

Croydon Joint Strategic Needs Assessment

2011/2012

Overview Chapter

The big picture of health and wellbeing in Croydon.



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South West London
Croydon Borough Team

Joint Strategic Needs assessment

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1. Background

This chapter, which provides an overview of health and wellbeing in Croydon, forms the first part of the 2011/12 Joint Strategic Needs Assessment. Further chapters on the agreed key topic areas (the ‘deep dive’ chapters) will be produced on the Croydon Observatory website as they are completed.

The agreed key topic areas for 2011/12 are:

- Repeat abortions
- Children in poverty
- Support for those with long term conditions, with a focus on dementia

JSNA 2011/12: <http://www.croydonobservatory.org/jsna/jsna2011-12>

What is a Joint Strategic Needs Assessment?

The Department of Health has defined Joint Strategic Needs Assessment (JSNA) in the following ways:

- Joint Strategic Needs Assessment describes 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

The JSNA has retained its importance under the new political administration and in many ways has taken centre stage as a key strategic process to inform commissioning.

JOINT

- To be meaningful, the JSNA should be produced jointly - through effective partnership working between statutory bodies, agencies, patient and public representative groups and community engagement

STRATEGIC

- The JSNA is different from many other plans and strategies produced by Croydon Council and the NHS South West London Croydon Borough Team (formerly NHS Croydon) as it looks across a broader time frame - both medium term (3 to 5 years) and longer term (5 to 10 years)

NEEDS

- The JSNA examines *needs*, not *wants* or *demands*, an important distinction. It concentrates on the gaps between what is provided in Croydon and what is deemed to be required, rather than simply focusing on what is demanded, although it should incorporate the views of users. In addition, it focuses on the needs of populations, rather than individuals.

ASSESSMENT

- The JSNA does not simply report on identified needs, but attempts to assess these and place them appropriately in context.

Why carry out a JSNA?

The JSNA is a statutory responsibility placed on local authorities and NHS Primary Care Trusts to ensure that they regularly review the needs of the populations they serve¹.

Department of Health guidance describes the JSNA as:

“...a systematic method for reviewing the health and wellbeing needs of a population, leading to agreed commissioning priorities that will improve health and wellbeing outcomes and reduce inequalities.”

¹ Local Government and Public Involvement in Health Act 2007

So there is one key aim (reviewing health and wellbeing needs) with two important objectives: improving outcomes and reducing inequalities.

The JSNA review process should drive commissioning priorities. The JSNA is primarily a document for commissioners, although it will be of interest to a range of stakeholders in giving the high level view of the health and wellbeing of the population. To effectively influence commissioning, the JSNA must be prepared in such a way as to provide commissioners with the information they require to commission appropriate and successful services, in an accessible and useful format.

Commissioning decisions must address the needs raised by the JSNA if health and wellbeing are to improve. The JSNA process can help reveal where there is inequity in need, so that, through commissioning decisions, more equal health and wellbeing outcomes can be achieved.

Important changes for 2011/12 JSNA

The process for production of the JSNA in Croydon has changed this year. We have taken on board feedback from a variety of stakeholders to improve both the process used to develop the JSNA and the usefulness of the final document.

In April 2011, a **JSNA Steering Group** was established, replacing the previous Board. Membership of the Steering Group is listed in Appendix 1. The Steering Group reports to the Health and Wellbeing Board (HWBB). As well as being used by individual commissioners, the JSNA is a key document informing the Health and Wellbeing Strategy.

We have taken guidance from the JSNA steering group as well as Croydon Borough Team and local authority commissioners on how best to move the JSNA forward into a practical everyday document. For example, we have **reviewed the range of data indicators** included in this year's key dataset, removing those not considered useful by stakeholders and adding more relevant indicators where appropriate. For the first time this year, we have incorporated **trend data**, moving away from provision of a simple 'snapshot' view, and drawing out those indicators which show an improvement relative to other areas, as well as those data indicators that show a deterioration compared to other areas. This added depth allows users of the key dataset to better interpret the data available. For example, if the trend data demonstrates worsening performance over one year and three years, this may highlight the potential problem earlier than waiting for Croydon's performance to become significantly worse than the English national average.

We have chosen to **restructure** the way in which we present information in this year's chapter to make information easier to find, using primarily a '**life course**' approach, and signposting users to information that may be relevant to more than one stage or section of the lifecourse.

We have taken on board many of the useful suggestions made from meetings facilitated by and with **Croydon Voluntary Action and community groups**, for example, making greater use of sub-sections and using different 'keys' for different sections, and adopted the suggestion of including a subtitle ('the big picture of health and wellbeing needs in Croydon') to ensure that the aim of the Overview Chapter is immediately apparent. We hope to be able to develop some of the ideas more fully within the 'deep dive' chapters as well as in future JSNAs.

We have tried to improve **public, patient and community involvement** in the JSNA this year. In Croydon there are a variety of ways for individuals to get involved in services, including the **shadow HealthWatch**, which, subject to parliamentary approval of the Health and Social Care Bill, will become the new statutory organisation for patient and public involvement. Both shadow HealthWatch and Croydon Voluntary Action are represented on and integral to the JSNA steering group and have been involved in the process of consultation and review of the Overview Chapter. However we recognise that there is potential to further engage with community groups, representatives and individuals. The 'deep dive' chapters which will follow this Overview Chapter are key areas in which we can work with local groups to ensure we add depth and meaning to specific priority areas, to complement the more 'high level' information in this Overview Chapter.

Finally, we have improved the **transparency and accountability** of the JSNA authors through the JSNA Steering Group and the shadow Health and Wellbeing Board, as well as making plans to fully utilise the Croydon Observatory website as the main portal for information and reports from the JSNA. This allows an even wider range of stakeholders to participate in the development of the JSNA.

The key dataset (or 'spine chart')

What is the key dataset?

The Croydon key dataset is a series of indicators relating to health and wellbeing which allows an 'at a glance' view of Croydon in comparison to the rest of the country. Each of the indicators contains data which are published and publicly available, allowing comparison between the local area, London region and England as a whole. This sometimes means that the time periods

covered by the data are older than would be expected (see Limitations of the Data below).

The key dataset covers a broad range of health and social care indicators, including those related to the social determinants of health (see below) and patient satisfaction.

The complete key dataset is included at the end of this section. A list of the data sources for each indicator is shown in Appendix 2.

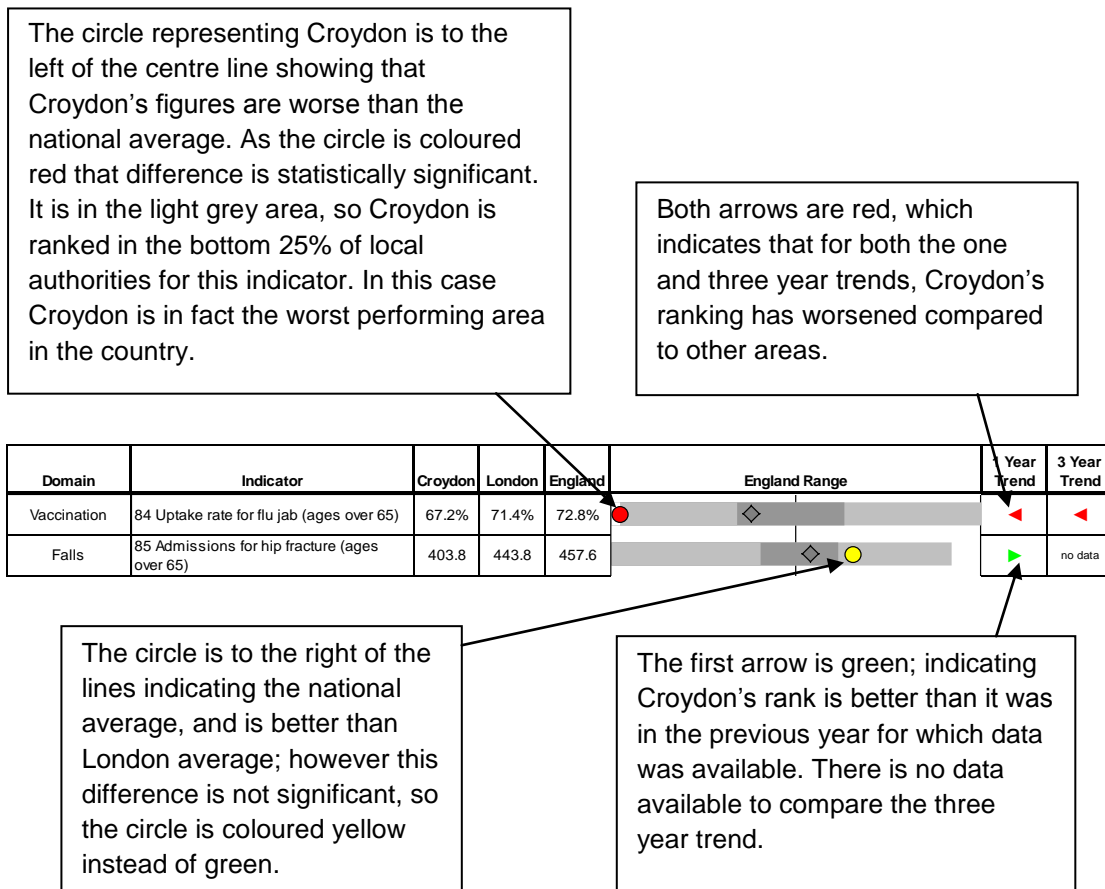
Understanding the Key Dataset/spine chart

For each indicator in the key dataset, Croydon's figures are represented by a circle. The black line running through the centre of the key dataset marks the national average. When the circle representing Croydon is to the left of the line, it is below average, when it is to the right, it is above average. To represent how important differences between figures are, we use the phrase 'statistically significant'. If the figures for Croydon and the national average are not statistically significantly different from each other, the circle is coloured yellow. However, when there is a statistically significant difference between Croydon and the national average, the circle is coloured green (if Croydon's performance is better than national average) or red (if it is worse). In a small number of cases it has not been possible to calculate statistical significance and the circle is coloured white.

The spine chart also allows relative comparison to other local authority areas. The London region figures are represented by a diamond shape. Again, if the Croydon circle is to the left of the diamond representing London region, its performance is worse than London, when it is to the right, it is better than the London average. In addition, the light grey area to the right hand side of the central spine represents the top 25%, and the light grey area to the left of the spine represents the bottom 25% of local authorities across the country. The further to the right Croydon is here, the better the performance.

Trend data has been included for the first time this year. Trends for one and three years are marked using arrows. A green arrow pointing to the right indicates that Croydon's ranking relative to other areas has improved over that time period, whereas a red arrow pointing to the left indicates that the ranking has worsened. Since the key dataset relies on published data (to make national and regional comparisons possible) the time periods referred to may vary. It is therefore important to check which time period an indicator refers to. This information is included for each indicator in the information provided in the **Indicator Notes**, where a source of each data item is also listed. The Indicator Notes are included as Appendix 2 to this document.

The extract from the key dataset below illustrates how to interpret the spine chart.



In the text of the chapter, indicators are referenced by numbers in square brackets and bold text. For example “[1]” refers to indicator 1 of the key dataset, which is the Index of Multiple Deprivation Score.

Limitations of the dataset

As with all data, there are a number of important caveats and limitations of which all stakeholders need to be aware.

- The key dataset contains only those data indicators which are **publicly and routinely available** at local level across the country. Without doing this, we would not be able to make the sorts of comparisons we make here between Croydon and the rest of England
- Although JSNAs rely heavily on this sort of comparative information, this creates an inevitable **time lag**, with the data sometimes being a year or two out of date. This is because local areas have access to their own data much sooner than when this is put into the public domain.

- Locally, we have done what we can to reduce this time lag. We have used only the **most recent data which are publicly and routinely** available at the time of finalising the dataset (mid October 2011).
- We have also **removed indicators based on data from the 2001 census**, as this is now out of date. The results of the 2011 census are due later in 2012.
- We have also **consulted key stakeholders** on the dataset. Many have chosen to provide additional commentary, with more recent updates to the data which were either made available just after our cut off point of mid October 2011, or which have been recorded locally but not yet been made available nationally.
- **The dataset should therefore be used in conjunction with the comments in the chapter**, where these are available, and in general, be seen as a **starting point** for discussion regarding local performance with an indicator, and not an end point.
- It is also important to note that the data presented in the key dataset are for Croydon as a whole. There are **wide variations within Croydon** (such as the differences in life expectancy between different parts of the borough) that must always be considered when commissioning services for Croydon.
- The data included in this chapter relates to those indicators which were considered most useful during our consultation with local stakeholders. However, some things are easier to measure than others! In addition, it is not always appropriate to measure aspects of people's lives in numbers or 'hard' data. In the key topic chapters which accompany this overview chapter (such as the key topic area of repeat abortions) we have used 'softer', more **qualitative approaches**, such as interviews with local service users

What is the 'life course' approach?

This year we have chosen to structure the overview chapter using a 'life course' approach. For the Croydon JSNA, we have adapted the life course approach taken in the Marmot review on inequalities² as follows (Table 1).

The central concept behind a life course model is that the needs of individuals and groups, and the best ways to meet those needs, change over the course

² Marmot, M. (2010) Fair society, healthy lives. Strategic review of health inequalities in England post-2010. The Marmot Review

of a lifetime. As a person grows older, the health behaviours adopted, and environmental factors encountered, accumulate. This means each individual has a unique and complex series of influences, both positive and negative, on their health and well being.

Table 1 Croydon life course

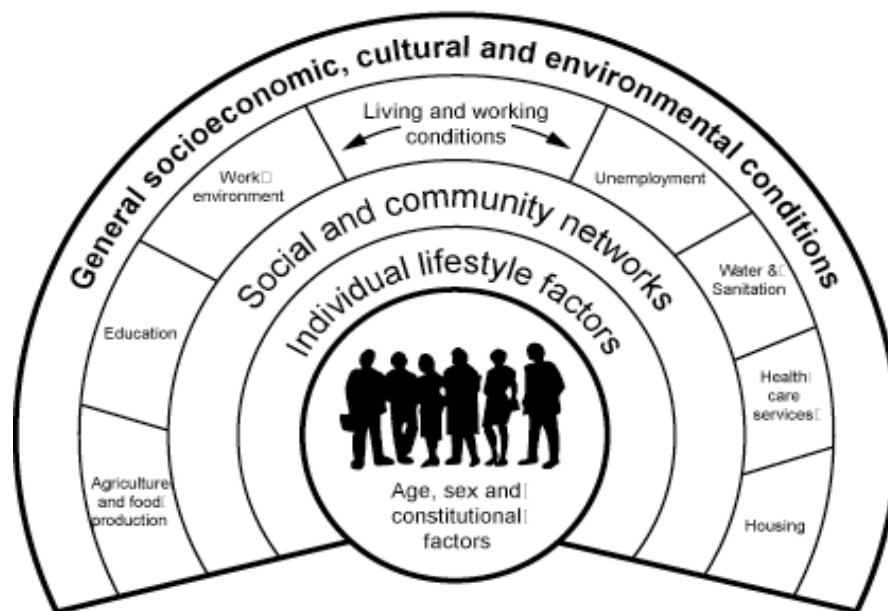
Section	Definition	Topic Areas
Community Life	Influences on health and wellbeing occurring through our environment and with each other	Civil unrest, housing, social care, asset based community development
Early Life	Most aspects of health and wellbeing from birth up to age 16 or 18 (dependent on indicator)	Child poverty, education and attainment to GCSE level, immunisation, child obesity, youth crime.
Working Age	Aspects of health and well being relating to those aged between 16 and 60.	Post-GCSE education, work and training, unemployment and other benefits, adult mental health and learning disability
Family Life	Aspects of health and wellbeing related to maternal and reproductive health	Family structure and cohesion, pregnancy, sexual health, domestic violence
Later Life	Over 60 years of age	Independence and reablement, flu vaccination.
Healthy Life	Burden of disease, healthy lifestyles, health service performance	Long term conditions, mental health, cancer, addictive behaviours, physical activity, patient satisfaction, healthcare utilisation

What are the ‘wider social determinants’ and why are they important?

Health and wellbeing is not just determined by an individual’s life choices, or by the availability of health and social care services, though they are important. Other factors, such as employment, deprivation, education, social cohesion, housing, crime and so on also have a major impact on health and wellbeing. The wide range of stakeholders involved in this broader view of health and wellbeing includes teachers, police, parents, voluntary organisations, community leaders and individuals, as well as health and social care professionals.

Social determinants have been considered an important part of health and wellbeing for many years. They are perhaps most famously demonstrated by the Dahlgren and Whitehead 'rainbow' model, which visually demonstrates the main influences on health and wellbeing.

Figure 1 Socio-economic model of the main determinants of health



Source: G Dahlgren and M Whitehead, *Policies and strategies to promote social equity in health*. Institute of Futures Studies, Stockholm, 1991

Professor Marmot's report on the social determinants of health follows on from other key documents such as the Black report³ and Acheson report⁴, and has raised this important health and wellbeing concept up the political agenda. Key to this is the recognition that many of these central determinants can only be modified by policy changes that have traditionally been seen as outside the remit of healthcare.

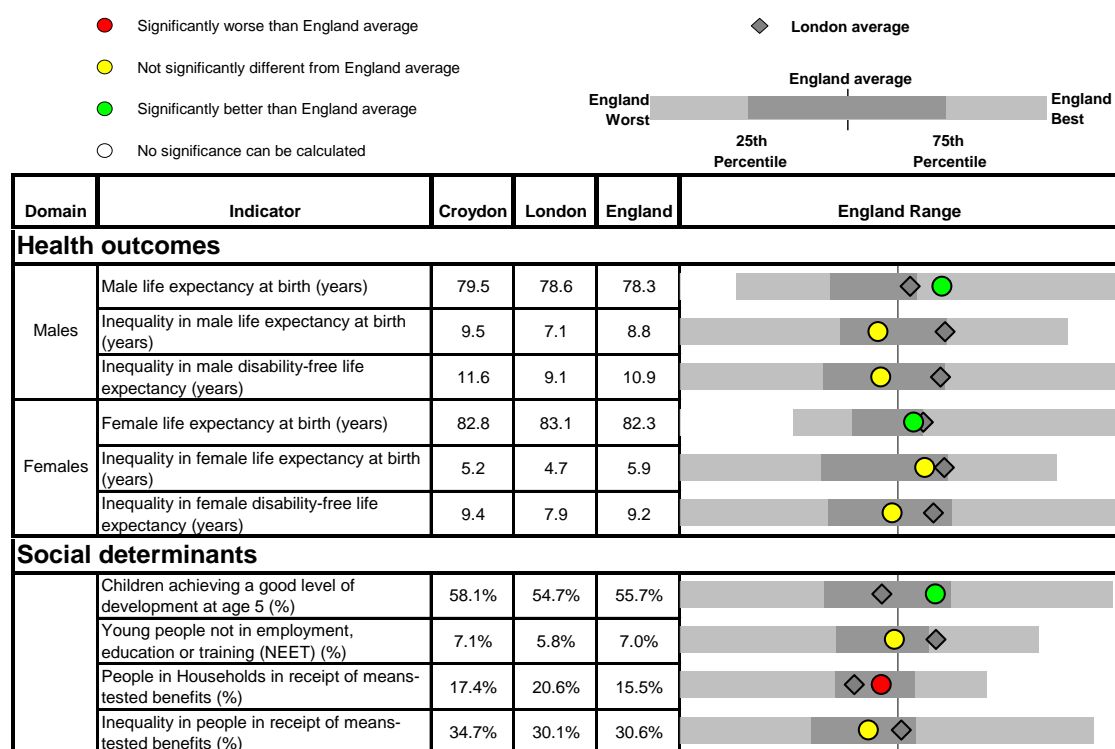
Social Equality

As part of his report, Professor Marmot recommended a series of indicators which would demonstrate how equally distributed health and wellbeing are within the community. Croydon's results for those indicators are shown in the table below. They indicate we are doing well in some areas, e.g. male and female life expectancy, and childhood development, but less well in others, such as the percentage of people in households receiving means-tested benefits.

³ Black, D (1980) Report of the working group on inequalities in health. London: DHSS

⁴ Acheson, D (1990) Inequalities in health: report of an independent inquiry. London: HMSO

Figure 2 Marmot indicators, Croydon



Source: London Health Observatory

Conclusions

Each section of the 2011/12 JSNA will include key findings (at the start of the section) and both recommendations and questions for commissioners (at the end of the section).

Recommendations will be made where the needs assessment leads to a clear action which the Health and Wellbeing Board, commissioners or other specific actors should take into account when preparing strategies and commissioning plans.

Questions for Commissioners will be posed when the way forward on an issue is less clear, and will require further close working across stakeholders to develop the best possible strategies for Croydon's population in the future.

The data in this chapter was the most recent published data as at 15 October 2011. Readers should note that more up-to-date data may have been subsequently published, and are advised to refer to the source shown under figures or listed in the appendices for the chapter for the latest information.

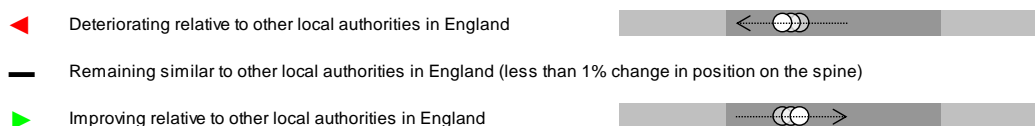
Croydon Key Dataset 2011/2012

The chart below compares Croydon with both London and the rest of England across a number of key indicators which are relevant to health and wellbeing. For each indicator, figures for the latest data period which was available (as of October 2011) are shown for Croydon, London and England in the first few columns, with full details of each indicator (including time period and data source) included in Appendix 2. The right hand side of the chart visually represents Croydon's performance in relation to London and England, and the direction of travel of each indicator. Looking at the 'England range' column, Croydon figures for each indicator are shown as a circle. A red circle means that Croydon is significantly worse than England for that indicator; a green circle that it is significantly better than the England average. The London average is shown by a grey diamond.

The 'England range' column also illustrates the average rate for England for each indicator (shown by the vertical dark line running through the centre) and the range of results for all local authorities/PCTs in England (the horizontal grey bar, with the darker grey section representing the middle 50% of values.)



The final two columns shown the direction of travel over one and three years, where data is available.



After each relevant section or indicator, we have provided signposts to information that is included in other sections and may be of relevance to the reader.

Croydon Key Dataset 2011/2012

Domain	Indicator	Croydon	London	England	England Range	1 Year Trend	3 Year Trend
Deprivation							
Deprivation	1 Index of multiple deprivation	22.8	25.2	21.5		no data	◀
<i>See also 7 Fuel poverty, 22 Children in poverty, 82 Older people in poverty</i>							
Community life							
Migration	2 International migration turnover	17.8	39.5	12.4		▶	—
	3 Internal migration turnover	109.5	149.1	97.8		—	▶
	4 International migrants identified on GP register	18.4	30.4	11.6		▶	▶
Housing	5 Statutory homelessness	3.0	3.0	1.9		◀	no data
	6 Households in temporary accommodation	8.80	12.28	2.38		—	—
	7 Fuel poverty	9.5%	10.8%	15.4%		no data	no data
<i>See also 83 Older people's satisfaction with home and neighbourhood</i>							
Crime	8 Violent crime	20.7	22.9	15.8		◀	no data
	9 Total notifiable offences	93	106	74		—	◀
	10 First time entrants to the youth justice system	1520	1610	1472		▶	◀
Environment	11 Carbon emissions	4.8	5.9	6.8		no data	no data
	12 Household waste recycling	32.2%	31.8%	39.7%		▶	▶
Road accidents	13 Road injuries and deaths	38.8	45.8	48.1		—	no data
Social care	14 Timeliness of social care assessment	94.0%	87.9%	81.3%		◀	▶
	15 Timeliness of social care assessment packages	98.0%	90.4%	90.5%		▶	▶
	16 Social care clients receiving Self Directed Support	5.9%	13.4%	13.0%		◀	◀
	17 People supported to live independently through social services	4062	3230	3067		▶	▶
	18 Delayed transfers of care	7.9	9.9	12.9		◀	▶
	19 Social care-related quality of life	18.3	18.0	18.7		no data	no data
	20 User reported measure of respect and dignity in their treatment	83.7%	81.9%	87.0%		no data	no data
<i>See also Social Care in Later Life section</i>							
Carer support	21 Carers receiving advice and information	12.7%	24.6%	26.4%		◀	◀
Early life							
<i>See also Teenage Pregnancy in Family Life section, 149 Emergency admissions for children with asthma</i>							
Poverty	22 Children in poverty	27.0%	29.7%	21.9%		—	◀
	23 Free school meals (primary schools)	22.3%	25.0%	18.0%		—	no data
	24 Free school meals (secondary schools)	17.7%	23.4%	14.6%		—	no data
Infant mortality	25 Infant mortality	5.0	4.4	4.7		▶	no data
	26 Neonatal mortality	3.7	3.0	3.2		▶	no data
	27 Perinatal mortality	9.4	8.0	7.6		◀	◀
	28 Low birth weight	8.8%	7.9%	7.5%		▶	◀

See Appendix 2 for full details of each indicator.

Domain	Indicator	Croydon	London	England	England Range	1 Year Trend	3 Year Trend
Immunisation	29 Children aged 1 immunised for D/T/P/P/Hib	91.0%	90.7%	94.2%		◀	◀
	30 Children aged 2 immunised for pneumococcal infection	81.0%	82.4%	89.3%		▶	no data
	31 Children aged 2 immunised for meningitis and Hib	85.9%	84.9%	91.6%		◀	no data
	32 Children aged 2 immunised for measles, mumps and rubella (MMR)	82.1%	83.8%	89.1%		◀	◀
	33 Children aged 5 immunised for D/T/P/P	76.5%	74.7%	85.9%		◀	◀
	34 Children aged 5 immunised for measles, mumps and rubella (MMR)	75.1%	76.6%	84.2%		◀	◀
Dental health	35 Children accessing NHS dentistry	67.0%	67.0%	70.6%		—	▶
	36 Decayed, missing or filled teeth in 5 year olds	1.05	1.31	1.11		no data	no data
<i>See also 178 Adults accessing NHS dentistry</i>							
Childhood obesity	37 Obese children (Reception Year)	11.1%	11.6%	9.8%		▶	no data
	38 Obese children (Year 6)	22.1%	21.8%	18.7%		—	no data
Physical activity	39 Participation in PE and school sport (children)	55.2%	55.2%	55.1%		◀	no data
	40 Children travelling to school by public transport, cycling or walking	71.0%	79.4%	70.8%		—	no data
School attainment	41 Children achieving a good level of development at age 5	58%	55%	56%		▶	▶
	42 Attainment at key stage 2	73%	75%	74%		◀	—
	43 GCSE achieved (5 A*-C inc. Eng & Maths)	54.4%	58.0%	55.3%		◀	no data
<i>See also Education and Training in Working Age section</i>							
Absence from school	44 Overall absence rate	6.6%	6.4%	6.8%		▶	▶
	45 Persistent absentees	4.0%	3.6%	4.2%		▶	▶
<i>See also 10 First time entrants to the youth justice system</i>							
Looked after children	46 Looked after children with stable placements	69.9%	68.5%	68.0%		—	◀
Disability	47 Parental experience of services for disabled children	60%	59%	61%		no data	no data
Family life							
Smoking during pregnancy	48 Smoking in pregnancy	9.1%	6.5%	13.5%		◀	no data
Breastfeeding	49 Breastfeeding initiation	85.9%	86.3%	73.6%		◀	no data
	50 Prevalence of breastfeeding at 6-8 weeks from birth	67.3%	64.1%	45.7%		—	no data
Teenage pregnancy	51 Under 18 conception rate	45.7	40.7	38.2		▶	▶
	52 Under 16 conception rate	10.90	8.70	7.90		▶	◀
Abortions	53 Access to NHS funded abortions before 10 weeks gestation	79.5%	79.1%	76.5%		◀	◀
	54 Repeat abortions (ages under 25)	40.8%	32.3%	25.1%		—	◀
	55 Repeat abortions (all ages)	50.0%	41.3%	34.3%		—	no data
Contraception	56 GP prescribed long acting reversible contraception (LARC)	40.4	25.0	46.9		—	no data

See Appendix 2 for full details of each indicator.

Domain	Indicator	Croydon	London	England	England Range	1 Year Trend	3 Year Trend
Sexually transmitted infections	57 Chlamydia screening coverage	26.2%	29.7%	25.6%		no data	no data
	58 Chlamydia diagnoses (ages 15-24)	3631	2507	2219		◀	no data
	59 Chlamydia diagnoses (ages 25 and over)	176	189	93		◀	no data
	60 Gonorrhoea diagnoses at GUM clinics	88.1	82.3	30.8		▶	no data
	61 Syphilis diagnoses at GUM clinics	5.3	13.6	4.8		—	no data
	62 Herpes diagnoses at GUM clinics	95.7	86.0	55.6		◀	no data
	63 Warts diagnoses at GUM clinics	142.9	165.4	141.7		◀	no data
	64 HIV prevalence	4.4	5.2	1.8		—	—
	65 Persons presenting with HIV at a late stage of infection	34.1%	26.4%	29.6%		▶	no data
Working age							
See also <i>Healthy Lifestyles</i> in <i>Healthy Life</i> section							
Education and training	66 Qualified to 2 A-levels or equivalent	57.3%	55.7%	50.7%		▶	▶
	67 Qualified to degree level or equivalent	40.4%	41.9%	31.1%		▶	▶
	68 Young people aged 16-18 not in Education, Employment or Training	6.6%	5.0%	6.1%		◀	no data
	69 19-year-olds attaining 2 A-levels or equivalent	60.3%	56.2%	52.0%		◀	◀
See also <i>School Attainment</i> in <i>Early Life</i> section							
Employment	70 Overall employment rate	72.4%	68.1%	70.4%		▶	▶
	71 Self employment rate	9.9%	10.6%	9.3%		▶	◀
	72 Unemployment rate	7.3%	8.8%	7.8%		▶	▶
	73 Job seekers allowance claimants aged 16-64	4.3%	4.1%	3.7%		◀	◀
	74 Job seekers allowance claimants aged 18-24	8.1%	6.8%	7.1%		—	—
Disability	75 Working age people on key out-of-work benefits	12.8%	12.4%	11.9%		◀	◀
	76 Working age people who are claiming disability benefit	1.00%	0.80%	1.00%		—	◀
Mental health*	77 Adults with mental illness in settled accommodation	33.0%	62.1%	58.7%		◀	no data
	78 Adults with mental illness in employment	4.9%	6.0%	7.9%		◀	no data
* There are concerns that the data for indicators 77 and 78 is incorrect for Croydon due to a data processing issue.							
See also <i>Mental Health</i> in <i>Long Term Conditions</i> section							
Learning disability	79 GP recorded learning disability prevalence (adults)	0.49%	0.31%	0.42%		◀	no data
	80 Adults with learning disabilities in settled accommodation	70.5%	58.1%	60.6%		▶	no data
	81 Adults with learning disabilities in employment	8.5%	8.5%	6.4%		▶	no data

See Appendix 2 for full details of each indicator.

Domain	Indicator	Croydon	London	England	England Range	1 Year Trend	3 Year Trend
Later life							
See also <i>Long Term Conditions</i> in <i>Healthy Life</i> section, <i>Social Care</i> and <i>Carers</i> in <i>Community Life</i> section							
Poverty	82 Older people in poverty	20.6%	27.0%	20.6%		no data	◀
Satisfaction with local area	83 Older people's satisfaction with home and neighbourhood	77.2%	77.1%	83.9%		no data	no data
Vaccination	84 Uptake rate for flu jab (ages over 65)	67.2%	71.4%	72.8%		◀	◀
Falls	85 Admissions for hip fracture (ages over 65)	403.8	443.8	457.6		▶	no data
Social care	86 Permanent admissions to residential and nursing homes	0.70	1.05	1.60		◀	▶
	87 Achieving independence through rehabilitation/intermediate care	65.3%	81.4%	81.2%		▶	no data
	88 Support for older people to live independently at home	23.6%	23.3%	30.0%		no data	no data
Healthy life							
All cause mortality	89 All-age all-cause mortality (males)	610.1	655.8	673.5		▶	▶
	90 All-age all-cause mortality (females)	456.2	449.3	478.3		▶	▶
	91 Life expectancy (males)	79.5	78.6	78.3		▶	▶
	92 Life expectancy (females)	82.8	83.1	82.3		▶	▶
	93 Inequality in life expectancy (males)	9.5	7.5	7.4		▶	▶
	94 Inequality in life expectancy (females)	5.2	4.8	5.3		▶	▶
Deaths from individual diseases are shown at the end of each section on the specific disease. See also <i>13 Road injuries and deaths</i> and <i>Infant Mortality</i> in the <i>Early Life</i> section.							
Suicide	95 Deaths from suicide and injury of undetermined intent	4.6	7.0	7.9		▶	▶
Mortality from causes amenable to healthcare	96 Deaths from causes considered amenable to healthcare	88.9	98.6	96.4		▶	▶
	97 Deaths from causes considered amenable to healthcare excluding CHD	56.8	58.1	56.9		▶	▶

See Appendix 2 for full details of each indicator.

Domain	Indicator	Croydon	London	England	England Range	1 Year Trend	3 Year Trend
Cancer	98 Spend on cancers and tumours	£106	£105	£107		◀	▶
	99 Breast screening rate	69.8%	67.0%	76.9%		◀	◀
	100 Cervical screening rate	76.3%	73.9%	78.9%		▶	▶
	101 Incidence of all cancers	368.4	351.3	374.0		—	◀
	102 Early deaths from cancer	95.1	108.2	112.1		◀	▶
	103 Deaths from cancer (all ages)	150.7	164.2	171.7		◀	▶
	104 Incidence of oesophageal cancer	7.3	8.0	9.4		▶	▶
	105 Deaths from oesophageal cancer	6.4	6.7	8.4		▶	▶
	106 Incidence of stomach cancer	7.7	8.4	8.5		▶	◀
	107 Deaths from stomach cancer	4.9	5.1	5.3		▶	▶
	108 Incidence of colorectal cancer	47.3	41.9	46.4		◀	◀
	109 Deaths from colorectal cancer	16.8	16.3	17.4		▶	◀
	110 Incidence of lung cancer	40.3	45.0	45.2		◀	—
	111 Deaths from lung cancer	31.7	37.3	38.2		▶	▶
	112 Incidence of all skin cancers	36.8	31.6	118.5		◀	◀
	113 Deaths from malignant melanoma	2.4	2.1	2.6		—	—
	114 Incidence of breast cancer	113.1	108.9	121.8		▶	◀
	115 Deaths from breast cancer	20.6	25.3	26.1		▶	▶
	116 Incidence of cervical cancer	6.6	6.1	8.1		—	◀
	117 Deaths from cervical cancer	1.6	2.1	2.3		▶	▶
	118 Incidence of prostate cancer	117.1	96.6	97.6		▶	▶
	119 Deaths from prostate cancer	20.9	22.4	24.2		▶	▶
120 Incidence of bladder cancer	11.7	10.7	11.5		▶	▶	
121 Deaths from bladder cancer	4.7	4.5	4.9		◀	◀	
122 Deaths from leukaemia	6.5	5.0	4.9		◀	◀	
Infectious diseases	123 Spend on infectious diseases	£39	£58	£27		—	▶
	124 Notifications of food poisoning	67.3	57.2	102.4		▶	no data
	125 Lab confirmed gastrointestinal disease	157.2	454.3	328.9		◀	no data
	126 New cases of tuberculosis	34	44	15		—	no data
	127 Deaths from infectious and parasitic diseases	8.1	9.3	7.6		▶	—

See also *Sexually Transmitted Infections* in *Family Life* section, *84 Uptake rate for flu jab*

See Appendix 2 for full details of each indicator.

Domain	Indicator	Croydon	London	England	England Range	1 Year Trend	3 Year Trend
Long term conditions							
Long-term conditions	128 Support for people with long-term conditions	73.1%	72.4%	78.5%		▶	no data
Diabetes	129 Spend on endocrine, nutritional and metabolic problems	£47	£49	£49		▶	—
	130 GP recorded diabetes prevalence (adults)	5.6%	5.3%	5.4%		▶	no data
	131 Blood sugar control (HbA1c<7)	53.3%	51.6%	53.8%		no data	no data
	132 Emergency admissions for diabetes	37.0	26.2	26.8		◀	—
	133 Deaths from diabetes	5.5	6.1	5.9		—	▶
Circulatory disease	134 Spend on circulatory diseases	£129	£132	£138		◀	▶
	135 Early deaths from circulatory diseases	71.0	75.3	70.5		—	—
Coronary heart disease	136 GP recorded CHD prevalence (adults)	2.9%	2.8%	4.3%		—	no data
	137 Deaths from coronary heart disease	72.9	81.4	83.7		◀	◀
Stroke	138 GP recorded stroke/TIA prevalence (adults)	1.5%	1.3%	2.1%		◀	no data
	139 Emergency admissions for stroke	123.9	109.6	114.7		◀	◀
	140 Emergency readmissions within 28 days of discharge for stroke	10.5	13.2	11.4		▶	▶
	141 Early deaths from stroke	13.8	13.4	12.8		—	◀
	142 Deaths from stroke (all ages)	38.1	39.4	44.7		—	▶
COPD	143 Spend on problems of the respiratory system	£71	£81	£84		▶	▶
	144 Estimated COPD prevalence (adults)	4.0%	3.9%	3.7%		no data	no data
	145 GP recorded as % of estimated COPD prevalence (adults)	27.8%	32.2%	53.0%		no data	no data
	146 Early deaths from COPD	12.8	11.4	11.8		no data	no data
	147 Deaths from COPD (all ages)	27.8	25.4	26.2		▶	▶
Asthma	148 GP recorded asthma prevalence	4.9%	4.8%	5.9%		▶	no data
	149 Emergency admissions for children with asthma	236.6	213.7	256.7		▶	◀
	150 Deaths from asthma	1.6	1.4	1.2		▶	▶
Mental health	151 Spend on mental health	£216	£255	£204		◀	—
	152 GP recorded dementia prevalence	0.35%	0.31%	0.45%		—	no data
	153 GP recorded depression prevalence	7.2%	7.7%	10.9%		▶	no data
	154 GP recorded severe mental illness prevalence	0.97%	0.96%	0.77%		—	no data
	155 Hospital stays for self-harm	163.9	114.8	198.3		no data	no data

See also *Mental Health in Working Age* section

See Appendix 2 for full details of each indicator.

Domain	Indicator	Croydon	London	England	England Range	1 Year Trend	3 Year Trend
▪ Healthy lifestyles							
See also <i>Teenage Pregnancy</i> and <i>Sexually Transmitted Infections</i> in <i>Family Life</i> section							
Smoking	156 Estimated smoking prevalence	19.7%	20.0%	21.2%		no data	no data
	157 Quit rates	804	813	911		▶	▶
	158 Deaths attributable to smoking	192.7	207.9	216.0		▶	no data
See also <i>48 Smoking during pregnancy</i>							
Alcohol	159 Alcohol related recorded crimes	10.9	11.7	7.6		—	◀
	160 Hospital stays for alcohol attributable conditions	1658	1684	1743		—	◀
	161 Alcohol attributable mortality (males)	27.3	33.4	35.9		▶	▶
	162 Alcohol attributable mortality (females)	12.7	12.5	14.9		▶	▶
Drugs	163 Drug offences	6.6	8.2	4.1		▶	▶
Adult obesity	164 Estimated obesity prevalence (adults)	23.5%	20.7%	24.2%		no data	no data
See also <i>Childhood Obesity</i> in <i>Early Life</i> section							
Physical activity	165 Participation in sport and active recreation (adults)	7.7%	10.0%	11.5%		▶	no data
See also <i>Physical Activity</i> in <i>Early Life</i> section							
Eating habits	166 Estimated healthy eating prevalence (adults)	34.4%	36.4%	28.7%		no data	no data
▪ Health services							
See also <i>Immisation</i> in <i>Early Life</i> section, <i>57 Chlamydia screening coverage</i> , <i>84 Uptake rate for flu jab</i> , <i>99 Breast screening rate</i> , <i>100 Cervical screening rate</i>							
End of life care	167 Proportion of deaths at home	16.9%	18.8%	19.9%		◀	◀
Satisfaction with primary care services	168 Satisfaction with telephone access to GP practice	71.0%	67.0%	69.2%		—	no data
	169 Satisfaction with GP practice opening times	78.4%	77.8%	80.5%		◀	no data
	170 Ability to see GP quickly	73.6%	75.1%	78.8%		—	no data
	171 Ability to book GP consultation ahead if wanted	72.4%	70.1%	71.0%		▶	no data
	172 Ability to see a specific GP if wanted	69.0%	68.2%	73.0%		—	no data
Admission to hospital	173 All cause elective hospital admissions	109.9	112.2	120.6		▶	—
	174 All cause emergency hospital admissions	84.5	80.2	86.7		◀	◀
	175 Emergency readmissions to hospitals within 28 days of discharge	8.7%	8.2%	7.7%		◀	◀
	176 Emergency admissions for ambulatory care sensitive conditions	13.8	14.1	14.5		◀	◀
Dental health	177 Spend on dental problems	£72	£72	£67		◀	◀
	178 Adults accessing NHS dentistry	50.4%	48.4%	52.3%		—	▶
See also <i>35 Children accessing NHS dentistry</i>							

See Appendix 2 for full details of each indicator.

2. Croydon's population

The first step in any scientific study is to identify the population under investigation, and the same is true in a needs assessment. Before trying to assess what a population needs, we must ensure that we know who our population are.

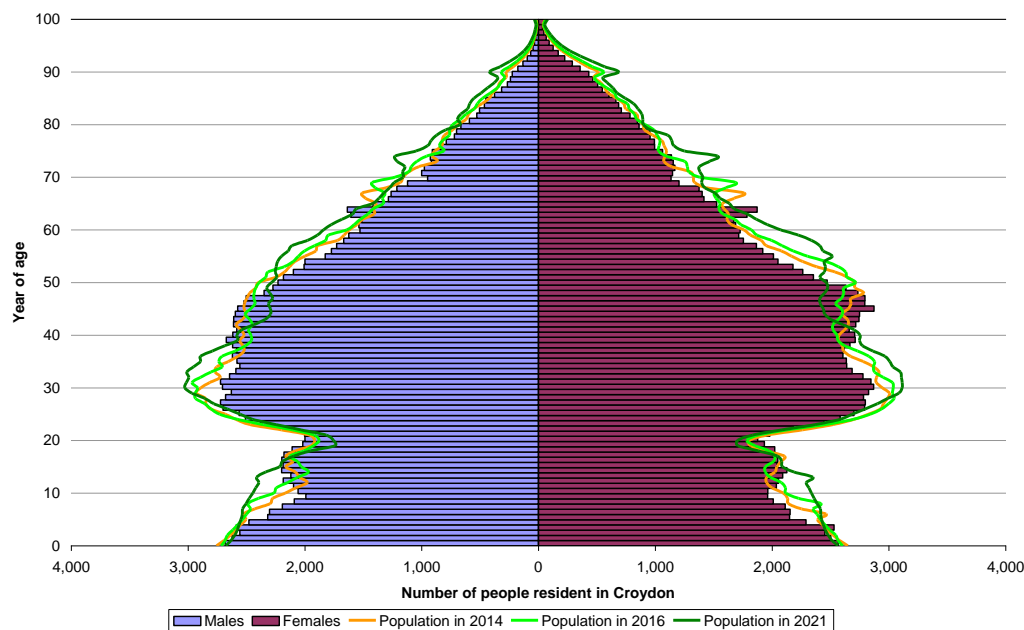
Understanding the structure of the population and the way demographics change – including such characteristics as age, gender, disability and ethnicity - forms the basic intelligence on which many commissioning decisions are made.



Key findings

- Croydon has a large and growing population – it is the second largest Borough in London.
- Croydon has particularly large numbers of those aged 20-50.
- Further growth is predicted in specific age groups, such as the under 15s, and those aged 25-40.
- Croydon's is a diverse population and becoming increasingly so. Nearly 100 languages additional to English are spoken in Croydon and the black and minority ethnic community is expected to reach 50% by around 2025.

Figure 3 Projected population change, by gender and age, Croydon 2011, 2014, 2016 and 2021



Source: Greater London Authority Population Projections: 2010 Round for London Plan

Population highlights

Croydon’s population is estimated at 345,600 (2010 mid-year estimates) which is up by 2,700 people from 2009. This is one of the highest increases across the London boroughs. Croydon was the most populous borough until 2009, when it was overtaken by Barnet. In comparison, about 7.75 million people (or 12.5% of the UK population) live in London, an increase of 5.9% from 2001 to 2009.

Figure 3 shows the structure of Croydon’s population and how it is expected to change in coming years. Croydon’s population is weighted towards those in their late 20s – 50, with fewer people in their teens/early twenties. There is also a high population aged around 65 - the immediate post-war generation. Croydon’s population is estimated to grow to 377,100 by 2031 (London Plan estimates). In particular, increases are expected in the under 15 and the 25 to 40 age groups.

Population turnover in Croydon between 2008 and 2009 was 45,200 - equivalent to a turnover rate of 132 per 1,000 population (average for London was 186). This means Croydon’s population is less transient (mobile) than the average for London.

Population changes due to internal migration within Greater London produced a net reduction in Croydon's population in 2009 of 2,100 people with 17,800 people moving into the borough and 20,000 leaving.

Ethnicity

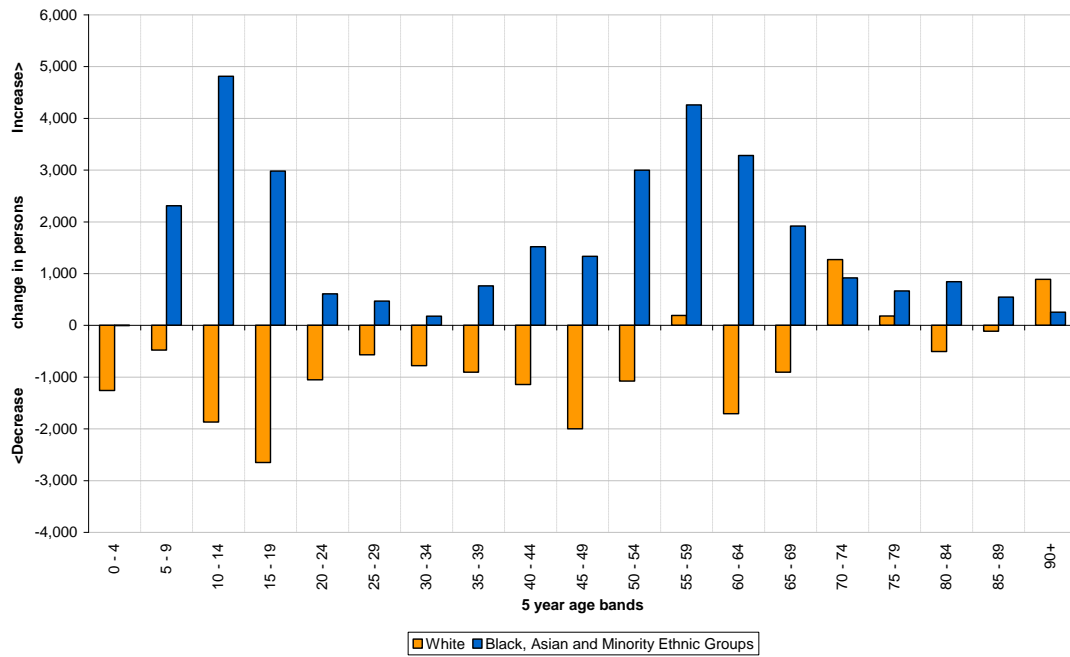
Croydon is home to a thriving immigrant population. The number of immigrants registered with GPs, (which will under-represent the true picture) was up from 5,977 in 2009 to 6,560 in 2011; this represents a reduction from 2007 (6,631). The most popular destinations for the immigrant community are Broad Green, Fairfield and West Thornton.

There is an increasing proportion of immigrants to Croydon from India and Pakistan. These now account for over 34% of all immigrants (up from 24% in 2007).

About 42% of Croydon's population are from ethnic minority communities – the total Black and Minority Ethnic (BME) population is estimated to grow to more than 50% of the total population by around 2025. The largest increases are estimated in the Black African, Black Caribbean and Indian ethnic populations.

The changing ethnicity pattern is demonstrated in figure 4. This figure illustrates not only the expected changes in ethnicity over the next decade, but also how these change are expected to vary between age groups. The figure is a good illustration of the interactions between demographic factors such as ethnicity and age, and act as a reminder to both commissioners and providers that individual needs will vary both between and within groups, and to consider such data to ensure services are culturally sensitive.

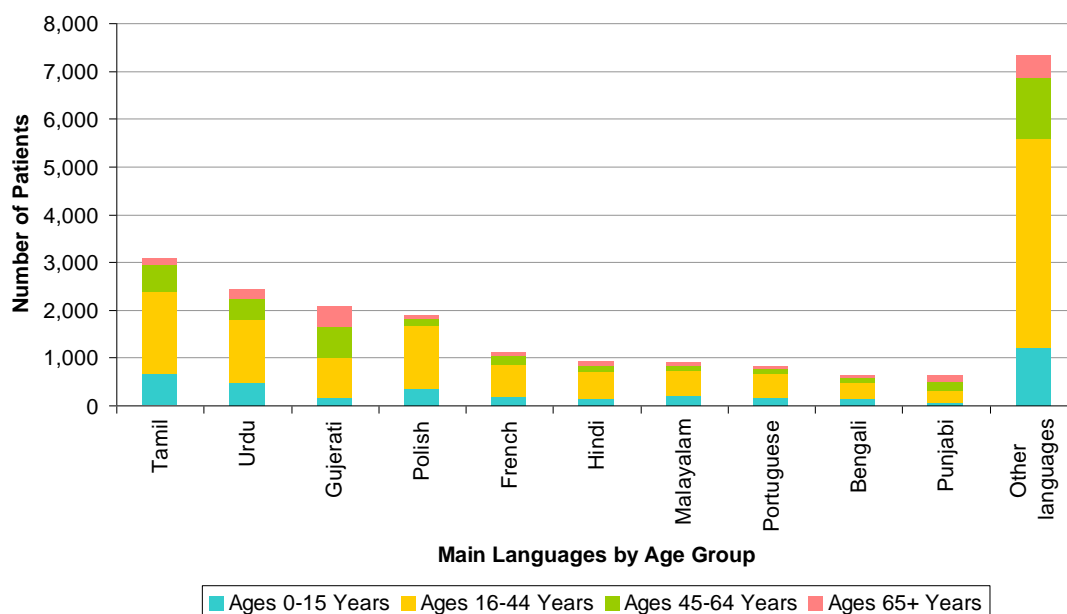
Figure 4 Projected change in population in White and BAME (Black, Asian and Minority Ethnic) groups, Croydon 2011 to 2021



Source: Greater London Authority ethnic group population projections: 2009 Round for London Plan

Given the diversity of our population, there is naturally diversity in the languages spoken by Croydon’s citizens. As well as the ten most common minority languages highlighted in Figure 5, “other languages” represents an additional 96 different languages spoken as the first language by patients registered with Croydon GPs.

Figure 5 Primary languages spoken by patients in Croydon general practices by age groups, 2010



Source: Data from Croydon general practices, March 2011

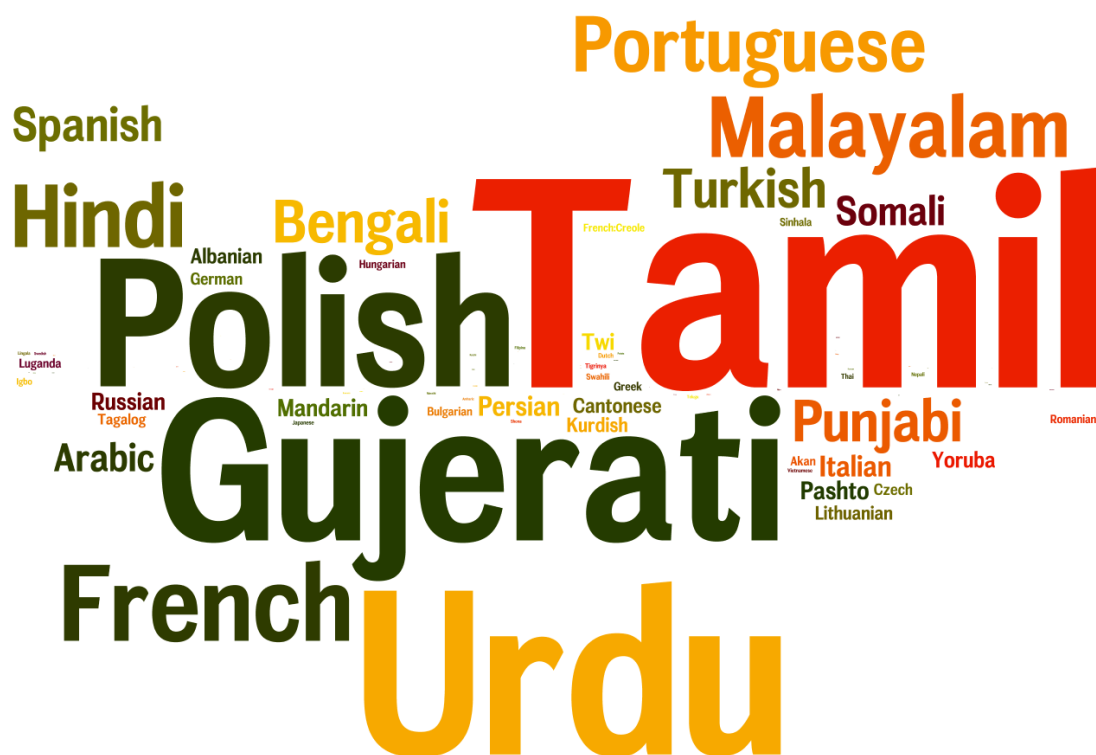
As of March 2011, there are 21,766 people (5.6% of the registered population of Croydon, or 18.3% of the population of Croydon for whom primary language is known) who have a language other than English as their first language. However, there is much underreporting of this information: only 69.4% of the registered population in Croydon have their language recorded. These figures are therefore likely to under-represent the proportion of Croydon’s population who do not speak English as their first language.

As well as demonstrating the languages spoken, this chart also gives an insight into changing patterns of immigration. For example, Polish speakers tend to be in 16-44 years age group, which is perhaps related to EU expansion and recent immigration of those of working age. In contrast, those who speak Gujarati are more likely than Polish speakers to be in the 45-64 and 65+ age bands and they may have settled in Croydon many years ago.

Figure 6 further illustrates the most common minority languages spoken in Croydon general practices.

The diversity of Croydon's population is seen as a strength. However, those for whom English is not their first language face clear barriers to communication and accessing services without sufficient English.

Figure 6 Primary languages spoken by patients in Croydon general practices, 2010 (excludes English) – the larger the word, the more common the language



Source: Data from Croydon general practices, March 2011

Some Londoners report that they feel excluded due to cultural and language barriers. People with poor English may be particularly limited in accessing mental health services, where there is a lack of ‘talking therapies’ available in languages other than English⁵. The London Health Equality Strategy includes improving access and investing in advocacy, information, advice and language support as one of its ten commitments.

The fact that a significant proportion of the Croydon population are from ethnic minority backgrounds, with a diverse and growing range of languages being reflected in many communities, presents challenges for Croydon’s commissioners in terms of effectively meeting these needs. If these needs are met now, then more serious health and wellbeing problems in the future can be prevented, reducing the future costs of health and social care. Providing effective and culturally sensitive services to non English speakers needed as part of the London Health Equalities Strategy will involve additional thought and investment.

⁵ London Health Equality Strategy, Mayor of London’s Office, April 2010

Asylum seekers

Asylum seekers and refugees are a further important component part of Croydon's population. Although the number of asylum seekers settled in Croydon is small compared to the national total⁶, there is a much larger transient population who are resident for a short time, often only a few weeks.

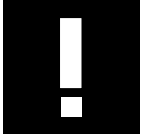
This temporary population are in Croydon as the Home Office UK Border Agency is based here. This is where the majority of asylum seekers who are already in the country make their applications. Unaccompanied children seeking asylum are automatically placed in the care of the local authority. Any unaccompanied minor under 16 is referred to Croydon Council for support. Croydon Council also administers the London rota for placement of 16 and 17 year olds.

Many asylum seekers arrive in the UK in good physical health, but their health and wellbeing can deteriorate rapidly once they enter the UK. Reasons for this include difficulty in accessing health services, lack of knowledge of entitlement, difficulty in registering for primary or community services as well as language barriers⁷.

Many asylum seekers have needs additional to those of other migrant groups, due to either the conditions in their home country, the difficulties of the journey to the UK, or the loss of family, friends and other support networks. They may not have had access to health care, and may also bear the physical and mental scars from war, torture and abuse⁶.

⁶ UK Borders Agency statistics

⁷ *The health needs of asylum seekers*; S Haroon, Faculty of Public Health; May 2008



Recommendations

- 1) Commissioners and strategy leads will want to be confident that all new and existing strategies and commissioning decisions take account of changes in Croydon's demographics anticipated over the next 10 years. New and existing services will need to adapt to meet the needs of our changing population.



Questions for commissioners

- 1) Should the changing balance of ethnicities impact on the arrangement of services, and in what ways? How do ethnicity and age interrelate? For example, what are the needs of older people from different ethnic backgrounds?
- 2) How are those services in Croydon which do not have good access to translation services and multi-lingual information and advice reducing barriers to accessibility?
- 3) How do we ensure that all providers understand the importance of accurate reporting on ethnicity and language and that we begin to improve recording of ethnicity locally?
- 4) Are services designed to reflect the needs of and reduce inequalities across all protected groups, including but not exclusively ethnic minorities?

3. Deprivation



Key findings

- Deprivation is a key determinant of health and wellbeing. Several aspects associated with deprivation, such as low income, housing, lack of car ownership and low levels of education will all have an important influence on whether and how individuals access services or find themselves able to maintain and protect the health and wellbeing of themselves and their families.
- In Croydon, there is much affluence, but also much deprivation. Although deprivation levels are greater in the north of Croydon, there are pockets of deprivation in other parts of Croydon such as Coulsdon East and New Addington.
- Compared to other areas, Croydon is becoming relatively more deprived. **Croydon is now in the top 100 most deprived areas in England.**
- The main domains of deprivation where Croydon seems to have lost ground compared to its neighbours are income and employment.

Deprivation is a relative indicator of the status of a population in relation to predetermined basic standards. The most deprived groups tend to lack, or have difficulty accessing, the conditions which would allow them to achieve these standards of living. There is strong evidence that higher levels of deprivation are associated with poorer health and wellbeing outcomes.

Not all of those living in 'deprived' areas will fit the archetype for deprivation. However, it is important for all of those working with or designing services for populations with high levels of deprivation to fully understand and appreciate the ways in which deprivation tends to impact upon individuals, families and communities, and respond accordingly. Deprivation is not just about low incomes, although limited access to money is obviously a key factor to

deprivation and a major barrier to health and wellbeing: it limits a household's ability to maintain and protect their health (e.g. to eat healthily, heat and maintain the home, enjoy leisure pursuits and so on) as well as to respond and react to 'emergencies'. The sorts of stresses that we all find hard to deal with from time to time, such as an unexpectedly large bill or a broken washing machine, can be catastrophic for the lives of families on low incomes.

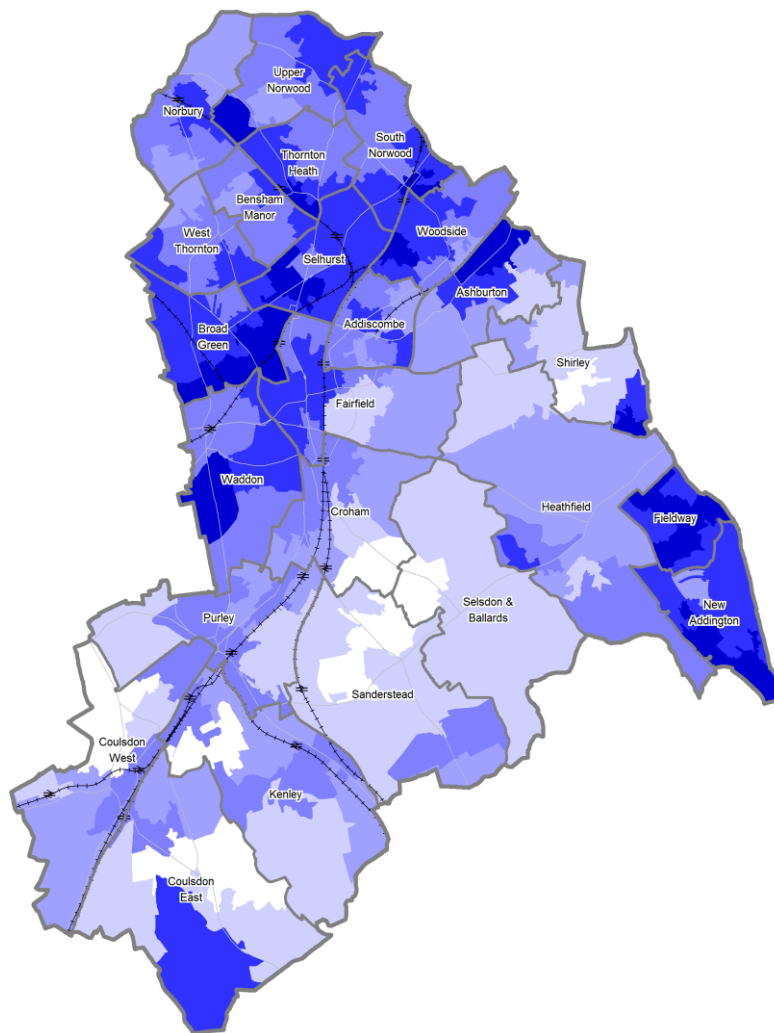
Numerous additional factors are associated with deprivation, such as poor housing, lack of access to a car and lower levels of education. All will impact on an individual or family's ability to lead the sorts of lives that the relatively better off will take for granted. A cold, overcrowded house will make homework difficult. Children from families with little education will be less likely to be encouraged to have high aspirations.

Factors associated with deprivation at the community level, such as noise, anti-social behaviour and fear of crime will also impact on those living in the area. Perhaps, above all else, it is important to recognise that the cumulative effects of living with deprivation over a period of years can present real challenges to the levels of motivation for all but the most resilient.

Having said this, it is often argued that those in the most deprived areas frequently build and rely on strong support networks and display high levels of resilience, all of which are assets and attributes which should be harnessed to the best advantage of the community.

To measure deprivation, we use the Index of Multiple Deprivation [1] which is a combination measure of indicators covering different aspects of deprivation such as poverty, transport, health, and education. The distribution of deprivation across Croydon is shown in figure 7. Super Output Areas (SOAs) are geographical areas defined as part of the census process. The Lower SOAs used in producing the map in figure 7 split the borough into groups of roughly 1,500 households each.

Figure 7 Index of multiple deprivation, Croydon lower super output areas, 2010



Compared with super output areas in England

- | | |
|---|--|
| Most deprived 15% | Least deprived 50% |
| Most deprived 30% | Least deprived 30% |
| Most deprived 50% | Least deprived 15% |

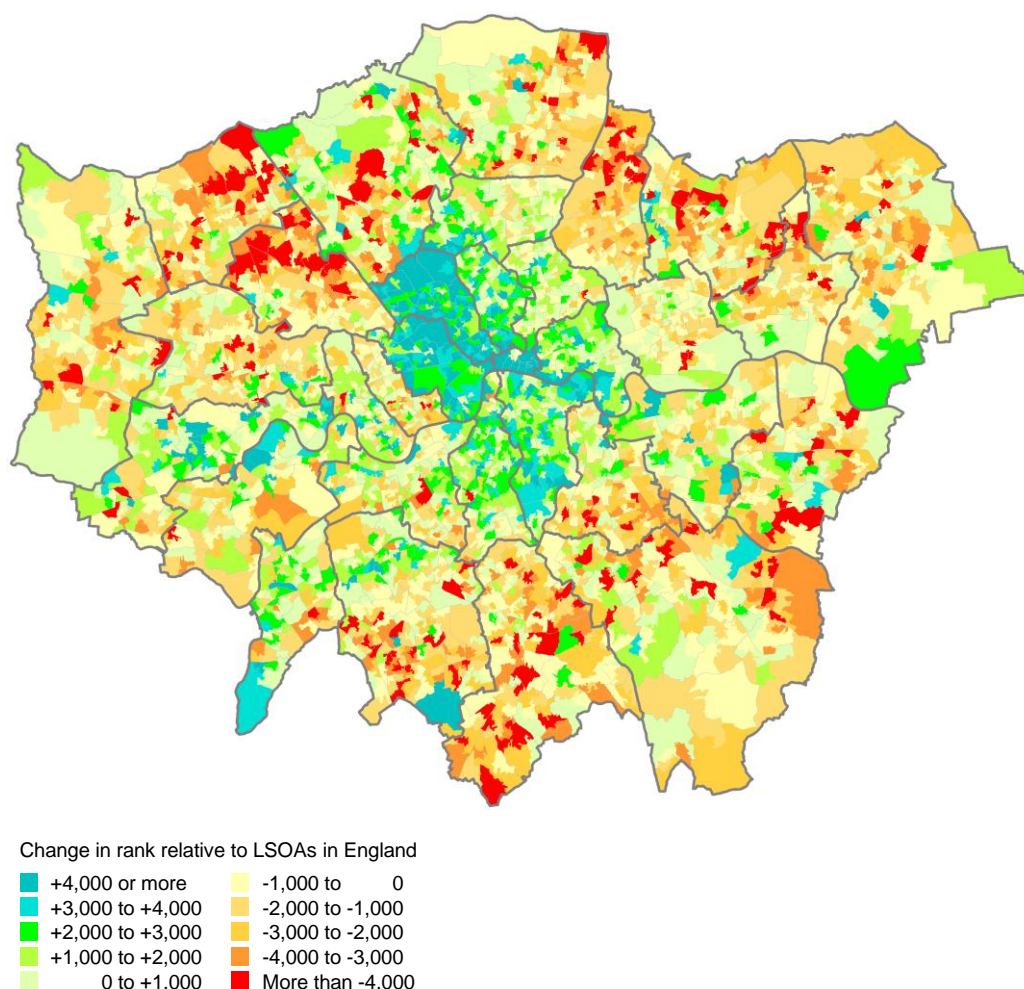
Source: Department of Communities and Local Government, Indices of Deprivation 2010

The pattern of deprivation in Croydon demonstrates a broadly north-south divide, with higher levels of deprivation in the north of Croydon. However, there are also significant pockets of deprivation in areas such as Coulsdon East and New Addington. In addition, there are major variations in deprivation within Croydon, with several areas lying in the *least* deprived 15% in the country.

Changes in the Index of Multiple Deprivation

Changes in the Index of Multiple Deprivation (IMD) scores between 2004 and 2010 show that, overall, Croydon has become relatively more deprived compared with the rest of England (see figure 8). Its average ranking has shifted dramatically from the 137th most deprived local authority out of 354 authorities in England in 2004 to the 99th most deprived local authority out of 326 authorities in England in 2010, placing it in the top 100 most deprived local authorities in England.

Figure 8 Change in Index of Multiple Deprivation in London, relative to England as a whole, 2004-2010

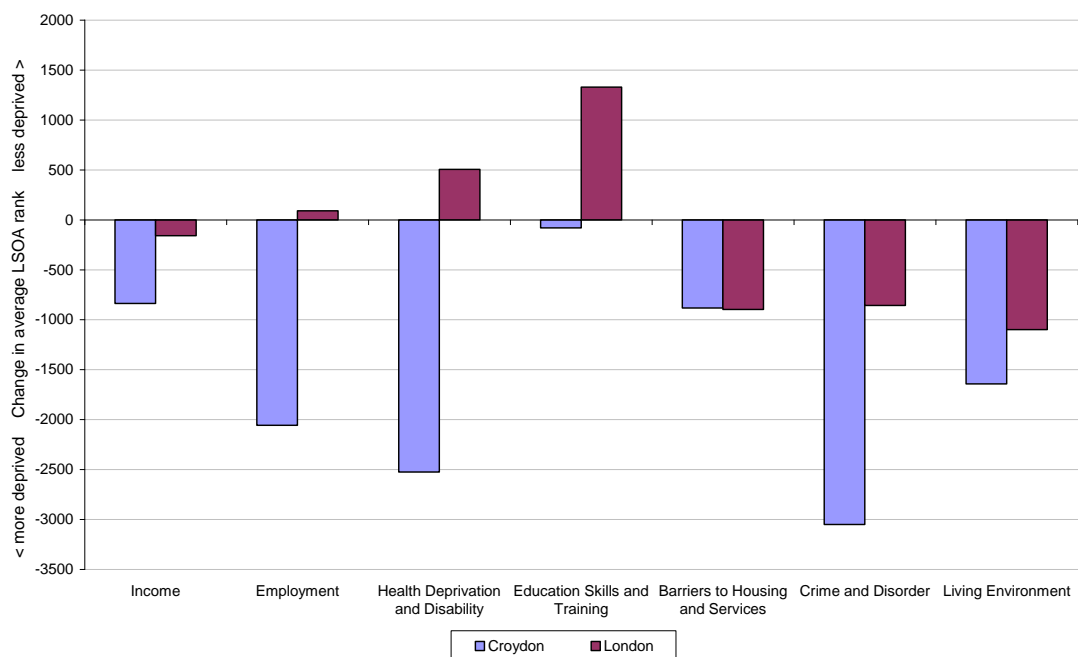


Source: Department of Communities and Local Government, *Indices of Deprivation 2010*

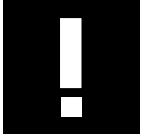
Figure 8 shows that there has been a more significant change for outer London boroughs in the south. As areas in central London such as Westminster have become less deprived, areas in the South of London in particular have become relatively more deprived, although they remain much less deprived overall than their inner London neighbours.

The IMD is made up seven domains, listed along the bottom of the bar chart in figure 9, which reflect different aspects of deprivation. Figure 9 illustrates how each domain changed between 2004 and 2010, comparing Croydon with London. For three of the seven domains (employment; health deprivation and disability and education, skills and training) the average deprivation level in Croydon increased over this time period, in contrast to the overall trend for London. For another three of the seven domains, income, crime and disorder and living environment, both Croydon and London as a whole have become more deprived; however the changes in Croydon have been greater than the London average. Deprivation related to barriers to housing and services has increased equally in Croydon and London, therefore this domain is unlikely to be contributing to the disparity demonstrated in figure 8.

Figure 9 Change in index of multiple deprivation, by domain, Croydon 2004-2010



Source: Department of Communities and Local Government, *Indices of Deprivation 2010*



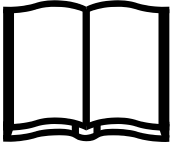
Recommendations

- Given the strong links between deprivation and ill health, as well as between deprivation and the underlying determinants of health (such as education and housing) commissioners should be keenly aware of, and take account of, the changing pattern of deprivation in Croydon in recent years.



Questions for commissioners

- Have commissioners adequately taken account of the particular needs of those living in areas of deprivation? Have existing services correctly targeted those with particular needs, given changes in deprivation in recent years, and are the services appropriate to the needs of the population in terms of key aspects of deprivation?



Further Reading

Population demographics and estimates:

Office for National Statistics – population data:

<http://www.ons.gov.uk/ons/taxonomy/index.html?nscl=Population>

Greater London Authority London data store:

<http://data.london.gov.uk/taxonomy/categories/demographics>

Interactive maps on London pupils by languages:

<http://data.london.gov.uk/visualisations/atlas/language-2011/atlas.html>

Indices of deprivation:

<http://www.communities.gov.uk/corporate/researchandstatistics/statistics/subject/indicesdeprivation>

Home office on equality strategy:

<http://www.homeoffice.gov.uk/equalities/>

London Health Inequality Strategy:

<http://www.london.gov.uk/who-runs-london/mayor/publications/health/health-inequalities-strategy>

Croydon equality and diversity:

<http://www.croydon.gov.uk/community/equality/>

The King's Fund:

http://www.kingsfund.org.uk/topics/health_inequalities/#keypoints

4. Community Life

Our surroundings and how we interact with them are an integral part of our wellbeing. The importance of community and societal factors as determinants of health has been recognised for thousands of years.

The World Health Organisation, in its ground-breaking definition of health, states:

“Health is a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity”⁸

Our health and wellbeing are influenced by both the physical environment itself (i.e. our housing, transport, access to green spaces and air and water quality) and the people and networks within these communities. Although harder to quantify than aspects of the built and natural environment, issues such as community cohesion, social isolation, trust and fear are also important determinants of wellbeing.

The indicators on which this section is based are included on page 18. As with each section of this report, there is an inevitable time lag in terms of the data that is available for comparison (see Limitations of the Data, page 11). Commissioners and heads of strategy will wish to compare the information in the dataset with more recent data which they may have available, to provide additional trend data.

⁸ Preamble to the Constitution of the World Health Organisation as adopted by the International Health Conference, New York, 19 June - 22 July 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948. The definition has not been amended since 1948



Key findings

- The civil unrest witnessed in Croydon, along with the overwhelmingly positive response from larger numbers of our community, reflects both the resilience and positivity of our Croydon residents, as well as the potential for relatively small numbers to provoke chaos and harm.
- In one part of Croydon, asset based approaches are being used to identify and harness the many assets we have within our communities.
- Housing is a key determinant of health. Housing and homelessness represent a significant and growing challenge for Croydon in coming years.
- There have been large increases in the proportion of social care clients receiving self directed support in Croydon.
- An action plan to develop additional advice and support for carers has been developed.

Civil Unrest

On 8th August 2011, civil unrest that had started elsewhere in the capital spread to Croydon. A few hundred people, a tiny proportion of the population, brought chaos to our streets. Looting, arson, criminal damage and violent disorder, including the destruction of Croydon landmark House of Reeves store, made for some iconic images on the national news, and, for a short time, turned our streets into 'no-go areas'.

The next day, many more of Croydon's residents came out on to the streets to help clean up the damage and reclaim Croydon for the community. Over the August Bank Holiday weekend, the "I Love Croydon" campaign was launched by the Council as a way of emphasising the positive side of Croydon life, and promoting local business and fund raising events.

Since then, Croydon Council has provided £1 million to support local families and businesses directly affected by the disturbances. In addition, the Mayor of London's office has pledged a fund of £23 million over three years to be split between Croydon and Tottenham to support regeneration, with £6 million of this for economic development and inward investment and £17 million for the public realm. The fund will be managed jointly with the Greater London Assembly. An independent local inquiry is tasked with establishing what happened in the run-up to and on the night of the riots, as well as the local and national response during the civil unrest and the aftermath. Academic analysis is now emerging which demonstrates a close link between the conditions of poverty and disconnection to school and work in the backgrounds of the majority of those responsible across the UK. Around 41% live in the most deprived neighbourhoods (lower super output areas) in England. The results also demonstrate that not only are the majority of the areas deprived, but 66% of them have been getting worse between 2007 and 2010⁹.

Everyone in Croydon will have had their own experience of what happened that night. There is good evidence that poor health and wellbeing and deprivation are linked through fear and civil unrest¹⁰. For some, particularly

⁹ Web-published research by Alex Singleton, Lecturer in Urban Planning, University of Liverpool. <http://www.alex-singleton.com/?p=507>

¹⁰ Neighbourhood Disadvantage, Disorder, and Health; CE. Ross and J Mirowsky; *Journal of Health and Social Behavior* ;Vol. 42, No. 3 (Sep., 2001), pp. 258-276

those who lost homes or businesses, as well as those who may be dealing with evidence of criminal activity from friends and family members, the events of 8th August may have a significant and enduring impact on wellbeing. However the responses of the authorities, emergency services and people of Croydon have also demonstrated the resilience of our communities.

The civil unrest that occurred in Croydon in August 2011 has therefore accentuated many positive aspects of Croydon life, as well as highlighting the potential for small numbers of the population to cause major disruption. It may be some time before the long-term impact of the civil unrest is known.

Asset Based Community Development

Croydon Borough Team and Croydon Council are using an Asset Based Community Development (ABCD) approach to map community assets in Thornton Heath. This is being delivered in partnership with Croydon Voluntary Action (CVA), and the project aims to strengthen social connections, particularly among people aged 50+, to improve their health and wellbeing. It seeks to build a stronger sense of shared community across the generations and ethnic groups. It aims to bring together communities, the local public sector and third sector in innovative new ways and promote greater community empowerment and active citizenship. Through the project, we aim to connect individuals with skills to others who need them and increase the level of interpersonal activity in the community, with new bonds and projects being created to address local priorities.

ABCD is described by the Improvement and Development Agency as follows:

“An asset based approach emphasises the capacity, skills, knowledge, connections and potential in a community and its members. It does not just focus on needs, problems and deficiencies of the traditional approach. In an asset based approach, the glass is reconceptualised as half full rather than half empty.

Think of a carpenter who lost one leg in an accident years ago. Clearly he has a deficiency. However he also has a skill. If we know he has a missing leg, we cannot build our community with that information. If we know he has capacity as a wood worker that information can literally build our community.”¹¹

¹¹ A Glass Half Full: how an asset-approach can improve community health and wellbeing

Housing and homelessness

Many people associate homelessness with sleeping in shop doorways. However, homelessness goes beyond actual rooflessness or rough sleeping and includes those living in temporary homeless accommodation (such as hostels) as well as the large number of people who find themselves sleeping in the spare bedroom or on the sofa of friends and relatives.

Rough sleeping actually accounts for a very small proportion of homelessness. [5] Twenty five individuals were reported to be sleeping rough in Croydon in the past 12 months¹². This may be an underestimate, since accurately counting rough sleeping is difficult. However, this is still a small number compared to the numbers who are housed in temporary accommodation.

The number of households living in temporary accommodation provided under the homelessness legislation has increased from 1,478 last year to 1,531 to August 2011 [6]. The continuing economic downturn and housing benefit reforms are expected to lead to further rises in statutory homeless acceptances and reliance on temporary accommodation. This is expected to rise to about 2,070 by 2012/13.

In particular, changes to the housing benefit legislation, and principally the introduction of national caps to the rates payable, reduction in the basis for setting local housing allowance (LHA) rates from the median to the 30th percentile of market rents, and the increase of the age restriction below which only a shared room rate is payable, from 25 to 35, will present significant challenges for the prevention of homelessness, improvement of housing options for people in housing need and for supported housing residents, and procurement of private sector accommodation for households at risk of homelessness.

Croydon remains a relatively inexpensive area to buy, compared to the rest of London, with average prices about 30% cheaper than London. The gap has continued to widen recently and the average house price index has fallen in Croydon from August 2007 by 9.3% in comparison to a 0.7% increase in the average for London. These prices are still out reach of many of Croydon's residents.

Housing can have both positive and negative impacts on health and wellbeing, depending on the quality, availability and affordability of the housing stock. Overcrowding, damp, mould, and environmental hazards such

¹² CHAIN, Annual Borough Report, Outer Boroughs, 2010/11

as asbestos or carbon monoxide can all have significant negative impacts on health. Well designed housing, which is safe, with green spaces for recreation, can improve physical, mental and social wellbeing.¹³

Self-directed support

Data shown in the Key Dataset is for 2009/10, which was the last available data at the time of producing the chart. Since then, data for 2010/11 has become available and shows that the proportion of social care clients receiving self directed support (including direct payments and individual budgets) has increased steadily over the past 12 months with a year-end outturn for 2010/11 of 20.18% - a significant improvement against the previous year-end of 5.9% **[16]**.

Results to August 2011 show continued improvement against the same period last year, with 1,512 clients receiving self directed support, compared to 484 for the same period last year. There is much more to be done, and Croydon is committed to working towards the government targets which are for 100% of those eligible to receive social care services meeting their needs through self-directed support by 2013. This includes receiving direct payments and / or having control over care planning.

Self-directed support has been rolled out, offering personal budgets to all new service users and carers with assessed need and to all current service users whose care plans were subject to review. Independent support brokerage is provided through partnership with four third sector organisations to help people to develop their support plans and establish an inclusive forum for providers, users and carers.

Advice and information for carers

National 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.

Carers are entitled to receive an assessment of their needs or a review quite separately from those they look after and to receive a specific carer's service, or advice and information.

¹³ Social Determinants of Health: Housing – A UK Perspective, J Hacker, D Ormandy, P Ambrose, 2011

Since the Key Dataset was produced, the proportion of those who choose to do so has increased slightly, from 12.7% **[21]** as it was in 2009/10 to 14.9% in 2010/11. This remains a low proportion and below the average for London. This could partly be explained by the fact that support provided by the voluntary and community sector is not formally captured through a separate assessment and subsequent provision of a service for many, but commissioners and strategy managers will want to investigate whether need is being met.

Croydon has developed an action plan for information and advice to ensure the public can identify and access local options for meeting their care and support needs. An enhanced website, with clear signposting to resources across the borough, is now available.

Croycare, launched in 2009, is an emergency service for carers, which provides up to 72 hours of care support should something happen to the carer. Over the past full year of operation, the number of carers registered for the Croycare service has increased from 110 to 228. Ten new carers' services (in relation to support, training, respite activities/breaks and peer support) delivered 4,051 breaks for carers, to enable them to live ordinary lives and manage their caring duties towards vulnerable people.

Delayed transfer of care

Delayed transfer of care (often referred to in the media as 'bed blocking') occurs when it is deemed clinically appropriate for a patient to be discharged from hospital, but they cannot be transferred. The causes of delayed transfer are multifactorial.

The last data for which national and regional comparisons are available was for 2008/09. In that year Croydon's rate of delayed transfers, at 7.9 per 100,000, was better than the London and national average **[16]**. Given the lack of national data, commissioners and providers should ensure they have robust mechanisms in place for monitoring and evaluating data locally.

Youth Crime

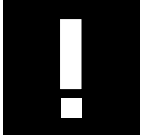
Youth crime is a key indicator of the needs of a community. Deprivation, poor education and lack of employment or training opportunities are linked to

higher rates of youth crime. Fear of crime is less well correlated with actual crime, with perceived levels of crime being much higher than actual crime rates.

The number of new entrants to the youth justice system in Croydon is slightly lower than the London average and slightly higher than the national average, though overall there is no significant difference. **[10]** Despite a slight improvement in performance over one year, Croydon is still significantly worse relative to other local authorities compared to three years ago.

Just under 40% of young offenders are reconvicted within a year; this increases to 75% for those completing custodial sentences¹⁴. Working with young people to divert them away from the criminal justice system is important, as a cycle of repeat offending can otherwise develop, and an individual's life chances can be significantly reduced – as well as costs to the public purse escalating over the lifetime of an individual's 'career' within the criminal justice system. Early years interventions such as parenting support and pre-school education have been shown to reduce youth offending, as have projects such as mentoring programmes and constructive leisure opportunities.

¹⁴ *Time for a fresh start*: The report of the Independent Commission on Youth Crime and Antisocial Behaviour, 2010



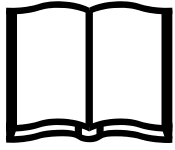
Recommendations

- 1) Local and national findings from reports and enquiries into the civil unrest should be considered at a strategic level, with recommendations built into all commissioning and strategy plans as appropriate
- 2) A new housing strategy for Croydon is currently being developed. Those preparing the emerging housing strategy may wish to take full consideration of the strong links between health and housing and adopt a systematic approach to both maximising the positive health benefits and minimising the negative health benefits of housing



Questions for commissioners

- 1) The challenge of the civil unrest will require a carefully thought out response. Are there further actions that can be taken to support victims in both short and long term? Can Croydon lead the way in providing innovative and constructive approaches to the rehabilitation back into the community of those responsible for the riots?
- 2) Are there opportunities for commissioners to harness the positive response of the people of Croydon after the civil unrest, and how can an asset-based approach be used to help this process?
- 3) What can we do to best co-ordinate prevention of youth crime and local initiatives to divert those with a criminal record from future criminal activity?
- 4) As the use of self-directed support increases, there is likely to be an increase of provision from third sector organisations, which are already very involved in social care in Croydon. Do we collect the data necessary to ensure that commissioners can evaluate these services? Do we have the knowledge to best support partnership working in this individualised, multi-sector environment? How do we balance the needs of user and carer choice with efficiency in the social care system?



Further reading

For web links to data in this section please refer to Appendix 2 on page 105.

Croydon community and living:

<http://www.croydon.gov.uk/community/>

Croydon Community Strategy:

<http://www.croydon.gov.uk/community/advice/cstrategy/>

Croydon Civil Disorder:

<http://www.croydon.gov.uk/advice/emergencies/civil-unrest/>

Love Croydon campaign:

<http://www.croydon.gov.uk/community/equality/lovecroydon/>

Improvement and development agency:

<http://www.idea.gov.uk/idk/core/page.do?pagelId=1>

Asset based community development:

<http://www.idea.gov.uk/idk/core/page.do?pagelId=18364393>

Community support groups and organisations:

<http://www.croydon.gov.uk/community/supportgroups/csgroups>

Housing in Croydon:

<http://www.croydon.gov.uk/housing/?WT.svl=dd>

Croydon self-directed support – helping people live the lives they want:

<http://www.croydon.gov.uk/healthsocial/sdsmain/>

NHS information for carers:

<http://www.nhs.uk/CarersDirect/guide/practicalsupport/Pages/Chargingforresidentialcare.aspx>

Croydon support for carers:

<http://www.croydon.gov.uk/healthsocial/carers/>

Carer statistics:

<http://www.ic.nhs.uk/statistics-and-data-collections/social-care/carer-support>

Crime statistics:

<http://www.crime-statistics.co.uk/>

5. Early life

This section covers key aspects of the health and wellbeing of children and young people aged from birth to school leaving age (ie ages 0 – 18 years). Influences on our health and wellbeing actually begin even before birth. For example, factors associated with the lifestyle of the mother (such as smoking) have an effect on the growing fetus, and are associated with low birth weight, which is itself associated with health problems in later life. Our development, the environment we grow up in and the behaviours and attitudes we take on in our early years impact on our health and wellbeing for the rest of our lives.

As an individual gets older, the influences of their education, socialisation, peer pressure and support, and the difficult transition from adolescence to adulthood become more important.

Young people are among the most vulnerable in society. As well as being the most susceptible to negative influences, they are also the group where the greatest opportunities for long term improvement of health and wellbeing lie. The *Marmot Report* recognises this and suggests interventions and policies aimed at early years should be prioritised

The indicators on which this section is based are included on pages 18 and 19. Many of the indicators in the early life section of the spine chart (such as those relating to child poverty, infant mortality, immunisations and obesity) suggest that Croydon's performance is significantly worse than much of England. In other areas, such as school attainment, Croydon's performance is much more favourable.

As with each section of this report, there is an inevitable time lag in terms of the data that is available for comparison. Commissioners and heads of strategy will wish to compare the information in the dataset with more recent data which they may have available, to provide additional trend data.



Key findings

- In terms of early years attainment, Croydon compares well to the rest of the country and continues to improve.
- Absence rates from school have been improving.
- The number of children in poverty appears to be increasing in Croydon and is higher than average for England.
- Stillbirths and early infant deaths are significantly higher in Croydon than England or London, and Croydon's performance compared to other areas has deteriorated in previous years.
- Croydon is in the bottom 10% of local authorities for low birth weight babies.
- Levels of childhood obesity in Croydon are worse than for England, although there has been a slight improvement for reception year.
- Childhood immunisation rates do not compare favourably and appear to be moving in the wrong direction.

Education and development

The key dataset shows a good performance in early years' attainment in Croydon. In 2010, the percentage of children attaining a good level of development at age five is higher than national and London averages [41], and has improved compared to both one year and three year trends. Provisional data published just after the deadline for inclusion in the Key Dataset shows continued improvement in this indicator in 2011, and as in 2010, performance exceeded targets.

The rate for attainment at key stage 2 [42] has been relatively static, with 73% attainment in 2009, 74% in 2010 and (provisionally) 73% in 2011. This places Croydon just below the London and national averages, a difference that is not statistically significant.

Data suggest that absence from school in Croydon is not significantly worse than England or London, and has been improving. In Croydon, both overall absence [44] and persistent absence [45] rates are just above national average but lower than the London average. Importantly, both absence rates have fallen over the past three years. This change should result in a reduction in the negative effects listed below, and will create a positive environment of increased attainment.

Research commissioned by the Department for Education and Skills¹⁵ suggests that the causes of school absence include a mixture of home-related and school-related factors. These include bullying, problems with teachers, problems with the curriculum, boredom, peer pressure, social isolation, family break-up and having carer responsibilities. The impact of persistent absence is felt at the individual level, with poor educational attainment and increased social isolation, and at a community level with disruption of classes, waste of teaching resource and in some cases antisocial behaviour.

The improvement in educational attainment demonstrates the assets in Croydon's education system. Croydon's performance in GCSEs has been improving year on year [43]. Provisional data for 2010/11, which was published after the deadline for inclusion in the key data set, shows an excellent increase in pass rates this year of 6.9% compared with 2009/10.

¹⁵*Absence from School: A study of its causes and effects in seven LEAs* Research Report 424, DfES, 2003

This provisionally puts Croydon's GCSE pass rate at 60.3%, compared to averages for London of 61.0% and for England of 58.3%. It is expected that this data will be validated in January 2012. It is important that attainment at early stages of education is translated into improved results at GCSE, A-level and further education.

Child Poverty

Relative to local authorities in England, the proportion of children in poverty in Croydon has been increasing in the past three years, and is significantly higher than the England average [22]. With 27% of children in Croydon living in poverty, the Borough is amongst the 25% of local authorities with the highest levels of child poverty.

Child poverty is a vitally important issue, since it has a lasting effect on so many aspects of an individual's life. Children brought up in poverty tend to achieve a lower level of educational attainment than similarly able children from well-off backgrounds. They are more likely to die in infancy, develop chronic illness, or be injured in an accident, and they have a shorter life expectancy than children born to wealthier families.²

The Joseph Rowntree Trust estimates the cost to society of child poverty in Britain to be £25 billion a year¹⁶. Since 1999 there has been a government pledge to end child poverty by 2020. This is now enshrined in law in the Child Poverty Act 2010. This includes duties for local authorities and partner organisations to act together to reduce child poverty, including the production of a child poverty needs assessment and a child poverty strategy.

'Children in poverty' has been prioritised as a key topic area for the JSNA 2011/12. A more detailed needs assessment is being prepared and will be published on the Croydon Observatory website when available:
<http://www.croydonobservatory.org/jsna/jsna2011-12>.

Infant mortality

Perinatal mortality [27] 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. Croydon is in the worst 10% of local authorities for low birth weight babies. Low birth weight,

¹⁶ *Estimating the costs of child poverty*, Joseph Rowntree Foundation, October 2008

which is associated with child poverty, contributes to the infant mortality rate and is linked to poorer development and worse health in later life.

Infant mortality has been identified as a significant issue previously and was the subject of a key topic assessment in the 2010/11 JSNA. This produced a number of recommendations to help reduce Croydon's unacceptably high infant mortality rate. Updated infant mortality figures are included in table 2. A report on the progress with the infant mortality work is included on the Croydon Observatory website:

<http://www.croydonobservatory.org/jsna/updates>

Table 2 Infant mortality numbers and rates, Croydon and England and Wales, 2008 to 2010

	Croydon					England and Wales
	Number of infant deaths	Number of neonatal deaths	Number of post-neonatal deaths	Number of live births	Infant mortality rate	Infant mortality rate
2008	29	17	12	5,331	5.4 (3.8 - 7.8)	4.7 (4.5 - 4.9)
2009	25	22	3	5,235	4.8 (3.1 - 7.0)	4.6 (4.5 - 4.8)
2010	24	14	10	5,536	4.3 (2.8 - 6.5)	4.3 (4.2 - 4.5)
2008-2010	78	53	43	16,102	4.8 (3.8 - 6.0)	4.6 (4.5 - 4.7)

Source: Office for National Statistics

Child Immunisation

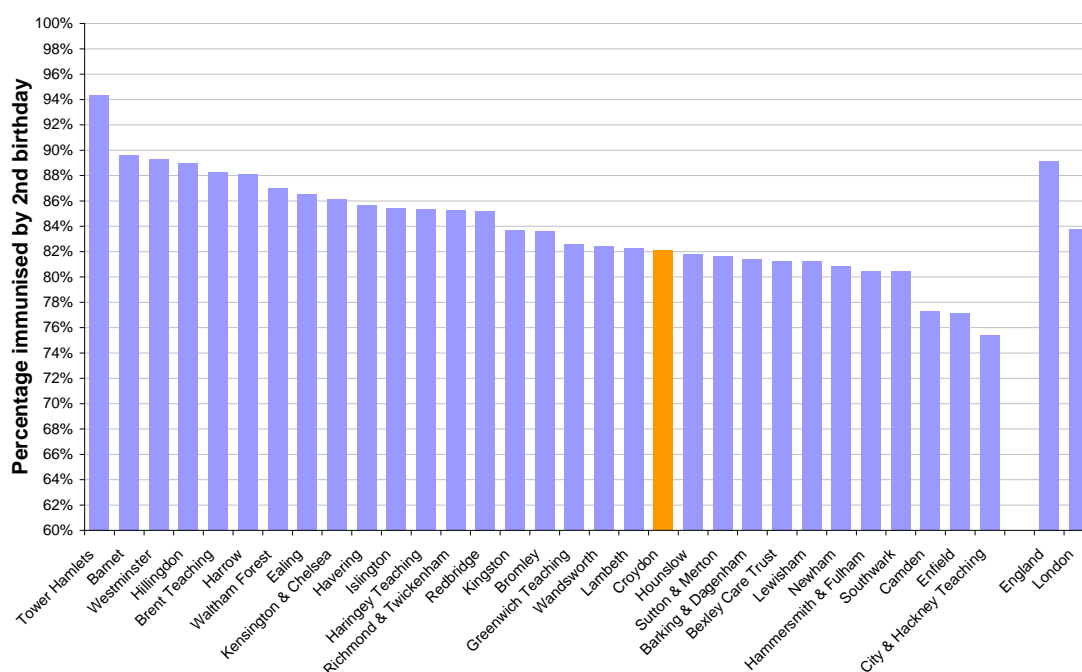
Vaccine-preventable diseases such as measles, polio and diphtheria remain important causes of mortality and morbidity globally. Such diseases can be very severe, with long-lasting consequences, and are potentially fatal. Immunisation programmes save lives and reduce healthcare utilisation.

As well as protecting the individual from specific disease, vaccination levels at a high enough rate can prevent the spread of the disease through the population: this is called population or 'herd' immunity. For example the risk of severe complications and death from whooping cough is highest in the very young. Children are offered whooping cough vaccine at two, three and four months of age as part of the routine childhood vaccination programme. The pre-school booster is also important, not only to boost protection in that child but also to help prevent them passing the infection on to vulnerable babies, as

those under four months of age cannot be fully protected by the vaccine¹⁷. When vaccination rates drop below the level needed for herd immunity, outbreaks of infectious disease become more likely.

Croydon is significantly below the England average on all the indicators of immunisation rate included in this year's JSNA [29-34]. 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's MMR immunisation rates are shown compared to other London boroughs in figure 10.

Figure 10 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

The Failsafe project in 2010 aimed to improve immunisation uptake. Whilst it only had a small impact on immunisation rates, evaluation of the project has produced a number of recommendations on how to improve immunisation rates. The immunisation steering board, with increased engagement with GP

¹⁷ Health Protection Agency (2012) Press release 5th January 2012
<http://www.hpa.org.uk/NewsCentre/NationalPressReleases/2012PressReleases/120104pert/>
 Accessed 27 January 2012

commissioners, is reviewing the Croydon immunisation action plan in light of these findings.

Child Obesity

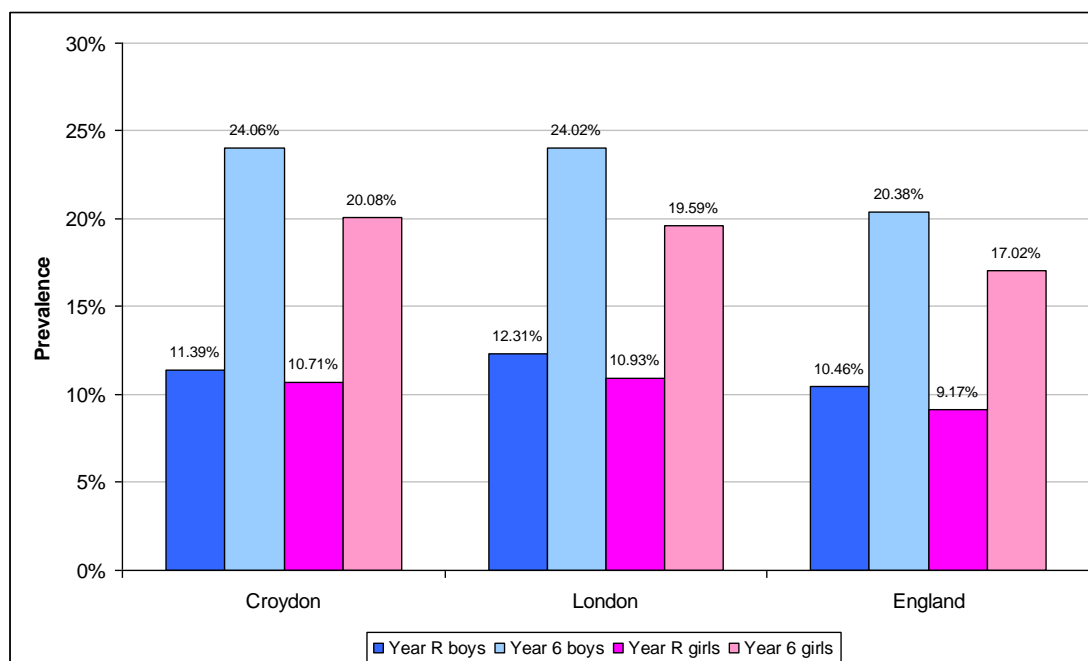
Childhood obesity is an important issue due to the long term health impact¹⁸. People who are obese as children are more likely to be obese as adults and so develop health problems related to obesity such as heart disease and diabetes. In the short term, being obese may limit a child's ability to participate in activities with peers or result in bullying. This can result in problems with mental health, social isolation and wellbeing. Severely obese children and adolescents have lower health-related Quality of Life (QOL) than children and adolescents who are healthy, and a similar QOL as those diagnosed as having cancer¹⁹

Croydon is significantly worse than the England average for the percentage of obese children in both reception [37] and Year 6 [38] (the two school years for which children are measured as part of the National Child Measurement Programme). 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.

¹⁸ National Obesity Observatory, Health Risks of child hood obesity, http://www.noo.org.uk/NOO_about_obesity/obesity_and_health/health_risk_child; Accessed October 2011

¹⁹ Schwimmer JB,Burwinkle TM,Varni JW. Health-related quality of life of severely obese children and adolescents. JAMA, Apr 2003, vol./is. 289/14(1813-9)

Figure 11 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

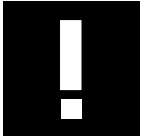
There are commissioned programmes in place aimed at tackling childhood obesity, such as Boost Croydon. Obesity is a multi-factorial problem with no single, simple solution. To achieve the 2014 targets set in the current Croydon obesity strategy will require close partnership working between health, education and other partners. Obesity was considered in depth by the JSNA of 2009/10. As part of the 2011/12 JSNA, we will be refreshing the childhood obesity key topic area report from this JSNA:

<http://www.croydonobservatory.org/jsna/updates>

Looked After Children [46]

In addition to those areas highlighted above, the 2010/11 JSNA also included a specific focus on Looked After Children. An update on the recommendations from this needs assessment is being produced as part of the 2011/12 JSNA process and will be made available on the Croydon Observatory website:

<http://www.croydonobservatory.org/jsna/updates>



Recommendations

1. Retaining the focus on early years interventions is essential, as the evidence is clear that these interventions have the most impact, leading to significant and sustained life-long improvements to health and wellbeing.^{20 21} The Health and Wellbeing Board should work through the Children and Families Partnership Board to co-ordinate activities that promote the wellbeing of children and young people. Supporting these activities will help maintain early life interventions as a key policy priority.
2. Croydon has a worsening child poverty problem. Child poverty has already been recognised as a key priority and, as part of the 2011/12 JSNA, a children in poverty needs assessment will be completed. This needs to inform the completion of a local child poverty strategy.
3. Both infant mortality and looked after children were identified as key issues for Croydon in 2010/11, and needs assessments were undertaken at this time. These needs assessments, and the recommendations contained within them, need to continue to inform the work involved in tackling these key priority areas for Croydon.
4. The link between early attainment and performance in national exams such as GCSEs should be closely monitored/evaluated to ensure local performance continues to improve

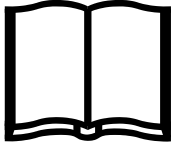
²⁰ Early intervention: the next steps. An independent report to Her Majesty's Government, by Graham Allen, MP January 2011 <http://www.dwp.gov.uk/docs/early-intervention-next-steps.pdf>

²¹ An independent review on the early years foundation stage to Her Majesty's Government. March 2011 <http://www.education.gov.uk/tickellreview>



Questions for commissioners:

1. Croydon performs poorly for all childhood immunisations. Are we fully aware of the local barriers to immunisation? What lessons can be learned from previous approaches locally and nationally? Is there a need to consider how immunisation programmes are organised and resourced?
2. Childhood obesity continues to present a challenge for Croydon. Tackling this complex issue requires long term, multifactorial interventions. A detailed Croydon childhood obesity strategy has already been developed locally. How can activity be better co-ordinated to meet the targets identified in the obesity strategy?
3. Given the importance of early intervention, how can commissioners encourage the further integration and cross-agency working in ways that will facilitate children's health and wellbeing?



Further Reading

For web links to data in this section please refer to Appendix 2 on page 107.

Department for Education – Children and young people:

<http://www.education.gov.uk/childrenandyoungpeople>

Child poverty:

Government child poverty policy

<http://www.dwp.gov.uk/policy/child-poverty/>

Joseph Rowntree Foundation:

<http://www.jrf.org.uk/work/workarea/child-poverty>

Childhood Obesity:

<http://www.noo.org.uk/NCMP>

Child Mortality Statistics:

<http://www.ons.gov.uk/ons/taxonomy/index.html?nscl=Child+Mortality>

Immunisations:

<http://www.dh.gov.uk/en/Publichealth/Information/index.htm>

Looked after children:

Croydon – Fostering, adoption and Looked after children:

<http://www.croydon.gov.uk/healthsocial/falaseservices/>

<http://www.publications.parliament.uk/pa/cm200809/cmselect/cmchilsc/111/111i.pdf>

6. Family life

This section of the overview chapter deals with matters relating to family structure, sexual health, fertility, maternity and family cohesion.

Over recent decades, there have been dramatic changes in society's understanding of what family is. In many ways, families are as unique as individuals. This is important to recognise, as many families do not fit into the 'traditional' model of the family. Approaches which do not recognise this may fail to fully address needs.

The indicators on which this section is based are included on page 19 and 20. Overall, there are several indicators where Croydon compares very well nationally (such as smoking in pregnancy, breastfeeding initiation and continuation, access to abortion, and screening coverage for chlamydia.) However, there are also many indicators where Croydon both compares badly and is moving in the wrong direction, particularly around the prevalence of many sexually transmitted diseases, and repeat abortions.

As with each section of this report, there is an inevitable time lag in terms of the data that is available for comparison. Commissioners and heads of strategy will wish to compare the information in the dataset with more recent data which they may have available, to provide additional trend data.



Key Findings

- In Croydon, as nationally, there has been a movement away from the traditional family unit. Although married couples are still the predominant family 'type', one in four families in Croydon are headed by lone parents (usually mothers).
- Breastfeeding initiation and continuation is a real success in Croydon, although initiation rates did begin to slip over the last year.
- Sexual health continues to present some real challenges for Croydon, which has comparatively high rates of diagnosis for chlamydia, gonorrhoea, herpes and HIV.
- Croydon compares particularly badly in terms of repeat abortions.
- Teenage pregnancy has been a challenge for Croydon; however a focus on this issue has led to some real progress in the reduction of under-18 conception rates recently.

Family structure

Family life in the UK has seen tremendous change in recent decades. The Office for National Statistics now defines a family as 'a married, civil partnered or cohabiting couple with or without children, or a lone parent with at least one child, where children may be dependent or independent'.²²

This increased flexibility in our definition of 'family' to accommodate different forms and types of family units translates practically into more flexible structures which may change many times during an individual's lifespan, also making them less stable and more prone to breakdown. Looser family structures have been linked to poorer health and happiness, and children in single parent homes are said to be more likely to experience poverty, poor health and wellbeing, underachieve at school, or join in antisocial behaviour.²³

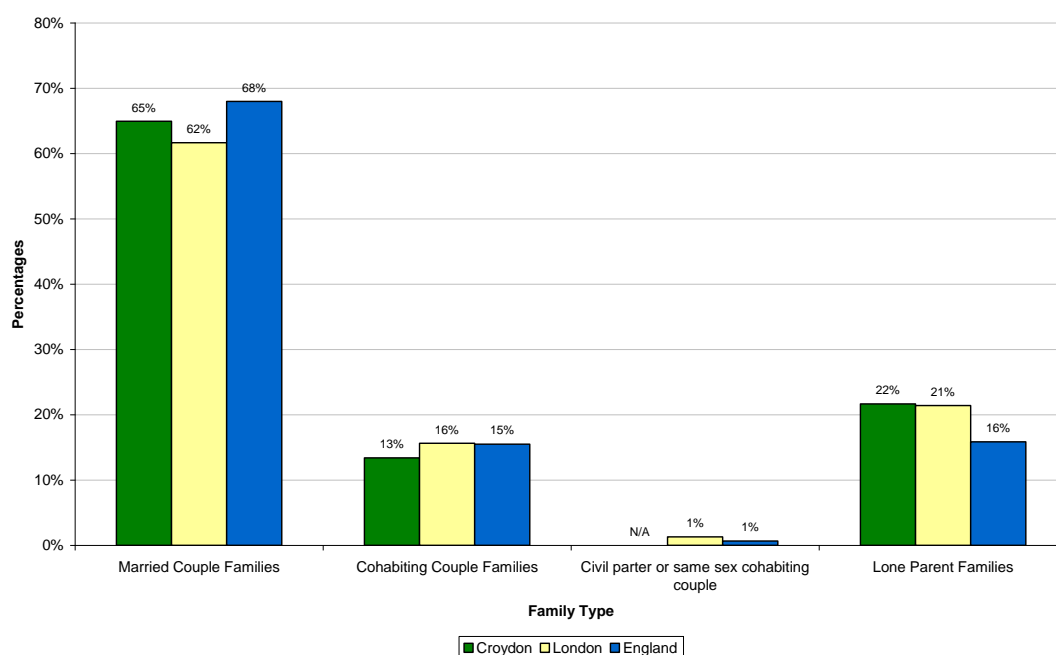
UK trends show fewer married couple families, consistent with the decreasing number of marriages, a significant increase in numbers of families with cohabiting couples of opposite sex, and remarriages. The step-family is one of the fastest growing forms of family. There has also been a significant increase (12% between 2001 and 2010) in the number of lone parents with dependent children. In nine out of ten cases, it is the mother who acts as the lone parent and heads the family unit. Since the introduction of civil partnerships in 2005, the number of families consisting of same-sex civil partnered couples has also steadily increased.

In 2010, similar to national figures, estimates show married couple families accounted for 65% of all families in Croydon while the second largest type was lone parent families at 22% (see figure 12).

²² *Families and households in the UK, 2001 to 2010*. Office for National Statistics.

²³ *Families in Britain; The impact of changing family structures and what the public think*; S.Jenkins, I Pereira, N Evans. Ipsos MORI and Policy Exchange. <http://m-workers.com/researchpublications/publications/1215/Families-in-Britain.aspx>

Figure 12 Broad types of family units, Croydon, London and England 2010



Source: Annual Population Survey, Office for National Statistics

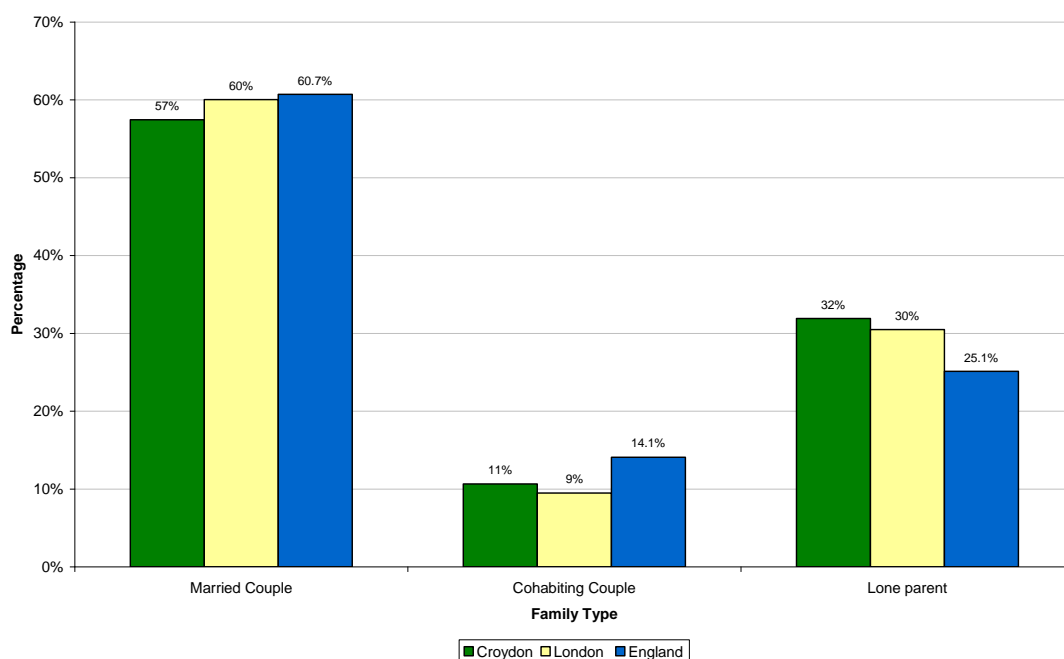
NA = Data are not robust enough to be published and hence proportions cannot be calculated

When compared to London and England, estimated figures suggest Croydon has a slightly higher proportion of dependent children in lone parent families, while the proportion of dependent children in married couple families was slightly lower than the national average²⁴ (see figure 13). Reports suggest that in most cases lone parent family units with dependent children are headed by single mothers²⁵.

²⁴ Annual Population Survey, Office for National Statistics

²⁵ *Families in Britain; The impact of changing family structures and what the public think*; S.Jenkins, I Pereira, N Evans. Ipsos MORI and Policy Exchange. <http://m-workers.com/researchpublications/publications/1215/Families-in-Britain.aspx>

Figure 13 Dependent children, by family type, Croydon, London and England 2010



Source: Annual Population Survey, Office for National Statistics

Families with complex needs

It is estimated that £8 billion is spent on around 120,000 families with complex needs nationally. In June 2010, the Coalition Government announced a set of pilots for 'community budgets', building on previous place based budgeting approaches. Croydon was one of the sixteen 'Total Place' pilot areas to be given direct control over a specified set of Whitehall funding streams around the theme of families with complex needs.

The fact that Croydon is now a Community Budget pilot allows different funding streams to be pooled into a single programme, tackling social problems which involve families who have children with complex needs. It will also build on similar work that has been done to align resources around other complex needs groups, such as people with dementia and young offenders. By being able to redesign services for some of Croydon's more vulnerable residents, the local authority and its partners will be better able to meet their needs whilst also making cost savings across the board.

The Family Resilience Service (FRS) is the over-arching umbrella programme covering the issues faced by families who have children with complex needs. So far some 700 families have been identified as potentially benefitting from support from the FRS.

Part of the FRS is the Family Nurse Partnership which operates through home visits by trained Family Nurses. This is an evidence based programme of early intervention through pregnancy until the child is two years old. The aim is to improve antenatal health, child health and parents' economic self-sufficiency.

Breastfeeding

The benefits of breast milk to both baby and mother are well known. Babies who are breastfed have fewer ear and chest infections, are less likely to develop constipation, and less likely to develop eczema. The benefits last throughout life. Breastfeeding 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.²⁶

Croydon has a good record of both initiating breastfeeding **[49]** and maintaining breastfeeding at six to eight weeks after birth **[50]**. For both indicators, Croydon has a significantly higher rate than the national average. In Croydon, 86% of mothers initiate breastfeeding, compared to only 74% nationally. At six to eight weeks after birth, 67% of mothers in Croydon are still breastfeeding, compared to only 46% nationally.

There are geographical trends in breastfeeding, 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.

Support for breastfeeding comes from the Community Specialist Breastfeeding programme team, who work to provide comprehensive, accessible support designed to complement the breast feeding support already provided by Community Health Services. The specialist team are implementing the UNICEF Baby Friendly Initiative and are providing a peer support programme in areas of high health inequalities. The one-year trend indicates that Croydon's improvement in breastfeeding initiation has slowed relative to improvements in other local authority areas. Care has to be taken to ensure Croydon's excellent performance in this important, lifelong determinant of health and wellbeing is maintained.

²⁶ *Off to the Best Start*; Department of Health and UNICEF; 2011
http://www.unicef.org.uk/Documents/Baby_Friendly/Leaflets/4/otbs_leaflet.pdf

Sexual health

Croydon's performance on almost all sexual health indicators is significantly worse than the national average. Sexual health was prioritised as a key topic area for the 2010/11 Joint Strategic Needs Assessment. A report on progress with the recommendations from that chapter, as well as all key topics areas from 2010/11, is included on the Croydon Observatory website:

<http://www.croydonobservatory.org/jsna/updates>

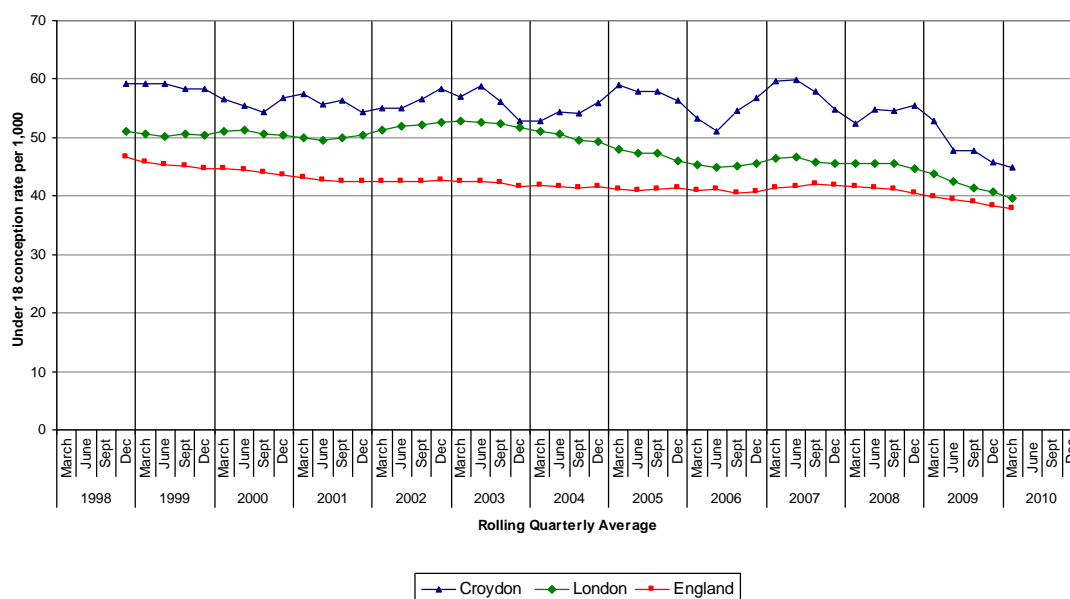
Repeat abortions

Croydon currently has the highest rate of repeat abortions in the country. Proportionally, 41% of terminations for those under 25 [54], and 50% of terminations at all ages [55], are for women who have previously had an abortion. Work on reducing repeat abortions currently focuses on two key areas: preventing unintended or mistimed pregnancies and researching the characteristics of women who have repeat abortions, to aid the development of further, targeted, interventions. Repeat abortions have been chosen as one of the key topic areas for this year's needs assessment and the needs assessment will be published on the Croydon Observatory website when available.

Teenage pregnancy

Croydon's under 18 [51] and under 16 conception [52] rates are both significantly higher than the national average. Whilst the under 16 conception rate in Croydon is worse relative to its position three years ago, for both age groups the one year trend shows Croydon has improved relative to other local authorities. The under 18 conception rate is 22.7% lower than it was ten years ago. The success of the Croydon Teenage Pregnancy Strategy is credited with the increase in additional sexual health services for young people, strong focus on the development of targeted interventions with at risk groups and improved support and delivery of SRE in school, college and non-school settings. Croydon's performance compared to regional and national averages is shown in figure 14.

Figure 14 Under 18 conception rate, Croydon, London, England 1998-2010 (rolling quarterly averages)



Source: Office for National Statistics

Services to help reduce teenage pregnancies are important: there are real risks of worse health, social and educational outcomes for teen parents and their children. There is a 60% higher infant mortality rate for children of teenage mothers and a higher chance of the baby having a low birth weight. Teenage girls are more likely to smoke during pregnancy, less likely to breastfeed and more likely to develop post-natal depression. Both teen parents and their children are likely to have lower educational outcomes than their peers, and children of teenage parents are three times more likely to become teenage parents themselves²⁷.

The topic of teenage pregnancy was also considered last year as part of the sexual health key topic area, which is available on the Croydon Observatory website, along with the progress report.

Domestic violence

Much domestic violence goes underreported, and therefore it is notoriously difficult to provide an accurate measure of the extent of the problem. However, a lack of accurate statistics does not mean that this crucial issue of health and wellbeing should be ignored. Not all abusive behaviour is 'violent' – domestic violence can include psychological and financial control. Domestic

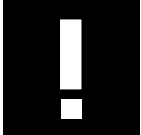
²⁷ Review of Teenage Pregnancy, Briefing paper for Croydon Health Scrutiny Committee, December 2009

violence has in the past been thought of exclusively in terms of male on female abuse, however domestic violence is perpetrated by both men and women, and occurs in both heterosexual and same-sex relationships. Both intimate partners and children can be victims.

Regardless of who the victim and the abuser are, domestic abuse is felt to occur because of the need for the abuser to exert power and control over their victim(s). Studies show that in between 30% and 40% of cases the domestic violence started during pregnancy and between 4% and 9% of pregnant women are subject to violence during pregnancy or after the birth.⁵ The World Health Organisation (WHO) recognises intimate partner violence as a major cause of gender based health inequalities. The effects of domestic violence include isolation, loss of employment and income, physical and mental ill-health, injury and death. It is estimated that, nationally, two women a week are killed by their partners.²⁸

Women's Aid estimates that domestic violence costs £1 billion a year to the criminal justice system and represents 3% of the total NHS budget. Domestic violence also has costs to housing and social services.

²⁸ *Domestic Violence: Frequently Asked Questions Factsheet*; Women's Aid 2009



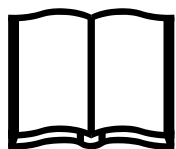
Recommendations

- 1) Croydon has a good performance in breastfeeding and to maintain that position will require continued support for initiatives which encourage breastfeeding. Given the drop in performance over the previous year, close monitoring of this indicator is advisable so that any future worsening of performance can be identified quickly and rectified.
- 2) Croydon currently has the highest rate of repeat abortions in England. As part of the 2011/12 JSNA, repeat abortion has been selected as a key topic area for needs assessment. The recommendations arising from this needs assessment will need to be addressed to ensure that Croydon begins to move away from the worst position in the country here.
- 3) The 2010/11 JSNA 'deep dive' focus on sexual health produced a series of recommendations relating to sexual health (including teenage pregnancy). This needs assessment, and the recommendations contained within it, needs to continue to inform the work involved in tackling this priority area for Croydon.



Questions for commissioners

- 1) One in four families in Croydon is a lone parent family. Do current services adequately accommodate the additional needs of lone parent families? If not, how will services need to change to provide appropriate care and support to the changing family unit?
- 2) Recent years have seen a good improvement in Croydon's teenage pregnancy rates. How will associated commissioners ensure the sustained improvement in performance and associated outcomes? Is further improvement in services possible given the recent significant improvement? If so, what might this look like?
- 3) Domestic violence is a major challenge to the safety and wellbeing of victims. Given that much domestic violence begins during pregnancy, are our services adequately equipped to work together to identify and support victims of domestic violence, particularly during pregnancy?
- 4) The Family Resilience Service is designed to support families with complex needs. Does Croydon currently have the correct balance of support for families who have children with complex needs, including those where there has been a history of domestic violence? Going forward, how will these services be evaluated?
- 5) What learning is there to be had from the evaluation of the various family support programmes in Croydon? How can successful programmes be made sustainable?



Further reading

For web links to data in this section please refer to Appendix 2 on page 109.

Croydon Observatory:

<http://www.croydonobservatory.org/>

Children and Families:

<http://www.croydon.gov.uk/healthsocial/families/>

Family Resilience Service:

<http://www.croydon.gov.uk/contents/departments/democracy/pdf/714464/1016597/1124666/stepupsept11.pdf>

Family Nurse Partnership:

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_118530

Children and young people's service directory:

<http://www.croydoncsd.co.uk/>

Support in Croydon:

<http://www.croydon.gov.uk/community/dviolence/>

Women's Aid (National domestic violence support charity):

<http://www.womensaid.org.uk/>

Smoking and pregnancy:

<http://smokefree.nhs.uk/smoking-and-pregnancy/>

NHS Choices Breastfeeding support and information:

<http://www.nhs.uk/Planners/breastfeeding/Pages/breastfeeding.aspx>

UNICEF Baby Friendly Initiative (global breast feeding programme):

<http://www.unicef.org.uk/BabyFriendly/>

Croydon Teenage Pregnancy Strategy:

<http://www.croydon.gov.uk/democracy/dande/policies/cfl/intro>

Sexual Health Screening:

<http://www.nhs.uk/Tools/Pages/Toolslibrary.aspx?Tag=Sexual+health>

Abortions in the NHS:

<http://www.nhs.uk/conditions/abortion/Pages/Introduction.aspx>

7. Working Age

Those of working age, particularly men, tend to be the group least likely to engage with traditional health professionals. This is one of the many reasons that make the workplace a key setting for the promotion of health and wellbeing.

Those who work spend a large proportion of their daily life in their workplace. The nature of the work undertaken and the culture of the employing organisation can have both positive and negative effects on health. For example, most jobs offer opportunities to network with others, give structure and bring meaning to life, and offer an income. Many jobs, however, are now largely sedentary, contracts can be short or insecure, and unhealthy amounts of stress and pressure can be placed on individuals in a society which has some of the longest working hours in Europe.

As well as providing occupational health and health and safety, the workplace presents opportunities to promote health with individuals in group settings, where individuals may be more amenable to making lifestyle changes, such as being more physically active (such as via active travel promotion or lunchtime activities) and eating more healthily.

The indicators on which this section is based are included on page 20. This section looks at education, training and employment opportunities, and those groups of working age adults who require additional support to fully meet their potential, such as those with severe mental health problems and those with learning disabilities.

As with each section of this report, there is an inevitable time lag in terms of the data that is available for comparison. Commissioners and heads of strategy will wish to compare the information in the dataset with more recent data which they may have available, to provide additional trend data.

Much of the information in this section comes from the routinely published Croydon Economic Bulletin.



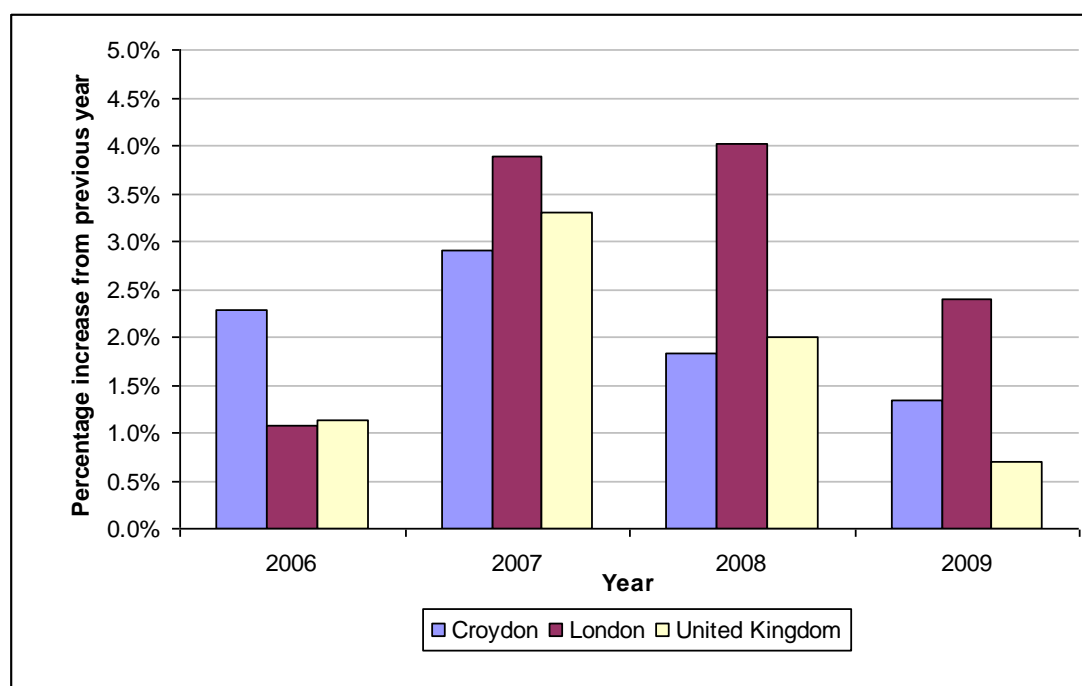
Key findings

- Croydon's economy appeared to grow faster than the national average between 2005 and 2009, though the current financial crisis makes it difficult to state if that has been maintained at the current time.
- The biggest sectors of Croydon's economy are in retail, business administration, and the public sector.
- There has been a large increase in the number of people in Croydon educated to degree level or equivalent significantly reducing the gap between regional and local attainment at this level: Croydon is now very similar to London with respect to the proportion of its population with degrees or equivalent qualifications.
- The proportion of young people who are NEET appears to have been improving, but it is still higher than the national average; however data are not available for all 16 to 18 year olds.
- Apprenticeship opportunities have been increasing in Croydon; however, the drop out rates seems extremely high at nearly half.
- Supporting adults with learning difficulties into housing and employment appears to be a strength in Croydon. Conversely, supporting adults with mental illness into settled accommodation and employment is not. As stated below, caution should be taken when interpreting this data.

Croydon's economy

Accurate figures on total economic activity, such as Gross Domestic Product (GDP) are only available at regional level and are not available on a borough by borough basis. An alternative measure of economic growth is the number of active enterprises. The number of active enterprises in Croydon has increased from 11,130 in 2005 to 12,090 in 2009. This is an increase of 8.6% and compares favourably with the increase in the number of active enterprises across England, which for the same period was 7.3%, but not London as a whole, which was 11.8%.

Figure 15 Annual percentage increase in active enterprises, Croydon, London and UK 2006-2009

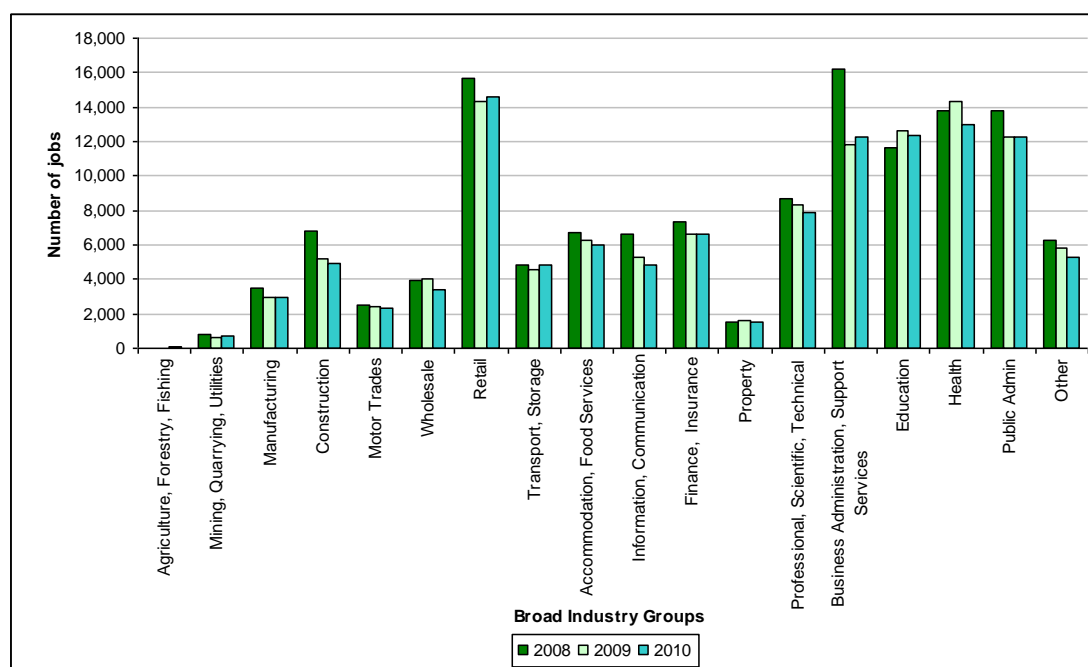


Source: *Business demography 2009*, Office for National Statistics

An active enterprise is defined as a business that had either turnover or employment at any time during the reference period.

Retail and business administrative functions are the largest sectors in the Croydon economy, followed by public sector roles such as health, education, and public administration (see figure 16). Senior private sector jobs and manual, trade and construction groups are much smaller. Most sectors showed a decline in the number of jobs between 2008 and 2009 with the exception of wholesale, education and health, which all experienced small increases. Given the impact that the recession and current financial climate have had on the public sector, this picture is likely to be very different with more timely data.

Figure 16 Employee jobs by sector, Croydon 2008-2010



Source: Business Register and Employment Survey, Office for National Statistics

Post-16 education and training

A well-educated population is essential to a strong economy. Higher levels of education are also associated with higher levels of health and wellbeing, greater social mobility and lower levels of deprivation.

Currently, 40.4% of Croydon's population are educated to NVQ 4+ (degree level or equivalent) [66]. As with many suburbs of London, this is significantly higher than the national average of 31.1%. Historically, Croydon's performance has been worse than the London average and that gap was increasing as London improved more quickly. However, a 9% improvement in Croydon between 2009 and 2010 means Croydon is now just 1.5% below the London average.

There has been an increase in the number of apprenticeships available in Croydon, though at a slower rate than nationally. Between August 2010 and January 2011 there were 1,005 apprenticeship starters; however, only just over half of those who start an apprenticeship complete it with a recognised qualification. The 2009/10 data shows that only 56% of apprenticeships ended successfully.

Young people not in education, employment or training

Young people not in education, employment or training (NEET) are a diverse group. Many young people are NEET only temporarily, for example as they change jobs, or move from training to employment. It is extremely uncommon for young people to be out of education, employment or training for the full three years, with only 1% of young people classified as NEET for the three consecutive years from 16 to 18²⁹.

At a national level, the government has estimated that one in 10 young people is a NEET, but the Audit Commission has found this figure is closer to one in four, and a tenth of those – 85,000 young people nationally – have been inactive for six months or longer.

This diverse group have a wide range of needs that need to be addressed locally. Young people who are NEET at 16 and 17 years old are more likely to have engaged in behaviours such as smoking or vandalism, at ages 13 and 14, and are more likely than their peers to have a disability or long term health condition. Nationally, looked after children are also more likely to be NEET and young white people are more likely to be NEET than those from other ethnic groups. Disadvantage in childhood increases the risk of becoming NEET when older.³⁰ The University of York has carried out research on the lifetime cost of being NEET.³¹

At 6.6%, the percentage of 16 to 18 year olds who were NEET in Croydon was 0.5 percentage points higher than the national average for 2010. **[68]**

More recent locally available data shows that between April 2011 and August 2011, local NEET levels were significantly lower than the previous year, although in September 2011 levels rose to equal levels for the same month in 2010. This data also shows that NEET levels in Croydon are consistently higher than our sub-regional neighbours, Sutton, Merton, Kingston, Bromley and Richmond.

Data on NEETs should be considered with caution on two counts. Firstly there is a proportion of young people in Croydon whose current employment,

²⁹ <http://www.education.gov.uk/16to19/participation/neet/a0064101/16-to-18-year-olds-not-in-education-employment-or-training-neet>. accessed October 2011

³⁰ *Eighth Report: Young people not in education, employment or training*. Children, Schools and Families Select Committee; HC 316-I and -II; April 2010

³¹ http://www.york.ac.uk/media/spsw/documents/research-and-publications/NEET_Executive_Summary_July_2010_York.pdf

education or training status is not known, which could be masking the true scale of young people who are NEET in the borough. Secondly, annual trends for young people who are NEET show seasonal variations, increasing significantly in August and September after the end of the academic year and generally reducing in October when this group enrolls in further education or enters employment. Due to these seasonal variations NEET levels should be compared to levels for the previous year.

Employment rate

There was a fall in the employment rate from 2008 as the recession and financial crises hit. The most recent data shows that employment in Croydon is beginning to increase again. The data included in the JSNA key dataset shows that at 72.4%, the employment rate in Croydon is higher than both the national and London average. [70] Clearly, the recession and financial crisis will have an impact on employment and unemployment locally and nationally, although it is too early to provide an accurate assessment of the extent.

The employment rate for BME population is slightly lower than the overall rate in Croydon, at 70%, but is significantly higher than the BME employment rates across London and nationally.

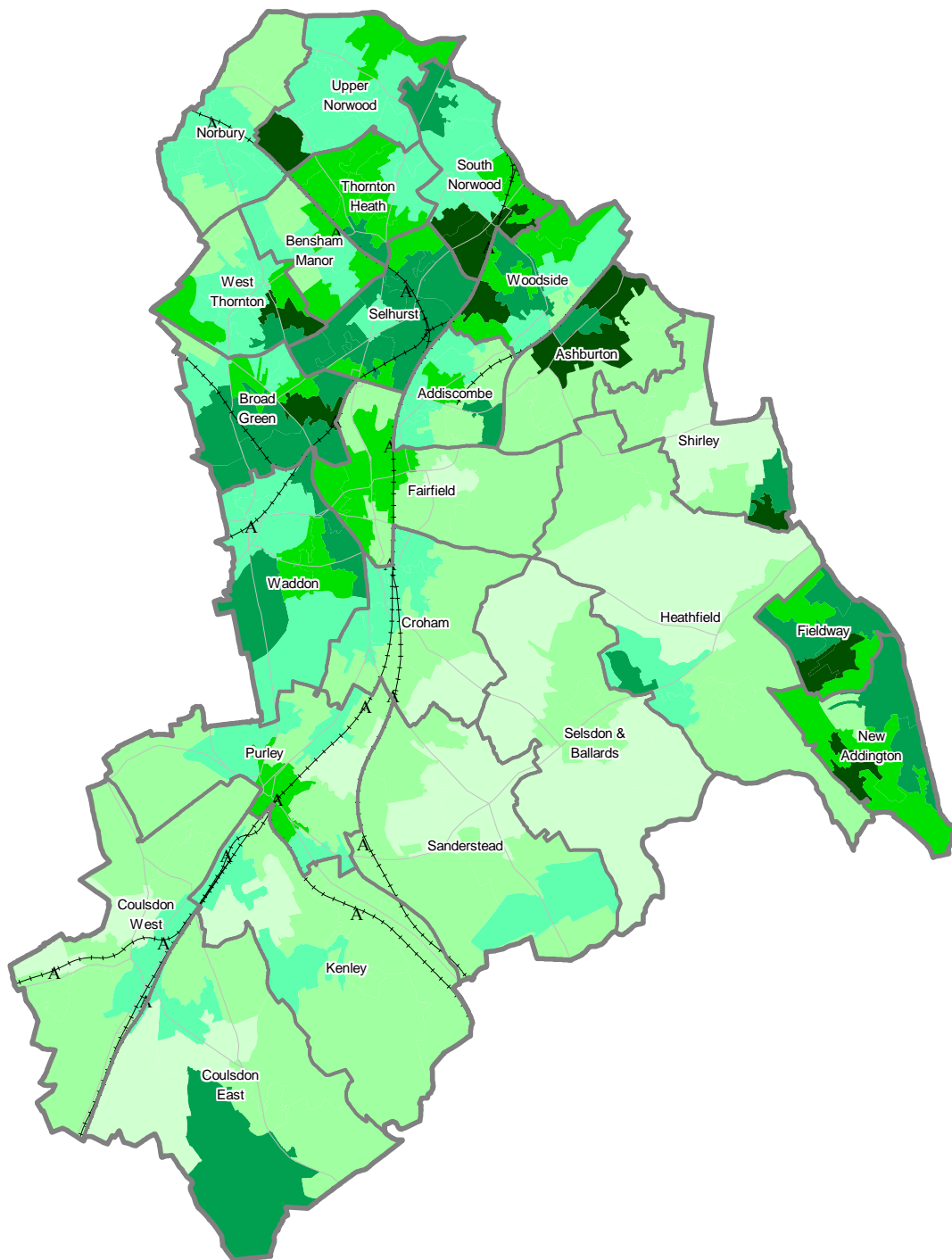
Out of work benefits

In Croydon, 12.8% of working age people are on out of work benefits, which is slightly higher than national average (11.9%) and Croydon's rate compared to other local authorities has worsened over both one year and three year trends [75]. The key out of work benefits include Jobseekers Allowance, Employment Support Allowance and Disability Allowance.

The proportion of the working population claiming Job Seekers' Allowance in 2010/11 was 4.3% for ages 16-64 [73]. When limited to the 16-24 age group, the rate nearly doubles to 8.1%. Both are significantly higher than the national average statistically, though the absolute gap is small.

Croydon's position relative to other local authorities for Job Seekers' Allowance claimants is worse compared to one year and three years ago for the 16-64 age group. The position for the 16-24 age group is unchanged. This means that potentially the impact of the financial crisis is being felt more in the over 25s, and indicates that locally it may be necessary to put more resource into the older age group.

Figure 17 Working age people (aged 16-64 years) on key out-of-work benefits, Croydon LSOAs, February 2011



People aged 16-64 years (working age) on key out-of-work benefits
Croydon LSOAs

- More than 25%
- 20% to 25%
- 15% to 20%
- 10% to 15%
- 5% to 10%
- Less than 5%

Source: Office for National Statistics, February 2011

Areas of Croydon where there are high rates of benefit claims include parts of Ashburton, South Norwood, Upper Norwood, Broad Green, West Thornton and Woodside. There are also areas of higher claims in Fieldway, New Addington and Coulsdon East (see figure 17). This pattern of concentration in the north of the borough with a few pockets in the south is what might be expected, given the overall distribution of deprivation in Croydon.

Learning disability

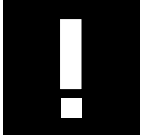
Croydon's prevalence of learning disability in adults is higher than the national and regional averages. [79] A higher prevalence of learning disability means there is a greater burden placed on services supporting those with a learning disability in Croydon than in other areas. Croydon does however perform well in supporting adults with learning disabilities into settled accommodation [80] and employment [81] and both indicators are improving

Croydon's performance for the two issues of employment and housing for adults with mental illness appears from the Key Dataset to be poor. The proportions of those with mental illness in settled accommodation [77] or employment [78] are both shown to be significantly lower than the national average, and trend data for both suggest that these are worsening.

However, there is evidence to suggest that the two indicators for adults with mental illness are not reliable for Croydon. The sudden drop in performance for these indicators for 2009/10 was unexpected. Locally held data puts these figures much higher, and as such, it has been suggested that there are specific local issues relating to the methods of data collection (which were manual until recently) that have caused a time lag in the data processing. The most recent data available shows a better performance; however, even here, there are discrepancies between the locally held data and that published nationally which continues to cause concern for these indicators. The data issues are being addressed.

For reasons of transparency, we have chosen to include the data here, rather than ignore the issue that this is the data currently in the public domain.

This may be an area that should be considered within the 2012/13 JSNA, which will focus on mental health.



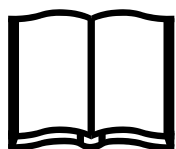
Recommendations

- 1) All economic and growth policies should explicitly state the expected impact on health and wellbeing, for example by including a Health Impact Assessment.
- 2) There was a decrease in the percentage of 16-18 year olds who were NEET for the period between April and August 2011. Investigating the causes of this improvement may lead to learning which can be harnessed to create a sustainable improvement in employment and training opportunities.



Questions for commissioners

- 1) Do economic and growth policies consider the potential knock-on effects to health and wellbeing? Is there enough capacity in services to handle the increasing burden caused by the current financial situation?
- 2) Does Croydon have the right balance of higher and further education, and vocational skills training such as apprenticeships? How can the success rate of apprenticeships be improved?
- 3) Commissioners need to be aware of issues with data collection for some mental health indicators. What can be done to improve the robustness of this data? Even accounting for data validity problems, are commissioners happy that this level of performance is acceptable?
- 4) Are commissioners aware of the potential for improving health in their own employees? How can commissioning levers be used to encourage well workforce programmes in provider organisations?



Further reading

For web links to data in this section please refer to Appendix 2 on page 110.

Croydon Economic Bulletin:

<http://www.croydon.gov.uk/contents/departments/planningandregeneration/pdf/1029165/economicbulletin1>

Croydon Employment Support Services:

<http://www.croydon.gov.uk/healthsocial/helpforadults/cess>

Disability employment support in Croydon:

<http://www.croydon.gov.uk/healthsocial/helpforadults/dissupport>

UK Business statistics:

<http://www.ons.gov.uk/ons/taxonomy/index.html?nscl=Business+and+Energy>

Department for work and pensions:

<http://www.dwp.gov.uk/>

Young people not in education, employment or training:

<http://www.education.gov.uk/16to19/participation/neet>

Apprenticeships:

Direct Gov website on apprenticeships:

http://www.direct.gov.uk/en/EducationAndLearning/14To19/OptionsAt16/DG_4001327

Department for Education website on apprenticeships:

<http://www.education.gov.uk/16to19/qualificationsandlearning/apprenticeships>

Learning Disability:

<http://www.mencap.org.uk/>

Mental Health:

<http://www.nhs.uk/conditions/Mental-health/Pages/Introduction.aspx>

<http://www.dh.gov.uk/health/category/policy-areas/social-care/mental-health/>

8. Later life

The health and wellbeing needs of those who are beyond working age differ significantly from those in younger groups. Most of the health behaviours, attitudes and exposures have already been established by later life. In addition, many people will already be living with a long term condition, or more than one condition.

Maintaining quality of life and preventing deterioration begin to take on more importance than preventative and behaviour change activities. Preventing social isolation and providing continued independence are also key social goals.

The indicators on which this section is based are included on page 21. Those indicators which stand out as in need of improvement are uptake rates for flu jabs, achieving independence through rehabilitation, and support for older people to live independently at home.

As with each section of this report, there is an inevitable time lag in terms of the data that is available for comparison. Commissioners and heads of strategy will wish to compare the information in the dataset with more recent data which they may have available, to provide additional trend data.



Key findings

- Croydon has one of the lowest uptake rates for flu jabs in the over 65 age group in the country.
- Current data shows that Croydon is ranked in the worst performing 10% of local authorities for helping older people achieve independence through rehabilitation, as well as for supporting older people to live independently at home.

Later life was prioritised as a key topic area for the 2010/11 Joint Strategic Needs Assessment. As part of this year’s JSNA there has been a progress report on the recommendations from last year's needs assessment. Both the specific chapter itself (from 2010/11) and the progress report are available on the Croydon Observatory website:

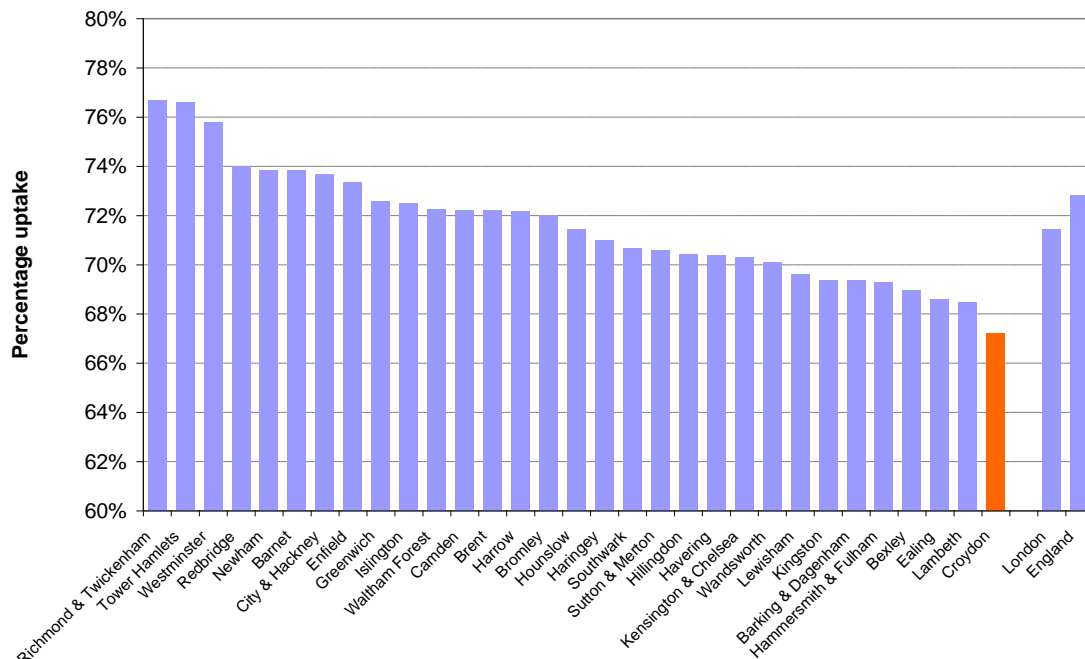
http://www.croydonobservatory.org/docs/strategies/1049047/JSNA_2010-11_living_well.pdf

<http://www.croydonobservatory.org/jsna/updates>

Seasonal flu immunisation

Croydon is amongst the bottom 10% of local authorities for uptake of immunisation against influenza in those over 65 years old. Last year, 67% of over 65s in Croydon received a flu jab, compared to 73% nationally [84]. Comparing this to the one year and three year trends, Croydon's performance has fallen by more than 10% relative to other local authority areas, leaving Croydon with one of the lowest uptake rates in the country, and has the lowest uptake rate of any London borough (see figure 18).

Figure 18 Uptake of seasonal flu vaccine, London boroughs, 2010/11



Source: Information Centre for Health and Social Care

The aim of providing vaccination against seasonal flu is to try and prevent illness developing. Preventing flu is not only of benefit to the individual, who avoids the potentially serious illness, but also aids wider health and social care services by helping to reduce the significant burden of seasonal influenza on the system³². The elderly are at higher risk of developing serious illness and complications from seasonal flu than most other age groups³³. This higher risk means over 65s are targeted for immunisation each year.

This year the Department of Health has decided not to run a national flu vaccination campaign, and a local campaign is being run instead. The impact of this change on flu uptake rates will need to be carefully evaluated.

Independence for older people

Croydon is ranked in the worst performing 10% of local authorities for helping older people achieve independence through rehabilitation [87], as well as for supporting older people to live independently at home [88]. The poor performance in this area has been recognised, and there are a number of programmes aimed at improving outcomes.

These programmes may be having an impact as the outcome from rehabilitation and intermediate care in 2009/10 [87] is improved compared to the previous year, and continues to improve, with the proportion of older people (aged 65 and over) who were still at home 91 days after discharge from hospital increasing from 65.3% to 73.3% in 2010/11.

'Virtual wards' provide care for patients in their own home, allowing suitable patients to leave hospital earlier than they otherwise could, but to remain under the care of their health team. Although these individuals are being cared for at home, time spent on the 'virtual ward' does not count towards the 91 day target discussed above.

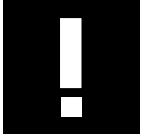
³² Mangtani P, Cumberland P, Hodgson CR et al (2004) *A cohort study of the effectiveness of influenza vaccine in older people, performed using the United Kingdom general practice research database*. *Journal of Infectious Diseases* 190 (1) 1 - 10

³³ Department of Health (2006) *Immunisations against infectious diseases – "The Green Book"* : Chapter 19: (influenza (updated 7 November 2011))
http://www.dh.gov.uk/dr_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_131001.pdf Accessed 07/11/2011

It should be noted that the key data set indicators on achieving independence through rehabilitation or intermediate care [87] and helping older people live independently at home [88], cannot be compared directly to the indicator for people supported to live independently through social services [17] due to differences in the underlying dataset.

In addition to work on improving advice and support for carers, Croydon has used information from predictive modelling to target early interventions by the occupational therapy service to delay and prevent admissions to care homes and nursing homes. It has also piloted the use of Information and Communication Technology to support tenants with early onset dementia and clients in special sheltered accommodation to remain independent, and repositioned the occupational therapy service to focus on delivering rehabilitative and reablement services.

Croydon has also funded major aids and adaptations to 160 council homes (exceeding the target of 100) and 187 private sector homes to enable people with physical disabilities to remain safely and independently within their own homes and supported 660 people through the Staying Put home improvement agency to enable them to stay in their homes through repair and improvement works and handyperson services, exceeding the target of 600.



Recommendations

This section should be read in conjunction with the chapter: 'Living Well in Later Life' from last year's JSNA, and the progress report on this chapter for 2011/12, both of which are available on the Croydon Observatory website:

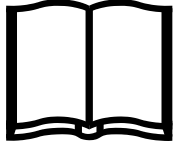
http://www.croydonobservatory.org/docs/strategies/1049047/JSNA_2010-11_living_well.pdf

<http://www.croydonobservatory.org/jsna/updates>



Questions for commissioners

1. Although Croydon's figures for flu uptake in the over 65s are statistically significantly worse than the national average, the difference is relatively small, and one of only a few percentage points. Are there diminishing returns for extra effort in increasing flu jab uptake? How important is it to improve this indicator?
2. If it is considered important to improve this indicator, are we confident that we know and can describe the local barriers to take up of flu immunisation? Are there any cultural issues involved here, or is this a service issue? If we cannot already describe the local barriers, how can we ensure that we have a better understanding of the issues at play here? How can commissioned services reduce known barriers to flu immunisation take up?
3. There has been an improvement in performance in supporting older people to live independently at home that has occurred in the past year. Are we confident that these improvements will be maintained, or are there further actions that need to be taken? How do commissioners consolidate the recent improvements?
4. There is an apparent discrepancy between the low numbers of individuals being admitted to residential care and the number of social care clients supported to live at home. What is the cause of this discrepancy? Is this due to issues with the available data, or is there a cohort of elderly people with unmet need?



Further reading

For web links to data in this section please refer to Appendix 2 on page 111.

Adult social care:

<http://www.ic.nhs.uk/statistics-and-data-collections/social-care/adult-social-care-information>

Older people:

<http://www.ic.nhs.uk/statistics-and-data-collections/social-care/older-people>

National Adult Social Care Information Service:

<http://www.ic.nhs.uk/nascis>

Housing for older people:

<http://www.communities.gov.uk/housing/housingolderpeople/>

Croydon - Housing for older people:

<http://www.croydon.gov.uk/contents/departments/planningandregeneration/pdf/912686/917223/ophs>

Croydon services for older people:

<http://www.croydon.gov.uk/healthsocial/olderpeople/>

Croydon older people's strategy:

<http://www.croydon.gov.uk/democracy/dande/policies/health/olderpeople>

Croydon older people and mental health:

<http://www.croydon.gov.uk/healthsocial/disabilities/mhealth/olderadults>

Vaccines for adults

<http://www.nhs.uk/Planners/vaccinations/Pages/Adultshub.aspx>

Immunisation statistics:

<http://www.ic.nhs.uk/statistics-and-data-collections/health-and-lifestyles/immunisation>

Croydon Council support and advice:

<http://www.croydon.gov.uk/healthsocial/helpforadults/adult-rescare/>

Croydon – Home care:

<http://www.croydon.gov.uk/healthsocial/homecare/>

9. Healthy life

This final section concentrates on those aspects of wellbeing which are most closely aligned with health and healthcare. It contains important information on disease prevalence, mortality rates, hospital utilisation and user satisfaction.

This section also looks at important lifestyle factors such as tobacco, alcohol and drug use. Also grouped within this section are indicators associated with prevention, including risk factors for specific diseases, screening rates, and support for those with long term conditions.

The indicators on which this section is based are included on pages 21-24. This section of the key dataset has a very large number of indicators, which have been sub-divided into those related to mortality and disease, healthy lifestyles, and health services. We have highlighted those areas where Croydon has a particularly good, or particularly poor ranking compared to other areas, or where there has been a large change in that ranking in recent years.

As with each section of this report, there is an inevitable time lag in terms of the data that is available for comparison. Commissioners and heads of strategy will wish to compare the information in the dataset with more recent data which they may have available, to provide additional trend data.



Key findings

- Breast and cervical screening rates are both significantly worse than the national average. Cervical screening performance is starting to improve; however, trend data suggests that breast cancer screening rates are dropping relative to other local authorities.
- Excellent progress has been made in Croydon in supporting people to quit smoking. For the first time in seven years, Croydon not only met, but exceeded, its smoking cessation targets.
- Less progress has been made in turning around alcohol related crime, drug offences, and increasing physical activity levels.
- Croydon is in the bottom 10% of local authorities 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 local authorities than they were three years ago. Croydon's performance for emergency admissions for ambulatory care sensitive conditions has also deteriorated in comparison to the one year and three year trends.
- The rate of emergency readmissions to hospital within 28 days of discharge is also significantly higher in Croydon than nationally.

Mortality and disease

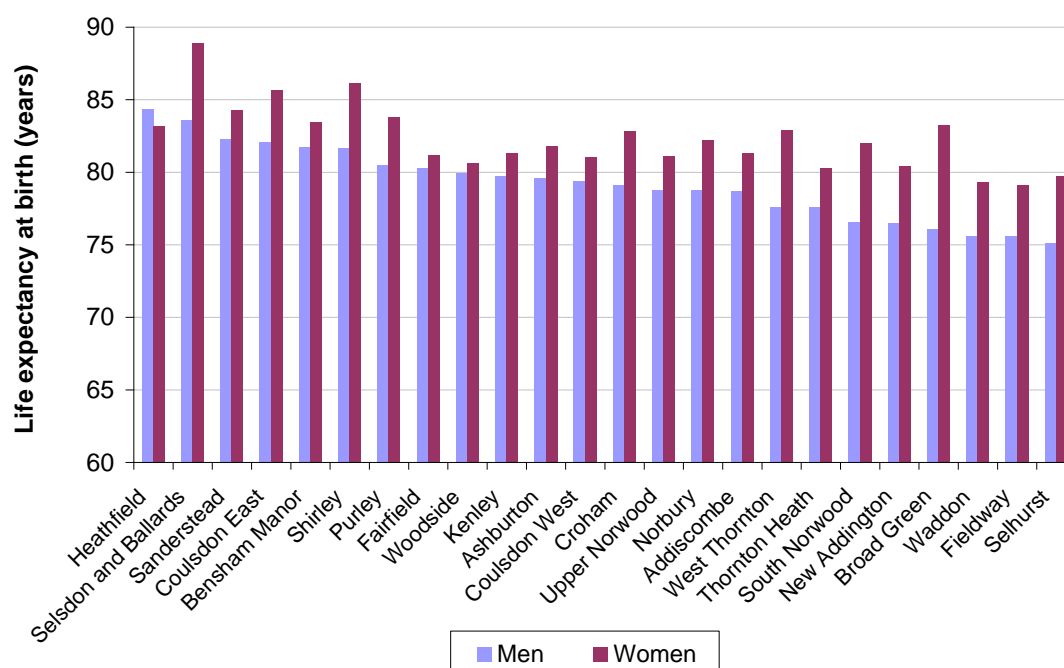
There are two generic measures of disease burden – all-age all-cause mortality, and life expectancy. For males, all-age all-cause mortality is much lower than the national average at 610.1 per 100,000 compared to 673.5 per 100,000 across England [89]. Men in Croydon live on average 1.2 years longer than the English average [91].

Women in Croydon also do better than the national average, though the gap is smaller. Female all-age all-cause mortality is 456.2 per 100,000 compared to 478.3 per 100,000 nationally [90]. Female life expectancy in Croydon is 82.8 years compared to a national average of 82.3 years [92].

The trend information indicates that Croydon’s position relative to other local authorities for all four of these indicators is comparatively better compared to one and three years ago.

However, this good performance at a borough level hides the large differences between areas within Croydon [93, 94]. There is approximately a 10 year difference in life expectancy between the highest and lowest wards.

Figure 19 Life expectancy at birth, Croydon electoral wards, 2006-2010



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

Cancer [98 – 122]

Overall, the data suggests a mixed picture in terms of cancer in Croydon, with good or average relative performance on many of the indicators. However, many are moving in the wrong direction compared to other local areas. Those that stand out are the incidence of prostate cancer, and deaths from leukaemia. The incidence of prostate cancer may be explained by the ethnic mix in Croydon, and mortality from prostate cancer is around the national average. Deaths from leukaemia are discussed below.

Mortality from cancer is lower in Croydon than the national average for all the common cancers in the key dataset, and is significantly lower for early deaths from cancer, all deaths from cancer, and deaths from oesophageal cancer, lung cancer, and breast cancer.

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, occurring at a rate significantly lower than the national average, have both been increasing relative to other areas over the past three years. It may be useful to further investigate why the incidence of these particular cancers is increasing, as that will allow commissioners to design services to meet potential future need.

Over the past 12 months Croydon has fallen relative to other local authority areas for early deaths from cancer and all deaths from cancer. Deaths from bladder cancer and deaths from leukaemia have worsened compared to other areas for both one year and three year trends. However, with some cancers, such as leukaemia, where there are only a few deaths each year, small fluctuations in the number of deaths can have a large impact on the calculated rate. It is important therefore to monitor trends from cancer mortality over time to assess if there is a true worsening in mortality, whilst ensuring that there is adequate access to services currently.

Screening

Another area of cancer care that is of concern is the uptake of screening for breast and cervical cancer^{34 35}. Screening programmes are important as they

³⁴ Peto J, Gilham C, Fletcher O, Matthews F E. (2004) *The cervical cancer epidemic that screening has prevented in the UK*. The Lancet Vol 364 (9430) p249 - 256

³⁵ Duffy S W, Tabar L, Olsen A H et al (2010) *Absolute numbers of lives saved and overdiagnosis in breast cancer screening, from a randomized trial and from the Breast Screening Programme in England*. Journal of Medical Screening Vol 17 (1) p25 - 30

allow early detection and treatment or prevention of potentially serious illness. National screening programmes are subject to a rigorous process of review to ensure they are appropriate.

The breast screening [99] and cervical screening [100] coverage rates in Croydon are both slightly lower than the national average, a difference which is statistically significant. London has generally had a lower uptake of screening than other parts of England. Croydon is going against this trend with both coverage rates better than the London-wide average, and meeting the national standards for screening coverage.

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 compared to the one year and three year trends.

Circulatory diseases [134-142]

Diseases of the circulatory system, which include heart disease and stroke, are becoming a worsening problem in Croydon. Though deaths from coronary heart disease (CHD) in Croydon are significantly lower than the national average, Croydon's mortality rate for CHD has worsened compared to other areas on both one year and three year trends. The same is true for emergency admissions for stroke, where Croydon has a higher rate of emergency admission than both the London and national average (123.9 per 100,000 in Croydon versus 114.7 per 100,000 nationally). Compared with other areas, Croydon also has a higher rate of early death from stroke than it did three years ago. CHD and stroke share many risk factors, including high blood pressure, high cholesterol and obesity. Although rates for deaths from these diseases currently appear to be not much different from the national averages, the worsening trend is a cause for concern and indicates that circulatory diseases require closer monitoring. The current Croydon heart health review may help address these issues.

Diabetes [129-133]

Croydon has an emergency admissions rate of diabetes that is significantly higher than the national and regional averages. Diabetes shares some of the risk factors of circulatory diseases, and is itself an independent risk factor for developing these conditions³⁶. Diabetes was prioritised as a key topic area in

³⁶ NHS Croydon (2010) Croydon Joint Strategic Needs Assessment 2010/11

last year's JSNA. Both the needs assessment on diabetes and the progress report for this year can be found on the Croydon Observatory:

http://www.croydonobservatory.org/docs/strategies/1049047/JSNA_2010-11_diabetes.pdf

<http://www.croydonobservatory.org/jsna/updates>

Respiratory disease [143-150, and 126 (TB)]

Health spending on COPD in Croydon is lower than both national and London averages, at £71 per head of population. However, this difference is not statistically significant, even though Croydon is in the lowest 10% of PCTs for spend on respiratory diseases. Spend itself is not necessarily a useful indicator; it has to be considered in the context of the needs of the population, and the outcomes achieved for that spend. This is the approach used in Programme Budgeting Marginal Analysis (PBMA).

Chronic obstructive pulmonary disease (COPD) is a descriptive term covering long term conditions affecting the lungs, primarily emphysema and chronic bronchitis. Most COPD is caused by smoking, and it develops over many years. It has a high cost to the health service, and dramatically limits the quality of life of sufferers.

To ensure services are correctly designed and there is sufficient capacity, it is important that commissioners are aware of the size of the need in the community. The number of people with a condition can be measured in different ways. One way is through disease registers maintained by GP practices. It is also possible to estimate the prevalence of a disease by extrapolating study data to the local area.

In Croydon, there is a large discrepancy between the number of COPD patients on GP registers and the number expected by the prevalence estimates. In Croydon the GP COPD registrations are only 27.8% of the number expected through the estimation process, which is half the national average [150]. The model used to estimate the number of patients suffering from COPD might overestimate the number of COPD patients, or Croydon's population may be different from that used in the modelling. However, given the difference between Croydon's performance and the national average, it is likely, even with these factors, there is a large burden of unknown need in COPD.

Tuberculosis

Croydon is in the 10% worst performing local authorities for new cases of tuberculosis (TB) [126]. However, London is known to have a TB rate vastly greater than the rest of the country, with 38% of all new TB cases in 2010 occurring in London, therefore taken out of context, this result could be misleading³⁷. It is therefore important to see how Croydon compares with London. Croydon has a TB incidence rate of 34 new cases per 100,000 population, compared to the London average of 44 per 100,000. Croydon compares favourably to neighbouring boroughs for TB incidence.

There is an unequal distribution of TB in Croydon, with most cases concentrated in the north of the borough. The risk factors for deprivation and TB are similar so we would expect TB to be more common in more deprived communities³⁸. Currently there is a drive towards a unified TB model of care in London, with TB services designed and commissioned on a pan-London basis being seen as the best means of combating London's high TB rate.

Healthy Lifestyles

Several indicators within the healthy lifestyles section of the dataset stand out as being particularly in need of attention: smoking quit rates, alcohol related crimes, drug offences, and adult participation in sport.

Addictive behaviours

Smoking is a major cause of disease, with over 18% of deaths in over 35s attributable to smoking. In England, deaths from smoking are more numerous than the next six most common causes of preventable death combined (i.e. drug use, road accidents, other accidents and falls, preventable diabetes, suicide and alcohol abuse.³⁹ Smoking cessation services are among the most cost-effective services the NHS commissions.

In Croydon, the smoking prevalence rate is roughly the same as the London and national averages [156]. Quit rates were slightly lower than the national average in previous years, but have been improving relative to other local authorities, as shown by both the one year and three year trend data, and are

³⁷ *Tuberculosis in the UK: Annual report on tuberculosis surveillance in the UK 2010*; Health protection agency 2011. http://www.hpa.org.uk/web/HPAweb&HPAwebStandard/HPAweb_C/1287143581697

³⁸ Crofts JP, Gelb D, Andrews N, Delpech V, Watson JM, Abubakar I. *Investigating tuberculosis trends in England*. Public Health, Dec 2008, vol./is. 122/12(1302-10),

³⁹ *Healthy Lives, Healthy People: A Tobacco Control Plan for England*; Department of Health, 2011

now better than the national average **[157]**. The last year (2010/11) has been the best ever year for smoking cessation in Croydon. For the first time in seven years, Croydon not only met, but exceeded, its smoking cessation targets. This improvement in smoking cessation rates is shown in figure 20

Figure 20 Smoking cessation service performance, Croydon 2008/09-2010/11

Year	Number of clients receiving service	Successful quits	Quit Rate	% of annual target delivered
2008-09	2775	660	23.8	37%
2009-10	4196	1604	38.2	89%
2010-11	4312	2184	50.6	114%

Source: Reversing the fortunes of Croydon's Stop Smoking Services, A report to the Addictive Behaviours Alliance, September 2011

Other addictive behaviours continue to be a serious problem in Croydon. The number of hospital stays for alcohol attributable conditions is higher than it was compared to three years ago **[160]**. The same is true for alcohol-related crimes **[159]** and drug offences **[163]**, both of which are significantly more common in Croydon than nationally. The number of drug offences have, however, fallen compared to one year previously.

Physical activity

With only 7.7% of Croydon's adult population regularly taking part in sports or other active recreation, Croydon ranks in the bottom 10% of local authorities for physical activity **[165]**. Being active is key to maintaining health, and to the prevention of obesity and related health problems⁴⁰. People who regularly take part in active recreational activities often have a higher quality of life and better mental health and wellbeing than those who do not⁴¹.

⁴⁰ O'Gorman DJ, Krook A (2011) *Exercise and the treatment of diabetes and obesity*. Medical Clinics of North America, Sep 2011, vol./is. 95/5(953-69)

⁴¹ Martin CK, Church TS, Thompson AM, Earnest CP, Blair SN (2009) *Exercise dose and quality of life: a randomized controlled trial*. Archives of Internal Medicine, Feb 2009, vol./is. 169/3(269-78), 0003-9926;1538-3679 (2009 Feb 9)

Low rates of physical activity are often due to actual or perceived barriers to opportunities to take part in exercise⁴². Projects which aim to remove these barriers may improve physical activity rates. Attitudes to health and wellbeing are more difficult to change in adult life than they are in childhood. A successful strategy to tackle childhood obesity will, over time, lead to a fall in the rate of adult obesity and improve participation in sport.

A detailed needs assessment relating to obesity and including physical activity, Healthy Weight, Healthy Lives, was carried out as part of the 2009/10 JSNA. This included a number of recommendations on weight management and physical activity.

Health Services

Although the key dataset indicators on mortality and disease suggest that there is high quality care available in Croydon, many indicators within the health services section of the dataset suggest that there are still areas where we can continue to improve.

Patient and public involvement in service design can produce changes to services and new care pathways that are of high quality and better meet the needs and expectations of service users. One mechanism of achieving involvement was through the Local Involvement Network (LINK), and now via the shadow HealthWatch. HealthWatch is the new organisation being developed by the government as part of the ongoing health and social care reforms to ensure wider public engagement and advocacy in the production of strategic policies

End of life care

It is estimated that the majority of health care spending on an individual occurs in the last six months of their life⁴³. Ensuring that, even as someone approaches death, they are able to maintain a good quality of life is an essential part of health and wellbeing.

⁴² Korkiakangas EE, Alahuhta MA, Laitinen JH (2009) *Barriers to regular exercise among adults at high risk or diagnosed with type 2 diabetes: a systematic review*. Health Promotion International, Dec 2009, vol./is. 24/4(416-27)

⁴³ Kelley AS, Ettner SL, Morrison RS, Du Q, Wenger NS, Sarkisian CA (2011) *Determinants of medical expenditures in the last 6 months of life*. Annals of Internal Medicine, Feb 2011, vol./is. 154/4(235-42),

Palliative care services can provide support and comfort to both the individual who is dying, and their loved ones, and must be designed to meet the needs of both⁴⁴.

A key outcome measure of end of life care services is the proportion of deaths which happen at home. If an individual wishes to die at home in familiar surroundings rather than in a medically advised environment, they should be supported to do so. As well as improving the quality of life for the person who is dying, end of life care in the home setting is a more cost-effective intervention than hospital admission at the end of life.

With only 16.9% of deaths occurring at home, Croydon performs significantly worse than the national average in this key indicator of end of life care **[167]**. Croydon's performance relative to other areas has been worsening over the past three years, and places Croydon in the bottom 10% of areas for this indicator. Knowledge of palliative care services by both professionals and public, lack of capacity, or difficulties accessing palliative care services may be barriers to allowing patients to die at home.

In the light of this information, Croydon Council and Croydon NHS will be piloting a new approach to supporting end of life care, with the support of hospice care. The Gold Standard Framework (GSF) in end of life care will be implemented and results monitored throughout a two year evaluation period. GSF is a systematic evidence based approach to optimising the care for patients nearing the end of life delivered by generalist providers. It is concerned with helping people to live well until the end of life and includes care in the final years of life for people with any end stage illness in any setting, including a residential care or nursing home setting as well as at 'home' in the usual sense.

The initiative will enable more patients to receive the type of care they want, in their preferred place, with greater cost efficiency through reduced hospitalisation⁴⁵.

⁴⁴ United Kingdom, Department of Health. (2008) *End of life care strategy. Promoting high quality care for all adults at the end of life*. Department of Health
http://www.endoflifecareforadults.nhs.uk/assets/downloads/pubs_EoLC_Strategy_1.pdf. Accessed 11/11/2011

⁴⁵ Simoens S, Kuttan B, Keirse E, Berghe PV, Beguin C, Desmedt M, Deveugele M, Leonard C, Paulus D, Menten J (2011) *The costs of treating terminal patients*. Journal of Pain & Symptom Management, Sep 2010, vol./is. 40/3(436-48),

Satisfaction with primary care services [168-172]

Satisfaction with primary care services is variable. Croydon residents are significantly more likely to be satisfied with telephone access to their GP practice, and the ability to book GP appointments in advance, than the national average. However Croydon is in the bottom 10% of local authorities for satisfaction with ability to see a GP quickly.

Satisfaction with the ability to see a specific GP and with GP practice opening times are also significantly lower than the national average. The one year trend indicates that Croydon has fallen relative to other areas for satisfaction with opening times.

If patients are not satisfied with the availability of primary care services, then they may present inappropriately at other providers, such as accident and emergency or urgent care centres, or not attend at all, risking their health⁴⁶.

Secondary care utilisation [173-174]

Rates for emergency hospital admissions are higher compared to other local authorities than they were three years ago. Croydon's performance for emergency admissions for ambulatory care sensitive conditions has also deteriorated in comparison to the one year and three year trends. Ambulatory care sensitive conditions are those for which hospital admission could be avoided through intervention in primary care.

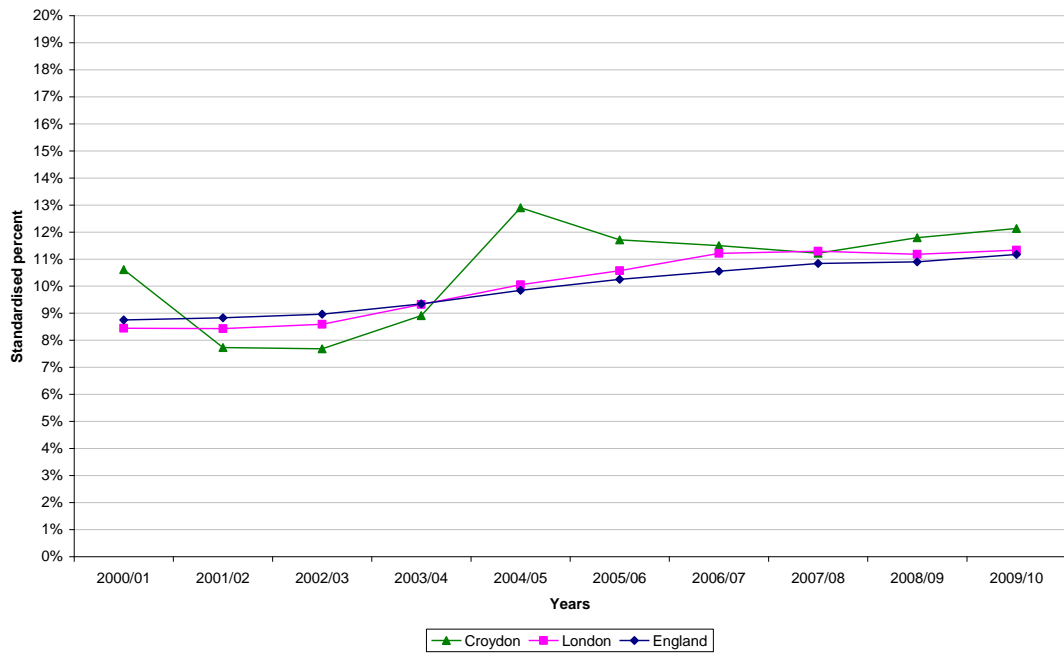
Interventions aimed at individual patients such as self-management and care planning, and structural changes such as the introduction of intermediate care facilities, and better integration between primary, secondary and social services have all been shown to help reduce emergency admission rates.⁴⁷

The rate of emergency readmissions to hospital within 28 days of discharge is significantly higher than the national average at 8.7% compared to 7.7% nationally, and Croydon's position relative to other areas has deteriorated by more than 10% compared to the previous year (see figure 21). Some emergency readmissions are unavoidable, whilst others may be due to the patient being discharged too early, a lack of proper discharge planning, or the unavailability of services once the patient is discharged.

⁴⁶ Carret ML, Fassa AC, Domingues MR (2009) *Inappropriate use of emergency services: a systematic review of prevalence and associated factors*. Cadernos de Saude Publica, Jan 2009, vol./is. 25/1(7-28),

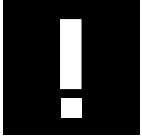
⁴⁷ *Avoiding hospital admissions what does the evidence say?*; The King's fund; December 2010

Figure 21 Emergency readmissions to hospital within 28 days of discharge: ages 16+, Croydon, London and England, 2000/01-2009/10



Source: *Compendium of Population Health Indicators*

Percentage is indirectly standardised for age, sex, method of admission, diagnosis and procedure



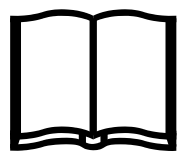
Recommendations

- 1) Diabetes was identified as a key issue for the Croydon JSNA in 2010/11, and a full needs assessment was undertaken at this time. This needs assessment, and the recommendations contained within it, should continue to inform the work involved in tackling this key priority area for Croydon.
- 2) Commissioners will be aware that the Croydon heart health review is ongoing and will be published in due course. This will also be a key document for informing commissioning decisions around this crucial public health issue. Circulatory diseases were last subject to a needs assessment in 2009, so may be a suitable topic for review.
- 3) Mental health remains central to health and wellbeing. It has been agreed that the 2012/13 JSNA should concentrate solely on mental health and wellbeing and the recommendations from this will be key to informing the long term direction of mental health in Croydon.



Questions for commissioners

- 1) Commissioners may wish to investigate further why the incidence of and mortality from certain cancers appear to be increasing in Croydon. If these are true increases, what is causing them? How should these be monitored? What actions could be taken to reverse these trends?
- 2) What further actions are needed to improve cancer screening rates? Are there lessons to be learned from improvement in the cervical screening programme?
- 3) Should all addictive behaviours be treated in the same way? What synergies can be gained between programmes aimed at tobacco, alcohol and drugs?
- 4) What barriers exist which prevent people from being able to choose to die at home? Do providers start end of life planning discussions with patient and family at the right time?
- 5) Is there a link between lower GP satisfaction rates and increased secondary care utilisation? Have commissioners worked with providers to identify root causes of high rates of emergency admissions and readmissions, and to develop solutions for these causes?



Further reading

For web links to data in this section please refer to Appendix 2 on page 112.

Croydon Health information and advice for young people:

<http://www.croydon.gov.uk/healthsocial/ia/health>

Croydon health advice:

<http://www.croydon.gov.uk/healthsocial/sdsmain/>

NHS Choices – Health encyclopaedia on a range of conditions:

<http://www.nhs.uk/Conditions/Pages/BodyMap.aspx?Index=A>

Office for National Statistics – Health and Social Care Statistics:

<http://www.ons.gov.uk/ons/taxonomy/index.html?nscl=Health+and+Social+Care>

NHS cancer screening programmes:

<http://www.cancerscreening.nhs.uk/>

NHS smoke free:

<http://smokefree.nhs.uk/>

Cancer:

<http://www.cancerresearchuk.org/>

<http://www.macmillan.org.uk/Cancerinformation/Cancertypes/AtoZ.aspx>

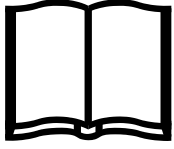
Diabetes:

Diabetes services in Croydon:

<http://www.southwestlondon.nhs.uk/About/NHSCroydon/Diabetes/Pages/default.aspx>

Diabetes UK (voluntary organisation)

<http://www.diabetes.org.uk/>



Further reading (continued)

Circulatory disease and heart health:

<http://www.bhf.org.uk/heart-health/conditions/cardiovascular-disease.aspx>

Respiratory Disease:

London Health Observatory on respiratory disease.

http://www.lho.org.uk/LHO_Topics/Health_Topics/Diseases/RespiratoryDisease.aspx

World Health Organisation – World COPD Day

<http://www.who.int/respiratory/en/>

Physical activity:

World Health Organisation:

http://www.who.int/topics/physical_activity/en/

Department of Health

<http://www.dh.gov.uk/health/category/policy-areas/public-health/physical-activity-2/>

Croydon Drug and Alcohol Team (DAAT):

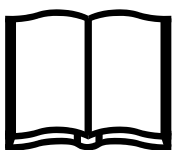
<http://www.croydon.gov.uk/healthsocial/helpforadults/daservices/>

Local Involvement Network (LINK):

<http://www.nhs.uk/NHSEngland/links/Pages/links-make-it-happen.aspx>

Croydon LINK:

<http://www.croydon.gov.uk/democracy/dande/policies/health/croydonlink/>



Further reading (Continued)

HealthWatch (shadow form):

What is HealthWatch:

<http://healthandcare.dh.gov.uk/what-is-healthwatch/>

HealthWatch Pathfinders:

<http://www.dh.gov.uk/health/2011/08/healthwatch-pathfinders/>

HealthWatch the policy:

<http://healthandcare.dh.gov.uk/healthwatch-core-presentation/>

End of life care:

Department of Health – End of life care:

<http://www.dh.gov.uk/health/category/policy-areas/social-care/end-of-life/>

National End of Life Care Programme:

<http://www.endoflifecareforadults.nhs.uk/>

NHS Choices – End of life care:

<http://www.nhs.uk/Planners/end-of-life-care/Pages/End-of-life-care.aspx>

National Institute for Health and Clinical Excellence (NICE) – quality standards:

<http://www.nice.org.uk/guidance/qualitystandards/indevelopment/endoflifecare.jsp>

Croydon Palliative Care:

<http://www.croydon.gov.uk/healthsocial/helpforadults/palliativecare>

Appendix 1 Membership of the Joint Strategic Needs Assessment Steering Group 2010/11

Bernadette Alves	Acting Public Health Consultant	NHS SW London Croydon Borough Team
Fouzia Basit	Acting Managing Director	NHS SW London Croydon Borough Team
Peter Boffa	General Practitioner	Croydon clinical commissioning group
Tony Brzezicki	Joint Chair	Croydon clinical commissioning group
Eileen Callaghan	Chief Pharmacist	NHS SW London Croydon Borough Team
Elaine Clancy	Assistant Director of Operations	Croydon Health Services
David Claydon	Policy Manager, Performance and Efficiency, Resources and Customer Services	Croydon Council
Cynthia Davis	Interim Director of Nursing	Croydon Health Services
Agnelo Fernandes	Joint Chair	Croydon clinical commissioning group
Dipti Gandhi	General Practitioner	Croydon clinical commissioning group
Sharon Godman	Head of Corporate Equalities and Cohesion	Croydon Council
Jacqueline Goodchild	Acting Head of Commissioning	NHS SW London Croydon Borough Team
Jo Gough	Head of Community Involvement	Croydon Voluntary Action
Janet Grant	Representative	Croydon Shadow HealthWatch
Jenny Hacker	Consultant in Public Health Intelligence	NHS SW London Croydon Borough Team
Sadia Halim	Junior Doctor, Public Health	NHS SW London Croydon Borough Team
Barbara Jesson	Community Pharmacy Advisor	NHS SW London Croydon Borough Team
Iain Kennedy	Specialist Registrar in Public Health Medicine	NHS SW London Croydon Borough Team

Jam Khan	General Practitioner	Croydon clinical commissioning group
Fatima Koroma	Representative	Croydon Shadow HealthWatch
Anesa Kritah	Service development manager, planning, regeneration & conservation	Croydon Council
Alex Luke	Head of clinical pathway (neuro-sciences)	South London and Maudsley NHS Foundation Trust
Hannah Miller	Executive Director, Adult Services, Health and Housing	Croydon Council
Steve Morton	Head of Health and Wellbeing	NHS SW London Croydon Borough Team and Croydon Council
Maria Nawrocka	Children and Families Partnership Manager	Croydon Council
David Osborne	Senior Public Health Intelligence Analyst	NHS SW London Croydon Borough Team
Claudette Parchment	QIPP Delivery Officer	NHS SW London Croydon Borough Team
Minal Patel	Engagement and Equality Manager	NHS SW London Croydon Borough Team
Steve Peddie	Head of Strategy, Commissioning, Procurement and Performance (SCPP), DASHH	Croydon Council
Terri Saich	Customer Service Programme Manager	Croydon Council
Brenda Scanlan	Director of adult care commissioning, DASHH	Croydon Council
Folake Segun	Croydon Shadow HealthWatch Co-ordinator	Croydon Voluntary Action
Jennifer Williams	Knowledge Manager, Croydon Public Health Intelligence Team	NHS SW London Croydon Borough Team

Appendix 2

Indicator Notes

1 Index of multiple deprivation (IMD) score. The IMD is a general measure of deprivation for small areas in England made up of 38 indicators grouped into 7 domains and combined into a single index score, 2010, Source: Department of Communities and Local Government, Indices of Deprivation (<http://www.communities.gov.uk/publications/corporate/statistics/indices2010>)

2 In and out-migration (in the year to June) per 1,000 resident population. An international long-term migrant is defined as a person who moves to a country other than that of his or her usual residence for a period of at least a year, so that the country of destination effectively becomes his or her new country of usual residence, Mid 2009 - Mid 2010, Source: Office for National Statistics (<http://www.ons.gov.uk/>)

3 In and out-migration (in the year to June) per 1,000 resident population. An internal migrant is defined as a person who moves between one local authority and another local authority within the UK in the period of one year, Mid 2009 - Mid 2010, Source: Office for National Statistics (<http://www.ons.gov.uk/>)

4 Patients newly registered with a GP in England and Wales in the last 12 months who were previously living outside of the UK (Flag 4 registrations), Mid 2009 - Mid 2010, Source: Office for National Statistics (<http://www.ons.gov.uk/>)

5 Statutory homeless households per 1,000 households, 2009/2010, Source: Health Profiles, Association of Public Health Observatories (<http://www.apho.org.uk/default.aspx?RID=49802>)

6 Households living in temporary accommodation per 1,000 households, 2009/2010, Source: Department of Communities and Local Government (<http://www.communities.gov.uk/housing/housingresearch/housingstatistics/>)

7 Percentage of households which are fuel poor, meaning they spend more than 10% of their income on fuel to maintain a "satisfactory heating regime" (usually 21 degrees for the main living area and 18 degrees for other occupied areas), 2008, Source: Department of Energy and Climate Change (http://www.decc.gov.uk/en/content/cms/statistics/fuelpov_stats/fuelpov_stats.aspx)

8 Violence against the person offences recorded per 1,000 population, 2009/2010, Source: Health Profiles, Association of Public Health Observatories (<http://www.apho.org.uk/default.aspx?RID=49802>)

9 Total notifiable offences per 1,000 population, 2010/2011, Source: Home Office and Office for National Statistics Mid-Year Population Estimates (<http://www.homeoffice.gov.uk/publications/science-research-statistics/research-statistics/crime-research/local-police-recorded-crime/>)

10 Rate of first time entrants to the criminal justice system per 100,000, where first time entrants are defined as young people aged 10-17 who receive their first substantive outcome (relating to a reprimand, a final warning with or without an intervention, or a court disposal for those who go directly to court without a reprimand or final warning) (NI 111), 2008/2009, Source: National Indicator Set data (<http://www.places.communities.gov.uk/latestnews.aspx>)

- 11 Total end user carbon dioxide emissions per capita (tonnes of carbon dioxide per resident), 2007, Source: Health Profiles, Association of Public Health Observatories (<http://www.apho.org.uk/default.aspx?RID=49802>)
- 12 Percentage of household waste sent for reuse, recycling or composting (NI 192), 2009/2010, Source: Department for Environment, Food & Rural Affairs (<http://www.defra.gov.uk/statistics/environment/waste/>)
- 13 People killed or seriously injured on roads, crude rate per 100,000 population, all ages, 2007-2009, Source: Health Profiles, Association of Public Health Observatories (<http://www.apho.org.uk/default.aspx?RID=49802>)
- 14 Percentage of new clients whose assessments were completed within 4 weeks of first contact (NI 132), 2009/2010, Source: Information Centre for Health and Social Care (<http://www.ic.nhs.uk/statistics-and-data-collections/social-care/adult-social-care-information>)
- 15 Percentage of new clients aged 65 and over for whom all services were put in place within 4 weeks of completion of assessment (NI 133), 2009/2010, Source: Information Centre for Health and Social Care (<http://www.ic.nhs.uk/statistics-and-data-collections/social-care/adult-social-care-information>)
- 16 Clients and carers receiving social care through self directed support as a percentage of the total number of clients and carers receiving services (NI 130), 2009/2010, Source: Information Centre for Health and Social Care (<http://www.ic.nhs.uk/statistics-and-data-collections/social-care/adult-social-care-information>)
- 17 Adults per 100,000 population aged 18 and over that are assisted directly through social services assessed/care planned, funded support to live independently, plus those supported through organisations that receive social services grant funded service (NI 136), 2009/2010, Source: Information Centre for Health and Social Care (<http://www.ic.nhs.uk/statistics-and-data-collections/social-care/adult-social-care-information>)
- 18 Average weekly rate of delayed transfers of care from all NHS hospitals, both acute and non-acute, per 100,000 population aged over 18. A delayed transfer of care occurs when a patient is ready for transfer from a hospital bed, but is still occupying such a bed (NI 131), 2008/2009, Source: National Indicator Set data (<http://www.places.communities.gov.uk/latestnews.aspx>)
- 19 This is a composite measure using responses to questions from the Adult Social Care Survey covering eight domains (control, how people are treated, personal care, food and nutrition, safety, occupation, social participation and accommodation). Questions indicate whether the individual has unmet needs in any of the eight areas. The definition is identical to NI 127 'Self reported experience of social care users', 2010/2011, Source: Information Centre for Health and Social Care (<http://www.ic.nhs.uk/statistics-and-data-collections/social-care/adult-social-care-information>)
- 20 User reported measure of respect and dignity in their treatment (NI 128), 2009/2010, Source: Information Centre for Health and Social Care (<http://www.ic.nhs.uk/statistics-and-data-collections/social-care/adult-social-care-information>)
- 21 Percentage of carers receiving needs assessment or review and a specific carer's service, or advice and information (NI 135), 2009/2010, Source: Information Centre for Health and Social Care (<http://www.ic.nhs.uk/statistics-and-data-collections/social-care/adult-social-care-information>)

- 22 Percentage of children aged under 16 living in families in receipt of out of work benefits or tax credits where their reported income is less than 60% median income, 2009, Source: HM Revenue & Customs (http://www.hmrc.gov.uk/stats/personal-tax-credits/child_poverty.htm)
- 23 Percentage known to be eligible for free school meals, maintained nursery and primary schools, 2011, Source: Department for Education (<http://www.education.gov.uk/rsgateway/>)
- 24 Percentage known to be eligible for free school meals, state-funded secondary schools, 2011, Source: Department for Education (<http://www.education.gov.uk/rsgateway/>)
- 25 Infant deaths under 1 year of age per 1,000 live births, 2007-2009, Source: Compendium of Clinical and Health Indicators (<https://indicators.ic.nhs.uk/webview/>)
- 26 Infant deaths under 28 days of age per 1,000 live births, 2007-2009, Source: Compendium of Clinical and Health Indicators (<https://indicators.ic.nhs.uk/webview/>)
- 27 Stillbirths and infant deaths under 7 days of age per 1,000 total births, 2007-2009, Source: Compendium of Clinical and Health Indicators (<https://indicators.ic.nhs.uk/webview/>)
- 28 Percentage of live and still births under 2500 grams, 2009, Source: Office for National Statistics (<http://www.ons.gov.uk/>)
- 29 Immunisation rate for children age 1 who have received all 3 doses of DTaP/IPV/Hib vaccine i.e. immunised for diphtheria, tetanus, polio, pertussis and Hib, 2010/2011, Source: Information Centre for Health and Social Care (<http://www.ic.nhs.uk/statistics-and-data-collections/health-and-lifestyles/immunisation>)
- 30 Immunisation rate for children age 2 who have received Pneumococcal booster (PVC), 2010/2011, Source: Information Centre for Health and Social Care (<http://www.ic.nhs.uk/statistics-and-data-collections/health-and-lifestyles/immunisation>)
- 31 Immunisation rate for children age 2 who have received Hib/MenC booster, 2010/2011, Source: Information Centre for Health and Social Care (<http://www.ic.nhs.uk/statistics-and-data-collections/health-and-lifestyles/immunisation>)
- 32 Immunisation rate for children age 2 who have received first dose of MMR vaccine, 2010/2011, Source: Information Centre for Health and Social Care (<http://www.ic.nhs.uk/statistics-and-data-collections/health-and-lifestyles/immunisation>)
- 33 Immunisation rate for children aged 5 who have received all 4 doses of DTaP/IPV vaccine i.e. immunised for diphtheria, tetanus, polio, pertussis, 2010/2011, Source: Information Centre for Health and Social Care (<http://www.ic.nhs.uk/statistics-and-data-collections/health-and-lifestyles/immunisation>)
- 34 Immunisation rate for children age 5 who have received first and second dose of MMR vaccine, 2010/2011, Source: Information Centre for Health and Social Care (<http://www.ic.nhs.uk/statistics-and-data-collections/health-and-lifestyles/immunisation>)
- 35 Percentage of children accessing NHS dentistry in the last 2 years, March 2011, Source: Information Centre for Health and Social Care (<http://www.ic.nhs.uk/statistics-and-data-collections/primary-care/dentistry>)
- 36 Average number of decayed, missing or filled teeth in 5 year olds, 2007/2008, Source: Health Profiles, Association of Public Health Observatories (<http://www.apho.org.uk/default.aspx?RID=49802>)

37 Percentage of children aged 4-5 years with height and weight recorded who are obese, 2009/2010, Source: National Childhood Measurement Programme, Information Centre for Health and Social Care (<http://www.ic.nhs.uk/statistics-and-data-collections/health-and-lifestyles/obesity>)

38 Percentage of children aged 10-11 years with height and weight recorded who are obese, 2009/2010, Source: National Childhood Measurement Programme, Information Centre for Health and Social Care (<http://www.ic.nhs.uk/statistics-and-data-collections/health-and-lifestyles/obesity>)

39 Percentage of Year 1 to Year 13 pupils who spend at least 3 hours per week on high quality PE and school sport, 2009/2010, Source: Health Profiles, Association of Public Health Observatories (<http://www.apho.org.uk/default.aspx?RID=49802>)

40 Percentage of children aged 5-15 travelling to school by public transport, cycling or walking, or using some means other than car (including vans and taxis) or car share, 2009/2010, Source: Department for Transport (<http://www.dft.gov.uk/statistics>)

41 Percentage of children achieving a good level of development at the Early Years Foundation Stage. A good level of development is defined as children who achieve a score of 6 or more and 78 points or more in total across seven scales measuring Personal, Social and Emotional Development and Communication, Language and Literacy, 2010, Source: Early Years Foundation Stage Profile Results, Department for Education (<http://www.education.gov.uk/rsgateway/>)

42 Percentage of pupils achieving level 4 or above at Key Stage 2 in English and Mathematics in schools maintained by the Local Education Authority, at the end of the academic year, 2011, Source: Department for Education (<http://www.education.gov.uk/rsgateway/>)

43 Percentage of pupils achieving 5 or more GCSEs at grades A*-C (including English and Maths) or equivalent in schools maintained by the Local Education Authority at the end of the academic year, 2009/2010, Source: Health Profiles, Association of Public Health Observatories (<http://www.apho.org.uk/default.aspx?RID=49802>)

44 Percentage of half-days missed due to authorised and unauthorised absence at maintained secondary schools, 2009/2010, Source: Department for Education (<http://www.education.gov.uk/rsgateway/>)

45 Persistent absentees as a percentage of the total number of enrolments at maintained secondary schools. Persistent absentees are defined as having 64 or more sessions of absence (authorised and unauthorised) during the year, around 20 per cent overall absence rate, 2009/2010, Source: Department for Education (<http://www.education.gov.uk/rsgateway/>)

46 Percentage of children looked after aged under 16 at 31 March who had been looked after continuously for at least 2.5 years who were living in the same placement for at least 2 years, or are placed for adoption and their adoptive placement together with their previous placement together last for at least 2 years (NI 63), 2010, Source: Department for Education (<http://www.education.gov.uk/rsgateway/>)

47 Overall score for parental experience of services for disabled children (NI 54), 2009/2010, Source: Department for Education (<http://www.education.gov.uk/rsgateway/>)

48 Percentage of women who are smokers at the time of delivery, 2010/2011, Source: Department of Health
(http://www.dh.gov.uk/en/Publicationsandstatistics/Statistics/StatisticalWorkAreas/Statisticalpublichealth/DH_124185)

49 Percentage of mothers initiating breastfeeding within 48 hours of birth, 2010/2011, Source: Department of Health
(http://www.dh.gov.uk/en/Publicationsandstatistics/Statistics/StatisticalWorkAreas/Statisticalpublichealth/DH_124185)

50 Percentage of infants breastfed at 6-8 weeks after birth, 2010/2011, Source: Department of Health
(http://www.dh.gov.uk/en/Publicationsandstatistics/Statistics/StatisticalWorkAreas/Statisticalpublichealth/DH_124185)

51 Under 18 conception rate per 1,000 girls aged 15-17, 2009, Source: Department for Education
(<http://www.education.gov.uk/childrenandyoungpeople/healthandwellbeing/teenagepregnanc>)

52 Under 16 conception rate per 1,000 girls aged 13-15, 2006-2008, Source: Department for Education
(<http://www.education.gov.uk/childrenandyoungpeople/healthandwellbeing/teenagepregnanc>)

53 Percentage of NHS funded abortions under 10 weeks gestation, 2010, Source: Department of Health
(<http://www.dh.gov.uk/en/Publicationsandstatistics/Statistics/StatisticalWorkAreas/Statisticalpublichealth/index.htm>)

54 Percentage of abortions in women who have previously had an abortion (women aged under 25), 2010, Source: Department of Health
(<http://www.dh.gov.uk/en/Publicationsandstatistics/Statistics/StatisticalWorkAreas/Statisticalpublichealth/index.htm>)

55 Percentage of abortions in women who have previously had an abortion (all ages), 2010, Source: Department of Health
(<http://www.dh.gov.uk/en/Publicationsandstatistics/Statistics/StatisticalWorkAreas/Statisticalpublichealth/index.htm>)

56 Items of long acting reversible contraception (LARC) prescribed by GPs per 1,000 registered female population aged 15-44, 2009/2010, Source: Sexual Health Balanced Scorecard, Association of Public Health Observatories
(<http://www.apho.org.uk/sexualhealthbalancedscorecard>)

57 Percentage of people aged 15-24 screened for chlamydia during the 2010/2011 financial year, 2010/2011, Source: National Chlamydia Screening Programme
(<http://www.chlamydiascreening.nhs.uk/>)

58 Rate of new chlamydia diagnoses at genito-urinary medicine (GUM) clinics and through the National Chlamydia Screening Programme for people aged 15-24 per 100,000 population, 2010, Source: Health Protection Agency (HPA)
(<http://www.hpa.org.uk/Topics/InfectiousDiseases/InfectionsAZ/STIs/STIsAnnualDataTables/>)

59 Rate of new chlamydia diagnoses at genito-urinary medicine (GUM) clinics and through the National Chlamydia Screening Programme for people aged 25 and over per 100,000 population, 2010, Source: Health Protection Agency (HPA) (<http://www.hpa.org.uk/Topics/InfectiousDiseases/InfectionsAZ/STIs/STIsAnnualDataTables/>)

60 Rate of new gonorrhoea diagnoses at genito-urinary medicine (GUM) clinics per 100,000 population, 2010, Source: Health Protection Agency (HPA) (<http://www.hpa.org.uk/Topics/InfectiousDiseases/InfectionsAZ/STIs/STIsAnnualDataTables/>)

61 Rate of new syphilis diagnoses at genito-urinary medicine (GUM) clinics per 100,000 population, 2010, Source: Health Protection Agency (HPA) (<http://www.hpa.org.uk/Topics/InfectiousDiseases/InfectionsAZ/STIs/STIsAnnualDataTables/>)

62 Rate of new herpes diagnoses at genito-urinary medicine (GUM) clinics per 100,000 population, 2010, Source: Health Protection Agency (HPA) (<http://www.hpa.org.uk/Topics/InfectiousDiseases/InfectionsAZ/STIs/STIsAnnualDataTables/>)

63 Rate of new genital warts diagnoses at genito-urinary medicine (GUM) clinics per 100,000 population, 2010, Source: Health Protection Agency (HPA) (<http://www.hpa.org.uk/Topics/InfectiousDiseases/InfectionsAZ/STIs/STIsAnnualDataTables/>)

64 Prevalence rate of diagnosed HIV infection per 1,000 population aged 15-59, 2009, Source: Sexual Health Balanced Scorecard, Association of Public Health Observatories (<http://www.apho.org.uk/sexualhealthbalancedscorecard>)

65 Percentage of diagnosed HIV-infected adults (aged 15 years or more) who have a CD4 count of less than 200 cells per mm³ within 91 days of HIV diagnosis, 2009, Source: Sexual Health Balanced Scorecard, Association of Public Health Observatories (<http://www.apho.org.uk/sexualhealthbalancedscorecard>)

66 Percentage of population aged 16-64 qualified to NVQ level 3 equivalent or higher e.g. 2 or more A levels, advanced GNVQ, NVQ 3, 2 or more higher or advanced higher national qualifications (Scotland) or equivalent, Jan 2010 - Dec 2010, Source: ONS Annual Population Survey, NOMIS (<http://www.nomisweb.co.uk/>)

67 Percentage of population aged 16-64 qualified to NVQ level 4 equivalent or higher e.g. HND, Degree and Higher Degree level qualifications or equivalent, Jan 2010 - Dec 2010, Source: ONS Annual Population Survey, NOMIS (<http://www.nomisweb.co.uk/>)

68 Percentage of young people not in education, employment or training at 16 and 18 years of age, 2010, Source: Department for Education (<http://www.education.gov.uk/rsgateway/>)

69 Percentage of people studying in a local authority at age 19 who reach the level 3 threshold. A learner is defined as having reached the level 3 threshold if they have achieved the equivalent of 4 AS/2 A-levels, 2009, Source: Department for Education (<http://www.education.gov.uk/rsgateway/>)

70 Percentage of the working age population (aged 16-64) in employment (NI 151), Jan 2010 - Dec 2010, Source: ONS Annual Population Survey, NOMIS (<http://www.nomisweb.co.uk/>)

71 Percentage of the working age population (aged 16-64) who are self-employed, Jan 2010 - Dec 2010, Source: ONS Annual Population Survey, NOMIS (<http://www.nomisweb.co.uk/>)

72 Percentage of the working age population (aged 16-64) who are unemployed, Jan 2010 - Dec 2010, Source: ONS Annual Population Survey, NOMIS (<http://www.nomisweb.co.uk/>)

73 Percentage of people aged 16-64 claiming job seekers allowance, 2010/2011, Source: ONS claimant count, NOMIS (<http://www.nomisweb.co.uk/>)

74 Percentage of people aged 18-24 claiming job seekers allowance, 2010/2011, Source: ONS claimant count, NOMIS (<http://www.nomisweb.co.uk/>)

75 Percentage of the working age population (aged 16-64) on key out-of-work benefits, February 2011, Source: ONS claimant count, NOMIS (<http://www.nomisweb.co.uk/>)

76 Percentage of working age population (aged 16-64) who are claiming disability benefit, February 2011, Source: ONS claimant count, NOMIS (<http://www.nomisweb.co.uk/>)

77 Percentage of adults receiving secondary mental health services known to be in settled accommodation at the time of their most recent assessment (NI 149), 2009/2010, Source: Information Centre for Health and Social Care (<http://www.ic.nhs.uk/statistics-and-data-collections/social-care/adult-social-care-information>). NB There are significant concerns that the data for Croydon in this indicator is incorrect due to a data processing issue.

78 Percentage of adults receiving secondary mental health services in employment (NI 150), 2009/2010, Source: Information Centre for Health and Social Care (<http://www.ic.nhs.uk/statistics-and-data-collections/social-care/adult-social-care-information>)

79 Percentage of patients aged over 18 on GP registers diagnosed with a learning disability, 2009/2010, Source: Quality and Outcomes Framework, Information Centre for Health and Social Care (<http://www.ic.nhs.uk/statistics-and-data-collections/audits-and-performance/the-quality-and-outcomes-framework>)

80 Percentage of adults with learning disabilities known to Councils with Adult Social Services Responsibilities (CASSRs) in settled accommodation (NI 145), 2009/2010, Source: National Adult Social Care Intelligence Service (NASCIS), Information Centre for Health and Social Care (<https://nascis.ic.nhs.uk/>)

81 Percentage of adults with learning disabilities in employment (NI 146), 2009/2010, Source: National Adult Social Care Intelligence Service (NASCIS), Information Centre for Health and Social Care (<https://nascis.ic.nhs.uk/>)

82 Percentage of older people (aged 60 and over) living in income deprived households (Indices of Deprivation), 2010, Source: Department of Communities and Local Government, Indices of Deprivation (<http://www.communities.gov.uk/publications/corporate/statistics/indices2010>)

83 Percentage of people over 65 satisfied with both home and neighbourhood (NI 138), 2008, Source: Place Survey (<http://www.places.communities.gov.uk/latestnews.aspx>)

84 Percentage of people aged 65 and over immunised against influenza, 2010/2011, Source: Information Centre for Health and Social Care (<http://www.ic.nhs.uk/statistics-and-data-collections/health-and-lifestyles/immunisation>)

85 Emergency hospital admissions of older people for fractured neck of femur, 2009/2010, Source: Health Profiles, Association of Public Health Observatories (<http://www.apho.org.uk/default.aspx?RID=49802>)

- 86 Council-supported permanent admissions to nursing and residential care during the year, rate per 1,000 population., 2009/2010, Source: ASC-CAR, National Adult Social Care Intelligence Service (NASCIS), Information Centre for Health and Social Care (<https://nascis.ic.nhs.uk/>)
- 87 Percentage of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services (NI 125), 2009/2010, Source: Information Centre for Health and Social Care (<http://www.ic.nhs.uk/statistics-and-data-collections/social-care/adult-social-care-information>)
- 88 Percentage of people who think that older people in their local area get the help and support they need to continue to live at home for as long as they want to (NI 139), 2008, Source: Place Survey (<http://www.places.communities.gov.uk/latestnews.aspx>)
- 89 Age standardised mortality rate per 100,000 population for all causes, all ages, males, 2007-2009, Source: Compendium of Clinical and Health Indicators (<https://indicators.ic.nhs.uk/webview/>)
- 90 Age standardised mortality rate per 100,000 population for all causes, all ages, females, 2007-2009, Source: Compendium of Clinical and Health Indicators (<https://indicators.ic.nhs.uk/webview/>)
- 91 Life expectancy at birth in years (males), 2007-2009, Source: Office for National Statistics (<http://www.ons.gov.uk/>)
- 92 Life expectancy at birth in years (females), 2007-2009, Source: Office for National Statistics (<http://www.ons.gov.uk/>)
- 93 Slope index of inequality for life expectancy in years (males). The slope index measures the difference between the most and least deprived areas with a local authority, 2005-2009, Source: Association of Public Health Observatories (<http://www.apho.org.uk/>)
- 94 Slope index of inequality for life expectancy in years (females). The slope index measures the difference between the most and least deprived areas with a local authority, 2005-2009, Source: Association of Public Health Observatories (<http://www.apho.org.uk/>)
- 95 Age standardised mortality rate per 100,000 population for suicide and injury of undetermined intent, persons, all ages, 2007-2009, Source: Compendium of Clinical and Health Indicators (<https://indicators.ic.nhs.uk/webview/>)
- 96 Age standardised mortality rate per 100,000 population for causes considered amenable to health care. This indicator measures mortality for people aged under 75 for selected diseases including coronary heart disease, stroke, pneumonia, early neonatal deaths, hypertensive disease, chronic rheumatic heart disease, leukaemia (ages under 45), abdominal hernia, diabetes (ages under 50), epilepsy, all respiratory diseases (ages 1-14), influenza, asthma (ages under 45), peptic ulcer, congenital cardiovascular anomalies, misadventures to patients during surgical and medical care. For a full definition, see the Compendium of Clinical and Health Indicators website (www.nchod.nhs.uk), 2007-2009, Source: Compendium of Clinical and Health Indicators (<https://indicators.ic.nhs.uk/webview/>)

97 Age standardised mortality rate per 100,000 population for causes considered amenable to health care excluding coronary heart disease. This indicator measures mortality for people aged under 75 for selected diseases including stroke, pneumonia, early neonatal deaths, hypertensive disease, chronic rheumatic heart disease, leukaemia (ages under 45), abdominal hernia, diabetes (ages under 50), epilepsy, all respiratory diseases (ages 1-14), influenza, asthma (ages under 45), peptic ulcer, congenital cardiovascular anomalies, misadventures to patients during surgical and medical care. For a full definition, see the Compendium of Clinical and Health Indicators website (www.nchod.nhs.uk), 2007-2009, Source: Compendium of Clinical and Health Indicators (<https://indicators.ic.nhs.uk/webview/>)

98 Spend on cancers and tumours, £ per weighted head of population. The Unified Weighted Population is the PCT responsible population adjusted for the age structure of the population, its additional need over and above that accounted for by age, and the unavoidable geographical variations in the costs of providing services, 2009/2010, Source: Programme budgeting data, Department of Health (<http://www.dh.gov.uk/en/Managingyourorganisation/Financeandplanning/Programmebudgeting/index.htm>)

99 Percentage of women aged 53-70 screened in the last 3 years, March 2010, Source: Information Centre for Health and Social Care (<http://www.ic.nhs.uk/statistics-and-data-collections/screening>)

100 Percentage of women aged 25-64 screened in the last 5 years, 2009/2010, Source: Information Centre for Health and Social Care (<http://www.ic.nhs.uk/statistics-and-data-collections/screening>)

101 Age standardised registration rate per 100,000 population for all cancers, 2006-2008, Source: Compendium of Clinical and Health Indicators (<https://indicators.ic.nhs.uk/webview/>)

102 Age standardised mortality rate per 100,000 population for all cancers, persons, ages under 75, 2007-2009, Source: Compendium of Clinical and Health Indicators (<https://indicators.ic.nhs.uk/webview/>)

103 Age standardised mortality rate per 100,000 population for all cancers, persons, all ages, 2007-2009, Source: Compendium of Clinical and Health Indicators (<https://indicators.ic.nhs.uk/webview/>)

104 Age standardised registration rate per 100,000 population for oesophageal cancer, persons, all ages, 2006-2008, Source: Compendium of Clinical and Health Indicators (<https://indicators.ic.nhs.uk/webview/>)

105 Age standardised mortality rate per 100,000 population for oesophageal cancer, all ages, 2007-2009, Source: Compendium of Clinical and Health Indicators (<https://indicators.ic.nhs.uk/webview/>)

106 Age standardised registration rate per 100,000 population for stomach cancer, persons, all ages, 2006-2008, Source: Compendium of Clinical and Health Indicators (<https://indicators.ic.nhs.uk/webview/>)

107 Age standardised mortality rate per 100,000 population for stomach cancer, all ages, 2007-2009, Source: Compendium of Clinical and Health Indicators (<https://indicators.ic.nhs.uk/webview/>)

- 108 Age standardised registration rate per 100,000 population for colorectal cancer, all ages, 2006-2008, Source: Compendium of Clinical and Health Indicators
(<https://indicators.ic.nhs.uk/webview/>)
- 109 Age standardised mortality rate per 100,000 population for colorectal cancer, persons, all ages, 2007-2009, Source: Compendium of Clinical and Health Indicators
(<https://indicators.ic.nhs.uk/webview/>)
- 110 Age standardised registration rate per 100,000 population for lung cancer, persons, all ages, 2006-2008, Source: Compendium of Clinical and Health Indicators
(<https://indicators.ic.nhs.uk/webview/>)
- 111 Age standardised mortality rate per 100,000 population for lung cancer, all ages, 2007-2009, Source: Compendium of Clinical and Health Indicators
(<https://indicators.ic.nhs.uk/webview/>)
- 112 Age standardised registration rate per 100,000 population for all skin cancers, persons, all ages, 2006-2008, Source: Compendium of Clinical and Health Indicators
(<https://indicators.ic.nhs.uk/webview/>)
- 113 Age standardised mortality rate per 100,000 population for malignant melanoma, persons, all ages, 2007-2009, Source: Compendium of Clinical and Health Indicators
(<https://indicators.ic.nhs.uk/webview/>)
- 114 Age standardised registration rate per 100,000 female population for breast cancer, all ages, 2006-2008, Source: Compendium of Clinical and Health Indicators
(<https://indicators.ic.nhs.uk/webview/>)
- 115 Age standardised mortality rate per 100,000 population for breast cancer, females, all ages, 2007-2009, Source: Compendium of Clinical and Health Indicators
(<https://indicators.ic.nhs.uk/webview/>)
- 116 Age standardised registration rate per 100,000 female population for cervical cancer, all ages, 2006-2008, Source: Compendium of Clinical and Health Indicators
(<https://indicators.ic.nhs.uk/webview/>)
- 117 Age standardised mortality rate per 100,000 population for cervical cancer, females, all ages, 2007-2009, Source: Compendium of Clinical and Health Indicators
(<https://indicators.ic.nhs.uk/webview/>)
- 118 Age standardised registration rate per 100,000 male population for prostate cancer, all ages, 2006-2008, Source: Compendium of Clinical and Health Indicators
(<https://indicators.ic.nhs.uk/webview/>)
- 119 Age standardised mortality rate per 100,000 population for prostate cancer, males, all ages, 2007-2009, Source: Compendium of Clinical and Health Indicators
(<https://indicators.ic.nhs.uk/webview/>)
- 120 Age standardised registration rate per 100,000 population for bladder cancer, all ages, 2006-2008, Source: Compendium of Clinical and Health Indicators
(<https://indicators.ic.nhs.uk/webview/>)
- 121 Age standardised mortality rate per 100,000 population for bladder cancer, persons, all ages, 2007-2009, Source: Compendium of Clinical and Health Indicators
(<https://indicators.ic.nhs.uk/webview/>)

122 Age standardised mortality rate per 100,000 population for leukaemia, persons, all ages, 2007-2009, Source: Compendium of Clinical and Health Indicators (<https://indicators.ic.nhs.uk/webview/>)

123 Spend on infectious diseases, £ per weighted head of population. The Unified Weighted Population is the PCT responsible population adjusted for the age structure of the population, its additional need over and above that accounted for by age, and the unavoidable geographical variations in the costs of providing services, 2009/2010, Source: Programme budgeting data, Department of Health (<http://www.dh.gov.uk/en/Managingyourorganisation/Financeandplanning/Programmebudgeting/index.htm>)

124 Age standardised rate of food poisoning cases reported to the Health Protection Agency through formal notification and cases known to the Local Authorities and believed by the Proper Officer to be food poisoning per 100,000 population, all ages, all persons, 2010, Source: Health Protection Profiles, Health Protection Agency (HPA) (<http://profiles.hpa.org.uk/>)

125 Age standardised rate of laboratory confirmed cases of gastrointestinal disease per 100,000 population, all ages, all persons, 2010, Source: Health Protection Profiles, Health Protection Agency (HPA) (<http://profiles.hpa.org.uk/>)

126 Incidence of tuberculosis rate per 100,000 population, 2007-2009, Source: Health Profiles, Association of Public Health Observatories (<http://www.apho.org.uk/default.aspx?RID=49802>)

127 Age standardised mortality per 100,000 population for infectious and parasitic disease, persons, all ages, 2007-2009, Source: Compendium of Clinical and Health Indicators (<https://indicators.ic.nhs.uk/webview/>)

128 Percentage of people with a long-term condition who "had enough support from local services or organisations to help manage their long-term health condition(s)" (NI 124), 2010/2011, Source: GP Patient Survey, Department of Health (<http://www.gp-patient.co.uk/results>)

129 Spend on endocrine, nutritional and metabolic problems, £ per weighted head of population. The Unified Weighted Population is the PCT responsible population adjusted for the age structure of the population, its additional need over and above that accounted for by age, and the unavoidable geographical variations in the costs of providing services, 2009/2010, Source: Programme budgeting data, Department of Health (<http://www.dh.gov.uk/en/Managingyourorganisation/Financeandplanning/Programmebudgeting/index.htm>)

130 Percentage of patients on GP registers aged 17 and over diagnosed with diabetes, 2009/2010, Source: Quality and Outcomes Framework, Information Centre for Health and Social Care (<http://www.ic.nhs.uk/statistics-and-data-collections/audits-and-performance/the-quality-and-outcomes-framework>)

131 Percentage of patients with diabetes whose last HbA1c reading (taken in the last 15 months) was less than 7, 2009/2010, Source: Quality and Outcomes Framework, Information Centre for Health and Social Care (<http://www.ic.nhs.uk/statistics-and-data-collections/audits-and-performance/the-quality-and-outcomes-framework>)

- 132 Age standardised rate of admissions for diabetic ketoacidosis and coma per 100,000 population, 2008/2009, Source: Compendium of Clinical and Health Indicators (<https://indicators.ic.nhs.uk/webview/>)
- 133 Age standardised mortality rate per 100,000 population for diabetes, persons, all ages, 2007-2009, Source: Compendium of Clinical and Health Indicators (<https://indicators.ic.nhs.uk/webview/>)
- 134 Spend on problems of circulation, £ per weighted head of population. The Unified Weighted Population is the PCT responsible population adjusted for the age structure of the population, its additional need over and above that accounted for by age, and the unavoidable geographical variations in the costs of providing services, 2009/2010, Source: Programme budgeting data, Department of Health (<http://www.dh.gov.uk/en/Managingyourorganisation/Financeandplanning/Programmebudgeting/index.htm>)
- 135 Age standardised mortality rate per 100,000 population for all circulatory diseases, persons, ages under 75, 2007-2009, Source: Compendium of Clinical and Health Indicators (<https://indicators.ic.nhs.uk/webview/>)
- 136 Percentage of patients on GP registers aged 16 and over diagnosed with coronary heart disease, 2009/2010, Source: Quality and Outcomes Framework, Information Centre for Health and Social Care (<http://www.ic.nhs.uk/statistics-and-data-collections/audits-and-performance/the-quality-and-outcomes-framework>)
- 137 Age standardised mortality rate per 100,000 population for coronary heart disease, persons, all ages, 2007-2009, Source: Compendium of Clinical and Health Indicators (<https://indicators.ic.nhs.uk/webview/>)
- 138 Percentage of patients on GP registers diagnosed with stroke or transient ischemic attack for ages 16 and over, 2009/2010, Source: Quality and Outcomes Framework, Information Centre for Health and Social Care (<http://www.ic.nhs.uk/statistics-and-data-collections/audits-and-performance/the-quality-and-outcomes-framework>)
- 139 Emergency hospital admissions for stroke, age standardised rate per 100,000 population, persons, 2008/2009, Source: Compendium of Clinical and Health Indicators (<https://indicators.ic.nhs.uk/webview/>)
- 140 Emergency readmissions to hospital within 28 days of discharge for stroke, age standardised percent, persons, 2008/2009, Source: Compendium of Clinical and Health Indicators (<https://indicators.ic.nhs.uk/webview/>)
- 141 Age standardised mortality rate per 100,000 population for stroke, ages under 75, 2007-2009, Source: Compendium of Clinical and Health Indicators (<https://indicators.ic.nhs.uk/webview/>)
- 142 Age standardised mortality rate per 100,000 population for stroke, all ages, 2007-2009, Source: Compendium of Clinical and Health Indicators (<https://indicators.ic.nhs.uk/webview/>)
- 143 Spend on problems of the respiratory system, £ per weighted head of population. The Unified Weighted Population is the PCT responsible population adjusted for the age structure of the population, its additional need over and above that accounted for by age, and the unavoidable geographical variations in the costs of providing services, 2009/2010, Source: Programme budgeting data, Department of Health

(<http://www.dh.gov.uk/en/Managingyourorganisation/Financeandplanning/Programmebudgeting/index.htm>)

144 Estimated percentage prevalence of chronic obstructive pulmonary disease (diagnosed and undiagnosed), aged 16 and over, 2010, Source: Eastern Region Public Health Observatory (<http://www.apho.org.uk/resource/view.aspx?RID=48308>)

145 Patients on GP registers diagnosed with chronic obstructive pulmonary disease (COPD) as a percentage of the estimated population with COPD, ages 16 and over, 2009/2010, Source: Quality and Outcomes Framework, Information Centre for Health and Social Care and Eastern Region Public Health Observatory (<http://www.ic.nhs.uk/> and <http://www.apho.org.uk/resource/view.aspx?RID=48308>)

146 Age standardised mortality rate per 100,000 population for bronchitis, emphysema and other chronic obstructive pulmonary disease, persons, ages under 75, 2007-2009, Source: Compendium of Clinical and Health Indicators (<https://indicators.ic.nhs.uk/webview/>)

147 Age standardised mortality rate per 100,000 population for bronchitis, emphysema and other chronic obstructive pulmonary disease, all ages, 2007-2009, Source: Compendium of Clinical and Health Indicators (<https://indicators.ic.nhs.uk/webview/>)

148 Percentage of patients on GP registers diagnosed with asthma, all ages, 2009/2010, Source: Quality and Outcomes Framework, Information Centre for Health and Social Care (<http://www.ic.nhs.uk/statistics-and-data-collections/audits-and-performance/the-quality-and-outcomes-framework>)

149 Age standardised rate of admissions for children for asthma per 100,000 children aged under 16, 2008/2009, Source: Compendium of Clinical and Health Indicators (<https://indicators.ic.nhs.uk/webview/>)

150 Age standardised mortality rate per 100,000 population for asthma, persons, all ages, 2007-2009, Source: Compendium of Clinical and Health Indicators (<https://indicators.ic.nhs.uk/webview/>)

151 Spend on mental health disorders, £ per weighted head of population. The Unified Weighted Population is the PCT responsible population adjusted for the age structure of the population, its additional need over and above that accounted for by age, and the unavoidable geographical variations in the costs of providing services, 2009/2010, Source: Programme budgeting data, Department of Health (<http://www.dh.gov.uk/en/Managingyourorganisation/Financeandplanning/Programmebudgeting/index.htm>)

152 Percentage of patients on GP registers diagnosed with dementia, all ages, 2009/2010, Source: Quality and Outcomes Framework, Information Centre for Health and Social Care (<http://www.ic.nhs.uk/statistics-and-data-collections/audits-and-performance/the-quality-and-outcomes-framework>)

153 Percentage of patients on GP registers diagnosed with depression, ages 18 and over, 2009/2010, Source: Quality and Outcomes Framework, Information Centre for Health and Social Care (<http://www.ic.nhs.uk/statistics-and-data-collections/audits-and-performance/the-quality-and-outcomes-framework>)

154 GP recorded prevalence of schizophrenia, bipolar disorder and other psychoses (all ages), 2009/2010, Source: Quality and Outcomes Framework, Information Centre for Health and Social Care (<http://www.ic.nhs.uk/statistics-and-data-collections/audits-and-performance/the-quality-and-outcomes-framework>)

155 Emergency hospital admissions for self-harm, age standardised rate per 100,000 population, persons, 2009/2010, Source: Health Profiles, Association of Public Health Observatories (<http://www.apho.org.uk/default.aspx?RID=49802>)

156 Estimated smoking prevalence as a percentage of the adult resident population using data from the Integrated Household Survey, 2009/2010, Source: Association of Public Health Observatories (<http://www.apho.org.uk/>)

157 Self-reported 4-week smoking quitters per 100,000 adult population, 2010/2011, Source: Information Centre for Health and Social Care (<http://www.ic.nhs.uk/statistics-and-data-collections/health-and-lifestyles/nhs-stop-smoking-services>)

158 Deaths attributable to smoking per 100,000 population aged over 35, 2007-2009, Source: Health Profiles, Association of Public Health Observatories (<http://www.apho.org.uk/default.aspx?RID=49802>)

159 Recorded crime attributable to alcohol: Persons, all ages, crude rate per 1000 population, 2010/2011, Source: Local Alcohol Profiles for England (<http://www.lape.org.uk/>)

160 Alcohol related harm admissions, age standardised rate per 100,000 population (NI 39), 2009/2010, Source: Local Alcohol Profiles for England (<http://www.lape.org.uk/>)

161 Age standardised mortality rate per 100,000 population for alcohol attributable mortality, males, all ages, 2009, Source: Local Alcohol Profiles for England (<http://www.lape.org.uk/>)

162 Age standardised mortality rate per 100,000 population for alcohol attributable mortality, females, all ages, 2009, Source: Local Alcohol Profiles for England (<http://www.lape.org.uk/>)

163 Drug offences recorded per 1,000 population, 2010/2011, Source: Home Office and Office for National Statistics Mid-Year Population Estimates (<http://www.homeoffice.gov.uk/publications/science-research-statistics/research-statistics/crime-research/local-police-recorded-crime/>)

164 Estimated percentage prevalence of adults who are obese, 2006-2008, Source: Health Profiles, Association of Public Health Observatories (<http://www.apho.org.uk/default.aspx?RID=49802>)

165 Participation in moderate intensity sport and active recreation on 20 or more days in the previous 4 weeks, Oct 2008 - Oct 2010, Source: Health Profiles, Association of Public Health Observatories (<http://www.apho.org.uk/default.aspx?RID=49802>)

166 Percentage of adults estimated to eat at least five portions of fruit and vegetables a day, 2006-2008, Source: Health Profiles, Association of Public Health Observatories (<http://www.apho.org.uk/default.aspx?RID=49802>)

167 Percentage of all deaths that occur at home (NI 129), 2008, Source: National Indicator Set data (<http://www.places.communities.gov.uk/latestnews.aspx>)

168 Percentage of people rating it easy to get through to the surgery on the phone (in the past 6 months) (unweighted data), April 2010 - March 2011, Source: GP Patient Survey, Department of Health (<http://www.gp-patient.co.uk/results>)

- 169 Percentage of people satisfied with GP practice opening hours (unweighted data), April 2010 - March 2011, Source: GP Patient Survey, Department of Health (<http://www.gp-patient.co.uk/results>)
- 170 Percentage of people able to get an appointment with a GP fairly quickly (in the past 6 months) (unweighted data), April 2010 - March 2011, Source: GP Patient Survey, Department of Health (<http://www.gp-patient.co.uk/results>)
- 171 Percentage of people able to book ahead for an appointment with a GP (in the past 6 months) (unweighted data), April 2010 - March 2011, Source: GP Patient Survey, Department of Health (<http://www.gp-patient.co.uk/results>)
- 172 Percentage of people able to see preferred doctor always or a lot of the time (unweighted data), April 2010 - March 2011, Source: GP Patient Survey, Department of Health (<http://www.gp-patient.co.uk/results>)
- 173 All cause elective inpatient hospital admissions plus daycases, age-sex standardised rate per 1,000 population, 2009/2010, Source: NHS Comparators (<http://www.ic.nhs.uk/nhscomparators>)
- 174 All cause emergency hospital admissions, age-sex standardised rate per 1,000 population, 2009/2010, Source: NHS Comparators (<http://www.ic.nhs.uk/nhscomparators>)
- 175 Percentage of emergency admission to any hospital in England occurring within 28 days of the previous discharge from hospital, 2009/2010, Source: NHS Comparators (<http://www.ic.nhs.uk/nhscomparators>)
- 176 Emergency admissions for 19 ambulatory care sensitive conditions, age-sex standardised rate per 1,000 population. These conditions have been identified as ones where community care can avoid the need for hospitalisation, 2009/2010, Source: NHS Comparators (<http://www.ic.nhs.uk/nhscomparators>)
- 177 Spend on dental problems, £ per weighted head of population. The Unified Weighted Population is the PCT responsible population adjusted for the age structure of the population, its additional need over and above that accounted for by age, and the unavoidable geographical variations in the costs of providing services, 2009/2010, Source: Programme budgeting data, Department of Health (<http://www.dh.gov.uk/en/Managingyourorganisation/Financeandplanning/Programmebudgeting/index.htm>)
- 178 Percentage of adults accessing NHS dentistry in the last 2 years, March 2011, Source: Information Centre for Health and Social Care (<http://www.ic.nhs.uk/statistics-and-data-collections/primary-care/dentist>)

