

CROYDON HEALTH AND WELLBEING BOARD

Joint health and wellbeing strategy

2013-2018

STRATEGY DOCUMENT

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Foreword

We make a significant investment in health and wellbeing in Croydon, and as a result we have a lot to be proud of. We are helping more people stop smoking than ever before. Fewer people are dying from cancer and heart disease. Teenage conceptions have reduced. More people are being supported to remain independent for longer. We also face significant challenges however. There are differences in health outcomes across the borough. Increasing numbers of people in Croydon are overweight or obese. There are more older and disabled people needing our support or care. There are reduced resources because of the economic downturn. Many of our health and care services still need to be modernised.

We believe that everyone has the right to good health. We want people in Croydon to be healthy, happy, and resilient. We want our health and care services to be joined up, high quality and safe. When you use our services we want you to have a positive experience of the care you receive. Good health and wellbeing is in everyone's interest. It is everyone's responsibility and requires everyone to play their part. We are committed to ensuring that Croydon becomes a place that supports and enables positive mental and physical health and wellbeing.

Our strategy sets out how we will build on our successes and address the challenges. We will work together with local people, with businesses and with health and social care service providers. We will also work with other boroughs and with the London Health Improvement Board to agree the health issues that need to be tackled across a wider area. This includes the best configuration of services to meet people's needs within the resources available.

This strategy sets out our high level priorities for health and wellbeing in Croydon. It provides a framework for action by organisations who commission and provide the services that promote people's physical and mental health and also their more general wellbeing..

Councillor Margaret Mead

Cabinet member for health and adult social care, Croydon Council

Toni Letts

Vice chair, NHS South West London

Dr Tony Brzezicki

Chair, Croydon Clinical Commissioning Group

Introduction

The Health and Social Care Act 2012 places health and wellbeing boards at the heart of planning to transform health and social care and achieve better population health and wellbeing. Health and wellbeing boards have been given a number of core responsibilities. These include assessing the health and wellbeing needs of the local population through the joint strategic needs assessment (JSNA) and preparing a joint health and wellbeing strategy.

Leaders from across the community have come together to form Croydon's health and wellbeing board. Our focus is on improving health and wellbeing so that individuals and communities are able to live healthier lives, have better health outcomes, and have a better experience of using the health and care system. Health and wellbeing is more than the absence of disease; it is the ability for everyone to fulfil their potential, make a contribution and to be resilient to life's challenges.

This strategy sets out our vision and the long term improvements in people's health and wellbeing that we want to achieve. It also sets out our priorities for action and indicators that will help us measure progress. We expect that it will inform commissioning and service planning for 2013/14 and beyond. We expect that both commissioners and service providers will seek to implement the strategy by seeking integration wherever this can deliver better health outcomes, a better experience for patients and service users and better value for money.

We face significant challenges in the future including an ageing population, rising demand for services, high public expectations of those services and reduced public sector resources. Our strategy, therefore, aims to strengthen the role and impact of positive health promotion and ill health prevention as well as delivering integrated, safe, high quality services within the resources available to us. There are clear links between unhealthy lifestyles and the rise in many long term conditions. It makes sense to invest effort and resources in prevention to help stop people from developing those conditions in the first place.

Our two overarching goals are to increase healthy life expectancy and to reduce differences in life expectancy between communities. We also want people to be as resilient and independent as possible. People have told us that when they do use our services they want to be treated with dignity and respect – to have a positive experience of the care they receive. In order to deliver these goals we have chosen six areas for improvement and twenty six priorities for action. We have also identified measures that will help us track progress.

Our approach begins with work to ensure that our children have the healthiest possible start in life. We want to enable all children, young people and adults to make the best of their capabilities, have control over their lives and to be resilient to

life's challenges. When people use our services we want them to have a positive experience of the care they receive.

There is a strong link between poverty and health: the poorer you are the unhealthier you are likely to be. This is caused by many things, including differences in housing conditions, employment and working conditions, diet, levels of smoking and drinking, access to sport and leisure, social and support networks as well as barriers to accessing healthcare (such as language and literacy barriers). The recent national Strategic Review of Health Inequalities in England emphasised how important access to good education and employment opportunities are for health and wellbeing. Our strategy aims to address these broader determinants of health through working across Croydon's family of partnerships. We will focus on addressing levels of child poverty, improving educational attainment, tackling homelessness and reducing worklessness and long term unemployment.

Some ethnic groups tend to have poorer health outcomes than others. Work by the London Health Observatory suggests that Bangladeshi, Black African and Black Caribbean ethnic groups have significantly higher premature mortality rates than the overall population.

We recognise the importance of economic and social factors on people's health and wellbeing. We will support broader initiatives in Croydon to create fair employment and good work for all and to ensure a healthy standard of living. We also want to work with partners to develop healthy and sustainable places and communities. Action to address health inequalities requires action across all the social determinants of health. However, focusing solely on the most disadvantaged will not reduce health inequalities sufficiently. To reduce the steepness of Croydon's social gradient in health, actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage. Action taken to reduce health inequalities will benefit us in many ways. It will have economic benefits in reducing losses from illness associated with health inequalities. These currently account for productivity losses, reduced tax revenue, higher welfare payments and increased treatment costs. We are committed to understanding the needs of different communities, eliminating discrimination, reducing inequality, protecting human rights and building good relations by breaking down barriers that may be preventing people from accessing the care and services that they need.

The 2010 Spending Review committed the NHS to finding £20 billion in productivity improvements by 2015. This means that the NHS is required to deliver efficiency savings of at least 4% a year – something which is unprecedented in its history. In addition to the efficiency challenge facing the NHS nationally, Croydon Clinical Commissioning Group is also addressing the significant local pressure on commissioned health services to ensure that services are sustainable for the future. In 2012/13, a savings target of £25m (4%) is being delivered, in addition to the national 4%, to address the historical position. Further savings (3%-4%) will be

required in 2013/14. Local authorities, including Croydon Council, are also expected to manage a funding reduction of 26% over a four year period.

Advances in medicine means that more procedures can be done on a day case basis or with a shorter hospital stay. More people can be supported to live independently with home adaptations and use of new technology. This means that our existing services may need to change. Public sector health and social care service providers will be seriously challenged in meeting people's expectations for more and better services whilst managing with fewer resources from central government. We also have the opportunity to create more efficient, evidence based, processes and interventions that benefit patients, service users and the public.

Like many other parts of London we have particular challenges in the recruitment and retention of skilled, professional, staff. A number of important changes are happening to the way our workforce is organised. There are also national skills shortages in some areas of practice, which affect how many of our services can be safely staffed.

We cannot achieve our aspirations alone. The health and wellbeing strategy is connected to a number of other core plans and strategies including the community strategy, the children and young people's plan, the housing strategy and the stronger communities strategy. The south west London Better Service Better Value is currently reviewing how health services are organised across five boroughs. They will be consulting on their proposals in the autumn. The Mayor of London has a general duty to improve the health of all Londoners and a statutory duty to reduce inequalities in health across the capital. The Mayor leads the London Health Improvement Board which has agreed its initial priorities for London wide action as alcohol abuse, childhood obesity and the prevention and early diagnosis of cancers.

Our strategy will be delivered by the actions of health and care commissioners working collaboratively with service providers, council planners, the police and probation service, schools and colleges, local businesses and the voluntary sector. We will need to find new ways to work together to improve the health and wellbeing of the whole community and meet the challenges that the future brings.

The members of the shadow health and wellbeing board have selected their priorities based on the joint strategic needs assessment and an appraisal of the areas where we are likely to have most impact. Our strategy has to be implemented in the context of resources which are shrinking in real terms. This means rigorously applying existing evidence of effectiveness as well as seeking innovative solutions to difficult problems. It also means being clear about the long term costs of not acting now, for example, by preventing health problems rather than just treating ill health.

Our vision

By implementing our strategy we want to achieve real and measurable improvements in health and wellbeing. We also want to reduce the unacceptable differences in health across the borough. We will invest in prevention and early intervention. We will use evidence of effectiveness to inform what we do and we will get the best value from our resources. We will deliver health and care services as close to your home as possible whenever this is appropriate.

Our vision is for longer, healthier lives for everyone in Croydon

Health and wellbeing is more than the absence of disease; it is the ability for everyone in Croydon to fulfil their potential, make a contribution and to be resilient to life's challenges.

Our goals are:

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

Our vision: What will success look like?

1: Increased healthy life expectancy and reduced differences in life expectancy between communities

1.1 Everyone will have the information and support they need to live healthy lifestyles and make healthy choices.

1.2 Local organisations will work together to address the factors that drive health problems amongst the poorest and most disadvantaged.

1.3 Everyone's health will be protected from outbreaks of disease, injuries and major emergencies and remain resilient to harm.

2: Increased resilience and independence

2.1 Everyone will have the opportunity to have optimum health throughout their life and proactively manage their health and care needs with support and information.

2.2 Earlier diagnosis and intervention means that people will be less dependent on intensive services.

2.3 When people become ill, recovery will take place in the most appropriate place, and enable people to regain their health and wellbeing and independence.

2.4 Everyone will live their own lives to the full and maintain their independence by accessing and receiving high quality support if they need it.

2.5 Carers will be able to balance their caring roles and maintain their desired quality of life.

2.6 Everyone will have choice and control and be able to manage their own support so that they can design what, how and when support is delivered to match their needs.

2.7 People will engage socially, as much as they wish, to avoid loneliness or isolation.

2.8 Everyone will enjoy physical safety and feels secure. People will be free from physical and emotional abuse, harassment, neglect and self-harm.

3: A positive experience of care

3.1 People using health and care services will be protected from avoidable deaths, disease and injuries.

3.2 People using health and care services and their carers will be satisfied with their experience.

3.3 Carers will feel that they are respected as equal partners throughout the care process.

3.4 Everyone will know what services are available to them locally, what they are entitled to, and who to contact when they need help.

3.5 People, including those involved in making decisions on care, will respect the dignity of the individual and ensure that support is sensitive to the circumstances of each individual.

How we will deliver our goals

These are the areas for improvement that we have agreed to work together on.

We will achieve our goals by:

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

Our priorities for action

Vision: Longer healthier lives for everyone in Croydon		
Goals <ol style="list-style-type: none"> 1. Increased healthy life expectancy and reduced differences in life expectancy between communities 2. Increased resilience and independence 3. A positive experience of care 		
Improvement area 1: giving our children a good start in life <ol style="list-style-type: none"> 1.1 Reduce low birth weight 1.2 Increase breastfeeding initiation and prevalence 1.3 Improve the uptake of childhood immunisations 1.4 Reduce overweight and obesity in children 1.5 Improve children's emotional and mental wellbeing 1.6 Reduce the proportion of children living in poverty 1.7 Improve educational attainment in disadvantaged groups 	Improvement area 2: preventing illness and injury and helping people recover <ol style="list-style-type: none"> 2.1 Reduce smoking prevalence 2.2 Reduce overweight and obesity in adults 2.3 Reduce the harm caused by alcohol misuse 2.4 Early diagnosis and treatment of sexually transmitted infections including HIV infection 2.5 Prevent illness and injury and promote recovery in the over 65s 	Improvement area 3: preventing premature death and long term health conditions <ol style="list-style-type: none"> 3.1 Early detection and management of people at risk for cardiovascular diseases and diabetes 3.2 Early detection and treatment of cancers
Improvement area 4: supporting people to be resilient and independent <ol style="list-style-type: none"> 4.1 Rehabilitation and reablement to prevent repeat admissions to hospital 4.2 Integrated care and support for people with long term conditions 4.3 Support and advice for carers 4.4 Reduce the number of households living in temporary accommodation 4.5 Reduce levels of worklessness and long term unemployment 	Improvement area 5: providing integrated, safe, high quality services <ol style="list-style-type: none"> 5.1 Redesign of mental health pathways 5.2 Increased proportion of planned care delivered in community settings 5.3 Redesign of urgent care pathways 5.4 Improve the clinical quality and safety of health services 5.5 Improve early detection, treatment and quality of care for people with dementia 	Improvement area 6: improving people's experience of care <ol style="list-style-type: none"> 6.1 Improve end of life care 6.2 Improve patient and service user satisfaction with health and social care services

What we know about health and wellbeing in Croydon: a summary

Each year Croydon's health and wellbeing board reviews health needs in the borough. We have used the evidence in the joint strategic needs assessment (JSNA) to help us identify the needs of local people and agree draft priorities based on those needs. The full joint strategic needs assessment can be found at www.croydonobservatory.org/ihaw/JSNAmain/.

Our population

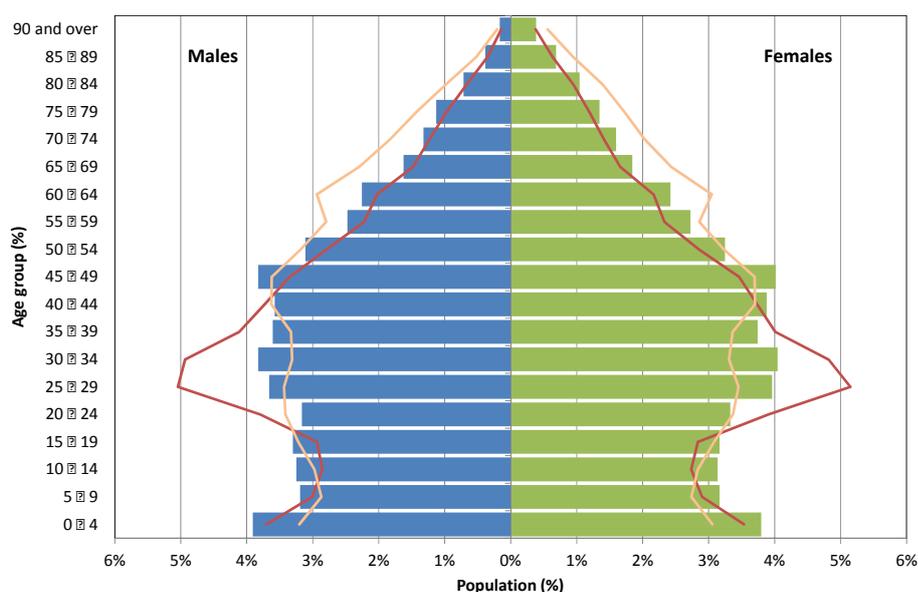
Population size

The first results of the 2011 census show that Croydon's population has grown more quickly in the last ten years than was projected by the Office for National Statistics. The usual resident population of Croydon was estimated to be 363,400 on 27th March 2011. This is 13,600 more people than was estimated by ONS in projections for 2011 based on the previous census (349,800), and 28,000 more people than in 2001 (335,100). If Croydon's population continues to grow at this rate, there will be over 390,000 people in Croydon by 2021.

Age and gender

Nationally, the population is ageing as life expectancy increases and the baby boomer generation approaches older age. Compared to other areas, however, Croydon has a relatively young population. The present high birth rate and effects of migration are expected to result in growth in some of the younger as well as older age groups in coming years.

Age structure of Croydon's population compared with London and England, 2011 Census

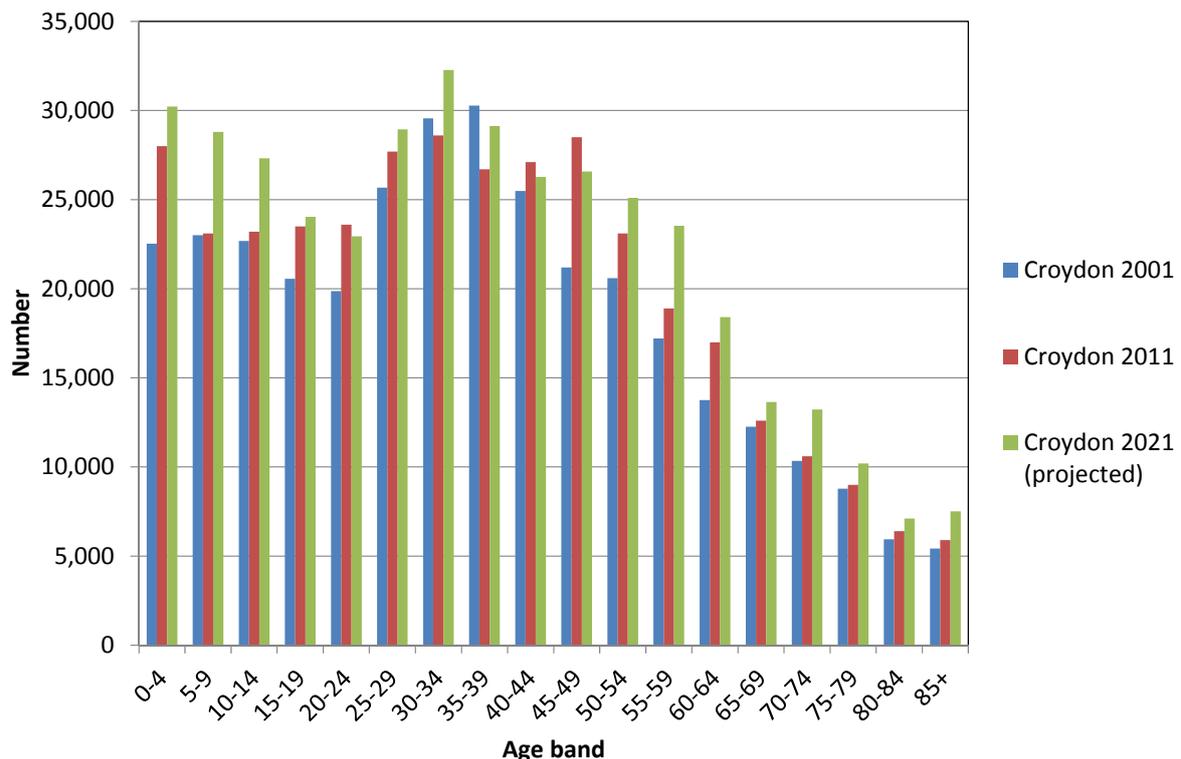


Source: 2011 Census: Population and household estimates for England and Wales, published 16/07/2012

Compared with 2001, in 2011, Croydon had a larger number of children aged under 5 and a larger number of people aged 45 to 64. Croydon has the 5th highest proportion of children aged 0 to 19 (26.9%) out of any London borough compared with London (24.5%) and England (24.0%). For people aged 20 and over, in general, Croydon has a younger population profile than England and older than London.

In the next decade, the highest growth is projected to be in the age groups 0 to 14, 30 to 39 and over 55.

Change in age structure of Croydon's population, 2001, 2011 and 2021 (projected)



Migration

Approximately 18,000 people move into Croydon and 20,000 people move out of Croydon from elsewhere within the UK each year. Croydon's population is subject to a net north to south movement of people migrating from Inner South London to Outer South London and from Outer South London to South Eastern England. Croydon has 6,000-7,000 new immigrants from outside the UK per year and at least 3,000 emigrants. The main areas immigrants have been coming from in recent years are South Asia (India, Pakistan and Sri Lanka: 2,300 people per year), Eastern Europe (Poland, Romania, Lithuania, Bulgaria, Hungary: 1,100 people per year) and certain countries in Africa (Ghana and Nigeria: 500 people per year).

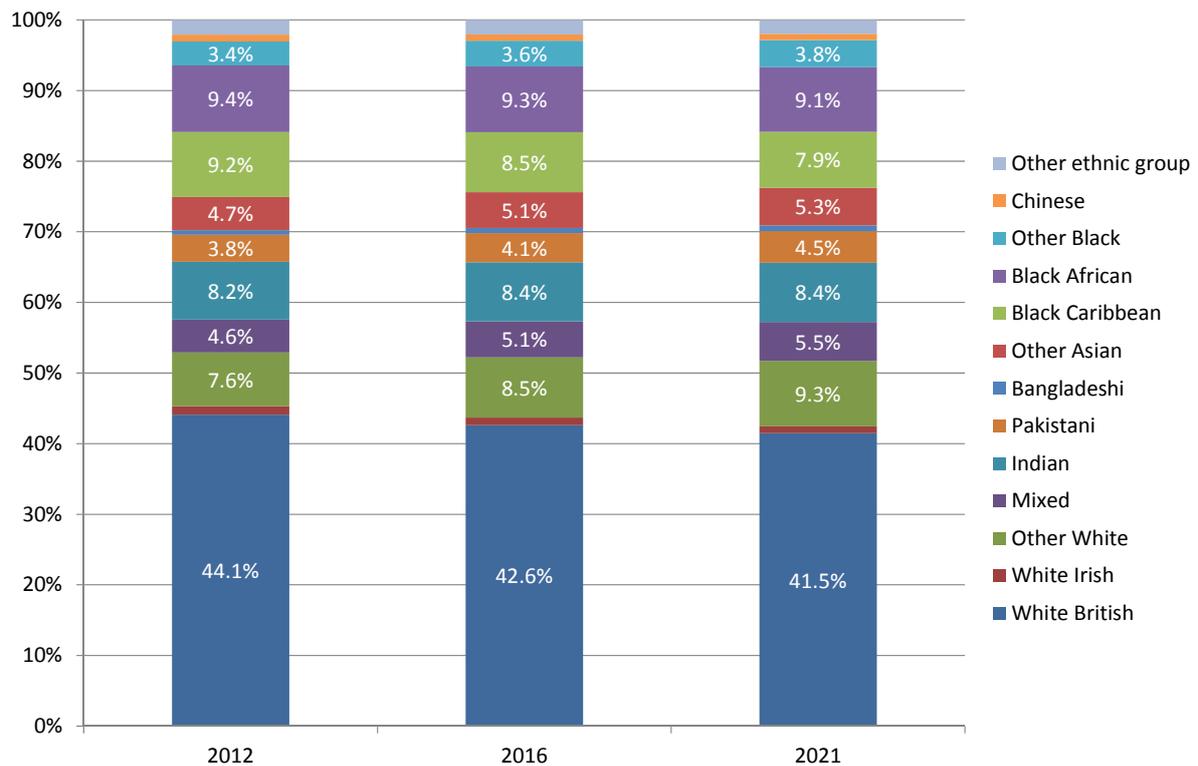
Ethnicity

Over half of Croydon's population are from Black, Asian and minority ethnic groups, and the proportion is increasing over time. The publication of 2011 Census data will provide more accurate estimates of the proportion of Croydon's population in each

ethnic group than the data available at present. The most common languages spoken by people in Croydon other than English are Tamil, Urdu, Gujarati and Polish.

The figure below shows projections based on data from Croydon general practices which will be less accurate than the census.

Projected ethnicity distribution for Croydon’s population based on recent trends in general practice data¹



Source: Data from Croydon general practices, March 2009 to March 2012

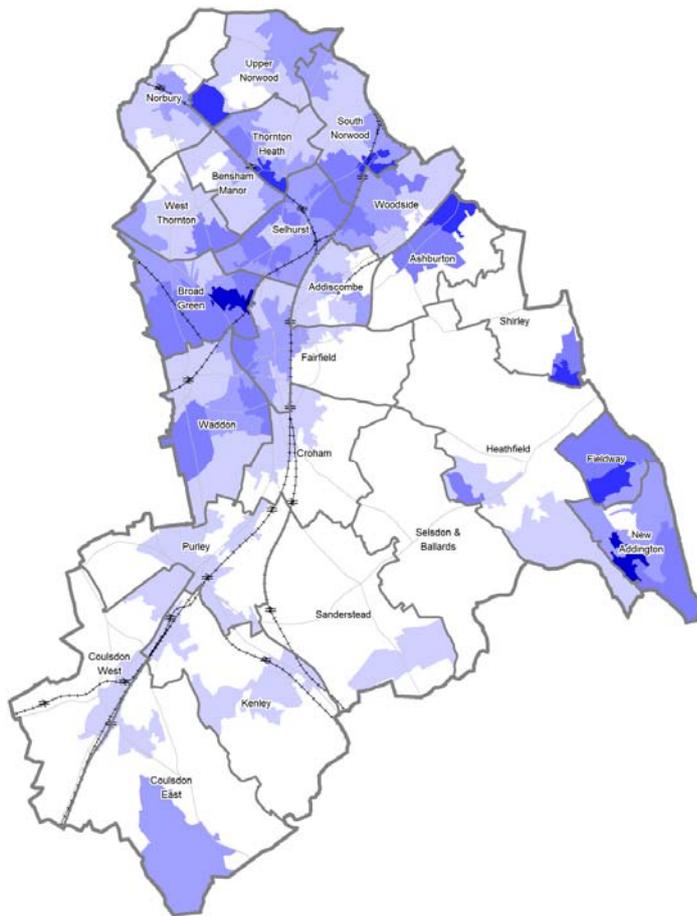
Croydon council provides housing and subsistence to a relatively small number of adult asylum seekers compared to other London boroughs, but is responsible for 43% of unaccompanied asylum seeking children in London (440 in March 2011).

Deprivation

Croydon is more deprived in the north of the borough than in the south, and there are also areas of high deprivation in the east of the borough in Fieldway, New Addington and the Shrublands estate in Shirley.

¹ These projections assume a linear trend within each 5 year age/sex band. Records with unknown ethnicity are excluded and White (not otherwise known) is included in the White British category.

Map showing areas of deprivation in Croydon compared to England, 2010



Compared with super output areas in England



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

In recent years, compared with England as a whole, Outer London has been becoming more deprived, and Inner London more affluent. Between 2004 and 2010, levels of deprivation increased in Croydon more than in any other borough in the south of London. Croydon is currently the 19th most deprived borough in London. If Croydon continues to grow more deprived at the same rate as recent years, by 2020 it will be the 12th most deprived borough in London.

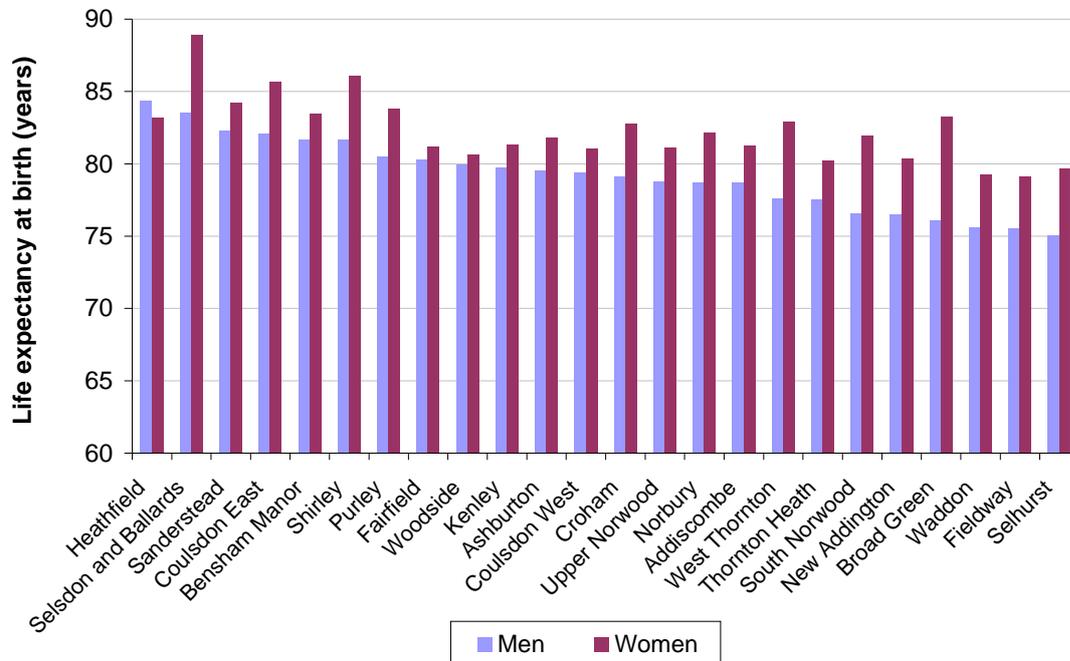
Many of the risk factors for poor physical and mental health are associated with deprivation including poor housing, unemployment, poverty, poor education, and high crime.

Our health needs

The health of people in Croydon is mixed compared to the England average. Life expectancy for both men and women is higher than the England average. However, life expectancy is 9.5 years lower for men and 5.2 years lower for women in the most

deprived areas of Croydon than in the least deprived areas. Deprivation in the borough is lower than average, however 21,565 children live in poverty. Over the last 10 years, all cause mortality rates have fallen. Early death rates from cancer and from heart disease and stroke have also fallen.

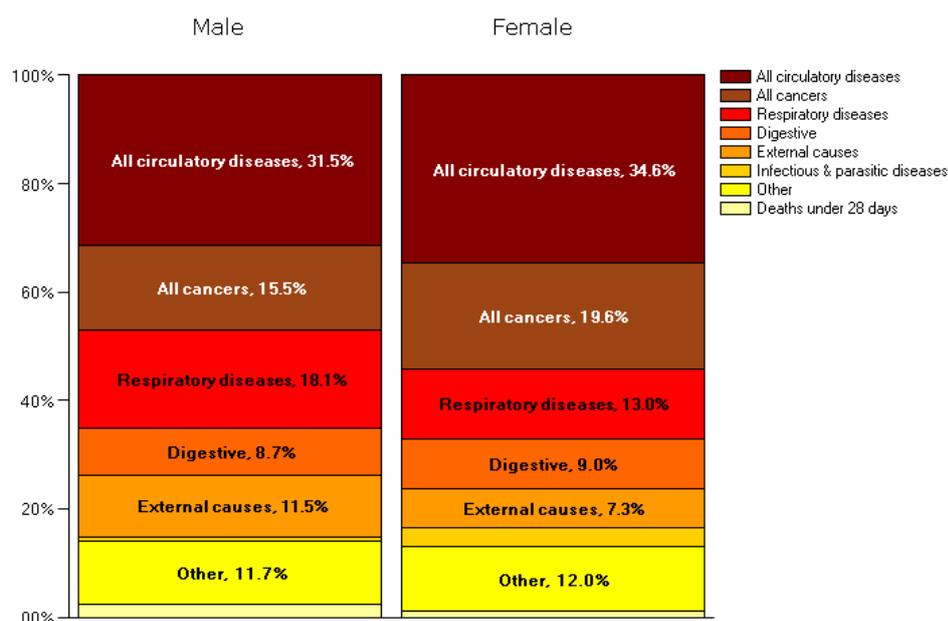
Life expectancy at birth, Croydon electoral wards, 2006-2010



Source: Death registrations and mid-year population estimates, Office for National Statistics

There has been little, if any, significant change in the gap in life expectancy between the most deprived areas and the least deprived areas between 1995 and 2010. Circulatory diseases, cancers and respiratory diseases cause the majority of excess deaths which contribute to the gap in life expectancy.

Breakdown of the mortality gap between the most and least deprived quintiles by cause of death, Croydon



Source: London Health Observatory health inequalities intervention toolkit

Stillbirths and early infant deaths are significantly higher in Croydon than England or London and our performance compared to other areas has deteriorated. Croydon is in the bottom 10% of local authorities for low birth weight babies. The overall infant mortality rate in Croydon has fallen over the last five years and is now close to the London and England average.

Infant mortality numbers and rates, Croydon and England and Wales, 2008 to 2010

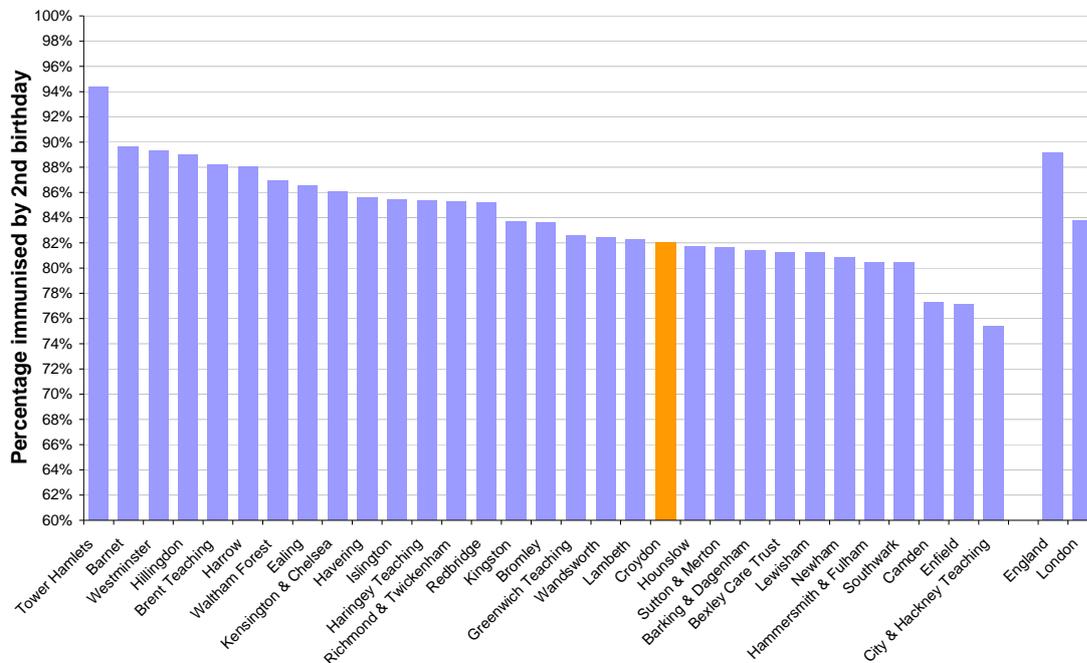
	Croydon					England and Wales	
	No. of infant deaths	No. of still births	No. of live births	Infant mortality rate	Still birth rate	Infant mortality rate	Still birth rate
2008	29	36	5,331	5.4 (3.8 - 7.8)	6.7 (4.7 - 9.3)	4.7 (4.5 - 4.9)	5.0 (4.9 - 5.2)
2009	25	35	5,235	4.8 (3.1 - 7.0)	6.6 (4.6 - 9.2)	4.6 (4.5 - 4.8)	5.2 (5.0 - 5.3)
2010	24	41	5,536	4.3 (2.8 - 6.5)	7.4 (5.3 - 10.0)	4.3 (4.2 - 4.5)	5.1 (4.9 - 5.3)
2008-2010	78	112	16,102	4.8 (3.8 - 6.0)	6.9 (5.7 - 8.3)	4.6 (4.5 - 4.7)	5.1 (5.0 - 5.2)

Source: Office for National Statistics

Breast feeding initiation and continuation is a real success in Croydon, although initiation rates did begin to slip in the last year. Increasing breast feeding will reduce childhood illnesses, which in turn will reduce hospital admissions in the under 1s. Infants who are not breast fed are more likely to become obese in later childhood, develop type 2 diabetes and tend to have slightly higher levels of blood pressure and

blood cholesterol in adulthood. Childhood immunisations rates for measles, mumps and rubella in Croydon do not compare favourably with other areas and appear to be moving in the wrong direction.

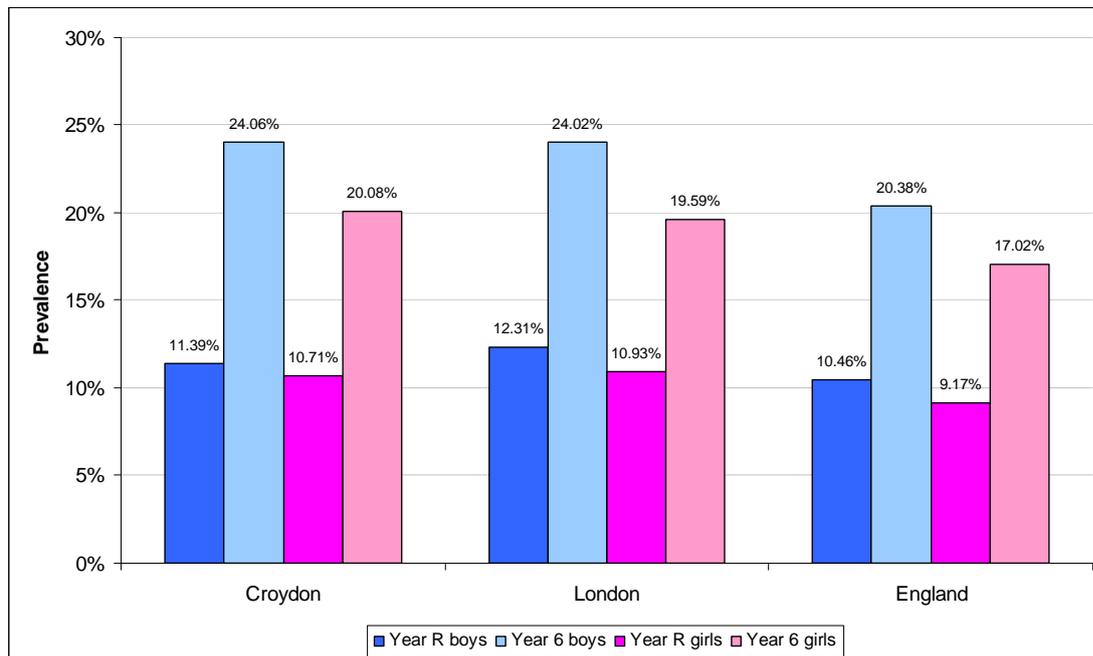
Percentage of children that received the first dose of MMR vaccine by their 2nd birthday, London boroughs 2010/11



Source: The Information Centre for Health and Social Care

Levels of childhood obesity in Croydon are worse than for England, although there has been a slight improvement for Reception Year children. However, nearly a quarter of Year 6 children are classified as obese. This is likely to lead to long term health problems for them as they grow older including diabetes, heart disease and some forms of cancer.

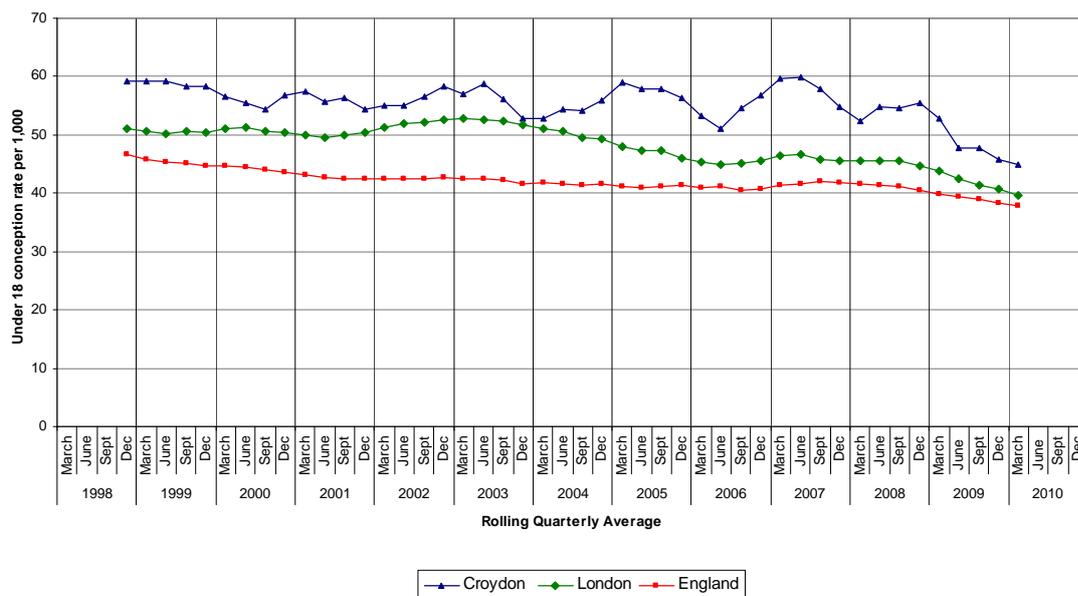
Prevalence of childhood obesity, in school reception year 'R' and year 6, Croydon, London and England 2009/10



Source: National Obesity Observatory and National Child Measurement Programme

Sexual health continues to present challenges for Croydon which has comparatively high rates of diagnoses of Chlamydia, gonorrhoea, herpes and HIV. Croydon compares particularly badly in terms of repeat abortions and late diagnosis of HIV infection. Teenage pregnancy has been a challenge for Croydon. A continuing focus on this issue, however, has led to some real reductions in teen conception rates.

Under 18 conception rate, Croydon, London, England 1998-2010 (rolling quarterly averages)



Source: Office for National Statistics

An estimated 19.7% of adults smoke and 24.3% are obese. There were 6,071 hospital stays for alcohol related harm in 2009/10 and there are 408 deaths from smoking each year. Breast and cervical cancer screening rates are both significantly worse than the national average. Croydon is in the 10% worst performing areas for new cases of tuberculosis.

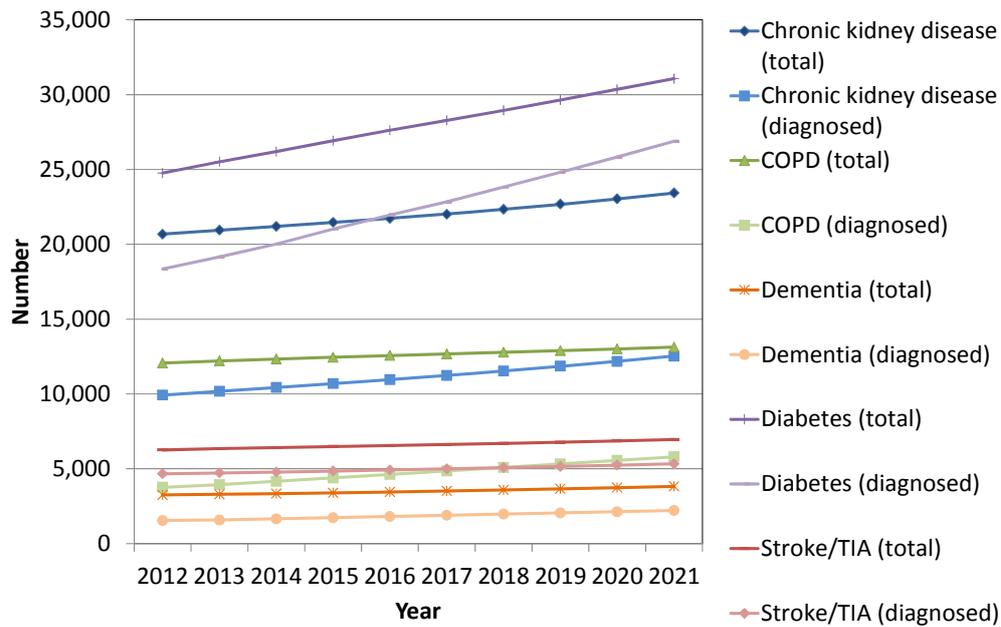
Excellent progress has been made in Croydon in supporting people to stop smoking. For the first time in seven years, Croydon not only met, but exceeded, its smoking quit targets. However, smoking is still the single largest cause of preventable illness and premature death and contributes more than any other identifiable risk factor to inequalities in life expectancy. There is still much work to be done in turning around alcohol related crime, drug offences and increasing physical activity levels

Croydon is in the bottom 10% of areas for satisfaction with ability to see a GP quickly. Croydon performs significantly worse than the national average for end of life care. Rates for emergency hospital admissions are higher compared to other areas than they were three years ago. Croydon's performance for emergency admissions for conditions normally requiring an outpatient appointment has also deteriorated. The rate of emergency readmissions to hospital within 28 days of discharge is also significantly higher in Croydon than nationally.

It is in everyone's interests to ensure that people are able to maintain their independence and stay healthy throughout their lives. However, changes to the make up of Croydon's population and lifestyle trends are likely to lead to more people needing care in the future. People are living longer and our population is ageing. The latest projections suggest the number of people aged over 85 will increase by two thirds by 2029. This is an important trend because we know that older people generally have more health problems and need to use health and care services more than younger adults. There will also be more births. As more women of child bearing age move to Croydon, it's expected that the number of births will rise by around 10% over the next five years. Both the very young and the very old need more care.

It's expected that many more people will be living with long term health conditions in the future. By this we mean health problems that are present for over a year or more, such as diabetes, heart disease, respiratory problems, asthma and epilepsy. People often have more than one of these conditions, especially as they get older. Three out of every five people aged over 60 suffer from a long term condition and as the population ages, this proportion is likely to rise. People with long term health conditions are the most intensive users of health services. They make up around 31% of the population but account for 52% of GP appointments and 65% of planned hospital appointments.

Projected number of long term conditions in Croydon's population, 2012-2021



Source: Projections based on data from Croydon general practices

In the future many people who have long term conditions will need better organised care, closer to home, to help them self manage their conditions and live as independently as possible. This is especially important, given that social trends – such as the increase in single-person households and people living further from their extended family – may mean many people won't receive the support they need from family members and loved ones.

Housing and homelessness represents a significant and growing challenge for Croydon in coming years. The roll out of self directed support has successfully reversed the trends of the previous three years and increased use of personal budgets for social care clients.

What people have told us about their needs

We have gathered information about people's needs from a range of sources. These include consultation findings, surveys, focus group and national evidence. People have a range of views and the findings summarised below reflect some of the tensions and variation in the views expressed.

People get information and advice about health and wellbeing from a wide range of sources. These include television, the internet, newspapers and magazines, social media, friends, family, community members and colleagues. Many people have a preference for face to face communication. They valued written information such as leaflets but usually only as a back up source of information that they could refer to later. Where text is used visual cues are also appreciated by many. Clarity and consistency of information were significant issues, with unnecessary jargon generally disliked. The perceived trustworthiness of the information provider was also important.

Personal responsibility was a recurring theme. Whilst some people felt that responsibility for decisions about lifestyle rest with the individual, others recognised the importance of factors like peer and family pressure and personal circumstances which could influence or shape decisions. Government intervention, such as restricting the sale of cigarettes was generally seen as acceptable but not by all.

Many people say they trade off health benefits or disbenefits against other things. This is not always about pleasure seeking. Many carers, for example, recognise the impact of their caring role on their own health and wellbeing but are prepared, to some extent, to accept this. Different people took different approaches to risk taking, with some prepared to accept higher levels of risk and the associated consequences. Income and time were seen as key factors in influencing healthy lifestyles. Healthy choices were often perceived as more expensive and, for some, out of their reach. Physical activity, for example, was frequently equated with gym membership and the time needed for structured exercise programmes.

Fairness was a key issue for many, although interpretations of what fairness meant varied. Many people wanted uniformity and consistency of provision, wherever they lived and whatever their circumstances. However, views on fairness in relation to others were more complex. Some felt that 'deserving' groups or individuals had greater need and should therefore receive an enhanced or different service. However, some saw it as unfair that 'undeserving' individuals should receive equal or enhanced support, treatment or care.

Independence was often defined as having choice and control. For example, significant numbers of people said that they want to be involved in making decisions about their care or treatment. This is sometimes expressed by the phrase 'no decision about me without me'. However, they also recognised the practical

difficulties that may get in the way of shared decision making, including the extra time this may take, the complexity of some of the information, and people's different capacities to understand and make informed decisions. Some carers also told us that they want to be treated as equal partners in the decision making process. They often felt excluded from decisions that not only affected the person they cared for but which also profoundly affected their own lives.

Whilst choice and control were clearly significant issues, many people also felt strongly about basic standards of services available to them locally, including cleanliness, timeliness, clarity and consistency of information given, professionalism and the attitude of staff. Being treated with dignity and respect was especially important in terms of people's experience of services.

Where can we have the greatest impact? The case for change

We have drawn on evidence of local need from the JSNA and evidence of effective interventions to select the areas where we need to improve and our priorities for action. The areas marked in **bold** in this section are those where we believe that there is the greatest potential for improving the health of people in Croydon across the life course.

Children and young people's health and wellbeing

Low birth weight, which is associated with child poverty, contributes to the infant mortality rate and is linked to poorer development and worse health in later life. Croydon is in the worst 10% of local authorities for low birth weight babies. Infant mortality in Croydon is significantly higher than the average for England and London, and Croydon's performance compared to other local authorities has deteriorated compared to one year and three years ago. Compared with the national average Croydon PCT spends more than average on maternal and reproductive health and achieves poorer outcomes. Evidence based interventions recommended by the National Institute for Health and Clinical Excellence (NICE) to prevent low birth weight and premature birth include helping pregnant women to stop smoking, to manage their weight in pregnancy and improving maternal nutrition.

The long term health benefits mean that **increasing breast feeding initiation and prevalence** is critical to the best possible start in life for our children. Babies who are breast fed have fewer ear and chest infections, are less likely to develop constipation, and less likely to develop eczema. The benefits last throughout life. Breast feeding and weaning appropriately at the right age are key factors linked with preventing obesity and type II diabetes in later life. There are also benefits for the mother, with a reduction in the risk of developing ovarian or breast cancer, as well as helping develop a strong bond between mother and baby.

Croydon has a good record of both initiating breast feeding and maintaining breast feeding at six to eight weeks after birth. For both indicators, Croydon has a significantly higher rate than the national average. However, there is some indication that Croydon's improvement in breast feeding initiation is slowing relative to improvements in other areas. There are geographical variations in breast feeding, with breast feeding initiation highest in Purley (84.2%) and lowest in New Addington (53.5%) and Fieldway (52%). Those groups who are least likely to breast feed are mothers who are young and white British. Evidence based interventions recommended by NICE to increase breast feeding include education and support programmes delivered by both health professionals and peer supporters in accordance with local population needs as well as policies designed to improve and shift attitudes towards breast feeding.

Childhood immunisation is a key element in any strategy to improve health and wellbeing. Infectious diseases such as measles, polio and whooping cough can be very severe with long-lasting consequences. They are potentially fatal. Immunisation programmes save lives and reduce healthcare utilisation. Croydon is significantly below the England average on all the indicators of immunisation rate included in the JSNA for 2011/12. In addition, for five of the six indicators Croydon's performance compared to other local authorities has fallen over the past three years. For the two indicators related to MMR, Croydon is in the bottom 10% of local authorities. Croydon PCT spends more relative to other PCTs on infectious diseases and achieves poorer outcomes. Evidence based interventions recommended by NICE to reduce differences in the uptake of immunisations include improving access to immunisation services; providing tailored information and support and discussing concerns; checking children and young people's immunisation status during health appointments and in other settings and offering vaccinations.

Reducing childhood obesity is important for Croydon due to its long term health impact and the numbers of children affected. People who are obese as children are more likely to be obese as adults and so develop health problems related to obesity such as heart disease and diabetes. Croydon is significantly worse than the England average for the percentage of obese children. In 2011, at Reception year, 10.6% of Croydon children were obese. Amongst Year 6 children the rate was 23.3%. Croydon is amongst the worst performing 10% of local authorities for obesity in Year 6, though our rate for obesity in reception year has improved relative to other areas in recent years. Evidence reviewed by the government sponsored Foresight project indicates that significant action to prevent obesity at a population level is required. Foresight's work indicates that a whole system approach is critical – from production and promotion of healthy diets to redesigning the built environment to promote walking, together with wider cultural changes to shift values around food and physical activity.

The proportion of children in poverty in Croydon has been increasing in the past 3 years, and is significantly higher than the England average. With 27% of children under 16 living in poverty, Croydon is amongst the 25% of local authorities with the highest levels of child poverty. Child poverty has a lasting effect on an individual's life. In terms of health outcomes individuals born in poverty are more likely to die in infancy, develop chronic illness, or be injured in an accident. They have a shorter life expectancy than individuals from better off families. There is significant variation across the borough. In Fieldway, nearly half of children aged under 16 live in poverty, whereas in some wards in the south of the borough, 1 in 10 children or fewer live in poverty. The Frank Field review on poverty found strong evidence that children's life chances are heavily influenced by their first five years of life.² The

² Field, F. (2010). The foundation years : preventing poor children becoming poor adults : the report of the Independent Review on Poverty and Life Chances. London, Cabinet Office.

evidence indicates that supporting a family in the earliest years of a child's life is the most effective and cost effective approach to child poverty and to improving outcomes across the life course. By targeting our **support for children and families with complex needs** we will improve their life chances and reduce their dependence on services in the future.

Good **emotional health and wellbeing** in infants, children and young people is essential for them to do well in later life. It is vital for their development. This includes physical development, as well as learning to get along with other people and being able to think and learn. Children and young people who are emotionally resilient are more able to deal with difficulties in their lives and to cope with uncertainty. At least 10% of children between the age of five and fifteen will have a diagnosable mental health disorder; 5% will have a clinically significant disorder that will need specialist support; 10% of young people self harm as a way of coping with emotional pressure; 15% of males and 25% of females aged fourteen to twenty-five will experience emotional health difficulties.

Reducing teenage conceptions has important benefits for short and long term health outcomes. Teenage parents are at increased risk for post natal depression and poor mental health in the three years following birth. They are more likely than older mothers to have low educational attainment, experience adult employment and be living in poverty at age 30. Their children experience higher rates of infant mortality and low birth weight, A&E admissions for accidents and have a much higher risk of being born into poverty.

Croydon's teenage conception rate for young women aged 15-17 years was 45.7 per 1000 in 2009. This is a reduction of 22.7% from the 1998 baseline and a significant improvement on previous years. However, Croydon's under 18 and under 16 conception rates both remain significantly higher than national average. Whilst the under 16 conception rate in Croydon is worse relative to its position three years ago, the one-year trend for both age groups shows Croydon has improved relative to other local authorities.

Reproductive and sexual health

Croydon's performance on almost all **sexual health** indicators is significantly worse than the national average. The total number of new sexually transmitted infections diagnosed by the Croydon genitourinary medicine (GUM) clinic fell by 11% between 2008 and 2009, after having risen by 36% between 2007 and 2008. Chlamydia is the most commonly diagnosed sexually transmitted infection at the Croydon University Hospital GUM clinic with 1,161 new diagnoses in 2009. Croydon currently has one of the highest rate of repeat abortions in the country. In 2008, 953 Croydon residents accessed care for HIV. In 2008, 40% of HIV patients in Croydon were diagnosed late compared with a London average of 30%. Croydon PCT spends less relative to other PCTs on sexual health and achieves poorer outcomes. Appropriate investment in sexual health services can deliver significant savings. For example, for every £1 spent on contraception £11 is saved in health care costs.

Illness, injury, premature death and long term health conditions

Coronary heart disease (CHD) is the major cause of premature death in Croydon, particularly amongst men, who are three times as likely as women to die of CHD before the age of 75. . Stroke is a less important cause of premature death in either men or women in Croydon relative to other areas. Croydon has the second highest inequality gap in London for premature deaths from cardiovascular diseases (CHD and stroke). The most deprived communities in Croydon have a death rate up to three times as high as the least deprived communities.

The London Health Observatory has estimated that about a third of the gap between the highest and lowest life expectancy in Croydon is accounted for by cardiovascular diseases. The prevalence of smoking and obesity – two key risks factors for developing cardiovascular diseases – follows the same pattern, with rates being higher in deprived areas. Estimated smoking prevalence amongst adults in Croydon is 19.7%. The estimated prevalence of adults who are obese is 23.5%. Physical inactivity also increases the risk of developing cardiovascular diseases, whether or not someone is overweight or obese. The limited evidence available suggests that socio-economic factors play a part here too.

Evidence based interventions recommended by the National Institute for Health and Clinical Excellence (NICE) to prevent cardiovascular diseases include helping people stop smoking, and helping people lose weight including increasing opportunities for people to be active. As well as preventing cardiovascular diseases the **early detection and management of cardiovascular diseases** will improve health outcomes overall.

Cancers are the second largest cause of death in Croydon. This category of diseases includes lung cancer, breast cancer, prostate cancer, colorectal cancer, and cancers of the stomach and oesophagus. Mortality from cancer is lower in Croydon than the national average for all the common cancers, and is significantly lower for early deaths from cancer, all deaths from cancer, and deaths from oesophageal cancer, lung cancer, and breast cancer. Deaths from cancers make up 15.5% of excess deaths in men and 19.6% of excess deaths in women when comparing mortality between the most and least deprived parts of Croydon. However, performance against some indicators is moving in the wrong direction compared to other local areas. The number of new cases of colorectal cancer, where Croydon has a rate close to the national average, and the number of new cases of skin cancers, (while occurring at a rate significantly lower than the national average), have both been increasing relative to other areas over the past three years.

As well as primary prevention, the **early detection and treatment of cancer** is likely to make a significant difference to people's health outcomes. For many cancers the earlier the cancer is detected and treated the better the outcome, either in terms of survival or quality of life. Some treatments also tend to be more straightforward and easier for patients if they are started earlier (with potential to avoid surgery or

radiotherapy, shorter courses of chemotherapy or radiotherapy). Early diagnosis is not cost saving, but can be cost effective, for example Department of Health modelling suggests £2,000 to £5,000 per year of life saved for the three cancers modelled (colorectal, breast, lung). An area of particular concern in Croydon is the uptake of screening for breast and cervical cancer. The breast screening and cervical screening coverage rates in the borough are both slightly lower than the national average. Whilst it appears that work on promoting cervical screening may be having an impact with improving performance, breast cancer screening rates are dropping relative to other local authorities on both one year and three year trends.

Respiratory diseases are Croydon's third biggest killer. Deaths from respiratory diseases make up 18.1% of excess deaths in men and 13% of excess deaths in women when comparing mortality between the most and least deprived parts of Croydon. Chronic obstructive pulmonary disease (COPD) is a descriptive term covering long term respiratory conditions affecting the lungs, primarily emphysema and chronic bronchitis. Most COPD is caused by smoking, and it develops over many years. It can be prevented by reducing the number of people who smoke. Stopping smoking also benefits people who already have COPD. It has a high cost to the health service, and dramatically limits the quality of life of sufferers. In Croydon, there is a large discrepancy between the number of COPD patients on GP registers and the number expected by the prevalence estimates. It is likely that there is a large burden of unknown and unmet need in people with COPD.

Smoking is the single largest cause of preventable illness and premature death with over 18% of deaths in over 35s attributable to smoking. It contributes more than any other identifiable risk factor to inequalities in life expectancy. **Reducing the prevalence of smoking** will have a considerable impact on a range of health outcome indicators, particularly deaths from the three biggest killers in Croydon: cardiovascular diseases, cancer and respiratory diseases. Smokers in the lowest income decile spend over one tenth of their income on tobacco (compared to an average for all smokers of around one twentieth). In 2008, 493 deaths were caused by smoking in Croydon, which led to a cumulative loss of 3,099 life years. This took £7.7m out of the economy in 2008, and £47.6m in total. Smoking related sick days cost Croydon nearly £28m. Smoking breaks taken during working hours cost Croydon businesses £65m. Fewer than 200 jobs are dependent on tobacco sales in Croydon. Twenty three fires were caused by smoker materials in Croydon in 2007 at a cost of £0.66m. If Croydon achieves the national target to halve the smoking prevalence rate by 2020, it will save the local economy over £470m, which is the equivalent of over £15,000 per smoker who quits.³

³ Kearney, J. (2010). Quantifying the cost of smoking to Croydon PCT. London, NHS Croydon.

Diabetes shares some of the risk factors of circulatory diseases, and is itself an independent risk factor for developing these conditions. It is a long term disabling condition. There are higher rates of diabetes amongst men compared with women at all ages and the obesity rates for patients diagnosed with diabetes are twice as high as those in the general population. The **early detection and management of diabetes** will lead to improved outcomes for the large number of people in Croydon affected. The estimated prevalence of diabetes in Croydon was 5% in 2009. At the end of March 2010, 16,516 or just over one in 23 of all patients registered with Croydon GPs had been diagnosed with diabetes. It is estimated that a further 2,666 patients registered with Croydon GPs have either not been diagnosed or have not had their diabetes recorded correctly. Diabetes causes around 14% of deaths in Croydon residents aged between 22 and 79. In 2008/09, diabetes accounted for 9.7% of all NHS Croydon's prescribing costs. Croydon diabetes services underwent a major restructuring in 2009 and comparative data allowing an assessment of the effects of the restructuring shows some improvement. Evidence based interventions recommended by the National Institute for Health and Clinical Excellence (NICE) to prevent diabetes include helping people lose weight through promoting a healthy diet and promoting physical activity.

Although the amount of alcohol most people drink poses little harm to their health around 24% of adults drink a hazardous or harmful amount. **Reducing alcohol related harm** will improve health overall as well as contributing to reducing crime and disorder and a range of other social problems. Alcohol consumption is associated with many chronic health problems including psychiatric, liver, neurological, gastrointestinal and cardiovascular conditions and several types of cancer. It is also linked to accidents, injuries and poisoning. Drinking during pregnancy can also have an adverse effect on the developing foetus. The resulting problems can include lower birth weight and slow growth, learning and behavioural difficulties and facial abnormalities.

The number of hospital stays for alcohol attributable conditions in Croydon is higher than it was compared to three years ago. The same is true for alcohol related crimes which are significantly more common in Croydon than nationally. Deaths from digestive disorders, many of which are alcohol related, make up 9% of excess deaths in men and 5.9% of excess deaths in women when comparing mortality between the most and least deprived parts of Croydon.

Influenza is a serious illness which can be life threatening amongst vulnerable groups, including older people and those with long term health conditions. It is preventable by annual immunisation against current strains of the flu virus. Croydon is amongst the bottom 10% of local authority areas for uptake of immunisation against influenza in those over 65 years old. Last year, only 67% of over 65s in Croydon received a flu jab, compared to 73% nationally. Croydon's performance has fallen by more than 10% relative to other areas, leaving Croydon with one of the lowest uptake rates in the country and the lowest uptake rate of any London

borough. **Increasing the uptake of influenza vaccination** in vulnerable groups will result in reductions in influenza related respiratory illness and GP consultations, hospitalisation and deaths and work absenteeism.

Resilience and independence

The JSNA highlights that Croydon performs poorly against indicators for helping older people achieve independence through rehabilitation, as well as for supporting older people to live independently at home. However, outcomes from rehabilitation and intermediate care are improving, with the proportion of older people who were still at home 91 days after discharge from hospital increasing from 65.3% to 73.3% in 2010/11. A focus on **promoting rehabilitation and reablement** will help us continue to improve outcomes for older people and people with long term conditions.

Three out of every five people aged over 60 have a long term health condition and as the population ages, this proportion is likely to rise. This trend has important implications for both the amount of health and social care needed in the future and the type of care that will be most appropriate. Many people with long-term conditions go undiagnosed. It is thought that up to one third of people with diabetes may be undiagnosed. We know that people with long term health conditions are the most intensive users of health services. Across the UK, they make up 31% of the population but account for 52% of GP appointments, 65% of planned hospital appointments and approximately 80% of all prescriptions. They also account for one of every three hospital bed days. Long-term conditions also lead to many people going to hospital in an emergency. The main challenge is connecting parts of the health and social care system so people are supported to manage their own health problem better. At the moment, people who want to manage their own condition better are not always supported. There is often poor coordination between GPs, practice nurses, community pharmacists, social services and hospital staff. Redesigning **support services for people with long term conditions** will ensure that they are able to stay independent as much as possible and that the care they receive is appropriate and cost effective within the resources available.

Estimates suggest that Croydon has about 30,000 carers, 5,000 of whom are providing more than 50 hours of care each week. These are the wives, husbands, daughters, sons and friends of people who are disabled, frail or ill – many of whom also receive some social care support. **Support and advice for carers**, including young carers, is important to ensure that those they care for stay as independent as possible and do not have to use services unnecessarily. It is also important to ensure the health and wellbeing of carers themselves.

One in four people will experience a mental illness in their lifetime. There are around 105,000 people in Croydon who suffer from depression and mood disorders and there are about 4,000 who have been diagnosed with severe mental illness. The World Health Organisation predicts that by the year 2030 there will be more people

affected by depression than any other health problem. Those with a mental health problem are also more likely to have problems with their physical health, experience isolation, housing and financial problems. National data indicates that the life expectancy of someone with a severe mental illness is between 18 and 20 years less than average life expectancy.

£1 pound out of every £8 spent by the NHS in Croydon goes on the treatment of mental health problems. Although this is our biggest single programme budget spend, we spend less per head of population than similar areas, but more on secondary and tertiary care. A large proportion of investment goes into high end services for the relatively small number of people with more serious problems. A very small number require specialist, high cost, placements outside the NHS, sometimes for a number of years. The majority of people with mental health problems have less serious conditions, are often seen only in primary care and may benefit hugely from prevention and early intervention approaches. **Redesign of mental health pathways** will help us rebalance the local system of care for people with mental health problems and enable us to respond to their needs more flexibly.

Dementia is a growing problem locally and nationally. Estimates suggest that Croydon has approx 3,200 people with dementia but this is set to rise to 4,200 by 2025 and exceed 6,000 by 2040. **Support for people with dementia** needs to address this trend. We need to ensure that people with dementia can remain independent for longer without placing unreasonable demands on those who care for them. Service redesign and the use of assistive technology and telecare will help us do this.

Health and care services

Demographic trends and financial pressures mean that the organisations that purchase or provide health and social care services for local people have to find new ways of delivery. Advances in surgical techniques, drugs and equipment means that more surgery can be done on a day case basis or with a shorter hospital stay. There is evidence that greater specialisation in surgery, the development of comprehensive pathways and the separation of planned and unplanned surgery often leads to better outcomes for the patient, improved quality and safety and an improved patient experience. In some areas of planned care there is also scope for increased productivity through the development and consistent application of clear pathways for specific conditions. This is important given projections of greater demand for planned surgery as a result of population growth and advances in surgical techniques. At the moment patients requiring planned surgery can come off second best when pressure increases in hospitals for theatre time or beds to treat patients with urgent or emergency care needs. This can result in cancellation or delays in their planned surgery. **Redesign of planned care pathways** will help us address these factors and deliver the best possible outcomes within the resources available.

Urgent (or unscheduled) care is urgent advice or treatment in cases that are not life threatening. Emergency care is care provided in a medical emergency, when life or long term health is at risk. A number of factors mean that we need to **redesign urgent and emergency care pathways**. There is increasing demand for accident and emergency (A&E) services. Some people use A&E for non emergency needs and could be more appropriately treated elsewhere. There are also not enough senior doctors present in our local accident and emergency departments. As a result patient safety and outcomes are being compromised. The responsiveness and quality of our urgent care services is variable with many people finding it difficult to access urgent GP appointments, particularly out of hours.

Improving the quality of maternity and newborn services is critical. There is an increasing demand for maternity services and, generally speaking, pregnancies are becoming more complicated. More women of child bearing age are living in or moving to Croydon. The number of women giving birth is expected to increase by 10% over the next five years. The average age of women giving birth is going up, leading to a higher risk of complications. Obesity among women is also rising, which tends to increase the risk of complications during pregnancy and birth. There are not enough senior doctors present during childbirth. There is also not enough one to one midwife care during childbirth. There is evidence that one-to-one care has a positive impact on the health and wellbeing of mother and child. There are challenges recruiting enough midwives and many midwives end up leaving.

End of life care helps people with incurable illness or worsening health problems to live as well as possible until they die. Not enough people are spending the end of their lives in locations of their choice. Around one in three Croydon residents dies in their place of usual residence, although nearly two thirds of people say they would prefer to die at home. There are too many people who die in hospital when equally good end of life care can be provided in other places. This is because people will tend to be taken to A&E when they become ill and, if their poor prognosis is not recognised or if support in the community cannot be arranged quickly, it is likely that they will die in hospital. A great many people may be involved in providing end of life care including doctors, nurses, therapists, social workers, volunteers, equipment suppliers. This can be confusing for people and their carers. Better coordination of care across different locations and by different professionals is needed. **Improving the quality of end of life care** in hospitals and across all other settings will make a positive difference to people at the end of life and their carers. The aims of end of life care are that everyone should have a dignified and peaceful end to their life in a location of their choice (at home, in care homes, in hospitals, in hospices), regardless of their age or cause of death.

Improving people's experience of health and care services will be an important measure of success. Different services have different opening times, serve different needs and have different eligibility criteria, often leaving people confused. They may end up using emergency services, such as accident and emergency departments,

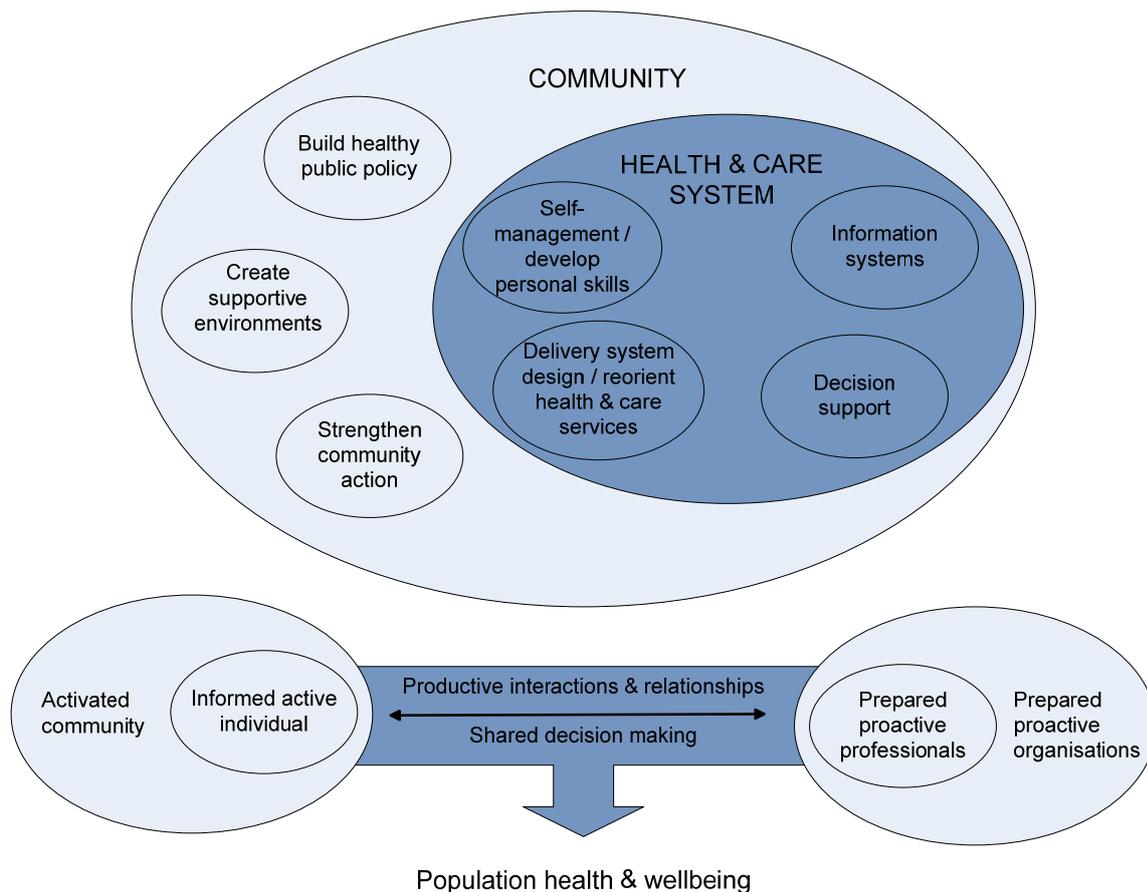
because they don't know where else to go. Services don't always work well together. People experience duplication, often having to give the same information several times. Some people don't receive the services that they need and are entitled to. There are still too many examples of poor communication, poor listening skills amongst staff and a lack of accessible information. This has a marked impact on the experience of people and their families.

How will we deliver the improvements we want to achieve?

In order to deliver our goals of increased healthy life expectancy and reduced differences in life expectancy; increased resilience and independence and a positive experience of care, we have identified six areas for improvement. These are areas where we expect commissioners, service providers and organisations to work together to deliver improved outcomes for local people. They are:

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

The model below identifies areas in our health and care system, organisations and the broader community which we need to change to help us improve health and wellbeing. We have chosen to use this model as it is an evidence based, population focused, and person centred framework. This will help us work towards informed, active and empowered individuals making choices about their lifestyle, taking responsibility for self-management where appropriate, and working with professionals to make shared decisions about treatment and care.



4

As well as changing the way we deliver health and care services and empowering individuals and communities, we also need to address the social factors which affect people's ability to live healthy lives. These include poverty, education, housing and employment. We will work with community partners to build healthy public policy, create supportive environments and strengthen community action for health and wellbeing. The Marmot Review *Fair society, healthy lives* identified six areas where additional action is needed to improve health and reduce inequalities. These are:

- Give every child the best start in life
- Enable all children young people and adults to maximise their capabilities and have control over their lives
- Create fair employment and good work for all
- Ensure a healthy standard of living for all
- Create and develop healthy and sustainable places and communities
- Strengthen the role and impact of ill health prevention

⁴ Adapted from BARR, V. J., ROBINSON, S., MARIN-LINK, B., UNDERHILL, L., DOTTS, A., RAVENSDALE, D. & SALIVARAS, S. 2003. The expanded chronic care model: an integration of concepts and strategies from population health promotion and the chronic care model. *Hospital Quarterly*, 7, 73-82.

We have chosen a small number of priorities relating to the broader determinants of health where we intend to work across Croydon's family of partnerships to address areas of particular concern for Croydon. These are to reduce levels of child poverty; to improve educational attainment for vulnerable groups; to reduce the number of families living in temporary accommodation; and, to reduce levels of worklessness and long term unemployment. There are a number of plans and strategies already in place that will help us achieve this. We will also need to identify gaps and work with our partners to address these. Existing plans and strategies which address the broader social and economic determinants of health in Croydon are set out on the following page.

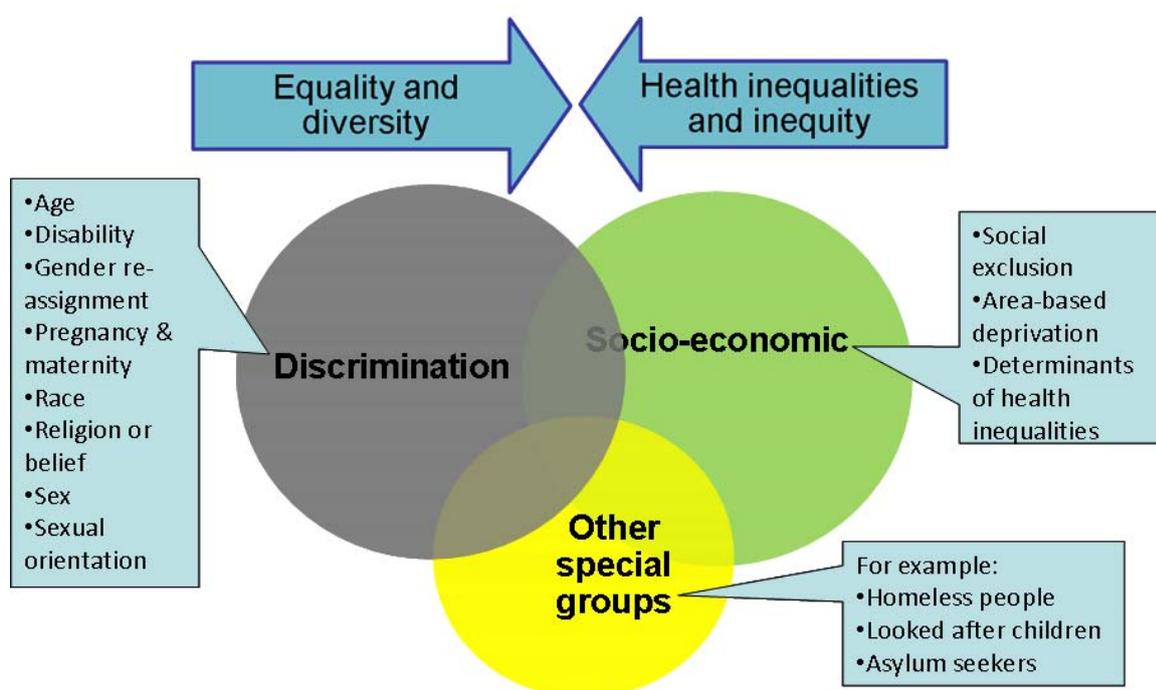
[TABLE OF MARMOT POLICY AREAS AND RELEVANT CROYDON PLANS AND STRATEGIES HERE]

Promoting equality

Everyone in Croydon can be described in terms of their age, disability status, ethnicity, gender/sex, religion/belief, sexual orientation or transgender identity. Understanding the characteristics of an individual can help to improve individual care and support at the point of service delivery. Recording and analysing information about personal characteristics can help to plan services that are accessible and beneficial to all.

The public sector duty on equalities included in the Equality Act (2010) places a requirement on all public bodies to consider the impact of policies and services on the needs of individuals with the 'protected characteristics' of age, disability, gender, gender reassignment, pregnancy and maternity, race, religion or belief and sexual orientation. There is also a legislative requirement that human rights are considered by public bodies and this has some crossover with equality legislation. So as well as reducing differences in health between communities we also have a duty to promote equality. Our expectation is that those who commission or provide health and care services take account of this. The diagram below shows how work to address these goals interacts.

Dimensions of equality⁵



⁵ Diagram reproduced by permission of Nick Doyle, Clinical and public health analyst – policy, NICE

How we will track progress

The board expects that this strategy will be used by commissioners to shape their future commissioning intentions. We will regularly review the plans of health and social care commissioners to ensure that they are aligned to the strategy. We may also wish to periodically review and amend the strategy in line with changing patterns of need identified through the joint strategic needs assessment.

We will use the indicators on the next page to help us track progress over the life of the strategy. Our performance management framework will include baseline information against these indicators and set out the improvements we want to see over time.

[Indicators and targets here]

<p>Vision: Longer healthier lives for everyone in Croydon</p>		
<p>High level outcome measures:</p> <ol style="list-style-type: none"> 1. Increased healthy life expectancy 2. Reduced differences in life expectancy between communities 		
<p>Improvement area 1: Giving our children a good start in life</p> <p>Under 18 conceptions Low birth weight of term babies Smoking status at time of delivery Breastfeeding initiation and prevalence Tooth decay in 0-5s Excess weight in 4-5 and 10-11 year olds</p>	<p>Improvement area 3: preventing premature death and long term health conditions</p> <p>Infant mortality Life expectancy at 75 Deaths from causes amenable to healthcare Early deaths from cardiovascular disease Early deaths from cancer Early deaths from respiratory disease Early deaths from liver disease Recorded diabetes Cancer screening coverage Take up of NHS Health Checks</p>	<p>Improvement area 5: providing integrated, safe, high quality services</p> <p>Emergency admissions for conditions that should not usually require hospital admission Patient safety incidents reported Safety incidents involving severe harm or death Reduce the incidence of avoidable harm Admission of full term babies to neo-natal care Incidence of harm to children due to 'failure to monitor'</p>
<p>Improvement area 2: Preventing illness and injury and helping people recover</p> <p>Population vaccination coverage Smoking prevalence Excess weight in adults CH amydi a diagnoses (15-25 year olds) People presenting with HIV at a late stage of infection Cancer survival rates (colorectal, breast, lung) Alcohol related hospital admissions Fuel poverty Falls and injuries in the over 65s Patient reported outcomes for elective procedures</p>	<p>Improvement area 4: supporting people to be resilient and independent</p> <p>Proportion of older people still at home 91 days after discharge Emergency readmissions Health related quality of life for people with long term conditions Proportion of people feeling supported to manage their condition Employment of people with long term conditions, people with learning disabilities and people with mental illness Health related quality of life for carers</p>	<p>Improvement area 6: improving people's experience of care</p> <p>Patient experience of primary care Patient experience of hospital care Access to GP and NHS dental services Women's experience of maternity services Patient experience of community mental health services</p>