HEALTH & WELL-BEING BOARD (CROYDON)

To: **Elected members of the council:**
Councillors Margaret BIRD, Patricia HAY-JUSTICE, Yvette HOPLEY (Vice-Chair), Maggie MANSELL (Chair), Callton YOUNG

Officers of the council:
Barbara PEACOCK (Executive Director of People)
Rachel FLOWERS (Director of Public Health)

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

Healthwatch Croydon
Jai JAYARAMAN (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:
Ashtaq ARAIN (Faiths together in Croydon)
Adam KERR (National Probation Service (London))
David LINDRIDGE (London Fire Brigade)
Andrew McCOIG (Croydon Local Pharmaceutical Committee)
Cassie NEWMAN (London Community Rehabilitation Company)
Claire ROBBINS (Metropolitan Police)

A meeting of the **HEALTH & WELL-BEING BOARD (CROYDON)** will be held on **Wednesday 8th February 2017** at **2:00pm**, in **The Council Chamber, The Town Hall, Katharine Street, Croydon CR0 1NX**.

JACQUELINE HARRIS-BAKER
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
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www.croydon.gov.uk/agenda
30 January 2017

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.
PLEASE NOTE: This meeting will be paperless. The agenda can be accessed online via the mobile app: http://secure.croydon.gov.uk/akscroydon/mobile - Select 'Meetings' on the opening page

AGENDA - PART A

1. Apologies for absence

2. Minutes of the meeting held on Wednesday 14th December 2016
(Page 1)

To approve the minutes as a true and correct record.

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. Strategic items:
Primary care co-commissioning (Page 13)

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

7. Business Items:
Better Care Fund (Page 27)

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

8. JSNA programme for 2017 (Page 33)

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

9. Healthwatch Croydon report

A verbal report will be given by the Interim Chief Executive Officer of Healthwatch Croydon.

10. Report of the chair of the executive group (Page 43)

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

11. 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.

12. FOR INFORMATION ONLY
Progress reports on:
South West London Sustainability and Transformation Plan (STP)
Outcomes Based Commissioning for over 65s (Page 63)

13. [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 14th December 2016 in The Council Chamber, The Town Hall, Katharine Street, Croydon CR0 1NX

Present:

Elected members of the council:
Councillors Margaret BIRD, Patricia HAY-JUSTICE, Yvette HOPLEY (Vice-Chair), Maggie MANSELL (Chair), Callton YOUNG

Officers of the council:
Rachel FLOWERS (Director of Public Health)

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

Healthwatch Croydon
Jai JAYARAMAN (Healthwatch Croydon)

NHS service providers:
John GOULSTON (Croydon Health Services NHS Trust)

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

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

Non-voting members:
Ashtaq ARAIN (Faiths together in Croydon)
Andrew McCOIG (Croydon Local Pharmaceutical Committee)
Duncan McMILLAN (Metropolitan Police)

Also present: Dr Jack Bedeman (Public Health Registrar, Croydon Council), Anita Brako (Public Health Principal, Croydon Council), Steve Morton (Head of Health & Wellbeing, Croydon Council), Matt Phelan (Public Health Principal, Croydon Council) and Gordon Kay (Marketing Officer, Healthwatch Croydon)

Absent: Dr Jane Fryer (NHS England), Adam Kerr (National Probation Service (London)), David Lindridge (London Fire Brigade), Cassie Newman (London Community Rehabilitation Company), Barbara Peacock (Executive Director of People), Zoe Reed (South London & Maudsley NHS Foundation Trust), Stuart Routledge (AgeUK), Helen Thompson (Carers Support Centre)

Apologies: Apologies were received from Barbara Peacock (Executive Director of People), Dr Jane Fryer (NHS England), Stuart Routledge (AgeUK), Helen Thompson (Carers Support Centre), Sarah Burns (CVA) and Darren Morgan (Healthwatch Croydon).

A61/16 Statement from the Chair

At the beginning of the meeting, the Chair made an opening statement:

"**The tram incident:**
On Wednesday 9th November The tram from New Addington tram took the Sandilands corner at speed, left the track and overturned. Seven passengers died; some passengers were injured, some shaken and shocked. The first ambulances were there in minutes. Croydon and Transport Police, Fire service, and Croydon Resilience team swung into action. Voluntary services gave support. Local people, John Ruskin School, and a nursery, none trained for a major incident rallied round to support the rescue teams through the night and the next few days. A book of condolences was opened. The Mayor of London came and promised support for those effected.

Croydon University hospital received 30 patients at A&E in a temporary accommodation. St Georges received some people including serious trauma cases. Some out-patient clinics were cancelled. The event touched the whole community of New Addington and many others in Croydon.
Can we please observe a minute's silence to remember the dead, their families and everyone touched by this terrible incident."

There followed a minute's silence for the victims of the tram incident on 9 November.

John Goulston mentioned that everyone should feel proud of the speed with which people worked and came together over the tram incident. A number of families visited Croydon University Hospital wanting to know what had happened and staff responded wonderfully in the difficult circumstances.

Rachel Flowers announced that a multi-agency group is looking at recovery procedures. "This was the first time an incident has occurred in Croydon with major injuries since the Health & Social Care Act 2012. Meetings are being held to find out what we can learn. The recovery went really well but it was new territory for many staff from various agencies working together. Teams are learning from the psychological first aid but we are at an early stage. NHS England and CCG are involved and we would welcome input from the emergency services and voluntary sector."

Cllr Maggie Mansell emphasised the importance of staff involved being well supported. Some of the police responders were new to the job and did very well.

Duncan McMillan stated that the officers who went to the scene learnt a lot from the experience. The police are building inexperienced staff back up. Young officers were much affected. The body recovery team has experience but borough officers are unfamiliar.

Councillor Mansell also reported on two other matters:
"**STP:**
The Sustainability and Transformation plans for the NHS 2020 have been published. The NHS and Local Councils have been meeting to work on the STP for South West London. There is general agreement on the direction of travel for the out of hospital services. This is familiar to all of us: accessibility of information, advice and self-help, supported by GPs, Pharmacies, social services and the voluntary sector. These matters have been discussed here and elsewhere. The future of Hospital services was not discussed publically. There is an engagement process, but the detailed work for SW London has not been done, so there are no plans and no options to discuss. What is clear is that the financial envelope within which the NHS planners are operating is severely constricted and does not match the increasing needs of the population.

The STP said that a saving could be made by reducing the number of acute centres from 5 to 4 but it would cost more to reduce to 3. More work needs to be done and NHS England (London) will engage with the public next year.

The Council leaders of Richmond, Kingston, Sutton and Merton wrote to NHS England (London) to express concern at the lack of public engagement on the acute services. The Croydon Leader and I wrote similarly but separately because Croydon has some unique characteristics compared with the others. That letter has been circulated to members.

We also wrote to the Secretary of State. Mr Phillip Dunne MP, Minister of State for Health, replied and I have subsequently written a longer letter. Both have been circulated to members. I recognise that some members of the committee are unable to discuss fiscal allocations because they are politically restricted or work for the NHS. My letter has pointed out the inadequacy of the funds provided for the NHS and social care and asked the government to allocate more money to the NHS and train more health staff now."

Cllr Mansell confirmed that correspondence will be circulated later today regarding the STP.

"**Mental Health:**
Members will remember that we agreed a strategy for mental health strategy in October 2014 to improve assessments and community services to reduce out of borough in patient placements. Since then concerns have been raised about access to CAMHS, and availability of talking therapies both of which have received a little finance from government. Concerns have also been raised as to whether Black patients are treated differently.

There have been other studies in Lambeth and elsewhere. I have discussed this with Cllr Tony Newman, Council Leader who has agreed that the H&WB should conduct a Review into the effectiveness of the Mental Health Strategy and services to the people of Croydon including the experience of Black people. It was also agreed that Cllr Louisa Woodley would conduct an initial review into the working of the joint strategy and report to the Cabinet and H&WB. We will then be able to consider what further investigations or we should take.

Thank you."

Councillor Maggie Mansell also mentioned that Stuart Routledge is retiring after many years of valued work in the voluntary sector. He was unable to attend this last meeting but was representated by Julia Powley, also from AgeUK.

A62/16 Minutes of the meeting held on Wednesday 19th October 2016

The minutes of the meeting held on 19 October were agreed as an accurate record, apart from the following correction on page 4:

Originally the strategic planning authority came from the CCGs but it is now recognised that all providers should be involved. There are significant benefits in working together in order to deliver more effectively and we are looking at how to use commissioning support more effectively. Currently it is not appropriate for Croydon to look at a shared Chief Officer along with the other CCGs in South West London as Croydon is pursuing an Accountable Care Organisation approach. There is however no suggestion that Croydon is not working with the other CCGs - the future could look very different for strategic commissioning.

A63/16 Disclosure of Interest

There were none.

A64/16 Urgent Business (if any)

There was none.

A65/16 Exempt Items

There were none.

A66/16 Strategic items:
Annual report of the director of public health 2016

Rachel Flowers introduced her report.

The 2016 Director of Public Health Report focuses on social isolation and loneliness and identifies risk factors for these issues across the life course (pregnancy and early years, children and young people, working age, and retirement and later life).

For her first report, the new Director wanted it to be asset based - something ordinary people can do to improve the isolation of individuals. It is evidence based - linked around data. The photographs reflect Croydon's community. It was presented at Cabinet and is now going through the process of sharing it. Board members were encouraged to look through the report and 'do one more thing' to further improvements.

Cllr Yvette Hopley: It was well reported in the Croydon Advertiser and will be something the public will understand. How will monitoring performance be indicated in the future?
Rachel Flowers: It is about describing the health of the population. This is a snapshot of what is happening in Croydon. We wanted to make it readable and helpful for people in the future.

Cllr Patricia Hay-Justice: It is an excellent report. A major concern is mental health. The cuts make it difficult for individuals to be motivated. We need to expand on plans for mental health and older people in the community. Depression can occur regardless of individuals' financial situation.
Rachel Flowers: The report is around what we can do not about the services we provide. Acts of kindness to support those around us, particularly with mental health issues, can help. People coming together to worship together will help their social isolation. People can pop in to see their neighbours and ask if they can help with shopping or invite them in to share a meal.

Cllr Callton Young: It is a great paper. How will the information be disseminated?

Rachel Flowers: It emphasises how we can talk about it. Each tip can be printed off. Dissemination is an important part.

John Goulston: Being overweight is a huge issue in both young people (e.g. one in four 5 year olds) and adults (2 out of 3). How do we address this?
Rachel Flowers: We have an increasingly obese population. It is about where they work, schools they attend, how they travel etc.

Cllr Mansell: The whole issue is covered in the Croydon Congress report.

The Board **NOTED** the report.

A67/16 For Information only:
Social isolation action plan

Rachel Flowers briefly summarised the report.

This report provides feedback on the 10th meeting of Croydon Congress, held on 21 June 2016. The theme of the Congress was Social Isolation and Loneliness. The aim was to raise awareness and change attitudes and behaviours of people and organisations in the borough, and to better equip the community to take an active role to address the issue. A crucial element now to be developed, is understanding the extent to which local agencies in the public and voluntary sector are able to facilitate and enable these aims. This outcome is aligned with key priorities identified by the Health and Well-being Board and the Opportunity and Fairness Commission, and supports the Independence and Liveability themes within the Corporate Plan.

A round-table discussion followed, covering the theme of Social Isolation:
The Health & Wellbeing Board has been asked to lead the development of an action plan to tackle social isolation in Croydon. The plan will be for the whole Local Strategic Partnership, so actions could be taken forward by other partnerships, including Safer Croydon, Children & Families, Economic Development etc.

Each table had to identify a small number of high level actions:
For each of the following life stages, what actions should we include in our plan?

- pregnancy and early years
- children and young people

Table 1

- Social isolation the product of a modern democratic society which is financially secure
- Slogan: Stop minding your own business
- Pop Bus refurbished
- Talk Bus being discontinued - should be continued
- Be alert and mindful of social isolation

Table 2

- Need for opportunities for people to get out - clubs, pubs
- Campaign: The pub is a hub
- Day centres
- Council invest to save
- Walk and talk - elders go round parks etc
- Cook and taste
- Retirement plans - helpful tips

Table 3

- Pregnancy and early years - services well covered with midwives - health visitor contact - phone calls to follow up?
- 100 different languages - pro-active approach - communities together rather than different cultural groups
- Children and young people - support via schools, after-school clubs, youth groups - can't afford? - grants

Cllr Hay-Justice: There is lack of support for people in sheltered housing - volunteers are needed to hold regular lunch clubs
Cllr Mansell: It is important to develop social resilience in young people.

The draft action plan will be brought back to the Board when further developed.

A68/16 Business items:
Live Well Croydon

Rachel Flowers introduced the report. Matt Phelan (Public Health Principal), Anita Brako (Public Health Principal) and Jack Bedeman (Public health registrar) highlighted the key points.

The Live Well Croydon programme aims to:

- Make it easier to access the relevant services for weight management, alcohol screening and smoking cessation

- Redesign and integrate these services into one

The following issues were raised:

- It is about empowering people to find services to address these issues.
- How will Public Health promote the Health Impact Assessment (HIA)?
- Communication and engagement - how will people who are isolated engage with the website?
- How will success be measured?
- Who is using the app and how can we ensure the most needy get the best use of it?
- It is important for all agencies to work together on communication.
- How will the impact on patients across the borough and on pharmacies and GP practices be assessed?
- It is vital that the outcome is a reduction in work is achieved
- The website has generic information - it needs to be more local

Rachel Flowers: We worked closely with partner agencies. There is a formal process around the HIA. We would like to support other organisations preparing HIAs. There is a need for consideration around 'what if?' in dealing with vulnerable people.
Matt Phelan: Every time someone has clicked or downloaded from the website can be tracked. The Council has not had lifestyle data by post codes before. We can also reach out to Facebook and Twitter communities. It will be important how we work with voluntary and community sectors to raise the profile.
Rachel Flowers: We are continually reviewing the website. It is a tool to support people not a signpost to primary care, unless that is needed. It is about a different way of working. The challenge is when to launch. This is a work in progress. We will provide an update in 6-8 months.

Insp Duncan McMillan agreed to liaise with Andy Opie to assist communications through the Safer Neighbourhood Partnership.

The Board **NOTED** the direction of travel of the programme.

A69/16 Health protection update

Rachel Flowers introduced the report.

Health protection includes infectious diseases, chemicals and poisons, radiation, emergency response and environmental health

hazards. The Croydon Health Protection Forum (HPF) was established in July 2015 with the purpose to have a strategic overview of health protection matters and with the aim to provide assurance to the Director of Public Health that arrangements in place to protect the health of residents, are robust and implemented appropriately to local health needs. The health protection issues discussed at the Forum include adult and children immunisation programmes, and national screening programmes.

There were no questions.

A70/16 Pharmaceutical needs assessment (PNA) update

Rachel Flowers summarised the report. It is a statutory requirement for the Health & Wellbeing Board to develop a PNA. The report provided an update on its development.

Andrew McCoig commended the report. There are four LPS sites (Local Pharmaceutical Service). The LPS contract ends in March and the East Croydon Medical Practice will be the urgent care hub.

The Board **NOTED** the report.

A71/16 Outcomes based commissioning for over 65s

Paula Swann gave a summary of the report.

The report is an update on the progress of the OBC Programme towards a 10 year contract to develop an Integrated Health and Social Care system for the over 65s population in Croydon.

- Over 65s programme - different way of working and contracting to improve outcomes
- To develop an integrated Health and Social Care system for the over 65s population in Croydon

The following issues were raised:

- It is an important programme for joint working. It gives headway in meeting Croydon's responsibilities to make services better for most people.
- Concern about the delivery of the service - not a one fix fits all
- How does it work with the size of the borough?
- With underfunding, managing financial risk is pivotal. 7 Commissioners need to work together to manage the risk.
- Increasingly ageing population

- Investing in new ways of working but will it be enough?
- Must not underestimate the size of the challenge.
- Both young and old populations are growing - these are the main users of the NHS.

Paula Swann: We are not looking after people as well as we could do and not in most appropriate setting. In many cases people can be supported at home but they are being admitted into hospital.

The Board **NOTED** the report.

A72/16 Healthwatch Croydon report

The new Chief Executive Officer of Healthwatch Croydon, Jai Jayaraman, introduced the report.

Context:

- Based on primary research - the living experience of what people said
- About people facing real hardship
- Interviewed 105 people

Key findings:

- Access to services - to many refugees and asylum seekers, healthcare was not a priority
- Little access to mental health care
- Women refugees, particularly Tamil, waited over a month when they requested to be seen by a female GP
- Lack of awareness of interpreting services
- Tamil community pleased with care in hospitals and treated with dignity and respect

Cllr Mansell: It is important all refugees and asylum seekers are welcomed and treated with respect.

The following issues were raised:

- Emphasis made on mental health services welcomed.
- Concerns about young people under 18 - they worry about whether they can remain when they are 18.
- There are some good examples of good practice. Ian Lewis (in children's services) got some excellent practice on what is happening in primary care.
- Croydon is well ahead of the curve in terms of what we have done but there is further dialogue to be had around how we continue.

- Due to having the Home Office here, Croydon staff do have extra experience.
- Over the last decade Croydon has improved dramatically but we cannot recruit GPs at the moment
- It is in their own interest for individuals to learn English - providing interpreters is very expensive
- The interpreting service exists and does not necessarily need to be increased. It is important that refugees are aware of what they can access
- Children are concentrated in the north of borough but the support is not there
- We have become very good at community dependency but need to help people integrate and become self sufficient
- Important to emphasise that the gender of a GP is not a concern in an emergency. It cannot be an expectation

Paula Swann: Healthy London Programme - distributing card for homeless people about care services. There is a lack of understanding about what services can be accessed. There is E-learning for NHS receptionists and we have developed a commissioning guide for CCGs.

The Board **NOTED** the report

A73/16 Report of the chair of the executive group

The report summarised work undertaken by the health and wellbeing board executive group since the last meeting of the board on 19 October 2016.

There were no questions.

The Board **RESOLVED** to:

- Note work undertaken by the executive group since the last board meeting on 19 October
- Note risks identified at appendix 1.
- Agree revisions to the board work plan for 2016/17 in section 3.4.

A74/16 Public Questions

There were none.

A75/16 **For information only:**
Proposed changes to prescribing in Croydon

Foxley Lane Women's Service

NHS Croydon Clinical Commissioning Group (CCG) is asking local people to have their say on the following proposals:

- Proposed changes to prescribing in Croydon to reduce the prescribing of gluten-free foods, vitamin D for maintenance, baby milk and self-care medications. Visit the website: www.croydonccg.nhs.uk/news-publications/news/Pages/NHS-in-Croydon-seeks-views-on-prescribing-changes.aspx
- Foxley Lane Women's Service to change the services currently provided at this women's mental health service in Purley. Visit the website: www.croydonccg.nhs.uk/news-publications/news/Pages/Seeking-views-on-Foxley-Lane-Women%E2%80%99s-Service-in-Purley-.aspx

The engagement process for both of these ends on Friday 6 January 2016.

There will be a seminar on 25 January 2017 focusing on dementia.

The next Health & Wellbeing Board meeting is on Wednesday 8 February.

The meeting ended at 4:35pm

REPORT TO:	**HEALTH AND WELLBEING BOARD (CROYDON)** **8 February 2017**
AGENDA ITEM:	**6**
SUBJECT:	**Primary Care Co-Commissioning**
BOARD SPONSOR:	**Paula Swann, Chief Officer, Croydon Clinical Commissioning Group**

BOARD PRIORITY/POLICY CONTEXT:

This report sets out the process for applying for Delegated Primary Care Commissioning, as part of Croydon Clinical Commissioning Group's (CCG) plans to deliver the General Practice 5 Year Forward View, the Out of Hospital Strategy, and Sustainability and Transformation Plan (STPs).

FINANCIAL IMPACT:

Delegated Primary Care Commissioning enables the Clinical Commissioning Group (CCG) to have greater influence over the primary care allocation. To avoid conflicts of interest the CCG will be reviewing and revising its corporate governance structures, and these will be ratified by NHS England.

1. RECOMMENDATIONS

1.1 This report recommends that the health and wellbeing board note the CCG's application for delegation as a key to delivering Croydon's out of hospital plan, and the South West London sustainability and transformation plans.

2. EXECUTIVE SUMMARY

2.1 Croydon CCG, alongside the 5 other CCGs in South West London, have been moving towards increasing their ability to have greater influence over the commissioning of primary care services, to support the implementation of local out of hospital strategies, since April 2015.

2.2 There are three levels of primary care co-commissioning:

- Greater involvement – an invitation to CCGs to work more closely with their local NHS England teams in decisions about primary care services
- Joint commissioning – enables one or more CCGs to jointly commission general practice services with NHS England through a joint committee
- Delegated commissioning –an opportunity for CCGs to take on full responsibility for the commissioning of general practice services

2.3 All 6 South West London CCGs became joint commissioners in April 2015, with 5 becoming delegated commissioners (apart from Croydon) from April 2016. Croydon CCG has submitted an application to NHS England for delegated commissioning, to be effective from the 1st April 2017, to increase its ability to influence primary care commissioning and outcomes.

2.4 Delegated Primary Care Commissioning aligns to the CCG's objectives which are:

- To commission high quality health care services that are accessible, provide good treatment and achieve good patient outcomes
- 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
- To achieve sustainable financial balance by 2020/21
- To support local people and stakeholders to have a greater influence on services we commission and supporting individuals to manage their care
- To have all Croydon GP practices actively involved in commissioning services and to develop as a responsive and learning commissioning organisation

2.5 The CCG is required to strengthen its Governance processes to avoid conflicts of interests that may arise with increased clinical input into local decision making. NHS England are responsible for the assurance of the application, and Croydon CCG is following their recommended governance frameworks to revise Terms of References for its committees involved in primary care commissioning.

2.6 NHS England are due to advise CCG's in January 2017 as to whether or not their application for delegated commissioning has been successful, following a review of each application through their assurance processes.

3. DETAIL

3.1 Delegated Primary Care Commissioning as set out in the NHS Five Year Forward View, gives Clinical Commissioning Groups (CCGs) an opportunity to take on greater responsibility for general practice commissioning. The change in policy was introduced by NHS England to support the development of out of hospital services, based around the needs of local people.

3.2 In April 2015, a decision was taken for Croydon CCG to apply for joint commissioning of primary care services with NHS England, alongside the 5 other CCG's in South West London. Kingston, Merton, Sutton, Richmond, and Wandsworth CCGs took a decision to apply for delegated commissioning in Autumn 2015. At that time Croydon CCG members decided to continue as co-commissioners.

3.3 The General Practice Forward View, which was published in 2016, set out the national policy and funding for primary care transformation to enable delivery of STPs, and local out of hospital strategies. A decision was also made by the CCG's GP council of members in Autumn 2016, to proceed to delegated commissioning as this gives the opportunity for:

- Local communities and patients to have more say in the care they receive
- Patients to influence and lead on shaping and delivering high quality, responsive services which meet local needs
- Provision of a wider range of services closer to home
- Building stronger local GP services

3.4 Delegated commissioning will allow the CCG to have more influence over commissioning of primary care to design services to meet the needs of its population, and address local challenges. Transforming primary care is key to delivering our out of hospital strategic priorities, as set out in the STP, as well as the further development of the Croydon Outcome Based Commissioning (OBC) approach.

3.5 The CCG has updated its Terms of Reference for its Primary Care Commissioning Committee, and its Conflicts of Interest Policy in line with NHS England guidelines for establishing governance arrangements for primary care commissioning. These policies will need to be approved by NHS England as part of the assurance process.

3.6 Delegated Commissioning will allow for the following key objectives:

- Focus on outcomes of patient care through the use of primary care levers and enablers
- Focus on meeting the needs defined by patients
- Increased integration of care pathways
- Providing a more rounded picture of practices from all data sources
- Reducing variation across practices and increasing the universality of care for the population of Croydon
- Reducing inequalities in health provision across the localities
- Reducing confusion amongst practices over contractual matters

3.7 Delegated commissioning arrangements give CCGs full responsibility for commissioning general practice services. The specific opportunities from delegated commissioning are:

- Enables all primary care commissioned services (QoF, LIS, PMS, GMS, and PDDS) to be managed together and re-designed as appropriate, with members, to meet the changing needs of the population, and encourages delivery of primary care at scale to support equitable access to services.
- Ability to make local investment decisions in primary care, including flexing investment based on local demographics in individual networks. This is particularly important for Croydon which has significant variation in population demographics across our networks.
- Aligns with the development of seamless integrated out of hospital services for local people through OBC, with community resource being allocated where needed.
- Supports the development of sustainable and resilient local services in primary care through collaborative working to manage our significant workforce challenges in primary care.
- Supports local solutions to operational and organisational primary care issues to expedite resolutions

4. CONSULTATION

4.1 The CCG has engaged extensively with member practices, other clinical commissioning groups, NHS England, and the LMC on the process for delegated commissioning. Information for patients in South West London on primary care co-commissioning has been made available on the CCG's website since 2015.

4.2 Discussions held at executive committees and Governing Body meetings, (in workshop and public meetings) to understand and test the case for change which clearly outlined the opportunities offered through delegation of primary care commissioning. Approval to apply for delegated primary care commissioning for 1 April 2017 was received in a Public meeting of the Governing Body on the 1st September 2015, subject to agreement of the Council of Members, which was agreed by a majority vote on the 30th November 2016.

4.3 The benefits of delegated commissioning, as seen by CCGs across SWL, and agreed by our members are:

- Primary care services designed to meet population need and reduce variation
- Primary care services designed to meet the challenges of Croydon CCG, including increased mental health support in primary care, and greater community care to support early discharge and out of hospital care.
- Ability to commission primary care services using the GP collaborative and a network model to address the workforce challenges faced by primary care in Croydon
- Ability to work closely with the LMC, GP collaborative, and Healthwatch to design services to meet patient need at a network level.

5. FINANCIAL AND RISK ASSESSMENT CONSIDERATIONS

5.1 The CCG will continue to invest in primary care, and will not be able to use its primary care allocation to balance its commissioning deficit. All decisions for primary care investment will be through the Primary Care Committee, with membership from NHSE. The CCG will follow a parallel governance process for assurance in primary care commissioning as the other SWL CCGs to ensure due diligence. Croydon CCG will continue to work alongside the other SWL CCGs to align services where appropriate.

6. LEGAL CONSIDERATIONS

6.1 The CCG's constitution was reviewed by Capsticks in 2015, on the understanding that it would meet the purpose of joint commissioning, or fully delegated co-commissioning.

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

Longer, healthier lives for
all the people in Croydon

NHS
Croydon
Clinical Commissioning Group

Primary Care Co-commissioning

Croydon CCG

Primary Care Co-Commissioning

There are currently three levels of primary care co-commissioning:

- Greater involvement – an invitation to CCGs to work more closely with their local NHS England teams in decisions about primary care services
- Joint commissioning – enables one or more CCGs to jointly commission general practice services with NHS England through a joint committee
- Delegated commissioning – an opportunity for CCGs to take on full responsibility for the commissioning of general practice services

Summary to date

In March 2016, the CCG council of members agreed that the CCG should continue to co-commission primary care, and review the case for full delegated authority in Autumn 2016.

Since this decision there have been significant changes in primary care nationally, driven by the STPs and GP 5 year forward view, which have given commissioners the mandate to transform primary care.

The current mechanisms for commissioning services from General Practice will not deliver this transformation, which relies on primary care delivery at scale.

Delegated commissioning will allow the CCG to have influence over primary care transformation and its integration with community and hospital services.

Delegated Commissioning Opportunities

- ✓ Enables all primary care commissioned services to be managed together and re-designed as appropriate, with members, to meet changing needs of the population
- ✓ Ability to make local investment decisions in primary care, including flexing investment based on local demographics in individual networks
- ✓ Aligns with development of seamless integrated out of hospital services for local people through OBC, with community resource being allocated where needed.
- ✓ Supports the development of sustainable and resilient local services in primary care through collaborative working rather than outsourcing.
- ✓ Supports local solutions to operational and organisational primary care issues to expedite resolutions

What would change?

- NHSE would still be responsible for core GMS/PMS/APMS contract regulation and monitoring, as well as managing the performer's lists.
- Decisions would be agreed locally, but NHSE would still be members of all our primary care committees and influence these.
- Currently the CCG influences decisions in relation to primary care commissioning, but the sign off has to be from NHSE.
- The CCG would need to have clear and transparent processes for decision making available to practices and the public.
- The CCG would need to provide practices with more primary care support.
- The CCG's decisions would need to follow protocol, and there would be a dispute resolution process
- The CCG would work closely with South West London CCGs to manage conflicts of interest

NHS England

CCGs have reported the following benefits from delegated commissioning so far…

We have developed a clearer vision for the entire health economy

Decision making is based on a solid understanding of need on the patch

It has improved relationships with LMCs, practices and patient participation groups

There is a greater feeling of clinical leadership across the locality

There are more local discussions happening on practice sustainability

There is better coordination of primary care and a greater sense of decisions that impact on local healthcare are taken closer to local people

We have the ability to ensure that the enhanced services are fully aligned with our plans

There is an increased appetite to change primary care for the better

There is greater involvement of the membership and the local community in future decision making

We can now start to get a joined up strategy for primary and secondary care

There is increased leverage to encourage new models of primary care at scale

GP Forward View: Strategic Context

The General Practice Forward View (GPFV) sets out the aspiration for significant transformation of primary care nationally, supported by additional funding

Key areas for transformation mentioned in the GPFV include Enhanced Access, Provider Development, Workforce, Estates and Technology. All of these are part of our Out of Hospital Strategy, and Sustainability and Transformation Plan.

The CCG will continue to invest in primary care, but a new approach is needed to address the challenges being faced by primary care, as well as the wider health economy.

What does the GPFV and STP aim to address for Croydon?

- The significant challenges to Croydon in relation to workforce, estates, and population growth.
- The significant variation in demography across Croydon
- The establishment of the SWL commissioning collaborative to deliver the STP means there is more local primary care commissioning support available
- Funding for primary care is being consolidated across SWL, and the CCG needs to make a case for investing its allocation into primary care
- NHSE will still sign off the CCGs use of funds and plans are shared with members and the public, as well as the LMC and HWBB

The CCG's Ambitions for Primary Care

The CCG wants primary care to be able to manage more patients in the community. To do so will require transformation:

- Premises will need to manage a larger footfall
- Technology will need to allow for improved sharing of records, and more electronic or remote consulting
- The workforce skill needs to be increased using newer roles available
- Practices will need to work collaboratively to deliver equitable services to patients.

Discussions have already taken place at network meetings, PM Forums, and LMC liaison

What does this really mean for patients and the public?

These changes are about giving local communities and patients more say in the care they receive and doctors and nurses more freedom to shape services to meet people's needs, to improve the quality of the support, care and treatment we all receive

Primary care services can be tailored to meet local needs as the CCGs will have the ability to make local decisions.

Patients will still contact their local GP practice when they are unwell and will continue to receive healthcare free at the point of need just as before.

REPORT TO:	**HEALTH AND WELLBEING BOARD (CROYDON)** **8 February 2017**
AGENDA ITEM:	**7**
SUBJECT:	**Progress update on the Better Care Fund**
BOARD SPONSOR:	**Barbara Peacock, Executive Director People, Croydon Council** **Paula Swann, Chief Officer, NHS Croydon Clinical Commissioning Group**

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 administered through a Section 75 Agreement 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 revised final plan for 2016-17 was submitted.

FINANCIAL IMPACT:

BCF funds of £24.5m for 2016/17 are managed via a pooled budget, administered through a Section 75 Agreement and governance arrangements.

1. RECOMMENDATIONS

This report recommends that the health and wellbeing board:

1.1 **Note the status of BCF delivery**

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. BCF plans must:

- Be jointly agreed
- Maintain provision of social care services
- Include better data sharing between health and social care
- Have a joint approach to assessments and care planning, and an accountable professional where funding is used for integrated packages of care

- Have agreement on the consequential impact of the changes on providers that are predicted to be substantially affected by plans

2.2 A previous report on the Croydon Better Care Fund Plan was presented to the Health and Wellbeing Board on 19th October 2016.

2.3 The BCF plan comprises a wide range of schemes across health and social care which are delivering against 5 key metrics. These are:

- Admissions to residential and care homes
- Effectiveness of reablement
- Delayed transfers of care
- Patient/service user experience
- Locally proposed metric

2.4 The BCF continues in 2016/17, and each Health and Wellbeing Board was required to submit a final plan for 2016/17 by 15th June 2016. This was submitted by Croydon on 15th June 2016.

2.5 April – October 2016 performance against the BCF performance metrics is positive with achievement of the target in 4 out of the 6 indicators.

3. BCF PLAN FOR 2016/17

3.1 The table below sets out the performance against the reported BCF metrics

Performance trend	Indicator	2016/17 YTD Target	2016/17 YTD Actual	Baseline (2015/16 YTD actual)	RAG rating and trend
BCF1 	Total non-elective admissions in to hospital (general & acute), all-age, per 100,000 population	21,916	21,492	**21,968**	**G**
BCF2 	Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	210.0	152.0	**237.2**	**G**
BCF3 	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	86%	90.5%	**89.8%**	**G**
BCF4 	Delayed transfers of care (delayed days) from hospital per 100,000 population (average per month)	165	253.7	**157.0**	**R**
BCF5 	Local Performance Metric: '% of discharges over the weekend for Croydon Healthcare Service'.	20%	20.6%	**17.6%**	**G**
BCF6 	Patient/Service User Experience Metric Social Care related quality of life (ASCOF 1A) ***N.B. figures are annual and show 2015/16 achievement***	19	18.6	**18.4**	**A**

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

3.2 Performance for April – October 2016 is positive with the targets being met for the BCF 1, 2, 3, and 5 indicators.

3.3 Performance against BCF4 (Delayed transfers of care (delayed days) (DTOCs) from hospital per 100,000 population) is negative and exceeding the target threshold. This is a London wide issue and not limited to Croydon.

3.4 Current mitigating actions include:

- Weekly meetings at Croydon University Hospital to review any barriers to discharge – ongoing
- Greater direct liaison between Croydon University Hospital and Croydon Council Housing Needs team to arrange temporary emergency accommodation. – ongoing
- Undertaking further mapping of current discharge/patient flow work-in-progress to identify any need for greater co-ordination across the patient flow/discharge activity (perfect journey programme led by Croydon Health Services) – programme ongoing
- Closer scrutiny of recording to ensure Delayed transfers of care are correctly captured – ongoing
- Assessing options for increasing enhanced shared lives provision for mental health service users – February 2017
- Weekly Delayed transfers of care teleconference with SLAM and Local Authority to review any barriers to discharge – ongoing
- Fortnightly Task and Finish Group meetings with key stakeholders to address systemic issues affecting length of stay and discharge planning within the Mental Health System. – ongoing

3.5 Performance against BCF6 (Social Care related quality of life (ASCOF 1A)) showed a small improvement from 2014/15 to 2015/16. The next data will be available in July 2017. It is important to note that:

- The surveys consist of a number of pre-set questions which cannot be altered or amended in anyway by Local Authorities
- That in some cases results can be influenced by sample sizes, survey fatigue and the responders interpretation of the question, some of these factors are beyond the control of Local Authorities.

4. BCF PLAN FOR 2017/18

4.1 The BCF planning guidance for 2017/18 was due to be released in December 2016, but has been postponed to end of January 2017.

4.2 There is an expectation that CCGs and Councils will then have about 5-6 weeks after publication to draft their 2017/18 plans

4.3 The BCF Executive Group is therefore undertaking further reviews of current schemes and funding to inform discussions on priorities and options for 2017/18.

4.4 New funding initiatives are starting to be developed for 2017/18; however these will need to be considered in a strategic context in line with the released guidance conditions, and Croydon's strategic objectives.

4.5 Further priorities and options for beyond 2017/18 will be determined following the release of the 2017/18 guidance.

5. CONSULTATION

5.1 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.

5.2 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.

6. SERVICE INTEGRATION

6.1 Croydon Council, Croydon CCG and Croydon Health Services continue to maintain close partnership working to jointly deliver innovative community-based patient/client-focused services that continue to deliver the best outcomes for patients.

7. FINANCIAL AND RISK ASSESSMENT CONSIDERATIONS

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

7.2 The signed section 75 partnership agreement includes the risk share agreement notified to NHSE that the first call on any scheme underspends will be to offset the costs of any over-performance on non-elective admissions to a maximum of £900,000.

8. EQUALITIES IMPACT

8.1 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

REPORT TO:	**HEALTH AND WELLBEING BOARD (CROYDON)** **8 February 2017**
AGENDA ITEM:	**8**
SUBJECT:	**Proposal for changes to JSNA process**
BOARD SPONSOR:	**Rachel Flowers, Director of Public Health**

CORPORATE PRIORITY/POLICY CONTEXT:

The Health and Social Care Act (2012), requires local authorities and clinical commissioning groups to collaborate through the health and wellbeing board to produce a JSNA. JSNAs, along with joint health and wellbeing strategies, are intended to form the basis of CCG and local authority commissioning plans, across health, social care, public health and children's services.

FINANCIAL IMPACT:

There are no immediate financial issues arising from this report. However, a key role for needs assessment is to identify gaps in service provision. As such, the needs assessments themselves are likely to contain recommendations for commissioners across health, social care and beyond relating to investment, and potentially disinvestment.

1. RECOMMENDATIONS

This paper outlines proposals for a new approach for Croydon's JSNA process. Specifically it recommends:

1. Retention of a key dataset to enable the health and wellbeing board and stakeholder organisations to have an overview of health and wellbeing needs in the borough.
2. A commissioner led process for identifying and conducting topic based needs assessment
3. A more rapid turnaround of needs assessments and a wider range of JSNA 'briefings' rather than a small number of detailed needs assessment

2. EXECUTIVE SUMMARY

2.1 Croydon's approach in recent years has been to combine production of an annual key dataset with a small number of chapters on key topic areas, with the latter guided by an agreed prioritisation process to rank proposals received from stakeholders each year. This paper sets out recommendations for a change to the process of producing Croydon JSNA.

3. DETAIL

3.1 The purpose of the JSNA, as set out in statutory guidance published in April 2012, is to improve the health and wellbeing of the local community and reduce inequalities for all ages. JSNAs assess the current and future health and social care needs of the local community. These are needs that could be met by the local authority, Clinical Commissioning Groups (CCGs), the wider NHS or the voluntary and community sector. This analysis of needs is used to help to determine what actions local authorities, the local NHS and other partners need to take to meet health and social care needs, and to address the wider determinants that impact on health and wellbeing.

3.2 Croydon's JSNA process was designed some time ago and has not been reviewed subsequently. The approach chosen was to maintain an annually updated core dataset as well as to conduct two or more in depth topic based needs assessments. The Public Health Intelligence team has continued to annually update the JSNA Key Dataset (last updated September 2016). All JSNA documents are published on the Croydon Observatory website.

3.3 In depth JSNA chapters on maternal health and older people were published in early 2016. These were the last in depth needs assessments conducted. Work was also undertaken on learning disabilities to inform commissioning decisions. This was originally planned as part of the JSNA process but was taken outside the then programme and the work has not been published on the JSNA section of the Croydon Observatory site. The chapter will now be completed in 2017 with additional information included on the needs of people with autism.

3.4 Issues with the current process include:

- An annual update of key dataset means that some data published after the cut-off point are not included. This means that the picture of needs can be inaccurate.
- The process for producing JSNA in depth chapters is resource intensive and slow. Commissioning decisions often need to be taken more rapidly.
- Lack of commissioner 'buy in' to JSNA (for a variety of reasons) means that needs assessments are being conducted outside the JSNA process.
- Whilst the current process aims to engage a broad range of stakeholders in proposing, selecting topics and conducting needs assessments, this can slow the process significantly. A more streamlined process for stakeholder engagement will facilitate timely but well balanced needs assessment.

3.5 The proposed approach is set out below

1. **Key dataset**
   It is proposed to retain the key dataset, with data updated as it is published rather than annually. A review of the indicators in the key dataset is also proposed

2. **A commissioner led process**
   It is proposed that topics for more in depth needs assessment are collated on a rolling basis by commissioners with agreement of priorities by the Joint Commissioning Executive. A commissioner lead will need to be identified to develop a specification for each needs assessment and oversee its production. The Public Health Intelligence team will support the process.

3. **JSNA briefings**
   As part of the JSNA we are suggesting producing a wider range of commissioner led, less detailed briefing papers – for an example see attachment or follow link **http://www.norfolkinsight.org.uk/jsna/reports-activity/jsna-briefing-papers**

3.6 The commissioner lead will need to

- Give a clear brief for the needs assessment
- Identify clear outcomes
- Facilitate access to data (including financial data)
- Liaise with relevant stakeholders

3.7 The Public Health Intelligence team will then provide all the analysis required and manage the process through a project plan that will include catch up sessions with the lead commissioner to make sure everything is on track.

4. CONSULTATION

4.1 Stakeholder views will be elicited by the lead commissioner as part of a streamlined process for the JSNA briefings.

5. SERVICE INTEGRATION

5.1 JSNA briefing leads are asked to consider levels of service integration / scope for integration as part of their assessment of current provision and recommendations for future provision of services.

6. FINANCIAL AND RISK ASSESSMENT CONSIDERATIONS

6.1 There are no immediate financial issues arising from this report. However, a key role for needs assessment is to identify gaps in service provision. As such, the needs assessments themselves are likely to contain recommendations for commissioners across health, social care and beyond relating to investment, and potentially disinvestment.

7. LEGAL CONSIDERATIONS

7.1 There are no legal issues arising from this report beyond the statutory duty for local authorities and clinical commissioning groups to produce a JSNA.

8. HUMAN RESOURCES IMPACT

8.1 There are no specific human resource implications arising from this report.

9. EQUALITIES IMPACT

9.1 The JSNA process with retain an assessment of equality issues. Each JSNA briefing lead will be required to identify the equality and inclusion issues in relation to the main equality groups that share protected characteristics for which data is available. This will also help us to identify equality groups where data is currently not available but may need to be considered.

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BACKGROUND DOCUMENTS None

Mental Health in Children and Young People

Introduction

Mental ill-health in children can manifest in different ways to adults, often resulting in behavioural and conduct problems, such as Attention Deficit Hyperactivity Disorder (ADHD) or Oppositional Defiant Disorder (ODD), as well as emotional problems such as depression or anxiety. These conditions can also be symptoms of underlying problems, which may be environmental (for example, parental conflict) or developmental (for example, Autistic Spectrum Disorders). [1]

Summary

1 in 10 children aged 5 to 16 years have a clinically diagnosable mental disorder, and research suggests that over half of these children will go on to suffer from mental ill-health as adults.[2] Good mental health allows children to develop resilience and grow into well-rounded, healthy adults, which is important in its own right and because it affects their physical health and can determine how well they do at school. Good social, emotional and psychological health helps protect young people against emotional and behavioural problems, violence and crime, teenage pregnancy and the misuse of drugs and alcohol.[3] Child and adolescent mental health services are currently being redesigned under the Local Transformation Plan, including better engagement with universal services, more specialist services, and improved crisis services.

Headlines

A survey carried out in Norfolk schools in 2015 found that 5% of secondary school pupil scored very low on the Warwick-Edinburgh Mental Wellbeing Scale (a validated screening tool), similar to the national average.[4] National studies suggest 1 in 10 children aged 5 to 16 years have a clinically diagnosable mental disorder, and when this estimate is applied to the Norfolk population – it equates to 10,790 people aged 5-16 (see Figure 1 below).[5]

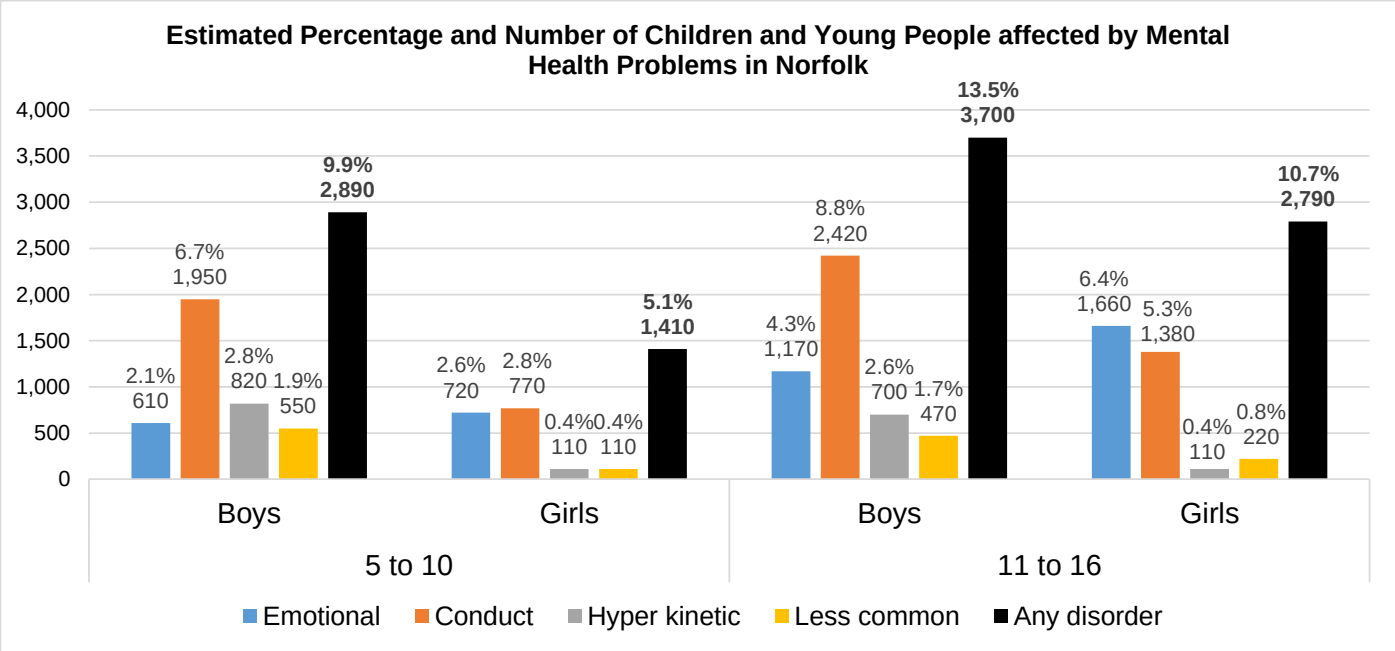

Figure 1: Estimates of the prevalence of common mental health problems using national survey results applied to ONS 2015 population estimates, controlling for age, sex and socio-economic grouping [6]

[1] ONS (2015) Insights into children's mental health and wellbeing
http://webarchive.nationalarchives.gov.uk/20160105160709/http://www.ons.gov.uk/ons/dcp171766_420239.pdf
[2] http://worldhappiness.report/summary/
[3] NICE (2008) *PH12 Social and emotional wellbeing in primary education*. National institute for Health and Care Excellence.
[4] Norfolk County Council (2015) Norfolk's Health Related Behaviour Survey of Children and Young People
http://www.norfolkinsight.org.uk/resource/view?resourceId=1282
[5] Green et. al. (2004) 'Mental health of children and young people in Great Britain
[6] Estimates use the prevalence from the most recent national survey (Green et. al. 'Mental health of children and young people in Great Britain, 2004) applied to the local population, controlling for age, sex and socio-economic grouping (NS-SEC).

Being bullied was strongly related to mental ill-health; children who were bullied frequently were four times more likely to report poor mental health. Other significant factors that influence a child's wellbeing are quality of relationship with parents, body image and satisfaction with appearance, happiness with school, use of social media. [7]

Eating disorders are a significant mental health issue for young people. Young women are most likely to develop an eating disorder, particularly those aged 12 to 20, but children as young as seven have developed anorexia and there is a greater proportion of boys in this younger age group. Eating disorders claim more lives than any other mental illness – one in five of the most seriously affected will die prematurely from the physical consequences or suicide.[8] Locally referrals for treatment for eating disorders Norfolk Community Eating Disorder Service increased from 100 in 2013/14 to 170 in 2014/15. [9]

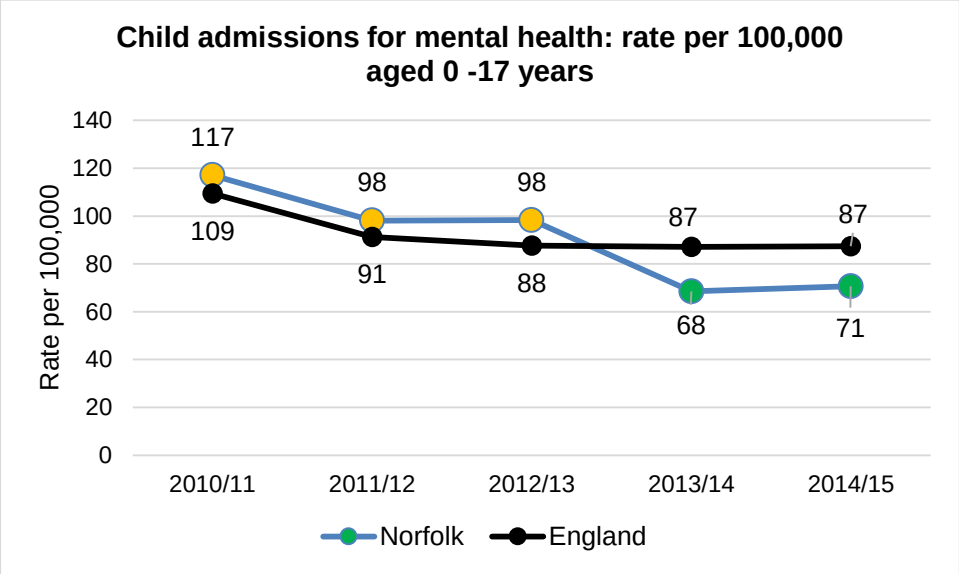

Figure 2: Hospital Admissions due to mental health conditions, rate per 100,000, trend. Source Hospital Episode Statistics.

Each year in Norfolk just over 100 children are admitted to hospital for conditions relating to mental health (113 in 2014/15). The trend in Figure 2 above is largely due to changes in the number of *regular planned* admissions between 2012/13 and 2013/14 – suggesting a change in the pathway for these children rather than a specific trend in prevalence of conditions. Emergency admissions have remained stable over the period (around 80 each year). The most common cause of emergency hospital admissions relating to mental health are eating disorders (33 in 2014/15, 91% female) followed by alcohol-related admissions (12 admissions), anxiety disorders (7 admissions) and depressive episodes (6 admissions).[10]

Influences on Health and Wellbeing

Children with mental disorders are more likely than those without to have time off school, especially unauthorised absences, and are less likely to have a network of family and friends with whom they feel close. [11, 12] Both of these are important factors in developing resilience to cope with adult life. Failure to treat mental health disorders in children can have a devastating impact on their future, resulting in reduced job and life expectations.[13]

[7] ONS (2015) Insights into children's mental health and wellbeing
http://webarchive.nationalarchives.gov.uk/20160105160709/http://www.ons.gov.uk/ons/dcp171766_420239.pdf
[8] B-EAT https://www.b-eat.co.uk/about-eating-disorders/types-of-eating-disorder
[9] Norfolk County Council (2015) Norfolk CAMHS Transformation Plan Needs Analysis
[10] Hospital Episode Statistics 2012-2015. Copyright © 2016, re-used with the permission of The Health & Social Care Information Centre. All rights reserved.
[11] http://www.ons.gov.uk/ons/about-ons/business-transparency/freedom-of-information/previous-foi-requests/people--population-and-community/mental-health-of-children-from-separated-parents/report-on-mental-health-of-children-and-young-people.pdf
[12] Green et. al. (2004) 'Mental health of children and young people in Great Britain
[13] Public Health England

Self-harming and substance abuse are known to be much more common in children and young people with mental health disorders. The 2015 Child and Young People Health and Wellbeing Survey carried out in Norfolk schools demonstrated that Norfolk Year 10 pupils with medium-low resilience scores were more likely to smoke, drink alcohol and less likely to have a healthy diet. This study also found that 5% of Norfolk school children disclosed having 'cut or hurt themselves' in response to emotional stress.[14]

Over the last ten years there have been nine suicides of Norfolk residents aged under 18.[15] For more information about suicide of Children and Young People see Child Suicide Thematic Review carried out by the Norfolk Child Suicide Review Group on behalf of the Child Death Overview Panel and Norfolk Safeguarding Children Board.[16]

Social, environmental, population context

Social disadvantage and deprivation increase the risk of developing mental health problems. Children and young people from the poorest households are three times more likely to have a mental health problem than those growing up in better-off homes. Almost three quarters (72 per cent) of children in residential care experience some form of emotional and mental health problem. Evidence has also linked mental health problems in boys to the absence of a father or significant male attachment figure.[17]
One large-scale study conducted in 2004 found that boys were more likely to have conduct and hyperkinetic disorders than girls (see figure 1 above), and that girls were slightly more likely to have emotional problems, which also increase with age.[18, 19] The Adult Psychiatric Morbidity Survey 2014 found a pronounced gender gap in mental illness in young people but that:

- 26% of women aged 16-24 reported symptoms of common mental disorders, compared to just 9% of men in the same age group.
- Post-traumatic stress disorder was seen in 12.6% of women of that age compared with 3.6% of men.
- One in five 16-to-24-year-old women (25.7%) reported having self-harmed at some point, twice the rate for men in this age group (9.7%).[20]

So this may suggest that while young boys have more obvious mental health problems in childhood, girls are developing emotional problems that manifest later in adolescence and as young adults - as such young women present a high risk group for mental health problems. The 2015 Health Related Behaviour Survey carried out in Norfolk schools demonstrated that emotional resilience declined with age, especially in girls (just 11% displayed high resilience, compare to 23% of boys, and 10% of Year 10 girls self-harmed compared to 2% of boys).[21]

Current services, local plans and strategies

Norfolk has an Early Help and Prevention Strategy that includes developing locality Early Help Hubs where a range of teams and services (including mental health teams) can collaborate to better meet the needs of the population. One of the four priorities of the Norfolk Health & Wellbeing Board's Strategy is to promote the social and emotional wellbeing of preschool children, and another is improving mental health in general.

Specialised Child and Adolescent Mental Health Services (CAMHS) services are provided by Norfolk and Suffolk Foundation NHS Trust (NSFT) for children with moderate to severe needs (including an eating disorder service and inpatient services). Targeted services for children with mild to moderate needs are provided by the

[14] Norfolk County Council (2015) Norfolk's Health Related Behaviour Survey of Children and Young People http://www.norfolkinsight.org.uk/resource/view?resourceId=1282
[15] In 2016, the National Statistics definition of suicide has been modified to include deaths from intentional self-harm in 10- to 14-year-old children in addition to deaths from intentional self-harm and events of undetermined intent in people aged 15 and over.
[16] Available on request from Bianca Finger-Berry: Bianca.finger-berry@norfolk.gov.uk
[17] Frith, E (2016) CentreForum Commission on Children and Young People's Mental Health: State of the Nation.
[18] http://www.ons.gov.uk/ons/about-ons/business-transparency/freedom-of-information/previous-foi-requests/people--population-and-community/mental-health-of-children-from-separated-parents/report-on-mental-health-of-children-and-young-people.pdf
[19] Green et. al. (2004) 'Mental health of children and young people in Great Britain http://content.digital.nhs.uk/catalogue/PUB06116
[20] Adult Psychiatric Morbidity Survey (2016) Survey of Mental Health and Wellbeing, England, 2014. http://content.digital.nhs.uk/catalogue/PUB21748
[21] Norfolk County Council (2015) Norfolk's Health Related Behaviour Survey of Children and Young People http://www.norfolkinsight.org.uk/resource/view?resourceId=1282

Point 1 consortium. There are also specialist services for children and young people with learning disabilities and ADHD.

In March 2015 the government pledged £1.25 billion to improve children and young people's mental health services over the next five years. In tandem with this announcement the Department of Health and NHS England published 'Future in mind' identifying ways of improving mental health services and access to these services for children and young people.

In July 2016 NHS England published an Implementation Plan to set out the actions required to deliver the Five Year Forward View for Mental Health in the years up until 2020/21 – including the need for local authorities to develop Local Transformation Plans (LTPs) and what these are expected to achieve.[22] LTP specific priorities in the NHS England Implementation Plan include explicit numeric targets each year until 2020/21 for improved access to services. One of the key national expectations is that by 2020/21 at least 35% of children with diagnosable mental health problems will be able to access support and treatment. In Norfolk & Waveney this is already achieved, with 36% of under 18 year olds (7,011) with a diagnosable mental health problem accessing support and treatment during 2014/15.[23] However, Norfolk's ambition is to reach as many of the 13,000 (64%) of under 18s with diagnosable mental health conditions who do not currently access support and treatment.

The Norfolk 'Local Transformation Plan' (LTP) sets out the vision for Norfolk CAMHS. This will include building on current provision:

- Perinatal Infant Mental Health provision for infants on the edge of care (and their primary care giver/s),
- Promoting Alternative Thinking Strategies (PATHS) programme in primary schools
- Compass Centres - specialist school provision with onsite, integrated therapy and specialist support/training for carers of children with mental health needs and challenging behaviour.
- High quality substance misuse service offer for children and young people and their families
- Integrated Mental Health Team – specialist mental health nurses based in the Police Control Room providing advice and support to police staff and others
- A vibrant and diverse voluntary sector offer for children young people with mental health needs

There is a rich supply of providers and services in Norfolk and Waveney, the majority of which are provided by the voluntary sector and offer a wide variety of provision: training, whole-school programmes, group work, drop-in sessions and one-to-one support. Examples include, PATHS, Thrive, Nurtured Heart Approach, Young Mental Health Champions, Early Action and Time For You. However, awareness about these services can to improved, especially with schools. The majority of the current provision and programmes are aimed at and delivered via schools, and there are opportunities to use of other universal settings such as children's centres, early help hubs and other community provision.

There is an identified need to train staff in universal settings to identify early signs of poor mental health, deal with emerging issues and escalate when required. Current provision of this training is not currently sufficient to meet demand, and requires better co-ordination and consistency across the county. As part of the Local Transformation Plan all schools and universal settings will have a named 'lead' for emotional well-being and mental health. There will also be 'link workers' in specialist mental health services offering support to emotional well-being and mental health in universal settings.

The Local Transformation Plan also specifies the development of a Single Point of Contact for requests for help, advice and referrals – crucial to navigating a complex system of provision. There will also be investment in unified, safe online support and treatment options for children, young people and families through a range of web and mobile phone app based routes. This will allow service users to make use of self-help, peer and professional support during and beyond usual hours of provision.

[22] NHS England (2016) Implementing the five year forward view for mental health https://www.england.nhs.uk/wp-content/uploads/2016/07/fyfv-mh.pdf

[23] East of England Clinical Network Benchmarking Report, 2016, not published

Opening hours for core Specialist Mental Health services will be extended and delivered by a re-modelled, integrated workforce with sufficient numbers of skilled staff to respond to needs, including those from vulnerable or hard to reach groups. This has meant an increase in capacity for the CAMHS Eating Disorders service (11 new clinical posts have been recruited to). As well as increased capacity to Point 1 the countywide Targeted CAMHS (six new posts have been recruited to).

Currently, crisis support and specialist assessment in Norfolk is very limited and there is a recognition that 'out of hours' staff availability is inadequate to meet the growing need. There is also a very urgent need to improve access to specialist inpatient CAMHS beds as the current waiting period can contribute to use of inappropriate settings. This will be delivered by extending the emergency and Out of Hours offer/availability of CAMHS and Learning Disability CAMHS Crisis services, increasing the size and capacity of teams and establishing robust collaborative commissioning arrangements with NHS England for patients requiring inpatient specialist CAMHS bed.

The following groups have been identified as being in need of additional services:

- children and young people on the edge of care and those who are looked after or adopted
- looked after children being considered for reunification with their family
- children and young people who have been affected by domestic abuse, sexual exploitation (or at risk of) and trauma
- children and young people who display sexually inappropriate or harmful behaviours

Under the LTP there will be increased CAMHS support for Children & Young People affected by domestic abuse and sexually harmful behaviours.

Voice – the perspective from the public, service users, referrers and front line staff

The Norfolk Youth Parliament selected mental health as its key priority though a vote of children and young people in Norfolk schools, demonstrating the importance of this issues for young people. The Child and Young People Health and Wellbeing Survey carried out in Norfolk school (next in October 2017) provides an opportunity to gather experiences of young people and their views on how well schools support mental health. Service user views are important to the development of mental health services and young people have been consulted in the development of the Local Transformation Plan.

Considerations for Health and Wellbeing Board and Commissioners

This is a time of significant change for mental health services for children and young people. There is a recognition that the Norfolk CAMHS system is fragmented, hard to access and navigate for children, families, and partner organisations. Commissioners will need to support the redesign of services and make the most of this opportunity to resolve some of the complexities of the current system. Improvements will be achieved by joint commissioning, the standardisation of services across the county and by consistent performance management frameworks that supply the right information to develop services in the future.

Commissioners should also endorse the Time to Change anti-stigma campaign and support the development of a local action plan for Norfolk, ensuring that children and young people are involved in its design and delivery.

The National Children's Bureau has created a new toolkit for schools to help them face the issue of student mental health and wellbeing.[24] In addition Public Health England commissioned a toolkit to encourage schools and colleges to measure student mental wellbeing and advice on how to make use of a range of validated survey questions and instruments available,[25] which should be promoted to schools.

[24] https://www.ncb.org.uk/sites/default/files/uploads/documents/Policy_docs/Briefings/NCB%20School%20Well%20Being%20Framework%20Leaders%20Tool%20FINAL.pdf

[25] http://www.annafreud.org/services-schools/schools-in-mind/resources-for-schools/mental-health-toolkit-for-schools/

References and information

Other relevant JSNA Briefings – Self-harm in Children and Young People, Substance Misuse in Children and Young People, Children with Disabilities and Special Educational Needs, Mental Health in Adults.

Norfolk and Waveney's CHAMHS Local Transformation Plan
https://www.norfolk.gov.uk/care-support-and-health/health-and-wellbeing/childrens-health/mental-health-camhs/professionals

Future in Mind: Promoting, protecting and improving our children and young people's mental health and wellbeing
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/414024/Childrens_Mental_Health.pdf

The National Children's Bureau Mental Health Toolkit for Schools
https://www.ncb.org.uk/sites/default/files/uploads/documents/Policy_docs/Briefings/NCB%20School%20Well%20Being%20Framework%20Leaders%20Tool%20FINAL.pdf

Author and key contacts

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Online feedback:
Send us your query or feedback online using our online feedback form at
http://www.norfolkinsight.org.uk/feedback

Email: JSNA@norfolk.gov.uk

REPORT TO:	**HEALTH AND WELLBEING BOARD** **8 February 2017**
AGENDA ITEM:	**10**
SUBJECT:	**Report of the chair of the executive group: incorporating risk register and board work plan**
LEAD OFFICER:	**Barbara Peacock, Executive Director of 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 work undertaken by the executive group since the last board meeting on 14 December 2016.
- Support a proposal from the board workshop held on 25 January 2017 that Croydon works to achieve dementia friendly community status and that this is included in the social isolation action plan for Croydon.
- Note risks identified at appendix 1.
- Agree revisions to the health and wellbeing board work plan in section 3.4.

2. EXECUTIVE SUMMARY

2.1 This report summarises work undertaken by the health and wellbeing board executive group since the last meeting of the board on 14 December 2016.

2.2 The board risk register was developed by the board at a seminar on 1 August 2013. The board agreed that the executive group would keep strategic risks under review and update them as required. A summary of current risks and their ratings is at appendix 1.

2.3 The health and wellbeing board agreed its work plan for 2016/17 at its meeting on 13 April 2016. 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.

3. DETAIL

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

Work undertaken by the executive group

3.2 The executive group met on 11 January 2017. Key areas of work undertaken in January 2017 are set out below. The executive group will next meet on 28 February 2017.

- Reviewed the board work plan including preparation of board meeting agenda and topic prioritisation against the joint health and wellbeing strategy.
- Planned and held the board seminar on dementia. A recommendation from the seminar is that Croydon works to achieve dementia friendly status and that this is included in the social isolation action plan for the borough. Guidance on achieving dementia friendly status is at appendix 3.
- Liaised with other strategic partnerships including Croydon Local Strategic Partnership and the children and families partnership.
- Reviewed board strategic risk register.
- Considered 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 reviewed by the executive group at its meeting on 11 January 2017, with existing controls updated and a number of new controls identified. There have been no changes to the overall risk ratings since the board meeting on 14 December 2016.

Board work plan

3.4 Proposed changes to the 2016/17 board work plan from the version agreed by the board on 14 December 2016 are summarised below. This is version 80 of the work plan. The work plan is at appendix 2.

Appendices

Appendix 1 risk summary.
Appendix 2 board work plan.
Appendix 3 guidance on dementia friendly status

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

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08 February 2017

Risk Status

			Risk rating		Control measures			
Risk Ref	**Business Unit**	**Risk**	**Current**	**Future**	**Future**	**Existing**	**Total**	**% Implemented**
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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Agenda Item 10 – Appendix 2
HWB work plan version 80.0

Topic proposed: date to be agreed
Early years update – deferred from September 2016 meeting
Update from Safer Croydon (proposed by Rachel Flowers)
Update on People Gateway (proposed by Maggie Mansell)

Date	Item	Purpose	JHWS priority	Board sponsor	Lead officer / report author
5 April 2017	**Strategic items**				
	Social isolation action plan	To review draft social isolation action plan	Supporting people to be resilient and independent.	Rachel Flowers	Jack Bedeman / Mar Estupinan
	Business items				
	CCG operating plan 2017/18	The board has a statutory duty to give an opinion on the alignment of the CCG's commissioning plan to the JHWS	All	Paula Swann	Stephen Warren
	Review of the local strategic partnership and health and wellbeing board (including partnership group review)	To agree proposed changes to board governance arising from the review of the LSP and HWB	n/a	Barbara Peacock	Steve Morton

Agenda Item 10 – Appendix 2

Date	Item	Purpose	JHWS priority	Board sponsor	Lead officer / report author
	Health protection update	To inform the board of key health protection issues for the borough	Preventing illness and injury and helping people recover	Director of public health	Ellen Schwartz
	Healthwatch Croydon report	To report on relevant issues to the board	n/a	Jai Jayaraman	Darren Morgan
	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	Barbara Peacock	Steve Morton
May 2017 (date tbc)	**Board seminar – mental health strategy review (led by Cllr Woodley)**				
7 June 2017	**Strategic items**				
	Business items				
	Joint commissioning executive report	To provide an overview of the work of the joint commissioning executive	All	Barbara Peacock / Paula Swann	Sarah Ireland / Sarah Warman
	Better Care Fund	To inform the board of progress on the work schedule of the Better Care Fund	n/a	Paula Swann / Barbara Peacock	Paul Young & Ivan Okyere-Boakye / Graham Terry & Steven Buck

Agenda Item 10 – Appendix 2

Date	Item	Purpose	JHWS priority	Board sponsor	Lead officer / report author
	Healthwatch Croydon report	To report on relevant issues to the board	n/a	Jai Jayaraman	Darren Morgan
	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	Barbara Peacock	Jack Bedeman
13 September 2017	**Strategic items**				
	JSNA key dataset 2017	To consider key challenges and needs identified by the key dataset	n/a	Rachel Flowers	Ellen Schwartz / Craig Ferguson
	Business items				
	Health protection update	To inform the board of key health protection issues for the borough	Preventing illness and injury and helping people recover	Rachel Flowers	Ellen Schwartz
	Healthwatch Croydon report	To report on relevant issues to the board	n/a	Jai Jayaraman	Darren Morgan
	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	Barbara Peacock	Jack Bedeman

Agenda Item 10 – Appendix 2

Date	Item	Purpose	JHWS priority	Board sponsor	Lead officer / report author
18 October 2017	**Strategic items**				
	Commissioning intentions 2017/18	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.	All	Paula Swann/Barbara Peacock	Stephen Warren / Pratima Solanki / Ian Lewis / Sarah Ireland
	Business items				
	Safeguarding adults annual report	To inform the board of the work of the Safeguarding Adults Board	n/a	Barbara Peacock	Sean Olivier
	Safeguarding children annual report	To inform the board of the work of the Safeguarding Children Board	n/a	Barbara Peacock	Lorraine Burton / Maureen Floyd
	Joint commissioning executive report	To provide an overview of the work of the joint commissioning executive	All	Barbara Peacock / Paula Swann	Sarah Ireland / Sarah Warman
	Better Care Fund	To inform the board of progress on the work schedule of the Better Care Fund	n/a	Paula Swann / Barbara Peacock	Paul Young & Ivan Okyere-Boakye / Graham Terry & Steven Buck

Agenda Item 10 – Appendix 2

Date	Item	Purpose	JHWS priority	Board sponsor	Lead officer / report author
	Healthwatch Croydon report	To report on relevant issues to the board	n/a	Jai Jayaraman	Darren Morgan
	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	Barbara Peacock	Jack Bedeman
November 2017 (date tbc)	**Board seminar – diabetes**				
13 December 2017	**Strategic items**				
	Business items				
	JSNA programme for 2017	To agree the JSNA programme for 2017	n/a	Rachel Flowers	Ellen Schwartz / Craig Ferguson
	Health protection update	To inform the board of key health protection issues for the borough	Preventing illness and injury and helping people recover	Rachel Flowers	Ellen Schwartz
	Healthwatch Croydon report	To report on relevant issues to the board	n/a	Jai Jayaraman	Darren Morgan
	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	Barbara Peacock	Jack Bedeman

Agenda Item 10 – Appendix 2

Date	Item	Purpose	JHWS priority	Board sponsor	Lead officer / report author
7 February 2018	**Strategic items**				
	Business items				
	Pharmaceutical Needs Assessment	To agree the PNA	The board has a statutory duty to agree a PNA for Croydon	Rachel Flowers	Tbc / Claire Mundle
	Joint commissioning executive report	To provide an overview of the work of the joint commissioning executive	All	Barbara Peacock / Paula Swann	Sarah Ireland / Sarah Warman
	Better Care Fund	To inform the board of progress on the work schedule of the Better Care Fund	n/a	Paula Swann / Barbara Peacock	Paul Young & Ivan Okyere-Boakye / Graham Terry & Steven Buck
	Healthwatch Croydon report	To report on relevant issues to the board	n/a	Jai Jayaraman	Darren Morgan
	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	Barbara Peacock	Jack Bedeman
18 April 2018	**Strategic items**				

Agenda Item 10 – Appendix 2

Date	Item	Purpose	JHWS priority	Board sponsor	Lead officer / report author
	Business items				
	CCG operating plan 2017/18	The board has a statutory duty to give an opinion on the alignment of the CCG's commissioning plan to the JHWS	n/a	Paula Swann	Stephen Warren
	Healthwatch Croydon report	To report on relevant issues to the board	n/a	Jai Jayaraman	Darren Morgan
	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	Barbara Peacock	Jack Bedeman

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Alzheimer's Society | Leading the fight against dementia

Guidance for communities registering for the recognition process for dementia-friendly communities

In partnership with

DAA Dementia Action Alliance

2013

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1. Dementia-friendly communities: the background

Across England many cities, towns and villages are now exploring what they need to do to become dementia friendly; recognising the need to act and change to better support people with dementia and enable them to live well in the community. From Preston to Plymouth, Newcastle to Norwich communities are setting out on a journey to transform the experiences of people with dementia and their carers. As part of the Prime Minister's challenge on dementia, Alzheimer's Society and others are working in partnership with members of the Dementia Action Alliance to support communities that want to become dementia friendly.

2. What does it mean to become dementia friendly?

In order to create a dementia-friendly community the views and opinions of people with dementia and their carers must be at the heart of any considerations or decisions.

A dementia-friendly community can be described as:

'A city, town or village where people with dementia are understood, respected and supported, and confident they can contribute to community life. In a dementia-friendly community people will be aware of and understand dementia, and people with dementia will feel included and involved, and have choice and control over their day-to-day lives.[1]'

Based on the available evidence it is possible to identify 10 areas of focus that people with dementia want to see in any dementia friendly community and which underpin the definition. This is summarised in the following diagram:

[1] Alzheimer's Society, 2013

[2] Building dementia friendly communities: A priority for everyone, Alzheimer's Society, 2013

3. The journey - how the dementia-friendly communities recognition process developed

Becoming a dementia-friendly community will take a number of years. During this time it is vital that there is a process that enables communities to be part of an officially recognised group working towards becoming dementia friendly. The recognition process will ensure that communities are able to work towards a common and consistent vision based on what we know is important to people affected by dementia and will truly change their experience.

Alzheimer's Society proposed a model for a recognition process, which was consulted on in October and November 2012. This model was based on an analysis of existing evidence, which highlighted the need for dementia-friendly communities and provided early findings on what a dementia-friendly community is, as well as extensive and available evidence and discussion with experts.

The Society launched a pilot recognition process for dementia-friendly communities that tested a set of values and standards. Fourteen early adopters, chosen for their work in leading the way to become dementia friendly, took part in the pilot. Based on feedback we have refined the values and standards of the recognition process to make it easier for communities to get involved. It is envisaged that these, the foundation criteria, will be built on as the recognition process develops.

The journey to become a dementia-friendly community will take time. Working with communities we will develop the necessary standards or criteria to become dementia friendly.

4. How does my community apply to become dementia friendly?

To become part of the dementia friendly communities recognition process, a representative from a community will need to fill out an online application form. This can be accessed through the Alzheimer's Society website:

alzheimers.org.uk/recognitionprocess

By registering for the process your community commits to the following conditions:

- meeting the foundation criteria for a dementia-friendly community that have been developed (please see separate document)
- providing a brief six-monthly update
- completing an annual self-assessment of progress towards the criteria

- providing information on progress on a local webpage or site, for example this could be the local Dementia Action Alliance page
- complying with the terms and conditions for use of the 'working to become dementia friendly' symbol.

Once you have submitted your online application form the dementia- friendly communities team will assess it and get back to you within 14 working days and let you know if it has been successful or not. If your application is not successful you will be given advice and information on the things that you need to do to re-apply.

If your application to join the recognition process is successful you will receive information on how to participate. This will include:

- access to the 'working to become dementia friendly' symbol and guidelines for how it can be used
- advice and support from the dementia-friendly communities team
- information on the annual self-assessment process
- regular updates from the dementia-friendly communities team.

5. How do we use the 'working to become dementia friendly' symbol?

Once a community has successfully registered with the recognition process, the named representative from the community will be granted use of the 'working to become dementia friendly' symbol that is date stamped 2014-15 issued by Alzheimer's Society. They will be able to issue the symbol to organisations and businesses in their community that wish to be part of the dementia friendly communities' initiative and have stated what their actions will be to towards becoming dementia friendly. A community will have to outline to whom they have issued the symbol as part of their annual self-assessment.

There is separate guidance on how the symbol can be issued and should be used which will be supplied on successful registration. The symbol is trademarked by Alzheimer's Society and to use it the community and organisations must comply with the terms of use. Alzheimer's Society retains the right to withdraw that permission if it is felt that the conditions of use have been breached.

6. Measuring progress

An important aspect of taking part in the recognition process is tangible progress. This can be helpful in showing the impact of your work and activities. As a community taking part you will be asked to do this in two ways:

Six-month progress update

All communities taking part in the recognition process will need to submit a brief six-month progress update to the dementia-friendly communities team.

Annual self-assessment

A community will be expected to complete an annual self-assessment which shows what progress has been made and what actions have been taken on meeting the foundation criteria. The method of self-assessment can be chosen by the community but the dementia-friendly communities team will provide you with guidance on how to carry out the self-assessment.

As part of the self-assessment process the community will be asked to notify Alzheimer's Society of the organisations and businesses to which they have issued the symbol. Once the annual self-assessment has been submitted Alzheimer's Society will issue a new symbol for each year a community continues to meet the conditions of the recognition process to become dementia-friendly.

7. Overall governance and monitoring

The recognition system has been developed at this stage to encourage as many communities as possible to join the process and to support progression. The system will be developed in the longer term (over a period of years) to ensure that there is a continuous improvement pathway. This will be achieved by working closely with committed communities and others wanting to be dementia friendly.

8. Further information

For further information on the recognition process please email:

dementiafriendlycommunities@alzheimers.org.uk

Croydon Clinical Commissioning Group

South West London Sustainability and Transformation Plan (STP) Brief

The South West London Health and Care system in accordance with NHS Planning guidance, which seeks to ensure services are planned by place rather than around institutions, has developed a Sustainability and Transformation Plan (STP).

The plan is the product of unprecedented collaboration between all NHS commissioners and providers in SW London, working with our six local authorities and GP federations.

The draft STP was submitted to NHS England on 30th June and a revised version on the 21 October. The draft STP has been published at http://www.swlccgs.nhs.uk/2016/11/our-plan-for-south-west-london/

The local NHS faces significant challenges. Demand challenges include; life expectancy, a growing and aging population with increasingly complex mental and physical healthcare needs as well as inequality in outcomes. There are also provision challenges; variation in the quality of services, none of our acute hospitals meet all of the required standards for acute and emergency care, we do not have enough money or staff to go on as we are and some of our estate requires significant investment to bring it to an acceptable standard.

The STP aims to deliver health services differently to improve services to ensure that we address these challenges and improve outcomes. It is a strategic plan that outlines our; Mission, Vision and service design principles and suggests 'good practice' changes to:

- improve focus on Prevention, Early Intervention and Proactive Care to keep people healthier for longer and to support people to manage their health
- deliver care in the best setting and wherever possible out of hospital
- transform access to Outpatients; community based clinics, reducing unnecessary appointments
- develop new improved models of care for; Primary Care, Maternity, Children Services, Mental Health & Urgent Care

For acute hospital services we are looking at how acute services are configured to improve quality, optimise our workforce and meet clinical standards. We need to make better use of clinical networks across our five acute hospitals and consolidate our services as not every hospital can effectively provide every service. Our work suggests that four acute hospitals is the optimum number to provide sustainable quality care. More work is being undertaken to model what this would mean and how it could be delivered in line with the other plans to improve community and primary care services. We would need to undertake public engagement to help us develop this and no changes would be made without public consultation and consideration of feedback from local people and stakeholders.

NHS England has also announced a review of specialised services in South London which in SWL are predominately delivered at St. Georges NHS Foundation Trust and The Royal Marsden.

The plan will be formally published once national assurance is complete. A number of public events in the next few months across SWL will help inform the development of the plan. If consultation is required this is likely to take place in late 2017.

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REPORT TO:	**HEALTH AND WELLBEING BOARD (CROYDON)** **08 February 2017**
AGENDA ITEM:	**12**
SUBJECT:	**Progress on outcomes based commissioning for over 65s**
BOARD SPONSOR:	**Paula Swann, Chief Officer, Croydon Clinical Commissioning Group** **Barbara Peacock, Executive Director People, Croydon Council**

BOARD PRIORITY/POLICY CONTEXT:

The vision for Croydon OBC Programme 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 Croydon Alliance Agreement and Contract for Outcomes Based Commissioning (OBC) for over 65s 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. The outcomes are aligned to "Ambitious for Croydon" promises:

- creating growth in the economy;
- helping residents be as independent as possible, and;
- creating a pleasant place in which people want to live.

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.

OBC integrates health and social care for the over 65s and has a comprehensive outcomes framework that is focussed on improving outcomes for people. Extensive consultation with local people on what outcomes they wanted took place, and they chose the following:

- Staying healthy and active for as long as possible;
- Having access to the best quality care available in order to live as I choose and as independent a life as possible;
- Being helped by a health and social care team that has had the training and has the specialist knowledge to understand how my health and social care needs affect me;
- Being supported as an individual, with services specific to me;

- Having improved clinical outcomes.

OBC draws on a number of recommendations from existing strategies that have been developed, including The Independence strategy 2015-181 and Croydon-wide End of Life Strategy 20152 and the emerging Out of Hospital Strategy 2016. It aligns with the wider health system changes outlined in the South West London Sustainable Transformation Plan (SWL STP).

The contract for delivery of integrated health and social care will go further than before and takes a pro-active and transformational position. The individual and their family will be at the centre of Croydon's health and care system, ranging from the promotion of good health and well-being, through early intervention and support and, when needed, the delivery of treatment and care services. Croydon's older people and their families should expect to experience seamless, joined- up care and health provision of consistent quality and high standard; services will be arranged around them and their needs, rather than their having to fit in with how health and social care professionals structure or organise services.

FINANCIAL IMPACT:

The ambition for the contractual arrangements for OBC for the over 65s will be to use a capitated (per head) payment mechanism that incentivises the providers to improve outcomes for the population. This means that the providers will be given a fixed amount (the capitated fee) to cover the costs of health and care for the population rather than being paid directly for activity. The aim is to ensure a financially sustainable economy with a transformed health and care system for Croydon residents. The contracting options for year one are being defined and will allow for a transition year to support a secure move to a capitated budget from year two.

There are defined efficiency savings in the early years of the contract which align with the CCG's QIPP targets and the Council's agreed savings programme plus 5% social care efficiency built in for future years. Business cases for the delivery of these savings are in development.

In the transition year risk share arrangements will be developed where each party will share risk proportionally.

1. RECOMMENDATIONS:

1.1 The Health and Wellbeing Board is asked to note the progress of the OBC Programme.

2. EXECUTIVE SUMMARY

2.1 The purpose of this report is to update the Health and Wellbeing Board members on the progress of OBC Programme towards a 10 year contract to develop an Integrated Health and Social Care system for the over 65s population in Croydon.

2.2 OBC brings together a number of recommendations from existing strategies that have been developed, including The Independence strategy 2015-18, Croydon-wide End of Life Strategy 2015 and the Out of Hospital Strategy 2016. The contract for delivery of integrated health and social care will go further than before and takes a pro-active and transformational position. The individual and their family will be at the centre of Croydon's health and care system, ranging from the promotion of good health and well-being, through early intervention and support and, when needed, the delivery of treatment and care services. Croydon's older people and their families should expect to experience seamless, joined- up social care and health provision of consistent quality and high standard; services will be arranged around them and their needs.

3. DETAIL

3.1 **Croydon OBC Alliance -** The Commissioners and Providers have agreed to combine their strengths to form a Commissioner / Provider Alliance from year 1 with the view of Commissioners stepping out of the Alliance in a few years when the capability for managing the whole system as an Accountable Care System has been established.

3.2 An Alliance of Commissioners and Providers in Croydon has been formed to deliver the transformation with the following parties:

- Age UK Croydon
- Croydon Council Adult Social Care
- Croydon GP Collaborative
- Croydon Health Services NHS Trust
- South London and Maudsley Mental Health NHS Foundation Trust
- Croydon Council as Commissioner
- Croydon Clinical Commissioning Group

3.3 The signing of the Alliance Agreement and in scope service contracts in phase one is planned to be completed between the 31 January and 31 March 2017 for a commencement date of April 2017.

3.4 The Alliance Board has been established and an independent Chair is to be recruited. The Chair the Croydon GP Collaborative has been agreed as the Senior Responsible Officer, on behalf of the Alliance Board.

3.5 To enable a contract to be signed to commence from April 2017 it was agreed at the Alliance Board that a 1 year contract with the option to extend by 9 years is the best option. Year 1 will be a transition year to a full capitated Outcomes contract from year 2.

3.6 The Outcomes framework has been agreed and further work to establish the measuring of the Outcomes is underway.

3.7 Progress has been made on the New Model of care initiatives, with Personal Independence Co-ordinators (PICS) now in place for 2 of the 6 GP networks. Lessons learned in this early implementation stage will be implemented in the wider rollout of PICS to the remaining 4 networks.

4. CONSULTATION

4.1 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.

4.2 OBC 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.

4.3 The Service User Engagement Specialist Group (SUESG) has been established for over a year and has diverse representation from the over 65 age group. There is an established feedback loop between the SUESG members and the transformation workstream to enable user input into system changes and design.

5. SERVICE INTEGRATION

5.1 The transformation team have created a vision for the New Model of Care in Croydon and is illustrated below.

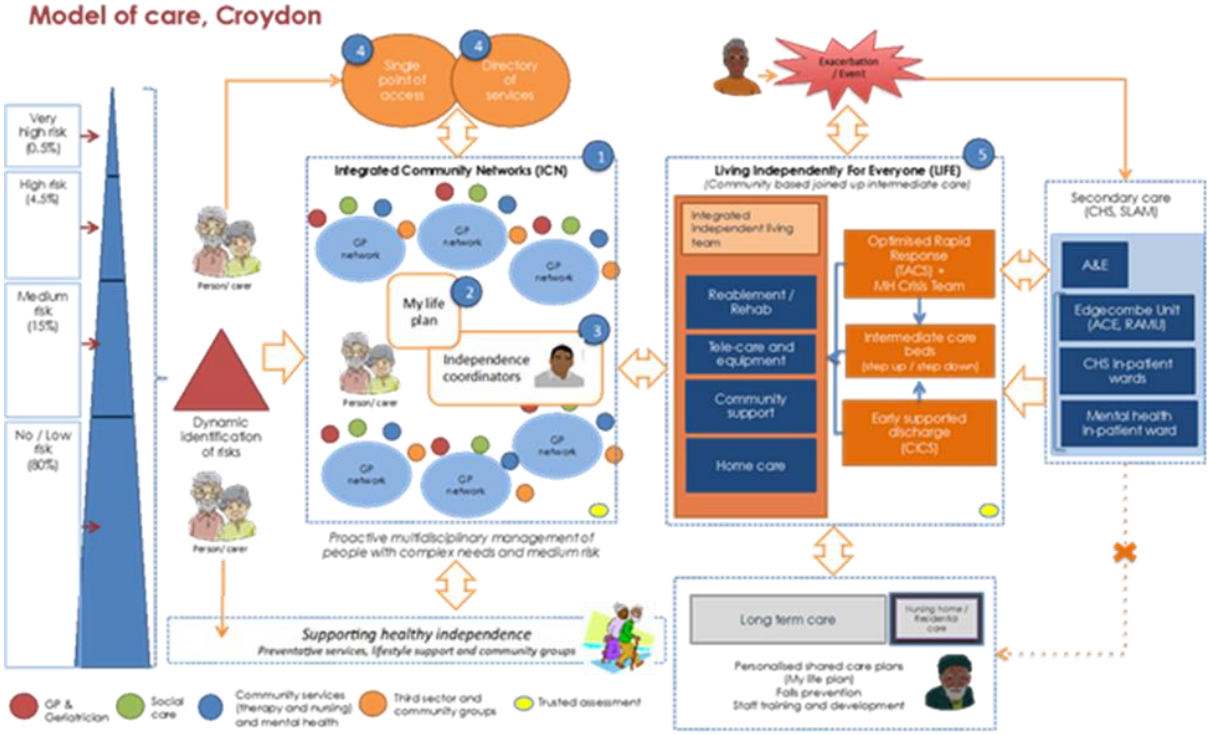

Figure 3: New Model of Care in Croydon

5.2 The two key programmes of transformation, ICNs and LIFE, are described in more detail below.

5.3 **Integrated Community Networks (ICNs) -** a tranche of the OBC Portfolio is the development of Integrated Community Networks (ICN) Programme, which has a remit to deliver the solution through 6 projects, these being:

5.3.1 **The Core ICN Team Multi-Agency Working Project** - The purpose of the Core ICN Team Multi-Agency Working project is to align and integrate staff from the five provider alliance organisations to each of the 6 GP Networks within Croydon. This to ensure medium to high-risk patients are identified quickly and are proactively case managed by one or more members of the multi-disciplinary team.

5.3.2 The key features of core ICN team multi-agency working are:

- One, trusted assessment between the core team
- Risk stratification, including both health and social risk indicators
- Worry score
- Huddles
- One to one support in planning and co-ordinating seamless care

5.3.3 **The Complex Care Hubs Project** - The purpose of the Complex Care Hub (CCH) is to meet as a MDT to discuss people who are deemed or proven to be too complex and challenging for the core ICN team and are deemed to be very high risk. The frequency of these CCH MDT meetings will initially be weekly (for two hours). The plan is to have two hubs; one in the north of the borough and one in the south.

5.3.4 **The My Life Plan (MLP) Project** - A MLP is a dynamic care plan based on input from the person through guided conversations. Every person over 65 in Croydon (and their carer) will have access to a website / app or hard copy that takes them through a systematic process of developing a personalised MLP. Care planning will be undertaken at various levels; initial planning will be undertaken with the person/family/carer by a skilled professional within the ICN.

5.3.5 **The Personal Independence Coordinators Project** – A new role titled Personal Independence Coordinator (PIC) has been created. This person will be a member of the core ICN team, bringing together the local voluntary sector and health and care organisations to support people over the age of 65. The PIC will be independent of social services and the NHS, and not part of the person's family or friends and will work intensively with people with long term conditions, if necessary, on a one to one basis.

5.3.6 **The Points of Access and Information Project** - Points of Access and Information will deliver high quality, easily accessible information and advice services which give people over the age of 65, and their families/carers, real choice and control over their lives – equipping them to identify and access services and products which meet their individual needs; supporting them to stay independent, healthy and safe; and enabling them to play an active role in their local community.

5.3.7 This will be provided via an advertised central telephone advice line, text messaging/ email service and face to face help via home visits and a General Advice Drop In within each of the 'front doors' in the 6 ICNs. The trained advisers will have access to a comprehensive and intuitive directory of service, which will provide information about statutory and voluntary sector services available, including online factsheets.

5.3.8 **The Galvanising Community Networks Project** - the Galvanising Community Networks project aims to strengthen the formal and informal social networks and focuses on the strengths and assets of an ICN, including:

- Recognising the skills and abilities of individuals within the ICN and finding people who are passionate about the community and who are good at making connections;
- Identifying voluntary and community organisations and networks and what they offer (or could offer) to the ICN; and
- Encouraging the voluntary and community organisations who are commissioned to provide preventative services to Croydon residents to work together to find new ways of developing services and/or activities that meet the growing and changing needs of a diverse population within each of the ICNs.

5.4 **LIFE -** The LIFE (Living Independently for Everyone) Programme seeks to establish an integrated reablement and rehabilitation service across the borough, comprising services from across Adult Social Care, Croydon Health Services and Croydon University Hospital. The long term ambition of LIFE is that it will see key services brought into a new LIFE integrated Reablement and Rehabilitation service – a new intermediate care service.

5.4.1 **Community-based Reablement** - As a step towards the long term ambition is the intention to establish a community-based reablement service funded by existing resources within Adult Social Care and additional resources from the Better Care Fund.

5.4.2 This project therefore is to establish the new community-based reablement service. Much work has been carried out prior to now to develop the LIFE model. There exists a Programme Development Group (PDG) and a Focus Group. It is therefore anticipated that these 2 groups will become central to the project and form the Project Team to undertake the work to establish the service.

5.4.3 **Multi-disciplinary Intermediate Care Service** - The Project will review the current reablement/ rehabilitation pathways for people leaving hospital. At the moment the council and Croydon Health Services (CHS) have a fragmented approach, with some people qualifying for a CICs service and other people being referred for a reablement service which is provided from one of the nine home care providers. The new service will be a multi-disciplinary team that includes nurses, occupational therapists, and physiotherapists. The service will work alongside the PACE, Community neuro rehab, Stroke. The following services will be in scope:

- Falls services
- Reablement following hospital discharge
- Rapid Response
- CICS
- A&E Liaison Team
- Step up/ Step down beds

5.4.4 **First Stop services**

5.4.5 The project will review the current S75s for the Occupational Therapy and Equipment and develop a new joint service; the service will also include a new one stop shop for equipment, telecare and telehealth.

5.5 **Transformation Strategy** - Further work is required to develop a comprehensive strategic ambition for the whole system including the impact on the delivery of planned care and the wider implications for the whole health and social care system.

5.6 The development of the ambition will form the cornerstone of the 5 year transformation plan for the OBC programmes. This plan needs to influence and be aligned to the Croydon STP and the strategic plans for all alliance partner organisations. A work plan has been developed to complete this work within the tight timeframe whilst also aligning with the South West London transformation case for change.

5.7 The development of the ambition will include working with an Innovation Think Tank: a group of Clinical and non-Clinical Leaders, along with private sector experts, to be used as a sounding board for developing and testing out ideas and ambitions for service improvement.

6. FINANCIAL AND RISK ASSESSMENT CONSIDERATIONS

6.1 **Revenue and Capital consequences of report recommendations -** The Commissioners wish to move to a capitated payment mechanism incentivised to improve outcomes for the population. With the 1+9 contract term, year 1 budget will be the value of the service contracts with the Providers in the Alliance. It is intended that from year 2 the capitated payment mechanism, as described below, will be in place.

6.2 This means that the Providers will be given a fixed amount per capita to cover the costs of care for the population rather than being paid directly for activity. The outcomes framework supports the capitated payment approach as it will incentivise the Providers to manage the quality and cost of provision – the Providers will be able to decide where to invest in order to deliver these outcomes, incentivising early intervention and prevention and thereby keeping patients well and out of hospital. The incentivisation of outcomes is expected to cascade through the care system to align and focus care teams such that each care pathway/intervention maximises outcomes for the population.

6.3 **Risks -** There are a number of programme risks being managed by the OBC PMO. These are monitored monthly by the OBC Programme Board, with membership from the CCG and Council. This will be monitored by the Alliance Board going forward to assure all parties that effective programme management is in place and that risks are suitably mitigated.

6.4 **Health Efficiency Saving Assumptions -** The health Quality, Innovation, Productivity and Prevention (QIPP) scheme is designed to ensure that each pound spent is used to bring maximum benefit and quality of care to patients.

6.5 There are defined efficiency savings in the early years of the contract which align with the CCG's QIPP target. Business cases for the delivery of these savings are in development.

6.6 **Council Efficiency Saving Assumptions -** The Council also has efficiency savings they expect to make. Savings of 5% in futures years of the contract and a slightly lower efficiency target in the earlier years.

6.7 It is expected that the shift of resources through whole system transformation will be from acute to community and preventative provision; including to social care, the voluntary sector and primary care. Detailed financial modeling being completed in year 1 will show this and will model the requirement for growth and savings per year.

7. LEGAL CONSIDERATIONS

7.1 Gowling WLG LLP, (Formerly Wragge & Co LLP) have been supporting the OBC programme from the outset. Gowling are leading on the production of the commercial documents on behalf of all parties.

7.2 The Council are being supported further by legal advisors from Trowers LLP. Other Providers may engage legal advisors to undertake a final review of the contract prior to agreement and signing.

8. EQUALITIES IMPACT

8.1 The equality analysis (EqIA) has previously been completed in the early phase of OBC, and has now been refreshed.

8.2 Evidence that underpinned the refresh of the EqIA included the draft Joint Strategic Needs Assessment (JSNA) that assesses the 'Health and Social Care Needs of Croydon's Older Adults & Carers. This provides a detailed understanding of the demographic characteristics, social determinants and health and social care needs of Croydon's over 65 population, and carers of people over 65. Following a high level appraisal of current need, the JSNA makes recommendations in areas for improvement.

8.3 Another key evidence base used is the 'Croydon Outcomes Framework for Older People's Care, Technical Specification'. This provides details of the indicators and metrics which will demonstrate delivery of outcomes that matter to local people and ensure health equity.

8.4 The updated EqIA includes actions detailing how potential impacts are being responded to and how future arrangements will continue to identify and address equality monitoring and performance requirements.

8.5 Approved by: Sarah Ireland (Director of Commissioning, Commercialism & Improvement)

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