# Croydon joint strategic needs assessment 2010/11

# Executive summary

# Contents

## What is a joint strategic needs assessment?

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

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.

Much has changed since Croydon published its joint strategic needs assessment for 2009/10. We have a new government, a markedly different economic environment and an NHS which is entering a period of rapid and unprecedented change, posing new challenges in terms of maintaining a focus on health and wellbeing. The government has confirmed its commitment to the JSNA at the heart of the commissioning process.[1]

As in previous years, the JSNA aims to inform strategic planning in Croydon. It is a resource for the new shadow health and wellbeing board to help it select priorities to inform a new joint health and wellbeing strategy. It begins with a chapter giving a broad *overview* of health and wellbeing in Croydon. Areas where Croydon is performing significantly differently from the London and England averages are highlighted and discussed. This year we have presented our core dataset as a 'spine chart' at the end of the overview chapter in order to make it easier to interpret and to compare Croydon with national and London figures. Supporting tables are included as appendices. There is also an appendix which aims to help people understand and interpret the data.

The JSNA is also intended to inform detailed commissioning plans. This year we have focused on five topics proposed by commissioners and taken forward in consultation with partners and members of the public. These are *infant mortality, looked after children, sexual health, diabetes* and *living well in later life.*

## An overview of health and wellbeing

The overview chapter describes Croydon in terms of its population size and structure, social and environmental context, burden of ill health, lifestyles and health and social care services and spending. Croydon's population is young, like much of London, but the borough is also experiencing a growth in older age groups. As age is a determinant of health, this clearly has implications for demand for health and social services. Croydon also has a growing ethnic minority population, which affects patterns of demand due to the influence of ethnicity over certain illnesses but also will affect the way we need to provide our services, ensuring that they are sensitive to a wider range of cultures, religions and beliefs.

Croydon is less deprived than the average for London or England but has wide and significant variations between different parts of the borough. The borough contains some of the most affluent and some of the most deprived areas in England. There is a strong association between deprivation and poor health outcomes in Croydon. Whilst average life expectancy for both men and women in Croydon is above the England average, this masks major differences within the borough. In 2008, men living in the most affluent fifth of areas of Croydon could expect to live an average of eight years longer than men living in the most deprived fifth of areas and women an average of five years. There has been little, if any, change in the gap in life expectancy between the most deprived areas and the least deprived areas between 1995 and 2008. The main causes of death which are helping to sustain the gap in life expectancy in Croydon are circulatory diseases, cancers and respiratory diseases. Lifestyle factors contributing to ill health in Croydon include smoking, obesity, alcohol use and sexual behaviour.

1 Department of Health. *Liberating the NHS: legislative framework & next steps.* London: The Stationery Office; 2010.

Health and social care services in Croydon are becoming more likely to be provided in the home or closer to home. Service providers have a number of challenges including the ageing population and relatively high numbers of adults with severe mental illness and also people with learning disabilities. Croydon has a higher proportion of looked after children than many other boroughs. There are challenges in terms of meeting targets for flu vaccinations, some childhood immunisations, gaining access to a dentist and seeing a GP quickly.

In 2008/09, NHS Croydon spent £485 million. The largest areas of spending were on mental health (13.9%) and GP services (10.3%). In some areas, such as maternity, Croydon has high expenditure and poorer outcomes compared with other primary care trusts. In others, such as diabetes, Croydon has lower expenditure and poorer outcomes. The annual report of the director of public health for 2010/11 gives a detailed assessment of NHS spending against outcomes.

## Infant mortality

Every year in Croydon, around five in every 1,000 babies born alive will die in the first year of life. This represents around 28 deaths a year. Infant mortality had declined greatly in the last 100 years, however, Croydon has the seventh highest infant mortality rate in London and each death represents a tragedy for the family concerned. Doing everything possible to prevent infant mortality remains a priority and this chapter is intended to inform work to further reduce the infant mortality rate.

Prematurity and low birthweight are the biggest risk factors for infant mortality and are strongly interrelated, with prematurity leading to low birthweight and vice versa. For babies of low birthweight, the risk of infant death is 20 times greater than babies with normal birthweight. For babies born before 32 weeks of gestation, the risk of infant death is 70 times greater than for babies born at full term. Other groups at higher risk include babies born to mothers with multiple births (twins, triplets or more); mothers from Black ethnic groups; mothers not born in the UK; single mothers and mothers who register their baby alone; mothers from routine and manual socio economic groups; mothers aged less than 20; mothers who smoke and mothers who are obese.

The chapter recommends that the director of public health leads the development of an infant mortality strategy, drawing on the findings of the needs assessment and with clear targets and actions which can be used to inform commissioning and service development.

Commissioners should use Department of Health guidance to reduce infant mortality overall and also reduce the health inequalities associated with infant mortality. This should identify where services ought to change and identify opportunities for the release of resources to enable the change to happen. This includes commissioning evidence based interventions that reduce infant mortality overall by improving the quality of maternity and neonatal care, increasing screening and reducing maternal and infant infections.

Evidence based interventions that reduce the inequalities gap in infant mortality would focus resources on families of routine and manual workers and other high risk groups. They include reducing maternal obesity and maternal smoking, improving access to maternity care and increasing breastfeeding rates. At a wider level the evidence indicates we should aim to reduce teenage pregnancy, reduce sudden unexpected deaths in infancy, tackle child poverty and address household overcrowding and housing quality.

Commissioners and service providers should build on existing mechanisms and develop new mechanisms to continually learn from patients' experiences of using maternity services.

## Looked after children

At March 2010, Croydon Council was responsible for 1,008 looked after children. This is a rate of 126 looked after children per 10,000 population under 18. This is significantly higher than London (66 per 10,000) and England (58 per 10,000). Since the year 2000, the proportion of looked after children in Croydon has risen significantly from a rate of 50 looked after children per 10,000 population under 18. The rise is mainly explained by the increasing numbers of unaccompanied asylum seeking children and young people placed in the borough.

Children and young people often enter the care system with a worse level of health than their peers. This is due, in part, to the impact of family breakdown or the abuse or neglect that led to them being placed in care. They are more likely to have been exposed to traumatic events such as bereavement, violence or sexual abuse. They often face discord within their own families, frequent change of home or school and lack of access to the support and advice of trusted adults. This can lead to poor emotional wellbeing or mental health problems as well as physical ill health. Looked after children are more likely to be teenage parents and to have problems with drugs or alcohol. Many looked after children under achieve in formal education. Lower levels of educational attainment have an impact on their future life chances, including their health.

It is recommended that a multi agency working group oversees the implementation of the JSNA recommendations and reports to the children's trust. This would include reviewing the implementation of statutory and best practice guidance at a local level and making recommendations for improvements. The group should also review local assessment and screening procedures and the provision of support and services to looked after children and care leavers.

Commissioners should review the collection and analysis of local data and ensure that any inconsistencies between local authority and NHS data are addressed and minimised. They should explore the potential for additional health outcomes data for looked after children.

Consideration should be giving to providing a range of information about local services available to looked after children and care leavers. Local practitioners should improve their awareness of services available to looked after children and care leavers and ensure better communication between local partners and agencies. The children's trust should review the training needs of people working with looked after children and care leavers. Work is also required to improve the use and uptake of the strengths and difficulties questionnaire for looked after children.

Mainstream services across the NHS and local authority should work to improve the self esteem and life skills of looked after children and care leavers. The mental health needs of looked after children should remain a high priority for the children's trust which should ensure that adequate levels of provision are in place, including provision for looked after children placed in Croydon by other boroughs. Commissioners should consider the need for a dedicated psychologist within the child and adolescent mental health services team for looked after children. They should agree objectives and targets with providers to increase the proportion of looked after children with a drug or alcohol problem who receive an appropriate intervention.

Further work is required to assess the needs of looked after children and young people with a mental health problem and with learning or physical disabilities. Work is also needed to identify specific needs relating to sexual orientation, religion and belief. Commissioners and service providers should consult and feed back to looked after children and care leavers about the planning and development of local services. Further work is required to assess spending on looked after children, including estimating long term spending on those who have been looked after. This could be taken forward through Croydon's community budget programme.

## Sexual health

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. 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%.

Recommendations to reduce sexually transmitted infections include integrating sexual health promotion into appropriate mainstream health and social services programmes. Work is needed to improve awareness and uptake of sexual health services in Croydon, including access to Croydon University Hospital GUM clinic. Commissioners and service providers should also aim to increase access to, and uptake of, condoms through the Croydon C-card scheme. Uptake of chlamydia screening needs to be increased and the outcome of chlamydia testing improved. HIV prevention should be prioritised with prevention programmes targeted at high risk groups. Priority should be given to increasing early diagnosis and treatment through increased uptake of HIV testing.

Commissioners should implement the five standards set out in the London sexual health strategic framework and implement the sexual health strategy for Croydon. There is a need for sustainable commissioning arrangements including investigation of the cost effectiveness of sexual health programmes. Commissioners should include standards for the quality of data collected and robust outcome measures in the sexual health strategy and commissioning of services. They should work to improve the integration of sexual health promotion, contraception, testing and treatment of sexually transmitted infections including chlamydia into all provider services for sexual health. This work should be taken forward through local and regional sexual health networks.

Almost 20% of women in Croydon are using oral contraception and only 3.6% are using long acting reversible contraceptive methods. In 2009, the abortion rate in Croydon was 29.7 per 1,000 women (aged 15 to 44), higher than the rate in both London (26.4) and England (17.7). Patterns of abortion in Croydon indicate that in some instances abortion may be being used as a form of birth control and that there are unmet contraceptive needs. A local plan is needed to reduce the repeat abortion rate. This should take place alongside work to increase uptake of all methods of contraception among all sexually active groups. Commissioners should review fertility services in Croydon and develop the provision of intrauterine insemination in line with NICE guidance. They should improve access to specialised psychosexual medicine.

In 2008, there were 366 conceptions to women under 18 in Croydon. This is a rate of 55.5 per 1,000 girls aged 15 to 17 years, higher than the London (44.6) or England (40.4) averages. Of these conceptions, 59% led to abortion. Between 2005 and 2007, there was an average of 73 conceptions a year in girls under 16 years in Croydon. This represents a conception rate of 11.2 per 1,000 girls aged under 16, higher than the rates for London (8.7) and England (7.9). Of the conceptions to girls under 16 years, 67% led to abortion. In 2008, there were 145 live births to mothers under 18 years in Croydon. This is a rate of 23 births per 1,000 population, compared with 17 per 1,000 for London and 20 per 1,000 for England.

Adequate resources need to be in place to implement the local teenage pregnancy strategy and action plan. Services should improve targeting to reach groups of young people who are at greater risk and prioritise those groups who are easily identifiable. The provision and quality of sex and relationship education in schools, colleges and non school settings should be improved alongside advice and support for parents of teenagers.

The chapter identifies a number of groups of people who are likely to be more vulnerable to sexually transmitted infections or unwanted pregnancy. These include children and young people looked after by the local authority or leaving care and young people who are not in education, employment or training. Some Black and minority ethnic groups, especially younger Black Caribbean, Black African and Other Black population groups are disproportionately affected. Men who have sex with men are a high risk group for sexually transmitted infections, including HIV.

People who use drugs and alcohol are more likely to take risks that endanger their health and the health of others. Sexual health services should target identified high risk and vulnerable groups.

Further work is needed to investigate the sexual health needs of people with mental health problems, people with physical disabilities or sensory impairment, people with learning disabilities, refugees and asylum seekers, and sex workers.

## Diabetes

Diabetes is a significant health issue in Croydon. 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. The estimated prevalence of diabetes in Croydon is 5% for 2009. 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.

In 2008/09, diabetes accounted for 9.7% of all NHS Croydon's prescribing costs. It is estimated that 167 or 13.6% of all deaths of Croydon residents aged between 22 and 79 in 2008 could be attributed to diabetes. Data from 2008/09 shows Croydon as having low expenditure and poor health outcomes for diabetes. Croydon diabetes services underwent a major restructuring in 2009 but comparative data allowing an assessment of the effects of the restructuring on outcomes are not yet available.

Commissioners should ensure that services are consistent with recognised national standards. They should identify variation in service quality and examine patterns of spend to assess if there are opportunities to reprofile and reinvest in high impact and high priority areas. They should also investigate all aspects of the secondary care pathway in order to improve patient experience and outcomes.

There is a strong association between diabetes and deprivation in the borough. Prevalence rates are 70% greater for people in the most deprived areas of Croydon than those in the least deprived. There are inequalities in diabetes prevalence rates between people of different ethnicities in Croydon. There is a prevalence rate of 13.1% amongst patients with severe mental health problems, compared with a prevalence rate of 5% in the general population.

Commissioners should work to improve data collection on ethnicity and deprivation in relation to diabetes. They should commission interventions targeting local communities with high prevalence and poor levels of blood glucose control. They should ensure that services are able to meet the needs of people with diabetes in care homes and nursing homes, and those with mental illness and learning disabilities.

The goal of diabetes therapy is to maximise healthy life expectancy and avoid medical complications. One of the main ways that this is achieved is through normalising blood glucose levels. The percentage of children and young people aged 18 or under with an HbA1c of 7.5% or less is worse than the national average and has been so for the last five years. There are unexplained differences in blood glucose control between different general practices in Croydon. Commissioners should ensure that general practices are supported to improve levels of blood glucose control and identify undiagnosed patients. They should also ensure that HbA1c levels for children with diabetes are monitored and develop services to drive improvement.

Self management is central to diabetes care. However, only a very small proportion of diabetes patients in Croydon have been on a structured education programme. People with diabetes who took part in focus groups as part of the needs assessment were not aware of the existence of these programmes but stated that they would welcome the opportunity to attend one. A number did not see a role for self management. Some participants also expressed the view that diabetes was a 'mild' condition, and had little awareness of the term HbA1c and the importance of monitoring levels of blood glucose.

There is a need for a local diabetes awareness campaign and stronger links between diabetes services and services which deliver preventive activities such as physical activity and healthy eating. There is a need for increased capacity in the voluntary and community sector to support diabetes awareness and prevention.

Care planning is the process whereby the patient and clinician work together to support the patient to self manage their condition. There are currently no data monitoring the extent and quality of care planning in general practices in Croydon. People who have diabetes may also need psychological support but there is currently no disease specific support being provided. There is a need for services that support effective patient self management including increasing the availability and uptake of structured education programmes. Commissioners should collect data on the extent and quality of care planning provided by local diabetes services. They should ensure that services that are commissioned are able to respond to and facilitate care planning. They should increase the capacity of psychological and emotional support services to help people with diabetes.

There is a strong association between obesity and diabetes in Croydon. Of those patients with diabetes who had their weight measured, 36.7% of males and 48.4% of females were obese. Although the first standard of the National service framework for diabetes (NSF) relates to prevention, physical activity, healthy eating and other preventative services in Croydon are not being explicitly linked to diabetes. Diabetes strategies should be integrated with wider programmes, particularly those with an impact on obesity and physical activity rates.

## Living well in later life

In 2009, there were 101,000 people (29.4% of the population) aged over 50 and 44,400 people (12.9% of the population) aged 65 or over in Croydon. The number of people aged over 85 will rise from 6,200 in 2009 to 8,400 by 2020. This is the group that is most likely to need healthcare and social care support.

Smoking is a risk factor for many chronic diseases associated with ageing. Many people with chronic diseases, for example stroke and hypertension, continue to smoke. Around 17% of men in their 50s with hypertension smoke, mainly White British and White Irish men. The prevalence of hypertension increases with age and is highest in the 80 to 84 year age group in Croydon. Black and Mixed populations have the highest recorded prevalence of hypertension at GP practices at all ages, and have earlier onset than White British and other ethnic groups. Hypertension rates are higher in the more deprived wards of Croydon.

In Croydon, there were 4,272 (1.1%) patients registered with stroke in GP practices in 2008/09. Onset of stroke in men tends to be earlier (60s) than women (70s). If national prevalence figures are applied to Croydon, then the prevalence rate is estimated at 2% which indicates that there may be some unmet need. Local data demonstrates a significant difference in the rate of strokes in Black men compared with White British men.

Influenza causes substantial ill health in older people, including hospitalisation. Croydon's flu immunisation rate of 68.7% in 2008/09 was lower than that for London (72.5%) and England (74.1%).

The number of people with osteoarthritis starts to increase from age 50 and it typically affects more Asian and Black women and people from Mixed ethnic groups. Local GP data show a social class gradient which demonstrates a small association between increased deprivation and increased rates of diagnosed arthritis. Arthritis is the most common reason for a visit to the GP for pain management and a diagnosis of chronic pain was highest in the 60 to 64 age group, with women far more likely than men to visit the GP for chronic pain.

Chronic obstructive pulmonary disease (COPD) commonly starts at around 40 years of age. In 2008/09, 3,089 (0.8%) patients were registered with COPD in Croydon GP practices. However, if national prevalence figures are applied to Croydon then the prevalence rate is estimated at 4%. This indicates there may be significant unmet need in terms of the numbers of people not yet diagnosed or receiving support. COPD is associated with smoking in nine out of 10 cases and in Croydon White British and White Irish males are most at risk.

In Croydon, patients' visits to their GPs for prostate cancer begin in their mid 50s and men from Black ethnic groups are the most affected. Numbers are low, with around 250 men visiting the GP for prostate cancer in Croydon in 2009. The incidence (new cases) of prostate cancer is high in Croydon compared with London and England and death rates are also high. This may be because patients are not accessing services when the disease is in its early stages and more treatable or because they are not being diagnosed,

Croydon has more people recorded with a learning disability than expected and this difference is greater than any other London primary care trust. People with learning disability often have complex health and social care needs and their life expectancy is increasing because of better care. As their parents or carers age, this population will increasingly need support.

GP data shows 1,336 people registered with dementia in 2009/10, compared with estimated prevalence figures of 3,052, indicating there may be a large number of persons with dementia in Croydon who are not diagnosed or in receipt of services. Among Black and minority ethnic groups in the UK, 6.1% of cases of dementia are early onset compared with only 2.2% for the UK population as a whole, reflecting the younger age profile of Black and minority ethnic communities. Age is the most important risk factor for dementia.

In 2009, most carers receiving support from the council were between 16 and 64, however, there were also many carers aged over 65 and more than 2,000 aged over 75. The percentage of carers being supported with services, advice and information in Croydon is 12.7%, significantly below the London average (24.6%) and the England average (26.4%).

Ending employment, increasing ill health, bereavement or a drop in income can all be factors which lead older people to becoming socially isolated. Projects such as local exchange trading schemes or time banks bring people into contact with one another through trading skills and can build local communities, as can volunteering. The over 45 age group is more likely to volunteer than those under 45 locally.

Commissioners and service providers in Croydon should implement the older people's strategy, emphasising work on prevention and taking a broad approach to wellbeing (including financial planning, maintaining health and volunteering). They should consider the piloting of community development models to reduce isolation and increase volunteering. They should also consider work with local business to pilot vocational rehabilitation schemes and develop education opportunities for the over 50s. There is also a need to improve the uptake of the flu vaccination in Croydon for people in risk groups of all ages and people aged 65 and over.

Commissioners and service providers should build on the forthcoming evaluations of local telehealth and telecare projects to increase their usability, efficiency and acceptability if they prove effective. They should consider different approaches to help people manage pain for common conditions such as osteoarthritis, for example through more use of pharmacies or other community services. There is a need to improve the prevention and early management of dementia and training for carers and staff.

There is a need to further investigate the apparently high incidence of prostate cancer in Croydon and develop appropriate strategies to reduce this, such as helping people recognise early signs and symptoms.