HEALTH & WELL-BEING BOARD (CROYDON)

To: **Elected members of the council:**
Councillors Jane AVIS, Adam KELLETT, Maggie MANSELL, Margaret MEAD - chair, Tim POLLARD - vice-chair

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

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

Healthwatch Croydon
Vanessa HOSFORD (Healthwatch Croydon)

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

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

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

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

A meeting of the **HEALTH & WELL-BEING BOARD (CROYDON)** will be held on **Wednesday 26th March 2014** at **2:00pm**, in **Room F10, The Town Hall, Katharine Street, Croydon CR0 1NX**.

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

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

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

AGENDA - PART A

1. Introduction

2. Minutes of the meeting held on Wednesday 12th February 2014 (Page 1)

To approve the minutes as a true and correct record.

3. Apologies for absence

4. Disclosure of Interest

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

5. Urgent Business (if any) (Page 9)

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

6. Exempt Items

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

Agenda.

7. CHS Emergency Care Department business case (Page 27)

The report of the Chief Executive of Croydon Health Services NHS Trust is attached.

8. Final Commissioning Intentions 2014-15: CCG Operating Plan 2014/15-2016/17 (Page 41)

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

9. Final Commissioning Intentions 2014-15: Children and Families Plan (Page 47)

The report of Croydon Council's Executive Director of Children, Families & Learning

10. JSNA 2013-14 Domestic Violence Chapter - Final Draft (Page 51)

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

11. JSNA 2013-14 Alcohol Chapter - final draft (Page 57)

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

12. Children & Young People's Emotional Wellbeing & Mental Health Strategy (Page 63)

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

13. Public Questions

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

Questions should be of general interest, not personal issues.

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

14. Report of the Chair of the Executive Group (Page 69)

The report of the Executive Group is attached, covering the Work Programme and Risk Register.

15. FOR INFORMATION ONLY (Page 85)

Pharmaceutical Needs Assessment Work Plan 2014-15 - report attached

16. Dates of future meetings in 2014

Wednesday 16 July
Thursday 11 September
Wednesday 22 October
Wednesday 10 December
Time: 2pm
Venue: Either the Council Chamber in the Town Hall or Bernard Weatherill House

17. Camera Resolution

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

AGENDA - PART B

None

HEALTH & WELL-BEING BOARD (CROYDON)
Minutes of the meeting held on Wednesday 12th February 2014 at 2pm in Room F10, The Town Hall, Katharine Street, Croydon CR0 1NX

Present:

Elected members of the council:
Councillors Jane AVIS, Adam KELLETT, Maggie MANSELL, Margaret MEAD - chair, Tim POLLARD - vice-chair

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

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

Healthwatch Croydon
Guy PILE-GREY (Healthwatch Croydon)

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

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

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

Non-voting members:
Andrew McCOIG (Croydon Local Pharmaceutical Committee)

Also present:
Fiona Assaly (office manager, health & wellbeing, Croydon Council), Andrew Maskell (Strategic Projects Manager, Personal Support), Steve Morton (head of health & wellbeing, Croydon Council), Brenda Scanlan (Director of Adult Care Commissioning)

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

A1/14 INTRODUCTION

The Chair, Cllr Margaret Mead, welcomed all to the meeting.

A2/14 MINUTES OF THE MEETING HELD ON WEDNESDAY 4TH DECEMBER 2013

The Board **RESOLVED** that the minutes of the meeting of the Health & Wellbeing Board (Croydon) on 4 December 2013 be agreed as an accurate record.

A3/14 APOLOGIES FOR ABSENCE

Apologies were received from Ashtaq Arain (Faiths Together in Croydon), Dr Jane Fryer (NHS England), Paul Greenhalgh (Executive Director of Children, Families & Learning), David Lindridge (London Fire Brigade), Lissa Moore (London Probation Trust), Lynette Patterson (Croydon Voluntary Sector Alliance - Croydon Guyana Link), Steve Phaure (Croydon Voluntary Action), Annette Robson (Croydon College), Barbara Scott (Healthwatch Croydon)

A4/14 DISCLOSURE OF INTEREST

There were no disclosures of pecuniary interest at this meeting.

A5/14 URGENT BUSINESS

Better Care Fund (formerly known as Integration transformation fund) 2014-15

Reasons for urgency: The special circumstances for non-compliance with Access to Information Procedure Rule 5.01/Section 100B(4) of the Local Government Act 1972 (items not to be considered unless open to inspection at least 5 days before the meeting) are that the national deadline is the 14th February 2014 and that this is such a significant piece of legislative change that joint work is needed to meet the requirements of NHS England.

Andrew Maskell gave a presentation on the Croydon Better Care Fund proposal:

The Better Care Fund gives us the opportunity to drive forward integration agenda for health and social care. There has already been a strong focus on joint work between the council and the NHS to produce health outcomes through the reablement programme previously discussed by the board.
The team developing the proposal have been working to extremely tight timescales. We received initial notification in October 2013 - very high level with no detail. Detailed guidance was only issued on 20 December. The guidance has raised more questions than it has answered. There are a number of significant risks within the programme for the council and the NHS. One of key elements of the

initial scheme set out by government was particularly problematic - pay by performance. On 10 February that element was removed.

Next milestone in the development of our proposal is 14 February 2014 to submit draft to NHS England. It will be a joint submission between the council and Croydon CCG (Clinical Commissioning Group). After 14 February there will be further work on the proposal including addressing feedback from NHS England based on an assurance process – they will come back with queries and challenges.

Target date for final submission is 4 April 2014.

The context in which this work is being undertaken is that all organisations working in health and social care in Croydon are facing significant financial challenges. It is important to be clear that the Better Care Fund is not new money. The government has specified what it expects partners to contribute financially.

Board members' attention was drawn to appendix one – we want to ensure that we are measuring things appropriately; and proposed allocations (appendix 2)

We still need to finalise targets – to be clear of baseline and targets which need to be set jointly.

The following issues were raised:

- Treasury rules disadvantage Croydon. Can we be sure that the allocations are sufficient to address local need?
- Multi-skilling of delivery staff not mentioned - district nurse could be a key worker for those needing ongoing treatment
- Integrating the staff – treasury rules say so much should come from acute services – already have community services doing work – should be included.
- Map of 6 areas – what is basis? GP practices? Difference in cost between peripatetic staff based in GP practice or on geographical areas
- Concern about cut off of services
- Drugs and alcohol service not included – is there scope for improvement and savings in this area?
- What is the role of the Integrated Commissioning Unit in this?

The following responses were made:

- The map shows the pre-existing GP networks in Croydon
- The objectives of the Better Care Fund are multiple but they aim to ensure overall that people are cared for in the most appropriate setting. In particular we want to reduce unnecessary admissions in acute unit. This is both a risk and an opportunity for Croydon Health Services who provide both acute and community health services.

- The Integrated Commissioning Unit is where CCG and council commissioners are coming together within a single management structure to look at how we can commission more effectively across mental health, children's services, continuing care etc. A report on the Integrated Commissioning Unit was made some months ago to the board.
- Need to remember vital role of carers, family members and neighbours in keeping people out of hospital.
- Role of voluntary and community sector important.

The health and wellbeing board **RESOLVED** to:

- Approve Croydon Council and Croydon CCG draft Croydon Better Care Fund Plan 2014-16 at Appendix A in readiness for submission to NHS England by 14th February 2014. Please note that appendices 1 and 2 of the Submission will be presented at the Board Meeting on 12th February2014.
- Agree that the Executive Director of Adult Services Health and Housing, in consultation with the Chair of the Health and Wellbeing Board, be delegated authority to approve the final Croydon Better Care Fund Plan 2014-16 for submission to NHS England by 4th April 2014.

A6/14 EXEMPT ITEMS

There were no exempt items.

A7/14 DIGNITY AND SAFETY IN CARE - SEMINAR REPORT

Steve Morton summarised the main points of the report and a discussion followed on the issues it raised.

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

- Note local work being local work being taken forward by partners to implement recommendations arising from the Francis Report and Winterbourne View Hospital Serious Case Review
- Agree the recommendations from the health and wellbeing board seminar on 5 December 2013 as set out in paragraph 3.12 of the report

A8/14 PUBLIC QUESTIONS

The following questions were received:

John Holman: Recently I went to my GP for my audiology problem. I needed to see a consultant. My GP said he was required to send

the consultant request to a private company in Brighton, who would vet it. Croydon University Hospital later sent me an appointment. Gavin Barwell MP said this was NOT government policy but a local decision?

Responses:
This is a local system implemented by the CCG 18 months ago. It helps GPs to make referrals into secondary care. The organisation is based in Brighton. It is staffed by GPs who review referrals to secondary care. This is to ensure that referrals are made in a way which reflects best clinical practice. The systems also educates and support GPs in making referrals. The service will talk through with a GP the pathway selected and the most appropriate providers.

A follow up question was made by **Peter Howard:** How much do referrals cost? Why not trust GPs? Referral sent to Brighton - patient has to wait - comes back to CUH. Why has Croydon chosen to do this unilaterally? Not national policy. Are we paying private companies to second guess GPs?

Response: The system was introduced to address significant variation in referrals. There were a relatively high number of instances where forms were not correctly filled in and where referrals to secondary care were not appropriate. Overall the system helps to reduce the costs of inappropriate referrals or treatments.

Anne Milstead: I asked a question last time about the levels of care available in the Borough which are noted in the minutes. They also say, "we will go back to service and ask for information requested". It seems to me that the question about whistleblowers has not been answered, nor has the question about PUBLIC involvement BEFORE the commissioning and implementation of a service.
My question this time follows from last time and is how much does Croydon Council pay for care per hour bearing in mind that the Care Home Association have costed for a minimum realistic and economic and sustainable charge to Local Authorities of £15.19 per hour, which is made up by:
£6.31 minimum wage
00.71 N/I contributions
00.81 holiday pay
15.91 with nothing for pension, which is mandatory now and I imagine that you would like the carers to have a pension?

Written response (after the meeting) from Steve Peddie (Head of Commissioning for Older People and Long Term Conditions):
In answer to the issue of whilstleblowing I do not know what the issue was but the Council clearly has a Whilstleblowing policy and in terms of commissioned services there are numerous examples of commissioners investigating allegations made by whilstleblowers of provided services.

The answer to the second issue is that the Council considers it good commissioning practice to consult with users and carers, as well as

existing providers of services, before commissioning and implementation of services. The Council's Commissioning Strategy p15:

> "We will understand the needs and priorities of our citizens, now and in the future and clearly specify our requirements;
> We will involve customers and service users in the planning, design, monitoring and evaluation of services;"

Lastly, in terms of how much the Council pays for care per hour, this can depend on which setting we are talking about. Residential and nursing rates have previously been provided as an FOI and are in the public domain (see Appendix P&V)

Peter Howard: How many deprivation of liberty orders are made in Croydon? How many were refused? I am concerned that the only person who has to sign off is Director of Social Services? If prisoners are deprived of liberty, there is an independent review process. Why is there not an outside body overviewing these decisions by Council?

Response:
Hannah Miller: The figures are reported in annual safeguarding report. We follow the legislation on deprivation of liberty safeguarding orders to the letter. Concerns about the process would need to be made to Secretary of State. Case assessment is carried out by one of the council's care managers. It will also include a doctor's report. The recommendation will be to agree or refuse the request. My experience is that the reports are of a very high quality and if I have any doubts, will challenge.

A9/14 REPORT OF THE CHAIR OF THE EXECUTIVE GROUP

Steve Morton drew attention to a number of amendments to the **Work Plan**:

The following issues were raised in relation to the **Performance Report:**

- Comparators - are they set down nationally and comparisons with whom?
- Obesity - figures still worrying
- Diabetes - disappointing progress
- Why is there such poor take up of NHS Health Checks?
- Falls worsened but strategy was doing well, so what is happening?
- Pleased to note a significant increase in satisfaction with social care services
- Increase in immunisations 2-5 years but still no data on 12 year olds who missed out during the MMR scares - are we measuring achievements?
- How do we address the issue of immunisations as it is becoming an acute problem? How can it be enforced with parents?

Responses:
mmunisations: Special scheme introduced by NHS England, to send out letters. Not seen report about success of scheme but will ask NHS England. We are planning to look at the communications strategy and continue to discuss with NHS England. We need to ensure people are aware of the risk from choosing not to immunise. The transfer of public health from the NHS to the council has raised a number of information governance issues with our NHS Health Checks programme model. For this reason we are redesigning the approach and have a recovery plan in place. We are expecting performance to be back on target by autumn 2014.

Risk Register:

- Summary indicating current status of risks and progress
- Does not show risk movement - none at the moment
- Detail being kept under review by Executive Group as agreed by the Board

The following issues were raised:

- It is important to be able to demonstrate the value of having the Health & Wellbeing Board and what has it achieved. In terms of the Health Scrutiny meeting, it will be good to have tangible headlines as to what difference the Health & Wellbeing Board has made..

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

- Agree proposed changes to the board work plan set out at paragraph 3.3
- Comment on performance against joint health and wellbeing strategy indicators at appendix 2. Areas of success and challenge identified by the performance report are set out in section 3.5
- Note risks identified at appendix 3

A10/14 FOR INFORMATION ONLY

The Chair mentioned that there was a Heart Town display available, with literature, in F4.

A11/14 DATE OF NEXT MEETING

Wednesday 26 March at 2pm in F10, Croydon Town Hall

The meeting ended at 4:15pm.

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URGENT ITEM: This information needs to be considered by June and the next meeting of the Health & Wellbeing Board has been moved from June to July.

REPORT TO:	**HEALTH AND WELLBEING BOARD (CROYDON)** **26th March 2014**
AGENDA ITEM:	**5**
SUBJECT:	SWL Collaborative Commissioning – Five Year Strategic Plan
BOARD SPONSOR:	**Paula Swann, Chief Officer, Croydon Clinical Commissioning Group**
CORPORATE PRIORITY/POLICY CONTEXT: This report is for information only	

1. RECOMMENDATIONS

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

2. EXECUTIVE SUMMARY

2.1 CCGs are required to develop a 5 year strategy collaboratively with CCGs within their Strategic Planning Group for submission in June 2014. The strategy for South West London (SWL) builds on the clinical case for change in SWL and has been broadened to include mental health and primary care transformation.

2.2 Health and Wellbeing Boards and Local Authorities are key partners, however the timing of the draft and final submissions of the high level strategy and the movement from BSBV to a collaborative commission approach, alongside the timing of local elections means that it is a challenge to engage with HWBB members to share an overview of the approach and ambition of SWL CCGs.

2.3 The presentation provides a summary of the approach for developing the SWL CCGs' 5 year strategy, the timeline, the governance structure and an overview of the case for change, context and clinical priorities for each of the clinical areas.

3. DETAIL

3.1 Following the withdrawal of Surrey Downs CCG from the Better Services Better Value Programme the remaining CCGs; Croydon, Kingston, Merton, Richmond, Sutton and Wandsworth have agreed to continue to work collaboratively.

3.2 The case for change has not diminished. Our clinicians want to achieve the best possible quality in our health services and are committed to delivering the London Quality standards.

3.3 Since the BSBV proposals there have been two significant developments. The first is NHS England's 'call to action' which describes the significant challenges the NHS is facing and that only bold and transformative change to how services are delivered we enable us to continue to provide high quality and sustainable services. The second is the impact of the Better Care Fund which whilst this funding will support better integration will leave CCGs with less money to commission hospital services.

3.4 The SWL CCGs are working collaboratively together in a Strategic Planning Group, alongside NHS England, to develop a SWL 5 year commissioning strategy/framework to deliver the required service changes in SW London to address the case for change in SWL.

3.5 The presentation provides an overview of the approach for developing the 5 year strategy, the timeline, the governance structure and an overview of the case for change and context and clinical priorities for each of the 7 clinical design groups.

3.6 The strategy which will be published in June will be a high level strategy. It is highly unlikely, for instance, to include specific proposals for local hospitals. We expect Local Authorities with representatives on the Strategic Commissioning Board to be involved in helping us to shape the detail in the months following publication of the strategy. Existing HWB strategies will inform our five-year strategy. Engagement with a wider group of stakeholders will be achieved through the SWL Forum. Additionally, each Clinical Design Group will also have social care representation.

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

BACKGROUND DOCUMENTS: Presentation

Croydon Health & Well-Being Board

SWL collaborative commissioning – process for developing the 5 year strategy

Paula Swann – Chief Officer, Croydon Clinical Commissioning Group

26th March 2014

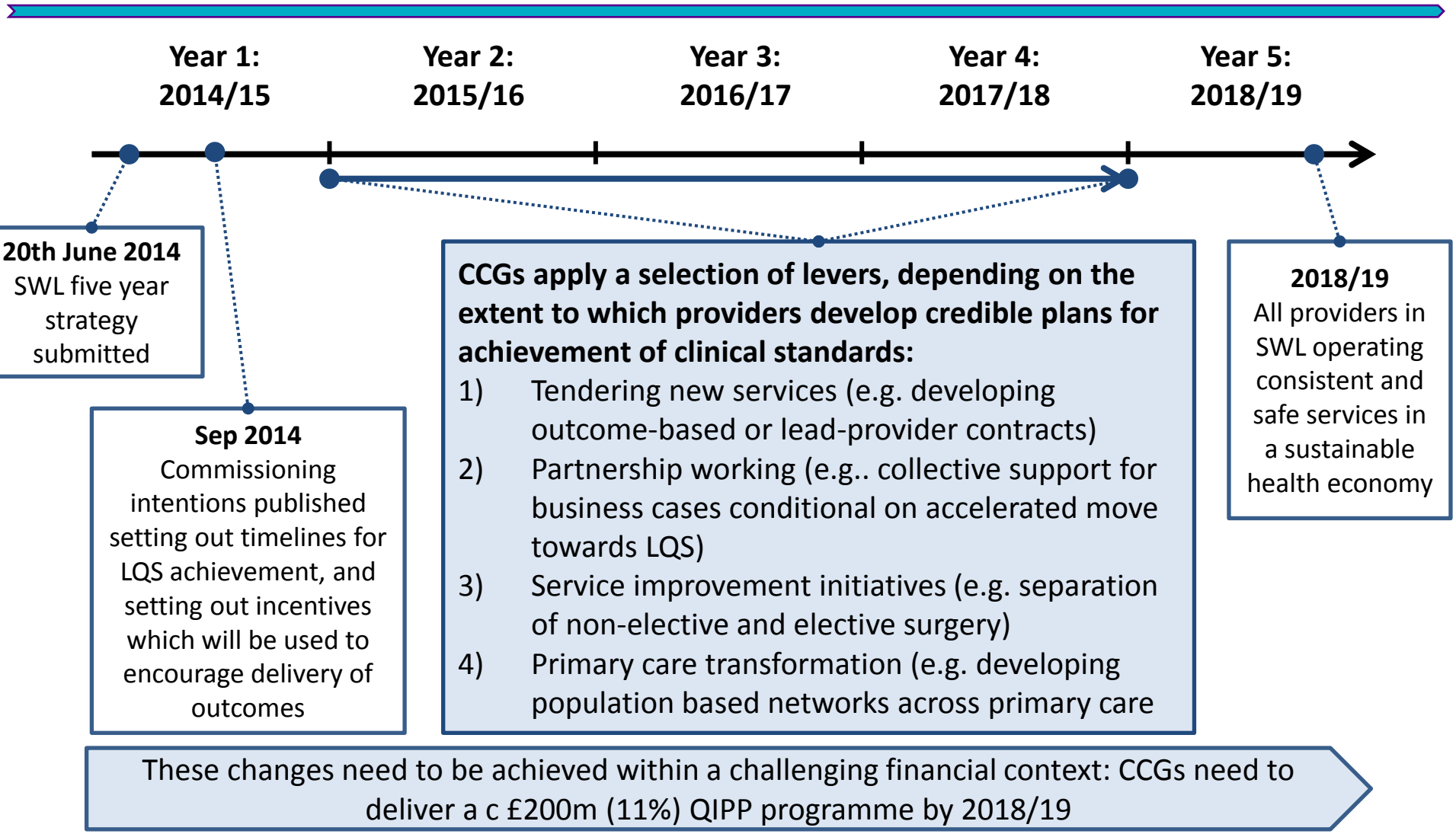
The BSBV case for change remains sound but our approach for addressing it is changing

- CCGs still unanimously support the clinical case for change in SWL and addressing this will be at the heart of our new approach
- The case for change is being refreshed as part of the five year strategy and its scope will be broadened to include mental health and primary care transformation and further development on urgent and emergency care in the light of the national strategy
- Commissioners are committed to delivering seven day working and LQS as soon as possible and believe that all commissioners and providers must take shared responsibility for achieving this
- It is our expectation that these standards cannot be met in full across all SWL acute, community and primary care providers without significant change to the provider landscape
- We will be using commissioning incentives and interventions to drive delivery of the required standards and reduce variations in care
- In developing the response to the case for change we need strong clinical engagement from all our providers; we also recognise the importance of working closely with local authorities, both in their role in relation to public health and social care and as crucial partners who are working with CCGs through their local health and wellbeing boards

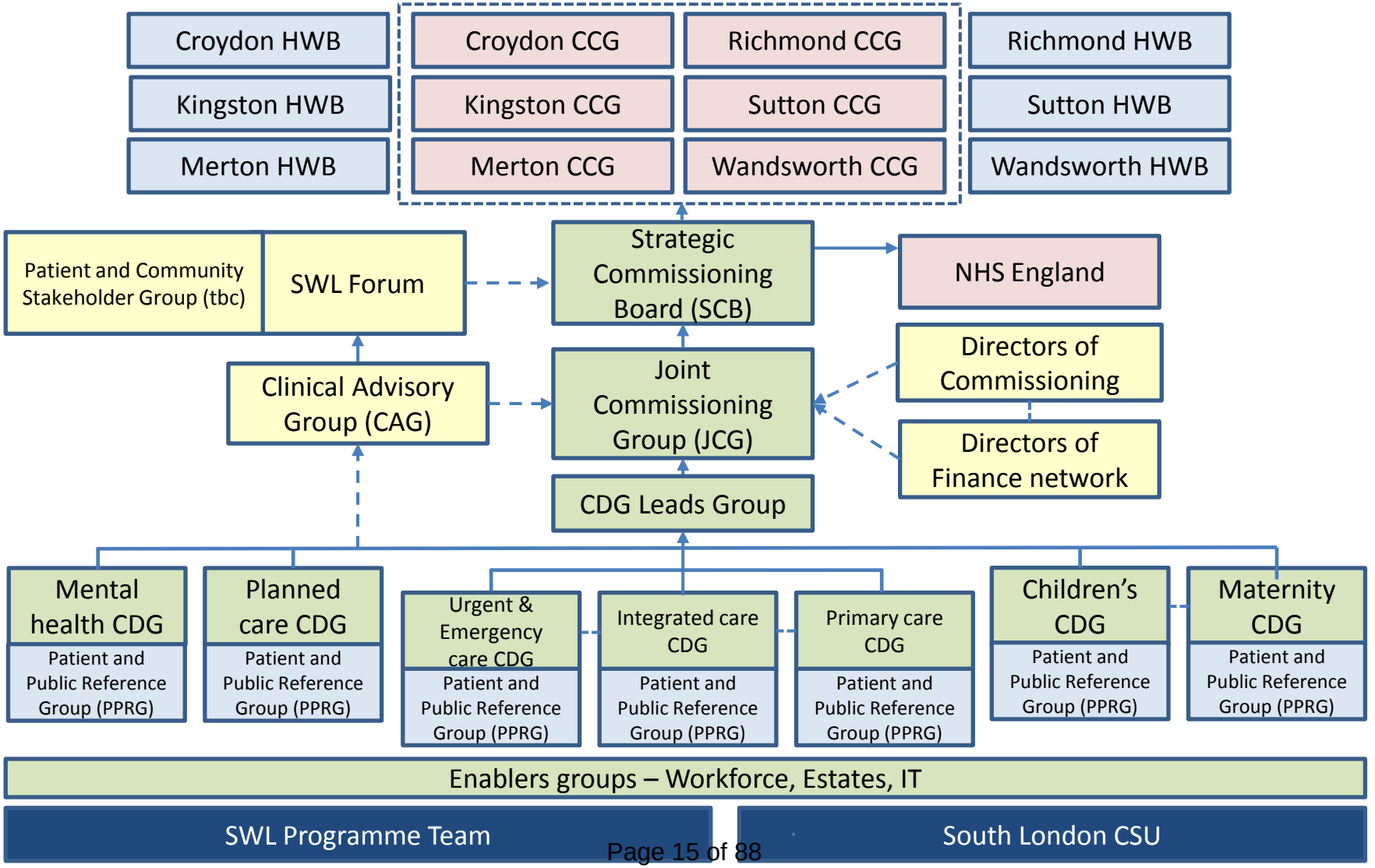
The Vision for the south west London five year strategy

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

Five year strategic timeline – overall approach



Governance for SWL Collaborative Commissioning



FIVE YEAR STRATEGY – HOW WE ARE RESPONDING TO THE CALL TO ACTION

The five year strategic plan

- The case for change for SWL has been refreshed in response to NHS England's *A Call To Action*
- Seven clinical design groups (CDGs) have been formed to lead the process of developing the strategy:
  - Children's
  - Integrated care
  - Maternity
  - Mental health
  - Planned
  - Transforming primary care
  - Urgent and emergency
- Where appropriate, the CDGs are building on clinical models already designed through the work that has taken place under the BSBV programme

The case for change in SWL – two main drivers

Driver 1: We need to **improve quality**

People admitted as emergencies at the weekend are 10% more likely to die compared to on week days

There is variation in the availability of consultant-led services, and vital clinical support services

Providing higher quality and more integrated care out of hospital is a local and national priority
Hospitals are not the most appropriate settings for many patients

- 48% of 2010/11 SWL A&E activity was coded 'minor'
- Patients can develop dependencies in hospitals which can affect their ability to cope post discharge

Driver 2: We need to deliver services that are **financially sustainable**

CCGs are facing a "do nothing" savings target of 12% of expenditure in 2018/19

Local CCGs are required to transfer a minimum of £85m to the Better Care Fund in 2015/16, signalling a transformation in the way care is provided outside of hospital

Acute, mental health and community providers need to make large savings over the next five years, and these challenges will be particularly significant for acute trusts, which face substantial cost pressures in part as a result of shifts of activity to the community

We cannot address these issues without significantly changing how the care we commission is delivered

1. **We cannot meet the London Quality Standards at all of our hospitals**
2. **We cannot deliver on our out of hospital promises without significantly changing how care is provided**

Children's clinical design group – context and clinical priorities

South West London Collaborative Commissioning

National / London context

- The London Quality Standards (LQS), based on those set out in Facing the Future, represent the minimum level of quality which clinicians expect in children's care
- Nationally, A&E attendances of children aged up to five are growing faster than any other age group
- Advances in treatment mean that more children are surviving but often with long term health problems

Local context

- In 2009, the CQC found that levels of training among clinicians varied and In some cases, clinicians are not undertaking enough of certain types of work to maintain their specialist paediatric skills
- Only 33% of Urgent Care Centres, and 56% of A&Es have at least one paediatric trained nurse on duty at all times

Existing priorities to be further developed

- Hospitals to achieve the paediatric London Quality Standards by 2018/19
- Development of a range of services for children outside of hospital
- Further development of ambulatory care pathways, based on experience of Sutton and Croydon

New priorities

- Greater focus on preventing ill health in children
- More collaboration with mental health services to direct children to psychological therapies at an early stage
- Improving access to Child and Adolescent Mental Health Services (CAMHS)

Priorities for years 1-2 (2014/15-2015/16)

- Benchmarking and mapping existing children's community services
- Support the establishment of a children's network to develop common pathways and standards in paediatric care
- Develop standard guidance for the management of common conditions and ambulatory care pathways
- Refine the Paediatric Assessment Unit (PAU) model, based on data from existing PAUs, and commission a standard model at all providers
- Work with Health Education South London (HESL) to specify training needs for community based paediatric working
- Pilot an enhanced children's community model

Priorities for years 3-5 (2016/17-2018/19)

- Evaluate the benefits of the pilot of the enhanced community model
- Review the performance of the PAUs, in order to ascertain if the required levels of quality of care are being achieved
- Ensure all our providers are delivering LQS and seven-day-working.
- Commission ongoing research into population assessment and analysis of need

Integrated care clinical design group – context and clinical priorities

South West London Collaborative Commissioning

National / London context

- The Better Care Fund takes effect in 2014/15 and will be fully implemented in 2015/16
- Health needs are changing as the population ages - for over 65s most people have one long-term condition and for those over 75 most people have two or more

Local context

- South west London health profile is better than that of the nation as a whole, with higher life expectancy and lower rates of smoking, obesity and alcohol consumption
- In south west London the number of >65s is expected to grow by 13% by 2020

Existing priorities to be further developed

- Further development and learning from the Better Care Fund, with a focus on the elderly and aging population
- Embedding integrated working between primary and community care throughout south west London

New priorities

- Ensuring the treatment of mental health care is embedded into physical health pathways
- Development of technology enabled care
- Developing a response to information governance issues

Priorities for years 1-2 (2014/15-2015/16)

- Implement local BCF plans
- Share best practice across south west London, and develop detailed implementation plans for integrated working in the following areas:
    - Integrated service design
    - Multidisciplinary team working
    - Workforce transition
- Embed mental health into existing physical health pathways, and into the design of all new services
- Identify enablers for integrating care and develop detailed plans to ensure that these are realised in years three to five

Priorities for years 3-5 (2016/17-2018/19)

- Develop an area-wide response to information governance (IG) issues, ensuring the free flow of information and data
- Implement innovative contracting arrangements that incentivise providers to drive improved outcomes and integrated working
- Embed technology-enabled care into integrated pathways, which will allow for better management of long term conditions
- Commission new training for graduate staff

Maternity clinical design group – context and clinical priorities

South West London Collaborative Commissioning

National / London context

- The London Quality Standards set out a minimum level of quality which clinicians expect in maternity care
- Women planning births in a midwifery led unit experience fewer interventions than those planning birth in an obstetric led unit
- Birth complexity is increasing with rising maternal age and increasing prevalence of diabetes and obesity

Local context

- Outcomes and intervention rates vary widely between maternity units
- 8 out of 27 LQS are not currently being consistently met by trusts in south west London

Existing priorities to be further developed

- Achievement of the London Quality Standards for maternity
- Promotion of midwifery led birth settings for women with lower risk pregnancies

New priorities

- Developing whole pathways of care based around the woman not the service
- Providing continuity of care wherever possible
- Improving the experience of post-natal care
- Investigating outcome based commissioning

Priorities for years 1-2 (2014/15-2015/16)

Achieve 26 out of 27 LQS by year 2 including the following priorities:

- Standard 4: One-to-one midwife care during labour
- Standard 6: A midwife labour ward co-ordinator to be present on duty on the labour ward 24 hours a day, seven days a week
- Standard 7: All postpartum women are to be monitored using the national modified early obstetric warning score (MEOWS) chart.
- Standard 10: obstetric units to have a consultant anaesthetist present on labour ward for a minimum of 40 hours (10 sessions) per week.
- Postnatal care – the Clinical Network is working on defining a standards

Priorities for years 3-5 (2016/17-2018/19)

- Develop, agree and implement ambitious but achievable target ratios for obstetric-led births, midwife-led births and home births
- Achieve all the London Quality Standards by 2018-19 including 168 hour obstetric consultant cover on labour wards
- Measurably improve patient experience of care
- Further explore outcome-based commissioning for maternity, and implement elements that can be readily agreed with providers
- Create a seamless, family focused community maternity service for antenatal and postnatal care as well as home birth where requested.

Mental health clinical design group – context and clinical priorities

South West London Collaborative Commissioning

National / London context

- Everyone Counts planning guidance set out 'parity of esteem' for mental health care
- Closing the Gap outlined 25 priority areas
- Mental ill health is the single largest cause of disability in the UK

Local context

- Current services are too focused on caring for patients when they are acutely unwell and require inpatient care or crisis intervention. We need a greater focus on prevention and early intervention

Existing priorities to be further developed

- Continued borough-level development of services such as IAPT

New priorities

- New south west London strategic focus on the 25 priorities outlined in Closing the Gap, grouped into four categories:
  1. Increasing access to mental health services
  2. Integrating physical and mental health care
  3. Starting early to promote mental wellbeing and prevent mental health problems
  4. Improving the quality of life of people with mental health problems

Priorities for years 1-2 (2014/15-2015/16)	Priorities for years 3-5 (2016/17-2018/19)
• Achieving the six objectives in No Health without Mental Health by making significant progress towards achieving the 25 priorities in Closing the Gap • Review and redesign the rehabilitation care pathway and introduce community recovery services • Work with mental health providers to understand the implications of the move to a tariff in 2015/16 • Develop CQUINS to reward good outcomes, for example to improve crisis planning or develop physical health checks for patients with psychosis	• Further work to deliver the 25 priorities in Closing the Gap – in particular delivering the priorities that will require cooperation and coordination across different organisations: e.g.. health, social care, criminal justice and housing • Work with providers to help them respond and adapt to the introduction of the tariff; we will particularly focus on maintaining clinical and financial sustainability

Planned care clinical design group – context and clinical priorities

South West London Collaborative Commissioning

National / London context

- Greater specialisation in surgery, the development of comprehensive pathways and the separation of planned and unplanned surgery can lead to better outcomes
- Planned care is often the first to be cancelled when pressure increases on acute capacity
- Advances in surgical techniques, drugs and equipment enable more surgery to be done on a day case basis

Local context

- Average length of stay for elective admissions is lower than the national and London average
- Average cancellation rates above the national / London average

Existing priorities to be further developed

- Development of a multi-specialty elective centre (MSEC)
- Using this experience plan for the shift of further specialties to a "Centre of Excellence"
- Development of clinical networks to support the move to a new centre and develop emergency cover rotas

New priorities

- Identification of other specialties suitable for moving to the "Centre of Excellence"
- Reviewing whether technological advances warrant the centralisation of day case procedures into a MSEC

Priorities for years 1-2 (2014/15-2015/16)

- Engagement with clinical leaders in urology to complete a feasibility study for moving elective procedures to a 'Centre of Excellence'
- Develop a formal clinical network in urology that will support emergency cover provision at all sites through an area-wide rota
- Identify suitable estate for the 'Centre of Excellence' and have transfer all elective surgical procedures in urology to the centre
- Identify additional specialties where inpatient elective procedures are suitable for transfer to a 'Centre of Excellence'
- Clarify the clinical interdependencies between specialties that support a phased transition plan

Priorities for years 3-5 (2016/17-2018/19)

- Implementation of end-to-end pathways for other specialties identified in years one and two
- Updating plans to move other specialties into a 'Centre of Excellence' based on the latest available evidence
- Foster and promote clinical networks within specialties
- Consider whether technological advances warrant the centralisation of some day case procedures into the MSEC
- Monitor the impacts of proposed changes to take a whole health economy view of the system's resilience and sustainability

Transforming primary care clinical design group – context and clinical priorities

South West London Collaborative Commissioning

National / London context

- The King's Fund paper 'Securing the future of General Practice ' argues that general practice teams can no longer work in isolation to meet the increasing demands on primary care

Local context

- The prevalence of conditions affecting the ageing population is increasing, including dementia and falls
- General practice teams are being required to be more productive overall, with consultation rates growing year-on-year
- Patient satisfaction scores for seeing a GP of choice and satisfactory opening hours are below England average

Existing priorities to be further developed

- Review of primary care estates
- Development of additional services to support patients to self-manage, e.g.. 'expert patient programmes' and structured education for an expanding range of long term conditions
- Development of practice networks to take collective responsibility for their 'networked' populations

New priorities

- Development of technology enabled services such as online booking, e-consultations, electronic prescription requests and data sharing

Priorities for years 1-2 (2014/15-2015/16)	Priorities for years 3-5 (2016/17-2018/19)
• Development of practice networks who take a collective responsibility over the health of their 'networked' population • Running a programme of NHS Improving Quality workshops on transforming primary care • Establishing co-commissioning with NHS England • Development of additional services to support patients to self-manage, e.g.. 'expert patient programmes' and structured education for an expanding range of long term conditions • Improved multi-disciplinary working, particularly with mental health services	• Further planning and development of the primary care workforce to support the transition of the existing workforce from acute settings • Invest in new primary care estate which encourages collaborative working between practices • Commission care that brings specialist teams, including geriatricians, psychiatrists, and pharmacists into the community

Urgent and emergency care clinical design group – context and clinical priorities

South West London Collaborative Commissioning

National / London context

- The Keogh review sets out urgent and emergency care as a national priority
- 40% of patients who attend emergency departments in England are discharged without requiring any treatment
- The London Quality Standards for emergency services represent the minimum level of quality which clinicians expect

Local context

- Between 2008/09 and 2012/13, A&E attendances in south west London increased by 13%
- 111 service launched across the area, working as a 'gateway' to urgent and emergency services

Existing priorities to be further developed

- Strengthen the urgent and emergency whole-system, including 111, pharmacies and LAS, and improve connection between services
- Further development of ambulatory emergency care pathways, building on the programme launched in 2013
- Coordination around the use of the Better Care Fund
- Workforce planning and development

New priorities

- Development of technology-enabled care
- Introduction of two levels of emergency departments; Major Emergency Centres and Emergency Centres

Priorities for years 1-2 (2014/15-2015/16)

- Review urgent care services across south west London to assess what needs to be done to achieve the LQS
- Improve access to urgent and emergency care services outside of emergency departments
- Harness the Better Care Fund to improve access to health and social care schemes, such as reablement, and self-care management
- Implement Ambulatory Emergency Care (AEC) pathways to ensure more patients are treated the same day
- Improve patient and public education to promote prevention and self-care
- Linking urgent care services with mental health liaison services

Priorities for years 3-5 (2016/17-2018/19)

- Workforce planning and development to address workforce challenges such as an ageing workforce and adopting to new models of care and 7-day working in the community
- Developing technology enabled care as an alternative to face to face care and to promote self-management
- Support advances in emergency care services where benefits can be realised through a collaborative, strategic approach
- Further engagement to enable implementation of two levels of emergency departments following further national recommendations

Future engagement opportunities

- Clinicians from providers involved in Clinical Design Groups and communications teams to work together keeping NHS staff informed
- Local authorities are key partners – local election purdah a challenge, but aim to work with LAs before and after publication of strategy (June strategy will be high level and unlikely to make site-specific proposals) and CDGs will have social care representation.
- CCGs have engaged with public through Call to Action and over 500 meetings on BSBV – feedback and local HWB strategies will inform 5-year strategy
- Public/stakeholder engagement strategy in development – likely to include large SWL-wide stakeholder event in early May. PPI in programme structures being finalised

REPORT TO:	HEALTH AND WELLBEING BOARD (CROYDON) 26 March 2014
AGENDA ITEM:	7
SUBJECT:	CROYDON HEALTH SERVICES EMERGENCY DEPARTMENT REFURBISHMENT BUSINESS CASE
BOARD SPONSOR:	John Goulston, Chief Executive, Croydon Health Services NHS Trust

CORPORATE PRIORITY/POLICY CONTEXT:

This report summarises the business case for the redevelopment of the Croydon University Hospital (CUH) Emergency Department (ED). The planned redevelopment is being undertaken in response to the urgent and compelling case for change identified by the Croydon Health Services (CHS) Board and recognised and outlined in the Care Quality Commission's (CQC) recent report on the ED. The current ED sees and treats around 120,000 patients annually in buildings designed in the 1980s with an original capacity of 70,000 patients each year. Continuing to provide safe, secure services for patients in the current environment is not sustainable. The Croydon population is projected to continue to grow and to age which will mean continued pressures of demand on urgent and emergency care.

The ED provides care for patients with serious or life threatening conditions. It is staffed by a number of clinicians who specialise in emergency care and who are difficult both to recruit and retain. A key factor for staff wanting to work in EDs is the quality of the environment. Currently, the quality of the ED facilities is a long way from the standards of today's best ED departments and going forward the Trust will not be able to attract high calibre staff if this is not addressed, particularly given the level of investment going into other emergency departments across London, market in which the Trust competes for these staff.

The ED is a critical service for the Trust and represents the front end of the pathway in the Hospital for patients requiring emergency care. The existing design does not support the delivery of an efficient service. CHS continues to deliver against the standard of 95% of patients seen, treated, admitted or discharged within 4 hours. This is a high priority standard for CHS as well as nationally. Changes to the design will enable the ED to operate more efficiently and effectively and ensure resilience.

In addressing these challenges, the proposed ED redevelopment will enable the Trust to provide appropriate standards of care in a building which is fit for purpose and meets the needs of the Croydon community it serves. The proposals for the new ED are fully aligned with Croydon Clinical Commissioning Group's (CCG) Emergency and Urgent Care Strategy and will include a fully integrated, primary care led urgent care centre which will ensure patients who do not require treatment in the ED are seen and cared for in the most appropriate setting.

- **The Community Strategy**. The new ED will ensure patients are seen in the right place at the right time. The Trust will work closely with the team responsible for managing the urgent care centre to ensure patients' needs can be met equally effectively elsewhere. The Trust already has arrangements in place designed to improve General Practitioner (GP) access to the opinion of an acute consultant physicians Monday to Friday, 0900 – 1800 and if required patients can be admitted directly to the Acute Medical Unit. The Trust has introduced a new ambulatory care pathway across a range of conditions which allows patients to be

seen outside of the ED.

- **The Health and Wellbeing Strategy**. The plans for the new ED are aligned with the principles relating to redesign of urgent and emergency care pathways as set out in the Health and Wellbeing Strategy. The new ED model of care will help to ensure patients are only seen in the ED when this is clinically appropriate. This will be underpinned by a fully integrated ED and Urgent Care Centre (UCC) in the new facility which will support close working between ED staff and UCC colleagues.
- The outline business case for redevelopment of the ED is a key priority for the Trust, Croydon CCG, the CQC (in its role as regulator of care standards) and the London Ambulance Service. The scheme is essential to ensure that the ED continues to provide good quality and safe services for the community of Croydon.

FINANCIAL IMPACT:

The need for the new ED facilities is driven by a quality imperative. The investment will enable the ED at CUH to transform into a leading example offering Emergency Services for the local population of Croydon and to address key issues identified by both the Trust and the Care Quality Commission (CQC) in respect of the current provision.

The key benefits of the ED redevelopment scheme are:

- Increased quality and safety of the department.
- Improved clinical environment and better layout leading to a sustained improvement in both the quality of care and productivity
- Flexible capacity to meet future needs.
- Ability to implement new Model of Care offering a better patient experience and more efficient operations.

The tariff system under which the Trust receives income for emergency care provided within the ED generates a loss for the Trust. This is consistent with the national trend to incentivise a reduction in emergency attendances at acute hospitals. The investment of c. £17.5 million of capital investment to fund the new ED will add a further cost pressure to the Trust's existing financial position. The detailed financial implications of the scheme are currently being developed by the Trust and discussions with Croydon CCG are ongoing in relation to the future levels of activity to be commissioned from the Trust.

The Trust has reviewed all aspects of its Cost Improvement Programme (CIP), including 13 CIP schemes based on national experience.

1. RECOMMENDATIONS

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

1.1 understands the key objectives addressing the Trust's and CQC's issues as set out in the Outline Business Case (OBC) for the redevelopment of the ED, supports the case for change; and

1.2 endorses the proposals for redevelopment of the new ED.

2. EXECUTIVE SUMMARY

2.1 The redevelopment of the ED will enable the Trust to address the comments made by the Care Quality Commission (CQC) in its reports, following inspections carried out in July and September 2013. The existing ED is poorly laid out, fragmented with poor sight lines in majors and paediatrics, the environment has inadequate ventilation and cramped facilities. The design solution included in the preferred option addresses the points raised in the latest CQC reports as follows:

- up-to-date design enabling a more suitable environment for maintenance through the replacement of the temporary / modular buildings;
- significant improvements in the space standards, with appropriate spaces for clinical activities. The open layout with central staff areas greatly improves the visibility and observation of all patients by staff;
- designed to Health Building Note (HBN) standards;
- generic nature of the spaces allowing for greater flexibility for future use and providing significant opportunities for the ED to work in a different way.

The redevelopment will address the environmental conditions and will enable patients to be seen in an appropriately specified space. It also addresses the privacy and dignity issues currently experienced within the existing department.

2.2 The Strategic Outline Case (SOC) for the ED Redevelopment has been approved in April 2013 and an initial OBC was issued in December 2013. A revised OBC (with updated financial information) is currently being prepared and will be issued to the Trust Development Authority (TDA) in April 2014. The Full Business Case (FBC) will be issued in August 2014 for approval by the TDA.

2.3 The redevelopment proposals are consistent with the Croydon CCG/Croydon Council integrated strategic operating plan which is aligned to the Health and Wellbeing Strategy. The OBC draws upon the epidemiological and demographic assumptions within the Croydon Joint Strategic Needs Assessment.

2.4 The Trust has worked closely with Croydon CCG on the development of the ED scheme. The proposals reflect the key principles set out in the CCG Urgent and Emergency Care Strategy in relation to the top 5 priorities with particular emphasis on improving system access and improving patient care and flow within the ED and the hospital.

2.5 The OBC also aligns with the whole system pathway, elderly frail pathway and children's pathway for Level 4 Specialised Services and how they relate to ED and UCC services.

2.6 The Trust has recognised that it has an important role to play in demand management for the ED. Over the past 18 months, the Trust has explored the scope for addressing demand management.

2.7 The Trust has undertaken considerable joint working to date with a wide range of stakeholders on a number of QIPP initiatives. These initiatives include:

- Implementing new model of care – GP referred patients
- Introduction of ambulatory pathway
- Diverting activity to UCC

The Trust will recognise this important work and will ensure this is reflected adequately in the updated OBC.

2.8 The Project Team has developed the outline design for the new ED to include the level of engagement with clinical and other stakeholders, and ensure that flexibility has been incorporated to enable the new ED to flex to meet changing needs over time, notably in relation to different activity and capacity requirements.

2.9 A fundamental difference with the ED will be the new ways of working reflecting best practice nationally. These changes will lead to an improved patient experience and a more efficient and effective ED. The new ED will enable:

- proactive management of patients;
- generic use of space which leads to efficient use of the department and leads to areas having multi use;
- an increase in the efficient delivery of care due to improved visibility and observation (complemented by the CRS Millennium (Cerner) clinical information system)
- clinicians to move to the patients not the patient to the clinician reducing hand offs and improving safety;
- timely intervention as the clinical spaces will be equipped with appropriate lighting and equipment to perform minor procedures and treatments;
- improvement in patient flow and management as the design affords areas to be opened or closed depending on activity and demand; and
- identifying clinically how teams want to work and allowing the estate to respond to clinical need and requirements.

2.10 The new ED provides a major the opportunity for the Trust to make a step change in the quality and efficiency of care it offers to the community it serves; a case which the CQC believes is urgent and compelling.

3. DETAIL

3.1 Background

3.1.1 The ED at CUH provides Accident and Emergency care for local patients and visitors in the Croydon area. It has an integrated Urgent Care Centre (UCC) which is operated by the private provider Assura Wandle, a partnership between 29 local GP practices and Virgin Care. There is a separate area within the ED for children under 16.

The department was built in the 1980's with an upgrade in the 1990s in temporary / modular build to accommodate the increase in demand. Currently activity of 120,000 patients is significantly in excess of the 70,000 patients the department was designed to serve.

The department is poorly laid out and fragmented with poor sight lines in majors and paediatrics. The environment is poor with inadequate ventilation and cramped facilities.

3.1.2 The redevelopment of the ED will enable the Trust to address the comments made by the Care Quality Commission (CQC) in its reports, following inspections carried out in July and September 2013.

3.2 Funding Process

3.2.1 The Outline Business Case (OBC) for the ED Redevelopment has been prepared to consider options for refurbishment and reconfiguration of the ED at CUH. The OBC follows on from a Strategic Outline Case (SOC) which received approval in April 2013. The OBC sets out the case for investment in improved and expanded facilities to support the future delivery of high quality Emergency services. It demonstrates that the proposed investment offers the best available solution to address the inadequacies of the current environment and would allow the flexibility to adapt to future changes in activity.

3.2.2 The OBC was approved by the CHS Board on the 25th November 2013 for submission to the TDA. The project is being funded from public dividend capital made available from the Department of Health (DH) via NHS TDA. The OBC has been prepared in accordance with HM Treasury's best practice 'Five Case Model' and Business Case guidance from the TDA.

3.2.3 As part of the funding process the NHS TDA requires that a SOC, an OBC and FBC are submitted for all business cases with a value that exceeds £10 million. In addition NHS Trusts need to complete the generic business case checklist provided by the TDA and this is submitted with each OBC and FBC version of the business case.

3.2.4 The OBC reflects the broad range of healthcare needs covered by emergency and urgent care services:

- the implementation of the Transforming Adults and Community Services (TACS) business case which the Trust has implemented in its role as an Integrated Care Organisation which is commissioned by Croydon CCG;
- responding to the National Dementia Strategy – the Trust's existing ED includes a dementia zone, one of the first in the country to do so, which will be incorporated into the new ED; a proposal for better line of sight to enable the new ED to respond more effectively to the complex needs of mental health patients; and
- continued co-location of the UCC which will be fully integrated with the new ED and which will include a dedicated paediatric area.

3.2.5 All of Croydon CCG's strategies (Primary and Community, Self-Care, Prevention and Shared Decision Making) focus on preventing ill health in the first place, facilitating more 'self-care' (people doing more to treat minor illnesses and injuries) and improving access to primary and community care. Further, the Urgent and Emergency Care Strategy follows the same emphasis to ensure that people are seen in the right place, right time, first time. The OBC and the design of the scheme fully embrace these principles.

3.2.6 A revised OBC will be issued to the TDA in April 2014 and the FBC will be issued to the TDA in August 2014 for approval.

3.3 Design Process

3.3.1 The Trust established a Project Team to undertake a comprehensive options appraisal process. A list of nine options was considered including both a Do Nothing and a Do Minimum option. The options were developed and appraised in conjunction with the Project Team and User Groups reporting to the ED Project Board.

3.3.2 The following constraints were applied in order to produce a short list of options

- Options must allow the continued provision of the ED during the development period (Constraint 1);
- Proposals should clearly demonstrate that future services can be delivered within the financial constraints of the Trust and its commissioners (Constraint 2);
- Proposals should ensure that capacity is available to meet activity forecasts including the flexibility to adapt to changed activity (Constraint 3).

3.3.3 The weighting of criteria was carried out in a workshop attended by key stakeholders. Non-financial benefits were assessed to give a weighted benefits score for the short-listed options. Quantified benefits (savings) were included in the revenue costs for the options and used in the value for money comparison.

The risk comparison of options focussed on qualitative risks. A detailed Risk management register will be developed during the development of the FBC.

3.3.4 Following the assessment the preferred option was identified. This option (Option F) is to refurbish the whole of the ED, replacing current modular facilities and providing limited new build components to achieve an appropriately configured and designed ED service, able to deal with the volume of activity the department is required to manage going forward.

The scope of the Project is as follows:

- ED Services for both Adults and Children
- Urgent Care Centre Services for both Adults and Children
- Associated ED equipment
- Associated infrastructure
- Requisite enabling works (including requisite decanting works).

The proposed departmental layout will improve visibility and patient flows as well as access and adjacencies, and thus enable staff to provide the best care. The design incorporates the ability to 'flex' key areas, so as to accommodate periods of high demand on the service. The projected activity is in line with current Trust projections. In addition, the design enables the build to be extended appropriately should there be significant changes in the provision of emergency care in the health economy.

The layout for the preferred option is attached as an appendix to this report.

4 CONSULTATION

4.1 During the development of the OBC the following stakeholders were consulted:

- Croydon CCG
- Croydon Council
- Croydon Planning Department

We have received letters of support from Croydon Council and Croydon Planning Department and have an initial letter from the CCG which acknowledges the case for change.

4.2 During the design stage the following stakeholders were advised and engaged with and their comments incorporated in the design:

- Trust Clinical Team from ED including medical, nursing, administrative and management personnel responsible for delivering the clinical services within the main department;
- Members of Virgin Care including medical, nursing and administrative and estates personnel responsible for the delivery of 'front end' Urgent Care services; and
- Clinicians from South London and Maudsley mental health team.
- London Ambulance Services with regard to the design and the decant strategy.
- CCG who have representation on the Project Board.

4.3 Currently the Outline Design has been completed with the drawings at 1:200. All the designs have been developed with the User Groups and further detailed layouts will be signed-off by the ED and the Project Board. Membership of the User Groups has included representation from the CCG, Assura Wandle LLP, London Ambulance Service, South London & Maudsley Trust and the Trust's Infection Control Team.

4.4 The Project Team presented the ED Redevelopment Project at the IPEC (Improving Patients Experience Committee) on 29th November 2013, which was attended by patient representatives, to brief them on the proposals.

4.5 Going forward, the Trust recognises its engagement activities need to be expanded to reach out more effectively to wider stakeholders. This will be a priority as the Trust moves on to development of the Full Business Case (FBC). The Trust will pay particular attention to engaging with users and the public. It is intended that the project team will present the scheme in a public location in the hospital for members of the public and patients to ask questions and make comments. The comments will then be reviewed at the Project Team meetings as part of the process. While there has been consultation with users through the design development process, this will be expanded as part of the wider engagement strategy. The Project Board governance has been strengthened to include a Non-Executive Director and patient/user representation.

4.6 The Trust will also focus on extending engagement with the Health and Wellbeing Boards as key stakeholders for the new ED project.

5 SERVICE INTEGRATION

5.1 In providing a new facility, the ED will be fully aligned with the CCG Urgent and Emergency Care Strategy. The following elements are identified in supporting these improvements:

- Full integration of the ED and UCC as part of a single pathway with robust gateways and thresholds.
- Close co-operation with all of the Trust's partners to ensure only appropriate attendance at the ED. This will include close working with the London Ambulance Services in how the new facility is operated to minimise inappropriate ambulance attendances.
- Clear communication strategy and effective signposting to ensure that service users are directed to appropriate non-ED services.
- Implementation of the Transforming Adults and Community Services (TACS) business case which the Trust has implemented in its role as an Integrated Care Organisation which is commissioned by Croydon CCG.

6 FINANCIAL AND RISK ASSESSMENT CONSIDERATIONS

6.1 Revenue and Capital consequences of report recommendations

The financial implications of the proposed ED do not affect any of the partner organisations other than Croydon CCG. We have discussed and agreed future activity and income levels with the CCG. The basis of this agreement will be modeled within the revised OBC to be submitted to the Trust Development Authority in April 2014.

In preparing the OBC, the Trust has focused both on the CIP and Quality, Innovation, Productivity and Prevention (QIPP) aspects in the development of plans for the new ED. The Trust has reviewed in detail its CIP plans and looked at a range of 13 potential ED CIP schemes based on national experience. This has identified no additional opportunity for Croydon Health services (CHS) ED CIP savings beyond those factored in relating to substituting substantive for agency nursing posts.

6.2 Risks

A project risk workshop was held to determine risk headings and agree risk ratings 'prior to mitigation'. The meeting was attended by representatives of the Project Team and the Trust. The risks where established and loadings discussed and agreed against each heading. A mitigation strategy for the risks were agreed and will be reviewed during the development of the FBC.

6.3 Options

The option appraisal was carried out as described items 3.3.1 to 3.3.2 earlier in this report. The costs for the preferred option were within the costs approved in the SOC.

6.4 Future savings/efficiencies

The new ED will enable modest savings to be realised through being able to recruit to a number of substantive posts, thus avoiding premium agency costs, and the saving of one post through service redesign (albeit with no redundancies). However, the scheme will be a cost pressure for the organisation and the fundamental rationale for the new ED is to improve significantly safety and quality of care for patients.

7 LEGAL CONSIDERATIONS

There are no significant legal issues identified arising from the ED scheme.

8 HUMAN RESOURCES IMPACT

8.1 The new ED, with its improved environment, will assist the Trust in retaining and recruiting staff.

8.2 The Trust has developed a workforce strategy for the new ED. This comprises:

- Foundations of Emergency practice course for newly qualified Nurses in ED.
- Emergency Nurse Practitioners/Paramedics role to allow senior nurse and paramedics to use and develop skills and knowledge in Emergency care predominately in the Resuscitation room.
- Band 5-8 Development map which is a guide to mapped development, education and competency assessment for each level and grade.

Elements relating to paediatric workforce strategy covering: enhanced assessment skills for nurses; supporting co-location of safeguarding staff; and supporting future development opportunities for paediatric nursing staff.

9 EQUALITIES IMPACT

9.1 It is not envisaged that there will be any significant service change as a result of the ED scheme. However, as part of the detailed Full Business Case the Trust will be undertaking a full equality impact assessment.

10 ENVIRONMENTAL IMPACT

10.1 The new ED will be developed in broadly the same location as the existing department. It is not envisaged that there will be any significant environmental impact, although it is likely to lead to an improved façade to the ED and better access for patients and ambulances.

10.2 The completed building will be rated as BREEAM Excellent and will provide a more energy efficient facility than the existing ED with reduced running costs.

11 CRIME AND DISORDER REDUCTION IMPACT

11.1 Although there are no crime or disorder considerations arising from the ED Outline Business Case by implementing some of the measures identified in the document 'Reducing violence and aggression in A&E' there should be a reduction in assaults on staff. The layout of the new design and good visibility will also improve safety for the staff and patients.

CONTACT OFFICER: Karen Breen, Chief Operating Officer,
Croydon Health services.
Karen.Breen@croydonhealth.nhs.uk,
Tel no: 020 8401 3000 extension 4191

BACKGROUND DOCUMENTS

Appendix A – Proposed Layout – Option F	
Appendix B – Strategic Programme	

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Proposed ED GF Plan

Croydon University Hospital

Key

- Working with Existing Structure
- Subterranean Duct

Notes

Rev. A - 18/10/13
Layout of Majors, UCC & Support Space Amended

Rev. B - 08/11/13
Layout Amended as per Comments from the Trust

Rev. C - 11/11/13
Layout Amended as per Comments from the Design Team

DO NOT SCALE OFF DRAWING
REPORT ALL DISCREPANCIES
CHECK ALL DIMENSIONS ON SITE

NORTH

SCALE - 1:200 @ A1 (1:400 @ A3)

0 5 10 15 20m

PRELIMINARY

PROPOSED ED GF PLAN
at
CROYDON UNIVERSITY HOSPITAL

2612/00_100 Rev: C
11 October 2013
1:200 @ A1 (1:400 @ A3)

MURPHYPHILIPPS
140 Old Street Tel: 020 7490 8008
London EC1V 9BJ Fax: 020 7490 8778

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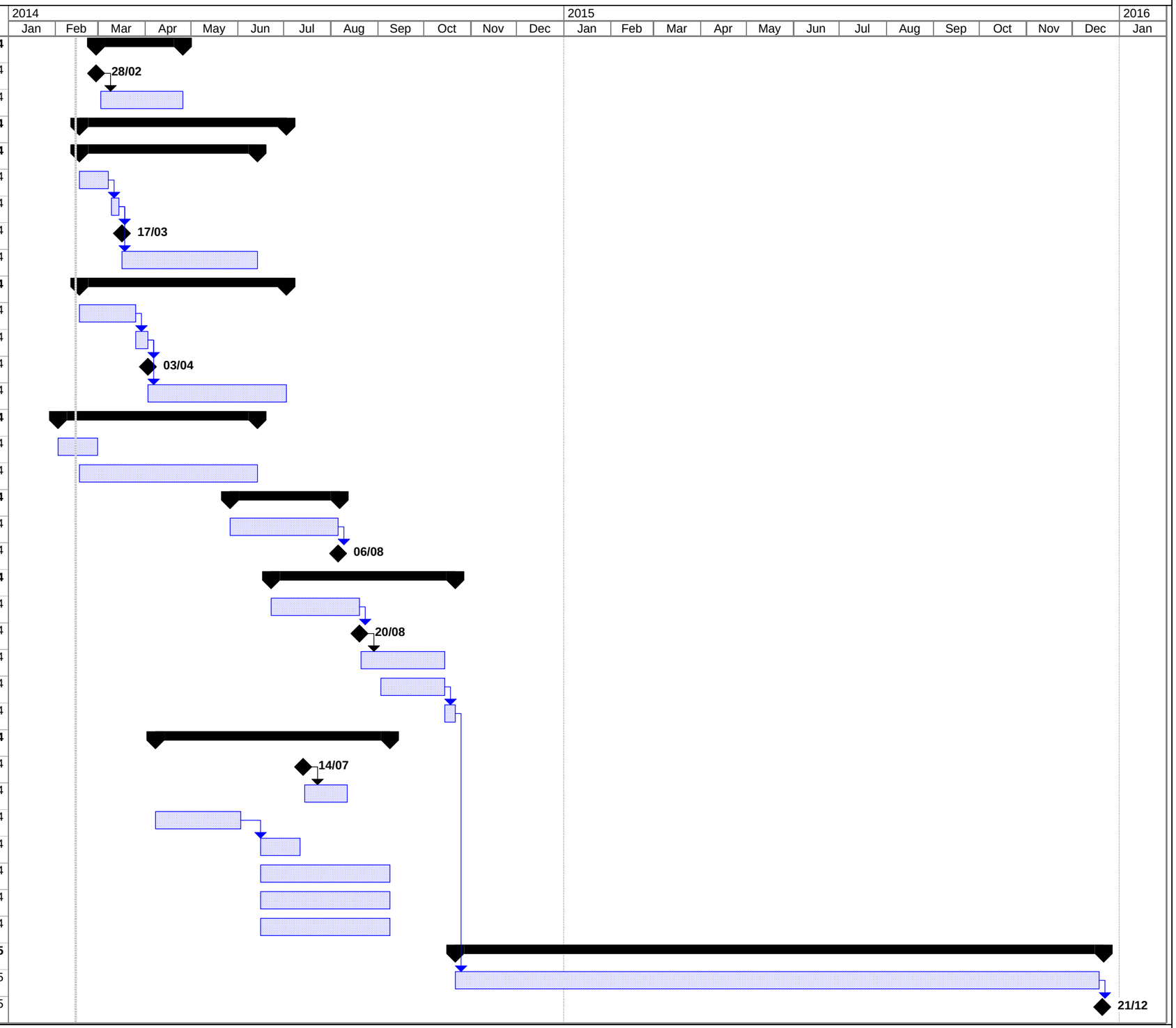
ED REDEVELOPMENT
CROYDON UNIVERSITY HOSPITAL
PROGRAMME OVERVIEW

Fri 14/02/14

ID	Task Name	Start	Finish
1	**OBC PROCESS**	**Fri 28/02/14**	**Fri 25/04/14**
2	Issue OBC Checklist	Fri 28/02/14	Fri 28/02/14
3	OBC Approval Process	Mon 03/03/14	Fri 25/04/14
4	**PLANNING PROCESS**	**Mon 17/02/14**	**Wed 02/07/14**
5	**Decant Works**	**Mon 17/02/14**	**Fri 13/06/14**
6	Prepare Drawings/ Documents	Mon 17/02/14	Fri 07/03/14
7	Documents/ Drawings Approval by Trust	Mon 10/03/14	Fri 14/03/14
8	Issue Planning	Mon 17/03/14	Mon 17/03/14
9	Determination Period	Mon 17/03/14	Fri 13/06/14
10	**Main Works**	**Mon 17/02/14**	**Wed 02/07/14**
11	Prepare Drawings/ Documents	Mon 17/02/14	Tue 25/03/14
12	Documents/ Drawings Approval by Trust	Wed 26/03/14	Wed 02/04/14
13	Issue Planning	Thu 03/04/14	Thu 03/04/14
14	Determination Period	Thu 03/04/14	Wed 02/07/14
15	**STAGE 3**	**Mon 03/02/14**	**Fri 13/06/14**
16	Surveys	Mon 03/02/14	Fri 28/02/14
17	Detailed Design Information	Mon 17/02/14	Fri 13/06/14
18	**GMP**	**Tue 27/05/14**	**Wed 06/08/14**
19	BQ Production and Tender Process	Tue 27/05/14	Tue 05/08/14
20	Issue GMP	Wed 06/08/14	Wed 06/08/14
21	**FBC PROCESS AND CONTRACT**	**Mon 23/06/14**	**Tue 21/10/14**
22	Trust Prepare FBC	Mon 23/06/14	Tue 19/08/14
23	Submit FBC to TDA	Wed 20/08/14	Wed 20/08/14
24	TDA Approval Process	Thu 21/08/14	Tue 14/10/14
25	Prepare Contract Documents	Wed 03/09/14	Tue 14/10/14
26	Sign Contract with PSPC	Wed 15/10/14	Tue 21/10/14
27	**DECANT WORKS**	**Tue 08/04/14**	**Mon 08/09/14**
28	Kenley 1 Vacated to Dementia	Mon 14/07/14	Mon 14/07/14
29	Kenley 1 Works	Tue 15/07/14	Mon 11/08/14
30	Kenley 2 Works	Tue 08/04/14	Mon 02/06/14
31	Norwood Works	Mon 16/06/14	Fri 11/07/14
32	Temporary Building for UCC (with lead-in)	Mon 16/06/14	Mon 08/09/14
33	Temporary Building to extend Majors	Mon 16/06/14	Mon 08/09/14
34	Temporary Building to extend Paeds	Mon 16/06/14	Mon 08/09/14
35	**MAIN BUILD CONSTRUCTION WORKS**	**Wed 22/10/14**	**Mon 21/12/15**
36	Construction Works inc Mobilisation	Wed 22/10/14	Fri 18/12/15
37	Areas available for occupation	Mon 21/12/15	Mon 21/12/15



Project: 140214 ED Redevelopment H
Date: Fri 14/02/14

Task | Progress | Summary | External Tasks | Deadline
Split | Milestone | Project Summary | External Milestone

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REPORT TO:	**HEALTH AND WELLBEING BOARD (CROYDON)** **Date: 26th March 2014**
AGENDA ITEM:	**8**
SUBJECT:	**DRAFT - Croydon CCG 2 Year Operating Plan**
BOARD SPONSOR:	**Paula Swann, Chief Officer, Croydon CCG**

CORPORATE PRIORITY/POLICY CONTEXT:

Croydon CCG Operating Plan sets out the plans to deliver our strategic direction and ambitions over the next two years 2014/15 and 2015/16. The strategic direction aligns to the Health and Wellbeing priorities 2013/18:

1. increased healthy life expectancy and reduced differences in life expectancy between communities
2. increased resilience and independence
3. a positive experience of care

To drive forward the outcomes and ambitions described within the plan, Croydon CCG has agreed joint strategies with LBC and wider stakeholders which include the Health and Wellbeing Strategy and Transformation Strategy.

The CCG has also developed in conjunction with its member practices and public its' Prevention, Self-Care and Shared Decision Making Strategy, Primary and Community Care Strategy, and a Whole Systems Urgent and Emergency Care Strategy signed up by all partners delivering urgent and emergency care and a Mental Health Strategy.

These strategies set the direction to transform how we deliver our services. The main priority for how we commission our services is to ensure that the public receive the right care, in the right place at the right time.

In the current financial environment and with the growth in our populations it is vital we keep challenging how we deliver our services to ensure sustainability in quality and the management of demand.

Within all our pathway redesign and reflected within the Operating Plan is the emphasis on prevention, self-care and shared decision making where appropriate to do so.

FINANCIAL IMPACT:

The 2 year Operating Plan sets out Croydon CCG ambitions to reduce the inherited financial deficit, through quality, innovation and productivity and prevention plans. These are described in section 14.

1. RECOMMENDATIONS

This report is for information on the progress in development of Croydon CCG 2 Year Operating Plan.

The HWBB considers the planned improvements in quality premium measures and the specified increased level of reporting of medication errors from specified local providers between Q4,2013/14 and Q4, 2014/15 (page 22).

2. EXECUTIVE SUMMARY

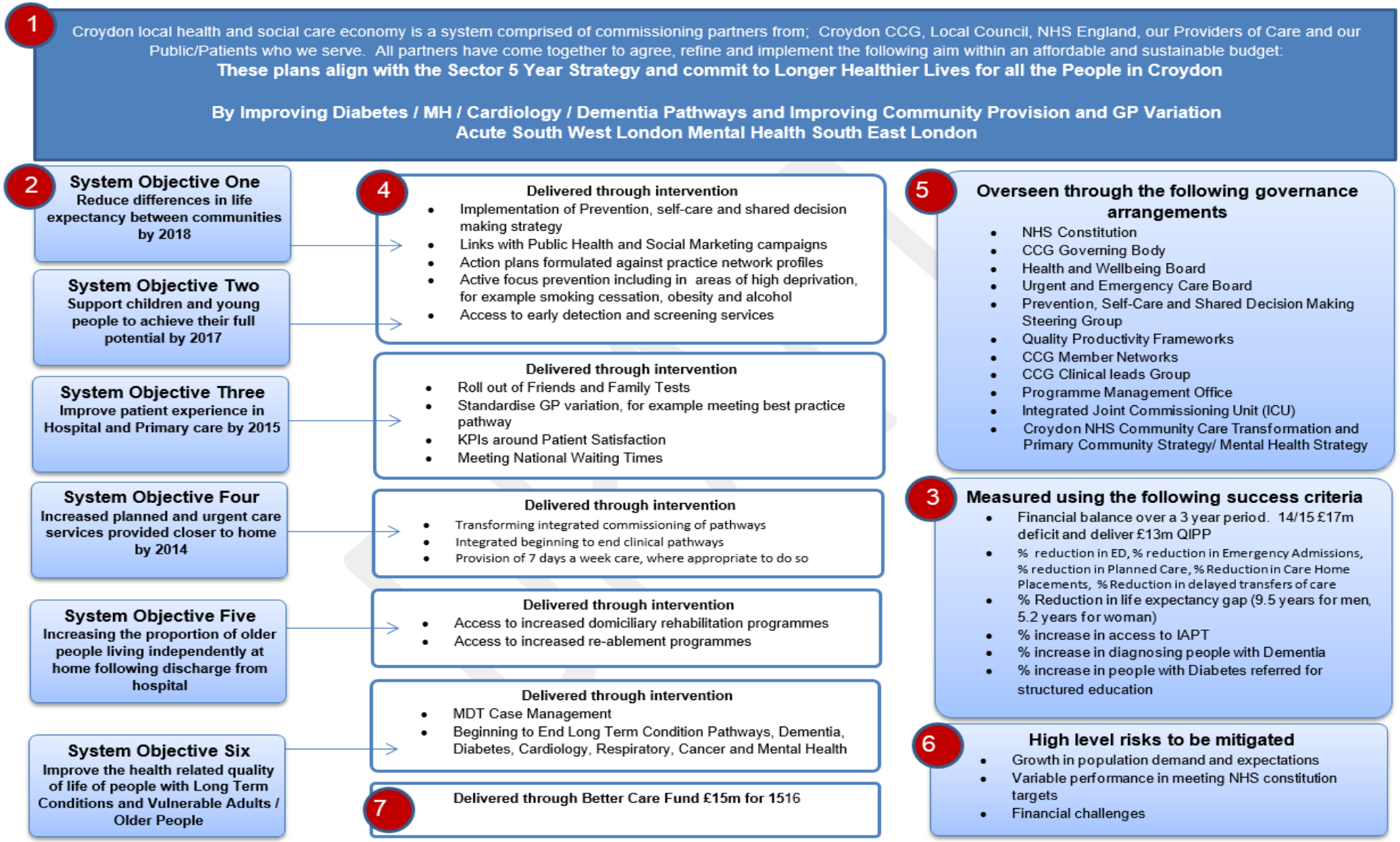
2.1 As part of Everyone Counts Planning for Patients 2014/15 and 2015/16 Croydon CCG is required to develop a 2 Year Operating Plan, in addition to this a 5 Year Sector Strategic Plan is also due to be submitted in Draft on 4 April and finalised in June 2014.

2.2 Croydon CCG is working with SWL sector in developing the 5 Year Strategy and is also taking the opportunity to further refresh its 5 Year Strategy with further emphasis on for example Out of Hospital Care, Integration, outcomes based commissioning and Parity of Esteem.

2.3 NHS England, guidance for the 2 year Operating Plan sets out key national overarching aims, these include:

- Reducing the number of potential years of life lost (PYLL) from treatable conditions
- Improving the health related quality of life of people with one or more long-term conditions and being prepared for the predicted rise of people with dementia
- Reducing the amount of time people spend avoidably in hospital
- Increasing the proportion of older people living independently following hospital discharge
- Reducing the proportion of people reporting a very poor experience of inpatient care and primary care
- Making significant progress towards eliminating avoidable deaths in our hospitals.

2.4 In response to this Croydon CCG has agreed the following overarching framework. Formal sign off is due in April 2014 by the CCG Governing Body



3. DETAIL

3.1 The Draft Operating Plan can be viewed by clicking on the link provided under 'Background Documents'; the detail within the Operating Plan covers:

- Our Challenges
- National Priorities
- Our Priority Programme Areas
- Our Financial Position
- Our Commissioning Enablers

3.2 It also updates on progress to date with baseline information that is required to populate the templates see excel CCG Commissioning Outcomes Template and Provider/Commissioning Template.

3.3 National guidance encourages CCGs to explicitly discuss with their Health & Well Being Boards their proposed quality premium measures.

3.4 The 'quality premium' is intended to reward clinical commissioning groups (CCGs) for improvements in the quality of the services that they commission and for associated improvements in health outcomes and reducing inequalities.

Area	In Appendix pages 14 - 22 (see 'Background Documents' link at end of paper)
Self-Certification	NHS Constitution CIPs HCAIs / MRSA
Ambitions for Improving Outcomes	Outcome Ambition 1 E.A.1: i) What is your ambition for securing additional years of life from conditions considered amenable to healthcare? Outcome Ambition 2 E.A.2: ii) What is your ambition for improving the health-related quality of life for people with long-term conditions? Outcome Ambition 3 E.A.4: iii) What is your ambition for reducing emergency admissions? Outcome Ambition 5 E.A.5: iv) What is your ambition for increasing the proportion of people having a positive experience of hospital care? Outcome Ambition 6 E.A.7: v) What is your ambition for increasing the proportion of people having a positive experience of care outside hospital, in general practice and the community?
Quality Premium Measures	E.A.1: i) Potential years life lost (PYLL) from amenable causes in 2014/15 E.A.4: ii) What trajectory are you aiming for in the composite avoidable emergency admissions indicator in 2014/15? E.A.3: iii) For IAPT, what proportion of people that enter treatment against the level of need in the general population are planned in 2014/15 and 2015/16? E.A.6: iv) Do you plan meet the nationally set objective for the Friends and Family Test in 2014-15 and 2015/16? Yes/No E.A.9: v) Have you agreed (in conjunction with your Health and Wellbeing Board and NHS England area team) a specified increased level of reporting of medication errors from specified local providers between Q4, 2013/14 and Q4, 2014/15? vi) Where there are requirements for Quality Premium measures and/or planned levels of improvement to be agreed with the relevant Health and Wellbeing Board and NHS England area team, do you have their agreement to each of these?
Local Priorities	Local Priority 1: C2.5 People with diabetes diagnosed less than a year who are referred to structured education.
Other Measures	E.A.S.5 i) Number of C.Difficile infections in 2014/15 E.A.S.1 ii) What dementia diagnosis rate are you aiming for in 2014/15 and 2015/16 E.A.S.2 iii) What level of IAPT recovery are you aiming for in 2014/15 and 2015/16?
A&E Activity	Baseline data against MAR

4. CONSULTATION

4.1 The priorities with the Operating Plan follow the same themes that were widely consulted on in developing the 5 Year Integrated Strategic Operating Plan 2013/14. NHS England in setting its national ambitions has worked with a wider range of stakeholders to agree these and Croydon CCG through networks, established steering groups, patients participation groups has continually consulted on pathway redesign and local priorities.

5. SERVICE INTEGRATION

5.1 The Operating Plan sets out the pathways redesign for the priority areas.

6. FINANCIAL AND RISK ASSESSMENT CONSIDERATIONS

6.1 Not Applicable

7. LEGAL CONSIDERATIONS

7.1 Not applicable

8. HUMAN RESOURCES IMPACT

8.1 Not applicable

9. EQUALITIES IMPACT

9.1 The operating plan seeks to reduce health inequalities in Croydon. A full assessment of the impact of the plan will be carried out within the next two weeks prior to submission to NHS England.

10. ENVIRONMENTAL IMPACT

10.1 Not Applicable

11. CRIME AND DISORDER REDUCTION IMPACT

11.1 Not Applicable

CONTACT OFFICER: Kendel Fairley, Director, Kendel Fairley Consulting Ltd.
Email: kf@kendelfairley.com

BACKGROUND DOCUMENTS
CCG Operating Plan 2014-16
http://egeprapwv01lc.lbcbau.croydon.net/akscroydon/images/att3615.pdf

REPORT TO:	**HEALTH AND WELLBEING BOARD (CROYDON)** **26 Mar 2013**
AGENDA ITEM:	**9**
SUBJECT:	**Commissioning priorities 2014-15 for Children and Families Partnership**
BOARD SPONSOR:	**Paul Greenhalgh, Executive director – children, families and learning, Croydon council**

CORPORATE PRIORITY/POLICY CONTEXT:

This report shows how the Children and Families Partnership addresses the following improvement areas in the Health and Wellbeing Strategy

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

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

FINANCIAL IMPACT:

Not applicable

1. RECOMMENDATIONS

This item is for information from the Croydon Children and Families Partnership

2. EXECUTIVE SUMMARY

2.1 This report informs the Health and Wellbeing Board of the commissioning priorities for children's health and care services from the Children and Families plan 2014-15. The plan was agreed by the Children and Families Partnership and then Council Cabinet on 10 Feb 2014 and is appended to this report.

3. DETAIL

3.1 The Children and Families Plan 2014-15 set out the commissioning priorities for health and care services which will inform the work programme of the new children's integrated commissioning team in the joint Council and Clinical Commissioning Group's integrated commissioning unit.

3.2 These are shown below and have been updated to take account of developments since 10 Feb 2014 when the plan was agreed.

3.3 **Joint Council and Clinical Commissioning Group priorities for children's services are:**

- Implementing children's emotional health and well-being strategy.
- Improving health, education and training outcomes for Looked After Children
- Implementing single assessment and planning for children with learning difficulties and disabilities including transition to adulthood and development of local offer.
- Implementing jointly commissioned Speech and Language Therapy services.
- Implementing the outcome of School Nursing Commissioning Review.
- Preparing for commissioning of health visiting and Family Nurse Partnership from 2015.
- Increase the impact of early intervention through commissioning
- Strengthen the consistency of engagement of children, young people and families across partnership and commissioning
- Meeting the health needs of increasing numbers of children.

3.4 **Clinical Commissioning Group's additional priorities for children's services:**

The CCG additionally has a number of other priorities for children's services detailed in pages 34 and 55 of the 2 Year Operating Plan, which will be finalised by the 4th April 2014.

3.5 **Council's additional priorities for children's health-related services are:**

- Reducing childhood obesity, including through implementation of the new weight management service contracts.
- Ensuring that children are safe from maltreatment, neglect and abuse (Croydon Safeguarding Children Board) and continue to strengthen children's social care.

4. CONSULTATION

4.1 See appended plan

5. SERVICE INTEGRATION

5.1 See appended plan

6. FINANCIAL AND RISK ASSESSMENT CONSIDERATIONS

6.1 Not applicable

6.2 (Approved by: Lisa Taylor, Head of Departmental Finance, Children, Families and Learning)

7. LEGAL CONSIDERATIONS

7.1 Not applicable

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

8. HUMAN RESOURCES IMPACT

8.1 Not applicable

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

9. EQUALITIES IMPACT

9.1 An equalities impact assessment is due to be completed for the detailed action plans by end of June 2014.

10. ENVIRONMENTAL IMPACT

10.1 Not applicable

11. CRIME AND DISORDER REDUCTION IMPACT

11.1 See appended plan

CONTACT OFFICER: Amanda Tuke, head of partnerships and children's integrated commissioning, Integrated Commissioning Unit, Croydon Council/Croydon Clinical Commissioning Group]
amanda.tuke@croydon.gov.uk

BACKGROUND DOCUMENT
Children & Families Plan 2014-15
http://egeprapwv01lc.lbcbau.croydon.net/akscroydon/images/att3640.doc

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REPORT TO:	**HEALTH AND WELLBEING BOARD (CROYDON)** **26 March 2014**
AGENDA ITEM:	**10**
SUBJECT:	**Domestic Violence Joint Strategic Needs Assessment 2013/14**
BOARD SPONSORS:	**Mike Robinson, Director of Public Health** **Hannah Miller, Director of Adult Services, Health and Housing** **Paul Greenhalgh, Director of Children, Families and Learning** **Paula Swann, Chief Officer, Clinical Commissioning Group**

CORPORATE PRIORITY/POLICY CONTEXT:

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

FINANCIAL IMPACT:

There is no financial impact arising directly from this report.

1. RECOMMENDATIONS

This report recommends that the health and wellbeing board:

1. Consider the domestic violence JSNA chapter, approve the document in principle and delegate final approval of any further amendments to the responsible directors
2. Note the conclusions from the report

2. EXECUTIVE SUMMARY

2.1 The domestic violence Joint Strategic Needs Assessment is one of 4 needs assessments forming part of Croydon's JSNA in 2013/14.

2.2 The aim of the domestic violence JSNA chapter is to provide an overview of the local prevalence, patterns and trends around domestic abuse and sexual violence, and to enable the benchmarking of Croydon's efforts to reduce DV. The chapter includes an assessment of the current evidence of best practice and a mapping of local services.

2.3 **The DV JSNA chapter was started at a time when a Croydon Domestic Violence Strategy was already in place and a newly formed Domestic Abuse and Sexual Violence Group (DASV) had taken the lead in developing and implementing a local action plan. Throughout the development of the JSNA, emerging data and evidence for effective interventions have been taken into account to inform the action plan.**

2.4 Key issues that will be of particular interest to the Health and Wellbeing board are:

2.5 Croydon has a Borough wide strategic approach to tackling domestic violence. Information on the current prevalence, patterns and trends of DV will enable improved targeting of interventions and resources as well as the evaluation of the results of interventions. An overview of best available evidence of effectiveness of interventions will support strategic planning. The results of an extensive local service mapping will support the commissioning of services.

2.6 The DV JSNA chapter uses the 2013 Home Office definition of DV as any incident of controlling, coercive, threatening behaviour, violence or abuse between those aged 16 or over who are, or have been, intimate partners or family members regardless of gender or sexuality. The abuse can encompass, but is not limited to psychological, physical sexual, financial and emotional abuse. The new definition includes so called 'honour' based violence, female genital mutilation (FGM) and forced marriage.

2.7 Using British Crime Survey data, it is possible to estimate the expected prevalence of domestic violence and abuse in Croydon. It is likely that around 13,700 women and 8,800 men experienced at least one incident of domestic abuse during 2011/12. It is likely that during the same period around 12,160 women experienced four or more incidents of domestic abuse (with a mean average of 20 incidents) and just fewer than 1,000 men experienced four or more incidents (with a mean average of 7 incidents).

2.8 In contrast to the expected prevalence, there were just fewer than 6,000 allegations of domestic abuse in Croydon in 2011/12, with around 1,800 of these being allegations of violence of a serious nature, including grievous and actual bodily harm, rape and harassment. However, there is almost certainly a large underreporting as to the actual extent of domestic violence and abuse in the borough.

2.9 There has been a 8.6% increase in domestic violence allegations in Croydon, and a 4% increase in offences in the period from September 2012 to August 2013. Croydon has the largest number of offences by volume, but it ranks 19th out of 32 London boroughs in terms of rates of domestic violence offences per 1000 population. Croydon's domestic violence rate per 1,000 population at 7.0 is higher than the average for similar Crime and Disorder Reduction Partnership (CDRP) boroughs (5.7) and for London as a whole (6.4). However the increase in offences at 4% is less than the CDRP borough average (5.8%) and London's percentage increase of 6.4%.

2.10 Over the longer term, domestic violence offences in Croydon have remained roughly constant or even shown a slight decrease.

2.11 Data on 'honour' based violence; FGM and forced marriage are not currently systematically collected in Croydon, although these may be common within a number of local communities.

2.12 The majority of recorded victims of DV in Croydon are women aged 21-30 (586 allegations) followed by women aged 31-40 (426 allegations).

2.12.1 There is a small number of recorded allegations of what could be considered elder abuse.
2.12.2 There are very poor data on domestic violence and abuse within LGBT communities.
2.12.3 An association between ethnicity and domestic violence allegations in Croydon cannot be demonstrated.

2.13 In February 2014, NICE issued Public Health guidance on Domestic violence, outlining evidence for cost-effective interventions for the prevention and response to DV.

2.14 The draft recommendations from reviews of two local domestic homicides have been included into chapter conclusions and into the local DV action plan.

2.15 Conclusions from the JSNA chapter have been fed into the development of the local action plan on DV:

1. Domestic Abuse and Sexual Violence Group (DASV) to have a named lead from every local partner agency.

2. DASV to lead on the evaluation of the impact of local interventions.

3. Safer Croydon Partnership and Domestic Abuse and Sexual Violence Group to continue to oversee implementation of Croydon's Domestic Homicide Review recommendations.

4. Safer Croydon Partnership and Domestic Abuse and Sexual Violence Group to assess and take account of NICE domestic violence and abuse guidance and continue to update DV strategy in the light of best available evidence.

5. Croydon Clinical Commissioning Group to set up a Health Services Working Group reporting to Domestic Abuse and Sexual Violence Group with membership including Croydon CCG, Public Health Croydon, Croydon Healthcare Services (including urgent and emergency care services and Midwifery Departments), Croydon DAAT and SLaM, to ensure coordinated health service response to domestic violence and abuse.

6. Safer Croydon Partnership to decide strategic approach and governance arrangements relating to Female Genital Mutilation, Forced Marriage and 'honour' based violence. This should include data collection.

7. Domestic Abuse and Sexual Violence Group to continue, as part of the DV action plan, to develop and implement measures to prevent domestic violence and abuse including early intervention targeting children, young people and families.

8. Training and communications to highlight that vast majority of domestic violence and abuse involves coercive and controlling relationships rather than criminal acts of physical violence.

9. Training and communications to cover use of technology and social media in perpetrating domestic violence and abuse.

10. Work with local partners to further assess needs in relation to elder abuse building on the work of the LBC safeguarding team.

11. Work with partners to further assess needs of Croydon's LGBT communities in relation to domestic violence and abuse.

12. Systematic engagement with the wide range of non-specialist voluntary and community sector organisations working with groups at risk of experiencing domestic violence and abuse.

13. Public Health Croydon to carry out regular reviews of the evidence around effective interventions.

3. DETAIL

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

3.2 The chapter identifies the prevalence, patterns and trends in domestic violence. A local service mapping identifies a wealth of local partners. Key findings, data and conclusions have been fed into the development of a local action plan and the review of the local Domestic Violence Strategy.

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

4. CONSULTATION

4.1 The findings from interviews with victims of DV, data from local services and engagement with partner organisations have been included into the chapter.

4.2 The chapter was shared widely during the JSNA process. Input and direction have been obtained from a wide range of stakeholders across Croydon. The

DASV group acted as a reference group and guided the development of the chapter.

Presentations of drafts of the chapter were given to:

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

5. SERVICE INTEGRATION

5.1 Several of the JSNA conclusions address the continued integration of partners in the local strategic process. Partnership working and engagement of all relevant stakeholders are key to a successful approach to address DV.

6. FINANCIAL AND RISK ASSESSMENT CONSIDERATIONS

6.1 According to cost estimates, Croydon incurs £37.4 million in tangible costs, and a further £64.5 million in human and emotional costs related to DV.
However, it is likely that this is a significant underestimate of the economic impact of domestic violence.

6.2 As stated in the JSNA chapter there are evidence based cost effective interventions for both the prevention and the response to DV. Therefore, investment in prevention and response to DV can save money and improve the health and well-being of the population.

7. LEGAL CONSIDERATIONS

7.1 Producing a local JSNA is a statutory requirement.

8. HUMAN RESOURCES IMPACT

8.1 There are no staffing issues arising directly from this report. One of the conclusions addresses the need for training of front line staff. This is taken forward in the local DV action plan.

9. EQUALITIES IMPACT

9.1 The domestic violence JSNA chapter has considered equality and diversity implications, by examining the impact of DV on vulnerable groups in Croydon's population. The chapter also considers needs for those people with protected characteristics. However, there are insufficient data to estimate the impact on LGTB groups and one of the conclusions is that there is a need to explore the needs of this community further.

10. ENVIRONMENTAL IMPACT

10.1 There is no specific environmental impact arising from this report.

11. CRIME AND DISORDER REDUCTION IMPACT

11.1 The DV JSNA reports on the current prevalence, patterns and trends of DV related crime, both as allegations of crime as well as offences. The conclusions of the JSNA will support strategic approaches to reduce crime in Croydon.

CONTACT OFFICER: Ellen Schwartz, Consultant in Public Health, Public Health Croydon

Ellen.Schwartz@croydon.gov.uk Telephone: 020 8726 61644

BACKGROUND DOCUMENTS
Domestic violence JSNA Chapter 2013/14

REPORT TO:	**HEALTH AND WELLBEING BOARD (CROYDON)** **26 March 2014**
AGENDA ITEM:	**11**
SUBJECT:	**Rapid Alcohol Joint Strategic Needs Assessment 2013/14**
BOARD SPONSORS:	**Dr Mike Robinson Director of Public Health** **Hannah Miller, Director of Adult Services, Health and Housing** **Paul Greenhalgh, Director of Children, Families and Learning** **Paula Swann, Chief Officer, Clinical Commissioning Group**

CORPORATE PRIORITY/POLICY CONTEXT:

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

FINANCIAL IMPACT:

The main financial implications for the Rapid Alcohol JSNA lie in the unmet need that is identified and the growing need in the future if trends continue to deteriorate.

1. RECOMMENDATIONS

This report recommends that the health and wellbeing board:

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

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

3. Endorse the recommendations of the rapid Alcohol JSNA

2. EXECUTIVE SUMMARY

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

2.2 The aim of the rapid JSNA alcohol chapter is to provide an overall summary of the prevalence of alcohol problems and the harm caused by alcohol in Croydon and make recommendations for future development. An evidence based assessment of gaps in Croydon's current approach to tackling alcohol issues is also included. This evidence has informed the suggested recommendations for future action listed at the end of the chapter.

2.3 The conclusions of the JSNA are in section 7 and the recommendations section 8 of the chapter. The key issues that will be of particular interest to the Health and Wellbeing board are:

2.4 Croydon does not currently have a Borough wide strategic population approach to encouraging a sensible drinking culture and reducing alcohol related harm. The key to success is partnership working. An evidence based strategy will help partners to focus limited resources in the right place and make efficiency savings where possible.

2.5 Alcohol harm is increasing in Croydon. The consequences of high levels of alcohol intake can take a number of years to become visible. The fact that Croydon's trends are getting worse may reflect a change in drinking patterns and behaviour in our population, which may need further exploration as we could be storing up problems for the future.

2.6 Approximately 1 in 6 of Croydon's adult population (51,862) is drinking at increasing and higher risk levels. This level of drinking is harmful to health and also has a negative impact on families and communities.

- Alcohol kills people early and is a cause of health inequalities. Compared with those living in most affluent areas, people in the most deprived fifth of the country are 3-5 times more likely to die of an alcohol-specific cause.[1]
- More than two in five (44%) violent crimes are committed under the influence of alcohol.[2] Rates of alcohol related crime in Croydon are 50% higher than in England and are getting worse.
- Nationally, alcohol may be a contributory factor in up to one million assaults and is associated with 125,000 instances of domestic violence and is often a contributory factor to marital breakdown [3]
- 27% of serious case reviews mention alcohol misuse and children who have parents who misuse alcohol can have physiological, physical and behavioural problems. [4]

2.7 For Croydon, based on its population size, alcohol related harm costs an estimated £144 million per year. Of this, half is alcohol related crime (£72 million) one third is lost productivity (£48 million) and the rest is NHS costs

[1] Association of Public Health Observatories 2007. Indications of public health in the English regions 8: alcohol
[2] Budd T. 2003. Alcohol-related ssault: findings from the British Crime Survey. Home Office Online Report 35/03. London: Home Office
[3] Domestic violence and marital breakdown, Physical, psychological, and behavioural problems for children of parents with alcohol problems: Gmel, G Rehm, J (2003): Harmful alcohol use. Alcohol Research and Health 27, 52–62 & Rossow, I (2000): Suicide, violence and child abuse: review of the impact of alcohol consumption on social problems. Contemporary drug problems 27, 397–434
[4] New learning from serious case reviews: a two year report for 2009-2011 (Department for Education, 2013)

(£24 million). This figure does not include the associated costs to families and communities.[5]

2.8 There are evidence based cost effective interventions that can reduce alcohol misuse and alcohol related harm. Therefore, investment in alcohol interventions, particularly before drinking becomes problematic, can save money and improve the health and well-being of the population.

2.9 The rapid assessment shows that like the national picture, Croydon's relationship with alcohol is complex. The majority of adults who consume alcohol in Croydon are not dependent on alcohol. Only a very small minority of Croydon's population match the public image of the "alcoholic" and are dependent on alcohol. Most adults who drink alcohol live fully functioning lives; have jobs, families and positions of respect in the community. However, a large number (50,000+) of these people are drinking at levels that place them at greater risk of alcohol related harm.

2.10 Evidence suggests that it is possible to support people drinking at increasing or higher risk (50,000+ in Croydon) to change their drinking behaviour by providing information and brief advice (IBA). Brief advice for increasing and high risk drinkers is a short, structured conversation to motivate and support people to think about and/or plan a change in their drinking behaviour. The majority of these at risk drinkers could benefit from simple, brief advice delivered by mainstream professionals, with no alcohol specialism at all e.g. pharmacy staff, probation staff, housing officers.

2.11 Croydon's key dataset contains five indicators for alcohol. Where trend data is available these indicators show that Croydon's ranking has been consistently deteriorating relative to England as a whole over the last three years

- Nationally, between 2002/13 and 2010/11, alcohol related hospital admissions more than doubled. Local three year trends show that alcohol related hospital admission rates are lower in Croydon compared with rates in London or across England, but are increasing. The data currently held does not provide demographic data such as age, gender or geographical origin.

- Trends show that alcohol related crime is getting worse and has been over a 3 year period. Alcohol related crime is closely linked to domestic violence which has also seen higher levels of reported offences in Croydon.

- Data shows that Croydon's ranking for deaths attributable to alcohol has been consistently deteriorating relative to England as a whole. In 2011 an estimated 73 deaths were wholly attributable to alcohol

- Croydon has a significantly high number of alcohol related ambulance call outs compared with other London Boroughs. Over the last three years the number of alcohol related ambulance call outs in Croydon has increased from 1947 calls in 2010-11 to 2493 calls in 2012-13.

[5] These costs are estimated from the Department of Health's written evidence to the Health Select Committee (19 July 2012) http://www.publications.parliament.uk/pa/cm201213/cmselect/cmhealth/132/132we02.htm

3. DETAIL

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

3.2 The chapter identifies gaps in the current approach to reducing alcohol related harm. Key conclusions are highlighted and future priorities for improvement and development are made in the recommendations.

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

4. CONSULTATION

4.1 As this is a rapid JSNA no additional formal consultation was carried out. However, the findings of previous consultations and engagement events from the last three years have been included where relevant.

4.2 The chapter was shared widely during the JSNA process. Input and direction have been obtained from a wide range of stakeholders across Croydon. A reference group guided the development of the chapter and included service users and carers who had the opportunity to input and give feedback and their comments have been incorporated.

Presentations of drafts of the chapter were given to:

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

5. SERVICE INTEGRATION

5.1 One of the JSNA recommendations is that partners develop a comprehensive Borough wide alcohol strategy that is driven by the Local Strategic partnership. Having a strategic population approach to encouraging a sensible drinking culture and reducing alcohol related harm is key to reducing the harm caused by alcohol.

6. FINANCIAL AND RISK ASSESSMENT CONSIDERATIONS

6.1 As outlined in the Alcohol JSNA, for Croydon, based on its population size, alcohol related harm costs an estimated £144 million per year. Of this, half is alcohol related crime (£72 million) one third is lost productivity (£48 million) and the rest is NHS costs (£24 million). This figure does not include the associated costs to families and communities.

6.2 Rough estimates are that approximately £18 million per year are hospital based alcohol related costs for Croydon. There are no figures for CCG costs based on future trends at present, but there is a JSNA recommendation for further work on cost analysis.

6.3 As stated in the JSNA chapter there are evidence based cost effective interventions that can reduce alcohol misuse and alcohol related harm. Therefore, investment in alcohol interventions, particularly before drinking becomes problematic, can save money and improve the health and well-being of the population.

6.4 Tackling alcohol misuse can save money at a local level[6]:

- Every 5000 patients screened in Primary Care may prevent 67 A&E visits and 61 hospital admissions (cost £25,000, saves £90,000).[7]
- For every £1 invested in specialist alcohol treatment services, £5 is saved on health, welfare and crime costs.
- One alcohol liaison nurse can prevent 97 A&E visits and 57 hospital admissions.[8] Costs are estimated at £25k, and savings at £90k.[9]
- Specialist alcohol treatment can deliver savings of nearly £1,138 per dependent drinker treated and reduce hospital admissions.

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

7. LEGAL CONSIDERATIONS

Producing a local JSNA is a statutory requirement.

8. HUMAN RESOURCES IMPACT

8.1 Recommendations are made about the need for frontline staff to be able to screen for alcohol problems. There may be an impact on releasing appropriate frontline staff across health and social care and associated frontline professions so that they are able to deliver Information and Brief Advice to Croydon's population.

[6] Alcohol Concern, Making alcohol a health priority - Opportunities to reduce alcohol harms and rising costs, 2011, p23-24
[7] TrEAT trial. Fleming MF, Mundt MP, French MT, Manwell LB, Stauffacher EA, Barry KL. Brief physician advice for problem drinkers: long-term efficacy and benefit-cost analysis. Alc Clin Exp Res 2002;26:36-43
[8] Alcohol: Can the NHS Afford It (Royal College of Physicians, 2001) and an unpublished report of a comparison between two hospitals. Owens L. Chapter Six Making a Difference: Interventions by an Alcohol Specialist Nurse, and Owens L. Chapter 6 Efficacy of Brief interventions for dependent drinkers. A prospective cohort study.
[9] Ready Reckoner, from PHE Alcohol Learning Resources: http://www.alcohollearningcentre.org.uk/Topics/Browse/Data/Datatools/?parent=5113&child=5109

9. EQUALITIES IMPACT

9.1 The JSNA Alcohol chapter has considered equality and diversity implications, by examining the impact of alcohol related harm on vulnerable groups in Croydon's population. (See Section 4.) The chapter also considers needs for those people with protected characteristics (see Appendix 3)

9.2 GP data shows that rates of both overall alcohol misuse and dependence are 2-3 times higher in Croydon's White British population than for other ethnic groups. This is different to the national picture, where there is no difference in alcohol dependence between ethnic groups. This may indicate inequalities for BME screening of alcohol dependence in Croydon.

9.3 The key equalities implications of the JSNA are that alcohol kills people early cause health inequalities. In Croydon, rates of GP diagnosed alcohol quintile compared to those living in the least deprived quintile.

10. ENVIRONMENTAL IMPACT

There is no specific environmental impact arising from this report.

11. CRIME AND DISORDER REDUCTION IMPACT

11.1 The JSNA highlights that Croydon reports a rate of 10.8 alcohol related crimes per 100,000 population, which is similar to the London figure of 11.1 and statistically significantly higher than the England figure of 7.0. Croydon's rate has become relatively worse over the last three years. Alcohol related crime is a significant indicator because of the impact it can have on local communities. There are many factors where alcohol has an effect on community safety. These include the night time economy, violent crime, domestic abuse, sexual violence, street drinking, anti-social behaviour and licensing issues.

11.2 Recommendations in the JSNA include getting commitment to introduce a 'Cardiff model' evidence based approach to violence prevention and data sharing in Croydon. By pulling together and analysing the data on alcohol-related offences from police, probation, health services and other key partners an increased understanding will be built of the local picture and the types of alcohol related crime, groups perpetrating and those affected in Croydon.

CONTACT OFFICER: Rachel Nicholson, Health Improvement Manager, Public Health Croydon

Rachel.Nicholson@Croydon.gov.uk Telephone: 020 8760 5794

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

REPORT TO:	**HEALTH AND WELLBEING BOARD (CROYDON)** **26 March 2014**
AGENDA ITEM:	**12**
SUBJECT:	Children & Young People's Emotional Wellbeing & Mental Health Strategy
BOARD SPONSOR:	**Paul Greenhalgh, Executive Director of Children, Families and Learning, London Borough of Croydon** **and** **Paula Swann, Chief Officer, Croydon Clinical Commissioning Group**

CORPORATE PRIORITY/POLICY CONTEXT:

Priority has been given to production of a JSNA in Croydon in recent years. The approach taken has been to produce an overview of health and wellbeing in Croydon alongside three additional 'deep dive' chapters on key topic areas selected by the health and wellbeing board after a formal prioritisation process. In 2011/12, it was agreed by the health and wellbeing board that the 2012/13 JSNA would focus on mental health.

The 2012/13 JSNA consists of an overview chapter on mental health and wellbeing (alongside separate, 'deep dive' chapters on depression, schizophrenia and emotional health and wellbeing of children. From the final chapter on emotional health and wellbeing of children the recommendation was to produce this strategy (Appendix 1).

Nationally, mental health is moving up the policy agenda across government and is now a major policy priority for many government departments. *'No Health Without Mental Health' (DH July 2012)* made clear that tackling premature mortality of people with mental health problems is a priority, recognising that more must be done to prevent mental ill health and to promote emotional well-being.

Since the development our Croydon's Emotional Health and Wellbeing Strategy for Children and Young People, the Department of Health have issued *'Closing the Gap: priorities for essential change in mental health' (DH January 2014)* . It is recognised that the Croydon strategy will need to reflect the national priorities outlined within this policy document, as well as further expected guidance referred to therein.

'Closing the Gap' identifies 25 aspects of mental health and support where government expect to see tangible changes in the next couple of years to improving mental health. The policy recognises that half of those with lifetime mental problems first experience symptoms by the age of 14 and that early identification and intervention can make a massive difference in school achievement and avoidance of poor health outcomes. Some key aspects include;

- The development of a range of clinical commissioning tools that will support integration of physical and mental health care;
- The establishment of a Mental Health Intelligence Network (MHIN) to support

HWBBs, CCGs and partners to decide what types of health and social care services are needed locally;

- The development of access and waiting time standards, including the delivery of nationwide service transformation for children and young people's mental health services;
- Actively incentivising CCGs to increase access to psychological therapies through the Quality Premium scheme;
- Increased use of the Friends and Family Test as a means of identifying poor quality services early;
- Ensuring young carers' assessments are simplified;
- The allocation of £3.8billion nationally to help HWBBs in their plans to support the integration of physical and mental health care;
- Improving the care and support offered to those who self-harm, with the aim of preventing the development of long-term mental conditions, or in some cases suicide;
- A focus on maternal mental health, including the plans of Health Education England to ensure there is enough training in perinatal mental health so that there are specialist staff available for every birthing unit by 2017;
- Improved training for health visitors and midwives to enable them to spot the early signs of mental health problems to ensure that families and children have the best start in life;
- Helping schools to identify mental health problems in their pupils sooner, highlighting the statutory guidance set out in the Special Educational Needs (SEN) Code of Practice to ensure a child's mental health needs are captured in any assessment of their education, health and social care needs (expected to be introduced from September 2014);
- The improvement of transition planning through a cross-service approach, identifying the work of NHS England to develop a service specification for transition from CAMHS, to enable CCGs anf Las to build on best practice;
- Ensuring appropriate assessment and support from the outset as soon as a young person comes into contact with the youth justice system, including through the Liaison and Diversion model.

FINANCIAL IMPACT:

Resources required tocontribute to the strategy's action plan.

1. RECOMMENDATIONS

1.1 The Health and Wellbeing Board is asked to:

- Note the contents of the report and attached strategy (Appendix 1)
- Agree the action plan for 2014

2. EXECUTIVE SUMMARY

2.1 The Children & Young People's Emotional Wellbeing & Mental Health Strategy provides a clear direction for promoting the emotional wellbeing and mental health of Croydon's Children & Young People, from conception to their 18th birthday, for the period 2014 to 2016. It is recognised that for some young people with significant special educational needs (SEN), the Council will maintain its responsibility until 25 years. The board is asked to note the strategy and ensure all partner organisations put the action plan into place.

3. DETAIL

3.1. The JSNA 'deep dive' on the Emotional Health and Well Being of Children & Young People aged 0-18 was completed in August 2013. This included a comprehensive needs analysis and a key recommendation for a strategy to be developed in order to progress the wider recommendations of the JSNA. The Executive Group of the Children and Families Partnership accepted in broad terms the recommendations of the JSNA and agreed to establish a task and finish group to develop the Strategy and action plan. This was endorsed by Croydon's Health and Well-being Board in September 2013.

3.2. The Children and Families Partnership constituted a task and finish group to devise the strategy to implement the proposals from the JSNA, with representatives involved from SLAM, CCG, Croydon Council, GPs, Schools, Croydon Health Services NHS Trust and the third sector.

3.3. The strategy details the response of Croydon's Children & Families Partnership to the needs and recommendations outlined in the recent Joint Strategic Needs Assessment (JSNA) which assessed the Emotional Health and Well Being of Children and Young People aged 0-18. The Partnership has seized this opportunity to develop a shared set of principles and clear strategic direction to provide a coherent and effective 'whole systems' approach to promotion, prevention, early intervention and treatment of mental health conditions to ensure the best possible outcomes for Croydon's Children & Young People.

3.4. The strategy summaries the needs analysis taken from the JSNA chapter and describes the intent of the strategy and the desired outcomes for stage 1 through to 4. It sets out the commissioning arrangements going forward and the operational arrangements for all partner agencies. The action plan focusses on a smaller number of strategic objectives, which embrace the recommendations of the JSNA chapter.

3.5. A new sub-group of the Children and Families Partnership is being establishedto take forward the implementation of the action plan. The sub group will have representatives from Croydon Council, schools/colleges, the third sector, Public Health, CCG and GP representation, Integrated Commissioning Unit, Croydon Health Services, South London and Maudsley NHS Trust, with links for young people's involvement.

3.6. A first task of the sub group will be to review the action plan to ensure that the aspects outlined within the newly published policy *'Closing the Gap'* are adequately addressed and cross referenced.

4. CONSULTATION

4.1 Engagement with children and young people, parents, carers and other associated stakeholders across the council, the NHS and the voluntary sector, was undertaken as part of the JSNA 'deep dive' and this strategy builds on outcomes of that engagement. Continued engagement with children and young people to enable them to shape service delivery will be critical as the strategy is taken forward.

4.2 The strategy recommends a change to governance arrangements. The Children and Families Partnership: Emotional Health & Wellbeing in schools sub-group and the CAMHS Partnership Commissioning Group will be merged to create the CYP Emotional Wellbeing & Mental Health Group. In governance terms the new group will report into the Children and Families Partnership.

5. SERVICE INTEGRATION

5.1 All board paper authors are asked to explicitly consider service integration issues.

6. FINANCIAL AND RISK ASSESSMENT CONSIDERATIONS

6.1 Financial and activity data shows Croydon to have comparatively low investment levels compared with other boroughs. Comparative figures on pages 17 and 18 of the strategy are undergoing further validation.

6.2 The opportunities presented through *'Closing the Gap'* should be fully utilised.

7. LEGAL CONSIDERATIONS

7.1 Legal advice has not been sought on proposals set out in this paper.

8. HUMAN RESOURCES IMPACT

8.1 Capacity modelling will inform this.

9. EQUALITIES IMPACT

9.1 A full equalities impact assessment has not been carried out on this report. Equalities analysis was completed as part of the JSNA.

9.2 One in four people will experience at least one mental health condition at some point in their life. They can affect anyone in Croydon, regardless of age, race, gender or social background, although some groups have a higher risk of mental disorder and lower levels of well-being.

9.3 Evidence clearly shows that particular groups who suffer disadvantage and discrimination may be at risk of higher rates of mental ill health and have poorer mental well-being. Factors that influence mental health and well-being are interrelated. At any one time, a mix of social, psychological, and biological factors determine the level of mental health of a person.

9.4 Half of lifetime mental illness (excluding dementia) starts by the age of 14 and early intervention to treat childhood mental illness may reduce the risk of mental health problems in adulthood.

9.5 Reducing stigma associated with mental health is improving, but remains a

challenge. The Time to Change campaign (led by MIND and Rethink Mental Illness charities) is recognised as a significant driver of long-term change, highlighting the importance of targeting children and young people to this end.

10. ENVIRONMENTAL IMPACT

10.1 There is no specific environmental impact arising from this report.

11. CRIME AND DISORDER REDUCTION IMPACT

11.1 Achieving more, participating more fully with their peers and their community, engaging in less risky behaviour and developing resilience throughout the life course can support reductions in crime and disorder in this age group.

CONTACT OFFICER: Paul Greenhalgh, Executive Director of Children, Families and Learning, London Borough of Croydon
020 8726 6000 ext 65729

BACKGROUND DOCUMENTS
Strategy for children and young people's emotional well-being and mental health 2014 – 2016

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REPORT TO:	**HEALTH AND WELLBEING BOARD** **26 March 2014**
AGENDA ITEM:	**14**
SUBJECT:	**Report of the chair of the executive group: board work plan and risk**
BOARD SPONSOR:	**Hannah Miller, executive director of adults services, health and housing & deputy chief executive, Croydon Council**

CORPORATE PRIORITY/POLICY CONTEXT:

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

FINANCIAL IMPACT:

None

1. RECOMMENDATIONS

The health and wellbeing board is asked to:

- Agree proposed changes to the board work plan set out at paragraph 3.3
- Note risks identified at appendix 2

2. EXECUTIVE SUMMARY

2.1 The health and wellbeing board agreed its work plan for 2013/14 at its meeting on 24 April 2013. The work plan is regularly reviewed by the executive group and the chair. This paper includes the most recent update of the board work plan at appendix 1. A number of strategic risks were identified by the board at a seminar on 1 August 2013. The board agreed that the executive group would keep these risks under review. A summary of risks is at appendix 2.

3. DETAIL

3.1 The purpose of health and wellbeing boards as described in the Health and Social Care Act 2012 is to join up commissioning across the NHS, social care, public health and other services that the board agrees are directly related to health and wellbeing, in order to secure better health and wellbeing outcomes for the whole population, better quality of care for all patients and care users, and better value for the taxpayer.

Work undertaken by the executive group

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

- Review of the work plan including preparation of board agenda and topic prioritisation against joint health and wellbeing strategy
- Discussion of proposals for a board engagement event to be held in March 2014
- Consideration of future learning and development for board members including new board member induction, future board away day and learning events
- Liaison with other strategic partnerships including Croydon strategic partnership and children and families partnership
- Review of health and social care partnership groups accountable to the board
- Review of board strategic risk register
- Review of responses to public questions and general enquiries relating to the work of the board

Board work plan

3.3 Changes to the board work plan from the version (8.0) agreed by the board on 12 February 2014 are summarised below. Changes were discussed by the executive group on 18 February 2014 and with the chair on 14 March 2014. This is version 9.0 of the work plan. The work plan is at appendix 1.

3.3.1 Pressure ulcers in the community item moved from 26 March 2014 to 16 July 2014

3.3.2 Inclusion of item CHS emergency department business case 26 March 2014

3.3.3 Joint mental health strategy item moved from 26 March to 16 July 2014

3.3.4 Commissioning intentions for adult social care deferred until 16 July 2014

3.3.5 Update on adults with learning disabilities moved from 26 March to 11 September 2014

3.3.6 Inclusion of items on adults and children's safeguarding reports on 22 October 2014

3.3.7 Update on dignity and safety on 22 October 2014

3.3.8 Confirmation of engagement event as 27 March 2014

3.4 A board away day will be held on 16 June 2014 to take forward the review and refreshing of the joint health and wellbeing strategy. A further away day is planned for September 2014 to finalise proposals (date to be confirmed).

Risk

3.5 Risks identified by the board at the seminar on strategic risk held on 1 August 2013 are summarised at appendix 2. The executive group regularly review the board risk register. There has been no risk movement since the last report to the board on 12 February 2014.

4. CONSULTATION

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

Recommendations were taken to the chair's meeting on 24 January 2014 and are reflected in the proposed work plan.

5. SERVICE INTEGRATION

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

6 FINANCIAL AND RISK ASSESSMENT CONSIDERATIONS

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

7. LEGAL CONSIDERATIONS

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

8. HUMAN RESOURCES IMPACT

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

9. EQUALITIES IMPACT

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

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

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

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

BACKGROUND DOCUMENTS
None

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Health & Wellbeing Board - Work Plan version 9.0

Agenda Item 14 - Appendix 1

Date	Item	Purpose	Board sponsor	Lead officer / report author
	CHS emergency care department business case	Decision	John Goulston	Karen Breen
	Final commissioning intentions 2014/15 • CCG Operating Plan 2014/15 – 2016/17 • Children's plan 2014/15	For information	Paula Swann/Hannah Miller/Paul Greenhalgh	Stephen Warren / Brenda Scanlan / Jane Doyle
	JSNA 2013/14 domestic violence chapter final draft	Decision	Mike Robinson	Ellen Schwartz
	JSNA 2013/14 alcohol chapter final draft	Decision	Mike Robinson	Bernadette Alves
	Children & young people's emotional wellbeing & mental health strategy	Discussion	Paul Greenhalgh / Paula Swann	Geraldine Bradbury / Stephen Warren
	Pharmaceutical needs assessment work plan 2014/15	Information	Mike Robinson	Matt Phelan
	Report of the chair of the executive group • Work plan • Risk register	Discussion & decision	Hannah Miller	Steve Morton Malcolm Davies
27 March 2014	Board engagement event: review of progress against joint health and wellbeing strategy			
16 June	Board away day: review of joint health and wellbeing strategy priorities			
16 July 2014	Appointment of chair	Decision	n/a	Solomon Agutu
	Annual report of the director of public health	Discussion	Mike Robinson	Jenny Hacker
	Focus on outcomes: Pressure ulcers in the community	Discussion	Paula Swann / Hannah Miller	Fouzia Harrington / Kay Murray

Health & Wellbeing Board - Work Plan version 9.0

Agenda Item 14 - Appendix 1

Date	Item	Purpose	Board sponsor	Lead officer / report author
	JSNA 2013/14 healthy weight chapter final draft	Decision	Mike Robinson	Sarah Nicholls / Anna Kitt
	JSNA 2014/15 key chapter topics	Decision	Mike Robinson	Jenny Hacker
	Final commissioning intentions 2014/15 • Adult services commissioning plans 2014/15	For information	Hannah Miller	Brenda Scanlan
	Joint mental health strategy	Discussion	Paula Swann / Hannah Miller	Paula Swann /' Stephen Warren / Brenda Scanlan
	Reform of services for children with special educational needs (including those with disabilities)	Information	Paul Greenhalgh	Linda Wright
	Partnership groups report	Information	Hannah Miller	Steve Morton
	Report of the chair of the executive group • Work plan • Performance against health and wellbeing strategy indicators (quarterly standing item) • Risk	Discussion & decision	Hannah Miller	 Steve Morton Martin Ellender Malcolm Davies
25 July 2014	Board public engagement event: review of progress against joint health and wellbeing strategy			
11 September 2014	Focus on outcomes: primary care : general practice	Discussion	Dr Jane Fryer	tba
	JSNA 2013/14 homeless households chapter final draft	Decision	Mike Robinson	Dave Morris
	Update on adults with learning disabilities (from April 2013)	Information	Hannah Miller	Alan Hiscutt

Health & Wellbeing Board - Work Plan version 9.0

Agenda Item 14 - Appendix 1

Date	Item	Purpose	Board sponsor	Lead officer / report author
	Partnership groups report	Information	Hannah Miller	Steve Morton
	Report of the chair of the executive group • Work plan • Risk register	Discussion & decision	Hannah Miller	 Steve Morton Malcolm Davies
22 October 2014	Focus on outcomes: household income and health	Discussion	tba	tba
	Update on Heart Town • NHS Health Checks	Information	Mike Robinson	Steve Morton / Bevoly Fearon
	Partnership groups report	Information	Hannah Miller	Steve Morton
	Report of the chair of the executive group • Work plan • Performance against health and wellbeing strategy indicators (quarterly standing item) • Risk	Discussion & decision	Hannah Miller	 Steve Morton Martin Ellender Malcolm Davies
	Update on dignity and safety	Information	Hannah Miller / Paula Swann	Kay Murray / Fouzia Harrington
	Safeguarding adults report	Information	Hannah Miller	Kay Murray
	Safeguarding children report	Information	Paul Greenhalgh	Jeneen Hatt
10 December 2014	Commissioning intentions 2015/16	Discussion	Paula Swann/Hannah Miller/Paul Greenhalgh/Mike Robinson/Jane Fryer	Stephen Warren / Brenda Scanlan / Jane Doyle/PH & NHS England leads tbc

Health & Wellbeing Board - Work Plan version 9.0

Agenda Item 14 - Appendix 1

Date	Item	Purpose	Board sponsor	Lead officer / report author
	Health protection update • Immunisation & vaccination	Discussion	Mike Robinson	tba
	Partnership groups report	Information	Hannah Miller	Steve Morton
	Report of the chair of the executive group • Work plan • Risk	Discussion & decision	Hannah Miller	Steve Morton Malcolm Davies
11 February 2015	Focus on outcomes: health and wellbeing of offenders & their families	Discussion	tba	tba
	Pharmaceutical needs assessment final draft for agreement	Decision	Mike Robinson	tbc
	Joint health and wellbeing strategy 2015-20	Decision	Hannah Miller / Paula Swann / Paul Greenhalgh / Mike Robinson	tba
	JSNA 2014/15 chapter drafts	Decision	Mike Robinson	tba
	Report of the chair of the executive group • Work plan • Performance against health and wellbeing strategy indicators (quarterly standing item) • Risk	Discussion & decision	Hannah Miller	Steve Morton Martin Ellender Malcolm Davies
25 March 2015	Focus on outcomes: topic to be agreed	Discussion	tba	Tba

Health & Wellbeing Board - Work Plan version 9.0

Agenda Item 14 - Appendix 1

Date	Item	Purpose	Board sponsor	Lead officer / report author
	Final commissioning intentions 2015/16	Information	Paula Swann/Hannah Miller/Paul Greenhalgh/Mike Robinson/Jane Fryer	Stephen Warren / Brenda Scanlan / Jane Doyle/PH & NHS England leads tbc
	Partnership groups report	Information	Hannah Miller	Steve Morton
	Report of the chair of the executive group • Work plan • Risk	Discussion & decision	Hannah Miller	 Steve Morton Malcolm Davies

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

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

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

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

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

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

Date	Items	Purpose	Board sponsor	Lead officer / report author
	Performance report (standing item)	Discussion	Hannah Miller/Paul Greenhalgh/Paula Swann	Martin Ellender
	Work plan (standing item)	Decision	Hannah Miller	Steve Morton
	Integration transformation fund	Information	Hannah Miller / Paula Swann	Andrew Maskell
	Safeguarding adults	Information	Hannah Miller	Kay Murray
	Safeguarding children	Information	Paul Greenhalgh	Jeneen Hatt
	Update on carers (from April 2012)	Information	Roger Oliver	Harsha Ganatra
	Update on children's primary prevention plan (from Feb 2013)	Information	Paul Greenhalgh	Dwynwen Stepien
4 December 2013	Commissioning intentions 2014/15	Discussion	Paula Swann/Hannah Miller/Paul Greenhalgh/Mike Robinson	Stephen Warren / Brenda Scanlan / Jane Doyle
	Substance misuse commissioning plans	Discussion	Hannah Miller	Alan Hiscutt
	Pharmaceutical needs assessment	Decision	Mike Robinson	Kate Woollcombe
	Work plan and report of the chair of the executive group (standing item)	Decision	Hannah Miller	Steve Morton
	Risk register (standing item)	Discussion	Hannah Miller	Steve Morton
5 December 2013	Board seminar – dignity and safety in care			
12 February 2014	Better Care Fund (formerly the integration transformation fund) 2014/15	Discussion & decision	Hannah Miller / Paula Swann	Andrew Maskell

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

Date	Items	Purpose	Board sponsor	Lead officer / report author
	Dignity & safety in care seminar report	Discussion	Hannah Miller / Paula Swann	Kay Murray / Fouzia Harrington
	Report of the chair of the executive group • Work plan • Performance against health and wellbeing strategy indicators (quarterly standing item) • Risk	Discussion & decision	Hannah Miller	 Steve Morton Martin Ellender Malcolm Davies
	Local account 2012/13	Information	Hannah Miller	Tracey Stanley
	Heart Town update	Information	Mike Robinson	Steve Morton

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28 February 2014

Risk Status

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

REPORT TO:	HEALTH AND WELLBEING BOARD (CROYDON) 26 March 2014
AGENDA ITEM:	15
SUBJECT:	Pharmaceutical Needs Assessment Update
BOARD SPONSOR:	Dr Mike Robinson, Director of Public Health
CORPORATE PRIORITY/POLICY CONTEXT: This report is for information only	

1. RECOMMENDATIONS

1.1 The health and wellbeing board is asked to note the contents of the report. Any questions should be directed to the report author outside of the meeting.

2. EXECUTIVE SUMMARY

This paper provides an update to Croydon's health and wellbeing board) of the development of Croydon's new pharmaceutical needs assessment (PNA).

3. DETAIL

3.1 From 1st April 2013, every health and wellbeing board in England has been given 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 NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 (the 2013 Regulations), which came into force on 1 April 2013, require each health and wellbeing board 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; and publish its first PNA by 1 April 2015.

3.2 PNAs are used by the NHS to make decisions on which NHS funded services need to be provided by local community pharmacies. These services are part of local health care and affect NHS budgets. PNAs are also relevant when deciding if new pharmacies are needed, in response to applications by businesses, including independent owners and large pharmacy companies. Applications can be keenly contested by applicants and existing NHS contractors and can be open to legal challenge if not handled properly.

3.3 Health and wellbeing boards need to ensure that the NHS England and its Area Teams have access to their PNAs. The revised PNA will require board-level sign-off and a period of public consultation beforehand.

3.4 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.

3.5 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.

4. NEXT STEPS

4.1 At the board meeting on 4 December 2013 HWB, the board

- Agreed to the publication of the current PNA (Appendices NHS PNA 2011 on the council website)
- Agreed that the three supplementary statements (PNA2011_3,4 & 5) to this report be published alongside the current PNA on the council website
- Approved the two further supplementary statements (PNA2011_1 and PNA2011_2) as set out at 3.7 in the report.

(All papers are accessible via the link below)

4.2 Croydon Council has appointed Cynthia Folarin, assistant director of public health DPH and Matt Phelan, interim public health principal to lead on the development of the new PNA.

4.3 Croydon Council are currently working with Croydon Clinical Commissioning Group and Croydon Local Pharmaceutical Committee to agree a steering group to support the PNA development.

4.4 Croydon Council is working with partner organisations in writing a specification to appoint a provider to develop the PNA with the intention to appoint by end of April 2014.

4.5 Initial timescales for the development of the PNA can be viewed in the programme plan in Appendix A.

4.6 Croydon Public Health will provide an update to the HWB once a provider has been appointed and a working group has been established to update on how the PNA development is progressing.

CONTACT OFFICER: Matt Phelan, Interim Public Health Principal, Public Health Croydon. Matt.phelan@croydon.gov.uk *(Report Author)*

Cynthia Folarin, Deputy Director of Public Health, Public Health Croydon, Cynthia.folarin@croydon.gov.uk *(Public Health Lead Consultant)*

BACKGROUND DOCUMENTS

Link to current Pharmaceutical Needs Assessment, published following the December 2013 HWB Meeting: Papers under A69/13

Appendix A

Pharmaceutical Needs Assessment														
	2014											2015		
	Feb	March	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Health and Wellbeing Board PNA Development Programme Plan														
HWB Update						Optional					Optional			
HWB Sign-off														
Procurement														
Tender Exercise														
Project Governance and Meetings														
Build a Steering Group														
Steering group meeting														
Analysis														
Benchmarking against other areas (including ONS peer group)														
- Detailed local analysis (pharmaceutical services and other services)														
Meetings with Service Commissioners														
To understand details of each service commissioned, gaps and future plans for service development														
PNA Document Development														
- Developing Framework for PNA document														
- Ghost writing PNA document to produce draft for consultation														
Consultation														
Manging the consultation														
Developing the consultation Report														
Updating draft PNA to produce final document														

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