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
Charlotte LADYMAN (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 10th June 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)
(020) 8726 6000 Extn.62564
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www.croydon.gov.uk/agenda
1 June 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 25th March 2015

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. Local Government Declaration on Tobacco Control (Page 1)

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

7. PART 1 - Strategic items
Croydon Council commissioning plans 2015/16 (Page 5)

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

8. Household income and health (Page 23)

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

9. JSNA 2013/14 homeless households chapter final draft (Page 29)

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

10. Healthy weight strategic action plan (Page 47)

The report of Croydon Council's Executive Director of People and the Director of Public Health is attached.

11. Deprivation of liberty safeguards (Page 61)

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

12. Sexual health procurement strategy (Page 69)

The report of Croydon Council's Executive Director of People, the Director of Public Health, the Chief Officer of Croydon's Clinical Commissioning Group and the Medical Director for South London, NHS England, is attached.

13. PART 2 - Business items
Francis Review action plans (Page 79)

The report of the Chief Officer of Croydon Clinical Commissioning Group, Chief Executive of Croydon Health Services NHS Trust and Director of Mental Health of South London & Maudsley NHS Foundation Trust (SLaM) is attached

14. Local alcohol action area
(Partnership group: Drugs & alcohol (DAAT); Healthy Behaviours) (Page 139)

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

15. 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.

16. Report of the Chair of the Executive Group (Page 143)

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

17. FOR INFORMATION ONLY (Page 193)

Carers partnership group report (Partnership group: Carers) - The report of Croydon Council's Executive Director of People is attached
Heart Town annual report - The report of Croydon's Director of Public Health is attached

18. 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

REPORT TO:	**HEALTH AND WELLBEING BOARD (CROYDON)** **10 June 2015**
AGENDA ITEM:	**6**
SUBJECT:	**Local Government Declaration on Tobacco Control**
BOARD SPONSOR:	**Mike Robinson, Director of public health, Croydon Council**

BOARD PRIORITY/POLICY CONTEXT:

Croydon's joint health and wellbeing strategy set out to increase healthy life expectancy and reduce differences in life expectancy between communities. Smoking is a major cause of death and ill health in the borough and a significant contributor to differences in life expectancy between communities.

FINANCIAL IMPACT:

There are no financial impacts arising from this report.

1. RECOMMENDATIONS

1.1 Agree that Croydon Council become a signatory to the Local Government Declaration on Tobacco Control.

2. EXECUTIVE SUMMARY

2.1 The Local Government Declaration on Tobacco Control (the Declaration) sets out a commitment to tackle smoking and the harms that it causes to the communities in the local area. Endorsing it will commit the Council to:

- Reduce smoking prevalence, and health inequalities;
- Develop plans with partners and local communities to address causes and impact of smoking;
- Participate in local and regional networks;
- Support Government action at national level to help local authorities reduce smoking prevalence and health inequalities;
- Protect tobacco control work from the interests of the tobacco industry;
- Monitor the progress of their plans.

3. DETAIL

3.1 Tobacco remains the single greatest cause of preventable death, causing almost one in five adult deaths, and is the biggest cause of health inequality. Smoking is estimated to cost Croydon over £80 million per year, through health and social care costs, smoking breaks at work, domestic fires and litter. Two thirds of smokers start smoking before the age of 18.

3.2 The Declaration was originally developed in Newcastle in 2013. Over 80 English local authorities have now signed up. The Declaration is endorsed by the Public Health Minister, the Chief Medical Officer, Public Health England, the Association of Directors of Public Health, the Trading Standards Institute, the

Chartered Institute of Environmental Health and others. In August 2014, a sister document to the Declaration, the NHS Statement of Support, was launched to allow NHS organisations to show their support for tobacco control.

3.3 The Declaration will add impetus and profile to the development of Croydon's local tobacco control plan. It will empower stakeholders to work with regional partnerships to develop comprehensive and effective tobacco control measures. This will help drive down local smoking rates and protect children and young people from tobacco harm. It will help reduce health and social care costs, save money for local businesses and reduce the trade in illicit tobacco.

3.4 There is no direct cost associated with becoming a signatory, above the local investment already being made in local tobacco control. The Declaration would, as a principle, commit Croydon to refusing offers of investment in tobacco control from tobacco companies, however regional and national networks may provide efficiency opportunities through partnership work.

4. CONSULTATION

4.1 This proposal has been discussed informally at the multi-agency, multi-disciplinary Healthy Behaviour Change Alliance, which includes representatives of regulatory services, primary, secondary, and mental health services, community pharmacy, schools third sector and a public representative. Members of the Alliance expressed broad assent for the proposal. No member opposed the proposal. No formal consultation is required.

5. SERVICE INTEGRATION

5.1 There are no service integration implications arising from this report.

6. LEGAL CONSIDERATIONS

6.1 The Council Solicitor comments that in considering implementation measures as they relate to the tobacco industry the case shows that Council must still exercise its powers and functions reasonably and lawfully.

6.2 Approved by: Gabriel MacGregor, Head of Corporate Law on behalf of the Council Solicitor & Director of Democratic & Legal Services

7. EQUALITIES IMPACT

7.1 The proposal concerns a policy decision to refrain from engaging with commercial entities who undertake activities harmful to our communities, especially the most deprived. There are no detrimental equalities concerns associated with implementing this proposal.

CONTACT OFFICER: Jimmy Burke, Public health principal, Croydon Council
jimmy.burke@croydon.gov.uk 020 8726 6000 x88339

BACKGROUND DOCUMENTS Local Government Declaration on Tobacco Control

Local Government Declaration on Tobacco Control

We acknowledge that:

- Smoking is the single greatest cause of premature death and disease in our communities;
- Reducing smoking in our communities significantly increases household incomes and benefits the local economy;
- Reducing smoking amongst the most disadvantaged in our communities is the single most important means of reducing health inequalities;
- Smoking is an addiction largely taken up by children and young people, two thirds of smokers start before the age of 18;
- Smoking is an epidemic created and sustained by the tobacco industry, which promotes uptake of smoking to replace the 80,000 people its products kill in England every year; and
- The illicit trade in tobacco funds the activities of organised criminal gangs and gives children access to cheap tobacco.

As local leaders in public health we welcome the:

- Opportunity for local government to lead local action to tackle smoking and secure the health, welfare, social, economic and environmental benefits that come from reducing smoking prevalence;
- Commitment by the government to live up to its obligations as a party to the World Health Organization's Framework Convention on Tobacco Control (FCTC) and in particular to protect the development of public health policy from the vested interests of the tobacco industry; and
- Endorsement of this declaration by the Department of Health, Public Health England and professional bodies.

We commit our Council from this date .....to:

- Act at a local level to reduce smoking prevalence and health inequalities and to raise the profile of the harm caused by smoking to our communities;
- Develop plans with our partners and local communities to address the causes and impacts of tobacco use;
- Participate in local and regional networks for support;
- Support the government in taking action at national level to help local authorities reduce smoking prevalence and health inequalities in our communities;
- Protect our tobacco control work from the commercial and vested interests of the tobacco industry by not accepting any partnerships, payments, gifts and services, monetary or in kind or research funding offered by the tobacco industry to officials or employees;
- Monitor the progress of our plans against our commitments and publish the results; and
- Publicly declare our commitment to reducing smoking in our communities by joining the Smokefree Action Coalition, the alliance of organisations working to reduce the harm caused by tobacco.

Signatories

Leader of Council	Chief Executive	Director of Public Health

Endorsed by

Jane Ellison, Public Health Minister, Department of Health	Duncan Selbie, Chief Executive, Public Health England	Professor Dame Sally Davies, Chief Medical Officer, Department of Health	
Dr Janet Atherton, President, Association of Directors of Public Health	**Dr Lindsey Davies, President, UK Faculty of Public Health**	**Graham Jukes, Chief Executive, Chartered Institute of Environmental Health**	**Leon Livermore, Chief Executive, Trading Standards Institute**

Department of Health | Public Health England | Association of Directors of Public Health | Faculty of Public Health | Chartered Institute of Environmental Health | trading standards institute

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REPORT TO:	HEALTH AND WELLBEING BOARD (CROYDON) 10 June 2015
AGENDA ITEM:	7
SUBJECT:	Council Commissioning Plans 2015/16
BOARD SPONSOR:	Paul Greenhalgh, Executive Director of People Department, Croydon Council

BOARD PRIORITY/POLICY CONTEXT:

This report identifies how the Council's commissioning plans which are delivered through the ICU contribute to Health and Wellbeing Board priorities as set out in the Joint Health and Wellbeing Strategy:-

1. giving our children a good start in life
2. preventing illness and injury and helping people recover
3. preventing premature death and long term health conditions
4. supporting people to be resilient and independent
5. providing integrated, safe, high quality services
6. improving people's experience of care

The national policy context has also shaped the Council's commissioning priorities for 2015/16. This background context includes the requirements arising from the Care Act 2014, in particular
~ new statutory duties relating to universal information, advice and advocacy,
~ engaging communities so that they can play a stronger role in supporting individuals, particularly in preventative initiatives,
~ duties to shape, manage and sustain the local care and support market and
~ extended responsibilities to address the needs of family carers.

"Ambitious for Croydon" encapsulates the council's vision as a stronger, fairer borough where no community is held back. The council has recently restructured itself to help deliver this ambition into three departments for Place, Resources and People each with its own enabling strategy. Within the recently formed People Department (where the ICU is based) an Independence Strategy is being developed with key priorities to support the strategy's delivery. These priorities also have informed the Council's commissioning plans which:
~ Empower individuals and communities to be better able to take more responsibility for themselves and each other
~ Enable residents to make informed choices about how to meet their needs through the provision of high quality information, advice and guidance
~ Provide people with the best opportunity to maximise their life chances and have a good quality of life through the provision of high quality universal services, including an excellent learning offer
~ Empower people to resolve issues early through the provision of joined up assessment and support
~ Enable children and adults to maximise their independence and ensure they are safe from harm through the provision of high quality specialist services

FINANCIAL IMPACT: The ICU carries out its work within the budgets and financial governance requirements of each of its partners. The work streams detailed in this report are in line with agreed budgets and financial plans for 2015/16.

It should be noted that in the current financial environment for local government and the NHS, where funding is constrained and service demand pressures are increasing, the council through the ICU continues to focus on the challenge of how we can deliver services within allocated resources, through better integrated working on behalf of both partners, whilst at the same time ensuring we can sustain quality and manage demand.

1. RECOMMENDATIONS

This report is for information. The Board is asked to give an opinion on the council's discharge of its commissioning responsibilities with respect to the Board's priorities.

2. EXECUTIVE SUMMARY

2.1 This report outlines the 2015/16 commissioning plans of Croydon Council, which are to be delivered through the Integrated Commissioning Unit (ICU).

2.2 The ICU was established in April 2014 to bring together joint commissioning under a single management line on behalf of both the council and the CCG. In practical terms therefore, the council's commissioning plans for prevention, care, support and well-being are the responsibility of the ICU to develop and implement. Through the Director and senior team structure, the ICU is accountable to each of the partner organisations for the effective discharge of their commissioning responsibilities. The ICU has made good progress in its first year of operation (2014/15) to strengthen joint working and thereby to support the delivery of improved outcomes for Croydon people.

2.3 This report sets out those key commissioning priorities in the ICU plan for 2015/16 which fall within the council's remit. Inevitably, when considering the purpose of an integrated unit, many of the commissioning plans and objectives represent joint areas of work. For reference therefore, the table (attached as Appendix 1) illustrates the full range of commissioning plans and priorities which form the ICU's work programme for 2015/16, which are either commissioned by the Council or commissioned jointly between the council and the CCG.

2.4 For completeness, the Appendix also references those CCG commissioning plans for 2015/16 which are to be delivered through the ICU (shown as *CCG* in italics).

3. DETAIL

3.1 The Appendix shows the commissioning priorities within the 2015/16 plan for the different work streams within the ICU in its second year of operation. It is very much a working document and will be subject to review, monitoring and updating as the year progresses.

3.2 The ICU comprises 5 main teams of integrated commissioning, each led by a Head of Service:-

~ Children and Maternity,
~ Vulnerable Older people, physical disabilities, end of life care and carers
~ Mental Health & Substance Misuse
~ Working Age Adults, which includes learning disabilities, public health commissioning, supported housing, market development/contracts support
~ In addition the ICU benefits from the input of a Strategic Projects post which enables support on cross-cutting projects across the ICU.

4 Key Priority Areas

4.1 The Appendix sets out the full work programme. Within this, there are some key council or joint commissioning objectives to bring to the Board's attention. Their importance reflects our local vision to ensure children get a good start in life, to improve health and well-being outcomes, to increase healthy life expectancy and reduce differences in life expectancy between communities and improve people's positive experience of care. In summary:-

- Strengthen children's emotional wellbeing and mental health through the Partnership strategy, implementing a blended model across the tiers of support – in line with the Young People's Mental Health Taskforce.

- Implement service development priorities for services supporting children with Special Education Needs and Disability including preparation for a new child development centre and a service review for audiology.

- Strengthen early intervention by assuring the smooth transfer of 0-5 public health services to local authority commissioning and ensuring they are optimised within the Best Start model.

- Jointly with the CCG implement a re-designed service for adult mental health which focuses on prevention, increased access to psychological therapies, early intervention and crisis prevention, supporting developments in primary care and community settings.

- Jointly with the CCG, re-design mental health services for older adults to improve choice, personalisation and outcomes, including developments to support people with dementia and their family carers.

- Review services for people with learning disabilities, including people with complex needs, to ensure we commission a range of good quality, personalised services, that promote independence, inclusion and citizenship.

- Continue to progress re-commissioning of substance misuse services, focusing on recovery outcomes

- Re-commissioning of key public health preventative services including smoking cessation and weight management

- Jointly with the CCG, support the implementation of Croydon's major transformation programme for over 65s – an outcomes-based approach focusing on proactive person-centred care, and to address demographic demands on a sustainable basis through a whole systems focus on prevention.

- Jointly with the CCG, improve end of life care by working closely with partners and the public so that people nearing the end of their lives can make plans to die in the place of their choice and families and friends feel supported

- Ensure wide variety of information, advice and support is available to unpaid carers locally to enable them to continue in their vital caring roles

- Develop our strategic approach to market shaping and market management in line with Care Act duties, working collaboratively with other local commissioners and provider partners.

4.2. In developing this work programme, risks have been fully considered and evaluated in the development of the plan and mitigating actions have been factored in. The key themes arising from the risk analysis across the plan include:

- Seeking through the two partner organisations to ensure adequate resources are in place and maintained in order to achieve specific commissioning objectives;

- Ensuring the effective management of the network of relationships across the wider health and social care system.

5 CONSULTATION

5.1 Consultation and engagement with service users is carried out as part of the commissioning cycle to develop commissioning strategies and for any services undergoing development. Examples of service user input range from their participation in recruitment of key posts in the ICU and in the design of service specifications and provider selection. Service users also provide commissioners with consumer views and feedback in terms of service "gaps" or where services are felt to be of valued quality. They can provide a "critical friend" perspective through groups such as Croydon Adult Social Services User Panel (CASSUP).

6. SERVICE INTEGRATION

6.1 The key objectives of the Integrated Commissioning Unit are to strengthen integration across health and social care, across services for different ages and between health and social care/wellbeing services, by effective and evidence-based commissioning . This should enable people to experience care or support in a more truly personalised way with the individual and their family at the centre.

6.2 Another key outcome is to identify and address any unnecessary duplications or overlaps in commissioned services, helping to streamline processes and support systems' efficiencies.

6.3 Finally, there is "added value" that comes from working in an integrated unit which bridges health and social care organisations. The ICU structure enables staff to gain a better understanding of different organisational cultures, governance systems and performance regimes. This can contribute to their ability to identify opportunities for service development and quality improvement, along with finding practical solutions to problems that cross organisational boundaries.

7. EQUALITIES IMPACT

7.1 Equality impact assessments are carried out as part of the commissioning cycle to develop commissioning strategies and for any services undergoing development.

8. FINANCIAL IMPLICATIONS

8.1 The ICU must carry out its work within the financial governance requirements of each of its partners. It is required to ensure it delivers services with the financial resources available and provides financial reporting to all partners on a regular basis. The work streams detailed in the report are in line with agreed budgets and financial plans for 2015/16.

8.2 Approved by: Lisa Taylor, Head of Finance and Deputy S151 Officer.

CONTACT OFFICER

Brenda Scanlan Director, Integrated Commissioning Unit & Adult Care Commissioning.
Brenda.scanlan@croydon.gov.uk
020 8700 5727

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ICU 2015-16 commissioning priorities

APPENDIX 1

Link to HWB priorities	Commissioning Workstream & Objective (plus Service Area & lead officer)	Commissioned by Council / CCG?	Milestones	Wider Impact/Implications on the H&S Care system
Integrated Commissioning - Children and Maternity				
Improve educational attainment in disadvantaged groups.	**1. CCG operating plan: Improve health outcomes for LAC** by strengthening service performance against an agreed outcomes framework. Implement referral pathway improvements. Agree outcomes framework with key stakeholders.	*Health service for local CLA commissioned by CCG* . Health service for UASC commissioned by Council.	• Implement and monitor improved health assessment process clarifying health service role and performance expectations - Oct 15 • Work with provider to strengthen service performance and with the provider and other partners to develop an outcomes framework and appropriate pathways for CLA health services – Mar 16	Improving health outcomes for CLA is a key contribution to achieving permanence.
Reduce overweight and obesity in children. Improve children's emotional and mental wellbeing. Improve the uptake of childhood immunisations	**2. Strengthen early intervention** by implementing commissioning strategy for school-aged nursing and taking steps to increase integration with other 5-19 health improvement services	School-aged nursing and weight management commissioned by Council.	• Identify and implement route map towards a 5-19 integrated service and closer integration with adult public health services –Dec 15 • Review weight management services and identify opportunities for greater integration with school aged nursing – Sep 15 - Implement commissioning strategy for 5 - 19 health improvement services (including school aged nursing) - Sep 16	Strengthened early intervention to divert CYP where possible from needing specialist and more costly services.
Improve children's emotional and mental wellbeing.	**3. CCG operating plan: Strengthen the contribution of commissioned health services to the local Autism Spectrum Disorder pathway** in line with best practice guidelines as part of a wider review of the Community Paediatric service.	*Community paediatric service commissioned by CCG*	• Complete and implement recommendations from community paediatrics service review. .Strengthen the evidence base to better understand the rate of ASD diagnoses and needs in the borough • Identify opportunities for increased integration between children's and adults' ASD services • Contribute to redesigning the ASD pathway in partnership with wider stakeholders – Sep 15 • Contribute to implementing new ASD pathway – Mar 16 • Implement improvement plan for community paediatric service in relation to ASD - Mar 16.	Strengthened early intervention to divert CYP where possible from needing specialist and more costly services.
Improve educational attainment in disadvantaged groups. Improve patient and service user satisfaction with health and social care services. Integrated care and support for people with long term conditions.	**4. CCG operating plan: Implement service development priorities for services supporting children with SEN and Disability** (special school nursing, paediatric OT and physiotherapy services) including preparation for child development centre and a service review for audiology. Implement recommendations from commissioning reviews of therapies and special school nursing including agreeing outcomes for special school nursing, paediatric OT and physiotherapy services. Preparation for child development centre progressed against agreed project timeline.	SALT commissioned jointly by CCG and Council. *Physiotherapy, audiology and Special school nursing commissioned by CCG* .	• Support implementation of service development objectives – Sep 15 • Review development progress and consider whether commissioning strategy is effective - Sep 15 • Identify further opportunities for greater integration between children and adults' services – Sep 15 • Refresh service specification for audiology – Mar 16	To ensure appropriate health contribution to Education, Health and Care plans.

Link to HWB priorities	Commissioning Workstream & Objective (plus Service Area & lead officer)	Commissioned by Council / CCG?	Milestones	Wider Impact/Implications on the H&S Care system
Integrated care and support for people with long term conditions. Rehabilitation and reablement to prevent repeat admissions to hospital. Self management and self care.	**5. CCG Operating Plan: Reduce avoidable A&E attendance for children by** realising benefits of new asthma service. - Analysis of differential paediatric referral rates across networks delivered for asthma and other conditions. Delivery a feasibility analysis of a rapid access service and phone clinic for paediatrics to improve the timeliness and appropriateness of referrals to clinics and outpatients and implement agreed approach. Service implemented in line with agreed project plan and collaboratively with SW London CCG wide training delivery.	*Children's Hospital at Home and Asthma team commissioned by CCG* .	• Transition new asthma service to business as usual as part of a wider review of Children's Hospital at Home service – Mar 16 • Review new service and identify opportunities for extending service model to other long term conditions which impact on A&E attendances – Mar 16	
Increase breastfeeding initiation and prevalence. Reduce overweight and obesity in children. Improve children's emotional and mental wellbeing. Improve the uptake of childhood immunisations. Improve educational attainment in disadvantaged groups.	**6. Strengthen early intervention** by assuring the smooth transfer of 0-5 public health services to local authority commissioning and ensuring they are optimised within the Best Start model.	Health Visiting and Family Nurse Partnership - commissioning responsibility transferring to Local Authority from NHSE from Oct '15	Novated contract in place for safe receipt of Health Visiting and FNP services - Oct 2015 Implementation Plan in place for Best Start including Health Visiting and Family Nurse Partnership - Jul 15 Best Start Service commences - Oct 15 Future Commissioning strategy for Best Start developed - 2016	Strengthened early intervention to divert CYP where possible from needing specialist and more costly services.
Improve children's emotional and mental wellbeing.	**7. Strengthen emotional wellbeing and mental health** by continuing to implement the Partnership strategy, strengthening support at tier 1 and recommissioning tier 2 and 3 support as required – in line with the YP Mental Health Taskforce.	Jointly commissioned	• Implementation plan in place for workforce development approach - July 15 • Recommission and mobilise voluntary sector open access counselling services - Apr 16 • Develop business case for Single Point of Access approach for consideration through governance routes - Aug 15 • Contribute to implementing new ASD pathway including role of SLaM – Mar 16	Strengthened early intervention to divert CYP where possible from needing specialist and more costly services.
Reduce low birth weight. Increase breastfeeding initiation and prevalence.	**8. Improve outcomes for expectant and young mothers** by delivering improved local maternity services in line with the SWL 5 year strategy.	*CCG*	South West London Maternity specification developed - Sept 15 Local implementation plans in place - Jan 16	Improving health outcomes for children and mothers through the achievement of the London Quality Standards across South West London.
Improve patient and service user satisfaction with health and social care services. Integrated care and support for people with long term conditions.	**9. Strengthen arrangements for agreeing funding (by LA or CCG) for support packages for children with complex needs (education, health and/or care) by implementing recommendations from reviews carried out in 2014-15.**	CCG & Council	All PHB development sessions attended and 1 PHB in place. 3rd Markers of Progress completed and submitted to NHSE. Complete implementation plan relating to the recommendations for the all client groups review of continuing health care (CHC) – June 15 Implement agreed recommendations from review of CHC relating to multi-agency decision-making processes – Sep 15 or TBC	Improving outcomes for children with complex needs, who are likely to require further education, health and care support.

Link to HWB priorities	Commissioning Workstream & Objective (plus Service Area & lead officer)	Commissioned by Council / CCG?	Milestones	Wider Impact/Implications on the H&S Care system
Integrated commissioning - Mental Health				
Redesign of mental health pathways. Integrated care and support for people with long-term conditions. Self management and self care. Improve patient and user satisfaction with health and social care services.	**1. Invest and redesign Adult Mental Health Services, (AMH) to focus on delivery in community settings, prevention, early intervention and integration. 2015-18. By investing in services and the new Adult Mental Health Model, there will be additional services and increased capacity in local services to meet peoples integrated health needs and keep people well and out of hospital.**	*CCG*	New services start date agreed & AMH implementation plan is in place May 2015	Strengthened community / preventive services will lead to reduction in urgent and crisis care as a result of mental ill health
		CCG	New services become operational Aug 15 - including; Assessment & Liaison Teams Promoting Recovery Teams Primary Care MH Support Services Home Treatment Teams Personality Disorder Services	New model will strengthen links and integration with primary and social care. This will enable more people to remain at home and live well with positive mental health and have their holistic health needs addressed. GP's will have improved easy in easy out approach to working with secondary care though dedicated assessment & liaison teams
Redesign of mental health pathways. Integrated care and support for people with long-term conditions. Self management and self care. Improve patient and user satisfaction with health and social care services.	**2. Strengthen the role secondary care have in supporting patients with their physical health**	*CCG*	Enhanced Physical Health CQUIN Agreed with SLaM - June 2015	This will achieve the NHS England objective "Parity of Need" aligning Physical health needs/checks into the Mental Health care pathway
Redesign of mental health pathways. Integrated care and support for people with long-term conditions. Self management and self care. Improve patient and user satisfaction with health and social care services.	**3. Support the understanding and link between MH and long-term conditions within front-line staff so that they can respond more effectively to people's needs and reduce stigma.**	*CCG*	HESL funded training begins to be delivered - “No Health without Mental Health” training for front line workers April 2015-Feb 2016	Across Croydon 800 Health & Social Care front line staff will receive Mental Health and Long Term Condition training to increase awareness and reduce stigma of MH conditions.

Link to HWB priorities	Commissioning Workstream & Objective (plus Service Area & lead officer)	Commissioned by Council / CCG?	Milestones	Wider Impact/Implications on the H&S Care system
Improve the early detection, treatment and quality of care for people with dementia.	**4. Strengthen Local Crisis Care Services and consistency of approach**	CCG/Council	Croydon signed up to Crisis Care Concordat in accordance to Mind & DoH - March 2015 Action Plan Submitted - March 2015 Action Plan updated Quarterly 15/16	Key local stakeholders will feed into action planning process and local actions identified and implemented to improve the crisis care response of local Croydon services
	5. Increase Access to Crisis Advice Services 24/7	*CCG*	The 4 Borough Crisis Line becomes operational and seamlessly replaces the current Street Triage Pilot - July 2015	Crisis Line will be open to other professionals involved in Crisis Care, expected to include, BTP, LAS, MPS, to enable greater access to advice and patient records at time of crisis. Service users and carers to have access to advice line 24/7 to obtain advice, signposting,
	6. Effective Liaison Psychiatry model in place (to be achieved by April 2016)	*CCG*	• Monthly monitoring of Liaison Psychiatry services between CCG / CUH / SlaM to commence from July chaired by CCG. • Changes made and agreed to existing PLN capacity - Sep 2015 • Progress against Crisis Care Concordat to be monitored monthly via AMH steering group- monthly 15/16	Patients presenting at A&E where primary needs are Mental Health are more effectively supported leading to better health care for them, and reduced pressure on A7E units and waiting times for people presenting with physical health issues..
	7: Secondary Care better able to meet needs of BME Users, Action Plan developed in conjunction with BME forum to improve BME inpatient experience, and Mind the Gap Recommendations addressed	*CCG*	Increased focus on Quality with regards to commissioned SLaM services and increased engagement with the BME forum and Hear Us - Sep 15 Increased engagement with BME Forum - June 2015 Mind the Gap Recommendations Actions are developed and agreed - Oct 2015	Aims to increase in BME service users accessing IAPT & a reduction in BME inpatients
Redesign of mental health pathways. Integrated care and support for people with long-term conditions. Self management and self care. Improve patient and user satisfaction with health and social care services.	**8: New service pathways developed that support early intervention / prevention,** including the development of an early direction service to support young people at risk of developing psychosis	*CCG*	OASIS Service agreed - Feb 2015 Service Promoted to GP's and Potential Users - March 15-June 15 Service operational- Summer 2015	Young People supported to avoid becoming unwell or to reduce the untreated duration of illness which is evidenced to led to better lifelong health outcomes
	9. Specialist Referral Pathways are reviewed and appropriate	*CCG*	Revised Tertiary referral process - July 2015	This will ensure that treatment pathways are scrutinised and the most appropriate treatment will be delivered.
	10. Early Intervention Services meet national targets	*CCG*	Early Intervention in Psychosis to be treated within two weeks (> 50% to be achieved by April 2016)	More people accessing services to promote positive mental health and live well in the community, leading to a reduction in specialist secondary care, crisis care, emergency care and better health outcomes

Link to HWB priorities	Commissioning Workstream & Objective (plus Service Area & lead officer)	Commissioned by Council / CCG?	Milestones	Wider Impact/Implications on the H&S Care system
Increased proportion of planned care delivered in community settings	**11. Increase take up of IAPT**	*CCG*	Increased access to IAPT – on trajectory to meet 8% target 15/16 March 15/16 Joint NHSE and Voluntary Sector IAPT Future Opportunities Event takes place to explore role Vol Sector can play in IPAT delivery - May 2015 Review of CIPS waiting list in train - July 2015	This will ensure that more people can access effective counselling treatment in shorter timeframes Reduce waiting times fro services
	12: IAPT Services Developed that meet National Standards	*CCG*	6. To achieve IAPT Access rate - 8.16% of Croydon Prevalence (42k) *n.b. National target is 15%* *To achieve IAPT recovery rate - 50%* *IAPT six week referral to first treatment appointment (75% to be achieved by April 2016)* *IAPT eighteen week referral to first treatment appointment (95% to be achieved by April 2016)*	More people accessing services to promote positive mental health and live well in the community, leading to reduction in specialist secondary care, crisis care, emergency care and better health outcomes
Improve early detection, treatment and quality of care for people with dementia	**13. To achieve the National Ambition Dementia Diagnosis rate - 66.7% of Croydon Prevalence by March 2016**	CCG	Pilot GPwSI project to Support Care Home Diagnosis - July 2015 All Croydon GP practices complete coding and memory clinic patient list review - May 2015	Earlier diagnosis allows forward future planning and decision making, and access to post diagnosis services.
	14: Mental Health Older Adults Services are redesigned, to increase access, choice, quality, deliver better outcomes for users / carers and use resources more efficiently.	Joint - CCG & Council	Development of Post Diagnostic Support, Dementia advisors. - June 2015 Agreement of single point of access for carers to access support - July 2015 Agreed service specification for Care Home Intervention Team and Home Treatment Team - Aug 2015 Revision to the CMHT service Specification - Aug 2015 Rescoping of memory service and future service change recommendations - Sep 2015	Increased post diagnostic support options available for patients, carers, to use and for GP's to make referrals into. Services developed to reduce hospital admissions and allow p[people to live at home for as long as possible whilst receiving treatment / support for dementia.
Working Age Adults and Contract Support Services				
Improve patient and service user satisfaction with health and social care services. Integrated care and support for people with long term conditions.	**1. Learning disabilities Transforming Care** - Strategic review & implementation of the Winterbourne View Concordat 2 in line with Transforming Care.	*CCG (NHS Operating Plan target)*	For the 2 patients in the original cohort: Submission of 2-weekly and monthly monitoring to HSCIS. Move on for one client secured by May 2015. Agreed move on plan for the second client by June 2015.	Potential transfer of liability for part of costs from health to social care, dependent on securing appropriate support and accommodation
			For the additional 6-8 clients subject to Transforming Care from April 2015: Submission of monitoring to HSCIS (to be confirmed). Move on target to be confirmed by NHSE.	Potential transfer of liability for part of costs from health to social care, dependent on securing appropriate support and accommodation
	1a NHS Operating Plan Winterbourne View Transforming Care targets - TBA	*CCG (NHS Operating Plan target)*	To be determined	There is likely to be an expectation of joint initiatives across health and social care, potentially also including criminal justice and housing agencies

Link to HWB priorities	Commissioning Workstream & Objective (plus Service Area & lead officer)	Commissioned by Council / CCG?	Milestones	Wider Impact/Implications on the H&S Care system
Improve patient and service user satisfaction with health and social care services. Integrated care and support for people with long term conditions.	**2. LD Strategic Review** **Review a**ll commissioned health & social care services for (a) people with diagnosis of LD and complex needs and/or challenging behaviour, and (b) for people diagnosed as having ASD/ADHD to ensure there are streamline pathways, quality outcomes and good value across the health / social care system.	Joiint - Council & CCG		
	3. Learning disabilities - continuing health care - complete assessments in line with national targets and review existing placements against quality, outcomes and value for money	*CCG*	Recruitment of nurse assessor and reviewer, Reviews completed	Ensuring fit with the Council's Independence Strategy, ensuring cost of care is met from appropriate budget may result in transfer of liability or agreement for sharing costs
	4. Learning disabilities - day services - conduct a review and develop a project plan to improve value for money, ensure services are of good quality, personalised and optimise people's opportunities for inclusion and citizenship	Council	Review completed. Implementation plan prepared.	Enabling people to be independent and live full and active lives
Support and advice for carers.	**5. Learning disabilities - respite services** - conduct a review and develop a project plan to improve value for money, ensure services are of good quality, personalised and optimise people's opportunities for inclusion and citizenship	Council	Review completed. Implementation plan prepared.	Supporting family carers
Reduce the number of households living temporary accommodation.	**6. Learning disabilities/ supported housing** - review housing options for supported living where service users have tenancies with private rented sector landlords and develop a plan to ensure accommodation is good quality, affordable and provides a reasonable level of security of tenure	Council	Review completed. Implementation plan prepared.	Enabling people to live independently, enabling throughput from residential care and other institutional settings, capital funding for housing development
	7. Supported housing - conduct reviews of the generic floating support service, the home improvement agency service and the shared lives/ supported lodgings services to assure quality, improve outcomes and enhance value for money	Council	Reviews completed. Implementation plans prepared.	Sustaining independent living, supporting people to achieve independent living
	8. Supported housing - improve outcomes for vulnerable single homeless people by implementing plans to improve throughput rates in short term supported housing services and to reduce the incidence of "revolving door" cases	Council	Convert fixed term mental health throughput post to permanent. Recruit specialist case worker to prevent revolving door cases.	Link to Council's Croydon Challenge People Gateway project, enabling independent living, reducing demand on range of services including MH, drug treatment etc
	9. Supported housing - new housing development - enhance the range of options available and improve outcomes for vulnerable adults by making significant progress in working with eligible landlords to secure capital resources for developing new supported housing including: an extra care sheltered housing scheme for older people, cluster flats for people with learning disabilities and for people recovering from mental ill health, extra care scheme for older people with mental health needs, emergency hostel for homeless young people, expanded range of move on options from short term supported housing	Council	Detailed work programme agreed for the new Senior Commissioner for Supported Housing. Monthly review with Places Department colleagues. Design briefs, sites and funding routes agreed for specific proposals.	Enabling independent living

Link to HWB priorities	Commissioning Workstream & Objective (plus Service Area & lead officer)	Commissioned by Council / CCG?	Milestones	Wider Impact/Implications on the H&S Care system
Improve patient and service user satisfaction with health and social care services. Support and advice for carers.	**10. Market management** - To meet the new duties under the Care Act, develop the approach to market shaping including (i) the Care Homes Market Management project, (ii) implementation of the Integrated Framework Agreement for home care and support services, (iii) implementation of the Dynamic Purchasing System for residential care services, review and (iv) update the Market Position Statement, contract monitoring, liaison with CQC and market failure contingency planning	Council	Integrated Framework procurement and spot purchase procedures finalised and in use across all lots. Dynamic Purchase system in use for all residential placements. Editions 2 and 3 of the Market Position Statement published. Market risk analysis completed.	Better match between local supply and local demand for the range of care and support services, managing costs, improving outcomes, minimising safeguarding risks,
Reduce smoking prevalence. Reduce overweight and obesity in adults. Reduce the harm caused by alcohol misuse. Early diagnosis and treatment of sexually transmitted infections including HIV infection. Self management and self care.	**11. Substance misuse - implement phase 2** of the substance misuse recommissioning project including consultation on service redesign proposals for rehab and detox services, needle exchange and prescribing, and GP shared care	Council	Completion of consultation on redesign proposals. Dynamic Purchase system in use for residential detox and rehab services. Approach to recommissioning primary care services agreed.	impact on primary care providers, managing demand for acute hospital services
	12. Substance misuse - complete phase 1 of the substance misuse recommissioning including implementation of the contract mobilisation plan, reset the baseline for performance improvement plans using cleansed data and positive trajectories in the rates of engagement and recovery with the treatment system across the range of substances including alcohol	Council	Baseline for measuring performance improvement agreed. Quarterly monitoring through the PHE national data monitoring system for substance misuse. Quarterly contract monitoring.	improved rates of engagement with the treatment system, improved rates of recovery
	13. Sexual health services - consult on the redesign proposals and recommission services	Council	Consultation on redesign proposals completed. Recomissioning completed.	impact on related health services
	14. Public health contracting with primary care - scope implement a new dynamic purchase system to contract for public health services supplied by primary care providers	Council	Design the proposed contracting model. Consult providers. Procure and establish new contracts. Design and implement new contract monitoring and payments systems.	reduced administrative burden for primary care providers
	15. Healthy lifestyles - support recommissioning of public health funded preventive services including smoking cessation and weight management	Council	Service redesign proposals finalised. Consultation on proposals completed.	needs to be linked in with wider preventive role envisaged for the NHS in the Stevens' 5 year forward view

Link to HWB priorities	Commissioning Workstream & Objective (plus Service Area & lead officer)	Commissioned by Council / CCG?	Milestones	Wider Impact/Implications on the H&S Care system
Integrated commissioning - Old people/End of Life/Carers/Long-term conditions				
Prevent illness and injury and promote recovery in the over 65s. Improve end of life care. Improve patient and service user satisfaction with health and social care services. Support and advice for carers. Rehabilitation and reablement to prevent repeat admissions to hospital. Integrated care and support for people with long term conditions.	**1. Outcomes Based Commissioning** - Contribute to this major transformation programme including outcomes developed; Draft financial model; Confirmed outcomes and indicators; Implementation approach developed.	Joint Council & CCG	Support to "sign off" governance arrangements; legal agreements between CCG and Council established tender and evaluate Provider Alliance options shadow operation of Provider Alliance commissioning in place by Spring 2016	a major transformation programme to deliver system-wide changes and better outcomes for people with health and social care needs
	2. End of life programme. Approach agreed between Council and CCG, End of Life specialist care delivered as part of Integrated Framework Agreement for Care & Support (See Domiciliary Care); review of St. Christopher's pilot. Reduce avoidable non-elective admissions by re-prioritising community-based medical and non-medical approaches to supporting people at the end of their lives to enable them to die in the place of their choice. Improve GP & care home use of Advanced Care Plans through training programme. Implement culture change programme through delivery of community-based 'death cafes', 'doulas for the dying' promotion and publicity	Council	Ensure framework delivering value for money in End of Life care	Quality improvement - people enabled to die in the place of their choice; significant savings should be achieved from acute system through lower use of hospitals as place of death
		CCG	Coordinate my Care used consistently in all Care Homes - reduced number of deaths in hospital from Care Homes by 111 (15/16)	
		Joint - Council & CCG	Death café' and discussion groups provided - regular events occurring in Croydon	
		Joint - Council & CCG	End of Life care "everyone's business" communication events - Dying Matters week promoted, GP training events held with positive outcomes, other training events held	
		CCG	GPs and all health professionals using Coordinate my Care consistently - target all GPs using CMC - reduce hospital deaths from patients own homes by 222 (15/16), 480 (16/17)	
		CCG	GPs holding regular MDTs for patients identified at the end of Life	
		CCG	Train GPs around how to have difficult conversation - ACP (Currently less than 5% of people at end of life have an ACP)	
		CCG	GP scheme to monitor Coordinate my Care and Advanced Care Plans	
		CCG	Train cohort of 'doulas for the dying' in Croydon - 10 Doulas trained & delivering support	
		Joint - CCG& Council	Hold regular End of Life care events and training in Croydon among staff members and all stakeholders	
		CCG	Close work with CHS palliative care team to help embed & integrated services, strengthen Marie Curie provision	

Link to HWB priorities	Commissioning Workstream & Objective (plus Service Area & lead officer)	Commissioned by Council / CCG?	Milestones	Wider Impact/Implications on the H&S Care system
	3. Care Homes management - Ongoing management of cost and quality of provision across this service area. Commercial negotiations with providers to achieve efficiencies.	Council	Refreshed contract management arrangements in place for £8.5m block contract with Care UK;	
		Council	Provider quality and market management;	
		Council	development of extra-care schemes to meet demand and reduce costs of residential care	
		Council	Review of PFI scheme to achieve savings	
		Council	Implement a preferred supplier system to ensure best value services used	
		CCG	To review all current support services to care homes (more than 22 support services have been identified) and ensure no duplication. To target high users of 999 and hospital services, and through aligning appropriate support services, including GP cover, to reduce these significantly.	Improved management of care homes through better GP allocation and clear pathways for support to care homes will improve quality of life for people living in care homes, and reduce use of LATC and hospital.
		CCG	Ensure 121 GP cover for care homes (nursing esp.) across Croydon to reduce care home use of ED, LAS = target 45% reduced use of ED and LAS by care homes	
	4. Pooled Equipment budget: To manage this pooled budget effectively and ensure local people obtain the equipment they need to live safely and independently at home for longer. Improve hospital discharge.	council	• To review current spend by partners and re-negotiate arrangements based on ordering patterns. • To review pathways and ordering patterns and ensure optimum value and quality of delivery achieved. • To review current telecare/health purchasing and identify future opportunities for improvement	Equipment provision reduces DTOCs and enables people to live in their homes safely for longer. At present it appears that demand outstrips budget, and this needs reviewing.
	5. Falls programme. To provide a robust specialist Falls and Bone Health Service in line with current NICE, DH and NSF Guidelines, and agreed service specification providing high quality, personalised care, as close to home as possible.	*CCG*	Falls Programme expansion business case focusing on prevention and early identification to be agreed	a comprehensive preventative programme providing early prevention, and early identification of those already at high risk will lead to reduced hospitalisation from falls
		CCG	Reduce hospital attendances due to Falls by preventative exercise, nutrition & other community based programmes	
		CCG	Target at-risk patients using GP lists for preventative services	
	6. Domiciliary Care. To implement the Integrated Framework Agreement (IFA) for care at home; to expand use of Domiciliary care to deliver health benefits ('eyes and ears') Lead officer: CCG PM lead: Lucky Hossain; Council BAU: Olufunke Oluwafemi	Council	• Review the quality of specialist care (re-ablement, end of life) to ensure that appropriate services are in place for people at the end of their life. • Continue to work with providers on the framework to improve the quality of services which support people to live safely at home.	Good quality provision of domiciliary care service ensures that people can leave hospital to return home at increasing levels of need. Higher needs levels are being seen in social care with costs rising and 2-hander care packages increasing.
		CCG	Development of 'Captive Audience' programme to achieve health benefits ('eyes and ears' approach)	Will upskill staff to enable wider prevention of healthcare issues such as pressure sores, falls, UTIs
	7. Carers support. To provide support to unpaid carers to enable them to continue meeting their carer's roles for as long as possible. To meet Care Act requirements in this regard.	Council	Review both existing service provision and assessment process and re-commission to meet Care Act requirements and needs of carers in Croydon.	Ensuring adequate support for carers to reduce their reliance on health and social care systems at crisis points. Can mitigate against CHC costs and social care costs, and reduce impact on hospital/care home/dom care/other services

Link to HWB priorities	Commissioning Workstream & Objective (plus Service Area & lead officer)	Commissioned by Council / CCG?	Milestones	Wider Impact/Implications on the H&S Care system
	8. Physical Disabilities & Sensory Impairment commissioning. Review and implement service redesign for physically disabled adults to provide appropriate support solutions that promote and support independence, as an alternative to residential and nursing care.	Council	• Improve outcomes for people with a physical disability by strengthening service performance against agreed specifications. • Renegotiate contracts in terms of service delivery models	Joint commissioning is likely to lead to reduced costs where CHC required, by ensuring that prices paid are equivalent. Could help streamline negotiating processes within agreed rates.
	9. Care Act - Information, Advice & Advocacy. To ensure that the Council's offer on Information, Advice and Advocacy meets the requirements of the Care Act and the needs of local citizens.	Council	• Implement CarePlace, an online directory of care services, linked with NHS Choices to provide guidance on health and social care issues. • Ensure wide-ranging support for access to information such as mobile information bus, library-based volunteer services and other ways for people to access information and advice which are not internet-based.	Links with CCG PSS programme to encourage prevention, self-management and self-care. Reduce reliance on statutory services.
		Joint Council & CCG	Review of current Advocacy commissioning across all areas; re-commissioning where needed	result of care act may be higher demands for this service on both health and social care
	10. Community Resources. To facilitate the prevention of children and adults requiring statutory social care services by strengthening and promoting preventative and community support. To do this the project will (a) facilitate culture change within care management to encourage wider use of community resources; (b) expand the use of Community Navigators to increase participation in community groups, volunteering programmes etc.; (c) promote the use of information and advice, which will be designed to encourage people to self-help; (d) links with existing carers programme.	Council	• Implement a multi-faceted programme to deliver the efficiencies and changes set out in the programme brief. • This programme also supports the CCG QIPP programme to deliver Prevention, Self-Management and Self-Care	Links with CCG PSS programme to encourage prevention, self-management and self-care. Reduce reliance on statutory services.
	11. Contract management - a range of smaller contracts are being managed, including delivery of services to provide: reablement, vision and hearing support, stroke services, OT services, nursing services, interpreting, wheelchairs, meals on wheels and lunch clubs.	*CCG Principally (some Council)*	• Ensure value for money being achieved, and services delivered and monitored • Ensure that there is not duplication of commissioning across organisations	Analysis of contracts across health and social care will lead to improved outcomes for local population and better management of service outcomes.

Link to HWB priorities	Commissioning Workstream & Objective (plus Service Area & lead officer)	Commissioned by Council / CCG?	Milestones	Wider Impact/Implications on the H&S Care system
Strategic Integrated Commissioning Projects				
Integrated care and support for people with long term conditions. Improve patient and service user satisfaction with health and social care services.	**1. Learning Disability Development Fund (Mansell)** Access capital funding from NHS England for the development of an assessment and training service for adults with learning disability and complex needs.	Council / CCG	• Business Case sign off by NHSE • Legal agreements completed and funding transferred to LBC • Design and build contract tender and award via Croydon Capital Delivery Hub • Service specification development and contract award for service delivery	Reduce/eliminate the need for out of area placements. Contribute to Winterbourne requirements. Reduction in overall costs for residential through providing training for supported living.
	2. Autism Development of services for adults with autism across all care pathways in line with the Autism Act 2009 and Statutory Guidance.	Council	• Re-establish Autism Reference Group • Develop and deliver workplan based on the 2015 Autism Self Assessment	Improved diagnostic and care pathways which support adults with Autism and ASD will potentially increase demand. Improved support services available to people with Autism and their carers leading to reduced reliance on statutory services.
	3. Co-location of ICU. The colocation of the ICU in a single shared space to enable fully integrated working across health and social care commissioning.	Council / CCG	• Business case development and sign-off • Identification of space • Agree lease and financial arrangements • Agree and deliver any pre-move construction, ICT and security requirements • Agree move-in timetable including FM input	A fully integrated service which enables joined up commissioning within health and social care both within customer group and across them. Greater opportunity for innovation and creative service development/provision. Improved effectiveness and efficiencies in commissioning, procurement, monitoring and reviewing of contracts and services. Major risks to business effectiveness if colocation is not achieved as soon as possible.
Reduce the number of people seeking job seekers allowance.	**4. Employment Support Services.** Undertake a review of employment support services funded by the council and NHS for people with disabilities, to ensure in line with Strategic priorities & offer good value	Council / CCG	• Review of existing services which are joint funded by NHS and Council	improve the social inclusion of adults with disabilities through the mainstreaming of provision with Universal services. Enable customers to move into, return to or remain in employment. Increase financial activity within the customer group. Studies show positive links between work and good mental health. Increase opportunities for therapeutic work to support recovering and reablement.
	5. Supporting the Voluntary Sector. Oversee the work of the Invest to Save Officer in the delivery of a number of projects which have clear and identifiable benefits to the health and social care economy.	Council / (Potential CCG Opps)	• Develop a voluntary sector funding group consisting of commissioners from the ICU and CCG to appraise funding opportunities and align them with current or potential workplans and desired outcomes.	Improved commissioning and procurement relationship with Vol Sector, council and NHS. Vol Sector aligning to meet shared council and NHS objectives. Increase sustainability of Vol Sector.

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REPORT TO:	**HEALTH AND WELLBEING BOARD (CROYDON)** **10 June 2015**
AGENDA ITEM:	**8**
SUBJECT:	**Household Income and Child Poverty**
BOARD SPONSOR:	**Paul Greenhalgh, Executive Director of People, Croydon Council**

BOARD PRIORITY/POLICY CONTEXT:

Joint health and wellbeing strategy priorities:
Priority 1.6 Reduce the proportion of children living in poverty
Priority 4.5 Reduce levels of worklessness and long term unemployment

Children and Families Partnership priority:

- Reduce child poverty and mitigate the impact of child poverty.

FINANCIAL IMPACT:

Not applicable

1. RECOMMENDATIONS

1.1 This report is for information only.

2. EXECUTIVE SUMMARY

2.1 Reducing child poverty is a key priority for the both the Health and Wellbeing Board and the Children and Families Partnership. This report describes the links being made between implementing the Financial Inclusion plan agreed by Cabinet on 19 Jan 2015 and the 2014-16 Child Poverty plan agreed by Cabinet on 29 April 2014 in particular the Child Poverty plan objective of supporting lone parents into sustainable jobs. Supporting families, particularly lone parent families, in achieving financial stability and finding sustainable employment which enables them to meet their child care responsibilities will contribute to reducing child poverty.

3. DETAIL

3.1 The Financial Inclusion plan will contribute to the delivery of the Child Poverty plan objective of supporting lone parents into sustainable jobs.

3.2 The most recent data show that around three quarters of children (estimated at 15,000) living in poverty in Croydon live in lone parent families. A number of these families will be the focus of the Financial Inclusion plan as without a bank account and/or using payday lenders.

3.3 These families will include workless families and those with low paid jobs. Although the official figures from 2006-2012 (latest available) show that in Croydon there is a decreasing proportion of children living in workless households, the indications are that for some, the move into employment has been into low paid jobs . Proportion of children living in workless households: 2006 – 19%; 2012 – 12%. The proportion of children in low income working households (i.e. receiving Child Tax Credit / Working Tax Credit) increased by 5.1 percentage points between 2006/7 and 2010/11 (HMRC – Children in out of work benefit households).

3.4 An issue was identified by Croydon Jobcentre Plus in engaging with lone parents to understand barriers to them finding sustainable jobs with sufficient net benefits to enable them to lift their families out of poverty. In response to this a survey of lone parents in Croydon was carried out by council officers in early 2014 in partnership with Jobcentre Plus and children's centres. The parents, all of whom used children's centre services, reported that barriers to finding sustainable work were high costs of childcare and a lack of part-time and flexible jobs which allow parents to combine caring responsibilities with work.

3.5 Nearly two thirds of respondees reported that Children's Centres had provided valuable support in particular in relation to building self-esteem and confidence.

3.6 Around half of respondees recognized that beyond the additional income, being in work would increase their independence and to provide a positive role model to their children. In addition a sense of purpose (by one in four) and social contact (by one in five) were identified as factors.

3.7 However disadvantages of being in work were identified as less time to care and support their children, cost of childcare and availability of flexible childcare, for example at weekends, and therefore potentially having overall less money once childcare costs were taken into account.

3.8 The majority were seeking work which would enable them to work term time only, school hours or flexible hours but were concerns about zero hours contracts were raised and the ability to earn enough.

3.9 In addition to lack flexible jobs and affordable childcare, lack of skills, lack of confidence with applying for jobs, worrying about interviews and inability to afford appropriate clothes for interviews and work were also reported as obstacles to working.

3.10 One in ten respondees identified that their physical and mental health had suffered as a result of not being in work.

3.11 The Child Poverty plan is addressing these issues by:

- Local strategies being developed to increase opportunities for flexible working through developing a Flexible Working Borough policy to increase the number of flexible working opportunities in the borough.
- Piloting a course, aimed at lone parents commenced (devised and delivered by CALAT and a local children's centre), to provide targeted support for lone parents into work.

3.12 However the impact of financial instability and debt worries on emotional wellbeing and mental health will remain an obstacle if families living in poverty are not sufficiently supported in achieving financial stability. The Financial Inclusion plan agreed in Jan 2015 by Cabinet sets out how the council is planning to tackle this for both families and other Croydon residents. The key features of the plan are summarised below. The full report can be found at https://secure.croydon.gov.uk/akscroydon/users/public/admin/kabatt.pl?cmte=CAB&meet=32&href=/akscroydon/images/att4786.DOCX

3.13 The key to the Council's work in this area is catching problems before they become larger and helping people become more prepared and better equipped for the future.

3.14 Financial inclusion means stability of a resident's household budget; making educated financial decisions that are right for their needs and developing their skills to realise their personal ambitions in employment - making employment work for them. For the Council, financial inclusion represents providing the infrastructure that enables customers to maximise each of these aims; utilising engaging digital services, closer third party partnerships, the local community and volunteer groups. Promoting proactive intervention to all, but also responding where customers are in most need.

3.15 Realising financial inclusion for customers will have significant wider social and economic benefits; greater capacity generated from their income can be moved away from high interest debt repayments into spend within the local economy and also reduced effects from the mental health issues caused through debt[1]. The approach will be built to support those directly accessing council services, to improve links and referrals from other local support and public bodies and where the council pro-actively aims to support local residents.

3.16 Enhancing residents' opportunities to utilise on-line/digital services is a key element of helping many families. It is estimated that household's offline are missing out on savings of £560 per year from shopping and paying bills online, or being able to keep in touch with family members and friends. The internet also provides improved job prospects as being digitally capable is critical in finding and securing a job.

3.17 The approach to Financial Inclusion is being led by the Council although it is recognised that in order to best reach out to those most in need and to provide the broadest range of support it will ensure the right engagement and support with third party partners and local community organisations.

3.18 The financial inclusion principles underpinning the strategy are shown in the table overleaf with particular issues which will need to be addressed to ensure families living in poverty benefit from the plan.

[1] MIND report "Still in the Red – Update on debt and mental health" in 2011 showed that 1 in 4 adults with a mental health problem is living with debt or arrears. The report also states that "debt can be a catalyst of mental health problems"

Table 1: Ensuring financial inclusion principles contribute to reducing family poverty

Principle	What does this mean	Consideration to ensure families living in poverty benefit from Financial Inclusion plan
Ensuring customers have access to financial products; such as bank accounts and insurance	Allowing customers to maximise the most of financial products; receive faster payment, direct debit cost savings (and to assist budget management) and cover for unexpected events	Ensuring the primary carer has necessary control of family income.
Educate and develop the skills for all residents to allow them to budget and manage money, or plan for the unexpected	Through budgeting each resident can understand the reality of their income and expenditure, ways to maximise their income, prioritise debts, make lifestyle choices, understanding ways of saving money – food banks, charity shops, energy suppliers, transport etc.	Encouraging families to register for free school meals. Planning ahead for costs in relation to children for example replacing school uniform and other clothes and shoes and having access to secondhand school clothes.
Enabling people to make the most of their money through digital services	Each customer to recognise and have access to the financial benefits of using digital services (paying rent online, requesting benefits) and opportunities to save money through internet deals; freegle, uSwitch, shopping deals, ways to eat healthily for less	Both the benefits of savings but also accessing job websites, IT use for children's homework, accessing course and training materials and preparation for job interviews. This will not always be practical in a library or children's centre depending on childcare demands.
Ensuring there is access to affordable credit	Residents can source the credit that is required for unplanned unexpected events and what impact does this have on their budget. Promotion of Credit Unions, or social fund as an alternative to high interest credit (pay day lenders etc)	Promotion of safe lending in Children's Centres. Making use of school payment plans for school trips for example when these are available.
Provide skills and opportunity to enter and own their future in employment	Residents understand their capability and the skills required to realise their ambitions. Having access to employment opportunities that match their skills, and keenly recognise the value of employment to them and society.	Having access to employment opportunities which would provide sustainable work because it will flex round available and affordable childcare. This will need to take into account the local child care market for example availability of weekend or evening childcare and differential costs of child care at different times of day for example for before school care or after school care.

3.19 As the new operating model in the Council's People Department evolves we are reviewing how we can join up services to improve financial outcomes and support for residents. Our new Gateway and Welfare division leads on this. We are focusing on maximising income in reviewing current entitlements and supporting residents in making new applications where appropriate, finding work and support in overcoming barriers to find work, stabilising finances in carrying out a budget support and offering debt advice. We are currently piloting our new approach with early evidence highlighting clear improvements with regard to increasing entitlements, including working tax credits and housing benefits.

4. CONSULTATION

4.1 As part of the roll out of financial inclusion we are engaging with all affected groups holding awareness sessions and working with 3rd sector partners, this includes drop in sessions update on planning and outcomes.

4.2 A young people's led child poverty strategy is being developed during 2015-16 to strengthen the impact the 2016-18 strategy will have

5. SERVICE INTEGRATION

5.1 This report addressed strengthening integration across a range of services delivered by and commissioned by the council.

6. EQUALITIES IMPACT

6.1 An Equality impact assessment was carried out in relation to the development of the Child Poverty Strategy

6.2 The Financial Inclusion plan sets out the key principles and activities around financial inclusion that the Council is proposing to use to better support residents especially the most vulnerable (including those that share a protected characteristic) who are facing economic challenges and financial exclusion. These principles will be used to achieve a financially inclusive Croydon where residents have access to a comprehensive range of appropriate financial and money advice services, as well as the knowledge, skills and confidence to maximise their own financial well-being. An equality analysis will be undertaken as part of the development of the business case and the delivery plan for the key principles that the Council will use to promote financial inclusion as set out in the January 2015 Cabinet report.

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

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BACKGROUND DOCUMENTS

None

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REPORT TO:	**HEALTH AND WELLBEING BOARD (CROYDON)** **10TH JUNE 2015**
AGENDA ITEM:	**9**
SUBJECT:	**Homeless households in temporary accommodation needs assessment**
BOARD SPONSOR:	**Paul Greenhalgh, Executive Directorof People** **Mike Robinson, Director of Public Health**

CORPORATE PRIORITY/POLICY CONTEXT:

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

FINANCIAL IMPACT

Homelessness and living in temporary accommodation has a range of impacts on the health and wellbeing of homeless households that are set out in the report below. These impacts have immediate financial implications for the health service in terms of additional demands placed on emergency and other health care services. They also have longer term implications in respect of education, accessing and maintaining employment and social exclusion.

There are no commitments to additional expenditure set out in the report and any changes in service provision have been achieved within existing expenditure levels.

1. RECOMMENDATIONS

This report recommends that the Health and Wellbeing Board:

1.1. Considers the homeless households in temporary accommodation chapter, approves the document and principleand delegates final approval of any further amendments to the responsible directors

1.2. Notes and endorses the recommendations set out in the needs assessment.

2. EXECUTIVE SUMMARY

2.1. This chapter on homelessness is the final of four key topic chapters which, alongside the Annual Key Dataset, form the 2013/14 Joint Strategic Needs Assessment.

2.2.

2.3. The scope agreed for this chapter was an assessment of the impact on health and wellbeing of living in temporary accommodation, with a focus on bed and breakfast. The agreed scope did not include other forms of homelessness such as rough sleeping, nor the prevention of homelessness, although reducing the need for temporary accommodation is clearly part of the challenge facing the Borough. A homelessness plan focussing on prevention strategy, reducing the use of temporary accommodaton, tackling rough sleeping and improving services will be published in the Winter of 2015/16.

2.4. The aim of the JSNA Homeless Households in Teemporary Accommodation chapter is to provide an overall piture of the extent of homelessness in Croydon, the number of households accommodation in temporary accommodation, and the impact this emergency provision has on the health and wellbeing picture of the households living in this type of accommdation.

2.5. The key issues that will be of particular interest to the Health and Wellbeing board are:

The known association between health and homelessness

- Research on the subject of homelessness is difficult: poor health can be both a cause and effect of homelessness, much of the research focuses on rough sleeping as opposed to temporary accommodation, and the research that does exist on temporary accommodation often fails to distinguish the type of accommodation they cover (i.e. bed and breakfast, shared or self-contained accommodation.)
- However, there is sufficient evidence to support the conclusion that living in temporary accommodation is associated with poor physical and mental health
- In terms of physical health:
  - multiple housing problems increase the risk of severe ill-health or disability during childhood and early adulthood by up to 25%.
  - respiratory problems such as asthma and bronchitis, which can be directly caused by damp inside properties, are more common. Infectious diseases, such as tuberculosis and meningitis in children are also more common particularly where overcrowding occurs.
- In terms of mental health problems:
  - Accident and emergency attendances for homeless clients are five times more likely to be for mental health problems than in the general population.
  - Living in temporary accommodation is associated with increased stress, depression and anxiety in particular.
- The effects of temporary accommodation on children have been shown to be particularly problematic and long lasting.

Engagement with homeless households in Croydon emphasised the impact of temporary accommodation on mental health

- Being depressed was a particularly common theme in the focus groups carried out to support this chapter, with many volunteering that they had been prescribed anti-depressants.
- The main perceived causes were:

- Overcrowding/living in confined spaces: feeling imprisoned with no freedom; lack of privacy
- Lack of cleanliness
- Problems eating healthily due to restricted cooking facilities: reliance on takeaways
- Antisocial behaviour of residents (eg drug taking) not being addressed by housing providers
- Communication problems with/perceived lack of support from Council staff/lack of choices being offered/assumptions they were to blame for their situation and weren't making efforts to change this
- Disruptive effect on children and their education

Homelessness is a growing problem in Croydon and nationally

- How homelessness is caused is not straightforward and different causal factors interact. Housing market trends and policies have a more direct impact on homelessness than structural economic and labour market factors which have a direct impact, however, are subject to some time lag and can be mitigated by welfare policies. Individual factors including vulnerability, mental and physical health, support needs, addiction and substance misuse play a part, but are often (although not always) exacerbated by poverty and disadvantage. Family and other relationships, which help support people and prevent homelessness, can also be strained by economic circumstances and result in relationship breakdown and loss of accommodation.
- The economic recession therefore has been an underlying factor in terms of homelessness, and the way the housing market has changed since the Credit Crunch in 2008, particularly in terms of affordability and access to home ownership in London. Particular issues for Croydon are the relatively small social housing stock in the borough making it difficult for the Local authority to "absorb" rapid increases in homelessness, and a decrease the supply of private rented accommodation available to the council has can be used to both prevent homelessness and provide temporary accommodation.
- Croydon has one of the highest rates of households in temporary accommodation in the country, at 16.2 per 1000 households (nearly 5% higher than London and six times higher than the England average).
- This represents around 2,700 households being accommodated in temporary housing in Croydon at any one time, including around 600 families/ more than 1,000 children at any one time in emergency (B&B type) accommodation. The largest accommodation offered is Gilroy Court, which housed more than 250 families last year, a sizeable proportion of the total
- These numbers also do not include, for example, people living in hospital accommodation who cannot be discharged due to lack of accommodation, nor those who are homeless but not known to the council, nor the small number of rough sleepers.
- Many of the causes of homelessness are beyond the control of local authorities.

Cost of homelessness to the NHS is high and increasing

- The Department of Health suggest that the cost of homelessness to the NHS as a whole is £64 million a year. As this does not distinguish the costs of rough sleeping from those living in temporary accommodation, it is not possible to quantify the specific costs of temporary accommodation to the NHS in Croydon. However, the association of homelessness with poor health, particularly poor mental health, and the long term effect of periods of homelessness on children mean that the growth of homelessness in Croydon will be of concern to the CCG.

Homeless health team

- Croydon's Clinical Commissioning Group currently commissions a homeless health team which targets those in bed and breakfast and hostels, as well as the street homeless and asylum seekers. The service provides specialised services tailored to meet health needs, GP registration, primary health care as well as outreach services. The team also offer an advice service around housing and welfare benefits.

2.6. The recommendations are set out in Section 6 of the chapter, and are formed around the following objectives:

- Improving information, advice and support for homeless families
- Improving access to health services
- Ensuring children do not miss education
- Improving access to employment and training opportunities
- Increasing the supply of temporary accommodation
- Preventing homelessness

3. THE NEEDS OF HOMELESS HOUSEHOLDS LIVING IN TEMPORARY ACCOMMODATION

3.1. The overall aim of the homeless households in temporary accommodation JSNA chapter is to improve outcomes for the homeless people in Croydon through influencing commissioning by analysing information of current and future need and access to services.

3.2. The chapter identifies the impacts on the health and wellbeing of homeless households placed in temporary accommodation under the local authoriy's legal responsibilities in respect of homelessness. The key findings, data and conclusions have shaped the recommendations set out i n the report and will also influnce Croydon's future homelessness plan and the development of the People Gateway.

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

4. CONSULTATION

4.1. As part of the drafting of this chapter of the JSNA focus groups were held with homeless households living in temporary accommodation. The chapter also includes details from focus groups also carried out previously with households living in temporary accommodation as part of the development of the Council's

Child Poverty Strategy. The findings from this consultation, as well as data on homelessness and information about local services have also been included in the chapter.

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

- JSNA Steering group
- Croydon Clinical Commissioning Group Senior Management Team
- Croydon Clinical Commissioning Group Governing Body
- Council Leadership Team

5. FINANCIAL AND RISK ASSESSMENT CONSIDERATIONS

5.1. It is very difficult to estimate the cost incurred in Croydon from additional demand on health services, or from the longer-term impacts in terms of access to and maintaining employment, educational attainment and social exclusion generally.

5.2. The JSNA chapter includes a range of cost effective interventions in relation to the preventing homelessness, improved communication and support, and improvements in targeting services to this often "hard to reach" group which are designed to improve health and well-being and reduce overall expenditure through earlier intervention.

6. LEGAL CONSIDERATIONS

6.1. Producing a local JSNA is a statutory requirement.

7. HUMAN RESOURCES IMPACT

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

8. EQUALITIES IMPACT

8.1. The JSNA Homeless Households in Emergency Accommodation chapter has considered equality and diversity implications, by examining the impact of living in emergency accommodation on homeless households and considering the needs for those people with protected characteristics (see the data on homelessness set out in section 2).

8.2. There are differences in who becomes homeless in terms of ethnicity. In Croydon, as well as London and England, black or black British households are disproportionately represented in the homeless population.

8.3. In Croydon, 20% of the general population are black or black British, but 48% of homeless households are of black or black British ethnicity. These disparities are not seen with white or Asian populations.

8.4. Young people, women, and people with mental health problems are also disproportionately represented amongst those in temporary accommodation.

8.5. In addition the impact of living in temporary accommodation on children's physical and mental health, and their development is particularly stark .

9. ENVIRONMENTAL IMPACT

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

10. CRIME AND DISORDER REDUCTION IMPACT

10.1. There are no specific crime and disorder considerations arising from this report.

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BACKGROUND PAPERS - LOCAL GOVERNMENT ACT 1972:

Key Topic 4 JSNA Homeless households in temporary accommodation Chapter 2013/14

Commissioners' response to the recommendations of Croydon's 2013/14 JSNA chapter on homeless households in TA

Section 1: Recommendations

The recommendations of the 2013/14 JSNA chapter on homeless households in temporary accommodation are derived from review of the literature dealing with the health impacts of homelessness and on focus groups held with homeless households living in emergency accommodation. The recommendations will enable an efficient use of resources to improve the health of Croydon's population and should also reduce costs by minimising the impact on the health and wellbeing of homeless households arising from extended stays in emergency accommodation.

The services the Council and other agencies are providing to homeless households and those at risk of homelessness are set out in Section 4 of the JSNA chapter, as are the projects and initiatives underway to increase housing supply in the borough. This information is not reiterated in any great detail in this response to the recommendations. Rather, the response focuses on better targeting of existing services/resources, improved joint working and new projects to tackle the impacts identified in the JSNA chapter.

The recommendations are described in detail in Section 6 of the 2013/14 JSNA chapter on homeless households in temporary accommodation and tackle the areas highlighted in the JSNA concerning:

- Information, advice and support for homeless families
- Access to health services
- Children missing education
- Access to employment and training opportunities
- The supply of temporary accommodation
- Homelessness prevention

Information, advice and support for homeless families

Households applying as homeless currently receive limited information directly related either to the progress/outcome of their application, or concerning their temporary accommodation. This is due to the high volume of applications and the number of placements in temporary accommodation required in recent years. Feedback from the focus groups was that more information on the progress of homeless applications would be reassuring and helpful, general information about how to report problems with accommodation would also help, and general information about how/where to find or organise, food, healthcare, benefits and schools once placed in temporary accommodation. Providing this information will help homeless households cope with the disruption caused by homelessness and living in temporary accommodation, will alert the Council to problems with the accommodation provided earlier, and reduce the amount of unneeded contact on the progress of homeless applications.

Access to health services

Households homeless often become "harder to reach" in relation when providing routine healthcare /prevention services once placed in temporary accommodation. Visits from health

visitors, registration with a GP, and attending regular clinics, contact with midwives, nurses, consultants and accessing other healthcare services are inevitably disrupted, particularly when households are placed some distance away from their previous accommodation. Better targeting healthcare services to households in temporary accommodation and encouraging registration with GPs local to temporary accommodation will help tackle this issue and reduce reliance on emergency health care.

Children missing education

Being placed in temporary accommodation can also be disruptive to a child's education and can result in them missing school, and not being able to participate fully in educational activities (for example, accessing/submitting homework online). The emotional impact of homelessness can also impact on focus in lessons, behaviour and result in bullying. Providing information on how to make in year school applications and closer working between education and other professionals will help reduce this impact and provide better support to children in homeless households

Access to employment and training opportunities

Homelessness may include loss of employment as an underlying cause, and living in temporary accommodation can also make maintaining employment difficult, particularly if the employment requires attendance at short notice, is largely outside normal office hours, or is difficult to access due to the distance from the temporary accommodation. Whilst acknowledging that accessing employment may not be possible/feasible for all households experiencing homelessness, for some the support of colleagues in Job Centre Plus to tackle some of the barriers to employment (training, language, child care) and opportunities to work may be the start of a journey towards independence and a sustainable future.

The supply of temporary accommodation

The Council does not have sufficient accommodation to provide permanent accommodation immediately for all homeless applicants. Levels of homelessness have been so high in recent years that the Council has had no option but to use all available sources of temporary accommodation in Croydon and at times outside the borough, including bed and breakfast hotels providing shared facilities, in order to meet its statutory duty to secure accommodation for homeless households. Securing an adequate supply of self-contained accommodation for homeless households is an on-going priority for the Council.

Homelessness prevention

Preventing homelessness is a key part of a strategic approach to tackling homelessness. Identifying households early that are at risk of homelessness, providing support to deal with the underlying causes of homelessness or vulnerability, and taking a holistic view of the needs of households approaching the Council and other partner agencies for support each make a significant contribution to reducing the demands on temporary accommodation and help to minimise the length of time households stay in this situation. Projects and initiatives that prevent homelessness continue to be a priority for the council.

Section 2: Commissioners' response to the recommendations

The commissioners' response to the recommendations included in the 2013/14 JSNA chapter on homeless households living in temporary accommodation is set out in the table below. The response has been completed by:

- Leonard Asamoah, Director of Housing Need
- Brenda Scanlan, Director of Integrated Commissioning Unit and Adult Commissioning
- Mike Robinson, Director of Public Health
- Mark Fowler, Director of Gateway and Welfare Services
- Jane Doyle, Director of Universal People Services
- David Butler, Head of School Standards

Summarised Recommendations from the JSNA	**Commissioners' response**	
	Action currently being taken	**Future actions being considered**
Improved information, advice and support for homeless families (Lead: Director of Housing Need)		
6.1 Improved information, advice and support for homeless families	• The Council provides a 24 Hour homelessness service (out of hours provided by Emergency Duty Team) • Emergency accommodation is provided for homeless households in priority need of housing (which includes families with children, and vulnerable single people) • A Family Liaison Officer also provides support for families in large B&B hotels (e.g. Gilroy Court)	(Set out below)
• Write to homeless applicants providing reasons why their application has not been decided within 40 days	• Applicants receive a letter setting out the Council's decision on their homeless application (S184 letter).	• The Council will write to all applicants who have not received a decision on their application within 40 days explaining why the decision is delayed

Summarised Recommendations from the JSNA	Commissioners' response	
	Action currently being taken	**Future actions being considered**
• Provide an information pack (Emergency Accommodation Pack) to every household admitted to emergency accommodation including information on: o GP registration o Location of GP surgeries o Dentists o Schools and education o Access to specialist health care o Shops o Advice and information	• An Emergency Accommodation Pack has been developed for households placed in emergency accommodation including information on GPs, Dentists, other health services, Childrens Centres, Education etc.	• To develop the Emergency Accommodation Pack into a smartphone app • To develop Emergency Accommodation web pages
• Target household budgeting and money management advice services to homeless families in temporary accommodation	• Council provides welfare benefits advice, a hotline and benefit surgeries, debt advice and discretionary support to households needing support • The Council also commissions the Citizens Advice Bureau to provide a housing advice services • The Citizens Advice Bureau also provides debt advice service • Croydon and Sutton Law Centre also provide free money and debt advice • Croydon, Merton and Sutton Credit Union	• As part of the People Gateway project households in TA will be identified as requiring /income budgeting support around income maximisation, household budgeting and debt management
• As a priority develop a new TA Placement Policy which will clarify how long households will have to wait in temporary accommodation before receiving	•	• A new TA Placement policy will be developed as part of the TA Action Plan (see 6.6 below) explaining the process by which TA is allocated. • The Council will also be developing a long-term TA procurement plan which will provide a more accurate

Summarised Recommendations from the JSNA	Commissioners' response	
	Action currently being taken	**Future actions being considered**
an offer of permanent accommodation		picture of the need for TA, and the length of stay for homeless households
Improving access to health services (Lead(s): Director of Housing Need with Director of Public Health, Director of Integrated Commissioning Unit and Adult Commissioning (in liaison with Croydon CCG))		
6.2 Improving access to health services	**Local GP services and SLaM** • Croydon's aim is to provide mental health services at the lowest point of intervention • Access to most mental health services is via GP referral [issue to increase GP registration] • Homeless households can also self-refer to psychological therapies **Local GP services and Homeless Health Team Childrens Social Care** • The Rainbow Centre surgery provides the full range of primary care services to homeless households • Meningitis is preventable via completion of vaccination programmes in childhood, plus additional vaccinations for those travelling to high risk areas (such as parts of Saudi Arabia and Africa) **Turning Point @ Lantern Hall** • Services provided to anyone aged 18+ registered with a GP and with a drug or alcohol issue • Also services provided through Croydon recovery network • A nurse is also provided to support clients in	(Set out below)

Summarised Recommendations from the JSNA	Commissioners' response	
	Action currently being taken	**Future actions being considered**
	Palmer House (supported housing for former rough sleepers)	
• Include GP Registration Forms in the new Emergency Accommodation Pack	• The Emergency Accommodation Pack includes details on how to register with a local GP	• Identify effective methods to improve GP registration among homeless families placed in TA
• Work with local GPs to improve GP registration rates	• Homeless households placed in B&B in Thornton Heath can register with a local GP (on Brigstock or London Road)	• Identify effective methods to improve GP registration among homeless families (see above concerning registration information in Emergency Accommodation Pack)
• As part of the Healthy Child Programme ensure health visitors follow up of childhood immunisations and new born screening with families in emergency accommodation.		• Healthy Child Programme to target hard to reach families through health visitors and follow up of childhood immunisations and new born screening.
• Improve information on how to access psychological therapies and other mental health services		• Improve information and identify effective methods on how to sign post and improve access to psychological therapies and other mental health services (see Emergency Accommodation Pack above)
• Publicising surgery times of the Homeless Health Team and Rainbow Health Centre		• Update information and in the Emergency Accommodation Pack to include Rainbow Health Centre details
Ensuring children do not miss education (Lead(s): Director of Housing Need with the Head of School Standards)		
6.3 Ensuring children do not miss education	• Notify – a database designed to track children in B&B and inform housing, childrens social services and education staff of placements in	(Set out below)

Summarised Recommendations from the JSNA	Commissioners' response	
	Action currently being taken	**Future actions being considered**
	temporary accommodation • The Council's Children Missing Education (CME) Officer takes referrals from professionals concerned about children not going to school • Professionals refer also issues to Reintegration and Exclusions Officer (deals with behaviour and exclusion) • Information about these services is also provided on councils web site • Families can make referrals to Reintegration and Exclusions Officer if they are concerned about their child's behaviour at school	
• Improve liaison between housing and education on children placed in emergency accommodation	• Notify - liaison and communication between housing, social services and education has improved and a better understanding of the benefits and remit of Notify developed	• Develop effective methods to improve recording and update of housing circumstances on referral forms into Reintegration and Exclusions Officer and CME Officer
• The Council will develop closer links between with B&B hotels and Children Missing Education Officer (CME Officer)		• Develop closer links between with bed and breakfast hotels and the CME Officer
• Carry out comparative research to determine how many children in emergency accommodation are likely to be missing school		• Analyse bed and breakfast data and CME data to provide a better understanding of the impact of homelessness on children missing education
• Provide information on school admission (including in year admissions process), attendance and exclusions in the Emergency Accommodation Pack		• Information on school admission (including in year admissions process), attendance and exclusions will be included in Emergency Accommodation Pack
• Improve recording of housing		• Steps will be taken to improve recording of housing

Summarised Recommendations from the JSNA	Commissioners' response	
	Action currently being taken	**Future actions being considered**
circumstances on referral forms into Reintegration and Exclusions Officer and CME Officer		circumstances on referral forms into Reintegration and Exclusions Officer and CME Officer
Improving access to employment and training opportunities (Lead(s): Director of Housing Need with Director of Gateway and Welfare Services and Director of Universal People Services)		
6.4 Improving access to employment and training opportunities	• Job Centre Plus (JCP) provides employment and employment support services • Housing Welfare Reform Team also provides support to families impacted by welfare reform and works with them to achieve sustainable housing and employment solutions	(Set out below)
• Identify homeless households in B&B that are unemployed and work with JCP to target communications and services to them	• As part of the People Gateway project a pilot initiative is underway to target households in TA and support them overcome barriers to accessing employment into training/work • Another People Gateway pilot project is targeting support to potentially homeless households at an earlier stage – when they make an appointment to meet housing advisor. The aim being to provide a solution to the housing problems and prevent a homeless application	• The People Gateway project will develop and expand shaped by the learning gained from this and other pilot projects.
• Provide DWP outreach service to Gilroy Court	• DWP Outreach has been included in the People Gateway pilot above to carry out initial assessments	
• Link eligible households into the new Gateway Project	• See People Gateway pilots above	

Summarised Recommendations from the JSNA	Commissioners' response	
	Action currently being taken	**Future actions being considered**
• Link eligible households into Child Poverty Strategy work on flexible working/employment		• As part of the Child Poverty Strategy Croydon is considering becoming a Flexible Working Borough and increasing the flexible working for families, in particular lone parent families, to help in lifting them out of poverty
Increasing the supply of temporary accommodation (Lead(s): Director of Housing Need)		
6.5 Increasing the supply of temporary accommodation	• See page 41 of the JSNA which sets out a range of initiatives to increase supply, including: ○ Converting surplus/redundant council buildings ○ Empty properties ○ Setting up a pilot lodgings scheme ○ Purchasing up to 100 properties on the open market ○ Investing in the Real Lettings Property Fund ○ Developing a "Market Rent" and a "Guaranteed Rent" scheme ○ Securing Concord House and Sycamore Houses as TA	• This work is ongoing and the Council engages with housing providers to explore new opportunities to increase supply
• Continue to focus on maintaining a lawful position on the use of shared bed and breakfast accommodation	• The position on the lawful use of bed and breakfast is monitored weekly and action taken to move households into suitable TA, and to increase the supply of TA is taken in response to spikes in demand	
• Continue to bring forward innovative projects to diversify the council's temporary accommodation portfolio and to	• (See supply initiatives above)	

Summarised Recommendations from the JSNA	Commissioners' response	
	Action currently being taken	**Future actions being considered**
move away from the use of shared B&B for households with children (e.g. the pilot Croydon Lodgings For Families scheme)		
Preventing homelessness (Lead(s): Director of Housing Needs		
6.6 Preventing homelessness	• The Council works in partnership with the voluntary sector and others to prevent homelessness or relieve homelessness by providing alternative accommodation. This includes: o Family mediation/conciliation o Financial payments from prevention fund o Debt Advice o Resolving HB/rent/arrears problems o A domestic violence sanctuary scheme o Crisis intervention o Negotiation or legal advocacy o Mortgage arrears interventions • In addition to the statutory housing advice and options service the Council also commissions the following services aimed at preventing homelessness: o Independent housing advice service o Preventing repossessions service o Turnaround Centre Housing Advice Reception o A rent in advance service to help people move-on from supported and hostel accommodation and prevent repeat homelessness	• (Set out below)

Summarised Recommendations from the JSNA	Commissioners' response	
	Action currently being taken	**Future actions being considered**

	• The Peoples Gateway project includes work streams aimed at preventing homelessness through:
	  ○ Empowering individuals & communities to be better able to take more responsibility for themselves and each other
	  ○ Providing information and advice so that residents can make informed choices about how to meet their needs
	  ○ Providing high quality universal services which give everyone the best opportunity to have a good quality of life
	  ○ For residents requiring support, providing a joined up approach to assessing the needs of individuals and families, empowering people to resolve issues early
	  ○ Providing high quality specialist services so that children and adults maximise independence and are safe from harm	

• Develop a prevention response to the current homeless situation including research on landlords ending assured shorthold tenancies, a supply of immediately available private rented accommodation sufficient to reduce the flow of households	• Work is underway with colleagues in the People Gateway pilots to work with households living in private rented accommodation about to be made homeless and their landlords	• Cabinet will receive a report in July 2015 setting out and action plan on the Council's use of TA which will include proposals to introduce a new prevention allocation priority on the housing register for households who are working with the People Gateway

Summarised Recommendations from the JSNA	Commissioners' response	
	Action currently being taken	Future actions being considered
into emergency accommodation, plus a prevention allocation priority on the housing register for households who are working with the People Gateway to achieve affordable and sustainable solutions to their homelessness		

Commissioners Response prepared by: **Leonard Asamoah**
Director of Housing Need
People Department, London Borough of Croydon

REPORT TO:	**HEALTH AND WELLBEING BOARD** **10 June 2015**
AGENDA ITEM:	**10**
SUBJECT:	**Healthy Weight Action Plan (2015-2017)**
BOARD SPONSOR:	**Dr Mike Robinson, Director of Public Health, Croydon Council** **Paul Greenhalgh, Executive Director People, Croydon Council** **Paula Swann, Chief Officer, Croydon Clinical Commissioning Group**

CORPORATE PRIORITY/POLICY CONTEXT:

Excess weight and obesity amongst children and adults is identified as a local priority for action in the joint health and wellbeing strategy 2013-18.

The refresh of the Healthy Weight action plan sets the context for joint work between the Council, The Clinical Commissioning Group (CCG) and other stakeholders such as local community services, in order to reduce the rise in obesity and improve weight-related health outcomes.

This action plan is supported by Croydon Physical Activities Strategic Guide 2014-2016.

FINANCIAL IMPACT:

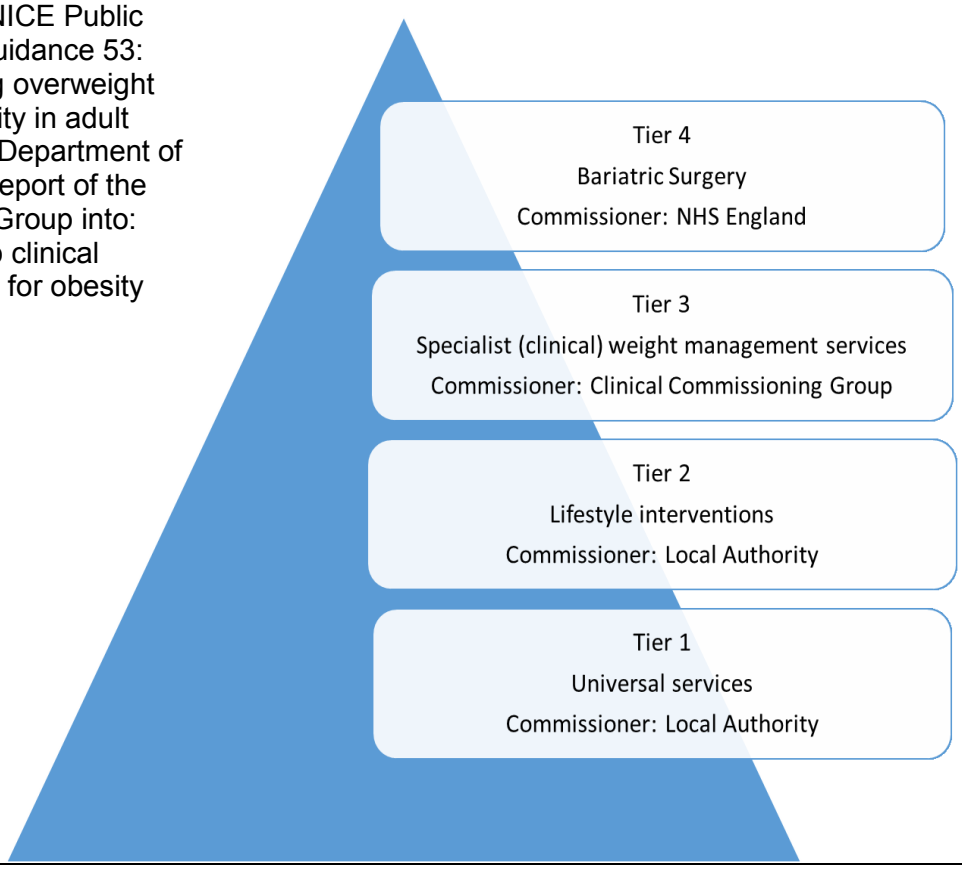
The cost to the UK economy of excess weight was estimated at £15.8 billion per year in 2007. From 2007 to 2015, the estimated annual cost of obesity to the NHS in Croydon is predicted to rise significantly. During this period, the cost to the NHS is predicted to rise by 24% in Croydon (£11.2 million).

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

There may be financial implications for the funding of Tier 3 Adult and Child weight management services as the clinical services recommended by NICE may not currently commissioned in their entirety. A recent report commissioned by the Department of Health contended that Clinical Commissioning Groups should have responsibility for Tier 3 local weight management multi-disciplinary team interventions (Tier 3)[1]. This may have financial implications for Croydon Clinical Commissioning Group.

[1] Report of the Working Group into: Joined up clinical pathways for obesity (2014)

Source: NICE Public Health Guidance 53: Managing overweight and obesity in adult (2014) & Department of Health: Report of the Working Group into: Joined up clinical pathways for obesity (2014)



1. RECOMMENDATIONS

1.1 The Health and Wellbeing Group is asked to endorse the attached Healthy Weight action plan (2015 – 2017)

2. EXECUTIVE SUMMARY

2.1 The Healthy Weight action plan takes forward the recommendations from the Healthy Weight JSNA (2013/14) for action.

2.2 England has one of the highest rates of obesity in Europe and one of the highest in the developed world. In 2011, the Department of Health released the *National Strategy: a call to action on obesity*[2] to build upon the aspirations in the public health White paper: Healthy Lives, Healthy People'. The report's ambition was to encourage a combined effort across sectors and environments to:

- Produce a sustained downward trend in the level of excess weight in children by 2020.
- Produce a downward trend in the level of excess weight averaged across all adults by 2020.

2.3 The Croydon Healthy Weight action plan is our local response to the national strategy, using evidence of the most cost-effective approaches and local data on the needs of our local population.

[2] Department of Health. 2011, Healthy Lives, Healthy People: A call to action on obesity in England. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213720/dh_130487.pdf

2.4 In Croydon, one in three children aged 10-11 are overweight or obese (2013/14 National Child Management Programme (NCMP)) and for adults the situation is more serious as over half of all adults are overweight or obese. This equates to over 170,000 residents (Croydon GP Data 2011/12 and Active People survey, 2012)[3] [4] . This means that children in Croydon are growing up in a borough where it is normal to be overweight.

2.5 Responsibility for the management of overweight and obese adults and children falls to three different commissioners leading to fragmentation of the care pathway. This has resulted in the lack of a clear joined up pathway, available service interventions and referral guidelines within and between the service tiers outlined above. Further work to map the existing pathway services is required to identify gaps, consider service interventions and agree referral processes.

2.6 Croydon has recently been awarded Food Flagship borough status by the Greater London Authority. The borough was successfully awarded this status, through a competitive bid process. The grant allocation from the Greater London Authority is £300k per annum/ 2yrs. The Food Flagship programme sets out to transform school meals through the development of Croydon's School Food Plan. In addition, it takes a whole system approach to foster a love of good food through developing cookery skills, and gardening skills to grow fruits and vegetables.

3. BACKGROUND

Body Mass Index is a strong predictor of mortality among adults. Morbid obesity reduces life expectancy by 8-10 years which is equivalent to the effects of lifelong smoking.

There is a strong association between socio-economic deprivation and a high prevalence of obesity in both child and adult obesity.

The prevalence of obesity is highest amongst black ethnic groups.

3.1 Obesity in Croydon

In the 2013/2014 school year, approximately 23.1% (more than one in five) of children starting school in Reception (4-5 years old) are overweight or obese. By the time children reach Year 6 (10-11 years old) approximately 38.3% (one in three) are overweight or obese. This means that obesity and overweight increases significantly (almost doubles) between the school years reception and year 6.

In Croydon, there is an intergenerational cycle of obesity whereby child obesity tracks into adulthood and is associated with several physical and psychological comorbidities[5]. This suggests that the next generation is likely to experience

[3] Croydon (2012) General Practice Data
[4] The Active People Survey (2012)
[5] National Collaborating Centre for Primary Care. Obesity: the prevention, identification, assessment and management of overweight and obesity in adults and children. London: National Institute for Health and Care Excellence; 2006

increased rates of morbidity and mortality if the obesity problem is not addressed[6]. This intergenerational cycle of obesity can be more strongly seen in the less affluent areas of the borough.

3.2 Healthy Weight: Action plan aims and objectives

The action plan's vision is the creation of an environment where the healthy choices are the easy choice.

The aim of the action plan is to:

- Co-ordinate efforts in Croydon to reduce the burden of death, disability and distress caused by excess weight.
- To halt the rise in the prevalence of obesity in adults and children by 2020 and then maintain this level through a focus on both prevention and management.

3.3 It is proposed that the health and wellbeing board executive group oversee the action plan pending a broader review of health and social care partnership groups accountable to the board. The children's elements of the action plan will also be reported to the children and families partnership.

4. CONSULTATION

4.1 The JSNA led to the formulation of recommendations, which have been incorporated into the Healthy Weight action plan.

4.2 The Children and Families Partnership Executive have been consulted on the Healthy Weight action plan and provided a number of comments. These comments have been considered and the action plan has been updated accordingly. The action plan relating to children has now been endorsed by the Children and Families Executive for 2015-2016.

5. SERVICE INTEGRATION

5.1 There are opportunities for commissioners to work together to join up the care pathway for overweight and obese adults and children to deliver a clear integrated approach to weight management and obesity which will deliver services that meet local need.

6. FINANCIAL AND RISK ASSESSMENT CONSIDERATIONS

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

[6] Whitlock et al. Body mass index and cause-specific mortality in 900000 adults: collaborative analyses of 57 prospective studies. Lancet 2009;373:1083e96

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

6.2 There are evidence based cost effective interventions[8] which demonstrate that investment in child weight management intervention is a cost-saving intervention providing a return of investment of between 10 to 13 times on public investment.

7. LEGAL CONSIDERATIONS

7.1 Not applicable

8. HUMAN RESOURCES IMPACT

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

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

9. EQUALITIES IMPACT

An equalities impact was undertaken for the Healthy Weight JSNA (2013/2014).

10. ENVIRONMENTAL IMPACT

10.1 Not applicable

11. CRIME AND DISORDER REDUCTION IMPACT

11.1 None.

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Appendix 1: Healthy Weight strategic action plan (2015-2017)

BACKGROUND DOCUMENTS
Healthy Weight Joint Strategic Needs Assessment (2013/14) – online here:
http://www.croydonobservatory.org/resource/view?resourceId=218

[8] New Economics Foundation

Appendix 1 Healthy Weight Strategic Action Plan 2015-2017

Strategic Aims	How will we do this – strategic approach/ high level areas for action	Current Position (Q1 2015-2016)	Measuring Progress (2015 – 2017)	Partner responsible for delivery
Prevention of child obesity in the Early Years	Increase the proportion of new-born children exclusively breast-fed by providing support and encouragement through Baby Friendly Initiative	Hospital and community services awarded Stage 2 Baby Friendly Accreditation.	Progression towards Baby Friendly Initiative Accreditation to Stage 3 within CHS by **Q1 2015-2016** to increase breastfeeding rates. (Croydon Health Services – Hospital and Community)	Commissioner is NHS England (to be transferred alongside the Health Visiting and Midwifery Services (commissioned by the CCG)
Reduction in child obesity in school aged children Transform school meals	Take up of Universal Free Infant School Meals at Key Stage 1 (Reception and Year 1 & 2 pupils in primary school)	Autumn School Census, DfE 83% take-up (Oct 2014)	**Target of 87%** take up of Universal Free School Meals by **Q1 2016-2017**	Laura Flanagan (School Food Improvement Officer) Croydon Council
	Implementation of Croydon's School Food Plan	To date, there is sign off from Greater London Authority of Croydon's School Food Plan.	Robust evaluation of Croydon's School Food Plan (2015-2017)	Laura Flanagan (School Food Improvement Officer) Croydon Council
Reduction in child obesity in school aged children Increase opportunities for physical activity in schools **Commission weight management services for overweight and obese children**	Increase the take-up of the Healthy Schools programme to support schools to improve opportunities for physical activity. - Primary Schools - Secondary Schools - Academies - Free schools		95% of state funded primary schools and 95% of secondary schools achieve Bronze Award of London Healthy Schools by **Q2 2016-2017**. 60% of state funded schools achieve the Healthy Schools Silver Award by **Q2 2016-2017**.	Daniel Davis (Healthy Schools) Croydon Council
	Implementation of the Sustainable Travel Active, Responsible, Safe (STARS) programme (Active travel programme in schools)	3 Gold, 2 Silver and 37 Bronze accredited STARS schools. 80 schools currently engaged with STARS. (July 2014 data)	Target for 100 schools to be engaged with STARS programme by **June 2015**. 60 schools to achieve Bronze STARS status by **June 2016**,	Peter McDonald, (Travel & Transport Planning Officer) Croydon Council
	Performance review the	To date, current	Annual and quarterly monitoring reports from	Nick Clinch

Strategic Aims	How will we do this – strategic approach/ high level areas for action	Current Position (Q1 2015-2016)	Measuring Progress (2015 – 2017)	Partner responsible for delivery
	performance of two contracts for Child Healthy Weight against the Key Performance Indicators in the monitoring schedule.	performance of both providers is adequate	the providers (**ongoing**): - Phunkyfoods - Alive n'Kicking	(Children's Commissioning Manager) Integrated Commissioning Unit Croydon Council Anna Kitt (Public Health Principal) Croydon Council
	Review the performance of Child Healthy Weight services to identify opportunities for integration with school Nursing	Weight management and School Nursing are being reviewed through the wider 5-19yrs Health Improvement Commissioning Strategy work.	Based upon performance of Child weight management contracts: 1. Joint tender for April 2016 for child weight management and school nursing. OR 2. Continue contract with existing child weight management providers for financial year 2016-2017.	Nick Clinch (Children's Commissioning Manager) Croydon Council Caroline Boardman (Senior Commissioning Manager) Integrated Commissioning Unit Croydon Council Anna Kitt (Public Health Principal) Croydon Council
	Clarify the funding responsibility with Croydon CCG for the commissioning of child (including maternal) to ensure there is a full weight management pathway.	Currently there is no Tier 3 child obesity service.	Review the funding arrangements for Tier 3 child obesity pathway (**ongoing**).	Commissioner for Croydon Clinical Commissioning Group

Strategic Aims	How will we do this – strategic approach/ high level areas for action	Current Position (Q1 2015-2016)	Measuring Progress (2015 – 2017)	Partner responsible for delivery
Commission joined up weight management services for overweight and obese adults and children	Performance review the one contract for Adult Healthy Weight service against the Key Performance Indicators in the monitoring schedule.	To date, there have been 144 referrals to the service. Numbers are too low to report on 5% weight loss (completers)	Annual and quarterly performance of tier 2 adult services (**ongoing 2015-2016**). - Weight Watchers % of adults completing the 12 week programme that have lost 5% weight **(annual)**	Anna Kitt (Public Health Principal) Croydon Council
	Review the Adult Healthy Weight services for integration into the 'Integrated Healthy Lifestyles Service' with a single point of access.	Meetings ongoing to review the service specification for an 'Integrated Health Service'	Specification for an Integrated Healthy Lifestyles service commissioned from **Q1 2016-2017**	Anna Kitt (Public Health Principal) Croydon Council

Strategic Aims	How will we do this – strategic approach/ high level areas for action	Current Position (Q1 2015-2016)	Measuring Progress (2015 – 2017)	Partner responsible for delivery
	Review the pathway for weight management and obesity for adults and children, identify existing pathway services and gaps, consider services interventions, agree criteria and referral processes to join up the tiers and provide a clear patient journey through the pathway.	The CCG currently commissions drug interventions and dietician advice as well as psychological and psychiatric services. These may not however follow a clear pathway or NICE guidance (multi-disciplinary teams).	Review the pathway, consider gaps, service interventions. Review the responsibility and funding arrangements. for Tier 3 services. Agree a clear pathway, criteria and referral processes.	Aarti Joshi Associate Director – Planned Care & Service Redesign Croydon Clinical Commissioning Group Anna Kitt (Public Health Principal) Croydon Council
Access to parks, green spaces, and leisure facilities	Croydon Challenge – review of Croydon's Parks and Leisure facilities to ensure there is adequate provision of parks and green spaces, and seek to maintain such facilities at reduced cost.	The Croydon Challenge project is for completion by Q2 2015-16	Review the implementation of the Croydon Challenge project (**ongoing**)	Anna Kitt (Public Health Principal) Croydon Council
Increase provision and access to healthy food in takeaways and cafes across the borough (Healthier Catering Commitments)	Implementation of Croydon's Eat Well awards for healthier catering.	To date: 20 accredited Eat Well food businesses	Target: **40 food businesses (cafes and takeaways) accredited Q4 (2015-2016)**	Anna Kitt (Public Health Principal) Croydon Council
Workforce Health	Support and challenge local businesses to do more to help employees lead a healthier life through encouraging sign-up to the London Healthy Workplace Charter, and in particular introduce policies to prevent,	Croydon Council is awarded Achievement level (for organisations that have a more advanced and comprehensive approach to	Implementation of the Workplace action plan within Croydon Council **(2015 – 2017).**	Anna Kitt (Public Health Principal) Croydon Council

Strategic Aims	How will we do this – strategic approach/ high level areas for action	Current Position (Q1 2015-2016)	Measuring Progress (2015 – 2017)	Partner responsible for delivery
	support and manage obesity.	employee wellbeing)		
Increase the number of physically active adults	Performance review the Exercise on Referral service against the key performance indicators.	The Exercise Referral scheme has merged with the existing MI Change project to offer Croydon residents the opportunity an referral service with Motivational Interviewing used as the core intervention	% of adults who have increased participation in physical activity as a result of taking part in the MI Change project **(Await annual report 2014/15)**	Daniel McDermott (Physical Activity Development Officer) Croydon Council
Whole system approach to reduce child and adult obesity	Food Flagship programme – Develop practical cookery skills; foster a love of good food; (Greater London Authority funded programme)	Service specification being developed with providers - Garden Organic - Community Food Learning Centre	Performance review and evaluate the impact of the programme against the quarterly monitoring report to the Greater London Authority. **Programme deliverable 2015-2017**.	Ashley Gordon (Food Flagship Officer) Croydon Council

Monitoring Tool – Healthy Weight Action Plan

Long Term Indicators		**Data Measures**	**Indicator Measure**	**RAG rating in comparison with England average** (Source: PHOF data)
1.	Proportion of men and women overweight and obese (Excess weight in adults)	% adults classified as overweight or obese, Active People Survey 2012 *PHOF Indicator*	62.1%	Amber
2.	Obese adults	% adults classified as obese, Active People Survey 2012 *PHOF Indicator*	24.3%	Amber
3.	Proportion of overweight and obese children (4-5yrs age; Year R)	% school children in R Year (age 4-5) , 2013/14 *PHOF Indicator*	23.1%	Amber
4.	Proportion of overweight and obese children (10-11yrs age; Year 6)	% school children in Year 6 (age 10-11), 2013/14 *PHOF Indicator*	38.3%	Red
5.	Prevalence of recorded type 2 diabetes	% of recorded QOF type 2 diabetes in adult population 17yrs +, 2013/14 *PHOF Indicator*	6.4%	Red
Intermediate Term Indicators		**Data Measures**	**Indicator Measure**	**RAG rating in comparison with England average** (Source: PHOF data)
6.	Breastfeeding initiation	% of all mothers who breastfeed their babies in the first 48hrs after delivery, 2012/13 *PHOF Indicator*	86% *2013/14 data not available (date quality reasons)*	Green

7.	Breastfeeding prevalence at 6-8 weeks after birth	% of all infants due a 6 to 8 week check that are totally or partially breastfed, 2013/14 *PHOF Indicator*	70.2%	N/A
8.	Percentage of physically active adults	% of adults achieving at least 150 'equivalent' minutes of at least moderate intensity physical activity per week in accordance with Chief Medical Officer recommended guidelines on physical activity, 2012 *PHOF Indicator*	55.5%	Green
9.	Take up of free school meals (Reception, Year 1 & Year 2 pupils)	% of children taking up free school meal *Department of Education data*	83%	*England data: 85%*
Short Term Indicators		**Data Measures**	**Indicator Measure**	
10.	Number of business with Eat Well award (targeted wards)	Local data (annual)	20	N/A
11.	Number of schools awarded Bronze for active travel to school (STARS)	STARS accredited schools,2014 (Transport for London data)	37	N/A

School Food Plan Monitoring Tool (2015-2017)

School Food Plan Priority	Description of target (To be met by March 2017)	Annual Target (2015-16)	Actual
1. Children eat healthy breakfasts and lunches	All 10 Croydon main caterers will meet the School Food Standards	8 caterers	
	80% of Croydon schools will offer a breakfast club and be signed-up to meeting the minimum requirement of the Croydon Breakfast Club menu	40%	
	The uptake of Universal Infant Free School Meals at Key Stage 1 will be 87% across Croydon schools	83%	
	The uptake of school meals at Key Stage 2 will be an average of 70% across all Croydon junior and primary schools	60%	
	The uptake of school meals in Croydon secondary schools will be an average of 75%	70%	
2. Flagship schools demonstrate best practice food provision	All Flagship schools with complete the Head Teacher checklist	3 checklists complete	
	All Flagship schools will develop their own School Food Plans	3 School Food Plans completed	
	Flagship schools will deliver 12 parent/carer healthy eating workshops and food demonstrations	4 workshops to be delivered	
3. A whole school approach to healthy eating and inspiring a love of food	120 staff will attend school food training sessions	60 staff to attend school food training sessions	
4. Good practice and learning is disseminated	Flagship schools will support 40 staff from their own local schools to improve food provision in their own schools.	20 staff to be supported	

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REPORT TO:	**HEALTH AND WELLBEING BOARD (CROYDON)** **10 June 2015**
AGENDA ITEM:	**11**
SUBJECT:	**MENTAL CAPACITY ACT / DEPRIVATION OF LIBERTY SAFEGUARDS**
BOARD SPONSOR:	**Paul Greenhalgh, Executive Director for People Department**

BOARD PRIORITY/POLICY CONTEXT:

- *the joint health and wellbeing strategy – see www.croydonobservatory.org/Strategy_Health_and_Social_Care/*

This report addresses the priority of improving people's experience of care by ensuring that those people who lack capacity to consent to their care arrangements and whose care arrangements amount to a deprivation of their liberty are afforded the protection of the Deprivation of Liberty safeguards. This is a legal requirement under the Deprivation of Safeguards legislation as qualified by Case Law via the Supreme Court ruling regards the Cheshire West case.

FINANCIAL IMPACT:

The Supreme Court ruling has led to a significant additional spend for the Council during 2014/15 due to the significant increase in number of assessments that need to be undertaken.

In order to be able to meet the increased demand a business case for growth in revenue funding in 2015/16 has been approved and an additional £558k has been allocated for this work.

More recently the Department of Health has announced a one-off additional contribution for Councils for 2015/16 in response to concerns that had been highlighted nationally about the financial implications for councils of the Supreme Court ruling. Through this process Croydon has been allocated £149K..

1. RECOMMENDATIONS

This report recommends that the health and wellbeing board:
Notes the content of this report and takes steps to ensure that all health and social care agencies affected by this ruling are aware of their responsibilities to people who lack capacity and who may be deprived of their liberty.

2. EXECUTIVE SUMMARY

2.1 Deprivation of liberty safeguards is the system put in place under the Mental Capacity Act to ensure that people who lack capacity to consent to their care arrangements are afforded proper scrutiny of these arrangements if the level of care amounts to them being deprived of their liberty.

2.2 Until recently people living in care homes and hospitals were only considered to be deprived of their liberty if they were being supported under the most restrictive forms of care – for example if they were clothed in specialist garments, such as a person placed in an all-in-one body suit to prevent ingestion of continence pads, or a person who kept trying to leave the home and was constantly prevented. It had been viewed that people who showed no obvious unhappiness with their care arrangements and who made no attempt to leave, were not being deprived of their liberty. They may be restricted in what they can do for their best interest, but that this was not viewed as amounting to deprivation of liberty.

2.3 For any person who may be deprived of their liberty, the MCA - DOLS framework allows for the deprivation to be authorised and made lawful via a process of careful and very specific assessment. This determines if the deprivation is in their best interests. There are many people who could lack capacity to agree to care arrangements, such as people with advanced dementia and people with a severe learning disability. In a hospital setting it may also apply to a person who would normally be able to agree to their care or treatment but due to specific circumstances is now unable to – for example following a serious accident.

2.4 It is worth emphasising that it is not necessarily a bad thing for a person to be deprived of their liberty. For someone who lacks capacity to maintain their own safety, providing 24/7 care and supervision and not allowing them to leave can be a necessary arrangement to keep the person safe. What the Deprivation of Liberty Safeguards assessment process does is to ensure that the arrangement is necessary, proportionate to their needs and that it is the least restrictive way of supporting the person.

2.5 When a person is considered to be deprived of their liberty, the assessment to check that this is acceptable and to authorise it, includes 6 separate assessments; that the person is:

- 18 and over
- Suffering from a mental disorder
- Lacking capacity for the decision to be accommodated in the hospital or care home
- No decision previously made to refuse treatment or care, or conflict relating to this such as Lasting Power of Attorney
- Not ineligible for DoLS (such as for example when applications of the Mental Health Act may be more appropriate)
- That the person needs to be deprived of their liberty, in their best interests and that it is the least restrictive solution.

2.6 The Deprivation of Liberty Safeguards legislation requires that all applications to authorise a deprivation are completed within strict timescales. There are two types of authorisations – urgent and standard.

2.7 An urgent authorisation is made when the person concerned is already being deprived of their liberty. The care provider or hospital (termed the ‘managing authority’) can give themselves an urgent authorisation for up to 7 days and apply to the Local Authority (termed the ‘supervisory body’) to ratify this. The assessment process for an urgent authorisation, when a deprivation suddenly occurs, must be completed within 7 calendar days by the supervisory body, ie

the Local Authority. In exceptional circumstances only, the urgent authorisation can be extended for a further 7 days. No other extension period is possible.

2.8 A standard authorisation is an agreement given by a supervisory body, giving lawful authority to deprive a person of their liberty. It must be requested by the managing authority whenever they believe that a person may be deprived of their liberty in the next 28 days. The application for a standard authorisation should always be requested in advance wherever possible. The Local Authority has 21 calendar days to complete the assessment and authorise the deprivation.

2.9 <u>New definition of what it is to be deprived of one's liberty</u>

2.10 In March 2014 the Supreme Court overturned the accepted definition of the meaning of what it is to be deprived of one's liberty, by broadening the scope to include many more people. The judgement widened the definition of when a person who lacks capacity to agree to the arrangements for their care and support and who is receiving care support funded by a statutory body, is deemed to be deprived of their liberty. The new ruling says that anyone lacking capacity to agree to being in a care home, nursing home or hospital, or anyone living in a tenancy or the family home and who is subject to 24 hour supervision and control and who would be prevented from leaving if they tried, is deemed to be deprived of their liberty. This is said to be the new 'acid test'. This is regardless of whether they and other key people such as relatives are happy with the arrangements.

2.11 The new ruling makes clear that even people supported to lead full and active lives are to be considered to be deprived of their liberty if they are supervised 24/7 and would not be free to leave if they tried.

2.12 In order to make this deprivation lawful, the local authority as the supervisory body for this process has to arrange for an assessment, as described above, within a strict timescale. This 6 part assessment needs to be carried out jointly by a s12 doctor and a Best Interest Assessor. Both will have received specialist training to be qualified to do this work.

3 DETAIL

3.1 This report provides follow up on the very serious demand issues created by the Supreme Court ruling of March 2014 regarding the 'acid test' for Deprivation of Liberty Safeguards which widened the numbers of people now falling under the 'deprivation' category and hence requiring assessment. Over the past year this has led to a twelve fold increase in numbers of people deprived of their liberty for which the MCA/DOLS service was not resourced to meet.

3.2 The immediate response to this unprecedented change to the case law interpretation of existing legislation was that the MCA/DOLS Coordinator led a programme of information sharing with providers who needed to understand the implications of the ruling, and to meet with them to look at individual cases to ensure that applications were appropriate. This included setting up various forums for providers and involved the MCA/DOLS lead from the Department of Health, Dr Lucy Bonerjee.

3.3 As a result of this initial work providers began to make increasing numbers of applications for DOLS assessments which then led to demands exceeding capacity. ADASS (Association of Directors of Adult Social Services) provided guidance on prioritising cases. It must be noted that this issue has affected all Local Authorities as supervisory bodies for DOLS and across the country there has been a 10 – 12 fold increase in numbers of people subject to DOLS. This has also meant that it has not been possible to meet statutory timescales for assessments.

3.4 Although a number of social workers employed within Adult Social Services were licenced Best Interest Assessors (BIAs) and were accustomed to carrying out DOLS assessments on a rota, the huge increase in referrals during 2014/15 meant that this arrangement was no longer sufficient to deal with the volume of applications. The service therefore commissioned Bournemouth University to deliver a Best Interest Assessor course for social workers employed in Adult Social Services, with 23 staff undertaking the training in January and March 2015. Once these social workers have successfully completed the written assignments and shadowed existing BIAs, they will become licensed and able to join the rota.

3.5 Part of the additional funding granted for 2015/16 is being used to create a dedicated BIA team to carry out the majority of DOLS assessments, supported by the BIA rota. This team began to operate in late 2014 with locum BIA social workers, to address the increased number of overdue assessments, although it has been difficult to find suitable locum BIAs, and so the team is not yet operating at full capacity. Adult Care Services will be advertising for registered social workers within the coming weeks and will be seeking to employ a number of BIA licensed social workers in BIA team. The assessment process also requires involvement of s12 approved doctors and again there have been problems sourcing sufficient numbers of doctors able to carry out this work although there are signs of more s12 doctors coming on stream to manage demand.

3.6 During recent months the MCA/DOLS team has relied to a large extent on independent BIA's to supplement the Croydon staff, and this poses considerable additional costs, which should be mitigated once the above actions have been achieved.

3.7 At the end of April 2015 the volume of DOLS assessments was as follows:

Total Number of DoLs by Quarter for 2014/15

Quarter 1 – 58

Quarter 2 – 105

Quarter 3 – 170

Quarter 4 – 236

This included 72 referrals of people in hospital as follows:

CUH – 35

SLAM- 18

Ceased due to patient being discharged – 19

3.8 The plan for 2015-16

3.9 A business case has been made and accepted by Council's Cabinet which has resulted in £558k being put into the budget for 2015/16 in order to meet the demands for DOLS assessments. This includes not only people who are within residential, nursing homes and hospitals but also people living in their own home who may be deprived of their liberty but for whom the DOLS assessment process is not a legal option and instead applications and assessments must be submitted direct to the Court of Protection. Although social workers are aware that individuals within this group of people may potentially be being deprived of their liberty, work to increase the awareness of providers has not yet been prioritised given the overwhelming demands of assessing those people currently living in residential and nursing homes and hospitals.

3.10 Plans to manage the current situation over the forthcoming year include:

- Recruitment to another BIA locum post as an interim measure.
- A recruitment campaign across adult social care which will include 3 posts for full time BIA assessors.
- Complete training programme for 23 Croydon staff to become licensed as BIAs and to commence work on the rota.
- Implementation of revised DH forms for DOLS assessments aimed at streamlining the process.
- More focus to be given to people living in their own homes by social workers / care managers and applications to the Court of Protection being made as appropriate. The staff on the BIA rota will be well placed to undertake this work.

3.11 It is expected that these measures will enable timely processing of applications and avoid unlawful deprivations.

3.12 The HWBB is asked to note the content of the report and to ensure that:

- Partners who are managing authorities (where people who lack capacity to consent to their care arrangements and who may be deprived of their liberty reside) understand the implications of DOLS and that if there is any doubt advice is sought from the MCA/DOLS lead. This will apply to nursing and residential care home providers and to hospitals. This includes the CCG who commissions providers of health care including people subject to Continuing Health Care funding or to those in receipt of Registered Nursing Care funding.

- Similarly, the Board is asked to be aware that providers supporting people in their own homes must ensure that they and their staff understand the implications of DOLS and to approach the care manager if they have concerns that a person who lacks capacity may be being unlawfully deprived of their liberty.

- The Board is asked to note that the supervisory body for people potentially unlawfully deprived of their liberty is the funding Local Authority and not where the person is placed.

3.13 The Board is asked to note that the Supreme Court ruling has led to a twelve fold increase in DOLS applications and that this number is likely to continue to increase. It is a legal requirement that people who are deprived of their liberty are afforded a comprehensive assessment of their needs.

4 CONSULTATION

There has been very wide consultation regarding this change with:

- The CCG
- Providers of residential, nursing care and hospitals.
- Social workers and case managers
- Best Interest Assessors
- Legal services
- Commissioners

5 SERVICE INTEGRATION

5.1 The Local Authority as the Supervisory body has responsibility for ensuring that any one potentially deprived of their liberty has a comprehensive assessment under the DOLS process.

5.2 However this requires that Managing Authorities understand their role in notifying the Local Authority of people subject to a deprivation.

5.3 We continue to negotiate with SLAM who have integrated health and social care teams with staff who are BIA trained and who could carry out DOLS assessments rather than pass this responsibility to the DOLS team which is part of the Council. Similarly SLAM employs doctors who are s12 approved and who could carry out this work. This would create a much more efficient and patient responsive service, but may create resourcing pressures for the mental health service.

6 FINANCIAL AND RISK ASSESSMENT CONSIDERATIONS

6.1 The unanticipated and unprecedented additional demands created by the Supreme Court ruling has led to the need

6.2 Within the Council a business case for 2015/16 has been approved and an additional £558 k made available and recently the Department of Health has provided an extra £149,476 on a one off basis for this work.

6.3 At this stage it is not possible to accurately predict the financial demands of this ruling over the next 2 years as more applications are being made due to managing authorities understanding their responsibilities. We are aware that the number of applications for people living in their own homes who are being deprived of their liberty is likely to increase.

6.4 As the year progresses the budget and spend will be carefully monitored and reported as part of the Council's budget monitoring process.

6.5 Approved by: Lisa Taylor – Head of Finance and Deputy S151 Officer – Croydon Council.

7 LEGAL CONSIDERATIONS

The Supreme Court ruling has created an additional statutory responsibility by widening the definition of someone deprived of their liberty.

7.1 The Law Commission is aware of the national pressures arising from the Supreme Court Judgement and is working on an amendment to the law which resolves the current tensions. It is expected that the Law Commission will consult on proposed changes to the law in July 2015. Even if this consultation is positive, it is not expected that any new legislation will come into effect until 2017.

7.2 Approved by: Jacqueline Harris-Baker, head of social care and education law on behalf of the Borough Solicitor & Director of Democratic & Legal Services

8. Human Resources Impact

8.1 This report makes recommendations that will have implications for the recruitment and selection of adult social workers in the Council to ensure we have the right people with the right skills, such as licenced Best Interest Assessors. As such, the service has begun working with colleagues in HR consultancy and recruitment to ensure the appropriate HR/recruitment processes is followed.

8.2 Approved by: Deborah Calliste on behalf of the Director of Human Resources, Croydon Council

9. EQUALITIES IMPACT

9.1 The Supreme Court ruling impacts on any adult who lacks capacity to agree to decision about their care and support, including healthcare and when these arrangements may amount to a deprivation of their liberty.

As such the ruling impacts on people who possess a range of protected characteristics such as disability, ethnicity, religion, gender and age and is intended to protect the rights and freedoms of this group of people. The one overriding factor however, is that the adult must lack capacity to consent to their care and support arrangements. Any adult who is able to give consent does not fall under the Deprivation of Liberty Safeguards.

This ruling has impacted across the whole country. We have not yet been able to ascertain whether the DH has carried out an equality analysis

9.2 An Initial equality analysis was undertaken to ascertain the potential impact on protected groups compared to non-protected groups. This concluded that further equality analysis was not required as the change would not have any impact on protected groups.

9.3 Approved by: Yvonne Okiyo, Equality Officer, Equality and Community Relations Team

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CONTACT OFFICER: Kay Murray Head of Quality Assurance and Adult Safeguarding Board.

BACKGROUND DOCUMENTS None.

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REPORT TO:	**HEALTH AND WELLBEING BOARD (CROYDON)** **10 June 2015**
AGENDA ITEM:	**12**
SUBJECT:	**Croydon Integrated Sexual Health Services**
BOARD SPONSOR:	**Mike Robinson** **Director of Public Health, Croydon Council** **Paul Greenhalgh** **Executive Director, People Department, Croydon Council** **Paula Swann** **Chief Officer, Croydon CCG** **Jane Fryer** **NHS England**

BOARD PRIORITY/POLICY CONTEXT:

Following the Health and Social Care Act 2012, responsibility for sexual health commissioning was split between NHS England, Clinical Commissioning Groups (CCGs) and local authorities.

Under the Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2013 (the Regulations), the Council is required to provide or make arrangements to secure provision of open access sexual health services in its area. This includes:

- Advice on, and reasonable access to, a broad range of contraceptive substances and appliances;
- Advice on preventing unintended pregnancy;
- Services for preventing the spread of sexually transmitted infections;
- Services for treating, testing and caring for people with such infections;
- Services for notifying sexual partners of people with such infections.

The commissioning responsibilities and the Council's service redesign plans address several of the recommendations made by the 2010/11 Joint Strategic Needs Assessment (JSNA) chapter on Sexual Health. Following the needs assessment, four strategies were developed:

- An overarching sexual health strategy (http://www.croydonobservatory.org/resource/view?resourceId=28)
- Sub-strategies focusing on:
    - HIV testing
    - Repeat abortions
    - Sexual health promotion and education

They also address the priorities of the joint health and wellbeing strategy as 'Early diagnosis and treatment of sexually transmitted infections including HIV infection' is a priority under improvement area 2 (preventing illness and injury and helping people recover).

In addition, this area of commissioning contributes to the Council's corporate outcome of Independence in the following ways:

- To help families be healthy and resilient and able to maximise their life chances and independence
- To help people from all communities live longer, healthier lives through positive lifestyle choices
- To prevent domestic and sexual violence where possible, support victims and hold perpetrators to account

It will also contribute to the CCG's transformation shifts by increasing the emphasis on prevention, self-care, primary and community activity. This is of particular relevance as many of the complications arising from poor sexual health will result in a need for CCG-commissioned services, such as pelvic inflammatory disease, infertility and abortion services.

There has been a national strategy for sexual and reproductive health (A Framework for Sexual Health in England) in place since March 2013. Public Health England's document 'Making it Work: a guide to whole system commissioning for sexual health, reproductive health and HIV', details the responsibilities of different commissioning organisations and the importance of working together to deliver the best outcomes through the most effective patient pathways.

The proposals detailed below will contribute towards the delivery of the strategy locally, in the context of this commissioning landscape.

FINANCIAL IMPACT:

There are no direct financial implications associated with this report, which details the responsibilities of the three main commissioning organisations responsible for sexual and reproductive health.

1. RECOMMENDATIONS

This report recommends that the Health and Wellbeing Board (Croydon):

1.1 Consider the proposals in this report and the Council's public sector equalities duty, and the mitigating actions detailed at para.8 and:

1.2 Endorse the local priorities identified for sexual health in Croydon set out at para.3.4.1 and 3.4.2;

1.3 Note the principles for the re-design of sexual health services commissioned by Croydon Council set out at para.3.4.3;

1.4 Discuss opportunities for collaborative working between health and wellbeing board member organisations to improve sexual and reproductive health outcomes in Croydon.

2. EXECUTIVE SUMMARY

2.1 Croydon generally has poorer outcomes in sexual and reproductive health than the England average and, for several indicators, is also worse than the London average.

2.2 Following the Health and Social Care Act 2012, commissioning responsibilities for different elements of the sexual health system were split between NHS England, Clinical Commissioning Groups (CCGs) and local authorities.

2.3 Croydon Council is in the process of redesigning the services it commissions to place a greater focus on the integration of sexual health and contraception services and on targeted prevention and outreach work for those with the greatest sexual health needs and this report sets out the principles for that re-design.

2.4 There are opportunities for greater collaborative working to ensure pathways between services are streamlined and outcomes for residents are optimised, and these should be explored between Croydon Council, Croydon CCG and NHS England.

3. DETAIL

3.1 Evidence of need for interventions to improve sexual and reproductive health

3.1.1 Croydon has significantly higher diagnosis rates of sexually transmitted infections (STIs) including chlamydia, gonorrhoea, syphilis and genital herpes than England; chlamydia diagnosis rates are also significantly higher than London, although rates of gonorrhoea and syphilis are significantly lower than the London average and rates of genital herpes are not statistically different to London's.

3.1.2 The prevalence rate of diagnosed HIV is high in Croydon at 5.07 per 1,000 people aged 15-59 compared to an England average of 2.14 per 1,000; it is, however, lower than the London average of 5.69 per 1,000 (range across London boroughs: 1.82-14.70 per 1,000). 57% of people diagnosed with HIV in 2011-13 were diagnosed after the point at which treatment should have begun, which is significantly higher than both London (40.5%) and England (45.0%).

3.1.3 The under-18 conception rate is significantly higher in Croydon than the London and England averages and, in 2013, Croydon had the highest rate of repeat abortions among young people aged under 25 of any London Borough (38.7%).

3.1.4 In 2013/14, rates of pelvic inflammatory disease and ectopic pregnancy were significantly higher in Croydon than in London or England. Sexually transmitted infections such as chlamydia can increase the risk of these conditions, which are likely to present cost pressures to the CCG.

3.1.5 The Joint Strategic Needs Assessment (JSNA), completed in 2010/11, identified a number of groups that experience worse sexual health outcomes including: young people, particularly those being looked after by the local authority, those leaving care, and those not in education, employment or training; younger Black Caribbean, Black African and other Black population groups; men who have sex with men; those who misuse drugs or alcohol; and sex workers.

3.2 Strategic frameworks

3.2.1 **National strategic framework**:
The national strategy for sexual health, A Framework for Sexual Health in England, 2013, identifies the following areas as having a good evidence base for improving outcomes:

- Accurate, high-quality and timely information that helps people to make informed decisions about relationships, sex and sexual health;
- Preventative interventions that build personal resilience and self-esteem and promote healthy choices;
- Rapid access to confidential, open-access, integrated sexual health services in a range of settings, accessible at convenient times;
- Early, accurate and effective diagnosis and treatment of STIs, including HIV, combined with the notification of partners who may be at risk; and
- Joined-up provision that enables seamless patient journeys across a range of sexual health and other services – this will include community gynaecology, antenatal and HIV treatment and care services in primary, secondary and community settings.

The report highlights the necessity of the different commissioning organisations to work closely together to ensure that the care and treatment people receive is of a high quality and is not fragmented. In addition, it describes a role for the local health and wellbeing board in bringing organisations together and ensuring that the care people receive is comprehensive, high quality and seamless.

3.2.2 **Local strategic framework:**
A local sexual health strategy for Croydon was approved by Cabinet in 2012. This draws on the needs identified in the JSNA chapter, details the evidence for intervention and makes recommendations for further action.

In addition to the overarching strategy, three sub-strategies were approved covering the priority areas of:

- HIV testing
- Repeat abortions
- Sexual health promotion and education.

3.3 Commissioning landscape

3.3.1 Under the Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2013, the Council is required to provide or make arrangements to secure provision of open access sexual health services in its area. This includes:

- advice on, and reasonable access to, a broad range of contraceptive substances and appliances
- advice on preventing unintended pregnancy
- services for preventing the spread of sexually transmitted infections
- services for treating, testing and caring for people with such infections
- services for notifying sexual partners of people with such infections

3.3.2 These services must be available for the benefit of all people present in the local authority's area. The local service arrangements currently include open access Contraception and Sexual Health (CASH) and Genitourinary Medicine (GUM) services and a specialist young people's sexual health outreach and teenage pregnancy prevention team. These services are in the process of being brought together into one integrated sexual health service with a new service model that increases the focus on prevention and high risk/target groups.

3.3.3 The document 'Making it Work: a guide to whole system commissioning for sexual health, reproductive health and HIV' (PHE, 2014), provides additional detail on which commissioning organisations are responsible for which elements of the sexual health system:

Local authorities:

- Contraception advice on preventing unintended pregnancy in specialist services and those commissioned from primary care
- Sexually transmitted infection (STI) testing and treatment in specialist services and those commissioned from primary care, chlamydia screening, HIV testing including population screening in primary care and general medical settings, partner notification for STIs and HIV
- Sexual health aspects of psychosexual counselling
- Any sexual health specialist services, including young people's sexual health services, outreach, HIV prevention and sexual health promotion, service publicity, services in schools, college and pharmacies.
- Social care services, including HIV social care and wider support for teenage parents (unchanged as a result of the Health and Social Care Act 2012).

CCGs:

- Abortion services, including STI and HIV testing and contraception provided as part of the abortion pathway (except abortion for foetal anomaly)
- Female sterilisation
- Vasectomy (male sterilisation)
- Contraception primarily for gynaecological (non-contraceptive) purposes
- HIV testing when clinically indicated in CCG-commissioned services (including A&E and other hospital departments)
- Non-sexual health elements of psychosexual counselling

NHS England:

- Contraceptive services provided as an "additional service" under the GP contract

- HIV treatment and care services and the cost of all antiretroviral treatment
- Testing and treatment for STIs (including HIV testing) in general practice when clinically indicated or requested by individual patients
- HIV testing when clinically indicated in other NHS England-commissioned services
- Sexual assault referral centres
- Cervical screening in a range of settings
- HPV immunisation programme
- Specialist foetal medicine services, including late surgical termination of pregnancy for foetal anomaly between 13 and 24 weeks
- NHS Infectious Diseases in Pregnancy Screening Programme including antenatal screening for HIV, syphilis and hepatitis B.

3.3.4 There are a number of areas where commissioning responsibilities overlap that require agreement between commissioners on the pathways to be in place and how services will be commissioned, e.g. psychosexual services and HIV testing and diagnosis and post-exposure prophylaxis (PEP) for HIV.

3.3.5 In Croydon, the Sexual Health and HIV Partnership Board is the mechanism for co-ordination of the whole sexual health system and has representation from all local partners, including providers and community groups. This Board provides the opportunity for commissioners and providers to review whole-system performance and pathways together. This includes overseeing and contributing to the joint strategic needs assessment and strategy development and leading the strategic discussion on local service redesign.

3.4 **Local priorities for Croydon**

3.4.1 The Croydon HIV and Sexual Health Partnership Board has identified five main priorities for sexual health:

- Reducing the rates of late diagnosis of HIV
- Reducing repeat abortions
- Reducing the prevalence of STIs
- Reducing the rates of teenage pregnancy
- Locally delivered, community-focused services

3.4.2 Croydon Council supports the two core national principles for sexual health services:

- Integrated services (i.e. the provision of STI testing, diagnosis and treatment and contraception being available on one site, at levels which are appropriate to that site);
- Open access services (i.e. individuals from anywhere in the country can access services in Croydon, and Croydon residents will also be able to access services out of the borough)

3.4.3 Croydon Council is in the process of redesigning the sexual health services for which it holds commissioning responsibility to place a greater focus on the integration of sexual health and contraception services and on targeted prevention and outreach work for those with the greatest sexual health needs,

with the intention of addressing the priorities detailed above. Key principles of the redesign include:

- A shift from the current hospital-based provision, to a more community-focused service.
- Targeted provision to address areas of high need and individuals and groups with particularly high rates of STIs and unwanted conceptions.
- Integrated STI and contraception provision at the appropriate levels for different venues
- Dual-trained staff
- Provision of psychosexual services (to be considered in conjunction with the CCG, as the commissioners of non-sexual health elements of psychosexual services).
- Development of a self-care approach, including provision of information, availability of home-sampling.
- HIV outreach testing to vulnerable and at risk groups, potentially in partnership.
- Work with clinical colleagues in primary and secondary care to reduce late diagnosis through increased awareness.
- Improved targeting of provision to those most at risk of STIs and unplanned pregnancy, particularly through partnership work with other providers/agencies/departments and outreach into target communities.
- Re-balancing of resources to increase the capacity of the young people's sexual health team and put a greater focus on prevention.
- Provision of training for front line sexual health staff on safeguarding, domestic violence and FGM.
- Training and skills for front line staff working with particularly vulnerable groups to identify need and proactively sign post patients to relevant services (e.g. sex workers, drug and alcohol users, victims of domestic violence, asylum seekers).

3.4.4 Croydon Council intends to continue to commission sexual health and Long Acting Reversible Contraception (LARC) provision within primary care settings in addition to the integrated services being redesigned.

3.4.5 Any changes to service provision will be carefully communicated to potential service users. A joint communications plan for CHS and Croydon Council has been drafted and will provide the basis for communication. In addition, the survey asks people how they would prefer to find out about services; this will be used to inform further development of the communications plan.

3.5 **Conclusion/recommendation(s)**

3.5.1 There are significant sexual and reproductive health challenges for Croydon, with four key priorities on which to deliver.

3.5.2 There are opportunities for collaborative planning of services that may help to improve outcomes in Croydon. All providers delivering elements of sexual health provision should therefore work together to improve pathways between services and signpost/refer patients to other elements of the system where appropriate.

3.5.3 Opportunities for collaborative working should be considered by Croydon Council, Croydon CCG and NHS England where these might improve patient pathways and outcomes.

4. CONSULTATION

4.1 A programme of service user and target group engagement is underway that will inform the detail of the proposed integrated sexual health service model. This is seen as of key importance in terms of the current and ongoing developments in this area of service.

4.2 The engagement work already undertaken includes a survey and face-to-face work with target groups, as well as collation of all engagement activity recently undertaken by the current service provider. The survey deadline has been extended to 12 June 2015; however, analysis of the initial responses has found:

- Access to services is the most commonly reported barriers to using sexual health services: service opening time reported by 57% of respondents and the service being too far away/ difficult to get to reported by 28% of respondents. However, not knowing about what the services are, what they provide or where they are were also commonly reported barriers to using services.
- The large majority of respondents reported that they would be comfortable using sexual health services in a clinical/healthcare setting (94%) while 46% were comfortable using sexual health services in a community setting (e.g. children's centre) and 33% were comfortable using sexual health service online.
- 64% of respondents reported that being able to access sexual health service on a bus route was important to them.
- The most popular location for sexual health services in the borough was central Croydon (64% reported that services should be located in the central area).

These findings will be updated following the survey closing date and may therefore be subject to change. More detailed focus groups will be undertaken later in the summer to provide additional information on how we can better meet the needs of specific target groups.

4.3 Croydon jointly hosted a market warming event with five other South West London boroughs in January 2015. As well as informing potential providers about the boroughs' commissioning intentions at that time, it was also a useful opportunity to learn from providers about what they would like to see in a service or tendered contract, such as longer contract terms, mixture of block and tariff/outcomes-based payment models, and what some of the barriers to delivering integrated services can be for providers. The findings from this event have informed the planning of the proposed integrated sexual health service.

5. SERVICE INTEGRATION

5.1 Responsibility for commissioning of sexual health-related services is spread across several organisations, principally local authorities, CCGs and NHS England, as described above.

5.2 Work is underway via the Integrated Commissioning Unit (ICU) to integrate previously separate services commissioned by Croydon Council to provide testing and treatment for sexually transmitted infections (STIs), contraception and young people's outreach sexual health services, including teenage pregnancy prevention. This will improve patient accessibility to timely testing, treatment and contraception, thus improving outcomes, and ensure that, where appropriate, service users' can have all of their sexual health needs met in one visit. It is also important that, as services are re-designed, any unintended consequences for other parts of the broader health and social care system can be identified and addressed.

5.3 There are opportunities to improve pathways between providers of sexual health services in different settings including the integrated services provider, GP practice providers, pharmacies, abortion services and HIV treatment and support. The HIV and Sexual Health Partnership Board leads on bringing these partners together to consider the whole sexual health system and identify where improvements can be made that will improve outcomes.

6. FINANCIAL AND RISK ASSESSMENT CONSIDERATIONS

There are no direct financial considerations arising as a direct result of this report.

6.1 Approved by: Lisa Taylor Head of Finance and Deputy S151 Officer, Croydon Council

7. LEGAL CONSIDERATIONS

7.1 The Council solicitor comments that there are no specific legal considerations beyond the requirements of the Regulations referred to in the body of this report.

7.2 Approved by: Gabriel MacGregor Head of Corporate Law on behalf of the Council Solicitor & Monitoring Officer

8. EQUALITIES IMPACT

8.1 A full Equalities Analysis was completed in February 2015 to ascertain the potential impact on protected groups compared to non-protected groups and inform the development of the integrated sexual health services (see Appendix A). This will be reviewed to incorporate findings from the engagement work by September 2015.

8.2 This identified that there is greater sexual health need in certain protected groups, for example: HIV prevalence is higher among Black Africans and men who have sex with men (MSM); chlamydia prevalence is higher among young people.

8.3 The Equality Analysis identified that there the protected groups that should experience a positive impact were: BME groups; LGBT individuals and those who have undergone gender reassignment; younger people; men; women; those with disabilities; and some religious groups. The positive benefits

identified were: improved access to full range of contraceptive services, STI testing and treatment; reduction in unplanned pregnancy including teenage pregnancy; improved access to pregnancy testing and referral to maternity or abortion services; reduction in STI prevalence, HIV incidence and HIV late diagnosis. These proposals will therefore contribute towards the Council's achievement of Objective 7 of its Equalities Strategy 2012-2016: to improve health and wellbeing by reducing health inequalities.

8.4 Potential negative impacts were identified among the same protected groups as detailed above if the increase in local, community-based services results in increased concerns over anonymity. However, this risk will be mitigated by maintaining a choice of setting, location and times to access sexual health services. Lack of awareness of service locations following changes may also be a negative impact of the proposed changes; however, this will be mitigated by the implementation of a comprehensive communication plan to raise awareness among potential service users. In addition, there is limited research and data on the potential impact of the proposed changes on people with disabilities so the potential negative impact on this group is not known, although it is considered likely that the provision of integrated, community-based services should improve accessibility for those with complex needs or those who may be unable to travel to central service locations. This will be evaluated once the service is established.

8.5 Engagement with target groups and potential service users, including protected groups, is being undertaken as part of the service design process; this will inform the changes to service delivery to ensure that potential negative consequences are minimised or eliminated and that positive impacts are maximised. The project was considered to already include appropriate actions to advance health equality and foster good relations between groups.

8.6 The service specification will include a requirement to identify and provide services that meet any specific needs of protected groups as identified in the analysis and to share data and actively participate in the evaluation of the service so that access and outcomes among protected groups can be monitored. It will also detail the requirement to undertake engagement work with target groups, the wider community and NHS services and organisations working with these populations. This will help to minimise barriers, improve engagement for people with more complex needs and actively tackle health inequalities.

8.7 Approved by: Yvonne Okiyo, Equalities Officer

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BACKGROUND DOCUMENTS: There are no background documents

REPORT TO:	**HEALTH AND WELLBEING BOARD** **10 June 2015**
AGENDA ITEM:	**13**
SUBJECT:	**Update on actions arising from the Francis Report**
BOARD SPONSORS:	**Paula Swann, Chief Officer, Croydon CCG** **John Goulston, Chief Executive, Croydon Health Services NHS Trust** **Steve Davidson, Director of Mental Health, South London & Maudsley NHS Foundation Trust**

BOARD PRIORITY/POLICY CONTEXT:

The report of the full public inquiry into the failings at the Mid Staffordshire Foundation Trust was published on 6 February 2013. The inquiry, led by Robert Francis QC, looked at the role of commissioning, supervisory and regulatory bodies and why serious problems at the Trust were not identified and acted on sooner. The report referred to the checks and balances in the NHS system that should have prevented serious systemic failure of this sort but did not in this case.

The Report made 290 recommendations which were clustered into 5 key areas reflecting a common culture across the NHS that puts patients first. A culture which:

- supports compassionate care;
- is open and transparent;
- has accurate, useful and relevant information;
- is compliant with fundamental standards;
- has strong and patient centred leadership.

A number of initiatives have been introduced nationally as part of the response to the Francis Report, including the introduction of the **Duty of Candour**. It encompasses three concepts: 1) openness – enabling concerns and complaints to be raised freely and without fear; 2) transparency – sharing true information about performance and outcomes; 3) candour – informing any patient harmed by a healthcare provider and offering an appropriate remedy, regardless of whether they complain. Under the regulation the person harmed must be informed face to face as soon as reasonably practicable.

All NHS organisations, including Croydon CCG, Croydon Health Services NHS Trust and South London and the Maudsley NHS Foundation Trust, considered the findings and the 290 recommendations, and agreed an action plan against those recommendations during 2013.

The Francis Report recommended that each organisation should report on progress with its action plan, at least annually.

FINANCIAL IMPACT:

None

1. RECOMMENDATIONS

The health and wellbeing board is asked to:

- Note local work being taken forward by partners to implement recommendations arising from the Francis Report

2. EXECUTIVE SUMMARY

2.1 The February 2014 meeting received a report on the steps taken by Croydon CCG, Croydon Health Services NHS Trust and South London and the Maudsley NHS Foundation Trust to consider the implications of the Francis Report and to agree individual organisation actions plans.

2.2 This report provides an update on progress with the implementation of the Francis Report actions plans by Croydon CCG, Croydon Health Services NHS Trust and South London and the Maudsley NHS Foundation Trust, as at the end of the 2014/15 financial year.

3. DETAIL

3.1 The report of the public inquiry led by Robert Francis QC into Mid Staffordshire was published on 6 February 2013. It detailed the suffering of many patients at Stafford Hospital run by Mid Staffordshire NHS Foundation Trust. It concluded that this was primarily caused by a serious failure on the part of an NHS Trust Board that did not listen sufficiently to patients and staff or ensure the correction of deficiencies brought to the Trust's attention. It failed to tackle a culture involving a tolerance of poor standards and a disengagement from managerial and leadership responsibilities. The report referred to the checks and balances in the NHS system that should have prevented serious systemic failure of this sort but did not. The report set out 290 recommendations but its overarching theme was that a fundamental culture change is needed in the NHS to put patients first.

3.2 Whilst the Francis Review made no specific recommendations for health and wellbeing boards it did recommend that guidance should be given to promote coordination and cooperation between local Healthwatch, health and wellbeing boards, and council scrutiny committees (Recommendation 147).

3.3 The Department of Health published its interim response to the Francis Review, 'Patients First and Foremost' in March 2013 and indicated an expectation that local Francis Action Plans should be in place in health and care organisations across the country by the end of 2013. A further response, 'Hard Truths: the journey to putting patients first', was published in November 2013.

3.4 Croydon Clinical Commissioning Group has undertaken a full review of the Francis recommendations and has an action plan that has informed the development of a quality framework. Together they will further develop the CCG's assurance mechanisms to ensure quality is improving across all providers. The framework and action plan was agreed by the CCG governing body on 24 September 2014.

3.5 Croydon CCG Governing Body received an annual update report at its 26 May 2015 meeting, which is appended. The report includes a summary of the key action taken under each of the 11 themes identified in the Francis Inquiry Report. Risks relating to patient safety and quality are specifically reviewed at the CCG's Quality Committee. The committee also periodically considers whether it is satisfied with the presentation of information on quality, so that the data, analysis and accompanying narrative are providing the insight required to give assurance to the Governing Body.

3.6 The key quality metrics are identified and reported to CQRGs and to every meeting of the Quality Committee and the Governing Body. Information from providers is compared with information from other sources, including patient feedback and soft intelligence from regulators. The CCG quality lead now has a regular programme of visits to clinical areas and the feedback from these is reported to the Quality Committee. Through adherence to this framework the CCG is assured about the quality of local services, and where performance concerns arise that they are identified and appropriate action is initiated

3.7 The CCG has continued to work with providers, regulators and stakeholders including patients and the local public to progressively improve the safety and quality of services commissioned for Croydon residents. To this end the changes in practice envisaged by the Francis Report have been embedded in the approach the CCG takes to commissioning, including through the clinically-led quality monitoring of local services (including through the Clinical Quality Review Groups) and its governance via the Quality Committee and the Governing Body.

3.6 In July 2013 an action plan was presented to the Croydon Health Services NHS Trust Board detailing the actions against existing programmes of work and new reviews to be undertaken in response to the Francis Report. A further update on the progress of this work was presented to the Quality & Clinical Governance Committee in April 2014.

3.7 Following the Care Quality Commission (CQC) Inspection in 2013 a Trust wide Quality Improvement Plan was developed to address all the recommendations from the CQC inspection. The Quality Improvement Plan (QIP) which is an overarching Trust wide document not only includes the recommendations and compliance actions from the CQC inspection in September 2013 but also includes outstanding actions from previous inspection reports, the Francis report into Mid Staffs, the Government's response to Francis and the Clwyd/Hart report into complaints handling.

3.8 The majority of QIP milestones have now been delivered or are on track within agreed timescales and the remit of the QIP has been expanded to become the Quality, Experience and Safety Programme (QESP).

3.9 QESP sets out to drive continued improvements in quality, safety and patient experience by embedding best practice throughout the Trust.

3.10 In reviewing the 28 Francis recommendations within the Quality Improvement Plan, the Trust has made significant progress in addressing actions, as described in the report appended.

3.11 The South London and Maudsley NHS Foundation Trust Board received a further update paper on the Francis Report at its 24 March 2015, which is appended.

3.12 In 2013 a working party was established which identified four essential work streams to:

1. Create the right culture for positive challenge and positive action (Francis themes of leadership, openness and transparency, values and standards)
2. Work with service users in a spirit of co-production and co-creation
3. Look after staff, each other and ourselves
4. Assure quality of care in every corner of the Trust (information)

3.13 An action plan followed progress against which was reviewed in September 2014 and a very large number of local initiatives were identified. A few of the main ones are described in the table below:

	Example of CAG work	Example of Corporate work
Culture for positive challenge and action	Scheduled patient safety Walk Rounds	Value based recruitment Revalidation of doctors and nurses 6 C's Compassionate Nursing Practice
Working with service users in a spirit of co-production and co-creation.	PPI meetings are established Examples of excellent practice in co-production in areas around the Trust including winners of national awards	The Recovery College EPIC is established to develop governance around service user and carer involvement. Duty of Candour Policy implementation.
Looking after staff, each other and ourselves	Reflective Practice groups Individual coaching Staff invited to executive team meetings Senior managers visiting services on regular basis to listen to staff concerns	Coaching and workshops from SLaM partners. Schwartz Rounds® planned Arts Strategy Whistleblowing Policy Debriefing Policy review Staff Counselling service developments Well-being services initiatives
Assuring quality of care in every corner of the Trust	Work with teams to prepare for CQC visits to new standards Establishment of new quality governance structures	Trust Quality Strategy Care Delivery System implemented to address violent incidents.

3.14 The review concluded that a more systematic approach was required across the whole organisation. The membership if the Trust Board changed significantly in early 2015 and the new Chair, Roger Pafford and CEO Matthew Patrick agreed that the Trust Board would listen to patient voices as the most important source of feedback on organisational performance. It was agreed that patient experiences would be presented at Trust Board meetings. Furthermore the Board leadership would be visible and available to listen to staff through visiting services. In January 2015 approval was given to implement Schwartz Rounds in the organisation beginning in Autumn 2015.

3.15 In March 2015 a further paper to the Trust Board proposed the establishment of a Speak up Guardian role. This individual will support a change of culture in the organisation to enable staff to speak up and raise concerns which impact on the organisation constructively and without fear of recrimination. The Guardian seeks to instil confidence in staff to report concerns and believe that something can be done about them. A further proposal outlining that role will be considered at the July Trust Board.

3.16 A commitment was made to a 'zero tolerance of bullying' campaign led by HR. This will begin by using focus group methodology to understand the Staff Survey 2014 results from SLaM which indicate that 'bullying, harassment and discrimination at work' are worse for BME staff.

4. CONSULTATION

4.1 The Croydon CCG action plan includes utilisation of patient and public feedback on service quality by both providers and commissioners as a core part of quality monitoring. The detailed reports from Croydon Health Services NHS Trust and South London and Maudsley NHS Foundation Trust describe how patient and carer feedback is a key part of their quality monitoring frameworks.

5. SERVICE INTEGRATION

5.1 As we develop the new approach to outcomes based commissioning of health and social care for people over the age of 65 the focus on quality monitoring will be rooted much more in the outcomes that older people have identified matter to them. The new type of contract will incentivise the provider alliance to deliver the outcomes specified through a different style of service specification.

6 FINANCIAL AND RISK ASSESSMENT CONSIDERATIONS

6.1 There are no financial implications for the health and wellbeing board.

6.2 The implementation of quality improvements in part prompted by the Francis Report, such as with respect to establishing Safer Staffing levels for each inpatient ward, has resulted in additional expenditure across the NHS.

7. LEGAL CONSIDERATIONS

7.1 Legal advice has not been sought on the content of this report.

8. HUMAN RESOURCES IMPACT

8.1 There are no human resources impacts for the board, however partner organisations have experienced challenges in recruiting additional staff, which has been a significant implication across NHS providers.

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.

9.2 The equality analysis conducted by the Department of Health on *Hard Truths: the journey to putting patients first*, the government response to the Francis Report, states that:

> There is little evidence to show that the vulnerability faced by different groups actually leads to an increased risk of harm. However, there are particular groups who may be more vulnerable in a healthcare setting, and it is thought that vulnerability could well result in a less safe service being delivered to them. *(Hard Truths The Journey to Putting Patients First Equality Analysis p.4)*

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APPENDICES

The following papers from partner organisations are appended to this report.

1. Croydon Clinical Commissioning Group Francis Report Update. Sean Morgan, Interim Director of Quality Improvement and Governance, Croydon Clinical Commissioning Group
2. Croydon Health Services NHS Trust Francis Action Plan update. Michael Fanning, Director of Nursing, Croydon Health Services NHS Trust
3. South London and Maudsley NHS Foundation Trust: Francis Inquiry Report. Alison Beck, Head of Psychology and Psychotherapy; Neil Brimblecombe, Director of Nursing, South London and Maudsley NHS Foundation Trust

BACKGROUND DOCUMENTS

The report of the Mid Staffordshire NHS Foundation Trust Public Inquiry chaired by Robert Francis QC can be found at www.midstaffspublicinquiry.com/report

NHS
Croydon Clinical Commissioning Group

REPORT TO CROYDON CLINICAL COMMISSIONING GROUP
GOVERNING BODY MEETING IN PUBLIC

26 May 2015

Title of Paper: FRANCIS REPORT UPDATE

Lead Director	Sean Morgan, Interim Director of Quality and Governance
Report Author	Sean Morgan, Interim Director of Quality and Governance
Committees which have previously discussed/agreed the report.	CCG Senior Management Team - 19 May 2015 The Governing Body agreed the Francis Report action plan on 30 July 2013. The six-monthly review of the action plan was presented to the Quality Committee in February 2014
Committees that will be required to receive/approve the report	Croydon Health and Well-Being Board
Purpose of Report	For information and noting

Recommendation:

The CCG Governing Body is asked to:

- Note the update against each of the actions identified in July 2013 in response to the publication of the Francis Report following the events at Mid-Staffordshire NHS FT

Background:

The report of the full public inquiry into the failings at the Mid Staffordshire Foundation Trust was published on 6 February 2013. The inquiry, led by Robert Francis QC, looked at the role of commissioning, supervisory and regulatory bodies and why serious problems at the Trust were not identified and acted on sooner.

All NHS organisations considered the findings and the 290 recommendations, and Croydon CCG Governing Body agreed an action plan against those recommendations that related to CCGs, on 30 July 2013.

It was recognised in July 2013 that understanding the recommendations of the Francis report was not about creating a new work stream of CCG activity but was fundamentally about strengthening the CCG's quality assurance, systems and processes. The Francis action plan aimed to ensure that the recommendations are embedded in the mainstream activities of the CCG.

The Francis Report recommended that each organisation should report on progress with its action plan, at least annually. This report provides an update as at the close of the 2014/15 financial year.

Key Issues

The CCG action plan

The Francis Report recommendations relating to CCGs come under the following themes:

- Accountability for the implementation of the recommendations
- Putting the patient first
- A common culture made real throughout the system – an integrated hierarchy of standards of service
- Responsibility for, and effectiveness of, healthcare standards
- Effective complaints handling
- Commissioning for standards
- Local scrutiny
- Performance management and strategic oversight
- Openness, transparency and candour
- Caring for the elderly
- Information

The CCG has continued to work with providers, regulators and stakeholders including patients and the local public to progressively improve the safety and quality of services commissioned for Croydon residents. To this end the changes in practice envisaged by the Francis Report have been embedded in the approach the CCG takes to commissioning, including through the clinically-led quality monitoring of local services (including through the Clinical Quality Review Groups) and its governance via the Quality Committee and the Governing Body.

The key developments and issues under each theme are as follows:

Accountability for the implementation of the recommendations

One of the CCG's key objectives is '*to commission safe, high quality services in the right place, in the right time'.* This is a commitment to ensure high quality patient-centred care and that the issues identified by Robert Francis do not occur in Croydon. The CCG action plan was developed to address the recommendations of the report and built on the quality and safety agenda already identified within the CCG. Good progress has continued to be made across the action plan, since the last review in February 2014, as set out below.

Putting the patient first

The fundamental workstream at the heart of the CCG's development of a new Organisational Development Plan is to reconfirm the organisation's core values and the behaviours expected of all staff, which will include the core values expressed in the NHS Constitution. The Organisational Development Plan will have an implementation plan describing how these values will be incorporated within staff's individual and team objectives.

Fundamental standards of behaviour

There is one recommendation under this theme relating to the encouragement to staff to report incidents of concern, which relates primarily to provider staff, and the CCG continues to work with local providers to raise awareness of the importance of reporting incidents and concerns about patient safety, and is supportive of providers when incident reporting rates rise as a result. This objective is coordinated through the CQRGs.

A common culture made real throughout the system – an integrated hierarchy of standards of service

The CCG chooses local standards, including those incentivised through the CQUIN element of the standard NHS contract, to complement the national quality standards, e.g. there is a focus on improving the care of patients with dementia in 2014/15. There is an annual process of reviewing these local standards including input from the CCG's clinical leaders, prior to the next year's contracts being set.

Responsibility for, and effectiveness of, healthcare standards

These recommendations primarily relate to the enforcement of contractual requirements and to working with health care regulators. With respect to patient safety and quality the CCG adopts a rigorous approach to contract management to ensure that high standards are set and adhered to, and any contract penalties are implemented. The CCG works with NHS England and the regulators to share information of interest and soft intelligence on the quality of local services, including through the South London Quality Surveillance Group.

One of the main priorities at the present time is to improve the access times to emergency care, which are currently below the standards set. The CCG is also working to improve the accessibility of mental health services, both in terms of the range of services on offer and improving the waiting times for both assessment and treatment.

Effective complaints handling

The action plan update attached sets out how the Complaints Policy operates to ensure that complainants are supported in raising concerns, which are heard and addressed and that learning is identified and acted on. The CCG receives regular reports on complaints and PALS contacts and builds these into contract monitoring and to informing future commissioning decisions.

The CCG receives a complaints report from each provider which shows the trends by area and by topic and analyses the main themes raised, but the CCG does not receive individual complaints directed to providers. This is sufficient to give assurance on the quality of services commissioned and further detail can be requested of providers when required.

Commissioning for standards

There were 12 recommendations relating to CCGs responsibilities under this theme, and the update attached sets out the actions to take each of these forward. Fundamentally, the CCG is commissioning to improve the quality of care for the population of Croydon including through redesigning patient pathways (with 18 improved pathways now in place). There are comprehensive monitoring arrangements in place with the main local providers focused through the CQRGs.

An area where quality monitoring could be extended is in relation to nursing home care commissioned by the CCG, and this will be a focus for the future.

Local scrutiny

There is one recommendation under this theme for CCGs relating to the safe transfer of patients in the event of the immediate suspension of a service being necessary. Planning for such an eventuality will be reviewed to ensure that it is in line with current best practice.

Performance management and strategic oversight

The key quality metrics are identified and reported to CQRGs and to every meeting of the Quality Committee and the Governing Body. Information from providers is compared with information from other sources, including patient feedback and soft intelligence from regulators. The CCG quality lead now has a regular programme of visits to clinical areas and the feedback from these is reported to the Quality Committee. Through adherence to this framework the CCG is assured about the quality of local services, and where performance concerns arise that they are identified and appropriate action is initiated.

Openness, transparency and candour

Since the publication of the Francis Report and the CCG adoption of this action plan a new legal Duty of Candour has been established, and the approach to monitoring of compliance against this duty has been agreed with Croydon Health Services.

Caring for the elderly

The specific recommendations under this theme are primarily directed at providers. The CCG monitors the implementation of these actions, including through the provider quality reports at the CQRGs but also now through the programme of visits to clinical areas being undertaken by the Quality Lead.

Information

The information utilised in quality monitoring includes patient feedback, through the Friends and Family Test and also through complaints, compliments and PALS contacts. Risks relating to patient safety and quality are specifically reviewed at the Quality Committee. The committee also periodically considers whether it is satisfied with the presentation of information on quality, so that the data, analysis and accompanying narrative are providing the insight required to give assurance to the Governing Body.

This Report provides an update on the current status against each of the recommendations directly relevant to the CCG. The appendix shows that good progress has been made across all recommendations. An additional column has been added to the right of the action plan, with the March 2015 update.

Governance:

Corporate Objective	To commission integrated, safe, high quality service in the right place at the right time.
Risks	The risk register includes risks relating to patient safety and commissioning of high quality services.
Financial Implications	None
Conflicts of Interest	None
Clinical Leadership Comments	The action plan was presented to the Clinical Leaders on 20 July 2013.
Implications for Other CCGs	Croydon CCG works with the lead commissioner of non-local providers which provide assurance regarding the quality of care and the CCG provides assurance to associate commissioners of Croydon Health Services NHS Trust in fulfilling its responsibilities as lead commissioner
Equality Analysis	Equality of outcomes is a significant measure of service quality, and quality monitoring information needs to be continually refined to enable assurance against this objective.
Patient and Public Involvement	The action plan includes utilisation of patient and public feedback on service quality by both providers and commissioners as a core part of quality monitoring.
Communication Plan	The action plan is available on the website
Information Governance Issues	Information Governance is not a concern with respect to this report.
Reputational Issues	Failure to manage quality issues effectively would attract adverse attention from patients, the public and NHS England.

Appendix 1

Francis Report Recommendations: Actions for Croydon Clinical Commissioning Group

Note: Whilst not a regulatory body, the CCG can use the principles of some recommendations relating to regulatory bodies in its role as a commissioner. Therefore there are some actions against recommendations not directly for the CCG.

Rec	Theme	Recommendation	Recom. for CCG	Comments and Actions	Lead	March 2015 update
	Accountability for the implementation of the recommendations These recommendations require every single person serving patients to contribute to a safer, committed and compassionate and caring service.					
1	**Implementing the recommendations**	It is recommended that ▪ All commissioning, service provision regulatory and ancillary organisations in healthcare should consider the findings and recommendations of this report and decide how to apply them to their own work ▪ Each such organisation should announce at the earliest practicable time its decision on the extent to which it accepts the recommendations and what it intends to do to implement those accepted, and thereafter, on a regular basis but not less than once a year, publish in a report information regarding its progress in relation to its planned actions; ▪ In addition to taking such steps for itself, the Department of Health should collate information about the decisions and actions generally and publish on a regular basis but not less than once a year the progress reported by	✓	**Actions:** Review recommendations and publish statement beginning of August CCG to write to all providers for response to Francis Report and monitor progress through normal contractual routes. CCG to amend contracts where necessary during 2013/14 as result of commissioner and provider outcomes of review	Director of G&Q Quality Team Contracting Team	Actioned as business as usual, the Clinical Quality Review Groups (CQRGs) monitor progress periodically (e.g. Croydon Health Services report for 27/02/15 meeting)

Rec	Theme	Recommendation	Recom. for CCG	Comments and Actions	Lead	March 2015 update
		other organisations; ▪ The House of Commons Select Committee on Health should be invited to consider incorporating into its reviews of the performance of organisations accountable to Parliament a review of the decisions and actions they have taken with regard to the recommendations in this report				
2		The NHS and all who work for it must adopt and demonstrate a shared culture in which the patient is the priority in everything done. This requires: ▪ A common set of core values and standards shared throughout the system; ▪ Leadership at all levels from ward to the top of the Department of Health, committed to and capable of involving all staff with those values and standards; ▪ A system which recognises and applies the values of transparency, honesty and candour; ▪ Freely available, useful, reliable and full information on attainment of the values and standards; ▪ A tool or methodology such as a cultural barometer to measure the cultural health of all parts of the system.	✓	**Actions:** The CCG will implement the Francis report recommendations that directly relate to the CCG. It will work with partners and respond to any changes to the system as result of changes brought on by other partners as a result of these recommendations	Director of G&Q	Actioned, see below for further detail
	Putting the patient first The patients must be the first priority in all of what the NHS does. Within available resources, they must receive effective services from caring, compassionate and committed staff, working within a common culture, and they must be protected from avoidable harm and any deprivation of their basic rights.					

Rec	Theme	Recommendation	Recom. for CCG	Comments and Actions	Lead	March 2015 update
3	**Clarity of values and principles**	The NHS Constitution should be the first reference point for all NHS patients and staff and should set out the system's common values, as well as the respective rights, legitimate expectations and obligations of patients.	✓	Recruitment and contracts already evidence the essential requirement for staff to comply with the NHS Constitution, Professional, NHS Managers and Management Codes of Conduct. The NHS Constitution is also reflected in the CCGs Constitution	HR Team	Original action stands. The CCG is developing a new Organisational Development Plan which will reconfirm the organisation's core values and the behaviours expected of all staff
4		The core values expressed in the NHS Constitution should be given priority of place and the overriding value should be that patients are put first, and everything done by the NHS and everyone associated with it should be informed by this ethos.	✓			
5		In reaching out to patients, consideration should be given to including expectations in the NHS Constitution that: ▪ Staff put patients before themselves; ▪ They will do everything in their power to protect patients from avoidable harm; ▪ They will be honest and open with patients regardless of the consequences for themselves; ▪ Where they are unable to provide the assistance a patient needs, they will direct them where possible to those who can do so; ▪ They will apply the NHS values in all their work.	✓			
7		All NHS staff should be required to enter into an express commitment to abide by the NHS values and the Constitution, both of which should be incorporated into the contracts of employment.	✓			
	Fundamental standards of behaviour Enshrined in the NHS Constitution should be the commitment to fundamental standards which need to be applied by all those					

Rec	Theme	Recommendation	Recom. for CCG	Comments and Actions	Lead	March 2015 update
	who work and serve in the healthcare system. Behaviour at all levels needs to be in accordance with at least these fundamental standards					
12		Reporting of incidents of concern relevant to patient safety, compliance with fundamental standards or some higher requirement of the employer needs to be not only encouraged but insisted upon. Staff are entitled to receive feedback in relation to any report they make, including information about any action taken or reasons for not acting.	✓	The CCG welcomes feeding back to staff action taken or not. **Action** This will be formalised as part of the Serious Incident policy and the Complaints policy review.	Quality Team	The CCG works to the national guidance for the reporting and management of SIs
	A common culture made real throughout the system – an integrated hierarchy of standards of service No provider should provide, and there must be zero tolerance of, any service that does not comply with fundamental standards of service. Standards need to be formulated to promote the likelihood of the service being delivered safely and effectively, to be clear about what has to be done to comply, to be informed by an evidence base and to be effectively measurable.					
13	**The nature of standards**	Standards should be divided into: ▪ Fundamental standards of minimum safety and quality – in respect of which non-compliance should not be tolerated. Failures leading to death or serious harm should remain offences for which prosecutions can be brought against organisations. There should be a defined set of duties to maintain and operate an effective system to ensure compliance; ▪ Enhanced quality standards – such standards could set requirements higher than the fundamental standards but be discretionary matters for commissioning and subject to availability of resources;	✓	Fundamental standards are those defined by national standards. The CCG sets enhanced standards through CQUINs. **Action:** The CCG will work with providers and regulators to establish other enhanced and developmental standards.	Commissioning and Contracting teams	The CCG has an annual process of setting local enhanced standards for its main local providers, which are incentivised through the CQUIN contractual process.

Rec	Theme	Recommendation	Recom. for CCG	Comments and Actions	Lead	March 2015 update
		▪ Developmental standards which set out longer term goals for providers – these would focus on improvements in effectiveness and are more likely to be the focus of commissioners and progressive provider leadership than the regulator. All such standards would require regular review and modification.				
15		All the required elements of governance should be brought together into one comprehensive standard. This should require not only evidence of a working system but also a demonstration that it is being used to good effect.	✓	**Actions:** Whilst this requires a national response, locally the CCG will produce a schematic representation of the health and social care governance to ensure clarity for all local stakeholders	Quality Team	The Commissioning for Quality Improvement Framework describes the governance relating to quality and is in the process of being updated for 2015/16
17		The NHS Commissioning Board together with Clinical Commissioning Groups should devise enhanced quality standards designed to drive improvement in the health service. Failure to comply with such standards should be a matter for performance management by commissioners rather than the regulator, although the latter should be charged with enforcing the provision by	✓	The CCG sets enhanced standards through CQUINs. These are monitored through the formal contractual process	Commissioning and Contracting teams	Quality monitoring of both national standards and local enhanced standards is through the

Rec	Theme	Recommendation	Recom. for CCG	Comments and Actions	Lead	March 2015 update
		providers of accurate information about compliance to the public.				Clinical Quality Review Groups (CQRGs)
	Responsibility for, and effectiveness of, healthcare standards					
28		Zero tolerance: A service incapable of meeting fundamental standards should not be permitted to continue. Breach should result in regulatory consequences attributable to an organisation in the case of a system failure and to individual accountability where individual professionals are responsible. Where serious harm or death has resulted to a patient as a result of a breach of the fundamental standards, criminal liability should follow and failure to disclose breaches of these standards to the affected patient (or concerned relative) and a regulator should also attract regulatory consequences. Breaches not resulting in actual harm but which have exposed patients to a continuing risk of harm to which they would not otherwise have been exposed should also be regarded as unacceptable.	✓	**Actions:** Zero tolerance - The CCG will instigate its contractual levers and work with regulators as necessary.	Commissioning and Contracting teams	Performance management of providers against the contractual standards is ongoing. Contractual penalties are applied as set out. SIs are investigated and RCAs reviewed. SI themes are reviewed.
30	**Interim measures**	The healthcare regulator must be free to require or recommend immediate protective steps where there is reasonable cause to suspect a breach of fundamental standards, even if it has yet to reach a concluded view or acquire all the evidence. The test should be whether it has reasonable grounds	✓	**Actions:** The CCG will work to this principle and work with the regulatory as necessary.	Commissioning and Contracting teams	The CCG discusses provider performance with the NHS TDA, NHS

Rec	Theme	Recommendation	Recom. for CCG	Comments and Actions	Lead	March 2015 update
		in the public interest to make the interim requirement or recommendation.				England and the CQC
31		Where aware of concerns that patient safety is at risk, Monitor and all other regulators of healthcare providers must have in place policies which ensure that they constantly review whether the need to protect patients requires use of their own powers of intervention to inform a decision whether or not to intervene, taking account of, but not being bound by, the views or actions of other regulators.	✓	**Actions:** The CCG will develop a programme of review with all its providers	Quality team	Principal responsibility is with the regulators, the CCG works with them (e.g. through the South London Quality Surveillance Group)
32		Where patient safety is believed on reasonable grounds to be at risk, Monitor and any other regulator should be obliged to take whatever action within their powers is necessary to protect patient safety. Such action should include, where necessary, temporary measures to ensure such protection while any investigation required to make a final determination is undertaken.	✓	**Actions:** The CCG will work to this principle and work with the regulatory as necessary.	Director of G&Q Quality Team	As per 31 above.

Rec	Theme	Recommendation	Recom. for CCG	Comments and Actions	Lead	March 2015 update
35	**Need to share information between regulators**	Sharing of intelligence between regulators needs to go further than sharing of existing concerns identified as risks. It should extend to all intelligence which when pieced together with that possessed by partner organisations may raise the level of concern. Work should be done on a template of the sort of information each organisation would find helpful.	✓	**Actions:** The CCG will develop relationships with regulators to share data, information and intelligence.	Director of G&Q Commissioning and Contracting teams	As per 31 above.
42	▪ **Serious Untoward Incidents**	Strategic Health Authorities/their successors should, as a matter of routine, share information on serious untoward incidents with the Care Quality Commission.	✓	**Actions:** The CCG will work with the CQC to share SIs This will be formalised as part of the Serious Incident policy review.	Director of G&Q / Quality Team	Regulators are able to access SIs notified through the STEIS system
43	▪ **Media**	Those charged with oversight and regulatory roles in healthcare should monitor media reports about the organisations for which they have responsibility.	✓	The CCG currently monitors all media reports relating to Croydon	Communications Team	Action ongoing as business as usual
	Effective complaints handling Patients raising concerns about their care are entitled to: have the matter dealt with as a complaint unless they do not wish it; identification of their expectations; prompt and thorough processing; sensitive, responsive and accurate communication; effective and implemented learning; and proper and effective communication of the complaint to those responsible for providing the care.					
109		Methods of registering a comment or complaint must be readily accessible and easily understood. Multiple gateways need to be provided to patients, both during their treatment and after its conclusion, although all such methods should	✓	The CCG has a complaints and Patients Advice Liaison Service which supports patients to make a complaint in a number of ways.	Quality Team	The PALS service is still in place

Rec	Theme	Recommendation	Recom. for CCG	Comments and Actions	Lead	March 2015 update
		trigger a uniform process, generally led by the provider trust.		The CCG also has a number of methods to receive patient comment and feedback such s as the PALS Service and website The CCG establishing other engagement forums to promote discussion such as the quarterly patient forum. The CCG has also established the amber alert card for GPs to feedback issues. **Action:** Role out amber alert card to commissioning managers	Quality Team PPI Team Quality Team Quality Team	The Patient Forum is still meeting quarterly The GP amber alert system is still in place The amber alert system has been dedicated for GP practices. Commissioning managers raise concerns through line management processes
110	**Lowering barriers**	Actual or intended litigation should not be a barrier to the processing or investigation of a complaint at	✓	The CCG would not prevent the investigation of a		Section 6.11 of the

Rec	Theme	Recommendation	Recom. for CCG	Comments and Actions	Lead	March 2015 update
		any level. It may be prudent for parties in actual or potential litigation to agree to a stay of proceedings pending the outcome of the complaint, but the duties of the system to respond to complaints should be regarded as entirely separate from the considerations of litigation.		complaint due to potential litigation. **Action:** This will be formalised as part of the complaint policy review.	Quality Team	Complaints Policy makes it clear that the complaints procedure should not automatically be suspended or cease because a complainant is taking legal action. However, the Policy emphasises the need to ensure handling of the complaint does not prejudice any legal action.
112		Patient feedback which is not in the form of a complaint but which suggests cause for concern should be the subject of investigation and response of the same quality as a formal complaint, whether or not the informant has indicated a desire to have the matter dealt with as such.	✓	Where the CCG sees cause for concern through any route it would be formally investigated **Action:**	Quality and	The Policy provides for both informal complaints (concerns) and formal

Rec	Theme	Recommendation	Recom. for CCG	Comments and Actions	Lead	March 2015 update
				This will be formalised as part of the complaint policy and PPI strategy review	PPI teams	complaints to be investigated. Section 3.3 of the Policy which requires logging and processing of informal complaints and provision of a summary of the outcome to the Complaints Team for logging and closure. In the event that the complainant remains dissatisfied with the local resolution they have the right for the complaint to be handled through the

Rec	Theme	Recommendation	Recom. for CCG	Comments and Actions	Lead	March 2015 update
						formal route.
113	**Complaints handling**	The recommendations and standards suggested in the Patients Association's peer review into complaints at the Mid Staffordshire NHS Foundation Trust should be reviewed and implemented in the NHS.	✓	**Actions:** CCG to review	PPI Team	This is incorporated within the Complaints Policy
114		Comments or complaints which describe events amounting to an adverse or serious untoward incident should trigger an investigation.	✓	Where the CCG sees cause for concern through any route it would be formally investigated **Action:** This will be formalised as part of the SI policy review	Quality Team	Section 4.6 of the Complaints Policy covers Serious Incidents and Safeguarding issues. It requires that where a complaint leads to the identification of a serious incident (SI), the CCG's serious incident policy should be followed. The

Rec	Theme	Recommendation	Recom. for CCG	Comments and Actions	Lead	March 2015 update
						SECSU serious incident policy will apply. There is a also a process for escalation of GP Amber Quality Alerts
116	**Support for complainants**	Where meetings are held between complainants and trust representatives or investigators as part of the complaints process, advocates and advice should be readily available to all complainants who want those forms of support.	✓	**Actions:** Work with providers to ensure feedback surveys from complainants on complaint support.	Quality Team	Section 2.1 of the Complaints Policy highlights the role of the advocacy services in supporting complainants. All complainants are provided with a Complaints Guidance Sheet by the CSU Complaints Team at the acknowledgement stage.

Rec	Theme	Recommendation	Recom. for CCG	Comments and Actions	Lead	March 2015 update
						This explains the process, including access to advocacy services and provides the relevant contact details.
118	**Learning and information from complaints**	Subject to anonymisation, a summary of each upheld complaint relating to patient care, in terms agreed with the complainant, and the trust's response should be published on its website. In any case where the complainant or, if different, the patient, refuses to agree, or for some other reason publication of an upheld, clinically related complaint is not possible, the summary should be shared confidentially with the Commissioner and the Care Quality Commission.	✓	**Action:** This will be formalised as part of the complaints policy review	Quality Team	This is actioned by providers for complaints to them. The CCG policy is next due for review in December 2015 and this requirement will be formalised through the policy at that time.

Rec	Theme	Recommendation	Recom. for CCG	Comments and Actions	Lead	March 2015 update
120		Commissioners should require access to all complaints information as and when complaints are made, and should receive complaints and their outcomes on as near a real-time basis as possible. This means commissioners should be required by the NHS Commissioning Board to undertake the support and oversight role of GPs in this area, and be given the resources to do so.	✓	**Action:** The CCG will work with Trusts and NHS England as required to agree an appropriate mechanism to share complaints.	Director of G&Q / Quality Team	Providers submit a Complaints Report to the CCG setting out the trends and the significant issues and themes raised. The CCG does not expect to receive copies of individual complaints. NHS England continues to hold responsibility for handling complaints about GPs, and that information is not shared with CCGs

Rec	Theme	Recommendation	Recom. for CCG	Comments and Actions	Lead	March 2015 update
	Commissioning for standards					
123	**Responsibility for monitoring delivery of standards and quality**	GPs need to undertake a monitoring role on behalf of their patients who receive acute hospital and other specialist services. They should be an independent, professionally qualified check on the quality of service, in particular in relation to an assessment of outcomes. They need to have internal systems enabling them to be aware of patterns of concern, so that they do not merely treat each case on its individual merits. They have a responsibility to all their patients to keep themselves informed of the standard of service available at various providers in order to make patients' choice reality. A GP's duty to a patient does not end on referral to hospital, but is a continuing relationship. They will need to take this continuing partnership with their patients seriously if they are to be successful commissioners.	✓	The CCG has established an amber alert system for GPs to report concerns and issues about providers. The CCG is using this information to ensure individual concerns are address but also that theme can be identified and acted upon.	Quality Team	The GP amber alert system is still in place, and thematic reports are produced on a quarterly basis for review at the Quality Committee
124	**Duty to require and monitor delivery of fundamental standards**	The commissioner is entitled to and should, wherever it is possible to do so, apply a fundamental safety and quality standard in respect of each item of service it is commissioning. In relation to each such standard, it should agree a method of measuring compliance and redress for non-compliance. Commissioners should consider whether it would incentivise compliance by requiring redress for individual patients who have received sub- standard service to be offered by the provider. These must be consistent with	✓	Fundamental standards are those defined by national standards. The CCG sets enhanced standards through CQUINs. **Action:** The CCG will work with providers and regulators to establish other enhanced and	Commissioning and Contracting teams	All contracts contain schedules of standards and KPIs, and developmental standards are incentivised through the contractual CQUINs

Rec	Theme	Recommendation	Recom. for CCG	Comments and Actions	Lead	March 2015 update
		fundamental standards enforceable by the Care Quality Commission.		developmental standards. The CCG will develop a programme of review for the services it commissions	Quality Team	
125	**Responsibility for requiring and monitoring delivery of enhanced standards**	In addition to their duties with regard to the fundamental standards, commissioners should be enabled to promote improvement by requiring compliance with enhanced standards or development towards higher standards. They can incentivise such improvements either financially or by other means designed to enhance the reputation and standing of clinicians and the organisations for which they work.	✓			As per 124 above
126	**Preserving corporate memory**	The NHS Commissioning Board and local commissioners should develop and oversee a code of practice for managing organisational transitions, to ensure the information conveyed is both candid and comprehensive. This code should cover both transitions between commissioners, for example as new clinical commissioning groups are formed, and guidance for commissioners on what they should expect to see in any organisational transitions amongst their providers.	✓	A rigorous national and local transition process took place to ensure safe hand over of functions to new organisations post 1 April	Director of G&Q	This was actioned as part of the legacy process when the PCT functions were transferred to successor bodies, including the CCG
128	**Expert support**	Commissioners must have access to the wide range of experience and resources necessary to undertake a highly complex and technical task, including specialist clinical advice and procurement	✓	The CCG obtains its wide range of expertise from the South London Commissioning Support Unit. It as a	Director of Commissioning	Clinical advice is provided by the Clinical Leaders and

Rec	Theme	Recommendation	Recom. for CCG	Comments and Actions	Lead	March 2015 update
		expertise. When groups are too small to acquire such support, they should collaborate with others to do so.		contingency in case other expertise is required.		other Members, and clinical advice on quality monitoring is sourced from South East CSU. Expert procurement advice is sourced from SBS, via SECSU
129	**Ensuring assessment and enforcement of fundamental standards through contracts**	In selecting indicators and means of measuring compliance, the principal focus of commissioners should be on what is reasonably necessary to safeguard patients and to ensure that at least fundamental safety and quality standards are maintained. This requires close engagement with patients, past, present and potential, to ensure that their expectations and concerns are addressed.	✓	**Actions:** The CCG will identify the key indicators of safety	Quality Team	The CCG Quality Report includes a range of quality indicators including from the NHS Safety Thermometer, other published national data and data sourced from local providers.

Rec	Theme	Recommendation	Recom. for CCG	Comments and Actions	Lead	March 2015 update
130	**Relative position of commissioner and provider**	Commissioners – not providers – should decide what they want to be provided. They need to take into account what can be provided, and for that purpose will have to consult clinicians both from potential providers and elsewhere, and to be willing to receive proposals, but in the end it is the commissioner whose decision must prevail.	✓	The CCG fully supports this. The commissioning of high quality and safe services is one of its key objectives.	Director of G&Q	The CCG exercises its responsibility to commission safe, high quality services, based on assessments of local population need
131	**Development of alternative sources of provision**	Commissioners need, wherever possible, to identify and make available alternative sources of provision. This may mean that commissioning has to be undertaken on behalf of consortia of commissioning groups to provide the negotiating weight necessary to achieve a negotiating balance of power with providers.	✓	The CCG has collaborative agreements with other South West London CCGs to work together	Director of Commissioning	The South West London CCGs continue to work together through the Commissioning Collaborative
132	**Monitoring tools**	Commissioners must have the capacity to monitor the performance of every commissioning contract on a continuing basis during the contract period: ▪ Such monitoring may include requiring quality information generated by the provider. ▪ Commissioners must also have the capacity to undertake their own (or independent) audits, inspections, and investigations. These should, where appropriate, include investigation of	✓	**Action:** The CCG will develop a systematic approach to all its contracts, although the approach may vary from provider to provider depending on the size and risk of the service provider.	Commissioning and Contracting teams	The CCG leads contract monitoring with CHS as lead commissioner and leads a local CQRG with SLaM, as

Rec	Theme	Recommendation	Recom. for CCG	Comments and Actions	Lead	March 2015 update
		individual cases and reviews of groups of cases. ▪ The possession of accurate, relevant, and useable information from which the safety and quality of a service can be ascertained is the vital key to effective commissioning, as it is to effective regulation. ▪ Monitoring needs to embrace both compliance with the fundamental standards and with any enhanced standards adopted. In the case of the latter, they will be the only source of monitoring, leaving the healthcare regulator to focus on fundamental standards.				well as participating in the four-borough CQRG. Contract monitoring is consolidated into an Integrated Report which contains finance, activity, performance and quality sections for the other main acute providers. There is a separate monthly meeting to review the consolidated information on all integrated care contracts

Rec	Theme	Recommendation	Recom. for CCG	Comments and Actions	Lead	March 2015 update
133	**Role of commissioners in complaints**	Commissioners should be entitled to intervene in the management of an individual complaint on behalf of the patient where it appears to them it is not being dealt with satisfactorily, while respecting the principle that it is the provider who has primary responsibility to process and respond to complaints about its services.	✓	**Actions:** Work with providers to agree a process to intervene	Quality Team	The CCG would intervene on a patient's behalf if requested, whilst respecting the principle that the provider is primarily responsible
135	**Public accountability of commissioners and public engagement**	Commissioners should be accountable to their public for the scope and quality of services they commission. Acting on behalf of the public requires their full involvement and engagement: ▪ There should be a membership system whereby eligible members of the public can be involved in and contribute to the work of the commissioners. ▪ There should be lay members of the commissioner's board ▪ Commissioners should create and consult with patient forums and local representative groups. Individual members of the public (whether or not members) must have access to a consultative process so their views can be taken into account. ▪ There should be regular surveys of patients and the public more generally.	✓	The CCG is implementing its PPI strategy and establishing key forums for engagement, and ensuring patients are involved it there design of services. **Actions:** Review PPI plans against these recommendations	PPI Team	The Patient Involvement Reference Group supports the CCG to meet its legal duties to engage and involve patients, carers and the public. The PPI Forum meets quarterly, through which the public inputs to commissionin

Rec	Theme	Recommendation	Recom. for CCG	Comments and Actions	Lead	March 2015 update
		▪ Decision-making processes should be transparent: decision-making bodies should hold public meetings. Commissioners need to create and maintain a recognisable identity which becomes a familiar point of reference for the community.				g strategy development. All service redesign planning should incorporate public and patient engagement at each stage of the commissioning cycle, and the CCG is striving to embed this. A PPI Update Report is presented to the Governing Body quarterly
136		Commissioners need to be recognisable public bodies, visibly acting on behalf of the public they serve and with a sufficient infrastructure of technical support. Effective local commissioning can only work with effective local monitoring, and that cannot be done without knowledgeable and skilled local personnel engaging with an informed public.	✓			
137	**Intervention and sanctions for substandard or unsafe services**	Commissioners should have powers of intervention where substandard or unsafe services are being provided, including requiring the substitution of staff or other measures necessary to protect patients from the risk of harm. In the provision of the commissioned services, such powers should be aligned with similar powers of the regulators so that both commissioners and regulators can act	✓	The CCG will continue to use its current contractual levers to greatest effect to ensure quality and safe services	Commissioning and Contracting teams	The CCG uses the NHS standard contract to commission all services and utilises the contractual

Rec	Theme	Recommendation	Recom. for CCG	Comments and Actions	Lead	March 2015 update
		jointly, but with the proviso that either can act alone if the other declines to do so. The powers should include the ability to order a provider to stop provision of a service.				levers as required to secure improved quality
	Local scrutiny					
138		Commissioners should have contingency plans with regard to the protection of patients from harm, where it is found that they are at risk from substandard or unsafe services.	✓	The CCG develops a plan tailored to the service in question. **Action:** The CCG will develop a framework to ensure that the safe transfer of patients is achieved, should immediate suspension of a contract take place	Contracting team	A tailored plan would be put in place to manage this circumstance safely, in accordance with the best practice framework
	Performance management and strategic oversight					
139	**The need to put patients first at all times**	The first priority for any organisation charged with responsibility for performance management of a healthcare provider should be ensuring that fundamental patient safety and quality standards are being met. Such an organisation must require convincing evidence to be available before accepting that such standards are being complied with.	✓	**Actions:** The CCG will use national data sources and benchmarking to understand over all performance The CCG will use the contractual levers to understand and manage provider performance i.e.	Quality Team / BI Team Commissioning and Contracting teams	As well as using data from the local providers the CCG also reviews national data sources, and attends the South London

Rec	Theme	Recommendation	Recom. for CCG	Comments and Actions	Lead	March 2015 update
				unannounced visits		Quality Surveillance Group. The Quality lead regularly visits clinical areas at CHS
140	**Performance managers working constructively with regulators**	Where concerns are raised that such standards are not being complied with, a performance management organisation should share, wherever possible, all relevant information with the relevant regulator, including information about its judgement as to the safety of patients of the healthcare provider.	✓	**Actions:** The CCG will develop relationships with regulators to share data, information and intelligence.	Director of G&Q / Quality Team	The CCG liaises with regulators, including with the TDA, NHS England and the CQC. Judgements about quality and safety issues are shared at the South London Quality Surveillance Group
141	**Taking responsibility for quality**	Any differences of judgement as to immediate safety concerns between a performance manager and a regulator should be discussed between them and resolved where possible, but each should recognise its retained individual responsibility to take whatever action within its power is necessary in the interests of patient safety.	✓			
142	**Clear lines of responsibility supported by good information flows**	For an organisation to be effective in performance management there must exist unambiguous lines of referral and information flows, so that the performance manager is not in ignorance of the reality.	✓	The CCG has established a monitoring group to enable the sharing of information from a range of sources.	Director of G&Q / Quality Team	There is an established programme of both Quality and Performance Reports, to

Rec	Theme	Recommendation	Recom. for CCG	Comments and Actions	Lead	March 2015 update
						SMT, the Quality Committee and the Governing Body
143	**Clear metrics on quality**	Metrics need to be established which are relevant to the quality of care and patient safety across the service, to allow norms to be established so that outliers or progression to poor performance can be identified and accepted as needing to be fixed.	✓	The CCG is reviewing the indicators of safety	Director of G&Q / Quality Team	The relevance of metrics is reviewed through discussion at CQRGs, and also annually through the process of setting the information requirements for each contract
	Openness, transparency and candour Openness – enabling concerns and complaints to be raised freely without fear and questions asked to be answered. Transparency – allowing information about the truth about performance and outcomes to be shared with staff, patients, the public and regulators. Candour – any patient harmed by the provision of a healthcare service is informed of the fact and an appropriate remedy offered, regardless of whether a complaint has been made or a question asked about it.					
173	**Principles of openness, transparency and**	Every healthcare organisation and everyone working for them must be honest, open and truthful in all their dealings with patients and the public, and organisational and personal interests	✓	Recruitment and contracts already evidence the essential requirement for staff to comply with the NHS	HR Team	The Duty of Candour is now established as

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	candour	must never be allowed to outweigh the duty to be honest, open and truthful.		Constitution, Professional, NHS Managers and Management Codes of Conduct, which advocate openness and honesty.		a contractual requirement and monitoring arrangements on compliance have been established
180	**Candour about incidents**	Guidance and policies should be reviewed to ensure that they will lead to compliance with *Being Open*, the guidance published by the National Patient Safety Agency.	✓	**Actions:** To be included in the SI Policy as part of the policy review.	Quality Team	The CCG works with its providers, including through the CQRGs and the SI Panels to encourage increased reporting of incidents
	Caring for the elderly Approaches applicable to all patients but requiring special attention for the elderly					
236	**Identification of who is responsible for the patient**	Hospitals should review whether to reinstate the practice of identifying a senior clinician who is in charge of a patient's case, so that patients and their supporters are clear who is in overall charge of a patient's care.	✓	Review the Care for the Elderly recommendations against the clinical pathway redesign work.	Director of Commissioning	This is a contractual requirement, and compliance is monitored through the CHS Quality Report to the

Rec	Theme	Recommendation	Recom. for CCG	Comments and Actions	Lead	March 2015 update
						CQRG
237	**Teamwork**	There needs to be effective teamwork between all the different disciplines and services that together provide the collective care often required by an elderly patient; the contribution of cleaners, maintenance staff, and catering staff also needs to be recognised and valued.	✓			Quality monitoring includes the visits to clinical areas by the Quality Lead
238	**Communication with and about patients**	Regular interaction and engagement between nurses and patients and those close to them should be systematised through regular ward rounds: ▪ All staff need to be enabled to interact constructively, in a helpful and friendly fashion, with patients and visitors. ▪ Where possible, wards should have areas where more mobile patients and their visitors can meet in relative privacy and comfort without disturbing other patients. ▪ The NHS should develop a greater willingness to communicate by email with relatives. ▪ The currently common practice of summary discharge letters followed up some time later with more substantive ones should be reconsidered. ▪ Information about an older patient's condition, progress and care and discharge	✓			CHS has a system of Executive patient safety walk rounds and of nursing quality rounds, to check quality issues such as whether their pain is well managed. Patients are asked a set of questions at the nursing quality rounds.

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		plans should be available and shared with that patient and, where appropriate, those close to them, who must be included in the therapeutic partnership to which all patients, are entitled.				Monitoring is also through tracking complaints themes
	Information					
252	**Access to data**	It is important that the appropriate steps are taken to enable properly anonymised data to be used for managerial and regulatory purposes.	✓	The is following the national Caldicott Review 2 guidance and reviewing its commissioning activities to ensure compliance	Information Governance Team	The NHS Number is the standard identifier, which is reinforced in all contracts
253	**Access to quality and risk profile**	The information behind the quality and risk profile – as well as the ratings and methodology – should be placed in the public domain, as far as is consistent with maintaining any legitimate confidentiality of such information, together with appropriate explanations to enable the public to understand the limitations of this tool.	✓	**Actions:** The CCG will to review how it present information in the public domain	Quality Team / BI Team	The Governing Body assurance framework includes risks relating to patient safety and quality and is presented to the meetings in public, and is accessible on the CCG website

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255	**Using patient feedback**	Results and analysis of patient feedback including qualitative information need to be made available to all stakeholders in as near "real time" as possible, even if later adjustments have to be made.	✓	**Actions:** The CCG will review how to enable this	Communications and PPI Team	Analysis of the data from the Friends and Family Test is included within all Quality Reports, by the CCG and by local providers. CHS adopts a visible 'you said; we did' feedback approach on the wards. Feedback in the form of complaints, compliments and PALS enquiries is presented in a separate report

Croydon Health Services NHS
NHS Trust

REPORT TO THE CLINICAL QUALITY REVIEW GROUP

Date: 29th May 2015	**Agenda No:**
Date Paper produced: **27th May 2015**	**Paper Title: Francis Action Plan update**
Sponsoring Director (responsible for signing off report):	**Michael Fanning Director of Nursing**
Author:	**Moya Berry Head of Compliance & Regulation**
Purpose/Decision required:	Note the progress made against the Francis Report recommendations
Impact on Patient Experience:	The actions all relate and have an impact on the patient experience
Impact on Financial Improvement	Not applicable
History: (which groups have previously considered this report)	None

Executive Summary

Background

In July 2013 an action plan was presented to the Trust Board detailing the actions against existing programmes of work and new reviews to be undertaken in response to the Francis Report. A further update on the progress of this work was presented to the Quality & Clinical Governance Committee in April 2014.

The Quality Improvement Plan

Following the Care Quality Commission (CQC) Inspection in 2013 a Trust wide Quality Improvement Plan was developed to address all the recommendations from the CQC inspection. The Quality Improvement Plan (QIP) which is an overarching Trust wide document not only includes the recommendations and compliance actions from the CQC inspection in September 2013 but also includes outstanding actions from previous inspection reports, the Francis report into Mid Staffs, the Government's response to Francis and the Clwyd/Hart report into complaints handling.

The majority of QIP milestones have now been delivered or are on track within agreed timescales and the remit of the QIP has been expanded to become the Quality, Experience and Safety Programme (QESP).

QESP sets out to drive continued improvements in quality, safety and patient experience by embedding best practice throughout the Trust.

Update on Progress against the Francis Recommendations

In reviewing the 28 Francis recommendations within the Quality Improvement Plan, it is clear that the Trust has made significant progress in addressing actions

- 24 actions have been closed with continuing work on-going
- 3 actions are in progress for completion

These are

- Re-launch of the Mortality Review Framework

- Inpatient Global Trigger tool
- Audit of all patient information leaflets

Freedom to Speak Up Report

The Freedom to Speak Up report was published in February 2015 following a review undertaken by Robert Francis in response to concerns about the way in which the NHS deals with concerns raised by NHS staff and the treatment of those who have spoken up.

In response to this report, the Trust presented a paper to the Trust Board in March 2015. The Director of HR&OD has established a Whistleblowing task and finish group made up of representatives from across the organisation to review the recommendations. This group had its first meeting on the 8th April and has undertaken a gap analysis and will develop an action plan to be approved by the Trust Board and made public on the Trust's website. This work will be led by the Director of HR and OD, supported by the Director of Nursing and the Medical Director. The work will include a conducting a 'big conversation ' with staff and trade union representatives on how to ensure that staff feel able to raise their concerns.

Key Issues for discussion	Note the progress made against the Francis Report recommendations

Related Corporate Objective:

Corporate Objectives: Links to corporate objectives to improve quality and manage resources.

Related CQC 5 Key Areas of Care:	☐ **Safe** ☐ **Effective** ☐ **Responsive** ☐ **Caring** ☐ **Well-Led**

Has an equality impact assessment form been completed? No

If not applicable, Please state why not applicable. There is no one group or individual affected by this paper

Has legal advice been taken? No

Does this report have any financial implication? No

If so, has the report been approved by the Financial Department?

Reference Number	Recommendation	Update	RAG
Fr/2013/3b Being open	Deliver a programme of 'Being open ' Training to all front line staff	Training programme rolled out to key staff groups, (matrons, ward managers & medical staff) as part of Serious Incident training, junior doctor induction and Trust induction. Staff awareness raised through Trust Focus and What's New. Duty of candour has superseded being open. Policy has been reviewed and updated and is now called 'Duty of Candour – Being Open'. Staff Duty of Candour leaflet has been approved at Patient Safety and Mortality Committee and the Nursing & Midwifery Board. Duty of Candour leaflet distributed to all staff with Payslips in May 2015. Gap analysis on the new regulations and Trust compliance with duty of candour which is monitored through the Patient Safety & Mortality meeting and the Quality and Clinical Governance Committee. Work to include Duty of candour within the Whistle blowing Policy is being included as part of the policy's update. Duty of Candour is included in Trust induction, junior doctors induction and nursing induction and training sessions for existing staff will need to be set up but duty of Candour is included within the Quality Reviews and the QESP programme of work. Business Case for a 'Duty of Candour' lead has been approved and recruitment has commenced. Duty of Candour meetings are monitored weekly at the Executive Review Group.	**Action Complete**
Fr/2013/13a Recruitment	Implement the workforce recruitment and retention strategy that includes compassion testing as part of the interview and selection process	The Workforce Recruitment & Retention strategy has been reviewed and is current. Further review is underway with the appointment of a new Head of Resourcing looking at 'values based' recruitment. Additional work to support the strategy will include a retention and recruitment QIPP for 2015/16. Retention rates are monitored monthly at directorate and Trust Board level In order to support the on-going recruitment and retention strategy the following initiatives has been undertaken	**Action complete and on-going**

		• Review of staffing levels on all wards based on Safer Nursing Care tool kit • Recruitment action plan developed and implemented • Employment process for staff recruitment completed as part of the 60:40 recruitment programme for the elderly care wards and 70/30 for other ward areas and an additional 160 nurses have been recruited • LIA sponsor group established to respond to the challenges of recruitment and retention in front line teams • Rolling recruitment programme with a dedicated nursing post to oversee recruitment • Elderly care wards have had an uplift of 40 HCA's and there have been 4 additional band 6 posts and 1 neurology specialist nurse put in place. • Retention and recruitment task force established • Nurse recruitment advertising campaign and the use of social media • Additional resources to support recruitment and retention- which includes a full colour brochure about Croydon nursing to be used at recruitment fairs and a prospectus that details development opportunities for nurses	
Fr/2013/14a Staff survey	Deliver LiA programme as the Trust vehicle for embedding a systematic and sustainable way of engaging and empowering staff around all major challenges	13 Wave 3 LiA work streams were ratified by the Trust Board in April 2014 and on 3rd December 2014 were able to present their achievements at the LiA 'Pass It On Event' to the Executive Team, senior managers and staff from across the Trust On 19th November 2014, the Trust invited back more than 100 members of the Croydon Community who had attended Big LiA Listening Events held in January 2014 to hear directly from staff some of the progress which is being made in the Trust. The Trust is continuing to lead in partnership with our patients, staff and stakeholders and two further listening events took place with our patients and stakeholders in March 2015, to hear from their perspective their views about where the organisation should focus its attention next. The overall increase in staff satisfaction and staff engagement with their work since the introduction of LIA in September 2012 is demonstrated by the most recent results of the LiA Pulse Check Survey in December 2014 and the National Staff Survey Results 2014 published in February 2015. On 16th March 2015, Croydon Health	**Action complete**

		Services became the first NHS Trust in the country to be awarded the Listening into Action Kite-Mark for its commitment to the engagement and empowerment of its staff. The announcement of the accreditation for 2015 is in recognition of the significant and sustained progress in how staff feels working at the Trust and the positive impact this has had on the quality and safety of care in South West London. In March the Trust held listening events with our patients and stakeholders to hear what we should focus on in 2015 and will then meet with staff to find out where they think the LiA can make the biggest difference this year. The LiA 'Let's do it' initiative has been set up to help staff improve the safety patient experience agenda. Duppas ward fully embraced the opportunity to improve both the patients' experience and the staff securing funds to purchase equipment items such as backed ward chairs, collapsible wheelchairs and night lights in the bays to enable staff to remain at the bedside when completing paperwork at night. In addition the infection control team have organised an Infection prevention and control stand for World Hygiene day, the clinical neurophysiology team have improved their clinic environment and created an updated information leaflet about their service, the Croydon falls team have updated their leaflet for patients and carers and have trained to rum more staff	
Fr/2013/19a Dementia Training	Implement the Trust training plan	Training has been delivered to 100% of staff who attend induction. A dementia training package has been developed and implemented. Training sessions rolled out for all acute and community staff throughout 2014. Training continues to be given to all staff at induction and specialist training is provided i.e. all security staff have completed their dementia training. Staff are also trained in the use of the Forget-me-not scheme The Forget-Me-Not scheme uses discrete flower symbols above a patient's bed to indicate to staff that they have dementia or confusion. When staff see this symbol they will be able to make sure that the patient is fully supported to manage their dementia or confusion during their admission, given extra help where necessary and that their care is explained to them in a way that they can understand. The scheme is automatically given to all people with a diagnosis of dementia or who are assessed by staff to be suffering	**Action complete**

		confusion.	
Fr/2013/16a Supervisory shifts	Implement inpatient supervisory shift workforce plan to achieve supervisory ward leaders with time devoted to supervision	Implementation completed - Paper on Supervisory Role was presented to Nursing & Midwifery Board in July 2014. Review carried out in June 2014 showed that ward managers are having 1-2 supervisory shifts per week. The numbers of band 6 staff on the elderly care wards has increased to ensure there are 2 band 6's and 1 band 7 on each ward and these help to provide additional support for supervisory shifts.	**Action complete**
Fr/2013/2a Patient information	Health information group to develop a work plan to support the delivery of high quality, reliable and trustworthy information to patients as an integrated part of their care.	There is well functioning patient information leaflets group which includes patient representatives. The group reviews and ratifies patient information which is published on the intranet. Further work is required to audit existing information on the wards and departments.	**Action on going**
Fr/2013/10a Patient and Public Engagement	To continue to work collaboratively with Healthwatch to improve patient experience	Patient and Public Voice (PPV) strategy approved in Sept 2014 and has been updated in April 2015 to include links with stakeholders and information about LiA. The Patient and Public Voice strategy is due for ratification at the Trust Board in June 2015. The Improving Patient Experience Committee (IPEC) which includes representation from Healthwatch and other patient group representatives monitors the implementation of the strategy. IPEC leads on the delivery of the PPV strategy on behalf of the Trust and partners. There is wider input from the public across the Trust and a mapping exercise will be undertaken in 2015 to identify this. The oversight of the governance of PPV representatives in the Trust is through the Improving Patient Experience Committee, which receives a report annually on PPV representation. The strategy will provide guidance on which internal Trust groups and committees will benefit from membership of patients and the public, to support and inform a patient perspective on core issues of patient experience. In addition work on patient discharge in collaboration with Healthwatch is due to start in June 2015.	**Action complete**
Fr/2013/11a Hourly Rounds	Carry out hourly rounds to support safer care and help to reduce the 4 harms	Hourly Rounds continue across the wards and each month the matrons undertake an audit of compliance by speaking with patients. Compliance with the Hourly Rounds are monitored through the matron's Quality Rounds and the nursing scorecard. Two Hourly Rounds commenced in April 2015 in the A/E Observational ward. The new Matron's Quality rounds were re-launched in March 2015. In April eighteen	**Action complete**

		wards were reviewed and feedback is collated and reported monthly on key findings.	
Fr/2013/3a Being Open Policy	Review the Trust Being open policy to ensure it is aligned to the new requirements of the NHS standard contract implemented in April 2013	The Being Open policy has been reviewed and updated and was ratified at the Risk Assurance & Policy Group in January 2014 and launched through the Trust's What new and at Trust Focus. The policy has now been by the 'Duty of Candour – Being Open'. A gap analysis on the new regulations and Trust compliance with duty of candour is monitored through the Patient Safety & Mortality meeting and the Quality and Clinical Governance Committee. The Freedom to Speak Up report was published in February 2015 following a review undertaken by Robert Francis in response to concerns about the way in which the NHS deals with concerns raised by NHS staff and the treatment of those who have spoken up. In response to this report, the Trust presented a paper to the Trust Board in March 2015. The Director of HR&OD has established a Whistleblowing task and finish group made up of representatives from across the organisation to review the recommendations. This group had its first meeting on the 8th April and has undertaken a gap analysis and will develop an action plan to be approved by the Trust Board and made public on the Trust's website. This work will be led by the Director of HR and OD, supported by the Director of Nursing and the Medical Director. The work will include a conducting a 'big conversation ' with staff and trade union representatives on how to ensure that staff feel able to raise their concerns.	**Action complete**
Fr/2013/3c Coroner Requests	To review the support provided to the provision of information in support of coroners requests	Substantive Trust Solicitor and Coroners Liaison Officer in post. Coroner's cases and key learning points are monitored weekly at the Executive Review Group.	**Action complete**
Fr/2013/4d Monitor Patient Experience	The Trust will continue to monitor the patient experience action plan as part of the work schedule for the Improving patient Experience Committee.	The patient experience action plan for 2014/15 which is part of the Quality Improvement Programme is monitored quarterly by the Improving Patient Experience Committee. The action plan will be updated and following the publication of the results of the national inpatient survey in May 2015.	**Action complete**

Fr/2013/12a TACS	Implement Adult Care Services (TACS)	TACS has been implemented from 2013-RRT is up and running and referrals are increasing with 150 people seen per month. 96% of patients seen within 2 hours of referral within their own home. Intermediate beds increased to 12. SPA in place with dedicated clinician to support administration staff. Enhanced case management – community matrons working with GPs to prevent patients being admitted with hospital. Two community gertriacians support the whole TACs service.	**Action complete**
Fr/2013/1a Serious Incident protocols	Review incident protocols to ensure they are compliant with best practice	Incident policy has been reviewed and updated. The policy was ratified at the Risk Assurance & Policy Group March 2014. The serious incident policy and the Incident & Investigation Policy are currently being updated in line with the new NHS England Serious Incident Framework and will be presented at the Patient Safety & Mortality Committee on the 21st May. Serious incidents are monitored weekly at the Executive Review Group.	**Action complete**
Fr/2013/1b Quality Report Framework	Establish a Quality Reporting Framework to analyse quality data and softer intelligence including patient feedback	The Quality Report is produced every two months and is presented at Quality & Clinical Governance Committee and Trust Board. The report provides information on quality under the 5 heading of Safety, Effective Caring, Well led, and Responsive.	**Action complete**
Fr/2013/4a Harm Free Care	To continue participation in the 'Harm free Care ' Initiative	The 14/15 CQUIN has been achieved reducing pressure ulcers across the whole health and social care economy. On-going wok to reduce pressure ulcers as part of an LiA project with all care providers including CQC, nursing homes, carers , safeguarding, Croydon council to standardise processes and documentation. 2014/15 pressure ulcer incidents have reduced by 55% Harm free care is higher than the national average at 96% Falls committee continues to monitor falls monthly with monthly reporting to the Nursing and Midwifery Board Quality Report presented to Trust Board every 2 months provides an update to the Board on 'Harm free' care. For March & April 2015 the overall trends in 'Harm free' care for CHS shows that the Trust has outperformed the delivery of harm free care compared to all other NHS	**Action complete**

		organisations, has performed well against the national benchmark for 'All pressure ulcers' and has seen a reduction in the prevalence of falls.	
Fr/2013/4b Inpatient Global Trigger Tool	To re-launch the inpatient Global trigger tool	Every inpatient cardiac arrest is reviewed using the UK version of the global trigger tool. The Mortality Framework is being developed and a Mortality Operational Group is being established led by the Mortality lead for the Trust. The Trigger tool will be incorporated into the framework. The screening tool has now been developed on Datix and is being rolled out in June 2015. A new post for a mortality reviewer is being developed and is to be funded from the CQUIN.	**Action on-going**
Fr/2013/4c Mortality Review Framework	Continue to implement and strengthen the Mortality Review Framework across all inpatient services	Mortality Framework reviewed and updated. Further work is being undertaken to include the requirements for the 2015/16 CQUIN. The screening tool has now been developed on Datix and is being rolled out in June 2015. A new post for a mortality reviewer is being developed and is to be funded from the CQUIN.	**Action on-going**
Fr/2013/5a National Portal	The Trust will fully support information to the National Portal	SUS submissions are a statutory requirement and as such all submissions are complete and in accordance with the submission timetable. The Trust Board receives a monthly report.	**Action complete**
Fr/2013/6a To use and respond to the NRLS report	6 monthly reports to the Patient Safety Committee	NRLS is reported quarterly to the Patient Safety & Mortality Committee. On-going monitoring of the data continues.	**Action complete**
Fr/2013/7a Quality Accounts	Production of the Quality Accounts	Quality Accounts completed for 2013/14. The quality accounts for 2015/16 have been completed and will be published on the 30th June 2015. The Quality Accounts are currently out for consultation with our key external stakeholders.	**Action complete**
Fr/2013/8a National Outcome data	Participation in the national audit programmes and the publication of data surgeon level reporting data where applicable	The Trust participates in all national audits as required and reports presented to Quality & Clinical Governance committee and the Trust has participated in all National Audits as part of the Quality Accounts.	**Action complete**
Fr/2013/11b Consent	Audit of consent and treatment on annual basis	Audit included in the 2014/15 audit plan and was completed in July 2014. The Audit is next due to be undertaken in July 2016. A project group is looking at how consent can be incorporated into the electronic patient record.	**Action complete**

Fr/2013/11c	To implement the Infection control action plan for 2014	24 out of the 25 actions have been implemented with the exception of consistently meeting the 2 hour standard to isolate patients with infection risk. The Infection Control Committee monitors compliance with the action plan with monthly infection control reports presented at the Quality & Clinical Governance committee and Trust Board.	**Action complete**
Fr/2013/11d WHO checklist	To monitor compliance with use of the surgical safety checklist	On-going audit continues and reported to Quality and Clinical Governance and Trust Board 2015 as part of the Clinical Audit Committee summary.	**Action complete**
Fr/2013/15a 6 C's	To implement compassion in practice 6C's	Gap analysis undertaken and presented to the Nursing & Midwifery Board in March 2014 with further 6 monthly reports. The 6 C's are embedded within the matron quality rounds and the Quality Reviews undertaken as part of the Quality Experience and Safety programme led by the Director of Nursing.	**Action complete**
Fr/2013/17a ACE	To develop the ACE service	ACE team established and commenced in-reaching into ED from February 2014. The Acute Care of the Elderly (ACE) Service assesses people aged 80 years and older who need to be seen urgently, to help improve their health and well-being. Clinics are run Monday to Friday where elderly patients >80 on the Observation Ward are reviewed by an elderly care consultant to identify patients with confusion. Mobile phone access is available to GPs for any concerns relating to patients >75. There is a Monday to Friday 'Hot Clinic' for GPs to send any patients that they have concerns about and where patients can have investigations such as x-ray, bloods and ECGs carried out.	**Action complete**
Fr/2013/20a Trust Board Governance Review	To implement the recommendation of the Trust Board Governance review in 2013	The non- executive director appointments to correct establishment have been made and are in place. Committee secretary in place and Clinical Governance review conducted. An options paper was presented to the Executive Management Board and Trust Board in April 2015. A revised governance review is in the process of being consulted on to ensure the long term success of governance within the organisation	**Action complete**
Fr/2013/20b Board analysis	To develop a Board analysis and plan will be developed and implemented	Board development programme commenced in December 2013 and is on-going.	**Action complete**

South London and Maudsley NHS
NHS Foundation Trust

TRUST BOARD OF DIRECTORS

SUMMARY REPORT

Date of Board meeting:	24 March 2015
Name of Report:	Francis Inquiry Report
Author:	Alison Beck, Head of Psychology and Psychotherapy
Approved by:	Matthew Patrick, Chief Executive
Presented by:	Neil Brimblecombe, Director of Nursing & Alison Beck, Head of Psychology and Psychotherapy

Purpose of the report:

To inform the Board about the main findings from the Francis reports dated 2010, 2013 and 2015. To explore the evidence which lies behind these findings. To consider the action implications for the Board.

Action required:

The Trust Board is asked to review the paper and consider 1) any further requirements for knowledge or exploration, 2) implications for Board, 3) appointment of Speak up Guardian to champion staff concerns.

Recommendations to the Board:

Agree a review period and a method to monitor progress.

Relationship with the Assurance Framework (Risks, Controls and Assurance):

This paper contributes understanding the risks associated with not providing compassionate care.

Summary of Financial and Legal Implications:

The Trust is encouraged to identify Speak up Guardian and may want to adopt other approaches to ensure compassionate care.

Equality & Diversity and Public & Patient Involvement Implications:

The risks associated with inequalities are discussed and importance of a diverse workforce highlighted.

Service Quality Implications:

The Board need to be aware of the importance of this report when weighing the pressures of achieving financial efficiency and people focused care.

CONTENTS OF REPORT

1. EXECUTIVE SUMMARY

Robert Francis's report into the failings at the Mid Staffordshire Foundation Trust was published in 2010. It has been followed by further Inquiries and a series of Reviews which altogether require a change of culture in the NHS.

It is argued there has been a disproportionate emphasis on regulatory compliance and financial management, at the expense of high quality, patient-centred care, provided with safety and compassion. There is now general recognition that regulation cannot tackle poor quality alone. Good care requires a compassionate workforce, dedicated to the care and welfare of the people it serves, supported by professional attitudes that prioritise the primacy of the patient and those receiving care, managed by people who see good governance as an essential to be embedded in everything it does.

The responsibility for leading the culture change remains with Trust Boards and now the consequences of failures such as those at Mid-Staffs are greater for a Board and its members than any failure to meet specified targets.

The leadership required of Trust Boards is one which will support a compassionate workforce to put patients and the quality of care they receive at the centre of healthcare.

This paper summarises the Francis Inquiries and subsequent Reviews and the Trust response. It reviews the literature behind the key findings the purpose of which is to inform the Board.

The Francis Reviews support visible, effective Board leadership which prioritises cultural change to ensure compassionate and safe patient care. This will involve supporting reflective practices at all levels of the organization. It will not promote a culture of hierarchy.

This paper recommends better ways of listening to patients and staff in order to gain a granular understanding of where there are problems in the Trust as well as areas where 'we are getting it right'. Appointing a 'Speak up Guardian' to champion staff concerns will assist. A 'You said-We did' communications approach would engage staff and patients and build organizational learning. Trust-wide planning is necessary to address the concerns highlighted, for example, in the Staff Survey and to support staff more widely as well as to implement Francis' recommendation for zero tolerance for bullying.

2. INTRODUCTION

The Inquiries led by Sir Robert Francis and subsequent Reviews represent a line in the sand for a change of culture in the NHS in order to put patients and the quality of care they receive at the centre of healthcare. This paper will briefly overview the key findings of the Francis Inquiries and associated Reviews. The Board is invited to consider the implications of this work for SLaM going forward in terms of culture change.

The Kings Fund (2013) summarises the leadership requirement of Trust Boards in order to change NHS culture. This involves setting the tone for 'the way we do things around here' in their behaviour which is kind, available, empathic, fair, respectful, compassionate and empowering. Staff who feel valued and are treated well by their organisation will usually reflect this in how they treat their patients.

The Kings Fund (2013) suggests that Boards should understand the patient experience by talking to patients directly and the patient experience should be on the agenda of every Board meeting (Steward 2012), with significant time devoted to these discussions, preferably early in the meeting rather than towards the end (Ramsay and Fulop 2010).

Also strongly encouraged is that Boards actively listen. If the Board is to fulfil its core business, clinical staff and each and every member of the Board must feel comfortable about 'bringing bad news' and it might be necessary for specific arrangements to be in place for staff to bring issues of concern to the attention of the Board. Boards must also be prepared to change organisational systems that hinder high quality care, whether physical infrastructure, unnecessary bureaucracy, IT etc. Often, staff cannot initiate the necessary changes independently and need help to do so. This reinforces the message that the Board is actively listening to staff and working hard to address problems around quality.

3. THE FRANCIS INQUIRIES AND ASSOCIATED REVIEWS – SUMMARY OF FINDINGS

The **first inquiry report by Sir Robert Francis into care at Mid Staffs (published in February 2010)** identified that there had been too great a focus on processes at the expense of outcomes; and on assurance, statistics and reports at the expense of information from patient and staff experience. There was a lack of basic care across a number of areas; low morale amongst staff; lack of openness and a resignation to poor standards. Management thinking was dominated by financial pressures (and achieving FT status) to the detriment of quality of care.

The **second Francis Inquiry (February 2013)** signalled the need for significant culture change in the NHS. The Inquiry examined the involvement of numerous agencies involved with the events at Mid Staffs during 2005-2009 and the 290 recommendations were clustered into 5 key areas reflecting a common culture across the NHS that puts patients first. A culture which:

- supports compassionate care;
- is open and transparent;
- has accurate, useful and relevant information;
- is compliant with fundamental standards;
- has strong and patient centred leadership.

Six independent Reviews were also commissioned to consider key issues: 1) Review into the Quality of Care and Treatment provided by 14 Hospital Trusts in England, led by Bruce Keogh. 2) The Cavendish Review: An Independent Review into Healthcare Assistants and Support Workers in the NHS and Social Care Settings, by Camilla Cavendish. 3) A Promise to Learn – A Commitment to Act: Improving the Safety of Patients in England, by Don Berwick. 4) A Review of the NHS Hospitals Complaints System: Putting Patients Back in the Picture by Ann Clwyd and Professor Tricia Hart. 5) Challenging Bureaucracy, led by the NHS Confederation. 6) The report by the Children and Young People's Health Outcomes Forum by Ian Lewis and Christine Lenehan.

The Government's initial response, **Patients First and Foremost**, set out a plan to prioritise care, improve transparency and ensure that where poor care is detected, there is clear action and clear accountability. The changes included a new set of fundamental standards for Care Quality Commission inspections – principles of safe, effective and compassionate care must underpin all care – and enabled the prosecution of providers in serious cases where patients have been harmed.

Hard Truths: The Journey to Putting Patients First January 2014 focused on changing culture preventing and detecting problems quickly. Among the changes, monthly reporting of ward staffing levels was introduced.

From **April 2014** all NHS Trusts were required to implement the **Friends and Family Test** (FFT). Don Berwick, in his Safety Review following the Francis Inquiry, said the NHS should be 'engaging, empowering and hearing patients and their carers all the time'. The FFT seeks to capture important information about quality of patient care by listening to staff.

In **November 2014** CQC brought two regulations for NHS bodies into force: 1) **The Fit and Proper Persons requirement (FPPR)** and 2) The Duty of Candour. The FPPR regulates the quality of Board level Trust appointments to ensure they are fit to perform their role. The CQC can remove a director where a breach is identified. During the inspection process CQC will ask: How does the leadership and culture reflect the vision and values, encourage openness and transparency and promote good quality care?

The introduction of the **Duty of Candour** arises from a recommendation in the original Francis Inquiry. It encompasses three concepts: 1) openness – enabling concerns and complaints to be raised freely and without fear; 2) transparency – sharing true information about performance and outcomes; 3) candour – informing any patient harmed by a healthcare provider and offering an appropriate remedy, regardless of whether they complain. Under the regulation the person harmed must be informed face to face as soon as reasonably practicable.

On **February 11th 2015 Sir Robert Francis published the "Freedom to Speak up – A Review of Whistleblowing in the NHS"** which highlighted the "lack of awareness by NHS leadership of the existence or scale of problems known to the frontline. In many cases staff felt unable to speak up, or were not listened to when they did. The 2013 NHS staff survey showed that only 72% of respondents were confident that it is safe to raise a concern".

In the 2014 Staff Survey the national average for mental health trusts in percentage of staff agreeing they would feel secure raising concerns about unsafe clinical practice was 69% and SLaM was 73% (with variation across CAGs 63% to 77%).

The Review requires NHS bodies to encourage openness and transparency in handling concerns. It **prioritises cultural change to improve patient safety, ensure concerns are raised, ensure freedom from bullying, value staff and promote reflective practice**. The mechanism for culture change is **effective and visible leadership** which will instil teamwork and reflective practices and not promote a culture of hierarchy.

The Review recommends the appointment of "Freedom to Speak up Guardians" who will be independent and impartial, have the authority to speak to anyone within or outside the trust, be an expert in all aspects of raising and handling concerns, have the tenacity to ensure safety issues are addressed and have dedicated time to perform the role.

The Review recommends the appointment of an Independent National Officer (INO), jointly established and resourced by the CQC, Monitor, the NHS TDA and NHS England. The INO will review the handling of concerns raised by NHS workers and/or their treatment, advise organisations on appropriate action, act as a support for Freedom to Speak up Guardians, and provide national leadership and good practice guidance

The Review notes that some staff groups are particularly vulnerable when raising concerns and require particular support to voice concerns. Additional recommendations include improvement in the handling of cases to promote their early resolution and that staff should have access to mediation, mentoring, advice and counselling.

The Review is predicated on a culture free from bullying as it is unlikely that staff will be able to voice concerns in that context. It advocates **zero tolerance to bullying**.

4. LITERATURE BEHIND FRANCIS

The literature is organised against the three of the key areas of culture change outlined in the Francis Inquiry 2013: compassionate care, openness and transparency, and leadership.

COMPASSIONATE CARE

Staff engagement has consistently been found to be a key indicator of patient satisfaction. Trusts with higher levels of staff engagement have higher patient satisfaction scores, consistently lower patient mortality rates and better financial performance (West & Dawson, 2009). Staff are more engaged when they are clear about their roles, feel involved in decision-making and are able to influence practice. In SLaM Staff Survey results 2014 indicate that staff engagement in SLaM is 'better than average' which and greater understanding of where things are working well might help improve on this further.

Borrill et al. (1999) found that staff working in **well-structured teams** had higher levels of engagement. They are not over-burdened and are able to push upwards if the demands on them become too great. They are also not asked to take responsibility for things over which they have no control.

Staff well-being is also clearly linked to improvements in organisational performance in areas such as productivity and customer satisfaction.

Communication with staff needs to take the form of listening. It is through **being listened to** staff become engaged and motivated. Staff need to feel they have been heard and attempts to listen which are not experienced as such can reduce staff engagement.

Where staff see equal opportunities for career progression and where they feel enabled to grow and develop, there are higher levels of patient satisfaction (West & Dawson, 2009). This is linked to the concept of '**psychological safety**' where staff can be 'true self' (including their ideas and beliefs) without fear of negative consequences (Edmondson, 1999; Edmondson & Lei, 2014).

Psychological safety explains why some people are more engaged at work, better able to speak out, better able to share information, better able to learn from mistakes and admit to errors, better able extend themselves in their roles, and to be more innovative than others.

Edmondson (1996, 1999) found significant differences in 'psychological safety' between groups in same organization. Singh et al (2013) found that BME staff were more vulnerable to psychologically unsafe environments and less likely to extend themselves in their roles resulting in lower performance and career achievement etc.

An ethnically and socially **diverse workforce is good for all** employees, even members of dominant group, as well as the organization because it encourages staff to explore their difference and can be open and transparent about mistakes and misunderstandings (Phillips & Loyd, 2006).

One of the most important advantages to having a sufficiently diverse workforce is that it mitigates against **organizational biases** ('groupthink', Janis, 1972), for example the tendency of groups to agree rather than explore controversial issues or alternative solutions.

Intergroup biases (in-group/out-group) play a powerful role in creation of psychological safety and effective leaders acknowledge this and mitigate the risks it can pose to the establishment of a '**Just Culture**' and to patient safety.

Diversity needs to be grounded in a sense amongst staff of **fairness and equality** which presents a significant challenge in the NHS. For example, the NHS recruitment processes has been shown to disproportionately favour white applicants (Kline, 2014). Staff who describe being bullied or harassed and staff who perceive unfair career opportunities are less likely to be engaged.

In SLaM HR data indicates that whilst Black staff make up 25% workforce they are disproportionately in lower paid jobs (eg 50% unqualified nursing staff). In recruitment white applicants are significantly more likely to be appointed; white staff are significantly more likely to be promoted; black Africans significantly less likely to be promoted than other black groups and the total. Black staff are more likely to be involved in disciplinary process, formal sickness review and to be redeployed.

Staff Survey results 2014 indicate that SLaM is in the lowest 20% of Trusts in terms of bullying, harassment and discrimination at work. SLaM is also in the worst 20% of Trusts in terms of the percentage of staff who experience physical violence (from patients/relatives/public and from other staff) and staff who perceive inequalities in terms of career progression. The latter has deteriorated since last staff survey and both are worse for BME staff compared to white staff.

OPENNESS AND TRANSPARENCY

The principle of a Just Culture lies behind the Francis Inquiries and other Reviews. This represents a shift from blaming individuals for errors and towards understanding the systems factors which contribute to the error occurring. Frontline staff often trigger the error by actively failing but this failure is generally the consequence of prior conditions more deeply embedded in the system such as understaffing, unworkable procedures or inadequate training. In this context blaming staff is unlikely to prevent further harm occurring and is likely to leave them (and their colleagues) feeling psychologically unsafe, less likely to explore the contribution of different factors and work towards building a safe culture (Vincent et al., 2013). Senior leaders can review the design of the system to correct obvious deficiencies and vulnerabilities in the system (Reason, 1990).

Sir Robert Francis's report highlights the value of reflective practice so that staff have "time to explore issues, analyse systems and share good practice". Human error is pervasive, even among skilled practitioners, and complex systems also generate errors. In order to learn and improve, staff need to know that it is safe to discuss mistakes and near misses.

LEADERSHIP

Leadership is the most influential factor in shaping organisational culture and so ensuring the necessary leadership behaviours, strategies and qualities are developed is fundamental (Kings Fund, 2013).

The leadership qualities required are those which support the findings of the Francis Reviews. Leaders need to be kind, available, empathic, fair, respectful, compassionate and empowering. They listen to patient voices as the most important source of feedback on

organizational performance. They listen to staff about how to support them to deliver safe, effective and compassionate services. They show that they have acted on what they heard. They create a strong sense of team identity whilst simultaneously being committed to collaborative cross-team and cross boundary working (a key element of collective leadership).

Collective leadership does not assume that organizations are safe (i.e. "It couldn't happen here") but instead actively seeks out the stories about harm to patients that has occurred to drive improvement (Leonard & Frankel, 2012). It provides psychological safety that ensures speaking up is not associated with being perceived as ignorant, incompetent, critical or disruptive. Leaders must create an environment where no one is hesitant to voice a concern and staff know that they will be treated with respect when they do.

Leaders must ensure organisational fairness, where staff know that they are accountable for not engaging in unsafe behaviour, but are not held accountable for system failures. Engaged leaders hear patients and front-line staff concerns regarding defects that interfere with the delivery of safe care, and address them.

5. THE TRUST RESPONSE

In **July 2013 a group of Senior Managers and Heads of Professions in SLaM formed a Francis Working Group**, to lead the development of an organisational response to the Francis Report. The group proposed four essential work-streams:

1. Creating the right culture for positive challenge and positive action (Francis themes of leadership, openness and transparency, values and standards)
2. Working with service users in a spirit of co-production and co-creation
3. Looking after staff, each other and ourselves
4. Assuring quality of care in every corner of the Trust (information)

An action plan followed (February 2014) and became the responsibility of the Forward Planning Delivery Group receiving regular updates from CAGs every month and reporting to Board Quality Sub-Committee.

In **September 2014 the Department of Health requested an update on Trust progress** in response to Francis. This was presented to Board Quality Sub-Committee In January 2015 in the form of a gap or 'next steps' analysis. Both CAGs and Corporate Functions had put considerable effort into work to improve compassionate and safe patient care. This cannot be described fully here; however an example will be provided for each area:

	Example of CAG work	Example of Corporate work
Culture for positive challenge and action	Scheduled patient safety Walk Rounds	Value based recruitment Revalidation of doctors and nurses
Working with service users in a spirit of co-production and co-creation.	PPI meetings are established Examples of excellent practice in co-production in areas around the Trust including winners of national awards	The Recovery College EPIC is established to develop governance around service user and carer involvement.
Looking after staff, each other and ourselves	Reflective Practice groups	Coaching and workshops from SLaM partners Schwartz Rounds® planned Arts Strategy
Assuring quality of care in every corner of the Trust	Work with teams to prepare for CQC visits to new standards	Trust Quality Strategy Care Delivery System

The learning from this exercise includes:

1. Some approaches are only within individual CAGs but could work well more widely effectively work across CAGs
2. Adopting a consistent approach to actively listening to staff and patient feedback and to being transparent about 'what you said and what we did' would be helpful.
3. Cross-cutting themes, such as the impact on staff from a range of diverse backgrounds, require exploration to develop granular understanding eg. why is SLaM in the lowest 20% on Staff Survey results 2014 on 'bullying, harassment and discrimination at work' and why is this worse for BME staff?
4. We need to evidence that we are closing gaps in relation to quality priorities.

6. GOOD PRACTICE EXAMPLES

Active listening to staff good practice examples:

- Helena Donnelly was a whistleblower at Stafford Hospital and gave evidence at the first Francis Inquiry. She took up a role as Ambassador for Cultural Change at Staffordshire and Stoke on Trent Partnership Trust with a remit from the Trust Board and CEO "to act freely and with complete autonomy from the management team as another route for issues of concern to be raised at the highest level … to visit teams and services across the organisation … gathering feedback about how staff feel, if they feel listened to and what might prevent staff from raising concerns".
  http://www.staffordshireandstokeontrent.nhs.uk/About-Us/ambassador-for-cultural-change.htm

- Oxleas NHS Foundation Trust have achieved excellent staff survey results by creating a Head of Partnership Engagement reporting to CEO. She actively engages staff across the Trust and has an understanding of local issues. She is able to challenge on behalf of staff and to ensure that the executive team responds.

Listening to Patients about Quality of Care good practice example:

- Nottinghamshire Healthcare 'Positive about Change' collects web based patient and carer feedback in co-operation with Patient Opinion. The site is monitored to ensure staff respond in a timely fashion and to gather evidence around common areas of concern. The site constructs reports by theme and service area. It also provides transparent feedback about 'what we've done'.
  http://feedback.nottinghamshirehealthcare.nhs.uk/

7. RECOMMENDATIONS

1) The Board to consider how to best meet the expectation that Boards provide visible, effective leadership which prioritises cultural change to ensure compassionate and safe patient care. Also how to ensure non-hierarchical reflective space at all levels of the organization.

2) To continue to develop new and improved ways of hearing the patient voice, for example to have 'Patient Stories' regularly at the Board and to review processes as recently recommended by the Quality Sub Committee.

3) Demonstrate visible leadership by actively encouraging staff to voice concerns, actively listening to staff and acting on what is heard. Utilise a "You said - We did" approach to communications so that staff and public can consistently hear how the Board has acted on staff and patient advice and concerns.

4) Appoint a Speak up Guardian to champion staff concerns. To develop a model of this informed by the Board's views.

5) Further exploration of issues of staff experience that we do not always currently understand fully. For example a zero tolerance policy for bullying will require a wider understanding of the issues involved and why bullying and harassment are worse for BME groups. A staff support policy will require deeper understanding of factors affecting different staff groups feeling support and where there are gaps.

REPORT TO:	**HEALTH AND WELLBEING BOARD (CROYDON) 10 JUNE 2015**
AGENDA ITEM:	**14**
SUBJECT:	**Croydon Local Alcohol Action Area Update**
BOARD SPONSOR:	**Dr Mike Robinson, Director of Public Health, Croydon Council**

BOARD PRIORITY/POLICY CONTEXT:

The LAAA Programme supports delivery against the Health and Wellbeing Board's Strategic Priority Improvement Area 2: Preventing illness and injury and helping people recover by reducing the harm caused by alcohol misuse.

FINANCIAL IMPACT:

There are no financial implications or risks from this programme of work.

1. RECOMMENDATIONS

The Board is asked to note and endorse the proposals made by the LAAA board (section 2.4) for a sustainable approach to reducing alcohol related harm in Croydon.

2. EXECUTIVE SUMMARY

2.1 Croydon was one of twenty areas nationally that was awarded Local Alcohol Action Area (LAAA) status in Feb 2014. The LAAA programme provided an opportunity to work with national colleagues within the Home Office and Public Health England to coordinate Croydon's approach to tackling the harmful effects of excessive drinking. The National LAAA programme ends in June 2015.

2.2 In early 2014, a multi-agency LAAA Programme Board, led by public health, was set up in Croydon to oversee the local programme. It reported to both the Safer Croydon Partnership (SCP) and the Drug and Alcohol Action Team (DAAT) Board.

2.3 The programme identified three priorities: Prevention; partnership and communication; and data sharing. Progress in these areas is described in detail in section 4.

2.4 At the final meeting of the LAAA programme board in March 2015, the following proposals were made:

- The DAAT board takes on the strategic lead for alcohol harm reduction in Croydon
- Two of the three priority work streams (prevention and partnership and communication) report to the DAAT
- One of the three priority work streams (data sharing) reports to the SCP

- That the DAAT produces a developmental alcohol action plan
- That the links between the SCP and the DAAT are strengthened by greater joint membership and regular updates.
- A report on alcohol harm reduction is presented by the DAAT to the Health and Wellbeing Board at regular intervals
- That the membership and Terms of reference of the DAAT is reviewed to reflect its extended role

2.5 Moving forward Leadership of the LAAA Priorities will be guided by Brenda Scanlon, Director of the Integrated Commissioning Unit (ICU / DAAT), Andy Opie, Director of Safety (Safer Croydon Partnership) and Bernadette Alves, Consultant in Public Health (Public Health).

3. DETAIL

3.1 Reducing alcohol related harm in Croydon is a priority for all of its partners and Croydon's alcohol JSNA conducted in 2013/14 found:

- Approximately 1 in 6 of Croydon's adult population (over 50,000 adults) is drinking at increasing and higher risk levels
- An estimated 1 in 9 are binge drinkers
- Excessive consumption increases the risk of developing over 200 conditions, most notably, mental health, heart disease, liver cirrhosis, cancers and injuries
- It is England's second biggest cause of premature deaths, after smoking
- Alcohol related harm costs Croydon an estimated £144 million per year. Half is alcohol related crime, one third is lost productivity and the rest is NHS costs.
- More than two in five (44%) violent crimes are committed under the influence of alcohol.
- Alcohol harm is increasing in Croydon
- Vulnerable groups, including homeless people, people with mental health problems and women experiencing domestic violence are at higher risk of harm from alcohol
- It is a cause of health inequalities. Compared with those living in most affluent areas, people in the most deprived fifth of the country are 3-5 times more likely to die of an alcohol-specific cause.

3.2 Through consultation with stakeholders in June 2014, Croydon identified the following three priorities for the LAAA programme:

- **Prevention.** To encourage sensible drinking habits in the estimated 50,000 adults who drink at increasing and higher risk levels through developing Croydon's alcohol IBA (Identification and Brief Advice) programme.
- **Partnership and communication**. To develop a multi-faceted partnership approach to reduced alcohol harms.
- **Data sharing**. To prevent alcohol related violent crime through sharing anonymized data between A&E (accident and emergency) services and the Safer Croydon Partnership.

3.3 Work stream sub groups were established for both the 'Prevention' and 'Partnership and Communication' themes, which will run to oversee the work programmes until April 2016.

4. ACHIEVEMENTS

4.1 The Croydon programme, so far, has achieved the following:

Achievements	Detail
1. **Taken forward recommendations of Croydon's alcohol JSNA**	Through developing a strategic partnership and through alcohol IBA programme development, it has addressed two of the three key recommendations of the JSNA.
2. **Built strong partnership and engagement** with local, regional and national stakeholders	Developed a strong strategic and operational partnership through establishing the LAAA Programme Board, running a cross –borough, priority setting workshop, hosting a regional LAAA conference and through LAAA multi-agency working groups.
3. **Mapped Croydon's alcohol harm reduction initiatives**	The LAAA programme developed a map of alcohol-related initiatives, and harm reduction forums. It illustrated the complexity of alcohol harm reduction across the borough, has generated discussion and led to setting of LAAA priorities.
4. **Multidisciplinary working groups** supporting development of the LAAA priorities	Multi-agency working groups were established for both the Prevention and Partnership and Communication work streams to provide strategic and operational oversight developing these themes. Work stream groups have each met twice and have established delivery plans, owned by partners for the next 12 months.
5. **Evidence based alcohol website tailored for Croydon.**	The LAAA programme commissioned the 'Don't Bottle It Up' website tool to raise awareness, assess consumption and support behaviour change in people living and working in Croydon. In the first 5 weeks since the service was commissioned, we have received 775 hits to the site, leading to 389 residents already receiving support around their alcohol consumption
6. Coordinated **multi-agency alcohol awareness campaigns**	Dry January 2015 achieved four times more sign ups (259) in Croydon than 2014. Evidence suggest that beyond the 31 day challenge, participants are likely to achieve and sustain a reduction in their alcohol consumption and felt more confident to refuse alcohol in social settings.
7. **Launch of pharmacy based alcohol IBA pilot**	Launch planned for July 2015. Expressions of interest from 28/74 Croydon pharmacies. Target of 750 to 1500 screenings in the first 12 months
8. Discussions underway for an **alcohol IBA service in general practice**	Public Health Croydon are in discussions with colleagues in the CCG and LMC (Local Medical Committee) to establish a screening programme within general practice.
9. **Promoting workforce development** to encourage awareness of alcohol harms	30 colleagues from Pharmacy have already been trained to deliver Identification and Brief Advice and we are in the process of discussing how we further support 35 colleagues in the Probation service.
10. **Emerging Partnership** developed with Croydon University Hospital to establish A&E data sharing	Progress developing this area has been slow; however, recently good communications have emerged to strengthen development of establishing the A&E Data Sharing agreement. Ownership of these priorities by the HWB will hopefully influence delivery of all priorities.

CONTACT OFFICER: Bernadette Alves, Consultant in Public Health, Bernadette.alves@croydon.gov.uk 0208 726 6000 x*61317*

Brenda Scanlon, Director of Integrated Commissioning Unit, Brenda.scanlon@croydon.gov.uk 0208 726 x65727

Andy Opie, Director of Safety, andy.opie@croydon.gov.uk 0208 726 6000 x65686

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REPORT TO:	**HEALTH AND WELLBEING BOARD (CROYDON)** **10 June 2015**
AGENDA ITEM:	**16**
SUBJECT:	**Report of the chair of the executive group: incorporating risk register, board work plan and performance report**
BOARD SPONSOR:	**Paul Greenhalgh, Executive Director, People, Croydon Council**

CORPORATE PRIORITY/POLICY CONTEXT:

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

FINANCIAL IMPACT:

None

1. RECOMMENDATIONS

The health and wellbeing board is asked to:

- Note risks identified at appendix 1
- Agree changes to the board work plan set out in paragraph 3.4
- Consider the report at appendix 3 identifying performance against key indicators for board priorities set out in the joint health and wellbeing strategy

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 Areas of success and challenge in the delivery of the joint health and wellbeing strategy 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 reports 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 April and May 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 targets for inclusion in the joint health and wellbeing strategy
- Liaison with other strategic partnerships including Croydon strategic partnership and children and families partnership
- Agreed to review the role, function and governance of all partnership groups accountable to the board
- Review of board strategic risk register
- Review of responses to public questions and general enquiries relating to the work of the board

Risk

3.3 Risks identified by the board are summarised at appendix 1. The executive group regularly review the board risk register. Amendments to the risk register include:

- Current risk rating for HWB5 relating to financial allocations in health and social care has been raised from 20 to 25.
- Current risk rating for HWB3 relating to understanding of the role and purpose of the board has been reduced from 16 to 12.
- Removal of risk HWB9 as the new pharmaceutical needs assessment has been completed and agreed by the board.

Board work plan

3.4 Changes to the board work plan from the version agreed by the board on 25 March 2015 are summarised below. Changes were discussed by the executive group on 11 May 2015. This is version 72.0 of the work plan. The work plan is at appendix 2.

3.4.1 Addition of items on the Local Government Declaration on Tobacco Control and the sexual health procurement strategy to the agenda for 10 June 2015

3.4.2 The item on partnership groups moved to 9 September 2015 pending a full review of the groups.

3.4.3 Addition of items on the end of life strategy; maternal health JSNA chapter; young people and smoking JSNA chapter; community services for over 65s JSNA chapter to the agenda for 9 September 2015.

3.4.4 Allocation of proposed item on improving people's experience of care and addition of items on children's and adults' safeguarding to the agenda for 21 October 2015.

3.4.5 Allocation of proposed item on urgent and emergency care and addition of items on commissioning intentions for 2016/17 and health protection to the agenda for 9 December 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.

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** deaths from diabetes, breast screening rates and take up of NHS Health Checks 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.. Areas of challenge identified include the proportion of adults in contact with secondary mental health services living independently, with or without support and the proportion of adults with learning disabilities in paid employment.

3.5.5 For **improvement area 5: providing integrated, safe, high quality services** an area of challenge identified is the all cause emergency hospital admissions rate.

3.5.6 For **improvement area 6: improving people's experience of care** an area of challenge identified is patient satisfaction with the primary care out of hours service.

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

Appendix 1

10 June 2015

Risk Status

			Risk rating		Control measures			
Risk Ref	**Business Unit**	**Risk**	**Current**	**Future**	**Future**	**Existing**	**Total**	**% Impleme**
HWB5	HWB	Limited or constrained financial allocations in health and social care which gives rise to the inability to balance reducing budgets with a rising demand	25	20	4	5	9	70%
HWB6	HWB	Failure to ensure that the Board continuously develops and has the capacity and capability to operate effectively and efficiently.	16	12	3	2	3	67%
HWB8	HWB	Board is not able to demonstrate improved outcomes for the population	16	12	4	4	4	60%
HWB4	HWB	Failure to understand the community's expressed wants and choices and to ensure that ongoing engagement with the public is maintained and views	16	12	5	2	6	40%
HWB1	HWB	Failure to ensure that the board's focus is balanced (for example, between statutory requirements / national guidance and local priorities; or health and wellbeing)	16	8	2	4	6	67%
HWB3	HWB	Failure to clearly understand the purpose, boundaries and remit of the Board	12	4	2	3	3	67%
HWB2	HWB	Failure to successfully integrate commissioning or service provision due to inability or unwillingness to share data	15	12	3	2	5	71%
HWB7	HWB	The Board fails to respond flexibly and effectively to changes in national policy or developing local issues	12	8	2	4	4	80%

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Appendix 2 HWB work plan version 72.0

Topic proposed: date to be agreed

Fairness Commission initial report / final report
Integrated care/Transforming Adult Community Services / Outcomes Based Commissioning for over 65s/ Better Care Fund (reports in autumn 2015 timing to be confirmed)
SW London Commissioning Collaborative

Date	Item	Purpose	Board sponsor	Lead officer / report author
24 July 2015	**Board seminar – developing the system leadership role of the HWB**			
9 September 2015	**Strategic items**			
	End of life strategy	To agree the joint end of life strategy	Paul Greenhalgh / Paula Swann	Brenda Scanlan / Cynthia Abankwa
	Annual report of the director of public health	To discuss the content of the director of public health's annual report and agree any actions for the board arising from it	Mike Robinson	Jenny Hacker
	JSNA 2013/14 maternal health chapter final draft	To consider the findings of the chapter and agree to its publication.	Mike Robinson	Sarah Nicholls / Dawn Cox
	JSNA 2013/14 young people and smoking chapter final draft	To consider the findings of the chapter and agree to its publication.	Mike Robinson	Bernadette Alves / Jimmy Burke

Appendix 2 HWB work plan version 72.0

Date	Item	Purpose	Board sponsor	Lead officer / report author
	JSNA 2013/14 community based services for over 65s chapter final draft	To consider the findings of the chapter and agree to its publication.	Mike Robinson	Steve Morton / Nerissa Santimano
	Business items			
	Appointment of chair and executive group	To agree the chair and members of the board executive group	n/a	Solomon Agutu
	JSNA 2015/16 key chapter topics	To agree the needs assessments to be carried out as part of the JSNA	Mike Robinson	Steve Morton
	Partnership groups report (Partnership group: All)	To provide an overview of the work of the partnership groups accountable to the board and to agree any changes as a result of a review of the partnership groups.	Paul Greenhalgh	Steve Morton
	Report of the chair of the executive group • Work plan • Risk	To inform the board of work undertaken by the executive group and consider the board risk register	Paul Greenhalgh	Steve Morton
21 October 2015	**Strategic items**			

Appendix 2 HWB work plan version 72.0

Date	Item	Purpose	Board sponsor	Lead officer / report author
	Improving outcomes: people's experience of care (including patient transport)	To consider work to deliver the joint health and wellbeing board priority of improving people's satisfaction with health and social care services	tbc	tbc
	JSNA key dataset 2014/15	Discussion & decision	Mike Robinson	David Osborne / Steve Morton
	Business items			
	Safeguarding adults annual report	To inform the board of the work of the Safeguarding Adults Board	Paul Greenhalgh	Kay Murray
	Safeguarding children annual report	To inform the board of the work of the Safeguarding Children Board	Paul Greenhalgh	Gavin Swann/ Ian Lewis
	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
Date to be agreed	**Public engagement event / HWB conference**			

Appendix 2 HWB work plan version 72.0

Date	Item	Purpose	Board sponsor	Lead officer / report author
9 December 2015	**Strategic items**			
	Commissioning intentions 2015/16	The board has a duty to give an opinion on the alignment of the CCG's commissioning plan to the JHWS and the power to give its opinion to the council on whether the council is discharging its duty to have regard to relevant JSNA and JHWS.	Paula Swann/Paul Greenhalgh	Stephen Warren / Brenda Scanlan / Jane Doyle
	Urgent and emergency care	To inform the board of work to transform urgent and emergency care	Paula Swann	tbc
	Business items			
	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
	Report of the chair of the executive group • Work plan • Risk	To inform the board of work undertaken by the executive group and consider the board risk	Paul Greenhalgh	Steve Morton

Appendix 2 HWB work plan version 72.0

Date	Item	Purpose	Board sponsor	Lead officer / report author
		register		
	Addressing the needs of people with autism	To inform the board of progress with the local implementation of the Autism Act 2009	Paul Greenhalgh	Simon Wadsworth
10 February 2016	**Strategic items**			
	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
13 April 2016	**Strategic items**			
	Final commissioning plans 2015/16	The board has a duty to give an opinion on the alignment of the CCG's commissioning plan to the JHWS and the power to give its opinion to the council on whether the council is discharging its duty to have regard to	Paula Swann/Paul Greenhalgh	Stephen Warren / Brenda Scanlan / Jane Doyle

Appendix 2 HWB work plan version 72.0

Date	Item	Purpose	Board sponsor	Lead officer / report author
		relevant JSNA and JHWS.		
	Business items			
	Report of the chair of the executive group • Work plan • Risk	To inform the board of work undertaken by the executive group and consider the board risk register	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
25 March 2015	**Strategic items**			
	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	Lissa Moore / Adam Kerr
	Joint health and wellbeing strategy 2015-18	To agree amendments to the joint health and wellbeing strategy	Members of the executive group	Steve Morton
	CCG commissioning plans 2015/16	The board has a statutory duty to provide opinion on whether the CCGs final commissioning plan has	Paula Swann	Stephen Warren

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

		taken proper account of JHWS.		
	Business items			
	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 / Stephen Warren / Sue Grose
	Winterbourne View action plan (Partnership group: Learning Disability)	To assure the board that the Winterbourne view action plan reported to board in February 2014 has been progressed.	Paul Greenhalgh	Brenda Scanlan
	Drug and alcohol recommissioning (Partnership group: Drugs & Alcohol)	To inform the board of progress with recommissioning of drug and alcohol services	Paul Greenhalgh	Alan Hiscutt / Shirley Johnstone
	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
	Report of the chair of the executive group • Work plan • Risk	To inform the board of work undertaken by the executive group and consider the board risk register	Paul Greenhalgh	Steve Morton

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

10 June 2015	**Strategic items**			
	Croydon Council commissioning plans 2015/16	The board 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.	Paul Greenhalgh	Brenda Scanlan
	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
	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
	Healthy weight strategic action plan	To agree local plan to address overweight and obesity.	Mike Robinson	Sarah Nicholls/ Anna Kitt
	Deprivation of liberty safeguards	To provide the board with assurance that appropriate safeguards are in place to protect vulnerable adults from arbitrary detention.	Paul Greenhalgh /	Edwina Morris / Kay Murray
	Sexual health procurement strategy	To provide the board with a briefing on the wider issues relating to the procurement strategy for sexual health	Paul Greenhalgh / Mike Robinson / Paula Swann / Jane Fryer	Lisa Burn / Ellen Schwartz

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

		services		
	Business items			
	Francis Review action plans	To assure the board that the Francis Review action plans reported to board in February 2014 has been progressed and that plans are in place in each of these areas	Paula Swann / John Goulston / Steve Davidson	Sean Morgan / Zoe Packman / Alison Beck
	Local alcohol action area (Partnership group: Drugs & alcohol (DAAT); Healthy Behaviours)	To inform the board of achievements of the programme and to note future recommendations	Mike Robinson	Bernadette Alves/ Matt Phelan
	Local Government Declaration on Tobacco Control	To ask the board to sign up to the Local Government Declaration on Tobacco Control	Mike Robinson	Bernadette Alves / Jimmy Burke
	Carers partnership group report (Partnership group: Carers)	To inform the board of the work of the carers partnership group in delivering board priorities.	Paul Greenhalgh	Amanda Lloyd / Harsha Ganatra
	Heart Town annual report	To inform the board of progress in the delivery of Croydon Heart Town	Mike Robinson	Steve Morton
	Report of the chair of the executive group	To inform the board of work undertaken by the	Paul Greenhalgh	Steve Morton

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

	• Performance report • Work plan • Risk	executive group, to consider performance and review the board risk register		

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APPENDIX A

Health & Wellbeing Board Performance Report

May-15

SCC - Performance Team Contact: Laura.Gamble@croydon.gov.uk

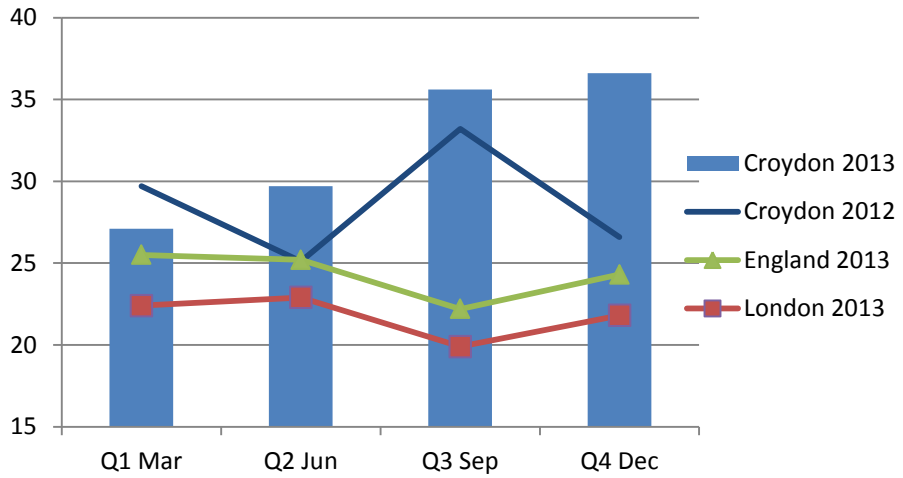
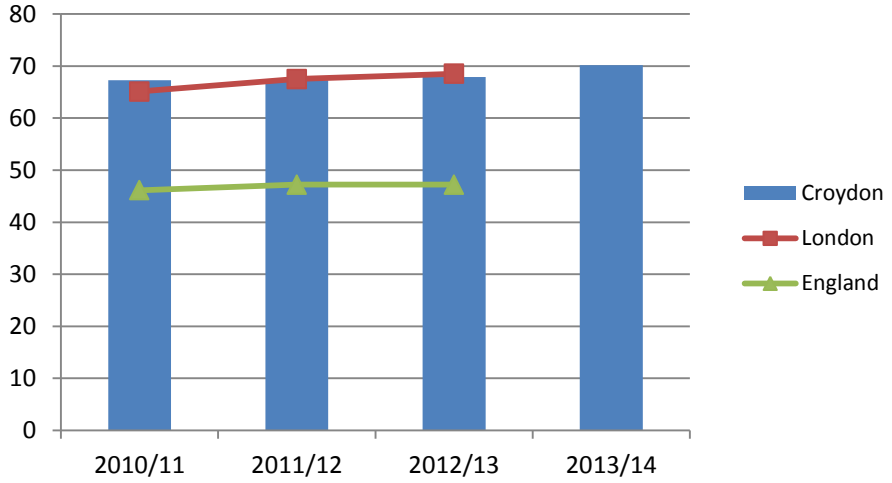
05 May 2015

Contents

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

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

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

Potential challenge areas	Areas of success
Conception rate per thousand Women aged 15 to 17	**% breastfeeding prevalence at 6-8 week health check**
	
The annual under 18 conception rate for 2013 was 32.4 per 1000 and showed a 14% increase from that seen in 2012. This increase is not statistically signnificant so we cannot be certain whether the increase represents a real increase due to underlying factors in the local strategy or whether this is due to random fluctuation.	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.

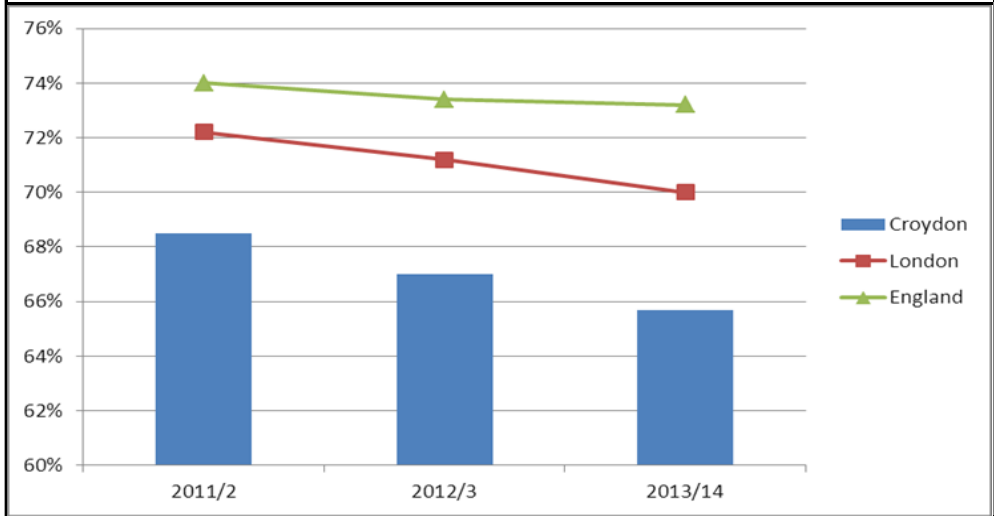
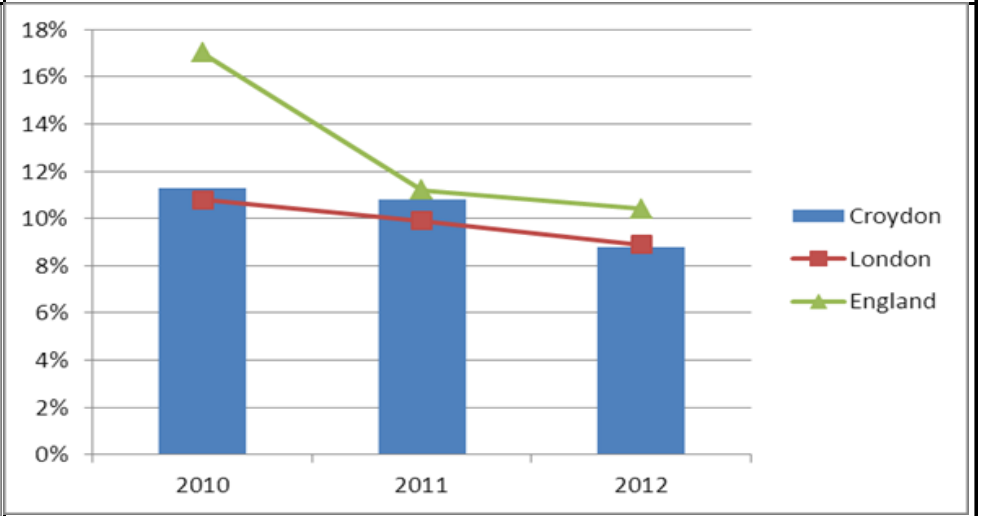
Performance measures

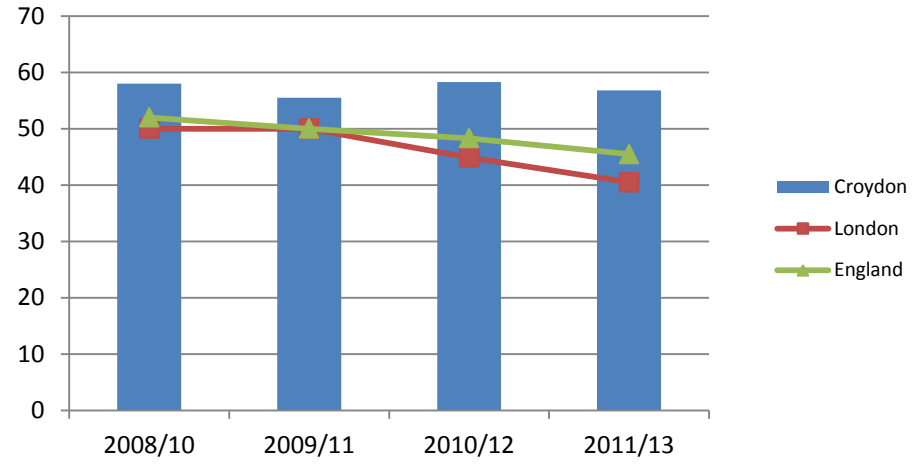
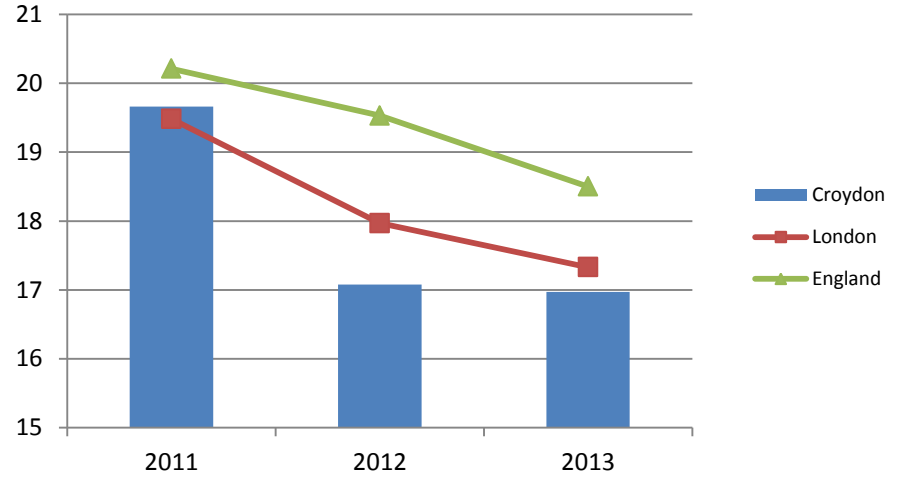
Measure description	Source	Polarity	Most recent annual data	From	Previous year	London Average	England Average	Comparison with previous year	Comparison with London Average	Comparison with England Average
Conception rate per thousand women aged 15 to 17	Croydon key dataset	LOW	36.6	2013 Q4	35.6	21.80	24.3	About the same	Worse	Worse
Breastfeeding initiation within 48 hours (% of mothers)	Croydon key dataset	HIGH	86%	2012/13	87%	86.80%	73.80%	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
Percentage 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
Percentage of children aged 4-5 years with height and weight recorded who are either overweight or obese	Croydon key dataset	LOW	23.40%	2013/14	23.70%	23.10%	22.60%	About the same	About the same	About the same
Percentage of children aged 10-11 years with height and weight recorded who are either overweight or obese	Croydon key dataset	LOW	38.40%	2013/14	38.20%	37.60%	33.50%	About the same	About the same	Worse
Percentage of live and still births under 2500 grams	Croydon key dataset	LOW	8.30%	2011	8.80%	8.00%	7.40%	About the same	About the same	About the same

Measure description	Source	Polarity	Most recent annual data	From	Previous year	London Average	England Average	Comparison with previous year	Comparison with London Average	Comparison with England Average
Immunisations - DTaP / IPV / Hib vaccination coverage (1 year old)	Croydon key dataset	HIGH	91.70%	2013/14	91.10%	89.80%	94.30%	About the same	Better	Worse
Immunisations - Hib / MenC booster vaccination coverage (2 years old)	Croydon key dataset	HIGH	87.70%	2013/14	86.60%	86.80%	92.50%	Better	About the same	Worse
Immunisations - PCV booster vaccination coverage (2 years old)	Croydon key dataset	HIGH	88.90%	2012/13	86.20%	86.30%	92.40%	Better	Better	Worse
Immunisations - MMR vaccination coverage for one dose (2 years old)	Croydon key dataset	HIGH	88.90%	2012/13	86.50%	87.50%	92.70%	Better	Better	Worse
Immunisations - DTaP / IPV vaccination coverage (5 years old)	Croydon key dataset	HIGH	92.80%	2012/13	92.70%	92.80%	95.60%	About the same	About the same	Worse
Immunisations - MMR vaccination coverage for two doses (5 years old)	Croydon key dataset	HIGH	76.90%	2012/13	74.20%	80.70%	88.30%	Better	Worse	Worse
Tooth decay in children aged 5 (average number of teeth)	Croydon key dataset	LOW	1.05 [1]	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	12.6	13.40	13.9	About the same	About the same	Better
Children living in poverty	Croydon key dataset	LOW	23.00%	2011	25.70%	23.70%	19.20%	Better	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**
	
The influenza immunisation rate for this age group in Croydon falls short of the national and London averages, although shows a similar rate of decline to the London average.	This indicator measures the percentage of households which are fuel poor, meaning they spend more than 10% of their income on fuel to maintain a "satisfactory heating regime" (usually 21 degrees for the main living area and 18 degrees for other occupied areas). The latest published data appears to show that this is improving in Croydon in line with the rest of London.

Potential challenge areas	Areas of success
Persons presenting with HIV at a late stage of infection (% of new diagnoses of HIV)	**Smoking prevalence (% of adults aged over 18 who responded to survey)**
	
The proportion of late HIV diagnoses has decreased for 2011/13, however not at the same rate as the London and England averages.	Smoking prevalence has fallen to 16.97% for 2013. This shows a continuing downward trend in smoking prevelance below averages for both London and England. Although the difference with London has narrowed.

Performance measures

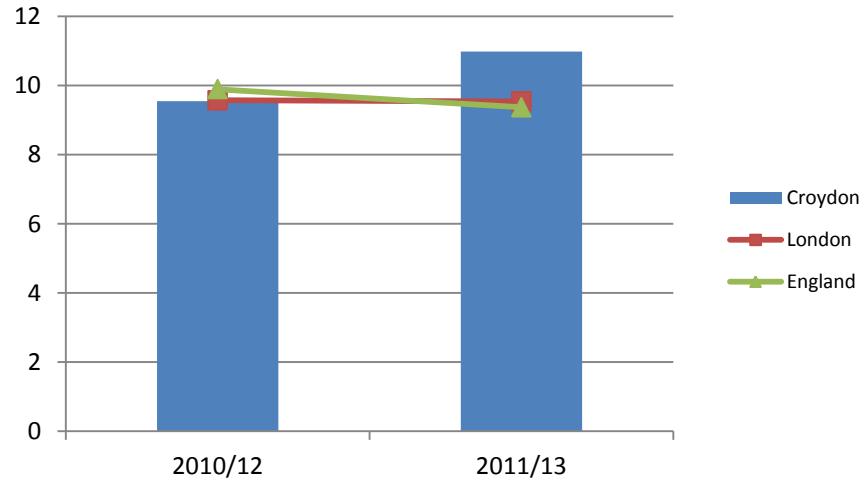
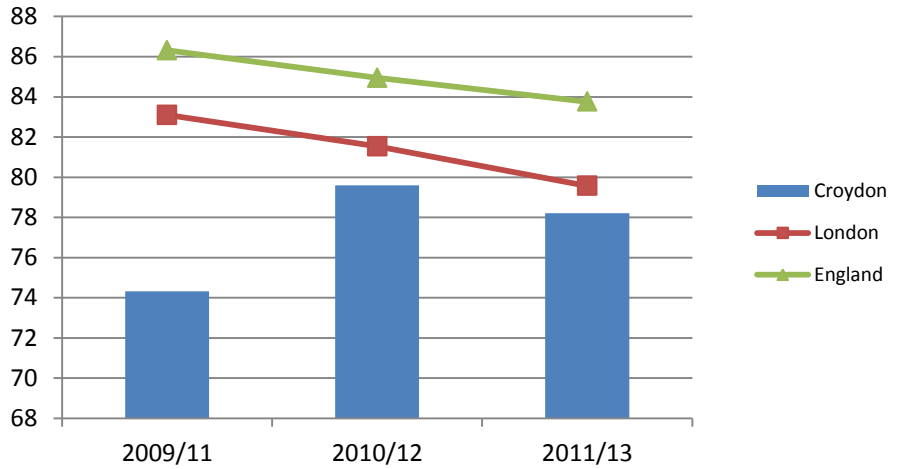
Measure description	Source	Polarity	Most recent annual data	From	Previous year	London Average	England Average	Comparison with previous	Comparison with London Average	Comparison with England Average
% of persons aged 65 and over immunised against influenza	Croydon key dataset	HIGH	65.70%	2014/15	66%	69%	72.80%	About the same	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

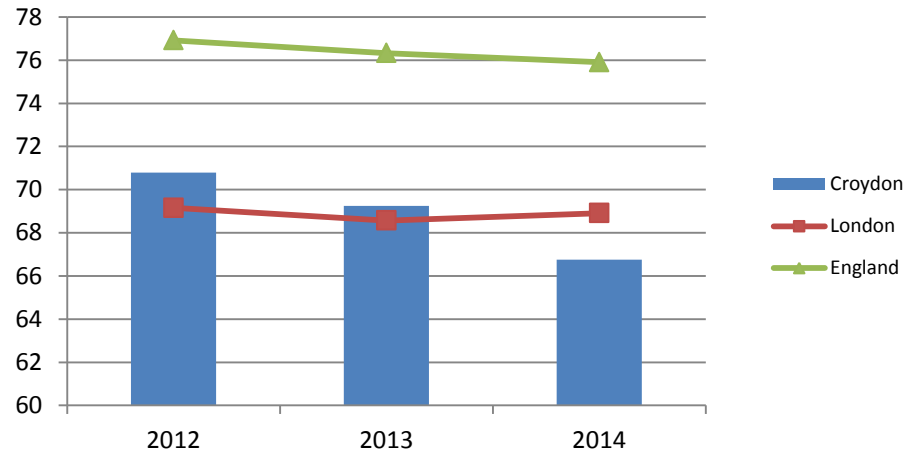
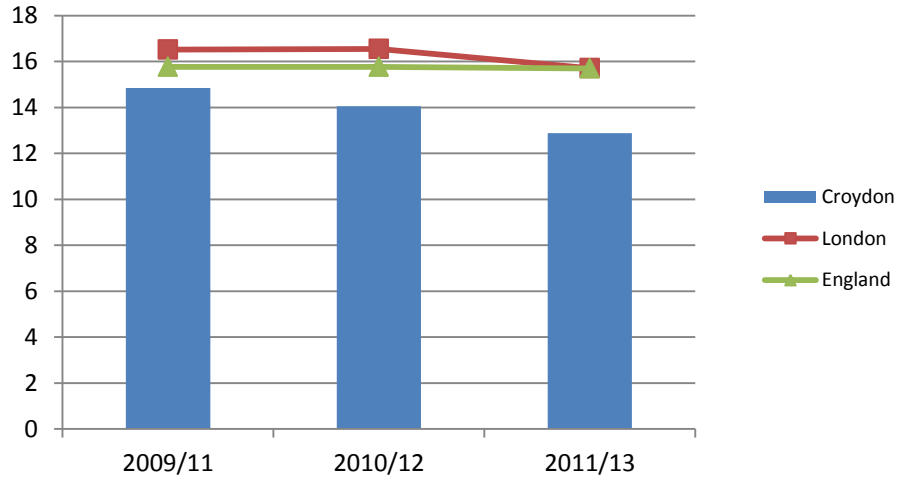
Measure description	Source	Polarity	Most recent annual data	From	Previous year	London Average	England Average	Comparison with previous year	Comparison with London Average	Comparison with England Average
Rate of hospital admissions with a primary or secondary diagnosis of obesity per 100,000 population	Public Health Outcomes Framework	LOW	526	2013/14	440	505	679	Worse	About the same	Better
Narrow Definition: Alcohol attributable hospital admissions (rate per 100,000 population)	Croydon key dataset	LOW	130.49	2014/15 Q2	128.23	131.3	159.8	About the same	About the same	Better
Percentage of patients on GP registers aged 17 and over diagnosed with diabetes	Croydon key dataset	LOW	6.48%	2013/14	6.39%	6.21%	6%	About the same	About the same	About the Same
Adults achieving at least 150 minutes of physical activity per week (% of adults aged over 16)	Croydon key dataset	HIGH	13.00%	2012	10.30%	12.80%	14.70%	Better	About the same	Worse
Persons presenting with HIV at a late stage of infection (% of new diagnoses of HIV)	Croydon key dataset	LOW	56.8%	2010/12	58.3%	40.5%	45.5%	Better	Worse	Worse
Chlamydia diagnoses (ages 15-24) (rate per 100,000 population)	Croydon key dataset	n/a	2704	2013	2511	2179	2016	n/a	n/a	n/a
Percentage of households identified as “fuel poor”	Croydon key dataset	LOW	8.80%	2012	10.80%	8.90%	10.40%	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

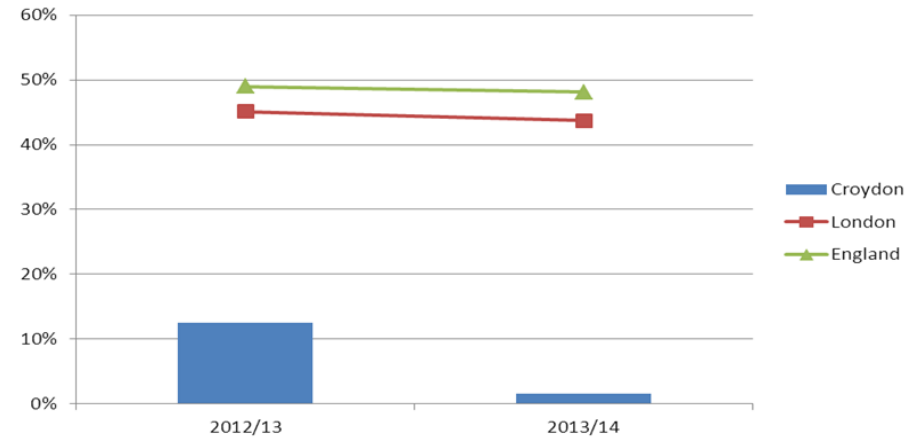
Measure description	Source	Polarity	Most recent annual data	From	Previous year	London Average	England Average	Comparison with previous year	Comparison with London Average	Comparison with England Average
Patient reported outcomes for elective procedures: Groin Hernia (EQ-5D- average health gain score 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 (	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	Areas of success
Deaths from diabetes (rate per 100,000 population)	**Early deaths from cancer considered preventable (rate per 100,000 population aged under 75)**
	
While London and England have both seen minor a fall in deaths from diabetes per 100,00 of the population; Croydon's rate has increased from 9.55 to 10.98 deaths from diabetes per 100,000 of the population.	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.

Potential challenge areas	Areas of success
Breast screening rate (% of women aged 53-70)	**Early deaths from liver disease considered preventable (rate per 100,000 population age<75)**
	
A decline in the % of eligible women receving breast screening from 69.2% to 66.7% occurred in 2014. This rate of decline is not replicated for the London or England averages.	The rate of early deaths form liver disease considered preventable has reduced from 14 to 12.8 per 100,000. A similar rate of reduction can be seen for the London average but not for England overall.

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.	

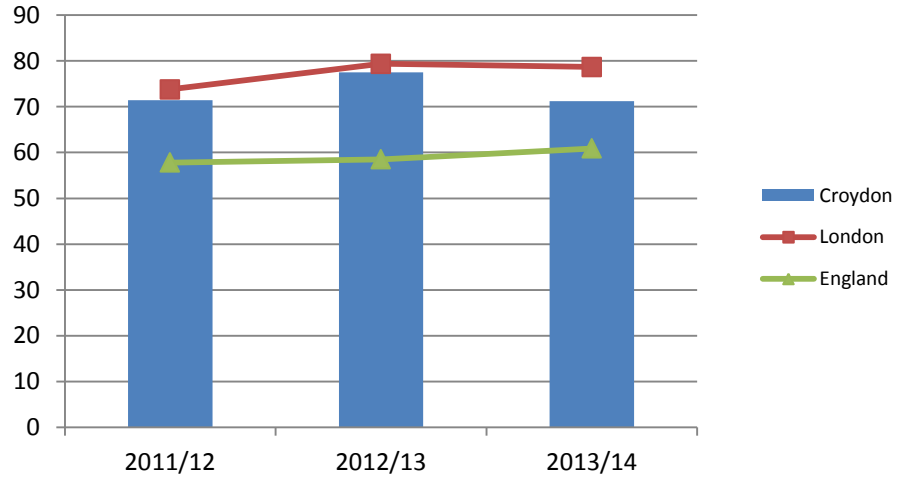
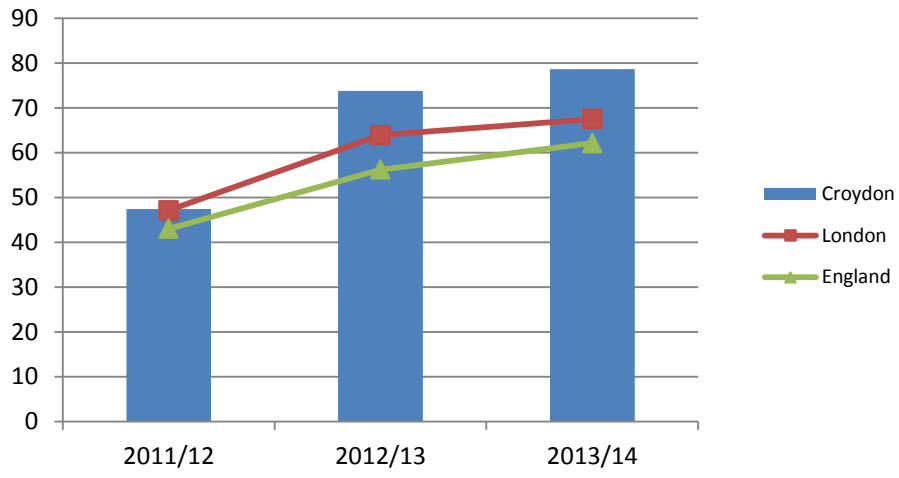
Performance measures

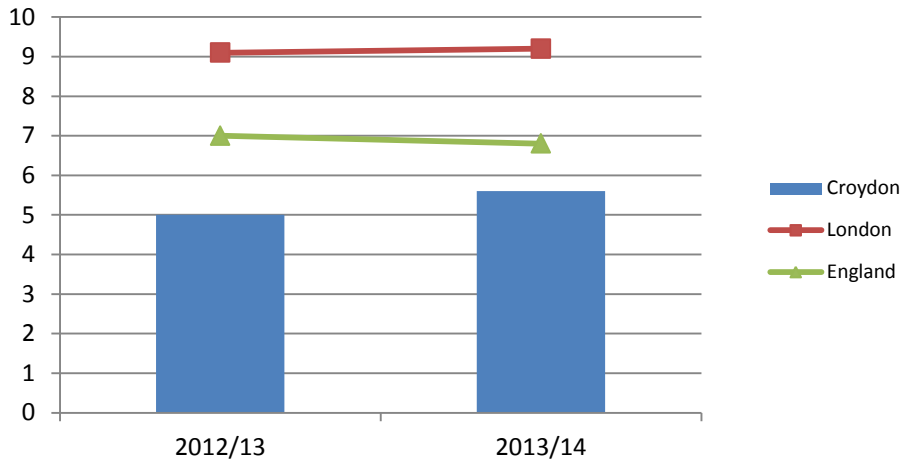
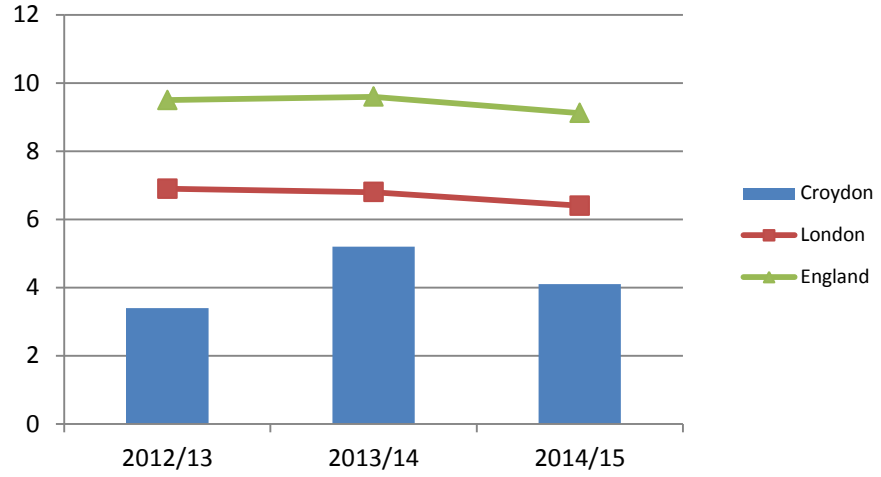
Measure description	Source	Polarity	Most recent annual data	From	Previous year	London Average	England Average	Comparison with previous year	Comparison with London Average	Comparison with England Average
Infant mortality - Rate per 1,000 live births,	Croydon key dataset	LOW	3.9	2010/12	4.4	4.1	4.1	Better	About the same	About the same
Life expectancy at age 75 (males) in years	Croydon key dataset	HIGH	12	2011-13	11.5	12.1	11.5	About the same	About the same	About the same
Life expectancy at age 75 (females) in years	Croydon key dataset	HIGH	13.5	2011-13	13.3	14	13.3	About the same	About the same	About the same
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

Measure description	Source	Polarity	Most recent annual data	From	Previous year	London Average	England Average	Comparison with previous year	Comparison with London Average	Comparison with England Average
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%[2]	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
% of NHS health checks that identify patients to be at high risk	TBC	TBC	12.30%	2012/13	10.20%	Local indicator	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	10.98	2011-13	9.55	9.54	9.37	Worse	Worse	Worse

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**
	
2013/14 has seen a decline in the proportion of adults in contact with secondondary 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.

Potential challenge areas	Areas of success
Proportion of adults with learning disabilities in paid employment	**Delayed transfers of care from hospital per 100,000 population**
	
While the proportion of people with learning disabilites in paid employment has slightly increased, it is still below avearge for both London and England.	Croydon's performance has remained below the averages for both London and England; and has futher decreased delays in the transfer of care.

Performance measures

Measure description	Source	Polarity	Most recent annual data	From	Previous year	London Average	England Average	Comparison with previous year	Comparison with London Average	Comparison with England Average
Survey Social care-related quality of life	ASCOF	HIGH	18.7	2013/14	18.2	18.5	19	About the same	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 year	London Average	England Average	Comparison with previous year	Comparison with London Average	Comparison with England Average
Proportion of people using social care who receive self-directed support	ASCOF	HIGH	78.60%	2013/14	73.80%	67.50%	62.10%	Better	Better	Better
Proportion of people using social care who receive direct payments	ASCOF	HIGH	9.30%	2013/14	9.60%	22.10%	19.10%	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
Proportion of adults with learning disabilities in paid employment	ASCOF	HIGH	5.60%	2013/14	5%	9.20%	6.80%	About the same	Worse	Worse
Proportion of adults in contact with secondary mental health services in paid employment	ASCOF	HIGH	5.80%	2013/14	8.00%	5.50%	7.10%	Worse	About the same	Worse
Proportion of adults with learning disabilities who live in their own home or with their family	ASCOF	HIGH	66.20%	2013/14	63.80%	68.50%	74.80%	Better	Worse	Worse
Proportion of adults in contact with secondary mental health services living independently, with or without support	ASCOF	HIGH	71.20%	2013/14	77.50%	78.70%	60.90%	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

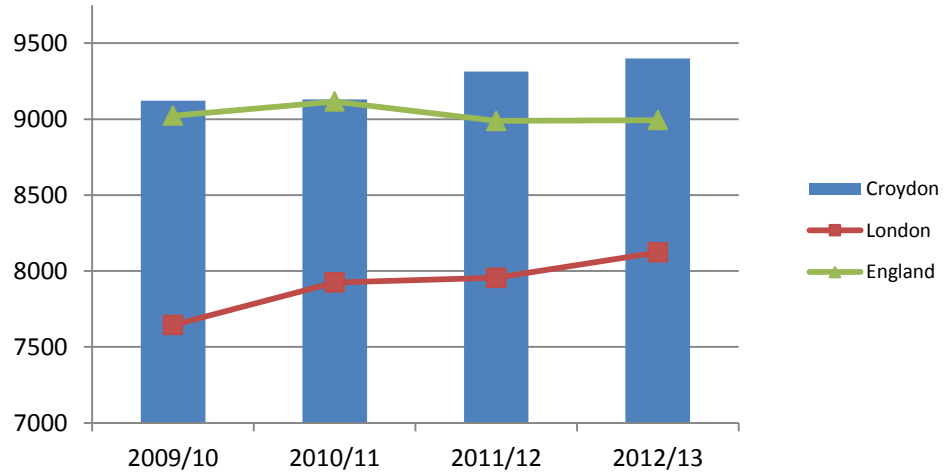
Measure description	Source	Polarity	Most recent annual data	From	Previous year	London Average	England Average	Comparison with previous year	Comparison with London Average	Comparison with England Average
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	ASCOF	LOW	374.2	2013/14	212	463.9	668.4	Worse	Better	Better
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/ rehabilitation services	ASCOF	HIGH	85.20%	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	4.1	2014/15	5.2	6.4	9.12	Better	Better	Better
Delayed transfers of care from hospital which are attributable to adult social care per 100,000 population	ASCOF	LOW	1.3	2014/15	1.4	2.1	2.5	About the same	Better	Better
Overall satisfaction of people who use services with their care and support	ASCOF	HIGH	57.90%	2013/14	54.20%	60.10%	64.90%	Better	Worse	Worse
Overall satisfaction of carers with social services	ASCOF	HIGH	29.20%	2012/13	Not available	35.20%	42.70%	UNKNOWN	Worse	Worse
Proportion of carers who report that they have been included or consulted in discussion about the person they care for	ASCOF	HIGH	63.40%	2012/13	Not available	65.90%	72.80%	UNKNOWN	About the same	Worse

Measure description	Source	Polarity	Most recent annual data	From	Previous year	London Average	England Average	Comparison with previous year	Comparison with London Average	Comparison with England Average
Proportion of people who use services and carers who find it easy to find information about services	ASCOF	HIGH	73.10%	2013/14	73.00%	72.60%	74.70%	About the same	About the same	About the same
Proportion of people who use services who say that those services have made them feel safe and secure	ASCOF	HIGH	71%	2013/14	59.70%	77.40%	79.20%	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)



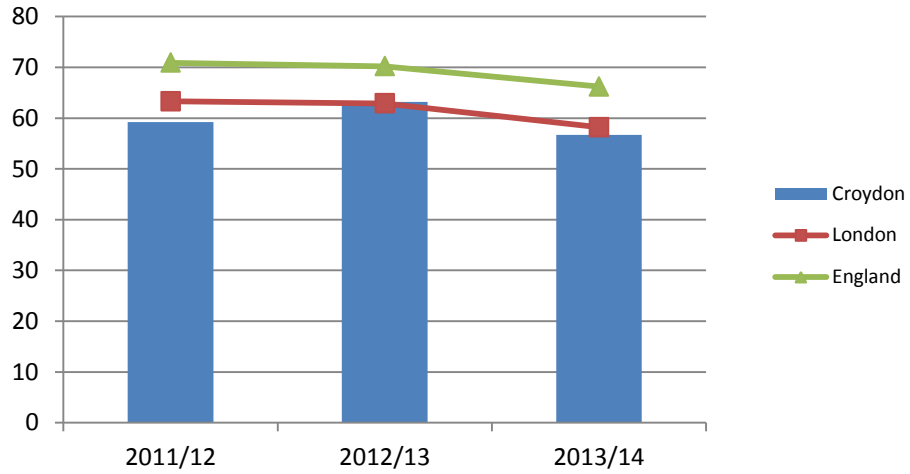
All cause emergency admissions have increased for the year 2012/13 at a similar incline to London's average. England's average remained similar to the previous year.

Measure description	Source	Polarity	Most recent annual data	From	Previous year	London Average	England Average	Comparison with previous year	Comparison with London Average	Comparison with England Average
All cause emergency hospital admissions (rate per 1,000 population)	Croydon key dataset	LOW	9399	2011/12	9312	8123.24	8993.11	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
Proportion of deaths from all causes that occur at usual place of residence	Croydon key dataset	NA	39.8	2012	38.1	35.8	43.7	Unknown	Unknown	Unknown
Safety incidents involving severe harm or death per 100 admissions	NHS outcomes framework	LOW	1.3	04/14-09/14	2.3	Not available	Acute Non specialist (Croydon's comparator group):0.5	Better	Unknown	Worse
Patient safety incidents reported rate per 100 admissions	NHS outcomes framework	LOW	26.48	04/14-09/14	25.6	Not available	Acute Non specialist (Croydon's comparator group):24.07	About the same	Unknown	Worse
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.difficle (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.

Measure description	Source	Polarity	Most recent annual data	From	Previous year	London Average	England Average	Comparison with previous year	Comparison with London Average	Comparison with England Average
Patient experience of primary care: GP Services	NHS outcomes framework	HIGH	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	73	2012	75.2	Not available	80.7	About the Same	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
Access to GP services	NHS outcomes framework	HIGH	73.40%	2014	74.80%	70.70%	74.60%	About the same	Better	About the same

Measure description	Source	Polarity	Most recent annual data	From	Previous year	London Average	England Average	Comparison with previous year	Comparison with London Average	Comparison with England Average
Women's experience of maternity services: Intrapartum[3] (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[4] (score between 1-10)	NHS outcomes framework	HIGH	7	2014	8.75	Not available	6.6	Worse	Unknown	About the same

[1] Data for 2011/12 is available but Croydons data set has been suppressed due to its small size

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

[3] 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.

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

FOR INFORMATION ONLY

REPORT TO:	**HEALTH AND WELLBEING BOARD (CROYDON)** **Date 10 June 2015**
AGENDA ITEM:	**17**
SUBJECT:	**Croydon Carers Strategy update**
BOARD SPONSOR:	**Paul Greenhalgh, Executive Director, People Department**

BOARD PRIORITY/POLICY CONTEXT:

The Croydon Carers Strategy 2011-16 (http://intranet.croydon.net/dash/Carers/carers.asp) contributes to Croydon Council's vision of promoting independence, live ability and growth.

FINANCIAL IMPACT:

There are no further financial implications associated with this update report. Carers are estimated to save the Council and local health services £541 million a year.

1. RECOMMENDATIONS

1.1 That the Health and Well Being Board notes and supports the work to support Carers in accordance with the Croydon Carers Strategy 2011 – 2016.

2. EXECUTIVE SUMMARY

The Croydon Carers' Strategy 2011- 2016 (the Strategy) was written in anticipation of the Care Act 2014. The strategy highlights the value of investing in carers, who provide an essential range of support to their person cared-for that would otherwise need to be undertaken by the local health and social care economy.

The strategy was the subject of consultation with all known stakeholders and their responses were incorporated within it. The strategy was used to implement commissioning plans (the Carers Support Network Funding Programme of 2012-15) for carers' services , including the development of the Carers Support Centre (the hub) – all to provide services which are preventative, personalized, cost effective and targeted to meet carers' needs. Plans are underway to re-commission carers services under a new commissioning programme in time for 1 April 2016.

3. IMPLEMENTATION OF THE CROYDON CARERS' STRATEGY

3.1. Implementation of the strategy, which received Cabinet approval in October 2011, is ongoing. Progress is highlighted below.

3.2. A range of preventative and early intervention carers' services were commissioned from 1st July 2012 as part of the Carers Support Network Commissioning Programme 2012-15 using the 'hub and spoke' service delivery model. Due to the implementation of the Care Act 2014, the Council has extended and varied these contracts to 31st March 2016. This has additionally involved signing a one year contract with the Whitgift Foundation and South Thames Crossroads Care to carry out carers assessments on behalf of the Council. This will allow the Council to firstly be demand ready for carers services; secondly, help assess the level and nature of demand for carers services; thirdly, maintain continuity and minimize disruption of services during the period of the Care Act implementation and fourthly, provide the space to prepare for the new carers commissioning programme 2016- 2019. The latter will, amongst other things, consider what further initiatives need to be developed in order to meet the Care Act duties.

3.3 One of the key aims of the Carers Strategy was to develop an accessible new Carers Support Centre for Croydon. Much has been achieved in this area, thanks to the significant investment by the Whitgift Foundation as part of a partnership venture between the Council and the voluntary sector. The Centre (24/26 George Street in Central Croydon) was officially opened on 7th October 2013. The Centre is now flourishing as the 'go to' point for information and other carers' services including a signposting service to more specialist carers' services. The Carers Support Centre brand/logo is now firmly established.

3.4. As a single point of access for carers, the Carers Support Centre has 13 offices and spreads over three floors. The ground floor is opened up as a reception, meeting space for carers and confidential meeting rooms. There is a training room which facilitates up to 30 people and houses services such as South Thames Crossroads Care, Horizon Care and Welfare, Young Carers Project, Healthwatch, Family Lives, Parents in Partnership, Croydon Neighbourhood Care Association and JAG foundation.

3.5 The Carers' Support Network provision has put in place early intervention and preventative services which are delivering good outcomes for cares. The services on offer are access to information, advice, advocacy and support (single contact centre, support groups, peer networks, counselling - either 121 or by telephone, training), befriending and short break services. These services are accessible through the Carers Support Centre or directly from the providers who provide these services. Outcomes information show that carers feel that that their quality of life has improved through the use of these services for example 72% of carers reported that through the use of respite services that their stress levels had decreased. The provision also includes culturally appropriate respite and breaks service for black, ethnic minority communities and offers office and home-based services. Over the last three years, this provision was increased through the Better Care Fund investment. In 2014-15, over 430 carers benefitted from this extra provision. The Carers Support Centre which is operated by the Whitgift Foundation, continues to maintain and expand carers services as follows:

- The carers café is now open every day during the morning period. This is where carers can enjoy some respite over a drink, receive a befriending service or meet up with other carers.
- Groups meet regularly at the Centre, e.g. carers singing group, carers reading group, Parkinson Society's support group, National Autistic Society's support group and carers support group (general).
- Advice surgeries take place on debt advice (monthly), benefits advice surgery(twice a month), mental health surgery, CAB advice surgery (once a month) and legal advice surgery (once a month) and employability skills (once a month); special educational needs drop in (twice a month).
- 20 training sessions on average are run quarterly. Training topics include first aid for carers of a child with special need or disability, caring for an adult with a substance misuse /addiction, speaking up on someone's behalf, caring for people with Alzheimer's and Dementia and understanding and acknowledging carer stress, pressure sores, Care Act, Wills and Trust and Makaton. The carers attending the training often meet other carers and form peer networks.
- Carers Support Centre website – there have been continued improvements of the website. Further developments could include having links to the free health apps e.g. NHS Direct's mobile app that allows access to trusted and reliable healthcare advice from wherever you are, straight to your smartphone.
- Free health checks every Wednesday for cares aged from 40 -74.
- Availability of radar keys for disabled toilets.
- Carers assessments on behalf of the Council from June 2015.
- The carers directory called 'How *to guide for carers'* is currently being updated and will contribute towards Council's Careplace initiative for having a single information and advice directory for the borough.

3.6. The development of the carers register at the Carers Support Centre has been completed. This has further progressed to allow the required data capture as part of completing carers assessments on behalf of the Council. Providers within the Carers' Support Network, make referrals of new carers, subject to consent, to the carers register. The register is a gateway to carers receiving benefits such as free membership to the Centre, discount card offering discounts to a few local shops and leisure facilities (the discount scheme is planned for expansion through a new initiative by the Whitgift Foundation which has been supported by the Council), receipt of regular *Carers News and* bulletins containing useful information about services and invitations to carers events.

3.8 In total, the Carers Support Centre has recorded 3,800 carers on the carers register. These numbers change periodically as a result of changes in the caring role. The carers register closely correlates with Croydon's census data. Through the carers register, we are able to be more efficient in terms of disseminating carers' information to all known carers. The register is building up an evidence base for carers which will be useful for future planning of carers services.

3.9 Regular Carers Partnership Group meetings are organised every quarterly and the Council's safeguarding team provides periodic briefings on safeguarding matters. Amongst other things, the Partnership Group has been involved in work and discussions on Care Bill/ Act consultations, service design for people (and their carers) with dementia, urgent care, care homes and the development of Careplace, the single information directory for Croydon. The Young Carers Steering Group meetings have been resumed to consider, amongst other things, the recent legislative changes that affect young carers. Borough-wide carers events continue to take place such as Carers Week and Carers Rights Day. The Carers Rights Day, scheduled for 3 June 2015, raises carers issues among carers and professionals and allows carers to access services early and at the right time. Last year, the Carers Rights Day attracted some 350 carers and professionals with excellent feedback received. The Carers Week event scheduled from 8 to13 June 2015 in Croydon has gone 'local' in that a wide range of carers events/activities will occur across the borough. The purpose of these events is to give carers a break, relieve isolation and are signposted to services if or when they need to.

3.10 As mentioned in paragraph 3.2, commissioned services under the Carers Support Network Commissioning Programme 2012-15 are coming to an end in March 2016. The Council 's new carers commissioning programme is currently being designed which will, inter alia, take into account the Care Act 2014 as it is being applied in Croydon, the statutory carers survey results of 2014, the carers register data, and emerging good practice for carer services. To date, two engagement sessions have taken place with the Carers Partnership Group. An engagement workshop is planned for 27 May 2015 to involve wider groups of stakeholders including carers. The workshop will focus on addressing any gaps in carers services, joining up services further as well as making ongoing improvements in the existing Carers Support Network service delivery model.

3.11 The arrangements set out above mean that Croydon is well-placed to meet the requirements of Phase 1 of the Care Act, which came into effect in April 2015.

CONTACT OFFICER: Amanda Lloyd, Head of Service for Older People, Long Term Conditions, End of Life and Carers, Integrated Commissioning Unit, extension 60224
Harsha Ganatra, Carers Lead, extension 62470.

FOR INFORMATION ONLY

REPORT TO:	**HEALTH AND WELLBEING BOARD (CROYDON)** **10 June 2015**
AGENDA ITEM:	**17**
SUBJECT:	**Croydon Heart Town Annual Report**
BOARD SPONSOR:	**Mike Robinson, Director of public health, Croydon Council**

BOARD PRIORITY/POLICY CONTEXT:

Croydon's joint health and wellbeing strategy set out to increase healthy life expectancy and reduce differences in life expectancy between communities. Heart and cardiovascular diseases are the major cause of death in the borough and the main contributor to differences in life expectancy between communities. Croydon Heart Town addresses a number of priorities in the strategy including child and adult obesity, helping people stop smoking, and early detection and management of people at risk for cardiovascular diseases and diabetes

FINANCIAL IMPACT:

There are no financial impacts arising from this report.

1. RECOMMENDATIONS

This report recommends that the health and wellbeing board notes the contents of the draft Croydon Heart Town Annual Report for 2014/15.

2. EXECUTIVE SUMMARY

2.1 At its meeting on 23 October 2013 the health and wellbeing board endorsed a strategic partnership approach to improving heart health in the borough and the extension of Croydon's Heart Town programme from two to five years. This report provides the health and wellbeing board with an update on Heart Town activity since the last report to the board on 12 February 2014.

3. DETAIL

3.1 Croydon Heart Town is intended to make a major contribution to the delivery of the joint health and wellbeing strategy 2013-18. This in turn reflects the community strategy's aim of protecting vulnerable people and offering good quality, accessible and joined up services and information so that agencies can make a difference to local people through coordinated prevention and early intervention.

3.2 Heart and circulatory diseases, including coronary heart disease and stroke, are responsible for around a third of all deaths in Croydon and are also major causes of early death (under 75 years) and disability. Women in the borough are over three times more likely to die of heart disease than breast cancer.

Croydon's population is increasingly overweight and inactive, putting those individuals at risk of cardiovascular diseases.

3.3 Core outcomes for Croydon Heart Town are to:

- Increase the proportion of people who take action to reduce their risk of heart and circulatory diseases by:
  - achieving a healthy weight
  - increasing their level of physical activity
  - stopping smoking
- Identify undiagnosed heart disease in people aged 40-74 through NHS Health Checks

3.4 Examples of work to deliver these outcomes are set out in the draft Croydon Heart Town Annual Report attached.

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BACKGROUND DOCUMENTS None

Croydon
Heart Town

DRAFT Annual Report

April 2014 to March 2015

Contents

Foreword

It is with very real pride in the achievements of our second year as a Heart Town, that I am writing the foreword to the Croydon Heart Town Annual Report for 2014/15.

[TO BE COMPLETED BY THE CHAIR]

Councillor Maggie Mansell
Chair of Croydon Health and Wellbeing Board

Introduction

Heart Towns were launched by the British Heart Foundation during its 50th anniversary year, with the aim of establishing 50 Heart Towns across the UK. The Heart Towns initiative aims to mobilise communities to prevent and fight Britain's biggest killers, circulatory and heart diseases. Heart Towns work by bringing communities together through local fundraising and volunteering to help beat heart disease.

Croydon became a Heart Town on 15 July 2013 with the signing of the Heart Town Pledge by the Mayor of Croydon and representatives of the British Heart Foundation. In our second year as a Heart Town we have continued to work closely with the British Heart Foundation to increase awareness and provide education around how to prevent heart disease with a particular focus on schools and workplaces. Since becoming a Heart Town we have also raised over £30,000 to help fight heart disease.

This report summarises the progress made during Croydon's second year as a Heart Town as well as our plans for future developments.

Heart and circulatory diseases in Croydon

Heart and circulatory diseases, or cardiovascular diseases (CVD), are responsible for around a third of all deaths in Croydon and are also major causes of early death (under 75 years) and disability. Almost half (46%) of these deaths are from coronary heart disease and nearly a fifth from stroke (18%). Whilst Croydon performs close to, or better than, the national average on most CVD indicators, CVD remains one of the borough's biggest killers. Women are over three times more likely to die of heart disease than breast cancer. Croydon's population is increasingly overweight and inactive, putting those individuals at risk of CVD.

The rate of early death from CVD in Croydon has been falling for over a decade and is similar to the national rate. However, 215 individuals die early every year in Croydon from CVD. It is estimated that around 133 of these deaths could have been prevented.

Data from the Joint Strategic Needs Assessment indicates that both the one and three year trends for early death from circulatory diseases and two other key indicators (deaths from coronary heart disease and emergency readmissions within 28 days of discharge for stroke) have been worsening. Although Croydon's performance is not significantly different from the national average, without action these may well become future challenges for the borough.

There are significant health inequalities for CVD in Croydon in terms of age, gender, ethnicity and deprivation. Deaths from CVD are concentrated in the over 75s age group. More men than women die of CVD. Croydon GP data on CVD (including hypertension, atrial fibrillation, stroke, heart attack, coronary heart disease and heart failure) record greater prevalence amongst men compared to women for all these conditions except hypertension. Black people had the greatest recorded prevalence for hypertension and stroke. Atrial fibrillation was greatest amongst White people, while for Asian people the greatest prevalence was for heart attack and coronary heart disease.

People from the most deprived communities in Croydon have a CVD death rate that is twice as high as people from the least deprived communities. Differences in smoking and obesity rates are factors that may partly explain this inequality.

Why did Croydon become a Heart Town?

The two outcomes that Croydon Heart Town is expected to make a significant contribution to are:

- increased healthy life expectancy
- reduced differences in life expectancy and healthy life expectancy between communities

The first outcome is to improve not only how long people live – their life expectancy, but also how well they live – their healthy life expectancy. The second goal focuses attention on reducing inequality in health outcomes between people, communities and areas in the borough. By focusing on longer healthier lives and narrowing the gap we will help increase independence, a key goal for both the council and the NHS locally. Heart Town aims to do this by reducing the levels of disease and disability caused by heart and circulatory diseases. A heart healthy lifestyle also provides protection against cancer, diabetes and, to some extent, liver and respiratory diseases.

Cardiovascular disease is estimated to cost the UK economy £19 billion a year. Of the total cost of cardiovascular disease around 46% is due to direct health care costs, 34% to productivity losses, and 20% to the care of people with cardiovascular disease (both social care and informal care). Local work to model the cost of just one modifiable risk factor for cardiovascular disease – smoking – estimated that the cost of smoking to the Croydon economy is around £82 million a year. By tackling cardiovascular disease we aim to reduce these costs and contribute to the growth of the local economy.

What can we do to prevent heart disease?

In Croydon there is a mixed picture in relation to the modifiable lifestyle factors that cause heart and circulatory diseases. Whilst the adult smoking rate is falling, there are rising levels of overweight and obesity in both adults and children. The estimated level of healthy eating in adults is better than the national average, with levels of physical activity in adults close to average.

Excess body fat and smoking are the two single most significant causes of cardiovascular disease and preventable death. Other contributory factors include high levels of alcohol consumption, too much fat and salt in the diet and stress. Conditions such as diabetes also carry an increased risk of developing cardiovascular diseases.

21% of heart disease is attributable to excess body fat. In Croydon, almost a half of all adults are overweight or obese (one in four are obese). One in three children under the age of 11 is overweight or obese. Helping people achieve and maintain a healthy weight, eating well and being more active is a key goal for Croydon Heart Town.

14% of deaths from cardiovascular diseases are caused by smoking. One in five adults (around 50,000 individuals) in Croydon smoke: this is close to the national average. Although the smoking rate is falling there remains considerable scope to help more people to quit through the Heart Town. This will also contribute to reducing sickness, disability and deaths from respiratory diseases and cancers.

Good mental health and the reduction of stress can also contribute to reducing the risk of cardiovascular diseases. Physical activity and volunteering are two elements of the Heart Town programme which contribute to better mental health and reduced stress.

Croydon Heart Town objectives

All Heart Towns are expected to:

- raise levels of public awareness of heart disease;
- activate and involve business and the community in charitable fundraising; and,
- provide education, advice and support on how people can reduce their risk.

In Croydon we also aim to:

- increase the proportion of people who take action to reduce their risk of heart and circulatory diseases by:
  - achieving a healthy weight
  - increasing their level of physical activity
  - stopping smoking
- identify undiagnosed heart disease in people aged 40-74 through NHS Health Checks

A range of indicators have been chosen to help us measure progress. These can be found at appendix 1.

Fundraising and volunteering

Croydon Heart Town has provided the impetus for a wide range of fundraising activities both large and small.

Teams from the borough have competed in the London to Brighton Bike Ride and the Ben Nevis Challenge. As well as a gruelling climb up Ben Nevis, the UK's tallest mountain, the Croydon team completed a bike ride and a canoe race to complete the challenge.

In September, Croydon Heart Town got behind the Great British Bagathon - the UK's biggest bag filling challenge. The idea behind the Bagathon is simple – British Heart Foundation can turn the things people don't need into bags of life-saving research. We promoted registration for the Bagathon amongst Croydon's workplaces, asking staff to fill as many bags as they could with unwanted clothes, shoes, toys, books, CDs or DVDs.

Croydon marked National Heart Month in February by promoting Wear It Beat It, British Heart Foundation's campaign to encourage as many people as possible to wear red for a day to raise awareness of heart disease and funds for lifesaving research.

The Big Lunch aims to get as many people as possible across the whole of the UK to have lunch with their neighbours. In June 2014 all organisers of lunches big and small were sent a Croydon Heart Town message and fundraising pack. Croydon Council also hosted its own Big Lunch in the centre of Croydon to raise funds for the British Heart Foundation.

Since becoming a Heart Town, Croydon has raised over £30,000 for the British Heart Foundation - a truly 'heartening' achievement.

[FUNDRAISING ACTIVITY PHOTOS HERE]

Campaigns & awareness raising

Croydon Heart Town has delivered a number of health promotion campaigns and awareness raising events over the year. These include:

- Surrey Street Market Harvest Festival (September 2014)
- Stoptober quit smoking campaign (October 2014)
- New Year quit smoking campaign (January 2015)
- Dry January Campaign (January 2015)
- NHS Health Checks campaign (October 2014 and January 2015)
- British Heart Foundation's 'Wear It, Beat It' campaign (February 2015)
- National No Smoking Day (March 2015)

[SELECTED CAMPAIGN IMAGES HERE]

Shockingly Easy

Croydon Heart Town has been proud to support the London Ambulance Service with their London wide Shockingly Easy campaign. We set out to persuade 50 businesses and organisations across Croydon to install a defibrillator in their premises and gain accreditation by training staff to use it. Having a defibrillator within easy reach of someone having a cardiac arrest can often mean the difference between life and death. Around 32 per cent of people survive an out of hospital cardiac arrest but, where there is a defibrillator and someone trained to use it, the chance of survival can increase to 80 per cent. So far, the campaign has led to 24 newly accredited defibrillators and another 11 new defibrillators purchased but yet to be accredited. Chris Hartley-Sharpe from the London Ambulance Service said: *'The Shockingly Easy campaign was launched to increase the number of public access defibrillators in London to help improve the cardiac arrest survival rate. We are heavily dependent on local ambassadors to spread the word on our behalf. Croydon is an excellent example of a borough that has championed the campaign at a local level. We hope other boroughs will follow their lead.'*

[SHOCKINGLY EASY LOGO HERE]

Healthy Living Hub

The Healthy Living Hub in the Central Library has promoted heart health throughout the year. This walk in service is aimed at those people who might need some extra help and encouragement to change to a more healthy diet and lose weight, to stop smoking or to increase their physical activity. It also acts as a signposting and referral service. Visitors can have an NHS Health Check or get one to one stop smoking support with no need to book. The Hub runs regular chair based exercise class that attracts older members of the community and table-tennis on Thursday for participants of all ages (the oldest participant is in her 70's). There are regular slots for host visiting agencies including Diabetes UK, British Heart Foundation, and Age UK. Over 5,000 people visited the Hub in 2014/15. It has been particularly successful in attracting men, with 52% of the visitors being male. This shows the acceptability of a neutral venue, like a public library, as a place for reaching out to men who are traditionally less likely to visit traditional health service settings. One visitor said: *'If I wasn't here I'd be sitting at home alone. This class has helped me greatly, not just with exercise but with my depression. It motivates me to come out of the house and I look forward to laughing and exercising with friends I have made.'*

Healthy eating

Phunky Foods & Alive N' Kicking

Croydon is pioneering a new approach to supporting children and young people to reach or maintain a healthier weight. In the last 12 months we have set up two new services: Phunkyfoods promote physical activity and healthy eating in early years, primary and special schools. Alive N' Kicking provides a weight management service for 4-12 year old children. The new service motivates and supports children to improve their health, well-being and self-esteem. Both services work in more deprived wards in Croydon (due to the local link between deprivation and obesity), and work with the whole family. Over the last year Phunkyfoods have worked in over 40 schools and pre-schools with a combination of curriculum support and activities. Alive N' Kicking have delivered their programmes in leisure centres, youth centres and schools. One parent said '*My son thoroughly enjoyed the sessions and looked forward to it every week. He has achieved so much and I'm very proud of him. Thanks to you all at Alive N' Kicking. I believe he will continue to make good progress and keep healthy*'.

One example of a project delivered by Phunky Foods is a six week 'back to school' cookery club for parents at South Norwood Primary. Parents were taught about the Eat Well Plate, what a balanced diet looks like. They learnt about the consequences of a healthy or not so healthy diet. They were also taught how to read food labels. Parents taking part reported that they had changed their family's eating habits by using the skills and knowledge they had learnt. All of them made new friends. Support has carried on in the school with a regular coffee morning for the parents. Claire Austridge, Families First Co-ordinator at South Norwood Primary said *'Hosting a cookery club at school without a kitchen is hard work, but the rewards from it have been fantastic. The school has been able to engage with parents through the cookery sessions. The parents not only enjoyed the sessions, the food and the social side but they have also made life enhancing changes for themselves and their families. The Cookery Club has had a very positive impact on all those attending.'*

[PHUNKY FOODS AND ALIVE N' KICKING LOGOS HERE]

Croydon Food Flagship

Croydon Food Flagship has been developed to transform eating habits across the whole community starting with the health and nutrition of children at school. This programme has 2 year funding from the Greater London Authority with a five year plan now agreed. The overall aim is to reduce childhood obesity, reduce type 2 diabetes in adults and increase attainment in schools.

Six outcomes have been identified for our Flagship work:

- More children eat good quality food in schools at breakfast and lunch time
- More families eat good quality food in and out of home
- More children know how to cook real food and aspire to do so
- More families cook real meals
- More children and parents know how to grow their own food and aspire to do so
- More food eaten in Croydon has been grown in Croydon

Croydon Food Flagship was launched at Rockmount School, Upper Norwood, in March 2015. Cabinet member for children, families and learning Councillor Alisa Flemming said: *'These schools, along with others in Croydon, are teaching us vital life skills, in particular that cooking doesn't have to be a boring chore and healthy meals can be fun, creative, affordable and easy to prepare.'*

[FOOD FLAGSHIP LAUNCH PICTURE HERE – CHECK RELEASES]

Eat Well Croydon Healthy Catering Award

Heart Town is working to encourage food businesses to provide healthier options for their customers. The Eat Well Croydon Healthier Catering Award is a voluntary scheme for food businesses in Croydon. It is based on the principle that small changes in food choices, preparation and cooking methods can make a big difference to health. The project is focused on the areas of highest childhood obesity in Croydon. Businesses are invited to apply for the Award and supported to make changes to their food service to make healthy eating easy and accessible for their customers. All businesses applying for the Award are required to meet set criteria adapted from the Chartered Institute of Environmental Health Healthier Catering Commitment award and to attain a minimum food hygiene standard rating of 3. So far, twenty businesses have been

signed up for the Eat Well Award. The Award is continuing for the next year with the aim of signing up a further 20 businesses and growing a network of venues in Croydon where people can choose to Eat Well.

What's My Veg?

What's My Veg is a project we asked Croydon People First to lead on. They organised 10 lunches for people with learning difficulties who each took turns to prepare a meal. Each meal included different vegetables. The participant preparing lunch was given one to one teaching by a professional cook about how to prepare each meal. The cook explained different ways the vegetable can be cooked and different foods which the vegetable goes with. People taking part viewed slides and information about all the vegetables with quiz questions like "why is spinach good for you?" The teaching included: Where does the vegetable come from? What does it look like in the ground? Why is it healthy for you? Where can you buy it and how much does it cost? When can you buy it if it is seasonal?

Physical activity

Croydon Heart Town is working hard to encourage everyone to be more active, whatever their ability and baseline activity level.

Go Tri

With the success of the Brownlee brothers in the Olympics, there has been increasing interest in triathlons, duathlons and aquathlons. For those new or returning to exercise, however, the prospect of doing more than one activity in an event can seem daunting. Together with the council's sport and physical activity team, Heart Town has sponsored three free GO TRI duathlons over the past year at Croydon Arena. GO TRI helped us set up these cycling and running events to encourage more people to give it a go. By keeping the distances shorter than standard events, people who wouldn't have considered signing up are dipping their toes into the world of duathlon. None of the participants, bar one, had ever taken part in this type of event. The feedback has been overwhelmingly positive and many participants have gone on to take part in longer distance events around London and the Home Counties. A number were also signposted to local running, cycling and swimming clubs where they are planning to improve their fitness and technique and carry on being more active in the longer term.

[GO TRI LOGO HERE]

Fitter Fans

Heart Town has given its backing to the Crystal Palace 'Fitter Fans' scheme. This is aimed primarily at men aged 30 and over and aims to improve overall health and fitness through a free 10 week course. Each session lasts two hours and includes a workshop and fitness session. The workshops cover topics like healthy eating, stopping smoking, CPR and general health and fitness, as well as a Q&A session with current and former players. The most recent group to graduate through the programme was made up of 22 fans aged between 30 and 70 years old. Fifteen of them managed to lose weight, 16 saw a reduction in blood pressure, one participant saw his waist shrink by a massive 12cm! After completing the course the fans can join the next level of the programme and take part in weekly football training sessions. The scheme has helped over 250 fans improve their health.

'The fitter fan session yesterday was awesome. The warm-up session was very professional and at a good level for all involved. The fitness test was gruelling but very rewarding... Basketball was so much fun… You don't even realise you're actually working out and getting healthier. I think it's because we all laugh and share the common goal of becoming fitter.'

Workplace health

Physical activity programmes at work have been found to reduce absenteeism by up to 20%. The results of Croydon Council's staff health and wellbeing survey showed that 90% of roles in the council are entirely sedentary. More than 50% of staff reported doing no or minimal physical activity during the week. Fifty four percent of staff who responded to the survey were overweight or obese. The council's workplace health group have developed a plan to increase people's level of physical activity, help them lose weight and reduce their level of stress. Some of the innovations introduced during the year include providing table tennis tables for staff to use during breaks; and exercise classes including ballroom dancing, circuit training and Pilates. In October 2014 the council held a Step Challenge to encourage people throughout the organisation to move more by taking part in a fun competition. Two hundred and fifty staff members (50 teams of five) took part in the Challenge. Twenty nine teams had scores of over 1,000,000 steps each by the end of the Challenge, with the winning team recording an amazing 1,644,304 steps. In recognition of its achievements in promoting workplace health the council has been awarded the Employer's Network for Equality and Inclusion Wellbeing at Work Award and the London Healthy Workplace Charter (LHWC) at Achievement Level Award.

NHS Health Checks

The NHS Health Check programme aims to help prevent heart disease, stroke, diabetes, kidney disease and certain types of dementia. Everyone between the ages of 40 and 74, who has not already been diagnosed with one of these conditions or have certain risk factors, will be invited (once every five years) to have a check to assess their risk and will be given support and advice to help them reduce or manage that risk.

In 2014/15 we commissioned a pilot NHS Health Check outreach service to increase take up in higher risk and harder to reach groups (including the homeless and people not registered with a GP). We also asked them to target areas where there is currently little or no NHS Health Check provision. The outreach service has proved popular exceeding its target of 2,250 health checks by delivering 2,549 health checks over the year. Of the people seen by the outreach service, 37% were referred to another service for follow up advice, support or for further tests by their GP. Eight percent of the people seen by the service were not registered with a GP and were given advice on how to get registered. The outreach pilot has been extended to 31st March 2016 with a focus on reaching the 55 to 74 year age group, South Asian men. We have also asked them to target workplaces.

[NHS HEALTH CHECK CAMPAIGN POSTER IMAGE HERE]

Stop smoking support

For several years, Croydon has successfully achieved its quit target - delivering over 2000 quits a year. Services we provide in the borough include stop smoking advice in GP surgeries and in pharmacies, an outreach service and a hospital based service for people wanting to give up before they have surgery or give birth. Although many people are able to give up smoking with little or no support some people need extra help. There are also differences in smoking rates between communities. This is one of the most significant drivers of health inequalities in the borough. Amongst routine and manual workers in Croydon, 29% of adults are smokers, whereas only 17% of the general population are. This is one of the reasons why we are now targeting our efforts at people from routine and manual groups, people who are unemployed and people living in areas of higher deprivation.

Quit rates of some targeted groups have been improving from a 2013 baseline. Quits from routine and manual workers increased by 13% and quits from sick and disabled people by 77%. Quits from people living in New Addington and Fieldway are also up 18.5%. We still have some way to go however. Quits from people who have never worked or long term unemployed people have fallen and it is unclear why this might be the case. To help us identify how we can provide better stop smoking services we have undertaken the ASH 'CLeaR' self-assessment and will use this to plan how we help people quit in the coming years.

Our plans for 2015/15

Croydon Heart Town brings together a wide range of programmes and project with the aim of improving heart health in the borough. In 2015/16 we will continue to promote healthy eating by developing the Food Flagship. We have some exciting new projects in the pipeline including a community food learning centre and support for new food businesses to set up in Croydon. We will be working to get Croydon moving by promoting active transport, including walking and cycling, as well as continuing to promote participation in sport and use of our green spaces. We also want to do more to support people with heart and circulatory conditions (like AF and angina) to manage their health and live active and productive lives.

Appendix 1 2014/15 Croydon Heart Town Outcome Indicators

Performance Indicator		Corporate Indicator	Local Indicator	National Indicator	Indicator Type	Description	Croydon 2011/12	Croydon 2012/13	Croydon 2013/14	Croydon Current		
Monthly and Quarterly Performance Measures												
PH.06	PHOF 2.03				National	Smoking status at time of delivery	n/a	7.8%	↘ 7.3%	Dec-14		**6.7%**
PH.16 (1)	PHOF 2.22iii	✓			National	Eligible population aged 40-74 **offered** an NHS Health Check (Year to Date)	n/a	20047	↘ 1519	Feb-15		**6733**
PH.01 (2)		✓		✓	Local	Rate of Smoking quitters (12 week quit rate) (Year to Date)	n/a	n/a	773	Dec-14		**576**
PH.01 (1)		✓		✓	Local	Rate of Smoking quitters (4 week quit rate) (Year to Date)	2174	↗ 2263	↘ 2214	Jan-15		**1706**
PH.09A	PHOF 2.18				National	Alcohol attributable hospital admissions (rate per 100,000 population) Narrow	534.0	↘ 525	↘ 513.7	Sep-14		**258.72**
PH.09B	PHOF 2.18				National	Alcohol attributable hospital admissions (rate per 100,000 population) Broad	n/a	2108.5	↘ 2057	Sep-14		**1036.9**
PH.16 (2)	PHOF 2.22iv	✓			National	Eligible population aged 40-74 offered an NHS Health Check who **received** an NHS Health Check (Year to Date) - **REPORTING OF THIS INDICATOR IS UNDER REVIEW / REVISION**	n/a	2514	↘ 1883	Feb-15		**4219**
Annual Performance Measures												
PH.05	PHOF 2.06ii	✓			National	Excess Weight in Year 6 children (Children aged 10-11 years who are obese or overweight)	38.2%	↘ 38.2%	↗	2013-14		**38.3%**
PH.07	PHOF 2.13i & ii	✓			Survey	Percentage of adults achieving at least 150 minutes of physical activity per week	10.3%	↗ 12.5%	↗ 13.0%	2012-14		**13.0%**
PH.02	PHOF 2.14	✓			Survey	Smoking prevalence (adults over 18)	19.7%	↘ 17.1%	n/a	2013		**17.0%**
PH.04	PHOF 2.06i	✓			National	Excess Weight in Reception age children (Children aged 4-5 years who are obese or overweight)	24.2%	↘ 23.8%	↘ 23.1%	2013-14		**23.1%**

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