HEALTH & WELL-BEING BOARD (CROYDON)

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

Officers of the council:
Paul GREENHALGH (Executive Director of People)
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:
Kim BENNETT (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)
Marie T BROWN (Croydon College)
TBA (Metropolitan Police)
Adam KERR (National Probation Service (London))
David LINDRIDGE (London Fire Brigade)
Andrew McCOIG (Croydon Local Pharmaceutical Committee)
Lissa MOORE (London Probation Trust (Croydon))

A meeting of the **HEALTH & WELL-BEING BOARD (CROYDON)** will be held on **Wednesday 11th February 2015** at **2:00pm**, in **The Council Chamber, The Town Hall, Katharine Street, Croydon CR0 1NX**.

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

MARGOT ROHAN
Senior Members Services Manager
(Democratic Outreach)
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www.croydon.gov.uk/agenda

3 February 2015

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

AGENDA - PART A

1. Minutes of the meeting held on Wednesday 10th December 2014 (Page 1)

To approve the minutes as a true and correct record.

2. Apologies for absence

3. Disclosure of Interest

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

4. Urgent Business (if any)

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

5. Exempt Items

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

6. Mental Health Strategy Action Plan (Page 9)

(Partnership: Mental Health)
The report of Croydon Council's Executive Director - People and the Chief Officer, Croydon Clinical Commissioning Group is attached.

7. Primary Care co-commissioning (Page 27)

The report of the Chief Officer of Croydon Clinical Commissioning Group and the Medical Director for South London, NHS England, is attached.

8. Care Act implementation and market position statement (Page 41)

The report of the Croydon Council's Executive Director - People is attached.

9. Proposal to establish a Croydon Health Protection Forum (Page 45)

The report of the Director of Public Health is attached.

10. Illicit tobacco, shisha, e-cigs and broader tobacco control (Page 65)

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

11. 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.

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

The report of the Executive Group is attached, covering the Work Programme, Performance Report and Risk Summary.

13. FOR INFORMATION: (Page 119)

Approval of Better Care Fund submission - information attached.

14. 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 10th December 2014 at 2pm in The Council Chamber, The Town Hall, Katharine Street, Croydon CR0 1NX

Present:

Elected members of the council:
Councillors Alisa FLEMMING, Maggie MANSELL (Chair), Margaret MEAD (Vice-Chair), Louisa WOODLEY

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

NHS commissioners:
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:
Kim BENNETT (Croydon Voluntary Sector Alliance)
Nero UGHWUJABO (Croydon BME)

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

Non-voting members:
Not represented

A68/14 MINUTES OF THE MEETING HELD ON WEDNESDAY 22ND OCTOBER 2014

The Board **RESOLVED** that the minutes of the meeting of the Health & Wellbeing Board (Croydon) on 22 October 2014 be agreed as an accurate record.

A69/14 APOLOGIES FOR ABSENCE

Apologies were received from Councillor Yvette Hopley, Dr Agnelo Fernandes (CCG), Dr Jane Fryer (NHS England), Mark Justice, David Lindridge (London Fire Brigade) and Lissa Moore (London Probation Trust) and (for lateness) Hannah Miller.

A70/14 DISCLOSURE OF INTEREST

There were no disclosures of a pecuniary interest not already registered.

A71/14 URGENT BUSINESS (IF ANY)

There was no urgent business.

A72/14 EXEMPT ITEMS

There were no exempt items.

A73/14 COMMISSIONING INTENTIONS 2015/16

Stephen Warren and Brenda Scanlan highlighted the main points of the report:

- The report set out the high level commissioning intentions for Croydon Council, Croydon Clinical commissioning Group and NHS England for the health and wellbeing board to comment on their alignment with the priorities identified in the joint health and wellbeing strategy 2013-18, as informed by the joint strategic needs assessment (JSNA). Detailed intentions are in the appendices.
- The aim of commissioning is to ensure that people's identified needs are addressed within the resources available; that commissioners commission the appropriate services to meet local needs; and that the right services are in place in order to improve health and to reduce health inequalities. Commissioning can be undertaken across a range of geographical areas depending on the nature and scale of the needs and services required. This can be at a national level for some highly specialised services, regionally and locally (for example, at borough or sub-borough level).

Issues raised were:

- Priorities have arisen from strategies developed over the last few years
- 23 December - further planning guidance on national priorities
- Local Authority and CCG priorities - working together
- Effective commissioning services are about providing more services in Primary Care and enhancing the work of GPs
- More clinics in the community for rapid access and a focus on Primary Care – including echo-cardiogram testing at GPs
- Redesigning mental health services in Croydon - clear about role of voluntary sector

- Multi-pronged approach to tackle issues affecting mental health, including helping people to manage debt and housing situations
- Asset based community services programme with funds for grants
- Explanation of tiers:
    - Tier 1 - interventions any professional expected to make to support SEND child;
    - Tier 2 - CAMHS services;
    - Tier 3-4 - more specialist provision
- Need to ensure child poverty is prioritised
- Importance of reduction in temporary accommodation for families
- With reduction in capacity and the introduction of new services, is there any loss of access?
- Urgent Care Centres - concern about people being unaware of these services – better signage and explanation needed
- Need to ensure enough support for nursing homes. Work around rapid response service
- Has deprivation of liberty led to more people falling through the gaps?
- Additional workload for GPs needs training to ensure quality of service
- Importance of listening to carers – additional support needed
- Diabetes and end of life care - how will self-management and prevention be managed?
- Early intervention - are there any plans to put support services into communities to make access easier?
- Concerns about over-medication
- Mental health in BME communities - concerns about how services relate to certain groups of people - Lambeth have a commission on the issue
- Resolution of housing issues to prevent people becoming unwell
- Access to GPs
- Difficulties in encouraging more consultants to specialise in Paediatrics
- London quality standards on Maternity over next 5 years - would need strategic change to provide maternity standards required to get 24/7 cover on maternity wards
- Transition from CAMHS to adult services difficult - important to have pathway
- Need to provide enhanced digital offer and more information for residents, particularly regarding cancer diagnosis
- Would be useful to have list of services and who is responsible for commissioning which (see attached) (PAULA SWANN TO PROVIDE)

The Board **RESOLVED** to note the report.

A74/14 HEALTH PROTECTION UPDATE

Dr Mike Robinson introduced Miranda Mindlin (Public Health England) who gave a summary of the report:

- Following a previous update by the Director of the SW London Health Protection, the Health & Wellbeing Board requested annual updates on local Health Protection issues.

Miranda Mindlin explained how SW London team is structured and the work they cover:

- 24 hour service
- Gastroenteritis and food safety are major parts of work
- Work on tuberculosis with partners in local hospitals
- Work with pollution team
- Flooding - provided support to Gold Command
- Immunisation - provide technical advice to colleagues in Primary Care
- Migration and infectious diseases
- Contribute to national work - such as Ebola issue

Issues raised were:

- Childhood infections - are we achieving better coverage with immunisations?
- Scrutiny has been looking at immunisation. Local Authorities are responsible for accounting for immunisation targets. We want to know if Croydon up to standard. (NHS England will be called back to Scrutiny – they apologised for being unable to attend yesterday)
- It would be useful to provide a list of the responsibilities of the Health Protection system. (see attached) (MIKE ROBINSON TO PROVIDE)

The Department of Health has suggested that Local Authorities may wish to form a Health Protection Forum to assist the Director of Public Health in providing assurance. The Committee agreed this should come back to a future meeting with a firm proposal. Currently the Director of Public Health relies on information from health colleagues. The Health Protection Forum would be accountable to the Health & Wellbeing Board.

The Board **RESOLVED** to note the report and to support the recommendation to set up a Health Protection Forum.

A75/14 **CROYDON FOOD FLAGSHIP**

Dr Mike Robinson introduced the report and John Currie attended to respond to questions:

- Obesity is an increasing problem in Croydon. The causes are multi-factorial and include greater consumption of processed food, more sedentary lifestyles in both adults and children, and changes in employment and family norms. Obesity rates in Croydon children and adults are higher than the London average.
- The national School Food Plan was published in 2013, with a recommendation that two London Boroughs be established as Food Flagship Pilots, with schools being the catalyst for change in a whole system transformation of the food landscape.
- The high level outcomes for the food flagship which have been specified by the London Food Board are:
  1. Reduction in levels of childhood obesity
  2. Increase in school attainment
  3. Decrease in the numbers of new cases of type-2 diabetes
- The pilot is intended to last five years, to allow time for the whole system transformation needed and for this to make an impact on the chosen outcomes. Initial funding is for two years. Local intermediate outcomes have been identified for impact over the initial funding period.
- The Food Flagship pilot links to Croydon Council's themes of "Ambitious for Croydon":
  - Longer, healthier lives
  - Healthy and resilient families
  - Quality schools and learning
  - Places that communities are proud of
  - Financial resilience and affordable living
- The connection between these outcomes and programme deliverables is set out in appendix 1 Food Flagship Plan on a Page.
- The pilot links to Croydon Clinical Commissioning Group's objectives of reducing the difference in life expectancy between communities and enabling children to achieve their full potential. It will contribute to the local priority of reducing diabetes.
- The principles underpinning the design of the pilot are as follows:
  - When children experience the benefits of eating good food at school, this will encourage longer term behaviour change not only in themselves but also in their parents, wider family and local community
  - Learning to cook real food at school (for parents as well as children) will influence food shopping habits and cooking at home
  - Learning how to grow food, and experiencing the satisfaction of cooking and eating the produce will similarly change longer term shopping habits and diets.

- Resources for the Food Flagship include a £530,000 GLA grant over 2 years. The council will provide a new cash match of £150,000 from the Public Health Grant, as well as other contributions in kind such as Healthy Schools.

Issues raised were:

- Strong engagement needed with BME sector. There are more pronounced issues in north of borough - particularly with the number of fast food outlets
- Need to continue to encourage fast food outlets to offer healthy options
- 'Good Food Matters' in New Addington is leading in this area, encouraging and enabling families to eat more healthily
- 'Eat Well Croydon Initiative' – a specialist made contact with fast food outlets, starting in north of the borough. We want businesses to offer a healthy choice but they were reluctant to sign up to the initiatve for fear of the loss of business
- Need to lobby central government - once fast food business established, we cannot stop it
- There is an allocated resource to develop new businesses to promote healthy eating, such as Community shops to reduce dependence on food banks
- Lot of allotments in north of borough - encourage schools to get involved
- More education needed about diabetes and reducing salt intake etc
- Need to raise issues with influencers - GPs, community leaders, religious leaders etc
- GPs have very important role as opinion formers

The Board **RESOLVED** to:

- note progress on development of the Food Flagship and health outcomes it will support
- endorse the proposed approach to its delivery

A76/14 **PUBLIC QUESTIONS**

There were no new public questions. The question raised by Anne Milstead and put to the October meeting had initially received an incomplete response but the revised version provides the reply regarding consultation: (see attachment).

A77/14 **REPORT OF THE CHAIR OF THE EXECUTIVE GROUP**

Steve Morton summarised the report:

- Impact of highest risk - differs for different partners of Board - remains the most significant risk
- Work plan - two additional items for February meeting and JSNA chapter moved to June

The Board **RESOLVED** to:

- Note risks identified at appendix 1
- Agree changes to the board work plan set out at paragraph 3.4

A78/14 **DATES OF FUTURE MEETINGS**

All Wednesdays in the Council Chamber in the Town Hall:
11 February 2015
25 March 2015

As this was the last meeting for the retiring Executive Director of Adult Services, Health & Housing, Hannah Miller, the Chair made a presentation of flowers and a card, in recognition of all her work for the Health & Wellbeing Board.

The meeting finished at 4:15pm.

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REPORT TO:	HEALTH AND WELLBEING BOARD (CROYDON) Wednesday , 11th February 2015
AGENDA ITEM:	6
SUBJECT:	Croydon Integrated Mental Health Strategy for Adults 2014-19
BOARD SPONSOR:	Paula Swann, Chief officer, Croydon Clinical Commissioning Group Paul Greenhalgh, Acting Executive Director - People, Croydon Council

CORPORATE PRIORITY/POLICY CONTEXT:

In July 2014 the Health & Wellbeing Board reviewed Croydon's Integrated Mental Health Strategy for adults. The Strategy covers the period 2014-2019 in line with NHS Croydon Clinical Commissioning Group's (CCG) five year strategy and the Council's forward plan for 2015-18).

The strategy was developed in response to the CCG's commitment to make significant service improvements for people with mental health conditions to address identified need and to adopt key recommendations within the 2012/13 Joint Strategic Needs Assessment (JSNA) on mental health. The Mental Health Strategy can be accessed via;

http://www.croydonccg.nhs.uk/news-publications/publications/Pages/Strategies.aspx

This report seeks to update the Mental Health Strategy Action plan, which was developed in alignment with the Strategy, and of the progress to date of the Adult Service Redesign work streams. It also informs the Board on the delivery of the CCG's agreed Mental Health targets in 14/15 and in relation to the new mental health indicators identified for mental health for 2015/16 in the recent 'Five Year Forward View'

FINANCIAL IMPACT:

The CCG has made significant investment in excess of £5m per annum in mental health services provided by South London and Maudsley NHS Foundation Trust in 2014/15 to meet current service pressures and to redesign services to achieve improved outcomes for patients.

Additionally, Health Education South London (HESL) Funding has been secured to deliver 'No health without Mental Health 'training in 2014/15 for front line workers across the full remit of services that service users within Croydon may access.

1. RECOMMENDATIONS

The Health and Well Being Board is asked to discuss and comment on the content of this report and actions being taken to implement the Croydon Integrated Mental Health Strategy 2014-19.

2. EXECUTIVE SUMMARY

2.1 The Mental Health Strategy (2014–19) was produced in the context of considerable pressures on acute inpatient services and demographic pressures identified in the major 2013 jointly commissioned review by Mental Health Strategies, Joint Strategic Needs Assessment (JSNA) 2012/13 and 'Mind the GAP' report 2012.

2.2 The growing population of Croydon is projected to become more deprived, and anxiety and depression projected to increase by 5% but with a greater increase projected in people with serious mental illness.

2.3 Historically, there has been a high reliance on inpatient services in relation to comparative boroughs, with Croydon spending 21% more on inpatient services than comparative boroughs.

2.4 The recommendations proposed in Croydon's 2012/13 mental health JSNA were further explored and detailed in the Strategy 2014-19 and refer to the need to ensure the wider determinants of health are addressed (e.g. housing, education, employment support)

2.5 The Strategy further evidences the need for easy access to whole life support to improve and maintain mental well-being, including working closely with the Community and Voluntary sector.

2.6 The recent 'Mind the Gap' follow up workshop (Nov 2014) identified the progress made and current ongoing needs of BME Communities within Croydon, who represent 40% of acute admissions

2.7 There are clear actions in place to reduce the acknowledged variation in primary care mental health services within the borough. The Mental Health Commissioning Team has worked steadily across the GP Commissioning Network Structure to ensure clear messages and updated information is being cascaded regularly to GPs in relation to Mental Health and service improvements /developments. More recently this has been evidenced by the significant work with GPs on improving dementia diagnosis.

2.8 The establishment of the Multi-Disciplinary Teams (MDTs) within GP practices has enabled a much wider consideration of the options available for a patient's social and health care needs, including their mental health needs.

2.9 The need to improve integration with physical health remains an area of particular focus but mental ill health is the single largest source of disease burden (greater than cancer or cardiovascular disease), and the costs extend well beyond health and social care.

2.10 Historically there has been a notable lack of early intervention services (particularly in relation to early identification and management of psychosis) compared to neighbouring and comparable boroughs and this was particularly significant when viewed against Croydon's needs.

2.11 There had been little historical funding to support Improving Access to Psychological Therapies (IAPT) services in Croydon and this is now being addressed through additional investment over 2014/15. There has also been a highly targeted approach to ensure the service has delivered increased capacity, easier access and it is on target to deliver against the increased trajectory as agreed with NHSE (5%). Whilst this remains below the national target of 15%, it is none the less a significant increase in service provision from 2013/14 (3.7 %)

2.12 The CCG is committed to expanding this target further again in 2015/16 and a meeting is scheduled for early February to allow interface between the Voluntary Sector providers of talking therapies and NHS E to consider further how the existing services can be included as part of the IAPT provision .

3. DETAIL

3.1 The key aims of the strategy can be summarised as follows:

- To improve the quality of life of people with mental health needs and parity of esteem in commissioning
- To ensure service users/patients are involved fully in the development of their care and support plans, and that services aim to maximise people's independence and support recovery.
- To ensure voluntary and third sector provision works alongside primary and secondary health care services
- To improve access to mental health services
- To strengthen partnership working
- To shift resources to community and primary care services and reduce reliance on inpatients
- To ensure there is education available on Mental Health awareness for front line workers, families and carers.

These key priorities align themselves to the priorities set out in the joint health and wellbeing strategy 2013-18 which can be accessed at http://www.croydonobservatory.org/Strategy_Health_and_Social_Care/

3.2 Mental health, Wellbeing, and the ability to 'live well with illness 'affects almost every part of a person's life. It has an impact on physical health, health behaviours, employment, education and quality of relationships with friends and family

3.3 Personalisation plays a key role in giving people greater choice and control. New packages of community-based social care arranged through Croydon's Integrated Adult Mental Health Services are provided through self-directed support (often with direct payments). Social Care increasingly aims to support serviced users with advice and support around the wider issues of housing and employment issues.

3.4 The Care Act 2014 has a range of implications which are relevant to Mental Health users. These include a greater focus on care and support planning, with an emphasis on meeting the outcomes an individual has identified, and drawing on

their own strengths and family/social networks. In addition, carers' rights will be strengthened, including being eligible for support services in their own right.

3.5 Social prescribing and how this could be most optimally developed in relation to mental health services in Croydon is the key agenda item for the February Mental Health Partnership Board and will be debated across the wide range of stakeholders (in addition to health and social care) who attend so that a true consensus of opinion can be established and built upon.

3.6 The Mental Health Strategy is being taken forward through a number of key work streams which share two central priorities:

- that the main setting for supporting people with mental health problems should be the community.

- that services should be easily accessible , easily understood (by service users , carers and other health professionals) and be developed in a manner that they ' join up 'and interface as seamlessly as possible

3.7 The role of the voluntary sector service provision and primary care has been equally fundamental to all aspects of service re design.

3.8 It is a driving principle that service users need to be supported adequately at an earlier stage, crisis points are avoided and that people are supported/empowered to take a more active role in their own care.

4. Increasing Access to Mental Health Services:

4.1 There was as previously referred to a pressing need at the commencement of the 2014/15 period to stabilise the existing bed based in patient provision and It was acknowledged that there was a need to increase core bed capacity within South London and Maudsley in order to be able to meet current need, stabilise the system, and to ensure there would be a reduction in out of borough placements or placements in the private sector.

4.2 It was also integral to the broader commitment to the redesigning of services in that it is not possible to transform an unstable service. A dedicated Triage Unit for Croydon was a core component part of this additional bed provision, creating equity of provision for Croydon patients within the SLaM system.

4.3 The use of out of borough/private hospital placements (2014/15) has now reduced to a minimum so that patients when treated within borough are much more able to access local pathways of care at the point of discharge.

4.4 The Mental Health Commissioning team has given considerable attention since July 2014 to establishing a full baseline of activity expectations from SLaM and has commenced a full review of all service specifications and service level agreements within the Block Contract to consider how 'fit for purpose' the breadth of the services are in relation to current need and projected altered need.

4.5 There has been an increased focus on Quality with regards to the main contract. A monthly Care Quality Review Meeting (CQRG) is now held and chaired by a CCG GPSI (GP with special interest in Mental Health) in addition to the 4 Borough CQRGs. (The 4 Boroughs comprise of Lambeth, Lewisham Southwark and Croydon).

4.6 The CQR practice replicates established practice for acute and community trust contracts and seeks to drive the improvement of quality of care of SLaM services.

5. Transformation of Croydon Mental Health Services – Adult Mental Health Model (AMH)

5.1 A commitment was given at the commencement of the 2014/15 year to developing within the borough a number of key community services which would be delivered by SLaM but within community settings and not further perpetuate the dependency on secondary care.

5.2 In November 2014 a monthly Adult Mental Health Steering group chaired by the clinical lead Dr Dev Malhotra was established to develop and oversee the implementation plan of the redesign of community services.

5.3 The steering group is taking forward the following services in a series of workshops over the next 3 months with the aim of agreeing key performance indicators, service specifications, and alteration in capacity and final agreement of patient pathways.

6. Primary Care Mental Health Support Service

6.1 This builds on the work that has been ongoing in Croydon for a number of years in relation to patients who could be managed in primary care but primary care may require some additional support at the outset to achieve the full transfer and onward management of these patients within the practice setting.

6.2 A cohort of patients has been identified and a meeting in January was held to both carry the work forward and ensure that "lessons learnt " were not lost and to begin to map fully the transfer time line of these patients to primary care .Ongoing work is being held with the GP Networks to progress this forward:

- **Assessment and Liaison Service** – This service is a priority service for 2015/16 and will be aligned to GP Networks but ensuring the GP's have immediate access to a senior clinical opinion at SLaM when they make contact and to ensure the patient is able to manage within the community if at all possible.

- **Personality Disorder Service** –This is a planned extension of Service User Network and additional treatment places in Touchstone, the personality disorder day service

- **Promoting Recovery Community Health Teams** – additional care co-ordinators are now in post enabling these teams to have the capacity to meet the level of need that Croydon has.

- **Home Treatment Team** – Additional capacity has been added to the team, again enabling them to have the ability to respond quickly to a request to offer a very real alternative to hospital based care.

6.3 Close working has also taken place over the last six months in relation to mental health for older adults – key areas of work are:

- a focused approach to dementia diagnosis by GP Practices and provision of support to practices to review their caseloads to ensure accurate reporting of patient numbers.

- a full review of the Memory Service is planned to identify required services changes to meet current need. This review is due to commence in February.

7. <u>Strengthening partnership working and integrating physical and mental health care:</u>

7.1 Public engagement has continued with the BME Forum via attendance at the recent 'Mind the Gap conference follow up meeting and inclusion from the outset within the AMH steering group of representation from the BME forum, service user voluntary sector and family/carer representation.

7.2 An enhanced physical health CQUIN (Commissioning for Quality and Innovation Payment) is being developed for 15/16 to focus further on the 'parity of esteem 'with physical health. (NHSE are expected to release this mid-February) parity of esteem and Croydon have committed to leading on the development of this CQUIN (in collaboration with SlaM) for the 4 Boroughs.

7.3 The Commissioning for Quality and Innovation (CQUINs) payments framework encourages care providers to share and continually improve how care is delivered and to achieve transparency and overall improvement in healthcare

7.4 Additional funding secured via NHS E winter monies funding has also been used to increase capacity in the Psychiatric liaison services in A&E liaison services, a development of a 4 Borough crisis line which will follow through on the success of the 'street triage service'. This has been able to offer a very robust interface with service users and has in a number of cases averted either attendance at A&E or the use by the police of a S136 or a need for admission.

7.5 The Mental Health Crisis Care Concordat is a national agreement framework between services and agencies involved in the care and support of people in crisis which sets out how organisations will work together better to make sure that people get the help they need when they are having a mental health crisisThe CCG and the Council are reviewing how to support the Crisis Care Concordat for whilst acknowledging the challenges it presents there is a shared view that

Croydon should commit to delivering against its requirements and in alignment with other London and neighbouring boroughs.

7.6 Development of the Early Intervention Service, initially intended for later delivery, has now been brought forward to Jan 2015 and is presently being recruited to. This service (referred to by SLaM as OASIS) works closely with primary care and other agencies to identify young people considered to be at high risk of developing psychosis. The service has demonstrated good outcomes in Lambeth Southwark and Lewisham and offers a clear pathway for early timely intervention to reduce the risk of escalating problems to a crisis point and improve availability and access to the broadest platform of services.

7.7 A new mental health indicator has been identified within the 'Five Year Forward View' with the longer term expectation that early intervention in psychosis will occur within 2 weeks this is in alignment with national expectations.

7.8 Investment has been established for development of a 24 hr crisis line which has been commissioned from SLaM. The intention is that this service will be able to replace the Street Triage Service funded for one year only 2014/15 via the Mayor's Office for Police and Crime- MOPAC. Close working relationship between SLaM, the CCG/NHSE and MOPAC has been established to ensure seamless continuity of service and referral contact methods.

7.9 In addition to the MDT meetings a 'Decision Support Tool' is being implemented across all GP Practices which facilitates a predictive clinical alert occurring alongside the GP's entries into patient notes. As new service initiatives and developments occur they will be loaded onto the Decision Support Tool 'meaning that all GP's will have access to information automatically.

8. <u>Starting early to promote mental wellbeing and prevent mental health problems</u>

8.1 Funding from NHS HESL has been secured through a partnership bid from the SW London Network of CCG's, (Richmond, Kingston, Merton and Croydon) to deliver a training programme developed by East London NHS Trust, across the four boroughs. 3 training packages will be delivered to front line health and social care staff from all sectors, designed to improve understanding of the links between physical and mental health.

8.2 The main training package, Mental Health Awareness is a ½ day course which will be delivered to approximately 800 front line workers. This training package will be supplemented by 'Train the Trainer' and 'Motivational Interviewing' to participants and organisations that wish to take their learning a step further. SLaM has been selected as the training provider to work in partnership with the Voluntary Sector in Croydon in order that training occurs throughout the geographical span of the borough and in a range of different settings to encourage participation from a diverse audience.

8.3 Training plan is scheduled to occur between April and December 2015, with final evaluation ending in March 2015.

9. IAPT Services

9.1 Additional investment has been made of £600K for 14/15 and the service is on track to achieve 5% access figures (as declared in the Operating Plan 14/15 and as agreed with NHSE).

9.2 The Commissioning Team are working more closely with the Voluntary Sector in 14/15 and a workshop identified for February 2015 to enable the Voluntary sector providers who presently deliver talking therapies to have discussions with NHSE and the criteria for IAPT inclusive services.

9.3 A one day workshop is being piloted from Jan – March 2015 to offer Saturday access for IAPT and with a key aim of reaching a wider cohort of service users. Ongoing review is being maintained of the pathway, benchmarking, accessibility and recovery rates of the service.

9.4 Further review is already underway in relation to the New Mental Health Indicators for IAPT as identified in 'Five year Forward View (The 75% standard of 6 week referral by April 2016 and the 95% standard of 18 week referral to first treatment appointment by April 2016).The long term conditions IAPT pilot has delivered good results and discussions are underway in regards to it being consolidated into one of the on-going work streams 2015/16.

9.5 The Mental Health Commissioning team have worked with NHS E and SLaM to review the present IAPT service model and establish what opportunities there are within the existing service to be available to further maximise its remit and capacity in relation to Croydon's specific needs (hard to reach groups including the BME population) The results of this desk top review are expected from NHS E in March 2015

10. Voluntary Sector Review

10.1 A review of the Voluntary sector has commenced and is due for completion in February 2015. This review has sought to re-establish contact with the wide range of voluntary sector providers Croydon CCG commissions from and to consider both the alignment and possible impact of those services within the wider context of the implementation of the Strategy.

10.2 The council also has a long history of commissioning services from the voluntary sector (many from the same organisations as the CCG). Increasingly, the aim across Health and Social Care is to ensure that commissioning is "joined up" so that the crucial contribution made by the voluntary sector is optimised and duplication of processes (e.g. returns of standard management and performance information) can be minimised.

11. Improving the quality of life of people with mental health problems

11.1 Implementation of the Mental Health Strategy is the responsibility of the statutory commissioners who are supported by the oversight of the following groups:

The Mental Health Partnership Board, has been reconvened with refreshed Terms of Reference, and will be the group responsible for overseeing the direction of Mental Health Services in Croydon. The partnership meets every three months and has wide representation of stakeholders across Voluntary Sector, Primary, Secondary Care, Service User groups and the BME Forum. Sub groups of the partnership will report progress at each quarterly partnership meeting.

The Mental Health Planning Group is an executive group of the Partnership Board. The Planning Group meets monthly, is chaired by a GP and brings together Mental Health Commissioners with Public Health to ensure that the actions of the Partnership Board are carried out and that ongoing commissioning work is aligned to the partnership, and effective communication exists between Mental Health Commissioning and the Partnership Board. The Planning Group's role is to sustain the progress of the Partnership Board.

The Mental Health Strategy/Adult Mental Health Steering Group has been developed. The group meets monthly and is chaired by a GP. The group comprises MH Commissioners, GP, Social Care, Secondary Care, Public Health, Contracting Support, and invited representation from the partnership board, of BME users, Patient Voice, Carers, and Voluntary Sector. The primary function of the group is to work on actions to implementation of the Mental Health Strategy, ensuring that the wider Mental Health System is represented and potential impact of any changes across all stakeholders is understood. A key early priority of the Strategy Steering Group will be to oversee the implementation of the AMH Model, but the groups remit will be the wider 5 year strategy.

Priorities and actions are able to flow from, and inform, each group.

The Mental Health Partnership Board is responsible for ensuring the progress of the Strategy Group and its alignment with the Mental Health Strategy

12. Conclusion

12.1 Good progress has been made to implement the Strategy and to take forward the service redesign work streams against a challenging platform.

12.2 The Mental Health Strategy is a live document, frequently referred to and utilised to inform the direction of Mental Health Commissioning in Croydon.

12.3 The Mental Health Strategy Action Plan has also been designed to be a live document shared by the Partnership Board which will demonstrate the progress made and invite participation by a wide range of stakeholders to achieve its goals and aspirations. Individual pieces of work relating to the strategy will where necessary require more detailed project plans, the progress and outcomes of these plans will be recorded on the Action Plan, which is attached in full (Appendix 1).

12.4 The recently published 'Five Year Forward View 'makes clear the strategic focus from NHS England in relation to additional mental health indicators in relation to early intervention in Psychosis and an effective Liaison Psychiatry Model. Both areas had already been identified as being areas of focus within the action plan.

12.5 The engagement and understanding of the voluntary sector has both increased and improved and the mental health Partnership board has an increased voice.

12.6 The AMH model continues to be under detailed review and further refinement via the AMH Steering group with a clear focus on the moving of investment into community services (for both adult mental health and MHOA services).

12.7 There will be further development of IAPT services and increased integration with physical health e.g. IAPT/LTC's. There is clear opportunity to further maximise opportunities for integration via the MDTs.

12.8 There are also developments to expand and improve upon the interface of crisis services and A&E liaison services.

12.9 The Adult redesign work streams have been developed in alignment with the CAMHS and MHOA service redesign initiatives.

13. CONSULTATION

13.1 The Mental Health Partnership Board meets quarterly with meetings identified for the full year ahead) and its terms of reference reviewed and agreed. There is a clear commitment from the CCG and council to the Partnership Board that it will be a key forum in taking forward the Mental Health Strategy in an open and transparent way. This engagement with key stakeholders has been well received and feedback has reported that those attending have felt very included in the process.

13.2 There has also been increased engagement with the BME forum and the CCG presented at the recent 'Mind the Gap 'follow up public meeting

13.3 There was a Public and Patient Involvement event in Sept 2014 at which the Mental Health Strategy was presented.

14. SERVICE INTEGRATION

14.1 The strategy was developed from the outset as an integrated strategy for Croydon, involving not just the CCG and the Council but the wider community of local stakeholders, It sought to draw on the experience of service users and carers to ensure their views on effective service delivery were taken into account and the service user voice has been further increased over the last six months.

14.2 Universal credit and broader welfare reform, along with homelessness, are also key factors which can substantially affect people's mental health. Through the Integrated Commissioning Unit and elsewhere there already have been projects which have attempted to support people facing such challenges. The council will shortly be seeking to establish a new "Welfare Gateway" approach which will proactively provide "joined-up" targeted advice and support to Croydon people by bringing together a range of existing services. This will involve the council's own provision, but will also work closely with a range of other statutory organisations

(such as JCP) as well as with key partners in the voluntary and community sectors.

14.3 An integrated review of the community and forensic pathways has just commenced with NHS E and Croydon CCG /Social Care but is likely to take some months before further recommendations are produced.

15. FINANCIAL AND RISK ASSESSMENT CONSIDERATIONS

15.1 In 2013/14 the CCG and Croydon Council spent approximately £60m directly on mental health services for adults of working age (£46.9m for the CCG and £12.3m for the Council) the strategic aim remains to strengthen prevention and early intervention services and to commission a broader range of services in the community. Investments in these types of services can deliver better outcomes for mental health service users and simultaneously deliver better value for money / cost effectiveness.

15.2 The need to “do things differently “was agreed by all, but implementation of the strategy requires significant service redesign and to support this the CCG has made significant investment to meet current service pressures but Gate keeping and demand management remains a strong area of focus to ensure investment committed to at the outset of the year is being tracked and a trajectory of reduction in inpatient activity established.

15.3 A full review of the Risk Register (as identified in the Governing Body Paper of October 2014) has taken place and the Croydon CQRG meeting which meets monthly with SLaM has been able to act as the key forum for onward management of any risks identified.

15.4 The Tertiary Referral process (the process by which a patient is referred for specialist tertiary services) has also been fully reviewed. A revised panel has been formed, which meets more frequently and with improved interface with GP’s and referring clinicians, meaning that there is now a notably improved means of access for patients.

16. EQUALITIES IMPACT

16.1 An Equality Impact Analysis for the strategy was carried out in July 2014 and the equality impact analysis is reviewed and updated as an integral part of the action plan in order to ensure that any potential equality impacts are identified and responded to as appropriate.

16.2 The Mental Health Strategy was presented to the CCG Equality and Diversity Board in November 2014 and was found Amber /Developing in all areas

16.3 We have made Equalities and Diversity a standing agenda item at all Mental Health meeting to ensure the matter is imbedded as ‘standard practice

17. CRIME AND DISORDER REDUCTION IMPACT

17.1 The Strategy referenced the mental Health London Street Triage service, an initiative which has been funded through the Mayor of London's office (MOPAC) from April '14 to March '15. The aim of the service was to improve outcomes for people experiencing mental health problems through services working with a shared commitment to ensure the person in crisis received the correct level of care, in the right environment. Croydon council and Croydon CCG have worked closely with partners from SLaM, NHS E, Police. London Ambulance Service and the Voluntary sector to deliver this pilot service and successes identified within that service have been fully incorporated into the 24/7 crisis service.

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BACKGROUND DOCUMENTS.

Action Plan

References:

Croydon Mental Health JSNA 2012/13

Mind the GAP: A report on BME Mental Health Provision (2012)

Croydon Integrated Mental Health Strategy for Adults 2014-2019

Five Year Forward View – October 2014

Croydon's Integrated Mental Health Strategy Action Plan 2014-2019

1: Increasing access to mental health services

Aims of Integrated Mental Health Strategy 2014-2019	Actions	Expected Timescale start	Expected Timescale finish	Lead	Update December 14	Outcome Measure
Improve access and experience of services for BME service users.	MH Commissioning Team to engage with patients / service users and community groups through the BME forum to progress the work and actions from the local BME Mental Health Report 'Mind the Gap'	Aug-14	Aug-15	NT	•30th Oct 2015. Attended and Presented at Mind the Gap follow up event to provide an update on SLaM's work at improving experience of BME services. •Public event with Hear Us, Off the Record, Healthwatch and Mind all invited. • Presented to Equality and Diversity Panel scoring developing in all sections. •Equality & Diversity to be agenda item at all meetings	To reduce health inequalities within the borough , to provide access to better mental health services and treatments
Reduce the use of inpatient settings for BME service users	MH Commissioning Team to engage with patients / service users and community groups through the BME forum to progress the work and actions from the local BME Mental Health Report 'Mind the Gap'	Aug-14	Aug-15	NT	Meetings have been arranged between SLaM, BME Forum, & Hear Us to look at this issue and develop actions that can lead to improvements, meetings are scheduled for; •27th Feb 2015 •10th March 2015 •17th March 2015	
Increase the referrals and take up of talking therapies for BME service users.	Explore IAPT market which could enhance services in Croydon	Apr-15	Apr-16	NT	• 10th December Started worked with Clinical Psychologist (SLaM) to develop a pilot of existing 'Tree of Life' service to meet IAPT criteria and to pilot with three user groups by 31st March 2015. •The 'Tree of Life' approach has demonstrated good outcomes with BME service users and Croydon CCG are keen to explore its potential wider use and expansion	
Reduce over representation of young BME males in acute psychiatric services	Work with Public Health to ensure appropriate Prioritisation of community service developments within the AMH model	Apr-15	Apr-16	NT	Will form part of the above work	
Develop & Implement disorder specific pathways for mental health.	All Mental Health pathways to be mapped. We will produce pathway maps for each of the services to better understand the patient journey. We will involve service users / patients and carers and produce a recommendation and action plan based on the mapping project.	Jan-15	Apr-18	NT	Pathways will be mapped for each part of the Adult Mental Model as part of its implementation between Jan - June 2015 prioritising; • Primary Care Mental Health Support Service - 21st May 2015 • Assessment and Liaison Team, - 21st May 2015 • Promoting Recovery Team - 21st May 2015 • Home Treatment Team - 21st May 2015 • Personality Disorder - 21st June 2015 • Oasis & Coast (Early Intervention Services) 21st June 2015 • Clozapine - 21st June 2015 • Enhancements have already been made to the Crisis and Home Treatment Service to increase capacity	
Reduction in the use of overspill beds for inpatients in acute care	We will monitor and review the usage of overspill beds, against the implementation of the new AMH model. Quarterly figures will be produced and shared which shows the reduction in overspill, and if the reduction is not evident or insufficient recovery action will be instigated.	Jan-15	Apr-18	SG / PR	Barriers to discharge is an agenda item for the Mental Health Planning Group. An initial proposal has been circulated on the 9th January and further action will be planned in February to work with provider SLaM to hold a multi agency meeting on the ward to assess current patients and develop actions remedy barriers to discharge. The use of out of borough placements is now minimal . This has further ensured that Croydon service users have robust access to IMHA provision	
Increase access rates and capacity of IAPT service	Additional investment of 700k into IAPT services for year 14/15 which will be recurrent. There is a review of current Voluntary Sector Talking Therapies provision and its potential IAPT inclusion	Apr-14	ongoing	BB / SG	IAPT Service on target to increase Access Rates to 5% by March 2015.The service has been expanded with additional funding and the waiting list reduced. Review of Voluntary Sector provision uinderway	To improve access to better mental health services and treatments
Support MH Needs of offenders sooner	Recommendation from closing the gap and area to explore in 2015/16	Oct-15	Apr-19	MH Commissioning	Expected to begin work in October 2015	To improve access to better mental health services and treatments
No one turned away from services	Recommendation from closing the gap and area to explore in 2015/16 - will link with work on parity of esteem	Apr-15	Apr-16	MH Commissioning	Forms part of the work stream rolling out the AMH Model	To improve access to better mental health services and treatments

2: Strengthening partnership working and integrating physical and mental health							Outcome Measure
Aims of Integrated Mental Health Strategy 2014-2019	**Actions**	**Expected Timescale start**	**Expected Timescale finish**	**Lead**	**Update December 14**		
Aim to reduce mortality rates for people with a serious mental illness	Work with partners in Public Health to benchmark current mortality rates and these will be reviewed year on year in order the impact of the AMH model can be assessed.	Jun-15	Apr-19	SG	The Commitment is to ensure that there is an improved in reach of specialist clinical care in relation to physical health needs and that out patient appointments are honoured (particularly when a patient has a lengthy in patient episode of care) To improve the Quality of discharge letters at the point of discharge .		To increase service users confidence in a Healthy life expectancy . To narrowing the life expectancy gap associated with Mental Health Service users
Improve physical health support to mental health service users	Develop an enhanced physical health CQUIN for 15/16	Apr-15	Mar-16	BB / SG	For 15/16 there will be a new physical health CQUIN with provider SLaM on national DoH standards. Guidance yet to be published but discussions have been held with 4 borough colleagues and a 4 borough CQIUN will be implemented.		Improve health and wellbeing through promotion of sports, participation rates in sporting activity, % adults meeting at least minimum levels of physical activity, adult obesity rates
Ensure Mental Health Community are included within Croydon's Improved Whole Population Health Promotion	Need to establish initial contact with other departments to align work	Aug-14	Apr-16	MH Commissioning	To work in alignment with Bernadette Elves in Public Health in the development of the 2015 Annual Public Health report which has as its focus Health Inequalities within the Borough and from which an action plan will be developed		Tackle health inequalities within the borough
Ensure carers services are appropriate and fit for purpose	Work to begin 15-16	Apr-15	Apr-19	MH Commissioning	Mental Health Commissioning represented at Carers Forum 12th December 2014, and will continue to have representation on an ongoing basis. This will ensure future work on carers services are aligned with Council services and the Carer Strategy		Self-reported wellbeing, social care carers with as much social contact as they would like
To Reduce attendance at A&E's	Review the results of the Audit currently being carried out at Croydon University Hospital (CUH). The results of the audit can be used to produce a report with further recommendations and action points.	Apr-15	Mar-19	NT	Croydon CCG secured additional money for winter services to cover period of December 2014-April 2015. The following additional services will be delivered; • Additional Staff Grade Doctor (Jan-March) within PLN team to further reduce A&E waiting times and improve experience of people in Mental Health Crisis presenting at A&E. This is expected to reduce A&E breaches by a further 5% • Increased Capacity within Early Intervention Services to reduce caseload and waiting times. This increased capacity will be ongoing and was planned for 2019 but has been brought forward 3years with the additional short term funding. • Development of New Early Detection service to work with young people at risk of developing psychosis. This service will be ongoing and was planned for 2019 but has been brought forward 3years with the additional short term funding. •Croydon is working with Southwark, Lambeth & Lewisham to develop a 24/hr Crisis Line which will be available to primary care and the police services and members of the public. This will ensure consistently of response across the 4 boroughs and support the aims of the Mental Health Concordat, to support people experiences or at risk of experiencing Mental health Crisis.		To reduce attendance at A&E
Medication adherence	Work to begin 15-16	Jan-15	Apr-19	MH Commissioning	Will form part of the wider service redesign about effectiveness of primary care and integration with self help, secondary care and community support services •To start Jan 2015		Tackle health inequalities within the borough
Ensure the partnership and governance has wide and appropriate membership to implement the strategy	TOR, governance, and mental health strategy action plan to be addressed and next MH partnership board meeting	Dec-15	Review Dec-16	NT	The Mental Health Partnership has been refreshed with meetings in Sep and Dec 2014. •ToR's and attendance have been refreshed The Partnership is actively attended from representatives of Service Users, Carers and BME forum. •Additionally 4 reps have been invited onto the Mental Health Strategy Steering Group to work on implementing the Mental Health Action Plan. The strategy group meets monthly.		To ensure there are clear Governance arrangements in place which can underpin the deliverance of the strategy.

2: Strengthening partnership working and integrating physical and mental health (cont.)						Outcome Measure
Aims of Integrated Mental Health Strategy 2014-2019	Actions	Expected Timescale start	Expected Timescale finish	Lead	Update December 14	
Ensure all services provide good intelligence and that targets are clear	Work will begin on both voluntary and secondary care to ensure that each service is clear and we understand data that relate to its key areas. Additionally, each service area will have updated key performance indicators and service spec's. Each service area will be tackled individually and will involve engagement and consultation with all stakeholders and include views service users.	Jan-15	Apr-19	NT	Activity & KPI monitoring in the SLaM contract is to be further enhanced and clearly set out in the 15/16 contract. Mental Health Commissioning currently undertaking a review of the Voluntary Sector which should result in a report by 28th Feb 2015. This report will inform commissioning and ensure organisations are working in alignment with the Mental health Strategy	To manage CCG & Council finances in a prudent manner
Secure long term provision of the London Street Triage Service	Street Triage Board meets quarterly, and Croydon attends	Sep-14	Sep-15	NT	Croydon CCG are working with the 4 boroughs and NHSE regarding the ongoing financial viability of the Street Triage Service. Last meeting 29th Jan 2015. •However, the key component of the service, the access to a 24/7 Crisis helpline has been secured to continue from April 2015 on an ongoing basis which will mitigate any risk of the one year pilot ending.	To reduce crime in partnership with local police

Section 3: Starting early to promote mental wellbeing and prevent mental health problems						Outcome Measure
Aims of Integrated Mental Health Strategy 2014-2019	**Actions**	**Expected Timescale start**	**Expected Timescale finish**	**Lead**	**Update December 14**	
Ensure the voluntary/third sector have an increased understanding of mental health preventative measures and primary care	A review of all voluntary sector services is being planned and will be carried out between Sep 14 and 30th Nov 14. This review will be used to inform the commissioning intentions for the voluntary sector. This review will cover a wide range of areas and will include the referral routes into each service in order that the services can be mapped and there relationship with primary and secondary care understood.	Sep-14	Aug-15	SM	Voluntary Sector Review planned for completion 28th Feb. Commissioning Recommendations to follow.	To help local families at an early stage
Deliver timely advice and signposting to reduce the risk of escalating problems, and improve availability and access to universal services	To form part of the Voluntary Sector Review and future commissioning of advice services. Roll out of the AMH Model.	Apr-15	Apr-16	MH Commissioning	• The increased investment into the Adult Mental Health Model will develop expansion with Assessment & Liaison services working with primary care to facilitate easy in / easy out pathways for Mental Health. This will result in better access to services and integration between primary, secondary and community care • Voluntary Sector Review to be completed 28th Feb 2015	To increase access to better mental health services and treatments
Ensure that Postnatal depression services are effective and can respond to expected increase in demand over the next 10 years	We will review postnatal services as a project and involve service users in this work. From this review we will share the results and recommendations with the partnership board.	Mar-15	Mar-16	MH Commissioning	SG will attend a national conference on Perinatal Services in January. Working group expected to be formed next year (15-16)	To increase access to better mental health services and treatments
Family Therapy	Access to family therapy identified in Closing the Gap, service area to be explored further in 15/16	Jan-16	Apr-19	MH Commissioning	As above - working group expected to pick up Jan 2016	To help families at an early stage
Transition Arrangements				MH Commissioning		
Ensure prevention and early intervention services for the 14-35 years olds are effective. Schools to feel supported to identify MH Earlier	Develop a project to work with service users, carers and children's services commissioners to review services and inform future commissioning decisions. it is a priority area for Croydon to develop early detection and intervention services (COAST & OASIS) to be operational by March 2015. Full specification and KPI's developed	Jan-15	Apr-16	MH Commissioning	Review of the expansion and development of Coast and Oasis service as part of core contract monitoring once established Jan 2016 •Further work review the transition process with children's commissioners Review of the expansion and development of Coast and Oasis service as part of core contract monitoring once established Jan 2016	To help local families at an early stage
Peer support	Service reviewed against existing evidence base but not currently prioritised for funding with Croydon, as funding directed towards early intervention and hospital liaison services	Jan-15	Mar-16	MH Commissioning	29th Jan Croydon CCG met with colleagues within the TAC's programme to explore social prescribing. • Croydon CCG working with Public Health to develop evidence base of Social Prescribing and its impact on isolation. • Report from Public Health an agenda item for March 2015 Partnership Board Meeting	To prevent people from becoming isolated
Increase promotion and support for self-care. Increase choice and control of people using mental health services. Including increase of decision making.	All of the service reviews and future commissioning decision will include feedback from service users. Contracts and revise service specifications will include KPI's and targets for increasing choice and control of service users.	May-15	Mar-16	MH Commissioning	MH Commissioning represented on Presentation, Self Care and Shared Decision Making working group Nov 14. Workshop set up for 26th Feb to test Mental Health App's with a stakeholder group. If positive feedback will consider with GP leads how we promote to Citizens. Work is beginning to review the information on Mental Health currently held on CRESS to be transferred to D-Sit.	To reduce health inequalities within the borough, to address the impact of alcohol, tobacco and substance misuse, self-reported wellbeing, to increase social contact for social care clients and carers

4: Improving the quality of life of people with mental health problems

Aims of Integrated Mental Health Strategy 2014-2019	Actions	Expected Timescale start	Expected Timescale finish	Lead	Update December 14	Outcome Measure
Increase the choice and control of people using Mental Health services, through increased personalisation and using personal care and support planning to put people in control.	Joint work with social care to explore opportunity for increased use of personalisation within social care	Mar-16	Apr-19	MH Commissioning	Expected to begin March 2016 to work closely with social care colleagues and the Mental Health Partnership to explore the greater use of personalisation and promotion of personal budgets within MH Social Care.	Self - reported wellbeing, & social care clients and carers with as much social contact as they would like
Croydon will work towards delivering Personalised Packages of self-directed support that meets assess need, that have a strong focus on promoting independence, recovery and resilience.	as above	Mar-16	Apr-19	MH Commissioning	Expected to begin March 2016 to work closely with social care colleagues and the Mental Health Partnership to explore the greater use of personalisation and promotion of personal budgets within MH Social Care.	Self - reported wellbeing, & social care clients and carers with as much social contact as they would like
The Mental Health Strategy has been graded by external stakeholders as 'developing' or 'amber' from assessment for EDS2, Equality and Diversity Performance. We will work towards obtaining a green score for each identified area. To facilitate this Equability and Diversity will be a standing agenda item at each Mental Health Planning Meeting, Team Meeting, & Partnership Board Meeting, were will review the actions from the assessment.	Progress against current performance reviewed and shared with partnership board. Updates will be compiled on a three monthly basis.	Sep-14	Apr-19	NT	Equality and Diversity is a standing agenda item across all Mental Health Working Groups	To increase access to better mental health services and treatments
Ensure community -based support is available	Will be part of the proposed AMH model and subsequent scoping and review of Voluntary Sector provision and community services	Jan-15	Apr-19	MH Commissioning	The Voluntary Sector are part of the mental Health Strategy Steering Group which will meet monthly throughout 2015. The role of the Voluntary Sector Rep's will be ensure that service expansion in secondary care is aligned with services available in the Voluntary Sector •The development of the Clozapine service will facilitate more people being able to manage their mental health within the community rather than as inpatients and this service should be in place by June 2015	To prevent people from becoming isolated, provide better access to mental health services and treatments, self-reported wellbeing, % social care clients and carers with as much social contact as they would like
Front line staff not equipped to deliver personalised training	Funding has been secured to deliver borough wide mental health awareness and first aid training to front line health and social care workers in Croydon to enhance service and experience of services by MH service users	Feb-15	Dec-15	NT / HESL Project Support TBC	Provider selected •Partnership Board consulted on content and delivery •Training content to be confirmed April 2015 •Training delivery April 15- Dec 15 •800 Mental Health Awareness Training Places •40 Train the Trainers Places •40 Motivational Interviewing Places	Right people in right jobs Task all council departments with improving health of residents
Promote the use of direct payments	Need to ensure a clear alignment with social care via the ICU	Mar-16	Apr-19	MH Commissioning	Expected to begin March 2016 to work closely with social care colleagues and the Mental Health Partnership to explore the greater use of personalisation and promotion of personal budgets within MH Social Care.	To prevent people from becoming isolated, provide better access to mental health services and treatments, self-reported wellbeing, % social care clients and carers with as much social contact as they would like
Enhanced Support for with MH who is a victim of crime	To work in close collaboration with the Community Safety team at Croydon Council	Oct-14	Oct-15	MH Commissioning	Work began in late 2014 with community safety team Croydon Council.	tackle disability hate crime to increase the percentage of social care clients who feel as safe as they want and are satisfied with care
Reduce Restraint	Identified as an area within the Closing the Gap report - to be explored 15-16 and as part of the ongoing AMH service development with SLaM	Nov-14	Oct-15	MH Commissioning	Work began in Nov 2014 with SLaM as part of work with Hear-Us and BME Forum to improve patient experience.	To commission for the best hospital and healthcare services fro Croydon
Change Approach to self harm	Identified as key area in Close the Gap report - will need to be taken forward as a quality issues in 15-16	Nov-14	Oct-19	MH Commissioning	Work to begin with SLaM in June 2015	To commission for the best hospital and healthcare services fro Croydon

4: Improving the quality of life of people with mental health problems (cont)						Outcome Measure
Aims of Integrated Mental Health Strategy 2014-2019	**Actions**	**Expected Timescale start**	**Expected Timescale finish**	**Lead**	**Update December 14**	
Develop personal health budgets	It is a government priority to increase choice and control in public services. Guidance is expected to be developed by NHS England on how Personal Health budgets will be implemented and this project area will be developed in the future	Mar-16	Apr-19	MH Commissioning	Expected to begin March 2016 to work closely with social care colleagues and the Mental Health Partnership to explore the greater use of personalisation and promotion of personal budgets within MH Social Care.	To prevent people from becoming isolated, provide better access to mental health services and treatments, self-reported wellbeing, % social care clients and carers with as much social contact as they would like
Review Reablement Service Pilot	Current pilot is being evaluated and a review of which will inform commissioning decisions.	Jan-15	Apr-15	MH Commissioning	Decision to be made in Jan regarding 15/16 funding. External evaluation is being completed by York University and will inform decision making process	To manage CCG & council finances in a prudent manner
Integration with transport, green space and leisure	Need to establish initial contact with other departments to align work and develop work plan	Mar-16	Apr-19	MH Commissioning	Expected to begin discussions with community safety team March 2016	To make parks and open spaces safe for all, to tackle disability hate crime
Review of Mental Health Day Services	Scoping to be undertaken in 2015/16	Mar-16	Apr-19	MH Commissioning	Expect to review to commence March 2016	Reduce social isolation and enable re-ablement and recovery
Develop a strategy for welfare reform	Action plan to be developed. To provide good welfare and debt advice. To work in alignment with Croydon Council and findings on Universal Credit. Barriers to discharge work will offer clarity regarding welfare concerns of service users	Nov-14	Apr-16	MH Commissioning	Work commenced with Council colleagues in Nov 2014 - to be further discussed at Partnership Board in March 2015	To provide access to a welfare benefits hotline, to assist those affected by the bedroom tax / universal credit to access timely advice
Develop a housing and housing related support action plan	A review of mental health commissioned supported housing is being carried out in 14-15. This review will form the basis of action planning and next steps. Housing services should focus on recovery and hospital admission.	Jun-15	Apr-16	MH Commissioning	Mental Health to expand links with housing department beginning Nov 2014 To work in liaison with the JSNA on homelessness due early 2015	To increase access to mental health services for those service users living in emergency accommodation
Use of friends and family test to allow all patients to evaluate services	Work to begin 15-16	Jun-15	Apr-16	MH Commissioning	Use of family and friends test to be a quality CQUIN for year 15/16.	Open and transparent and put communities at heart of decision making
Increase choice about mental health services	Work to begin 15-16	Jun-15	Apr-16	MH Commissioning	To be discussed at the Mental Health Partnership Agenda May 2015 along with Advocacy Services	Open and transparent and put communities at heart of decision making
Review employment support services	A full review of council employment services is planned and will need to include closer working arrangements with established mainstream services, Job Centre Plus, Disability Employment Advisors information and signposting services.	Apr-16	Apr-17	MH Commissioning	Develop links with Council colleagues April 2016	To increase employment and reduce poverty across all communities
Increase resilience of employers workforce	Action plan to be developed to work with Council, Primary Care and SlaM to support the workforce reduce risks of mental ill - health and support return to work.	Apr-17	Apr-19	MH Commissioning	Develop links with Council colleagues April 2015 - and to establish the level of need ahead of April 2017	Adults with mental health needs in paid employment

FOR INFORMATION

REPORT TO:	**HEALTH AND WELLBEING BOARD (CROYDON)** **11 February 2015**
AGENDA ITEM:	**7**
SUBJECT:	**Primary Care (Medical Services) Co-Commissioning**
BOARD SPONSOR:	**Paula Swann, Chief Officer, NHS Croydon Clinical Commissioning Group**
CORPORATE PRIORITY/POLICY CONTEXT: This report is for information only	

1. RECOMMENDATION

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

2. EXECUTIVE SUMMARY

2.1 NHS Croydon CCG in conjunction with NHS England and SWLCCGs has agreed to make an application to jointly co-commission primary care medical services from 1st April 2015 through a joint committee.

2.2 Co-commissioning describes two or more commissioners coming together, where a shared interest exists, to commission health services for local populations. It is the mechanism offered by NHS England to involve CCGs in the commissioning of primary care contractual arrangements. Co-commissioning is one of many changes set out in the NHS Five Year Forward View. It is expected that co-commissioning will form a key enabler in developing seamless integrated out of hospital services for local people as it supports the joining up of previously fragmented services. It also recognises the important role GPs play in commissioning and the provision of health services.

3. DETAIL

3.1 The expected benefits of joint commissioning of primary care medical services are:

- services that are more responsive to local needs, and designed in accordance with patients' expectations.
- improved quality of primary care provision, both within CCGs and across SWL.
- greater consistency in the provision of primary care services across SWL, including greater consistency of outcomes for SWL's population.
- greater stability in the provision of primary care.

- a primary care sector that, as part of broader out-of-hospital provision, has greater capacity and capability to address the local population's healthcare needs

3.2 It is recognised that local stakeholders including patients and the public need to have a greater voice in the commissioning of primary care services, and therefore this has been addressed in the membership of the Joint Committee.

3.3 The challenges of managing conflicts of interest robustly are also recognised and are reflected in the governance arrangements for the Joint Committee which adhere to the latest NHSE guidance.

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

BACKGROUND DOCUMENTS
None

NHS Croydon Clinical Commissioning Group

Co-commissioning arrangements for Primary Care (medical)

In conjunction with SWL Collaborative Commissioning

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The CCG's Council of Members & Governing Body have agreed :

- to make an application to **jointly co-commission** primary care medical services in conjunction with NHS England and SWL CCGs
- to amend the CCGs constitution to enable the CCG to form a SWL joint committee to support Primary Care Commissioning
- the Terms of Reference of the Joint Committee

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Clinical Commissioning Group

Co-commissioning of Primary Care

- Co-commissioning describes two or more commissioners to come together to commission health services

- It is the mechanism proposed by NHS England to involve CCGs in the commissioning of primary care contractual arrangements.

- It is one of many changes (along with specialised commissioning) set out in the NHS Five Year Forward View. The view is that co-commissioning is a key enabler in developing seamless integrated out of hospital services for local people as it supports the joining up of previously fragmented services

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What does primary care co-commissioning mean?

- NHSE have identified specific primary care functions which can be co-commissioned (core contracts will **not** be changing), namely:
  - Designing Contracts (APMS, PMS)
  - Contract monitoring
  - Contractual action
  - Removal of contracts
  - Local Enhanced Services
  - Directed Enhanced Services
  - Design of local incentive schemes as an alternative to QOF
  - The ability to establish new GP practices in the area
  - Approving practice mergers
  - Making decisions on ‘discretionary’ payments

NHS Croydon Clinical Commissioning Group

Three models for co-commissioning arrangements

Greater Involvement in Primary Care	Joint Commissioning Arrangements	Delegated Commissioning Arrangements
CCGs would work more closely with area teams around Primary Care commissioning intentions. No new governance arrangements required	CCGs would assume joint commissioning responsibilities with area teams. A joint committee would be set up and CCG constitutions amended.	CCGs would assume full responsibility for commissioning primary care services on behalf of NHSE who would closely monitor CCGs

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What does joint commissioning mean?

- **Joint commissioning** arrangements between all CCGs in SWL and NHSE allows shared responsibilities of many of the important functions for commissioning primary care
- Joint commissioning arrangements **will allow** CCGs to bring local knowledge and develop localised commissioning and incentives
- Joint commissioning arrangements **will allow** CCGs to improve their relationships and engagement with local primary care teams
- Joint commissioning, as opposed to delegated commissioning, may reduce risks associated with identifying and managing conflicts of interest, capacity/capability risks and financial risk

Primary care function	Greater involvement	Joint commissioning	Delegated Commissioning
General practice commissioning	Potential for involvement in discussions but no decision making role	Jointly with area teams	Yes
Pharmacy, eye health and dental commissioning	Potential for involvement in discussions but no decision making role	Potential for involvement in discussions but no decision making role	Potential for involvement in discussions but no decision making role
Design and implementation of local incentives schemes	No	Subject to joint agreement with the area team	Yes
General practice budget management	No	Jointly with area teams	Yes
Complaints management	No	Jointly with area teams	Yes
Contractual GP practice performance management	Opportunity for involvement in performance management discussions	Jointly with area teams	Yes
Medical performers' list, appraisal, revalidation	No	No	No

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Why the Joint Commissioning Model?

- SWL CCG Chairs & Chief Officers have reviewed options and respective benefits and challenges and recommend the joint commissioning model
- It offers an opportunity to commission general practice in partnership with NHS E and other CCGs
- It enables CCGs to better manage conflict of interests in their decision making
- It allows CCGs to build the capability and capacity to commission
- It enables risk to be managed as each body retains their statutory function and responsibility
- It provides a stepping stone to full delegated budgets

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Key Considerations for Co-Commissioning

Strengths	Weaknesses
▪ Enables CCGs 'as membership organisations' to influence Primary Care decisions with funding risk being held by NHS E ▪ Enables services to be commissioned in joined up way in line with local priorities – reduces current fragmentation ▪ Enables responsive services to meet local needs	▪ No new funding identified at this time ▪ Increase in CCG role in managing and monitoring GP practices

Opportunities	Threats
▪ Alignment primary medical services locally to meet needs of local populations eg, QOF plus ▪ Ability of CCG to resolve local organisational issues for GPs eg, local knowledge of contractual and payment issues, facilitating practice mergers and provision of safeguarding training ▪ Facilitates our ambition of providing a wider range of services closer to patients homes – shifting resource and focus from secondary care ▪ Supports the development of sustainable/resilient local services in primary care	▪ Increase conflicts of interests and potential for increased external interest ▪ Increased work load for GPs in delivering 'out of hospital agenda' ▪ LMC are concerned about co-commissioning ▪ Potential impact on membership engagement

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Key Concerns Raised & Mitigations

- **Short time scale for decision** – this is the NHS England timescale which we are required to meet. Guidance was very late. The joint commissioning option means that we can develop our approach and not hold any commissioning risk.

- **Governance of decision making** – transparency and scrutiny of decision making demonstrated through public joint committee with attendance from HWBB, Health Watch and LMC representatives

- **Conflict of Interests** – mitigated through revised conflict of interest requirements as well as joint decision making with other bodies

- **LMC Concerns** – mitigated through attendance of LMC representatives

- **CCG Resource** – mitigated through joint resource with NHS E & CCGs

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Joint Committee ToR

The Joint Committee shall consist of:

- Three representatives from each CCG; the CCG Chair, Chief Officer and Lay Member (one vote)
- Three representatives from NHS England's London Area Team, as follows: the Medical Director, Area Director and Head of Primary Care (or a named deputy of appropriate seniority for any of these representatives)

There will be one vote per organisation

The following non-voting attendees will be invited to attend meetings of the Joint Committee:

- One representative from each relevant Local Medical Committee, including the Surrey and Sussex Local Medical Committee
- One nominated representative from each relevant borough's Health and Wellbeing Board
- One representative from each relevant borough's Healthwatch

Next steps

- CCGs await feedback from their application submitted to NHSE by 30th January 2015
- The arrangements go live in April 2015

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FOR INFORMATION

REPORT TO:	HEALTH AND WELLBEING BOARD (CROYDON) 11 February 2015
AGENDA ITEM:	8
SUBJECT:	Market Position Statement for Adult Social Care
BOARD SPONSOR:	Paul Greenhalgh, Executive Director - People, Croydon Council
CORPORATE PRIORITY/POLICY CONTEXT: This report is for information only	

1. RECOMMENDATIONS

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

2. EXECUTIVE SUMMARY

2.1 From April 2015 local authorities will be publishing a market position statement (MPS) for adult social care services as part of a new general duty to manage the market. The Council is consulting the market about the draft Statement (Appendix 1). Members of the Health and Wellbeing Board are invited to submit questions and comments.

3. DETAIL

3.1 The Care Act 2014 imposes a duty on local authorities to promote the efficient and effective operation of a market in services for meeting care and support needs with a view to ensuring that any person in its area wishing to access services in the market has a variety of providers and high quality services to choose from and sufficient information to make an informed decision about how to meet the needs in question. In carrying out that duty the Council is required to have regard to the Department of Health's Care and Support statutory guidance issued under s.78 of the Act. The Chapter in the statutory guidance relating to Market Shaping and Commissioning of Adult Care and Support is presented in terms of those things which the local authority should or must do. The guidance states it is 'suggested that a local authority can best commence its duties under Sections 5 (market shaping and commissioning) and 48-57 (market oversight and provider failure) of the Care Act by developing with providers and stakeholders a published Market Position Statement'. However, while publication of the MPS may not be a duty it may be considered the most effective means of meeting those aspects of the Act and Guidance which are.

3.2 The purpose of an MPS is to help providers to develop their service offer to meet social care local needs regardless of whether they are paid for by the local authority or private individuals. Large national providers typically will have specialists developing their organisation's business strategy and there is limited scope for individual local authorities to influence their plans. Therefore the main target audience for the MPS is the range of local and small to medium size providers. The MPS brings together the local authority's view of local need in a format that providers can easily understand and translate into service/ product development.

3.3 A range of preparations have already taken place and there is a plan going forward:

- Officers in the Integrated Commissioning Unit and the Council's SCPP category management service have worked together to develop the document with input from a range of colleagues including from across adult social care, the CCG and the Council's Economic Development Team

- Officers have taken part in Department of Health commissioned support activities provided by Oxford Brookes University – this has generated guidance on what an MPS should look like.

- Officers have reviewed MPS documents prepared by other areas – their content, level of detail, range and usefulness to providers vary considerably.

- Much of the background work has already been done and is contained in the range of existing needs analyses, strategies and work-plans, policies and projects.

- The consultation draft MPS (Appendix 1) was published in January on the London Tenders Portal website inviting providers to submit comments on how useful they find the draft MPS and how it could be improved. Providers are being encouraged to respond through provider forums and at other events.

3.4 The MPS is intended to be a short, punchy and attractive document consisting of:

- A description of what an MPS is and how to use it
- An overview of the strategic direction for adult social care services in Croydon, including personalisation, prevention, commissioning for outcomes and integration with health services
- Summary of our analysis of future needs with links to on line needs data
- Resources, finance and funding - projections and issues
- Description of current supply, including gaps in provision and priorities for service development

- Details of how the Council is supporting the market and other resources available for business development activity

3.5 The MPS should assist in tackling inequalities, including health inequalities. The MPS sets out the Council's expectations of service providers to develop services that meet the needs of people with protected characteristics, particularly older people and people with a disability. The MPS sets out the Council's expectations of service providers in relation to workforce development and connecting people to economic opportunities. The MPS sets out the Council's expectations for providers to assist with addressing geographical gaps in provision.

3.6 The London branch of the Association for Directors of Adult Social Services, with support from London Councils, is co-ordinating the pan-London response to the Care Act. In London many care services work across borough boundaries. Therefore consideration is being given to also developing a London MPs.

3.7 The MPS will need to be regularly reviewed and updated. It is intended that a second edition will be published in autumn 2015 and further editions or updates will be published at least annually. The Council will consider how it resources future market management activity as part of proposals to reshape the Council, to create the People Department and to implement Croydon Challenge projects.

3.8 It is intended that the final draft version of the first edition of the MPS will be submitted to the Council's Cabinet for approval at its meeting on 16 March 2015.

3.9 Members of the Health and Wellbeing Board are invited to submit any comments or questions that they have about the draft MPS to the contact officer for this report.

CONTACT OFFICER: Alan Hiscutt, Head of Integrated Commissioning – Working Age Adults & Contracts Support Services, Integrated Commissioning Unit – Croydon Council and CCG
alan.hiscutt@croydon.gov.uk
020 8726 6000 extension 62627

BACKGROUND DOCUMENTS
Draft Market Position Statement for Adult Social Care

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REPORT TO:	**HEALTH AND WELLBEING BOARD (CROYDON)** **11 February 2015**
AGENDA ITEM:	**9**
SUBJECT:	**Proposal to establish a Health Protection Forum**
BOARD SPONSOR:	**Dr Mike Robinson, Director of Public Health,** **Croydon Council**

CORPORATE PRIORITY/POLICY CONTEXT:

Health protection seeks to prevent or reduce the harm caused by infectious diseases and minimise the health impact from environmental hazards such as chemicals and radiation.

The roles and responsibilities for the different aspects of health protection have changed as a result of the Health and Social Care Act 2012.

Public Health England provides the specialist health protection response, including the response to incidents and outbreaks.
Local Authorities have a statutory responsibility to protect the health of their population from all hazards, and to prevent as far as possible, those threats arising in the first place. This duty includes advice and information to key agencies on where to target resources to maximum effect. The Director of Public Health is responsible for the local authority's contribution to health protection matters.[1]
NHS England commissions major programmes such as national immunisation programmes, national screening programmes and the provision of health services to diagnose and treat infectious diseases and provide health services in the event of an emergency.

FINANCIAL IMPACT:

No direct financial impact, however, appropriate representation from each partner organisation and key agency at regular meetings is essential.

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 Agrees to the development of a Health Protection Forum for Croydon, by the Director of Public Health
1.2 Establish a standing item for the Director of Public Health at each HWB meeting to facilitate regular update on health protection issues

2. EXECUTIVE SUMMARY

2.1. This document proposes the development of a Health Protection Forum lead by the Director of Public Health (DPH), who reports findings and recommendations to the Health and Wellbeing Board.

[1] Section 8 of Local Authorities Regulations 2013 (Public Health Functions and Entry to Premises by Local Healthwatch Representatives)

2.2. The forum will bring local partners and key agencies together with the aims to:

- review current and emerging health protection issues and agree roles and responsibilities of each participating organisation
- assure the DPH that the arrangements in place to protect the health of local residents are robust and are implemented appropriately to local population need
- support the local response to health protection emergencies and other incidents which directly or indirectly affect the health and wellbeing of local residents

3. DETAIL

3.1 Background and policy context

Local Authorities already have statutory health protection functions and powers principally in the area of environmental health (such as ensuring good food hygiene). Since April 2013, local authorities have gained additional statutory duties to protect their population from threats to public health. The Director of Public Health is responsible for the local authority's contribution to health protection matters.[2]

Several organisations have a role to play in health protection, in particular Public Health England, Local Emergency Planning and Response Teams, health service providers, and the DPH. The roles and responsibilities of these agencies should complement each other in order to provide effective local planning and response.

The new health protection duties of Local Authorities under the Local Authorities Regulations 2013 are described fully in Appendix 1.

3.2 Aims

The aims of the Health Protection Forum would be to:

- review current and emerging health protection issues and agree roles and responsibilities of each participating organisation
- assure the Director of Public Health that the arrangements in place to protect the health of local residents are robust and are implemented appropriately to local population need
- support the local response to health protection emergencies and other incidents which directly or indirectly affect the health and wellbeing of local residents

3.2 Objectives

The objectives of the Health Protection Forum would be to:

- review local plans and issues that need escalation
- act as the main group convened to support the local response to any health related incidents that threaten Croydon residents
- ensure health protection issues are raised in the appropriate internal and external groups and fora, including the Borough Resilience Forum and the

[2] Section 8 of Local Authorities Regulations 2013 (Public Health Functions and Entry to Premises by Local Healthwatch Representatives)

Local Health Resilience Partnership
- establish communication pathways and systems to gather and disseminate information and intelligence
- ensure that plans set the key arrangements needed to respond to incidents and events including the release of clinical resources and clearly defined responsibilities for local partners
- assure the DPH on a range of health protection issues including:
  - Adult and children immunisation programmes
  - TB control
  - Infection control
  - Screening programmes
- ensure health protection has appropriate resources and contingency funds
- support the testing and exercising of plans in accordance with the requirements of the Civil Contingencies Act 2004.
- ensure that lessons identified from incidents, events and exercises are incorporated into plans in order to improve performance and response

3.3 Protection Forum – Terms of Reference

3.3.1 Role

The primary role of the Health Protection Forum would be to support the Director of Public Health in their statutory role around health protection by providing oversight of current and emerging health protection issues and reviewing plans and arrangements for Croydon.

3.3.2 Proposed membership

The proposed membership of the committee is:

- Chair – Director of Public Health
- Representative from LA People Department
- Representative from LA Places Department
- Representative from Borough Resilience Forum - via LA Corporate Resilience Team
- Representative from LA Communications
- Croydon CCG representative
- Public Health England – Local Health Protection Team
- NHS England – Local Area Team
- Representatives from Croydon University Hospital
- Voluntary sector representative
- Mental Health Services Representative (SLaM)

3.3.3 Frequency of meetings

The forum will meet quarterly to establish its programme of work, then six monthly to maintain and monitor progress.

In the event of an emergency or incident the forum will meet as required to support the local response.

3.3.4 Secretariat

Administrative support for the forum will be from within existing resources in the public health team.

3.3.5 **Review of the terms of reference**

These will be subject to review at least annually or more frequently if required following the de-brief process from health protection incidents, exercises or events.

4. CONSULTATION

The proposal to establish a Health Protection Forum in Croydon was discussed briefly by the DPH at the HWBB meeting on 14 December 2014. No further consultation has been carried to date.

5. SERVICE INTEGRATION

The purpose of the establishment of a Health protection forum is to facilitate a joined up approach to the prevention and management of health protection issues.

6. FINANCIAL AND RISK ASSESSMENT CONSIDERATIONS

There is no immediate financial risk connected with this proposal.

7. LEGAL CONSIDERATIONS

Legal advice on this proposal has not been sought at this point.

8. HUMAN RESOURCES IMPACT

Administrative support to the forum will be from within the Public Health team.

9. EQUALITIES IMPACT

An equality impact analysis on this proposal has not been carried out. However, the aim of the forum is to engage local partners and key agencies in the review of health protection issues and to direct their planning and commissioning efforts to areas of particular need in Croydon.

10. ENVIRONMENTAL IMPACT

As part of its remit, the forum will review current and potential local environmental hazards and the plans and arrangements in place to manage these.

11. CRIME AND DISORDER REDUCTION IMPACT

N/A

CONTACT OFFICER: Dr Ellen Schwartz, Consultant in Public Health, Croydon Council, ellen.schwartz@croydon.gov.uk,

BACKGROUND DOCUMENTS [*These must be attached for posting online*]

Appendix 1: Protecting the health of the local population: the new health protection duty of local authorities under the Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2013, May 2013

Department of Health

Public Health England

Local Government Association

Protecting the health of the local population: the new health protection duty of local authorities under the Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2013[1]

Purpose of this document

This document explains the new health protection duty of local authorities under regulation 8 of the Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2013, made under section 6C of the National Health Service Act 2006 ("NHS Act 2006") (as inserted by section 18 of the Health and Social Care Act 2012[2]), which came into force on the 1st of April 2013 ("6C Regulations")[3].

The 6C Regulations and this document focus principally on arrangements for preventing and planning response to health protection incidents and communicable disease outbreaks that do not require mobilisation of a multi-agency response under the Civil Contingencies Act 2004 ("CCA")[4]. It complements the Department's publications on emergency preparedness[5], resilience and response (EPRR) arrangements[6].

The Secretary of State has the overarching duty to protect the health of the population, a duty which will generally be discharged for him by Public Health England (PHE). The Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2013 delegate to local authorities the critical role of providing information and advice to relevant organisations (including PHE) so as to ensure all parties discharge their roles effectively for the protection of the local population.

If the Secretary of State considers that (for any reason, and in any location) the local arrangements are inadequate, or that they are failing in practice, then he must take the action that he believes is appropriate to protect the health of the people in that area.

Background

The arrangements for health protection from April 2013 build on the strengths of the existing system. The activity previously carried out by the Health Protection Agency (HPA) under the

Health Protection Agency Act 2004[7] is now the responsibility of the Secretary of State, under new statutory health protection functions (in particular section 2B of the NHS Act 2006). In practice that activity will be carried out by PHE) an executive agency of the Department of Health. Primary Care Trusts and Strategic Health Authorities were abolished on 1 April 2013[8].

The 6C Regulations provide for each local authority to “provide information and advice to every responsible person and relevant body within, or which exercises functions in relation to, the authority’s area, with a view to promoting the preparation of appropriate local health protection arrangements (“health protection arrangements”), or the participation in such arrangements, by that person or body”. More detail on the legislative framework is available at Annex A.

The director of public health (DPH) is responsible for the local authority’s contribution to health protection matters, including the local authority’s roles in planning for, and responding to, incidents that present a threat to the public’s health. PHE has a responsibility to deliver the specialist health protection response, including the response to incidents and outbreaks, through the PHE Centres which take on the functions of the former Health Protection Units. These roles are complementary and both are needed to ensure an effective response. In practice this means that there must be early and ongoing communication between the PHE Centre and DPH regarding emerging health protection issues to discuss and agree the nature of response required and who does what in any individual situation.

The local health protection system therefore involves the delivery of specialist health protection functions by PHE, and local authorities providing local leadership for health. In practice, local authorities and PHE will work closely together as a single public health system. This joint working with clarity of responsibilities between them is crucial for safe delivery of health protection, and practical guidance for these arrangements is at Annex B.

The aim of the new arrangements is for an integrated, streamlined health protection system that delivers effective protection for the population from health threats, based on:

- a clear line of sight from the top of government to the frontline;
- clear accountabilities;
- collaboration and coordination at every level of the system; and
- robust, locally sensitive arrangements for planning and response[5].

Unitary and lower tier local authorities have existing health protection functions and statutory powers under the Public Health (Control of Disease) Act 1984[9], as amended by the Health and Social Care Act 2008, and regulations made under it[10] as well as other legislation, such as the Health and Safety at Work Act etc 1974[11] and

the Food Safety Act 1990[12] and associated regulations, which enables them to make the necessary interventions to protect health.

The key elements of health protection

Health protection seeks to prevent or reduce the harm caused by communicable diseases and minimise the health impact from environmental hazards such as chemicals and radiation.

As well as major programmes such as the national immunisation programmes and the provision of health services to diagnose and treat infectious diseases, health protection involves planning, surveillance and response to incidents and outbreaks.

Local authorities (and directors of public health (DsPH) who would usually act on their behalf) have a critical role in protecting the health of their population, both in terms of planning to prevent threats arising, and in ensuring appropriate responses when things do go wrong.

The scope and scale of work by local government to prevent threats to health emerging, or reducing their impact, will be driven by the health risks in a given area.

Understanding and responding to those health risks needs to be informed by Joint Strategic Needs Assessments (JSNAs)[13], Joint Health and Wellbeing Strategies (JHWS), and the health and social care commissioning plans based upon them.

Local government will work with local partners to ensure that threats to health are understood and properly addressed.

PHE, with its expertise and local health protection teams, has a critical role to play in responding directly to incidents and outbreaks, and in supporting local authorities in their responsibilities to understand and respond to potential threats.

The NHS will also continue to be a key partner in planning and securing the health services needed to protect health and in mobilising NHS resources in response to incidents and outbreaks.

Prevention

Local authorities already have existing duties and powers to tackle environmental hazards (see earlier "Background" section). The move of local public health functions from the NHS into local government opens up new opportunities for joint work with environmental health colleagues to tackle areas where there are potential threats, including infectious diseases, and environmental hazards.

The local leadership of DPH, on behalf of local authorities, is critical to ensuring that the local authority and local partners are implementing preventative strategies to tackle key threats to the health of local people.

In taking forward this preventative role, local authorities, usually led by their DPH, will work closely with local PHE centres, which will provide a range of health protection services, including collection, analysis, interpretation of surveillance data, expert epidemiological and public health advice on hazards and effective interventions, and support to develop and implement local prevention strategies. Local teams will also wish to develop relationships with NHS England Local Area Teams, for example in relation to the commissioning of screening and immunisation programmes.

Planning and preparedness

Effective planning is essential to limit the impact on health when hazards cannot be prevented. The legal duty under the NHS Act 2006 to protect the population rests with the Secretary of State and is discharged through PHE, which provides the specialist health protection expertise to support local agencies in developing their plans to respond to public health emergencies and incidents.

Upper tier and unitary local authorities also have a new health protection duty, which involves the local authority discharging aspects of the Secretary of State's duty to take steps to protect public health. The duty takes the form of a statutory requirement (under the section 6C Regulations referred to above) to provide information and advice to certain persons and bodies, with a view to promoting the preparation of appropriate health protection arrangements. Such arrangements should cover threats ranging from relatively minor communicable disease outbreaks and health protection incidents to full-scale emergencies.

In practice, this means that the DPH will provide information, advice, challenge and advocacy on behalf of their local authority, to promote preparation of health protection arrangements by relevant organisations, operating in their local authority area[14]. The DPH, on behalf of their local authority, should be absolutely assured that the arrangements to protect the health of the communities that they serve are robust and are implemented appropriately to local health needs. They also need the opportunity to escalate concerns as necessary, when they believe local needs are not being fully met. They should expect a highly responsive service from PHE and other partners in this respect.

This local authority role in health protection planning is not a managerial, but a local leadership function. It rests on the personal capability and skills of the local authority DPH and their team, on behalf of the local authority, to identify any issues and advise appropriately. But it is underpinned by legal duties of cooperation, contractual arrangements, and clear escalation routes.

Responsibility for responding appropriately to the local authority's

information and advice (and accountability for any adverse impact if that advice is not heeded) rests with other organisations[15].

The 6C Regulations serve as a key lever for local authorities to improve the quality of health protection arrangements in their local areas through the effective escalation of issues. They may raise issues locally, with the partner concerned, the Health and Wellbeing Board (HWB), or directly with commissioners if there are concerns about commissioning of services.

To help ensure that public health advice is appropriately taken account of, there is a range of legal duties and escalation routes, which are discussed further below.

Relationships and accountabilities

Successful health protection requires strong working relationships at the local level. To underpin and support good working relationships, there are a number of legal and other levers to ensure that the relevant organisations do what is required of them to protect the public and take public health advice.

The Secretary of State expects PHE, as an executive agency of the Department of Health, to cooperate with the NHS (NHS England, CCGs, commissioning support units and providers) and local authorities, and to support them in exercising their functions.

PHE is able to provide a wealth of health protection expertise to local authorities to help them in their health protection function as well as delivering directly to the public. To assist this process, PHE should agree with local authorities the specialist health protection support, advice and services that they will provide; this agreement should build on existing arrangements between the NHS, local authorities and the PHE centres.

The NHS England Standard Contract outlines what NHS organisations are expected to deliver in terms of health protection generally, as well as emergency planning (including significant incident and emergency) management and any cooperation requirements necessary to achieve those objectives.[16]

NHS England and CCGs have a duty to cooperate with local authorities on health and well-being under the NHS Act 2006[17].

This includes cooperating around health protection, including the sharing of plans.

The Health and Social Care Act 2012 makes clear that both NHS England and CCGs are under a duty to obtain appropriate advice, including from persons with a broad range of professional expertise in “the protection or improvement of public health”[18]. This includes the advice of local authorities, usually delivered

through their director of public health. The leadership of the director of public health in this context is highlighted by local health resilience partnerships being co-chaired by a director of public health, ensuring their ability to scrutinise and be assured of the plans to respond to emergencies for the communities they serve.

Putting the new mandatory function into practice

Over and above their existing responsibilities as Category 1 responders under the CCA, under the Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2013 upper tier and unitary local authorities are required to take certain steps to protect the health of their local population. In particular, as explained above, they are required to provide information and advice with a view to promote the preparation of health protection arrangements by key health and care partners within the local area[19], recognising that PHE provides the specialist health protection functions of the Secretary of State.

The Department of Health does not expect local authorities to produce a single all-encompassing "health protection plan" for an area, but rather to promote preparation of effective health protection arrangements by local organisations, operating in their areas. This includes commissioning plans aimed at prevention of infectious diseases, as well as joint approaches for responding to incidents and outbreaks agreed locally with partners, including PHE and the NHS.

Local co-operation agreements, memorandums of understanding and protocols between key partners on response to outbreaks are already in place and work well in some areas. These need to be revised and updated for the new system, given the new statutory responsibilities of Public Health England and Local Authorities described in this factsheet. The content of these agreements is for local determination, and local partners may wish to review or update their existing documents, taking into account the core elements to local arrangements which experience suggests should be in place in every area (many of which are set out in regulation 8(7) of the section 6C Regulations) including:

- clearly defined roles and responsibilities for the key partners (comprising at least the local authority, PHE, NHS England, CCGs and primary and secondary care NHS providers), including operational arrangements for releasing clinical resources (e.g. surge capacity from NHS-funded providers) with contact details for a key responsible officer and a deputy for each organisation
- local agreement on arrangements for a 24/7 on-call rota of qualified personnel to discharge the functions of each organisation

- clear responsibilities in an outbreak or emergency response, including the handover arrangements
- information-sharing arrangements to ensure that PHE, the director of public health and the NHS emergency lead are informed of all incidents and outbreaks
- arrangements for managing cross-border incidents and outbreaks
- arrangements for exercising and testing, and peer review
- arrangements for stockpiling of essential medicines and supplies, as appropriate
- escalation protocols and arrangements for setting up incident/outbreak control teams
- arrangements for review (the Department of Health recommends this should take place at least annually).

Local authorities may wish to establish a local forum for health protection issues, chaired by DPH, to review plans and issues that need escalation. This forum could be linked to the HWB, if that makes sense locally.

Ensuring that data can flow to the right people in the new system in a timely manner will be key to making the new arrangements work.

The Public Health Outcomes Framework[20], published on 23 January 2012, contains a health protection domain. Within this domain there is a placeholder indicator, "Comprehensive, agreed inter-agency plans for responding to public health incidents". The Department of Health is taking forward work to ensure that it can effectively measure progress against this indicator.

Next steps and further work

The Department of Health and PHE will publish further guidance on the wider health protection system in due course, building on discussion with the NHS, local government and public health stakeholders. This will include guidance on escalation routes where agreement on any aspect of preparation or response cannot be reached locally.

Annex A: Legislative framework

Under section 2A of the NHS 2006 Act (as inserted by section 11 of the Health and Social Care Act 2012), the Secretary of State for Health has a duty to "take such steps as the Secretary of State considers appropriate for the purpose of protecting the public in England from disease or other dangers to health".

In practice, PHE will carry out much of this health protection duty on behalf of the Secretary of State.

Under the Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2013 unitary and upper tier local authorities have a new statutory duty to carry out certain aspects of the Secretary of State's duty take steps to protect the health of the people from England from all hazards[21], ranging from relatively minor outbreaks and contaminations[22] , to full-scale emergencies, and to prevent as far as possible those threats arising in the first place[23]. In particular, regulation 8 requires that they provide information and advice with a view to promoting the preparation of health protection arrangements by "relevant bodies" and "responsible persons", as defined in the regulations. In addition, regulation 7 requires local authorities to provide a public health advice service to clinical commissioning groups (CCGs), which includes advice on health protection.

They will continue to use existing legislation to respond to health protection incidents and outbreaks (see above).

Directors of public health (DsPH) are employed by local authorities and are responsible for the exercise of the new public health functions. Directors will also have a responsibility for "the exercise by the authority of any of its functions that relate to planning for, and responding to, emergencies involving a risk to public health"[24].

Under new section 252A of the NHS Act 2006[25], NHS England will be responsible for (a) ensuring that clinical commissioning groups and providers of NHS services are prepared for emergencies, (b) monitoring their compliance with their duties in relation to emergency preparedness and (c) facilitating coordinated responses to such emergencies by clinical commissioning groups and providers.

The Health and Social Care Act 2012 also amends section 253 of the NHS Act 2006 (see section 47 of the 2012 Act), so as to extend the Secretary of State's powers of direction in the event of an emergency to cover an NHS body other than a local health board (this will include NHS Commissioning Board and clinical commissioning groups); the National Institute for Health and Care Excellence; the Health and Social Care Information Centre;

any body or person, and any provider of NHS or public health services under the Act.

Under the consequential amendments made by the Health and Social Care Act 2012, the NHS England and Public Health England (as part of the Department of Health exercising the Secretary of State's responsibilities in relation to responding to public health emergencies) will be Category 1 responders under the CCA, requiring them to cooperate and work together in the planning of responses to civil contingencies.

CCGs will be Category 2 responders under the Act giving them a duty to provide information and cooperate with civil contingency planning as needed. Local authorities[26] will remain Category 1 responders under the CCA.

Annex B

Local authorities and Public Health England relationship in respect of health protection

This annex is intended to provide clarity around the respective roles of local authorities and Public Health England (PHE) in relation to health protection to support a safe transition of this function into the new system after 1 April 2013, and has been agreed by PHE, the Association of Directors of Public Health and the Faculty of Public Health. It summarises the statutory responsibilities and collaborative working relationships necessary between local authorities and PHE to deliver effective arrangements to protect the public's health.

1. The statutory responsibilities of local authorities government and of PHE

Health protection includes (but is not confined to) infectious disease, environmental hazards and contamination, and extreme weather events.

The statutory responsibility to protect the health of the population transferred from the Health Protection Agency (HPA) to the Secretary of State for Health on 1 April 2013. Secretary of State's responsibility will mainly be discharged through PHE. However, there are also some specific powers delegated to local authorities under the 6C Regulations. These are to give information and advice on appropriate health protection arrangements within their local area to every responsible person and relevant body, and to provide health protection advice to clinical commissioning groups.

PHE will be responsible for providing the specialist health protection functions previously carried out by the HPA including the specialist response to incidents.

As part of the local authority's responsibilities the director of public health (DPH), on behalf of the local authority, has a duty to prepare for and lead the local authority's response to incidents that present a threat to the public's health.

District and unitary authorities also have defined responsibilities in respect of environmental health, which may be discharged in a variety of different ways in different geographical areas. For example, some districts may wish to combine their environmental health capacity across a wider area with DPH leadership from the county; some unitary authorities may wish to have environmental health within the DPH's

leadership responsibilities, whilst in others they may be entirely separate.

The DPH is a statutory member of the Health and Wellbeing Board (HWB). HWBs is to ensure leaders from health and care systems and the public work together to improve the health and wellbeing of their local population and reduce health inequalities. Board also ensure public engagement and input to joint strategic needs assessments and to health and wellbeing strategies. Boards will also ensure that commissioners work collaboratively to meet the health and wellbeing needs of the community.

2. Practical implications of statutory changes, underlying principles and collaborative support arrangements

To deliver effective planning and response arrangements at local level there needs to be constructive and collaborative working relationships between PHE and the local DPH. Whilst there will be variations in different localities, it is possible to identify a set of principles and support arrangements to enable the delivery of effective local authority and PHE health protection functions. These include:

DPH and PHE relationship

The DPH has a duty to prepare for and lead the local authority's response to incidents that present a threat to the public's health. PHE has a duty to deliver the specialist health protection response. These roles are complementary and both are needed to ensure an effective response.

PHE delivery

PHE continues to deliver the specialist health protection functions described in the HPA's previous work on the "model health protection unit".

These are:

- Responding to and managing outbreaks and incidents
- Responding to cases, enquiries and providing advice
- Surveillance and epidemiology study
- Health protection leadership/ stakeholder relationship management
- Contributing to and influencing PHE Programme Board activities and other internal work streams
- Research and development
- Underpinning activities (management, governance arrangements, continuous professional development etc.)

  This includes the provision of PHE support for DsPH addressing issues of environmental health planning applications (e.g. for waste incinerators)

Health and Wellbeing Boards

Local authorities, with their Health and Wellbeing Boards (HWBs), and through their DsPH will wish to assure that acute and longer term health protection responses and strategies delivered by PHE are delivered in a manner that properly meets the health needs of the local population. PHE Centres and DsPH will agree the reporting of health protection arrangements to HWBs to include local agreement of health protection priorities on an annual cycle and any ad hoc reporting for serious incidents or areas of concern.

We would not expect PHE to be represented on the HWB but to attend for specific health protection related discussions. Attendance would be primarily in support of the DPH who is the local leader for health in the local authority.

Mobilising resources for incidents

DsPH, with their local health leadership role, will work with colleagues from PHE to establish arrangements for mobilising resources to respond to incidents and outbreaks. This will include advice to CCGs, discussions with the Local Area Teams of NHS England, and particularly through the joint chairmanship arrangements of the Local Health Resilience Forum. We would expect the work to establish these arrangements to take place as soon as possible so that PHE staff can access support directly from providers when needed. We would also expect that DsPH would wish to be assured that these plans will work effectively when required.

Communications, information and concerns

The PHE Centre and the DPH will develop a shared understanding around communications about health protection concerns. The PHE Centre will keep the DPH informed about health protection issues and of the action being taken to resolve them.

PHE will provide to Local authorities, via their DsPH, the information, evidence and examples of best practice to support the Joint Strategic Needs Assessments (JSNAs) and Joint Health and Wellbeing Strategies (JHWS). There needs to be a clear programme of engagement at national and local level to determine what form this information can most helpfully be provided in.

PHE will support transparency and accountability across the public health system including the provision of information and discussions with local authorities in relation to achievement of public health outcomes.

PHE will also highlight issues of concern to local authorities, for example if there is no system for Environmental Health Officer support to respond to outbreaks of infection.

Workforce and training

PHE will work with DsPH and, where appropriate, other council officers, in providing development, education and other support to the activities of HWBs on issues of relevance to the health of the local population.

PHE will support local authorities to develop a trained and knowledgeable public health workforce, including in the area of health protection.

Further guidance is to be provided separately on a number of other issues including out of hours and Science and Technical Advice Cells (STAC) arrangements.

References

[1] S.I. 2013/351; available at http://www.legislation.gov.uk/uksi/2013/351/contents/made

[2] The Health and Social Care Act 2012 is available at: http://www.legislation.gov.uk/ukpga/2012/7/contents/enacted

[3] These Regulations are made under section 6C of the National Health Service Act 2006 (“NHS Act 2006”) (as inserted by section 18 of the Health and Social Care Act 2012)

[4] Available at: http://www.legislation.gov.uk/ukpga/2004/36/contents

[5] “Emergency” is defined by the Civil Contingencies Act 2004, section 1 to mean: (a) an event or situation which threatens serious damage to human welfare in a place in the UK, (b) an event or situation which threatens serious damage to the environment of a place in the UK, or (c) war, or terrorism, which threatens serious damage to the security of the UK. Civil Contingencies Act 2004. Available at: http://www.legislation.gov.uk/ukpga/2004/36/section/1

[6] Arrangements for emergency preparedness, resilience and response in the new system from April 2013 are available at: http://www.dh.gov.uk/health/2012/04/eprr

[7] See The Health Protection Agency Act 2004. Available at: http://www.legislation.gov.uk/ukpga/2004/17/contents

[8] Factsheets on the role of public health in local government and the Public Health England operating model are available at: http://healthandcare.dh.gov.uk/public-health-system

[9] The Public Health (Control of Disease) Act 1984 is available at: http://www.legislation.gov.uk/ukpga/1984/22

[10] See Health protection legislation guidance 2010 at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_114510

[11] The Health and Safety at Work etc Act 1974 is available at: http://www.legislation.gov.uk/ukpga/1974/37

[12] The Food Safety Act 1990 is available at: http://www.legislation.gov.uk/ukpga/1990/16

[13] Joint Strategic Needs Assessment statutory guidance can be found at: http://healthandcare.dh.gov.uk/jsnas-jhwss-guidance-published/

[14] Regulations 8, S.I. 2013/351; available at http://www.legislation.gov.uk/uksi/2013/351/contents/made

[15] Regulations 8, S.I. 2013/351; available at http://www.legislation.gov.uk/uksi/2013/351/contents/made

[16] NHS Standard Contract 2012/2013 can be found at: https://www.gov.uk/government/publications/leave-for-will-pls-nhs-standard-contracts-for-2012-13

[17] The NHS Act 2006, section 72. Available at: http://www.legislation.gov.uk/ukpga/2006/41/section/72

[18] For NHS Commissioning Board: Health and Social Care Act 2012, part 1, section 23, inserting section 13J into the NHS Act 2006; for CCGs: HSC 2013, part 1, section 26, inserting section 14W into the NHS Act 2006. Available at: http://www.legislation.gov.uk/ukpga/2012/7/contents/enacted

[19] S.I. 2013/351; available at http://www.legislation.gov.uk/uksi/2013/351/contents/made

[20] *Improving outcomes and supporting transparency: a public health outcomes framework for England 2013-1016.* Available at: www.dh.gov.uk/health/2012/01/public-health-outcomes

[21] Building on the principle of the "all hazards" approach as outlined in health protection legislation and accompanying guidance. Available at:http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_114589.pdf

[22] All kinds of contamination, including chemical or radiation, as per section 45A of the Public Health (Control of Disease) Act 1984 as amended by the Health and Social Care Act 2008

[23] This is very similar to the principles set out in Health Services Guidance (93)56 on public health responsibilities of the NHS and the roles of others, which highlights the leadership role of the director of public health in a health authority and notes that he or she should "ensure that appropriate arrangements are in place for the control of communicable disease and of non-communicable environmental hazards and that the responsibilities of those involved are clearly defined in each case."

[24] See new section 73A(1)(d) of the NHS Act 2006, as inserted by section 30 of the Health and Social Care Act 2012

[25] Section 252A has been inserted by section 46 of the Health and Social Care Act 2012

[26] "Local authority" holds the definition as under section 2B of the National Health Service Act 2006 (as inserted by section 12 of the Health and Social Care Act 2012) means a county council in England; a district council in England, other than a council for a district in a county for which there is a county council; a London borough council; the Council of the Isles of Scilly; the Common Council of the City of London.

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REPORT TO:	HEALTH AND WELLBEING BOARD (CROYDON) 11 February 2015
AGENDA ITEM:	10
SUBJECT:	Illicit tobacco, shisha, e-cigs and broader tobacco control
BOARD SPONSOR:	Dr Mike Robinson, Director of Public Health

BOARD PRIORITY/POLICY CONTEXT:
Reducing smoking prevalence makes a significant contribution to the delivery of joint health and wellbeing strategy priorities of:

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

It also contributes to:

- supporting people to be resilient and independent

Tobacco control supports the council ambitions for Croydon of **growth**, **liveability** and **independence**

Relevant National and international Policy:

- Government's 'Healthy Lives, Healthy People': a tobacco control plan for England, 2011[1]
- European Union Tobacco Products Directive[2]

RECOMMENDATIONS
A. The health and wellbeing board is asked to support and oversee the continued development of a broad tobacco control approach including:

- Putting the involvement of children and young people (as key stakeholders and agents for change) at the forefront, through the involvement of:
  - Youth council
  - Healthy Schools programme whole-school smokefree policies
  - School-based smoking education and cessation
  - Monitoring all confiscations of illicit[3] tobacco in schools to provide health intelligence
  - Participation of volunteering pupils in Trading Standards training for local businesses and test purchasing (as part of the Citizenship curriculum)
- Strong communication with Shisha bars to ensure they comply with all necessary legislation and to take firm action where there are issues of non-compliance
- Developing guidance for schools on e-cigs and 'shisha-pens' in partnership with Healthy Schools Programme
- The continued development of a South-West London illicit tobacco partnership to tackle cross borough issues, based on the successful South-

[1] https://www.gov.uk/government/publications/the-tobacco-control-plan-for-england
[2] http://ec.europa.eu/health/tobacco/docs/dir_201440_en.pdf
[3] Illicit tobacco products are those that are not duty-paid (smuggled) or are counterfeit. These may be recognised by having foreign language on packs, poor quality packaging or obviously fake branding

East London model

B. The Board is asked to consider whether the council should follow the lead of other councils and sign up to the Local Government Declaration on Tobacco Control[4] as a demonstration of commitment to promoting the health, wellbeing and health equality of the local population.

1. EXECUTIVE SUMMARY

1.1 Tobacco is a significant danger to health. Children and young people are of particular concern, because about two-thirds of adult smokers report that they took up smoking before the age of 18 and over 80% before the age of 20.[5] Illicit tobacco, which is tobacco that is smuggled or counterfeit, poses even greater risks. A rising tobacco use trend is shisha, which evidence suggests is disproportionately popular amongst the young[6]. Anecdotal accounts from local schools suggest that e-cigs and so-called 'shisha-pens' are also an emerging issue.

1.2 This paper describes a range of measures that are available to take action against shisha, illicit tobacco, e-cigs and smoking more generally, including developing a comprehensive multi-agency, multi-disciplinary strategic approach and working with partners across South West London and the capital as a whole. Clear and firm communication, regulation and enforcement will assist in mitigating the risks from the proliferation of shisha bars as will strong engagement with schools, colleges and children and young people's services around the dangers posed by tobacco of all kinds, and nicotine delivery devices such as e-cigs.

1.3 Public Health Croydon recently conducted the first internal stage of a CLeaR[7] assessment, a self-assessment highlighting gaps and opportunities to improve local tobacco control. Local stop smoking services are to be redesigned as part of an integrated behaviour change model from April 2016. The CLeaR assessment provides a baseline for action and the services redesign provides the context. The plan in appendix 1 proposed by the Public Health Tobacco Team sets out key actions that are being taken forward by the Team and its partners. Delivery of the action plan will be overseen by the Croydon Healthy Behaviour Change Alliance.

1.4 A reducing children and young people's risk taking behaviour and substance misuse action plan is currently being finalised by the Children and Families Partnership, within which tobacco control actions have been embedded. This provides another timely opportunity to build awareness and momentum around this priority.

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[4] http://www.smokefreeaction.org.uk/declaration/

[5] Robinson S & Bugler C. Smoking and drinking among adults, 2008. General Lifestyle Survey 2008. ONS, 2010.

[6] Jackson D, Aveyard P. Waterpipe smoking in students: Prevalence, risk factors, symptoms of addiction, and smoke intake. Evidence from one British university. BMC Public Health. 2008;8(1):174. doi: 10.1186/1471- 2458-8-174

[7] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/332710/CLeaR_FAQs.pdf

2 Public Health Croydon's Tobacco Team Vision:

We want a Croydon where local people partner with the council and other agencies to protect their communities from tobacco related harm, especially harm to children and young people. We want a Croydon where people know the risks of tobacco and make healthier choices, encouraging and supporting their friends, families and neighbours to do the same. We want a Croydon where communities will not tolerate tobacco crime, especially when it preys on the young, and they know what to do about it, and we want a Croydon where children are born smokefree and grow up in smokefree households, with the adults around them role-modelling healthy behaviours.

3 DETAIL

Introduction

3.1 Tobacco imposes a massive burden of ill-health and avoidable expense on society. It is the biggest cause of avoidable sickness, death and health inequality[8]. It poses a special threat to the young and it creates debilitating long term conditions that engender unnecessary dependency. Smoking is a leading cause of ill health and premature death in Croydon. Almost 1 in 5 adult deaths in the UK are attributable to smoking[9]. In Croydon almost 500 deaths are caused by smoking each year[10]. For every death caused by smoking, approximately 20 smokers are suffering from a smoking related disease[11,12].

3.2 Illicit tobacco takes business away from legitimate vendors and circumvents the tax levy that contributes to addressing the financial burden smoking entails. Illicit tobacco is strongly associated with crime and organised crime.[13] Illicit tobacco is more available to the young because it is cheap and age restrictions on sales are not enforceable. Illicit tobacco is likely to contain contaminants that may be toxic, harmful and unhygienic.

3.3 Shisha, e-cigs and shisha pens are novel smoked products that seem to have a particular attraction for the young. They are emerging problems that need a formal policy response to prevent harm.

3.4 Smoking is responsible for half the 9 year difference in life expectancy between different wards in the borough and is the biggest preventable cause of health inequality.[14]

3.5 Modelling by Action on Smoking and Health (ASH) in 2014 suggested that smoking costs Croydon £84m per year, including over £5m in smoking related social care costs. The breakdown of these costs is shown in the table below.

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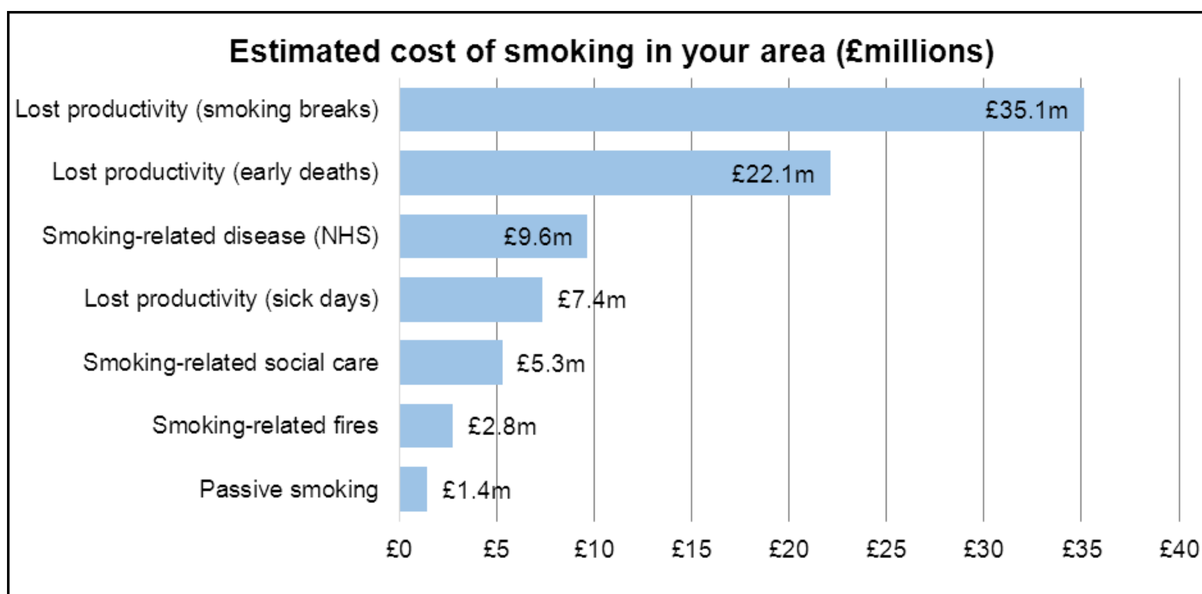
[8] Marmot, M. Fair Society, Healthy Lives: The Marmot review [online]. 2010.
[9] Statistics on smoking: England, 2012 The NHS Information Centre for Health and Social Care, 2012
[10] Quantifying the cost of Smoking in Croydon, The MacKinnon Partnership, June 2010
[11] U.S. Department of Health and Human Services. How Tobacco Smoke Causes Disease: The Biology and Behavioral Basis for Smoking-Attributable Disease: A Report of the Surgeon General. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2010
[12] Cigarette smoking-attributable morbidity – United States, 2000. MMWR Weekly Report. 5 Sep. 2003
[13] Home Affairs Committee - First Report: Tobacco Smuggling 11 June 2014
[14] Marmot, M. Fair Society, Healthy Lives: The Marmot review [online]. 2010.



3.6 Smoking rates amongst adults and young people have been falling but there is a risk that this progress will be slowed by the wide availability of illicit tobacco or the potential social acceptability of e-cigarette use, known as 'vaping'.

3.7 A summary of the recommendations from the first stage of Croydon's CLeaR assessment (self-assessment) are as follows:

- Leadership - identify senior level champion from HWBB
- Embed and see clear links across to key strategic plans
- Commissioning - develop mental health, maternity, children and young people's service provision to have more impact on smoking prevalence
- Tobacco Control Partnership - develop plan for organisation and involve key stakeholders
- Communication – develop a standalone communication strategy for Tobacco Control
- Innovation – identify innovative ways of using technology to increasing quit rate and delivering services
- Progress to the second stage of assessment, a peer review carried out by CLeaR / Public Health England.

3.8 Local stop smoking services will be re-commissioned during 2015 as part of a new integrated lifestyles service. The service will have a *single point of access* where residents can access a range of healthy behaviour advice, support and treatment. It is hoped it will be linked to the proposed people's gateway service. It will be accessed directly through self-referral, or referral from primary, secondary or social care and it will deliver tiered, holistic interventions according to individual and local community needs supporting people and their families to:

- Stop smoking
- Lose weight
- Drink less alcohol
- Increase physical activity
- Have an NHS health check and access lifestyle services as needed

The integrated lifestyle model will provide:

- A single service supporting lifestyle change

- A focus for a broader wellness approach encompassing a broad range of health welfare, employment, community development, leisure and family and early years services[15]
- A model procured to provide integrated services from April 2016

Shisha

3.9 Although a systematic survey has yet to be carried out, it is estimated that there are about 15 premises selling shisha in the borough currently and this seems likely to increase. In Croydon's Croydon Secondary School Health and Lifestyle Survey 2014, which surveyed 2,325 schoolchildren in years 8 and 10, 14% of pupils responded that they have smoked cigarettes, with only 4% reporting smoking a cigarette in the past seven days. Alarmingly 32% responding that they have smoked shisha[16]. The suggestion is that shisha as a niche or novel tobacco product, is gaining popularity among young people even as cigarette smoking rates are diminishing. A note of caution is warranted however. A recent variety of e-cigarette is marketed as a 'shisha-pen'. Though these products have nothing to do with waterpipe shisha, it is possible that children or young people may use the term shisha in regard to these devices, which are on sale in Croydon and have been discovered in secondary schools. That said there are signs that youth shisha use is increasing nationally with one cross-sectional study in the UK finding that younger adults were more likely to have ever used waterpipe and to more frequently use waterpipe than older adults[17]. A study of 937 students at Birmingham University reported that 38% had ever tried waterpipe and 8% smoked waterpipe at least monthly[18].

3.10 Waterpipes, also known as shisha, hookahs, or hubble-bubble pipes have long been used for smoking tobacco in the Middle East and parts of Africa and Asia, and are now increasingly used in Western countries. Waterpipes can be used to smoke a number of substances: tobacco and herbal mixtures, any of which may be flavoured with fruits or sugar syrup. Although herbal mixtures do not contain tobacco or nicotine, the negative health effects of smoking herbal shisha are similar to smoking tobacco shisha, not least because both involve burning charcoal and inhaling the smoke. A cigarette produces around one litre of smoke – a single session of waterpipe smoking can produce more than one hundred litres of smoke.

3.11 Common misconceptions surround the use of shisha, such as:

- Smoking shisha is safer than cigarette smoking because the water used in waterpipes filters harmful substances out of the smoking mixture
- Herbal shisha is safer than tobacco shisha

Both of these are untrue. In addition, shisha smoking mixtures, whether they contain tobacco or not, are often produced overseas in conditions that may be largely unregulated and so can contain higher levels of harmful contaminants.

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[15] NHS Confederation Model for an integrated wellness service

[16] Croydon Secondary School Health and Lifestyle Survey 2014, The Health-Related Behaviour Questionnaire, SHEU.

[17] Grant A, Morrison R, Dockrell M. The prevalence of shisha (narghille, hookah, waterpipe) use among adults in Great Britain, and factors associated with shisha use: data from cross sectional online surveys in 2012 and 2013. Submitted for publication. 2013.

[18] Jackson D, Aveyard P. Waterpipe smoking in students: Prevalence, risk factors, symptoms of addiction, and smoke intake. Evidence from one British university. BMC Public Health. 2008;8(1):174. doi: 10.1186/1471- 2458-8-174

There is also some evidence that sharing a waterpipe mouthpiece poses a serious risk of transmission of communicable diseases, including tuberculosis[19].

3.12 The smoke from tobacco or herbal waterpipes is a mixture of smoke exhaled by the smoker, plus smoke from the fuel used to heat the pipe. Second hand smoke from waterpipe poses a serious risk to the health of non-smokers. One study of machine-smoked waterpipes found that compared with cigarette smoking, waterpipe smoke contained five times the amount of ultrafine particles, four times the carcinogens and 35 times the carbon monoxide. These are all toxic or carcinogenic substances.

3.13 Of particular concern are staff who work in shisha bars that are improperly ventilated, and non-compliant with UK smokefree legislation. Continued exposure over periods of many hours and days may be particularly harmful. Due to the ethnic cultural context of many shisha bars, employees in such premises may be new immigrants and have poor levels of understanding of UK health and safety legislation and employees rights.

Smuggled and counterfeit tobacco

3.14 Smuggled tobacco counteracts the government's attempts to drive down smoking prevalence through increased taxation of tobacco, and because it is cheaper than legal tobacco it attracts the least affluent buyers including the most deprived as well as children and young people. Illicit tobacco makes up about a third of tobacco smoked by adults who admit to purchasing it, compared to about half of that consumed by buyers aged 14 and 15.[20]

3.15 Smuggled and counterfeit products can be even more injurious to health than legal tobacco products because they may be manufactured in countries with inadequate regulatory frameworks or are produced entirely illegally, using the branding of major tobacco companies without permission. There have been report of such tobacco containing contaminants such as human excrement, asbestos, mould and dead flies[21] but the fact is we do not know what goes into these products in most cases.

E-cigs

3.16 Electronic cigarettes do not contain tobacco or produce smoke so vaping is not smoking. Shisha-pens are just one variety of e-cig. Although quitting all forms of nicotine use is the best option for smokers, some choose to use e-cigs to help them replace cigarettes or to cut down instead of using medicinally licensed nicotine containing products, which are proven safe and effective. Research by ASH shows that their use has grown threefold in the last two years from 700,000 to 2.1 million users.[22] Nationally, there is little evidence that they are being used by never smokers and the number of children and young people regularly using electronic cigarettes seems to be

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[19] Munckhof WJ, Konstantinos A, Wamsley M, Mortlock M, Gilpin C. A cluster of tubercolosis associated with use of a marijuana water pipe. Int J Tuberculosis and Lung Function 2003;7:860-5.
[20] North of England Illicit Tobacco Study, 2011
[21] http://www.tobaccofreeluton.co.uk/news.php?news_id=92
[22] ASH. Use of electronic cigarettes in Great Britain. April 2014.

very low. Their use is almost entirely amongst those who are current or ex-smokers[23].

3.17 Data relating to children and young people in Croydon suggests some use, with 7% of year 8s and year 10s reporting having tried them. However, anecdotal reports from secondary schools suggest staff are concerned and confiscations of the devices are relatively common.

3.18 In February 2014 the Tobacco Products Directive (TPD) was passed by the European Parliament. Member States now have until 20 May 2016 to transpose the new rules into national law. Electronic cigarettes containing up to 20mg of nicotine come under the TPD.[24] Above that level, electronic cigarettes will require licensing as medicines if they are to remain on the market. Regulation will cover aspects of branding, advertising, safety and includes the ability for states to impose age restrictions and restrictions on flavouring. In addition, the Children & Families Act 2014 gave the Government powers to ban the sale of electronic cigarettes to persons under the age of 18. A consultation on draft regulations is expected soon.

4 NEXT STEPS

4.1 The next steps proposed by the Public Health Tobacco Team are outlined in appendix 1, one of the first priorities being the development of a tobacco plan. Delivery of the action plan will be overseen by the Croydon Healthy Behaviour Change Alliance, which reports to the Health and Well Being Board.

4.2 Public Health Croydon will work with the Healthy Schools Network to provide information and brief advice training to schools, promoting the adoption of comprehensive smokefree policies, inclusive of shisha and e-cig issues. They are also to be encouraged to report confiscations of identifiable illicit tobacco from pupils on school grounds to the Trading Standards Team.

4.3 Croydon should consider whether a chapter in one of the next JSNAs should be themed around children and young people and smoking and will provide further data on local needs to inform our responses.

4.4 Croydon will provide an information resource to operators of shisha bars to encourage compliance and work with Trading Standards and Safety Team to enforce where necessary.

4.5 Public Health Croydon have made links with the South-East London illicit tobacco group to explore replicating the model with neighbouring boroughs in South-West London.

4.6 Development is beginning on a structured tobacco control approach following the detailed self-assessment using the CLeaR model. It is intended that we will involve children and young people, their parents and schools, in the development and implementation of the approach to ensure its success. This will be further developed following the CLeaR / PHE peer review. The existing,

[23] ASH. Use of electronic cigarettes in Great Britain. April 2014.
[24] Revision of the Tobacco Products Directive. European Commission, March 2014

though dormant, Behaviour Change Alliance can provide the multiagency to forum to start the discussion

4.7 The council has the opportunity to sign up to the Local Declaration on Tobacco Control as a demonstration of the council's commitment to promoting the health, wellbeing and health equality of the local population.

4.8 A paper detailing the development of the Croydon Tobacco Control Approach can be brought to the board later in the year to report progress

CONTACT OFFICER:

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Jimmy.Burke@croydon.gov.uk
T: 020 8726 6000 ext: 88339

Appendix 1

Public Health Croydon Tobacco Team Vision: **We want a Croydon where local people partner with the council and other agencies to protect their communities from tobacco related harm, especially harm to children and young people. We want a Croydon where people know the risks of tobacco and make healthier choices, encouraging and supporting their friends, families and neighbours to do the same. We want a Croydon where communities will not tolerate tobacco crime, especially when it preys on the young, and they know what to do about it, and we want a Croydon where children are born smokefree and grow up in smokefree households, with the adults around them role-modelling healthy behaviours.**				
	Goal:	**Actions:**	**Lead Agencies:**	**When?:**
1	Local schools, colleges and CYP services are aware of tobacco control issues and know how to respond	Provide written guidance and training opportunities to schools around broad tobacco control including school policy development, training and information sharing events and sources of support	• Healthy Schools • Public Health Croydon • Children and Families Partnership	01-Apr-15
2	We have a greater understanding of local needs relating to children, young people and smoking	Consider authoring a JSNA shallow-dive chapter on CYP and smoking	• Public Health Croydon	TBA
3	Shisha bars know the law and stay within the law	Provide written guidance to shisha premises in Croydon and agree a joint interim approach to managing them with Regulatory Services	• Trading Standards Team • Public Health Croydon	20-Feb-15
4	Neighbouring boroughs work together to beat the illicit trade, pooling effort, intelligence and resources	To provide leadership in the development of a cross borough illicit-tobacco partnership based on the South-East London model, meeting regularly with a plan in place	• Regulatory Services • Public Health Croydon	30-Sep-15
5	Local agencies work together as partners harnessing the energy of young people to protect our residents from tobacco-related harm	To develop a written and agreed multi – agency tobacco plan to address all aspects of tobacco harm in Croydon	• Public Health Croydon	01-Oct-15
6	The council makes a public commitment to combat tobacco harm in Croydon	Council to consider sign-up to the Local Declaration on Tobacco Control as a demonstration of the council's commitment to promoting the health, wellbeing and health equality of the local population	• Croydon Council	National No Smoking Day 11-Mar-15
7	The Health and Wellbeing Board champion our local tobacco control approach	Report to the HWBB detailing progress on the actions above	• Public Health Croydon • Health and Wellbeing Board	TBA

Appendix 1

REPORT TO:	HEALTH AND WELLBEING BOARD 11 February 2015
AGENDA ITEM:	12
SUBJECT:	Report of the chair of the executive group: incorporating risk register, board work plan and performance report
LEAD OFFICER:	Paul Greenhalgh, Executive Director (Acting), People, Croydon Council
CORPORATE PRIORITY/POLICY CONTEXT: The Health and Social Care Act 2102 created statutory health and wellbeing boards as committees of the local authority. Their role is to improve the health and wellbeing of local people by promoting integration and partnership working between the NHS, social care, children's services, public health and other local services, and to improve democratic accountability in health.	
FINANCIAL IMPACT: None	

1. RECOMMENDATIONS

The health and wellbeing board is asked to:

- Note risks identified at appendix 1
- Agree changes to the board work plan set out in paragraph 3.4

2. EXECUTIVE SUMMARY

2.1 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 1.

2.2 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 2.

2.3 Comment on performance against joint health and wellbeing strategy indicators at appendix 3. Areas of success and challenge identified by the performance report are set out in section 3.5 of this paper.

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 in December 2014 and January 2015 are set out below:

- Review of the board work plan including preparation of board meeting agenda and topic prioritisation against the joint health and wellbeing strategy
- Review of proposed amendments to the joint health and wellbeing strategy
- Review of progress with the new pharmaceutical needs assessment
- Planned reports to overview and scrutiny committee and full council
- Liaison with other strategic partnerships including Croydon strategic partnership and children and families partnership
- Review of board strategic risk register
- Review of responses to public questions and general enquiries relating to the work of the board

Risk

3.3 Risks identified by the board are summarised at appendix 1. The executive group regularly review the board risk register. There are no amendments to the risk register proposed by the executive group.

Board work plan

3.4 Changes to the board work plan from the version agreed by the board on 10 December 2014 are summarised below. Changes were discussed by the executive group on 13 January 2015. This is version 65.0 of the work plan. The work plan is at appendix 2.

3.4.1 Addition of items on primary care co-commissioning and the Care Act implementation and market position statement to the agenda for 11 February 2015

3.4.2 Items on the health and wellbeing of offenders, mental health crisis care concordat and Heart Town moved to 25 March 2015.

Performance report

3.5 Appendix 3 shows results for a selection of performance measures relating to joint health and wellbeing strategy priorities. The selection of performance indicators was agreed by the board. The report shows graphs for a selection of successes and potential challenge areas, and results for a wider suite of measures in tabular form.

3.5.1 For **improvement area 1: giving our children a good start in life**,

breastfeeding prevalence is identified as an area of success. The teenage conception rate has been identified as an area of continuing challenge (although there has been significant improvement against this indicator).

3.5.2 For **improvement area 2: preventing illness and injury and helping people recover**, smoking prevalence and the proportion of households in fuel poverty are identified as areas of success. Areas of challenge include over 65s vaccinated against influenza and people with HIV presenting at a late stage of infection.

3.5.3 For **improvement area 3: preventing premature death and long term health conditions** take up of NHS Health Checks and breast screening are identified as areas of challenge. Areas of success identified include lower rates of preventable early deaths from cancers and liver disease.

3.5.4 For **improvement area 4: supporting people to be resilient and independent**, areas of success identified are the proportion of people using social care who receive self-directed support and the rate of delayed transfers of care from hospital which are attributable to adult social care.. An area of challenge is the proportion of adults in contact with secondary mental health services living independently, with or without support.

3.5.5 For **improvement area 5: providing integrated, safe, high quality services** and **improvement area 6 improving people's experience of care**, an area of challenge identified is the all cause emergency hospital admissions rate.

Appendices (as attachments)
Appendix 1 risk summary
Appendix 2 board work plan
Appendix 3 performance report

4. CONSULTATION

4.1 A number of topics for board meetings have been proposed by board members. These have been added to a topics proposals list on the work plan.

5. SERVICE INTEGRATION

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

6 FINANCIAL AND RISK ASSESSMENT CONSIDERATIONS

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

7. LEGAL CONSIDERATIONS

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

8. HUMAN RESOURCES IMPACT

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

9. EQUALITIES IMPACT

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

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

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

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

BACKGROUND DOCUMENTS

None

Agenda Item 12 Appendix 1

Health & Wellbeing Board

11 February 2015

Risk Status

Risk Ref	Business Unit	Risk	Risk rating		Control measures			
			Current	Future	Future	Existing	Total	% Impleme
HWB5	HWB	Limited or constrained financial allocations in health and social care which gives rise to the inability to balance reducing budgets with a rising demand	20	15	3	5	7	80%
HWB2	HWB	Failure to successfully integrate commissioning or service provision due to inability or unwillingness to share data	16	12	3	2	5	71%
HWB6	HWB	Failure to ensure that the Board continuously develops and has the capacity and capability to operate effectively and efficiently.	16	12	3	2	3	67%
HWB8	HWB	Board is not able to demonstrate improved outcomes for the population	16	12	4	4	4	60%
HWB4	HWB	Failure to understand the community's expressed wants and choices and to ensure that ongoing engagement with the public is maintained and views	16	12	5	2	6	40%
HWB1	HWB	Failure to ensure that the board's focus is balanced (for example, between statutory requirements / national guidance and local priorities; or health and wellbeing)	16	8	2	4	6	67%
HWB3	HWB	Failure to clearly understand the purpose, boundaries and remit of the Board	16	4	2	2	3	67%
HWB7	HWB	The Board fails to respond flexibly and effectively to changes in national policy or developing local issues	12	8	2	2	4	50%
HWB9	HWB	Failure to produce the pharmaceutical needs assessment	12	8	2	2	4	50%

nted

Agenda Item 12 Appendix 2

HWB work plan version 65.0

Topic proposed: date to be agreed

Fairness Commission
Update on integrated care / Transforming Adult Community Services
Improving outcomes: people's experience of care (including patient transport)
Services for people with autism
Access to urgent and emergency care

Date	Item	Purpose	Board sponsor	Lead officer / report author
25 March 2015	**Strategic items**			
	Joint health and wellbeing strategy 2015-18	To agree amendments to the joint health and wellbeing strategy	Members of the executive group	Steve Morton
	Healthy weight strategic action plan	To agree local plan to address overweight and obesity.	Mike Robinson	Sarah Nicholls/ Anna Kitt
	Dignity and safety • Deprivation of liberty safeguarding • Winterbourne View action plan • Francis report action plans	To assure the board that work to ensure dignity and safety reported to board in February 2014 has been progressed and that plans are in place in each of these areas	Paul Greenhalgh	Kay Murray / Edwina Morris/ Fouzia Harrington / Alan Hiscutt
	Final commissioning plans 2015/16	The board has a statutory	Paula Swann/ Paul	Stephen Warren /

Agenda Item 12 Appendix 2

HWB work plan version 65.0

Date	Item	Purpose	Board sponsor	Lead officer / report author
		duty to provide opinion on whether the CCGs final commissioning plan has taken proper account of JHWS. It also has the power to give its opinion to the council on whether the council is discharging its duty to have regard to relevant JSNA and JHWS	Greenhalgh	Brenda Scanlan / Jane Doyle
	Health and wellbeing of offenders & their families	To enable the board to consider issues affecting the health and wellbeing of offenders and their families	Lissa Moore / Adam Kerr	tba
	Household income and health	Household income is a key determinant of health. This item relates to the JHWS priority of child poverty.	Paul Greenhalgh	Mark Fowler / Amanda Tuke
	Business items			
	Pharmaceutical needs assessment final draft for agreement	The board has a statutory duty to publish a PNA by 31 March 2015	Mike Robinson	Sara Corben / Matt Phelan

Agenda Item 12 Appendix 2

HWB work plan version 65.0

Date	Item	Purpose	Board sponsor	Lead officer / report author
	Mental health crisis care concordat (Partnership: Mental Health)	To endorse the principles of the concordat and to provide assurance that plans are in place to deliver it	Paula Swann/Paul Greenhalgh	Brenda Scanlan / Sue Grose
	Heart Town annual report (Partnership: Heart Town)	To inform the board of progress in the delivery of Croydon Heart Town	Mike Robinson	Steve Morton
	Partnership groups report	To provide an overview of the work of the partnership groups accountable to the board.	Paul Greenhalgh	Steve Morton
	Carers partnership group report	To consider the work of the carers partnership group in delivering board priorities.	Paul Greenhalgh	Amanda Lloyd / Harsha Ganatra
	Drug and alcohol phase 2 recommissioning (Partnership: Drugs & alcohol)	To inform the board of progress with recommissioning of drug and alcohol services	Paul Greenhalgh	Alan Hiscutt / Shirley Johnstone
	Report of the chair of the executive group • Work plan • Risk	To inform the board of work undertaken by the executive group and	Paul Greenhalgh	Steve Morton

Agenda Item 12 Appendix 2

HWB work plan version 65.0

Date	Item	Purpose	Board sponsor	Lead officer / report author
		consider the board risk register		
June 2015	**Strategic items**			
	JSNA 2013/14 homeless households chapter final draft	To consider the findings of the chapter and agree to its publication.	Mike Robinson	Jenny Hacker / Dave Morris
	Business items			
	Report of the chair of the executive group • Performance report • Work plan • Risk	To inform the board of work undertaken by the executive group, to consider performance and review the board risk register	Paul Greenhalgh	Steve Morton

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

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

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

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

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

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

Date	Items	Purpose	Board sponsor	Lead officer / report author
	JSNA 2013/14 overview of health & social care needs	Discussion	Mike Robinson	Jenny Hacker
	Performance report (standing item)	Discussion	Hannah Miller/Paul Greenhalgh/Paula Swann	Martin Ellender
	Work plan (standing item)	Decision	Hannah Miller	Steve Morton
	Integration transformation fund	Information	Hannah Miller / Paula Swann	Andrew Maskell
	Safeguarding adults	Information	Hannah Miller	Kay Murray
	Safeguarding children	Information	Paul Greenhalgh	Jeneen Hatt
	Update on carers (from April 2012)	Information	Roger Oliver	Harsha Ganatra
	Update on children's primary prevention plan (from Feb 2013)	Information	Paul Greenhalgh	Dwynwen Stepien
4 December 2013	Commissioning intentions 2014/15	Discussion	Paula Swann/Hannah Miller/Paul Greenhalgh/Mike Robinson	Stephen Warren / Brenda Scanlan / Jane Doyle
	Substance misuse commissioning plans	Discussion	Hannah Miller	Alan Hiscutt
	Pharmaceutical needs assessment	Decision	Mike Robinson	Kate Woollcombe
	Work plan and report of the chair of the executive group (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
	Risk register (standing item)	Discussion	Hannah Miller	Steve Morton
5 December 2013	Board seminar – dignity and safety in care			
12 February 2014	Better Care Fund (formerly the integration transformation fund) 2014/15	Discussion & decision	Hannah Miller / Paula Swann	Andrew Maskell
	Dignity & safety in care seminar report	Discussion	Hannah Miller / Paula Swann	Kay Murray / Fouzia Harrington
	Report of the chair of the executive group • Work plan • Performance against health and wellbeing strategy indicators (quarterly standing item) • Risk	Discussion & decision	Hannah Miller	Steve Morton Martin Ellender Malcolm Davies
	Local account 2012/13	Information	Hannah Miller	Tracey Stanley
	Heart Town update	Information	Mike Robinson	Steve Morton
26 March 2014	CHS emergency care department business case	Decision	John Goulston	Karen Breen
	South west London collaborative commissioning	Discussion	Paula Swann	Stephen Warren
	Final commissioning intentions 2014/15 • CCG Operating Plan 2014/15 – 2016/17 • Children and families' 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

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

Date	Items	Purpose	Board sponsor	Lead officer / report author
	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 July 2014	Board induction session			
16 July 2014	Appointment of chair	Decision	n/a	Solomon Agutu
	Annual report of the director of public health	Discussion	Mike Robinson	Jenny Hacker
	Focus on outcomes: Pressure ulcers in the community	Discussion	Paula Swann / Hannah Miller	Michelle Rahman / Kay Murray
	JSNA 2013/14 healthy weight chapter final draft	Decision	Mike Robinson	Sarah Nicholls / Anna Kitt
	JSNA 2014/15 key chapter topics	Decision	Mike Robinson	Jenny Hacker
	SW London collaborative commissioning strategy	Information	Paula Swann	Paula Swann
	Joint mental health strategy	Discussion	Paula Swann /	Paula Swann /'

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

Date	Items	Purpose	Board sponsor	Lead officer / report author
			Hannah Miller	Stephen Warren / Brenda Scanlan
	Children's primary prevention plan	Discussion	Paul Greenhalgh	Dwynwen Stepien
	Reform of services for children who will be subject to education, care and health plans	Information	Paul Greenhalgh	Linda Wright
	Report of the chair of the executive group • Work plan • Performance against health and wellbeing strategy indicators (quarterly standing item) • Risk register	Discussion & decision	Hannah Miller	 Steve Morton Laura Gamble Steve Morton
11 September 2014	Better Care Fund	Decision	Hannah Miller / Paula Swann	Andrew Maskell
	Adults safeguarding board annual report	Information	Hannah Miller	Kay Murray
	Children's safeguarding board annual report	Information	Paul Greenhalgh	Steve Love
	Report of the chair of the executive group • Work plan • Risk register	Discussion & decision	Hannah Miller	Steve Morton
	Somewhere to go, something to do: a survey of the views of people using mental health day services in Croydon	Information	Maggie Mansell	Richard Pacitti
1 October 2014	Board public engagement event: joint health and wellbeing strategy review			

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

22 October 2014	Focus on outcomes: primary care : general practice	Information and discussion	Dr Jane Fryer	Dr Jane Fryer
	JSNA key dataset 2014/15	Discussion & decision	Mike Robinson	Jenny Hacker / David Osborne
	Outcomes based commissioning for over 65s	Information & discussion	Paula Swann / Hannah Miller	Brenda Scanlan / Stephen Warren
	Partnership groups report • Summary report from all partnerships • Update on adults with learning disabilities (from April 2013)	Information & discussion Information & discussion	Hannah Miller Hannah Miller / Paula Swann	Steve Morton Alan Hiscutt / Suzanne Culling
	Adult social care commissioning plan 2014/15	Information	Hannah Miller	Brenda Scanlan
	Report of the chair of the executive group • Work plan • Performance against health and wellbeing strategy indicators (quarterly standing item) • Risk	Decision	Hannah Miller	Steve Morton / Laura Gamble
7 November 2014	Board half awayday on the review of the joint health and wellbeing strategy, to discuss findings from the engagement event on 1 October			
10 December 2014	Commissioning intentions 2015/16	The board has a duty to satisfy itself that commissioning intentions are aligned with the joint health and wellbeing	Paula Swann/Hannah Miller/Paul Greenhalgh/Mike Robinson/Jane Fryer	Stephen Warren / Brenda Scanlan / Jane Doyle

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

		strategy		
	Health protection update	To inform the board of key health protection issues for the borough including uptake of immunisations & vaccinations	Mike Robinson	Ellen Schwartz / Miranda Mindlin
	Croydon Food Flagship	To inform the board on progress with the Food Flagship programme	Mike Robinson	John Currie
	Report of the chair of the executive group • Work plan • Risk	Discussion & decision	Hannah Miller	Steve Morton
11 February 2015	**Strategic items**			
	Mental health strategy action plan (Partnership: Mental Health)	To inform the board of key actions to be undertaken to deliver the mental health strategy	Paula Swann / Paul Greenhalgh	Brenda Scanlan / Sue Grose
	Primary care co-commissioning	To inform the board of local plans for primary care co-commissioning and enable board members to comment on those plans	Paula Swann / Jane Fryer	tba
	Care Act implementation and market position statement	To consult the HWBB on the draft statement before the new statutory requirement	Paul Greenhalgh	Alan Hiscutt/ Paul Heynes

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

		to publish such a statement is finalised		
	Business items			
	Proposal to establish a borough health protection forum	To consider and agree the proposal.	Mike Robinson	Ellen Schwartz
	Progress report on work undertaken to determine the scale and nature of the illicit tobacco problem	Information	Mike Robinson	Katie Cuming/ Jimmy Burke
	Report of the chair of the executive group • Work plan • Performance against health and wellbeing strategy indicators (quarterly standing item) • Risk	Discussion & decision	Paul Greenhalgh	Steve Morton Laura Gamble

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APPENDIX 3

Health & Wellbeing Board Performance Report

Jan-15

DASH Performance and Public Health Intelligence Team– Croydon Council

02 February 2015

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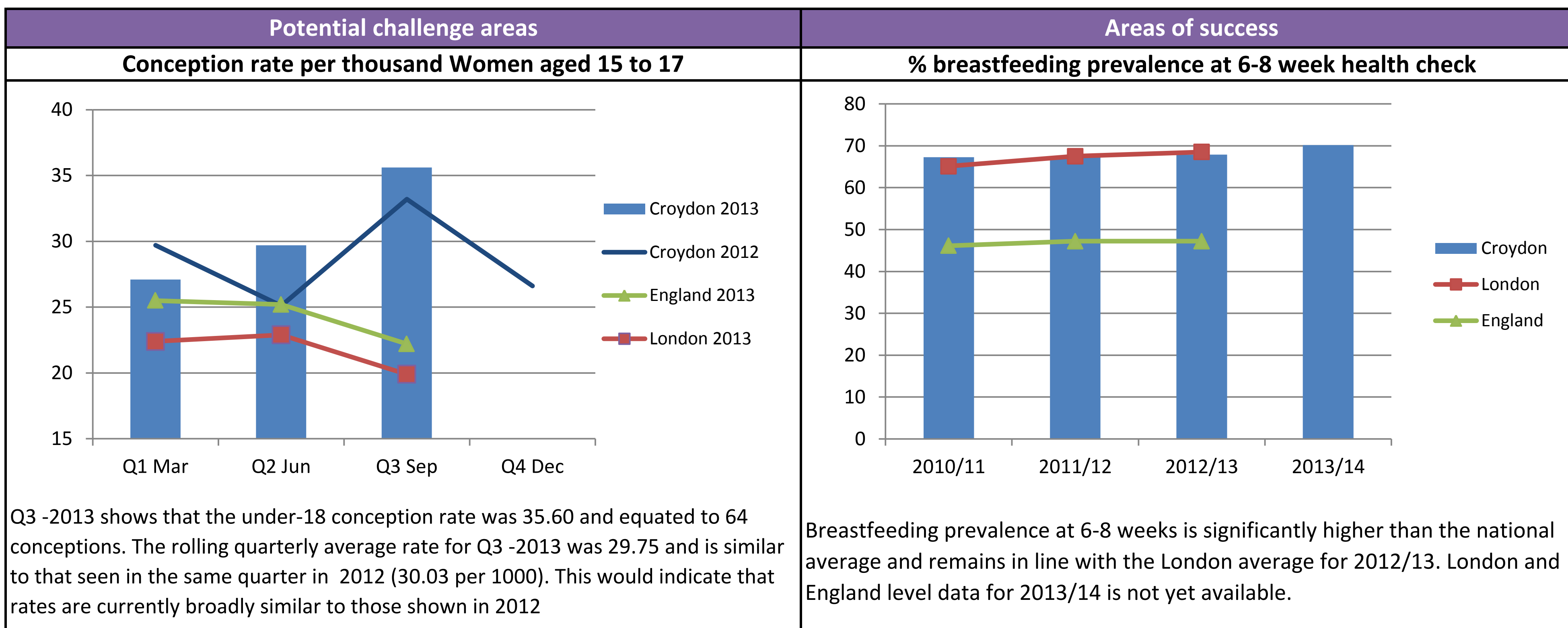
NOTE – the principal source of data within this report is the Croydon Key dataset developed by the Croydon Public Health Intelligence Team. Thanks to David Osborne (Senior Public Health Analyst) in particular for making this data source available and for his input into the selection of relevant performance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

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

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



Potential challenge areas

Conception rate per thousand Women aged 15 to 17

Q3 -2013 shows that the under-18 conception rate was 35.60 and equated to 64 conceptions. The rolling quarterly average rate for Q3 -2013 was 29.75 and is similar to that seen in the same quarter in 2012 (30.03 per 1000). This would indicate that rates are currently broadly similar to those shown in 2012

Areas of success

% breastfeeding prevalence at 6-8 week health check

Breastfeeding prevalence at 6-8 weeks is significantly higher than the national average and remains in line with the London average for 2012/13. London and England level data for 2013/14 is not yet available.

Performance measures

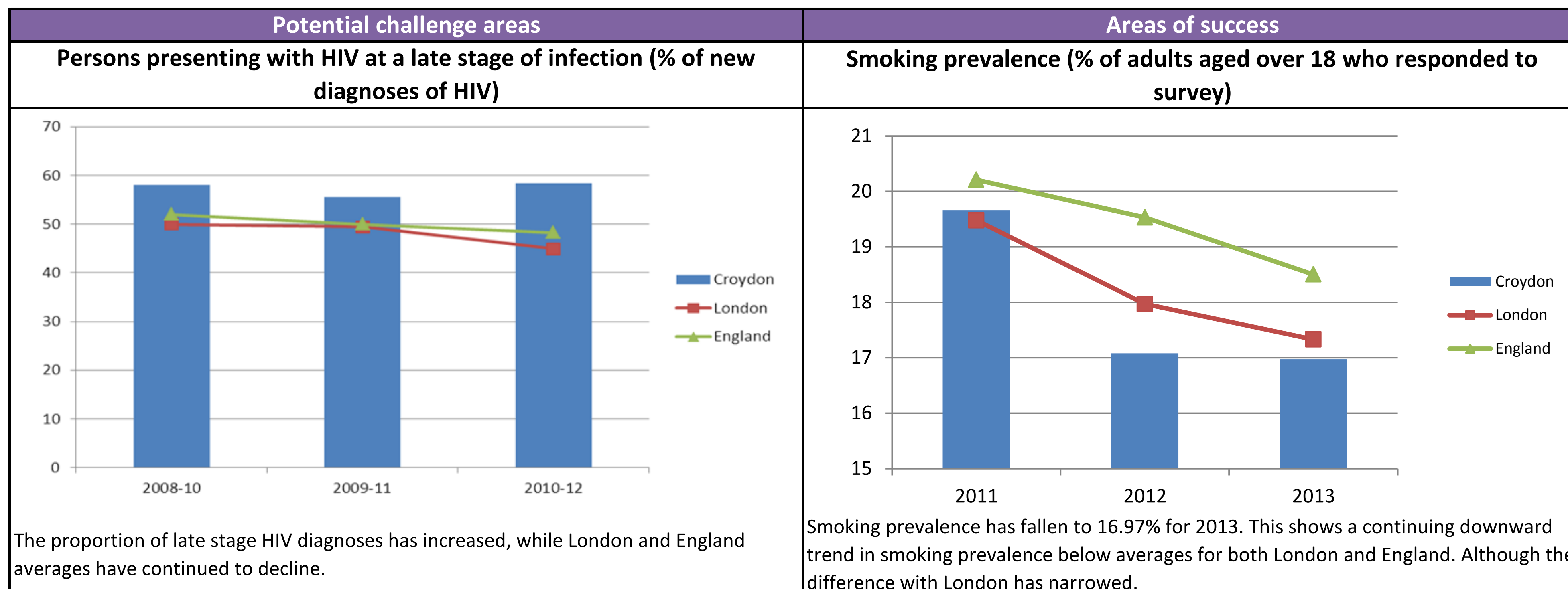
Measure description	Source	Polarity	Most recent annual data	From	Previous Result	London Average	England Average	Comparison with Previous Result	Comparison with London Average	Comparison with England Average
Conception rate per 1000 aged 15 to 17	Croydon key dataset	LOW	35.6	2012 Q3	29.7	19.90	22.2	Worse	Worse	Worse
Breastfeeding initiation within 48 hours (% of mothers)	Croydon key dataset	HIGH	86%	2012/13	87%	86.8%	73.8%	About the same	About the same	Better
% breastfeeding prevalence at 6-8 week health check (infants totally or partially breastfed as a % of all subject to a health check)	Croydon key dataset	HIGH	70.18%	2013/14	67.90%	Not yet Available	Not yet Available	Better	Unknown	Unknown
% of women who are smokers at the time of delivery	Croydon key dataset	LOW	7.35%	2013	7.80%	5.12%	11.99%	About the same	Worse	Better
% of children aged 4-5 years with height and weight recorded who are either overweight or obese	Croydon key dataset	LOW	23.4%	2013/14	23.7%	23.1%	22.6%	About the same	About the same	About the same
% of children aged 10-11 years with height and weight recorded who are either overweight or obese	Croydon key dataset	LOW	38.4%	2013/14	38.2%	37.6%	33.5%	About the same	About the same	Worse
% of live and still births under 2500 grams	Croydon key dataset	LOW	8.3%	2011	8.8%	8.0%	7.4%	About the same	About the same	About the same

Measure description	Source	Polarity	Most recent annual data	From	Previous Result	London Average	England Average	Comparison with Previous Result	Comparison with London Average	Comparison with England Average
Immunisations - DTaP / IPV / Hib vaccination coverage (1 year old)	Croydon key dataset	HIGH	91.1%	2012/13	91.30%	91.10%	94.70%	About the same	About the same	Worse
Immunisations - Hib / MenC booster vaccination coverage (2 years old)	Croydon key dataset	HIGH	86.6%	2012/13	82.4%	87.3%	92.7%	Better	About the same	Worse
Immunisations - PCV booster vaccination coverage (2 years old)	Croydon key dataset	HIGH	86.2%	2012/13	82.4%	86.6%	92.5%	Better	About the same	Worse
Immunisations - MMR vaccination coverage for one dose (2 years old)	Croydon key dataset	HIGH	86.5%	2012/13	83.5%	87.1%	92.3%	Better	About the same	Worse
Immunisations - DTaP / IPV vaccination coverage (5 years old)	Croydon key dataset	HIGH	92.7%	2012/13	92.5%	92.8%	95.8%	About the same	About the same	Worse
Immunisations - MMR vaccination coverage for two doses (5 years old)	Croydon key dataset	HIGH	74.2%	2012/13	73.10%	80.8%	87.7%	About the same	Worse	Worse
Tooth decay in children aged 5 (average number of teeth)	Croydon key dataset	LOW	1.05	2007/08	NA	1.31	1.11	Unknown	Better	Better
Emotional wellbeing of looked-after children (mean score out of 40)	Croydon key dataset	LOW	12.6	2012/13	11.5	13.50	14	About the same	About the same	Better
Children living in poverty	Croydon key dataset	LOW	25.20%	2011	25.70%	26.50%	20.60%	About the same	About the same	Worse

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

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

Potential challenge areas	Areas of success
% of persons aged 65 and over immunised against influenza	**% Fuel poverty**
76% 74% 72% 70% 68% 66% 64% 62% 60% 2011/2 2012/3 2013/14 Croydon London England	18% 16% 14% 12% 10% 8% 6% 4% 2% 0% 2010 2011 2012 Croydon London England
The influenza immunisation rate for this age group in Croydon falls short of the national and London averages, although there is a similar rate of decline for the London average.	This indicator measures the percentage of households which are fuel poor, meaning they spend more than 10% of their income on fuel to maintain a "satisfactory heating regime" (usually 21 degrees for the main living area and 18 degrees for other occupied areas). The latest published data appears to show that this is improving in Croydon in line with the rest of London.



The proportion of late stage HIV diagnoses has increased, while London and England averages have continued to decline.

Smoking prevalence has fallen to 16.97% for 2013. This shows a continuing downward trend in smoking prevalence below averages for both London and England. Although the difference with London has narrowed.

Performance measures

Measure description	Source	Polarity	Most recent annual data	From	Previous Result	London Average	England Average	Comparison with Previous	Comparison with London Average	Comparison with England Average
% of persons aged 65 and over immunised against influenza	Croydon key dataset	HIGH	65.7%	2013/14	67%	70%	73.2%	Worse	Worse	Worse
Self-reported 4-week smoking quitters per 100,000 adult population aged 16+	Croydon key dataset	HIGH	793	2012/13	796	805	868	About the same	Worse	Worse
Smoking prevalence (% of adults aged over 18 who responded to survey)	Croydon key dataset	LOW	16.97%	2013	17.08%	17.33%	19%	About the same	Better	Better

Measure description	Source	Polarity	Most recent annual data	From	Previous Result	London Average	England Average	Comparison with Previous Result	Comparison with London Average	Comparison with England Average
Rate of hospital admissions with a primary or secondary diagnosis of obesity per 100,000 population	Public Health Outcomes Framework	LOW	440	2012/13	307	462	551	WORSE	About the same	Better
Recorded crime attributable to alcohol: Persons, all ages, crude rate per 1000 population	Croydon key dataset	LOW	9.22	2012/13	9.65	9.02	5.74	About the same	About the same	Worse
%of patients on GP registers aged 17 and over diagnosed with diabetes	Croydon key dataset	LOW	6.39%	2012/13	6.1%	5.8%	6%	About the same	Worse	About the same
Adults achieving at least 150 minutes of physical activity per week (% of adults aged over 16)	Croydon key dataset	HIGH	13%	2012	10.3%	12.8%	14.7%	Better	About the same	Worse
Persons presenting with HIV at a late stage of infection (% of new diagnoses of HIV)	Croydon key dataset	LOW	58.3%	2010/12	55.5%	44.9%	48.3%	Worse	Worse	Worse
Chlamydia diagnoses (ages 15-24) (rate per 100,000 population)	Croydon key dataset	n/a	2704	2013	2511	2179	2016	Unknown	Unknown	Unknown
% of households identified as "fuel poor"	Croydon key dataset	LOW	8.8%	2012	10.8%	8.9%	10.4%	Better	About the same	Better
Injuries due to falls (rate per 100,000 population aged over 65)	Croydon key dataset	LOW	2318	2012/13	2418	2242	2011	Better	Worse	Worse

Measure description	Source	Polarity	Most recent annual data	From	Previous Result	London Average	England Average	Comparison with Previous Result	Comparison with London Average	Comparison with England Average
Patient reported outcomes for elective procedures: Groin Hernia (EQ-5D- average health gain score out of 1)	NHS outcomes framework	HIGH	Suppressed due to small sample	2011/12	0.067	0.072	0.084	Unknown	Unknown	Unknown
Patient reported outcomes for elective procedures: Hip Replacement (EQ-5D- average health gain score out of 1)	NHS outcomes framework	HIGH	0.373	2012/13	0.381	0.42	0.423	About the same	Worse	Worse
Patient reported outcomes for elective procedures: Knee Replacement (EQ-5D- average health gain score out of 1)	NHS outcomes framework	High	0.276	2012/13	0.283	0.28	0.313	About the same	About the same	Worse
Patient reported outcomes for elective procedures: Varicose Vein (EQ-5D- average health gain score out of 1)	NHS outcomes framework	High	Suppressed d	2012/13	Suppressed due to small sample	0.072	0.084	Unknown	Unknown	Unknown

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

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

Potential challenge areas

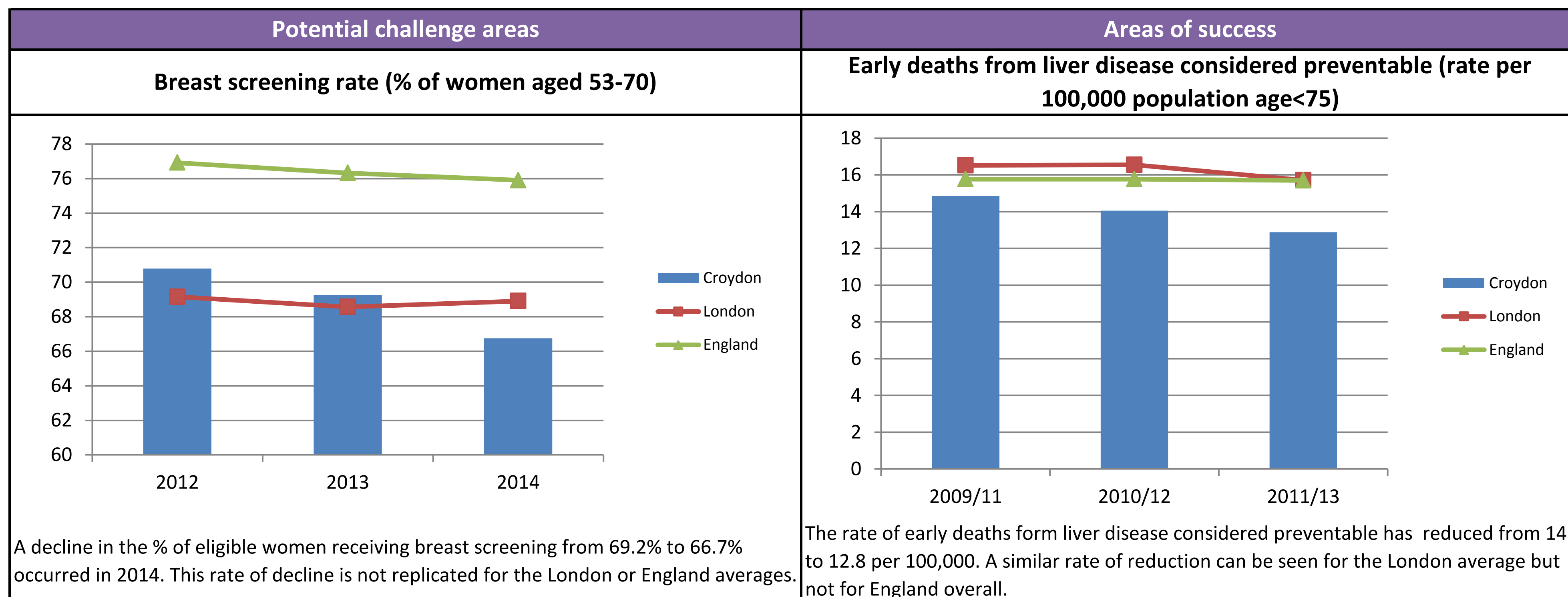
Take up of NHS health checks (% of people offered health checks)

A recovery plan is in place. Actions taken include amendment of provider contracts to allow for opportunistic NHS Health Checks; invitations to be issued directly by GPs; a community outreach pilot; recruitment of additional GP and pharmacy providers; and redesign and procurement of a new service model.

Areas of success

Early deaths from cancer considered preventable (rate per 100,000 population aged under 75)

Early deaths from cancer considered preventable rolling three year average, has fallen from 79.6 to 78.1. London and England averages have also shown a fall in these early deaths at a similar rate to Croydon.



Performance measures

Measure description	Source	Polarity	Most recent annual data	From	Previous Result	London Average	England Average	Comparison with Previous Result	Comparison with London Average	Comparison with England Average
Infant mortality - Rate per 1,000 live births,	Croydon key dataset	LOW	3.9	2010/12	4.4	4.1	4.1	Better	About the same	About the same
Life expectancy at age 75 (males) in years	Croydon key dataset	HIGH	11.5	2010-12	11.6	12	11.3	About the same	About the same	About the same
Life expectancy at age 75 (females) in years	Croydon key dataset	HIGH	13.3	2010-12	13.1	13.9	13	About the same	About the same	About the same

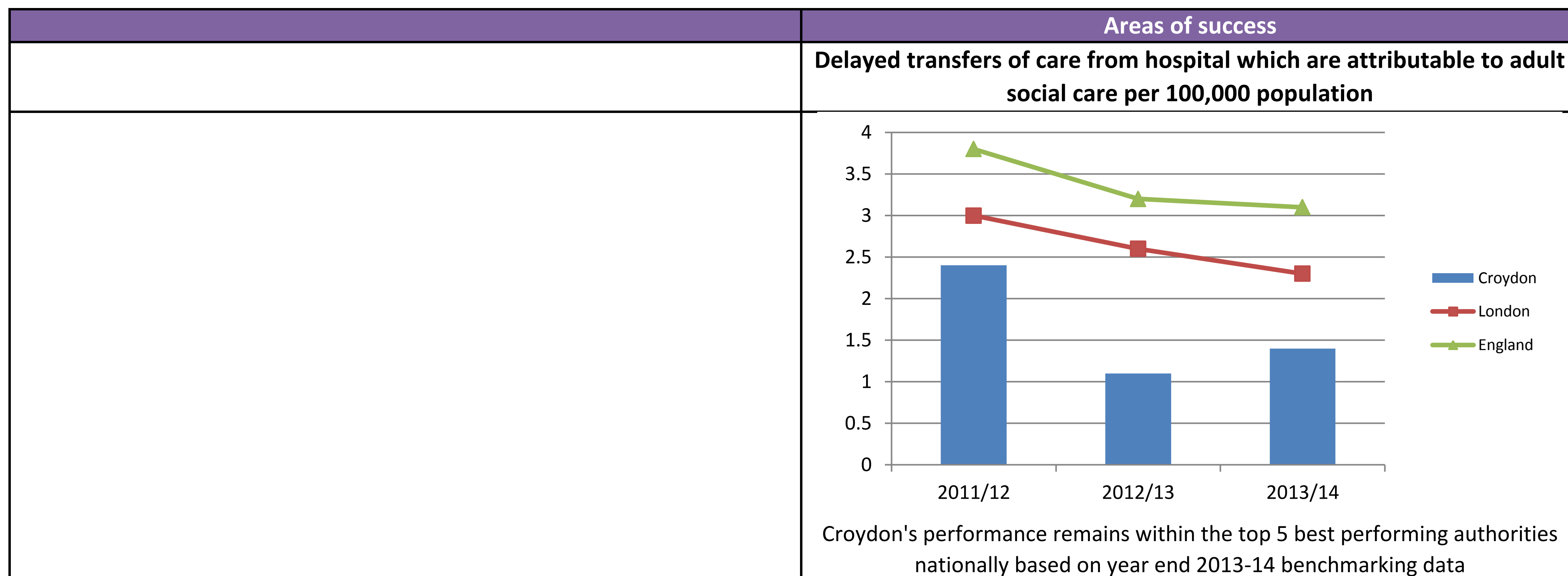
Measure description	Source	Polarity	Most recent annual data	From	Previous Result	London Average	England Average	Comparison with Previous Result	Comparison with London Average	Comparison with England Average
Early deaths from cancer considered preventable (rate per 100,000 population aged under 75)	Croydon key dataset	LOW	78.12	2011/13	79.6	81.5	84.9	About the same	Better	Better
Deaths from causes considered preventable (rate per 100,000 population)	Croydon key dataset	LOW	173	2011/13	179	171.81	183.85	Better	About the same	Better
Early deaths from cardiovascular diseases considered preventable (rate per 100,000 population age<75)	Croydon key dataset	LOW	53.92	2011/13	55.2	50.22	50.89	Better	Worse	Worse
Early deaths from liver disease considered preventable (rate per 100,000 population age<75)	Croydon key dataset	LOW	12.89	2011/13	14	15.72	15.7	Better	Better	Better
Early deaths from respiratory diseases considered preventable (rate per 100,000 population age<75)	Croydon key dataset	LOW	17.35	2011/13	17.9	17.14	17.85	About the same	About the same	About the same
Offered an NHS health check (% of eligible people aged 40-74)	Croydon key dataset	HIGH	0.8%[1]	2013/14	0.10%	5.30%	23.10%	About the same	Worse	Worse
Take up of NHS health checks (% of people offered health checks)	Croydon key dataset	HIGH	1.60%	2013/14	12.50%	43%	48%	Worse	Worse	Worse

Measure description	Source	Polarity	Most recent annual data	From	Previous Result	London Average	England Average	Comparison with Previous Result	Comparison with London Average	Comparison with England Average
% of NHS health checks that identify patients to be at high risk	TBC	TBC	12.30%	2012/13	10.20%	Local indica	local indicator	Unknown	Unknown	Unknown
Breast screening rate (% of women aged 53-70)	Croydon key dataset	HIGH	66.75%	2014	69.20%	68.91%	75.90%	**Worse**	**Worse**	**Worse**
Cervical screening rate (% of eligible women aged 25-64)	Croydon key dataset	HIGH	72.50%	2014	71.70%	70.31%	74.16%	**About the same**	**Better**	**Worse**
Deaths from diabetes (rate per 100,000 population)	Croydon key dataset	LOW	9.55	2010-12	6.19	9.57	9.89	**Worse**	**About the same**	**About the same**

Improvement area 4: supporting people to be resilient and independent

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

Potential challenge areas	Areas of success
Proportion of adults in contact with secondary mental health services living independently, with or without support	**Proportion of people using social care who receive self-directed support**
90 80 70 60 50 40 30 20 10 0 2011/12 2012/13 2013/14 Croydon London England	90 80 70 60 50 40 30 20 10 0 2011/12 2012/13 2013/14 Croydon London England
2013/14 has seen a decline in the proportion of adults in contact with secondary mental health services living independently	Across all services, all presenting clients with eligible needs, excluding those in crisis or receiving reablement services, are assessed utilising the single Resource Allocation System to determine the amount of personal budget they will receive to fund their social care services.



Performance measures

Measure description	Source	Polarity	Most recent annual data	From	Previous Result	London Average	England Average	Comparison with Previous Result	Comparison with London Average	Comparison with England Average
Survey Social care-related quality of life	ASCOF	HIGH	18.7	2013/14	18.2	18.5	19	Better	About the same	About the same
Proportion of people who use services who have control over their daily life	ASCOF	HIGH	74.90%	2013/14	72.30%	72%	76.70%	Better	Better	Worse

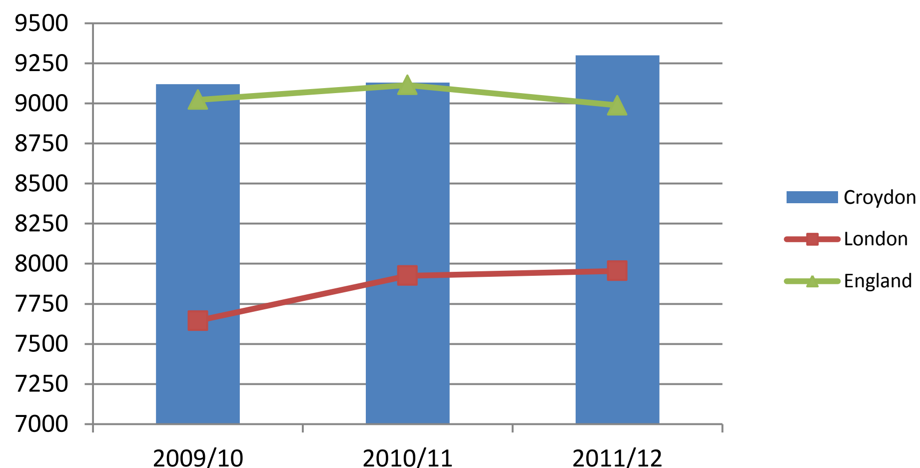
Measure description	Source	Polarity	Most recent annual data	From	Previous Result	London Average	England Average	Comparison with Previous Result	Comparison with London Average	Comparison with England Average
% of people using social care who receive self-directed support	ASCOF	HIGH	78.6%	2013/14	73.8%	67.5%	62.1%	Better	Better	Better
% of people using social care who receive direct payments	ASCOF	HIGH	9.3%	2013/14	9.6%	22.1%	19.1%	About the same	Worse	Worse
Survey: Carer-reported quality of life	ASCOF	HIGH	7.7	2012/13	n/a	7.7	8.1	UNKNOWN	About the same	About the same
% of adults with learning disabilities in paid employment	ASCOF	HIGH	5.6%	2013/14	5%	9.2%	6.8%	About the same	Worse	Worse
% of adults in contact with secondary mental health services in paid employment	ASCOF	HIGH	5.8%	2013/14	8.0%	5.5%	7.1%	Worse	About the same	Worse
% of adults with learning disabilities who live in their own home or with their family	ASCOF	HIGH	66.2%	2013/14	63.8%	68.5%	74.8%	Better	About the same	Worse
% of adults in contact with secondary mental health services living independently, with or without support	ASCOF	HIGH	71.2%	2013/14	77.5%	78.7%	60.9%	Worse	Worse	Better
Permanent admissions of younger adults (aged 18 to 64) to residential and nursing care homes, per 100,000 population	ASCOF	LOW	7.3	2013/14	6	10	14.4	Worse	Better	Better

Measure description	Source	Polarity	Most recent annual data	From	Previous Result	London Average	England Average	Comparison with Previous Result	Comparison with London Average	Comparison with England Average
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	ASCOF	LOW	374.2	2013/14	212	463.9	668.4	Worse	Better	Better
% of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/ rehabilitation services	ASCOF	HIGH	85.20%	2013/14	85.10%	87.80%	81.90%	About the same	Worse	Better
Delayed transfers of care from hospital per 100,000 population	ASCOF	LOW	5.2	2013/14	3.4	6.9	9.7	Worse	Better	Better
Delayed transfers of care from hospital which are attributable to adult social care per 100,000 population	ASCOF	LOW	1.4	2013/14	2.7	2.3	3.1	Better	Better	Better
Overall satisfaction of people who use services with their care and support %	ASCOF	HIGH	57.9%	2013/14	54.20%	60.1%	64.9%	Better	Worse	Worse
Overall satisfaction of carers with social services %	ASCOF	HIGH	29.2%	2012/13	Not available	35.2%	42.7%	UNKNOWN	Worse	Worse
% of carers who report that they have been included or consulted in discussion about the person they care for	ASCOF	HIGH	63.4%	2012/13	Not available	65.9%	72.8%	UNKNOWN	About the same	Worse

Measure description	Source	Polarity	Most recent annual data	From	Previous Result	London Average	England Average	Comparison with Previous Result	Comparison with London Average	Comparison with England Average
%of people who use services and carers who find it easy to find information about services	ASCOF	HIGH	73.1%	2013/14	73%	72.6%	74.7%	About the same	About the same	About the same
% of people who use services who say that those services have made them feel safe and secure	ASCOF	HIGH	71%	2013/14	59.7%	77.4%	79.2%	Better	Worse	Worse

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

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

Potential challenge areas	
All cause emergency hospital admissions (rate per 1,000 population)	
 All cause emergency admissions have increased for the year 2011/12, while London overall saw a slight decrease. England's average did increase marginally.	

Performance measures

Measure description	Source	Polarity	Most recent annual data	From	Previous Result	London Average	England Average	Comparison with Previous	Comparison with London Average	Comparison with England Average
All cause emergency hospital admissions (rate per 1,000 population)	Croydon key dataset	LOW	9299.78	2011/12	9130.52	7746.83	8987.99	About the same	Worse	Worse
Emergency readmissions within 30 days of discharge from hospital (%)	Croydon key dataset	LOW	12.60%	2011/12	12.00%	12.00%	11.80%	About the same	About the same	About the same
% of deaths from all causes that occur at usual place of residence	Croydon key dataset	NA	39.80%	2012	38.10%	35.80%	43.70%	Unknown	Unknown	Unknown
Safety incidents involving severe harm or death per 100 admissions	NHS outcomes framework	LOW	49	13- Mar 14	63	Not available	Medium Acute (Croydon's comparator group): 20	Better	Unknown	Worse
Patient safety incidents reported rate per 100 admissions	NHS outcomes framework	LOW	5.9	13- Mar 14	6.6	Not available	Medium Acute (Croydon's comparator group):7.82	Better	Unknown	Better
Incidence of avoidable harm: MRSA (crude count)	NHS outcomes framework	LOW	3	2013/14	1	Not available	5	Worse	Unknown	Better
Incidence of avoidable harm: C.difficile (crude count)	NHS outcomes framework	LOW	14	2013/14	30	Not available	5.2	Better	Unknown	Worse

Improvement area 6: improving people's experience of care

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

Potential challenge areas	
Patient experience of primary care: Out of Hours Service	
Patient satisfaction rates for experience of primary care: Out of Hours Service has decreased for the period 2013/14, However a similar drop in satisfaction is evident for both London and England averages.	

Performance measures

Measure description	Source	Polarity	Most recent annual data	From	Previous Result	London Average	England Average	Comparison with Previous	Comparison with London Average	Comparison with England Average
Patient experience of primary care: GP Services	NHS outcomes framework	HIGH	83.30%	2014	84%	81.40%	85.70%	About the Same	Better	Worse
Patient experience of primary care: Out of Hours Services	NHS outcomes framework	HIGH	56.70%	2013	63.20%	58.20%	66.20%	Worse	Worse	Worse
Patient experience of primary care: Dentistry	NHS outcomes framework	HIGH	82.90%	2014	81.90%	Not available	84.20%	About the Same	Unknown	Better
Patient experience of hospital care: Inpatient Overall Experience	NHS outcomes framework	HIGH	67.1	2013/14	68	Not available	76	About the Same	Unknown	Worse
Patient experience of hospital care: Outpatient Overall Experience (out of 100)	NHS outcomes framework	HIGH	74.4	2011	75.3	Not available	80	About the Same	Unknown	Worse
Patient experience of hospital care: Inpatient Responsiveness to Needs (out of 100)	NHS outcomes framework	HIGH	54.4	2014	57.4	Not available	68.7	Worse	Unknown	Worse
Patient experience of hospital care: A&E Overall Experience	NHS outcomes framework	HIGH	75.5	2012	72.3	Not available	80	Better	Unknown	Worse
Access to NHS dental services (out of 100)	NHS outcomes framework	HIGH	94.6	2014	95.5	93.1	94.8	About the Same	About the same	About the same

Measure description	Source	Polarity	Most recent annual data	From	Previous Result	London Average	England Average	Comparison with Previous Result	Comparison with London Average	Comparison with England Average
Access to GP services	NHS outcomes framework	HIGH	73.40%	2014	74.80%	70.70%	74.60%	About the same	Better	About the same
Women's experience of maternity services: Intrapartum[2] (score between 1 -100)	NHS outcomes framework	High	70.5	2013	73	Not available	74.5	Worse	Unknown	Worse
Patient experience of community mental health services[3] (score between 1-10)	NHS outcomes framework	HIGH	7	2014	8.75	Not available	6.6	Worse	Unknown	About the same

[1] A Data quality issue has been cited on Public Health Outcomes Framework

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

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

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To:
Croydon Health and Wellbeing Board
NHS Croydon CCG

Copy to:
Croydon Council

21 January 2015

Dear colleague,

Thank you for submitting further evidence to clear the conditions on your Better Care Fund (BCF) plan. We know that the BCF is an ambitious programme and preparing the plans at pace has proved an immensely challenging task. However, your plan is now part of an ongoing process to transform local services and improve the lives of people in your community.

It is clear that your team and partners have worked very hard over the last few months, making valuable changes to your plan in order to improve people's care.

NHS England is now able to approve plans following the publication of the 2015/16 Mandate. As a result I am delighted to let you know that, following the recent assurance process, your resubmitted plan has been classified as **'Approved'**. Appended to this letter is your NCAR Outcome Report for your information. Essentially, your plan is strong and robust and we have every confidence that you will be able to deliver against it. This puts you in a strong position for delivering the change outlined above.

Your BCF funding will be made available to you subject to the following standard conditions which apply to all BCF plans:

- The Fund being used in accordance with your final approved plan and through a section 75 agreement;
- The full value of the element of the Fund linked to non-elective admissions reduction target will be paid over to CCGs at the start of the financial year. However, CCGs may only release the full value of this funding into the pool if the admissions reduction target is met as detailed in the BCF Technical Guidance[1]. If the target is not met, the CCG(s) may only release into the pool a part of that funding proportionate to the partial achievement of the target. Any part of this funding that is not released into the pool due to the target not being met must be dealt with in accordance with NHS England requirements. Full details are set out in the BCF Technical Guidance

The conditions are being imposed through NHS England's powers under sections 223G and 223GA of the NHS Act 2006 (as amended by the Care Act 2014). These allow NHS England to make payment of the BCF allocation subject to conditions. If the conditions are not complied with, NHS England is able to withhold or recover funding, or direct the CCG that it be spent in a particular way.

We are confident that there are no areas of high risk in your plan and as such you should progress with your plans for implementation.

Any ongoing oversight of your BCF plan will be led by your NHS England Regional/Area Team along with your Local Government Regional peer rather than the BCF Taskforce from this point onwards.

Non-elective (general and acute) admissions reductions ambition

We recognise that some areas may want to revisit their ambitions for the level of reduction of non-elective admissions, in light of their experience of actual performance over the winter, and as they become more confident of the 2014/15 outturn, and firm-up their plans to inform the 2015/16 contracting round. Any such review should include appropriate involvement from local authorities and be approved by HWBs. NHS England will assess the extent to which any proposed change has been locally agreed in line with BCF requirements, as well as the risk to delivery of the ambition, as part of its assurance of CCGs' operational plans.

Once again, thank you for your work and we look forward to the next stage.

Yours sincerely,

Dame Barbara Hakin
National Director: Commissioning Operations
NHS England

[1] http://www.england.nhs.uk/wp-content/uploads/2014/08/bcf-technical-guidance-v2.pdf

How the plans have met the conditions

Croydon

Recommend for APPROVAL

Why the conditions should be lifted?

Condition(s)	*What is driving this?*	*How has it been addressed?*
Further demonstrate how they will deliver the planned NEL reduction	• The target of 3.5% takes into account an underlying population growth rate of 5.6%. This would make an overall reduction of 9.1%	✓ Croydon have introduced further schemes aimed to support meeting the non-elective target and include these throughout the plan
Address outstanding analytical risk	• The activity totals for reduction in admissions were not consistent across Part 2	✓ Financial discrepancy resolved

Other outstanding actions

Minimal

Risk of an ambitious plan still remains partially open as plan is very ambitious. This was recognised by the HWB during the first review.

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