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DATE: 17 July 2014

To: Members of the
HEALTH AND WELLBEING BOARD

Councillor Peter Fortune (Chairman)
Councillor David Jefferys (Vice-Chairman) and Councillor Diane Smith (Vice-Chairman)
Councillors Ruth Bennett, Mary Cooke, Ian Dunn, Judi Ellis, Robert Evans, William Huntington-Thresher, Terence Nathan and Angela Page

London Borough of Bromley Officers:

Dr Nada Lemic	Director of Public Health
Terry Parkin	Executive Director: Education, Care & Health Services (Statutory DASS and DCS)

Clinical Commissioning Group:

Dr Angela Bhan	Chief Officer - Consultant in Public Health
Dr Andrew Parson	Clinical Chairman

Bromley Voluntary Sector:

Linda Gabriel	Healthwatch Bromley
Sue Southon	Chairman, Community Links Bromley

A meeting of the Health and Wellbeing Board will be held at Bromley Civic Centre on **THURSDAY 24 JULY 2014 AT 1.30 PM**

MARK BOWEN
Director of Corporate Services

Copies of the documents referred to below can be obtained from www.bromley.gov.uk/meetings

AGENDA

1 APOLOGIES FOR ABSENCE

2 MINUTES OF THE MEETING HELD ON 20TH MARCH 2014 AND MATTERS ARISING (Pages 1 - 8)

3 QUESTIONS BY COUNCILLORS AND MEMBERS OF THE PUBLIC ATTENDING THE MEETING

In accordance with the Council's Constitution, questions to this Committee must be received in writing 4 working days before the date of the meeting. Therefore please ensure questions are received by the Democratic Services Team by 5pm on Friday 18th July 2014.

4 PHARMACEUTICAL NEEDS ASSESSMENT 2015-18 (Pages 9 - 14)

5 SOUTH EAST LONDON COMMISSIONING STRATEGY 2014-2019 (Pages 15 - 26)

6 2013/14 JSNA UPDATE (Pages 27 - 42)

7 HEALTH AND WELLBEING STRATEGY PRIORITIES AND THEIR DELIVERY (Pages 43 - 48)

8 HEALTH AND WELLBEING BOARD MATTERS ARISING AND WORK PROGRAMME (Pages 49 - 58)

9 ANY OTHER BUSINESS

10 DATE OF NEXT MEETING

The next scheduled meeting is on Thursday 2nd October 2014.

HEALTH AND WELLBEING BOARD

Minutes of the meeting held at 1.30 pm on 20 March 2014

Present:

Councillor Peter Fortune (Chairman)
Councillor David Jefferys (Vice-Chairman) and Councillor Diane Smith (Vice-Chairman)
Councillors Reg Adams, Ruth Bennett, Judi Ellis, Robert Evans, Peter Fookes, Ellie Harmer, William Huntington-Thresher and Charles Rideout

Dr Nada Lemic (Director of Public Health) and Terry Parkin (Executive Director: Education, Care & Health Services (Statutory DASS and DCS))
Dr Angela Bhan (Chief Officer - Consultant in Public Health) and Dr Andrew Parson (Clinical Chairman)
Linda Gabriel (Healthwatch Bromley) and Sue Southon (Chairman, Community Links Bromley)

Also Present:

Councillor Pauline Tunnicliffe

57 Apologies for Absence

All Members were present.

58 Minutes of Last Meeting and Matters Arising

Councillor Fookes asked for an update on the "Dementia Friendly Authority". A paper on this had been circulated at the meeting.

RESOLVED that the minutes of the meeting held on 30th January 2014 be approved.

59 Questions by Councillors and Members of the Public Attending the Meeting

3 Questions were received from Mrs Sue Sulis and one from Mrs Rosemary Cantwell. The questions and answers are appended to these minutes at appendix A.

60 Questions of the Health and Wellbeing Board Information Briefing

No questions were received on the HWB Information Briefing.

61 Winterbourne View Update

The Board received the scheduled update on Winterbourne View. Although nationally it had proved hard to reduce the numbers of the most challenging individuals from a hospital setting. However, officers were confident that in Bromley the very small numbers in placements locally were placed for a fixed period in a facility as close to their home address as possible, and reviewed regularly, and that they were continually monitored to meet the good practice guidelines.

The report also set out the In Depth Review process which came from the Winterbourne View Joint Improvement Programme.

RESOLVED that the report is noted.

62 Better Care Fund

Officers submitted a report on the position with the Better Care Fund (BCF). The two-year local plan was submitted to NHS England on 14th February 2014 for ratification as part of the CCGs Strategic and Operational Plans.

The Board considered the latest update on agreeing the final submission due to go to NHS England by 4th April 2014.

NHS England had provided feedback on specific points the CCG and Bromley needed to work on.

Dr Bhan outlined the various planning requirements for the CCG; the 5 year plan which was due for completion by 30 June, Bromley's 2 year operating plan due by 4th April and the Better Care Fund also due for submission on 4th April. In addition Bromley was refreshing its 5 year strategic plan by 4th April. She explained that there needed to be a sensible and realistic balance of priorities to ensure the right services were put in place to reduce the pressure on the Borough and Social care.

Councillor Jefferys raised concern that one of the recommendations required the Board to "champion" the local plan in the community but given the tight timescales wondered if this would be possible.

Officers explained that in terms of consultation the existing channels were used and discussions with various groups were ongoing.

Dr Bhan explained that there would be a lot of engagement from the "bottom up" and engagement with various agencies such as Healthwatch Bromley. Feedback on the public/patient feedback was one of the priorities and engagement with people with various chronic conditions.

The Portfolio Holder was happy to delegate the responsibility to the Board Chairman, Cllr. Fortune. However he raised concerns regarding the tight timescale. He was also concerned that it was clear that the CCG Board had yet to agree the plan and wondered what would happen if they did not agree.

Officers reported that they were in regular contact with the CCG so this should not be an issue but if there difficulties then Bromley would accept the assistance offered by NHS London to mediate.

The Chairman assured the board that he would keep them informed of developments.

RESOLVED that:

1. **The current progress with the Better Care Fund Local Plan is noted.**

2. **It is agreed authority be delegated to the Chairman of the Board to sign off the Local Plan final submission to NHS England in consultation with both the Local Authority and the CCG;**

3. **It is agreed the Local Plan is championed in the community and the positive communication of the Plan to respective colleagues, providers and service users is supported.**

63 Bromley CCG Two Year Plan

Officers submitted a report outlining the process for developing, and the key messages from, Bromley CCG's 5 year Strategic Plan and 2 year Operating Plan. It represented a refresh of the existing Strategic Plan, based on the Joint Strategic Needs Assessment and Health and Wellbeing Strategy, framed within the context of current Operating Framework requirements. It included the development of the Better Care Fund, financial forecasts and the QIPP plan. The final Operating Plan would be submitted by 4 April. The Strategic Plan would be submitted as part of a SE London Strategic Plan during June.

This presentation was drawn from a draft Integrated Plan which was considered by the CCG Governing Body on 13 March. It would form the basis of the CCG's final Operating Plan submission on 4 April, subject to finalisation of provider contracts, financial risk issues and the Better Care Fund Plan. The Strategic Plan would form part of the SE London Strategic Plan, which was due for completion in June. The draft Integrated Plan was available on the CCG website as part of the Governing Body papers for 13 March 2014.

Officers highlighted the Quality Innovation and Productivity Plan (QUIPP). They noted that part of the QUIPP was looking at a way of

reducing GP referrals for certain procedures such as grommets and tonsillectomies. It also aimed to encourage care of the "whole" person and encourage services that would support people and reduce the need for hospital admissions. For this reason it was very important that GP practices were involved. However it was noted that the GP's would be unable to undertake this alone so the ProMISE team would also be used. The purpose was to predict problems before they occurred. This element of work would also involve social care.

Members raised concerns that that there were staffing issues. Dr Bhan explained that the CCG was aware of this. At present a number of agency staff were being used where it had not been possible to recruit permanent staff.

In relation to equipment some Board members were concerned that some equipment was not recovered. Officers explained that it was not cost effective to recover lower value items. It was recognised that it was reliant on people advising they had equipment to be recovered.

In relation to the JSNA members noted the high incidence of certain diseases. These would be identified through health checks. It was noted that the prevalence of hypertension was reducing but the numbers of people dying of heart disease was still too high. The slides represented the national figures and Bromley's detection rate was better. It was recognised that things would take time to improve and trends would need to be observed over time. With regards to Mental Health provision it was noted that the capacity at Green Parks House had seasonal variations and concerns were raised that these variations would still be met if there was a shift of resources.

Dr Bhan clarified the position with Green Parks House that, although there were seasonal peaks, only 70% of beds were occupied by Bromley and 30% by other boroughs. The CCG wanted other boroughs to provide their own beds. The commissioning arrangements needed to be changed to overcome the beds shortages. Other boroughs would only be allowed to use the bed if was free and not needed for a Bromley patient.

RESOLVED that the report is noted.

64 Pharmaceutical Needs Assessment

The Pharmaceutical Needs Assessment (PNA) for Bromley was the formal document of the needs for pharmaceutical services in the area intended to identify what was needed at a local level to guide the current and future commissioning of pharmaceutical services that could be delivered by community pharmacies and other providers.

The Health and Wellbeing Board (HWB) had a statutory responsibility to publish a new PNA by 1st April 2015. Since 1st April 2013, every

Health and Wellbeing Board (HWB) in England had a statutory responsibility to publish and keep up to date statements ("Supplementary Statements") of any changes in pharmaceutical services of the population in its area. The current PNA had been updated and Supplementary Statements were now required to be published. A process for developing the new PNA was proposed.

The PNA would need to be considered by the Care Services Policy Development and Scrutiny Committee.

RESOLVED that

1. **It is agreed that the Supplementary Statement can be published**

2. **The proposed approach for the delivery of the PNA by 1st April 2015 is approved.**

65 Health Care Facilities in Bromley

Local ward members in Bromley Town had raised concern about the adequate future provision of primary care provision given the anticipated increase in new residents from new residential development.

The Board considered a report which provided an update on the progress to date with increasing the provision of healthcare services in Bromley Town Centre.

There was currently only one GP surgery, Dysart Surgery, serving the town centre, which was not of an adequate standard and needed to be re-located. In addition there was a proposal to include a new multi GP surgery, together with the new free School, in the disused DSS building at Bromley South. The relocation of the Dysart Surgery and the new surgery would address the current need.

The board commented that it would not want a single handed GP surgery at Bromley South as this would not address the shortage.

The Board commended the ward members on bringing this issue to its attention. A recommendation would be made to NHS England for consideration of an additional GP practice. NHS England wanted to be involved in the HWB and it was agreed it should be invited to a future board meeting.

The Board also wanted NHS London to provide a statement on this issue.

RESOLVED that:

1. **The report is noted**

2. **That NHS England are invited to a future meeting of the Board.**

3. **That NHS London are asked to provide a statement on the issue of a shortage of GP provision in Bromley Town Centre.**

66 Any Other Business

None

67 Date of Next Meeting

The next meeting would be arranged after the 4th June and would the clerk would inform Members of the Board.

The Meeting ended at 3.24 pm

Chairman

Appendix A

PUBLIC QUESTIONS TO HEALTH AND WELLBEING BOARD.

THE 'BETTER CARE PLAN' & THE CRISIS IN A&E WAITS; & CANCELLED AND DELAYED OPERATIONS AT THE PRINCESS ROYAL UNIVERSITY HOSPITAL. (ref. News Shopper article 12 March 2014 "Hospital delays left me suicidal")

From Susan Sulis Secretary, Community Care Protection Group.

Q.1 The BCP proposes to cut funding for Acute care, to fund Community Care, but reports on the poor performance in A&E require recruitment of large numbers of extra staff, and increased bed availability.

How can these measures be reconciled with the proposed cuts in funding?

Response

In line with Government policy there is a strategy that care should be shifted from the Acute sector into a Community setting. Not only is it better for many patients to be treated in their own home or close to home rather than in a hospital setting but also better value for money can be obtained for tax payers.

It is true that more staff recruitment is needed for A&E, partly because there is a large reliance on agency staff at the moment. As well as providing continuity, recruiting permanent staff can also reduce agency costs. By increasing Community Care more people can be discharged to their home or to other forms of community care which in turn reduces the pressure on hospital beds so that bed availability can be improved.

Q.2 An elderly man was reported to have waited 20 months so far for a knee replacement operation, which had been cancelled 6 times. He claims that "the PRUH is suffering from a beds crisis".

How can the proposed cuts in Acute funding improve this situation?

Response

We appreciate the frustration when any operation is cancelled. There has certainly been pressure on the hospital system across London in recent months which has unfortunately led to some cancelled operations, although it should be noted that operations are sometimes delayed for clinical reasons. A huge amount of work is going into improving processes so that beds can be freed up. As mentioned in the answer to Q1, bed availability can be improved without necessarily needing to increase overall numbers.

Q.3 When will a Public Consultation take place on the "Better Care Plan", and what is the timetable for producing the consultation documents?

Response

Both the Local Authority and Bromley's Clinical Commissioning Group are engaging with service users and the public through their existing channels to inform the Better Care Fund (BCF) submission rather than a specific public consultation. Whilst the tight submission timescales limit the extent of consultation through these channels, we will continue to engage with service users, especially through Healthwatch Bromley who sit on the HWB, and within our Patient Advisory Group throughout the 2014/15 planning year. In this time we aim to finalise and determine how these new funding arrangements may impact on users and the possible benefits from greater integration.

Our existing consultation has included the recent jointly commissioned adult social care conference, attended by over 150 service users and their representatives across the voluntary sector where both the Local Authority and CCG described at a high level their commissioning plans before breaking into a series of workshops where delegates were afforded the opportunity to both comment on existing services and inform and shape our plans going forward.

A joint event with our strategic providers in the voluntary sector early in 2014 also allowed us to engage on the possibility of jointly funding community services through the BCF and how we can jointly commission effectively. As well, an online survey of adult carers in Bromley was undertaken between September and October 2013 as part of the Local Authority and BCCG virtual service user panel. The Carers Survey directly reached approximately 1,400 known carers and received 271 responses. The results from the Carers Survey were used to inform the Adult Services Stakeholder Conference held on 19 November 2013. Individual commissioning and provider agencies will also be able to use the results to inform their provision of services.

From Rosemary Cantwell

1. The Winterbourne Review was where staff were prosecuted under the Mental Health Act 1983. As such, I am requesting information about how many people London Borough of Bromley has responsibility for as ***hospitalised*** patients under the Mental Health Act 1983.

Response

We have 43 people with a learning disability and/or mental health issue currently as inpatients under the Mental Health Act.

Report No.

London Borough of Bromley

HEALTH AND WELLBEING BOARD

Date: **Thursday 24th July 2014**

Report Title: **Pharmaceutical Needs Assessment 2015-18**

Report Author: Agnes Marossy, Consultant in Public Health, Education, Care & Health Services, London Borough of Bromley.
Tel: 020 8461 7531 E-mail: agnes.marossy@bromley.gov.uk

Chief Officer: Nada Lemic, Director of Public Health.

1. SUMMARY

1.1. The Pharmaceutical Needs Assessment (PNA) for Bromley is the formal document of the needs for pharmaceutical services in the area. It is intended to identify what is needed at a local level to guide the current and future commissioning of pharmaceutical services that could be delivered by community pharmacies and other providers.

1.2. The Health and Social Care Act 2012 gave the Health and Wellbeing Board (HWB) the statutory duty to develop and publish a Pharmaceutical Needs Assessment (PNA) by 1st April 2015. Requirements for a PNA are set out in the National Health Service (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013. These regulations cover the minimum information to be included in a PNA, the matters which must be considered, and the process to be followed. This process includes formal consultation with specific stakeholders for a minimum of 60 days.

1.3. Following a recognised Council procurement process a provider has been appointed to deliver the PNA. (Primary Care Commissioning).

2. REASON FOR REPORT GOING TO HEALTH & WELLBEING BOARD

2.1. The HWB received a report on the PNA giving an outline of the approach to be taken in March 2014. This report updates the current position including the milestones for Health & Wellbeing Board decisions as outlined in section 4.11.

2.2. Since the last report it has become apparent that there will be a role for the Health & Wellbeing Board to review the PNAs of neighbouring boroughs, and the Health & Wellbeing Board is asked to agree the approach as outlined in section 4.7.

3. SPECIFIC ACTION REQUIRED BY HEALTH & WELLBEING BOARD AND ITS CONSTITUENT PARTNER ORGANISATIONS

3.1 Whilst the Public Health team within LB Bromley have the lead responsibility for completing the JSNA, a project steering group has been established with representatives from:

- Local Pharmaceutical Committee
- Local Medical Committee
- CCG
- Healthwatch Bromley
- Voluntary Sector Strategic Network
- Communications, LBB
- NHS England

Health & Wellbeing Strategy

Financial

1. Cost of proposal: £41K

2. Ongoing costs: There will be an ongoing maintenance cost, bids were sought as part of the main tender process. The maintenance cost will be up to £5,000 pa.

3. Total savings (if applicable): Not applicable

4. Budget host organisation: London Borough of Bromley

5. Source of funding: Public Health Grant

6. Beneficiary/beneficiaries of any savings: Not applicable.

Supporting Public Health Outcome Indicator(s)

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4. COMMENTARY

Introduction

4.1. The Health and Social Care Act 2012 gave the Health and Wellbeing Board (HWB) the statutory duty to develop and publish a Pharmaceutical Needs Assessment (PNA) by 1st April 2015. Requirements for a PNA are set out in the National Health Service (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013. These regulations cover the minimum information to be included in a PNA, the matters which must be considered, and the process to be followed. This process includes formal consultation with specific stakeholders for a minimum of 60 days. The PNA lasts three years, but must be kept up to date and supplementary statements published. If there is a change in circumstances that cannot be addressed through a supplementary statement, a new PNA must be written.

4.2. A PNA is a key commissioning tool to ensure that local areas have high quality pharmaceutical services that meet needs. A PNA sets out the community pharmaceutical services that are currently provided and gives recommendations to address any identified gaps, taking into account future needs. A PNA supports the commissioning intentions for pharmaceutical services and other services that could be delivered by community pharmacies and other providers.

4.3. The completed PNA will inform commissioning decisions by NHS England (Area Teams) on certain pharmaceutical services and may inform the Local Authority, and potentially the Clinical Commissioning Group (CCG), on services not legally termed 'pharmaceutical services' that may be commissioned from pharmacies.

4.4. The Health & Wellbeing Board needs a thorough and robust PNA that complies with the regulations and follows due process. This will ensure that community pharmacy services are provided in the right place and that commissioned services meet the needs of local communities.

Current position

4.5. Following a recognised Council procurement process a provider has been appointed to deliver the PNA. (Primary Care Commissioning) and a Steering Group has been established. The structure and framework of the PNA have been agreed by the Steering Group (Appendix A).

Communications

4.6. There are three strands to the communications for the Bromley PNA:

- The first is a pharmacy contractor questionnaire which seeks information about pharmaceutical services currently delivered and services which could be delivered in the future. The content of this questionnaire has been agreed by the Steering Group and will be distributed online to contractors by the PCC with a deadline for response of 15th July.

- The second is a patient survey which seeks information about the current usage and experience of pharmaceutical services and demand for future services. The content of this questionnaire has been agreed by the Steering Group and this survey will be distributed both online and in hard copy through promotion by members of the Steering Group and other stakeholders between mid-July and mid-August.

- The third is the formal consultation on the PNA. The regulations state that certain persons (listed in the regulations) must be consulted at least once whilst producing the PNA. Those listed include the Local Pharmaceutical Committee (LPC), the Local Medical Committee

(LMC), Local Pharmacy Services Contractors, Healthwatch, other patient groups, Acute Trusts, NHS England Area Team and neighbouring Health & Wellbeing Boards. There must be at least 60 days given for responses. It is planned to run this consultation between mid-October and mid-December, and the Health & Wellbeing Board will be asked to agree the draft PNA for consultation at the meeting on 2nd October 2014.

PNAs of Neighbouring Boroughs

4.7. The Health & Wellbeing Board should be consulted on the draft PNAs of neighbouring boroughs, this must include consultation with Bromley's LMC and LPC if these are different from the originating borough.

4.8. It is proposed that the Health & Wellbeing Board delegate this review to the PNA Steering Group.

Risks

4.9. The Health & Wellbeing Board have a statutory duty to publish the PNA by 1st April 2015, and we are on course to deliver this responsibility.

4.10. The PNA will be included on the Corporate Risk Register as there is a potential for legal challenge if the PNA is considered not to be compliant with regulations or not to have followed due process and not be sufficiently robust to allow for reasonable commissioning decisions to be made. The risk is being mitigated by the processes being followed.

Health & Wellbeing Board Decisions

4.11. The Health and Wellbeing Board will be asked to agree the draft PNA prior to the formal consultation at the meeting on 2nd October 2014, and to agree the final version of the PNA at the meeting on 29th January 2015 prior to publication.

5. FINANCIAL IMPLICATIONS

5.1. The cost of the PCC contract to deliver the PNA is £41,000. There is an ongoing maintenance cost of up to £5,000 pa.

6. LEGAL IMPLICATIONS

6.1. The Health & Wellbeing Board have a statutory duty to publish the PNA by 1st April 2015, and we are on course to deliver this responsibility.

6.2. There is a potential for legal challenge if the PNA is considered not to be compliant with regulations or not to have followed due process and not be sufficiently robust to allow for reasonable commissioning decisions to be made.

Non-Applicable Sections:	**IMPLICATIONS FOR OTHER GOVERNANCE ARRANGEMENTS, BOARDS AND PARTNERSHIP ARRANGEMENTS, INCLUDING ANY POLICY AND FINANCIAL CHANGES, REQUIRED TO PROGRESS THE ITEM;** and **COMMENT FROM THE DIRECTOR OF PUBLIC HEALTH**
Background Documents: (Access via Contact Officer)	Update on the Pharmaceutical Needs Assessment 20th March 2014.

Pharmaceutical Needs Assessment

STRUCTURE AND FRAMEWORK – APRIL 2014

Principles:

- To set out a vision for building on the strengths of pharmacy, using the sector's capacity and capability to deliver further improvements in pharmaceutical services over the coming years as part of an overall strategy to ensure safe, effective, fairer and more personalised patient care
- A balance between three different aims:
  - A statement of commissioning intentions for the HWB
  - The basis of applications from pharmacy contractors and dispensing appliance contractors (new & existing)
  - The basis of determinations (and commissioning) by the area team
- Make the order logical to make it easy to read from front to back but use good chapter titles and table of contents to also make it a reference document
- A good map is worth a thousand words
- Satisfy various audiences in both electronic and printed media:
  - The public
  - Area teams
  - Applicants
  - NHS Litigation Authority's Family Health Services Appeal Unit and the courts
- To minimise unexpected consultation responses

Cover

- Look and feel like an HWB product

Version control

Executive summary

- Two page (?) summary
  - Purpose, consultation, LA/NHS background,
  - Summary of the assessment
  - Conclusion – are there any gaps?
  - Next steps – commissioning intentions

Introduction

- What a PNA is for
- The regulations – duty on HWB, revisions and updates
- What are pharmaceutical services - scope
  - Community pharmacy
    - Essential v. advanced v. enhanced services (limited)
    - 100 hours

        - Internet/mail order only
    - DACs
    - Dispensing doctors
    - Local pharmaceutical services (LPS and ESPLPS)
    - Hospital pharmacy
- How the assessment was carried out – steering group, determination of localities, engagement, consultation report, surveys

For each locality

- Map and/or description of the locality
- Health needs (that may be met using pharmaceutical services)
    - PH data and analysis, demographics, graphs, comparisons
    - Different needs of different populations (inc. protected characteristics)
    - Demography
    - Risks to health and wellbeing
    - Known future changes
- Pharmaceutical services provision (locations, opening hours, services)
    - Necessary services: current provision inc. cross border
    - Necessary service: gaps in provision - current & future
    - Other relevant services: current provision inc. cross border
    - Improvements and better access: gaps in provision – current & future
    - Other NHS services – current & future
- Assessment
    - conclusion
    - gaps
    - improvements or better access
    - choice

Public Health Services Commissioned from Pharmacies

- Current Provision
- Future Plans
- Potential Commissioning
- Other Services

Appendices

- Equality impact assessment
- Policy context and background papers
- Steering group membership
- Pharmacy contractor list (including local pharmaceutical services(LPS) and dispensing appliance contractors)
- Dispensing doctor list (where applicable)
- Cross border services
- Consultation report
- Glossary & abbreviations

Report No.

London Borough of Bromley

HEALTH AND WELLBEING BOARD

Date: **Thursday 24th July 2014**

Report Title: **South East London NHS Commissioning Strategy - update**

Report Author: Ross Graves on behalf of
Dr Angela Bhan, Chief Officer, Bromley Clinical Commissioning Group.
Tel: 01689 866168, E-mail: angela.bhan@bromleyccg.nhs.uk

Chief Officer: Dr Angela Bhan, Chief Officer, Bromley Clinical Commissioning Group.

1. SUMMARY

1.1. This report gives an update on the five year NHS commissioning strategy for South East London which has been developed in partnership with NHS England and five adjoining CCGs.

2. REASON FOR REPORT GOING TO HEALTH & WELLBEING BOARD

2.1. This report is to keep the Board updated on the ongoing strategy work. The strategy builds on local plans, including the Health and Wellbeing Strategy, Joint Strategic Needs Assessment and existing best practice to support improving the health and well being of the population of Bromley.

3. SPECIFIC ACTION REQUIRED BY HEALTH & WELLBEING BOARD AND ITS CONSTITUENT PARTNER ORGANISATIONS

3.1. The board is asked to note this item.

3.2. The CCG will continue to work with all key partners and stakeholders to develop the strategy and implementation plans and will report back to the HWBB at regular intervals.

Health & Wellbeing Strategy

Related priority: Diabetes, Hypertension, Obesity, Anxiety & Depression, Children with Mental & Emotional Health Problems, Dementia, Supporting Carers

Financial

1. Cost of proposal: Not applicable.
2. Ongoing costs: Not applicable.
3. Total savings (if applicable): Not applicable
4. Budget host organisation: Not applicable.
5. Source of funding: Not applicable.
6. Beneficiary/beneficiaries of any savings: Not applicable.

Supporting Public Health Outcome Indicator(s)

Improving mortality, reducing deaths from cancer and reducing inequalities.

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4. COMMENTARY

4.1. The strategy provides an overarching framework for the delivery of improved health services in the future. Over the coming months, CCGs in SE London will continue to work with key partners to develop implementation plans, in accordance with the strategy, to improve health. Many of these improvements will require joint working between the CCG and London Borough of Bromley, as well as engagement with the public and key providers.

5. FINANCIAL IMPLICATIONS

5.1. The strategy aims to ensure a financially sustainable health service.

6. LEGAL IMPLICATIONS

6.1. To be determined as part of implementation processes.

7. IMPLICATIONS FOR OTHER GOVERNANCE ARRANGEMENTS, BOARDS AND PARTNERSHIP ARRANGEMENTS, INCLUDING ANY POLICY AND FINANCIAL CHANGES, REQUIRED TO PROGRESS THE ITEM

7.1. Improvements and changes in health services will be undertaken under the oversight of the Health and Well Being Board and any service being significantly changed will be brought before the Health Scrutiny Committee. Commissioning decisions will be made, in partnership with the key stakeholders, through the CCG's governance structures and Governing Body.

7.2.

Non-Applicable Sections:	**COMMENT FROM THE DIRECTOR OF AUTHOR ORGANISATION**
Background Documents: (Access via Contact Officer)	

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NHS
Bromley
Clinical Commissioning Group

South East London NHS Commissioning Strategy
Update for Health & Wellbeing Board– July 2014

Introduction

Bromley Clinical Commissioning Group (CCG) and its five partner CCGs in south east London (Bexley, Greenwich, Lambeth, Lewisham and Southwark) are working with commissioning leads from NHS England and in close partnership with local authorities, hospitals, community health services, mental health services, patients, carers and local people on a five year strategy to improve health and health services across south east London.

The strategy focuses on the most important health issues for people in the region, as identified in the south east London Case for Change. The Case for Change has been developed by local clinicians, public health and social care colleagues and has been tested more widely with local people and other stakeholders. It is based on local needs and aspirations and builds on work at borough level, whilst taking into account national and London-wide policies.

The strategy addresses issues which need collective action or where there is added value in CCGs working together across south east London. It builds on local plans, including Health and Wellbeing Strategies, and draws on Joint Strategic Needs Assessments, and existing best practice. Bromley's (and the other boroughs') Joint Strategic Needs Assessment, commissioning plans and Health and Wellbeing Strategies will continue to be produced to identify borough-specific issues and challenges and the plans to address them and they will continue to shape the South East London Commissioning Strategy.

The strategy also meets the requirement of NHS England that every CCG should have a five year strategy. The current version of the strategy (published on Bromley CCGs website) has been submitted to NHS England for review, in accordance with a national deadline. It is very much a work in progress and the next stage of its development is described later in this paper.

Programme Vision

The problem we are trying to solve:

Our health outcomes in south east London are not as good as they should be:

- Too many people live with preventable ill health or die too early
- The outcomes from care in our health services vary significantly and high quality care is not available all the time
- We don't treat people early enough to have the best results
- People's experience of care is very variable and can be much better
- Patients tell us that their care is not joined up between different services
- The money to pay for the NHS is limited and need is continually increasing
- Every one of us pays for the NHS and we have a responsibility to spend this money well.

The longer we leave these problems, the worse they will get. We all need to change what we do and how we do it.

Our collective vision for south east London:

In south east London we spend £2.3billion in the NHS. Over the next five years we aim to achieve much better outcomes than we do now by:

- Supporting people to be more in control of their health and have a greater say in their own care
- Helping people to live independently and know what to do when things go wrong
- Helping communities to support one another
- Making sure primary care services are consistently excellent and with an increased focus on prevention
- Reducing variation in healthcare outcomes and addressing inequalities by raising the standards in our health services to match the best
- Developing joined up care so that people receive the support they need when they need it
- Delivering services that meet the same high quality standards whenever and wherever care is provided
- Spending our money wisely, to deliver better outcomes and avoid waste.

How is the strategy being developed?

The overall shaping of the strategy is undertaken by the programme's Partnership Group**.** Membership includes the CCG chairs and chief officers; NHS provider chief executives and medical directors; local authority chief executives; NHS England representatives; Healthwatch representatives; and local patient and public voices. It is chaired by a CCG clinical chair. Health and Wellbeing Boards have been briefed on the strategy as it has been developing and have reviewed and commented on the Case for Change. As work on the strategy has continued over the period of local elections and annual general meetings, it will be brought back in its current form to Health and Wellbeing Boards for discussion to inform the next stage of development.

The programme board for the strategy is the Clinical Commissioning Board. Membership of this is:

- the clinical chairs and chief officers from each of the CCGs
- representation from NHS England
- representation from local authority chief executives
- Healthwatch and local patient and public voices

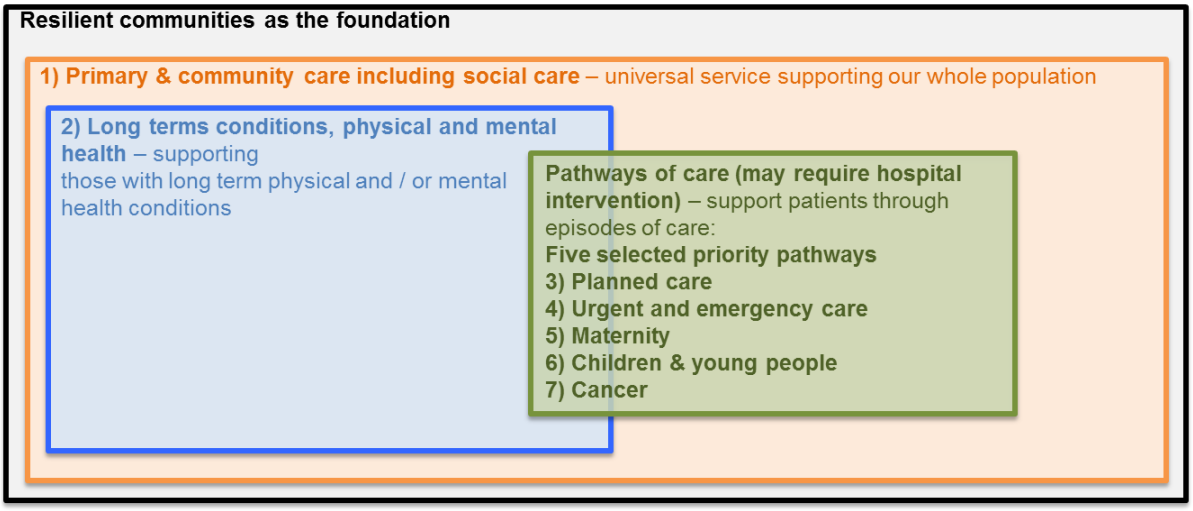
The Clinical Commissioning Board reports to the Clinical Strategy Committee of Bromley and its five partner CCGs, which in turn reports to each of the CCGs' Governing Bodies. Any decisions about investment and/or changes which may impact on services are taken by Bromley CCG's Governing Body and those of the other five CCGs.

The details of the strategy are being developed by the Clinical Executive Group (CEG), and the Clinical Leadership Groups (CLGs). These are groups of local clinicians, commissioners, social care leads and other experts, Healthwatch representatives and patient and public voices from each of the boroughs. They are working together on seven key areas:

- Primary and Community Care
- Long Term Conditions – Physical and Mental Health
- Urgent and Emergency Care
- Maternity
- Children and Young People
- Cancer
- Planned Care

The emerging model

Emerging thinking from the CLGs, the CEG and the Partnership Group has informed a system-level model of an integrated care system (below), delivered through the seven strategic interventions set out in the previous section.



South east London CCGs and NHS England are working together to develop an integrated care system, delivered through the seven strategic interventions set out above. In this system integrated services will have:

- Involved and informed patients and carers
- Engaged and supportive communities
- Adaptable and capable staff

Underpinned by the characteristics of our integrated system:

- **Build resilient communities**
- **Promote health and wellbeing**
- **Provide accessible & easy to navigate services**
- **Join up services from different agencies & disciplines**
- **Deliver early diagnosis & intervention**
- **Raise the quality of services to the same high standard**
- **Support people to manage their own health & wellbeing**
- **Achieve improved outcomes for all residents**

1) Primary and Community care

Primary and community care (defined in its broadest sense) will be provided at scale by 24 Local Care Networks supporting local populations. This will be a universal service covering the whole population 'cradle to grave'. The changes to primary care will focus on four high impact areas:

- Access
- Proactive care
- Coordinated care
- Continuity of care

2) Long term conditions, physical and mental health

Those with long term physical and / or mental health conditions will be supported with segmentation into three categories:

a) People with a stable / well managed long term condition – who need support from primary care with some occasional input from community and hospital services
b) People with complex long term conditions – requiring on-going support from co-ordinated health and social care
c) People with multiple complex needs where standard services are not effective – requiring personally designed support from multiple agencies including voluntary sector

Local care networks will play a lead role at all stages and there will be a consistent focus on reablement; not just the prevention of deterioration, but returning people to better health.

3-7) Priority pathways

Priority pathways support patients through episodes of care, often including hospital care. These pathways have been prioritised based on our Case for Change and strategic context, feedback from our stakeholders and partners, including Health and Well-being Boards. Local Care Networks will be engaged as patients access these pathways, as will the wider health and social care teams where people have on-going long term conditions.

EMERGING CONTENT – SUBJECT TO FURTHER REVISION / DEVELOPMENT

3. Planned care including the following key features:	• Pre-treatment and diagnosis: standardised and multidisciplinary approaches; clear care plans; hubs and 'one-stop-shops' where appropriate; diagnostics delivered once in right place at right time; senior opinion early in the pathway; more treatment in the community where appropriate • Treatment: delivered in the most productive and efficient way through standardisation; delivery at appropriate scale; specialty focus on specific areas; movement towards day case procedures - when safe; review current use of outpatient model • Post treatment: As much at home / in the community as possible; 7 day a week transfers to community; early planning throughout pathway • Close collaboration between primary, secondary, social care and social services throughout.
4. Urgent & emergency care including the following key features:	• Rapid access model: home ward + sub acute specialist response (co-located with hospital, emphasis on specialist gerontology/elderly/mental health) • UCC co-located with A&E and out of hours – minor illness, injuries and burns with diagnostics and prescribing • Admit to hospital to 'do and discharge' • Services meeting London Quality Standards
5. Maternity including the following key features:	• Single point of contact – to inform newly pregnant women of their options and choices • Promotion of normalised birth: incl. home birth for multips; birth centres for low risk primips • Continuity of care through a 'midwifery led' model with improved/extended consultant cover • Assessing for women's toxic stress during pregnancy • Services meeting London Quality Standards and other maternity quality standards
6. Children including the following key features:	• Collective focus on the child including, 'every contact counts' • Improved Access – 'no wrong door' • CAMHS/Psychological support • Integrated step-down from hospital designed around child • Services meeting London Quality Standards
7. Cancer including the following key features:	• Saving lives and improving outcomes through prevention and earlier detection, diagnosis and intervention. Reducing variation in care, supporting people and their carers living with cancer as a long term condition and improved end of life care.

Supporting Strategies

Clinical Leadership Groups and the Partnership Group have identified a number of cross-cutting supporting strategies to enable the delivery of interventions defined through the groups. Initially, five priority strategies will be developed. Other supporting strategies (for example, access to public transport) will be mobilised to support subsequent phases.

- IT and Information – to drive a consistent and accessible approach to IT and information across all providers
- Workforce – to develop a new workforce model that meets the needs of an increasingly community-based model of prevention and care
- Commissioning models – to develop innovative approaches to commissioning and contracting that incentivise the right behaviours across the system
- Communications and engagement – to support all aspects of the programme
- Estates – to support Local Care Networks promoting co-location of staff and services where appropriate; and ensure all estate is fit for the 21st century

Implementation work already underway

We understand the urgency to improve services and significant work is already underway to deliver parts of the strategy during years 1 - 2. CCG operating plans set out a series of bold changes that will be delivered in years one and two of the strategy, and we have begun the process of evaluation and continuous improvement for these services.

Some examples of significant work already being implemented include:

- Development of wider primary care, provided at scale
- Developing a modern model of integrated care
- Improving and enhancing local urgent and emergency care
- Transforming specialised services
- Building resilient communities
- Partnership working across south east London
- Promoting public health role and prevention

Current Position and Next Steps

A strategy document was submitted to NHS England for review on 20 June 2014. This document was discussed in public at Bromley CCG's Governing Body on 12

June, prior to submission. This submission is an early national milestone in the long-term development of the strategy.

From July 2014, considerable further work will be undertaken, including testing the models, reviewing the evidence to support them and modelling the impact of proposed interventions. Local and wider engagement will be taking place as part of this within Bromley and across south east London. There will be more opportunities for local people to become directly involved, and the strategy will be formally presented to each Health and Wellbeing Board for input and to shape it further.

Feedback from all the engagement and involvement will continue to inform development of the strategy.

If the strategy, as it develops further, results in proposals which would constitute significant service change; these would be the subject of formal consultation. The current thinking is that if any formal consultation is needed, it would be in the second half of 2015.

In the meantime, borough-level Joint Strategic Needs Assessments, the CCGs' commissioning plans and Health and Wellbeing strategies will continue to be produced locally to identify borough-specific issues and challenges and the plans to address them, which will in turn inform the further development of the strategy.

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Report No.

London Borough of Bromley

HEALTH AND WELLBEING BOARD

Date: **Thursday 24th July 2014**

Report Title: **2014 Joint Strategic Needs Assessment (JSNA) Update**

Report Author: Agnes Marossy, Consultant in Public Health, Education, Care & Health Services, London Borough of Bromley.
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Chief Officer: Nada Lemic, Director of Public Health.

1. SUMMARY

1.1. Joint Strategic Needs Assessment (JSNA) has been a statutory requirement of local authorities and NHS primary care trusts since 1 April 2008. Original guidance set out an expectation that the JSNA be carried out jointly by the director of public health, director of adult social services and director of children's services.

1.2. The government has since highlighted the 'equal and explicit' role of GP consortia and local authorities, including the director of public health, in preparing the JSNA, and endorsed the JSNA's key role in informing joint health and wellbeing strategies, to be developed by new Health and Wellbeing Boards.

1.3. The aim of the JSNA is to deliver an understanding of the current and future health and wellbeing needs of the population over both the short term (three to five years), and the longer term future (five to ten years) to inform strategic planning commissioning services and interventions that will achieve better health and wellbeing outcomes and reduce inequalities.

1.4. The JSNA is an evidence based document highlighting need, as such it is distinct from the Health & Wellbeing Strategy which it informs. The Health & Wellbeing Strategy outlines the priorities (based on the JSNA) agreed by the Health & Wellbeing Board together with the proposed actions and expected outcomes.

2. REASON FOR REPORT GOING TO HEALTH & WELLBEING BOARD

2.1 This report describes the current position regarding the JSNA for 2013-14 and includes the Executive Summary which highlights the key areas identified in the JSNA in order to inform discussions by the Health and Wellbeing Board relating to the Health and Wellbeing strategy priorities.

2.2 The Health and Wellbeing Board are also asked to agree the signatories to the Foreword of the JSNA.

3. SPECIFIC ACTION REQUIRED BY HEALTH & WELLBEING BOARD AND ITS CONSTITUENT PARTNER ORGANISATIONS

3.1 Whilst the Public Health Team within the Council have the lead responsibility for completing the JSNA, a project steering group has been established with representatives from:

- Education & Care Services
- Adult Social Care
- CCG Clinical Lead
- Children's Services
- Community Links Bromley
- Environmental Services
- Healthwatch Bromley
- LA Housing
- LA Planning
- Voluntary Sector Strategic Network

Health & Wellbeing Strategy

The JSNA is an evidence based document highlighting need, as such it is distinct from the Health & Wellbeing Strategy which it informs. The Health & Wellbeing Strategy outlines the priorities (based on the JSNA) agreed by the Health & Wellbeing Board together with the proposed actions and expected outcomes.

Financial

1. Cost of proposal: Not Applicable
2. Ongoing costs: n/a
3. Total savings (if applicable): n/a
4. Budget host organisation: n/a
5. Source of funding: n/a
6. Beneficiary/beneficiaries of any savings: n/a

Supporting Public Health Outcome Indicator(s)

The JSNA will record progress against the Public Health Outcome Indicators.

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4. COMMENTARY

Current Position

4.1. The aim of the JSNA is to deliver an evidenced based understanding of the current and future health and wellbeing needs of the population over both the short term (three to five years), and the longer term future (five to ten years) to inform strategic planning commissioning services and interventions that will achieve better health and wellbeing outcomes and reduce inequalities.

4.2. The JSNA is currently in draft format, and the individual sections have been circulated to relevant stakeholders for comment. The Executive Summary is appended to this paper and includes key areas highlighted in the JSNA to inform discussions on selection of priorities for the Health & Wellbeing Strategy.

4.3. There will be a further update paper on the JSNA together with the final version for the Health & Wellbeing Board meeting on 2nd October. Final approval will also be sought from the Health & Wellbeing Board at the meeting on 2nd October after which the final document and Executive Summary will be published on the My Life website.

JSNA Sign Off

4.4. The Statutory Guidance on Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies states that, under the Health and Social Care Act 2012, local authorities and clinical commissioning groups (CCGs) have equal and joint duties to prepare JSNAs through the health and wellbeing board. As the duties apply across the Health and Wellbeing Board as a whole, boards will need to discuss and agree their own arrangements for signing off the process.

5. LEGAL IMPLICATIONS

5.1. Under the Health and Social Care Act 2012 it is a statutory responsibility of local authorities and clinical commissioning groups (CCGs) to prepare JSNAs and JHWSs, through the Health and Wellbeing Board.

6. COMMENT FROM THE DIRECTOR OF PUBLIC HEALTH

6.1. The JSNA is important in painting a picture of Bromley's population. As such, it will be a useful resource to all stakeholders in promoting a population approach to commissioning of all services based on identified health and social care needs.

Non-Applicable Sections:	**FINANCIAL IMPLICATIONS;** and **IMPLICATIONS FOR OTHER GOVERNANCE ARRANGEMENTS, BOARDS AND PARTNERSHIP ARRANGEMENTS, INCLUDING ANY POLICY AND FINANCIAL CHANGES, REQUIRED TO PROGRESS THE ITEM**
Background Documents: (Access via Contact Officer)	None.

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2. The Population

The population of Bromley continues to grow, to a size of over 320,000 in 2014, and is predicted to expand still further over the next ten years.

Whilst the number of under 4 year olds has reached a plateau after ten years of growth, the proportion of older people in Bromley will continue to increase from 17.7% of the population in 2014, to 18.3% by 2024. Health and social care planning should take account for this rise in the numbers of older people particularly in the South of the Borough which will see the largest increase in numbers of over 75s.

The proportion of the population in Bromley which is made up of Black and minority ethnic groups has increased from 8.45% in 2001 to 17.3% in 2014. This increase has been mainly in the Black African community. Because the health risks of ethnic minority populations differ from the general population, attention should be given in health and social care planning in particular to the North West of the Borough which has the highest proportion of ethnic minorities, and also to the Cray Valley area which houses the Gypsy traveller population, who tend to experience poor health outcomes.

3. Life Expectancy and the Burden of Disease

Life expectancy at birth in Bromley has been rising steadily over the last 20 years, currently at 80.7 years for men and 84.5 years for women. However, there is an 8.7 year gap for men and 7.9 years for women between the highest and lowest life expectancy wards in Bromley, with the lowest life expectancy in the most deprived wards.

Mortality in Bromley is chiefly caused by circulatory disease (32%) and cancer (30%) with higher mortality rates for both conditions in the more deprived areas of the borough.

There is a need for continued action to address health inequalities associated with deprivation. One avenue is to improve early identification of increased circulatory disease risk through the **NHS Health Checks Programme**. However, evaluation of this programme shows low levels of uptake, particularly in the more deprived North West of the borough. Results from the programme also show that there is suboptimal follow up of patients who the programme has identified at need of further testing for diabetes, hypertension and chronic kidney disease.

In addition, there is evidence to show that there are many people living in Bromley with undiagnosed **hypertension,** and a number of people with known hypertension

which has not been adequately controlled. These people are at higher risk of stroke, kidney disease heart disease and other conditions.

Diabetes represents a continuing challenge in Bromley. The number of people affected has been rising since 2002, and for those diagnosed, control of the associated risk factors for circulatory disease is less effective than nationally. Work is necessary both to prevent and to improve identification of diabetes.

Cancer remains one of the key causes of mortality in Bromley, and although survival rates have been improving, incidence of all cancers is rising, indicating the need for good prevention strategies. In addition, a significant proportion of cancers are diagnosed outside the two week referral pathway, leading to later diagnoses, which will adversely impact survival rates, as will the low cancer screening uptake in the more deprived parts of the borough.

The rate of **sexually transmitted infections** is lower in Bromley than in London or nationally. The low prevalence of chlamydia in Bromley means that it has been necessary to adopt a targeted screening programme, which is proving successful with a high proportion of those tested proving positive for the disease.

Although Bromley as a whole has a low **HIV** prevalence, the HIV rate in the north West of the Borough is four times the Borough average and the prevalence is rising steadily. Whilst it is understood that migration from neighbouring boroughs is a contributing factor to the steady increase, further work is required to understand and ascertain if there are other contributing factors that require a particular approach to tackling the rise.

While early testing using Point of Care Testing in acceptable settings has been commissioned, further work is required to address perception of risk and transmission awareness with a view to increase the overall likelihood of actively seeking testing especially among at-risk females and also to understand which communities are more likely to confront stigma as a result of having a HIV test.

The number of **live births** is rising, reflecting the rising trends in the general fertility rates. The trends have implications for Bromley primary schools and children services in the borough.

There are higher birth rates in Bromley women aged 25-39 than England and London and there is a rising trend towards older motherhood. There is a need for reproductive healthcare services to reflect the population changes.

Abortion rates in women in their 20s are high. These women are also more likely to report a previous termination than other age groups. There is therefore a need to

understand contraception use and terminations particularly in women in their 20s in Bromley.

There is currently a gap in local data on Emergency Hormonal Contraception and Long Acting Reversible Contraception use which has created a gap in understanding of the need and use by different population groups. Further work is planned to understand the contraception service need and use in the borough.

Further work is needed to encourage the **uptake of childhood immunisations** as vaccination rates for several categories, such as MMR, Hib/MenC, DTaP/IPV (pre-school), and HPV, remain below the national recommendation of 95% coverage.

There remains a potential for **measles outbreaks**, particularly in older children and young adults due to poor immunisation uptake, as seen in the 11 confirmed measles cases in 2013.

There were 14 confirmed cases of **pertussis** (whooping cough) in 2013, highlighting the importance of immunisation against pertussis, in particular the uptake of maternal pertussis vaccination programme.

Seasonal flu vaccination rate in Bromley is lower than that of London and England, meaning a large proportion of at risk individuals remain vulnerable to the serious health effects of flu.

There is a rising prevalence of **smoking** in Bromley, this has a negative impact on Bromley's morbidity and mortality rates, local economy, health inequalities, local environment, hospital admission, re-admission and post-operative complication rates Bromley has a particularly high smoking prevalence within routine and manual worker groups, prevalence is 8% higher than the general population in Bromley and continues to increase (prevalence was 24.3% in 2011-12, rising to 26.1% in 2012-13). There is evidence that illicit tobacco and shisha use are becoming more common in Bromley.

Bromley has the third highest levels of overweight and **obesity** in London, 65% are either overweight or obese and the prevalence is rising. The prevalence of **childhood obesity** is higher than the England average and is now reducing slowly in reception year children, but continues to rise in the Year 6 cohort.

Excess weight contributes significantly to the incidence and progression of diseases such as type 2 diabetes, circulatory disease and cancer. A significant proportion of Bromley's residents (21.8% obese) are at higher risk of these conditions and of premature death.

There is scope to increase levels of **physical activity** participation in Bromley to increase health benefits. Targeting inactive populations will produce the greatest reduction in chronic disease.

There is evidence that interventions in the following areas have a positive impact on the health of the physically inactive:
- environmental changes designed to increase daily activity
- active transport – walking and cycling
- physical activity programmes for people with long term conditions
- physical activity for children in schools.

5. Housing

Housing is a fundamental need for good health and wellbeing and inequalities in a range of health issues can be tracked to the quality of housing.

The number of households in Bromley is predicted to increase steadily over coming years with the average household size set to decrease.

Approximately 71% of dwellings in Bromley are in owner occupation and approximately 13% are in the private rented sector, with 14% of social rented housing is supplied through Housing Associations.

Over the last ten years there has been a fall in the level of owner occupation and a growth in the private rental sector most likely as a result of the general economic downturn. The increase in demand in the private rental sector has driven a significant rise in rental prices for lower quartile rents.

A study of private sector housing conditions (2009 report) indicated that approximately 36% of private sector dwellings in the Borough fail the Government's Decent Homes Standard.

The volume of households faced with homelessness has risen dramatically during recent years predominantly in response to complex economic factors and the ensuing impact on housing markets, the onset of the recession and the welfare reform programme. The most significant area of increase continues to be the loss of private rented accommodation, which now accounts for more than one third of all homeless acceptances. An increasing number of households face a shortfall between benefits and housing costs and there are increasing numbers of households and children residing in temporary accommodation, in particular, outside the borough boundaries.

There is an increasing demand for private and intermediate older person's accommodation in Bromley.

6. Children and Young People

Indicators of child health in Bromley are rated higher than the national average for most aspects. **Family homelessness** and **A&E attendances in children** are rated as higher than the national average. The child mortality rate is also higher than the national and London rate.

Rates of **Type 1 Diabetes** in the children of Bromley are slightly lower than predicted rates based on national data and rates of **Type 2 Diabetes** (obesity-related) in Bromley are very much lower than predicted rates based on national data.

Although admissions to hospital for diabetic children are relatively low they could be lower if pro-active specialist support were in place. This specialist support is being increased in Bromley and future measures of both process measures and outcomes in Bromley's diabetic children is expected to improve.

Although admissions to hospital for asthma and epilepsy have been low in Bromley, the most recent data shows an increase in admissions for both conditions. Length of stay in hospital once admitted also tends to be high in Bromley. Arguably Bromley should be matching the best 5% of areas for both admissions and length of stay. These data indicate that we should be looking to reduce emergency admissions and length of hospital stay for Bromley children with asthma and epilepsy. The provision of specialist paediatric nurses for these conditions may be key to achieving this.

Self-harm appears to be an increasing issue for young people in Bromley, and there is some evidence that rates of presentation to services with self harm are higher in Bromley than in most London boroughs. In Bromley, most of the attendees presented due to self-cutting as opposed to self-poisoning suggesting a possible shift in self-harming behaviours. Of particular note were the common 'triggers' of a new episode of self-harm that presented to A&E, which included family arguments, bullying and already being an inpatient on a mental health unit. The most frequent chronic stressors of having separated parents, adoption, being a looked after child, having experienced domestic violence in the family or having been a victim of physical or sexual abuse highlights the significant psychological impact these can have on a child. The evidence that self-harm may be reduced by psychological well-being programmes for young people and gatekeeper training for those who they may present to is being taken forward in secondary schools, A&E at the PRUH and CAMHs services in the borough.

Teenage conception rates are falling in Bromley , however a higher percentage of these conceptions lead to terminations year on year. This upward trend of terminations is clearly an indication of unplanned or unwanted pregnancies.

It is therefore important to understand contraception service needs of teenagers in the borough by evaluating the impact of the provision of service such a condom provision, long acting contraceptive provision and Sex and Relationship Education (SRE) programmes in schools and FE Colleges with a view to establish if these have made a difference to avoiding unwanted teenage pregnancies.

Educational attainment at all levels in Bromley is generally above the national average, with girls outperforming boys at all levels. Despite this good achievement, however, there are certain groups of children, in particular those in receipt of Free School Meals who do not make the desired rate of progress.

Increasing birth rates and advances in modern medicine have resulted in more children with disabilities and complex needs surviving at birth and into later life. The increase in numbers and complexity of needs of children with learning difficulties and/or disabilities has required more specialist and high cost provision to be made available.

There has been an increase in the number of children in care over the last three years. Bromley is improving its efficiency in the amount of time it takes to move a child in with their adoptive family from coming into care. There are a higher number of children in care with 3 or more placements than the national average.

7. Older People

The number of older people in Bromley has been increasing, and is projected to continue to rise. One of the key consequences of this is a rise in the numbers of people with **dementia.** There is considerable work being done to develop an integrated approach to the commissioning and provision of services for people with dementia and their carers. Despite this, there is still under identification of people with dementia.

An increasing number of older people are being supported within their own home with a commensurate increase in demand on community services. A corollary of this is that those older people cared for in residential and nursing homes have more complex needs.

8. Learning Disability

The number of people with learning disabilities under the age of 64 years, is predicted to rise by 9.2% over the next eight years. Medical advances mean that more young people with profound and multiple disabilities are surviving to adulthood and increasing numbers of children with learning disabilities are making the transition to adult services.

Nationally, the median age at death for people with Learning Disabilities is approximately 24 years (30%) younger than for those who do not have learning disabilities, therefore it is important to ensure that good healthcare is available for people with learning disabilities. However identification of people with learning disabilities by GPs in Bromley is still lower than the expected level, and in addition, a low proportion receive health checks. This may be a contributing factor to the high rates of emergency admissions to hospital for adults with learning disability in Bromley.

9. Sensory Impairment and Physical Disability

The number of people in Bromley with physical disability or sensory impairment continues to increase.

The majority of people with hearing loss are in the older age groups and as the numbers of older people in Bromley increase, there is a need to minimise and address the consequences of hearing impairment, such a social isolation, depression and dementia.

Smoking, obesity, excessive alcohol consumption, hypertension and diabetes are all risk factors for the development of visual impairment, therefore their prevention and management should be a high priority.

Although there have been improvements in disabled access across Bromley, work is on-going in this area.

10.Mental Health

In Bromley, one person in six has a mental health problem at any one time, and one in four will have a problem during their lifetime. The percentage of over 18s with depression is significantly higher in Bromley than the percentages for both England and London, however, the suicide rate in Bromley is below the England average. In 2012, 91% of all people dying by suicide were men, of which the 45 years and over age group had the highest number of male deaths.

The number admitted to hospital with deliberate self harm have been rising over the last ten years, with the highest numbers in the 15 to 19 year age group.

Consequently, implementation of the Mental Health Strategy and CCG Mental Health Programme are key tasks over the next few years, in particular the development of Primary Mental Health Care Services.

The number of people in Bromley with dementia continues to rise, especially in the over 85 year age group, however identification of dementia is below expected levels.

Implementation of the Prime Minister's challenge on Dementia is important to improve this position.

11. End of Life Care

Good quality end of life care is critically important in giving the individual patient and their family a positive experience of care at a difficult time in their lives.

Evidence shows that the majority of people express a preference to die at home, however, in Bromley between 2010 and 2012, over half of deaths (53%) occurred in hospital. There has, however, been a consistent reduction in the proportion of hospital deaths and increase in the proportion of deaths at home, in care homes and hospices since 2006.

Coordinate My Care, a clinical service which coordinates care of patients nearing the end of life has been successful nationally in increasing the proportion of patients dying in their preferred place of death. This service has been introduced in Bromley, but an audit of some practices has shown that there is still scope for improvement in recognising patients as appropriate for end of life care and ensuring that it is possible for them to die in their preferred place of death.

Cancer patients are more likely than non-cancer patients to die at their preferred place of death, partly because it is more difficult to predict the end of life phase in these patients. Work is therefore being done in Bromley to introduce key workers to assist in proactive care planning for the end of life.

12. Carers

Data from the 2011 census indicates that 10% of Bromley's population (approximately 31,000 people) are carers. Just over 6000 of these carers provide more than 50 hours of unpaid care per week. The number of carers known to services in Bromley is much smaller. The 2013 Bromley Carers Survey found that only 45% of the respondents had undergone a Carers Assessment, which is significant given that many (particularly older) carers have a long term condition or disability themselves, and also many report that caring has a negative impact on their mental health.

There has been significant increase in the numbers of young carers identified in Bromley, however, as with adults, not all carers are known to support services. Young carers are known to experience bullying, educational difficulties and emotional problems, and so would benefit from good support.

The Carers and Young Carers Strategies are currently being refreshed.

13. Substance Misuse

Although estimates suggest that approximately 15,000 Bromley residents will have taken an illicit drug in the last year, the number of opiate, crack and injecting drug users is estimated to be under 3000.

The rates of opiate, crack and injecting drug use have been falling over the last two years and are lower than the rates for London and England.

In 2012-13, there were 529 treatment episodes for substance misuse in Bromley and an increase in the number of opiate users successfully completing treatment.

There is a higher proportion of older (60 years+) people being treated for substance misuse in Bromley. This age group often present with more complex problems which will impact on health and social care services.

14. Alcohol

Alcohol misuse is a significant public health issue, with over 26% of the population regularly consuming quantities of alcohol sufficient to damage their health. This is similar to national levels, which have been showing a trend towards an increasing proportion of people in higher risk groups.

Despite the extent of this problem, recording of alcohol consumption in primary care is low and needs to be improved.

Of concern is the trend of increasing alcohol specific hospital admission rates in under 18 year olds in Bromley.

Although alcohol-related crime rates in Bromley are lower than the national average, and have been falling, there is a gap in information relating to alcohol-related domestic violence as there are currently no national figures on prevalence.

Specialist Alcohol Treatment Services provide treatment to those whose drinking is harmful or who are alcohol dependent (5.9% of the population). In 2012-13, 380 adults received treatment, of whom 37% completed treatment successfully, this was an improvement on the previous year, but is lower than the national figure of 40%.

15. Frequent Attenders to Unscheduled Care

Increasing pressure has been put on Accident and Emergency (A&E) Departments across the country in recent years with rising numbers of attendances. Amongst these attendances are a proportion which can be attributed to a sub group referred to as A&E Frequent Attenders (attend A&E three or more times in a year).

The issue with A&E frequent attenders highlights the question of whether the healthcare needs of these patients are being met by the current service provision, and if these needs should be met by the emergency services or other alternative care pathways. Although these frequent attenders do not represent all the service users, we could see that a significant amount of resource could be saved if the number of frequent attendances could be reduced.

In 2012-13 in Bromley, 5,362 A&E frequent attenders accounted for 22.4% of all A&E attendances. The frequency of attendances ranged from 3 to 135 times, with an average of 4 visits per year. There was a particularly high proportion of frequent attenders under the age of 5 years (17.5%), with 41% of these being under the age of 1 year. The commonest presenting complaints in frequent attenders related to respiratory illness, feeling unwell, and abdominal pain. However, there were a significant numbers of attendances relating to conditions which might be better dealt with in settings other than A&E e.g. attendance for intramuscular or intravenous injections, catheter problems, blood tests, feeding tube problems.

Only a third of visits by frequent attenders resulted in hospital admission, with just under half of attendances (49%) resulting in discharge with either no follow up, or follow up by GP.

A sub group of 43 patients attended A&E 15 or more times in the year, of these, 72% were male and 23% were from outside the borough. This group of patients were most likely to present with chest pain, alcohol-related problems or mental health problems.

There are indications that improving/ developing primary and community care services could reduce the number of frequent attenders.

There is scope for further work to assess the needs of A&E frequent attenders.

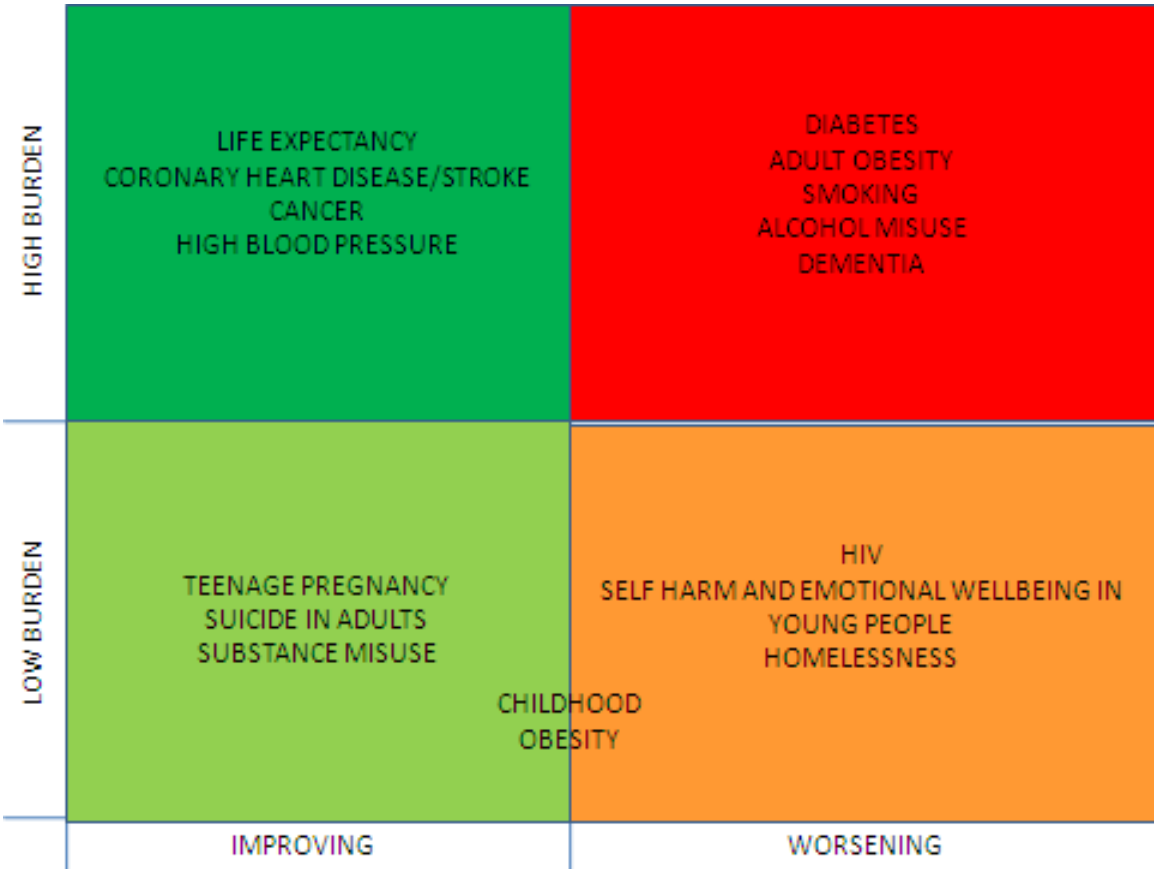
JSNA Priorities

In order to decide where best to focus our efforts to improve the health of the population it is helpful to use a prioritisation framework. A simple way of considering the relative priority of different health issues is to consider the burden in terms of the numbers of people affected, and then whether the problem is improving or worsening over time. The highest priority is allocated to the issues creating the highest burden which seem to be worsening over time.

The table below has been populated to show the relative priorities of the key issues.

The red box represents the highest priority issues according to this framework.

The orange box should be considered as a warning box i.e. areas where more in-depth work is necessary to understand and manage evolving problems.



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Report No.

London Borough of Bromley

HEALTH AND WELLBEING BOARD

Date: **Thursday 24th July 2014**

Report Title: **Health & Wellbeing Strategy Priorities and their Delivery**

Report Author: Terry Parkin, Executive Director of Education, Care & Health Services and Steven Heeley, Public Health Transition Manager.

Chief Officers: Terry Parkin, Executive Director of Education, Care & Health Services
Dr Nada Lemic, Director of Public Health.

1. SUMMARY

1.1. The Bromley Health & Wellbeing Strategy 2012–15 is a key responsibility of the Health & Wellbeing Board (HWB), setting out how it will meet the needs identified within the Joint Strategic Needs Assessment (JSNA) through a number of locally determined priorities. Nine priorities formed part of the initial Strategy agreed in 2012.

1.2. Following the annual refresh of the Strategy as set out in a report to the HWB in January and the recently updated 2013-14 JSNA, this report proposes a reduced number of priorities identified from the prioritisation process of the JSNA. It is important for the Board to select key strategic priorities for action, that will make a real impact on Bromley residents' lives.

2. REASON FOR REPORT GOING TO HEALTH & WELLBEING BOARD

2.1. To update the Board on the ongoing work to update Bromley's Health & Wellbeing Strategy, include proposals for a model of governance for integration and for identifying the 2014-15 priorities.

3. SPECIFIC ACTION REQUIRED BY HEALTH & WELLBEING BOARD AND ITS CONSTITUENT PARTNER ORGANISATIONS

For the Health & Wellbeing Board to:

3.1. Agree a model of governance for work on integration;

3.2. Agree that a joint integrated commissioning board should be established to drive work on integration of health and social care as given in paragraphs 4.8; and

3.3. Consider and comment on the prioritisation matrix set out in 4.4 and identify a small number of priority actions that might form the basis of our Health and Wellbeing Strategy for the Municipal Year 2014-15 as given in paragraphs 4.9 and 4.10.

Health & Wellbeing Strategy

The Health & Wellbeing Strategy outlines the priorities (based on the JSNA) agreed by the Health & Wellbeing Board together with the proposed actions and expected outcomes.

Financial

1. Cost of proposal: Within existing budgets.
2. Ongoing costs: Within existing budgets.
3. Total savings (if applicable): Not applicable.
4. Budget host organisation: Not applicable.
5. Source of funding: Not applicable.
6. Beneficiary/beneficiaries of any savings: Not applicable.

Supporting Public Health Outcome Indicator(s)

The Health & Wellbeing Strategy will record progress against the relevant Public Health Outcome Indicators.

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4. COMMENTARY

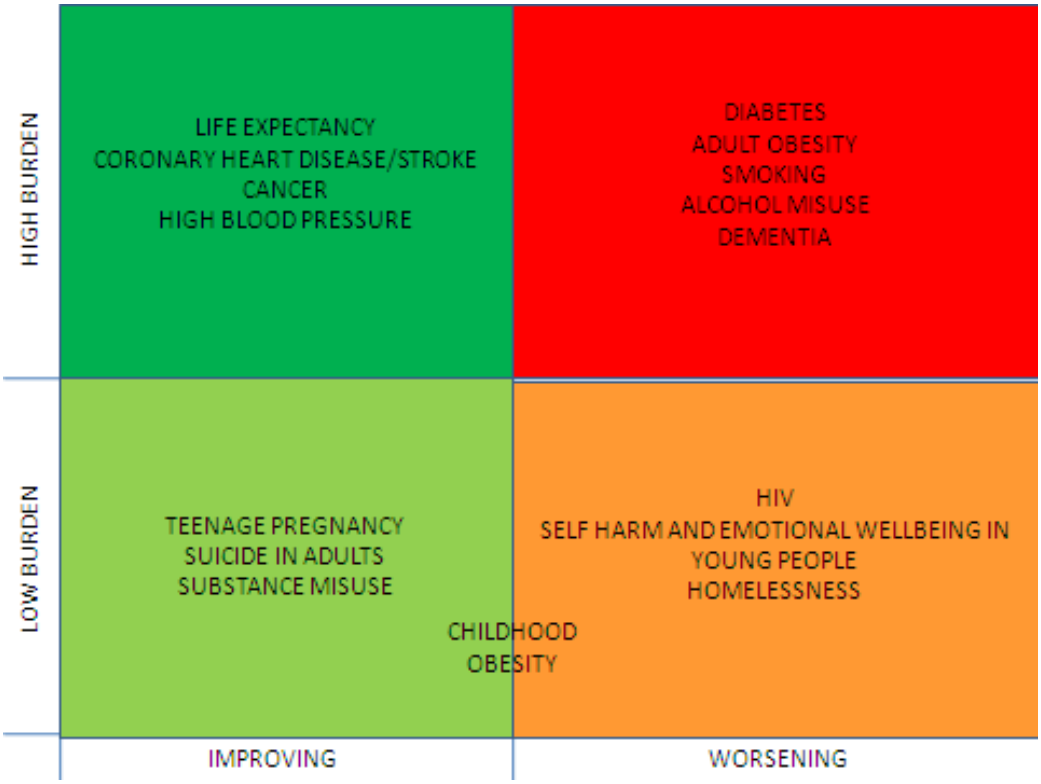
4.1. The Health & Social Care Act 2012 places a duty on Health & Wellbeing Boards to produce a Joint Strategic Needs Assessment (JSNA) and a Joint Health & Wellbeing Strategy (JHWS). Bromley's existing Strategy was agreed in 2012 with a commitment to annual review and refresh it in order for it to remain relevant and in accord with emerging needs identified in the annual JSNA.

4.2. The current Strategy has nine agreed priorities as follows:

- Diabetes
- Obesity
- Hypertension
- Anxiety and Depression
- Dementia
- Support for Carers
- Children with Mental & Emotional Health Problems
- Children Referred to Social Care
- Children with Complex Needs and Disabilities

4.3. Progress on each of the nine priorities was given to the Board at the January 2014 meeting [Report HWB14003] with a summary of the main achievements over the last two years along with a red, amber and green rating (RAG) based on the progress against the three year outcomes.

4.4. The 2014 JSNA is near completion with an Executive Summary presented to the Board. In this, specific need across the borough is identified in order to inform discussion on the selection of priorities for the Health & Wellbeing Strategy. The final chapter on the 2014 JSNA includes a prioritisation process which includes the following matrix populated to show the relative priorities of the key issues.



4.5. The red box represents the highest priority issues according to this framework. The orange box should be considered as a warning box, i.e. areas where more in-depth work is necessary to understand and manage evolving problems.

4.6. In addition, the acute Trust running the Princess Royal University Hospital (PRUH) continues to report very high numbers of unplanned admissions through attendance at their Accident and Emergency department.

4.7. In order for the Board to effectively focus upon and be accountable for the Strategy's priorities going forward, it is recommended that significantly fewer than nine priorities are agreed for 2014-15, and that a high level joint officer board is established to oversee progress on these priorities.

4.8. The Bromley Clinical Commissioning Group (BCCG) and the London Borough of Bromley (LBB) have been working for the last year now on mechanisms for promoting better integration of commissioning. Integration to a limited degree is seen in mental health and children's commissioning but more needs to be done to bring efficiencies. An officer group, the Joint Integrated Commissioning Executive (JICE) exists to explore issues of integration but lacks governance. It would therefore be wholly appropriate for the HWB to provide that governance.

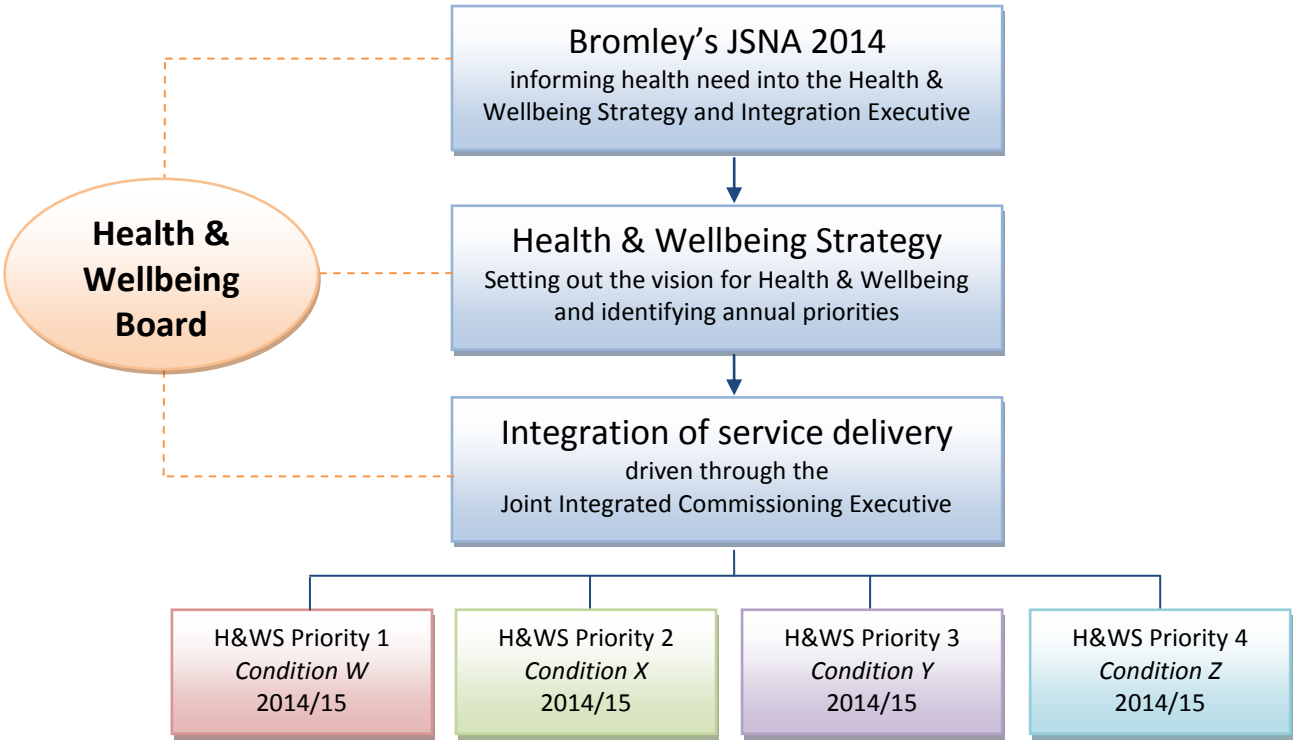
4.9. If the HWB agrees that this would be desirable, it could then use this model to drive improvement in the areas chosen for a focus. The present membership of the JICE is as follows:

- Chief Operating Officer, BCCG
- Director of Commissioning, BCCG
- Executive Director, ECHS
- Assistant Director – Commissioning, ECHS
- Lead Commissioner, ECHS

4.10. The Board may wish therefore to add one or two of its members to that executive to provide it with a strong governance oversight for integration.

4.11. The establishing of priorities in the past has focused on conditions. The recommendation to the HWB is that this model continues but is managed in a significantly different way. The Board should use the JICE to drive integration of services for our residents. The benefits of such integration are well known, not least as they can reduce significantly the numbers of professionals residents come into contact with through the management of their often very complex conditions but also, as we have begun to see with the proMISE programme, act in such a way as to maintain independence for longer allowing residents to stay in their homes reducing both emergency admissions but also the numbers moving into specialist residential care.

4.12. The following diagram sets out how the above model would work:



4.13. The HWB should task the JICE to develop a set of Terms of Reference to be approved by the respective governing bodies and then produce a work plan focusing on the integration of service delivery to residents with reducing the numbers of unplanned admissions a key performance indicator of that work.

4.14. The HWB should identify a small number of 2014/15 priorities from the 'red' sector in 4.4 above as exemplars of how those benefits might be realised. Evidence would suggest that the following would benefit significantly from this approach:

- Diabetes
- Dementia
- Obesity
- Emotional Wellbeing of Young People

4.15. It is not feasible for all conditions or population groups identified in the prioritisation matrix to be taken forward as a priority. This does not however mean that no action is being taken to address needs or improve services within the borough.

5. FINANCIAL IMPLICATIONS

5.1. We would expect the work to be undertaken through existing budgets but with better targeting of resources to see reductions in system costs, for example, through fewer emergency admissions, or reduced numbers of placements in nursing or other residential settings. These cannot be quantified at the outset of this programme but will be developed across the year.

5.2. The drive for integrated service delivery forms the basis of the Better Care Fund. At this point in time, it is unclear the financial implications of this on existing and pooled budgets.

6. LEGAL IMPLICATIONS

6.1. Under the Health and Social Care Act 2012 it is a statutory responsibility of local authorities and clinical commissioning groups (CCGs) to prepare JSNAs and JHWSs, through the Health and Wellbeing Board.

7. IMPLICATIONS FOR OTHER GOVERNANCE ARRANGEMENTS, BOARDS AND PARTNERSHIP ARRANGEMENTS, INCLUDING ANY POLICY AND FINANCIAL CHANGES, REQUIRED TO PROGRESS THE ITEM

7.1. The Health & Wellbeing priorities, integration of service delivery and the proposed model of governance requires the full agreement and support from the London Borough of Bromley, Bromley's Clinical Commissioning Group and all other partners of the Health & Wellbeing Board.

Non-Applicable Sections:	COMMENT FROM THE DIRECTOR OF AUTHOR PUBLICATION.
Background Documents: (Access via Contact Officer)	2014 Joint Strategic Needs Assessment (JSNA) Update report – 24th July 2014. Annual Refresh of the 2012 Health & Wellbeing Strategy report [HWB14003] – 30th January 2014.

Report No.

London Borough of Bromley

HEALTH AND WELLBEING BOARD

Date: **Thursday 24th July 2014**

Report Title: **Health and Wellbeing Board Matters Arising and Work Programme**

Report Author: Helen Long, Democratic Services Officer, London Borough of Bromley
Tel: 0208 313 4595 E-mail: helen.long@bromley.gov.uk

Chief Officer: Director of Corporate Services, London Borough of Bromley

1. SUMMARY

1.1. Members of the Board are asked to review the Health and Wellbeing Board's work programme for 2014/15 and to consider progress on matters arising from previous meetings of the Board.

1.2. The action list (Matters Arising) and Glossary of terms are also attached.

2. REASON FOR REPORT GOING TO HEALTH & WELLBEING BOARD

2.1. The Board is asked to consider its work programme and matters arising and indicate any changes that it wishes to make.

2.2. The Board is also asked to note that the Action List and Glossary of terms will be included in this report for each meeting.

3. SPECIFIC ACTION REQUIRED BY HEALTH & WELLBEING BOARD AND ITS CONSTITUENT PARTNER ORGANISATIONS

3.1 None.

Health & Wellbeing Strategy

Not Applicable.

Financial

1. Cost of proposal: No cost.
2. Ongoing costs: Not applicable.
3. Total savings (if applicable): Not applicable
4. Budget host organisation: Democratic Services, London Borough of Bromley
5. Source of funding: 2014/15 revenue budget.
6. Beneficiary/beneficiaries of any savings: Not applicable.

Supporting Public Health Outcome Indicator(s)

Not applicable.

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4. COMMENTARY

4.1. The Board's Matters Arising table is attached at **Appendix 1** this report updates Members on recommendations from previous meetings which continue to be "live".

4.2. The draft 2014/15 Work Programme is attached as **Appendix 2**. This requires further work to populate the projected agenda items for each meeting. Reports may be added to the programme or there may be references from other Committees, the Portfolio Holder or the Executive.

4.3. The Glossary of terms is attached at **Appendix 3**. This will be updated as necessary and will form part of this report at each meeting. The Administration Protocol is at **Appendix 4**.

Non-Applicable Sections:	**FINANCIAL IMPLICATIONS; LEGAL IMPLICATIONS; IMPLICATIONS FOR OTHER GOVERNANCE ARRANGEMENTS, BOARDS AND PARTNERSHIP ARRANGEMENTS, INCLUDING ANY POLICY AND FINANCIAL CHANGES, REQUIRED TO PROGRESS THE ITEM;** and **COMMENT FROM THE DIRECTOR OF PUBLIC HEALTH**
Background Documents: (Access via Contact Officer)	None.

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Appendix 1

Health and Wellbeing Board

Matters Arising

Agenda Item	Action	Officer	Notes	Complete
JSNA *(28/11/13)*	Voluntary Sector requested an easy to read executive summary	**Nada Lemic/ Angela Bhan**	Action Needed – outstanding from 28th November 2013	
Urgent Care	Dates on graphs confusing – should all be in English format Difficulties with patient transport	**Angela Bhan** **Angela Bhan**	 Update report in March	
Health care Facilities in Bromley *(20/3/14)*	(i)Recommendation to be made to NHS England for an additional GP practice. (ii) NHS England to be invited to a future meeting (iii) NHS London to be asked for a statement on the shortage of GP provision in Bromley Town centre.			

Appendix 2

HEALTH AND WELLBEING BOARD
DRAFT WORK PROGRAMME 2014/15

Title	Report Author	Notes
Health and Wellbeing Board – 24th July 2014 (1.30pm)		
Pharmaceutical Needs Assessment	Dr Agnes Marossy, LBB	
South East London Commissioning Strategy	Dr Angela Bhan/ Ross Graves, BCCG	
2013/14 JSNA Update	Dr Agnes Marossy, LBB	
Health and Wellbeing Priorities	Terry Parkin, LBB	
Health and Wellbeing Board – 2nd October 2014 (1.30pm)		
Winterbourne View	Peter Davis, LBB	
2013/14 JSNA – final update	Dr Agnes Marossy, LBB	
Draft PNA for consultation	Dr Agnes Marossy, LBB	
Health and Wellbeing Board – 27th November 2014 (1.30pm)		
Health and Wellbeing Board – 29th January 2015 (1.30pm)		
PNA – final version	Dr Agnes Marossy, LBB	
Winterbourne View	Peter Davis, LBB	
Health and Wellbeing Board – 26th March 2015 (1.30pm)		
Other reports/issues		
Visits to GP surgeries and other relevant establishments	TBC	Visits to GP surgeries and other relevant establishments

Appendix 3

Glossary of abbreviations – Health & Wellbeing Board

Acute Treatment Unit	(ATU)
Antiretroviral therapy	(ART)
Any Qualified Provider	(AQP)
Autistic Spectrum Disorders	(ASD)
Behaviour, Attitude, Skills and Knowledge	(BASK)
Better Care Fund	(BCF)
Black African	(BA)
Body Mass Index	(BMI)
British HIV Association	(BHIVA)
Bromley Clinical Commissioning Group	(BCCG)
Cardiovascular Disease	(CVD)
Care Quality Commission	(CQC)
Children & Adolescent Mental Health Service	(CAMHS)
Chlamydia Testing Activity Dataset	(CTAD)
Clinical Commissioning Group	(CCG)
Clinical Decision Unit	(CDU)
Community Learning Disability Team	(CLDT)
Director of Adult Social Services	(DASS)
Director of Children's Services	(DCS)
Disability Discrimination Act 1995	(DDA)
Emergency Hormonal Contraception	(EHC)
Florence – telehealth system using SMS messaging	(FLO)
Health & Wellbeing Board	(HWB)
Health & Wellbeing Strategy	(HWS)
Hypertension Action Group	(HAG)
Improving Access to Psychological Therapies programme	(IAPT)
In Depth Review	(IDR)
Integration Transformation Fund	(ITF)
Intensive Support Unit	(ISU)
Joint Health & Wellbeing Strategy	(JHWS)
Joint Strategic Needs Assessment	(JSNA)
Kings College Hospital	(KCH)
Local Medical Committee	(LMC)

Local Pharmaceutical Committee	(LPC)
Long Acting Reversible Contraception	(LARC)
Medicines Adherence Support Service	(MASS)
Medicines Adherence Support Team	(MAST)
Medium Super Output Areas	(MSOAs)
Men infected through sex with men	(MSM)
Mother to child transmission	(MTCT)
Multi-Agency Safeguarding Hubs	(MASH)
National Chlamydia Screening Programme	(NCSP)
National Institute for Clinical Excellence	(NICE)
Nicotine Replacement Therapies	(NRT)
Nucleic acid amplification tests	(NATTS)
Patient Liaison Officer	(PLO)
People living with HIV	(PLHIV)
Pharmaceutical Needs Assessment	(PNA)
Policy Development & Scrutiny committee	(PDS)
Primary Care Trust	(PCT)
Princess Royal University Hospital	(PRUH)
Proactive Management of Integrated Services for the Elderly	(ProMISE)
Public Health England	(PHE)
Public Health Outcome Framework	(PHOF)
Quality, Innovation, Productivity and Prevention programme	(QIPP)
Queen Mary's, Sidcup	(QMS)
Secure Treatment Unit	(STU)
Sex and Relationship Education	(SRE)
Sexually transmitted infections	(STIs)
South London Healthcare Trust	(SLHT)
Special Educational Needs	(SEN)
Supported Improvement Adviser	(SIA)
Tailored Dispensing Service	(TDS)
Unitary Tract Infections	(UTI)
Urgent Care Centre	(UCC)
Voluntary Sector Strategic network	(VSSN)
Winterbourne View Joint Improvement Programme	(WVJIP)

Appendix 4

Health and Wellbeing Board

Administration Protocol

1. The agenda will be published in line with the attached timetable.

2. Officers have been informed that late items, i.e. those that are too late for making it onto the agenda by the Friday prior to agenda publication, will be considered under Any Other Business. This will only be in cases where no specific action is required by the Board and that it is received four working days in advance of the meeting.

3. The electronic distribution of agenda papers will follow the standard protocol adopted by all other Council committees. The agenda pack link will be distributed via email five clear working days prior to the meeting date. Hard copies will be circulated in the van delivery at least two working days prior to the meeting.

4. In between meetings Officers will circulate information briefings where necessary, to enable Board Members to keep up to date with developments rather than waiting until the next meeting. Briefings will be distributed electronically. All information briefings circulated in this way will be included on the next agenda.

5. Following the meeting an action sheet and the minutes will be produced and distributed to the Chairman within 3 working days of the meeting. Once the Chairman has cleared the minutes they will be distributed to all Board Members.

6. Officers will produce a glossary of terms as a reference guide for Board Members. This will be updated and included in each agenda pack. Further copies will be available from the clerk.

Health and Wellbeing Board

Board Meeting and Publication Dates 2014/15

Agenda Published & Electronic Dispatch	Van Dispatch Date	Meeting Date
Wednesday 16 July	Tuesday 22 July	Thursday 24 July 2014
Wednesday 24 September	Tuesday 30 September	Thursday 2 October 2014
Wednesday 19 November	Tuesday 25 November	Thursday 27 November 2014
Wednesday 21 January	Tuesday 27 January	Thursday 29 January 2015
Wednesday 18 March	Tuesday 24 March	Thursday 26 March 2015
Wednesday 13 May	Tuesday 19 May	Thursday 21 May 2015