacher Leads for the three school clusters were already appointed in 2018; however, training of the first staff cohort of 12 Emotional Wellbeing Practitioners commenced in January 2019. Further bids followed for Wave 2 and 4 of the Programme in 2019/20, which were also successful and helped to establish 10 additional MHSTs up to Sept 2021:

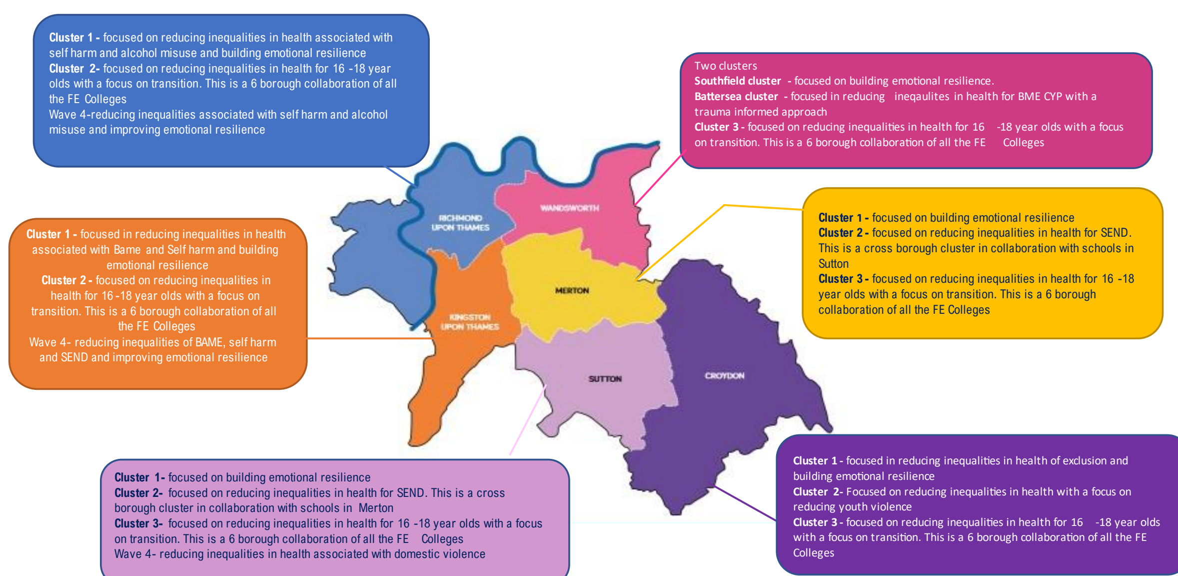
- 2 MHSTs in Croydon
- 2 MHSTs in Kingston

- 2 MHSTs in Richmond
- 1 shared additional MHST for Merton and Sutton with particular focus on SEND
- 1 additional MHST for Sutton
- 1 additional MHST for Wandsworth (Battersea)
- 1 MHST working across all six SW London Further Education Colleges

Over the last three years a total of 13 MHSTs were established, supporting 13 clusters of schools and colleges and consisting of a total population of around 104,000 students aged between 5-18 years. The diagram below sets out full distribution.

Given that we have around 222,000 children and young people in schools, we have achieved around 47% of pupils/students having access to the whole school approach to promoting emotional resilience as well as direct access to group and individual interventions for mild to moderate mental health problems. The Government ambition is for 44% coverage, meaning SW London has exceeded the target.

Trailblazer clusters in all of our boroughs



Most recently, SW London successfully bid for Wave 6 Trailblazer funding for another three MHSTs in Kingston, Merton and Croydon. Training for the Emotional Wellbeing Practitioners of the three new teams will commence in January 2022 and the MHSTs will become fully operational in September 2022. The additional MHSTs in 2021/22 will increase access to the whole school/college approach for a further 24,000 pupils and bring the total number of CYP with access to 128,000, which is 58% of the total population across SW London.

All cluster schools and MHSTs participate in the national evaluation of the Trailblazer Programme. In addition to the national evaluation, SW London has also commissioned a local evaluation of the work of the MHSTs, to be carried out by the South London Health Innovation Network over the next 12 months.

The aim of the evaluation is to determine the ideal Whole Schools Approach, assess the extent to which this has been achieved, and identify how to improve. Specifically, the evaluation will address the following questions:

1. What does good look like for Whole Schools Approach for CYP, parents/carers and teachers, commissioners, and policy makers (i.e., what are the criteria for assessing effectiveness)?
2. What is the impact of the Whole School Approach for CYP, parents/carers and teachers?
3. How can the Whole School Approach be improved? In terms of:
    a. What are the features associated with success?
    b. The 'blueprint' for implementing future clusters (i.e., How can the rollout/operationalisation of the Whole School Approach be improved?)
    c. Improving the provision within clusters (i.e., Whose needs are (not) being met by the Whole School Approach)?

As already reported in the 2019 Refresh of local CAMHS transformation plans, SW London CCGs also contributed funding to Children Wellbeing Practitioner (CWP) Programme, which is a Department of Health Initiative to train a new workforce for CAMHS. It was established in response to the FYFV for Mental Health plan to provide evidence-based interventions with focus on prevention and early intervention and to increase accessibility to help for children and young people who might not meet the threshold of current CAMHS provision.

There are currently five CWP Teams in SW London offering evidence-based interventions in Primary and Secondary Schools that are not participating in the Trailblazer Programme, thus complementing the prevention and early intervention in SW London schools that are not part of a Trailblazer school cluster. Each of the teams is supervised by an experienced clinical psychologist, who ensures that children and young people requiring more help will be supported to access this in a timely way. Further information about the CWP Programme can be found in the appendix to this section.

Given that demand for mental health help is rising faster than the increase in service capacity, SW London CCG is keen to explore innovative ways of making timely access to mental health help easier.

One idea, which we want to pilot in Kingston and Richmond, is to establish a local Emotional Wellbeing Hub run by a Voluntary Sector Provider that children and young people can access seven days per week without an appointment or prior referral. The Hub will have strong links to local and national voluntary sector services and will encourage children and young people to also access digital mental health support from Kooth. The Hub will also cooperate with CAMHS SPA, if access to specialist help is needed. Plans for the Hub are in development for delivery in 2021/22.

A second idea which we aim to establish across SW London are combined Paediatric/emotional wellbeing clinics in Primary Care, which means that Consultant Paediatricians, Psychiatrists and/or Psychologists will offer joint clinics with GPs as well as consultation slots for children and young people and their families at regular intervals in Primary Care Centres, thus offering access to specialist advice when this is needed rather than waiting for 8-12 weeks following a referral to a specialist service.

4.2. Improving Access to Help and More (Specialist) Help Locally as well as across SW London:

The Local System of Care

All CYP that require mental health support can be referred to a Children's Single Point of Access (SPA). There are three providers that operate local SPAs or Single Point of Contact (SPOC). These providers are:

- **Kingston and Richmond** led by Achieving for Children (AfC) with an integrated CAMHS SPA Team from SW London & St George's NHS Mental Health Trust (SWLStG)
- **Merton, Sutton and Wandsworth** operated by SWLStG
- **Croydon** led by Croydon Council with integrated mental health staff from SLAM

The SPA Assessment process

The SPAs/SPOC are integrated multi-agency teams, who work closely with a wide range of teams and partner agencies and facilitate different levels of support depending on the needs of the children and young people and their family. The SPA teams ensure that the triage assessment process captures the holistic needs of the family and child. It enables practitioners to contribute to the assessment based on their specialism. The assessment also takes into consideration additional issues that maybe contributing to the need for a referral. These include:

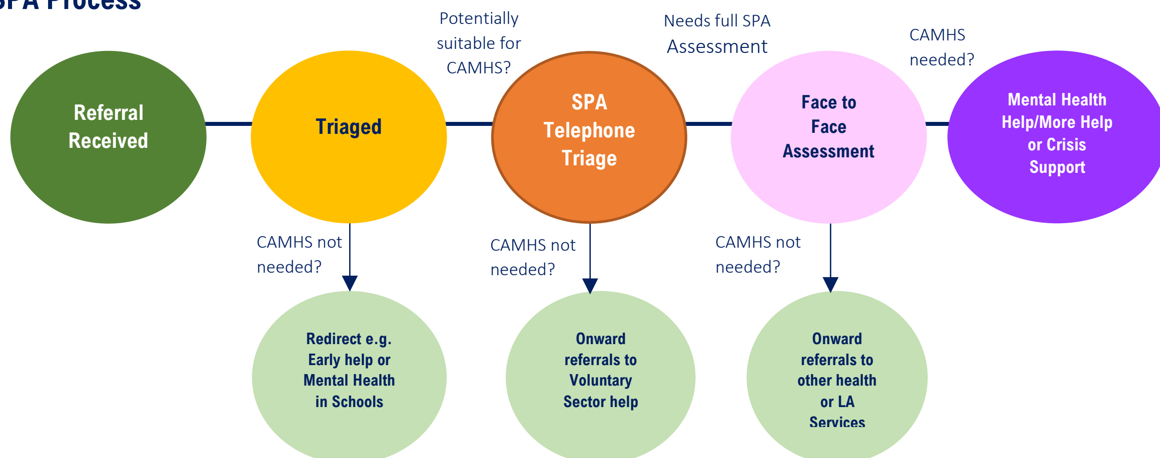
- The child's development
- Family issues that maybe affecting the child or young person
- A child or young person who is suspected of being neglected or subject to physical, sexual or emotional abuse

The support that may be offered following triage/assessment includes:

- Providing professional advice with consultation and support
- Making referrals to partner agencies
  - Access to Early Help Services
- Providing low level of interventions
- Making referrals to Children's Social Care Services
  - Making referrals to Mental Health Support Teams in Schools
- Signposting to help/more help or crisis support

The multiagency SPA team consists of Contact and Information Officers, Social Workers, CAMHS clinician(s) Health Teams, Police Officers, Health Visitor.

SPA Process



The SPA encourages prompt referral and access to services through the promotion of an online referral form, but also welcomes self-referrals from CYP or parents by phone. Around 40-45% of referrals come from GPs/Primary Care for common mental health challenges, such as anxiety and/or

low mood problems, mixed emotional and/or behaviour problems as well as querying neurodevelopmental problems. Between 15 and 20% of referrals are received from education staff, i.e., Head Teachers, Teachers, Special Educational Needs Coordinators (SENCos), School Nurses or Educational Psychologists, and 5-10% come from specialist child health professionals such as Paediatricians, Speech and Language Therapists, Occupational Therapists or Physiotherapists. Self-referrals from young people and parents/families are welcome but make up only a relatively small proportion of referrals (below 10%)

Following feedback received from parents/families in Kingston and Richmond, SW London recently commenced a joint review of the local system of mental health care for CYP and their families with particular focus on the challenges of accessing mental health help and more specialists help and treatment in a timely way.

Work is continuing but outputs thus far have included:
- Audit and review of the K&R CAMHS SPA, with improvement actions to include developing a simplified referral form and ensuring pathways are appropriately described
- Review of interfaces between providers, including step-up/down processes

Across our SPAs/SPOCs, demand and acuity of referrals is rising. Many CYP now need more specialist psychological or psychiatric input, with waiting lists growing across our more specialist services. As part of work plan in 2021/22, we will review all CAMHS SPA/SPOCs to ensure they are equipped to provide appropriate initial assessment and advice and establish a consistent SPA approach across SW London.

Increase access to NHS-funded community children and young people mental health services
SW London achieved its access requirements under the FYFV in 2020/21, when compared to 2019/20, which is a significant achievement considering the decrease in referrals during April and May 2020. With further investment through the Spending Review and the implementation of MHSTs across all boroughs we will be in a strong position to achieve further increases in access as required under the Long Term Plan.

Year	2019/20	2020/21	2021/22	2022/23	2023/24
Target	9,607	9,882	10,447	10,729	11,294
Actual	8985	9955			

Figure 1 - Source: Mental Health Services Monthly Statistics Final

How did Covid-19 impact on referral numbers and the way services were delivered?
COVID affected the delivery of services throughout the year, and though many psychological interventions went online, NHS-commissioned CAMHS still saw 42% of contacts face to face. Meeting at least some referred CYP face to face, especially with schools closed, was important to ensure the safety of some vulnerable young people as well as some interventions being more effective face to face.

COVID 19 had a large impact on the number of referrals. As the largest provider on the patch this can be demonstrated through referrals into SWLSTG CAMHS.

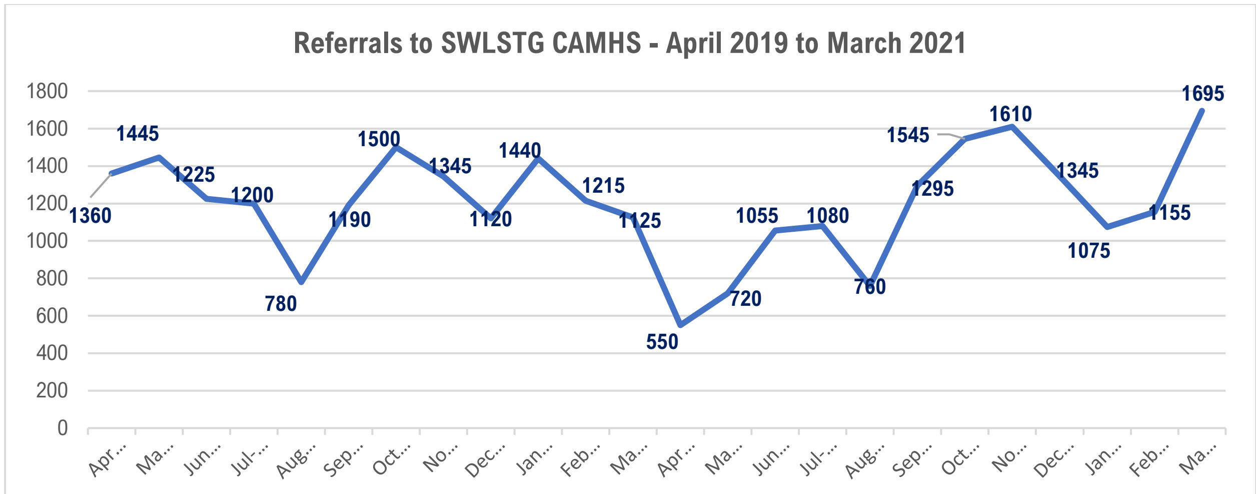


Figure 2 - Source: Mental Health Services Monthly Statistics Final

April 2019 compared to April 2020 demonstrates this the most starkly with referrals at 40% of the level they were the previous year. Referrals either directly or indirectly often involve school members of staff. The referral data over the last year demonstrates this with an out of the ordinary dip in January 2021 when schools were again closed for most pupils. Referrals for all providers across SW London have followed a similar pattern to SWLSTG, the overall figures for which are presented in the table below.

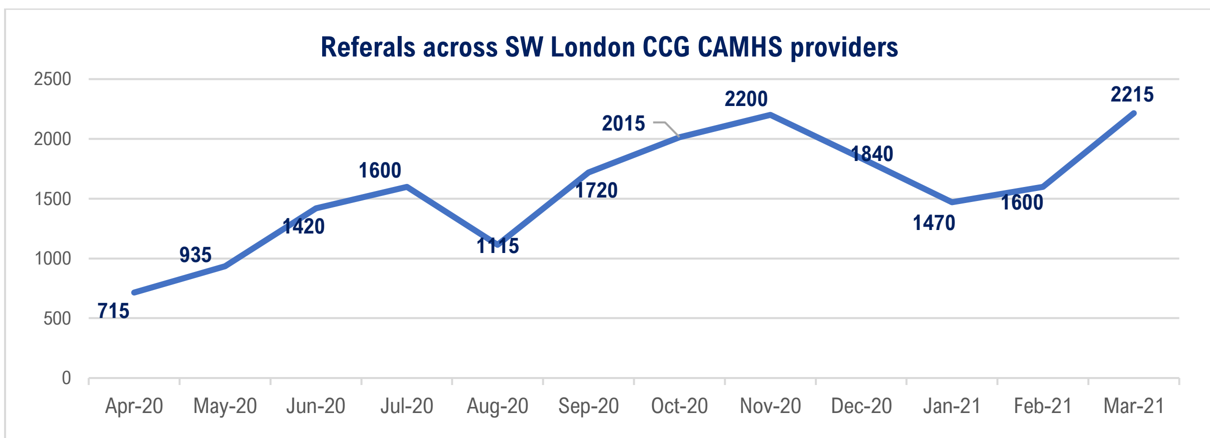


Figure 3 - Source: Mental Health Services Monthly Statistics Final

Consultation Type

From April 2016 to March 2020 73% of SWLSTG CAMHS contacts were face to face. From the March 2020 to May 2021 56.6% of contacts were face to face demonstrating the change in practice providers had to take during the pandemic. Some voluntary sector providers, such as Off the Record, a counselling provider in Croydon, Merton and Sutton, went to 100% remote working.

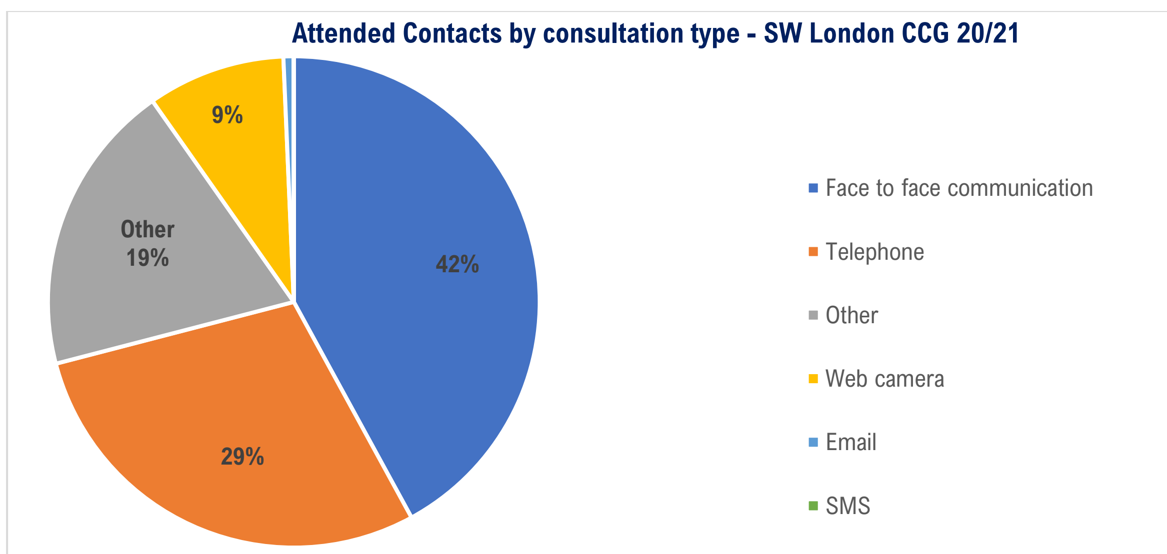


Figure 4 - Source: Mental Health Services Monthly Statistics Final

Achievements and challenges

COVID 19 has accelerated some of our plans across SW London by increasing access to NHS-funded online services. During the first lockdown we expanded the delivery of Kooth, which is an online counselling platform for CYP aged 11-21, to the whole of SW London. Qualified counsellors, therapists and support workers provide guided and outcome-focused support for each individual. Kooth is accessible through any connected device: young people can log on wherever they are to access professional counselling from 12.00pm to 10.00pm, 365 days a year.

Place-based transformation managers are also working closely with partners, such as the Local Authority and schools, to consider how we can further improve health promotion and preventative services to increase the resilience of SW London CYP. In this context, all local digital offers across SW London were updated and expanded to include more online self-help information and tools as well as advice on how to access help including support in a crisis (for more information on local system of care, local offer and information on local mental health help, more help, crisis help see appendix to section 4.2)

Supporting CYP with Special Educational Needs (SEN) and disabilities remains a priority for SW London, within the wider strategic aim of increasing access for CYP. Increasing access for these CYP involves the contribution of non-NHS funded services, such as School Nurses, teachers, and social workers. To support CYP with SEN, we must work with partners to provide the help and specific interventions summarised in Education, Health and Care (EHC) Plans, which are a statutory responsibility. There is further work to be done with partners to ensure CAMHS services are fully involved in multi-agency care planning processes and that mental health care plans are integrated with EHC plans. Further information on this work can be found in the Transforming Care Section 4.8.

Increase Capacity of early intervention provision

Several boroughs are looking at addressing the increasing demand for Tier 2 provision. For example, Croydon is looking at expanding their early intervention and support offer across the Croydon Health and Local Authority partnership to ensure more young people get access to the right support at the right time. In previous years, additional funding has gone into new schemes and pilot projects; however, the past four years have seen a substantial increase in demand for core services. Additional investment into core services is vital so that those children and young people who need help/more help or crisis help, can access it in a timely way. Sutton, Merton, and Croydon have all invested in their Counselling provider, Off the Record, due to the increase in demand for support.

ASD and ADHD services (additional information on Neurodevelopmental Assessment Pathways in section 4.4, and Investment Plan section 6)
In 2021/22, additional investment is being made into SW London ASD and ADHD diagnostic pathways to improve wating times. Merton, for example, is investing in a new local pathway that will have alignment to their educational psychology service. This will deliver more rounded assessments for ASD and ADHD as well reducing wating times for a diagnosis.

Kingston, Richmond, and Sutton are also looking at the delivery of post-diagnostic support in the form of the 'A plan'. This will look to offer adapted mental health interventions for young people that have often not been served well by the traditional CAMHS model and offer coordination support to the MDT in meeting these CYP's need.

Future Plans
SW London aims to achieve further increases in access to the whole range of children and young people's mental health services. Additional funding has been made available through the Spending Review this year as set out in the Investment Plan in section 6.

4.3. Specialist pathways for Children and Young People Eating Disorders

SW London CYP are served by two mental health trusts providing CYP Eating Disorders services.

- Kingston, Merton, Richmond, Sutton and Wandsworth. SWLSTG CYP Community Eating Disorders Service (CYP CEDS)
- Croydon. SLAM Maudsley Centre for Child and Adolescent Eating Disorders (MCCAED)

Both Teams operate with a similar service model in line with NICE guidance, offering assessment and treatment through a multi-disciplinary approach. Each service operates under the 'Access and Waiting Times Eating Disorder Commissioner Guidance 2015.'

MCCAED comprises: The Eating Disorder Clinic (EDC), formerly known as the outpatient service, which provides a service to seven local boroughs including Croydon and a new Avoidant restrictive food intake disorder (ARFID) service, that treats children and adolescents both locally in these seven boroughs and nationally.

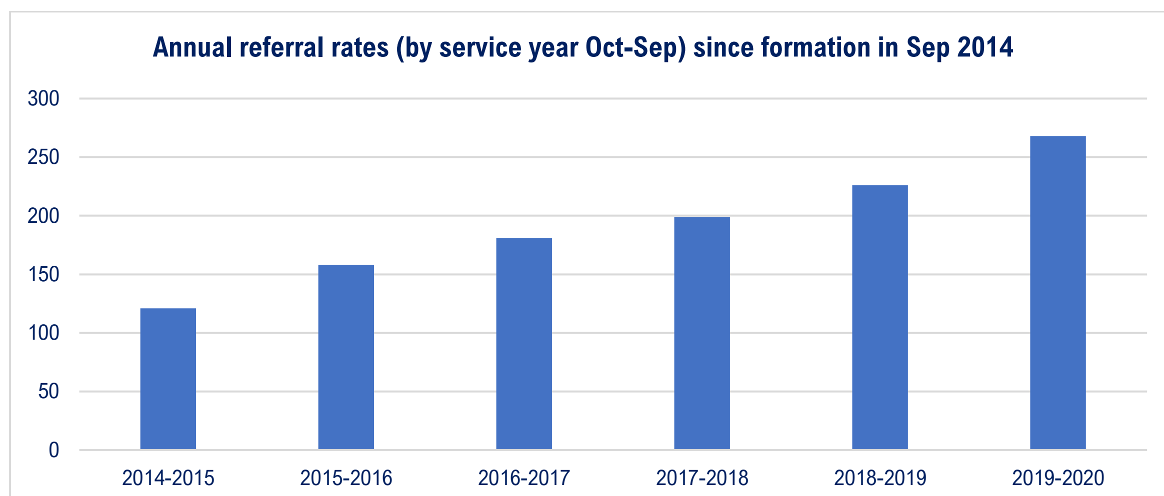
In 2016, MCCAED was one of the first eating disorder services, nationally, to also accept self-referrals. Although other teams have subsequently followed, self-referral provision in eating disorders services across the country remains very limited.

Self-referrals are available to local patients within the seven boroughs that are served by the EDC. They are also available for patients within these boroughs who wish to access our ARFID service. However, all national referrals to the ARFID service need to come from professionals. Self-referrals comprise about 30-35% of referrals to the EDC. Almost all self-referrals to the service are from parents or carers.

Capacity and Demand
The EDC received a total of 350 referrals from 1 March 2019 – 31 March 2020. The Service was able to meet the 95% access target for all of these referrals but was working almost at maximal capacity in that year.

From 1 March 2020 - 31 March 2021, EDC received a total of 550 referrals. From 1 April – 30 June 2021, EDC already received 183 referrals. Without a reduction in referral rate, this projects to 732 referrals by 31 March 2022, which would be more than double the number received in 2019/20. Acceptance rates steadily dropped from around 80% two years ago to now less than 50%.

Referral rates into the SWLSTG CEDS have also increased significantly over previous years. The table below shows the increase from 2014/15 to 2019/20.



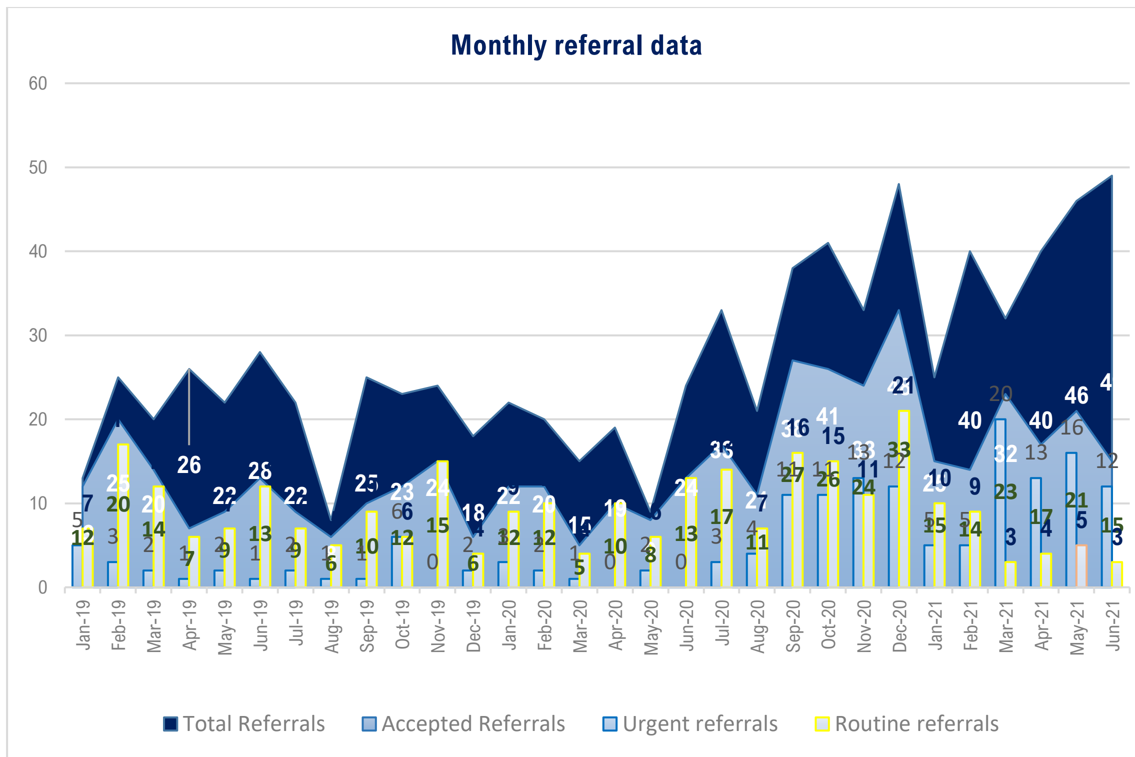
The SWLSTG CYP CEDS multi-disciplinary team delivers evidence-based treatments in line with the national service model while working to meet the national waiting times standards of urgent referrals seen within one week and routine within four weeks. Since 2019, capacity has reduced within the service owing to staffing and resourcing challenges and rising demand. Additional treatment options, such as day treatment or more intensive community treatments have reduced since 2019. Core treatments to individuals with Anorexia, Bulimia and Binge Eating Disorders are still in place but the service has not been able to take referrals for ARFID and thresholds for new referrals resulted in a reduction in referral acceptance rates from 80% in 2016/17 to 53% in 2020/21.

In 2019/20, SW London invested £232k into the service to bring it back in line with national service standards and work commenced to develop a revised service specification, with agreement to provide additional investment as a priority in subsequent annual business planning discussions.

What happened during Covid-19 and in what position is the Children and Young People's CEDS now?

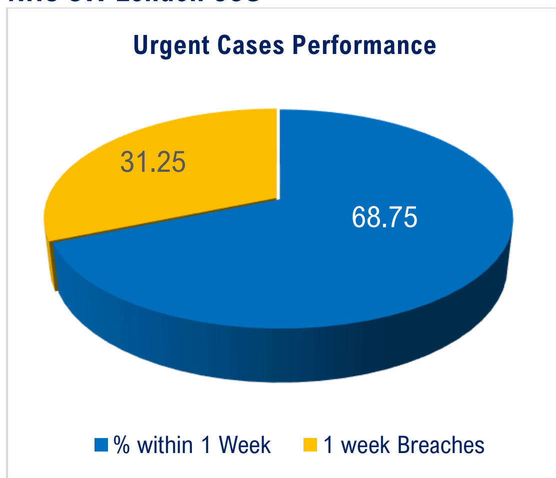
Surge in Demand during Covid-19

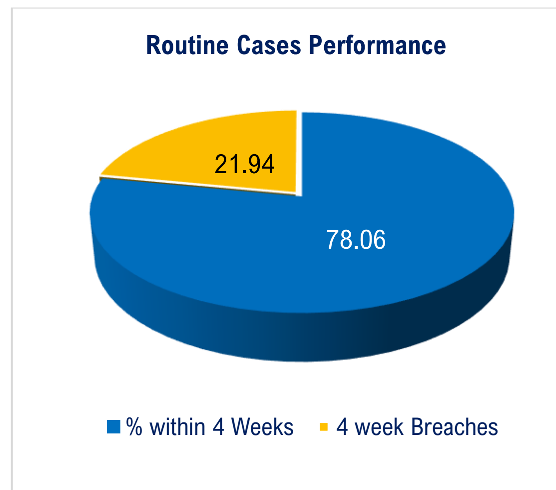
There was a surge in demand during COVID-19 (see below), particularly since Q2 2020/21, with increases in acuity, which was anticipated to continue for some time. This reflects the national picture of eating disorders referral increases.



In 2021/22, the CYP CEDS service has built up a waiting list of more than 50 CYP and is struggling to meet the national waiting time assessment targets. For urgent referrals 31% are having to wait longer than one week and 22% are having to wait longer than four weeks for a routine assessment.

NHS SW London CCG





In 2021/22, through the Spending Review and allocation of Transformation Funds, SW London CCG invested an additional £640k to provide the service with enhanced capacity and expanded staff skill mix to deliver NICE-compliant, evidence-based community support. A joint eating disorder working group has been established between SWLSTG and SW London CCG and is overseeing the agreed phased service developments. This group is currently also updating the shared care protocol with Primary Care Practitioners (GPs), which will clarify the responsibilities around the initial health checks as well as the monitoring of physical health parameters throughout the treatment with the specialist CEDS.

Specialist services cannot meet the significant increase in referrals by themselves but must be addressed by a whole system effort of better collaboration and communication between local and specialist mental health services. Voluntary sector partners, such as BEAT, offer help for young people and adults with Eating Disorders, if they don't meet the threshold for specialist treatment or when continued support is required following a treatment period with a specialist service.

We also wish to improve the transition arrangements between the children and young people and adult eating disorder services and will explore flexible solutions when a transfer of treatment/care is taking place in consultation with young people and their parents.

4.4. Specialist Pathways for Neurodevelopmental Disorders

Referrals for neurodevelopmental assessments for under-5s are delivered by Social Communication Teams that are linked to Community Paediatric Services in all six boroughs. The service is provided up to the age of seven in Wandsworth, through the Paediatric Outpatient Service at St George's University Hospitals NHS Foundation Trust. Information on referral numbers and waiting times can be found in the appendix to this report.

Requests for neurodevelopmental assessments of 6–17-year-old CYP make up between 20-25% of all referrals received by local CAMHS SPAs or SPOC. Once all necessary information is received, it will be screened by an experienced CAMHS clinician for severity of symptoms, consistency of reported problems and possible other underlying causes for reported differences when these are compared to age-matched 'range of normal developmental skills and behaviour.'

Following the clinical screening, the referrals from five SW London boroughs (Kingston, Merton, Sutton, Richmond, and Wandsworth) are either signposted to the Neurodevelopmental Team from SWLStG Mental Health Trust or a local neurodevelopmental assessment pathway in Kingston, Richmond or Sutton, if the referred CYP is resident in one of these boroughs and does not present with co-morbid physical and/or mental health conditions.

Neurodevelopmental referrals received by Croydon SPOC will be signposted to the neurodevelopmental Team of SLAM.

In the following section, we will initially report on the waiting times and performance of the NDT of SWLStG as the main provider of neurodevelopmental assessments for five boroughs and then summarise the waiting times development and performance of the three additional local pathways. Finally, we will summarise the information on waiting times and performance with regards to neurodevelopmental assessments for CYP from Croydon that were carried out by SLAM.

Has there been any progress achieved with shortening the Waiting Times for Neurodevelopmental Assessments in the last two years?

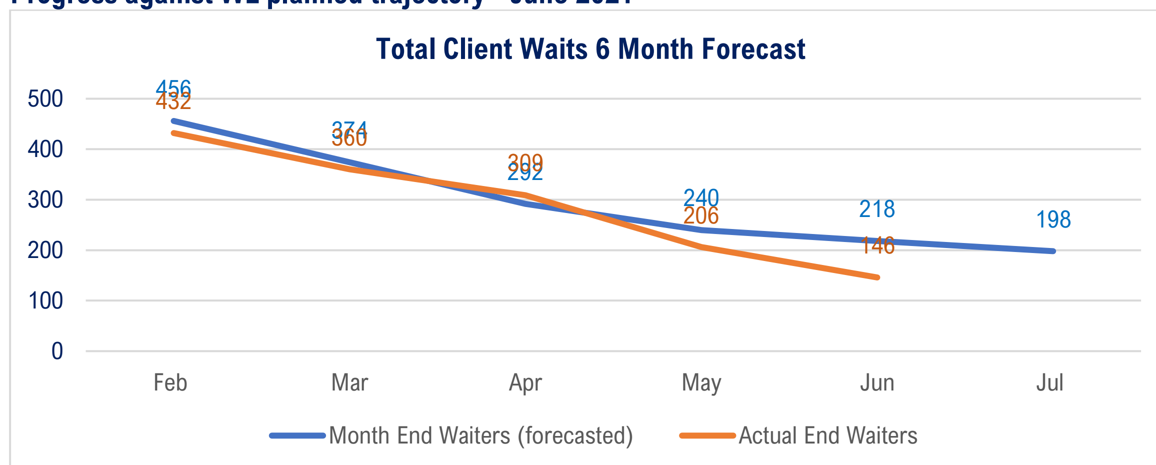
Although the pandemic and the first lockdown resulted in a slight drop in referrals in Q1 and Q2 of 2020 due to closure of schools and restricted access to GP surgeries, waiting times increased during this time as the service had to adjust its assessment practice to maintain safety, resulting in fewer weekly assessments and consequently longer waits.

In November 2020, SW London commissioners and SWLSTG collaborated to scope a waiting list initiative, which was agreed in December 2020. The agreed proposal included commissioning additional capacity from another provider for the CYP who had been waiting the longest. The provider Clinical Partners was sub-contracted to undertake work focusing on ASD and combined ASD/ADHD

assessments for those waiting longer than 40 weeks. These assessments take longer than those for only ADHD.

Additional internal resource within SWLStG focused on ADHD long waiters during the same period of time. A trajectory was set out to map progress against waiting list reduction during February and July 2021:

Progress against WL planned trajectory - June 2021



Waiting list position – June 2021

	0-14	15-17	18-29	30-39	40-51	70+	15 Week Plus	18 Week Plus	52 Week Plus	Total
Total	81	24	27	3	1	1	56	32	1	137
ADHD	31	2	5	1	1	0	9	7		40
ADHD/ASD Assessment	18	3	5	1	0	1	10	7	1	28
ASD	23	10	9	1	0	0	20	10		43
No presenting complaint	9	9	8	0	0	0	17	8		26

The above June 2021 data position shows:

- 137 Total waiters
- Only 5 waiters above 30 weeks (early July data shows no waiters above 30 weeks)
- Only 1 waiter above 52 weeks (now been seen in July 2021)
- Average wait for existing referrals 29.7 weeks (7.5 months)
- Average wait for new referrals 24.9 weeks (6 to 6.5 months)

July 2021 onwards

- The waiting list initiative completed at the end of July 2021, with a further reduction in waiting times expected, thus having had a positive impact Wait time for SWLStG is around 12 weeks at the beginning of September.
- Additional investment from previous years provided additional capacity for the service to manage current demand and there is ongoing internal work to improve processes and pathways, some of which is based on learning from the use of online work during the pandemic. This includes work to reduce the number of appointments where patients do not attend.

Ongoing performance is continuing to be reviewed monthly and Merton received additional local investment in 2021/22 through the Spending Review to enable a borough-based local service. This is expected to help address higher referral numbers seen in this borough.

Overall, the SWLSTG service achieved significantly reduced waiting times through a waiting list initiative, revised acceptance criteria and local CAMHS SPAs signposting more referrals to local pathways in Kingston, Richmond and Sutton, detail of which follows.

Current Borough-Based Providers/Other Services

Sutton
Cognos provides ASD-only assessments (144 per annum) for less complex cases. Like for all other services, Covid-19 has impacted on waiting times as assessment processes had to be adjusted and changed, utilising an online play-based assessment tool rather than the face-to-face Autism Diagnostic Observation Schedule (ADOS). Waiting times before the pandemic were on average seven to eight weeks and are now at 53 weeks due to an increase in demand/referral numbers. Additional funding has been made available in 2021/22 and a trajectory has been agreed for a reduction of the waiting times.

Kingston & Richmond
Achieving for Children is commissioned to provide 90-100 assessments per borough annually for both ASD and ADHD for less complex cases. Waiting times have significantly increased in the last 12 to 18 months due to the impact of Covid and also due to significantly more referrals being signposted from the CAMHS SPA. Annual referral numbers have risen from 147 in 2019/20 to 270 in 2020/21.

Croydon
Current Arrangements for Croydon ASD &/or ADHD Assessments and Diagnoses
The current pathway for ASD and/or ADHD assessment is predominantly offered within the community service. Two teams, operating within different organisations, provide assessments:
- **Croydon Health Services**: Children's Medical Services (CMS) provide ASD assessments for children under the age of five years at referral
- **SLAM**: Community CAMHS provides neurodevelopmental assessments for CYP aged 5 - 17 years referred for ASD and/or ADHD assessments

In addition, specialist assessments (often second opinions and specialist comorbidity assessments) are offered by the SLAM Complex Autism and Associated Neurodevelopmental Disorders (SCAAND) Team.

In 2020/21, Croydon carried out a detailed review of its local neurodevelopmental assessment provision with the aim to reduce waiting times for specialist assessments to establish a post-diagnosis help offer too. More information on next steps following the review can be found in the appendix to this section.

Our plans for the next 12 to 18 months:
We want to establish a more collaborative approach to screening and assessment of ASD and ADHD with shorter waits and more frequent feedback, whilst CYP wait for the assessment, as well as better support and help following diagnosis.

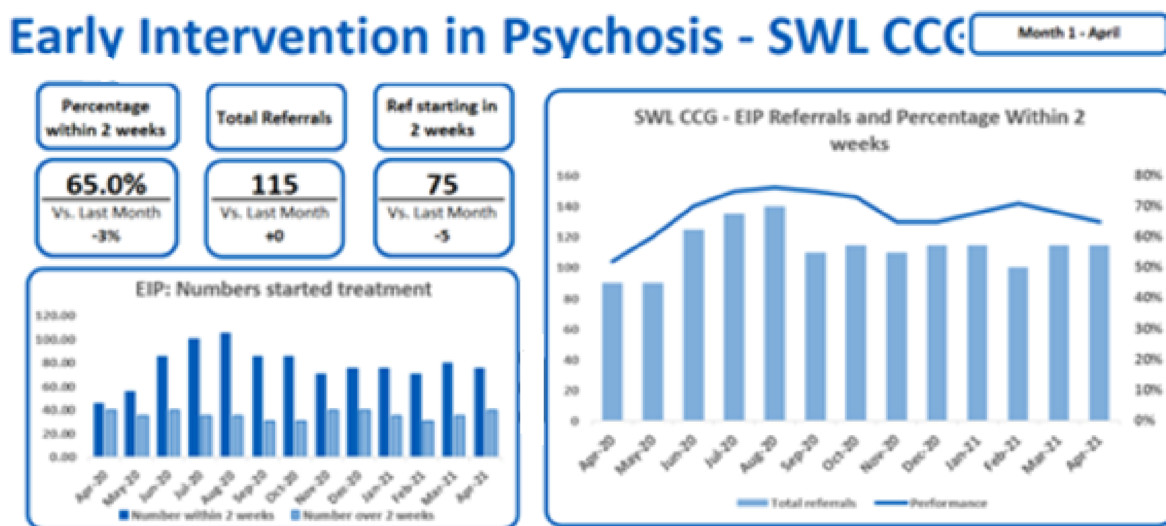
We want to establish a consistent neurodevelopmental assessment approach for children, young people and young adults 0-25 across SW London
- Joined up reporting and monitoring of referred demand, screening outcomes, flow (signposting) of referrals to various local and SW London pathways as well as outcomes of assessments
- Pilot post-diagnosis support services in Kingston, Richmond and Sutton
- Carry out a whole system review of the various neurodevelopmental pathways in Kingston and Richmond

- implement recommendations of the Croydon review and share the learning with other SW London boroughs

4.5. Specialist Pathway for Young People with Early Psychosis

The evidence based Early Intervention Service (EIS) model for treatment of first onset of psychosis was developed more than 20 years ago. It recommends an integrated multi-disciplinary assessment and treatment approach for young people and young adults aged 14-35 years and their families, ideally without the need for transitioning from CAMHS to Adult Mental Health.

However, as numbers of children and young people diagnosed with first onset of psychosis are low (single figures in five out of six boroughs), local CAMHS carry out timely initial assessments and also initiate multi-modal treatment without delay for under 18-year-old young people. Preparations for transitioning to one of the three EIP Teams from SWLStG (EIP Merton and Sutton, EIP Kingston and Richmond, EIP Wandsworth) or the EIP Croydon from SLAM tend to commence when the young person is 17 ½ years old.



Commentary: SWL CCG continues to meet the national threshold of 60% with latest performance (rolling quarter Feb-Apr) showing that 65.0% of clients started their treatment in line with NICE guidance within two weeks. The CCG have maintained compliance against the national standard for this metric since April 2020.

Where do we want to be?

Given that the original EIP service model suggested that an integrated youth/young adult mental health multi-disciplinary treatment model would be best to meet the needs of this group of patients, SW London ICS will jointly review options with both Trusts on how to strengthen an integrated 14-25 years EIP approach that

- focuses on the first three years of the psychotic illness
- aims to reduce the duration of untreated psychosis to less than 3 months and
- does not require the young person to transition at the age of 18 from CAMHS to AMH/EIS.

4.6. Specialist pathway for young people with emerging Borderline Personality Disorder piloting a SW London Dialectical Behaviour Therapy (DBT) Service

Dialectical Behaviour Therapy (DBT) is a highly effective, NICE recommended, treatment for CYP with traits of emerging borderline personality disorder/Emotionally Unstable Personality Disorder (BPD/EUPD) and acute self-harm and suicidality.

SLaM and Oxleas CYP DBT services have been established since 2009 and 2018, respectively. These services have evidenced the impact of DBT on CYP to be life changing but also highly effective at reducing high-cost demands on the health and care system through reduced need for inpatient care. The South London Mental Health and Community Partnership (SLP) CAMHS review in 2019 showed that SW London had the highest inpatient admissions for young people across south London with the primary problem as self-harm / suicidality despite having slightly lower demographic risk factors for self-harm. The review indicated that the absence of a locally accessible and effective DBT service in SW London was likely causing harm to over 30 young people a year through increased risk of suicide attempts, inpatient treatment, and referral to adult services at age 18.

The benefits of commissioning a standalone DBT service in SW London included:

- Reduction in adolescent and young adult suicide rate
- Enhancement to Tier 3 offer in SWLStG with good interface and smooth step-up / step-down pathways and better use of Tier 3 resource, i.e., it will free up consultant and care coordinator capacity in community CAMHS
- Reduced demands in terms of mental health assessments following suicide attempts, occupied bed days, A&E presentations, transitions to adult services, and risk management in Tier 3
- A crucial success factor for DBT services is the enabling of a locally accessible standalone service with fully trained DBT clinicians to provide a dedicated, safe and effective service
- SLP will be able to reinvest any savings in continuing to enhance crisis care.

Based on the above needs assessment and evidence, SLP, SWLStG and SW London commissioners agreed at the end of 2020/21 to fund a standalone pilot DBT service in 201/22 to enable the provision of a more cost-effective, equitable offer across SW London.

The SW London DBT service launched July 2021. The DBT programme consists of a 4–6-week pre-treatment phase (engagement and commitment phase), followed by eight to twelve months of specialist treatment, if the young person and the DBT team agree to start therapy. Treatment consists of weekly individual therapy and weekly skills training groups (for young people and parents/carers) plus telephone skills coaching, crisis management, medication management, family sessions and care co-ordination.

The pilot is funded for 18 treatments per year until late 2022 and will be reviewed by partners after the first 14/15 months, once the first cohort of young people have been treated.

Planning for the future

In line with the NHS Long-Term Plan ambitions to provide a comprehensive mental health service for young people up to age 25 years, SLP and SW London will explore extending and integrating DBT service models across CYP and adult services to better meet the complex and challenging needs of young people/young adults (14-25 years) with emerging borderline personality disorder without the disruption of transitioning from young people to adult services.

4.7. Help for Groups of Children and Young People, who have Increased Risks of Suffering from Mental Health Challenges

4.7.1. Help for children and young people in contact with Youth Justice service

Future in Mind outlined the need to transform CYP mental health services to create a system to support and bridge the gaps for the emotional wellbeing and mental health of children and young people. The three priority areas:

1. Development of Specialist Child and Adolescent Mental Health Services for High-Risk Young People with Complex Needs.
2. Development of a framework for integrated care for Children and Young People's Secure Estate

3. Development of Collaborative Commissioning Networks between Health & Justice regional teams and CCGs.

An assurance framework was also developed by NHS England to support the ongoing development and implementation of plans to utilise the funding allocated to ensure that we can best support CYP known to the Youth Justice system.

There are fully integrated pathways within the SW London boroughs for children and young people in contact with Health and Justice Services which include the following elements:

- Crisis care related to police custody
- Sexual assault referral centres (SARCs)
- Liaison and diversion (L&D) services
- Youth offending service (YOS) with referral pathway to SW London Forensic CAMHS
- Transitioning to and from Children and Young People's Secure Estate – there are several establishments e.g., at Feltham and Cookham Wood for children and young people to be placed on welfare and youth justice grounds (with dedicated mental health support provided within the facilities)

First time entrants are tracked, including young people who re-offend within 12 months (and whether the re-offending was more/less serious or more/less frequent). These form part of discussions within the Youth Crime and Prevention boards. All local YOS Teams have at least one CAMHS practitioner, who is an integral part of the multi-disciplinary and multi-agency team. This practitioner leads on (initial) mental health risks(s) screening, provides one or more consultations to young people and their families, and ensures that mental health needs are identified, and actions agreed on how to meet the identified needs, either from resources within the team or by organising access to additional specialist help from local (tier 2 or tier 3) CAMHS or by referring the young person to the SW London Forensic CAMHS.

Crisis Care Related to Police Custody
Urgent mental health assessments in police custody are undertaken by the on-call Mental Health Practitioner or out of hours Emergency Duty Team (EDT).

The number of severely mentally unwell children and young people being taken to police custody suites is very small and the L&D service also provides some support for them there. These types of referrals are rare; however, it is important that we maintain the pathway for these very vulnerable, children and young people as police custody suites are not suitable places.

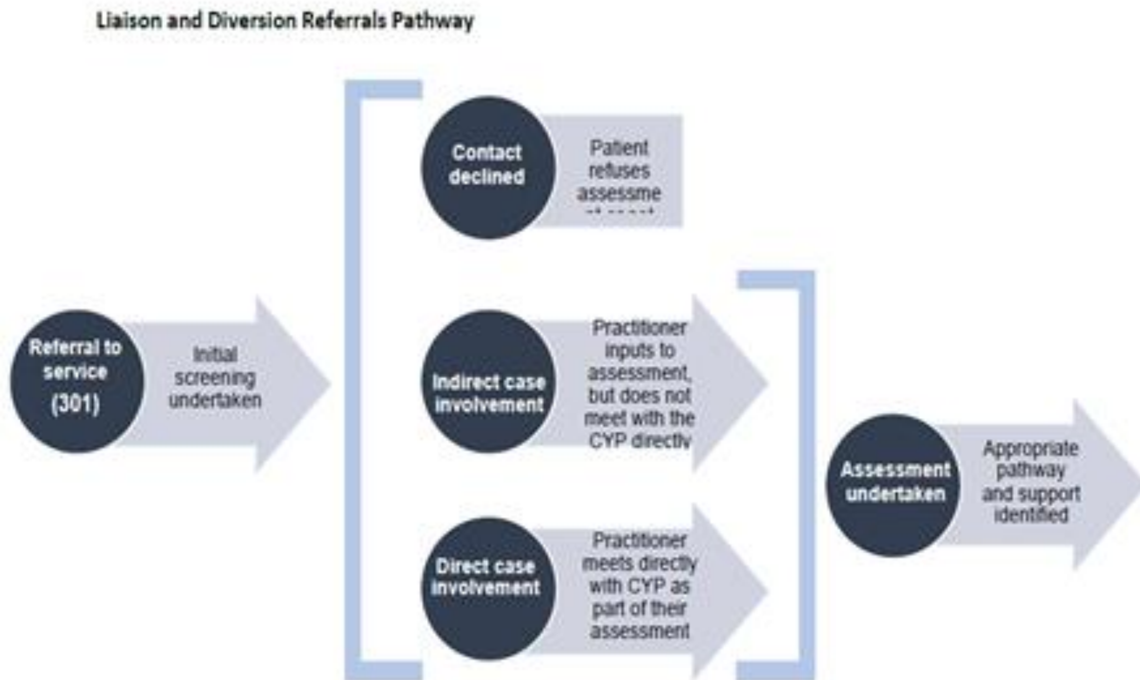
Liaison and Diversion (L&D) Services
The L&D pathway for SW London includes the following services:

- A custody suite
- Magistrates Court
- Transforming Families Team (Youth Justice Team, Anti-social Behaviour-Team and the Police
- Liaison & Diversion worker
- Forensic CAMHS service
- Speech and Language input

A CAMHS L&D worker is co-located with YOS and the police custody suite and young people on the edge of offending are assessed in custody or at the YOS office at the first opportunity.

All children and young people in contact with the L&D service have a screening of mental health and emotional wellbeing assessment, utilising a trauma informed approach. If a mental health need is identified the young person is referred on to CAMHS with their consent, for a full mental health

assessment and network meeting (if more appropriate). The current L&D pathway across the SW London is as below.



Whilst most young people known to youth justice service will only need to access local mental health help, some require specialist assessment and intervention from a Forensic Child and Adolescent Mental Health Service (FCAMHS):

South London Community FCAMHS is a Specialist Forensic Community Child and Adolescent Mental Health Service for young people and their families. It provides advice, consultation, assessment, and some limited short-term interventions. The service can also provide training for local professionals, and it is a multi-disciplinary service including Consultant Adolescent Forensic Psychiatrists and Psychologists.

In South London, FCAMHS is provided in partnership, through South London Mental Health Partnership (SLP), hosted by the South London and Maudsley NHS Foundation Trust (SLaM) on behalf of the three trusts also in the partnership i.e. Oxleas and South West London and St George's NHS Trusts. The service aims to be accessible to community mental health teams as well as other services working with young people and their families (such as Youth Justice Service, Social Care etc.).

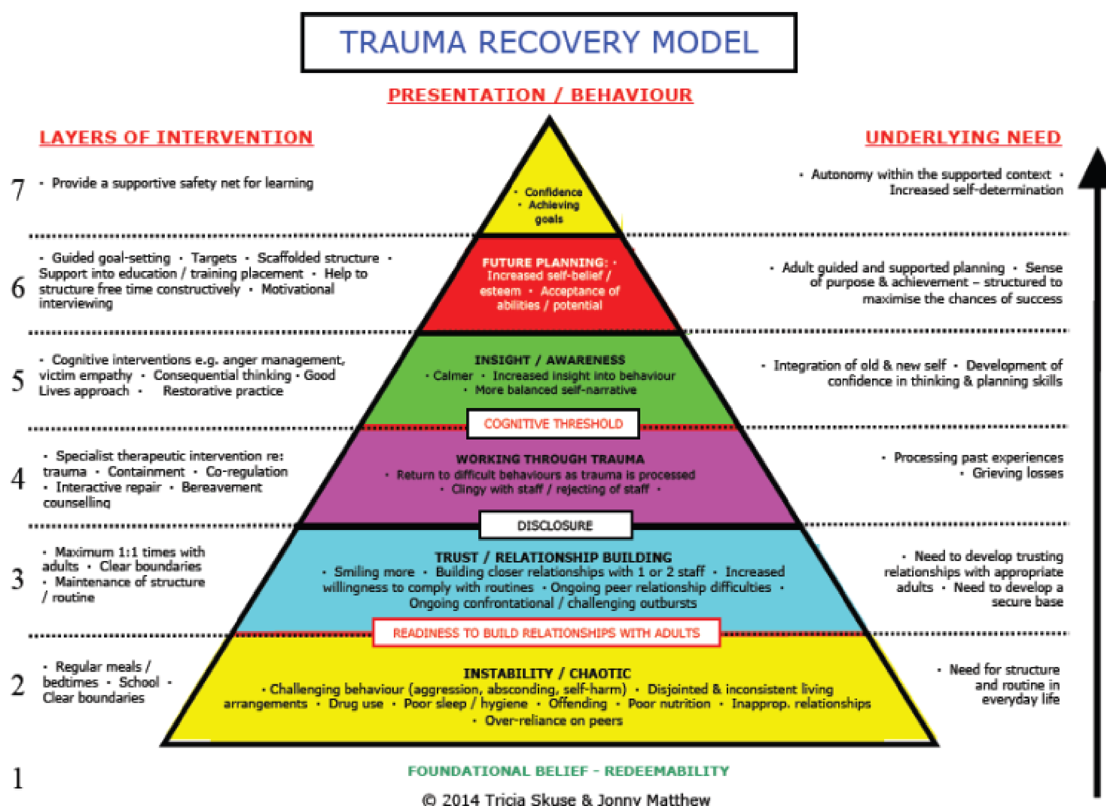
Input from FCAMHS depends on a number of factors and degree of need or risk, as well as what services are available locally. It is expected that the child or young person will be open to their local specialist CAMHS team, which will co-ordinate care and provide risk management and emergency care planning.

Our Ambitions at SW London
It is worth noting that the evidence base for desistence from serious youth violence supports a multisystemic approach. There is a high rate of non-engagement with mental health services or at the very best, inconsistent engagement, due to several factors, including fear of reprisals for discussing crimes the young person may have been a victim of with a professional.

We want to work more closely with other agencies providing services within the boroughs, e.g. teams tackling exploitation, gang workers, Redthread (Youth Charity) who can identify and work with victims of serious youth violence when identified at A&Es etc.

We will work as a system to address challenges of engagement of young people with time invested in forming therapeutic relationships to make young people feel safe enough that the topic of trauma and its impact on functioning can be introduced.

For our young people with more problematic clinical features of PTSD, a trauma informed way of working could be supported, for example, supporting professionals already working with the young person either directly or indirectly through a phased approach as depicted in the attached image below until they are in such a position that they can undertake formal therapy.



4.7.2. Access to Help for Children Looked After (CLA)

Specialist emotional wellbeing and mental health help is embedded within all social care teams for CLA across SW London boroughs. This includes the CLA Team, Leaving Care Team and Adoption and Fostering teams for children and young people looked after by the LA from birth to age 25 years. The service aims to improve the stability of placements by supporting the identification and care planning for those whose functioning is negatively impacted upon by their emotional and/or mental health. The service acknowledges the prevalence of mental health difficulties within this vulnerable population and thereby the importance of fostering children's emotional growth as an integral component to ensuring positive life outcomes.

They are supported by the Getting Help (Tier 2), Emotional Health Service, thereby maintaining essential links with evidence-based practice, continuing professional development, and securing access for children and young people looked after to all available psychological resources on offer

within the wider EHS service, Getting More Help (Tier 3) services, adult mental health services and services offered by partner organisations within and out of Borough.

The team consist of qualified Health and Care practitioners. These are:
- Systemic Family Therapist.
- Art Psychotherapist
- Clinical Psychologist

The Team also works closely with health services for CLA, such as Community Paediatricians/Designated Doctors for CLA and CLA Health Nurses, as well as Educational Psychologists and teachers within the Virtual School. This ensures that the emotional health and well-being of children and young people in care is monitored, and effective and timely action is taken to provide appropriate support.

In order to provide a fast response to a growing CLA population, the service has adopted a consultation-led service approach that includes:
- Consultation to all professionals within the team to Leaving Care, Unaccompanied Asylum-Seeking Children, Family Coaches, Virtual School, LAC Health, and Independent Reviewing Officer teams.
- Specialist assessment that includes mental health and emotional wellbeing (this includes the wishes and capacity of the children/young people to make use of therapeutic help), functioning, impact of adverse negative events on development and relationships with carers and peers, the behaviour they present, any issues of risk (e.g., sexual exploitation, absconding, self-harm, substance misuse, physically/sexually/emotionally harming or being harmed by others).
- Liaison and support regarding children and young people in care to the wider network (e.g., birth family, partners, schools/colleges, other agencies, adult mental health services) to support emotional wellbeing, care planning and placement.

Individual therapeutic and group work with children and young people, including art psychotherapy, clinical psychology/Cognitive Behavioural Therapy (CBT), Eye Movement Desensitisation and Reprocessing (EMDR), family/systemic therapy based on robust assessment and shared formulation of needs and hoped-for outcomes.
- Support and consultation to management and staff in residential homes for young people in care in the Borough, as well as the specialist assessment and formulation of the needs of residents to inform care planning. Supporting the provision of a psychologically informed residential home environment.
- Specialist training and professional development to social workers and network professionals regarding the mental health and emotional wellbeing of children and young people in care, especially regarding trauma and attachment.

4.7.3. Access to help for children and young people who have experienced sexual abuse (Emotional Support Service)

The SW London Early Emotional Support Service provides support to children and young people who have made a recent allegation of sexual abuse (CSA). The service was delivered by National Society for the Prevention of Cruelty to Children (NSPCC) up to October 2021. The current plan is for another local service in SW London to take over delivery on an interim basis while the service is put out for procurement formally for start in April 2022.

The Early Emotional Support service provides mental health and emotional wellbeing assessment and support to children and young people who have been a victim of child sexual abuse, as well their non-offending families and carers. The service will provide a consistent and timely offer to all children and young people aged up to 18 years of age within the catchment areas SW London boroughs.

Following a re-procurement in 2019/20, the service went live in April 2020. It must be noted that this service was launched within the midst of the pandemic and the resulting lockdown (March 2020) situation that occurred within the UK, whereby due to government restrictions in relation to social distancing, the NSPCC were unable to deliver face to face services as usual with fidelity to the service model and thus services were amended and delivered in a bespoke format.

CSA medical examinations
Due to the pandemic, NSPCC had not been attending CSA medical examinations in hospitals. This will be reviewed as the service transitions to another provider and for future commissioning. Non-attendance at the CSA medical examinations does not appear to have had a negative impact on referral numbers nor the timing of support being offered. This has not caused any obstacles in the referral pathway or in contact with families.

Total referrals across SW London

Description	Q1 20/21	Q2 20/21	Q3 20/21	Q4 20/21	Total 20/21
Referrals progressed to NSPCC support and assessment	9	17	9	11	46

4.7.4. Access to help for children and young people with a Learning Disability

All SW London boroughs have a clinical psychologist or behaviour specialist(s) that offer help and behaviour support for children and young people with moderate to severe LD and challenging behaviour. Frequently, this support and help for parents and their children with complex special needs is undertaken in close cooperation with other therapists already involved in the care of these children as well as colleagues from Social Care and Education. However, as this group of children and young people suffers from global developmental challenges including significant delay of language development, it takes longer to get to know the child and to observe and determine the underlying triggers and causes of the presenting behavioural, emotional and social communication problems. Local LD psychologists will refer to CAMHS or request a consultation, but colleagues working in generic CAMHS Teams frequently feel that they lack experience or the highly specialist expertise to offer more help than is already provided by various therapists within local services.

Wandsworth and Croydon are the only SW London boroughs with a Specialist LD CAMHS team offering consultations to parents and professionals as well as assessment and treatment of children and young people with a LD and challenging behaviour as well as emerging mental health problems.

SW London has recognised the need to develop a consistent LD CAMHS offer across all six SW London boroughs and invested £200k into the LD CAMHS team this financial year with the aim to gradually transform the Wandsworth LD CAMHS team to a SW London LD CAMHS provision.

SWLStG has commenced recruitment for additional LD CAMHS practitioners and will commence offering specialist consultation and advice for children and young people and their families open to local SW London CAMHS team in the next 3-4 months in line with the interim SOP that was agreed with Kingston and Richmond in 2020/21 (more information on this interim SOP can be found in the appendix to this section).

Where do we want to be?
SW London has identified the need to establish a consistent mental health and positive behaviour support offer for children and young people with LD and their families across all SW London boroughs and will gradually increase funding for this vulnerable group, both place-based, jointly with Local Authorities as well as SW London wide from an NHS perspective and in line with the aims and ambitions of the Transforming Care Programme (see 4.8).

4.8. Transforming Care Programme for children and young people with LD and/or ASD

Beyond Transforming Care. Our Vision for Mental Health Support for children and young people with LD and/or ASD

There has been a significant increase in the number of children with a diagnosis for Autism (ASD) and Learning Disabilities (LD) in SW London over the last 10 years. This increase has resulted in a scaling up of education, social care and health provision for these CYP and families. There has been a major expansion of Special Needs schools to cope with the increasing number of young people with Special Educational Needs and Disability (SEND) and the creation of more nurturing provision within mainstream schools, to support inclusive education.

In line with the increase in the number of CYP with SEND there has been an increase in CYP with ASD and/or LD who have emerging 'behaviours that challenge,' which can escalate into emotional and mental health needs. Children with LD and/or ASD who exhibit severe challenging behaviours often have nuanced sensory, social and communication needs, emotional dysregulation, and patterns of obsessive and ritualised behaviour which their family, school and professional network have struggled to understand and effectively respond to. For children with high functioning autism, often diagnosis happens in teenage years (between 12 and 16 years old) and their emotional needs and mental health may have already deteriorated ahead of the diagnostic process and (specialist) help being put in place.

To effectively respond to these emotional and mental health needs SW London CCG works with our Local Authorities Partners, SLP and voluntary sector organisations to commission a range of services locally as well as SW London wide. Our partnership and mental health trusts are also part of a national 'best practice' programme 'MELD' (Mapping Services for Children with Learning Disabilities and Behaviours that Challenge), which is helping us learn about good practice nationally and to improve services locally.

Under the Transforming Care Programme (TCP) children with LD and/or ASD at risk of admission are entitled to go onto (borough based) Enhanced Care Registers, which are held and regularly reviewed by local Transformation Managers of SW London CCG jointly with partner agencies from Health/Mental Health, Social Care and Education/SEND. The local Transformation Manager will call an urgent Care, Education and Treatment Review (CETR), if a children and young people on this register is acutely at risk of being admitted to an inpatient unit. This full day crisis meeting creates a more integrated approach and brings together a range of professionals from health, education, social care and independent experts from NHS England, along with the young person and their family, to identify packages of support that will maintain a young person at home or elsewhere in the community and avoid an admission to hospital. If an admission is necessary, then the CETR recommendations help to keep the admission as brief as possible.

Achievement: Low Number of Admissions

SW London has achieved a good record in maintaining low admissions for CYP with LD and/or ASD over the last two years. As a system we are committed to intervening early and effectively where children and young people with SEND experience emotional difficulties and emerging mental health needs, including 'severe challenging behaviour.' The relatively low rate of admissions has been achieved by our Place Based Teams working in an integrated way with colleagues in schools/special schools, Health/Therapy and Mental Health colleagues as well as colleagues from Local Authorities at a borough level.

The below table shows levels of admission of the TCP cohort of young people over that last three years and the trajectory going forward.

Year	2018/19	2019/20	2020/21
Total SWL Region (per 1 million population of 1.5 million)	25	19	15
London Regional Average (per 1 million population)	28	18	12

Reduced Length of Admission
In addition to reduced numbers of admissions, we have worked with partners to reduce the length of stay. For admissions that are necessary, we have worked to ensure they happened in a planned way to support de-escalation, assessments, and treatments in specialist inpatient settings and to allow a brief period in which professionals can put in place appropriate community provision to support effective discharge and reduce the risk of re-admission. Due to the relatively low numbers of admissions, average length of admission statistics significantly varies from year to year, with individual cases skewing the figures. The key process that we use to reduce admission and length of admission are Care Education and Treatment Reviews (CETRs). As part of this process Place-Based Transformation Managers organise follow-up professionals' meetings to ensure actions agreed at CETRs are met and that integrated care, education and treatment packages are put in place swiftly. Where delays persist, outstanding actions are quickly escalated to senior leaders within Local Authorities and other partner organisations.

Covid Support and Response
The SW London Covid response included borough teams working with Local Authority and SWLSTG colleagues (especially in CAMHS LD and CAMHS Tier 3 Teams) to identify the highest priority cases, where expanded monitoring and increased packages of support at home were needed. Covid was particularly difficult for CYP with LD and ASD for whom daily/weekly routine and familiar faces are a crucial part of their wellbeing and crisis avoidance. While some schools stayed open for vulnerable students, others closed because of lack of staff capacity. Additionally, some children's health vulnerabilities (or that of parents) meant that families had to isolate at home, in some cases refusing carer support that would usually be in place. As a result, there was an increase in challenging behaviours and crisis incidents, with emotional wellbeing deteriorating for many in the last 16 months. Consequently, requests for CETRs went up during this time.

Local health/mental health and social care colleagues stepped up monitoring of high risk and/or challenging young people. Local Authority colleagues increased respite and carer support packages for these high priority cases and local SW London CCG colleagues agreed specialist functional behaviour assessments recommended by external experts attending CETRs.

The overall outcome of our joined-up LD/ASD Covid response was to maintain low rates of admissions from our LD cohort on the Enhanced/Dynamic Risk Registers, but we also saw in some instances increased TCP admissions and length of admission for young people with (high functioning) ASD previously unknown to CAMHS, particularly young people in mainstream settings.

Challenge: High Cost Packages
High cost and multi-faceted packages of community support are needed to meet the nuanced needs of this cohort. This usually includes a mixture of specialist carer provision in the home, functional behavioural analysis, Positive Behaviour Support (PBS) training and ongoing PBS monitoring of the package, medication, aids and adaptations to the family home, respite care, special education provision, benefits, and carer support for family members. The cost of these packages can range from approximately £5,000 (for functional behavioural assessment and plan) to over £700k per year. These packages are funded jointly by health, education and social care (but how costs are divided varies depending on borough). The below table is an estimate of the typical costs of high-cost support for TCP young people when a package is put in place to avoid an admission:

Type of Package	Typical cost
Very low cost package: brief assessment and re-focused multi-agency approach: Because of the current focus on 'high priority' cases, these are less likely to have CETRs (but this may change with the introduction of the new Key Workers, which will increase capacity). Existing services (particularly education) and CAMHS LD Team are able to do the follow up work required. The CETR provides clarification and fresh impetus to work together to address the issues.	£1k - 4.5k
Low cost package: brief assessment and follow up intervention. 50% of all cases that come to CETR require a full functional analysis, positive behaviour support plan/strategies and a programme of follow up support and monitoring for existing staff and family members. This helps everybody to understand the behaviours and to break cycles of crisis. In these cases, family members have significant capacity and there is a network of support already in place. Sometimes new education provision is required, plus additional family support and crisis planning.	£16k - £20k
Medium cost package: three to six months of support & intervention: These cases arise for an estimated **25%** of cases that come to CETR. These are more often where a young person has ASD but no LD and so work that might be done by a CAMHS LD Team isn't possible and Tier 3 CAMHS colleagues don't have the specialism to do follow up work with the family. They include initial functional assessment and follow up work, but also require ongoing support for wider professionals to address more nuanced and intransigent issues. Sometimes this can include referral to one of the National Specialist CAMHS services (such as OCD service).	£30k - £45k
High cost long term package of support: These packages occur **25%** of the time for current 'high priority' cases that come for CETR. They include increased and tailored support from a wider range of health, education and social care services, full range of PBS ongoing support and RMNs/skilled carers working in the home at least some of the week and sometimes at weekends and nights.	£60k - £350k

Support for Children with Severe Challenging Behaviour

Some young people with ASD and/or LD experience 'severe challenging behaviours.' SW London works with a range of partners to ensure appropriate support is available as early as possible. In most boroughs this support begins with an Autism Advisory Service, often within the Children with Disabilities (CWD) Team (also called 0-18 or 0-25 Teams).
Additionally, SW London CCG has commissioned a comprehensive program of BILD (British Institute of Learning Disabilities) Training for all SW London boroughs to start in autumn 2021. Over 150 operational managers and front-line staff, including pastoral leaders in schools and autism advisory team staff, will receive training in functional behavioural approaches. Training will be others at three levels:

1. **Awareness training day-** Bespoke training for operational managers & other professionals.
2. **Awareness Training half day–** Bespoke training for service managers and clinical managers
3. **Foundation for families-** Understanding behaviour that is concerning or challenging. Training for families and front-line professionals working with families on a daily basis

The BILD training and new Behaviour Analyst posts are part of a SW London approach to system change, with regards to how children and young people and their families are supported when they experience 'emerging challenging behaviours' or 'severe challenging behaviours'.

'Severe challenging behaviour' is now included in Children's Continuing Care (CCC) as the eight domains under which CYP can be referred for support. Where these are assessed as meeting the 'severe' and 'priority' criteria for packages of support then a full package of nursing and carer support in the home is put in place. A new central CCC Team has been set up in SW London that will ensure 'severe challenging behaviour' referrals are swiftly assessed, so that appropriate care and support can be put in place, where this is needed.

Key Worker Pilot

To help SW London improve the quality and scale of support for LD and/or ASD young people in crisis we are piloting a new Key Worker approach, funded by NHS England. The Key Worker pilot will initially

focus on Wandsworth and Sutton, where there are functional CAMHS LD Teams and where there are advanced discussions about the role of CAMHS Tier 3 supporting children with ASD who are in crisis and whose needs are deteriorating. Other SW London areas will be fast followers from April 2022, benefitting from the learning that has taken place. The pilot will focus on CYP on the Enhanced Care Register and their families, which will include an expanded number of young people given the additional capacity created by the pilot programme.

SW London Part of National Research and Good Practice Sharing Programme
Both of our Mental Health Trusts are participants in the new Mapping Services for Children with Learning Disabilities and Behaviours that Challenge (MELD) programme, led by Warwick University, SLAM and NHS England. Through SW London providers' active participation in this programme we are exploring models of good practice and comparable outcome measures.

Participation will enable SW London and partners nationally to better describe the current range of service models and options for caring for and treating children with learning disabilities and behaviours that challenge. This will contribute to the evidence base about community-based service provision for these children, which will inform developments in service provision across England.

At the end of the study, a report of the research results will be completed and sent to the National Institute of Health Research who are funding the study. Once the research study is complete, SW London will provide commissioners and staff with a summary of the results and learning will help influence service development.

Next Steps in Transforming Mental Health Services for children and young people with LD and/or ASD:
To drive further improvement in services for children and young people with LD and/or ASD, SW London CCG will prioritise the following:

- Establish step by step a consistent local LD psychology and positive behaviour support offer, which can access local CAMHS as well as specialist SW London LD CAMHS for consultation, assessment and treatment advice and support
- Review intensive support and crisis support service models for children and young people and young adults (0-25) with LD and/or ASD and decide with service users and partner agencies, which model(s) we want to implement in the next 12 to 18 months
- create opportunities in the ICS for a more integrated approach to swiftly agreeing comprehensive packages of care and treatment across a spectrum of need
- mobilise a new system of Key Worker support for children at risk of admission to hospital, ensuring packages are tailored to the individual needs of children

4.9. Timely access to Crisis Help (Urgent and Emergency Pathway)

The NHS Long Term Plan has set out a clear ambition for all ICSs: "There will be 24/7 mental health crisis provision for Children and Young People that combines crisis assessment, brief response and intensive home treatment functions by 2023/24"

Key components consisting of a combination of local and SW London-wide crisis provision for CYP were already in place when we last reported on the crisis provision:

- A nurse led CAMHS Emergency Care Service (ECS) providing mental health and risk assessments for CYP that are presenting in a mental health crisis, including deliberate self-harm, at A&Es in Kingston Hospital, St George's Hospital, St Helier Hospital or West Middlesex University Hospital, currently operating seven days per week 9.00am to 8.00pm. This service will also carry out initial mental health and risk assessments if young people need to be admitted to a Paediatric Ward following an overdose or other self-harm attempt requiring clinical observation and medical intervention
- Various crisis telephone numbers depending on where you live and from time of the day, i.e. during office hours, after office hours between 5.00pm and 11.00pm and an all age 24/7 crisis telephone number
- An Adolescent Outreach Team (AOT) for young people with more severe and complex mental health challenges, who are already known to local CAMHS and present with risks to self and/or others. The AOT is providing short to medium term interventions in addition to the specialist help provided by local CAMHS.
- CYP from Croydon can access a CAMHS Crisis Team, which also offers short to medium-term more intensive help including home visits and more regular access to telephone advice and help, when needed, for young people already known to local CAMHS.

What happened in response to the pandemic?
There has been a lot of work undertaken due to the pandemic to coalesce all crisis help into one offer across children and young people and adult mental health services, resulting in the SLAM and SWLSTG all-age 24/7 crisis lines (see below). Crisis services were also co-located in the Orchid Hub

Dedicated CAMHS support is provided through SLP from 5.00-11.00pm weekdays and 9.00am-10.00pm weekends for children and young people or a parent/carer concerned about their child's mental health. During office hours, children and young people or a parent can either contact their local CAMHS SPA or their care coordinator, if the child or young person has already been assessed by a CAMHS Team but is waiting for treatment to start.

Where are we now?
Both SWLSTG and SLAM offer 24/7 all-age crisis lines, which were set up during the pandemic, with dedicated out of hours CAMHS support weekdays from 5.00-11.00pm and weekends 9.00am-10.00pm through SLP, with further investment into the crisis services in 2021/22. The new investment into the SWLSTG CAMHS Emergency Care Service (CECS) this year will expand hours of operation to 9.00am-10.00pm every day.

Where do we want to be?
Work has begun to introduce the "dial 2" option to NHS 111 for mental health crises calls; however, we need services in place for CYP to be diverted to on these calls. We need to work with SLP, SWLSTG, SLAM and NHS111 colleagues to link together the various lines, ensuring they can provide timely mental health advice, care and initiate follow up help, if indicated.

Most of the crisis service developments have focused on improving consistency and timeliness of CAMHS and Adult Mental Health Crisis Provision across SW London. However, we are planning to jointly review with partner agencies and service users, how we can further improve intensive home treatment functions, particularly for those children and young people/young adults who may need specialist crisis interventions for longer rather than the brief responses or short-term support already in place.

Consequently, SW London will review best practice intensive support and/or crisis support service models for children and young people with LD and/or ASD and engage with partner agencies and

children and young people and their families to decide what intensive and crisis support model would be best for these young people with additional needs and challenges in crisis situations.

5. NHS Long Term Plan Ambitions for next three years

The Long Term Plan set out 'fixed' and 'flexible' deliverables. A 'fixed' deliverable is one whereby we must achieve it with little to no flexibility on how we achieve it: e.g. we must deliver waiting times for eating disorders services based on national standards. A 'flexible' deliverable is one whereby we must achieve it by the year indicated but the way in which we do so can be locally determined: e.g., developing a SW London model of what 0-25 services look like. 'Targeted' deliverables are ones where there will be a specific process for chosen areas to put together proposals to access funding to transform services: e.g., delivering MHSTs, which are in selected waves.

Fixed	Flexible	Targeted
• Nationally, 345,000 additional children and young people aged 0-25 accessing NHS funded services [by 2023/24] (in addition to the FYFVMH commitment to have 70,000 additional children and young people accessing NHS Services by 2020/21) • Achievement of 95% children and young people eating disorder standard in 2020/21 and maintaining its delivery thereafter • 100% coverage of 24/7 crisis provision for children and young people which combine crisis assessment, brief response and intensive home treatment functions by 2023/24 (see also Mental Health Crisis]	Comprehensive 0-25 support offer in all STPs/ICS' by 2023/24 [drawing from a menu of evidence-based approaches to be made available in 2020]	Mental Health Support Teams (MHSTs) to between a quarter and a fifth of the country by 2023/24

Where are we now?

- CAMHS Transformation Plans have helped to deliver Future in Mind and the Mental Health Five Year Forward View over the last five years
- We have successfully achieved the access target increase from 25% to 35%, however we have the ambition to go further and will continue to invest both into preventive and early help services in schools, colleges and the community as well as expansion of core children and young people help, more help and crisis mental health services.
- The Eating Disorders service has consistently met the national waiting time standards for urgent and routine referral up to March 2020, but the recent surge in demand has clearly highlighted the need for additional investment in this specialist pathway
- The impact of COVID has dramatically changed the way services have been delivered: from face-to-face to digital and online assessments and treatment for the majority of referrals
- In response to COVID, a 24/7 all-age crisis pathway was established in April 2020 offering telephone triage and face-to-face urgent assessments in order to avoid hospital admission, but also provided the possibility for a short admission without delay, if this was necessary for the safety and stabilisation of the children and young people's mental health condition.
- We have closer working relationships between the CCG and Local Authorities to support CYP with SEND/EHCPs with improved access to specialist LD CAMHS and an integrated therapy offer, including psychology and positive behavioural support

Where do we want to be?

- We need to use the additional CAMHS investment to deliver Long Term Plan ambitions, including a more integrated 0-25 mental service delivery model that works in close collaboration with partners in children and young adult services.
- We need to transform access to services, including a digital offer and early help in schools and colleges to continue meeting national targets
- We need to join up specialist pathways to move away from tiers and age cut-offs to offer children and young people and families more choice when individuals transition to adult services

- We need to re-establish the intensive treatment option for children and young people with eating disorders to prevent the need for inpatient treatment
- We need to establish a fully integrated children and young people crisis service across SW London that includes timely self-harm assessments and urgent crisis assessments as well as the capacity to deliver outreach and home treatment for children and young people and their families when they need it

Data Access and Outcomes
Where are we now?

- The current CAMHS performance reporting on waiting times and other key metrics offers delayed information showing past demand. This data is regularly reviewed by various local groups with accompanying 'demand challenges' narrative that does not fully describe the picture.
- Overall feedback from CYP and their parents/families being seen by one or more CAMHS practitioners is positive and recorded outcome data for around 25% of CYP indicates a positive service experience and improvement of symptoms

Where do we want to be?

- We need a more meaningful and consistent data collection across the whole age range 0-25.
- The way waiting times are reported needs to be in weeks and months; the current categories are not always helpful to get the full picture.
- Data needs to show the whole patient journey from access to assessment, start of treatment and outcomes after so many weeks or months.
- This data needs to inform patient choices as well as supporting planning under the CAMHS transformation programme.

6. Investment Plan 2021/22

The Government announced a Spending Review in 2020/21 as part of its response to the impact of the Coronavirus pandemic on the NHS. Nationally, £500m was identified for mental health services. This funding is linked to either specific pandemic recovery and/or bringing forward Long Term Plan ambitions. Including annual transformation funding allocations, the SW London system received £4.3m to support transformation of CYP MH services.

A high-level breakdown of the use of this funding is below:

Allocations

Service/Area	Transformation Funding £000s	Spending Review £000s	Total £000s
CYP Community & Crisis	£1,872 (***can include ED)	£1,257	£3,129
Development of 18-25 services	£559	£363	£922
Eating Disorders	***	£363	£363

Investments

Service/Borough	Transformation Funding	Spending Review
Croydon	• Self-harm outreach • Targeted interventions for frequent, complex A&E attendees • Expand Tier 2 early intervention & support offer • Expand pathways from CAMHS into specialist services • Pilot 18-25 services	• Expand Eating Disorders support • Enhance crisis helpline • Enhance Single Point of Contact • Pilot Shared Lives model for those discharged from hospital
Kingston	LD PBS Support	• Develop 18-25 options • Transition worker
Merton	• 16-17 self-referral to CAMHS/MASH • Expand Off the Record capacity and extend to 25 • Transition worker	

Richmond	LD PBS Support	Pilot Emotional Wellbeing Hub
Sutton	• Enhanced CBT • Set up CAMHS 0-5	Enhanced Counselling
SWLSTG Services	• Enhance LD CAMHS • Eating Disorders service expansion • Expand support for implementing Thrive	Expand hours of operation for CAMHS Emergency Care Service
South London Partnership		Extend Crisis Line hours of operation

We have also used some of the all-age £2.4m Discharge funding to support expanded AOT ward in-reach.

7. Workforce Development

We are committed to developing a sustainable workforce with the appropriate skills mix to deliver a comprehensive and NICE-compliant range of services. Increasing the capacity of the workforce is at the heart of delivering the transformation plan but equally the workforce has the right skills to make a positive impact.

Where are we now?

- The CYP Mental Health workforce has grown over the last five years but requires additional investment to meet increasing demand
- Transformation funding has prioritised NHS services with the potential for voluntary sector and Local Authority services left unexplored: we need to look at how they can contribute to efficiencies and reducing waiting times
- LD psychology and functional behaviour assessment skills are in short supply and have been spot purchased across SW London previously
- In response to Covid, the whole CAMHS workforce has undergone a dramatic transformation in the way services are delivered

Where do we want to be?

- We need to explore more variety in the support offer: digital/online, crisis, etc. These will be an integral part of better-coordinated and integrated place-based services with more specialist pathways operating at a SW London level
- The future CAMHS workforce will need to combine different models including working flexibly or as part of two or more teams; help will need to be offered according to client needs and choices on accessing support.

8. Digitally enabled care pathways for 0-25 year old

Where are we now?

- We commission Kooth to offer online and text messaging support. Other organisations offer similar support (e.g., Off the Record and Croydon Drop-In.
- Some T2 services began offering online/digital support during Covid

Where do we want to be?

- We need to determine future arrangements for digital provision
- Explore additional digital options.

The impact of Covid on CYP MH services had an arguably positive impact in bringing forward digital technologies and the ability to deliver services remotely. While this is not always the best way of delivering treatment to individuals, it has no less offered the opportunity to review and assess what can be delivered remotely and what must be delivered face to face. SW London has just finalised its Digital Strategy and will be aligning the CYP MH programme to this work, to identify innovative digital

solutions and build upon the good work that has taken place in response to the dramatic shift during the pandemic.

9. Dependencies with other programmes

The CYP MH programme links with a wide range of programmes:

- Adult Mental Health Transformation Programme
- Digital programme
- Primary Care Transformation Programme
- Continuing Health Care services
- Quality and Safeguarding
- Personalised Care Programme
- Learning Disabilities Programme
- Urgent & Emergency Care Programme
- Workforce Programme

Appendices

More information relating to Section 4.1 (Prevention and Early Intervention)

MHST Coverage and Workforce across 6 SW London Boroughs:

Schools

Kingston	Richmond	Croydon	Merton	Sutton	Wandsworth
Tolworth Girls' School & Sixth Form The Holyfield School & Sixth Form Centre The Tiffin Girls' School Dysart School Grand Avenue Primary & Nursery School King Athelstan Primary School Christ Church CE Primary School Ellingham Primary School Malden Manor Primary & Nursery School Coombe Boys' School Burlington Infant & Nursery School Lovelace Primary School Richard Challoner School The Holy Cross School Malden Oaks Pupil Referral Unit King's Oak Primary School Coombe Hill Infant School Coombe Hill Junior School Robin Hood Primary School Lime Tree Primary School Christ Church New Malden Primary School Green Lane Primary & Nursery School Saint Joseph's Catholic Nursery School	Teddington School Waldegrave School Turing House School Trafalgar Infant School Trafalgar Junior School St Elizabeth's Catholic RC Primary School Hampton Wick Infant & Nursery School Carlisle Infant School Christ's School Richmond Park Academy Hampton High Grey Court School Sheen Mount Primary School The Russell School East Sheen Primary School Strathmore School Darrell Primary & Nursery School Lowther Primary School Hampton Hill Junior School Orleans Park School Holy Trinity CE Primary School	St Mary's Catholic High School Elmwood Infant School Winterbourne Junior Girls' School Royal Russell School Priory School The Quest Academy Norbury Manor Business and Enterprise College for Girls Applegarth Academy St Mary's Catholic Infant School The Crescent Primary School Meridian High School Gilbert Scott Primary School Kensington Avenue Primary School West Thornton Primary School Rockmount Primary School Norbury Manor Primary School All Saints CofE Primary School The Minster Junior School Archbishop Tenison's CofE High School Thomas More Catholic School Whitehorse Manor Junior School Oasis Academy Arena Chestnut Park Primary School Winterbourne Boys' Academy Broadmead Primary School Woodside Primary School Beckmead School	Ursuline High Gorring Park Hollymount Holy Trinity CoE Links Sacred Heart RC Sherwood SS Peter & Paul RC St John Fisher RC St Mary's RC St Teresa's RC St Thomas of Canterbury RC Raynes Park High Wimbledon College Melrose school Canterbury Harris Primary Academy (ARP) Hartfield (ARP) West Wimbledon (ARP) Cricket Green Perseid upper & lower Ricards Lodge High Stanford (ARP) Eagle House	Greenshaw High School Green Wrythe Primary School Muschamp Primary School Tweeddale Primary School Culvers House Primary School Avenue Primary Academy Wallington Primary Overton Grange School Cheam High School Sherwood Park School Bandon Hill Primary School Foresters Primary School Glenthorne High Secondary School Oaks Park School Carew Academy Eagle House School The Link Primary School The Link Secondary School Wandle Valley School	Southfields Academy Linden Lodge School Albermarle Primary School Allfarthing Primary School Beatrix Potter Primary School Earlsfield Primary School Our Lady of Queen Heaven Ronald Ross Riversdale Primary School St Joseph's Primary School Sherringdale Primary School Southmead Primary School Swaffield Primary School West Hill Primary School Burntwood School St Anne's Primary School Floreat Wandsworth Primary School St Faith's Primary School St Michael's Primary School John Bosco School Ark Bolingbrook Academy Harris Academy Battersea Shaftsbury Park Primary School Ark - John Archer Primary School Alderbrooke Primary School Wix Primary School Dolphin School
Colleges					
Kingston College	Richmond College	Croydon College	Merton College	South Thames Carshalton	South Thames College

School Mental Health Programme Website Links:

Mentally Healthy Schools	https://www.mentallyhealthyschools.org.uk/
Anna Freud Schools and Colleges	https://www.annafreud.org/schools-and-colleges/5-steps-to-mental-health-and-wellbeing/
Anna Freud Transforming the Workforce:	https://www.annafreud.org/transforming-the-workforce/cyp-mh-workforce-development/childrens-wellbeing-practitioner-programme/

Children's Wellbeing Practitioner (CWP) Programme:
The national CWP programme was established as a response to the target for offering an evidence based intervention to 70,000 more children and young people annually by 2020, by training up 1,700 new staff in evidence based treatments, outlined in **Implementing the Five Year Forward View for Mental Health**

The CWP Programme is a fantastic opportunity for services to create new trainee roles that:

- **Increase capacity by expanding the workforce** through creating a new sub-service with close links to local providers
- **Focus on prevention and early intervention** – diverting children and young people from specialist services through guided self-help for anxiety, low mood and common behavioural problems
- **Meet the gap in services**– increasing accessibility and seeing children and young people who might not meet the threshold for current services

There have been six cohorts of CWP training in London and the South East to date, with 397 CWPs (including current trainees) based in over 42 different services including NHS, Voluntary Sector and Local Authority. The CWP programme in London and the South East has produced some impressive outcomes for children and young people. You can find a thorough evaluation of the first year of the CWP programme here

What do CWPs do?
CWPs are trained to offer guided self-help to children, young people, and families with mild to moderate anxiety, low mood and common behavioural problems.

CWPs work in a variety of different settings including CAMHS, Local Authority and Voluntary Sector organisations. The work of CWPs is very varied as each service will be tailored to local need and provision but can include assessments, face to face sessions, telephone work, workshops, groups, and service user involvement activities.

Information for Prospective Students	Funding for Cohort 7 of the CWP programme has been confirmed by Health Education England. If you are a prospective student, please view our Postgraduate Studies page to find the relevant information. Please sign up to our mailing list to be informed of developments and receive notification of advertised roles.

You can see a variety of different CWP service models here:
CWP Booklet: Reflections from Year One
CWP Booklet: Reflections from Year Two
CWP Booklet: Reflections from Year Three
CWP Booklet: Reflections from Year Four

More Information relating to section 4.2 (Improving Access to help and more specialist help)

LOCAL SYSTEM OF CARE (KINGSTON AND RICHMOND EXAMPLE)

The Local System of Care

The Thrive Model

GETTING ADVICE

Promoting MH and Wellbeing in Schools & Community

GETTING HELP

GETTING MORE

GETTING RISK

Tier 1

Tier 2

Tier 3

Tier

Tier 4

Schools

Health

Voluntary Sector

Primary Care

CHILDREN'S SINGLE POINT OF ACCESS (SPA)

SINGLE POINT OF CONTACT (SPOC)

MULTI AGENCY SAFEGUARDIN G HUB (MASH)

MISSING PERSONS PANEL (MISPER)

CAMHS SPA

Voluntary and Community Independent Sector

Kooth/Relate

EHS

Early Help

Health

Supporting Families

Education (SEND)

Parenting Support

Youth Resilience

Social Care

Referral & Assessment Service

Children in Need

Advice & Support

Neuro Developmental Service

Eating Disorder Service

Community CAMHS

Children Looked After

Children in Need of Protection

Disabled Children's Service

Assertive Outreach Adolescent Team

Emergency Liaison

Health Based Place of Safety Section 136 Suite

First Call SPA

Dialectical Behaviour Therapy Service

Autism/LD Support Package

Home Assessments

Specialist Intensive Inpatient Eating Disorder Service (Wisteria)

General Inpatient Unit (Aquarius)

Adolescent Psychiatric Intensive Care Unit

National Deaf Service

UNIVERSAL SERVICES

TARGETED SERVICES

SPECIALIST SERVICES

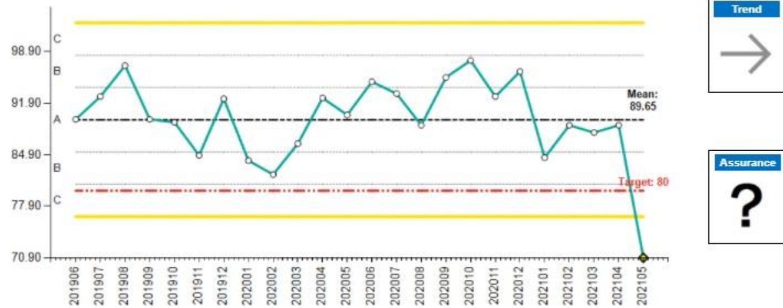
Tiered Model

Place based CAMHS Access information

Access To Children's Mental Health

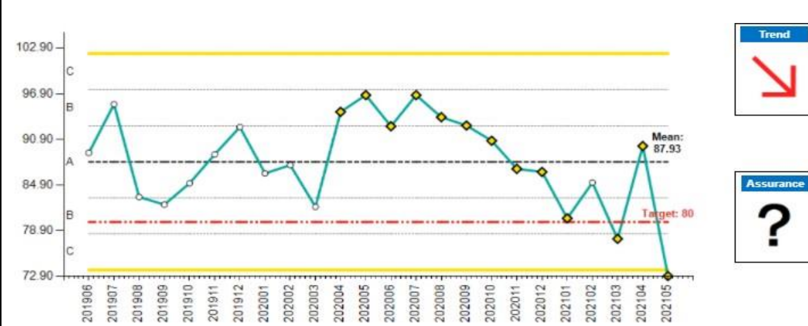
Access to CMHT within 28 days (Target >80%)

NHS Kingston; Access



NHS Kingston: Mean performance is above target indicating target will consistently be met. May 2021 has seen a significant decrease with performance below lower control limit.

NHS Richmond; Access

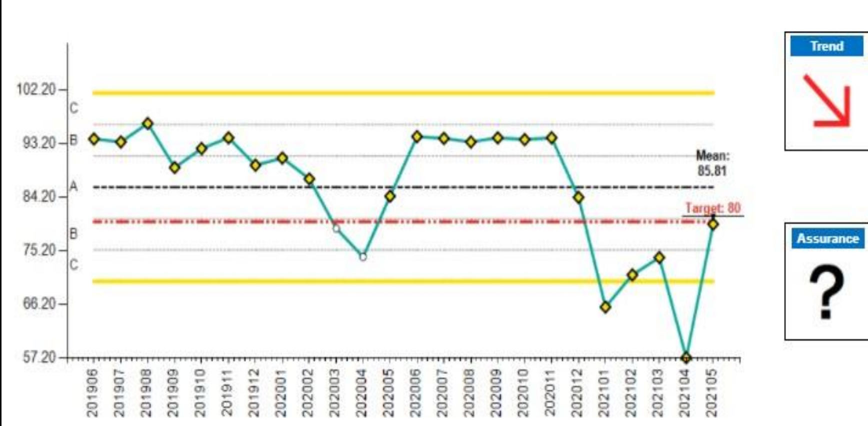


NHS Richmond: Mean performance is above target indicating target will consistently be met. Recent months have seen decrease in performance with May 2021 being below the lower control limit.

NHS Merton: Access

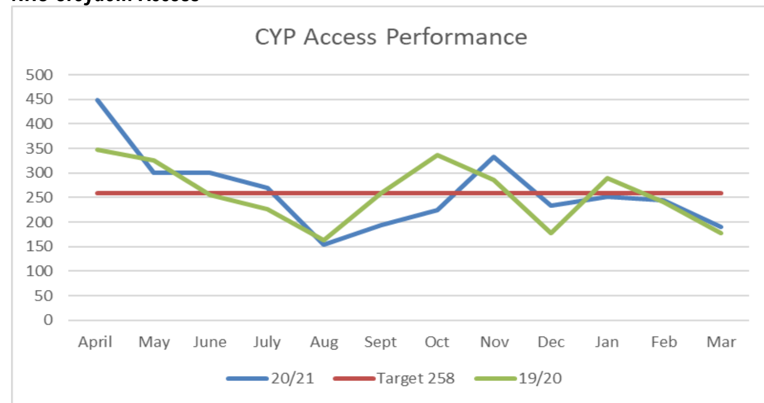
NHS Merton: Mean performance is above target indicating target will frequently be met. More recent months have seen decrease in performance.

NHS Wandsworth: Access

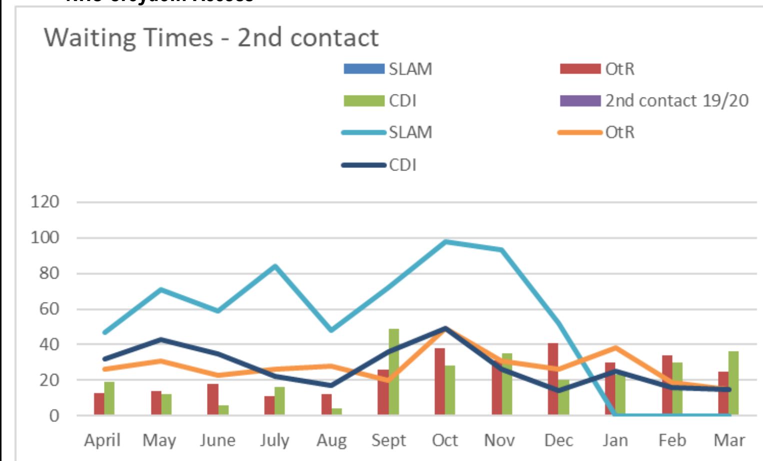


NHS Wandsworth: Mean performance is above target indicating target will frequently be met. More recent months have seen decrease in performance but improvement in May 21 is noted.

NHS Croydon: Access

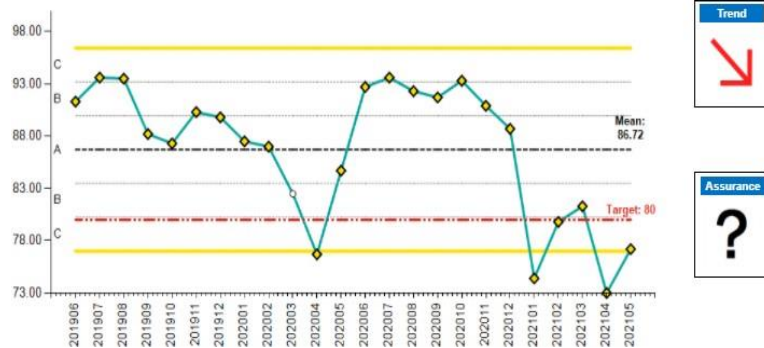


NHS Croydon: Access



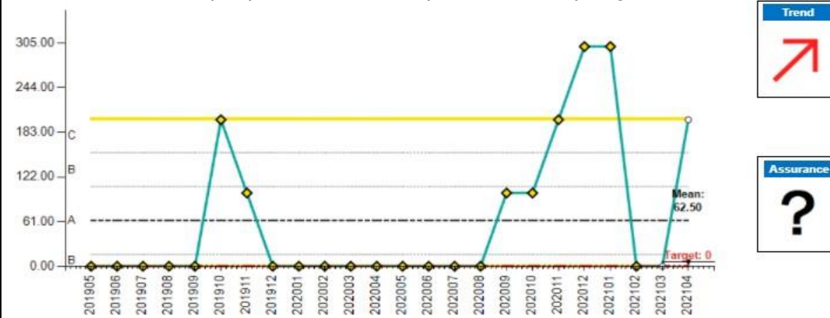
Waiting Times 20/21 average waiting time from assessment to first contact increased in Voluntary Sector provision to an average of **7 and 11 weeks** to second contact and access to treatment

Access



There has been a downturn in performance over last 5 months preceded by a period where target was consistently met.

Referral to Treatment (RTT) 52 week breaches (month in arrears) Target >92%



What the chart tells us:
Mean performance is just above target indicating that whilst the service will usually meet target there will be occasional breaches. (Excluding NHS Croydon)
Underlying issues that prevent us from consistently reaching the target: Merton CAMHS Tier 3: The breach relates to relates to delay in completion of the diagnostic assessment by the CAMHS Neurodevelopment Team which was moved to Merton CAMHS Tier 3 pathway after 52 weeks. At the time of reporting the young person was still waiting (77 weeks) for their medication commencement appointment due to backlog in ADHD clinic as a result of insufficient medical staff. Under current processes it is inevitable that there will be more breaches.

More information/resources for young people self harming, what it is and what young people can do about it.
https://headscape-swlondon.nhs.uk/headscape/

More information relating to section 4.3 (Specialist pathways for CYP Eating Disorders)

More information/resources for young people with eating challenges and their parents/carers

Resources for Young People and Carers	https://mccaed.slam.nhs.uk/young-person-and-families/resources
BEAT	https://www.beateatingdisorders.org.uk/
For Professional Referrals	https://mccaed.slam.nhs.uk/professionals/make-a-referral/
Anna Freud Centre	https://www.annafreud.org/

More information to section 4.4 (Specialist Pathways for Neurodevelopmental Disorders)

Croydon NDT

The Croydon NDT review is summarised in the link below as one of the key transformation areas:
https://democracy.croydon.gov.uk/mgConvert2PDF.aspx?ID=29979

Wandsworth ASD early help service	https://thrive.wandsworth.gov.uk/kb5/wandsworth/fsd/service.page?id=AI_HjBh6JUU&familychannel=0 Wandsworth Autism Advisory Service (WAAS)
ADHD Richmond	Welcome - home page - ADHD Richmond and Kingston

More information relating to section 4.7.4 (Help for Children and Young People with LD)

Specialist LD CAMHS assessment may include any of the following:

- Functional assessment of Behaviour that challenges both at school and home
- School observation
- Home observations and relevant visits, where identified
- Mental state assessment (including ADD/Trauma)
- Understanding of SLT and OT input and strategies
- Outcome: A Formulation meeting with family and/ or network as appropriate will occur and recommendations will be discussed.
- The LD team will always summarise in a report a formal consultation and assessment including a formulation and agreed outcome/recommendations

Process of referral allocation, for consultations and full assessments

- All accepted referrals will remain open to K&R CAMHS T3 for Care Coordination/risk management. It will be K&R CAMHS responsibility to complete risk assessments, relevant KPI's and open and close cases accordingly
- Referrals will be taken to the weekly team meeting every Wednesday for discussion and case allocation. The Wandsworth CAMHS LD team will be responsible for notifying the referrer of the outcome and informing when they would be able to offer the consult/assessment.
- For consultations, it is the Care Coordinators responsibility to record this as a non-clinical note on IAPTUS. The Wandsworth CAMHS LD team will log the time spent doing consultations on dummy files and will refer to patient notes for more detail.
- For referrals accepted for the full assessment and formulation package, they will receive up to 5 days of consultation/assessment.
- The tier 3 service should obtain consent from the young person and family for consultations and assessments, which should be clearly recorded in the notes.
- The Wandsworth CAMHS Learning Disability Service will follow aspects of their established referral pathway with regards to allocation of designated staff member, engaging young person and their family, and information gathering.

More information relating to Section 8 (Digitally Enabled Care Pathways information)

Kooth www.koothplc.com/
Data and Insights https://explore.kooth.com/wp-content/uploads/2021/05/Kooth-Pulse-2021-Report.pdf
Fresh Thinking The Thought Report | Fresh Thinking on Mental Health