Croydon Joint Strategic Needs Assessment 2009-10

Executive summary

Contents

What is joint strategic needs assessment?

Joint strategic needs assessment is a process that identifies current and future health and wellbeing needs in light of existing services, and informs future service planning taking into account evidence of effectiveness.

Joint strategic needs assessment identifies the big picture in terms of the health and wellbeing needs and inequalities of a local population.

Introduction

The Local Government and Public Involvement in Health Act 2007 requires NHS primary care trusts and local authorities to produce a joint strategic needs assessment (JSNA) of the health and wellbeing of their local community, informing the priorities and targets set by local area agreements and leading to agreed commissioning priorities that will improve outcomes and reduce health inequalities.

Croydon's JSNA document for 2009-10 is the second annual compendium of a rolling programme of strategic assessment of Croydon's health and social care needs. The updated **borough health profile** gives an overview of health and wellbeing in the area. This is followed by a **summary of our core dataset and 2009 health profile**. The chapter on **future demand for services** takes information from the core dataset, population projections and other sources of local data to assess the likely impact of changes on demand for health and social care services.

The JSNA contains three chapters which report findings and recommendations from needs assessments commissioned over the year by the JSNA programme board. The chapter on **geographical health inequalities** looks at variations in health outcomes in relation to deprivation in Croydon. It makes recommendations on interventions which are likely to have most impact on reducing geographical variations in health outcomes. It also describes existing work to address health inequalities. The chapter was commissioned to help partner organisations develop a local target and plan for reducing geographical variations in health outcomes.

The chapter on **healthy weight, healthy lives** assesses the scale and distribution of overweight and obesity in Croydon. It describes services in place to help people achieve and maintain a healthy weight, and makes recommendations on the prioritisation of services to be commissioned in the future. The assessment work has informed the development of a new joint healthy weight, healthy lives strategy for the borough.

Provision for **children with special educational needs and disabilities** is covered in the final chapter of the JSNA. The analysis of need and recommendations will shape the development of new joint commissioning and inclusion strategies for this group of children.

Topics for in-depth analysis in Croydon's joint strategic needs assessment programme are selected by the JSNA programme board following a process of engagement with partner organisations and members of the public. Proposals for needs assessment have been elicited from commissioners, clinicians, representatives of voluntary organisations, representatives of the public, and the chairs of Croydon's joint planning partnership groups. These stakeholders are brought together annually in September to review progress on current needs assessments and identify potential topics for the future. Selection criteria are reviewed annually.

The JSNA programme board is chaired by the council's executive director of adult services and housing. Membership includes the director of public health and the executive director of children, young people and learners. The voluntary sector is represented by the local umbrella body Croydon Voluntary Action. Members of the public are represented by Croydon Local Involvement Network (LINk) and Croydon Disability Forum. The JSNA programme board reports to the local strategic partnership.

The JSNA is intended to inform strategic planning in Croydon. It has helped us select priorities and targets for the local area agreement (LAA), community strategy, the council's corporate plan, and NHS Croydon's strategic and operational plans. It has also been used to review and refine more detailed plans. Last year's JSNA contained an assessment of work to address teenage pregnancy. This informed the development of a re-focused teenage pregnancy action plan agreed with government ministers in June 2009. This year's JSNA will be used to inform the forthcoming updates of the LAA and the local joint health improvement plan *Improving health and well-being*. Two pieces of work commissioned by the JSNA programme board as part of the forthcoming year's programme of needs assessment will underpin a new older people's strategy for the borough and the first sexual health strategy for Croydon.

Commissioners and clinicians have been actively engaged in identifying areas for needs assessment. A workshop in September 2008 involving commissioners, clinicians, providers and members of the public identified priority outcome areas from which the 2009-10 JSNA priorities were selected. Commissioners have also made use of the JSNA process to inform commissioning strategies. Recommendations from the 2008-09 mental health services needs assessment for example, have informed the review of provider contracts including services to improve access to talking therapies, support for people to return to work and community development in black and minority ethnic communities. The 2009-10 JSNA will help inform a new joint adults' commissioning plan and children's plan due for publication in 2010.

The JSNA is a key source of information for commissioners when setting investment and disinvestment priorities. Population projections in the 2008-09 JSNA, for example, modelled expected numbers of people with long-term conditions. This shaped detailed plans for services for people with long-term conditions set out in NHS Croydon's operating plan. The 2009-10 JSNA draws attention to the disparity between expected prevalence of people with chronic obstructive pulmonary disease (COPD) and the incidence as recorded by GPs. This disparity indicates that there are many more people in Croydon with COPD than GP data indicated. The health of these individuals will benefit if they are actively identified and managed by primary care. Given the contribution of COPD to excess deaths in the most deprived parts of the borough, a programme of case finding and management can also be expected to contribute to reducing health inequalities. A work stream has been set up by NHS Croydon to develop investment and implementation plans for work to improve the identification and management of people with COPD.

The 2009-10 JSNA draws on nationally available data sources including the core dataset. We have also used several of the growing number of custom tools to analyse nationally available data. This year we have used the health needs assessment toolkit provided by Commissioning Support for London.[1] The chapter on geographical inequalities in health uses London Health Observatory's health inequalities intervention toolkit to analyse the causes of excess deaths. The toolkit has also helped to identify the interventions which would have the greatest impact on health inequalities in the borough. Croydon's JSNA goes beyond the core dataset in its assessment of need. Each chapter has made extensive use of local and regional quantitative and qualitative data, such as Greater London Authority population projections, Croydon GP data, and service data including service user, public and patient user and patient feedback.

1 Commissioning Support for London health needs assessment toolkit available at http://hna.csl.nhs.uk/

There are a number of mechanisms being used to share the findings of the JSNA. For the specially commissioned in-depth needs assessments, the data analysts and chapter authors have worked alongside commissioners and representatives of people who use services to craft the needs assessment. The chapter on children with special needs and disabilities gives one example of how knowledge has been generated alongside the people who use services and those who provide them. This has proved a powerful mechanism for dissemination of knowledge spreading through networks of staff, parents and carers.

The Croydon Observatory, created in 2008, plays an important role in the dissemination of Croydon's JSNA. The observatory hosts the local strategic partnership's key plans and strategies. It is also a central repository for local data and needs assessment.[2] The JSNA is also made available on Talk2Croydon, the local public consultation website.[3] This enables findings to be shared with the public and comments and views to be sought on the process of needs assessment.

Several proposals for needs assessment have been put forward for the ongoing JSNA programme. A needs assessment on sexual health has been given provisional agreement, subject to more detailed project plans being approved by the JSNA programme board. Work is currently underway on an assessment of the needs of older people in Croydon with a final report available early in 2010.

Summary of the core dataset and 2009 health profile

The core dataset is a list of indicators designed to provide a broad overview of the local population and its health and social care needs. A health profile for each borough is also produced annually by the Association of Public Health Observatories. This section summarises key information from the core dataset and the 2009 health profile for Croydon.

With a resident population of 341,800, Croydon is the largest London borough in terms of population size. The population is typical of London in that there are more younger people and fewer older people as a proportion of the total population. However, the numbers of children and young people in Croydon are expected to fall while numbers of older people will rise in future years.

At 42%, the proportion of the population from black and minority ethnic groups is similar to the London average. This proportion is expected to increase to 47% by 2018. At 15%, the proportion of the population with a disability is slightly below average.[4]

Deprivation levels across Croydon vary considerably and Croydon includes some of the most and some of the least deprived areas in London. On average, Croydon is slightly less deprived than the England average and considerably less deprived than London as a whole. The proportion of children in poverty (one in four) is higher than the England average.

Overall the health of people in Croydon is similar to the England average. Average life expectancies at 78 years for men and 82 years for women are above the averages for England.

Over the last ten years the death rate from all causes combined has fallen for males and remains lower than the England average. Rates for females have also improved and they remain similar to the England average. Early death rates from heart disease, stroke and cancer have also fallen during this period.

Infant and neonatal mortality rates are higher than average. The proportion of people diagnosed with diabetes is higher in Croydon than the England average. Deaths from chronic obstructive pulmonary disease are above average. Hospital admission rates for coronary heart disease, renal failure and accidents are above the London and England averages.

2 Croydon Observatory is available at http://www.croydonobservatory.org/

3 Talk2Croydon is available at http://www.talk2croydon.co.uk/

4 Unless otherwise specified, 'average' refers to the England and London averages. Refer to full dataset at Appendix 1 for specific definitions in each case.

There are health inequalities within Croydon by location, gender and ethnicity. Healthy life expectancy in Croydon at age 65 is above the England average. Smoking prevalence is slightly lower than the England average. Rates of smoking during pregnancy are lower than the England average. Levels of breastfeeding initiation are better than the England average. Alcohol related hospital admissions and levels of binge drinking are below average.

Rates of teenage pregnancy and the level of childhood obesity are significantly worse than the England average. Levels of adult participation in sport and active recreation are below average.

Future demand for services

Croydon's population is expected to grow by 1.7% by 2013. The greatest increases are expected in the age groups over 50 years with declines anticipated in the numbers of children and young people. The rate of population increase will vary across Croydon. Published population projections indicate that the areas of greatest anticipated growth in the next five years are the Fairfield and Bensham Manor electoral wards where the increases are likely to be 19% and 6% respectively.

The current London plan requires Croydon Council to make provision for the development of at least 11,000 new homes over the next ten years. The greatest areas of growth will be around Croydon town centre. Up to 21,000 additional homes could be built over the next 20 years, with about half of these in central Croydon. The London plan includes a commitment to protecting the green belt, so all growth in London is to be accommodated by intensifying the use of existing developed areas. The London plan also sets the target that 50% of new homes should be affordable housing. This will impact upon community infrastructure requirements and increase the demand for public services. It will also alter the mix of individuals using those services. Analysis of future housing need in Croydon indicates that the greatest needs between now and 2021 are for family-sized homes and social rented properties.

Future demand for school places will be affected by local birth rates, migration trends and, to a lesser extent, activity in neighbouring boroughs. Consideration needs to be given to the locations of these school places in addition to total numbers, as changes in the numbers of children and young people will not be evenly distributed across the borough. If changing birth rates were the sole factor influencing demand for reception places, this would increase by 13% between 2009 and 2012. The actual increase is expected to be closer to 15% due to the influences of housing provision, migration and increasing ethnic diversity.

The nature and location of housing development will have a notable impact on future requirement for health services. The nature of the housing developments in particular areas will determine the type of people most likely to move to those areas, for example, families, single professional adults, or older people. This then influences the likely level of need for health services.

Alongside increases in life expectancy come increases in the need for health care. Increasing age is a major and unavoidable risk factor for a range of conditions, particularly cardiovascular and respiratory diseases, and musculoskeletal disorders.

Population projections also indicate that the population will become increasingly ethnically diverse, and immigration data from general practice registers suggests that numbers of new arrivals will also continue to rise. Certain ethnic groups are at increased risk of various conditions such as cardiovascular disease and diabetes, and low birth-weight babies. This will further increase future demands placed on health services.

As advances continue to be made with regard to the effectiveness of medical interventions, people diagnosed with many conditions live longer, resulting in increased prevalence of those conditions. Almost one in four of the population aged 65 or over has more than one chronic condition. This currently represents 10,900 people, rising to 12,700 by 2020. As people live longer with long-term conditions, the numbers of people with associated disabilities is likely to increase, as are the numbers of people requiring end of life care.

Geographical health inequalities: findings

Average life expectancy in Croydon is increasing. In 2007 average life expectancy in Croydon was 78 years for men and 82 years for women. Life expectancy in the borough is increasing faster for men than for women. However, 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 2007.

In Croydon the life expectancy gap between the most deprived 10% of areas and the least deprived 10% is 10.6 years for men and 5.7 years for women.[5]

There is a strong association between deprivation and poor health outcomes in Croydon. Amongst thirty one London boroughs[6], Croydon has the third widest gap in health outcome for men and eighth widest gap in health outcome for women[7]. Croydon has small pockets of significant deprivation rather than wider areas of disadvantage.

Death rates from all causes are falling across the borough. The rates are falling at approximately the same pace in the least deprived areas as in the most deprived areas. The gap in all cause mortality has therefore not reduced significantly between 1995 and 2007. There are substantial differences in all cause mortality rates between the most and least deprived parts of Croydon. The all age all cause mortality rate for the least deprived fifth of the borough's 220 lower layer super output areas (LSOAs) is 430.3 per 100,000; the rate for the most deprived fifth is 765.9 per 100,000.

Circulatory diseases, cancers and respiratory diseases cause the majority of excess deaths when comparing mortality between the most and least deprived fifths of LSOAs in Croydon. Deaths from circulatory diseases make up 31.5% of excess deaths in men and 34.6% of excess deaths in women. Deaths from cancers make up 15.5% of excess deaths in men and 19.6% in women. Deaths from respiratory diseases make up 18.1% of excess deaths in men and 13% in women.

Geographical health inequalities: recommendations

1. NHS Croydon, Croydon Council and the local strategic partnership should review their approach to addressing geographical variations in health within the borough. They should identify specific and measurable changes that partners can work together to achieve. Partner organisations should set out their contribution and the steps that they will take to deliver those changes. It is recommended that the overall focus is on reducing the gradient of the slope index of inequality.

2. The slope index of inequality should be used by NHS Croydon, Croydon Council and the local strategic partnership to track progress over time.

3. A long term (5 to 10 year) target and trajectory for reducing the slope index of inequality gradient should be set out in the community strategy and NHS Croydon's strategic plan.

5 This is as measured by the 2003-07 slope index of inequality indicator used in the NHS World Class Commissioning assurance framework. Males = 10.6 years (95% confidence interval: 8.9 to 12.33); Females = 5.7 years (95% confidence interval: 3.4 to 8). Source: Association of Public Health Observatories www.apho.org.uk/resource/view.aspx?RID=75050

6 Excluding the City of London

7 As measured by the 2007 slope index of inequality indicator

4. NHS Croydon and Croydon Council should agree one or more additional long term targets that focus on the three major causes of excess deaths that are driving health inequalities in Croydon (circulatory diseases, cancers and respiratory diseases). It is recommended that this target should be to reduce the gap in deaths between the most and least deprived areas, recognising that there are significant technical issues involved in setting differential targets at a local level.

5. Reducing smoking prevalence is likely to have the single biggest impact on the three major causes of excess deaths. The local strategic partnership should agree a local target that focuses the efforts of all partners on a reduction in smoking prevalence and not solely the NHS stop smoking quit rate. Delivery of stop smoking services, tobacco control and prevention initiatives should be focused on the areas with the highest smoking prevalence.

6. NHS Croydon, Croydon Council, Croydon Community Health Services, Mayday Healthcare and other partners should work together through the tobacco control alliance to speed up the reduction of smoking rates in the areas of highest prevalence. All frontline NHS and key council staff should be trained to stop smoking level 1 and be actively encouraging and supporting their patients, service users and customers to stop smoking.

7. NHS Croydon should commission services with an explicit aim of reducing excess deaths from circulatory diseases in areas of higher deprivation. This includes introducing NHS health checks to identify people at risk of circulatory diseases and using the vascular risk assessment programme to diagnose and manage people in high risk groups. Primary and secondary prevention programmes should be in place targeting people living in areas of high deprivation. They should also target groups known to be at risk within those areas, such as people from South Asian, African and Caribbean ethnic groups. Programmes should include equity measures and be monitored to ensure that people living in areas of higher deprivation have equitable access.

8. Croydon Council should ensure that there is equitable access to parks and green spaces, sport, and leisure facilities across the borough to encourage and support active recreation. The council should also use its role as a place-shaper to ensure that the built environment promotes walking and cycling. It should promote healthy food choices and physical activity in early years and amongst school age children, with a particular focus on the areas of highest deprivation.

9. NHS Croydon should commission services with an explicit aim of reducing excess deaths from cancers in areas of higher deprivation. This should focus on the prevention of lung cancer through reducing smoking prevalence and helping people stop smoking. Services should also aim to diagnose and treat lung cancer as early as possible with a focus on ensuring equity of access to early diagnosis and treatment in areas of higher deprivation.

10. NHS Croydon should commission services with an explicit aim of reducing excess deaths from respiratory diseases in areas of higher deprivation. This should focus on the prevention, detection and management of chronic obstructive pulmonary disease.

11. NHS Croydon should model expected disease prevalence within the most deprived areas, identify the gap between expected prevalence and recorded prevalence, and ensure that its contractors find and treat people with undiagnosed disease.

12. NHS Croydon and practice based commissioners should work to strengthen primary care in the most deprived areas, using local enhanced service agreements and the quality and outcomes framework to provide incentives for GPs and independent contractors to improve performance. People living in deprived areas should be encouraged to register with a GP.

13. Interventions should be of sufficient scale to make a measurable difference to life expectancy or excess mortality. This means that industrial scale systems need to be in place to deliver interventions and the workforce needs to have the right skills, for example in disease register management.

14. Interventions should be evidence based wherever possible with investment and disinvestment decisions taking the evidence base into account. Where evidence is less robust then appropriate evaluation measures should be put in place. The existing evidence base is less good for interventions to address the social determinants of health. This should inform, but not necessarily discourage, the commissioning of interventions which address social determinants.

15. The independent and third sectors can both play a major role in supporting the behavioural changes that people need to make and sustain. The third sector has a key part to play in reaching people who may not wish to use mainstream statutory service providers. Community activists and health champions have the potential to reach large numbers through social and informal networks. The existing health champions programme and similar initiatives should be independently evaluated for the extent of their reach into those networks. Croydon Council and NHS Croydon should continue to facilitate the development of the third sector in Croydon, particularly those organisations that serve communities in deprived areas.

16. Areas where further needs assessment work is recommended:

    a) The relationship between ethnicity and variations in health outcomes in Croydon

    b) Equity audits for planned and existing interventions with a focus on those which address the major causes of excess deaths

    c) Equity audit of health service and related spending in relation to deprivation and health outcomes in Croydon

Healthy weight, healthy lives: findings

Between the ages of 4-5 and 10-11, a significant number of children become overweight or obese. This is more likely to happen with boys than with girls. Black and black British children are at particular risk of overweight and obesity at any age. There is a clear link between deprivation and higher rates of overweight and obesity.

Around one in four of all adults in Croydon are obese, and by the age of 45 over 60% are overweight or obese. As with children, there is a clear link with deprivation. Some black and minority ethnic groups are at high risk of becoming overweight or obese, which in turn further increases their risk of developing long term conditions such as diabetes. Being overweight or obese, especially for women, significantly increases the risk of developing cancer, heart disease and diabetes. Overall it is estimated that more than 850 people in Croydon died during the last five years because of their obesity. Because of the link with deprivation, obesity is an important factor contributing to health inequalities.

Levels of physical activity reported by girls decline significantly from an early age. This may be related to peer pressure not to participate or a lack of access to preferred sports or non-sports alternatives such as dance. Most secondary school age children are not meeting the nationally recommended levels of physical activity and a significant proportion do not take part in any sports activity beyond timetabled PE. There is evidence to suggest that children living in deprived areas are significantly less active than their peers in more affluent areas. Disabled children may need specific support to enable their participation in play or sports.

Amongst adults of working age who responded to the patient survey, only 40% said that they exercised regularly. Other surveys suggest that a majority of adults in Croydon do not meet nationally recommended levels of physical activity, but there is insufficient data to identify differences by ethnic groups. As with children, there is evidence of geographical differences linked to deprivation.

Survey data suggest that popular sports include swimming and football but there is also a lot of interest in exercise movement and dance activities. Lack of time and cost are important barriers preventing people from making use of their local indoor sports facilities. There is some evidence to suggest differences between ethnic groups in the uptake of leisure centre membership may reflect deprivation. In general there are insufficient data at local level to be able to pinpoint specific communities that may need targeted support to increase their levels of physical activity and reduce their risk of becoming overweight or obese.

While the consumption of fruit and vegetables in Croydon, as in London, is estimated to be above the national average there are no local data which would demonstrate any variation in this by gender, age, ethnic group or locality. Extrapolating from national evidence it is likely that there are significant differences within and between wards.

Free school meal uptake is low and in most areas static or declining. The introduction and roll out across Croydon of a cashless catering system should help to reverse this and improve uptake of school meals in general. Many fast food outlets are situated in areas where rates of childhood obesity are high.

While there have been innovative developments in weight management services for children, weight management services for adults in Croydon are more mixed and have not been developed in a systematic or strategic way. Data are incomplete or inadequate to be able to determine outcomes and whether the people at highest risk have access to the support and advice they need.

For most services which promote physical activity there is a lack of robust outcome data. There is patchy or nonexistent provision for groups with special needs or who are at especially high risk, and much of what does exist is funded on an ad hoc basis. There is a good range of provision either in place or planned for the younger child, especially with the playbuilder programme and Croydon play strategy, but there is less consistent provision for teenagers and young adults, especially girls and young women and for those who may prefer to participate in non-sports physical activity such as dance.

Croydon adult learning and training (CALAT) run various programmes which promote healthy eating. These help to meet important needs in the community, but the funding base for them is unclear. Provision of cookery clubs in the borough is patchy and their impact on improving health and reducing inequalities is unclear. Local allotment projects which encourage people to grow their own fruit and vegetables also have benefits for increasing levels of physical activity and mental wellbeing through reducing social isolation. Although there is some after school provision for older pupils, consistent provision of timetabled cookery skills classes for 11 to 14 year olds is not yet established in Croydon.

Healthy weight, healthy lives: recommendations

NHS Croydon and Croydon Council should:

1. Ensure that mechanisms and structures are in place to enable greater integration between commissioned services.

NHS Croydon and Croydon Council commissioners should:

2. Invest in the collection and dissemination of local data which are needed to understand better which communities could benefit from targeted approaches to increase levels of physical activity and healthier eating.
3. Invest in further assessment and analysis to identify differential uptake of specific services and the reasons for this. For example, barriers to access and unmet cultural needs and expectations.
4. Establish evaluation frameworks to include the collection of core datasets for services relevant to healthy weight, healthy lives which support analysis of outcomes data and more robust assessment of the impact of interventions and facilitate health equity audit.
5. Require ongoing review and evaluation of funded projects and programmes to ensure that these are effective in delivering health gain and reducing inequalities.
6. Make greater use of national evidence in the design and delivery of local interventions especially social marketing approaches.
7. Require all new service proposals to be designed in such a way that the risk of widening inequalities is minimised.
8. Require all commissioned interventions to be based on the underlying principle that they are designed to empower and enable individuals to take responsibility for their health and wellbeing, as far as they can.

Croydon Council should:

9. Work with leisure services providers under contract to Croydon council to better understand the user base and to ensure that they provide appropriate services that are accessible to all whatever their needs.
10. Identify ways in which secondary school aged children, particularly girls, can be enabled to become more physically active and to sustain this.
11. Ensure that groups with special needs, such as people with mental health problems, people with learning disabilities and disabled children are taken into account in the design and delivery of mainstream services which facilitate physical activity so that the provision of niche services is focused and meets specific requirements that cannot be met otherwise.
12. Work with fast food outlets to encourage them to adopt healthier cooking techniques and to offer healthy food options, for example fresh fruit, to their customers.
13. Make use of existing planning mechanisms to regulate the numbers of fast food outlets in key locations such as close to schools.
14. Consider early implementation of practical cookery classes in secondary schools, prior to the national roll out in 2011.
15. Work with schools where there are high rates of overweight or obesity to develop action plans to encourage children to walk to school, make healthier food choices and participate more in physical activity programmes.

16. Continue to support, and consider extending, the Croydon adult learning and training education programmes which relate to healthy eating.

17. Develop and implement an action plan to increase the uptake of schools meals generally, and free school meals in particular, across all schools in Croydon.

18. Support the proposal by the children's trust to fund a food in schools strategy advisor post.

19. Consider the options for increasing the affordability of leisure facilities for people on low incomes supported by a targeted campaign based on social marketing principles to highlight the wide range of free or low cost activities on offer.

NHS Croydon should:

20. Carry out a full needs assessment and review of the current range of NHS funded or provided weight management services for adults. They should ensure that all investment in these services is appropriately targeted and focused on achieving health outcomes. They should make recommendations for reconfiguration or re-provision of services as appropriate.

Children and young people with special educational needs and disability: findings

With over 58,000 pupils, Croydon has the highest school population of the London boroughs with 22.6% of pupils in primary schools and 18.5% of pupils in secondary schools known to be eligible for free school meals.

Croydon has a very ethnically diverse school population, with 54% of pupils in primary schools and 51% of pupils in secondary schools coming from black and minority ethnic groups. There are links between deprivation and special educational needs and disability, which has implications for focusing service delivery.

A higher percentage of children and young people in Croydon's mainstream primary and secondary schools require additional support for special educational needs than the England average. This is particularly the case in secondary schools.

Croydon has 1,669 pupils with statements of special educational needs. A large number of children with special educational needs are placed in schools outside the borough, often with higher placement costs. Capacity needs to be increased to help meet these needs in local schools.

The most prevalent type of primary need amongst pupils with statements of special educational needs or at *school action plus* in maintained primary schools, is speech, language and communication needs; in maintained secondary schools it is behaviour, emotional and social difficulties. In out of borough independent and non-maintained special schools, severe learning difficulties are the most common need.

A significant number (almost 1000) of Croydon's children and young people in the mainstream school system have speech, language and communication as their primary area of need. Other children and young people have speech, language and communication needs but their primary need may be a physical disability or sensory impairment. This may mean that their speech, language and communication needs are not identified or addressed.

1.3% of the child population of Croydon is registered as disabled, most commonly for communication disorders including autistic spectrum disorders. The incidence of some disabilities is increasing; particularly the number of children with autistic spectrum disorders, complex health needs and palliative care needs.

Children and young people with autistic spectrum disorders form a significant group of approximately 700 in Croydon, with varied and complex needs which require multiagency support. The prevalence of autistic spectrum disorders in the UK child population is estimated to be about 1%.

A study undertaken by the Thomas Coram Research Unit (2008) estimated that 1.2% of England's child population has severe and complex disability. This includes severe learning and physical disability, autism, challenging behaviour, or a serious chronic health condition. This would equate to approximately 1000 children in Croydon. This is the group targeted through the *aiming high for disabled children* short breaks programme.

Children with disabilities and complex health needs, supported through the *continuing care* and the *early support* programmes, are increasing in number and require a multi-agency approach.

Children and young people with mental health needs, attention deficit hyperactivity disorder or challenging behaviour with disabilities, have considerable needs which can result in their being excluded from school, or ending up in high cost, distant, residential care. A virtual team approach is being implemented to help meet these needs.

There is a challenge to ensure high quality transition for children with special educational needs and disabilities when they move from children's services into adulthood and the need for adult services. This is being addressed by the *transitions transformation* programme.

A significant number of disabled children who are looked after by the local authority are placed in residential provision or foster placements which are out of borough. The aim of all services should be to prevent accommodation in residential or foster care. For those children where remaining at home is not possible, alternative provision within the borough needs to be developed.

Parents, children and young people have been asked for their views on service provision in a number of ways. Parents stressed the importance of information; access to support services, especially therapies; the need for better service integration; short breaks; and transport. Children and young people wanted access to a range of activities; to feel safe; and to be treated the same as other children.

Children and young people with special educational needs and disability: recommendations

Croydon's children's trust should:

1. Develop a joint commissioning strategy which focuses on meeting the therapy needs of children and young people.

2. Make therapies more available, more accessible and more ordinary by developing the skills of the workforce to identify and meet the therapeutic needs of children and young people.

3. Service development should focus on building capacity through the *transforming Croydon schools* programme, to help families, schools and other community settings play a proactive role in meeting the speech, language and communication needs of their children. This would help reduce dependence on the medical model of specialised one to one treatment by experts, and support a more inclusive user friendly approach, enabling homes, schools and other settings to become language friendly environments.

4. Respond to the *Bercow review* on children and young people with speech, language and communication needs, by working on a joint action plan. This may also help improve outcomes for children and young people who present as having challenging behaviour or are not currently in education, training or employment.

5. Develop a joint action plan to meet the needs of children and young people with very complex and palliative care needs.

6. Develop a joint children and adolescent mental health strategy linked to targeted mental health promotion and service provision in schools.

7. Jointly develop a systematic approach to information systems to enable comprehensive data sharing and provide tools to monitor and evaluate performance.

8. The *aiming high for disabled children* transformation programme should entail joint work and match funding to implement the *aiming high* project for short breaks and extended activities and the *early support* programme. It should also involve joint work to progress the *every disabled child matters* charter.

9. Develop a strategy for children and young people with autism.

10. Develop joint provision that is focused on early intervention and prevention in order to enhance the five outcomes for babies, children and young people set out in *every child matters*.

11. Develop and promote the use of the *common assessment framework* across the children's workforce and strengthen integrated working in line with the children's trust.

12. Enhance and develop additional school and recreational provision for children and young people with special educational needs and disability.

13. Work with schools and in other settings to enable them to build their capacity to be more inclusive of children with special educational needs and disability.

14. Work with parents and families through the *parental support* strategy, to enhance parental confidence and opportunities to become engaged and participate in service development, delivery and review.

15. Work on engaging children and young people in strategic design and delivery of provision.

16. Continue to develop the virtual team approach for children and young people with autistic spectrum disorders, learning disabilities with challenging behaviour and attention deficit and hyperactivity disorders.

17. Develop a transition policy and strategy to ensure that all young people who require transition planning from 14 years old (school year 9) onwards know what goals, actions and progress need to be achieved in the immediate and longer term.

Families, carers and teachers should:

18. Work in partnership with therapists to develop relevant interventions in the school and home setting, enabling a seamless approach to meeting children and young people's needs.