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DATE: 23 October 2015

To: Members of the

HEALTH SCRUTINY SUB-COMMITTEE

Councillor Judi Ellis (Chairman)
Councillor Pauline Tunnicliffe (Vice-Chairman)
Councillors Ruth Bennett, Mary Cooke, Ian Dunn, Hannah Gray, David Jefferys, Terence Nathan, Charles Rideout QPM CVO and Stephen Wells

Non-Voting Co-opted Members

Linda Gabriel, Healthwatch Bromley
Justine Godbeer, Bromley Experts by Experience - Alternate
Tia Lovick, Living in Care Council
Rosalind Luff, Carers Forum - Alternate

A meeting of the Health Scrutiny Sub-Committee will be held at Bromley Civic Centre on **WEDNESDAY 4 NOVEMBER 2015 AT 4.30 PM**

MARK BOWEN
Director of Corporate Services

Copies of the documents referred to below can be obtained from http://cds.bromley.gov.uk/

A G E N D A

1 APOLOGIES FOR ABSENCE AND NOTIFICATION OF SUBSTITUTE MEMBERS

2 DECLARATIONS OF INTEREST

3 QUESTIONS FROM 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 Thursday 29th October 2015.

4 MINUTES OF THE MEETING OF HEALTH SCRUTINY SUB-COMMITTEE HELD ON 11TH JUNE 2015
(Pages 3 - 8)

5 PRUH IMPROVEMENT PLAN - UPDATE FROM KINGS

6 URGENT CARE SERVICE - UPDATE FROM THE CCG

7 UPDATE ON BROMLEY NHS HEALTH CHECKS PROGRAMME (FUNDED BY NHS S.256 FUND)
(Pages 9 - 18)

8 DIABETES PREVENTION INTERVENTION
(Pages 19 - 30)

9 OUR HEALTHIER SOUTH EAST LONDON - JOINT HEALTH SCRUTINY COMMITTEE
(Pages 31 - 44)

10 WORK PROGRAMME 2015/16
(Pages 45 - 48)

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HEALTH SCRUTINY SUB-COMMITTEE

Minutes of the meeting held at 3.30 pm on 11 June 2015

Present:

Councillor Judi Ellis (Chairman)
Councillor Pauline Tunnicliffe (Vice-Chairman)
Councillors Ruth Bennett, Mary Cooke, Ian Dunn, Hannah Gray, Terence Nathan and Stephen Wells

Leslie Marks

56 APOLOGIES FOR ABSENCE AND NOTIFICATION OF SUBSTITUTE MEMBERS

Apologies for absence were received from Councillors David Jefferys and Charles Rideout, from Linda Gabriel (who was replaced by Leslie Marks), Justine Godbeer and Tia Lovick. Apologies were also subsequently received from Peter Moore.

57 DECLARATIONS OF INTEREST

There were no declarations of interest.

58 QUESTIONS FROM COUNCILLORS AND MEMBERS OF THE PUBLIC ATTENDING THE MEETING

Three questions for written reply had been received from Susan Sulis – these are attached as appendix 1 to these minutes.

In addition, the Chairman stated that a number of questions had been sent in from the Coppers Cope Area Residents Association about services at the Beckenham Beacon. Although these were submitted after the deadline Dr Angela Bhan had offered to provide an update on the issues raised, and commented as follows -

- Radiology Services should be available at weekends – Diagnostic services were available, although there was some variability on opening times. The CCG was in discussion with Kings.

- Blood Services: an appointment system was needed to reduce waiting – The CCG was starting work with Healthwatch to review phlebotomy services across the borough with the aim of making them more accessible and reducing waiting times. Services at the Beacon had improved in the last year, although more needed to be done.

- Urgent Care Centre Hours should be extended to 10pm – The service was already available 8am to 8pm 7 days a week, but demand for services after 8pm was being reviewed.

- A Fracture Clinic Services was needed – This required hospital back-up.

- Lack of Car Parking – The amount of parking provided was controlled by the planning permission for the site and could not be changed. All former PCT properties were now managed by NHS Property Services.

- Introduction of other services – A one-stop cardiology service was already provided, and discussions were being held about neurology services.

Members commented that more could be done to free up parking spaces if space at the Sainsbury's multi-storey car park was better used.

59 MINUTES OF THE MEETING OF HEALTH SCRUTINY SUB-COMMITTEE HELD ON 15TH APRIL 2015

RESOLVED that the minutes of the meeting held on 15th April 2015 be confirmed.

60 PRESENTATION FROM MONITOR ON KINGS COLLEGE HOSPITAL TRUST

The Sub-Committee received a presentation from Mark Turner, London Regional Director of Monitor, on their role and in particular on their work with King's.

The presentation included an overview on the role of Monitor in regulating Foundation Trusts, but then focussed on their involvement with Kings from the acquisition of the PRUH, enhanced monitoring, regulatory escalation and oversight of turnaround. Prior to the acquisition, the PRUH had suffered longstanding financial, operational and quality issues; many improvements had been achieved, but there were still some very challenging areas of performance. In particular, there was a planned deficit for 2015/16 of £65m. Monitor was requiring that Kings develop and implement one and two-year recovery plans, and a five year recovery plan by October 2015. There would be an intense programme of work in the next six months to ensure that plans were robust, to ensure that planned improvements were happening and making an impact and to put in place an appropriate funding package.

The Chairman thanked Mr Turner for his presentation.

61 UPDATE FROM KINGS ON THE PRUH IMPROVEMENT PLAN

The Acting Chief Executive of Kings, Roland Sinker, attended the meeting to update the Sub-Committee. The Chairman reported that the visit to the PRUH and Orpington Hospital had been very useful – Mr Sinker responded that the visit had been appreciated by staff, and also commented that engagement with Monitor had been very constructive.

Mr Sinker gave a presentation covering King's five point plan, performance and finances, the financial challenges in detail and how Members could help King's meet its challenges. The five point plan was –

- Continue to improve the quality of care for patients
- Deliver the one and two-year Monitor financial recovery plans
- Move to operational sustainability, particularly for the PRU Emergency Department (ED)
- Develop the Monitor 5 year plan
- Continue to invest in staff development and innovation

Despite the challenges, there was still an enormous strength within the Trust and great commitment from staff. There had been improvement in some areas such as maternity services at the PRUH, but particular challenges such as availability of medical records and Emergency Department performance, which was a greater challenge than had been anticipated. Infection control was very good for MRSA, but CDifficile was more difficult – partly because of a lack of space for isolating infected patients. He concluded his presentation by stating that both he and Lord Kerslake the Trust Chairman were spending o lot of time engaging with stakeholder, and by reporting that the process for appointing a permanent Chief Executive was underway.

Mr Sinker responded to questions from Members –

- A member was concerned that discharge rates were not good enough – officers confirmed that many of the delays were for patients who were self-funders or who were from outside the borough. Mr Sinker considered that the key to improving discharge was greater involvement with GPs a member commented that GPs said that they were not always informed when people were discharged.

- Asked about the Emergency department, Mr Sinker reported that there was an appreciation of a range of different risks and threats, and of the impact of population growth including an ageing population and a growth in numbers of young people.

- A Member commented that many people, particularly in the gay community, used sexual health services in Greenwich, which might be hiding levels of need in Bromley.

- Asked about whether CQC Inspections might reveal further issues, Mr Sinker responded that he received an escalation report each night and performance information was thoroughly triangulated, so he did not anticipate anything unexpected.

The Chairman thanked Mr Sinker and requested that the Trust provide update information to the Sub-Committee in advance of the next meeting on 4th November.

62 WORK PROGRAMME 2015/16
Report CSD15070

The Sub-Committee noted its work programme for 2015/16. Future meetings would revert to the normal 4.30pm start time.

The Meeting ended at 5.12 pm

Chairman

Appendix 1

HEALTH SCRUTINY SUB-COMMITTEE

QUESTIONS FROM MEMBERS OF THE PUBLIC FOR WRITTEN REPLY

From Ms Sue Sulis, Secretary, Community Care Protection Group *(Replies in italics)*

1. BROMLEY COUNCIL'S PUBLIC HEALTH BUDGETS AND EXPENDITURE IN 2013/14; 2014/15; & 2015/16.

(a) In 2013/14, what was:-

(i) The figure for the budget? *£12,600,800*

(ii) The under-spend carried forward? *£769k*

(iii) This under-spend used for in 2014/15? (Please give breakdown)
£98k Weight Management, £431k CAMHS, £240k Children's Centres

(b) In 2014/15, what was the figure for the budget? *£12,953,600*
(c) Was there an under-spend? (If so, how much?) *£141k*
(d) What is the Budget for 2015/16? *£12,953,600*
(e) Has this been cut? *No*

2. PROVISION OF ADEQUATE NUTRITION DURING SCHOOL HOLIDAYS FOR BROMLEY CHILDREN ASSESSED AS NEEDING FREE SCHOOL MEALS. (Ref. Appendix 1 – Answers to CCPG Public Questions to 15th April 2015 HSSC)

Adequate nutrition for the thousands of children at risk of malnutrition and food poverty is a Public Health issue. That the majority of children are not at risk is not an excuse to do nothing.

Why does the Director of Public Health not introduce initiatives for provision during school holidays?

During term time there are free school meals for children in school, and cookery classes offered through Children and Family Centres. The cookery classes aim to support mothers of young children in cooking healthy nutritious meals on a low budget. Although the classes do not run during the school holidays, the skills gained in the cookery classes should help to support adequate nutrition for children at risk of malnutrition.

Since September 2014 practical cooking and food education has been compulsory in the new curriculum for pupils up to the end of Key Stage 3. Schools actively involve parents in cooking and gardening clubs. Parents and children learn and develop food knowledge and cookery skills together which can be implemented in the home environment.

In addition the Healthy Start scheme provides vouchers directly to families where there are children at risk of malnutrition. A brief description is below.

Healthy Start scheme

If you're pregnant or have a child under 4, the Healthy Start scheme can help you buy basic foods like milk or fruit. You will qualify for the Healthy Start scheme if either:

- *you're at least 10 weeks pregnant*
- *you have at least 1 child under 4 years old*

In addition, you must be receiving any of the following:

- *Income Support*
- *income-based Jobseeker's Allowance*
- *Child Tax Credit (but only if your family's annual income is £16,190 or less)*
- *income-related Employment and Support Allowance*
- *Working Tax Credit (but only if your family is receiving the 4 week 'run-on' payment)*
- *You'll also be eligible for the Healthy Start scheme if you're pregnant and under 18, even if you don't receive any benefits.*

Working Tax Credit run-on is the payment you receive for a further 4 weeks immediately after you stop qualifying for Working Tax Credit. If you qualify for the scheme you'll be sent vouchers to spend on:

- *milk*
- *fresh fruit and vegetables*
- *plain frozen fruit and vegetables*
- *infant formula*

You get 1 voucher a week if:

- *you're pregnant*
- *have a child aged between 1 and 4*

You get 2 vouchers a week if you have a child under 1.

3. THE ROLE OF INTERMEDIATE CARE BED PROVISION IN ALLOWING PATIENTS NEEDING REHABILITATION TO BE MOVED OUT OF HOSPITAL ACUTE BEDS, AND BACK TO THEIR HOMES. (Ref. Min.54 'Winter Pressures – CCG Update). Bromley Care Services are to be congratulated on their ability to avoid delayed discharges at the PRUH.

(a) What role does the provision of Intermediate Care Beds play in this?

This service is jointly commissioned by the Council and Bromley CCG and provides a holistic service to people who are not yet able to return home but who no longer need acute health interventions. This enables us to provide a multi-disciplinary approach enabling the service user/ patient to regain their independence before they go home.

(b) When will we see a report on the performance of the Intermediate Care contract at Lauriston House on an agenda?

The service is monitored by the Bromley CCG on behalf of the CCG and the Council at the BHC Contract Management Board. Bromley CCG has recently commissioned consultancy support to review the discharge pathway and rehabilitation provision. Bromley CCG has engaged with the Council as a key partner in the review and transformation process and will share the outcomes of the work at the appropriate forums as it progresses.

Report No.
CS15932

London Borough of Bromley

PART ONE - PUBLIC

Decision Maker:	**Health PDS Committee**
Date:	**4th November 2015**
Decision Type:	Non-Urgent Non-Executive Non-Key
Title:	**Update on Bromley NHS Health Checks Programme (funded by NHS s.256 Funds)**
Contact Officer:	Gillian Fiumicelli, Community Vascular Co-ordinator Tel: 020 8461 7789 E-mail: Gillian.fiumicelli@bromley.gov.uk
Chief Officer:	Dr Nada Lemic, Director of Public Health, Education, Care and Health Services
Ward:	Boroughwide

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1. Reason for report

This report provides an update on the two projects supported from the monies moved to LBB under Section 256 Agreement in March 2013, previously agreed by the PDS Committee. A report was made to PDS committee in Oct 2014 and identified that a further update would follow. The purpose of the projects was to maximise the effectiveness of the NHS Health Check programme by conducting an evaluation.

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2. RECOMMENDATION(S)

The Members of the PDS committee are asked to note and comment on the progress that has been made since the previous report in October 2014.

Corporate Policy

1. NHS Health Checks is mandatory Public health programme for Health Improvement. REFERENCE The Local Authorities (Public health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2013 No. 351 Part 2 Regulation 4 and 5 http://www.legislation.gov.uk/uksi/2013/351/regulation/4/made)
2. BBB Priority: Promoting Independence: Diabetes is a Health and Wellbeing Strategy Priority

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Financial

1. Cost of proposal: £43,920
2. Ongoing costs: None
3. Budget head/performance centre: 800120
4. Total current budget for this head: £738,700 of which estimate £614,235 on NHS Health Checks
5. Source of funding: Section 256 Agreement in March 2013 underspend from Public Health whilst still Primary Care Trust.

Staff

1. Number of staff (current and additional): Current only
2. If from existing staff resources, number of staff hours: 400 hours

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Legal

1. Legal Requirement: Statutory Requirement to deliver the NHS Health Check programme:
2. Call-in: Applicable:

Customer Impact

1. Estimated number of users/beneficiaries (current and projected): Current: 93,215 (40 -74 year olds eligible for an NHS Health Check)

Ward Councillor Views

1. Have Ward Councillors been asked for comments? Not applicable
2. Summary of Ward Councillors comments:

3. COMMENTARY

3.1 Underspend in Public Health budget was moved from PCT to LBB in March 2013 using a Section 256 Agreement. The PDS agreed the use of this funding for two projects to improve the effectiveness of the NHS Health Checks programme. The two projects are:

- To perform evaluation of the NHS Health Check against the Pan London Standards (report presented to committee October 2014)

- To improve the diabetes element of the NHS Health Checks by conducting a diabetes prevention audit.

The projects have been completed and recommendations identified:

3.2 Evaluation of the NHS Health Checks

3.2.1 The majority of actions recommended in the Evaluation of NHS Health Checks report 2013-2014, have been implemented. (See Appendix 1)

3.2.2 Results of key findings and subsequent actions taken have been presented to both the Bromley CVD Strategy Group and NHS Health Check London Leads meetings.

3.2.3 Further evaluation against the Pan London Standards should be repeated in future, ideally based on 2015-16 data.

3.2.4 Current priority for audit is to assess if individuals identified at high risk at the time of their NHS Health Check, are managed appropriately, in order to maximise health outcomes.

An NHS Health Checks outcomes audit is currently being piloted in one General Practice, building on the findings of this evaluation project and the diabetes prevention audit. The aim of the pilot is to identify the most effective method of audit, which does not incur any additional cost. The plan is to rollout the Outcome audit to all GP Practices in December 2015.

3.3 Improving diabetes prevention in Bromley

3.3.1 The effectiveness of the NHS Health Check programme is essential in the identification of people at high risk of diabetes who require intensive lifestyle interventions to reduce their risk of progressing to diabetes.

A baseline audit has been completed for those people identified as meeting the criteria for the Diabetes Filter at the NHS Health Check between 1.4.11 and 31.3.13. This audit is an extension of the NHS Health Checks evaluation which identified the need for a comprehensive notes review element to increase understanding of clinical management.

3.3.2 The report with its recommendations has been shared with the Bromley Diabetes Network Group. Results have informed the implementation of the Diabetes Prevention Programme. The full audit report is available.

3.3.3 Summary of findings of the diabetes prevention audit

41 out of 45 GP Practices participated in the audit. The audit process had 3 phases:

- Computer searches of GP Clinical Systems
- Comprehensive notes reviews of a sample of consenting patients
- Intervention to increase identification of people at high risk of diabetes

Computer searches identified:

- Data on 15,367 patients who underwent an NHS Health Check in 2011-2013.
- Of this population, 5,379 (35%) met the NHS Health Checks diabetes filter criteria
- 3,593 (66%) of these patients underwent blood sampling for HbA1c and/or Fasting Plasma Glucose (FPG).
- 738 patients were found to be at high risk of diabetes and were requested by letter to give consent for a Public Health Vascular Nurse to access their clinical records for quality monitoring.
- 427 patients gave consent to notes review.
- A random sample of 20% or at least 2 sets of records from each practice equivalent to 112 patients were identified for comprehensive notes review.

The **comprehensive notes review** provided more detailed information in order to measure compliance with the audit standards. Notes assessed for:

- Frequency of patient review and further blood testing.
- Lifestyle interventions.
- Changes to risk factor profiles.
- Diagnostic coding

Findings included:

- Variation in presence and timing of follow up in both blood testing and review of risk factors and lifestyle management and interventions.
- Gaps in documentation of blood test sampling.
- Some improvement in patients risk factors e.g. 10 (8.9%) people improved the Body Mass Index category,
- 9 people had significant improvements in their repeat blood result, back to normal levels.
- 11% of patient records had a diagnostic code indicating high risk of diabetes.

Intervention to increase identification of high risk of diabetes

The intervention involved sending a letter and blood test request form, to individuals who had not had the required blood test post their NHS Health Check, but who had met the NHS Health Check diabetes filter criteria.

The computer searches were repeated in December 2014 to assess results of the intervention. Results were:

- 652 additional people had received a blood test for HBa1c
- 131(20%) more people, were found to be at high risk of diabetes from their blood test, following the intervention.

Implications of findings of diabetes prevention audit

The results have to be considered in context at the time these NHS Health Checks were performed (April 2011- March 2013). Although there was a recommended pathway for identification and management of high risk of diabetes in the NHS Health Checks best practice guidance, identification and management of people at high risk of diabetes was not part of usual care for General Practice at that time. NICE guidelines on the prevention of diabetes in high risk population were only published in July 2012. Therefore this audit is seen as a baseline position, from which we can identify those gaps and areas for improvement and requires improvement. Improvements are being implemented and re-audit planned as part of wider outcomes audit. (3.2)

To increase understanding of numbers people at high risk of diabetes regardless of the NHS Health Check an additional computer search of GP clinical systems was performed. 11,451 people had a raised blood test between 1.4.13 to 31.8.14, commensurate with 'high risk of diabetes' but not diagnosed with Diabetes. This search helped with the identification of people eligible for the Diabetes Prevention Programme.

4. LEGAL IMPLICATIONS

4.1 Under the requirements of The Local Authorities (Public Health Functions and Entry to Premises by London HealthWatch Representatives) Regulations 2013 No 351 Part 2 Regulation 4 and 5

4.2 The Local government will work with local partners to ensure that threats to health are understood and properly addressed in an efficient integrated streamlined system.

5. FINANCIAL IMPLICATIONS

Total allocation for the 2 projects was £44,000.

5.1 Evaluation of NHS Health Checks against the Pan London Standards: An underspend on this £20,000 budget allocated to this project as significant savings were made by not using an external academic institution but using internal expertise.

5.2 Improving diabetes prevention in Bromley: Final expenditure on this project was £19,070. against the allocated £24.000. The payments were made across 41 GP Practices dependent on activity. Maximum payment to one Practice was £1,800. An underspend was achieved on this budget by utilising resources CCG and Strategic Clinical Network.

Non-Applicable Sections:	**POLICY and PERSONNEL IMPLICATIONS**
Background Documents: (Access via Contact Officer)	References and further reading: http://www.healthcheck.nhs.uk/local_government/ Department of Health/ Public Health England (2013) NHS Health Check Programme. Best Practice Guidance

	http://www.healthcheck.nhs.uk/commissioners_and_healthcare_professionals/national_guidance/ Public Health England (2014) NHS Health Check programme standards: a framework for quality improvement http://www.healthcheck.nhs.uk/commissioners_and_healthcare_professionals/national_guidance/ NICE (2012) Preventing type 2 diabetes:risk identification and interventions for individuals at high risk http://www.nice.org.uk/guidance/PH38 NHS s.256 Funds approval to Use Carry Forward – Bromley NHS Health Checks Programme. 29th Oct 2013 (CS13046) Update on NHS s.256 Funds Approval – Bromley NHS Health Checks Programme 15th October 2014 Report of the Audit of the Prevention of Diabetes through the NHS Health Check

6. GLOSSARY OF TERMS USED IN REPORT

NHS Health Check diabetes filter criteria - When measured at the time of the NHS Health Check, if either:

- Body Mass Index ≥ 30 (or ≥27.5 in South Asian and Chinese population) and/or
- Blood Pressure ≥ 140mmHg Systolic and/ or ≥ 90 mmHg Diastolic

Then the individual should be further assessed for diabetes by having a blood test to measure HbA1c (or Fasting Plasma Glucose).

HbA1c – A blood test can measure a patient's glycated haemoglobin. By measuring glycated haemoglobin, clinicians are able to get an overall picture of a patients average blood sugar levels over a period of weeks/months. This is important as the higher the HbA1c, the greater the risk of developing diabetes and related complications. The measure can be expressed as mmol/mol or a %.

FPG – A simple blood test measures Fasting Plasma Glucose, blood is taken after several hours of fasting (8-10hours) to measure the glucose in the blood. This test helps diagnose diabetes or those at high risk.
Clinicians are advised to use HbA1c but where this is not available FPG has been used.

BMI - Body mass index is a measure of whether you're a healthy weight for your height.

NHS Health Check Evaluation
Progress to date of Implementation of Recommended Actions
October 2015

Group	Objectives	Actions	Progress to date	Pathway Outcome Measures
A **Call, Recall and Uptake**	**Objective 2:** To invite all eligible persons to attend an NHS Health Check 20% of eligible population aged 40-74 and no existing co-morbidities from list	• Target those practices with either too low or too high invitation rate • Further interrogation of the call/recall process • Develop a robust systematic approach for call/recall • Develop clearer guidance for general practices	• Individualised Practice feedback provided every quarter. • New call recall computer searches developed • Guidelines for call and recall reviewed and updated.	**Call/Recall** Updated guidelines developed and available for Primary Care Primary Care awareness of guidelines Evaluation of call/recall 2015-16 demonstrate robust systematic approach being used in Practice including monitoring of non responders and DNA's..
	Objective 7: Consistent approach to non-responders and those who do not attend: 100% eligible people receive 2 contacts	• Explore with practices if/how people who do not attend can be measured • Include method of recording in the guidance for general practice • Include monitoring within quarterly data returns from practices	• Data included in quarterly monitoring returns to assess 2 contacts. • To date not possible to have a consistent approach to non-responders due to different processes in the GP Practices. Continuing to work with key stakeholders to see if solution can be found to suit all.	
B **Data**	**Objective 4a:** Provision of the NHS Health Check: 100% of checks have 100% complete data	• Review new primary care template • Link mandatory data to payment • Establish if data collection by practice can be improved by utilising practice clinical systems • Provide further training • Ongoing review of data returns and report feedback to practices and alternative providers	• Recommendations implemented.	**Check completeness** Report on percentage of fully completed checks in GP Practice system regardless of Provider. Financial audit report on discrepancies Annual reports on Evaluation of the NHS Health Checks
	Objective 9: Confidential and timely transfer of patient identifiable data: 100% data sent to GP practice within 2 working days	• Develop process for GP practice to feedback to alternative provider if they have received information for a patient not registered with them • As part of financial audit review undertake notes review in pharmacies and follow through to GP practice • Complete review with financial audit department • Monitor timeframe for reporting data	• Recommendations implemented. • Public Health Vascular Team working with specific Providers when issues occur.	

		back to general practice and raise any issues as part of contract monitoring • Monitor quarterly data for practice discrepancies and target practices with input from Public Health Vascular Team to review and improve process for receiving patient reports		
C **Clinical**	**Objective 6:** Monitoring of quality within the programme: 100% devices have Quality Assurance programme	• Currently implementing new contract monitoring process, this will be reviewed at the end of the year • Closer monitoring of pharmacy now available through new database, this is being reviewed quarterly • Implementation of new Point of Care Testing Quality Assurance process and database (Aegis Image).	• Recommendations implemented. • Improvements in monitoring seen.	**Clinical measurements** Contract Monitoring Meeting minutes Robust Quality Assurance programme in place for Point of Care Testing devices using Image Data Management system Equipment audit report
	Objective 8: Equipment use (structure): 100% equipment validated and calibrated	• Develop a system where providers demonstrate to Public Health a documented process to ensure that the equipment used in an NHS Health Check is: ○ Validated ○ Serviced / calibrated (as per manufactures instructions) ○ Any non-compliance is acted upon	• GP Practice equipment calibration is part of CQC assessment. • Pharmacies compliance assessed at start of contract to provide NHS Health Checks.	
D **Quality**	**Objective 4b:** Provision of the NHS Health Check: Results communicated face to face	• Establish a robust way of recording and measuring results delivered face to face	• Template amended to incorporate monitoring of this objective.	**Cardiovascular Risk communication and management** Record of face to face communication end of year data. Training.
	Objective 5: Additional activity following NHS Health Check: Activated filters are completed	• More in-depth diabetes prevention audit is currently in progress which includes interrogating patient records. Results will be reviewed and actioned accordingly • Review the changed 2014-2015 template which now captures if a patient has been given a blood form	• Recommendations implemented. • Diabetes audit completed • Pilot of Outcomes Audit in progress.	

		• Recommend to practices that Audit-C and GPPAQ could be part of invitation letter or completed in waiting room • Review results by practice and target where necessary • Ongoing training and awareness raising of availability of lifestyle interventions in Bromley		
E **Uptake**	**Objective 3:** Maximise uptake: 50% of those offered an NHS Health Check take up the offer	• Establish how and why some practices have high uptake rate • Using Public Health Vascular Team to share this good practice with other practices with lower uptake rate • Develop and implement revised communication campaign based on new national branding • Evaluate pilot of Heart Age invitation letters to see if any impact on uptake. • Implement a discount card scheme for health related products	• New national branding incorporated into posters and leaflets • Due to financial constraints of the Public Health, efforts to maximise uptake are not currently being implemented.	New posters available

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Report No.
CS15933

London Borough of Bromley

PART ONE - PUBLIC

Decision Maker:	**HEALTH SCRUTINY PDS SUB COMMITTEE**
Date:	**4th November 2015**
Decision Type:	Non-Urgent Non-Executive Non-Key
Title:	**Diabetes Prevention Intervention**
Contact Officer:	Dr Agnes Marossy Tel: 020 8461 7531 E-mail: agnes.marossy@bromley.gov.uk
Chief Officer:	Nada Lemic, Director of Public Health
Ward:	Boroughwide

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1. Reason for report

This report provides an update on the Diabetes Prevention Programme Pilot resourced from funding approved to be carried forward from the weight management budget, previously approved by the Executive in January 2014.

The purpose of the pilot is to evaluate the effectiveness and cost effectiveness of an intervention to prevent diabetes in Bromley.

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2. RECOMMENDATION(S)

The Members of the PDS committee are asked to note and comment on the progress made to date.

Corporate Policy

1. Policy Status: In line with current policy, including BBB, Health and Wellbeing Board Strategy and ECHS plan.

2. BBB Priority – A Healthy Bromley.
Health and Wellbeing Board Strategy, obesity and diabetes priorities.

The Health & Wellbeing Strategy aims to:

- Slowdown the rise in the number of new cases of diabetes;
- Continue to slow the rate of increase of people diagnosed with hypertension;
- Raise awareness on the links to obesity, diabetes and hypertension.

Financial

1. Cost of proposal: £49,176

2. Ongoing costs: None

3. Budget head/performance centre: 8001603600

4. Total current budget for this head: £53,930

5. Source of funding: Carry forward of underspend from 2013-14 budget.

Staff

1. Number of staff (current and additional): Delivered from existing Public Health Officer resources, led by Public Health Programme Manager.

2. If from existing staff resources, number of staff hours:

Legal

1. Legal Requirement: NHS Health Checks are a statutory responsibility of the Local Authority, there is a duty of care to offer a service to address a patient's condition once the patient is identified as being at risk of developing diabetes through NHS Health Check screening.

2. Call-in:

Customer Impact

1. Estimated number of users/beneficiaries (current and projected): Current pilot had 129 beneficiaries start the programme.

Ward Councillor Views

1. Have Ward Councillors been asked for comments? Not at this stage.

2. Summary of Ward Councillors comments:

*** marked terms – for a full explanation see Glossary of terms – Section 6.**

3. COMMENTARY

Underspend from the obesity budget was approved to be carried forward from 2013-14 to 2014-15 to fund two pilot weight management schemes each to a value of £49,000.

The proposals were for;

1. Diabetes Prevention Programme Pilot – reported here.
2. Extension to the current Tier 2 weight management to provide for a service for higher weight patients. This proposal was not taken forward as a national decision was made for the commissioning of such services to be the responsibility of the CCG and not Public Health.

3.1 Background

Diabetes Mellitus* Prevalence: Diabetes prevalence in Bromley has been rising consistently since GP Registers were established in 2002. There are 14,013 people on the diabetes register (2013/14) compared to 4,846 in 2002.

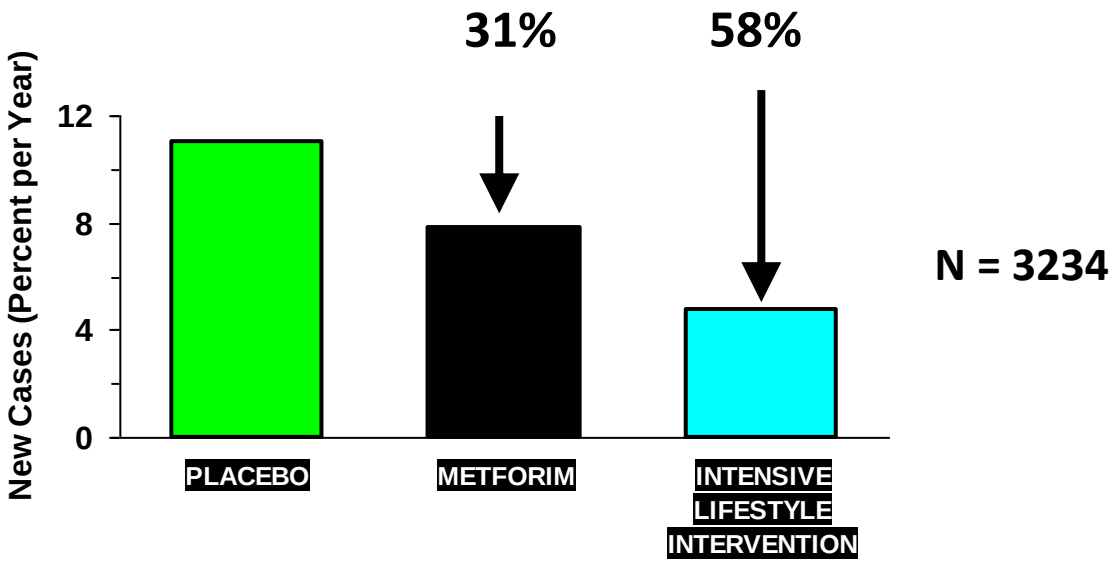
Identification of high risk patients: A Diabetes Audit was undertaken by the Public Health vascular team in 42 out of the 45 GP Practices covering a period of 16 months (from 1 April 2013 – 31 August 2014) which identified 11,451 patients at high risk of developing diabetes (see Appendix 1 – prevalence per ward).

Public Health England recently published modelled estimates which suggest that there are 29,872 residents at high risk of developing diabetes in Bromley (11.5% prevalence) compared to 11.4% across England (PHE, 2015[i]).

3.2 Evidence of Diabetes Prevention

There is substantial evidence to support that intensive lifestyle interventions reduce the rate of progression to type 2 diabetes or prevent it altogether. The US Diabetes Prevention Program (DPP) randomised clinical trial showed a 58% reduction of diabetes incidence with intensive lifestyle intervention versus only a 31% reduction with metformin (drug intervention), compared to placebo at 2.8 years (1996-1999)[ii]. These beneficial effects were shown to be sustainable in the subsequent 10-year follow up outcome study[iii]. Diabetes incidence was reduced by 34% in the lifestyle group and 18% in the metformin group (drug intervention), compared with placebo.

Diabetes Incidence in US DPP (2.8yrs)



DPP Research Group, *NEJM* 2002 346:393-403

3.3 Bromley Diabetes Prevention Programme Pilot

Weight Watchers conducted a 12 month study in the USA to support patients through an intensive lifestyle support programme which showed similar findings, a significant reduction in blood glucose and weight compared to controls. Bromley commissioned the Weight Watchers diabetes prevention programme to reduce risk in Bromley.

The Weight Watchers programme consists of a one year intensive lifestyle support programme, focusing on weight reduction through education and implementation of a healthy lifestyle, increased whole foods and physical activity (see Appendix 2 – Service Description). All patients will have completed the 12 month programme by April 2016.

3.4 Patient Recruitment

- 166 patients were referred
- 132 patients attended the activation session
- 129 started the 12 month programme
- 8 patients have dropped out (2 of which have been removed from the study due to ill health).

Table 1.1 Baseline characteristics – of those attending activation session (n=117)

Demographics	WWDPP Bromley
Gender -- Female -- Male	**88 (75%) 29 (25%)**
Ethnicity	**BME 10/114 (9%)**
Deprivation	**15/117 (12.8%) from the most deprived quintile***
	Mean ± SD
Age (years)	**58 ± 9**
BMI (kg/m^2)	**35.58 ± 5.5**
HbA1c (mmol/mol)*	**43.45 ± 1.42**
HbA1c (%)*	**6.14 ± 0.13**
FPG (mmol/L)*	**6.14 ± 0.39**

Baseline characteristics to note:

- 25% are male (higher than Tier 2 national average 10% and Bromley Tier 2 at 17%). More men are at high risk of developing diabetes both locally and nationally.
- Mean age is quite high (58 years) because a large percentage of the patients are identified at NHS Health Checks. Age range: 33 to 80 years.
- BMI* criteria: Range: BMI ≥27.5 (for ethnic minorities*) to 45.
- 9% of patients are from a black or minority ethnic (BME) community. If the programme is rolled out to all GPs then recruiting BME communities will be a priority due to their genetic predisposition for being at higher risk of developing type 2 diabetes. The expansion to the programme will increase the equity of access.

Patients have an increased risk of cardiovascular disease;

- 71% (83) at risk or known to have hypertension*
- 28% (32) at risk or known to have hyperlipidaemia*
- 32 of 78 (41%) who have been assessed, have >10% risk of heart attack or stroke in the next ten years.

Diabetes Prevention Outcomes - the early findings;

The early findings include the 6 month blood test results of 62 patients.

Mean reduction in diabetes risk n = 62:

- ✓ **38 (70%) patients no longer at risk**
- ✓ **10 (19%) patients have reduced risk**
- ✓ **2 (4%) patient's risk stayed the same**
- **X 4 (7%) patients have increased risk**
- **X 8 patients had no comparable baseline**

Attendance

- 62 out of 81 patients (77%) have a result at 6 months to date.

The mean risk of developing diabetes has reduced from being in the 'at risk of developing diabetes' category (Mean HbA1c: 6.14% or 43.34mmol/mol) to 'no longer being at risk of developing diabetes' (Mean HbA1c: 5.82% or 40.0mmol/mol) for the majority of patients, a mean reduction of -0.32%. The national evidence cites that a significant result for an intensive lifestyle programme such as this is to not increase risk, they look for no change in HbA1c.

3.5 Next steps

The National Diabetes Prevention Programme:

In March 2015, NHS England, Public Health England and Diabetes UK announced that the UK will undertake the first ever at-scale NHS Diabetes Prevention Programme. Part of delivering the commitment set out in the NHS Forward View and PHE's Evidence into Action last year. The format of the NHS Diabetes Prevention Programme went out for consultation from August - September 2015.

South London Expression of Interest:

At the same time areas in the UK were asked to submit 'Expressions of Interest' to become the first areas in the country to deliver the nationally funded prevention programme.

South East and South West London CCGs and Local Authorities have submitted a joint sub regional bid. Southwark is already one of the original seven 'demonstrator sites' and Bromley has extensive experience of implementation in this field. The National Diabetes Prevention Programme team invited Bromley Public Health to their Testimonial Day to present the findings of our programme documented in this report. It is hopeful that the South London application will be successful due to the size, demography and experience within South London.

4. FINANCIAL IMPLICATIONS

Diabetes Prevention Programme	**Cost per item**	**Total Cost**
Activation Sessions	£450	14 x £450 Activation session = £6,300
Programme Packs	£75 per 12 week pack	570 packs x £75 per pack = £42,750
Launch Event	£126 Bromley Library Hall Hire	£126
Total Cost of Programme		**£49,176**

Cost Avoidance

This is a cost avoidance initiative. The current pilot has produced a cost avoidance of £61,324 plus the additional benefits listed in Table 1.2, (See Appendix 3 - Cost of Diabetes to the Health and Care economy).

5. POLICY IMPLICATIONS

This work is in line with best practice national policy driven by the NHS England 5 year forward, supported by NICE guidance.

Non-Applicable Sections:	**LEGAL and PERSONNEL IMPLICATIONS**
Background Documents: (Access via Contact Officer)	1. Executive Paper CS14011 – 22/01/2014. 2. National Diabetes Programme Expression of Interest, South London bid (14 pages). 3. Public Health England - A systematic review and meta-analysis assessing the effectiveness of pragmatic lifestyle interventions for the prevention of type 2 diabetes mellitus in routine practice (173 pages).

6. GLOSSARY OF TERMS

Diabetes Mellitus – Also known as type 2 diabetes causes a person's blood sugar level to become too high. Type 2 diabetes occurs when the body doesn't produce enough insulin to function efficiently, or the body's cells are ineffective at using the insulin produced. This means that glucose stays in the blood and isn't used as fuel for energy.
A problem because it can cause serious long-term health problems; it is the most common cause of vision loss and blindness in people of working age, responsible for most cases of kidney failure and lower limb amputation (other than accidents) and people with diabetes are up to five times more likely to have cardiovascular disease (such as a stroke) than those without diabetes

Deprived quintile – The Indices of Deprivation provide a set of relative measures of deprivation for small areas (Lower-layer Super Output Areas) across England. The relative deprivation of neighbourhoods are ranked into quartiles, which represents 20% of a given population. Deprivation was measured in this pilot, patients from the most deprived quintile are shown in Table 1.1. Areas in the most deprived quintile experience the poorest health outcomes.

HbA1c – A blood test can measure a patient's glycated haemoglobin. By measuring glycated haemoglobin, clinicians are able to get an overall picture of a patients average blood sugar levels over a period of weeks/months. This is important as the higher the HbA1c, the greater the risk of developing diabetes and related complications. The measure can be expressed as mmol/mol or a %.

FPG – A simple blood test measures Fasting Plasma Glucose, blood is taken after several hours of fasting (8-10hours) to measure the glucose in the blood. This test helps diagnose diabetes or those at high risk.
Clinicians are advised to use HbA1c but where this is not available FPG has been used.

BMI - Body mass index is a measure of whether you're a healthy weight for your height.

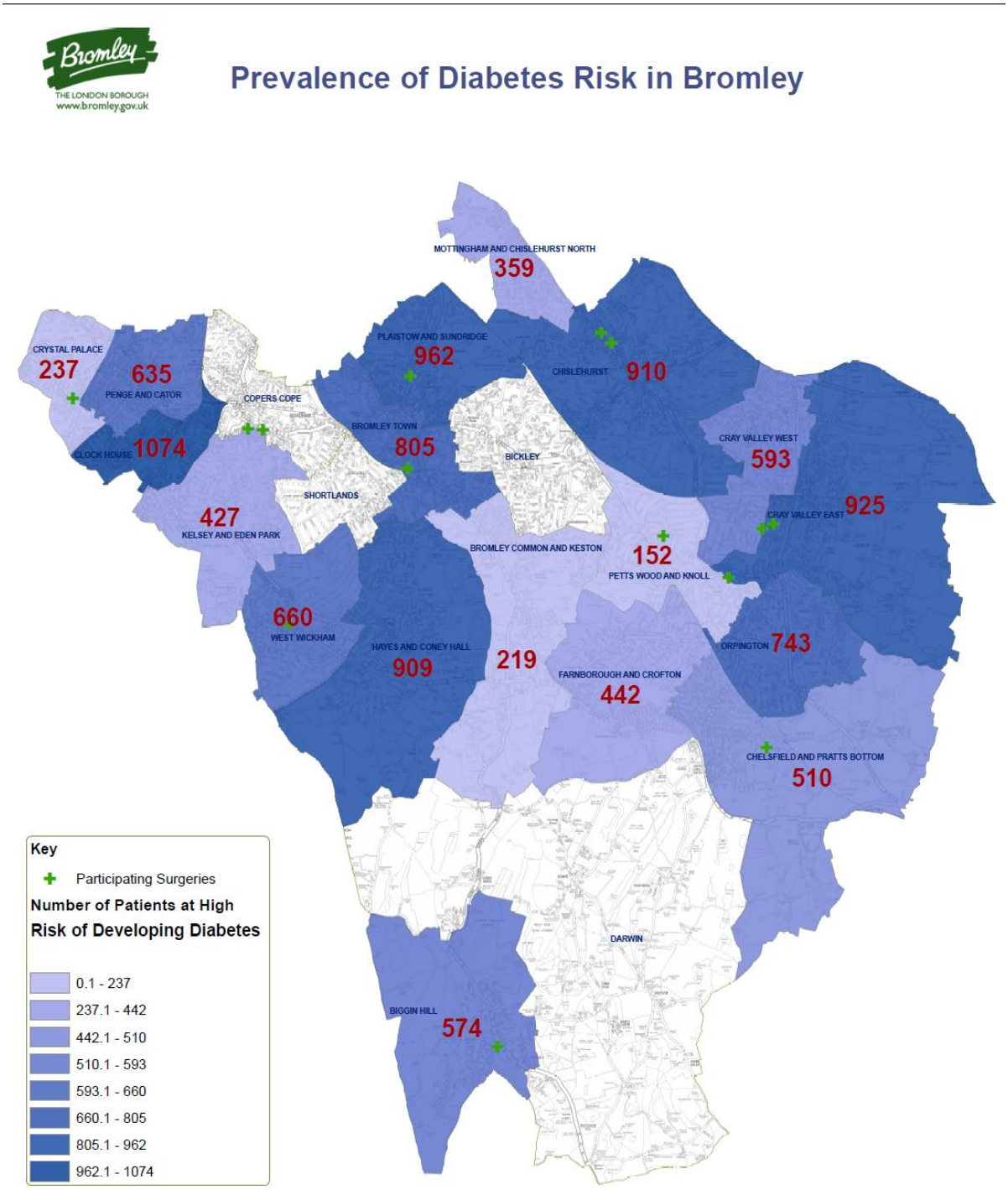
BMI ≥27.5 for ethnic minorities - New BMI advice was issued in July 2013 by the National Institute for Health and Care Excellence (NICE) to south Asian and Chinese adults, who have a higher risk of developing type 2 diabetes than white populations. Asians with a BMI of 27.5 or more are at high risk of developing type 2 diabetes.

Hypertension - High blood pressure. If untreated it increases the risk of heart attack, heart failure, kidney disease, stroke or dementia.

Hyperlipidaemia - Abnormally elevated levels of any or all lipids and/or lipoproteins in the blood. Most commonly used when a patient has high cholesterol. It causes an increased risk of coronary heart disease.

Appendix 1

Prevalence of diabetes risk per ward.



*** Map: Number of high risk of developing diabetes patients identified per GP practice.**
There are patients that are at high risk of developing diabetes within the four unshaded wards however, patients were recorded by GP practice address rather than lower super output area (LSOA) so do not show on the map above.

Appendix 2

Service Description

The intervention provides practical, tailored advice, support and encouragement to help people be more physically active, achieve and maintain a healthy weight and eat a healthier diet for at least 12 months. Quarterly monitoring is being undertaken by Primary Care and Weight Watchers as well as 24 month follow up.

The 12month programme includes;

Referral Hub

- Patient calls referral hub, identified by NHS number.
- Activation session booked.
- Patients receives welcome call prior to the activation session.
- Patient attends activation session.

Activation Session

- Patient's individual lifestyle goals identified personal management plan created, including:
  - ✓ Individual weight loss goal - at least a 7% weight loss
  - ✓ Physical activity goal - achieve 150 minutes exercise/week
- Teach patients how to report accurate physical activity levels and conduct reliable waist circumference measurements.
- Patient is given one year membership to Weight Watchers (online and community based).

Weekly Sessions

- Patients attend Weight Watchers sessions for 1 year.
- 4 courses consisting of 12 sessions each.
- Dedicated phone line for patients
- Redemption vouchers for a free pedometer / healthy eating cookbook and eat and shop guides – (redeem in meetings).
- Online support

Review of outcome measures

- Review of patient at session 12 in each course to monitor progress; Take measurements and gather self-reported evaluation questions
- Repeat blood test at 6, 12 and 24 at surgery.
- Repeat blood pressure measurement at 3, 6, 9, 12 and 24 months.
- Follow up weight at 24 months using proforma.
- Non-attendees to be contacted via text, care notes & telephone (at least 2 attempts) by meeting leader and every 3 months by co-ordinator. If no longer able or willing to attend feedback will be obtained.

The referral hub, the activation sessions and the on-going service is provided from community based venues at a variety of times during the week and weekends to suit the patients' needs. There are 31 weekly Weight Watchers meetings available in Bromley, the majority in deprived wards.

Appendix 3

The Cost of Diabetes to the Health and Care economy – why invest.
The current pilot has produced a cost avoidance of just over £60k, which encompass both direct healthcare costs in the short term and cost avoidance in the longer term.

Table 1.2: Treating adults who are high risk of type 2 diabetes, with an intensive lifestyle intervention will generate the following savings;

Calculated savings treating 100 adults via NICE recommended ILIs.	**Diabetes Prevention Programme Pilot treating 120 patients (Public Health Budget £49,176 investment).**
To prevent 1 new case of diabetes during a period of 3 years, numbers needed to treat is 6.9[iv].	17 cases of Type 2 Diabetes prevented within 3 years.
Prevent 162 missed work days[v]	Prevent 195 missed work days[2]
Avoid the need for BP/Cholesterol pills in 11 people[vi]	Avoid the need for BP/Cholesterol pills in 13 people[3]
Add the equivalent of 20 good years of health[vii]	Add the equivalent of 24 good years of health
An average Diabetic case costs £6,500 direct healthcare costs in the first 5 years[xix]	Avoid £110,500 in healthcare costs over 5 years.
Total Savings = Cost - Savings	**£49,176 - £110,500 = £61,324 saving**

The best way to reduce the holistic whole life cost of managing a patient with diabetes is to prevent Type 2 diabetes in the first place.

Diabetes is expensive, costing the NHS £10 billion each year[viii]. These costs are mainly associated with the complications of diabetes, e.g. amputation, blindness, kidney failure, stroke, etc. The Health and Social Care Information Centre[ix] shows that "prescribing for diabetes accounted for 4.4% of total items and 9.5% of the total cost of prescribing in 2013-14, compared with 3.8% and 6.6% respectively in 2005-6". Offering intensive lifestyle interventions to those at high risk will not only help to reduce future costs of diabetic complications, but will help to avoid these immediate costs that burden short term budgets.

There will ultimately be savings to adult social care budgets due to increased number of good health years and decreased morbidity. Although these are not quantifiable in fixed cashable savings, it demonstrates the cumulative effect of taking such a proactive self-management approach to avoid secondary and bed base care packages in the future. There is also a beneficial effect on the local economy due to reduced absenteeism from work. Patients that are morbidly obese (16 eligible patients on programme) are 3 times more likely to need social care than those who are a healthy weight (Making the Case for Tackling Obesity, 2015)[x]. Morbid obesity reduces life expectancy by 8-10 years and has a considerable impact on quality of life.

Obesity is a key risk factor for developing Type 2 Diabetes, 80% of people with type 2 diabetes are overweight or obese[1]. Type 2 diabetes is currently causing a significant drain on resources, and will continue to do so as the public health outcomes framework 2013 reported that 65% of Bromley's population are either overweight (≥25 BMI) or obese (≥30 BMI), which represents approximately 205,820 adults. This is higher than the England average (63.8%), and is ranked as the third highest prevalence of excess weight in London. As weight increases the risk of developing Type 2 Diabetes increases. In Bromley, the estimated prevalence of obesity is 21.8% (2013 Health Profile), which represents 54,163 adults.

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i Public Health England. NHS Diabetes Prevention Programme (NHS DPP) Prevalence estimates of non-diabetic hyperglycaemia. August 2015.

ii Knowler WC, Barrett-Connor E, Fowler SE, et al.: Reduction in the incidence of type 2 diabetes with lifestyle intervention or metformin. N Engl J Med 2002; 346(6):393-403

iii Knowler WC, Fowler SE, Hamman RF, et al.: 10-year follow-up of diabetes incidence and weight loss in the Diabetes Prevention Program Outcomes Study. Lancet 2009; 374(9702):1677-86.

iv Ackermann et al (2008) Translating the DPP into the community. Am J Prev Med 35 (4), pp. 357-363; estimates scaled to 2008

v DPP Research Group (2003) Within-trial cost-effectiveness of lifestyle intervention or metformin for the primary prevention of type 2 diabetes. Diabetes Care;26(9):2518-23.

vi Ratner et al (2005) Impact of Intensive Lifestyle and Metformin Therapy on Cardiovascular Disease Risk Factors in the Diabetes Prevention Program. Diabetes Care 28 (4): 888-894.

vii Herman et al (2005) The cost-effectiveness of lifestyle modification or metformin in preventing type 2 diabetes in adults with impaired glucose tolerance. Ann Intern Med. 2005;142:323-32.

viii Hex N, Bartlett C, Wright D et al. (2012) Estimating the current and future costs of type 1 and type 2 diabetes in the UK, including direct health costs and indirect societal and productivity costs. Diabetic Medicine 29: 855–62

ix Prescribing for Diabetes, England - 2005-06 to 2013-14. Health & Social Care Information Centre. Publication date: August 12, 2014

x Public Health England. Making the Case for Tackling Obesity, 2015.

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Report No.
CSD15127

London Borough of Bromley

PART ONE - PUBLIC

Decision Maker:	**HEALTH SCRUTINY SUB-COMMITTEE** **CARE SERVICES PDS COMMITTEE**
Date:	**Wednesday 4 November 2015** **Tuesday 17th November 2015**
Decision Type:	Non-Urgent Non-Executive Non-Key
Title:	**OUR HEALTHIER SOUTH EAST LONDON - JOINT HEALTH SCRUTINY COMMITTEE**
Contact Officer:	Graham Walton, Democratic Services Manager Tel: 0208 461 7743 E-mail: graham.walton@bromley.gov.uk
Chief Officer:	Mark Bowen, Director of Corporate Services
Ward:	All

1. Reason for report

1.1 The six clinical Commissioning Groups in South East London, working with NHS England, have been working together to address key challenges facing healthcare across the six boroughs. The programme is known as “Our Healthier South East London” (OHSEL). The NHS organisations have indicated that the proposals arising from their work are likely to require public consultation, and the six boroughs are working towards establishing a joint health scrutiny committee to scrutinise the proposals. Participation in a joint health scrutiny committee requires approval from full Council.

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2. RECOMMENDATIONS

That the Care Services PDS Committee recommends to Council that Bromley participates in the proposed joint health scrutiny committee on the Our Healthier South East London proposals and appoints two members to the joint committee.

Corporate Policy

1. Policy Status: Existing Policy:
2. BBB Priority: Excellent Council Supporting Independence:

Financial

1. Cost of proposal: No Cost:
2. Ongoing costs: Not Applicable:
3. Budget head/performance centre: Democratic Representation
4. Total current budget for this head: £1,055,820
5. Source of funding: revenue Budget 2015/16

Staff

1. Number of staff (current and additional): N/A
2. If from existing staff resources, number of staff hours: N/A

Legal

1. Legal Requirement: Statutory Requirement: Arrangements for joint health scrutiny committees are set out in Sections 7 and 8 of the Health and Social Care Act 2001 and associated regulations and guidance. The Local Government Act 1972 requires full Council approval to join a joint committee.
2. Call-in: Not Applicable: This report does not involve an executive decision

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Customer Impact

1. Estimated number of users/beneficiaries (current and projected): All residents

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Ward Councillor Views

1. Have Ward Councillors been asked for comments? Not Applicable
2. Summary of Ward Councillors comments: Not Applicable

3. COMMENTARY

3.1 The six Clinical Commissioning Groups (CCGs) in South East London (Bexley, Bromley, Greenwich, Lambeth, Lewisham and Southwark) have been working with NHS England on a programme entitled "Our Healthier South East London (OHSEL). The programme aims to address key challenges facing healthcare in South East London and develop a commissioning strategy to address these challenges. An update describing the programme is attached as Appendix A. The OHSEL Programme Director has stressed that there is no intention to reduce or change Accident and Emergency provision across the six boroughs as part of this programme.

3.2 Officers from the six boroughs have been working with OHSEL to establish a joint health scrutiny committee to scrutinise the proposals and the consultation arrangements. This work includes preparing draft terms of reference and proposals for working arrangements for approval by Members. All six boroughs will need to follow their own constitutional arrangements to establish the committee - the aim is to have an introductory meeting if possible before Christmas, followed by around six meetings in the first part of 2016. It is proposed that two members will be appointed from each participating borough.

4. FINANCIAL IMPLICATIONS

4.1 There are limited resources across the six boroughs to support the joint committee, and any costs, which will largely involve arranging and servicing its meetings, will be shared equally between participating authorities and would have to be found from within existing budgets.

5. LEGAL IMPLICATIONS

5.1 Arrangements for joint health scrutiny committees are set out in Sections 7 and 8 of the Health and Social Care Act 2001 and associated regulations and guidance. Where NHS proposals affect more than one authority any local authority overview and scrutiny committees wishing to be formally consulted have to form a joint committee through which formal scrutiny powers can be exercised. The Council does not have to join the proposed joint committee, but if it does not its scrutiny influence may be reduced. The Local Government Act 1972 requires full Council approval to join a non-executive joint committee.

Non-Applicable Sections:	Policy/Personnel
Background Documents: (Access via Contact Officer)	

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Our Healthier South East London: update August 2015

This paper sets out the progress to date of the *Our Healthier South East London* programme, which is led by the six south east London CCGs – Bexley, Bromley, Greenwich, Lambeth, Lewisham and Southwark – and NHS England. The programme aims to develop a commissioning strategy to ensure improved, safe and sustainable services across the six boroughs.

1. The case for change and our vision

We published the Case for Change in February 2014. It sets out how the six CCGs and NHS England are working together to address challenges around quality of care, finance and workforce. Commissioners recognise that while some issues can and should be addressed at local borough level by the CCG and its partners, others cross borough boundaries and require a joint response.
We have a shared understanding of the challenges facing south east London. These are outlined in our Case for Change.

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

Our collective vision
In south east London we spend £4 billion in the NHS. Over the next five years, commissioners aim to achieve much better outcomes than are achieved 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

2. Progress of the strategy

Our programme has been built around engagement with stakeholders and the public, with strong involvement of local provider Trusts, local authorities, public and patient voices and the general public (see section 3 below). We have been talking to local people and stakeholders at every stage of the programme and we have taken their feedback into account as our strategy has developed.

A draft strategy was published in June 2014 and in June 2015, we published an updated version, which we are calling the **Consolidated Strategy**. It will be signed off by commissioners by the end of August. The strategy sets out models of care across all of our clinical workstreams:

- Community-based care
- Urgent and emergency care
- Maternity
- Children's services
- Planned care
- Cancer

These new models of care have been developed by local clinicians, working with senior NHS project managers and public and patient voices. They suggest a number of interventions to improve health outcomes for people in south east London.

Our strategy envisages a transformation in the way care is delivered, with much more care taking place in community settings while hospitals provide specialist care for those who really need it. Community-based care delivered by Local Care Networks in each borough is the foundation of the integrated whole system model that has been developed for south east London (see attached diagram).

While the models of care are far-reaching, we have not at this stage developed any proposals for specific hospital sites. The extent to which services might change at particular sites is being examined over the autumn, after which the potential options will be clearer. Should proposals emerge for major service change, we would formally consult local people on these.

For most interventions, implementation planning can commence immediately. However, there are areas where the impact of the strategy needs further consideration because there is more than one option for delivery, and it could result in significant service change. These interventions will have to undergo a robust options appraisal process.

This option appraisal process aims to identify the best way, or way(s), of delivering the overarching strategy and realising its full benefits. It filters the many potential options for how the interventions can be implemented, and is designed to identify options that are recommended for further work, and, if appropriate, for formal consultation.

Will there be a consultation?

We are currently looking at the likely impact of the strategy in some detail, with a view to considering what changes we need to make in each area to implement it successfully.

Most of the recommendations set out in the strategy can move straight away to detailed design and implementation and some changes are already underway and do not require public consultation. These are mostly community-based care initiatives, designed to deliver more care in the community, which our engagement suggests have widespread clinical, stakeholder and public support.

For services based in acute hospitals, our strategy is for all our hospitals to meet the London Quality Standards, a series of quality and safety standards designed by clinicians working with patients and the public. All 32 London CCGs have signed up to these standards and are working towards them.

We are currently carrying out an analysis of where each of our acute hospitals in south east London is in relation to these standards, so that we can determine what the next steps should be. This analysis will form part of the assessment to determine if we need to go through an options appraisal process.

We expect the analysis to be complete by early September.

If an options appraisal process led to proposals for the reconfiguration of hospital services, and major service change, public consultation would be required.

3. Impact of the strategy

We have analysed the likely impact of the strategy, though further analysis will be needed once we have a clearer idea of what may be proposed for specific sites.

The NHS in south east London currently spends £4 billion in total across commissioners and providers and has 4,166 acute hospital beds. Over the five years of the strategy, the available money will grow by £800 million to £4.8 billion. However, if we do nothing, the spend will grow in total by £1.1 billion to £5.9 billion.

The requirement for acute hospital beds will grow because the demand for health services is increasing; people are living longer but many with long term conditions such as diabetes, high blood pressure and mental illnesses. The technical advances in diagnostics and treatments mean that the costs of providing care are rising faster than inflation each year.

Our Healthier South East London is about responding better to people's needs by providing an alternative high quality model of care that is focused on improved outcomes for the population we serve. This is because:

- The care models are focused on prevention and early intervention and keeping people healthy and therefore keeping people out of hospital
- Community Based Care is the foundation of the whole system and is intended to keep people closer to home, treating them in the community and enabling people to only visit hospital when they really need to
- Care pathways and professionals will be more integrated
- Productivity is expected to increase and providers will continue to deliver efficiency savings (eg through improved procurement, combined support services, improved rostering of staff) which will help to close the gap
- Our aim will be for bed occupancy to meet the national guidance (which is not the case now) which will improve safety, quality and efficiency
- **Our current modelling therefore shows that at the end of the five years, we shall need about the same number of hospital beds as now - but some of them will be used differently (more day case, fewer inpatient beds; shorter lengths of stay…)**
- This is therefore not about closing a hospital, but about avoiding the need to build a new one, which we could not afford, by improving health and outcomes and delivering services which better meet people's needs
- It is also about creating a legacy for the future as the improvements in prevention and care should result in benefits which will materialise beyond the current time horizon of the next five years.

4. Engagement

We are committed to involving stakeholders and the public in helping us to develop the strategy. This is reflected in our approach to date and in the programme's governance.

We have held a number of independently facilitated events:

- Two deliberative events in July 2014
- An event in each borough in November/December 2014
- An event for members of patient reference groups to discuss how the programme may make decisions (our draft options appraisal methodology
- An event in each borough in June 2015, for voluntary and community sector stakeholders (30%) and members of the public selected by random sampling to broadly represent their local communities (70%).

These events discussed the emerging case for change and the emerging ideas set out in the draft strategy. Feedback was collated and responded to in 'You Said We Did' reports produced by the programme, available on the programme website www.ourhealthiersel.nhs.uk

Issues Paper
In May 2015, we published an **Issues Paper**, summarising the case for change and the ideas set out in the strategy, together with some questions for local people and stakeholders to respond to. This has been widely distributed across south east London. The publication of Issues Papers is regarded as emerging best practice for programmes considering major service change. **We strongly recommend that all our stakeholders read and respond to the Issues Paper.**

Direct involvement of public and patient voices
Public and patient voices have been represented on all of our Clinical leadership Groups, which make recommendations about our six clinical workstreams - community-based care, urgent and emergency care, maternity, children' services, planned care and cancer. We also have a **Public and Patient Advisory Group (PPAG),**, which meets every six weeks to advise the programme on public engagement.

Equalities
An early, independent Equalities Impact Assessment was carried out in the summer of 2014 and a further Equalities Analysis was carried out in the summer of 2015. This will be published shortly on the programme website.

5. Governance and decision-making

Provider Trusts, local authorities and the public are all embedded in the programme's structures:

- They are represented on our **Clinical Leadership Groups**, which have recommended the new models of care. We also have a **Partnership Group**, drawn from CCGs, patients, local authorities, provider trusts and other stakeholder organisations, which meets on a monthly basis to discuss and feed back on key developments in the programme.
- Our **Clinical Executive Group** includes Medical Directors from local provider Trusts and NHS England and local authority and PPAG representatives.
- Both of these groups report to our **Clinical Commissioning Board**, drawn from the leadership of the local CCGs, which makes recommendations for CCGs governing bodies to consider.

In addition, CCGs have regularly updated **Health and Wellbeing Boards,** discussing the strategy with them at each key milestone.

Ultimately decision-making as to how services are commissioned rests with the Governing Bodies of the six CCGs and NHS England. Earlier this year, the six CCGs agreed that local decision-making would be taken through a **Committee in common** of the six CCGs, with each CCG nominating three representatives to this joint committee.

A full governance chart is attached.

Scrutiny
Up until now, CCGs have reported to their local Overview and Scrutiny Committees as part of business as usual arrangements. However, with the publication of the Consolidated Strategy and Issues Paper, we believe there is now a case for the establishment of a **Joint Overview and Scrutiny Committee** for south east London and we have raised this with local authorities. Our suggestion would be to have a first meeting of a Joint Overview and Scrutiny Committee before the completion of our options appraisal process.

6. Next steps

- We will continue to plan and implement most of the strategy: taking forward the new models of care and interventions that do not need public consultation. We will work with our partners in secondary, primary and community care, mental health trusts and with local authorities to do so.
- By September, we expect to know whether an options appraisal process will be required for some of the care model initiatives. If consultation is needed, we expect it to take place from July-September 2016, with preferred options agreed by December 2016.
- We will shortly publish a summary of the draft models of care and further thinking as a follow-up to the Issues Paper. This will summarise our very latest thinking, as set out the consolidated strategy.

How stakeholders and local people can help

- Respond to our Issues Paper at http://www.ourhealthiersel.nhs.uk/about-us/issues-paper.htm or by writing to Our Healthier South East London, 160 Tooley Street, London SE1 2TZ.
- Invite your local CCG and the programme team to a meeting to brief colleagues or to run a roadshow on your premises for your staff.
- Share this briefing and our Issues Paper with colleagues and stakeholders.

Staying in touch
You can email the programme team at SOUCCG.SELstrategy@nhs.net or follow @ourhealthiersel on Twitter.

Attached for your reference is a diagram of the programme's Whole System Model and a summary programme timeline.

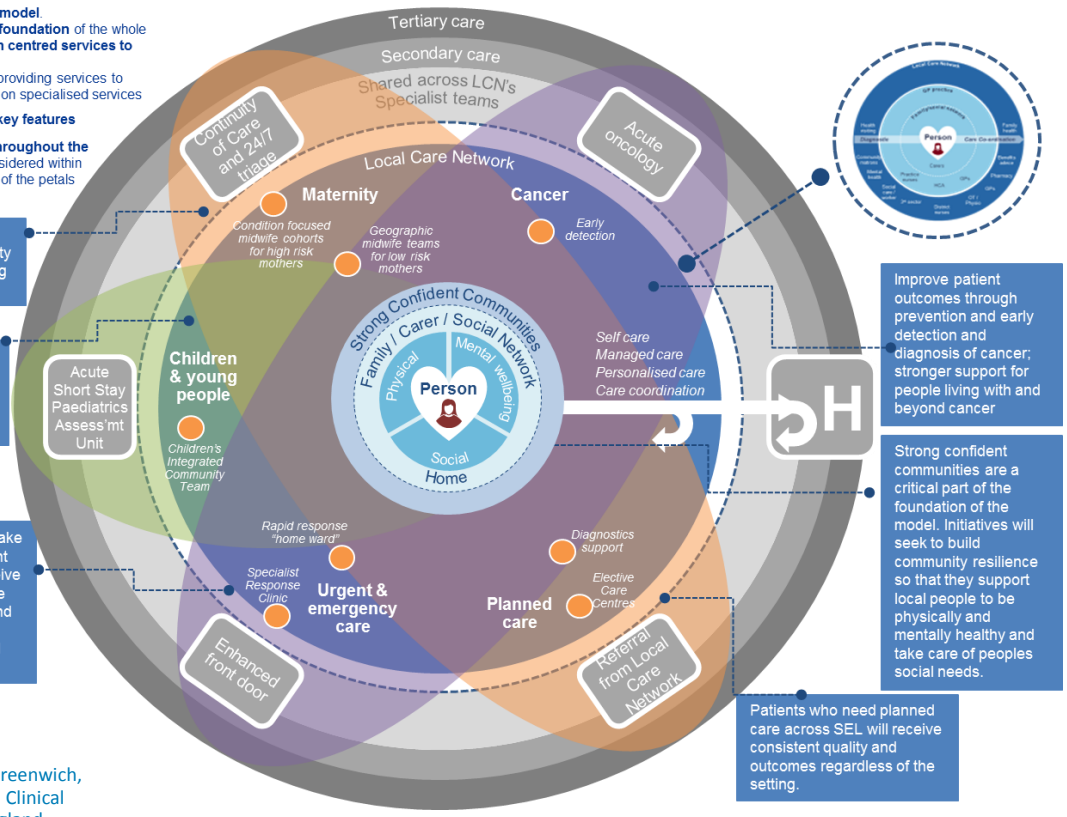
Our Healthier South East London
Improving health and care together

NHS

Our integrated whole system model

Community Based Care delivered by Local Care Networks is the foundation of the integrated whole system model that has been developed for south east London. This diagram provides an overview of the whole system model, incorporating initiatives from all 6 Clinical Leadership Groups.

- This is our **integrated system model**.
- **Local Care Networks are the foundation** of the whole system model providing **person centred services to populations**
- **The petals are the pathways** providing services to cohorts of people and drawing on specialised services
- The **orange circles** represent **key features**
- **Mental health is embedded throughout the whole system model**. It is considered within Local Care Networks and each of the petals



Mums-to-be will receive a personalised service, continuity of care and a range of birthing options

Children and young people will be able to access more specialised services through children's integrated community teams

A rapid response team will make sure patients who need urgent and emergency care will receive the treatment they need in the right place at the right time and will support patients to return home and move back to local health and care services

Improve patient outcomes through prevention and early detection and diagnosis of cancer; stronger support for people living with and beyond cancer

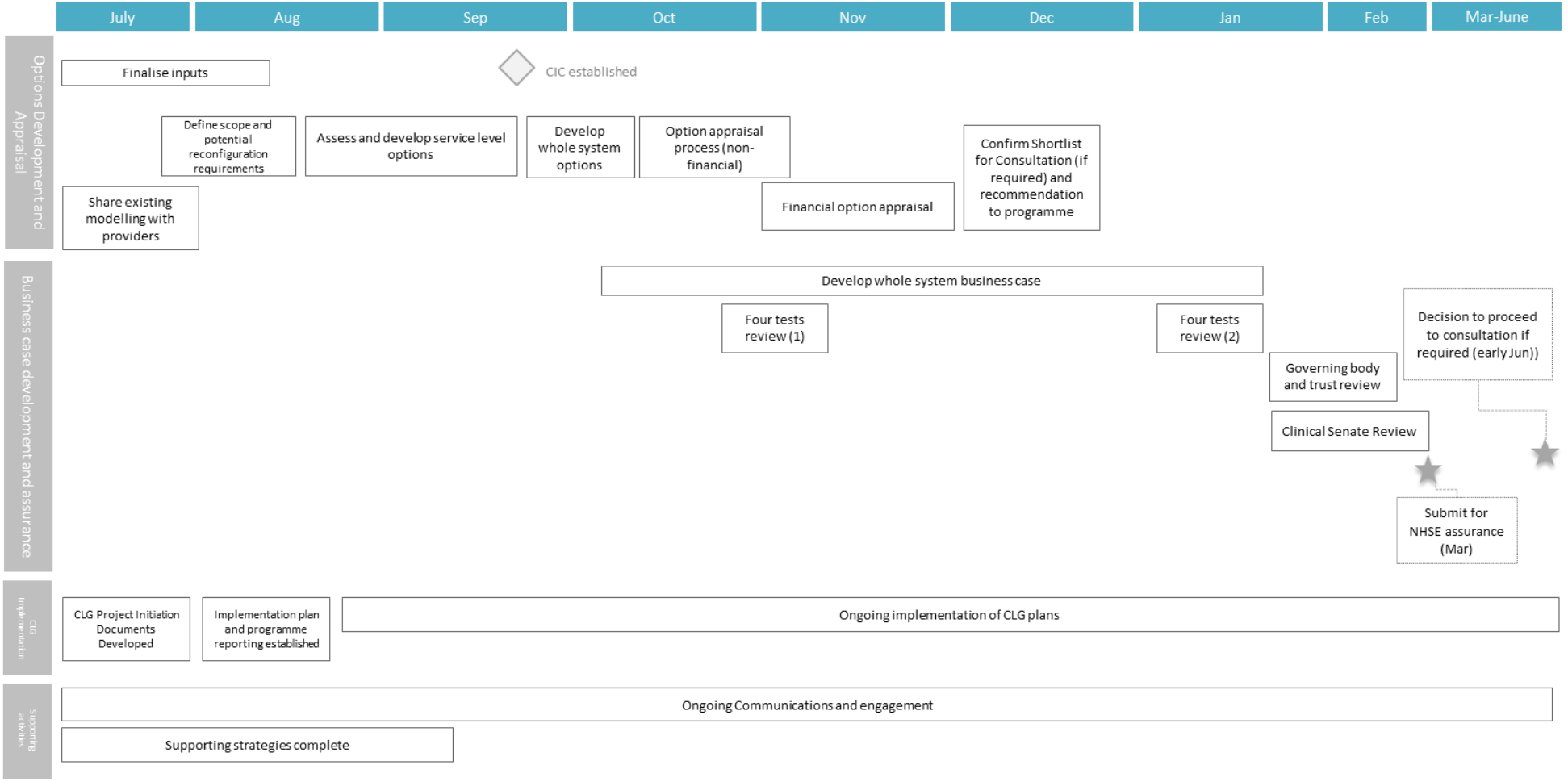
Strong confident communities are a critical part of the foundation of the model. Initiatives will seek to build community resilience so that they support local people to be physically and mentally healthy and take care of peoples social needs.

Patients who need planned care across SEL will receive consistent quality and outcomes regardless of the setting.

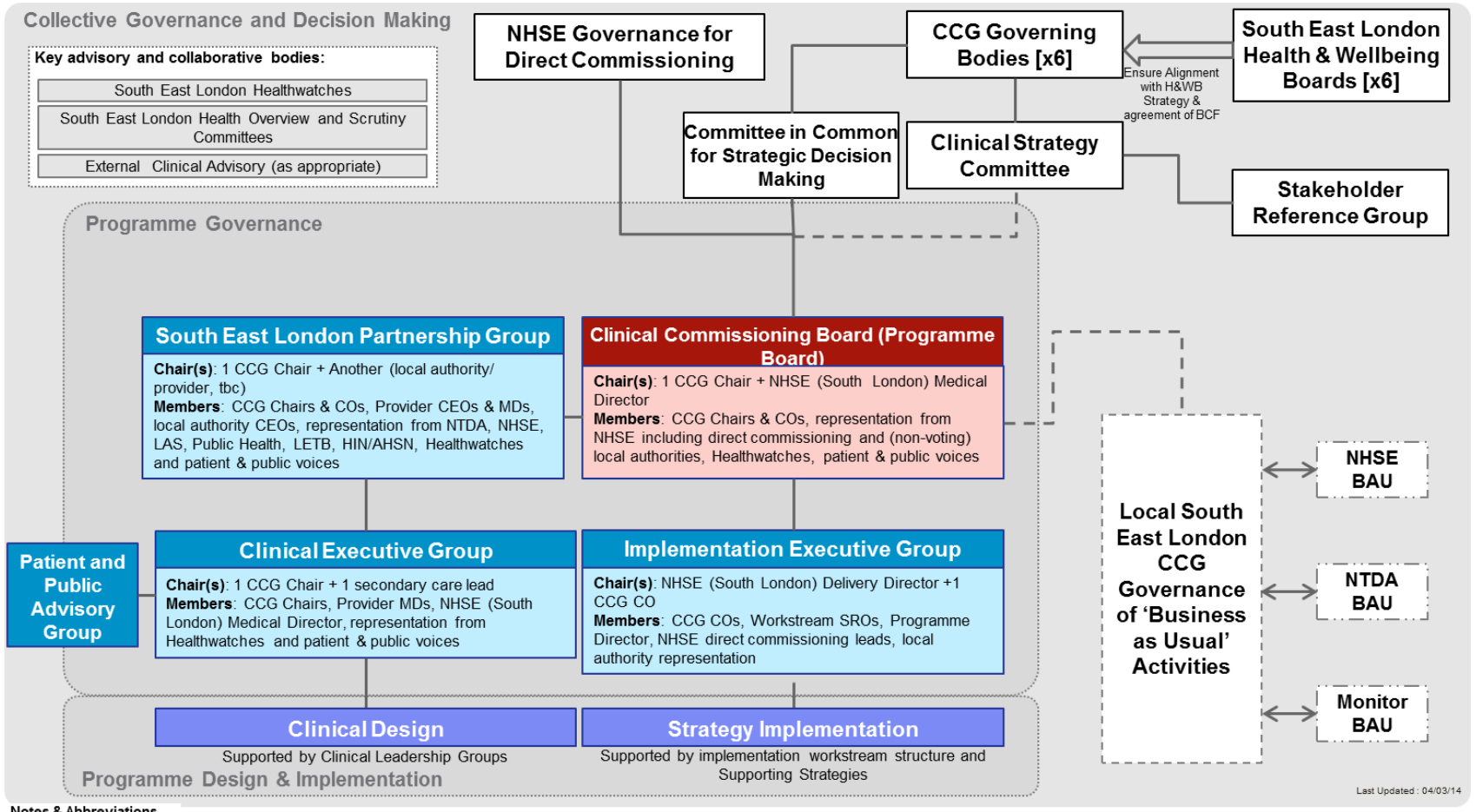
A partnership of Bexley, Bromley, Greenwich, Lambeth, Lewisham and Southwark Clinical Commissioning Groups and NHS England

A partnership of Bexley, Bromley, Greenwich, Lambeth, Lewisham and Southwark Clinical Commissioning Groups and NHS England

Timeline


July
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar-June
Options Development and Appraisal
Finalise inputs
CIC established
Define scope and potential reconfiguration requirements
Assess and develop service level options
Develop whole system options
Option appraisal process (non-financial)
Confirm Shortlist for Consultation (if required) and recommendation to programme
Share existing modelling with providers
Financial option appraisal
Business case development and assurance
Develop whole system business case
Four tests review (1)
Four tests review (2)
Decision to proceed to consultation if required (early Jun))
Governing body and trust review
Clinical Senate Review
Submit for NHSE assurance (Mar)
CLG Implementation
CLG Project Initiation Documents Developed
Implementation plan and programme reporting established
Ongoing implementation of CLG plans
Supporting activities
Ongoing Communications and engagement
Supporting strategies complete

Governance


Collective Governance and Decision Making
Key advisory and collaborative bodies:
South East London Healthwatches
South East London Health Overview and Scrutiny Committees
External Clinical Advisory (as appropriate)
NHSE Governance for Direct Commissioning
CCG Governing Bodies [x6]
South East London Health & Wellbeing Boards [x6]
Ensure Alignment with H&WB Strategy & agreement of BCF
Committee in Common for Strategic Decision Making
Clinical Strategy Committee
Stakeholder Reference Group
Programme Governance
South East London Partnership Group
Chair(s): 1 CCG Chair + Another (local authority/ provider, tbc)
Members: CCG Chairs & COs, Provider CEOs & MDs, local authority CEOs, representation from NTDA, NHSE, LAS, Public Health, LETB, HIN/AHSN, Healthwatches and patient & public voices
Clinical Commissioning Board (Programme Board)
Chair(s): 1 CCG Chair + NHSE (South London) Medical Director
Members: CCG Chairs & COs, representation from NHSE including direct commissioning and (non-voting) local authorities, Healthwatches, patient & public voices
Patient and Public Advisory Group
Clinical Executive Group
Chair(s): 1 CCG Chair + 1 secondary care lead
Members: CCG Chairs, Provider MDs, NHSE (South London) Medical Director, representation from Healthwatches and patient & public voices
Implementation Executive Group
Chair(s): NHSE (South London) Delivery Director +1 CCG CO
Members: CCG COs, Workstream SROs, Programme Director, NHSE direct commissioning leads, local authority representation
Local South East London CCG Governance of 'Business as Usual' Activities
NHSE BAU
NTDA BAU
Monitor BAU
Clinical Design
Supported by Clinical Leadership Groups
Strategy Implementation
Supported by implementation workstream structure and Supporting Strategies
Programme Design & Implementation
Last Updated : 04/03/14
Notes & Abbreviations
BCF = Better Care Fund
NHSE = NHS England
NTDA = NHS Trust Development Authority
LAS = London Ambulance Service
LETB = Local Education and Training Boards
HIN = Health Innovation Network
AHSN = Academic Health Science Networks
MD = Medical Director
BAU = 'Business as Usual'
CBC = Community Based Care
SRG = Stakeholder Reference Group
CSC = Clinical Strategy Committee
Key
Programme Decision Making
Existing Governance
Programme Governance
Advisory and Collaborative

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Report No.
CSD15126

London Borough of Bromley

PART ONE - PUBLIC

Decision Maker:	**HEALTH SCRUTINY SUB-COMMITTEE**
Date:	**Wednesday 4th November 2015**
Decision Type:	Non-Urgent Non-Executive Key Non-Key
Title:	**WORK PROGRAMME 2015/16**
Contact Officer:	Graham Walton, Democratic Services Manager Tel: 0208 461 7743 E-mail: graham.walton@bromley.gov.uk
Chief Officer:	Mark Bowen, Director of Corporate Services
Ward:	N/A

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1. Reason for report

1.1 The Sub-Committee is requested to consider its work programme for 2015/16.

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2. RECOMMENDATION

The Sub-Committee is asked to review its work programme and indicate any issues that it wishes to cover at forthcoming meetings.

Corporate Policy

1. Policy Status: Existing Policy:
2. BBB Priority: Excellent Council:

Financial

1. Cost of proposal: No Cost: Further Details
2. Ongoing costs: Not Applicable:
3. Budget head/performance centre: Democratic Services
4. Total current budget for this head: £326,980
5. Source of funding: 2014/15 revenue budget

Staff

1. Number of staff (current and additional): 8 staff (7.27fte)
2. If from existing staff resources, number of staff hours: N/A

Legal

1. Legal Requirement: None:
2. Call-in: Not Applicable: This report does not require an executive decision.

Customer Impact

1. Estimated number of users/beneficiaries (current and projected): This report is intended primarily for Members of this Sub-Committee to use in planning their on-going work.

Ward Councillor Views

1. Have Ward Councillors been asked for comments? Not Applicable
2. Summary of Ward Councillors comments: Not applicable

3. COMMENTARY

3.1 The Sub-Committee is asked at each meeting to consider its work programme, review its workload and identify any issues that it wishes to scrutinise. The Sub-Committee's primary role is to undertake external scrutiny of local health services and in approving a work programme the Sub-Committee will need to ensure that priority issues are addressed.

3.2 The three scheduled meeting dates during the 2015/16 Council year, as set out in the draft programme of meetings considered by General Purposes and Licensing Committee on 26th March 2015, are as follows –

11th June 2015

4th November 2015

25th February 2016

The draft work programme is set out in Appendix 1 below.

Non-Applicable Sections:	Policy/Financial/Legal/Personnel
Background Documents: (Access via Contact Officer)	Previous work programme reports

Appendix 1

HEALTH SCRUTINY SUB-COMMITTEE WORK PROGRAMME 2015/16

25th February 2016 (4.30pm)	
PRUH Improvement Plan	Update from Kings
Better Care Fund Projects Update	
Winter Pressures Update	
Joint Health Scrutiny Committee - Update	