Health & Wellbeing Board

To:
Dr Agnelo FERNANDES (NHS Croydon Clinical Commissioning Group)* (Vice-Chair)
Alisa FLEMMING (Councillor - Cabinet Member for Children, Young People & Learning)*
Barbara PEACOCK (Executive Director of People, Croydon Council)
Callton YOUNG (Councillor)*
Guy VAN DICHELE (Interim Director of Adults Social Care, (Croydon Council)
Jai JAYARAMAN (Healthwatch Croydon)*
Louisa WOODLEY (Councillor - Cabinet Member for Families, Health & Social Care)*
Manju SHAHUL-HAMEED (Councillor)* (Chair)
Margaret BIRD (Councillor)*
Mike BELL (Croydon Health Services NHS Trust)
Neil ROBERTSON (South London & Maudsley NHS Foundation Trust)
Rachel FLOWERS (Director of Public Health)
Simon HALL (Councillor - Cabinet Member for Finance & Treasury)*
Steve PHAURE (Croydon Voluntary Action)
Yvette HOPLEY (Councillor)*

(*Voting members)

A meeting of the **Health & Wellbeing Board** will be held on **Wednesday, 13 December 2017** at **2.00 pm** in **Council Chamber, Town Hall, Katherine Street, Croydon CR0 1NX**

JACQUELINE HARRIS-BAKER
Director of Law and Monitoring Officer
London Borough of Croydon
Bernard Weatherill House
8 Mint Walk, Croydon CR0 1EA

Michelle Gerning
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5 December 2017

AGENDA – PART A

1. Apologies for Absence

To receive any apologies for absence from any members of the Committee.

2. Minutes of the Previous Meeting (Pages 5 - 10)

To approve the minutes of the meeting held on 18 October 2017 as an accurate record.

3. Disclosure of Interests

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 to the value of which exceeds £50 or multiple gifts and/or instances of hospitality with a cumulative value of £50 or more when received from a single donor within a rolling twelve month period. 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 Democratic Services representative at the start of the meeting. The Chair 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 of any business not on the agenda which in the opinion of the Chair, by reason of special circumstances, be considered as a matter of urgency.

STRATEGIC ITEMS

5. Croydon Transformation Board & Alliance Update (Pages 11 - 20)

The report of the Croydon Transformation Board & Alliance Update is attached.

6. Mayor of London's Health Inequalities Strategy (Pages 21 - 36)

A presentation of the Mayor of London's Health Inequalities Strategy.

7. Director of Public Health Annual Report (Pages 37 - 76)

A presentation from the Director of Public Health.

BUSINESS ITEMS

8. PNA - Delegated Responsibility (Pages 77 - 90)

The report of the Pharmaceutical Needs Assessment – Delegated Responsibility is attached.

9. **Dementia Friendly Town** (Pages 91 - 104)

A presentation of the Dementia Friendly Borough.

10. **Health Protection Update** (Pages 105 - 108)

The report of the Health Protection Update is attached.

11. **Public Questions**

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

Questions should be of general interest, not personal issues, and must be received in writing no later than noon on the Friday prior to the meeting.

There will be a time limit of 15 minutes for all questions and responses which will be minuted. The responses to any outstanding questions will be included as an Appendix to the minutes.

12. **Exclusion of the Press and Public**

The following motion is to be moved and seconded where it is proposed to exclude the press and public from the remainder 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 items 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."

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Health & Wellbeing Board

Meeting of held on Wednesday, 18 October 2017 at 2.00 pm in Council Chamber, Town Hall, Katherine Street, Croydon CR0 1NX

MINUTES

Present: Dr Agnelo FERNANDES (NHS Croydon Clinical Commissioning Group)* (Vice-Chair)
Alisa FLEMMING (Councillor - Cabinet Member for Children, Young People & Learning)*
Callton YOUNG (Councillor)*
Guy VAN DICHELE (Interim Director of Adults Social Care, (Croydon Council)
Jai JAYARAMAN (Healthwatch Croydon)*
Louisa WOODLEY (Councillor - Cabinet Member for Families, Health & Social Care)*
Manju SHAHUL-HAMEED (Councillor)* (Chair)
Margaret BIRD (Councillor)*
Mike BELL (Croydon Health Services NHS Trust)
Rachel FLOWERS (Director of Public Health)
Simon HALL (Councillor - Cabinet Member for Finance & Treasury)*
Steve PHAURE (Croydon Voluntary Action)
Yvette HOPLEY (Councillor)*

Also Present: Maggie Mansell (Councillor); Jack Bedeman (Public Health Registrar); Laura Flanagan (School Food Improvement Officer), Georgia Ladbury (Public Health Principal); Michelle Gerning (Democratic Services Officer)

Apologies: Barbara PEACOCK (Executive Director of People, Croydon Council) and Neil ROBERTSON (South London & Maudsley NHS Foundation Trust)

(*Voting members)

PART A

111/17 **Minutes of the Previous Meeting**

RESOLVED that the minutes of the meeting held on Wednesday 13 September was agreed as an accurate record.

112/17 **Disclosure of Interests**

There was no disclosure at this meeting.

113/17 **Urgent Business (if any)**

There was no urgent business.

114/17 **Director of Public Health Annual Report**

Due to the Director of Public Health annual report going to Cabinet following this meeting of the Board, only an overview of the report was given to the Board. The rationale behind the report was to consider the challenges around Health and Wellbeing.

The Board learned that there were health inequalities in society that flowed from different economic circumstances. The report highlighted alternative lifestyle choices for better health that aimed to improve the socio-economic position of the individual.

The Board heard that there was a lot of evidence identifying the impact on health from what we do in life to the environment that we live in, which was identified in the report.

The Board learned that Croydon is said to have the second highest population of any borough in London with the highest population for people under eighteen years and had the third highest population for people over sixty-five years. The report estimated that the next generation in ten years' time would see Croydon still having the largest population of those under eighteen years. Croydon is said to have the fourth highest population of working age residents, and have over sixty-one thousand older people residing in the borough. The age range was notably diverse within different areas of the borough, however, it was recognised that Croydon broadly have younger people in the north of the borough and older people in the south of the borough.

The Board recognised that there were different ways to define health and was working hard to better understand the challenges in the health and wellbeing across Croydon society. The Board noted that adults' and children's social care, housing and community safety were all equally important when recognising health needs across society. The Board discussed the upcoming report and recognised that there was a need for policy to be evidence based, and that the detailed work identified in the report would help shape how the Board would work together to address the issue.

The Board discussed that there was plenty of opportunity to change the way the Board operated. The Chair highlighted that the upcoming workshop on the

three underlining priorities in line with the strategies would be delivered to identify:

- how the Board wants to work,
- what the priorities are,
- what the Board wants to achieve in twelve months,
- convening partnership meetings, and
- whether there would be other partners such as mental health involved in the Board

Members of the Board announced that the future focus should be on areas of highest need. The Board acknowledged that resources were limited for those that reside in North Croydon and New Addington.

The Board discussed that the 'Just Be' website was enabling people to help themselves to empower change in their own behaviours (such as stop smoking, alcohol awareness and healthy eating) and to access facilities to improve their health and wellbeing. It was recognised that obesity was a long-term cause of ill-health and therefore, to acknowledge the signs at an early stage, Members requested that a strong campaign to get the message out in schools, would help achieve earlier change.

The Board recognised that there was more that the Health and Wellbeing Strategy can do to support the BAME population who are more at a disadvantage. This was an opportunity to see the Board do something different and tangible.

Members of the Board aspired for Croydon to improve health massively in the next five years which would include sixteen thousand jobs coming into the borough. It would also show that the Public Health Report in 2025 would show Croydon to be 'the place to be' as the population would be benefiting from resources and better lifestyle.

The Health and Wellbeing Board was in consensus to develop what they would strive to achieve. The Board would need to set a challenge to do things in a systematic way on how to address the matter. The Board would also need to look into the funding for stability. The Chair acknowledged the above opportunities would help inform the work of the Croydon Health and Wellbeing Board.

115/17 **The Development of the Health & Wellbeing Strategy 2018- 22**

The Director of Public Health presented the Development of Health and Wellbeing Strategy for 2018-2022.

The Director welcomed the new Health and Wellbeing Board into their second Board meeting as the Board was growing together in its early stages.

The report outlined the purpose of the Health and Wellbeing Strategy for 2018-2022 and suggested options to the Board for developing the strategy.

There were three options discussed and the Board was in consensus that they were sensible and attainable. The Board deliberated in finding the best way forward, looking into the principles in developing strategy. The Board agreed that there was an opportunity to collaboratively work together, bringing in all Members involved with the development of the strategy.

The Board was in discussion over some areas where they need to be responsible in focusing a strategy in supporting communities. Issues concerning:

- Overall health in society;
- The need for diversity and the citizen's voice should be included in decisions as it was noted that young children were often missed in capturing information due to their age;
- Issues in the north of Croydon around parenting; and
- Issues in New Addington around environmental issues

The Board was reminded to include the voice of the child. The Local Strategic Partnership would also be linked into the shape of the Health and Wellbeing programme.

The voluntary sector would be beneficial to the Board, as it would represent engagement and networking where voices from the community would be heard; the Board heard that fantastic work and citizen led projects, had a great impact at the Upper Norwood Health and Wellbeing Oasis.

The Board discussed the issue of timescales and how they proposed to achieve their focus in developing strategy. Moving forward, the Board considered options of completing tasks by mid-2018, to have some steps and forward plans in what they would have achieved, and by when.

The Board agreed to a multi-agency workshop to begin the process in understanding each partner's roles and work on proposals to develop the joint health and wellbeing strategy. This workshop would help shape the identity of the Health and Wellbeing Board in Croydon. The idea of holding a summit in the coming future was also considered. The Board also recognised internal challenges, such as funding.

The Board was of the view that they would need to include all Members in the process around what they set out to achieve; thus work would not be duplicated, and with co-production as a new Board, the idea was to focus on being realistic in how they chose to go forward. It was emphasised that all Members should have an equal voice. The Board noted that they would have greater impact when specifically focusing on discrete areas to improve wider determinants of health.

The Chair stressed the idea of strategy as being an opportunity for the Board to take ownership of what they wanted to achieve. The Chair highlighted that the workshop would be an impeccable start to discuss the three underlining priorities in line with the strategies and the way the Board would progress forward. The Chair talked about taking ownership and making decisions in light of the Board effectively working together and thinking about looking at other partners such as those working in autism and mental health who may want to be included as part of a representation to the Board. The Chair concluded that the workshop would be used as a guideline to prepare their timeframe for what they had set out to achieve.

The Board **NOTED** the report and **AGREED** a timeline of the third option within the report being discussed.

116/17 **Healthy Weight Action Plan (including Food Flagship achievements and legacy)**

The Board received a presentation on the Healthy Weight Action Plan.

Officers explained the vision of what was achieved which was to improve access to food and the way it is sold. The programme for this plan had worked incredibly well for the last two and a half years. The Board learnt that three flagship schools had done intensive work, and by September 2017 four more schools had joined.

A video was played for the Board which evidenced success in healthy meals provided to children at schools. This was considered great for tackling obesity as it was observed what a child eats. The voice of a child was heard in the video as it was seen that children identified with food choices and habits and spoke of their appreciation in eating healthily.

The presentation further informed the Board that obesity remained a big issue nationwide and was a particular issues in Croydon. With obesity existing

through the life of many, it was noted that those who reside in poorer areas were more likely to be overweight.

The presentation was received well by all the Members of the Board, for the scope and depth of work demonstrated to support healthier eating in Croydon. The idea around involving all schools can be seen as a role for the voluntary sector, where the community could receive information in parks, open spaces, and organise healthy eating project for those on low incomes, to help across Croydon's communities.

The Board highlighted that the Sugar Smart project was making a difference as it was providing an informative measurement of sugar in our diet, also the Daily Mile challenge was already having an impact. The Board also noted that obesity was spreading in affluent areas too, as the Croydon population was increasing in size. There was talk of the complications in tackling the issue as there was no single solution to deal with obesity. The activities had been far greater but there remained a need to measure the impact on reducing obesity over time.

The Board **NOTED** the achievements and legacy of the Food Flagship programme, and **APPROVED** the borough's three-year Healthy Weight Action Plan (2017-2020). The Board further recommended the impact of the plan across the system, and committed to the Local Government Declaration on the Sugar Reduction and Healthier Food.

The meeting ended at 4.12pm

Signed: .....

Date: .....

REPORT TO:	**HEALTH AND WELLBEING BOARD (CROYDON)** **November 2017**
SUBJECT:	**One Croydon Alliance Agreement Extension Update**
BOARD SPONSOR:	**Guy Van Dichele, Director Adult Social Care Croydon Council** **Andrew Eyres, Chief Officer, Croydon CCG**

BOARD PRIORITY/POLICY CONTEXT:

The One Croydon Alliance integrates health and social care with the aim of working together to help people live the life they want, and achieve a sustainable health and social care system. The Alliance has developed a Transformation Plan that supports the joint health and wellbeing strategy objectives of:

- Increased healthy life expectancy
- Increased resilience and independence
- A positive experience of care

Both the Clinical Commissioning Group and Croydon Health Services NHS Trust are enabling delivery of the NHS five year forward view ambition to integrate care through their membership of the Alliance, which allows them to manage a 'system' of care, transform services and focus on outcomes.

The Alliance enables the Croydon Council to fulfil its duties in the Care Act 2014 *to promote the integration of care and support services with health services*. As a member of the Alliance the Council is promoting strategic integration, modelling the behaviours needed to achieve integration, and with fellow members of the Alliance has successfully integrated two new services.

1. RECOMMENDATIONS

1.1 This report is for information only providing an update to the Health and Wellbeing Board on progress towards the case for extending the alliance into its full 10 year term. The health and wellbeing board is asked to note the contents of the report.

2. EXECUTIVE SUMMARY

2.1 Six Organisations (Croydon Council, Croydon Health Services, Croydon GP Collaborative, Age UK Croydon, South London and Maudlsey MHT and Croydon Clinical Commissioning Group) have formed an Alliance of Health and Social Care providers and commissioners. These organisations entered into an Alliance Agreement for the delivery of Health and Social Care to Over 65s in Croydon on the 1st of April 2017. This Agreement is for a term of 1 year (Transition Year) with an option to extend for a further 9 years; the decision to extend is supported by demonstrable delivery of the transition criteria as set out in the Transition Plan in the Alliance Agreement.

2.2 This report gives an overview of progress against the two key components of transition year (2017/18); year one transformation and transition criteria. Year one transformation includes a new model of care, including the Living Independently for Everyone (LIFE) service and the Integrated Community Networks (ICN) Programme, and the transition criteria includes the development of the year 2-10 Extension Case.

2.3 Performance of the transformation programmes and the development of the 2-10 year Case will inform the Alliance Boards' recommendation as to whether or not to extend the Alliance Agreement for a further 9 years.

2.4 The Alliance Agreement for transition year covers over 65s. The ambition of the alliance is to develop plans to cover all of Croydon transformation in relation to health and social care integration. The alliance agreement remit will be requested to be extended to cover this although in order to extend our scope into further transformation programmes beyond over 65s specifically there will be individual governance and decision points as relevant for each organisation to agree this increase in scope.

3. DETAIL

Model of Care Programmes

3.1 Living Independently for Everyone (LIFE)

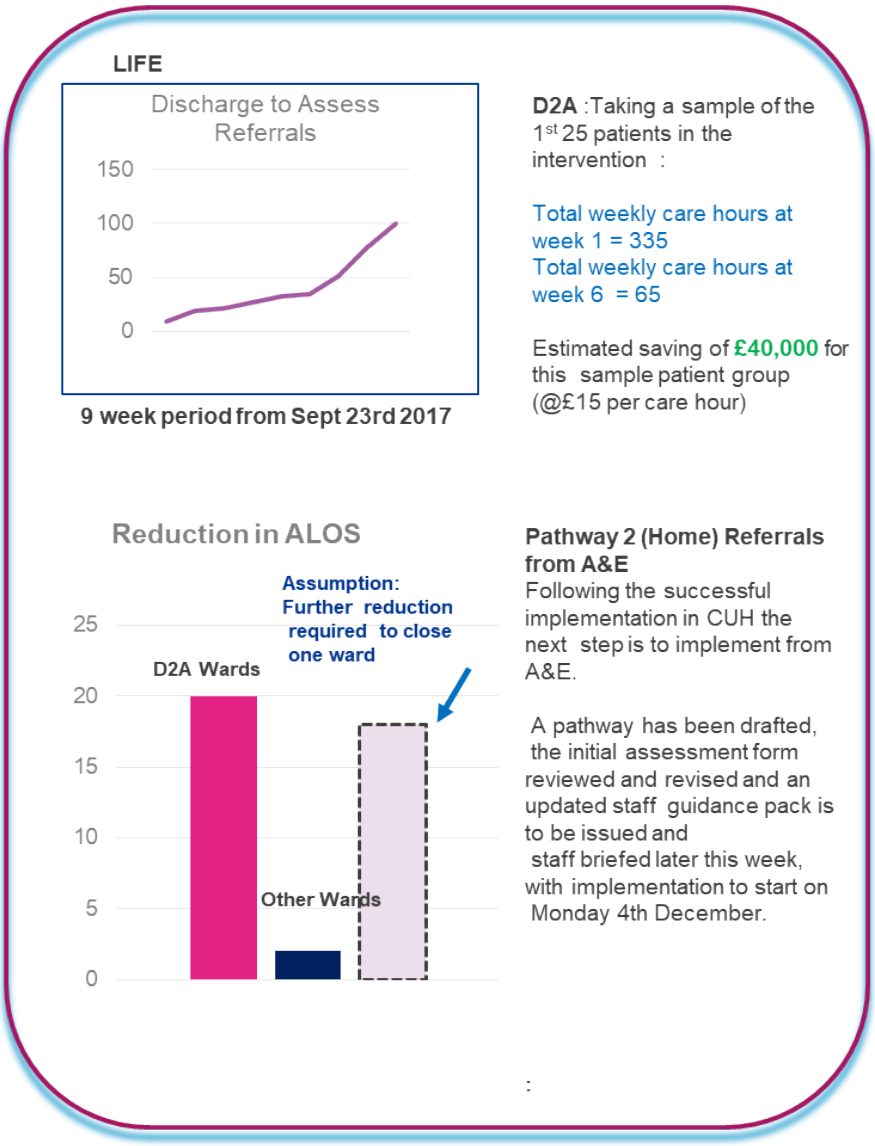
3.1.1 The LIFE Programme has established an integrated Reablement and rehabilitation service across the borough, comprising services from across Adult Social Care, Croydon Health Services and Croydon University Hospital. The long term ambition of LIFE is that it will see key services brought into a new LIFE integrated Reablement and Rehabilitation service – a new intermediate care service.

3.1.2 The integrated service model ensures a one name, one budget one team approach, use of an agreed single eligibility assessment and review process, and increased entry pathways. This service will contribute to:

- reductions in systems duplication
- reduction non-elective hospital admissions and bed days
- enable targeted and focussed effective use of more community services upstream
- reduce high cost packages of care and create capacity with an increase in flow at an earlier stage for people in need of the service
- services that are more person and outcome focused improving the person experience of health and care

3.1.3 A key component of the LIFE service is Discharge to Assess (Home First Pathway 2), This service is now operating in 13 wards in the Croydon University Hospital and having a positive impact, reducing people's length of stay and meeting immediate care needs, focusing on outcomes. This service ensures people are supported through a multi-disciplinary approach to reduce their length of stay in hospital, assess them in the best place to determine care and establish outcome focused care plans that aim to reable and maximise independence.

3.1.4 Initial performance data for the services shows a 20% reduction in length of stay for the first 100 people seen by the service, equating to 344 bed days saved, with some excellent service user feedback:



Email from son of person receiving D2A: "*Many many thanks to you and the whole team for looking so very well after my Mum. She had done immensely well over the 6 weeks. Your team has been patient and encouraging. Also thanks to your assistance; Mum has just received her Dial A Ride card. She will start using it this week. She will be very happy to be able to get out with her friends."*

3.2 Integrated Community Networks

3.2.1 The Integrated Community Networks (ICN) Programme is comprised of the following features:

- Huddles (proactive weekly case management by multi-disciplinary team working from GP practices);
- Complex Care Support (specialist support for issues such as mental health and frailty and support for care homes);
- My Life Plan (Co-ordinate My Care – shared care record);

- Personal Independence Coordinators (PICs – person centred support for non-medical issues);

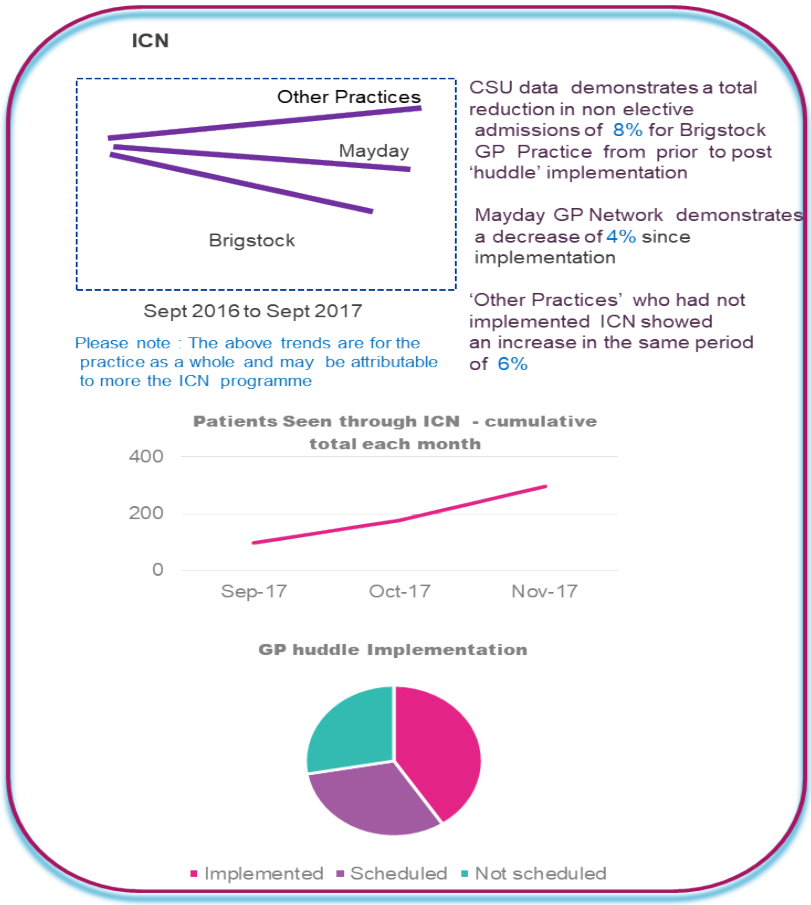
- Active and Supportive Communities (people and communities as assets).

3.2.2 The key aim is to engage, empower and build-up the Huddles so they are responsive, timely and flexible to individual needs Care will be organised around the individual, breaking down the boundaries between health and social care and the voluntary and community sector, and between formal and informal support. Huddles will focus on:

- preventing admissions
- focus on high risk and need people who have more than one long term condition (initially)
- enable individuals to support their own health and independence

3.2.3 An accelerated ICN Huddle programme is being implemented and the number of huddles rolled out will exceed business case plans by October 2017 with all GP practices saving them by March 2018.

3.2.4 The performance data shows early indications that the ICN programme is being successful in meeting its outcomes:



3.2.5 A key component of the ICN programme are the Personal Independence Coordinators (PICs). The PICs are a member of the core ICN team and are independent of Health and Social Care Services; they work intensively with people with long term conditions. Initial data shows an increasing trend in the number guided conversations and the proportion of people meeting their goals. A case study shows the impact and success of a PIC intervention and is detailed below.

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Background

- Robert is 77 years old.
- He lives alone
- Same rented accommodation for 30 years
- His wife was bed bound and he cared for her
- He used to be a professional magician
- Daughter lives in Wallington

In January 2016 he experienced shortness of breath and rapid weight loss

- Admitted to hospital where he stayed for 11 months on and off
- Discharged in November 2016
- Wife passed away in that period
- He did not return to work

Outcomes achieved as a result of PIC intervention:

- Attendance allowance granted
- More independence at home
- Heating installed in some rooms
- Garden work done
- House clean
- Healthy living and gained weight
- Started driving again

3.2.6 The ICN model is supported by building up our community and preventative services. The model of care aims to do this through aligning our provision of voluntary and community services within each of the six GP networks through appointing Locally Trusted Organisations and opening points of access, building awareness of assets and improving access and capacity.

3.3 Transition Workstreams: Progress against transition criteria is managed through the PMO.

3.3.1 The One Croydon Alliance Programme Management Office has been managing the delivery of the Alliance Agreement Transition Criteria through 10 workstreams, each having an executive responsible officer and lead officer. Progress against this criteria is continuously measured and reported to the Programme Delivery Board and the Alliance Board.

3.3.2 The Transition Plan specified 3 Transition Checkpoints for May, July and September 2017 respectively to gauge the progress of the Transition Programme and its workstreams in meeting the Transition Assessment Criteria & Providing the Alliance partners with sufficient assurance to be able to decide to extend for a further 9 years.

3.3.3 At Programme Delivery Board on the 21 September, the Board agreed to move the final Checkpoint 3 from September to October 2017, to allow more time for Year 2-10 Business Case development, in particular Financial Savings Assumptions, and to a

lesser extent the Alliance Risk Share agreement. The following table provides an overview of progress of these transition workstreams as reported at checkpoint 3.

3.3.4 The current progress and key challenges against the Transition Criteria (managed as workstreams) is set out in the following table:

#	Transition Workstream	RAG	Critical Path Summary
1	**Y2-10 Business Case – Business Case**		Workstream Red as while OBC Alliance Board business case sign-off has moved from 30 November to 14 December, the need to finalise the executive summary along with the extent of outstanding content across the 5 cases is back-ending a lot of document updates, thereby also reducing the time for internal review before submitting to Alliance Board 11 December.
2	**Y2-10 Business Case – Risk Share & Financial Model**		Workstream Red owing largely to lack of traction with Risk Share/Mgmt with its dependency on agreeing Finance Plans and uncertainty about when these will be agreed. Financial Savings Assumptions have progressed with plan to have these agreed by DOFs 30 November.
3	**Y2-10 Contract & Performance Management Model**		Workstream Green. Draft model completed for components to be included in the business case, The model is a live operating model and will evolve with the commercial structure.
4	**Y2-10 Financial Monitoring Model**		Work on Y2-10 Financial Monitoring Model progressing with phase 1 focusing on Out of Hospital monitoring and phase 2 on monitoring the initiatives in the Y2-10 Business Case – 1st draft to be included in October OBC governance cycle. Contract Map and Maximum Affordable Budget timelines being confirmed.
5	**Contract Variation (Alliance Agreement & Service Contracts)**		Workstream Amber owing to Commercial Leads signing off Service Contract variation for the Out of Hospital Business Case and decision on scope of Alliance Agreement.
6	**Workforce, OD, Comms & Engagement**		Workstream Amber as need to have Board Agreement for Strategic workforce reform group to secure engagement & leadership from all partners HR Leads. This is a key enabler to other workstreams.
7	**Out of Hospital Delivery – ICNs**		The overall ICN programme is Green. Delivery of the accelerated Multi-Agency Working (MAW) & Huddle Delivery Plan is within the agreed timelines. 22 (41%) Huddles have now been implemented, with another 7 scheduled before the end of the year. Carrying out activities to reaffirm Organisational Development (OD) and operational best practice with the Core ICN Teams and the ICN PMO, via GP Network, Practice and workforce meetings. POA/Active and Supportive Communities and complex care support work is progressing well but slightly behind schedule.
8	**Out of Hospital Delivery – LIFE**		Workstream Green 60% completed. Discharge to assess started on 13 wards on 25/09/17. 81 referrals have successfully been supported within 2 hours of discharge. Roll out plan in place. Moving onto the AMU,RAMU & ACE

3.4 Transformation and Case for Extension

3.4.1 The Croydon Transformation Board and Alliance Board agreed in September that the Alliance years 2-10 Transformation Plan was sufficient to proceed with it into the Case for Extension document Development. The timeline for development is as follows;

- **<u>THURSDAY 14TH DECEMBER</u>: Alliance Board agrees Y2-10 Business Case & recommends sign-off to Governing Bodies/**
- **<u>FRIDAY 26 JANUARY</u>: Y2-10 Business Case Signed-off by Governing Bodies/Cabinet**

3.4.2 The Business Case Executive Summary has been drafted to establish content and the full document will be structured in five parts; Strategic Case, Economic Case, Commercial Case, Financial Case and Management Case.

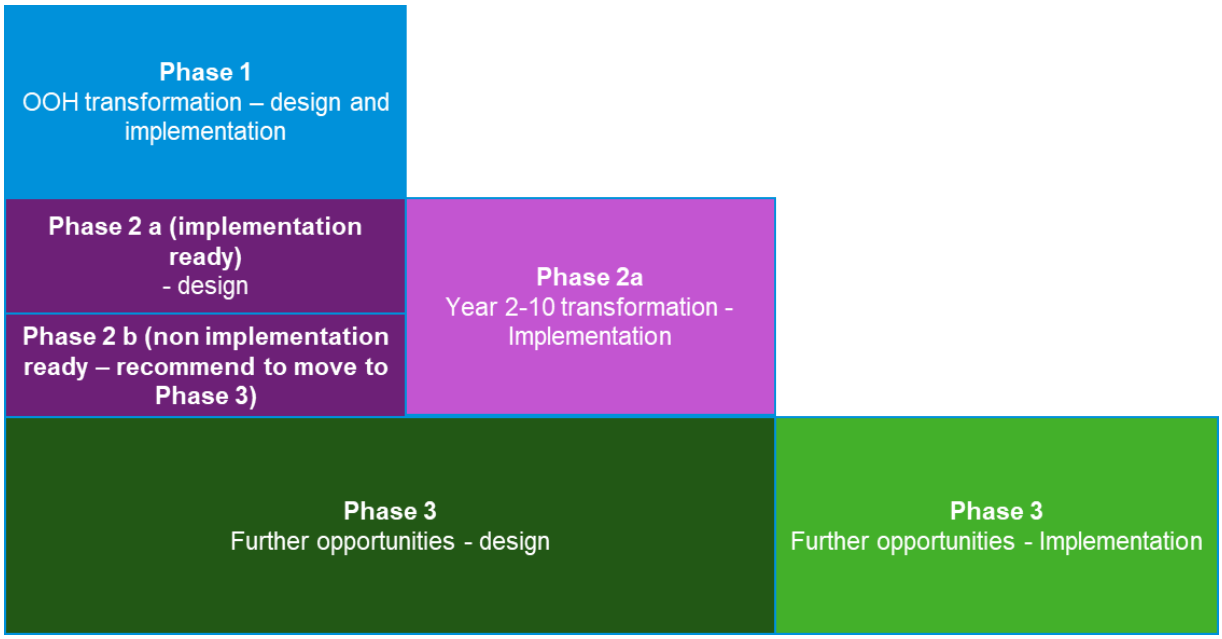
3.4.3 There are a number of challenges in the development of the Extension Case, mainly dependent on the development of transformation initiatives and the robustness of understanding of their impact on the health and care system and outcomes benefits.

3.5 Financial Assumptions

3.5.1 Alliance partners have agreed the baseline for 16/17 with growth that provides the Do Nothing position and this will become the new alliance baseline for 17/18. The system over 10 years is financially unstainable.

3.5.2 The financial assumptions for the current Out of Hospital Business Case (Year 1 Transformation) provides a contribution towards the deficit of an annual net saving impact to the whole system of £6.5m.

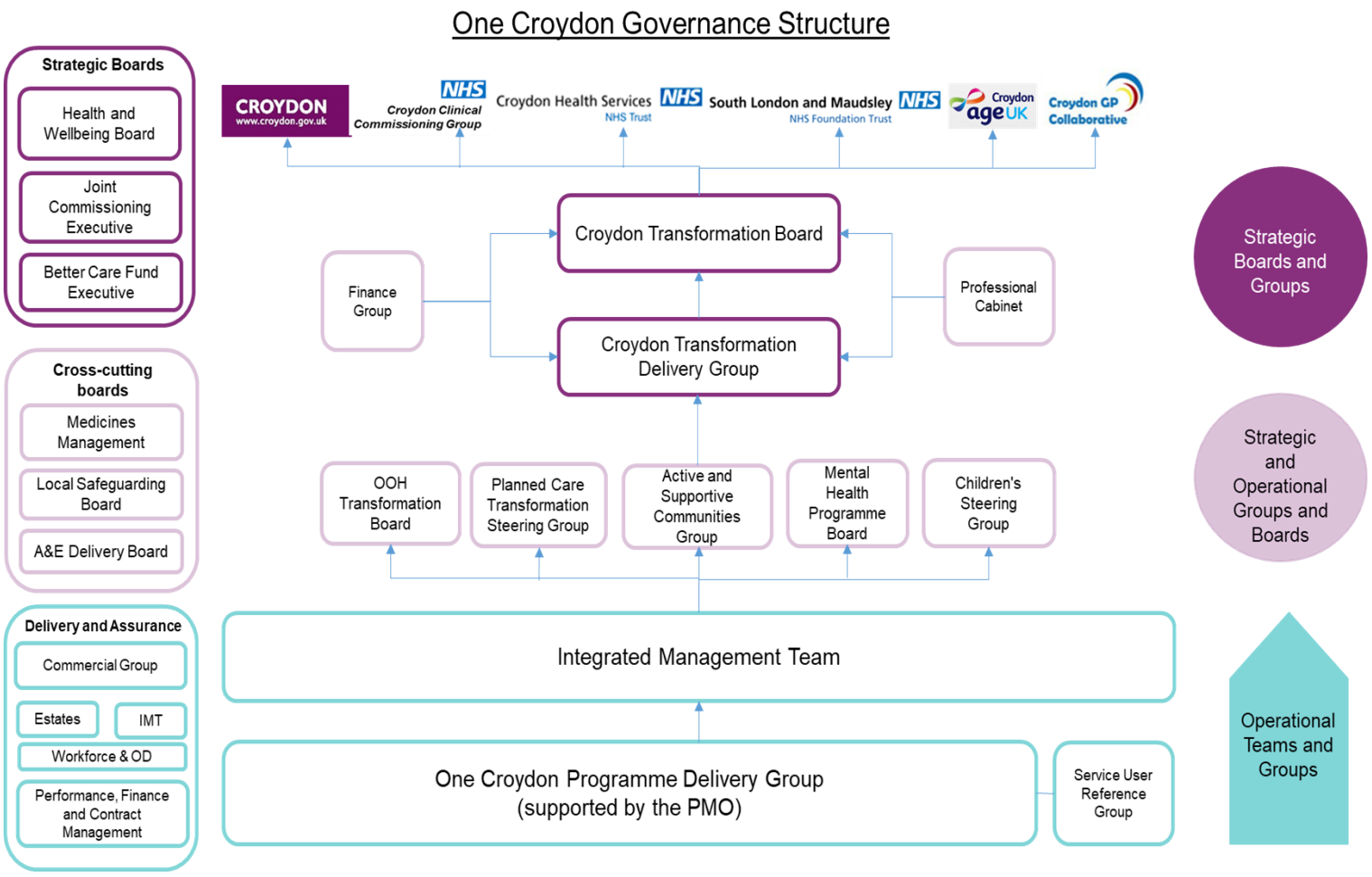
3.5.3 The Alliance planning sets out phases by which transformation will improve financial sustainability. The financial savings assumptions will be set out in the Alliance "Case for Extension" being presented to the Alliance Board and partner organisation governing bodies in December and January. The phases are shown below and provide a way for the system to manage transformation in manageable areas. The phases can run concurrently. Some schemes are more implementation ready than others at this stage.



3.5.4 A number of further opportunities are being developed for phase 3 transformation to bring maximum outcomes improvement for Croydon residents and maximum system financial sustainability. The case for extension will set these out as well articulating the boroughs total ambition.

4. Governance

4.1 The Croydon Strategic Review commissioned for the health economy in summer 2017 recommended that Governance for the alliance be consolidated with the Whole System Governance as soon as possible to reduce time spent in meetings. This has been recommended and is being taken through governance to implement as follows:

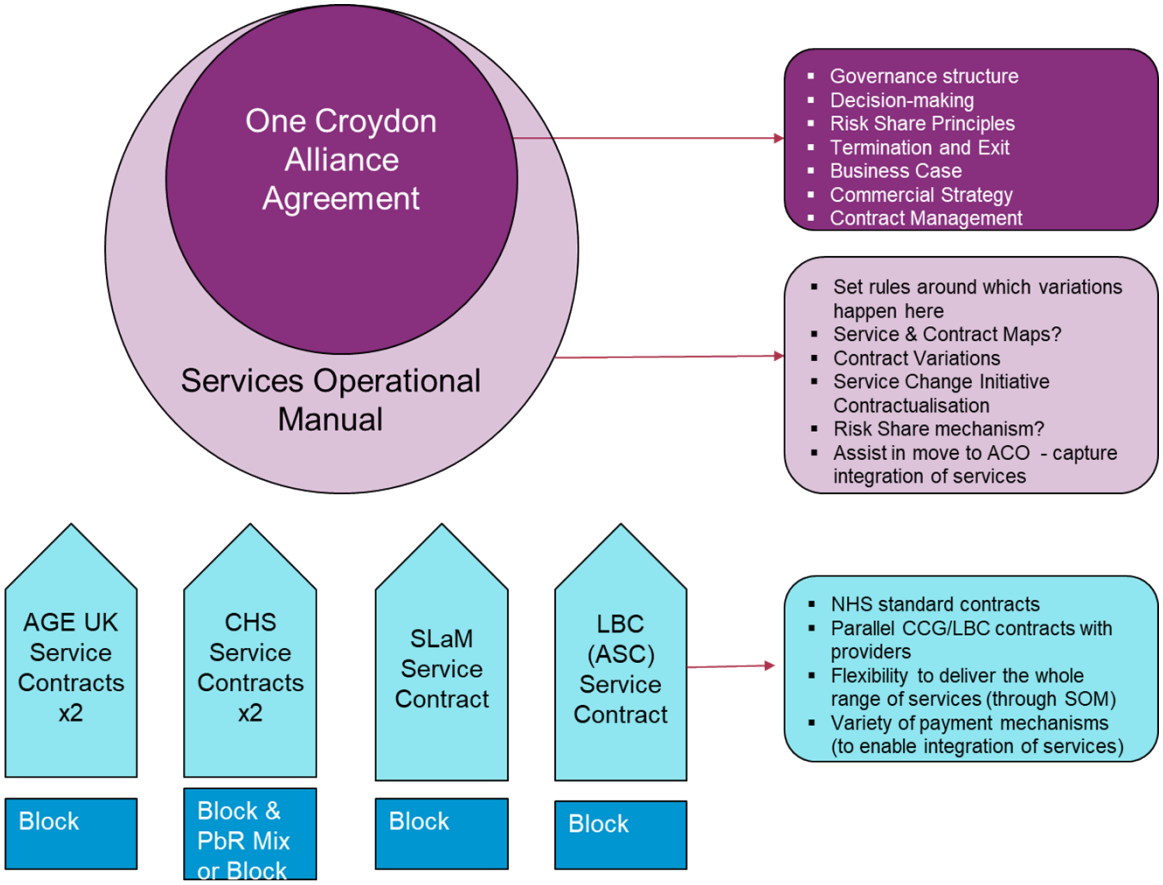


5 Commercial Structure

5.1 A draft Commercial Structure has been developed (see below) to enable delivery of the year 2-10 case for extension. The further development of this structure is being led by the Commercial Group supported by the One Croydon legal advisors (Gowling WLG).

5.2 Increase in programme scopes and investment will be governed by the decision-making process (to be developed) and will be planned and phased to allow the commercial structure to be amended i.e. service contracts to be added or Alliance membership to be widened.

5.3 The structure of the payment mechanism for the service contracts that sit below the Alliance Agreement are being reviewed to ensure that the most effective payment structure is achieved to allow maximum flexibility in the movement of resources and funds within the whole system, shown in the diagram below.



6 Engagement

6.1 There is an active Service User reference group that meets on a monthly basis to ensure the views of people in Croydon in how we are meeting their needs are captured. The group are also actively involved in feeding into the design of transformation services, as well as the delivery and monitoring of services in scope.

6.2 A communications and engagement workstream has commenced and the PMO have recruited a dedicated communications and engagement officer that will be key in ensuring service user involvement and staff engagement continues to develop, and that the workforce and organisational development workstream deliverables are achieved.

7 Next Steps

- The Case for Extension document will be presented at the Alliance Board on 14th December

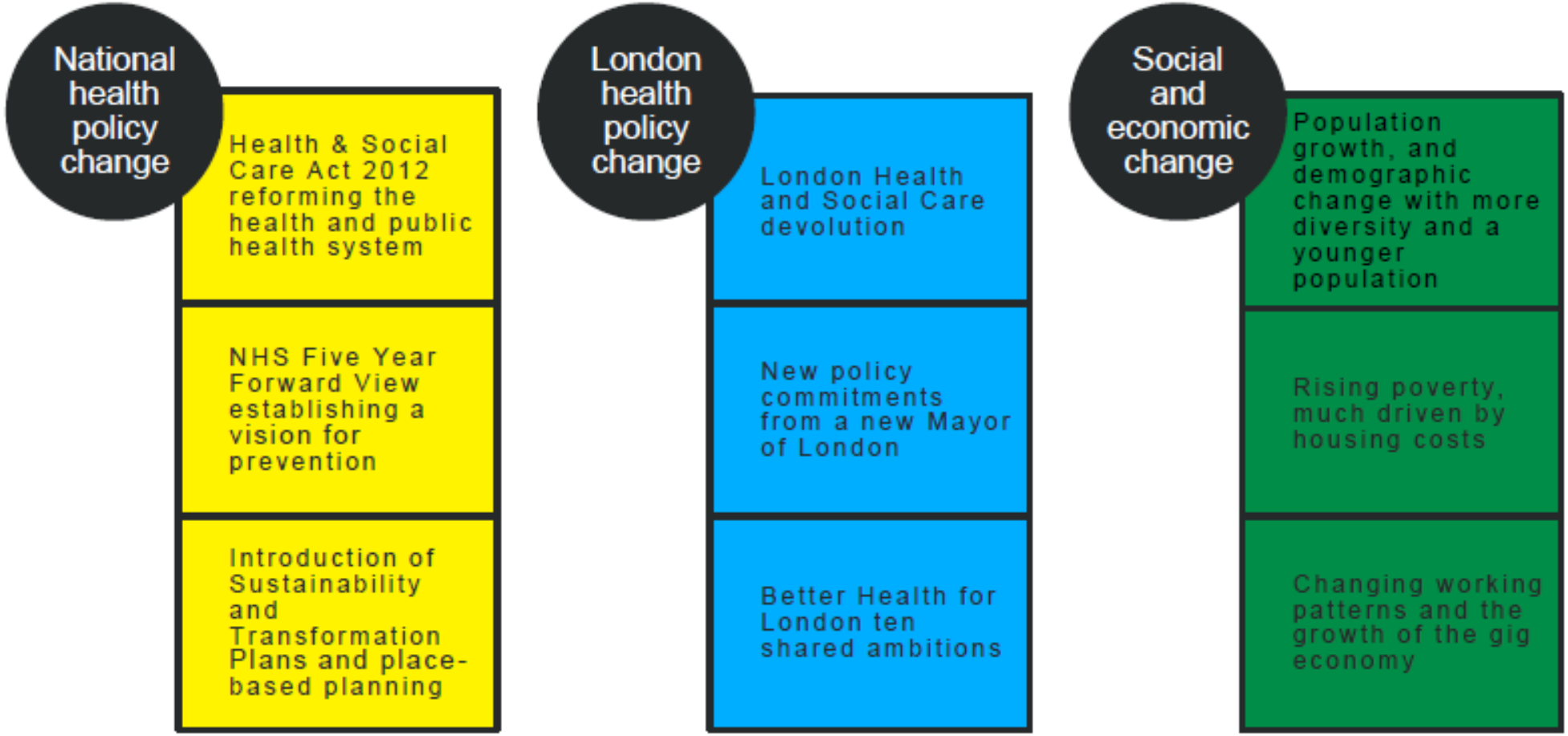
- The Board will make a recommendation to its respective governing bodies. The Council will hear the recommendation at Cabinet on 22nd January and the CCG at is governing body on 9th January.

CONTACT OFFICER:	Rachel Soni, Alliance Programme Director, One Croydon; Rachel.Soni@croydon.gov.uk
APPENDICES:	None

Mayor's Health Inequalities Strategy: How Croydon can help?

Presented by Rachel Flowers
Director of Public Health
December 2017

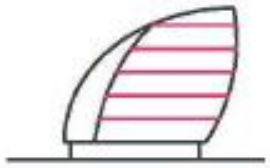
Why do we need a new health inequalities strategy?



What is the Mayor's role in health inequalities?

ENSURING ALL THE MAYOR'S WORK CONTRIBUTES

- Environment
- Planning
- Housing
- Transport
- Economic development
- Culture
- Policing



CHAMPIONING WORK FROM ACROSS LONDON

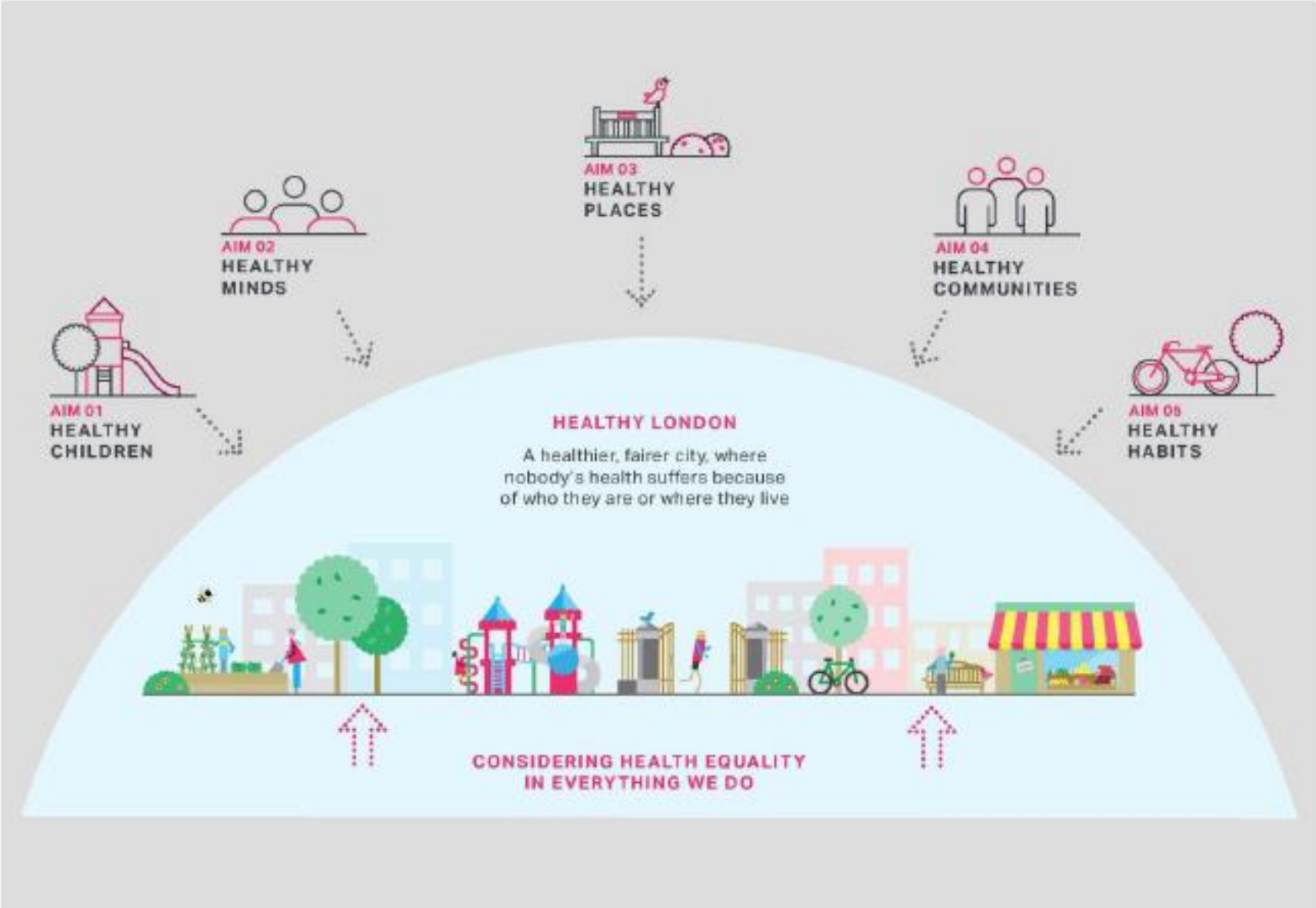
- Speaking out about health inequalities
- Challenging and championing the health sector to reduce inequalities
- Generating consensus from others as chair of the London Health Board

DIRECTING SUPPORT FROM CITY HALL

- Delivering City Hall's health programmes
- Consulting and engaging Londoners
- Reporting on actions and outcomes

NOT: setting health policy or commissioning health or public health services

London Health Inequalities Strategy DRAFT aims



Croydon's response to Health Inequalities Strategy: Summary

We are encouraging the mayor to:

- exert his influence in lobbying for national policy changes where there are implications for health inequalities

- routinely consider the needs of groups that are at higher risk of health inequalities, such as Unaccompanied Asylum Seeking Children, travellers, and carers; including emphasis on young and ageing carers

- include specific targets for each of the objectives to support evaluation, show progress, and define what success would look like

- use the new health devolution deal for London to be used as a vehicle to support local communities such as Croydon to reduce health inequalities

Croydon's offer on all the areas is to share its learning from the local initiatives and good practice. The key points on each of the five key areas and Croydon's offer are detailed on the next few slides.

AIM 1, healthy children: every London child has a healthy start in life

Draft objectives:

- London's babies have the best start to their life.
- Early years settings and schools support children and young people's health and wellbeing.

Key Mayoral ambition

- Launching a new health programme to support London's early years settings, ensuring London's children have healthy places in which to learn, play and develop.

1. Healthy Children

Croydon's key points:

- Very supportive of the Healthy Early Years Programme but need recognition of the resource implications
- We would welcome greater reference to peri-natal, post-natal, parental and child mental health
- Mayor to exert influence to assure continued support for Healthy Schools at local level
- Mayor to encourage the business community to provide work experience opportunities for young people.

Croydon's offer:

- The joint Croydon Healthy Weight Alliance
- A comprehensive evidence based Child Healthy Weight Action plan, which incorporates its approach to food poverty
- Its experience of piloting the Healthy Early Years Programme

AIM 2, healthy minds: all Londoners share in a city with the best mental health in the world

Draft objectives:

- Mental health becomes everybody's business across London.
- The stigma associated with mental ill-health is reduced, and awareness and understanding about mental health increases.
- London's workplaces are mentally healthy.
- Londoners can talk about suicide and find out where they can get help.

Key Mayoral ambition

- To inspire more Londoners to have mental health first aid training, and more London employers to support it.

2. Healthy Minds

Croydon's key points:

- There needs to be parity between mental and physical health
- Mental Health to be embedded throughout the strategy
- The strategy should include specific objectives for people with co-occurring mental, substance misuse and alcohol.
- Mayor to encourage businesses to support individuals with serious and common mental ill health conditions into employment i.e. help with "getting & sustaining jobs".

Croydon's offer:

- Engagement in Thrive LDN
- Long term engagement with MFHA
- Croydon's Good Employer's Charter
- The Councils engagement with the Healthy Work Place Charter, and
- The development and implementation of the multiagency Self-Harm and Suicide Prevention plan for Croydon.

AIM 3, healthy place: all Londoners benefit from a society, environment and economy that promotes good mental and physical health

Draft objectives

- Improve London's air quality
- Promote good planning and healthier streets
- Improve access to green space and make London greener
- Address poverty & income inequality
- More Londoners supported into healthy, well paid and secure jobs
- Housing quality & affordability improves
- Homelessness and rough sleeping is addressed

Key Mayoral ambition

- To work towards London having the best air quality of any major global city

3. Healthy Places

Croydon's key points:

- Encourage a system wide approach to healthy planning and greening the environment.
- Expand on how the strategy aims to balance the increase affordable, safe housing with maintaining an developing a healthy environment
- More actions on safety and social cohesion
- The Mayor should lobby for further and more extensive devolution of employment support to London sub-regions and boroughs.

Croydon's offer:

- Regenerating communities through the tram; linking more deprived communities with centres of employment
- Award winning play streets and Edible Play Grounds
- Job brokerage service, Croydon Works and The Gateway service
- Croydon Good Employer Charter

AIM 4, healthy communities: London's diverse communities are healthy and thriving

Draft objectives:

- It is easy for all Londoners to participate in community life
- All Londoners have skills, knowledge and confidence to improve health
- Health is improved through a community and place-based approach
- Social prescribing becomes a routine part of community support across London
- Individuals and communities supported to prevent HIV and reduce the stigma surrounding it
- TB cases among London's most vulnerable people are reduced
- London's communities feel safe and are united against hatred.

Key Mayoral ambition

- To support the most disadvantaged Londoners to benefit from social prescribing to improve their health and wellbeing

4. Healthy Communities

Croydon's key points:

- Mayor to explore opportunities to fund TFL space for local campaigns that support healthy communities.
- Mayor to work with BASH (the British Association for Sexual Health and HIV) and the London-wide GP Network to reduce HIV stigma in the Capital
- Mayor to take leadership on celebrating diversity and promote initiatives such as the Rise Festival

Croydon's offer:

- Its long term engagement with the Asset Based Community Development (ABCD) initiative
- The Social Isolation Plan

AIM 5, healthy habits: the healthy choice is the easy choice for all Londoners

Draft objectives:

- Childhood obesity falls and the gap between the boroughs with the highest and lowest rates of child obesity reduces
- Smoking, alcohol and substance misuse are reduced among all Londoners, especially young people

Key Mayoral ambition

- To work with partners towards a reduction in childhood obesity rates.

5. Healthy Habits: Obesity

Croydon's key points:

- Clear commitment to providing support to enabling access to healthy food and healthy environments that promote healthy options.
- Support for empowering families to improve their confidence and skills in cooking; shopping and food budgeting
- Promoting an environment where parents and children learn together.
- Make clear links between health habits and mental health.

Croydon's offer:

- Croydon's Food Flagship, one of two Borough across London who were awarded this status.
- This extensive programme has many strands that can inform practice and help tackle childhood obesity.

5. Healthy Habits: Tobacco

Croydon's key points:

- Strategy could go even further in addressing tobacco control because it is the largest cause of inequalities. We therefore ask the Mayor to expand this section and particularly focus on vulnerable groups such as children and young people, and pregnant women.
- Mayor to work with STPs to develop a consistent response to treating tobacco dependence that eliminates the postcode lottery in access to evidence based support for smokers in London.
- Specific focus on tackling inequalities due to alcohol and drug misuse including novel psychoactive substances and 'legal highs'

Croydon's offer:

- It's innovative integrated lifestyle service to address unhealthy behaviours: Live Well Croydon
- Work to tackle illicit tobacco locally

We are Croydon:
A changing population

2017 Annual Report
of the director of public health

Just BE CROYDON
www.justbecroydon.org

Delivering for Croydon | CROYDON
www.croydon.gov.uk

CONTENTS:

I'm pleased to be introducing the 2017 Annual Public Health Report. This is the second report from Rachel Flowers, our Director for Public Health. This report tells us about the health and wellbeing of Croydon residents. It's about real people, real lives and real issues that as a community we need to understand and improve.

We are delivering major positive change for Croydon – new homes, new jobs and new opportunities. Health is an important part of realising these opportunities.

Croydon residents make Croydon the exciting, young and ever-changing borough it is today. We are one of the biggest boroughs in London by population and have growing and welcoming communities. And with over 100 languages spoken, Croydon's diversity is something we celebrate.

The more we understand about the health of our borough, the more we can help bring about positive and sustainable change. It's challenging that Croydon, like many parts of London, has some stark health inequalities. You can see male life expectancy decrease by 10 years between the areas of Selsdon and Ballards to Selhurst – communities just a 30 minute bus journey apart. It's clear we need to take action.

I hope this report provides an opportunity for us to think, challenge and improve health outcomes in Croydon now and into the future.

I've been working in Croydon since February 2016 and what's clear is that most people outside the borough just don't understand it.

Did you know that if Croydon were a city it would be the 8th largest in the UK, ahead of Wakefield and Coventry? We are, in all but name, a City on the edge of a Global City, with a large and growing population of increasingly complex needs.

So my second Director of Public Health report will be setting out the Demographic Changes and Challenges for Croydon.

In particular, this report will highlight the high level population changes and challenges in:

1. Croydon overall
2. key geographical localities of Croydon, and
3. key sub-groups

Public Health is the art and science of preventing disease, prolonging life, and promoting health through the organised efforts of society. An essential part for me is that it includes working to reduce inequalities in health and society as a whole.

Fundamental to achieving this is the knowledge and understanding of populations. Demographics is the study of populations and involves collecting data on population characteristics such as age, sex, ethnicity, income, employment, state of health etc.

The intelligence that is generated is critical to how services are planned and resources are allocated. These may be health care or local authority services, street cleaning, housing, or welfare services, public safety, regeneration, or services of other agencies including the Police, Fire and Rescue.

Whilst understanding changes and future challenges is essential to good planning, sometimes events take place that cannot be predicted and where we need to respond rapidly and compassionately.

On 9th November 2016, a tram incident happened in Sandilands which killed many, injured many more and impacted on the local community, all of Croydon and beyond. We are still feeling the impact. My thoughts are with those families who lost loved ones, and the many who were injured, physically or emotionally.
I just want to acknowledge the work and dedication of every person involved in any part of this tragedy. Thank you.

SUMMARY:

This report presents the population changes and challenges in Croydon over the next 10-15 year period.

It highlights changes to the population in:

1. Croydon overall
2. key geographical localities of Croydon, and
3. key population sub-groups

The report raises the issue of differences in the various population data sources and stresses the importance of understanding these differences, particularly in choosing appropriately for service planning and resource allocation. It also highlights the issue of needs based formulae to conduct such planning and the inherent dependence on selecting the most appropriate need indicators, without which there is little scope to eliminate often avoidable health and socio-economic inequalities.

It also recognises and discusses that certain individuals and groups are more vulnerable than others and are therefore likely to be particularly at risk. It highlights, for three age ranges along the life course, key issues that require particular attention in order to achieve fairness in outcomes.

Overall, in 2016 there were 382,300 people in Croydon, the second largest population in London. By 2031, there will be 434,448 people in Croydon, an increase of 12% in the next 15 years.

Absolute increase alone, however, would not tell us how the local population is changing. Creating population profiles for specific age bands, community groups or small geographies helps to inform the targeting of services to specific characteristics of local communities.

Age: Geographically in Croydon, we appear to have a population age gradient across the borough from north to south. Croydon currently has the largest younger ages population (0-17), 3rd largest working age population (18-64) and 3rd largest older ages population (65 and over) in London.

Ethnicity: Currently, 50.7% of Croydon's population (all ages) are Black, Asian and Minority Ethnic (BAME) groups. By 2025 this is predicted to be 55.6%. Younger age groups are more diverse.

Population Mobility: Croydon's net migration figures are in the low hundreds. However, population turnover per year reaches figures over 20,000. One third of all London's unaccompanied asylum seeking children (UASC) are in Croydon, making us the borough with the highest numbers of UASC.

Deprivation: Overall, Croydon has become more deprived. 10,261 people in Croydon live in areas considered to be within the 10% most deprived in the whole country. Two small areas (Lower Super Output Areas) have become significantly more derpived since 2010. These areas are within the wards of West Thornton and Fieldway.

Key Geographical Localities: If we expect most planned developments in the Town Centre to be completed by 2031, around the same time, population in the Fairfield ward will have increased by 71.6% its current size, the 12th highest ward population increase across all of London's wards.

Stages across the life course:

A. Younger Ages: We have the highest number of 0-17 year olds in London. Ages 10-14 and 15-19 are showing the largest increases (2016 to 2025).

Events during pregnancy and early childhood lay the foundations for our physical, emotional and socio-economical resilience in adulthood and later years. It is a crucial time for services to engage parents and young children. National social return on investment studies showed returns of between £1.37 and £9.20 for every £1 invested.

For some children, however, life is more complex and inequalities can begin at a very early stage, holding back development and access to opportunities. In the worst cases, health outcomes are amongst the worst in the 'developed countries'.

B. Working Ages: We have the 3rd highest number of 18-64 year olds in London. Ages 55-59 and 60-64 are showing the greatest increases (2016 to 2025).

The health and wellbeing of our working age population often has impacts far beyond the individuals themselves. Families, children, workplaces, business and communities are all impacted.

Plans for a flourishing working age population cannot look in isolation at the population 'in work and well', and must include support for those with health or social problems to stay in work as well as supporting those who are unemployed to find work.

C. Older Ages: We have the 3rd highest number of people aged 65 and over in London. Ages 75-79 and 85+ are showing the greatest increases (2016 to 2025).

Older adults and carers of older adults are not just consumers of health and social care services but also important contributors to society and local communities and have a wealth of experience to offer.

It is important that we facilitate this section of Croydon's population to continue to make a contribution to society, be supported in their health and wellbeing, and to live lives to their full potential.

Concluding remarks:

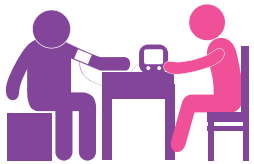
The information presented in this report is intended to bring about discussions regarding the way local services are planned and commissioned, taking local populations (current and future) into account. It is a tool we hope will find use amongst policy makers, services, and residents alike.

The three main sources of population data in the UK are:

Office for National Statistics

GREATER**LONDON**AUTHORITY
(GLA) for London boroughs only

General Practice Patient Registers



show people who are 'registered' with a GP in an area
(the registered population)

Whilst there is no set recommendation about which source of data is preferred, it is important to understand the differences between the datasets produced by these sources and the factors behind such differences. Some of these can be very large.

These differences are **important when choosing appropriate data for service planning and resource allocation.**

A general challenge with any dataset is its timely availability; how up-to-date the data are and how quickly it can become out-dated. A second challenge is selecting datasets which provide the most appropriate data for your project, service or analysis.

For example:

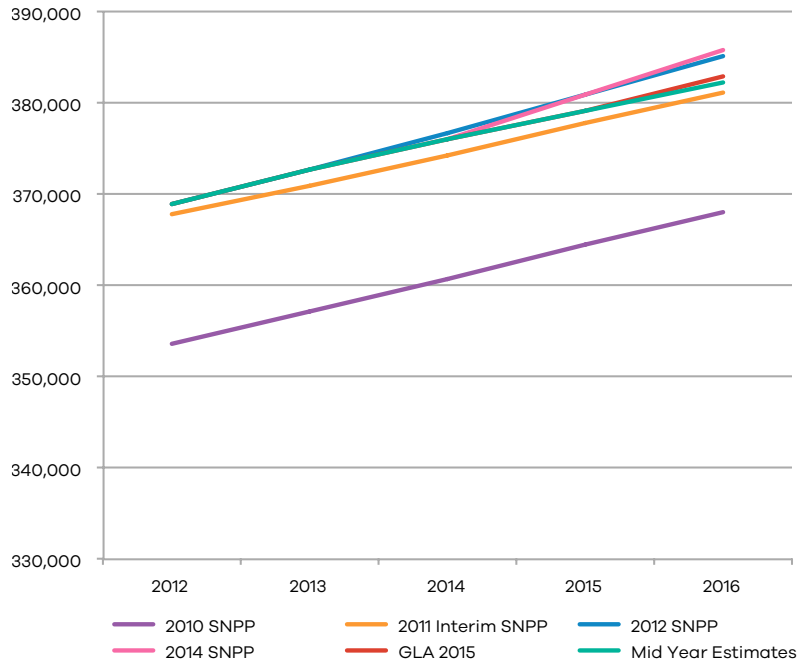
CURRENT CROYDON POPULATION ESTIMATES. THESE ARE ALL PUBLISHED STATISTICS ORDERED BY SIZE, BUT WHICH WOULD YOU USE?

382,304	2016 Mid year estimates, ONS
383,488	2015 Round SHLAA based projections, GLA
383,378	2011 Census, ONS
386,670	2014 Sub national population projections, ONS
401,627	2016 GP Population Register, GLA

Not only does this apply to current service planning, it also holds significance when planning for the future.

For example, the chart below shows various sources of population data and demonstrates how according to each the population is estimated to grow. Note that the ONS Sub-National Population Projections (SNPP) data released in 2010 under-represents the population as estimated by the other datasets. It is possible therefore, that services planned based on the 2010 SNPP estimates may have under-estimated size and/or need.

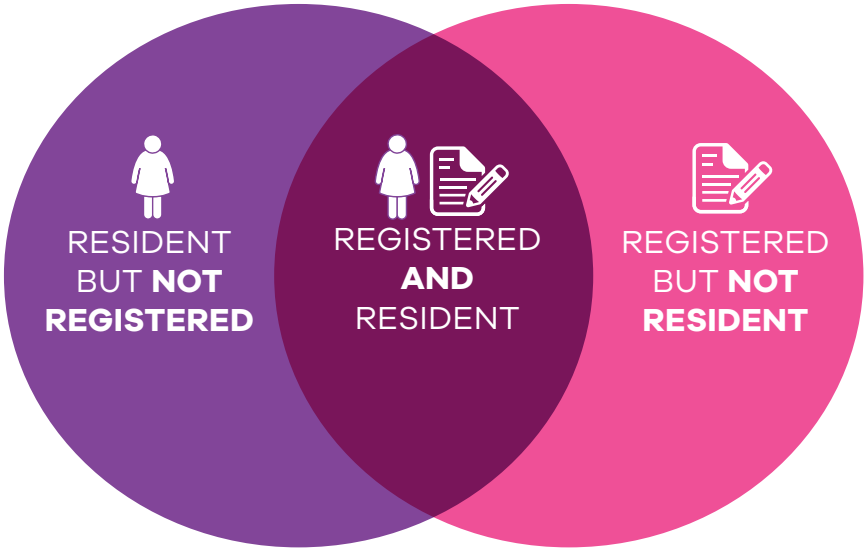
CROYDON POPULATION PROJECTION/ESTIMATE COMPARISON



Source: 2016 Mid year estimates, ONS. 2014 Sub national population projections, ONS. 2015 Round SHLAA based projections, GLA

In the case of population size taken from GP patient registers for an area, often these are overestimates of the population in that area. This is because they

- don't include those who are not registered with a local GP (the unregistered population), even if they are resident in that area.
- can however, include individuals who may have moved out of the area, but were not removed from the patient list.



The size of the shapes do not represent proportions or size of population in each category.

Despite variations and differences, each data source has its significance and provides valuable insight for resource planning and allocation.

In **2016** there were

382,300 people in Croydon

This is the 2nd highest in London

Source: 2016, Mid Year Population Estimates, ONS

By **2031** there will be

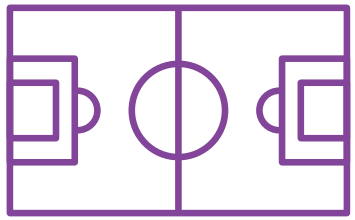
434,448 people in Croydon

a 12% increase in the next 15 years

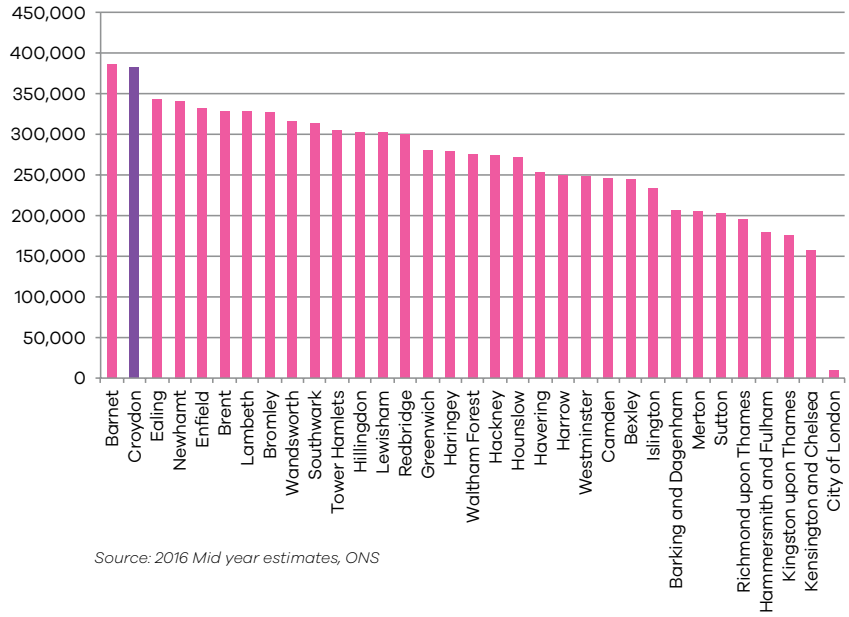
Source: 2015 Round SHLAA based projections, GLA

This is an increase of roughly twice the capacity of Crystal Palace Football Club at Selhurst Park. And yes, our population is slightly smaller than that of Barnet in this year's report. In another year, it might be larger.

2x
the capacity of Crystal Palace FC at Selhurst Park



TOTAL POPULATION FOR LONDON BOROUGHS, 2016



Source: 2016 Mid year estimates, ONS

Changes in population size are subject to a number of influences over time. Some take a few years, some take decades.

SOME OF THESE GLOBAL INFLUENCING FACTORS ARE PRESENTED BELOW WITH EXAMPLES OF THE SITUATION IN CROYDON

NATURAL FERTILITY AND BIRTH RATES[1]

In **2016**
there were **5,884**
live births in Croydon

General Fertility Rate (GFR)
73.7 live births
per **1,000** women
aged 15-44

4th highest GFR
in London and has increased from
71.0 in 2011

SOCIAL ATTITUDES TO FERTILITY AND REPRODUCTION[2]

In **2015**
58.1% of births
in Croydon were
to mothers who are
over 30

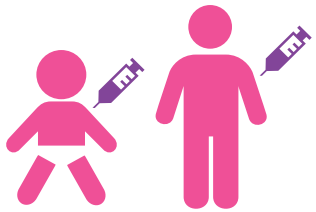
7th lowest rate
in London. This has
increased from just
50.6% in 2009

OUTBREAKS OF DISEASE[3]

Between **2013 and 2015**
113 deaths from infectious diseases
13.6 per 100,000 people
10th highest rate in London
This has increased from a rate of 10.2 in 2009-11

HEALTHCARE AVAILABILITY AND DEVELOPMENTS LIKE VACCINATIONS[4]

In **2015/16**
75.3% of eligible children received
two doses of MMR vaccine
on or after their 1st birthday and
at any time up to their 5th birthday



5th lowest rate in London
This is similar to the 75.1% rate in 2010/11

RATES OF MIGRATION[5]

Net migration (people
entering and leaving) for
Croydon in the last few years
was in the low hundreds

AND MANY OTHERS LIKE

SUSTAINABILITY IN TERMS OF FOOD AND NUTRITION

WAR

PUBLIC HYGIENE AND SANITATION

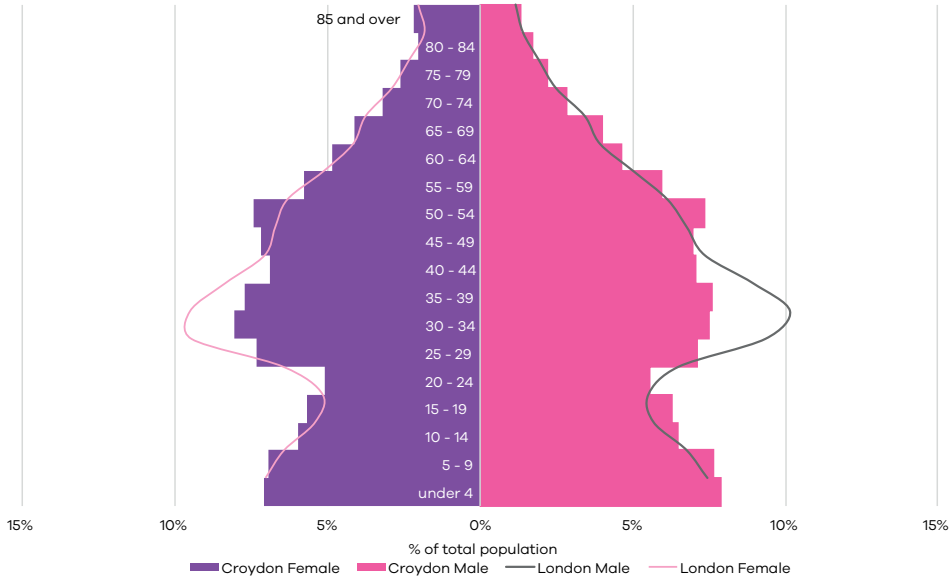
ECONOMIC POLICY

Age:

Looking only at the absolute increase in population size would not tell us the patterns of change locally. For this we create 'Population Profiles'. These may describe changes by age groups, community groups or geographically and can help services to be targeted to the specific characteristics of local population groups.

Let's look first at the **age** profile for Croydon

CROYDON POPULATION PYRAMID



Source: 2016, Mid Year Population Estimates, ONS

This population pyramid shows the percentage of Croydon's population in each 5-year age group. The line on the chart represents London's population.

For example;

Eight per cent of Croydon's males are aged under 4 years. This is 7% for Croydon's females aged under 4 years.

The middle of the pyramid represents the working age population. A notable difference is the gap between Croydon and London in the 25-44 age group. This shows Croydon has a smaller percetange of its population that is of working age when compared to London overall.

The age structure of the population as shown in the population pyramid above has an overwhelming influence on health and social care service needs. Some resource allocation calculations therefore account for this using a technique called 'age-weighting'.

The ages which entail the highest level of health and social care involvement are:

NEONATAL AND INFANCY

where advances in

hygiene and immunisation

have greatly reduced deaths in children

FERTILE YEARS FOR WOMEN, INCLUDING PREGNANCY[6]

Croydon's fertility rate is

4th highest in London

has increased by 3.8%

between 2011 and 2015

In **2016** Croydon had the

highest number of 0-17 year olds in London

and is projected to remain the highest when projected to the year 2025.

OLD AGE

when multiple pathologies are common and the likelihood of an

additional illness or condition arising

increases with age and healing tends to be slower.

As of 2015/16

4,277 clients aged 65 and over

received long-term support in Croydon

Similarly, comparing absolute numbers across London,

Croydon has the 3rd highest number of people aged 65 and over

and this is expected to remain 3rd highest when projected to 2025

Compared to London, a greater proportion of our population is aged 65 and over[7]. But compared to England this is smaller.

Locally, demand for maternity, including ante-natal, neo-natal and children's services, as well as health and social care, nursing and residential services for older adults will be influenced by population need and numbers in these broad life stages.

Geographically in Croydon, we appear to have a population age gradient across the borough from north to south. Therefore in addition to size of services, location is also important and affects our ability to deliver services in a targeted and timely manner.

0-17 YEARS OLD

2016: 94,434 (24.7%)

Highest number in London

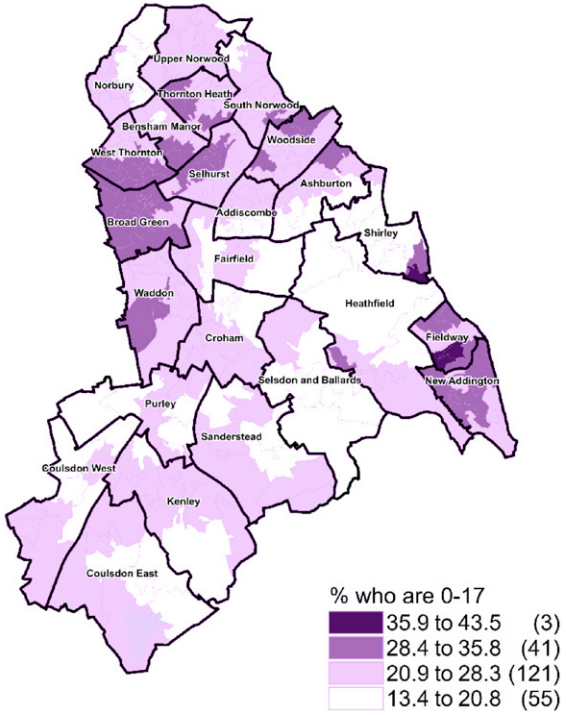
Source: 2016 Mid year estimates, ONS

2025: 102,074 (24.5%)

Highest number in London

Source: 2015 Round SHLAA based projections, GLA

% OF POPULATION WHO ARE 0-17, CROYDON 2015



18-64 YEARS OLD

2016: 237,663 (62.2%)

3rd highest number in London

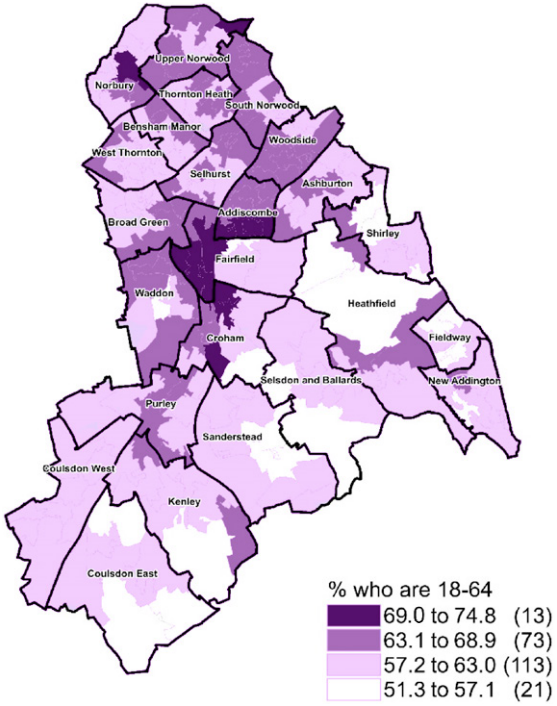
Source: 2016 Mid year estimates, ONS

2025: 252,046 (60.6%)

4th highest number in London

Source: 2015 Round SHLAA based projections, GLA

% OF POPULATION WHO ARE 18-64, CROYDON 2015



AGED 65+

2016: 50,206 (13.1%)

3rd highest number in London

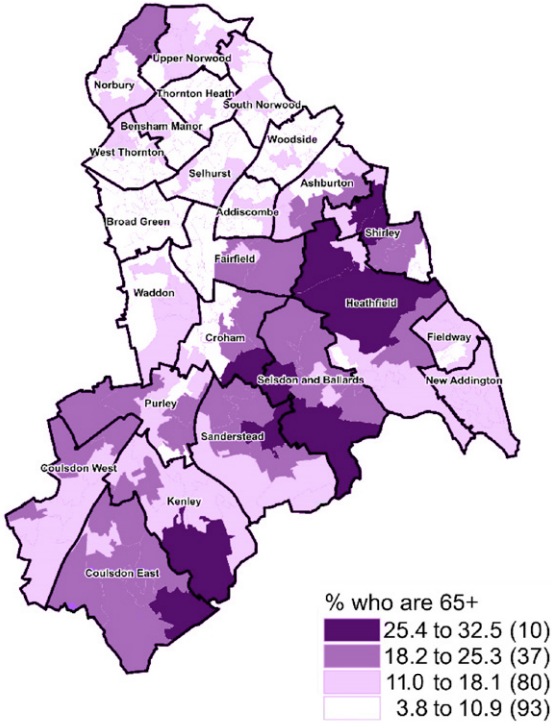
Source: 2016 Mid year estimates, ONS

2025: 61,859 (14.9%)

3rd highest number in London

Source: 2015 Round SHLAA based projections, GLA

% OF POPULATION WHO ARE 65+, CROYDON 2015



All maps source: 2016 Mid year estimates, ONS

Ethnicity:

A further aspect of population structure and change is **ethnicity**.

CROYDON HAS A DIVERSE POPULATION

In 2017

49.3% of Croydon are White*

(includes 'White British', 'Other White' and 'White Irish')

50.7% Black, Asian and Minority Ethnic (BAME)

BY 2025 THIS WILL BE

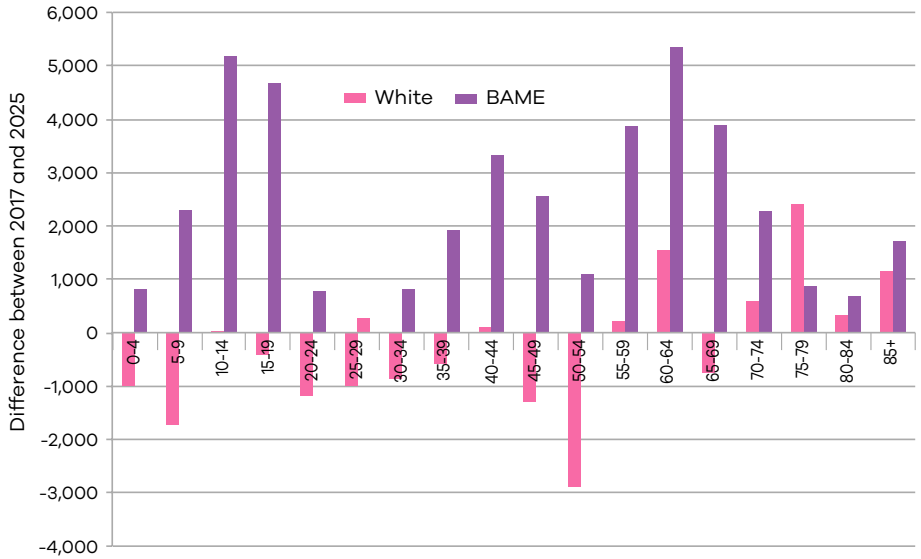
44.4% White **55.6%** BAME*

Source: 2015 Round SHLAA based projections, GLA

*For a break down of ethnic groups included within BAME please see page xx

The younger population is more diverse than the older population in Croydon. The figure below demonstrates how the ethnic profile for Croydon will change over the next 10 years across all age groups.

PROJECTED CHANGE IN ETHNICITY BY AGE IN CROYDON, 2017-2025



Source: 015 Round Ethnic Group short term projections, GLA

Croydon's communities speak more than 100 different languages, other than English, and this does not include sign languages! As with other London boroughs, Croydon has a higher proportion of residents from black and minority ethnic backgrounds than the national average.

Often, language barriers get in the way of residents accessing the most appropriate services at the right time. This can result in patients not attending their appointments, residents not responding to notifications or letters, or having to make multiple attempts before arriving at the right service.

Information needs to be made available in formats accessible to the full spectrum of Croydon's population, including very importantly, Braille and British Sign Language.

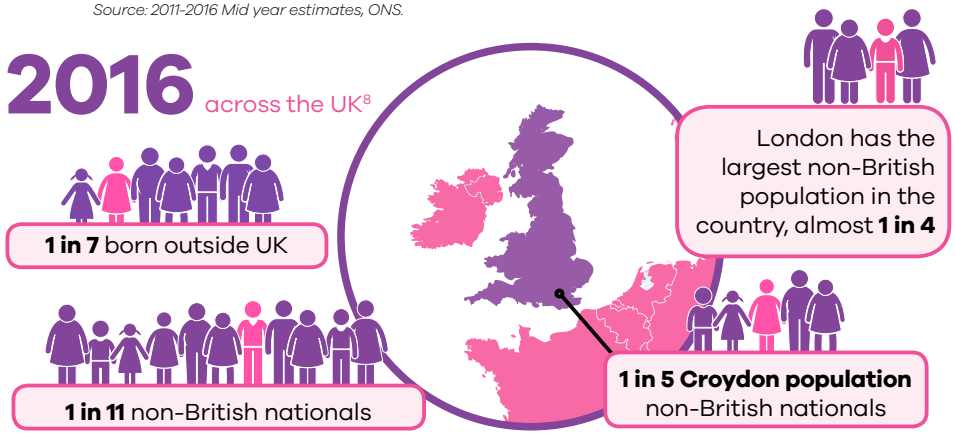
Source: Census 2011, ONS

The effects of population movement:

Population estimates and projections take into account migration data. This includes people moving into Croydon from other parts of the United Kingdom (UK) as well as from outside the UK.

MIGRATION INFLOWS AND OUTFLOWS IN CROYDON, 2011-2016

Source: 2011-2016 Mid year estimates, ONS.

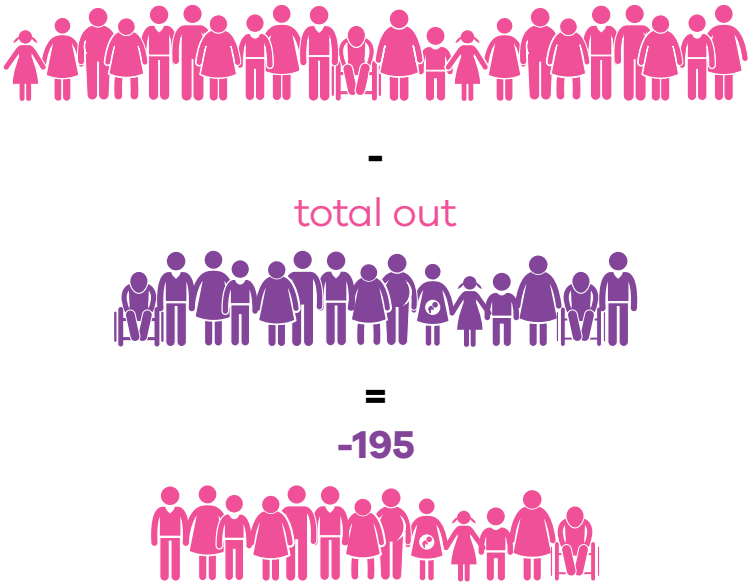


Source: 2011 Census, ONS

Ethnicity is different from country of birth or nationality.

CROYDON NET MIGRATION[9]

During 2015 - 2016



Source: 2016 Mid year estimates, ONS

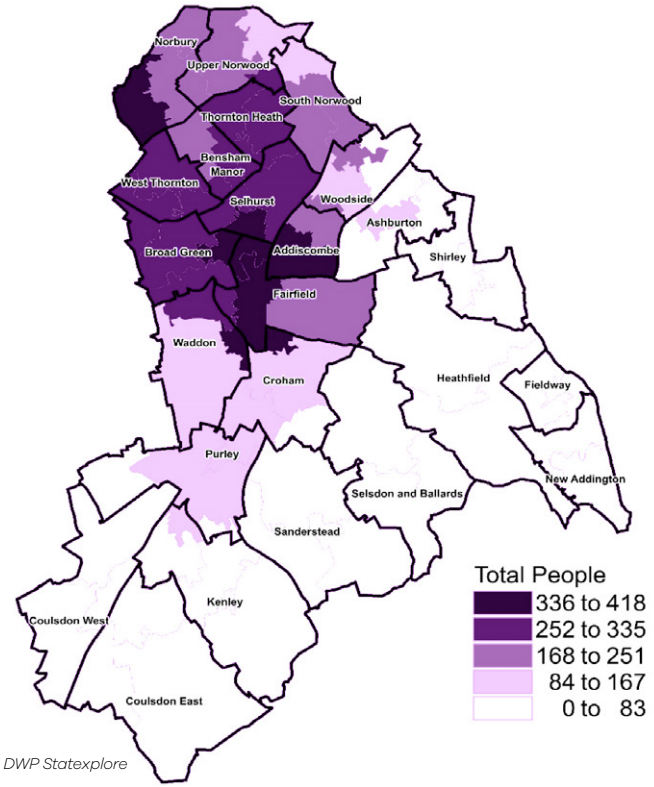
Although the **net migration** (used to calculate population projection) figure for Croydon **is only in the low hundreds, the turnover of people coming into and leaving** the borough reaches figures of roughly **25,000 per year**. The size of this turnover has been increasing over the last few years. Therefore whilst the overall population size isn't affected, the size and profile of turnover has an impact for services planning and delivery.

Croydon's turnover is average for London but notably Croydon ranks after primarily inner-London boroughs.

Data on National Insurance Number registrations[10] also sheds some light on the population transiting or entering Croydon.

For example, 7,279 people whose previous address was overseas, registered for a National Insurance Number in Croydon during 2016/17. This is the 13th lowest number in London and does not indicate how many continued to live in Croydon or for how long.

PEOPLE WHO REGISTERED FOR NATIONAL INSURANCE NUMBER (NINO) IN CROYDON WHOSE PREVIOUS ADDRESS WAS OVERSEAS (2016/17)



Source: 2016/17, DWP Statexplore

The map shows there are clear hotspots of new international populations near East Croydon Station and in the north west of the borough.

Having the Home Office based in Croydon also brings an added layer of complexity to our experience of population turnover compared with London.

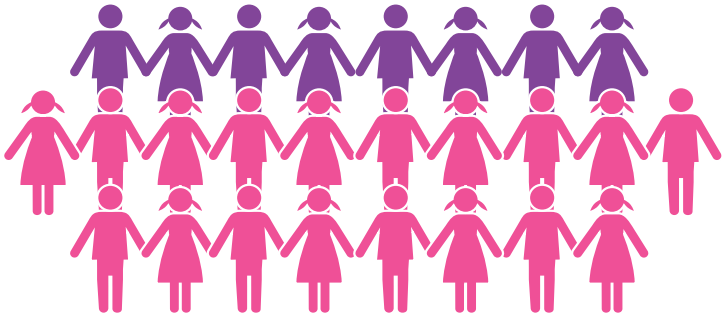
As a borough, we have the **largest number of Unaccompanied Assylum Seeking Children (UASC) in London** (430 in Croydon and only 1,440 in London all together).[11]

Roughly

1 in 3 of all London's

unaccompanied asylum seeking children (UASC)

are in Croydon



the Council has parental responsibility for them.

Source: 2015/16, looked after children statistics, www.gov.uk

It is important to note that the migration data sources presented here measure different things and vary in their definitions and the geographies they cover. Therefore, they cannot be directly compared with each other.

Socio-economic profile and deprivation:

Health, disability and life expectancy are linked with deprivation.

for example

if you are a
35-39 YEAR OLD
male in the
POOREST SECTIONS OF SOCIETY
you are

JUST AS LIKELY TO HAVE A DISABILITY[12]

=

as a
60-64 YEAR OLD
male living in the
MOST AFFLUENT PARTS OF SOCIETY

A similar gap, although slightly smaller, also exists for women

2011 Census, ONS

Additionally, inequalities in life expectancy exist geographically. For example in Croydon, male life expectancy increases by 10.6 years along a 30 minute bus journey.

Male Life Expectancy increases by 10.6 years during this 30 minute journey.

Start ..... CR0 2JT (Selhurst Ward)

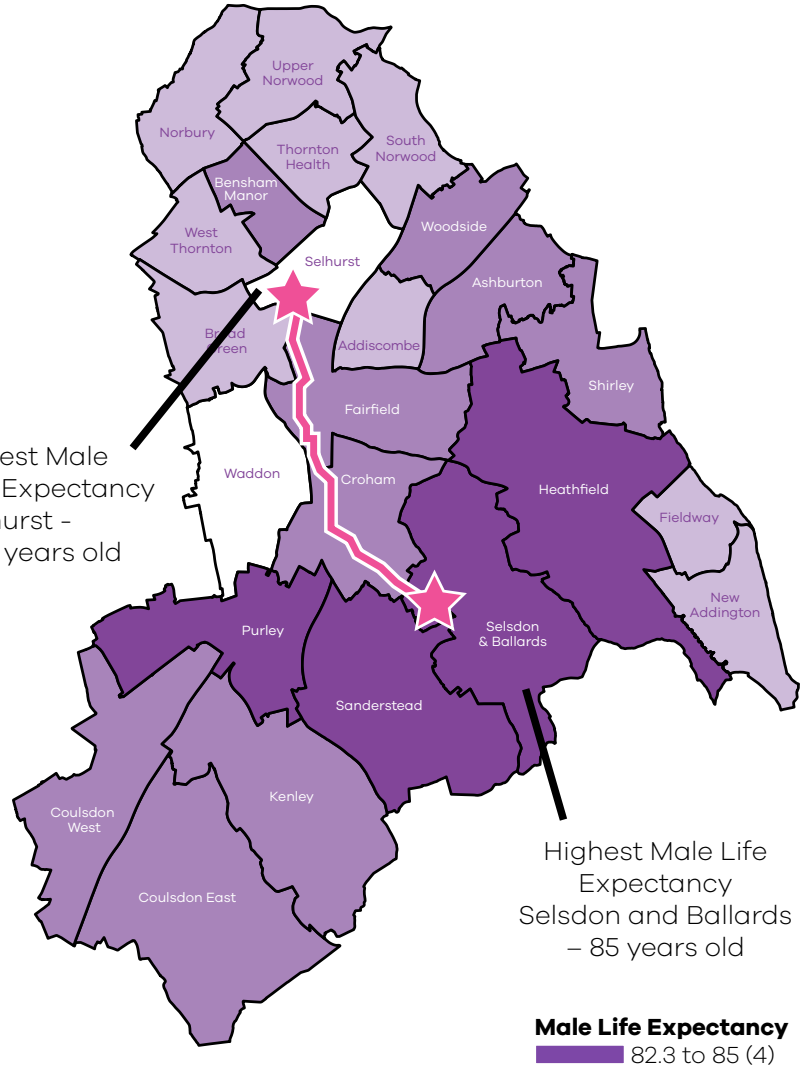
11 mins — Walk to Whitgift Centre

15 mins — 412 Bus to Arkwright Road

4 mins — Walk to Moir Close, South Croydon

Finish ..... CR2 0LQ (Selsdon and Ballards Ward)

MALE LIFE EXPECTANCY 2010 - 2014

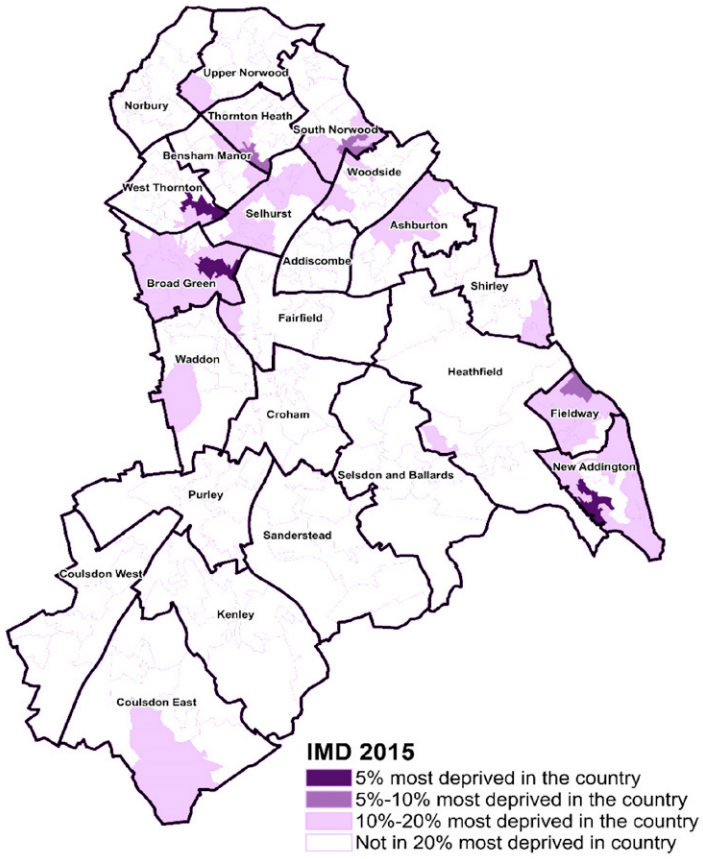


Source: 2010-2014, Male Life Expectancy, GLA

Croydon is the 17th most deprivedof London's 33 boroughs (IMD 2015 rank of average score). In 2010 it was the 19th most deprived[13].

The map below indicates areas in Croydon that are classed within the most deprived areas of the entire country.

INDICES OF DEPRIVATION 2015 CROYDON LOWER SUPER OUTPUT AREAS (LSOA)

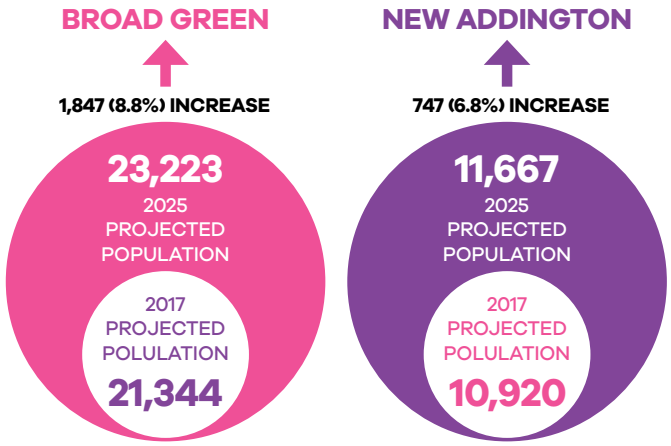


Source: 2015 Indices of Deprivation, Department od Communities and Local Government

The map shows that **10,261 people**[14]
live in areas across Croydon, considered to be within the
10% most deprived
in the whole country
(the darkest 2 shades of purple on the map)

Source: 2015 Indices of Deprivation, Department od Communities and Local Government

Broad Green and New Addington are the most deprived wards in the borough. By 2025, the population in these wards is expected to increase by 8.8% and 6.8% respectively[15].



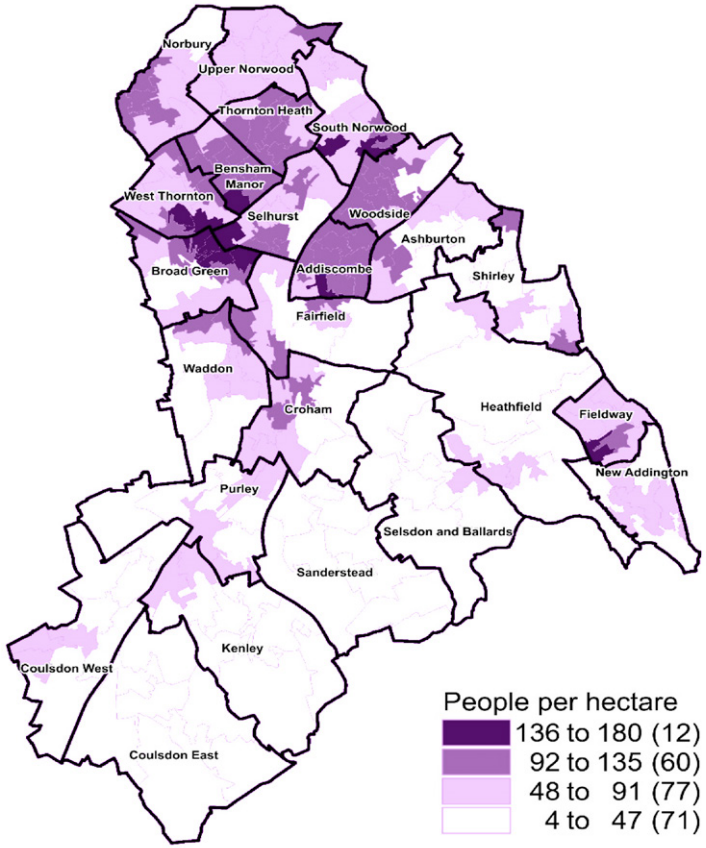
Source: 2015 Round ward based projections, GLA

Spatial changes:

The north of Croydon is more densely populated than the south of the borough.

In 2011, on average there were **42 people per hectare** in Croydon. **In 2015** this had risen to **43.8**

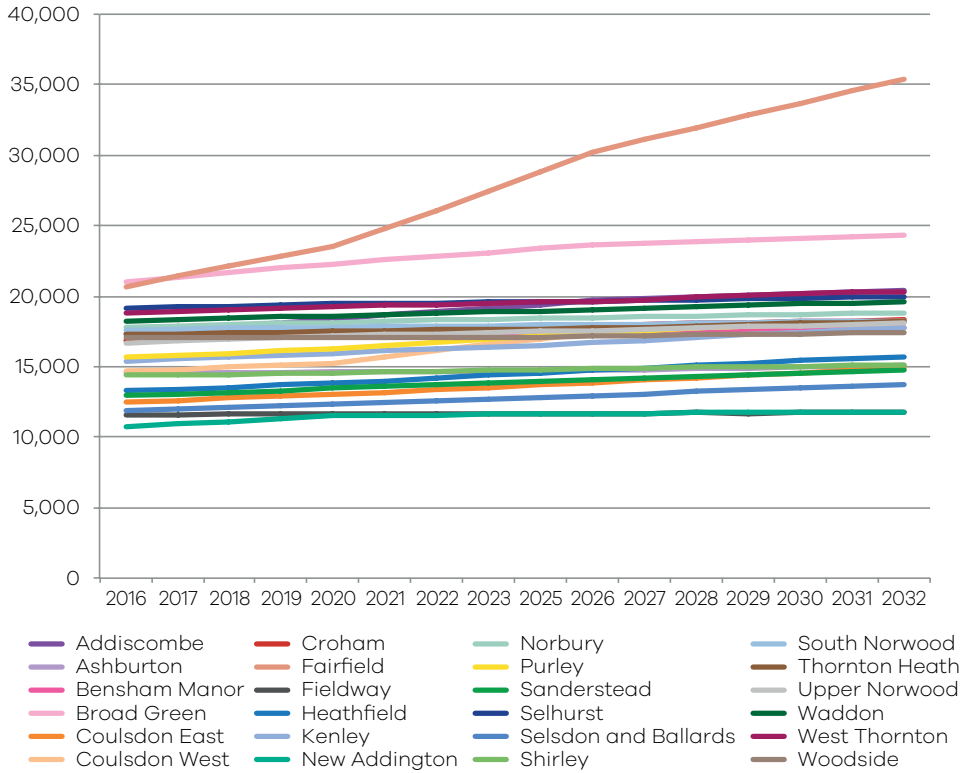
POPULATION DENSITY IN CROYDON, 2015



Source: 2015 Mid year estimates, ONS

The ward with the single most significant amount of projected change is **Fairfield ward**. It is **expected to experience the greatest population increase over the next 10-15 years; far more than any of Croydon's other 23 wards**.

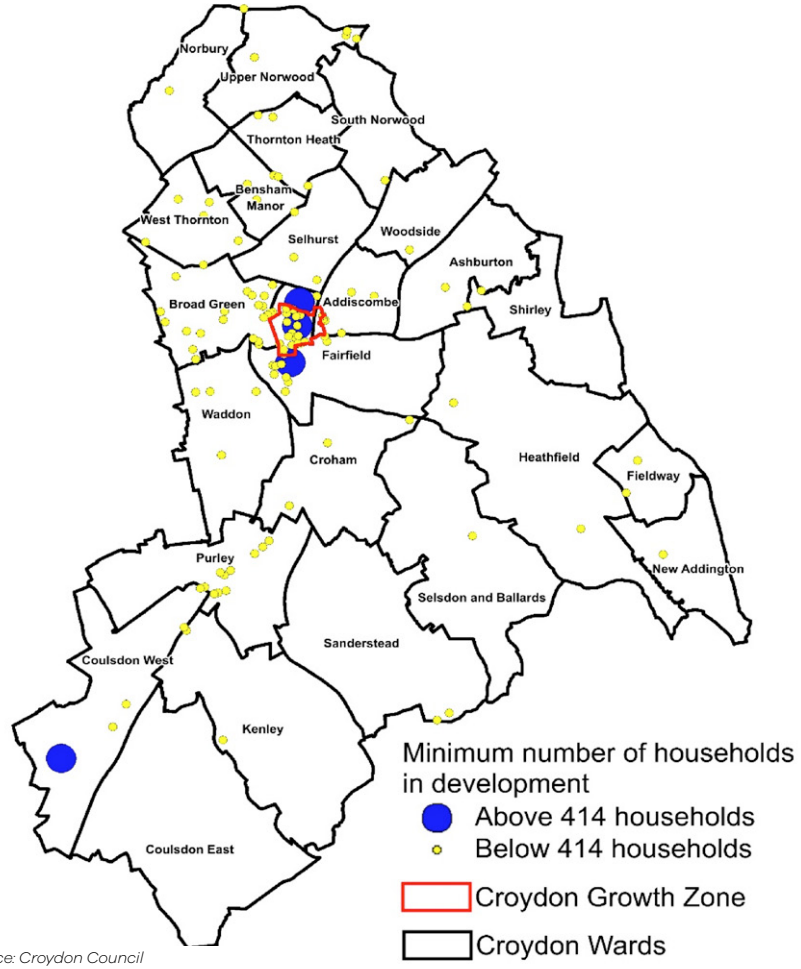
2015 ROUND WARD BASED PROJECTIONS, CROYDON WARDS 2011-2041



Source: 2015 Round ward based projections, GLA

The **Croydon Growth Zone is almost entirely encompassed within Fairfield ward** and includes a number of developments including housing in and around the town centre as shown in the map below.

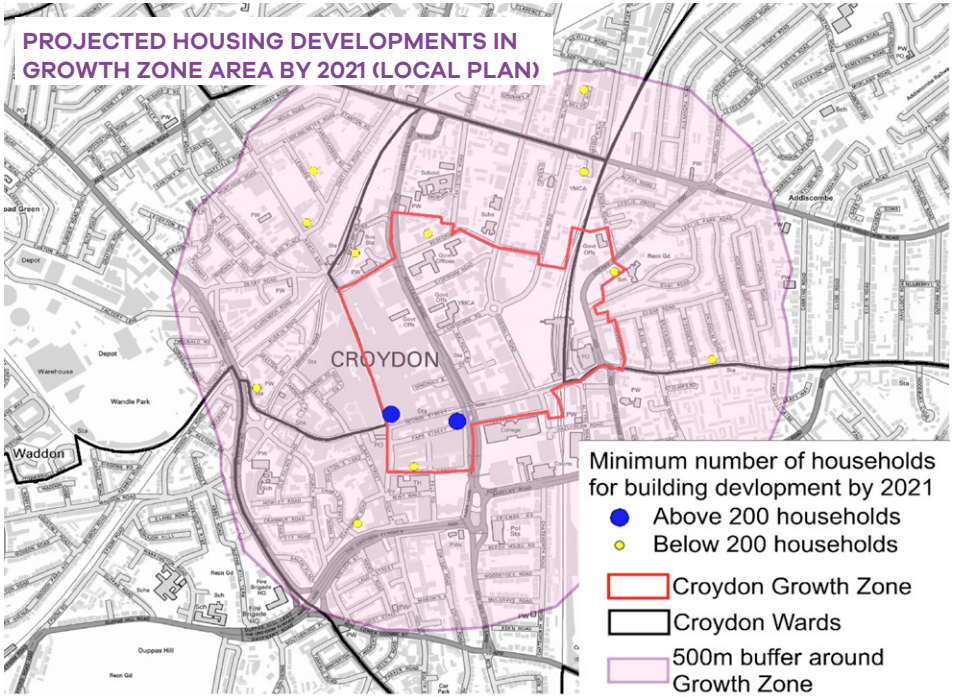
PROJECTED HOUSING DEVELOPMENTS IN CROYDON (LOCAL PLAN)



Source: Croydon Council

46% (61 out of 133)
of all Croydon developments spanning the duration of the Local Plan are within
500 metres of the **TOWN CENTRE**

In more immediate terms, **by 2021**
there will be between **1,147** and **2,230** new households
within **500 metres** of the **TOWN CENTRE**

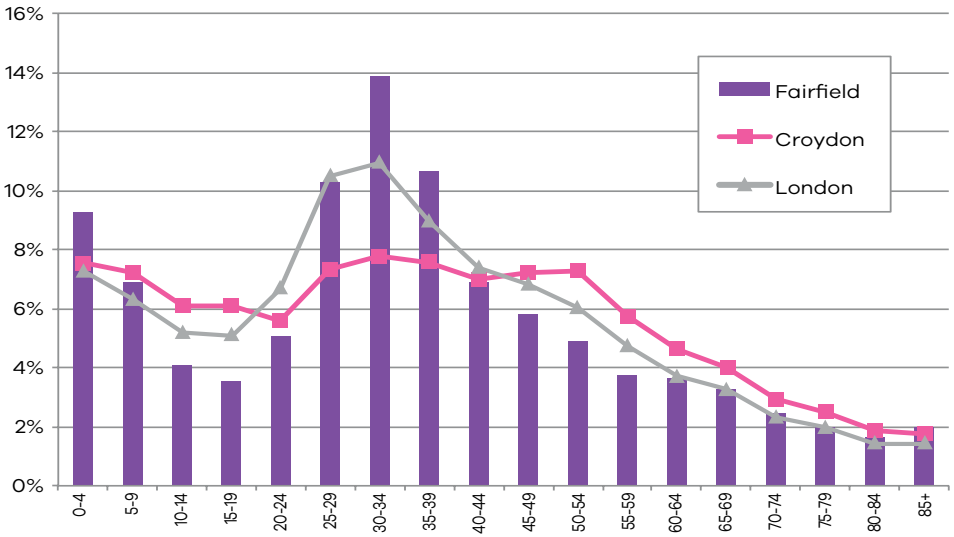


Population growth usually results in increasing levels of need.

A role when planning for the future, is to consider not only future housing needs but also education provision, children and adult social care, health provision, crime and environmental impacts.

The ward has a higher proportion than London and Croydon overall, of 25-39 year olds and 0-4 year olds; this could indicate a population of young families.

5 YEAR AGE BREAKDOWNS, FAIRFELD, CROYDON AND LONDON 2015

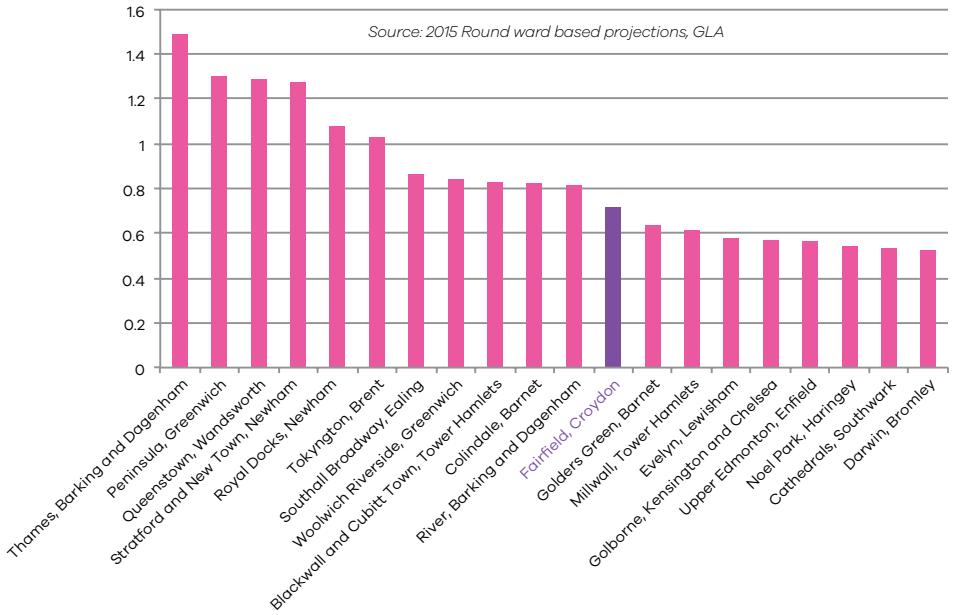


Source: 2011-2016 Mid year estimates, ONS.

Currently the size of **Fairfield ward's population ranks 3rd of Croydon's 24 wards.**

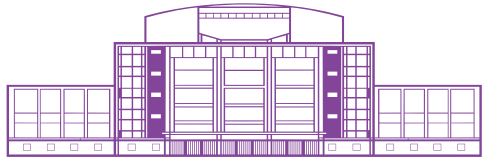
If we expect most planned developments to be completed by 2031, around the same time, population in the Fairfield ward will have increased by 71.6% its current size, the **12th highest ward population increase across all of London's wards**.

% INCREASE IN POPULATION FOR TOP 20 WARDS IN LONDON (OUT OF 625 WARDS) BETWEEN 2016 AND 2031



from **20,657** to **35,438** by 2031

an increase of 5 times the capacity of Fairfield Halls

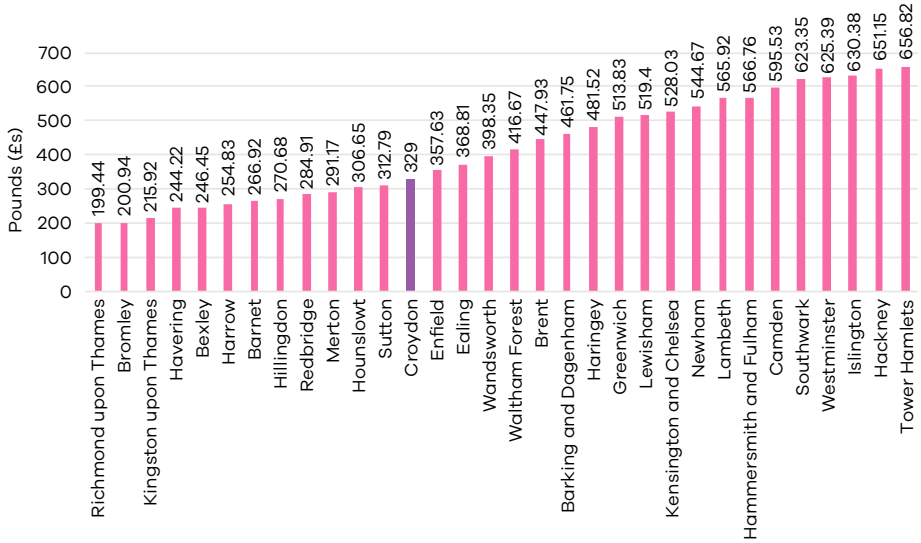


"A key policy objective in most publicly financed health and social care systems is to allocate resources according to need."

Therefore, the primary aim of any resource allocation calculation is not so much to guarantee that all needs are met, but to ensure using demographic intelligence, that as far as possible, all sub-populations have equitable or fair access to these resources at the time of need[16].

The graph here shows how funding per head of population available to Croydon differs from other London Boroughs. However, there are some interesting dynamics, for while Croydon ranks as average in relation to deprivation, it has the 2nd largest population in London.

FUNDING PER HEAD OF POPULATION, LONDON BOROUGHS (BASED ON LOCAL AUTHORIES CORE SPENDING POWER PER POPULATION)



Source: Croydon Council

The challenge for Croydon is that it is an outer London borough with inner London issues and a very large population. Although formulae can be used to systematically distribute resources, it is essential that the formulae are based on population need. The challenge with this, is then choosing the most appropriate indicators of need. Just like differences exist in population estimates, substantial differences in need also may exist between local areas or regions.

Without a formula that is sensitive to these differences in population size and need, there is little scope to eliminate the avoidable health and socio-economic inequalities that exist within and between populations.

POPULATION CHANGE; THE COMMUNITY STRATEGY AND CROYDON'S CORPORATE CONTRIBUTION

Croydon's Community Strategy is the overarching strategy for the entire borough and sets out the direction for the Local Strategic Partnership (LSP). It has 3 key objectives:

VISION: 'WE ARE CROYDON'

By 2040 Croydon will be an enterprising, learning, caring, connected, creative and sustainable place

Outcome 1: (Place)
A GREAT PLACE TO LEARN, WORK AND LIVE

- Priority 1 — **Deliver infrastructure for growth**
- Priority 2 — **Build new homes**
- Priority 3 — **Support the local economy to grow**
- Priority 4 — **Deliver a vibrant cultural offer**
- Priority 5 — **Secure a safe, clean and green borough**

Outcome 2: (People)
A PLACE OF OPPORTUNITY FOR EVERYONE

- Priority 1 — **Reduce poverty and deprivation**
- Priority 2 — **Support individuals and families with complex needs**
- Priority 3 — **Prevent homelessness**
- Priority 4 — **Deliver better education and the opportunity to reach full potential**
- Priority 5 — **Secure a good start in life, improved health outcomes and increased healthy life expectancy**

Outcome 3: (Community)
A PLACE WITH A VIBRANT AND CONNECTED COMMUNITY AND VOLUNTARY SECTOR

- Priority 1 — **Build cohesive and strong communities, connecting our residents, local groups and community organisations**
- Priority 2 — **Strengthen and mobilise our voluntary, community and social enterprise sector**

And Croydon's **Corporate Plan** sets out the **Council's own contribution to the Community Strategy** and also has 3 key objectives to help achieve this:

1. Growth: growth promise
2. Independence: independence strategy
3. Liveability: liveability strategy

The diagram illustrates the objectives that have been translated from the Corporate Plan into the Ambitious for Croydon Performance Framework. The framework is used to monitor how well we are achieving against these objectives.

Bearing these in mind, this year's Director of Public Health report presents examples of key issues or local groups that may require particular attention in order to achieve fairness in outcomes.

The following pages are laid out to present the evidence in some key areas, followed by the overall demographic profile and change in that population age-group. This is done consistently for three broad age groups along the life course.

GROWTH	INDEPENDENCE	LIVEABILITY	ENABLING
To create a place where people and businesses want to be	To help families be healthy and resilient and able to maximise their life chances and independence	To create a place that communities are proud of and want to look after as their neighbourhood	To be innovative and enterprising in using available resources to chage lives for the better
To enable more local people to access a wider range of jobs	To help people from all communities live longer, healthier lives through positive lifestyle choices	To make parks and open spaces a cultural resource	To have the right people with the right skills in the right jobs
To grow a thriving and lively cultural offer which engages communities and supports regeneration	To protect children and vunerable adults from harm and exploitation	To create a place where people feel safe and are safe	To drive fairness for all communities, people and places
To enable people of all ages to reach their potential through access to quality schools and learning	To help families and individuals be more financially resilient and live affordable lives	To build a place that is easy and safe for all to get to and move around in	To be digital by design in meeting the needs of local people
To provide a decent, safe, and affordable home for every local resident who needs one	To prevent Domestic Abuse and Sexual Violence where possible, support victims and hold perpetrators to account	To improve wellbeing across all communities through sport and physical activity	To be open and transparent and put communities at the heart of decision making

EVERY CHILD DESERVES THE BEST START IN LIFE

National social return on investment[17]

FOR EVERY £1 INVESTED

£1.37 to £9.20 RETURN

Our earliest experiences start in the mother's womb and can shape a baby's brain development.

Early months and years lay the foundations for our physical, emotional and socio-economical resilience in adulthood and later years.

It is a crucial time for services to engage parents and young children. Investing in early years services can improve babies' and children's health outcomes.

For some children however, life is more complex and inequalities can begin at a very early stage, holding back development and access to opportunities. In the worst cases, health outcomes are amongst the worst in the 'developed countries'. Here are some examples of some of these health and wellbeing determinants:

HOUSING

Children from households in temporary accommodation are at greater risk of respiratory problems, stress anxiety and depression, behavioural problems, bullying and social exclusion as well as lack of a safe environment.

LONG-TERM CONDITIONS

Poor management of long-term conditions like Asthma, Obesity or Diabetes in childhood can have lasting and severe health implications not only during childhood but also during later life.

LOOKED AFTER CHILDREN

Being in care when young affects mental health in adulthood, is linked with increased levels of antisocial behaviour, emotional instability, psychosis, increased risk of substance misuse and living in poverty. It is also associated with a higher risk of sexual exploitation. Unaccompanied asylum seeking children (UASC) leaving care may have specific difficulty in securing long-term tenure due to the uncertainty of their status in the UK – putting them at greater risk of homelessness.

DISABILITIES

Children with disabilities or special needs are more likely to experience or live in poverty.

YOUNG CARERS

Provide unpaid care and assistance for family, friends or others. There are likely to be young carers at every school and college. Many struggle to juggle education and caring, causing pressure and stress.

MENTAL HEALTH

Half of all mental health problems begin by age 14 years. Again, with delayed or no diagnosis and consequently inadequate treatment or management – significant numbers of children may grow into adulthood less resilient and ill-prepared to be able to flourish.

LOOKED AFTER CHILDREN

LOOKED AFTER CHILD

1 in 116
children aged under 18 in Croydon is a looked after child, the 3rd highest rate in London[18]. Includes young people in care and unaccompanied asylum seeking children (UASC).

UNACCOMPANIED ASSYLUM SEEKING CHILDREN

25 countries
Croydon is currently looking after children from 25 countries. The large majority are boys aged 16-17[19].

Almost 1 in 2
of all looked after children in Croydon is an unaccompanied asylum seeking child[20].

No UASC in Croydon are currently being overseen by the Croydon Multi-Agency Sexual Panel due to risks not being identified[19].

YOUNG CARERS

1 in 33
of Croydon's 0-24 year olds are unpaid carers[21].

1 in 9
of young carers (0-24) in Croydon, provides full time care[22].

Time spent caring appears to impact young carers the most.

LONG-TERM CONDITIONS

OBESITY

1 in 10
of 4-5 year olds in Croydon are obese[23]. This more than doubles by the ages of 10-11.

Almost 1 in 4
of 10-11 year olds in Croydon are obese[24].

ASTHMA

Hospital admissions for asthma among Croydon children aged 0-9 was worst in London[25].

MMR VACCINE

1 in 4
eligible children in Croydon have not received two doses of MMR vaccine on or after their 1st birthday and at any time up to their 5th birthday, the 6th lowest performance in London[26].

SMOKING

2 in 3
of people overall, start smoking before their 18th birthday. It is the #1 cause of health inequalities[27].

ALCOHOL

1 in 3
secondary school children have drunk alcohol[28].

Children of a problem drinker are **4x** more likely to also misuse alcohol[29].

HOUSING

HOMES/ HOMELESSNESS

2 in 3
of young people visits (18-21) to the Croydon Drop in Zone in the 1st quarter of 17/18, were for housing/homelessness advice[30].

HOMELESSNESS

1 in 747
households headed by young people (16-24) in Croydon were accepted as homeless[31].

MENTAL HEALTH

Anxiety and depression are **3x** more common among children who have lived in temporary accomodation for more than a year[32].

MENTAL HEALTH

CHILDREN IN POVERTY

mental health problems are **3x** more common in children in households with lowest 20% of income[33].

PARENTAL MENTAL HEALTH

emotional and conduct disorder is **4-5x** as common in children of those with poor parental mental health[34].

DISABILITIES

LEARNING

1 in 40
children under under 18 in Croydon, have a moderate, severe or profound and multiple learning disability[35].

Croydon young people[36] are

1 in 4 **aged 0-17 years (24.7%)**

1 in 3 **aged 0-24 years (32.2%)**

Croydon has the largest young person population in London (both 0-17 and 0-24).

0-17 YEAR OLDS

Ealing	Enfield	Newham	Barnett	Croydon
81,873	83,773	85,391	90,336	**94,435**

0-24 YEAR OLDS

Ealing	Enfield	Barnett	Newham	Croydon
107,651	111,574	120,971	121,176	**123,214**

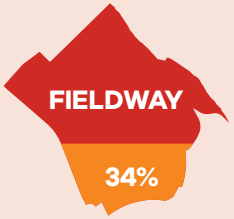
Proportionately compared to the other London boroughs, Croydon has the fifth highest proportion of its population aged 0-17 years and the eighth highest proportion aged 0-25 years[37].

1 in 30
or **3.3%**
or **3,090**
0-17
year olds

live in 6 of Croydon's (lower super output) areas considered to be in the 10% most deprived of the whole country.

All but two of these 6 areas have become more deprived since 2010, and two have become significantly more deprived. The two wards that contain these very deprived albeit small areas are West Thornton and Fieldway[38].

Fieldway ward has the highest proportion of young people[39]



aged 0-17 years

in 2016

0-17 YEAR OLDS

2 in 3
63.8%
BAME ethnic group

compared to over

1 in 4
26.1%
AGED 65+

by 2025

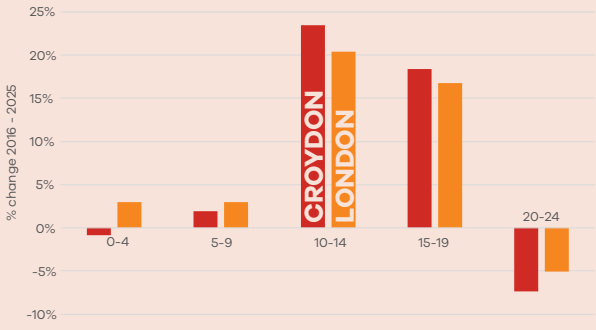
0-17 YEAR OLDS

69.6%
BAME ethnic group[40]

The overall rate of growth (2016-2025) in Croydon is **6.8%** in the **0-24** age group.

This is similar to London (**6.5%**).

10-14 and **15-19** age ranges show the **largest increases**[41].



WORKING AGES:

The health and wellbeing of our working age population often has impacts far beyond the individuals themselves. Families, children, workplaces, business and communities are all impacted. For many, work (paid or unpaid) is part of their identity and often underpins wellbeing. However a lot can get in the way of us purposefully engaging with society, community and business during our working age.

Plans for a flourishing working age population cannot look in isolation at the population 'in work and well', and must include support for those with health or social problems to stay in work, as well as supporting those who have not yet found work or become workless to return to work .

Examples of some determinants of working age health and wellbeing are:

HOUSING

Young adults are becoming the most likely group to live in poverty and to experience homelessness.

The most common reasons for homelessness in younger adults are parental evictions, exclusion by friends and relatives and general relationship breakdown. Increasing rents and housing prices contribute to this.

Growing numbers of females recorded as homeless in Croydon, (doubled in the last year). An identified gap in services for rough sleepers is the provision of "wet" accommodation – for individuals who are not able/prepared to reduce their alcohol use, but who need accommodation to address their vulnerabilities/health needs.

LONG-TERM CONDITIONS

The average age of retirement for someone with multiple sclerosis is 42 years.

Over 45 per cent of people with asthma report going to work when ill, increasing the risk of prolonged sickness and affecting their ability to perform effectively.

People with heart failure lose an average of 17.2 days of work per year because of absenteeism caused by their condition.

Lost earnings due to sickness-absence are currently estimated at £22 billion per year for the UK economy.

WORKING AGE CARERS

Providing 10 hours of unpaid care per week appears to be a threshold at which carers become at risk of losing income or employment. Ethnic minority carers are estimated to provide more unpaid care than the general population.

MENTAL HEALTH

Just 8 per cent of people with schizophrenia are in employment, despite evidence that up to 70 percent of people with severe mental illness express a desire to work.

LGBT

The LGBT population face a general lack of services. Where services exist, they are often under represented. For example: Croydon Domestic Abuse and Sexual Violence Service recognises that LGBT clients are underrepresented in caseload data and more work is needed to support this group.

DOMESTIC ABUSE AND SEXUAL VIOLENCE (DASV)

Service users typically tend to be female. Physical abuse is the 3rd most commonly reported type of abuse after emotional and verbal abuse. People experiencing DASV often have multiple vulnerabilities that add unique complexity to service delivery.

DISABILITIES

More people with disabilities are likely to be employed now than ever before, however they are still significantly less likely to be employed when compared to non-disabled people.

CHANGE AND CHALLENGE ACROSS THE LIFE COURSE:

WORKING AGES:

HOUSING

HOMELESSNESS

2,285
Croydon residents recorded homeless or in temporary housing[42].

ROUGH SLEEPERS (RS)

Croydon has seen a 22% increase (2014-2017), compared with 7% for London.

Almost 90%
in Croydon are aged between 18-55 years[43].

1 in 2
(44%) had spent time in care and prison as well as the armed forces (all 3)[45].

4 in 5
were male[44].

More than 1 in 2
rough sleepers have been without stable accommodation for longer than a year (60%)[46].

RS HEALTH

50%
been to A&E in last 6 months[47].

RS SAFETY

52%
attacked while sleeping rough. Homeless people have a 13x higher risk of experiencing violence[48].

RS SUBSTANCE MISUSE

1 in 7 (14%)
rough sleepers have substance misuse, as well as mental health needs. Croydon has more counted rough sleepers needing extra support than the London average[49].

DISABILITIES

LEARNING

1 in 40
aged 18-64 predicted to have a learning disability[50].

PHYSICAL

1 in 44
aged 18-64 in Croydon predicted to have a serious physical disability[51].

EMPLOYMENT

6%
of 18-64 year olds in Croydon receiving long-term support from social services are in paid employment[52].

ACCOMODATION

1 in 3
of 18-64 year olds with a learning disability are in unstable accommodation[53].

DOMESTIC ABUSE AND SEXUAL VIOLENCE (DASV)

2 in 3
aged between 21 and 40[54].

MENTAL ILLNESS

1 in 6
new referrals to the Croydon DASV service also had mental ill-health[55].

ALCOHOL

women suffering domestic abuse are **15x** more likely to misuse alcohol[56].

LGBT

FINANCIAL HARDSHIP

1 in 3
in London earn less than the London Living wage, even when professionally qualified[57].

WORKING AGE CARERS

WORKING CARERS

1 in 8
working age people (25-64) in Croydon provide unpaid care[58].

TIME SPENT CARING

More than 1 in 6
working aged carers (25-64) in Croydon provide full-time care (50 hrs or more per week), typically more females than males[59].

EMPLOYED CARER HEALTH

2-3x more
full-time carers report 'Not Good' health, if also in full-time work[60].

LONG-TERM CONDITIONS

OBESITY

2 in 3 (62.2%)
adults in Croydon are overweight or obese (aged 18 and over)[61].

DIABETES

1 in 31
working age people (18-64) in Croydon predicted to have diabetes. Expected to increase by 10% by 2025[62].

ENPLOYMENT AND ILLNESS

those unemployed are **2x** at risk of limiting long-term illnesses[63].

MENTAL HEALTH

1 in 6
adults has a common mental health problem at any one time[64].

1 in 95
adults has a serious mental health illness like schizophrenia or bipolar disorder[65].

Depression and anxiety are **4-10x** more common in those unemployed for more than 12 weeks[66].

2 in 3 aged 18-64 years (62.2%)[67]

Croydon has the third largest 18-64 population in London.

18-64 YEAR OLDS

Croydon **237,663**

Lambeth **238,959**

Barnet **241,532**

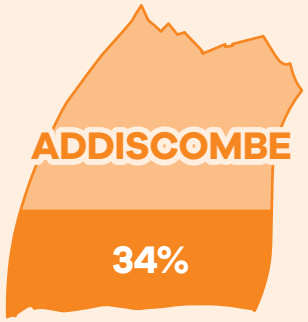
Proportionately compared to to the other London boroughs, Croydon has the ninth lowest proportion of their population aged 18-64 years[68].

1 in 38
or **2.6%**
or **6,204**
18-64
year olds

live in 6 of Croydon's (lower super output) areas considered to be in the 10% most deprived of the whole country.

All but two of these 6 areas have become more deprived since 2010, and two have become significantly more deprived. The two wards that contain these very deprived albeit small areas are West Thornton and Fieldway[69].

Addiscombe ward has the highest proportion of working age people[70].

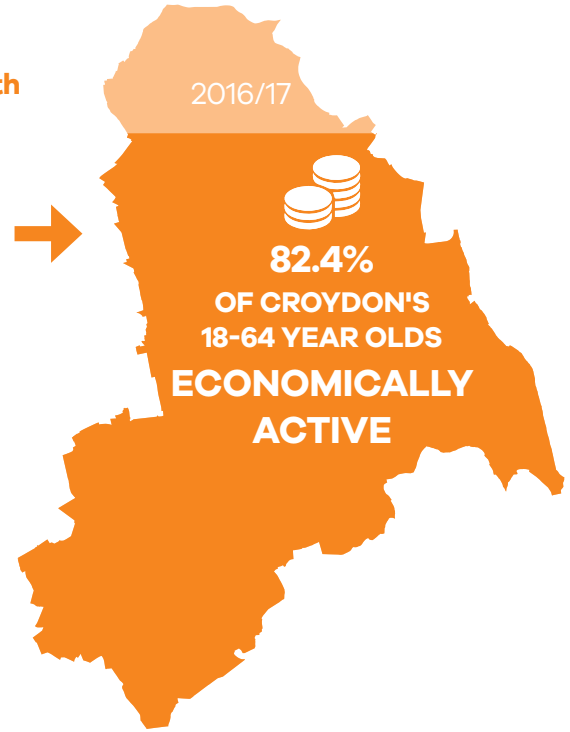


aged 18-64

in 2016 almost **half** **18-64 YEAR OLDS** **49%** **BAME ethnic group**

by 2025 over **half** **18-64 YEAR OLDS** **55%** **BAME ethnic group**[71]

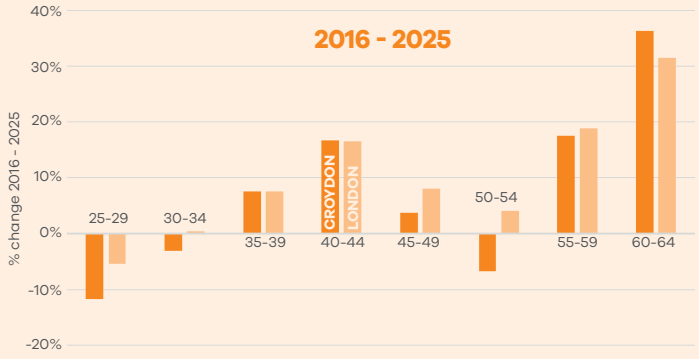
This is the **fifth highest % in London** and higher than the London average of 78.4% [73].



The rate of growth (2016-2025) in Croydon is **5.6%** in the **25-64** age group.

This is a smaller proportionate increase than London (**7.6%**).

55-59 and 60-64 age ranges show the **largest increase**[72].



CHANGE AND CHALLENGE ACROSS THE LIFE COURSE:

OLDER AGES:

As the population over the age of 65 continues to increase, and becomes more diverse in its ethnic composition, health and social care provision for older adults and carers of older adults in Croydon needs to evolve. However, older adults and carers of older adults are not just consumers of health and social care services but also important contributors and have a wealth of experience to offer. It is important therefore that we facilitate this section of Croydon's population to continue to make a contribution to their own health and wellbeing, to society and to live lives to their full potential.

HOUSING

Older adults, particularly those living alone and/or in larger family homes, those with disabilities and those with existing long-term conditions (physical or mental) are amongst those considered to be most vulnerable to fuel poverty and the iimpacts of cold, damp homes.

Croydon has the highest number of care homes in London. A large number of places are occupied by self-funders or out of borough placements. This can result in high demand for a few places for local authority funded eligible older adults who need nursing or residential care.

Projections for each of the groups within the life stages we have presented is not straightforward. We have presented the overall change in each age group as a whole. More work is required to model at a smaller level the projected population change in key cohorts.

MENTAL HEALTH

Mental health has an impact on physical health and vice versa. As well as the typical life stressors common to all people, many older adults also experience limited mobility, chronic pain, frailty or other mental or physical problems. In addition, older people are more likely to experience events such as bereavement, a drop in socioeconomic status with retirement, or a disability. All of these factors can result in isolation, loss of independence, loneliness and psychological distress in older people.

DISABILITIES

Disability develops earlier for people in the poorest sections of our society

LONG-TERM CONDITIONS

Long-term conditions are more common in older people and age increases the chances of having more than one condition. In addition, most individual long-term conditions are more common in poorer sections of society, and are more severe in nature even when less common. It is estimated there will be rising demand for prevention and management of multi-morbidity rather than of single disease.

OLDER CARERS

Older carers tend to be frail themselves and health decreases with increasing hours of caring responsibility. Social Isolation is common. The loss of a carer is likely to result in hospital admission or care home admission of the looked after individual. Supporting carers benefits both the carer as well as the person they care for.

DISABILITIES

SOCIAL CARE

1 in 10
older adults received social care[81]

LONG TERM LIMITING CONDITION

1 in 4
older adults with a limiting long term illness whose day-to-day activities are limited **a little**[82].

1 in 4
older adults with a limiting long term illness whose day-to-day activities are limited **a lot**[83].

LEARNING DISABILITIES

is the most commonly reported reason for needing care as reported in the Croydon carers database[84].

1 in 47
older adults predicted to have a learning disability[85].

VISUAL IMPAIRMENT

1 in 11
older adults predicted to have a moderate or severe visual impairment. Increases significantly with age and expected to increase by 24% to 2025[86].

LONG-TERM CONDITIONS

1 in 8
older adults are predicted to have diabetes[74].

1 in 10
older adults have 2 or more long-term health conditions[75].

HEALTH STATE

1 in 7
older adults are self-reportedly in bad or very bad health[76].

OBESITY

1 in 4
older adults are obese. Expected to increase by 22% by 2025[77].

STROKE

1 in 42
older adults predicted to have a longstanding health condition caused by a stroke. Expected to increase by 24% by 2025[78].

HOUSING

1 in 25
of Croydon's older adults live in households without central heating. Worse than England[79].

211
older adults per year are permanently admitted to care homes in Croydon[80].

MENTAL HEALTH

SOCIAL ISOLATION

1 in 17
experience loneliness always or often[87].

DEPRESSION

1 in 11
older adults are predicted to have depression[88].

1 in 36
older adults are predicted to have severe depression[89].

DEMENTIA

1 in 14
older adults are predicted to have dementia[90]

OLDER CARERS

1 in 8
older adults are carers themselves[91].

1 in 3
older carers provide 'full-time care' (50 hours or more per week)[92].

HEALTH STATE

1 in 10
older carers are in very bad health[93].

SOCIAL ISOLATION

1 in 2
adult carers reported having as much social contact as they wanted[94].

1 in 7 aged 65+ (13.1%)[95]

Croydon has the third largest 65+ population in London.

AGED 65+

Croydon	Barnet	Bromley
50,206	54,215	57,344

Proportionately compared to the 33 other London boroughs, Croydon has the eleventh highest proportion of their population aged over 65[96].

1 in 45
or **2.2%**
or **1,070**
aged
65+

live in 6 of Croydon's (lower super output) areas considered to be in the 10% most deprived of the whole country.

All but two of these 6 areas have become more deprived since 2010, and two have become significantly more deprived. The two wards that contain these very deprived albeit small areas are West Thornton and Fieldway[97].

Selsdon and Ballards ward has the highest proportion of older adults[98].

aged 65+

It is estimated in 2016 that 1 in 4 older adults (aged 65+) in Croydon were from a a BAME ethnic group (26.1%).

in 2016 AGED 65+ **1 in 4** BAME ethnic group

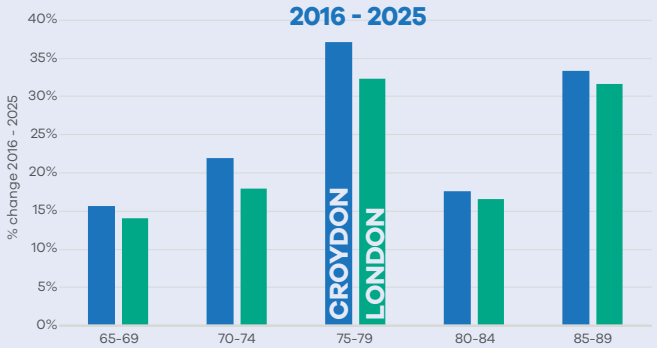
By 2025 it is expected that this will increase to 1 in 3 (35.5%)[99].

by 2025 AGED 65+ **1 in 3** 35.5% BAME ethnic group

The rate of growth (2016-2025) in Croydon is **23.6%** in the **65+** age group, overall.

This is a larger proportionate increase than London (**21.1%**).

75-79 and **85+** age ranges show the **largest increase**[100].



As I said at the beginning of my report, Croydon seems to be misunderstood by many. They don't see this wonderfully diverse borough with all its great opportunities and significant challenges.

I hope that my report can start to demonstrate that we are an outer London borough with inner London borough challenges and it's not just about the proportionality or percentages – after all, as I often say "100% of 4 is still only 4". It is about the considerable numbers of people who are impacted by poor health and those many things that can contribute to poor health and premature death.

Saying that, this report is also designed to provide you with a range of memorable facts and figures about our borough. My hope is that you are able to use them to improve the health of the people of Croydon and, more importantly for me, to reduce the inequalities that we still find here.

Rachel Flowers,
Director of Public Health

ACKNOWLEDGEMENTS:

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Jack Bedeman, Consultant in Public Health,
Mar Estupinan, Public Health Principal and
Richard Eyre, Strategy Manager for Adults.

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A special thank you to Louise Summers, Principal Designer at the council's design team, CroydonDesign for their amazing work on the report.

Finally, to anyone else I may have forgotten to name, a sincere thank you for your contribution.

Give us your feedback.

Do let me know your comments on the report, either by emailing me at **rachel.flowers@croydon.gov.uk**

or by post to:
Croydon Council,
Public Health Division,
People Department,
2nd floor Zone E,
Bernard Weatherill House,
8 Mint Walk,
Croydon, CR0 1EA

ONS 2011 Census – Ethnic Group (18)	GLA Ethnic Group (17)	GLA Ethnic Group (17)
White: English/Welsh/Scottish/Northern Irish/British	White British	White
White: Irish	White Irish	
White: Gypsy or Irish Traveller	Other White	
White: Other White		
Black/African/Caribbean/Black British: Caribbean	Black Caribbean	BAME
Black/African/Caribbean/Black British: African	Black African	
Black/African/Caribbean/Black British: Other Black	Other Black	
Mixed/multiple ethnic group: White and Black Caribbean	White & Black Caribbean	
Mixed/multiple ethnic group: White and Black African	White & Black African	
Asian/Asian British: Indian	Indian	
Asian/Asian British: Pakistani	Pakistani	
Asian/Asian British: Bangladeshi	Bangladeshi	
Asian/Asian British: Chinese	Chinese	
Mixed/multiple ethnic group: White and Asian	White & Asian	
Asian/Asian British: Other Asian	Other Asian	
Mixed/multiple ethnic group: Other Mixed	Other Mixed	
Other ethnic group: Arab	Arab	
Other ethnic group: Any other ethnic group	Other Ethnic Group	

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REPORT TO:	**HEALTH AND WELLBEING BOARD (CROYDON)** **18 October 2017**
SUBJECT:	**Pharmaceutical Needs Assessment: Delegated Responsibility**
BOARD SPONSOR:	**Rachel Flowers, Director of Public Health, Croydon Council**

BOARD PRIORITY/POLICY CONTEXT:

From 1st April 2013, every Health and Wellbeing Board (HWB) in England has had a statutory responsibility to publish and keep up to date a statement of the needs for pharmaceutical services of the population in its area, referred to as a pharmaceutical needs assessment (PNA).

The NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 (the 2013 Regulations) require each Health and Wellbeing Board to make a revised assessment as soon as is reasonably practicable after identifying changes to the need for pharmaceutical services which are of a significant extent.

Croydon, in line with national regulations, published its first PNA by 1 April 2015. Every area is required to publish a refreshed PNA document within 3 years, i.e. by 1 April 2018. Section 8 of the Regulations requires consultation with specific organisations and groups allowing them a minimum of 60 days for making their response to the consultation. The Consultation of the PNA in Croydon runs from 20 November 2017 to 21 January 2018. Following the Consultation, responses will be assessed and a final document prepared. It is expected that the final PNA will be available by the end of March 2018, this is after the HWB's February meeting. Therefore to publish the PNA document by 1 April 2018, as required by the 2013 Regulation, there is a priority for the board to delegate authority to the Director of Public Health and to the Chair of the Health and Wellbeing Board to sign off the final PNA document on its behalf.

FINANCIAL IMPACT:

No financial impact for Health and Wellbeing Board partners.

1. RECOMMENDATIONS

1.1 Note progress in developing the 2018 PNA for Croydon.

1.2 This report recommends that the Health and Wellbeing Board delegates authority to the Director of Public Health and to the Chair of the Health and Wellbeing Board to sign off the final PNA document to guarantee its publication by 1 April 2018, as required by the 2013 Regulations.

2. EXECUTIVE SUMMARY

2.1 This paper provides an update to Croydon's Health and Wellbeing Board (HWB) on the progress of the development of the Pharmaceutical Needs Assessment (PNA), including the process for publishing a refreshed PNA.

2.2 This paper also sets out a case to delegate authority to the Director of Public Health and to the Chair of the Health and Wellbeing Board to sign off the final PNA document to ensure it is published by 1 April 2018, as required by the 2013 Regulations.

3. DETAIL

Background

3.1 From 1st April 2013, every Health and Wellbeing Board in England has had a statutory responsibility to publish and keep up to date a statement of the needs for pharmaceutical services of the population in its area, referred to as a pharmaceutical needs assessment (PNA). Croydon's current PNA was published in accordance with national regulations, by 1 April 2015. Every area is required to publish a refreshed PNA document within 3 years, i.e. by 1 April 2018.

3.2 The information to be contained in the Pharmaceutical Needs Assessment is set out in Schedule 1 of The NHS (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013. The PNA should include:

- A list of pharmacies in Croydon and the services they currently provide, including dispensing, health advice and promotion, flu vaccination, medicines reviews and local public health services, such as sexual health services.
- Relevant maps of providers of pharmaceutical services in the area.
- Services in neighbouring areas that might affect the need for pharmaceutical services in Croydon.
- Potential gaps in provision that could be met by providing more pharmacy services, or through opening more pharmacies, and likely future needs.

3.3 The Pharmaceutical Needs Assessment should also be aligned with the Joint Strategic Needs Assessment and Health and Wellbeing Board Strategy for Croydon.

3.4 PNAs enable health and care partners to identify unmet pharmaceutical needs. PNAs are used by NHS England to make decisions on applications to open new pharmacies and dispensing appliance contractor premises; or applications from current pharmaceutical providers to change their existing regulatory requirements. Applications to open new pharmacies can be keenly contested by applicants and existing NHS contractors and can be open to legal challenge if not handled properly. PNAs also support local authority and NHS commissioners to make decisions on the locally funded services need to be provided by local community pharmacies, and ensure that service provision

is targeted in areas where there is population need for them.

3.5 Health and Wellbeing Boards need to ensure that the NHS England and its Area Teams have access to the local PNA, to support their decision-making and strategic planning processes. Croydon Council's Public Health team have ensured that NHS England know how to access and interpret the information provided in Croydon's current PNA. The current PNA is publicly accessible via the Croydon Observatory website: http://www.croydonobservatory.org/pna

3.6 A PNA should include information on local pharmacies and the services they already provide. These will include dispensing, providing advice on health, medicines reviews and local public health services, such as stop smoking, sexual health and support for drug users. It should look at other services, such as dispensing by GP surgeries, and services available in neighbouring areas that might affect the need for services in the local area. The PNA will take account of any changes to the commissioning of public health and CCG services in Croydon, and will also account for changes in NHS England commissioning arrangements.

3.7 The PNA should examine the demographics of the local population, across the area and in different localities, and their needs. It should look at whether there are gaps that could be met by providing more pharmacy services, or through opening more pharmacies. It should also take account of likely future needs. The PNA should also contain relevant maps relating to the area and its pharmacies. The PNA must be aligned with other plans for local health and social care, including the Joint Strategic Needs Assessment (JSNA) and the Joint Health and Wellbeing Strategy.

PNA Development and Progress

3.8 Following a tender process, Soar Beyond LTD was appointed as a provider to develop the 2018 PNA for Croydon on behalf of the Health and Wellbeing Board.

3.9 A Steering Group was created with members representing: Soar Beyond LTD, Croydon Council (including Public Health and Communications Teams), Croydon Clinical Commissioning Group, Local Pharmaceutical Committee and Local Medical Council.

3.10 The Steering Group was established to oversee the production of the 2018 PNA for the London Borough of Croydon, reporting progress and with the aim of presenting the final report the HWB on or before the March 2018 meeting (see Terms of References on Background Documents section).

3.11 Section 8 of the 2013 Regulations requires consultation with specific organisations and groups allowing them a minimum of 60 days for making their response to the consultation. The current Consultation is now live and runs from 20 November 2017 to 21 January 2018. Reponses gathered from the consultation will be subsequently analysed and a final document produced. This final PNA document is expected to be available by the end of March 2018. It is therefore not feasible to present the final PNA document to the board before the due publication date.

3.12 To meet the publication deadline (i.e. 1 April 2018), delegation of authority to the Director of Public Health and to the Chair of the Health and Wellbeing Board is

being requested to sign off the final PNA document on behalf of the HWB.

3.13 The HWB however has now access to a full copy of the draft PNA (see link provided below under the Background Section). This draft may differ from the final document all depending on the outcome from the current Consultation. However, it is envisioned that any amendments to the final version will be minor and therefore the draft available will give a close picture to the HWB.

3.14 Following to its publication, the final 2018 PNA is proposed and planned to be formally presented to the HWB at the meeting on the 16th April 2018.

4. CONSULTATION

4.1 The revised PNA will require Health and Wellbeing Board-level sign-off and a 60 day period of public consultation before it can be finalised.

4.2 The 2013 Regulations list those persons and organisations that the Health and Wellbeing Board must consult. This list includes:

- Any relevant local pharmaceutical committee (LPC) for the Health and Wellbeing Board area.
- Any local medical committee (LMC) for the Health and Wellbeing Board area.
- Any persons on the pharmaceutical lists and any dispensing GP practices in the Health and Wellbeing Board area.
- Any local Healthwatch organisation for the Health and Wellbeing Board area, and any other patient, consumer and community group which in the opinion of the Health and Wellbeing Board has an interest in the provision of pharmaceutical services in its area.
- Any NHS trust or NHS foundation trust in the Health and Wellbeing Board area.
- NHS England.
- Any neighbouring Health and Wellbeing Board.

4.3 A first Consultation on the views of pharmacy services users were gained from a questionnaire circulated for comments from the general public in the summer of 2017. In the same period, commissioners and contractors were also consulted using similar questionnaires. Results were used to inform the PNA process and the development of the final draft.

4.4 This Consultation on the final draft PNA is now currently available (i.e. Monday 20th November to 21st January 2018).

4.5 The Consultation is available on Croydon Get involved platform, and has been circulated via email to a distribution list based on the requirements set by the 2013 Regulations.

4.6 The Consultation is also being advertised on social networks such as Facebook or Twitter.

5. SERVICE INTEGRATION

5.1 PNAs provide a common structured framework within which commissioners and strategic planners can make decisions about pharmaceutical needs in a local area. They facilitate discussions between NHS England, local commissioners from the local authority and CCG, and local pharmacists around addressing local pharmaceutical needs, and provide a common framework for assessing activity and provision that should be in place to address these needs.

6. FINANCIAL AND RISK ASSESSMENT CONSIDERATIONS

6.1 There are no financial implications or risks that the board needs to consider. The PNA supports NHS England to make decisions about market entry. It has no direct cost implications to the Council or CCG.

6.2 The funding to undertake and develop the refreshed 2018 PNA was identified as part of the public health ring-fenced grant.

7. LEGAL CONSIDERATIONS

7.1 There is a statutory responsibility to produce a PNA. The Health and Wellbeing Board's review of the refreshed PNA will need to be supported by full legal clearance.

7.2 The Health and Social Care Act 2012 established Health and Wellbeing Boards and transferred to them (from the NHS Act 2006) the responsibility to publish and keep up to date a statement of the needs for pharmaceutical services of the population in its area, with effect from 1 April 2013. The requirements on how to develop and update PNAs are set out in Regulations 3-9 Schedule 1 of the NHS (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013.

7.3 The 2012 Act also amended the Local Government and Public Involvement in Health Act 2007 to introduce duties and powers for Health and Wellbeing Boards in relation to Joint Strategic Needs Assessments (JSNAs). The preparation and consultation on the Pharmaceutical Needs Assessment should take account of the Joint Strategic Needs Assessment (and other relevant local strategies in order to prevent duplication of work and multiple consultations with health groups, patients and the public). The development of Pharmaceutical Needs Assessments is a separate duty to that of developing Joint Strategic Needs Assessments. As a separate statutory requirement, Pharmaceutical Needs Assessments cannot be subsumed as part of these other documents but can be annexed to them.

7.4 The Health and Social Care Act 2012 also transferred responsibility for using PNAs as the basis for determining market entry to a pharmaceutical list from PCTs to NHS England.

8. EQUALITIES IMPACT

8.1 The purpose of any needs assessment, including the PNA, is to look at current and predicted future population needs for service provision or support. The PNA will identify the need for access to pharmaceutical services so that NHS England can approve or reject applications for additions to the pharmaceutical list. The PNA will also identify the need for locally commissioned services that local authority and CCG commissioners can respond to using relevant commissioning budgets.

8.2 As part of the PNA process, an "Equality Impact Assessment" (EIA) was completed (see Appendix K of draft PNA link provided in the Background Document Section) to identify if there had been any impact on any group with protected characteristics. No specific needs or impact on any particular group were identified. This EIA was approved and signed off by the DPH and Equality Analysis Officer from Croydon Council.

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BACKGROUND DOCUMENTS:

Link to current Pharmaceutical Needs Assessment, published following the March 2015 Health and Wellbeing Board Meeting: http://www.croydonobservatory.org/pna

Link to full copy of the draft PNA under Consultation: https://goo.gl/3UB9Ty

APPENDICES: Appendix A. PNA Development Project Plan

Appendix B. Croydon 2018 PNA Steering Group - Terms of Reference

Appendix A – PNA Development Project Plan

Project Plan for Croydon 2018 PNA

	Jul 2017	Aug 2017	Sept 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018
Contract commencement date (4th July 2017)									
Kick off meeting with local authority PNA lead • Detailed project plan shared and agreed • Agree accountabilities • Identify and approach potential members for PNA Steering Group • Draft Terms of Reference shared • Communications Plan, including frequency and mechanism for local authority checkpoint meetings • Contacts list developed for key stakeholders • RAG rated Risk and Issues log set up • Agree delegation and briefing updates required for Execs/HWB									
Steering Group and Project Governance established • First PNA Steering Group meeting conducted • Project plan shared and agreed • Communications Plan and Terms of Reference agreed • PNA localities agreed • Questionnaire templates shared and agreed									
Stakeholders identified • For dissemination of information • Contact details obtained and initial contact made • Share project plan and brief on what the Pharmacy Needs Assessment is									
Checkpoint web meeting with local authority PNA lead									
Data collection and stakeholder engagement • Distribution of online pharmacy user questionnaire (posters advertising also sent to all pharmacies and GP practices in each borough) • Distribution of online pharmacy contractor questionnaire • Distribution of online commissioner questionnaire									
Checkpoint web meeting with local authority PNA lead									

	Jul 2017	Aug 2017	Sept 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018
Deadline for questionnaires to be completed									
Information collection • Receipt and review of planning and strategy documents e.g. JSNA; Housing Strategy; Commissioning Intentions; STP; etc. • List of all providers of pharmaceutical services from NHS England e.g. pharmaceutical contractors, Internet pharmacies etc. • List of any commissioned services by CCG e.g. minor ailment services, out of hours, local hospitals • Information from local authority e.g. demographics, specific health needs, and any commissioned services • Second PNA Steering Group meeting to agree and finalise data for Draft PNA			7th						
Current and future service provision detailing and analysis • Pharmacies categorised by type (40hr/100hr/internet) – map provided as per Pharmaceutical Regulations 2013, to include cross-border pharmacies • Opening times map produced • Travel access maps: drive times (average, peak, off-peak), walking, public transport – plus population numbers by travel time • Demographics analysis (supported by local authority) • Health and lifestyle analysis (supported by local authority) • Planning: Housing developments and new care home developments listed, and analysed for prospective impact on future pharmaceutical needs (supported by local authority) • Pharmacies who provide advanced services • Pharmacies who provide enhanced / locally commissioned services • Pharmacy contractor workshop to develop a vision for the future of community pharmacy in LB Croydon									
Checkpoint web meeting with local authority PNA lead									
Collation and analysis of all information collected • Triangulate information received from duplicate sources, identifying and resolving any discrepancies and gaps (e.g. opening hours' information) • Comparison with information and recommendations from 2015 PNA									
Review and identify gaps in service, current and future • Identification of any changes (service provision, current and future needs etc.) • Identify potential gaps • Make recommendations									

	Jul 2017	Aug 2017	Sept 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018
Checkpoint web meeting with local authority PNA lead									
Draft PNA completed • Complete the draft assessment, clearly articulating any gaps identified, and propose recommendation • Compile specific consultation questions • Highlight any specific communities and/or providers identified as affected by the analysis of gaps • Third PNA Steering Group meeting: Agree Draft PNA and provide report for December Execs/HWB meeting (if required)					9th				
Consultation period (20th Nov 2017-19 Jan 2018) • Host Draft PNA on council's website (supported by local authority) • Advertise' consultation through existing consultation channels (e.g. communications and engagements leads with CCGs, HealthWatch, Patient Participation Groups etc.) • Send links of Draft PNA to consultees as required by the Pharmaceutical Regulations (listed within the Communications Plan), and any specific individuals, populations and stakeholder groups identified within the stakeholder engagement undertaken in the Summer • Hold direct stakeholder engagement events (face to face meetings, webinars, online surveys etc.) with specific populations/providers identified as potentially affected by the analysis of gaps									
Checkpoint web meetings with local authority PNA lead									
Consultation findings report • Collate, analyse and make recommendations on the consultation responses • Fourth PNA Steering Group: make changes necessary to the draft PNA and agree Final PNA								8th	
Final PNA • Produce final document in pdf format for uploading to council's website • Consultation findings report and Final PNA to Execs meeting in Mar 2018 and/or HWB meeting in April 2018 (if required) for approval/for information • Send links of Final PNA to consultees as required by the Pharmaceutical Regulations (listed within the Communications Plan), and any specific individuals, populations and stakeholder groups identified within the stakeholder engagement undertaken in the Summer									
Checkpoint web meeting with local authority PNA lead									
PNA published (expected completion date w/c 26th Mar 2018)									

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Croydon 2018 PNA Steering Group – Terms of Reference

Purpose

Ensure the development of 2018 Croydon's Pharmaceutical Needs Assessment (PNA) so that Croydon Health and wellbeing Board meet it's statutory responsibility for publishing the PNA in line with The National Health Service England (Pharmaceutical Services and Local Pharmaceutical Services) regulations.

Objectives

- To oversee the development of the pharmaceutical needs assessment in accordance with and ensure the Croydon PNA complies with the NHS Pharmaceutical Services and Local Pharmaceutical Services Regulations 2013.
- Ensure the PNA takes into account the local demography within Croydon Borough and ascertain whether there is sufficient choice and accessibility (e.g. physical access, language etc.) with regard to obtaining pharmaceutical services.
- Promote integration of the PNA with other strategies and plans including the Joint Strategic Needs Assessment, the Joint Health & Wellbeing Strategy, the CCGs' Commissioning Strategy Plans and other relevant strategies
- Ensure the consultation on the PNA meets the requirements of Regulation 8 of the 2013 Regulations. In particular, ensure that both patients and the public are involved in the development of the PNA.
- Ensure all appropriate stakeholders in Croydon are aware, engaged and involved in the development of the PNA.
- Present the PNA first and final draft to the Health and Wellbeing Board.
- Publish the PNA on the Council's website by April 2018.
- Develop a community pharmacy vision that is integrated across health and social care spectrum, ensuring direct link to the Health & Wellbeing vision for the borough
- Horizon scan for future policy direction and identify system decision makers to transform the vision into a reality for Croydon residents
- Ensure the vision paper has adequate and appropriate patient and public involvement along with the wider community pharmacies operating in Croydon

Governance

- The Health and Social Care Act 2012 transferred the statutory responsibility for PNAs from NHS Primary Care Trusts (PCTs) to Health and Wellbeing Boards (HWB), from 1 April 2013, with a requirement to publish a revised assessment at least every 3 years

- This Steering Group has been established to oversee the production of the 2018 PNA for the London Borough of Croydon, reporting progress and presenting the final report to the HWB on or before the March 2018 meeting.
- The Health and Wellbeing Board will be informed of progress towards the production of the PNA and relevant milestones through the HWB Programme Manager's quarterly updates.
- If a statement or decision from the Health and Wellbeing Board is needed in relation to the production of the draft PNA, the Chair of the Steering Group is welcome to draft a formal report for consideration.
- The steering group will report directly to the Director of Public Health and is accountable to Croydon Health and Wellbeing Board.

Frequency of meetings

Meetings will be arranged at key stages of the project plan. The Steering Group will meet in late 2017/early 2018 to sign off the PNA 2018 for submission to the Health and Wellbeing Board.

Responsibilities

- Provide a clear and concise PNA process
- Review and validate information and data on population, demographics, pharmaceutical provision, and health needs
- To consult with the bodies stated in Regulation 8 of The NHS Regulations 2013:
    - Any Local Pharmaceutical Committee for its area
    - Any Local Medical Committee for its area
    - Any persons on the pharmaceutical lists and any dispensing doctors list for its area
    - Any LPS chemist in its area
    - Any Local HealthWatch organisation for its area
    - Any NHS trust or NHS foundation trust in its area
    - The NHSCB
    - Any neighbouring HWB
- Ensure that due process is followed
- Report to Health & Wellbeing Board on both a Draft and Final PNA.
- Publish a Final PNA by end 1 April 2018.

Dates for Health and Wellbeing Board meetings, 2017/2018:

13th September 2017	7th February 2018
18th October 2017	18th April 2018
13th December 2017	

Membership:

Delegate	Job title	Organisation
Ian Mullan	Associate Director	Soar Beyond Ltd
Anjna Sharma	Associate Director	Soar Beyond Ltd
Claire Mundle	Public Health Principal	Public Health Croydon
Mar Estuphinan	Public Health Principal	Public Health Croydon
Ellen Schwartz	Public Health Consultant	Public Health Croydon
Denise Malcolm	Senior Communications Officer	London Borough of Croydon
Craig Ferguson	Principal Public Health Intelligence Analyst	Public Health Croydon
Jai Jayaraman	CEO	Healthwatch Croydon
Andrew McCoig	Chief Executive	Croydon LPC
Barbara Jesson	Principal Pharmacist	Croydon CCG
Stephanie Kendrick	Communications Lead	Croydon CCG
Karthiga Gengatharan	Medical Director	Surrey and Sussex LMCs

Soar Beyond are not to be a core member. The meeting will be chaired by LBC Public Health, with Soar Beyond supporting. Each core member has one vote. The Director of Public Health (or Public Health representative) will have the casting vote, if required. Core members may provide a deputy to meetings in their absence. The Steering Group shall be quorate with five core Members in attendance, one of which must be a pharmacist member. Non-attending members are unable to cast a vote – that vote may otherwise sway the casting decision. To be included in decision-making, members' (or their nominated deputies) attendance is essential.

In attendance at meetings will be representatives of Soar Beyond Ltd who have been commissioned by London Borough of Croydon to support the development of the PNA. Other additional members may be co-opted if required

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OUR FOCUS

Making a Dementia Friendly Croydon

by Rachel Carse, Dementia Action Alliance & Social Inclusion Coordinator

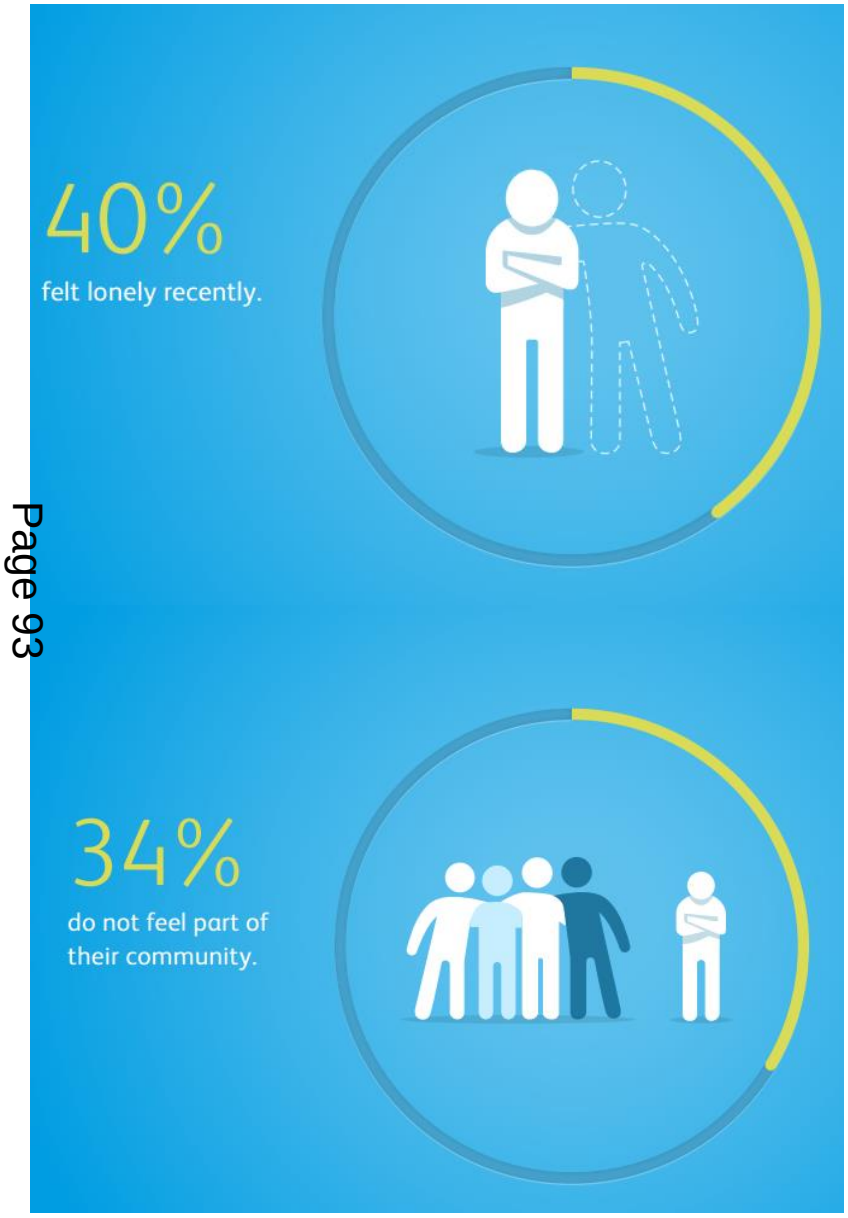
Why take action on dementia?

OUR FOCUS

- £26.3 billion per year (£11.6 billion unpaid care)
- Two thirds of people with dementia live in the community

Why take action on dementia?

OUR FOCUS



- An estimated **22 million** people in the UK have a family member or friend who has dementia (YouGov, 2011)

Croydon's figures at 30 April 2017

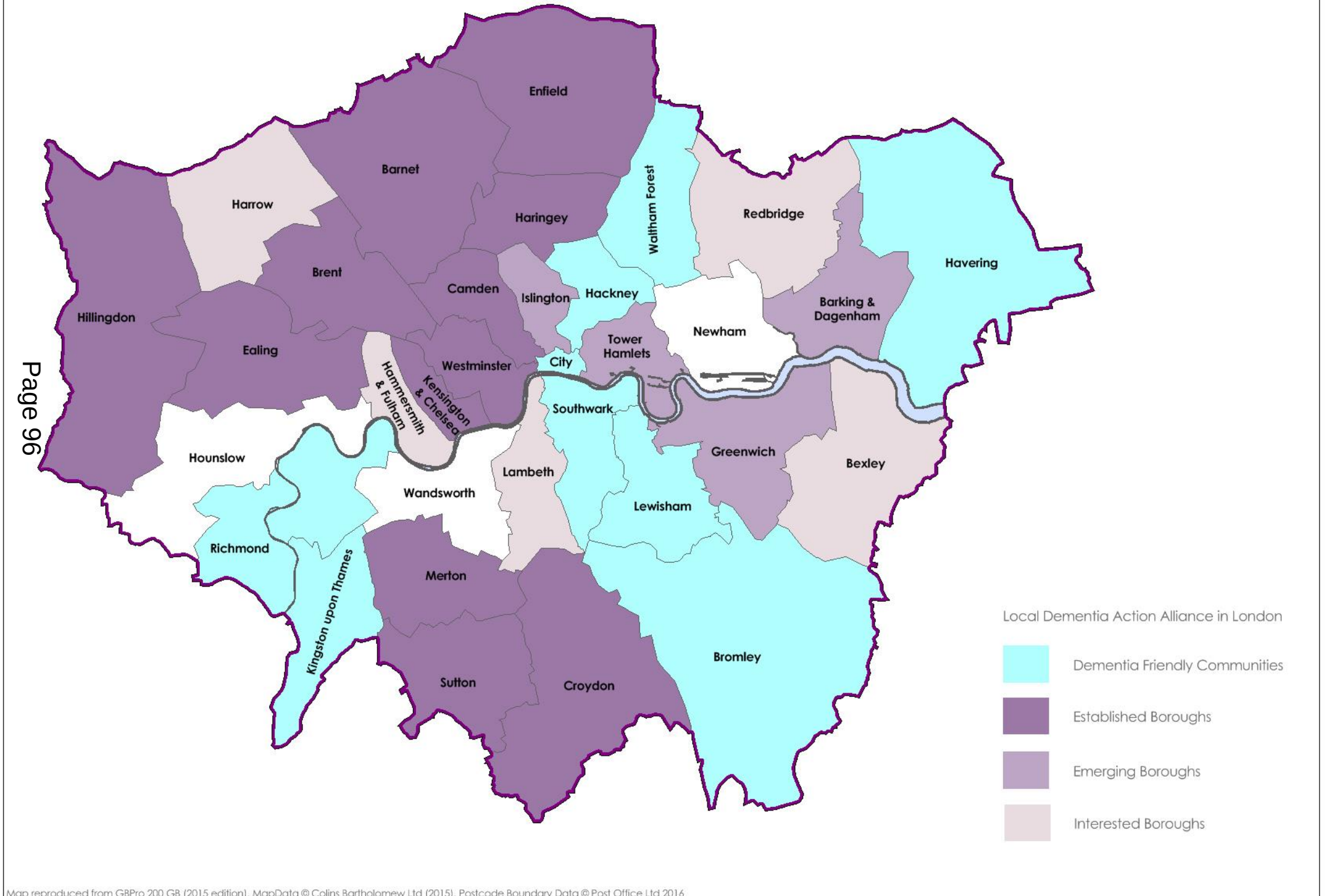
OUR FOCUS

- The number of people living with dementia in the over 65 population is approx. 3,290

- Of those, only 2,197 have been formally diagnosed, approx. 67% of the total with dementia.

- There is a national priority to increase diagnoses rates. In the same period, diagnosis rates across England were 67.9% and 71.1% for London.

Creating a Dementia Friendly London



DAA Dementia Action Alliance

Alzheimer's Society United Against Dementia

What other LDAAs have done

- **Hackney DAA**

  Dementia-friendly GP project

- **Waltham Forest DAA**

  Dementia-friendly housing conference

  New project targetting faith groups for membership

- **Southwark DAA**

  Raising awareness in local shopping places

  Arts activities for people with dementia workshop to educate care homes and local arts venues

- **Lincoln, Hackney, Haringey & Southwark DAAs**

  Dementia-friendly cinema screenings providing regular activity for people living with dementia and carers

OUR FOCUS

So how does Croydon become a dementia-friendly borough?

Answer

By embedding dementia-friendliness into the fabric of the borough using all avenues available including businesses, the voluntary sector, Croydon University Hospital, Croydon Clinical Commissioning Group and the Council

How to take action on dementia?

OUR FOCUS

Think

- People – raise awareness of dementia
  - Host dementia friends awareness sessions – there are an increasing number of Dementia Friends Champions who can deliver an awareness session in Croydon, just ask
  - Increase people from BME community accessing services (working with BME Community Forum on social isolation)
  - Refer people living with dementia to Croydon Memory Service at Heavers Resource Centre
  - Croydon Fire Brigade sharing learning from colleagues in Bromley (already dementia friendly) and become CDAA member
  - Police and Ambulance – link with both services to encourage them to join CDAA

How to take action on dementia?

Think

- Place – make Croydon accessible
  - Dementia friendly shops and high street - share dementia friendly environment checklist with businesses and shops in Croydon.
    - Work with Purley BID to identify how they went about changing their high street
    - Link with Croydon BID [meeting set up for December]
    - Use ground up intelligence from councillors about the business and community networks in their wards
  - People living with dementia / carers – workshops, “what do you want from your high street”
  - Work closely with ‘One Croydon’ Alliance (Croydon Council, Age UK, SLaM, Croydon CCG [Outcomes based commissioning over 65])

How to take action on dementia?

OUR FOCUS

- Process – how do services interact with people living with dementia?
  - Rubbish, recycling
  - Parking
  - Adult education
  - Planning
  - Paying bills/missing payments/arrears
  - Trading Standards
  - Social Care
  - Environmental health
  - Benefits and council tax exemption
  - Social care
  - Parks and gardens

Action plan

OUR FOCUS

Phase 1 – Oct 17 – Mar 18

Stakeholder engagement – businesses, council, councillors, people with dementia, carers

Workshops to establish local priorities and actions for each area of community

Key themes identified for phase 2 (e.g. dementia friendly high street and medical services) phase 3 (e.g. transport, parks and arts)

Phase 2 – April 18 – Sept 18

May – Launch of Dementia Friendly Croydon and re-launch of Croydon Dementia Action Alliance

Phase 3 – Sept 18 – Sept 19

Submission to be formally registered as part of the national Dementia Friendly Community programme

OUR FOCUS

Any questions or suggestions?

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REPORT TO:	**HEALTH AND WELLBEING BOARD (CROYDON)** **13 December 2017**
SUBJECT:	**Health Protection update**
BOARD SPONSOR:	**Rachel Flowers, Director of Public Health**

BOARD PRIORITY/POLICY CONTEXT:

This report addresses the following local priorities set out in the Joint Health and Wellbeing Strategy:

- Increased healthy life expectancy and reduced differences in life expectancy between communities
- Local organisations will work together to address the factors that drive health problems amongst the poorest and most disadvantaged.
- Everyone's health will be protected from outbreaks of disease, injuries and major emergencies and remain resilient to harm.
- Earlier diagnosis and intervention means that people will be less dependent on intensive services.

FINANCIAL IMPACT:

No immediate financial implications.

1. RECOMMENDATIONS

1.1 The Health and Wellbeing Board is asked to note the contents of the report.

2. EXECUTIVE SUMMARY

2.1 The Croydon Health Protection Forum (HPF) was established in July 2015 with the purpose of having a strategic overview of health protection matters with the aim to support the Director of Public Health in her statutory assurance role around the safety of the local population. In this role, the DPH seeks assurance 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 national screening programmes, adult and child immunisation programmes.

2.2 This report provides an update on HPF work since the last report to the board, developments around seasonal and pandemic influenza and progress against action plans around BCG (tuberculosis) and immunisations as well as HIV late diagnosis.

3. DETAIL

3.1 The Health Protection Forum meets quarterly bringing together various agencies including Croydon Council, Croydon Clinical Commissioning Group, Croydon University Hospital, NHS England, Public Health England and other agencies relevant to the particular theme under discussion. An update of the work of the HPF is below:

3.2 Viral Hepatitis

3.2.1 The March meeting focussed on blood borne viruses with a particular focus on viral Hepatitis.

3.2.2 The Antenatal and Neonatal Hepatitis B Subcommittee was convened in May where concerns around the following were discussed:

- the forthcoming change in the provider who delivers Hepatitis B vaccination and testing from 4 weeks of age onwards (changed from maternity/paediatric services to general practice in April 2017)
- the forthcoming change in co-ordination of child health data (changed from a Croydon Child Health Information System [CHIS] to a South West London CHIS)

3.2.3 Achievements of the subcommittee meeting included:

- Significant progress towards a comprehensive agreed map of local antenatal and neonatal pathways, roles and responsibilities for Hepatitis B services in the London Borough of Croydon, in the context of National Screening Committee Guidelines.
- Establishing a working network of key contacts in each of the organisations involved with viral hepatitis prevention, testing and treatment in the antenatal setting. This included new members of staff/contacts within the Child Health Information System.

3.3 Air quality and health

3.3.1 The June meeting focussed on Air Quality, bringing together local partner organisations with the aim to discuss how the local air quality strategy can be shaped and supported by all.

3.3.2 An Air Quality Action plan was updated for 2017-2022 and was put out for consultation from 26 June to 21 August 2017.

3.4 Seasonal Influenza

3.4.1 Croydon Council, through their Public Health department is working with local partners like the Croydon CCG and Croydon Health Services to minimize the health impact of seasonal flu in Croydon through strategic coordination of effective communication, robust monitoring, and prevention and treatment strategies.

3.4.2 There is work to ensure that provision for vaccinating frontline council staff is in place and that adequate communication is disseminated to staff.

3.4.3 The LBC seasonal flu plan/ strategy has been developed.

3.5 Pandemic Influenza

3.5.1 Croydon Council- the Public Health and Resilience teams – has been developing a Croydon Council Pandemic Influenza plan.

3.5.2 The plan was out for consultation from 25 September to 3 November 2017.

3.6 BCG

3.6.1 PHE have announced that there are sufficient BCG InterVax stocks to extend vaccination offer to all eligible groups – as listed in Annex A of the Vaccine Update Special edition.

3.6.2 NHS England (NHSE) is the responsible commissioner for the Section 7a neonatal BCG programme which covers the PHE priority groups A and B but it is not responsible for commissioning BCG vaccination services for group C. This commissioning responsibility falls onto CCGs.

3.6.3 As part of the assurance role of the Director of Public Health, the Public Health Department of Croydon Council is working with local partners to address the following issues:

- Implementation of universal vaccination of neonates
- Vaccination of children above the age of 1 who are in high risk groups and were not vaccinated during the shortage
- Pathways for BCG vaccination of looked after children

3.6.4 NHSE is looking to help local CCGs build a service for children in this group (priority group C).

3.6.5 Croydon Council's Public Health Department is also working with local partners to establish clear communication that will clarify the local position to parents and professionals alike.

3.7 MMR/DTaP vaccination

3.7.1 Croydon Council, using their Public Health department, has supported NHS England commissioners and the CCG to review the GP call recall process through visits to 3 of the highest performing and 3 of the worst performing GP surgeries for MMR 2 at 5 years in Croydon. The aim of these visits was to develop a Croydon call recall protocol based on local and NHS England informed best practice.

3.7.2 Croydon Council is working with the CCG variations team and GP IT lead to develop support for practices to ensure they can use the EMIS system to automatically search, and explore possibilities for capturing patient email addresses to increase the options for communicating call recall messages with parents.

3.7.3 The Behavioural Insights Team is working with Public Health specialists within Croydon Council to explore behavioural economics tools that will lead to an improved uptake of vaccine in Croydon.

3.8 HIV late diagnosis

3.8.1 A joint meeting between the Health Protection Forum and the Sexual Health and HIV partnership board was held in November to discuss late diagnosis of HIV.

3.8.2 An overview of the data on HIV prevalence, late diagnosis, testing and service provision in Croydon was presented to attendees.

3.8.3 Croydon University Hospital is working towards implementing HIV testing within the Emergency Department. This will allow for approximately 35-40,000 additional tests each year. Public Health specialists from Croydon Council will be working with partners to understand how other hospitals have implemented HIV testing in ED.

3.8.4 There were questions about how testing was managed within various services and therefore a resulting action to follow up with various providers to ensure that the NICE guidelines regarding testing are fully implemented in Croydon.

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APPENDICES: None