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

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

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

Non-voting members:
Lissa ANDERSON (London Probation Trust (Croydon))
Ashtaq ARAIN (Faiths together in Croydon)
Adam KERR (National Probation Service (London))
Sally CARTWRIGHT (London Fire Brigade)
Andrew McCOIG (Croydon Local Pharmaceutical Committee)
Des CONNORS (Metropolitan Police)

A meeting of the **HEALTH & WELL-BEING BOARD (CROYDON)** will be held on **Wednesday 13th April 2016** at **2:00pm**, in **The Community Space, Bernard Weatherill House, 8 Mint Walk, Croydon CR0 1EA**.

GABRIEL MacGREGOR
Acting Council Solicitor and Acting Monitoring Officer
London Borough of Croydon
Bernard Weatherill House
8 Mint Walk, Croydon CR0 1EA

MARGOT ROHAN
Senior Members Services Manager
(Democratic Outreach)
(020) 8726 6000 Extn.62564
margot.rohan@croydon.gov.uk
www.croydon.gov.uk/agenda
1 April 2016

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

AGENDA - PART A

1. Minutes of the meeting held on Wednesday 10th February 2016 (Page 1)

To approve the minutes as a true and correct record.

2. Apologies for absence

3. Disclosure of Interest

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

4. Urgent Business (if any)

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

5. Exempt Items

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

6. Appointment of second Vice-Chair

To appoint a Board Member from the CCG, as agreed at Council on 25 January 2016 (deferred from 10 February meeting).

7. Strategic Item
Improving people's satisfaction with care: learning from local best practice

- **Maternity services** (Page 9)

A presentation, which will be given at the meeting by the Chief Officer of Croydon's Clinical Commissioning Group and Croydon Council's Executive Director of People, will be circulated separately.

8. Business Items
Final CCG operating plans 2016/17 (Page 27)

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

9. Health and social care integration: Better Care Fund and Transforming Adult Community Services (Page 51)

The report of the Chief Officer of Croydon's Clinical Commissioning Group and Croydon Council's Executive Director of People is attached.

10. People Gateway - Household Income and Child Poverty (Page 97)

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

11. Report of the chair of the executive group (Page 107)

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

12. Public Questions

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

Questions should be of general interest, not personal issues.

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

13. FOR INFORMATION ONLY (Page 163)

Croydon Advertiser article covering Healthwatch Child Autism event on 15 March 2016

14. The following motion is to be moved and seconded as the "camera resolution" where it is proposed to move into part B of a meeting

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

AGENDA - PART B

None

HEALTH & WELL-BEING BOARD (CROYDON)
Minutes of the meeting held on Wednesday 10th February 2016 in The Council Chamber, The Town Hall, Katharine Street, Croydon CR0 1NX

Present:

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)

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

Healthwatch Croydon
Charlotte LADYMAN (Healthwatch Croydon)

NHS service providers:
Zoe REED (South London & Maudsley NHS Foundation Trust)

Representing voluntary sector service providers:
Sara MILOCCO (Croydon Voluntary Action)

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

Non-voting members:
Ashtaq ARAIN (Faiths together in Croydon)
Jamie KIRBY (London Fire Brigade)
Philip MOCKETT (Metropolitan Police)

Absent: Lissa ANDERSON (London Probation Trust (Croydon)), Sally CARTWRIGHT (London Fire Brigade), Dr Jane FRYER (NHS England), John GOULSTON (Croydon Health Services NHS Trust), Dr Ellen SCHWARTZ (Acting Joint Director of Public Health), Kim BENNETT (Croydon Voluntary Sector Alliance), Nero UGHWUJABO (Croydon BME), Karen STOTT (Croydon Voluntary Sector Alliance), Adam KERR (National Probation Service (London)), Andrew McCOIG (Croydon Local Pharmaceutical Committee)

Apologies: Lissa ANDERSON (London Probation Trust (Croydon)), Sally CARTWRIGHT (London Fire Brigade), Dr Jane FRYER (NHS England), John GOULSTON (Croydon Health Services NHS Trust), Kim BENNETT (Croydon Voluntary Sector Alliance), Nero UGHWUJABO (Croydon BME), Karen STOTT (Croydon Voluntary Sector Alliance)

Apologies for lateness were also received from Councillor Alisa Flemming

A1/16 MINUTES OF THE MEETING HELD ON WEDNESDAY 9TH DECEMBER 2015

The minutes of the meeting held on 9th December 2015 were agreed as an accurate record, following clarification and revision of item A74/15, as follows:

3rd paragraph to read:
"Charlie Ladyman explained every Friday Healthwatch volunteers go over the data in a Patient Experience Panel (PEP). The PEP scrutinises issues, applies clinical coding, identifies serious concerns, monitors equality and diversity, and discovers leading health and social care related trends. "

A2/16 DISCLOSURE OF INTEREST

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

A3/16 URGENT BUSINESS (IF ANY)

There was no urgent business.

A4/16 EXEMPT ITEMS

There were no exempt items.

A5/16 APPOINTMENT OF SECOND VICE-CHAIR

THIS ITEM WAS DEFERRED TO THE APRIL MEETING.

A6/16 STRATEGIC ITEMS

Steve Morton and Nerissa Santimano (Public Health Principal) introduced the report.

This JSNA chapter on Older Adults is one of two needs assessments forming part of Croydon's 2014/15 JSNA. It is based on the framework of goals and desired outcomes established as part of the Outcomes Based Commissioning Programme. The recommendations put forward in this needs assessment should directly influence future service provision and models of care.

The report highlights that older adults and carers of older adults are not just consumers of health and social care services but also important constributors to society and local communities, with a wealth of experience to offer.

Members of the Board raised the following issues:

- Cllr Louisa Woodley mentioned the pressures at work impinging on duties as carers and asked if they are higher amongst ethnic carers and also if there is a higher level of deprivation in BAME communities.
- Charlie Ladyman suggested that carers wanting to take more care of family members need to be identified and given more support.
- Cllr Maggie Mansell stressed that more men are now living alone and are more prone to drinking and earlier death.
- Paul Greenhalgh responded that the Local Strategic Partnership is working on this area.
- Cllr Maggie Mansell recommended working through the Black Forum and Asian Awareness Centre to raise awareness of services available for carers.

The Board **AGREED** that delegated authority be granted to the Acting Director of Public Health, Executive Director, People Department, Croydon Council and Chief Officer of Croydon CCG to agree any final changes to the document if required.

There was a table discussion on the issues raised in this report and the following item, both covering outcomes based commissioning for over 65s (see at the end of the following item).

A7/16 HEALTH AND SOCIAL CARE INTEGRATION: OUTCOMES BASED COMMISSIONING FOR OVER 65S

Paula Swann (Chief Officer, CCG) and Paul Greenhalgh (Executive Director of People, Croydon Council) introduced the report and gave a presentation (see attached).

The vision of the Croydon Outcomes Based Commissioning (OBC) Programme is for all partners (statutory, voluntary and community) to come together to provide high quality, safe, seamless care to the older people (age 65 and older) of Croydon that supports them to stay well and independent. Users will have a co-ordinated, personalised experience that meets their needs.

(N.B. Councillor Alisa Flemming entered the Chamber at 3pm)

There were table discussions following the presentation, each table looking at a different aspect and identifying particular areas or issues that the Board should keep under review in the coming year.

Table 1 - "I want to stay healthy and active for as long as possible"
The JSNA makes a number of recommendations on how older people can be supported to stay healthy and active.

Key issues raised:

- Transport - it is not specifically funded. The Freedom Pass is vital but people need to be able to access public transport. It is difficult for older and disabled people to get to places where activities are organised for them. Dial-a-Ride is not always available at the times when they are wanted. This can lead to isolation.
- Social prescribing - the importance of keeping people well in their communities, with positive roles. it is important to keep more people healthy and active by reducing the issues which prevent people from remaining so.
- GPs need to have the right information to signpost patients.

Table 2 - "I want access to the best quality care available in order to live as I choose and as independent a life as possible."
"I want to be supported as an individual, with services specific to me."
The JSNA makes a number of recommendations on how older people can be supported to live as independently as they choose and to be treated as an individual.

Key issues raised:

- Social isolation - it is important to ensure that those living alone have access to the right services.
- Needs of carers - planning and supporting individuals.
- Personal care packages - ensuring personal budgets meet the needs of the individual.

Table 3 - "I want to be helped by a team/person that has had the training and has the specialist knowledge to understand how my health and social care needs affect me."
"I want good clinical outcomes."
The JSNA makes a number of recommendations on how professionals and staff can be equipped with knowledge and skills and how good clinical outcomes can be delivered.

Key issues raised:

- Personalisation and variation - not everyone needs the same, so it is important to get the balance right.
- Clinical outcomes - maintaining the quality of services and patient care by responding to feedback, whilst managing patient expectations. Frontline staff need to have a wider view.

A suggestion was made of a councillor championing older people across departments. *(Councillor Mike Selva has been the Senior Citizens' Champion since May 2014.)*

The Board **NOTED** the report.

A8/16 BUSINESS ITEMS

Paula Swann gave a presentation (see attached).

In June 2014 the South West London Commissioners published a five year strategy and have been working to deliver it since that point. As part of the South West London Strategic Planning Group, this five year strategy is being refreshed for the period 2016/17 to 2021/22. Health and Wellbeing Boards and Local Authorities will be closely involved in the development and delivery of this strategy.

The following comments were made:

- People are being pushed to have more collaboration with SW London but we want to operate as Croydon.
- How can we ensure we continue to meet the needs of Croydon within a bigger footprint? For some things it is sensible to do them locally but for others it makes sense to do them over a bigger footprint.
- The same outcomes and standards of care need to be agreed across SW London.
- Implementation is a local issue, so SW London Strategic Groups at sub levels are being set up, in order to keep local focus, and Croydon is one.
- Mental health services for Croydon are provided by SLaM but other CCGs across SW London are covered by St George's Mental Health Trust.
- Whether there are more young people or more older people, we still have to deliver the right services to the same standard.

Some questions were also raised:

- National Government has put a ban on sending people to mental health beds miles away from their homes - how is Croydon coping?

Response: Numbers in Croydon had reduced but are creeping up again. It is a difficult issue, as we do not always have the right services available locally. There are not enough staff in mental health services and we need to look at how services are delivered. There is a need to resource the community side, to help deal with the problem locally.

- What support is there for housing, transport and other issues?

Response: There is a significant amount of investment now to improve these issues.

This report was for information only.

A proposal to have a seminar on this issue will be taken to the Executive Group.

A9/16 JSNA WORK PROGRAMME 2016

Steve Morton gave a summary of the report.

The paper set out revised proposals for the 2016 JSNA programme and governance of the JSNA process. Two focused JSNA needs assessments are to be taken forward in sequence in 2016:

- Social isolation
- Patient activation and health literacy

In addition, it was proposed to take forward a needs assessment on adults with learning disabilities, outside the JSNA process.
A simplification of JSNA governance arrangements was also proposed.

The Board **AGREED** the proposals.

A10/16 REPORT OF THE CHAIR OF THE EXECUTIVE GROUP

Paul Greenhalgh summarised the report.

At a seminar which took place in August 2013, Board members identified a number of strategic risks which have been kept under review.
The Work Plan for 2015/16 was agreed at the Board meeting on 25 March 2015. This is regularly reviewed by the Executive Group and the Chair.

The Board **RESOLVED** to

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

A11/16 PUBLIC QUESTIONS

There were no public questions.

The meeting ended at 3:55pm

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Longer, healthier lives for all the people in Croydon

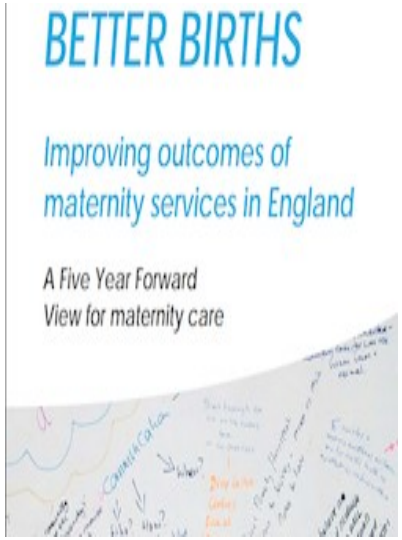
Croydon Health Services NHS
NHS Trust

NHS
Croydon
Clinical Commissioning Group

Maternity Services in Croydon – Improving People's Experience

Wednesday 13 April 2016

National Maternity Review 2016



- Women not offered choice, told what to do rather than information to make informed decisions
- Hospital services frequently operating at 100% capacity while community based services struggled to survive
- Whilst women wanted their midwife to be with them from the start, they rarely saw the same professional twice
- The quality of care varied considerably, thee was insufficient collaboration across professional boundaries and staff spent too much time collecting poor quality data
- Thing go wrong too often and fear of litigation inhibits staff from being open about learning from mistakes
- Outcomes on some measures are worse in the UK than for comparable services elsewhere in Europe

Vision for maternity services in SWL

Poor experiences can result in negative outcomes for the woman, her baby and her family.

Our vision is to strengthen the whole Maternity care pathway and service model through improving the quality of services and ensuring that provision is timely robust and delivered in the most appropriate setting.
We will do this by **improving**:

- Women's experience and outcomes through use of feedback
- Availability and quality of midwifery-led care for normal women
- Quality of Obstetric and specialist care for women with complex needs
- Continuity of carer and care throughout the whole maternity pathway
- Quality of care throughout pregnancy and childbirth and into infancy
- Out of hospital provision of antenatal and postnatal care

Vision for maternity services in SWL

Commissioners are working with all providers, through the maternity network in SWL, to deliver the maternity care clinical work stream of the SWL Collaborative Commissioning Strategy.

Delivery will be achieved through:

- Implementation of the Maternity Services Specification which reflects the London specification and supports London and National best practice
- Setting and monitoring clinical standards
- Reducing unwarranted variation
- Provision of networked peer support and guidance
- Training and development for the workforce across the whole pathway
- Improved education for women and their families
- Championing personalised care

Picture of maternity services in Croydon

- In 2015/16 (as at end Feb 2016), there were:
  - 3,697 births at Croydon university Hospital, a similar number to 2013/14 for the year (circa 6,000 births for Croydon resident women)
  - 2.13% of women gave birth at home – an increase on 1.94% from 2013/14
  - 13.7% had midwifery-led care throughout labour – broadly the same as in previous years but lower than our 40% aspiration
  - 86.3% had obstetric led care

- High degree of complexity in Croydon – deprivation/ language/ cultural factors/ late bookers

- Importance of integrated pathways for continuity of care and safeguarding

Croydon CQC Reviews 2011, 2013, 2015

Key Findings 2011

- During busy periods, the unit was not always able to provide adequate care and people indicated that they had not always received care and treatment which met their needs and welfare
- Improvements safe and accessible to support health and well being were identified to meet this standard
- Delays in equipment being repaired
- That the midwifery staff rotation system did not incorporate and induction programme for staff unfamiliar with a clinical area

Croydon CQC Reviews 2011, 2013, 2015

Key Findings 2013

- Most women and family members were happy with the maternity services and we saw evidence that they were both safe and caring
- The unit was well led with positive changes
- Women were offered choices and most found doctors and midwives caring (some exceptions at night)
- Systems were in place to respond to emergencies quickly
- The maternity unit cares for a relatively high number of high risk pregnancies – midwives were passionate about ensuring women got the right care and support
- The team included a range of specialists to meet the diverse needs of local women
- Staffing levels improving and staff were positive about the service they offered
- Some women mentioned delays in the antenatal clinic

Croydon CQC Reviews 2011, 2013, 2015

Key Findings 2015

- Safe – Requires Improvement (evidence of mandatory training)
- Effective – Good
- Caring – Good
- Responsive – Good
- Well-led – Good

- Overall Maternity and Gynaecology – Good

Croydon Maternity Unit

Where we are now – Improvements

Two successful DoH funding bids in 2012 & 2013 have enabled major improvements to be made to the maternity department:

- Refurbishment of the postnatal ward & birth centre
- Dedicated training suite for maternity staff
- Bereavement Suite for use by families experiencing pregnancy loss or with a sick child in the neonatal unit
- Butterfly Room on labour ward for families to use following a pregnancy loss which will include a 'cold cot' facility
- Improvements to the parents' facilities on the neonatal unit
- Recent successful bid for improving perinatal morbidity £30k for Dawes Redman CTG machines – 2016

Where we are now

Major refurbishment of the postnatal ward took place in 2012 including new flooring, a dedicated ensuite facility for post caesarean section women and a dedicated bathroom for partners to use when staying overnight.

Reclining chairs are also provided by each bed for partners to stay overnight.

Croydon Hospital Birth Centre

Improved facilities on the Birth Centre

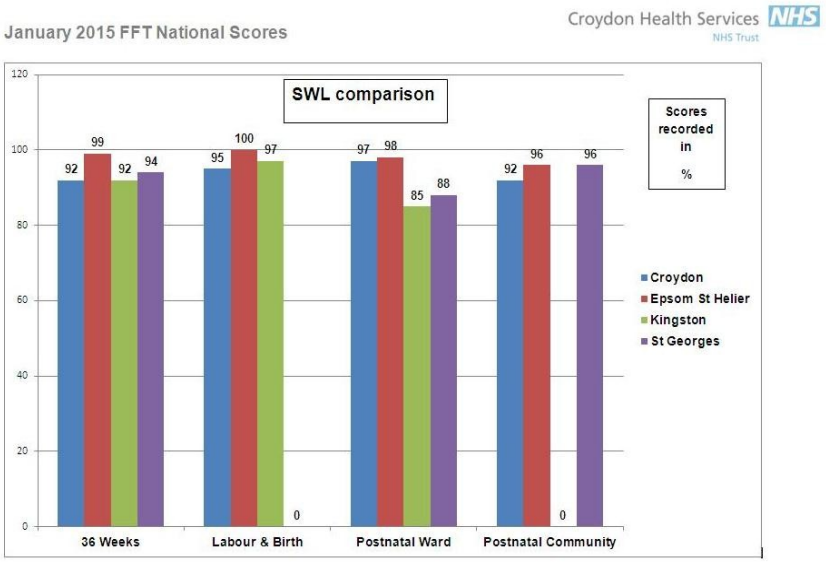
New birthing pools and larger rooms with beanbags and yoga balls to aid labour & a birthing pool installed on Labour Ward

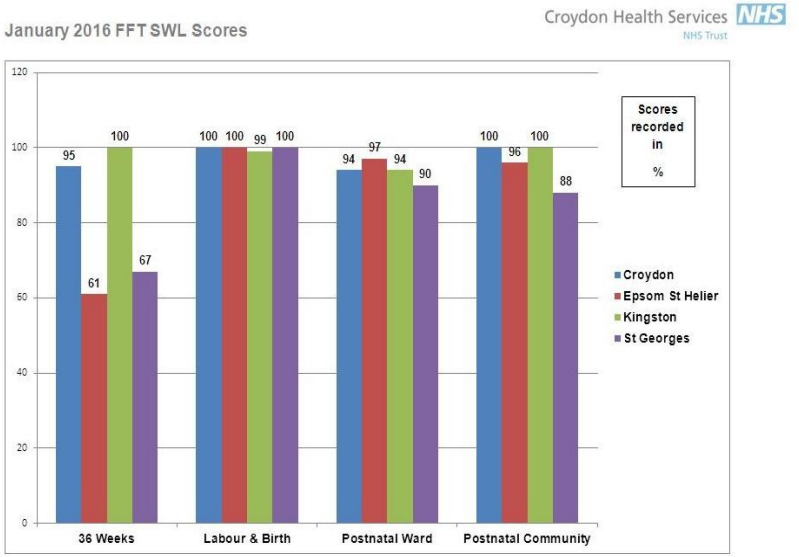
Maternity marketing campaign

- Visits have been made by the maternity team to five out of the six CCG cluster groups in Croydon to promote the unit and to highlight the services provided to local women.
- A new booklet 'Having your baby with Croydon Health Services' has been delivered to every GP surgery in Croydon.
- The maternity page of the trust website has been updated to include video footage which can be found by using the link below:

http://www.croydonhealthservices.nhs.uk/services/Maternity_Services/

Friends and Family Test Scores





Comparative scores for SWL trusts

Women are surveyed at four points during their booking with a hospital & scores reflect number of women who would recommend the trust

In comparison with January 2015 scores, all scores with the exception of Postnatal Ward have improved
Croydon did not receive a % score lower than 94% for January 2016.

Friends and Family Test - Compliments

FFT comments are reviewed every month and actions are drawn up for any 'quick wins' that can be achieved. Staff who receive positive feedback are named in the Maternity Unit newsletter each month.

Comments from FFT cards:

- Good communications very helpful and caring.
- Amazing staff and experience helpful informative and friendly. Thanks.
- Highly impressed.
- Very friendly attentive and helpful staff, great facilities.
- We were well looked after. Staff were very friendly and caring and helped us through the journey.
- Staff were knowledgeable, polite, confident & caring. Kept us up to date on every step.
- They made me feel welcome and reassured my partner.
- My wife wanted a VBAC and got one with the help of the midwives.
- Helpful midwifes and doctors.
- Incredible teamwork and all round support from everybody.
- The staff were amazing, the place has really changed in 3 years.

Friends and Family Test – Issues & Response

Each month the manager for each area is tasked with reviewing the negative comments on the FFT cards and formulating a 'Quick Win' action plan to address areas that can be improved quickly

Issues/Concerns raised by patients	Actions taken
Maternity – Antenatal, Hope Ward • Missed appointments and no contact from clinic	• Maternity DNA policy revised and midwifery ANC staff now follow up every DNA with the G.P first and then the patient and a new appointment sent.
Maternity – Postnatal, Mary Ward • Prompt answering of bells – poor response times • Long waits for discharges • Lack of cleaning in rooms	• Matron and Senior band 7 informing the staff on a daily basis in the morning handover that the buzzers need to be answered quickly. • We are piloting a discharge coordinator on the ward • Discussed cleaning with Facility manager and suggested 24 hour cover in maternity, especially regarding toilets/bathrooms on the ward
Maternity – Birth (Labour Ward) • Newer equipment • Consistency of staffing on each shift • Patients to have staggered arrival times for elective sections	• Equipment within the Labour ward is repaired or renewed with liaison and advice from EBME. • Numbers of medical and midwifery staff per shift is the same according to clinical capacity; however some staff are not Trust permanent staff. To continue with a recruitment drive to fill vacant posts. • Medical request to arrange arrival time for all elective caesareans at the same time in order to ensure all pre-operative checks and preparations are made for all women booked for caesareans. The order of the caesarean section list is decided by the anaesthetic and obstetric doctors on the day of the planned surgery.
Maternity – Postnatal Community • Give AM or PM times for visits	• Reduce numbers of postnatal home visits if not needed to be carried out in the home, but women will be offered timed appointments within community based postnatal clinics with a midwife, instead of a home visit if clinically appropriate.
Maternity – Antenatal Clinic/Community • Improve response rates for antenatal and postnatal community FFT cards	• Antenatal and Community Midwifery Manager has re-iterated the need to hand out FFT cards to increase response rates from women during the antenatal and postnatal period in both the hospital antenatal clinic and community services.

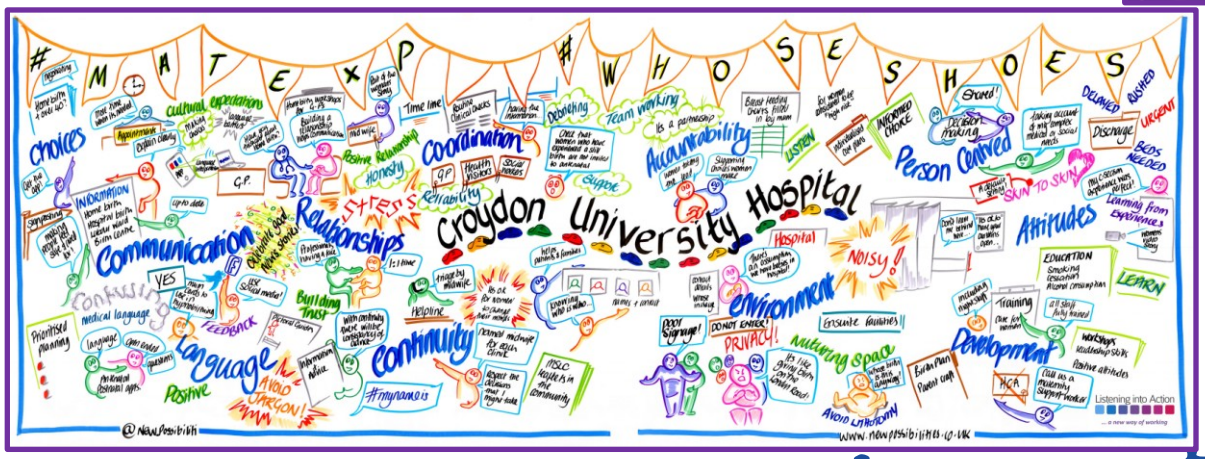
Feedback Events & Response
Whose Shoes – January 29th 2016

- 'Whose Shoes' is a Maternity Experience Workshop to improve maternity service users experience and environment
- London Maternity SCN established April 2013
- Patient experience subgroup created
  - Poor London performance in CQC maternity survey 2013
  - Snap shot SCN survey suggested basic communication and care sometimes lacking & looked for an innovative way to explore issues
- #MatExp created through collaboration – Support from Kath Evans and NHS England, and discussions with Gill Phillips, '*Maternity Whose Shoes?'* to improve maternity user experience and has been used to communicate the maternity workshops via Twitter to a wider audience

Whose Shoes – January 29th 2016

Art work in progress

Event in progress



Finished artwork

Whose Shoes – January 29th 2016

Key findings from the event

Meet with mothers who are in hospital due to the possibility of a pre-term delivery to reduce anxiety and fears, for the neonatal teams to visit the mum more post-delivery on labour ward following a traumatic delivery if they are unable to go to SCBU

Work with hard to reach communities so that their voices are heard, find ways to make staff retention better at CUH

Provide individualised women centred care with the woman taking the lead

Encourage skin to skin after c/s

Opportunity after pregnancy to follow up with a home visit from a midwife or see a consultant in hospital, inform GP's about birth options and address any concerns

Provide information to enable expectant parents to make informed decisions, make the information easier to digest and understand

Educate men about birth and breastfeeding and their role

Interact more with care providers to understand their roles, normalise birth even for high risk women to allow them to feel confident no matter what way they give birth

Support women's choices and remember that communication is the key between healthcare professionals and the patient

Adapt environment, buy equipment – telemetry, beanbags, challenge custom and practice, give informed choice, value patient feedback, feedback to women

REPORT TO:	**HEALTH AND WELLBEING BOARD (CROYDON)** **Date: 13 April 2016**
AGENDA ITEM:	**8**
SUBJECT:	**Croydon CCG's DRAFT Operating Plan 2016/17**
BOARD SPONSOR:	**Paula Swann, Chief Officer, Croydon CCG**

CORPORATE PRIORITY/POLICY CONTEXT:

This paper focuses on the CCG's draft operating plan for 2016/17. The final plan will be submitted to NHS England on 8 April. This year the Operating Plan sets out year one of the five year Sustainability and Transformation Plan (STP). The South West London STP is required to be submitted at the end of June. This paper also therefore outlines the process for developing the SWL STP. (See appendix 1)

The CCG, as a statutory organisation, is required to submit its commissioning plans and associated financial assumptions for the financial year 2016/17. The commissioning cycle is set out by NHS England.

CCGs are required to develop and publish an operating plan which balances local determination of priorities with sustaining and continuing to improve NHS performance on existing mandated priorities and deliver the foundations of its five year strategic plan.

Croydon CCG's draft Operating Plan sets out our plans to deliver our strategic direction and ambition for 2016/17 in the context of our local priorities and emerging national, London and South West London priorities as set out in:

- Delivering the Forward View: NHS Pplanning Guidance 2016/17 – 2020/21
- London Health Commission – Better Health for London
- South West London Five Year Strategic Plan – SWL Collaborative Commissioning and emerging SWL STP
- Croydon Health & Wellbeing Board – Joint Health and Wellbeing Strategy

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

The CCG has also developed in conjunction with its member practices, patients and public and where appropriate the Local Authority a number of key strategies which include:

- Prevention, Self-Care and Shared Decision Making Strategy
- Primary and Community Care Strategy
- Whole Systems Urgent and Emergency Care
- Integrated Mental Health Strategy
- Children and Families Plan
- Cancer Strategy

These strategies set out how we wish to transform our services to deliver better care. Our key priority in commissioning our services is to ensure that patients receive the right care, in the right place at the right time.

CCGs must involve each relevant Health and Wellbeing Board when preparing their commissioning plan or making revisions to their commissioning plans that they consider significant. In particular, they must give the Health and Wellbeing Board a draft of the plan and consult it as to whether it considers the draft plan has taken proper account of the Health and Wellbeing Strategy published by the board.

In October 2015, a paper from Croydon CCG was presented to the HWBB setting out each our commissioning intentions for 2016/17.

The CCG's strategic direction aligns to the Health and Wellbeing priorities 2013/18:

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

The delivery of the operating plan will have a positive impact on patients and carers. The implementation of the clinical and strategic priorities will enhance service quality and health outcomes and also promote equality of access and enable more patients to be treated closer to home.

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

Our emphasis, within our operating plan and our pathway redesign is on prevention, self-care and shared decision making where appropriate to do so.

FINANCIAL IMPACT:

The Operating Plan sets out Croydon CCG ambitions to reduce the inherited financial deficit, through quality, innovation and productivity and prevention plans. These are described in the 'Achieving Financial Balance' section of the operating plan.

1. RECOMMENDATIONS

The Health and Well Being Board is requested to:

- Note and comment on the draft operating plan and
- Comment on the alignment of the CCG's draft Operating Plan 2015/16 with the joint health and wellbeing strategy 2013-18.

2. EXECUTIVE SUMMARY

2.1 Our draft operating plan for 2015/16 sets out:

Our long term ambition:
'Longer healthier lives for all the people in Croydon'

Our vision is that through an ambitious programme of innovation and by working together with the diverse communities of Croydon and with our partners, we will use resources wisely to transform healthcare to help people look after themselves, and when people do need care they will be able to access high quality services

Aims

1. Maintaining and improving safe, effective and patient centred care
2. Transforming the way care is delivered for the future
3. Achieving financial sustainability
4. Having collaborative relationships to ensure an integrated approach
5. Evolving as an organisation

Objectives

1. To commission high quality health care services that are accessible, provide good treatment and achieve good patient outcomes.
2. To reduce the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital for physical and mental health.
3. To achieve sustainable financial balance by 2017/18.
4. To support local people and stakeholders to have a greater influence on service we commission and support individuals to manage their care.
5. To have all Croydon GP practices actively involved in commissioning services and develop a responsive and learning commissioning organisation.

Principles for everything we do include:

- Prevention is better than cure
- Ability to manage illness
- To be seen in the right place at the right time
- Shared Decision making

2.2 The draft Operating Plan also reflects implementation of emerging national, London and South West London priorities and the emerging SWL STP, as well as local service strategies. Our local plans continue to develop with the leadership of our five GP Clinical Governing Body and six GP Clinical Network Leaders. Through our GP networks we understand our population needs and are able to work towards delivering our priorities at a local level.

2.3 The national priorities are set out in the Five Year View and complement the requirements previously set out in the Everyone Counts Planning for Patients.

2.4 Across London and in particular across South West London CCGs are working together where collaborative working would lead to added value in supporting the delivery of local transformation priorities, including drawing on the learning from work already underway or developing in different parts of London. Croydon CCG is fully engaged with the London transformation programme (Better Health for Londoners) and South West London Collaborative Commissioning transformation programme.

2.5 The CCG must submit its final Operating Plan on 8 April with a potential refreshed submission in May to reflect final contract negotiations.

3. CONSULTATION

3.1 The priorities within the Operating Plan follow the same themes that were widely consulted on in developing the 5 Year Integrated Strategic Operating Plan 2013/14.

3.2 Patient and public engagement during 2015/16 has supported the development of many of our plans to be delivered during 2016/17. Further plans are currently being worked through in order that we can ensure robust engagement throughout the year. The PPI Reference Group will support the development of engagement plans further.

3.3 There has been significant engagement of national, London and South West London as part of priority and programme development. For example the London Programme Better Health for Care engagement included over 10,000 Londoners polled for their views; public events in every borough; and a number of events and meetings with key partners. The South West London Collaborative Commissioning programme engaged across all six boroughs.

4. SERVICE INTEGRATION

4.1 The Operating Plan sets out a number of transformation programmes with a range of partners which focuses on service integration:

- **Better Care Fund and Transforming Adult Community Services** –to integrate health and social care services to help people receive care more quickly in a community setting and preventing a hospital admission.
- **Outcomes Based Commission for Older People –** to use new models of care to improve health and social care services for over 65 incentivise provider focus on proactive care that keeps people healthy and at home
- **Transforming Primary Care –** through jointly commissioning primary care medical services with NHS England develop primary care services quicker to ensure people have greater access to services closer to home. The CCG will also be focussing on reducing unwarranted variation in referrals, diagnosis and outcomes in primary care
- **Transformation of Croydon Mental Health Services – Adult Mental Health Model (AMH) –** to stabilise services and transform community services to reduce inpatient need in the future and improve access.

5. FINANCIAL AND RISK ASSESSMENT CONSIDERATIONS

5.1 Not Applicable

6. LEGAL CONSIDERATIONS

6.1 Not applicable

7. HUMAN RESOURCES IMPACT

7.1 Not applicable

8. EQUALITIES IMPACT

8.1 The operating plan seeks to reduce health inequalities in Croydon. Individual plans require equality impact assessments.

9. ENVIRONMENTAL IMPACT

9.1 Not Applicable

10. CRIME AND DISORDER REDUCTION IMPACT

10.1 Not Applicable

CONTACT OFFICER: Fouzia Harrington, Associate Director for Strategy, Planning and Estates. Fouzia.harrington@croydonccg.nhs.uk

BACKGROUND DOCUMENTS
DRAFT CCG Operating Plan 2015/16 v1.11 (Presentation attached)

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NHS
Croydon
Clinical Commissioning Group

Draft Operating Planning 2016/17

Health and Well Being Board
13 April 2016

Longer, healthier lives for all the people in Croydon

Content

- Purpose
- Summary of our strategy
- Development of the Operating Plan and Alignment with the Sustainability and Transformation Plan
- Our focus for 2015/16

Purpose

Key Milestones

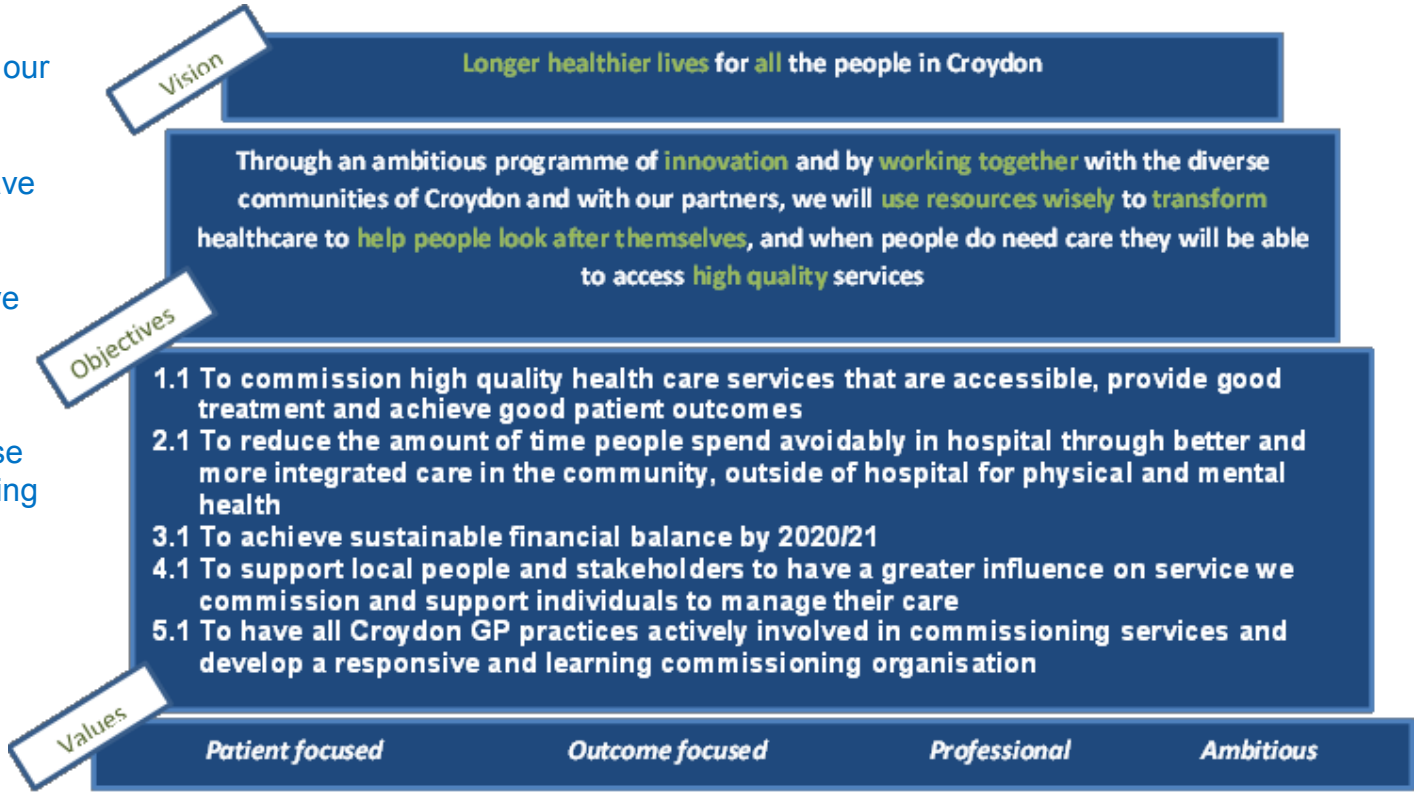
- **8 April** – Final submission
- **13 April -** Health and Well Being Board
- **24 May** – Receive at Governing Body
- **End of June** - Submission of full STPs
- **During July** - Assessment and Review of STPs

This paper

- Note and comment on the draft operating plan and
- Comment on the alignment of the CCG's draft Operating Plan 2015/16 with the joint health and wellbeing strategy 2013-18.

Summary of our organisational strategy (1)

We are currently refreshing our long term organisational strategy. Following a wide engagement process we have reconfirmed our vision and developed organisational values. In additional we have revised our objectives for 2016/17. The strategic direction of travel has been confirmed and we will finalise the outcomes over the coming months.

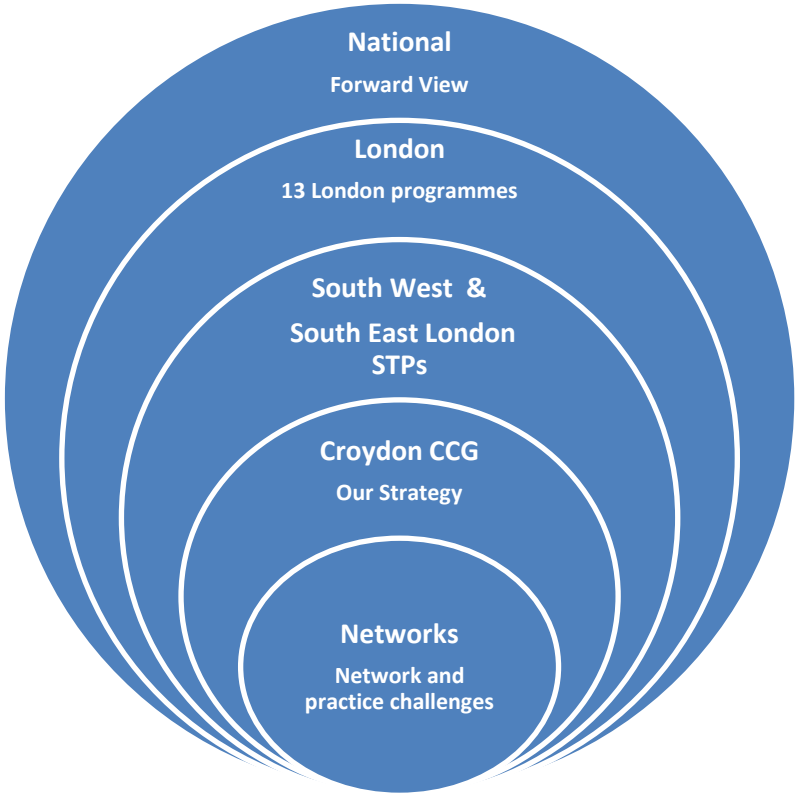


Summary of our organisational strategy (2)

Principles for everything we do

- Prevention is better than cure
- Able to manage illness
- Seen in the right place at the right time
- Shared Decision making

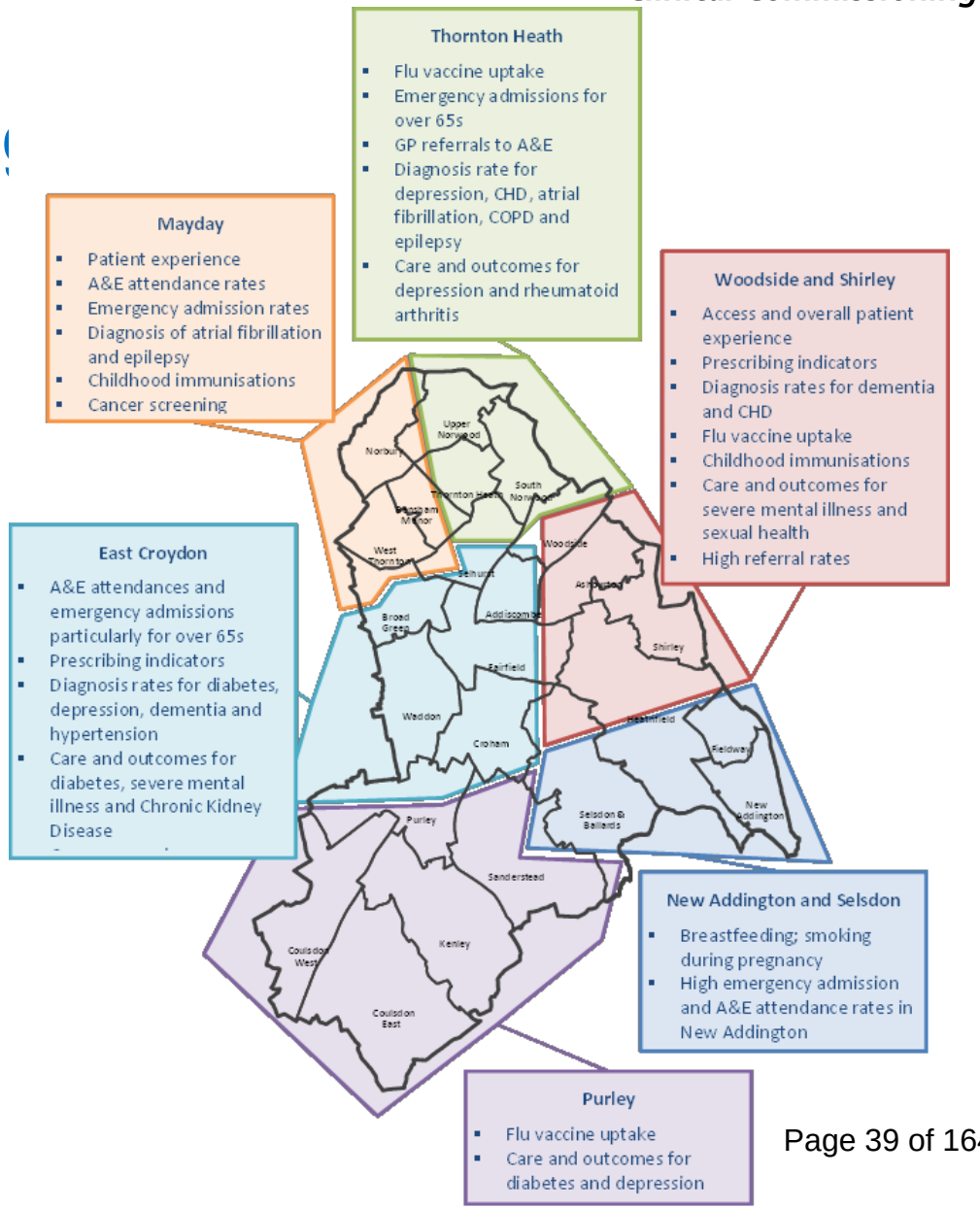
Development of the Operating Plan



- Local and wider priorities reflected
- Locally patient and public involvement in developing plans through the year
- Network and clinical leadership, involved throughout the year
  - Ongoing discussions in developing specific plans
  - Development of commissioning intentions (Aug /Sept)

Our Key Challen

We know that across Croydon there are different challenges to address



National priorities

The Delivering the Forward View: NHS planning guidance sets out the priorities for Sustainability and Transformation Plans and CCGs. In summary these are:

- Improvement in performance especially
  - Referral to treatment
  - Cancer 62 day waiting standard
  - A&E and ambulance waits
  - Psychosis access
  - IAPTS access
  - Dementia diagnosis rate
- Cancer
- Obesity and Diabetes
- Mental Health
- Dementia
- Learning disabilities
- New Models of Care and Health and Social Care integration

Our organisational focus for 2016/17

In addition we have our local priorities:

Implement

- Outcomes based Commissioning for over 65s
- Urgent Care Strategy

Implement at greater pace

- Prevention, self-management and shared decision making
- Mental Health Transformation

Develop and Implement

- Learning Disabilities Transformation plans
- Primary Care and Out of Hospital Strategy
- Obesity plan

Our plans for delivering national and local priorities

Prevention, Self Care and Shared Decision Making (PSSSD)

During 2015/16 the CCG has lay the foundations:

- Agreed outcomes framework for the delivery of the programme is in place.
- Recruited a Darzi Fellow to lead engagement and education amongst the clinical community in Croydon.
- Speciality specific PSSSD approaches have been developed amongst three of our clinical steering groups (MSK, Respiratory and Urgent Care).
- Delivered public information campaigns, such as self-care week and the Ask Three Questions campaign

Our focus for 2016/17

- Implement a training programme across Croydon practices to support clinician behaviours and delivery of shared decision consultations
- Enshrine the practical principles of PSSSD in acute and community
- Develop tier 3 weight management capabilities incorporating PSSSD interventions.

Our plans for delivering national and local priorities

Mental Health Transformation

During 2015/16 we have:

- Developed Dementia Advisors Services.
- Developed a 24hr Mental Health Crisis Line open to the public, carers, and professionals
- Developed an Early Detection in Psychosis service to identify and work with young people 18-35rs at risk
- Improved ADHD / ASD pathway for full implementation
- Expanded the Community Service in Adult Mental Health
- Community Services developed in Mental Health Older Adults services Home Treatment Teams and Care Home Intervention Teams.

Our focus for 2016/17

- Croydon to prepare for Perinatal target
- Develop an all age core 24 Psychiatric Liaison Service
- Further develop initiatives to improve physical health of people with mental illness
- Evaluate the impact of the community services and investment.
- Work towards establishing a Dementia Action Alliance.
- Evaluate the post diagnosis Dementia Advisors Service Pilot commissioned in 2015/16

Our plans for delivering national and local priorities

Learning Disability

During 2015/16 we have:

- Developed a Transformation Partnership Board with our strategic partners in SE & SW London.
- Been reviewing LD inpatients and ensuring placements have a CTR and have a discharge date

Our focus for 2016/17

- Review the current gaps in service provision commissioned and develop LD resources to provide short-term crisis and emergency care for people with complex and challenging behaviour in the community instead of unnecessary inpatient admissions.
- Improve service pathways with primary care and reduce waiting times to access LD community services
- Develop an LD 'at risk patient' register.

Our plans for delivering national and local priorities

Diabetes

During 2015/16 we have:

- Begun the upskilling of the primary care workforce
- Croydon CCG been successful in being the first wave of the National Diabetes Prevention Programme (NDPP)

Our focus for 2016/17

- Implement and promote national diabetes prevention programme (NDPP)
- Develop pre-diabetic register in primary care to recording patients with "Pre-diabetes"
- Ensure that there is coverage of Tier 2 diabetic care across Croydon GP practices

Obesity

During 2015/16 we have:

- Increased referrals to the weight management service which began June 2014.

Our focus for 2016/17

- Work with the Children and Young Peoples and Partnership to review adult and children obesity plans collectively
- Review and plan for the provision for obesity services including tier 3 weight management services and ensuring a clear pathway from tier 2 weight management services and bariatric surgery.

Our plans for delivering national and local priorities

Cancer

During 2015/16 we have:

- Introduced a programme of practice visits by the newly appointed Macmillan GP and CRUK Health Professional Engagement Facilitator
- Developed Acute Oncology Service at CHS
- Piloted the Enhanced Prostate Follow-Up in Primary Care.

Our focus for 2016/17

- Collaborative working across London on demand and capacity requirements for diagnostic services
- Provide education and support in primary care to follow for patient present with
- Implement the pan London cancer pathways including access for GP's to direct to test diagnostics

Our plans for delivering national and local priorities

Improving Performance

The CCG will meet all the expected national standards as of 1 April except for:

A&E Waiting Times (CHS) – Actions for 2016/17

- Resolve Outstanding Action from previous plan specifically: Discharge and Emergency Department Staffing and Process
- Focus on Emergency Department processes reflecting changes in the Breach Analysis
- A different focus predominantly on improving Front End (delay in ED review) plus implementing discharge/perfect ward

Improving Access to Psychological Therapies (IAPTS) Access and IAPTS Recovery – Action for 2016/17

- During 2015/16 we increased the number of patients entering treatment by more than 180% Performance is below the planned level due to referrals rates increasing at a slower rate than the IAPT access performance trajectory. The Croydon IAPT service has responded by expanding self-referral options including online self-referral, and is carrying out significant promotional work with general practice, community practice, community groups, and the public.

Our plans for delivering national and local priorities

New Models of Care / Health and Social Care Integration (1)

Outcomes Based Commissioning for over 65s

In partnership with the Council during 2015/16 we have:

- Undertaken significant capability assessment of the Accountable Provider Alliance

Our focus for 2016/17

- Ensure alignment with the Sustainability and Transformation Plan and the delivery of the Transforming Adult Social Care (TRASC) programme
- Intended start date for the new contract is at the end September 2016.

Our plans for delivering national and local priorities

New Models of Care / Health and Social Care Integration (2)

Out of Hospital and Primary Care Strategy

During 2015/16 we have

- Expanded the Rapid Response service
- Developing a care home management guide
- Improving the use of step up beds to support medically unwell people
- Implemented a GP Roving Service pilot to provide greater access to rapid medical care within the community
- Embedding proactive multi-disciplinary case management with health and social care input
- Increase intermediate care beds and step up facilities

During 2016/17 we will

- Refresh our Out of Hospital and Primary Care Strategy and ensure alignment with the Sustainability and Transformation Plan
- Work with the various health, social care and mental health services to ensure that the services are being fully maximised for patients
- Assess and develop additional services such as near patient testing and the provision of community intravenous services

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REPORT TO:	**HEALTH AND WELLBEING BOARD (CROYDON)** **11 April 2016**
AGENDA ITEM:	**9**
SUBJECT:	**Better Care Fund and TACS**
BOARD SPONSOR:	**Paula Swann, Chief Officer Croydon CCG & Paul Greenhalgh, Executive Director, People, Croydon Council**

BOARD PRIORITY/POLICY CONTEXT:

Croydon Council and Croydon Clinical Commissioning Group (Croydon CCG) are required to produce and implement a joint plan for the delivery of an integrated approach in transforming health and social care services to be delivered in the community (the Better Care Fund – or BCF- Plan) using pooled funds (the BCF) transferred from Croydon CCG's revenue allocation and the Council's capital allocation. The initial joint plan gained approval from NHS England (NHSE) in January 2015, and a refresh for 2016/17 is now due.
The report acts as an up-date to the Health and Wellbeing Board on key issues and the performance in regards the implementation of the plan, key metrics and planning for 2016/17.

FINANCIAL IMPACT:

BCF funds of £24.5m for 2016/17 are to be managed via a pooled budget.

1. RECOMMENDATIONS

This report recommends that the health and wellbeing board:

1.1 **Give delegated authority to the Health & Wellbeing Executive to approve Croydon's 2016/17 BCF plan.**

1.2 **Note the status of BCF delivery.**

1.3 **Note the progress of TACS implementations**

2. EXECUTIVE SUMMARY

2.1 The Better Care Fund (BCF) is a national initiative which aims to promote better integration between health and social care to provide a whole system approach to improving patient outcomes through investing in community based services and by doing so reduce demand on acute services.

2.2 A previous report on the Croydon Council and Croydon CCG Better Care Fund Plan 2014-16 was presented to the Health and Wellbeing Board on 21st October 2015.

2.3 The BCF plan comprises a wide range of schemes across health and social care which are delivering against 6 key metrics. Though there are individual scheme successes, mitigation actions are ongoing to bring delivery on track to achieve the metric targets, where these are not being met.

2.4 The transforming adult community services programme has successfully supported the delivery of integrated care in Croydon over the past year, with patients being cared for outside of a hospital environment. This has enabled people to be seen in the best place for their care, reducing the need for inappropriate high-cost hospital care for those patients.

2.5 BCF continues in 2016/17, and each Health and Wellbeing Board is required to approve its local BCF plan for 2016/17 by 25th April 2016.

3. BCF 2014-16

3.1 BCF changes for 2015/16 were planned to deliver benefits through

3.1.1 Improved self-management by providing individuals the support they need to stay at home

3.1.2 Improved primary and secondary prevention through better co-ordination of care for people with long term conditions through MDTs and access to a single point of assessment

3.1.3 Better management for people with ambulatory care sensitive conditions with rapid response services available

3.1.4 Increased integration and care co-ordination through both the single point of assessment and MDT meetings

3.1.5 Reducing emergency activity by better management of care and directing patients to the best available services

3.2 The 6 nationally reported indicators for Croydon's BCF are:

- Non-elective admissions
- Permanent admissions of older people to residential and nursing care homes
- Proportion of older people still at home 91 days after discharge from hospital into reablement/rehabilitation services
- Delayed transfers of care from hospital
- Discharges over the weekend for Croydon Healthcare Service (Croydon local metric).
- Social care-related quality of life

3.3 During 2015/16 a payment for the performance element of funding is linked to non-elective admissions.

3.4 In summary, Croydon's BCF performance is on an upward trajectory towards its ambitious performance targets, but performance is not yet meeting the required targets in all areas. A range of mitigating actions is in hand to bring performance to the required level.

3.5 In addition to performance against the BCF indicators (see following table), Croydon's BCF plan has enabled positive service delivery to accomplish the following:

3.5.1 TACS – The transforming adult community services programme has successfully supported the delivery of integrated care in Croydon over the past year, with patients being cared for outside of a hospital environment. This includes a dedicated social work team as part of an MDT approach, which has enabled people to be seen in the best place for their care, reducing the need for inappropriate high-cost hospital care for those patients.

3.5.2 ASC reablement service – primarily a “step-down” facility of 6 reablement beds and 2 reablement flats. 82% of service users have reduced or no further care needs.

3.5.3 IAPT (Improving access to psychological therapies) – improved access and capacity to support people with long-term conditions, enabling further delivery against Croydon’s IAPT access target.

3.5.4 Pilot of a mental health reablement service offering interventions that aim to restore life skills and build resilience in meeting non-medical issues such as accommodation, income, service navigation, social inclusion and symptom management. Of those who completed the programme, 90% were discharged to their GP.

3.6 A summary of performance against the BCF metrics is given in the following table:

TABLE: Performance summary by BCF indicator

The table below sets out the performance against the BCF metrics for the reporting period up to 31st January 2016.

REF	Indicator	2015/16 YTD Target	2015/16 (to date)	RAG rating and trend	Comments and mitigations
BCF1 	Total non-elective admissions in to hospital (general & acute), all-age, per 100,000 population	36,914	38,067 M8 YTD	R	To mitigate this performance the BCF Exec have put in place a set of service enhancements which collectively have started to demonstrate impact to reduce non-elective admissions from Nov/Dec 2015. ▪ Development of a Rapid Assessment Medical Unit (RAMU) to reduce admissions through clearer assessment of 'at risk' patients referred by A&E, Urgent Care Centre, GPs and London Ambulance Service (in place from late 2015) ▪ Enhancement, (from late 2015) of the Roving GP service for patients urgently at risk of being admitted to acute hospital. Immediate access to a GP medical opinion will allow the patient to remain at home or be place into a community bed (Step Up Beds). • Extension of rapid response service with nursing and specialist therapy support to care and nursing homes – in place from Sept 2015

REF	Indicator	2015/16 YTD Target	2015/16 (to date)	RAG rating and trend	Comments and mitigations
BCF2 	Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	317.0 (end Jan 16)	302.6 (end Jan 16)	G	Current performance is better than target. However, provisions data is often retrospectively uploaded, and there have been significant retrospective changes since the last report. Therefore it is likely that outturns could understate the true number of admissions being made.
BCF3 	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	88%	88.1%	G	Performance is fluctuating slightly around the target level but this appears to be due to random variations rather than any underlying issue for mitigation, and Croydon are on track to meet the target over the year.
BCF4 	Delayed transfers of care (delayed days) from hospital per 100,000 population (average per month)	145.7 (Dec 15)	214.6 (Dec 15)	R	The high volume of delays being seen for 2015-16 in part are attributable to a high number of delays from the mental health commissioned service provider. Mitigation actions in place include: • Weekly meeting in the Trust to review any barriers to discharge. • Closer scrutiny of recording to ensure DTOCs correctly captured. • Greater direct liaison between the Trust and Council Housing Needs team to arrange temporary emergency accommodation. • Transfer of the mental health supporting people facility to more suitable accommodation in Dec 2015, thereby ending a temporary reduction in capacity in the lead up to transfer. Planning for greater use of the “look ahead” contract to support service users in their own homes.

REF	Indicator	2015/16 YTD Target	2015/16 (to date)	RAG rating and trend	Comments and mitigations
BCF5 	Local Performance Metric: '% of discharges over the weekend for Croydon Healthcare Service'.	20%	18% M9 YTD (year end forecast = 18.5%)	**A**	The indicator is under-performing and is behind target predominantly due to a reduction in elective discharges over the weekend which has outweighed the increase in non-elective discharges. Mitigation plan in place with action on perfect wards, golden patients and ward rounds. Discharge improvement trend reflects current improvement plans created for the System Resilience Group (SRG) and the 95% Recovery Plan.
BCF6 	Patient/Service User Experience Metric Social Care related quality of life (ASCOF 1A)	19	18.4 (Mar 15)	**R**	This measure is an average quality of life score based on responses to the Adult Social Care Survey covering control, dignity, personal care, food and nutrition, safety, occupation, social participation and accommodation. The survey is run annually and next results will be available in June 2016. The survey is based on a sample (sent to approx. 28%) of service users that received services in the financial year, across all adult (18+) age groups.

Key:

Rating	Thresholds	Trend	Meaning
G	Improvement on baseline and target met		Performance from the last two data points indicates a positive direction of travel
A	Improvement on baseline yet below target		Performance from the last two data points indicates no change
R	Deterioration on baseline		Performance from the last two data points indicates a negative direction of travel

4. BCF PLAN FOR 2016/17

4.1 The Comprehensive Spending Review (25 November 2015), confirmed that the Better Care Fund will continue into 2016-17 – with a mandated minimum of £3.9 billion (nationally) to be deployed locally on health and social care through pooled budget arrangements between local authorities and Clinical Commissioning Groups.

4.2 The BCF 2016-17 policy framework was published on Fri 8th Jan and can be found here: https://www.gov.uk/government/publications/better-care-fund-how-it-will-work-in-2016-to-2017

4.3 Key points from the document are:

- Mandated minimum funding has increased from £3.8 to £3.9 billion
- The requirement for a pay for performance element of funding linked to non-elective admissions has been removed.
- There is a new requirement to fund NHS-commissioned out-of-hospital services. This is introduced as a new national condition.
- There is a new requirement to develop a clear, focused action plan for managing delayed transfers of care (DTOC), including locally agreed targets. The existing DTOC BCF metric remains in place, and the requirement for a local action plan is introduced as a new national condition.
- By 2017, plans are to be in place for health & social care integration for 2020 and beyond.
- A lighter touch is anticipated for 2016/17 plans, compared with the 2014 plans. “Brief narrative plans” are to be submitted via “short high level template” with a “reduced amount of finance and activity information”.
- Assurance of plans is to be carried out on a regional rather than national level.

4.4 The timescales for submitting Better Care Fund local plans will follow the timeline set out here:

Date (2016)	**Event**	**National/local deadline**
21/03	Submit first draft narrative plan and updated planning template to NHSE	National
11/04	Deadline for NHSE to respond to Croydon with assurance feedback on 21st March plan submission	National
13/04	Health and wellbeing board meeting – paper seeking delegated approval of BCF plan by Health & wellbeing Executive	Local
14/04	Deadline for papers to H&WB exec – this needs to be final version of BCF plan plus covering paper	Local
19/04	H&WB exec meeting – approval of 2016/17 plan	Local
25/04	Deadline for submission of H&WB-approved plans to NHSE	National
30/06	Deadline for s75 agreements to be signed	National

4.5 The timing of the nationally-set deadlines does not allow for presentation of the final version of the Croydon 2016/17 BCF plan for approval at the April meeting of the Health and wellbeing board.

4.6 **Therefore the health and wellbeing board are asked to delegate authority to the health and wellbeing executive for approval of Croydon's 2016/17 BCF plan.**

4.7 The BCF planning submission for 2016/17 is in 2 parts:

- A numerical planning template return
- A "brief narrative plan"

4.8 The draft narrative plan as submitted to NHSE on 21st March 2016 is attached as a supporting document, (Appendix A). The content of this plan is focussed on new requirements for 2016/17 and incremental change since Dec 2014. As such, extensive references are made to previous (Dec 2014) BCF plan and other supporting documents, but content from these other documents is not reproduced here.

4.9 The plan has been produced taking into account :

- The need to ensure stability in the local social and health care system
- Delivery against the BCF performance metrics, as well as individual BCF scheme delivery
- Alignment with other plans and strategic initiatives in particular Croydon's Outcomes Based Commissioning Contract (OBC) for over 65s which is expected to come into effect during 2016/17.
- Revisions to national requirements for 2016/17

4.10 Our 2016/17 BCF portfolio builds strongly on our 2015/16 delivery, but based on our review of 2015/16 activity, some adjustment to schemes and funding has taken place to increase investment in:

- GP roving services – extending to weekends and care and nursing homes
- End of life care – sitting service in care homes and at service user's homes
- Enhanced care co-ordination for frail and vulnerable patients – greater support to MDTs and improved sharing of care plans

5. TRANSFORMING ADULT COMMUNITY SERVICES (TACS)

5.1 Croydon CCG and Croydon Council's Model of Integrated Care in Croydon for over patients over 65 years is based on all partners (statutory, voluntary and community) coming together to provide high quality, safe, efficient, coordinated, seamless care to the people of Croydon (see Appendix B: A Proposed Model of Integrated Care in Croydon Over 65s).

5.2 The Transforming Adult Community Services (TACS) programme was implemented to support delivery of the Model of Integrated Care by:

5.2.1 Ensuring patients received the most appropriate care at the times they needed it through the development of a 24 hour, 7 days a week Integrated Single Point of Assessment.

5.2.2 Supporting the avoidance of unnecessary admissions by establishing a 24 hour, 7 days a week Rapid Response service to provide health and therapy support to patients in their own homes or in care homes.

5.2.3 Enhancing case management through the introduction of GP led primary and community care multidisciplinary team meetings that would increase the number of patients who would be supported through dedicated case management.

5.2.4 Increasing the capacity to provide intermediate care beds allowing patients to be supported away from hospital avoiding unnecessary admission and allowing swifter discharge from an acute setting.

5.3 The Programme has now been fully implemented with the following key achievements in 2015/16 (ytd performance at month 10) for the 4 targeted areas:

5.3.1 Single Point of Assessment – 25,368 referrals made to the 24/7 service have been triaged to the most appropriate service for the patient. In addition the service provides GPs and other healthcare professionals with the ability to speak to experienced community nurses to ensure that patients are seen by the most appropriate health team.

5.3.2 Rapid Response - 1,480 referrals made from GPs, London Ambulance Service, NHS 111, Accident & Emergency, and Social Services to the service to support patients to be cared for within the community rather than having an unnecessary visit to and possible admission in hospital. 94% of patients were seen within the target time of 2hrs, with an average of 20% subsequently appropriately admitted to hospital.

5.3.3 Intermediate Care Bed - 239 patients cared for in the service enabling:

- 149 patients who weren't yet fully capable of returning home after being in hospital to be cared for in a community environment rather than still being in a hospital ward, and;
- 90 patients who were too ill to be treated at home to still be cared for in a community environment rather than having to be in a hospital.

5.3.4 Enhanced case management - 1,256 patients supported through dedicated case management through the joint GP-led Primary, Community, Social Care and Mental Health multi-disciplinary team meetings (MDT).

- 67% of referrals were to Health Visitors for Older People service for frail/vulnerable people with lower level social care needs (e.g. social isolation support, carer assessments etc)
- The remaining 33% of referrals were to the Community Matron service for people with more complex health support needs

5.3.5 Social Care input to MDTs – Referrals have also been made to the social care workers supporting the MDTs. These have resulted in various outcomes following initial fact finding e.g. liaising with other agencies like Staying Put (service offered by Croydon housing in order to keep people in their own homes whilst essential blitz cleans and repairs are undertaken), Older People Floating Support (service funded by Croydon adult services and housing, delivered by One Support to provide housing related support to maintain independence), Careline Plus, Welfare Advice etc. to support people to still live at home under their terms, thereby improving their social care related quality of life.

5.4 Further service developments have also been taken forward in 2015/16 to improve care provision, including:

5.4.1 Elderly Care Consultants participating in more GP Practice MDT's to ensure that GPs can access specialist advice for supporting patients.

5.4.2 GPs having greater access to Older Adults Mental Health Consultant Psychiatrists advice for patients needing multidisciplinary input.

5.4.3 Proactive involvement in care homes by the Consultants in Elderly Care including ward rounds with GPs of patients in Nursing and Care Homes, and the development of a Purple Guide Care Home guide by the Consultants to support all care homes in understanding how to manage common problems in homes.

5.4.4 Investment in additional nursing and speech and language therapy capacity in the Rapid Response service from September 2015, to work proactively to improve care management and planning in nursing care homes, as well as working with the Care Support team to identify, support or deliver training for care homes.

5.4.5 Greater integration between the A&E Liaison and rapid Response services with both now working as one service to support unnecessary admissions within the community and at the Croydon University Hospital (CUH) Emergency Department (ED).

5.4.6 The Care Support team has also continued to provide support, education, specialist advice, observation and training to all provider services including residential, nursing home and domiciliary care providers, to raise standards so that servicer users receive a better quality of care, and incidents of harm and unnecessary hospital admissions are reduced.

5.4.7 In addition the service has widened its interventions to include clinical and direct observation, responding to requests from managers who have identified gaps in staff knowledge and skills. The multidisciplinary nature of the Care Support team enables them to draw on their shared knowledge to raise awareness about outcomes from current research and best practice e.g. National Institute for Health and Care Excellence guidelines, and Department of Health and Regulatory Frameworks.

5.4.8 Piloting of a mobile Roving GP service (initially 5 days a week between 08:30–17:00 from June 2015, and then 7 days/wk Mon-Fri 08:30:17:00 and Sat-Sun 13:00-01:00 from December 2015). The service which enables patients to seen and treated quickly (within 1hr) in their place of residence has successfully supported 221 people to be cared for at home, with the GP linking into other appropriate services like Rapid Response, Community Matrons or Social Services if needed for ongoing support.

5.4.9 The establishment of a Rapid Access Medical Unit (RAMU) in November 2015 operating 7 days/wk 09:00-21:00, providing a one-stop acute medical day care service for patients with urgent medical needs who have been either referred by their GP, or have attended CUH ED. Activity figures are currently being validated but performance at month 10 ytd indicates that around 2,000 patients have been appropriately cared for without the need for a hospital admission.

5.4.10 Co-location of the RAMU with the CUH Ambulatory Emergency Care Unit (a one stop medical day care unit for urgent medical intervention including same day diagnostics), the Acute Care of the Elderly service (a rapid assessment clinic for older people providing specialist treatment avoid unnecessary admissions), and the HOT Clinic provided by the respiratory team for patients with Chronic Obstructive Pulmonary Disease. This has enabled better care for patients with the ability to be seen quickly by the most appropriate clinician and/or multi-disciplinary team. The impact of these initiatives will be further evaluated so that the envisaged benefits can be fully assessed.

5.5 Some examples of the impact of the Transforming Adult Community Services programme at a patient level are provided in Appendix C: Health and Wellbeing Board TACS patient outcomes and experience.

6. CONSULTATION

6.1 Both Croydon Council and Croydon CCG are committed to ensuring that there is regular communication and engagement with our population, the wider health and social care community and our local stakeholders to maintain public trust and confidence in services for which we are responsible.

6.2 BCF draws on a range of existing services and work programmes, and receives inputs from consultation and engagement from those services/programmes. Service user and patient participation groups at GP network level and wider public forums, and service user feedback from Friends and Family Test surveys carried out by primary care, community, hospital and mental health services, will help to ensure we continually capture views and suggestions about services and service development. Examples of public engagement during 2015 on OBC include:

- Have held a public discussion and feedback event in Fairfield Halls 24th June with 50 people attending
- Attended and gained feedback from the CCG's PPI Reference Group 25th June
- Attended and distributed leaflets at Croydon's Ambition Festival 25th July
- Met with community leaders/ groups including PPG Groups, Cultural Groups, Carer Groups, Lunch Clubs and Community Panels, Day Centres, and the general public
- Public event, held on 19th October at Fairfield Halls
- OBC survey designed and online (both websites): closed 16th October (56 responses as at 12th October)
- https://www.surveymonkey.com/r/Croydon_Survey
- Continuing to update web pages to show what engagement has taken place and how it's informed the development of the future model:
- http://www.croydonccg.nhs.uk/get-involved/Pages/Outcomes-based-commissioning.aspx
- https://www.croydon.gov.uk/healthsocial/adult-care/outcome-based-commissioning
- Creation of the OBC Service User Engagement Specialist group that will inform the OBC Programme Board.

7. SERVICE INTEGRATION

7.1 Croydon Council, Croydon CCG, and Croydon Health Services have a history of close partnership working since 2011, and have worked together on a number of joint initiatives through the Council's Reablement and Discharge Programme and the CCG's Strategic Transformation Programme to jointly deliver innovative community-based patient/client-focused services. The BCF provides the momentum to continue this development, enable on-going joint service innovation, and facilitate the cultural change that will ensure that integration is sustained and continues to deliver the best outcomes for patients.

8. FINANCIAL AND RISK ASSESSMENT CONSIDERATIONS

8.1 BCF funding allocations by Health & Wellbeing Board area were published on 10/02/16. The minimum mandated allocations for Croydon are shown in the table below, and compared with the 2015-16 allocations.

Description	2016-17 £000	2015-16 £000	Difference
Mandated CCG contribution to BCF	22,454	21,498	956
Disabled Facilities Grant	2,046	1110	936
Adults social care capital grant		780	-780
Total - minimum mandated	24,500	23,388	1,112
Additional contribution s256 carry forward	-	754	-754
Total Croydon BCF fund	**24,500**	**24,142**	**358**

8.2 Croydon anticipate making a substantial commitment to integration of health and social care via OBC contracts of approximately £212m during 2016/17. Therefore, only the mandated minimum is planned for investment via BCF.

8.3 In 2016/17, the requirement for a pay-for-performance element of funding has been removed. All other arrangements for risk share and management of under- and over-spends will be set out in the section 75 partnership agreement governing the BCF pooled fund, as per the 2015/16 agreement.

9. EQUALITIES IMPACT

9.1 Any new initiatives that are commissioned through BCF are subjected to an Equalities Impact assessment where it has been assessed as being required.

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BACKGROUND DOCUMENTS

Appendix A: 2016/17 Draft BCF plan as submitted to NHSE on 21st March 2016
Appendix B:Model of care
Appendix C:TACS example outcomes

Croydon Better Care Fund Plan 2016-17

1 Authorisation and sign off

Signed on behalf of	Croydon Clinical Commissioning Group
By	Mrs Paula Swann
Position	Chief Officer
Date	19th April 2016 (planned date)

Signed on behalf of	Croydon Council
By	Mr Paul Greenhalgh
Position	Executive Director - People
Date	19th April 2016 (planned date)

Signed on behalf of	Croydon Health & Wellbeing Board
By	Cllr Maggie Mansell
Position	Chair of Health and Wellbeing Board
Date	19th April 2016 (planned date)

2 Introduction

2.1 About this document

This document sets out the essentials of Croydon's Better Care Fund (BCF) plan for 2016/17.

This year no plan template was defined by NHSE, but the document headings and content are structured in line with the NHSE assurance key lines of enquiry headings

The content of this plan is focussed on new requirements for 2016/17 and incremental change since Dec 2014. As such, extensive references are made to previous (Dec 2014) BCF plan and other supporting documents, but content from these other documents is not reproduced here.

2.2 Croydon BCF context

Croydon have a very real commitment to integration of health and social care. However, Croydon's BCF plan must be considered in the wider context of integrated service delivery: Croydon's Outcomes Based Commissioning (OBC) programme for over-65s service provision will be an integrated programme covering spend of approximately £212m per annum across health and social care, compared with approximately £24m invested via BCF.

Croydon's very significant and demonstrable commitment to integrated care via OBC supports our aspiration to "graduate" from BCF at the earliest opportunity.

2.3 Key references

Key documents referred to in this plan are:

a) Croydon Better Care Fund Planning Template Part 1 signed 12 Dec 2014 http://www.croydonccg.nhs.uk/get-involved/Documents/Croydon%20BCF%20Template%20(Part%20One)%20NEW%20FINAL VERSION.pdf

b) Outcomes based commissioning for over 65s – Update Report, report to Croydon Health & wellbeing Board 10th Feb 2016 https://secure.croydon.gov.uk/akscroydon/users/public/admin/kabatt.pl?cmte=WEL&meet=18&href=/akscroydon/images/att7014.pdf

3 The local vision for health and social care services

3.1 Our vision

Our vision for health and social care services is set out in the Dec 2014 BCF plan (P7-16) and has not changed.

The CCG and Council vision is to ensure that the services we commission and provide to our population are of the highest quality care, delivered at the right time and in the right place appropriate to their needs.

The CCG, the Council, and health providers have worked together since 2011 on a number of joint initiatives through the Council's Reablement and Discharge Programme, and the CCG's Strategic Transformation Programme, to jointly deliver innovative community-based patient/client-focused services. The BCF has provided the momentum to continue integrated working, on-going joint service innovation, and to facilitate the cultural change that would ensure that integration is sustained and continues to deliver the best outcomes for patients.

The CCG and Council proposed Model of Integrated Care in Croydon for over 65s, describes how Croydon will be moving forwards in implementing this vision with all partners (statutory, voluntary and community) coming together to provide high quality, safe, efficient, coordinated, seamless care to the people of Croydon and users that is proactive, focused on prevention, supports people to stay well and independent and is delivered as far as possible in the community.

Croydon's BCF plan should be considered in the context of its Outcomes Based Commissioning (OBC) programme for over-65s service provision which will be an integrated programme covering spend totalling approximately £206m per annum across health and social care.

OBC and BCF are foundations for integrated care in Croydon's future Sustainability & Transformation Plan, which will further extend the work already done in creating the 5 year strategy and CCG operating plan.

3.2 Outcomes based commissioning (OBC)

Croydon Clinical Commissioning Group (CCG) and Croydon Council have worked collaboratively to develop a transformation programme which will enable improvements to be achieved through a whole systems approach to health and social care.

The vision for Croydon is that people experience well-co-ordinated care and support in the most appropriate setting, which is truly person-centred and helps them to maintain their independence into later life. With an ageing population, the focus of the programme is on services for the over 65s and the outcomes that local residents have said are important to them – those factors that make a genuine difference to their health, well-being and quality of life.

The proposal has been developed to deliver Croydon CCG's vision of "longer, healthier lives for all the people in Croydon" and meets the key national overarching aims – 'Everyone Counts: Planning for Patients 2014/15 to 2018/19. NHS England' and supports the Council's key strategic priorities with regard to promoting and sustaining independence, well-being and good health outcomes for Croydon residents.

Additionally, the programme aligns with the aims of the Better Care Fund which are that health and social care services must work together to meet individual needs, to improve outcomes for the public, provide better value of money and be more sustainable. The programme builds on a long history of joint work in Croydon, including recent developments in delivering whole person integrated care through the Transforming Adult Community Services work.

Age UK Croydon, Croydon Council Adult Social Care, Croydon GP Collaborative Ltd, Croydon Health Services NHS Trust and South London and Maudsley NHS Foundation Trust agreed to form an Accountable Provider Alliance (APA) in June 2015 to be able to meet the decision by NHS Croydon Clinical Commissioning Group (CCG) and Croydon Council to transform the way services for people over 65 are commissioned.

The APA aims to deliver a model of care that is people centred, with an overall vision of 'Working together to help you live the life you want'. The APA has therefore defined a model of care that is focussed on staying healthy and independent to ensure people are at the centre of their care, enabling them to achieve the outcomes that are important to them. This will include in year 1 (2016/17) delivery of 5 key initiatives:

- Development of Multidisciplinary Community Networks;
- Development of 'My Life' plan;
- Establishment of Personal Independence Coordinators
- Single Point of Access and Information
- Integrated Independent Living Service

By joining forces, the APA believe they (a) are best placed to deliver community based healthcare services in people's homes and in the communities where they are comfortable and (b) will be able to provide a more holistic, well-rounded and bespoke health and social care service to our people.

For further detail on OBC, refer to the report "Outcomes based commissioning for over-65s – update report" to Croydon Health and Wellbeing Board 10th February 2016.

4 Evidence base supporting the case for change

4.1 Summary Case for change

The Dec 2014 BCF plan highlights (p 17-44) the case for change which **remains valid today.**

Key health and social care challenges arising from the changing demographic in Croydon have been highlighted as:

1. Increasing elderly population living for longer with one or more long term conditions;
2. Areas of deprivation in the borough with consequential impact on health;
3. Increasing numbers of younger people with disabilities requiring health and social care;
4. Increasing demand on mental health services
5. Increasing demand taking place at a time of financial challenge for health and social care

BCF changes had been planned to deliver benefits through

- Improved self-management by providing individuals the support they need to stay at home
- Improved primary and secondary prevention through better co-ordination of care for people with long term conditions through MDTs and access to a single point of assessment
- Better management for people with ambulatory care sensitive conditions with rapid response services available
- Increased integration and care co-ordination through both the single point of assessment and MDT meetings
- Reducing emergency activity by better management of care and directing patients to the best available services

4.2 New schemes in 2015/16

The Dec 2014 BCF plan refers (p23) to priority schemes to be delivered via BCF including some new schemes:

- Review of A&E Front of House
- Create a Roving GP Service
- Improving the Clinical Support and Competencies of Care Homes

These schemes have now been implemented. Progress and initial impact is described below.

4.2.1 Review of A&E Front of House

Over 2015/16 the CCG has worked closely with Croydon Health Services (CHS) to implement the proposed changes to support improvements in patient pathways at the Emergency Department (ED) at Croydon University Hospital.

This has included:

- Greater integration between the A&E Liaison and Rapid Response services with the services now operating as one service to support admission avoidance within the community and at the CUH ED. The integrated service (operating 7days/wk 09:00-

17:00 for the ED in-reach, and 24/7 for Rapid Response) enables patients to be assessed within 1hr of referral from the ED, treated if appropriate and to have a jointly developed discharge plan to enable the patient to return to place of residence with or without further intervention and support from appropriate services, including Rapid Response.

- The establishment of a Rapid Access Medical Unit (RAMU) in November 2015 operating 7 days/wk 09:00-21:00 providing a one-stop acute medical day care unit for urgent ambulatory patients who are either referred by their GP, or have attended the CUH ED. The Consultant-led team treat patients that require urgent medical review without the need for a hospital stay, including conditions such as DVT, Cellulitis, Low risk GI bleed, Low risk pneumonia, and Low risk pulmonary embolism.
- Co-location of the RAMU service with the Acute Care of the Elderly service (consultant-led team supporting elderly patients 75 years and over), and the HOT Clinic provided by the Respiratory Team (to provide care for Chronic Obstructive Pulmonary Disease patients who are acutely unwell). This has enabled better integration of care with patients being quickly seen by the most appropriate clinician and a multi-disciplinary team without having to be necessarily admitted to hospital.

4.2.2 Create a Roving GP Service

A Roving GP service has been piloted in Croydon since June 2015, providing a rapid medical response to patients with urgent care needs within 1 hour of referral to avoid unnecessary admissions into hospital. The initial phase of the pilot provided access during Mon-Fri 08:30-17:00, but has subsequently been extended to Mon-Fr 08:30-01:00 and Sat-Sun 13:00-01:00 as part of a wider service delivery model being piloted across the South West London CCGs.

To date (Jun 2015-Jan 2016) the service has seen 249 people and successfully supported 89% of people to be cared for at their place of residence without the need for a hospital attendance or admission. The service is now ramping up to higher volumes of patients per day.

4.2.3 Improving the Clinical Support and Competencies of Care Homes

A number of initiatives have been implemented over 2015/16 to establish the basis for improving the clinical support to nursing care homes, and for improving competencies of care home nursing teams. This has included:

- Additional investment in nursing, and speech and language therapy staffing in the Rapid Response team to work proactively with nursing care homes to support patients, improve care planning in conjunction with the care home nursing staff, and to work collaboratively with the Croydon Council Care Support Team to identify, support and provide appropriate nursing and speech and language therapy training to improve patient care and nursing home standards. This improved capacity began in September 2015 and have been working with the top 5 Nursing Homes with the highest London Ambulance Service conveyances to assess practice and support requirements
- Consultant Geriatrician input into the top 5 care homes with weekly joint ward rounds with the GPs of the care home residents and nursing home staff
- Development of a Purple Guide clinical guidance document for the management of common problems within the care home setting to support all nursing care homes in providing improved care to care home residents
- Undertaking a comprehensive review of services supporting care homes to develop a plan for better co-ordination of care provision, including rationalising GP Practice cover of care homes to improve accessibility and accountability

- A review of non-elective (NEL) emergency admissions for Oct-Dec 2015 vs Oct-Dec 2014 shows a reduction in the number of NEL admissions in 3 of the 5 care homes (15 less). Further work is ongoing with these care homes, and in identifying the next set of homes to support over Q1 2016/17.

4.3 2015/16 scheme review

All Croydon BCF schemes have been briefly reviewed in order to inform planning for 2016/17. Individual scheme performance has been considered, alongside the totality of delivery against BCF objectives.

Key questions considered were:

- Is performance on track?
- Is there evidenced delivery against BCF metrics?
- What is the need for improvement?
- What is the potential to impact on delivery of BCF targets

Each scheme was re-mapped to the relevant 2015-16 BCF national indicators, these being:

1. Non-elective admissions
2. Permanent admissions of older people to residential and nursing care homes
3. Proportion of older people still at home 91 days after discharge from hospital into reablement/rehabilitation services
4. Delayed transfers of care from hospital
5. Discharges over the weekend for Croydon Healthcare Service (Croydon local metric).
6. Social care-related quality of life

In addition, schemes were mapped to:

- OBC – whether the scheme is included (fully or partially) in Croydon's outcomes based commissioning for over-65s services.
- Out of Hospital services – whether the scheme can be considered as an Out of Hospital Service (new BCF national condition).

The review findings indicated that each of the current set of BCF schemes was delivering substantially as planned though, as was expected in a culture of continuous improvement, remedial actions and opportunities for further improvement were identified. Priority actions arising from the review have been incorporated into Croydon's BCF work plan for 2016/17.

Regarding the totality of BCF schemes, the review indicated that all BCF metrics were suitably well-served, and that the new national condition for investment in out of hospital services could be comfortably met by the current set of schemes.

The review also highlighted that approx. 80% of Croydon's BCF spend would become part of Croydon's over-65s OBC programme during 2016/17.

4.4 Emphasis for 2016/17

Our 2016/17 BCF portfolio builds strongly on our 2015/16 delivery as set out in 4.2 and 4.3 above. Based on our review of 2015/16 activity, some adjustment to schemes and funding has taken place to increase investment in:

- GP roving services – extending to weekends and care and nursing homes
- End of life care – sitting service in care homes and at service user's homes
- Enhanced care co-ordination for frail and vulnerable patients – greater support to MDTs and improved sharing of care plans

5 A co-ordinated and integrated plan of action for delivering that change

Much of the plan and governance arrangements set out in the Dec 2014 BCF plan (p 45-56) is still valid. This section sets out only the areas of change.

5.1 Governance structures

The BCF Executive Group will continue to exercise its functions providing overall accountability for the delivery of the Better Care Fund Plan. However, recognising the large (approx 80%) overlap of BCF with Croydon's OBC for over-65s, during 2016/17 there will be a planned transfer of governance functions to the OBC governance group.

5.2 Delivery milestones for 2016/17

The following table gives summary milestones for overall management of the BCF plan. Individual schemes have their own supporting work plans.

Date	Key milestones
Apr/May 2016	Plan signed off by Health & Wellbeing Board New schemes for 2016/17 formally initiated. S75 agreement signed.
Jun/Jul 2016	Q1 DTOC priority actions complete. DTOC plan refreshed. Priority 1 remedial/improvement actions (identified in 2015/16 scheme review) completed.
Aug/Sep 2016	Deep dive review completed on out of hospital activity – new national condition. Health check completed on new governance arrangements via OBC.
Oct/Nov 2016	Full review completed across all BCF schemes. First draft integration plan for 2020 and beyond prepared (subject to DoH making plan requirements available in a timely fashion)
Dec/Jan 2017	Bid prepared for "graduation" from BCF
Feb/Mar 2017	Plan approved for transfer of BCF schemes to new governance arrangements on "graduation" from BCF

5.3 Risk log

Key risks from the BCF risk log are shown in the following table:

Ref	There is a risk that..	How likely is the risk to materialise? (L)	Potential Impact (I)	Overall risk factor (LxI)	Mitigating actions
1	Demand pressures for social care services required to support health outcomes in Better Care plan exceeds projections	2	5	10	The council are implementing a comprehensive programme of transformation and demand management. BCF funding continues in 2016/17 at stable levels. The council and the BCF Executive Group will continue to monitor and take additional action as necessary.
2	Inadequate resourcing will restrict the ability of Croydon social care to provide the social work staffing resource to support plans under BCF	2	5	10	Realignment of Croydon social work resource has taken place during 2015/16 to meet additional demand, and this will continue through 2016/17 as part of Croydon's social care transformation plans. The council and the BCF Executive Group will continue to monitor and take additional action as necessary.
3	CCG 5 year financial improvement plan could be negatively impacted by introduction of BCF.	3	4	12	BCF financial planning taken into account CCG financial position, and BCF allocations have been agreed by joint Council and Social care Executive Group. Detailed and costed CCG Operational Plan – CCG workstreams/servic es have been planned pre BCF and are **operational**. QIPP programme overseen by CCG Project Management Office and QIPP Operational Board governance structure. CCG have engaged external support (PWC) to support COBIC and the development and infrastructure to deliver QIPP programme. BCF Executive Group will monitor progress throughout 2014/15 and 2015/16 and agree actions to be taken in response to any issues arising and adjust plans in liaison with Health and Wellbeing Board
4	Improvements in integrated care, early intervention and reablement services fail to translate into reductions in demand for acute services and/or social care costs.	3	4	12	Funding will continue via BCF in 2016/17 for reablement and early intervention schemes. The Council's social care transformation programme will further re-emphasise early intervention and reablement.

					BCF Executive Group will monitor progress throughout 2016/17 and agree actions to be taken in response to under performance.
5	Introduction of Care Bill results in significant increase in cost of care provision from 2016 and impact on current planning	2	4	8	Strong assurance from Government that full costs of care Bill will be funded Monies earmarked under BCF as contribution to ongoing delivery of new statutory duties.
6	CHS services are enablers in the success of implementing key BCF initiatives and realising the patient outcomes, and financial efficiencies resulting from integrated working. Their failure to perform could impact on key national BCF metrics	3	4	12	Managed by Transforming Care Implementation Group with escalation to Croydon Contract Management Group and Transforming Care Board as required. Managed via Outcome Based Commissioning contract arrangements.
7	Failure to deliver data sharing between health and social care will undermine ICU and integrated service delivery (G.P MDT's, Single Point of Assessment, and Rapid Response) and the realisation of benefits of integrated working and BCF	4	3	12	Development of health and social care portal through Reablement and Hospital Discharge programme. Engagement with S.W London CSU. Further integration of health care data is progressing between primary and secondary care including community. Planning with the APA includes shared care planning between health and social care with potential IT solutions.

5.4 Process for monitoring of scheme delivery and issue resolution

Each BCF scheme has a named delivery lead who is responsible for day to day implementation of the scheme, and for reporting on activity figures and key milestone delivery to the BCF Fund Manager. In the first instance, issues are managed through the usual operational channels for each scheme.

The BCF Fund Manager (CCG) and the Council BCF Lead regularly (currently monthly) review delivery across all schemes, and overall performance against BCF indicators, Where there is apparent under-performance, further enquiries area made, remedial actions initiated and/or issues escalated through the appropriate channels for that scheme.

Additionally in 2015/16 a deep-dive review across all schemes was conducted to review scheme performance and continued alignment with BCF objectives. Remedial and improvement actions arising from this review are allocated to named owners and progress is reviewed regularly with BCF Fund Manager and Council BCF lead. A similar review will be conducted in 2016/17.

The BCF Executive Group will meet quarterly during 2016/17 to provide oversight across the BCF programme. Standing items on the meeting agendas include:

- Performance and spend by scheme
- Performance against BCF indicators
- Key risks and issues

6 Compliance with National Conditions

6.1 Plans to be jointly agreed

NATIONAL CONDITION: *Plans to be jointly agreed.*

This plan has been developed jointly by colleagues across Croydon Council and CCG in close collaboration. The plan was approved firstly by Croydon's BCF Executive Group, with senior officer representation from both organisations including the Chief Officer, Croydon CCG; and Executive Director - People, Croydon Council. Secondly, it was approved by Croydon Health & Wellbeing Board, by means of delegated approval to the Croydon Health & Wellbeing Executive.

The various forums for engagement with providers were comprehensively set out in Croydon's BCF planning template dated 12/12/14 (p 86 onwards). Provider engagement has continued in this way throughout 2015/16.

Croydon's 2016/17 BCF plan shows a high level of stability from 2015/16, and implications for providers are therefore minimal in terms of any changes from those set out in the Dec 2014 BCF plan (p88 onwards). Implications for providers were highlighted to the Health & Wellbeing Board in the paper requesting approval of Croydon's 2016/17 BCF plan.

As the Disabled Facilities Grant is again allocated through the BCF, the local housing authority within Croydon Council have been fully engaged in planning for the use of DFG

monies within the BCF context. Given that, at time of writing, the grant conditions for DFG have not yet been published, DFG plans have not yet been finalised. However, the housing team are putting in place the capacity to ramp up the number of adaptations, and are working closely with commissioners to identify the optimum balance of adaptations and other capital projects to best meet local needs.

Commissioner and providers in Croydon have been working closely together to develop an Outcomes Based Commissioning delivery model, initially (from April 2016) for over-65s' services. OBC forms a core component of Croydon's strategic plans for integrated health and social care delivery. During 2016/17 it is expected, by commissioners and by providers, that the majority of Croydon's BCF delivery will be incorporated into OBC (while maintaining mandated BCF oversight and reporting).

6.2 Maintain provision of social care services

NATIONAL CONDITION: *Maintain provision of social care services.*

Our local definition for "maintain provision of social care services" is unchanged from the Dec 2014 BCF plan: that under BCF, the Council has sufficient resource to help meet current and any future increased demand in social care support in order to continue to manage demands on acute services and enable people to receive care at home.

All BCF social care schemes funded in 2015/16 are planned to continue in 2016/17, with funding uplifted for inflation and for demographic growth. This approach has been chosen to ensure stability in the local social and health care system. Management of the pressure on its budgets resulting from the support it gives in enabling timely and safe hospital discharge remains a key on-going issue for social care and the Council are therefore implementing a programme of demand management to mitigate this impact.

Schemes and figures for both years are given in Croydon's BCF planning return template. As in 2015/16, this approach is consistent with the 2012 Department of Health guidance to NHS England on the funding transfer from NHS to social care in 2013-14.

Croydon's 2016-17 BCF allocation to Care Act duties is £806,000, as per the LGA ready reckoner.

Our assessment of changes to services, and approach to managing interdependencies between Care Act and BCF are set out in our Dec 2014 BCF plan, pages 68-75.

6.2.1 Carer support

A reflection on the effectiveness of services commissioned in 2015-16

In 2015/16 Croydon have commissioned:

- 2 full time assessing & case work officers
- 2 part time assessing & case work officers

They have provided 337 assessments and 158 follow up case work on issues such as housing, benefits, social care, direct payments, employment advice, legal advice

The service offers assessments and follow ups in the carers home in addition to support in the Carers Support Centre on George Street, Croydon. As well as the additional support provided to carers as a result of the assessment, in some instances the carer assessment has identified a need to reassess the cared for person, thus increasing their package of support. This therefore has a positive impact on the carer and the cared for person.

The service is working well and is seeing an increasing number of referrals. The third sector is well placed to provide these assessments and have a long history of providing support to carers in Croydon.

Confirmation of services being commissioned in 2016-17 and how these will impact on the experience of carers.

Service for young adult carers: typically NEETs (not in education, employment or training), this cohort of individuals require peer support, one to one support, support with housing, benefits, CV building, education and employment. Without support this cohort of carers can become reliant on the state and even become patients themselves, due to the impact on their wellbeing (Burstow, 2016). 45% of young adult carers report a negative impact on their mental health (Carers Trust, 2014)

Service for working age adults: typical age of a carer is 45 – 64, this age range is also the age a person reaches their peak earning capacity. When people begin a caring role they are typically in work and continue to work for a number of years, either full or part time. Leaving work can cause financial issues for carers, and negatively impacts the local economy. £5bn nationally is wiped from the economy by carers leaving work to care (Carers Trust, 2012). To help support carers to stay in work for as long as possible, this service would encourage organisations to become 'Carer Friendly', allowing flexible working where suitable, educating management about the valuable role a carer can have in the workforce and provide carers with an early intervention that enables them to get information when they need it, thus reducing the chance of reaching a crisis point (RCGP, 2013).

Evidence-based consideration of how carer support will impact on patient-level outcomes.

Providing support to unpaid carers is the best way to help prevent a care breakdown, which can result in an emergency admission for the cared for person and/or the carer (RCGP, 2013). Moreover, new research indications that for every £1 spend on carers, creates £4 of long-term cost savings for a CCG (RCGP, 2015).

References:

Burstow, Rt Hon P. (2016) *Invisible and in distress: prioritising the mental health of England's young carers.* Carers Trust, London

Carers Trust (2012) *Carers & Employment.* Carers Trust [Online], available from: <https://www.carers.org/help-directory/carers-and-employment> [accessed 11.03.16].

Carers Trust (2014) *Who are young adult carers.* Carers Trust [online], Available from: <https://professionals.carers.org/who-are-young-adult-carers> [accessed 11.03.16].

RCGP (2013) *Supporting Carers in General Practice.* London, Royal College of General Practitioners.

Royal College of General Practitioners (2015) *Cost savings of supporting carers to Clinical Commissioning Groups.* Unpublished Data.

6.3 7 days services

NATIONAL CONDITION: *Agreement for the delivery of 7-day services across health and social care to prevent unnecessary non-elective (physical and mental health) admissions to acute settings and to facilitate transfer to alternative care settings when clinically appropriate;*

Our Dec 2014 BCF plan sets out the comprehensive range of 7-day services which were already in operation relating to physical and mental health, and social care, and their focus in terms of admission avoidance and smooth patient flow.

To ensure suitable visibility of progress on 7-day working, we have chosen for our locally-proposed BCF metric:

'20% of discharges over the weekend for Croydon Healthcare Service'.

The percentage of discharges over the weekend at Croydon Healthcare Service (from Friday midnight to Sunday midnight) for patients aged 18years plus after an inpatient (excluding day cases, obstetrics and regular day attenders).

During 2015/16 we have implemented the following enhancements to our 7-day services:

- The establishment of a Rapid Access Medical Unit (RAMU) in November 2015 operating 7 days/wk 09:00-21:00 providing a one-stop acute medical day care unit for urgent ambulatory patients who are either referred by their GP, or have attended the CUH ED.
- Started the procurement of an integrated Urgent Care service comprising a co-located Urgent Care Centre at Croydon University Hospital, GP Out of Hours, and 3 GP Hubs offering a 365 days service. The integrated service model will be commissioned to start from 1st April 2017.

6.4 Data sharing

NATIONAL CONDITION: Better data sharing between health and social care, based on the NHS number;

Croydon Council have made excellent progress in the use of NHS number: data matching of service user records has taken place to identify NHS number, NHS number is now available in the social care systems, a process is in place to capture NHS number at an early point of contact, and work is progressing to update standard letters and reports where appropriate to show NHS number.

Further integration of health care data is progressing between primary and secondary care including community. Planning with the APA includes shared care planning between health and social care with potential IT solutions.

Croydon are continuing to pursue open APIs as per the approach set out in the Dec 2014 BCF plan p78-81. Work on the planned data sharing portal has been temporarily paused while the ICT strategy for the OBC Accountable Provider Alliance (APA) is developed.

Lack of N3 connectivity from Croydon Council remains an obstacle to easy data sharing. This is expected to be resolved during 2016/17, enabled by means of a refresh of the Council's ICT estate.

Close collaboration is in place between Council and CCG on all relevant aspects of Information Governance. In relation to Caldicott principles, a dedicated group including the Caldicott Guardians for Council and CCG are working to ensure effective implementation, in particular to support the shared record being developed by the Accountable Provider Alliance for OBC.

We have ensured that local people have clarity about how data about them is used, who may have access and how they can exercise their legal rights through various means for example:
http://www.croydonccg.nhs.uk/about-us/YI/Pages/default.aspx

6.5 Joint approach to assessments and care planning

NATIONAL CONDITION: Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional;

The Dec 2014 BCF plan (p 81-84) sets out Croydon's approach to risk stratification, and the proportion of the population who are identified as "high risk"(2.4%) or "very high risk" (0.7%). The risk stratification multi-disciplinary teams are now fully active across all 6 of Croydon's GP networks, with approximately 2865 patients being case-managed through this process. In 2016/17 BCF funding is allocated for continued support to the two key schemes which underpin this approach: MDT delivery and the Practice Development and Delivery Scheme.

Dementia services have been identified as a particularly important priority for better integrated health and social care services. Since October 2015, four dementia advisors and a dementia support manager have been in post. Their remit is to provide 1-2-1 support to people recently diagnosed with dementia, and their carers. This is recognised as vital post diagnosis support where often the medical side steps back, particularly where there is no medication that can be offered. The dementia advisors provide support to dementia sufferers and their carers with: understanding diagnosis, coping strategies, prevent isolation, accessing peer support and community resources, obtaining social resources to live at home as long as possible / appropriate and ensuring people are supported to make choices and plan for the future. BCF funding for the dementia advisors continues via BCF in 2016/17.

6.6 Consequential impact of the changes on the providers

NATIONAL CONDITION: *Agreement on the consequential impact of the changes on the providers that are predicted to be substantially affected by the plans;*

The Dec 2014 BCF plan (p 85-89) sets out the engagement with service users, patients, public and providers that was undertaken in development of Croydon's BCF plan. Similar engagement has continued through 2015/16.

Many of the resultant changes are likely to be felt most intensely by acute providers. Recognising this, the Local Authority and Croydon CCG has had a long record of working with our key acute providers particularly Croydon Healthcare Services (CHS). All key defined Projects that have activity assumptions related to Non-elective Admission Reduction have been shared with the provider including our in-depth Project Initiation Documents. Plans for financial and activity shifts have also been shared.

BCF is aligned with and draws on a range of existing services and work programmes, and receives inputs from consultation and engagement from those services/programmes. Service user and patient participation groups at GP network level and wider public forums, and service user feedback from Friends and Family Test surveys carried out by primary care, community, hospital and mental health services, will help to ensure we continually capture views and suggestions about services and service development. Examples of public engagement during 2015 on OBC which have also informed BCF include:

- Have held a public discussion and feedback event in Fairfield Halls 24th June with 50 people attending
- Attended and gained feedback from the CCG's PPI Reference Group 25th June
- Attended and distributed leaflets at Croydon's Ambition Festival 25th July
- Met with community leaders/ groups including PPG Groups, Cultural Groups, Carer Groups, Lunch Clubs and Community Panels, Day Centres, and the general public
- Public event, held on 19th October at Fairfield Halls
- OBC survey designed and online closed 16th October https://www.surveymonkey.com/r/Croydon_Survey
- Continuing to update web pages to show what engagement has taken place and how it's informed the development of the future model:
- http://www.croydonccg.nhs.uk/get-involved/Pages/Outcomes-based-commissioning.aspx
- https://www.croydon.gov.uk/healthsocial/adult-care/outcome-based-commissioning
- Creation of the OBC Service User Engagement Specialist group that will inform the OBC Programme Board.

To ensure continuing visibility and political buy in, BCF has been reported through the year to a range of groups which are wholly or partly formed of elected members. These groups include:

- Health and Wellbeing board
- Health, Social Care and Housing Scrutiny committee
- Adult social services review panel

In addition, periodic BCF briefings are given to the Chair of Croydon Health & Wellbeing Board, and the Cabinet member for Families, Health and Social Care.

Mental and physical health are considered equal in Croydon's plans. Croydon's Vision for integrated services anticipates that integrated services will make better provision for mental health care to enhance overall wellbeing, independence and 'social capital'. Croydon's BCF includes provisions for mental health alongside physical health through e.g

- mental health professionals as a part of MDTs
- mental health reablement (in additional to physical reablement services)
- recognition of the links between poor physical and mental health through aspects of the IAPT provision targeted at older adults with long term conditions.

BCF is fully aligned with other CCG and Council initiatives and plans, as set out in the Dec 2014 BCF plan (p 60 – 65). Of particular note during 2015/16 has been the development of Croydon's plans for outcomes based commissioning for over-65s' services, with OBC contracts due to be put in place during 2016/17. Planning for BCF in 2016/17 has included close collaboration with the OBC programme team to ensure alignment of objectives and metrics, phased handover of scheme delivery as OBC contracts come on line, agreed reporting between OBC and BCF, and adjustment to Croydon BCF governance as BCF is gradually subsumed by OBC.

6.7 Out-of-hospital services

NATIONAL CONDITION: *Agreement to invest in NHS commissioned out-of-hospital services, which may include a wide range of services including social care;*

In 2016/15, Croydon's BCF investment in NHS commissioned out-of-hospital services will total approx. £12.5m, this being well in excess of the mandated minimum of £6.4m. Individual schemes and expenditure plans are listed in the BCF planning template return.

During 2015/16, Croydon has not achieved the planned improvement on non-elective admissions. However, performance has shown an improvement during Q3 which is expected to continue. This is attributed to the impact of new schemes such as Roving GP service, rapid response and ACE RAMU which have now started to become effective. This improved performance is expected to continue as the services bed in. To maintain this upward trajectory of performance, all 2015/16 out-of-hospital schemes will continue to be funded in 2016/17, at similar funding levels to 2015/16 but suitably uplifted for inflation and demographic growth. In 2015/16, the non-elective admissions target was not reached and the pay for performance risk share funding was not payable into the BCF fund. However, Croydon CCG chose to contribute the full equivalent funding to the BCF, on the basis that investment in out-of-hospital services directed at admission avoidance was the best mitigation of future risk on non-elective admissions performance.

In considering the need for a local risk-sharing arrangement, performance trends and attitude to risk mitigation have been reviewed. Bearing in mind:

- The improving trajectory of non-elective admissions performance
- The preference for investment in admission-avoidance activity

it has been decided not to put in place a pay-for-performance fund linked to non-elective admission performance.

Croydon is part of the South West London CCG's Out of Hospital Group who are working on the development of the 5 year SWL plan for Out of Hospital provision. This would provide at a strategic level what SWL CCG's are looking to move out of hospital, and how that is envisaged to happen.

A stock take of current services is currently underway, looking at the range of health and social care services in each of the 6 boroughs to understand: what's in place, the scale of impact, and workforce delivering it, any gaps that could support pan SWL developments or local developments to achieve the activity shift.

6.8 Delayed transfers of care

NATIONAL CONDITION: *Agreement on local action plan to reduce delayed transfers of care.*

Croydon's performance on delayed transfers of care is better than London and England averages, but falls short of our own target. The high volume of delays being seen for 2015-16 in part are attributable to a high number of delays from the mental health commissioned service provider. The first priority actions in our local action plan therefore relate to reducing mental health DTOC. Detailed analysis of patient flow and reasons for delay has been carried out by the provider. The plan for DTOC reduction has been co-produced by Council, CCG and provider. Mitigation actions in place include:

- Weekly meeting in the Trust to review any barriers to discharge.
- Closer scrutiny of recording to ensure DTOCs correctly captured.
- Greater direct liaison between the Trust and Council Housing Needs team to arrange temporary emergency accommodation.
- Transfer of the mental health supporting people facility to more suitable accommodation in Dec 2015, thereby ending a temporary reduction in capacity in the lead up to transfer.
- Planning for greater use of the "look ahead" contract to support service users in their own homes.

This plan is owned by the BCF Executive group.

Across the broader spectrum of discharge planning and patient flow, a range of initiatives are underway:

- Discharge planning sub-group at Croydon University Hospital is assessing barriers to discharge.
- A CQUIN target has been set relating to discharges before 1 p.m.
- Croydon Healthwatch have carried out a survey of patient experience of the discharge process.
- The Continuing Health Care action plan includes training for staff re. referrals so that awaiting CHC arrangements does not increase delay.
- SRG planning for discharge.
- Agreement on how to manage DTOC-reduction targets via OBC performance management process

Given the wide range of work underway, priorities for Q1 2016/17 are:

- Progress with the mental health DTOC-reduction actions noted above.
- Ensure DTOCs are being correctly recorded across all settings.
- Complete the mapping of current discharge/patient flow work-in-progress
- Identify any need for greater co-ordination across the patient flow/discharge activity
- Self-assess against the eight 'high impact interventions' that were agreed by ECIP (informal self-assessment done so far)
- Agree priority actions for Q2 and beyond.

The DTOC target for 2016/17 is given at section 9.4. Croydon have considered use of a risk-share agreement relating to DTOC. Taking a consistent approach to that applied to non-elective admissions (see section 6.7above), we have chosen not to put in place a pay-for-performance fund as part of our risk share agreement, choosing instead to invest in schemes to reduce DTOC.

7 Approach to financial risk-sharing and contingency

The general approach to risk-sharing and contingency is set out in the Dec 2014 BCF plan (p57-59).

In brief: Croydon CCG and Croydon Council have agreed that the principle underpinning the risk sharing agreement will be based on an "invest to save" policy, as opposed to holding a performance fund in contingency.

Specifically, for 2016/17 it has been agreed NOT to use a pay-for-performance risk share agreement for either non-elective admissions or DTOC.

The BCF section 75 agreement specifies details of financial risk-sharing with regard to over-spends and under-spends.

8 Scheme level spending plan

The BCF schemes and the allocated funding to each is given in the following table:

Scheme name	2016/17 allocation	Lead commissioner
St Christophers End of Life - Core Contract	£286,000	CCG
Marie Curie End of Life - Core Contract	£65,000	CCG

St Christopers End of Life - QIPP Scheme	£114,000	CCG
Marie Curie End of Life - QIPP Scheme	£145,000	CCG
End of Life Training - QIPP Scheme	£27,000	CCG
St Christophers Palliative Care	£1,354,000	CCG
Crossroads - Palliative Care	£121,000	CCG
End of Life - social care	£253,000	Local Authority
SLaM - Community Investment (HTT)	£1,591,000	CCG
SLaM - Older Adults Community Investment	£307,000	CCG
MHOA - Dementia - Altzheimers Society	£200,000	CCG
Care UK Amberley Lodge	£260,000	CCG
Mental Health - Reablement	£202,000	Local Authority
Mental Health - Packages of Care	£303,000	Local Authority
IAPT - Long Term Conditions Pilot	£177,000	Local Authority
Transforming Adult Community Services	£2,459,000	CCG
Transforming Adult Community Services - Nursing Homes	£204,000	CCG
TACS - Social Work Input	£455,000	Local Authority
Enhanced Care Management	£317,000	CCG
ACE/RAMU	£1,025,000	CCG
GP Roving Service	£401,000	CCG
COPD	£521,000	CCG
Extended Staying Put	£121,000	Local Authority
Specialist Equipment eg Telehealth / Telecare	£187,000	Local Authority
Disabled Facilities Grant	£2,046,194	Local Authority
Early Intervention & Reablement	£1,023,000	Local Authority
Demographic pressures - package of care	£2,043,000	Local Authority
Social Care Pressures	£1,111,000	Local Authority
Prevent return to acute / care home	£480,000	Local Authority
Falls Service	£220,000	CCG
Age UK - Integrated Falls Service	£30,000	CCG
Falls & Bone Health Communications	£10,000	CCG
Intermediate Care Beds	£480,000	CCG
Integrated Stroke Service	£64,000	CCG
Medicines Optimisation	£100,000	CCG
Diabetes Service	£1,000,000	CCG
Diabetes LES	£96,000	CCG
Basket LES	£414,000	CCG
Practice Delivery & Development Schemes	£2,020,000	CCG
Step Down & Convalescence Beds	£505,000	Local Authority
A&e Triage	£177,000	Local Authority
Hospital Discharge	£177,000	Local Authority
Care Support Team nurses	£126,000	Local Authority
Alcohol Diversion	£61,000	Local Authority
Care Act	£806,000	Local Authority
To be allocated during 2016/17	£415,598	Joint

TOTAL	£24,499,792

The BCF Planning Template return provides further detail.

For each scheme, the BCF section 75 agreement includes a 1-page summary of: funding allocation, scope of what is to be delivered, agreed reporting and activity or other metrics.

In addition, each scheme has a service delivery plan and/or project implementation plan suitable to the scheme size, complexity and maturity. The process for monitoring scheme delivery and management of issues is outlined in section 5.4 above.

These schemes are integral parts of other plans including CCG operating plan, and Sustainability and Transformation Plan (under development).

9 National metrics

The Council target-setting process for 2016/17 is currently (March 2016) underway. Therefore the information provided in this section is **PROVISIONAL** and may be amended for sections 9.2, 9.3, 9.4 and 9.6.

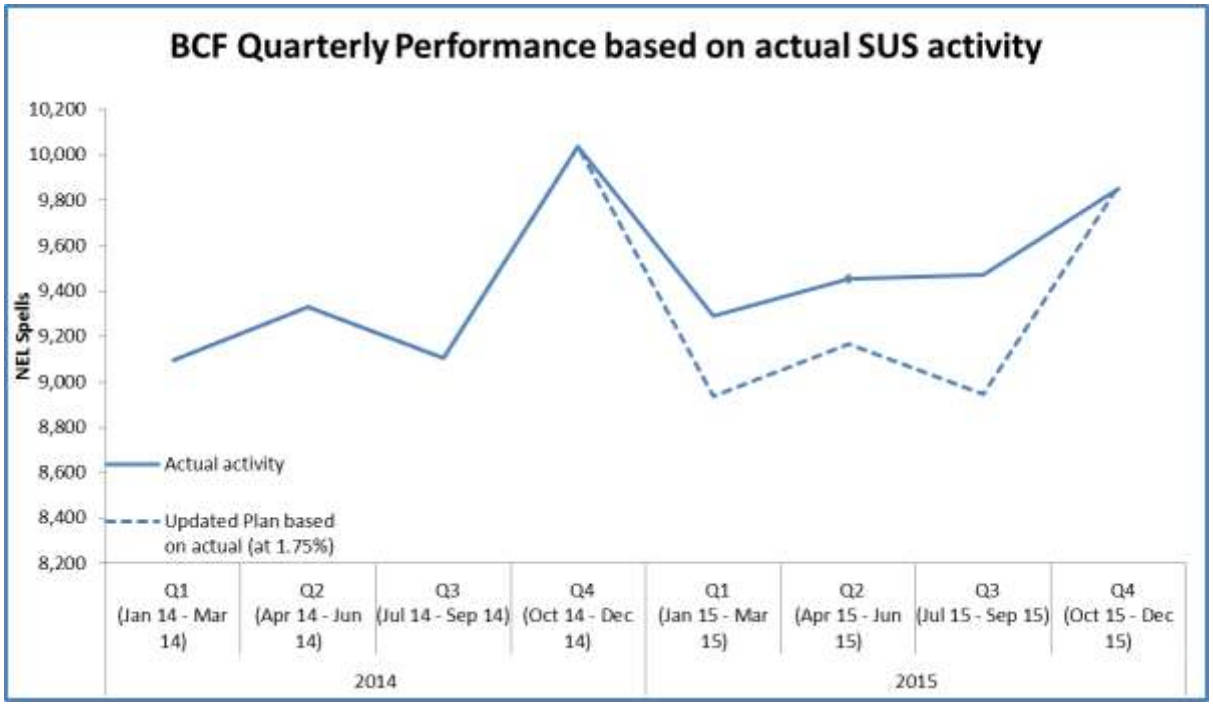
The target-setting process encompasses a robust analysis of current performance and trends in performance over the last few years, alongside consideration of relative performance to England average, London average and other comparators. Expected Impact of planned service changes, whether delivered through BCF or other initiatives, is also taken into account.

9.1 Non-elective admissions

Croydon CCG have continued to work collaboratively with our providers in 2015/16 to assess how further improvements in patient quality can be achieved in 2016/17. This has involved different approaches including use of national guidance and best practice, bench marking against local and London peers to identify areas for investigation, and working together with providers to identify areas where providers have highlighted could be provided in a different way to improve patient care. Discussions in the various clinically-led steering groups (including both CCG and providers) have enabled the CCG to define the QIPP initiatives we have stated in our 2016/17 Operating Plan, using specific HRGs to build and define the cohort of non-elective activity that is expected to be impacted upon as a result of the pathway improvement.

In 2015/16 performance against the year to date target at month 10 was 3% higher than planned (38,067 vs 36,914), however there was improvement over the previous 2 months (see Graphxx: Total Year to Date Non-Elective Admissions as at November 2015 forecasted to Full Year).Mitigating actions were implemented to improve performance across the year including validation of HRGs mapping following introduction of the new ETO tariff in 2015/16 and agreement with NHSE to measure activity based on SUS (HSCIC's Secondary Use Service) to improved accuracy of reporting, and expansion of admission avoidance service provision by the Rapid Response and GP Roving Services.

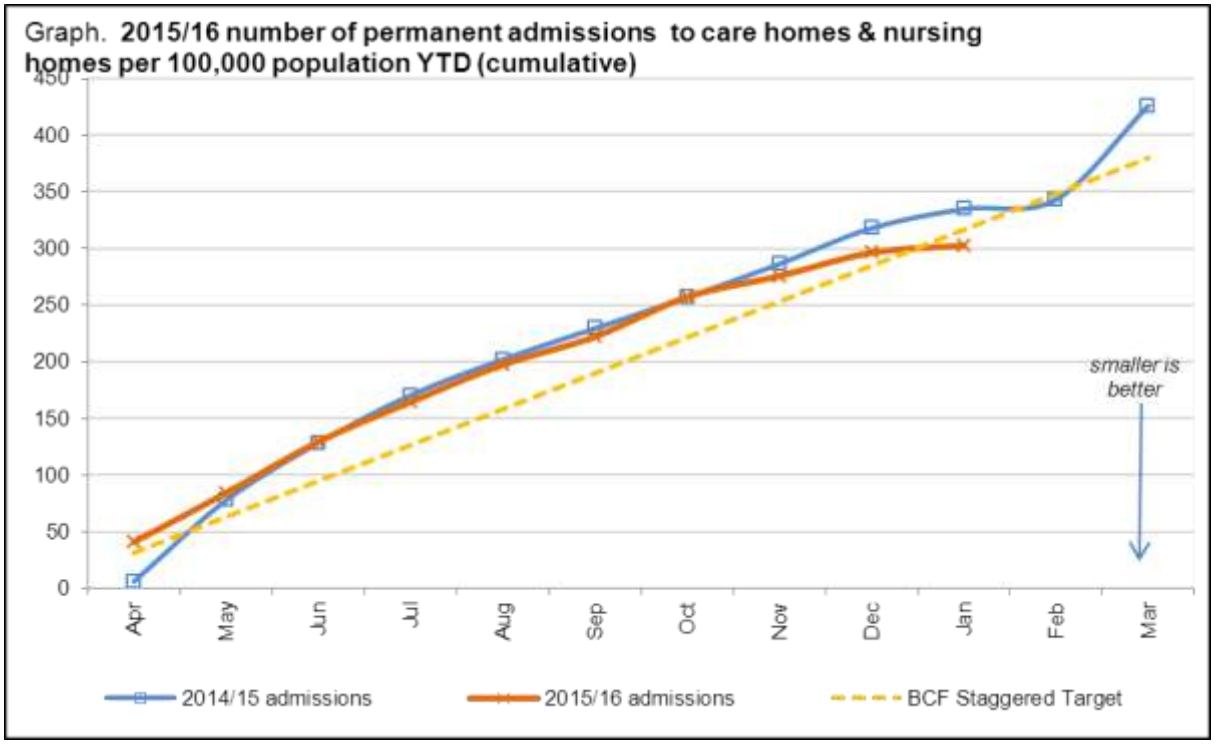
Graph: Total Year to Date Non-Elective Admissions as at December 2015 forecasted to Full Year



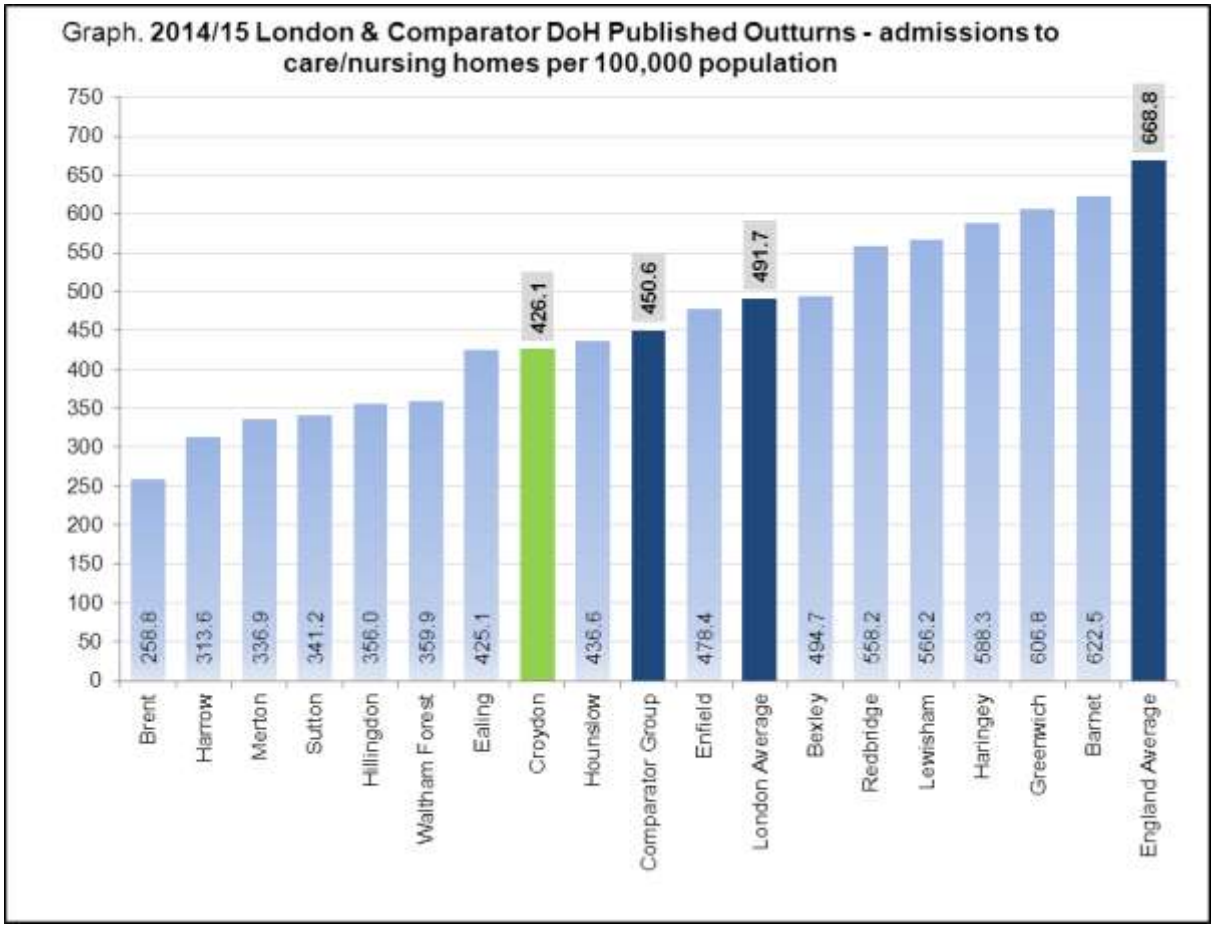
9.2 Admissions to residential and care homes

In 2014/15 Croydon did not meet its own ambitious target for admissions to residential and care homes. In 2015/16, Croydon are on track to just meet target. This has been accomplished at some significant cost pressure on home care packages, which has been partially alleviated through BCF funding, as well as investment in a range of preventative schemes via BCF and elsewhere.

Performance is shown in the following graph.



Croydon's performance on this measure is relatively good – better than the London average and less than 2/3 of the England average, as per the following graph:



BCF investment continues during 2016/17 on schemes to protect social care (including home care), as well as preventative measures. There is an increased investment in home adaptations in 2016/17 via the Disabled Facilities Grant, however that will take some time before impacting on performance. Through OBC, a range of improvements are anticipated which will have a positive outcome on this measure. However, pending completion of the Council's target setting exercise, the 2016/17 target for this measure remains unchanged from 2015/16 at **380 permanent admissions of older people to residential and nursing care homes, per 100,000 population.**

9.3 Effectiveness of reablement

In 2014/15 Croydon did not meet its own ambitious target for effectiveness of reablement, though there was an improvement on the previous year's performance. In 2015/16, Croydon are on track to just meet target. This has been accomplished at some significant cost pressure on reablment packages, which has been partially alleviated through BCF funding.

Performance is shown in the following table.

Table : **Performance Data - Effectiveness of reablement - 2013 - to date**

2015-16	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Target
	>>>>>>>>>>>>> Denominator			>>>>>>>>>>>>> Denominator			>>>>>>>>>>>>> Denominator			>>>>>>>>>>>>> Denominator			
Numerator	Jan-Mar 2015 Numerator		120	Apr-Jun 2015 Numerator		115	Jul-Sep 2015 Numerator		104	Oct-Dec 2015 Numerator			BCF 88%
Denominator	Apr-Jun 2015		138	Jul-Sep 2015		128	Oct-Dec 2015		119	Jan-Mar 2016			
Outturn			**87.0%**			**89.8%**			**87.4%**				

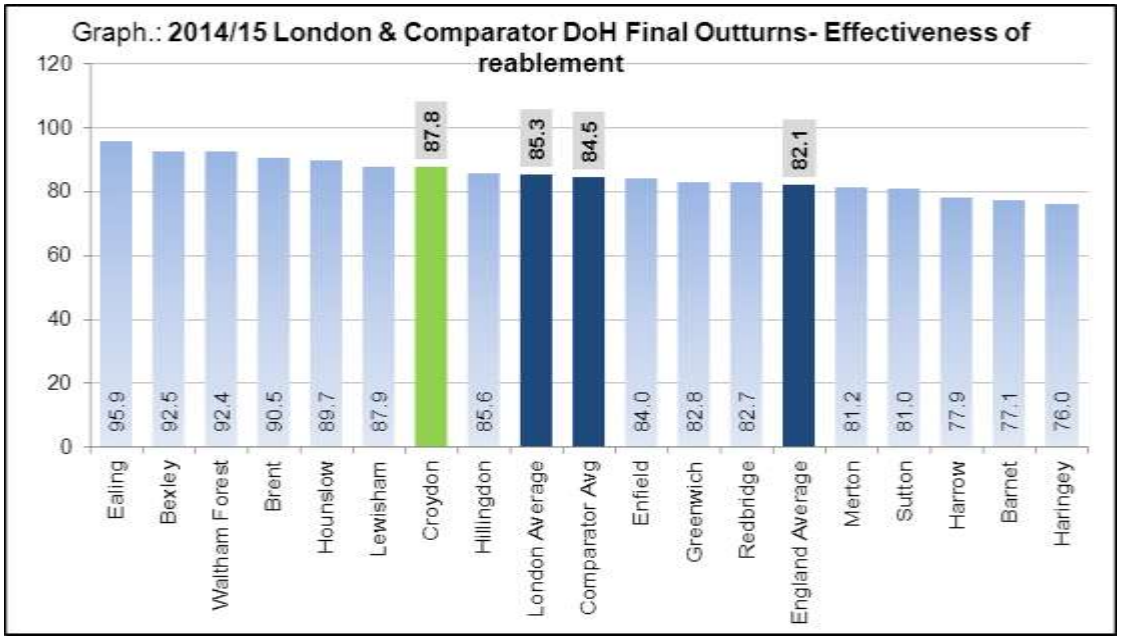
2014-15	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Target
Numerator												122	BCF 88%
Denominator												139	
Outturn												**87.8%**	

Year End 2014/15:
Denominator is calculated Oct-14 to Dec-14
Numerator is calculated Jan-15 to Mar-15

2013-14	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Target
Numerator												138	75%
Denominator												162	
Outturn												**85.2%**	

Year End 2013/14:
Denominator is calculated Oct-13 to Dec-13
Numerator is calculated Jan-14 to Mar-14

Croydon's performance on this measure is relatively good – better than the London and England averages as per the following graph:

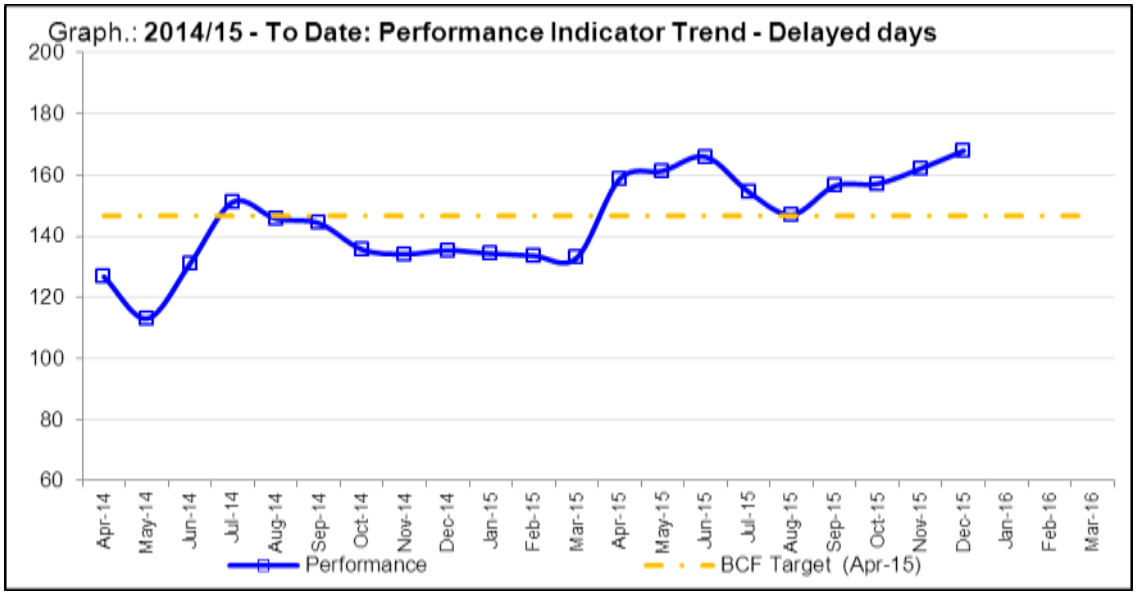


BCF investment continues during 2016/17 on reablement schemes. Through OBC, a range of improvements are anticipated which will have a positive outcome on this measure. However, pending completion of the Council's target setting exercise, the 2016/17 target for this measure remains unchanged from 2015/16 at **Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services (successful reablement) = 88%.**

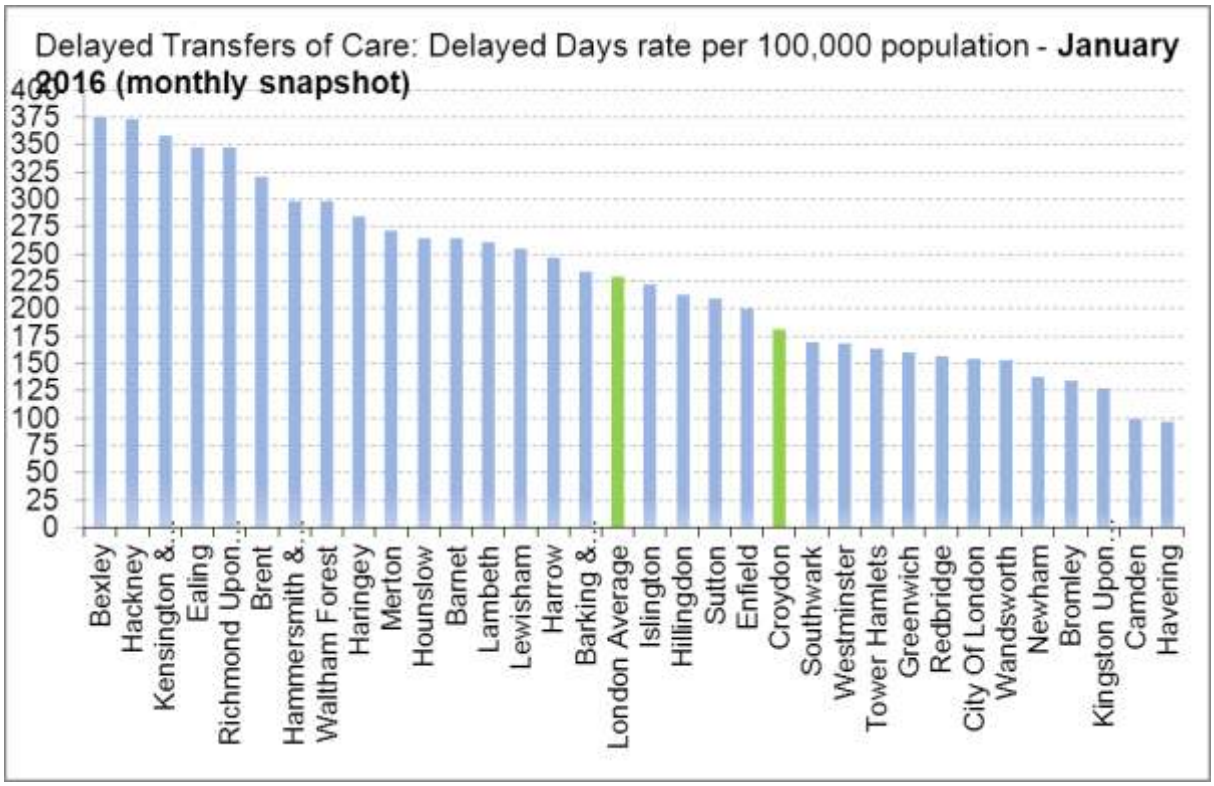
9.4 Delayed Transfers of Care

In 2014/15 Croydon met its own ambitious target for delayed transfers of care (DTOC). In 2015/16, Croydon will not meet the target.

Performance is shown in the following graph.



Performance issues and action plan for DTOC are detailed in section 6.8 above. Despite not meeting our own target for 2015/16, Croydon's performance on this measure is relatively good – better than the London and England averages as per the following graph:



Pending completion of the Council's target setting exercise, the 2016/17 target for this measure remains unchanged from 2015/16 at **Delayed transfers of care (DELAYED DAYS) from hospital per 100,000 population = 146.7**

9.5 Weekend discharges from CUH

In June 2014, the six South West London (SWL) CCGs submitted their 5 year strategy for health services across south west London, with a vision for integrated care services across SWL which included the development of services that:

support people who are in hospital to be discharged back home as soon as they no longer require hospital care, with appropriate plans in place for care to continue at home

Croydon's System Resilience Group as part of the development of an operational resilience strategy and plan for 2015/16 identified key initiatives that would be required to improve the operational resilience of Croydon University Hospital (CUH) and to support the achievement of the A&E 4-hour waits. These included changes that would improve patient flow through the emergency department and the hospital, including effective discharge planning, developing innovative solution tackle workforce challenges, building intermediate care capacity and flex, facilitating discharges to nursing and care homes at weekends, enhancing therapies to ensure early rehabilitation on wards and follow up on discharge at the weekends, enhanced social care support at weekends and access to emergency services e.g. housing.

A local metric for encouraging improvement in weekend discharges from CUH was therefore established based on assessment of performance over 2013/14 with a stretch target from 18.7% to 20%.

In 2015/16 performance against the year to date target at month 10 was lower than planned at 18.6% with a forecasted year end position of 18.5%. The main reasons for the underperformance were that although non-elective discharges had increased, elective discharges had reduced. Mitigating actions implemented across the year to address the situation included ongoing enforcement of the systems resilience group recovery plan and the 95% recovery plan, and the establishment in February 2016 of a discharge process working group by Croydon Health Services led by the Deputy Chief Operating Officer to develop solutions to address issues impacting on delivery.

The stretch target for 2016/17 remains at 20%.

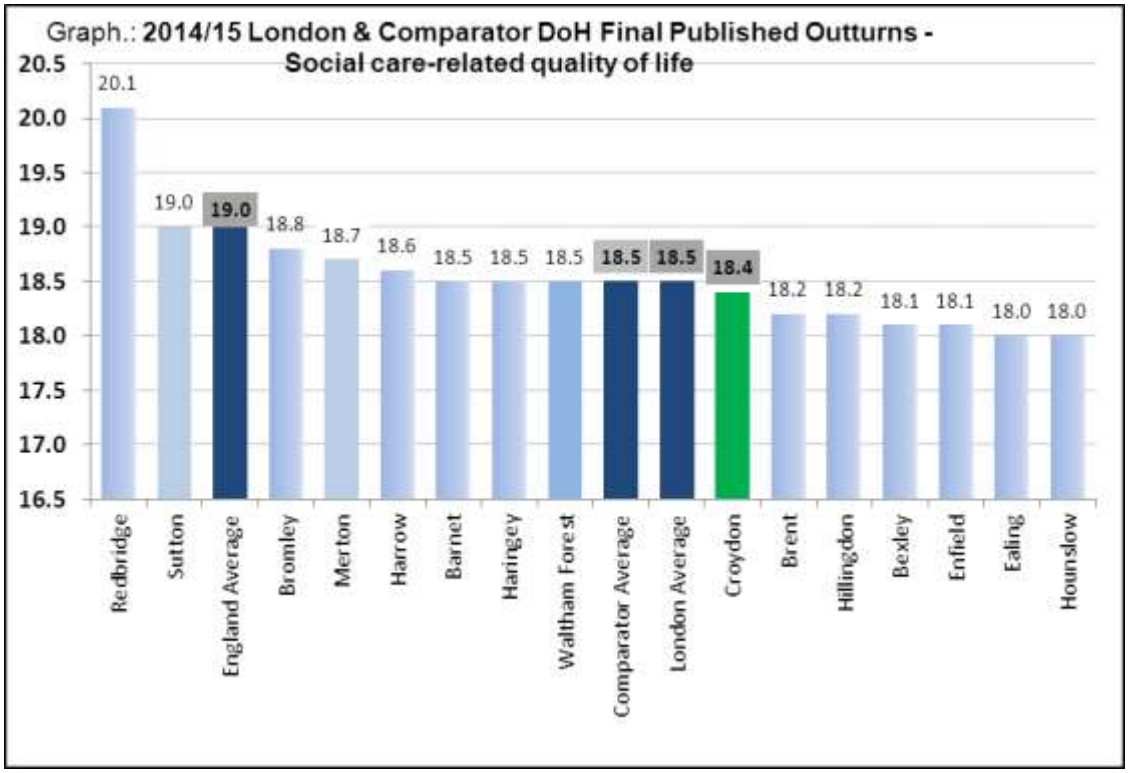
9.6 Social care-related quality of life

In 2014/15 Croydon did not meet its own ambitious target for social care related quality of life.. For 2015/16, data is not yet available, as the base information is collected only once annually. Performance is shown in the following graph.

Table: **Performance Data - 2012/13 - to date – Social care-related quality of life**

	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Target
	Annual ASCOF Survey												
Numerator												78980	BCF
Denominator												4300	19.0
Outturn												**18.4**	
	Apr-13	**May-13**	**Jun-13**	**Jul-13**	**Aug-13**	**Sep-13**	**Oct-13**	**Nov-13**	**Dec-13**	**Jan-14**	**Feb-14**	**Mar-14**	**Target**
Numerator												85493.4	n/a
Denominator												4561	
Outturn												↗ **18.7**	
	Apr-12	**May-12**	**Jun-12**	**Jul-12**	**Aug-12**	**Sep-12**	**Oct-12**	**Nov-12**	**Dec-12**	**Jan-13**	**Feb-13**	**Mar-13**	**Target**
Numerator												91430	n/a
Denominator												5015	
Outturn												→ **18.2**	

Croydon's performance on this measure is close to the London average but worse than the England average as per the following graph:



Pending completion of the Council's target setting exercise, the 2016/17 target for this measure remains unchanged from 2015/16 at **Social care related quality of life – annual adult social care survey score =19.**

Appendix B

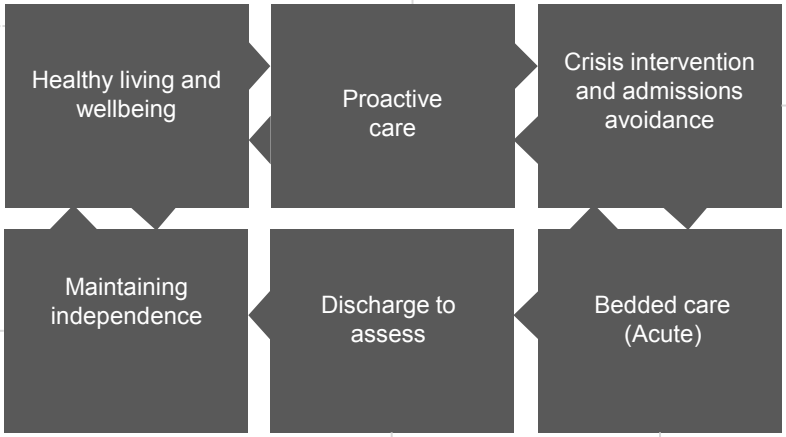
Enclosure 1b: A Proposed Model of Integrated Care in Croydon

For all partners (statutory, voluntary and community) to come together to provide high quality, safe, efficient, coordinated, seamless care to the people of Croydon and users that is proactive, focused on prevention and supports people to stay well and independent and is delivered as far as possible in the community.

- Promoting positive physical and mental health
- Asset Based Community Development
- Social prescribing
- Smoking/weight/alcohol programmes
- Falls prevention/strength and balance training
- Influenza and pneumococcal vaccination programmes
- Screening: Depression, Dementia LTC-DMT2, IHD, AF
- Home hazards risk assessment

- Risk stratification in Primary Care/MDT Integrated case management: physical and mental health
- LTC self care
- Advanced care planning
- End of life care
- Carer support
- Early Intervention Services MH/IAPT

- Longer term rehab/ reablement
- Equipment services
- Home adaptations
- 3rd Sector "Low level support" i.e. Social / Psychological /Physical
- Carer support
- Self management
- Personal budgets
- Promoting Recovery (Psychosis) Teams



- SPA and rapid assessment
- MH assessment and liaison teams
- GPs offering enhanced services
- Senior assessment (consultant/GP) of all frail/elderly in A+E and AMU
- Rapid response MDT team
- Outreach to community
- Inreach to A+E, AMU
- Comprehensive geriatric review
- Rapid access clinics
- Ambulatory service
- Step up beds in the community (care homes, community hospitals)
- Easy access to patient transport
- MH Crisis and Home Treatment Services/Crisis Line
- Support to nursing/care homes

- Coordinated discharge planning at the point of admission
- Early supported discharge before full recovery
- Geriatric follow-up in the community
- Community support teams
- Coordinated rehab/re-ablement in community setting
- Short term care packages
- Step down community beds (care home, comm hospital)
- Equipment services

- Elderly care specialists leading multidisciplinary teams
- Dementia awareness psychiatric liaison
- Proactive community teams in reach into hospital
- Information sharing with community teams
- Assertive community outreach/treatment

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Croydon Clinical Commissioning Group

Enclosure 1c – Health and Wellbeing Board Transforming Adult Community Services Patient Outcomes and Experience

Some of examples of the impact of the health and social care services in supporting patients are shown below using a mixture of case studies and patient experience feedback.

Examples of improved patient safety:

Case Study - Social Services (through GP Practice multidisciplinary meeting)

- 75 year old lady with severe Chronic Obstructive Pulmonary Disease (COPD), has continuous oxygen, and unable to leave the house without being taken in her wheelchair. Lady and her husband have 2 sons neither of whom lives locally, but she has a very supportive friend/neighbour who cooks her hot meal each day and accompanies her when she occasionally goes out in a taxi to the shops.
- Identified during visit that her husband had been recently diagnosed with motor neurone disease but was not accepting his diagnosis. He was fed via a peg feed and District Nurses visited him to help with the management of the feeds. Husband controlled the finances and was reluctant to spend any money.
- Identified issues included:
    - struggling to use the stairs, but had no downstairs toilet or suitable place for a commode.
    - unable to get help in an emergency without relying on her husband who had his own complex health issues.
    - was in need of some social support but was worried about paying for it.
- Successfully claimed attendance allowance for both of them.
- Occupational therapy assessment requested to support with accessing the toilet, however due to long waiting list and need becoming more urgent, managed to work with the husband to pay to have a stair lift installed.
- Due to sudden deterioration in husband's condition, GP recommended to refer him to St Christopher's. Husband died at home with support from St Christopher's.
- Care line alarm installed for wife after husband died, and referral made to Community Matron for on-going support for her COPD.
- Agreed with St Christopher's that she could be temporarily supported by St Christopher's, enabling her to access the hospice social care service, without further affecting her greatly depleted finances. Social care then put in place.
- Arranged for bereavement support to help with sorting out finances which had been solely managed by her husband prior to his death.
- She is now fully supported at home and managing all finances.
- She has not had any admissions to hospital and her health is stable.

Case Study - Rapid Response

- Referral received from GP for 81yr old lady with dizziness who was at risk of falling
- Reviewed by Community Matron within 2hrs of referral.

- Significant postural drop identified, and patient had an irregular pulse rate of 147.
- Appointment made by Rapid Response clinician for her to be seen in the Acute Care of the Elderly clinic for urgent electrocardiogram and assessment.
- Physiotherapy provided advice on falls prevention.
- Discharged back to GP care.

Examples of improved clinical effectiveness:

Case Study - Rapid Response

- Referral received from London Ambulance Service (LAS)
- 83yr old lady with right knee pain and stiffness. Unable to stand up from her chair.
- Diagnosis osteoarthritis right knee
- LAS had received 6 calls in the last 2 weeks from the patient
- Reviewed by Community Matron and physiotherapist within 30min of referral
- On assessment it was felt that the patient should be admitted to Barrington Lodge for a short period of rehabilitation- patient admitted that day to a step up bed
- Remained in Barrington Lodge for 2 weeks. During this time her analgesia was reviewed and she had rehabilitation.
- She is now at home with a minimal package of care

Case Study – Community Matrons (through GP Practice multidisciplinary meeting)

- 80yr old lady with a diagnosis of dementia and recurrent leg cellulitis living in a very unsafe, unkempt house with her 3 dogs.
- Discussed at GP Practice multidisciplinary meeting as patient memory had deteriorated and the frequency of leg cellulitis had increased due to self-neglect
- Referred to Community Matron and Social Worker.
- Joint visit undertaken which identified patient had very poor living conditions, hoarding issues and dog faeces covering all of the downstairs. A neighbour held Power of Attorney (POA) for health and welfare. Patients Mental Test Score 0/10.
- Matron and Social Worker concerned about financial abuse. No package of care in house.
- Three times a day package of care set up and key safe put in place.
- Due to dementia patient started to decline all services. Neighbours not fully aware of their role as POA.
- Best Interest meeting arranged which included the POA and all professionals involved with patient.
- On discussion POA did not fully understand the risks of the environment and how this can impact on patient's health.
- POA agreed for full deep clean of house and full refurbishment of downstairs.
- Patient went to care home while this was undertaken. Her dogs were cared for by the local vets.

- Patient now back at home and there have been no further episodes of cellulitis. Carers visit three times a day, and patient has regular chiropody.
- Significant improvement made to patients quality of life.
- Discharged from Community Matron and Social Worker.

Examples of improved patient experience:

Health Visitor for Older People (from friends and family test survey)

- Visits make a great difference plenty of information given really useful cheered me up
- Nice to have the help practical support
- Health visiting team have been a great help in ordering equipment and Dee has been a great listener
- Everything explained and comprehensive. I feel like I have support with HVOP Team
- Given information about services and support which I did'nt know about. Very helpful charming lady
- I feel I can always ask if I had any difficuties how to deal with them. I feel I can talk to health vistor really appreciate the support
- I find the chair for the kitchen useful and cushion very comfortable
- Personal felt safe and she was intrested in helping me
- Listened to me involved me in my care. Lovely lady
- Made my life feel brighter involved in my care. Has helped me arranged care I needed urgently

Rapid Response (from friends and family test survey)

- Rapid extremely helpful
- Positive and fast
- Superb service 10/10
- I think this is a much better way having a nurse to come to the home Lovely service lovely sisters and nurses
- Nurses always concerned of how I am
- Excellent service very kind nurses happy with the care
- Carolyn the young lady who came to see my mother was extremely helpful and understanding. She is going to provide me with some useful contacts and she is endeavouring to contact my mother's social worker on my behalf
- Wonderful girls kept me at home
- Friendly efficient organised made my mum feel comfortable and supported
- The Entire team are both professional and friendly a great team

Community Matrons (from friends and family test survey)

- Friendly nurses visit regularly
- My own experience with the NHS was wonderful. Treatment was second to none Very good treatment with nice people Already doing fantastic job
- Continue as you are
- The nurse that visits me is always really helpful and friendly

- Useful to build ones confidence. The exercises can help at times
- Help was professional and very caring
- Very good service nurse was very explicit in explanations
- The service offered carried out was delivered in a professional and caring manner
- Very encouraging and helpful treatment at home

REPORT TO:	**HEALTH AND WELLBEING BOARD (CROYDON)** **13 April 2016**
AGENDA ITEM:	**10**
SUBJECT:	**Household Income and Child Poverty**
BOARD SPONSOR:	**Paul Greenhalgh** **Executive Director of People, Croydon Council**

BOARD PRIORITY/POLICY CONTEXT:

Joint health and well being 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 To note and comment on progress to date.

2. EXECUTIVE SUMMARY

2.1 This report confirms progress against the council's Household income and child poverty paper agreed at cabinet on 15th June 2015.

2.2 It sets out the background behind the work the council has undertaken, clearly defning our rationale. How we have then linked these issues to wider pieces of work such as our approach to financial inclusion, considering whole family soltuions through gateway and outcomes from the opporutnites and fariness commission (OFC).

2.3 The report sets out the work completed to date the number of customers that have been assisted and our plans, next steps for the future.

3. BACKGROUND

3.1 Reducing child poverty is a key priority for both the Health and Wellbeing Board and the Children and Families Partnership. Supporting families, particularly lone parent families, in achieving financial stability and finding sustainable employment enables them to meet their child care responsibilities and contributes to reducing child poverty. It will also summarise key outcomes from work undertaken through the gateway teams which underpin some of these objectives.

3.2 The most recent data shows that around three quarters of children (estimated at 15,000) living in poverty in Croydon live in lone parent families.

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 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.

3.6 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.

3.7 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.

3.8 In addition to lack of 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.

3.9 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.

3.10 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.

3.11 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. 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.

3.12 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 employment opportunities.

3.14 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.

3.17 The financial inclusion principles underpinning the strategy are shown in the table overleaf with particular issues identifies being addressed to ensure families living in poverty benefit from the plan.

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

Principle	**What does this mean**	**Examples of 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.

3.18 As the new operating model in the Council's People Department evolves we are reviewing how we 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 by carrying out budgeting support and offering debt advice. After initialy piloting our new approach it is evident that there are clear improvements with regard to increasing entitlements, including working tax credits and housing benefits.

4. PROGRESS TO DATE

The progress made for each theme during 2015/16 is as follows:

4.1 Enable our staff to engage effectively with customers regarding financial inclusion

- Training has been provided to all staff within the following services to provide basic budgeting support to residents:
  - Enablement and Welfare
  - Service Development
  - Housing Needs and Assessments
  - Revenues and Benefits
  - Corporate Debt Recovery
  - Housing Income
- A staff tool kit has been developed and is shared across the above services containing a budgeting guide, budgeting tips, acceptable spend criteria along with cheaper alternatives

- Residents and all staff across the above services, our third and voluntary sector partners and our Job Centre Plus (JCP) co-workers now use one online budgeting tool
- Annual campaigns take place to promote financial inclusion to our residents:
    - Debt awareness week
    - 12 saves of Christmas

4.2 Undertake improvements to make tools and advice easier to navigate

- The council's website was reviewed and all money management advice and tools are now located on one web page for easy access for our residents and staff at https://www.croydon.gov.uk/advice/your-money
- A Croydon branded budgeting tool was developed for both residents and staff. This went live on the council's website in May 2015
- In partnership with Croydon Plus (previously Croydon Credit Union), web access to accounts is part of its launch on 4th February 2016
- The council has worked with Croydon Plus to segment it's residents and develop a variety of support offers to meet the varying level of need, see appendix 2
- The council has engaged with 10 local banks to clarify the criteria for basic bank accounts and identify financial products available. A factsheet has been developed and is located on the your money pages of the council's website at https://www.croydon.gov.uk/advice/your-money-1 see appendix 3

4.3 Promote the adoption of London Living Wage across the borough's businesses

- The council is an accredited London living wage employer
- It is also now a requirement for all new contractors to pay the London living wage and is working with existing contractors to make the transition

4.4 Building 3rd party relationships to support financial inclusion

- In June 2015, the council became a Universal Credit (UC) digital pilot site. In partnership with the Department for Work and Pensions (DWP) and JCP, budgeting support is provided to all residents migrating to UC
- The council meet bi monthly with our third and voluntary sector partners to promote services, support and products available to our residents
- A consistent approach to engagement and referral has been developed as well as monitoring of outcomes
- This work will continue to support the council's outcome based commissioning review and community empowerment agenda
- To improve their financial product offering the council has worked in partnership with Croydon Credit Union. It has been rebranded Croydon Plus and was launched on 4th February 2016

4.5 Develop skills and opportunities for citizens to maximise income

- The Gateway and Welfare directorate was established as part of the People Department in April 2015. Within the divison, the Enablement and Welfare service provide holistic solutions for residents to prevent crisis. Financial stability is at the core and support provision includes:
    - budgeting support
    - income maximisation
    - debt management
    - employment support
    - support in finding affordable homes
- Financial stability also supports 2 of the themes identified by Croydon's Opportunity and Fairness Commission (OFC); finding homes for all and supporting residents to better times. Over 2500 residents have been able to maximise their income through discretionary funding allowing them either to affordably remain in their home or move to an affordable home
- The council works in partnership with JCP to support residents into work. JCP are co-located within the People Department to work alongside Gateway and Welfare, Housing and the troubled families programme
- Croydon Healthy Homes is now in place; a project to provide energy efficiency / fuel poverty advice for vulnerable households in the borough with home visits for residents beginning in March

5. OUTCOMES DELIVERED TO DATE

5.1 Since October 2015 Gateway has engaged with over 7000 households. Over £11 million has been claimed in additional welfare entitlements and over 4000 residents yearly have access to in work and out of work benefits through phone advice, case work advice and one to one support, the welfare rights service operates in health settings, childrens health centres, home visits, and outreach in community centres. Included in this figure is a specific service targeting families whose child(ren) have a disability which since April 2015 has supported over 300 families claim disability benefits and in/out of work financial support worth over £2.1 million so far. This work is vital in supporting families who are then able to access the free 2 year nursery funding offer.

5.2 Financial stability also supports 2 of the themes identified by Croydon's Opportunity and Fairness Commission (OFC); finding homes for all and supporting residents to better times and Gateway has supported over 2500 residents maximise their income through discretionary funding allowing them either to affordably remain in their home or move to an affordable home suited to their need, 186 households have been supported with a move to a more affordable home.

5.3 Gateway and Welfare has supported nearly 200 households struggling with external debt and whose total debt was just under £1,4 million. By providing support the overall debt owed has been reduced by over £65,000 with payment plans and budgeting support in place. In addition 1100 budget planners have been completed for households to help stablise family income.

5.4 1317 children who previously had not made a claim have been identified as being eligble and have been provided with Free School Meals and take up is being promoted accorss services to increase this figure.

5.5 To help tackle fuel poverty Croydon Healthy Homes is working with Gateway to deliver a project to provide energy efficiency / fuel poverty advice and equipment for vulnerable households in the borough with home visits for residents beginning in June. 200 households at financial risk will benefit from a home visit ensuring that they are lifted out of fuel poverty and have a healthy home. Over 30% of these households will be single parent households.

5.6 Gateway is working collaboratively with Croydon Plus (the local Credit Union) to pilot and roll out innovative producst such as a “jamjar” account which will enable customers to have income paid into a budgeting account which will not only ensure that standing orders are in place for bill payments but will encourage and support a cultural change in terms of saving. This approach will have significant wider social and economic benefits; with greater capacity generated from their income families can move away from high interest debt repayments reducing the effects of debt on mental health. 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.

5.7 The council currently works in partnership with JCP to support residents into work and training reducing poverty by developing skills and opportinie.JCP are co-located within the People Department and work alongside Gateway and Welfare, the leaving care service and the troubled families programme. Of the 347 most vulnerable families referred to Gateway and welfare for employment support 100 (28%) have successfully gained sustainable employment.

5.8 Service areas within the People’s department that provide employment support are supporting the development of the Job Brokerage service which will maximise benefits from regeneration and growth, deliver preferential routes into sustainable work for our residents; and provide opportunities for better paid employment for our lowest paid households.

6. NEXT STEPS

6.1 The continuning ambition of the People’s deparment is to bring together existing support arrangements to promote household independence through an aligned financial, training/work and housing support offer, build it into business as usual and scale, moving towards a single front door. To include:

Collaborative work to identify NEETS - cross referencing housing benefit, School Standards and Troubled Families data. Using the segmented data pilot a cross service ‘move on’ approach to support NEETs into employment, education or training.

Using funding secured from the DWP , develop a Local Family Offer aimed at identifying and supporting those parents/co-parents who are at risk of financial instability at the earliest opportunity, thereby contributing to reducing the incidence of children in poverty.

Work with children's social care (CSC) to reduce the number of children presenting as homeless and subject to a "Southwark judgement" order, ensure that households have access to suitable housing to enable children living in care to be returned to their families and redesign the process of transfer from Looked after Children to Leaving Care.

6.2 Enable our staff to engage effectively with customers regarding financial inclusion

- Continue to develop effective customer insight to proactively engage with vulnerable customers
- Develop online learning for staff on financial inclusion to increase take up of our services

6.3 Undertake improvements to make tools and advice easier to navigate

- In line with the council's digital inclusion plan and through its digital and enablement programme, continue expand the use of MyAccount, digital zones and online provision of financial inclusion information, advice and tools
- Continue to develop and promote self-serve tools

6.4 Promote the adoption of London Living Wage across the borough's businesses

- Enforce the requirement for all new contractors to pay the London living wage
- Continue working with existing contractors to make the transition

6.5 Building 3rd party relationships to support financial inclusion

- Build on relationships with local banks to enable easier access to financial products for residents
- Simplify the process of verifying identity and residency
- Following the re-launch of Croydon's Credit Union, continue to develop financial products to meet local resident's needs. Initial ideas for jam jar accounts and flexible loans have been discussed. A timeline and approach is now to be agreed with a view to launch during 2016/17
- Agree approach to providing advice, be this signposting or working in partnership with the 3rd sector
- Deliver new operating model, agree measures, monitoring and timings to review

6.6 Develop skills and opportunities for citizens to maximise income

- Join up our customer insight on residents seeking employment with our economic regeneration policies
- Link CALAT provision to the skills gaps identified for our residents
- Enhance our links with provision already available in the 3rd sector
- Contribute to the council's commissioning review to support outcome based commissioning

6.7 Continue to develop our working relationship with "Croydon plus" (the newly branded credit union). Increasing the accessibility for all to access financial products that best support families to achieve stability.

7. EQUALITIES IMPACT

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

7.2 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.

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BACKGROUND DOCUMENTS

None

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REPORT TO:	**HEALTH AND WELLBEING BOARD** **13 April 2016**
AGENDA ITEM:	**11**
SUBJECT:	**Report of the chair of the executive group: incorporating risk register, board work plan and performance report**
LEAD OFFICER:	**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 the board work plan for 2016/17 at appendix 2.
- Consider performance issues identified in the report at appendix 3 and summarised at paragraph 3.5.

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 2015/16 at its meeting on 25 March 2015. 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 appendix 3.

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 Key areas of work for the executive group in February and March 2016 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.
- Liaison with other strategic partnerships including Croydon strategic partnership and children and families partnership.
- Review of board strategic risk register.
- Review of responses to public questions and general enquiries relating to the work of the board.

Risk

3.3 Risks identified by the board are summarised at appendix 1. The executive group regularly review the board risk register. The risk register was fully reviewed by the executive group at its meeting on 8 December 2015, with existing controls updated and a number of new controls identified. There have been no changes to the risk ratings since the board meeting on 10 February 2015.

Board work plan

3.4 Changes to the board work plan from the version agreed by the board on 10 February 2016 are summarised below. This is version 74 of the work plan. The work plan is at appendix 2.

3.4.1 Item on People Gateway added to agenda for 13 April 2016.
3.4.2 Items on the Community Strategy and Sustainable Transformation Plan added to agenda for 8 June 2016.
3.4.5 Item on early years added to agenda for 14 September 2016.

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 alcohol attributable hospital admissions are identified as areas of success. Areas of challenge include over 65s vaccinated against influenza and injuries due to falls

3.5.3 For improvement area 3: preventing premature death and long term health conditions, deaths from diabetes and breast screening rates 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

13 March 2016

Risk Status

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

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HWB 13 April 2016
Appendix 2
Item 11

HWB work plan version 74.0

Topic proposed: date to be agreed
People Gateway

Date	Item	Purpose	JHWS priority	Board sponsor	Lead officer / report author
8 June 2016	**Strategic items**				
	Cancers	To discuss work to increase the early detection and treatment of cancers	Early detection and treatment of cancers	Paula Swann	tbc
	Business items				
	Community Strategy	To ratify the Community Strategy	n/a	tbc	Sharon Godman
	Sustainable Transformation Plan	To agree the Sustainable Transformation Plan	n/a	Paula Swann	Fouzia Harrington
	Food Flagship annual report	To report on activity undertaken by the Food Flagship	Reduce overweight and obesity in children	Rachel Flowers	Ashley Gordon
	Heart Town annual report	To report on activity undertaken by the Heart Town project	Early detection & treatment of cardiovascular disease and diabetes	Rachel Flowers	Steve Morton

Date	Item	Purpose	JHWS priority	Board sponsor	Lead officer / report author
	Partnership groups proposal (Partnership group: All)	To propose a reconfiguration of the partnership groups accountable to the board to better align them to the board's core functions	n/a	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
14 September 2016	**Strategic items**				
	Self-care and self-management	To consider work to increase self-care and self-management	Promoting self-management and self-care	Paula Swann	tbc
	Business items				
	Tobacco control update	To report to the board on work to reduce smoking prevalence	Reducing smoking prevalence	Rachel Flowers	tbc
	Early years update	To report to the board on work to improve health and wellbeing in early years	Giving our children a good start in life	Tbc	tbc
	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

Date	Item	Purpose	JHWS priority	Board sponsor	Lead officer / report author
19 October 2016	**Strategic items**				
	JSNA key dataset 2016	To consider key challenges and needs identified by the key dataset	n/a	Director of public health	Steve Morton
	Business items				
	Safeguarding adults annual report	To inform the board of the work of the Safeguarding Adults Board	n/a	Paul Greenhalgh	Kay Murray
	Safeguarding children annual report	To inform the board of the work of the Safeguarding Children Board	n/a	Paul Greenhalgh	Gavin Swann
	Health and social care integration: Better Care Fund	To inform the board of progress on the work schedule of the Better Care Fund	n/a	Paula Swann / Paul Greenhalgh	Paul Young
	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.	n/a	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	n/a	Paul Greenhalgh	Steve Morton

Date	Item	Purpose	JHWS priority	Board sponsor	Lead officer / report author
14 December 2016	**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 the JSNA and JHWS.	n/a	Paula Swann/Paul Greenhalgh	Stephen Warren / Brenda Scanlan
	Business items				
	Health protection update	To inform the board of key health protection issues for the borough including uptake of immunisations & vaccinations	Improve the uptake of childhood immunisations	Rachel Flowers	Ellen Schwartz
	Pharmaceutical needs assessment (PNA) update	To consider any changes to the PNA and agree process for full update	n/a	Rachel Flowers	Claire Mundle
	Report of the chair of the executive group • Performance • Work plan • Risk	To inform the board of work undertaken by the executive group and consider the board risk register	n/a	Paul Greenhalgh	Steve Morton

Date	Item	Purpose	JHWS priority	Board sponsor	Lead officer / report author
8 February 2017	**Strategic items**				
	Business items				
	JSNA programme for 2017	To agree the JSNA programme for 2017	n/a	Rachel Flowers	Steve Morton
	Health and social care integration: Better Care Fund	To inform the board of progress on the work schedule of the Better Care Fund	n/a	Paula Swann / Paul Greenhalgh	Paul Young / Vanda Learey
	Report of the chair of the executive group • Work plan • Risk	To inform the board of work undertaken by the executive group, to consider performance and review the board risk register	n/a	Paul Greenhalgh	Steve Morton
5 April 2017	**Strategic items**				
	Business items				
	CCG operating plan 2017/18	The board has a duty to give an opinion on the alignment of the CCG's commissioning plan to the JHWS	n/a	Paula Swann	Fouzia Harrington

Date	Item	Purpose	JHWS priority	Board sponsor	Lead officer / report author
	Report of the chair of the executive group • Performance report • Work plan • Risk	To inform the board of work undertaken by the executive group and consider the board risk register	n/a	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
	Work plan (standing item)	Decision	Hannah Miller	Steve Morton
18 July 2013	Board workshop on strategic risk			

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

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

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

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

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

Date	Items	Purpose	Board sponsor	Lead officer / report author
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
	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

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

Date	Items	Purpose	Board sponsor	Lead officer / report author
	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 / Hannah Miller	Paula Swann/ 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

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

Date	Items	Purpose	Board sponsor	Lead officer / report author
	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			
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

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

Date	Items	Purpose	Board sponsor	Lead officer / report author
	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 strategy	Paula Swann/Hannah Miller/Paul Greenhalgh/Mike Robinson/Jane Fryer	Stephen Warren / Brenda Scanlan / Jane Doyle
	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

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

Date	Items	Purpose	Board sponsor	Lead officer / report author
	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 to publish such a statement is finalised	Paul Greenhalgh	Alan Hiscutt/ Paul Heynes

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

Date	Items	Purpose	Board sponsor	Lead officer / report author
	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 taken proper account of JHWS.	Paula Swann	Stephen Warren

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

Date	Items	Purpose	Board sponsor	Lead officer / report author
	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

Date	Items	Purpose	Board sponsor	Lead officer / report author
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

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

Date	Items	Purpose	Board sponsor	Lead officer / report author
	Sexual health procurement strategy	To provide the board with a briefing on the wider issues relating to the procurement strategy for sexual health services	Paul Greenhalgh / Mike Robinson / Paula Swann / Jane Fryer	Lisa Burn / Ellen Schwartz
	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

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

Date	Items	Purpose	Board sponsor	Lead officer / report author
	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 • 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
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 / Lucky Hossain
	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	Mike Robinson
	Business items			
	Appointment of chair, vice chair and executive group Appointment of board representative on SW London co-commissioning joint committee	To agree key appointments for the board and any changes to the terms of reference	n/a	Solomon Agutu

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

Date	Items	Purpose	Board sponsor	Lead officer / report author
	Better Care Fund	To inform the board of progress on the work schedule	Paul Greenhalgh / Paula Swann	Paul Young / Andrew Maskell
	JSNA 2015/16 key chapter topics	To agree the needs assessments to be carried out as part of the JSNA for 2015/16	Mike Robinson / Paula Swann / 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

Date	Item	Purpose	JHWS priority	Board sponsor	Lead officer / report author
21 October 2015	**Strategic items**				
	JSNA key dataset 2015/16	Discussion & decision	n/a	Mike Robinson	David Osborne
	Business items				
	Implementing the national autism strategy	To inform the board of progress with the local implementation of the Autism Act 2009	Not a JHWS priority	Paul Greenhalgh	Simon Wadsworth

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

Date	Item	Purpose	JHWS priority	Board sponsor	Lead officer / report author
	Safeguarding adults annual report	To inform the board of the work of the Safeguarding Adults Board	n/a	Paul Greenhalgh	Kay Murray
	Safeguarding children annual report	To inform the board of the work of the Safeguarding Children Board	n/a	Paul Greenhalgh	Gavin Swann
	Health and social care integration: Better Care Fund	To inform the board of progress on the work schedule of the Better Care Fund	n/a	Paul Greenhalgh / Paula Swann	Paul Young / Ivan Okyere-Boakye
	Report of the chair of the executive group • Work plan • Risk	To inform the board of work undertaken by the executive group, to consider performance and review the board risk register	n/a	Paul Greenhalgh	Steve Morton
23 October	**Joint workshop with Opportunity and Fairness Commission**				

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

Date	Item	Purpose	JHWS priority	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 the JSNA and JHWS.	n/a	Paula Swann/Paul Greenhalgh	Stephen Warren / Brenda Scanlan
	Urgent care transformation	To inform the board of work to transform urgent care	Redesign urgent care pathways	Paula Swann	Stephen Warren
	Business items				
	Health protection update	To inform the board of key health protection issues for the borough including uptake of immunisations & vaccinations	Improve the uptake of childhood immunisations	Director of public health	Ellen Schwartz
	JSNA maternal health chapter final draft	To consider the findings of the chapter and agree to its publication	Giving children a good start in life	Director of public health	Sarah Nicholls / Dawn Cox

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

Date	Item	Purpose	JHWS priority	Board sponsor	Lead officer / report author
	Patient transport	To receive a report on improvements to patient transport in response to patient and carer feedback	Improving people's experience of care	John Goulston	Allan Morley
	Report of the chair of the executive group • Work plan • Risk • Performance	To inform the board of work undertaken by the executive group and consider the board performance report, risk register and work plan	n/a	Paul Greenhalgh	Steve Morton
10 February 2016	**Strategic items**				
	Health and social care integration: outcomes based commissioning for over 65s	To update the board on progress since the last report on 22/10/14	Prevent illness and injury and promote recovery in the over 65s	Paula Swann / Paul Greenhalgh	Martin Ellis
	JSNA community based services for over 65s chapter final draft	To consider the findings of the chapter and agree to its publication.	Prevent illness and injury and promote recovery in the over 65s	Steve Morton / Ellen Schwartz	Nerissa Santimano

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

Date	Item	Purpose	JHWS priority	Board sponsor	Lead officer / report author
	Business items				
	South West London Commissioning Collaborative	To update the board on progress	n/a	Paula Swann	tbc
	JSNA programme for 2016	To agree the JSNA programme for 2016	n/a	Director of public health	Steve Morton
	Final report of the Opportunity & Fairness Commission	To consider the findings of the Opportunity & Fairness Commission	n/a	tbc	tbc
	Report of the chair of the executive group • Work plan • Risk	To inform the board of work undertaken by the executive group, to consider performance and review the board risk register	n/a	Paul Greenhalgh	Steve Morton
13 April 2016	**Strategic items**				
	Improving people's satisfaction with care: learning from local best practice • Maternity services • Mental health day services	To share learning on how services have improved people's experience of care	Improve people's satisfaction with care	Paula Swann (maternity services) Paula Swann / Paul Greenhalgh (mental health day services)	Caroline Boardman (maternity) Susan Grose (mental health)

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

Date	Item	Purpose	JHWS priority	Board sponsor	Lead officer / report author
	Business items				
	CCG operating plan 2016/17	The board has a duty to give an opinion on the alignment of the CCG's commissioning plan to the JHWS	n/a	Paula Swann	Fouzia Harrington
	Health and social care integration: Better Care Fund and Transforming Adult Community Services	To inform the board of progress on the work schedule of the Better Care Fund and provide an update on TACS	n/a	Paula Swann / Paul Greenhalgh	Paul Young / Vanda Learey
	People Gateway	To update the board of the work of the People Gateway	Household income is a key determinant of health. This item relates to the JHWS priority of child poverty.	Paul Greenhalgh	Mark Fowler
	Report of the chair of the executive group • Performance report • Work plan • Risk	To inform the board of work undertaken by the executive group and consider the board risk register	n/a	Paul Greenhalgh	Steve Morton

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HWB 13 April 2016

ITEM 11 Appendix 3

Health & Wellbeing Board Performance Report

Mar-16

SCC - Performance Team Contact: Lee.Lewis@croydon.gov.uk or Glory.Nyero@croydon.gov.uk

31 March 2016

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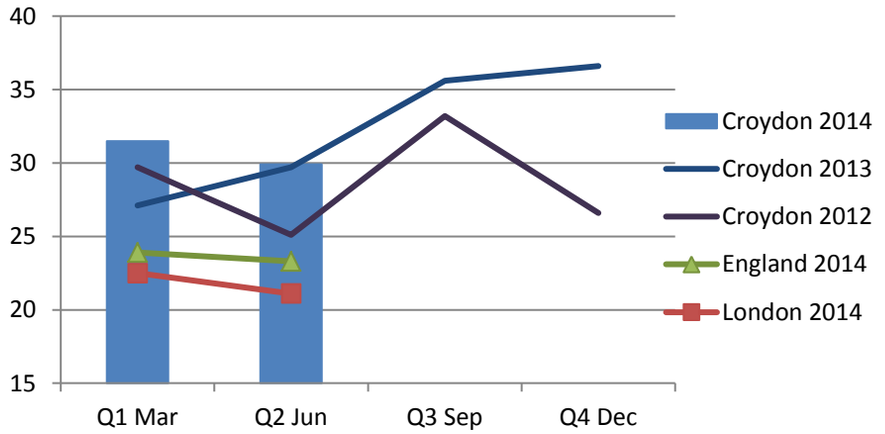
NOTE – the principal source of data within this report is the Croydon Key dataset developed by the Croydon Public Health Intelligence Team.

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

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

Potential challenge areas

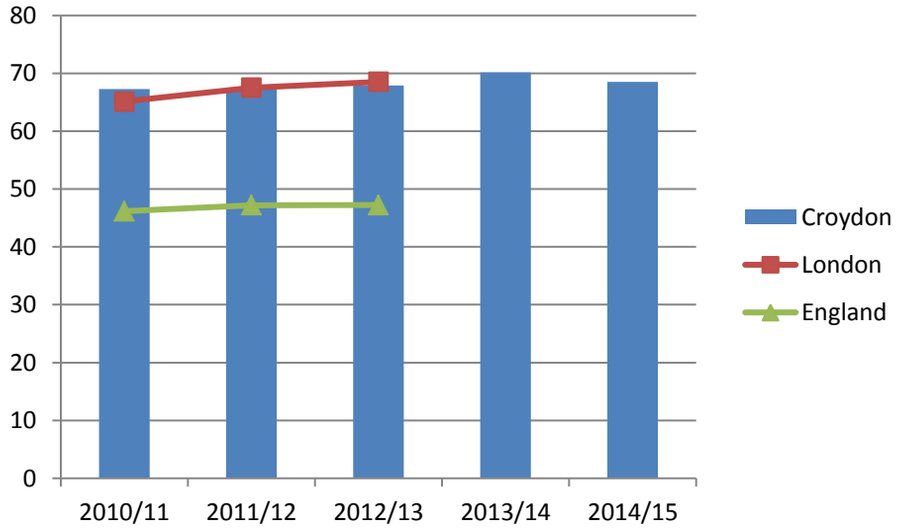
Conception rate per thousand Women aged 15 to 17



Conception rate (actual) was 29.9 per 1000 girls aged 15-17 years of age and equated to 53 conceptions. The rolling quarterly average conception rate for Q2-2014 was 33.4 per 1000 girls aged 15-17 years of age. This is unchanged from Q1 but, prior to Q2, the rolling quarterly average data showed consistent increases over the previous five quarters and this trend upwards was significant. That is, we are 95% certain that the rates are increasing rather than this observed increase being a random fluctuation. Therefore this is something we should consider as an emerging public health issue.

Areas of success

% breastfeeding prevalence at 6-8 week health check



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

Performance measures

Measure description	Source	Polarity	Most recent annual data	From	Previous 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	**33.4**	2014 Q2	29.2 2013 Q2	21.10	23.3	**Worse**	**Worse**	**Worse**
Breastfeeding initiation within 48 hours (% of mothers)	Croydon key dataset	HIGH	**86.1**	2013/14	87%	86.77%	73.86%	**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	**68.5%**	2014/15	67.88%	Not yet Available	Not yet Available	**Better**	Unknown	Unknown
Percentage of women who are smokers at the time of delivery	Croydon key dataset	LOW	**6.9%**	2014/15	6.8% 2014	5.00%	10.70%	**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	**22.2%**	2014/15	23.40%	23.10%	22.50%	**Better**	**Better**	**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	**39%**	2014/15	38.40%	37.60%	33.50%	**About the same**	**About the same**	**Worse**
Percentage of live and still births under 2500 grams	Croydon key dataset	LOW	**8.3%**	2011	8.80%	8.00%	7.46%	**About the same**	**About the same**	**About the same**

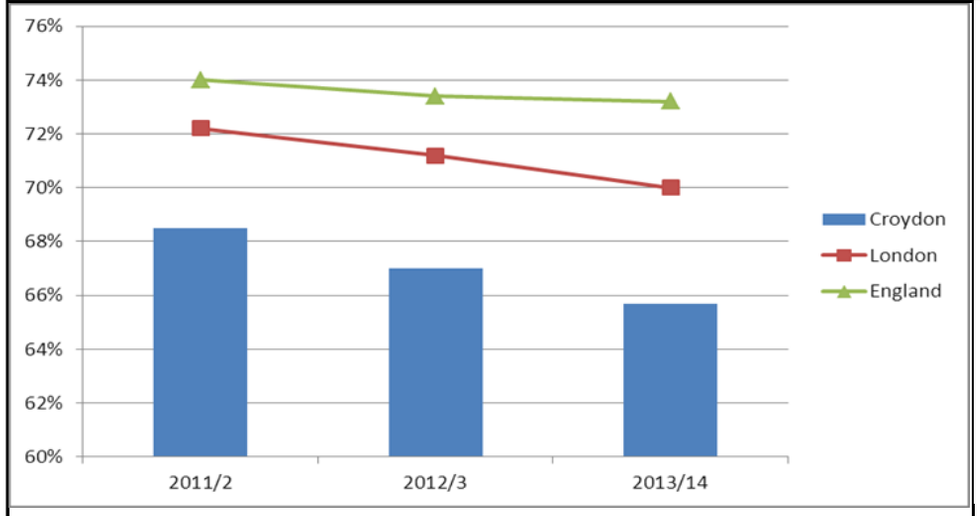
Measure description	Source	Polarity	Most recent annual data	From	Previous year	London Average	England Average	Comparison with previous year	Comparison with London Average	Comparison with England Average
Immunisations - DTaP / IPV / Hib vaccination coverage (1 year old)	Croydon key dataset	HIGH	**90.7%**	2014/15	91.69%	89.76%	94.34%	About the same	About the same	Worse
Immunisations - Hib / MenC booster vaccination coverage (2 years old)	Croydon key dataset	HIGH	**92.5%**	2014/15	87.67%	86.81%	92.51%	Better	Better	About the same
Immunisations - PCV booster vaccination coverage (2 years old)	Croydon key dataset	HIGH	**86.3%**	2014/15	88.88%	86.31%	92.44%	Worse	About the same	Worse
Immunisations - MMR vaccination coverage for one dose (2 years old)	Croydon key dataset	HIGH	**86.1%**	2014/15	88.93%	87.46%	92.66%	Worse	About the same	Worse
Immunisations - DTaP / IPV vaccination coverage (5 years old)	Croydon key dataset	HIGH	**92.8%**	2012/13	92.80%	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	**69.7%**	2014/15	76.90%	80.70%	88.32%	Better	Worse	Worse
Tooth decay in children aged 5 (average number of teeth)	Croydon key dataset	LOW	case too small	2011/12	NA	1.23	0.94	Unknown	Better	Better
Emotional wellbeing of looked-after children (mean score out of 40)	Croydon key dataset	LOW	**12.6%**	2013/14	12.6	13.40	13.9	About the same	About the same	Worse
Children living in poverty	Croydon key dataset	LOW	**21.8%**	2013	23.00%	23.70%	19.20%	Better	Better	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

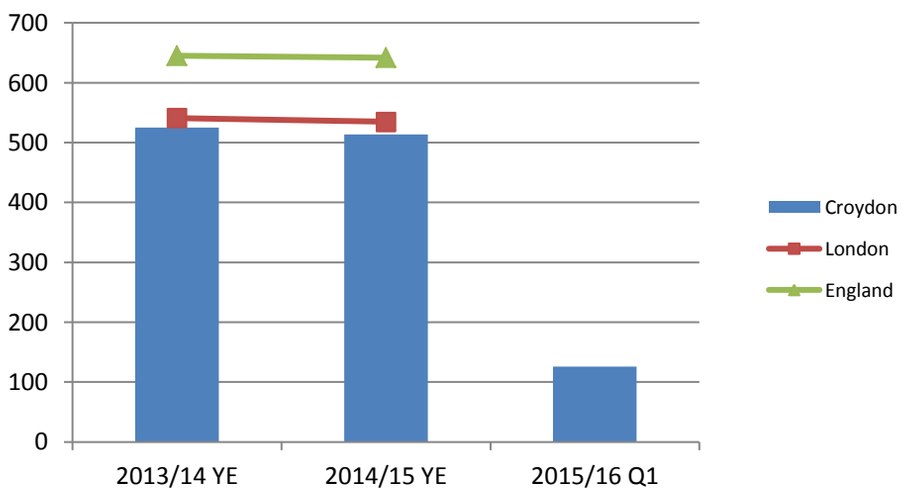
% of persons aged 65 and over immunised against influenza



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.

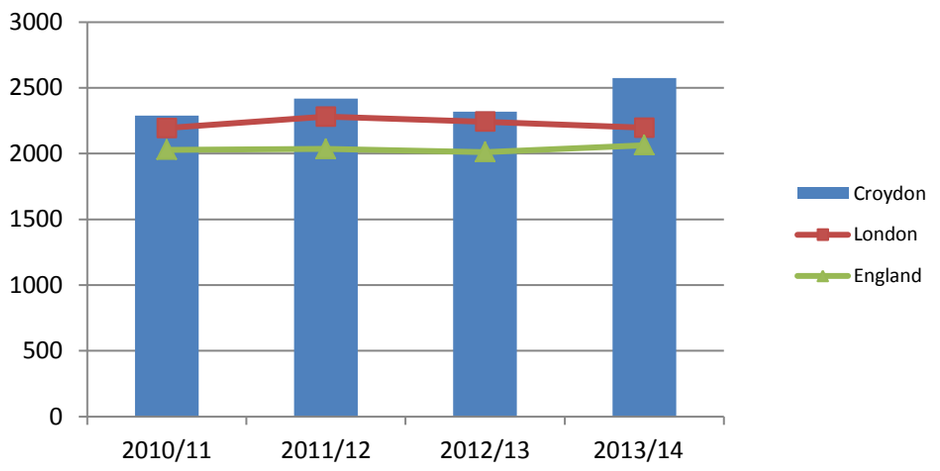
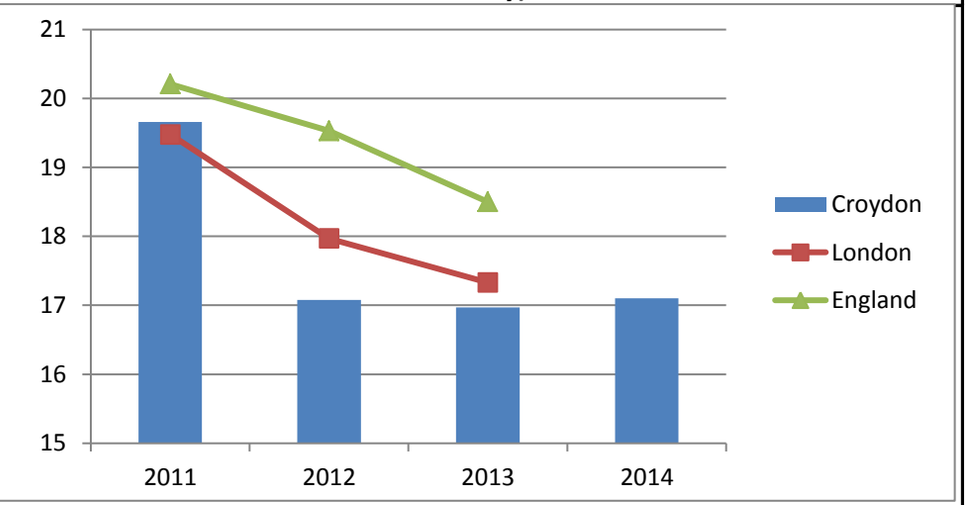
Areas of success

Narrow Def: Alcohol attributable hospital admissions (rate per 100,000 population)



The 2015/16 quarter 1 outturn (126.1) shows Croydon continues to perform slightly better than the London average (133.09) and England average (156.12) for this reporting period. The narrow indicator allows more accurate comparison of alcohol-related harm between different areas and over time.

In order to reduce alcohol related harm, Croydon Public Health is working in partnership to develop its borough programme of alcohol IBA to identify people who drink at higher risk levels and deliver brief interventions. Furthermore, it is working with the local emergency department to prevent alcohol related violence through sharing A&E data with the Safer Croydon Partnership.

Potential challenge areas	Areas of success
Injuries due to Falls (rate per 100,000 population aged over 65)	**Smoking prevalence (% of adults aged over 18 who responded to survey)**
	
The rate of injuries due to falls for over 65's has increased from 2318 (2012/13) to 2574 (2013/14)per 100,000 and is higher than both the averages for London and England.	Smoking prevalence has marginally increased to 17.1% for 2014. This still demonstrates smoking prevalence below averages for England; whereas the difference with London has narrowed.

Performance measures

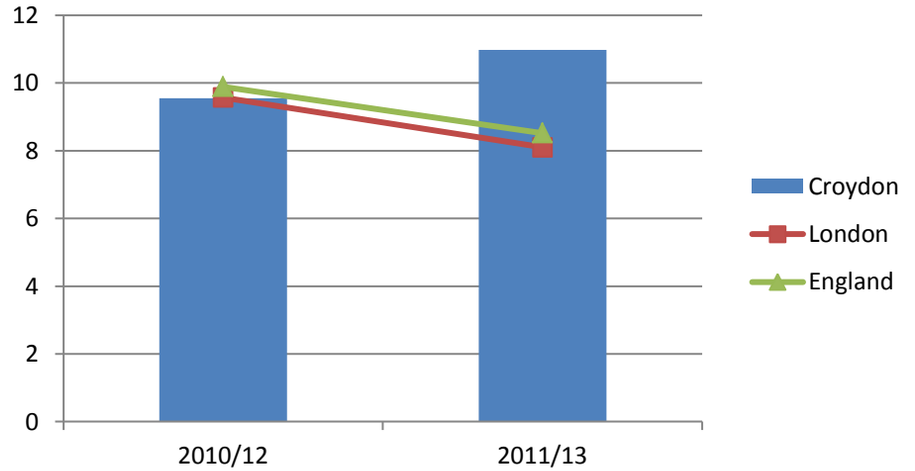
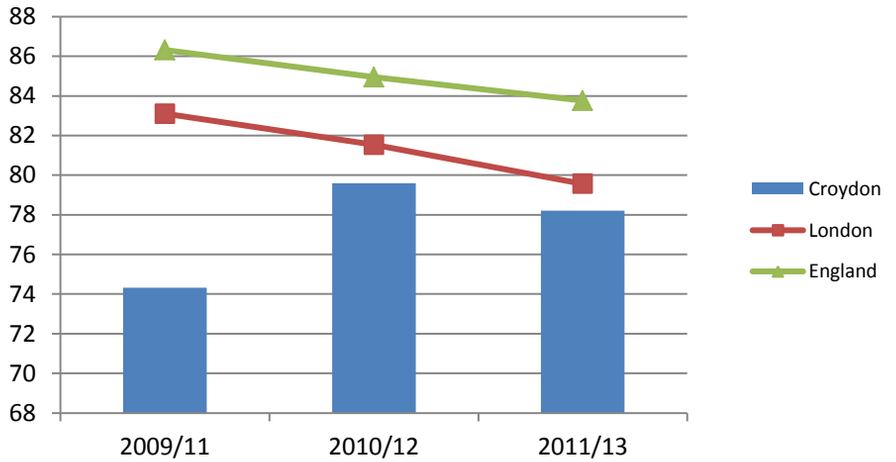
Measure description	Source	Polarity	Most recent annual	From	Previous year	London Average	England Average	Comparison with previous	Comparison with London Average	Comparison with England
% of persons aged 65 and over immunised against influenza	Croydon key dataset	HIGH	**65.9%**	2014/15	66%	69%	72.74%	About the same	Worse	Worse
Self-reported 4-week smoking quitters per 100,000 adult population aged 16+	Croydon key dataset	HIGH	**758**	2013/14	793	656	688	Worse	Better	Better
Smoking prevalence (% of adults aged over 18 who responded to survey)	Croydon key dataset	LOW	**17.1%**	2014	16.97%	17.33%	19%	About the same	Better	Better

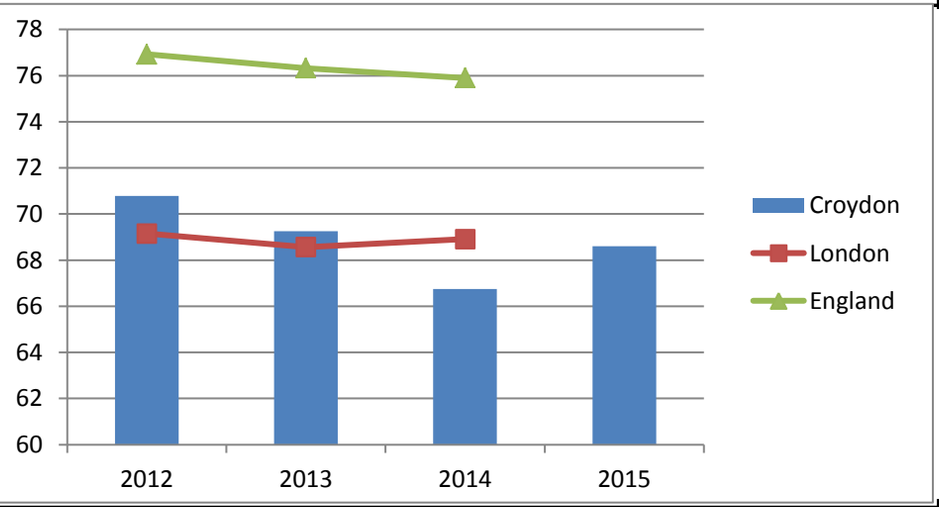
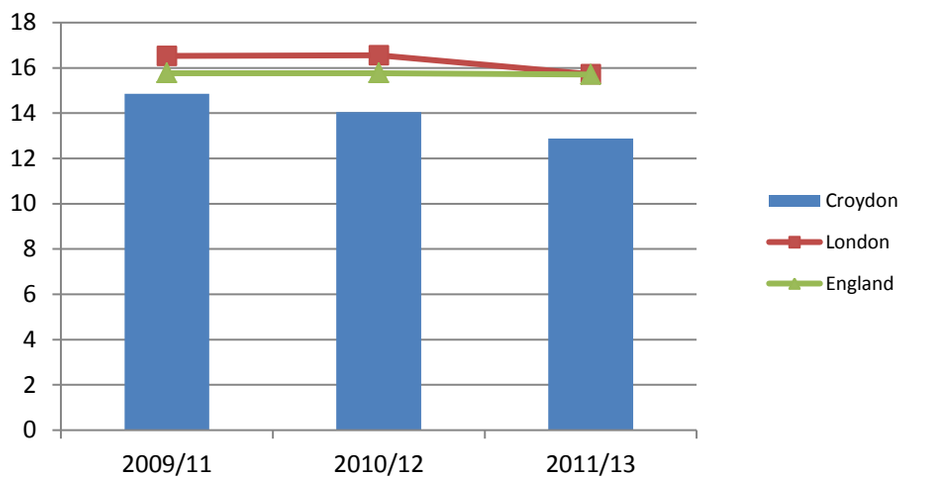
Measure description	Source	Polarity	Most recent annual data	From	Previous year	London Average	England Average	Comparison with previous year	Comparison with London Average	Comparison with England Average
Rate of hospital admissions with a primary or secondary diagnosis of obesity per 100,000 population	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	**126.1**	Q1 2015/16	Q4 14/15 128.84	Q1 15/16 133.1	Q1 15/16 156.1	**About the same**	**Better**	**Better**
Percentage of patients on GP registers aged 17 and over diagnosed with diabetes	Croydon key dataset	LOW	**6.6%**	2014/15	6.48%	6.00%	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	**57.10%**	2012-14	13.00%	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	**58.8%**	2012-14	56.7%	40.5%	45.5%	**About the same**	**Worse**	**Worse**
Chlamydia diagnoses (ages 15-24) (rate per 100,000 population)	Croydon key dataset	n/a	**2739**	Jan-Dec 2014	2704 (Q3 2014)	2178	2012	n/a	n/a	n/a
Percentage of households identified as “fuel poor”	Croydon key dataset	LOW	**9.9%**	2013	8.81%	9.79%	10.39%	**Worse**	**About the same**	**Better**
Injuries due to falls (rate per 100,000 population aged over 65)	Croydon key dataset	LOW	**2539**	2014/15	2318	2197	2064	**Worse**	**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**	2013/14	Suppressed due to small sample	Unknown	unknown	Unknown	Unknown	Unknown
Patient reported outcomes for elective procedures: Hip Replacement (EQ-5D- average health gain score out of 1)	NHS outcomes framework	HIGH	**0.423**	2013/14	0.391	0.43	0.423	**About the same**	**About the same**	**About the same**
Patient reported outcomes for elective procedures: Knee Replacement (EQ-5D- average health gain score out of 1)	NHS outcomes framework	High	**0.294**	2013/14	0.285	0.29	0.318	**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**	2013/14	Suppressed due to small sample	0.063	0.093	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 78.2. 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 slight increase in the % of eligible women receiving breast screening from 66.8% in 2014 to 68.6% by 2015.	The rate of early deaths form liver disease considered preventable has reduced from 14 to 12.9 per 100,000. A similar rate of reduction can be seen for the London average but not for England overall.

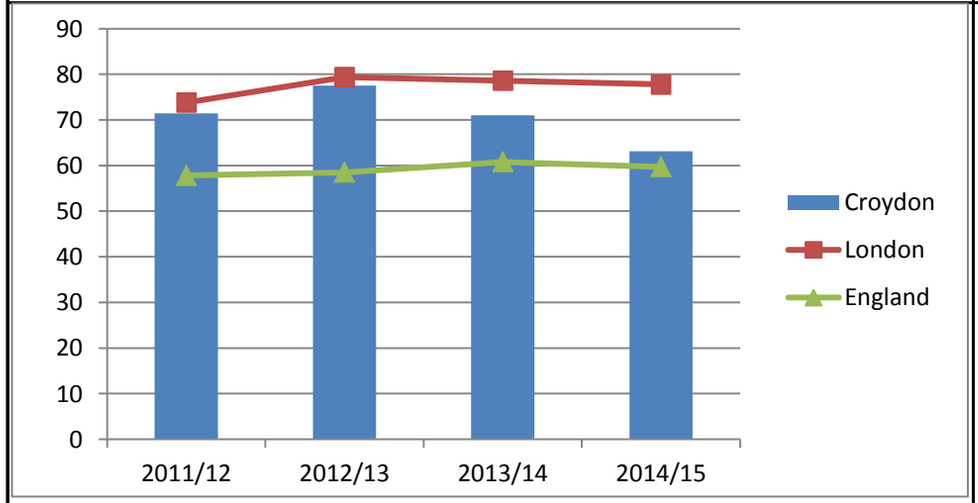
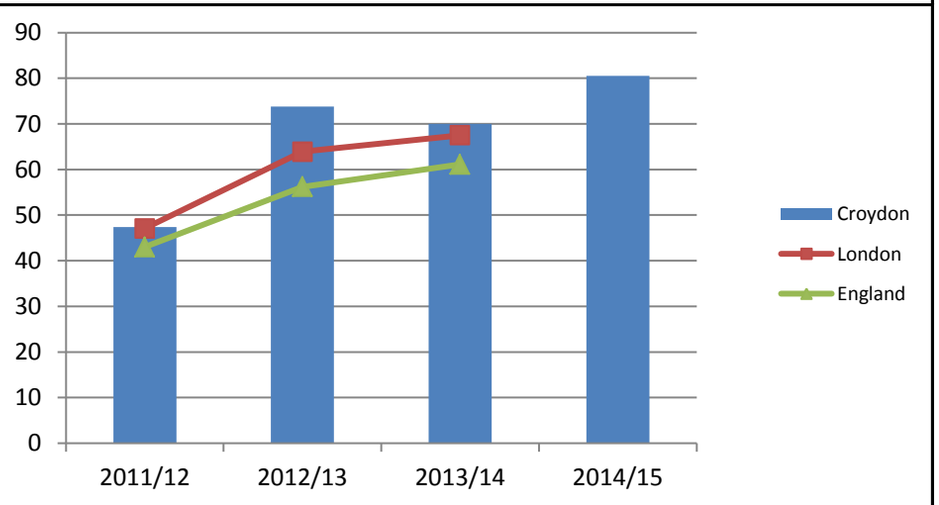
Performance measures

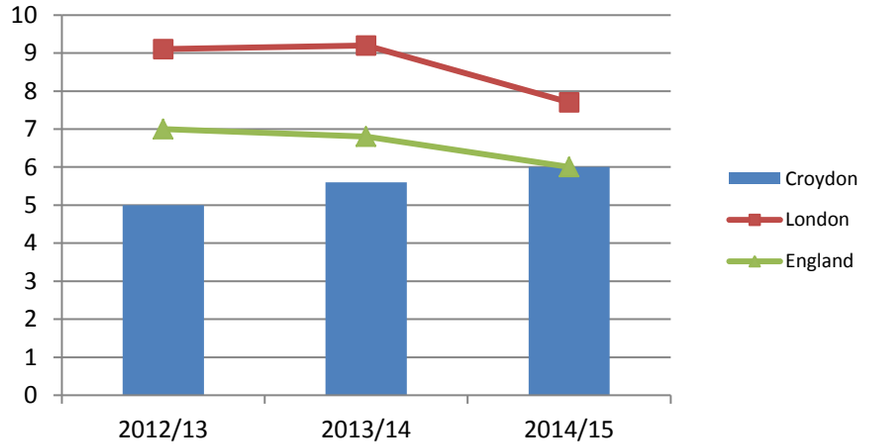
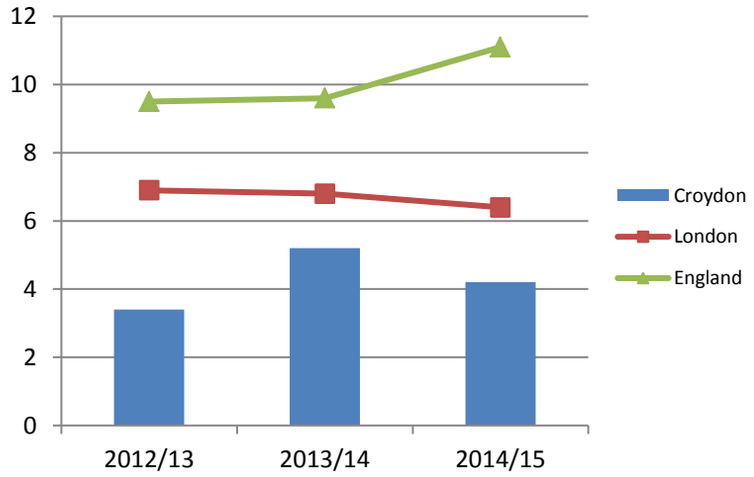
Measure description	Source	Polarity	Most recent annual data	From	Previous year	London Average	England Average	Comparison with previous year	Comparison with London Average	Comparison with England Average
Infant mortality - Rate per 1,000 live births,	Croydon key dataset	LOW	**3.95**	2011-13	3.91	3.84	3.98	About the same	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	**78.8**	2012-14	78.21	79.57	83.76	About the same	About the same	Better
Deaths from causes considered preventable (rate per 100,000 population)	Croydon key dataset	LOW	**173.52**	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	55.18	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	14.05	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	**11.9%**	2013/14 - 2014/15	0.80%	44.61%	37.94%	Better	Worse	Worse
Take up of NHS health checks (% of people offered health checks)	Croydon key dataset	HIGH	**6.9%**	2013/14 - 2014/15	1.60%	21%	19%	Better	Worse	Worse
% of NHS health checks that identify patients to be at high risk	TBC	TBC	**12.3%**	2012/13	10.20%	Local indicator	local indicator	Unknown	Unknown	Unknown
Breast screening rate (% of women aged 53-70)	Croydon key dataset	HIGH	**68.6%**	2015	66.80%	68.91%	75.90%	Worse	Worse	Worse
Cervical screening rate (% of eligible women aged 25-64)	Croydon key dataset	HIGH	**72.2%**	2015	72.50%	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	8.1	8.52	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**
	
2014/15 has seen a decline in the proportion of adults in contact with secondary mental health services living independently	Across all services, all presenting clients with eligible needs, excluding those in crisis or receiving reablement services, are assessed utilising the single Resource Allocation System to determine the amount of personal budget they will receive to fund their social care services.

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 disabilities in paid employment has slightly increased, it is still below average for both London and England.	Croydon's performance has remained below the averages for both London and England; and has further 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	18.4	2014/15	18.7	2013-14 18.5	2013-14 19.1	About the same	About the same	About the same
Proportion of people who use services who have control over their daily life	ASCOF	HIGH	**71.50%**	2014/15	74.90%	2013-14 71.6%	2013-14 76.7%	Worse	About the same	Worse

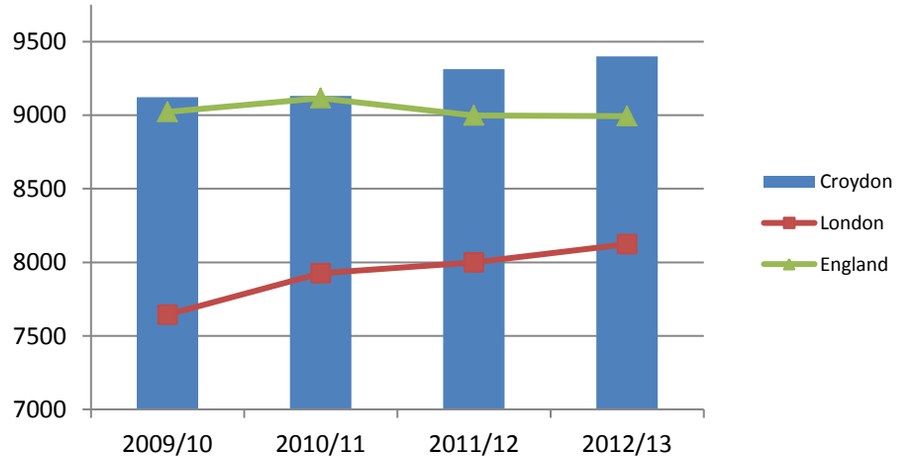
Measure description	Source	Polarity	Most recent annual data	From	Previous year	London Average	England Average	Comparison with previous year	Comparison with London Average	Comparison with England Average
Proportion of people using social care who receive self-directed support	ASCOF	HIGH	**80.50%**	2014/15	70.00%	2013-14 67.50%	2013-14 62.10%	Better	Better	Better
Proportion of people using social care who receive direct payments	ASCOF	HIGH	**14.50%**	2014/15	10.40%	2013-14 22.10%	2013-14 19.10%	Better	Worse	Worse
Survey: Carer-reported quality of life	ASCOF	HIGH	7.4	2014/15	7.7	2013-14 7.7	2013-14 8.1	About the same	About the same	Worse
Proportion of adults with learning disabilities in paid employment	ASCOF	HIGH	**6.00%**	2014/15	6%	2013-14 7.7%	2013-14 6%	About the same	Worse	Worse
Proportion of adults in contact with secondary mental health services in paid employment	ASCOF	HIGH	**4.40%**	2014/15	5.70%	2013-14 5.5%	2013-14 7.1%	Worse	Worse	Worse
Proportion of adults with learning disabilities who live in their own home or with their family	ASCOF	HIGH	**60.40%**	2014/15	66.20%	2013-14 68.5%	2013-14 74..8%	Worse	Worse	Worse
Proportion of adults in contact with secondary mental health services living independently, with or without support	ASCOF	HIGH	**63.10%**	2014/15	71.00%	2013-14 78.7%	2013-14 60.9	Worse	Worse	Better

Permanent admissions of younger adults (aged 18 to 64) to residential and nursing care homes, per 100,000 population	ASCOF	LOW	**9.4**	2014/15	7.7	2013-14 10.0	2013-14 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	**436**	2014/15	421	2013-14 463.9	2013-14 668 .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	**87.80%**	2014/15	85.20%	2013-14 87.8	2013-14 81.9	**Better**	**About the same**	**Better**
Delayed transfers of care from hospital per 100,000 population	ASCOF	LOW	**4.5**	2015/16	5.2	2013-14 6.4	2013-14 9.12	**Better**	**Better**	**Better**
Delayed transfers of care from hospital which are attributable to adult social care per 100,000 population	ASCOF	LOW	**1.8**	2015/16	1.4	2013-14 2.1	2013-14 2.5	**About the same**	**Better**	**Better**
Overall satisfaction of people who use services with their care and support	ASCOF	HIGH	**59.90%**	2014/15	57.90%	2013-14 60.10%	2013-14 64.09%	**Better**	**Worse**	**Worse**
Overall satisfaction of carers with social services	ASCOF	HIGH	**25.50%**	2014/15	29.90%	2013-14 35.2%	2013-14 42.7%	**Worse**	**Worse**	**Worse**

Proportion of carers who report that they have been included or consulted in discussion about the person they care for	ASCOF	HIGH	**68.60%**	2014/15	63.4	2013-14 65.90%	2013-14 72.80%	**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**
Proportion of people who use services and carers who find it easy to find information about services	ASCOF	HIGH	**71.60%**	2014/15	73.10%	2013-14 72.6%	2013-14 74.7%	**Worse**	**About the same**	**Worse**
Proportion of people who use services who say that those services have made them feel safe and secure	ASCOF	HIGH	**65%**	2014/15	64.00%	2013-14 63.1%	2013-14 66%	**Better**	**Better**	**About the same**

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

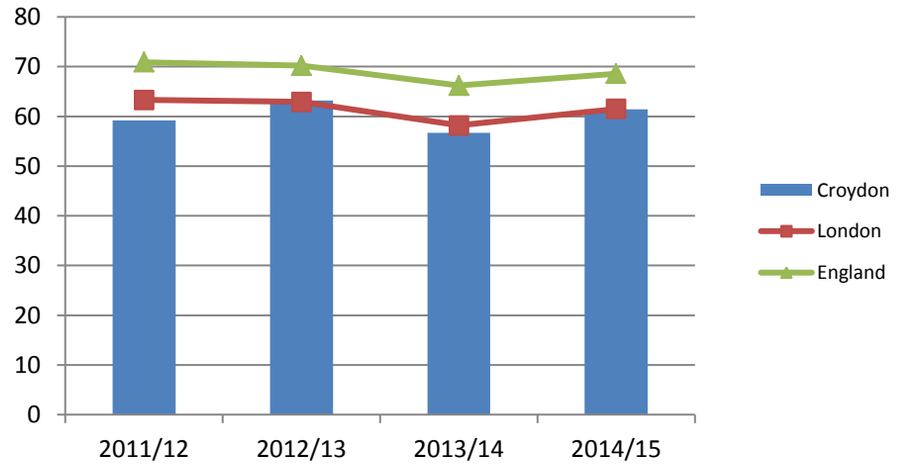
Priorities
5.1 Redesign of mental health pathways
5.2 Increased proportion of planned care delivered in community settings
5.3 Redesign of urgent care pathways
5.4 Improve the clinical quality and safety of health services
5.5 Improve early detection, treatment and quality of care for people with dementia

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**	2012/13	9312.91	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%	12.23%	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 increased for the period 2014/15, However remains just below the London average and considerably below England average.	

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	**82.60%**	2014/15	83%	80.20%	84.80%	About the Same	Better	Worse
Patient experience of primary care: Out of Hours Services	NHS outcomes framework	HIGH	**61.40%**	2014/15	56.70%	61.50%	68.60%	better	About the same	Worse
Patient experience of primary care: Dentistry	NHS outcomes framework	HIGH	**83.60%**	2014/15	82.90%	80.9	84.60%	About the Same	better	About the same
Patient experience of hospital care: Inpatient Overall Experience	NHS outcomes framework	HIGH	**70.5**	2014/15	67.1	Not available	76.6	better	Unknown	Worse
Patient experience of hospital care: Outpatient Overall Experience (out of 100)	NHS outcomes framework	HIGH	**74.4**	2011	75.3	Not available	79.5	About the Same	Unknown	Worse
Patient experience of hospital care: Inpatient Responsiveness to Needs (out of 100)	NHS outcomes framework	HIGH	**61.6**	2013/14	57.4	66.7	68	better	worse	Worse
Patient experience of hospital care: A&E Overall Experience	NHS outcomes framework	HIGH	**73**	2014	75.2	Not available	80.7	About the Same	Unknown	Worse
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 Croydon's data set has been suppressed due to its small size

[2] As this data is provisional England and London will remain at 2013/14 for benchmarking until the final release.

[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.

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Parents call for action over autism diagnosis

Watchdog says families also experience barriers getting help

By **Polly Albany-Ward**
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PARENTS of autistic children in Croydon have to wait up to 18 months for the condition to be diagnosed.

Patient watchdog Healthwatch published a report on Tuesday calling on the borough's health and social services to cut this time and make it easier for parents to get help after a diagnosis is made.

In 2012 there were 881 autistic children in the borough, the report said, with this number expected to increase to 1,414 by 2021.

According to the report, there are 486 undiagnosed autistic children in Croydon.

Support

Parents and carers at the launch of the report, at the CVA Centre in London Road on Tuesday (March 15), said even once their child was diagnosed they felt they received no support.

Karen Browne, from South Norwood, has an eight-year-old son with autism.

She said once he was diagnosed "it was like that was it".

"When you have a medical condition you get regular checks to see how you are doing. It should be the same with autism," she said. "My son was diagnosed but then we were just left to deal with it, there was no follow-up."

DEMANDING MORE: Cllr Andrew Rendle, Healthwatch CEO Charlie Ladyman and National Autistic Society family worker Linda Townsend

Parents quoted in the Healthwatch report said they had come up against "barriers, barriers, barriers" accessing help, with one parent phoning a social worker ten times in one day with no answer.

Charlie Ladyman, CEO of Healthwatch Croydon, said: "Waits of 18 months have a detrimental impact on the child's development, with consequences for family and carers."

The report said there should be a 'one-stop-shop' for parents so they can access health, council and other services in one place with just one phone number to call.

It also recommended more training for GPs and for more psychiatrists, counsellors and therapists to be employed.

The report welcomed Croydon Clinical Commissioning Group's Local Transformation Plan, which will see a multi-agency approach to children's mental and emotional wellbeing.

But Healthwatch said the same number of children need diagnosis in Croydon every month as in Richmond, Merton, Sutton, Kingston and Wandsworth combined.

Despite services set to receive an extra £1.2 million in NHS funding, equivalent to 25 per cent, Healthwatch called on the CCG to seek more funding to support services in the long term so they can provide a similar level of care to neighbouring boroughs. Andrew Rendle, councillor for Ashburton, was appointed at the council's autism champion in May 2014. The father of two autistic sons, he said he was working to influence council policy to make the borough more autism friendly.

Cllr Rendle said he worked with Croydon University Hospital to make sure the new accident and emergency currently under construction will be autism friendly.

He has also worked with Crystal Palace to create coaching lessons for primary school children with autism.

Welcome

A Croydon CCG spokesman said: "We welcome the publication of this report and will respond formally to the recommendations once we have considered them fully.

"Improving access to Child and Adolescent Mental Health Services (CAMHS), including Autistic Spectrum Disorder services, is a priority for Croydon CCG. Our 2015/16 Plan includes over £1m of further investment to redesign and improve access to all CAMHS services.

"We are working closely with South London and the Maudsley NHS Foundation Trust, Croydon Council and the voluntary sector to improve mental health services for children and young people in Croydon.

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