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DATE: 26 January 2017

To: Members of the
HEALTH AND WELLBEING BOARD

Councillor David Jefferys (Chairman)
Councillor Diane Smith (Vice-Chairman)
Councillors Ruth Bennett, Stephen Carr, Ian Dunn, Robert Evans, Colin Smith and Pauline Tunnicliffe

London Borough of Bromley Officers:

Janet Bailey	Director of Children's Social Care
Stephen John	Director of Adult Social Care
Dr Nada Lemic	Director of Public Health

Clinical Commissioning Group:

Dr Angela Bhan	Chief Officer - Consultant in Public Health
Harvey Guntrip	Lay Member-Bromley CCG
Dr Andrew Parson	Clinical Chairman CCG

Bromley Safeguarding Children Board:

Jim Gamble QPM	Independent Chair - Bromley Safeguarding Children's Board

Bromley Voluntary Sector:

Linda Gabriel	Healthwatch Bromley
Colin Maclean	Community Links Bromley

A meeting of the Health and Wellbeing Board will be held at Bromley Civic Centre on **THURSDAY 2 FEBRUARY 2017 AT 1.30 PM**

MARK BOWEN
Director of Corporate Services

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

AGENDA

1 APOLOGIES FOR ABSENCE

2 DECLARATIONS OF INTEREST

3 MINUTES OF THE MEETING HELD ON 1ST DECEMBER 2016 (Pages 1 - 16)

4 QUESTIONS FROM COUNCILLORS AND MEMBERS OF THE PUBLIC

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 5.00pm on 27th January 2017

5 SOCIAL ISOLATION--DEVELOPING A LOCAL CAMPAIGN (Pages 17 - 32)

6 PRESENTATION FROM THE LOCAL PHARMACEUTICAL COMMITTEE

7 PRIMARY CARE CO-COMMISSIONING REPORT (Pages 33 - 42)

8 ICN AND FRAILTY UNIT UPDATE

This will be a verbal update.

9 UPDATE FROM THE MENTAL HEALTH SUB GROUP

A verbal update will be provided by Mr Harvey Guntrip, Chairman of the Mental Health Sub Group.

10 JSNA 2016 PRESENTATION AND AN UPDATE ON THE HWB STRATEGY

Dr Agnes Marossy will present on the 2016 JSNA, and will update on the HWB Strategy.

11 CHILD WELLBEING NEEDS ASSESSMENT AND REVIEW OF PUBLIC HEALTH AND JOINTLY COMMISSIONED CHILDREN'S SERVICES (Pages 43 - 82)

The update will be provided by Dr Jenny Selway, and the Child Wellbeing Needs Assessment has been published as an Information Briefing.

12 QUESTIONS ON THE INFORMATION BRIEFING

The briefing comprises:

The Child Wellbeing Needs Assessment (Children's JSNA)

Members of the HWB have been provided with advance copies of the briefing via email.

The briefing is also available on the Council's Website at the following link:

http://cds.bromley.gov.uk/ieListMeetings.aspx?CId=559&Year=0

13 REPORT ON PERFORMANCE AGAINST THE WINTER PLAN

This Item is To Follow.

14 PHLEBOTOMY UPDATE

This will be a verbal update.

15 EMERGING ISSUES

Members are invited to express their opinions concerning what they regard as 'emerging issues' within the health and care sector. These issues may then be discussed in greater depth at future HWB meetings.

16 REPORT ON ALCOHOL USE IN BROMLEY (Pages 83 - 128)

17 LETTER FROM DAVID MOWATT CONCERNING END OF LIFE CARE AND THE RESPONSE FROM THE HEALTH AND WELLBEING BOARD (Pages 129 - 132)

18 WORK PROGRAMME AND MATTERS ARISING (Pages 133 - 144)

19 ANY OTHER BUISINESS

20 DATE OF THE NEXT MEETING

The date of the next meeting is 30th March 2017.

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HEALTH AND WELLBEING BOARD

Minutes of the meeting held at 1.30 pm on 1 December 2016

Present:

Councillor David Jefferys (Chairman)
Councillor Diane Smith (Vice-Chairman)
Councillors Ruth Bennett, Stephen Carr, Ian Dunn, Robert Evans, Colin Smith and Pauline Tunnicliffe

Stephen John, Director: Adult Social Care
Dr Nada Lemic, Director of Public Health

Dr Andrew Parson, Clinical Chairman CCG
Annie Callanan, Independent Chair - Bromley Safeguarding Children Board
Linda Gabriel, Healthwatch Bromley
Colin Maclean, Community Links Bromley
Mark Cheung, Chief Financial Officer, CCG

Also Present:

Ade Adetosoye, OBE (Education, Care & Health Services), Lorna Blackwood (Education, Care & Health Services), Jackie Goad (Environment & Community Services) and Dr Agnes Marossy (Bromley Health Authority)

90 APOLOGIES FOR ABSENCE

Apologies were received from Dr Bhan, and Mark Cheung acted as substitute.

Apologies were also received from Harvey Guntrip.

The new Deputy Chief Executive and Executive Director of Education, Care and Health, Ade Adetosoye OBE, attended the meeting, and was welcomed by Board members.

91 DECLARATIONS OF INTEREST

Colin Maclean declared an interest in agenda item 7 which was the BCF update.

92 MINUTES OF THE MEETING HELD ON 6TH OCTOBER 2016

The minutes of the previous meeting were agreed as a correct record.

93 QUESTIONS FROM COUNCILLORS OR MEMBERS OF THE PUBLIC

Questions were received from Sue Sulis, representing the Community Care Protection Group.

The questions were for written response, and will be appended to the minutes with the answers as Appendix A.

94 INTEGRATED CARE NETWORK AND FRAILTY UNIT UPDATE

The Integrated Care Network update was provided jointly by Mark Cheung and Dr Andrew Parson.

Dr Parson commenced by providing a brief summary of the key points of work undertaken to date, and by explaining that the aim of the Integrated Care Network (ICN) was to reduce hospital admissions. A summary was provided of the significant engagement that had already taken place with a variety of stakeholders. This was broken down into 4 main areas:

- Involvement of GP Members
- Involvement of GPs as Providers
- Involvement with other Partners
- Work in progress

The other partners involved included the GP Alliance, patients, Kings College Hospital, PRUH, Bromley Healthcare, Oxleas, St Christopher's, and Bromley Third Sector Enterprise. The initial stages in the ICN process would commence with all health care professionals case finding and identifying individuals deemed as high risk, and providing their details to the MDT Liaison Coordinator (MDT is Multi-Disciplinary Team).

It was noted that the next step in the process would be for the MDT Liaison Coordinator to support GPs with updating EMIS—the GP information system. Verification would be provided by consulting the patient to see if they were happy to be put on the Proactive Care Pathway.

Dr Parson informed the HWB that a number of GPs were already engaged in the process, and were involved in the mechanism of case finding deteriorating or difficult to manage patients. These details had been forwarded to the relevant MDT. The plan was to bring together a team around the patient to enhance patient care and experience. In most cases, initial holistic assessments would be undertaken by Community Matrons—this could be face to face or in a virtual environment. Information would be available to everyone involved to facilitate joint working.

The next stage in the Proactive Care Pathway would be the formulation of an Integrated Care and Support Plan—this would be developed by the Community Matron in conjunction with the patient, and supported as required by the Care Navigator. After this, there would be an initial MDT meeting, where the Care Plan would be ratified, and the Clinical Lead would be assigned.

The Board heard that in terms of governance, a nominated GP Chair would Chair the MDT meetings to ensure that the patient's needs were considered and actioned. A re-assessment would be undertaken when required, as would reviews of the Care and Support Plan. If the Integrated Care and Support Plan was updated, this would be shared with the patient and the most relevant person. Throughout the process, the patient's main point of contact for Primary Care would be the Clinical Lead, and the main point of contact for all other issues would be the MDT Liaison Coordinator. Dr Parson highlighted the key role that Geriatricians would play in implementing the Care Plan for the elderly. It was anticipated that input would also be provided from the voluntary sector, and that social prescribing would also be used where appropriate.

The Board heard that the recruitment process for recruiting into key MDT roles was nearly complete. The new key roles were outlined as follows:

- GP Chair
- MDT Liaison Coordinator
- Care Navigators
- Interface Geriatrician
- Mental Health Professional
- Social Prescribing Administrator

The Board heard that it was planned to roll out the new MDT system in three locations simultaneously. The Chairman asked if there was going to be a communications plan. Dr Parson responded that initially there would be no noticeable difference to patients, and so a direct marketing initiative was not required.

Cllr Evans asked for clarification of the role of Social Care in the process. He asked if Social Care would be consulted and officers involved. Dr Parson responded that the support of Social Care was required, and that plans were being developed with Lorna Blackwood (LBB Head of Adult and Community Services). The LBB Director for Adult Social Care assured that the appropriate Social Care systems would be in place.

The Board were referred to page 11 of the ICN report, and were given a brief overview of the Frailty Pathways for Step Up and Step Down services. The idea was to try and limit the admission of the elderly to A&E and to acute medical units. The gatekeeper for beds in the Integrated Unit would be a geriatrician who would be working to agreed criteria, and monitored by governance groups. Further objectives were to link more urgent out patients to the MDT, and to avoid the stress of unsuccessful discharges.

Cllr Carr expressed concern around the efficiency of other boroughs in discharging patients that had been treated in Bromley. Dr Parson replied that, it would be important to ensure that other boroughs were working efficiently. Work was being undertaken with Kings and Community GPs to ensure that the relevant protocols had been put in place. Cllr Carr was concerned that social care funding could be used to fund the acute sector, and was worried that the proposed model could

result in Bromley having to pay for the inefficiency of other boroughs. It was noted in this regard that other boroughs would be liable for excess charges. Cllr Carr was uneasy that the current model did not seem to provide any real incentives for other CCGs to be efficient, and Cllr Colin Smith expressed similar concerns.

Cllr Dunn referred to the section on the report regarding a level of frailty of 6-7 on the Rockwood Frailty Scale, and asked what this was. Dr Parson explained that this was a frailty score that was not based on age, but was based on function. Cllr Ruth Bennett asked if spare capacity in step up facilities could be sold to other CCGs. Mr Cheung responded that this had not been looked into, but in theory the answer was yes, subject to capacity allowing. A charging mechanism would need to be evaluated.

Cllr Colin Smith expressed concern around the potential waiting time for those awaiting transfers late at night, or in the early hours of the morning. Dr Parson gave assurances that this would not happen, and that any transfer required would be a deferred decision by a Geriatrician.

The Chairman concluded by welcoming the work undertaken to date to establish the ICN. He stated that much good and innovative work had been done and was encouraged to hear of the involvement of the third sector. He asked that an update report be brought to the Board in March 2017, with an emphasis on cross border flows.

RESOLVED that an ICN update report be brought back to the HWB in March 2017.

95 PRIMARY CARE CO-COMMISSIONING UPDATE

This was an update report drafted by Jessica Arnold, Head of Primary and Community Care at Bromley CCG.

The report had been presented to the HWB to explain the preparations being undertaken to move to delegated primary care commissioning in Bromley during 2017, together with the implications of such a move. The HWB were asked to note the report.

Dr Parson outlined the three levels of primary care commissioning:

- NHS Commissioning
- Joint Commissioning between the NHS and the CCG
- Fully delegated CCG commissioning

All six of the CCGs in South London had decided to apply for level 3 delegation, and the applications had to be submitted by December 5th 2016. Following submission of the applications, each CCG would be assessed for their readiness to assume fully delegated responsibility. This would include assessments of how the CCGs were preparing for changes to governance, conflicts of interest, and risk management. A specific new appointment had been made to deal with any potential conflict of interests. Dr Parson stated that primary care co-commissioning

needed to be transparent and provide good local commissioning.

Cllr Carr felt that providers may be beyond proper control and enquired how they could be influenced. Dr Parson responded that providers would need to consistently provide value for money, and that it would need to be ensured that GPs delivered the services needed as required. The workforce would need to be committed and well supported. It was noted that currently there was a shortage of GPs, and so the use of GP Federations may be required. The GP contract may need modifying to focus on local priorities.

Cllr Robert Evans asked if under the new arrangements, the CCG would have more influence to enforce GPs to fulfil expected requirements. Dr Parson responded that what was required was better, intelligent commissioning. Some GPs would have to join collectives in order to expand working hours.

The Chairman noted the importance of fully delegated commissioning, and stated that he hoped for more intelligent commissioning going forward.

96 BETTER CARE FUND 2016/17 PERFORMANCE UPDATE

The report on the Better Care Fund 2016/17 Performance Update was provided by Jackie Goad. The report provided an overview of the first and second quarter performance of the Better Care Fund 2016/17, regarding expenditure and activity levels up to the end of September 2016.

The report was provided to the HWB to keep members informed regarding the position of the pooled fund and progress of the locally agreed Better Care Fund schemes.

The Board was asked to note the latest financial position and the performance and progress of the BCF schemes. Ms Goad reminded the Board that the BCF 2016/17 local plan had been formally agreed and endorsed by the HWB at its meeting on the 21st April 2016. The plan was submitted to NHS England for approval in May 2016. The Board were informed of the performance metrics as outlined on page 3 of the report, and were also directed to the BCF Financial Implications table that detailed a total BCF budget of £21.6m.

Cllr Colin Smith referred to section 4.5.5. of the report (Delayed Transfers of Care-DTOC) and enquired how the 2016/17 planned figures had been formulated. This was because the Director for Adult Social Care had stated that the figures he was aware of, differed from the NHS figures noted in the report. Cllr Colin Smith asked why there were two different sets of figures. It was noted that the figures in the report were the product of a national data churn, and were not local figures. Mark Cheung and the Director for Adult Social Care offered to look into the reporting anomaly, and to report back to the Board.

Cllr Colin Smith and Cllr Carr felt that it was imperative that the issue of the TOCB data be followed up and clarified, and requested an answer by December 15th 2016.

RESOLVED that Mark Cheung and the LBB Director for Adult Social Care report back to the HWB on the anomaly around the TOCB data.

97 JSNA UPDATE REPORT

The report title was 'Approval of the 2016 JSNA'. It was presented to the HWB by Dr Agnes Marossy, Consultant in Public Health. The report asked HWB members to approve the 2016 JSNA (Joint Strategic Needs Assessment) and to consider the proposed structure for the 2017 JSNA.

The Board heard that the structure of the 2017 JSNA would consist of the following sections:

- Demography
- Life Expectancy and the Burden of Disease
- In depth analysis of Learning Disability
- In depth analysis of 'Carers'
- Integrated Care Network Profiles
- Older people
- Mental Health
- Substance Misuse

The Board were informed that there would be a separate JSNA prepared for Children and Young people. This was to better inform the Children's Services Commissioner. The Board agreed that the Children's JSNA should also be presented to the HWB in addition to the Children's Safeguarding Board.

The 2016 JSNA looked at the issue of homelessness, and the associated negative health impacts. In most cases, homelessness also meant losing access to health services, with a detrimental impact on both mental and physical health. There was often a low level of access to preventative services. Another problematic area that needed addressing was the issue of discharging homeless people from hospital. There was no standard protocol for this, and it was important to try and remove homeless people from the negative cycle associated with homelessness and ill health.

Other in-depth areas in the 2016 JSNA were domestic violence, sexual health and alcohol.

Cllr Colin Smith expressed concern regarding the population projections, which seemed to predict a reduction in the number of young people in Bromley. Dr Marossy explained that population prediction was not an exact science, and the figures in the JSNA were based on GLA data, which was the best data available for London and was based on population figures from the Census, with adjustments for migration and developments. Dr Lemic confirmed that the GLA data was the best available.

RESOLVED that

1) The report be noted, and the proposed Children's JSNA be presented to the HWB in due course.

2) The 2016 JSNA be approved.

3) The proposed structure of the 2017 JSNA was endorsed with the addition of sections on Homelessness and on Domestic Violence.

98 QUESTIONS ON THE DRAFT JSNA 2016 INFORMATION BRIEFING

The following questions were submitted by Cllr Ian Dunn:

1- Do we know why Clock House is the lowest Ward in the borough for NHS checks?

2- Do we know why scarlet fever has increased sharply in recent years?

3- What are the consequences for the health and social care systems of the work which has been done on housing and homelessness?

The answers are as follows:

Question 1

There are 7 GP practices bordering Clock House Ward who over the 5 years the data refers to, have each had either intermittent or ongoing issues which have reduced their ability to provide NHS Health Checks.

None of the practices providing services for Clock House Ward have been able to achieve the target numbers set each year. Therefore the lower numbers have accumulated over each year.

These issues include:

Staffing
Other services given priority
Reliance on alternative providers--as no capacity in house.

Question 2

Public Health England issued information on this in March 2016.

In 2014, unusually high numbers of scarlet fever cases were noted, the highest since 1969, which persisted into the following year's season and then into the current season. The reasons behind this increase are unclear but may reflect the long-term natural cycles in disease incidence seen in many types of infection. Assessment of bacteria obtained from patients has excluded the possibility of a

newly emerging strain of group A streptococcus with increased ability to spread between patients causing the increase in disease incidence.

Question 3

Homeless people are high users of health services including A&E. In addition, poor housing is known to be detrimental to health.

In the Homeless Health Needs Audit of single homeless, we found that:

- 74% had physical health problems
- 77% had mental health problems
- 71% had seen a GP in the last 6 months
- 30% had seen a GP more than 3 times in the last year
- 43% had visited A&E
- 28% had been admitted to hospital

We found that there were low levels of access to preventative services.

There are (according to official statistics, so an underestimate) approximately 147 single homeless in Bromley.

Much bigger is the number of homeless families (in 2015/16, 438 homeless applications were accepted owing to dependent children), often these are placed in temporary accommodation outside the borough. Moving out of the borough means being cut off from support services and networks and often having to change doctor, making it more difficult to manage any health problems.

Implications/Consequences:

- There is considerable health need in the homeless population
- Low levels of access to preventative services will exacerbate the health problems.
- There is an issue about discharging people from hospital when they are homeless, there is no systematic approach in place.
- We will be investigating the health needs of families early next year.

99 BROMLEY WINTER PLAN

The Bromley Winter Plan had been added to the agenda for noting. It was anticipated that a report on performance would be provided at the next meeting.

The report contained subsets of the Bromley Winter Plan 2016/17 and incorporated information from the PRUH Urgent Care Improvement Plan. The report was separated into three sections for clarity and ease of reading. The three areas were:

- Section A: Performance
- Section B: Delivery against 5 national initiatives
- Section C: Winter Surges.

The report had highlighted that the main cause of breaches in A&E performance at the PRUH was bed management and waiting times to see a first clinician.

Mr Cheung mentioned that plans were being developed to limit A&E admissions when they were not really required. Patient Champions may be used to check that individuals really needed to be seen in A&E. Plans were also be drafted to commission more appointments in primary care hubs.

Section 4.3 noted four escalation stages. These ranged from OPEL 1 to OPEL 4, where 4 represented the highest risk, and the possibility of operational failure. 'OPEL' was an abbreviation for Operational Pressures Escalation Level. Cllr Dunn requested more information regarding how many times the PRUH had been in the various escalation levels, and Mr Cheung promised to investigate this.

RESOLVED that the Winter/Escalation Plan be noted, and that a report on performance against the Plan be provided at the next HWB meeting.

100 PHLEBOTOMY UPDATE

The Board heard that investigations were under way to try and find ways to improve access to phlebotomy services, and to improve pathology. The immediate question was what could be achieved quickly. Currently GPs were helping, but this was regarded as a short term solution. GP Federations could also be used to increase capacity. It was not clear what increased level of capacity GP Federations could supply.

The Chairman stated that this was a matter that had been going on for some time, and needed resolving.

101 ELECTIVE ORTHOPAEDIC CENTRES

It was noted that a decision had been taken to progress with plans to develop the Elective Orthopaedic Centres on the two approved sites.

102 HEALTHWATCH INEQUALITIES REPORT

The Healthwatch report was entitled 'Banking on a Meal' and was presented by Folake Segun and Stephanie Wood.

Healthwatch highlighted the 'Living Well Project' based at Holy Trinity Church in Penge. Individuals attending the project were able to access a foodbank and various community services. It was noted that at one session there were over 100 people in attendance. The project offered a hot meal, shower, food parcel, as well as art and music sessions. Bromley Drug and Alcohol Team were also present for those that needed advice. The Board were concerned to learn that many present suffered from mental health challenges, and lacked any form of clinical or familial support.

Healthwatch cited an example of an individual who had identified as homeless, and had previously been given a prescription for a course of treatment from a local

drop in clinic. He had been unable to access the treatment as he was not registered with a GP. He had been turned down for registration by a local GP service because he did not have a permanent address. This happened despite the fact that it was no longer a legal requirement to have a permanent address to register with a GP. Healthwatch had to escalate the matter with the CCG and with NHS England before the matter was resolved; it was agreed that the church address could function as a temporary address for the client.

There were 5 main points that had been highlighted by Healthwatch's research:

1- Those suffering from financial hardship were more likely to suffer from lower standards of physical and mental wellbeing.

2- Zero hour contracts and insecure employment often left people with insufficient resources to support themselves and their families. This caused a dependency on local support such as food banks.

3- Lack of communication between services meant that people were susceptible to falling through the gaps. This was most evident with benefit processing and a delay in payments.

4- GP registration and access to primary care was severely restricted by a lack of permanent address, despite legislation stating that it was not a statutory requirement.

5- Those who were already at risk were unable to support themselves in day to day life, and as a result remained liable to further health complications. This picked upon the discussion of the proposed sections for the 2017 JSNA.

Colin Maclean referred to the proposed development of a Homeless Strategy, and requested an update concerning this. It was agreed that an update on the development of the strategy should come back to the Board.

Cllr Evans asked for clarification concerning the definition of 'homeless' in relation to the Healthwatch report. He stated that LBB had provided accommodation for homeless people in line with statutory obligations, and that as far as he was aware, there were currently less than 12 homeless people on the street. The basic problem was that more houses were required. He referred to section 9.3 of the report that recommended '*additional council support and advocacy for those who are struggling to live independently to prevent people from entering the cycle of deprivation'.* He stated that Council support and advice was already provided, and wondered what more the Council could do. Folake Segun from Healthwatch agreed that Council support was provided, but felt that it would be helpful if the public could be made more aware of how they could access services.

The Chairman noted that many of the recommendations had been presented to the CCG for consideration.

RESOLVED that the report be noted, and that an update on the development of the Homelessness Strategy be brought back to a future Board meeting.

103 BROMLEY SAFEGUARDING ADULTS BOARD ANNUAL REPORT--2015-2016

It was intended that the report be provided for information and noting, with a more detailed discussion to take place at the next meeting in February 2017.

Annie Callanan (former Independent Chair) clarified that she had now finished her work as the Independent Chair of the Bromley Safeguarding Adult's Board, and that recruitment was under way for a new Independent Chairman. She highlighted the significant pressures that were now being manifest in all parts of the sector. She emphasised the ongoing commitment of the Board in ensuring the success of cross sector services working together.

Cllr Evans highlighted page 17 of the report, which was referred to as 'Case Study 3—Mr Jones'. The case study highlighted the successful partnership working within LBB between the Housing Department, Adult Safeguarding, Legal and Trading Standards. Cllr Evans in particular praised the work of Mr Rob Vale and the Trading Standards Team.

RESOLVED that the report be noted and that a more detailed discussion of the report take place in February 2017.

104 LETTER FROM HOME OFFICE AND DEPARTMENT OF HEALTH--COLLABORATION BETWEEN POLICING AND HEALTH PARTNERS

The Board noted the letter from the Home Office and the Department for Health. The letter asked HWBs and Police and Crime Commissioners (PCCs) to consider how they could better work together by ensuring appropriate representation from both sectors on HWBs.

The Board agreed that a response to the letter should be drafted by 15th December.

RESOLVED that a response to the letter should be drafted by 15th December.

105 WORK PROGRAMME AND MATTERS ARISING

CSD 16160

The Board noted its Work Programme and progress on Matters Arising, and the need for an agenda planning meeting before the Christmas break.

106 ANY OTHER BUSINESS

Lorna Blackwood informed the Board that she had recently attended an Adults Stakeholders Conference about 'Isolation'. The event was well attended, and an action plan was being developed to deal with issues around social isolation. She asked if the HWB would be prepared to sponsor the action plan.

Cllr Tunnicliffe stated that the conference was good, and felt that it would be good if the HWB supported the action plan. She felt that many local pubs would be glad to help, particularly between the hours of 2.00pm and 6.00pm when they were not busy. It would be low cost but worthwhile initiative.

Cllr Colin Smith suggested that a funding stream may be required. The Chairman thought that it would be good to raise awareness of the issue, and the Director of Adult Social Care was also supportive. It was mentioned that a cab firm called 'Daisy Cabs' would be prepared to offer reduced rates for community groups.

Annie Callanan stated that it was good that people wanted to help, and that it had been proven that reducing isolation had beneficial effects on mental health. This being the case, it should be possible to build a valid business case to help and support any relevant initiatives.

Dr Parson felt that the HWB should be leading on any initiatives relating to combating mental health issues, and that any schemes designed to combat isolation should be supported.

Cllr Carr highlighted that LBB had a large potential resource in the form of 16-18 year olds, and that it may be beneficial to work with schools and community services to see what help they could provide. The Vice Chairman suggested that use could be made of the 'My Life' portal to provide information and direction. The Director for Adult Social Care proposed that a handout be provided that would list current resources and organisations that exist to provide support to those suffering from isolationism.

RESOLVED that the issue of Isolationism be reviewed at a future meeting, and that consideration be given to inviting the leaders of the stakeholder conference to address the HWB.

107 DATE OF THE NEXT MEETING

The date of the next meeting was confirmed as February 2nd 2017.

APPENDIX A-QUESTIONS FROM THE COMMUNITY CARE PROTECTION GROUP

The Meeting ended at 3.30 pm

Chairman

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Questions to the Health and Wellbeing Board—December 1st 2016

HWB Copy

(All questions are from the Community Care Protection Group)

Question 1:

1. DRAFT BROMLEY JOINT STRATEGIC NEEDS ASSESSMENT 2016: EXECUTIVE SUMMARY – CHILDREN & YOUNG PEOPLE (Agenda item 9, p.14).

The report identifies that:

"Children eligible for free school meals perform less well at every key stage than the rest of the population, and this gap increases as they move through the education system"…….

Q. *Since a significant deprivation factor is poor diet and malnutrition, what additional supportive action is proposed?*

Answer to Question 1:

Maternity and Health Visiting services provide advice to support families to feed babies and young children appropriate food. Families who are identified as vulnerable are followed up by Health Visiting services and may be referred to appropriate groups in Children and Family Centres. A specific group run jointly by Children's Social Care and Health Visitors provides a place where mothers can be supported in a community kitchen setting to provide cheap nutritious food for their children.

School age children and their families may be supported by the Children and Family Centres and also by some schools as part of the Healthy Schools initiative. Nearly 90% of Bromley Schools are registered as a "Healthy School".

If necessary, families may be referred by their Health Visitor, School Nurse or GP to dietetic services for expert assessment and advice.

Question 2:

2016 OFSTED REPORT ON BROMLEY'S CHILDREN'S SERVICES:- 21ST JULY 2016 REPORT TO BROMLEY CLINICAL COMMISSIONING GROUP BOARD.

At the Meeting, it was minuted that:-

"Both Cllr Evans and Jefferys expressed concern that they had not been sighted on the situation as it had developed, and had thus been unable to provide oversight".

Q. *Please explain clearly whose responsibility it was to ensure these Members had oversight of the situation?*

Answer to Question 2

There were regular reports provided to Members by the Quality Assurance and Improvement Team which unfortunately indicated a better level of performance than Ofsted found. All parts of the organisation are working with key partners to deliver the necessary improvements to service.

Question 3:

"They were members of the HWB, and felt that, due to the size of their portfolio, they had been unable to give due consideration to Children's Services."

Q. *Children's Services is a complex and challenging responsibility. Does Cllr. Evans consider that Statutory Guidance recommending not enlarging this portfolio should be followed?*

Answer to Question 3

This is a matter for the Leader. However the statutory guidance does not preclude the portfolio including other functions.

Report No.
Please obtain a report number

London Borough of Bromley

Decision Maker:	**HEALTH AND WELLBEING BOARD**
Date:	**2 February 2017**
Decision Type:	Non-Urgent Non-Executive Non-Key
Title:	**Social Isolation – developing a local campaign**
Contact Officer:	Jenny Manchester, Strategic Business Support Tel: 020464[7733 E-mail: jenny.manchester@bromley.gov.uk
Chief Officer:	Ade Adetosoye OBE, Deputy Chief Executive & Executive Director, Education, Care and Health
Ward:	N/A

1. Summary

The Adult Services Stakeholder Conference on social isolation was held in November on 2016. This paper presents a summary of the main recommendations arising from the Conference and seeks support from the Health and Wellbeing Board in the development of a local campaign.

2. Reason for Report going to Health and Wellbeing Board

2.1 The purpose of this report is to keep Board members apprised of the recent Adult Services Stakeholder Conference on social isolation. Members of the Health and Wellbeing Board are also asked to consider and support the recommendations arising out of the Conference.

3. Recommendations

3.1 Members of the Health and Wellbeing Board are asked to work with London Borough of Bromley in developing a campaign to help signpost people who may be experiencing social isolation.

3.2 If the Board agrees to 'sponsor' the campaign, an action plan detailing the timetable and next steps for partners will be circulated at the Board meeting in March.

Health & Wellbeing Strategy

1. Related priority: Diabetes Hypertension Obesity Anxiety and Depression Children with Complex Needs and Disabilities Children with Mental and Emotional Health Problems Children Referred to Children's Social Care Dementia Supporting Carers

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Financial

1. Cost of proposal: Not Applicable:

2. Ongoing costs: Not Applicable:

3. Total savings: Not Applicable:

4. Budget host organisation:

5. Source of funding:

6. Beneficiary/beneficiaries of any savings:

Supporting Public Health Outcome Indicator(s)

Yes

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4. COMMENTARY

4.1. The most recent Adult Social Care Users survey (2015/16) indicated that more people in Bromley, compared to residents in other London boroughs and elsewhere in the country, feel socially isolated or lonely. Not only does being socially isolated make you more vulnerable to abuse but also the impact of social isolation can be equivalent to obesity or smoking and can have a real impact on health and social care budgets. Age UK estimated that being isolated can be more damaging than smoking 15 cigarettes a day and also cites a study that found that lonely people have a 64% increased chance of developing clinical dementia.

4.2. The Adult Services Stakeholder Conference was held on 23 November 2016 to raise awareness of social isolation and specifically the link between social isolation and increased risk of abuse. Speakers at the Conference included the Portfolio Holder for Care Services and representatives from Bromley Voluntary Sector Strategic Network, Affinity Sutton, Advocacy for All and Bromley Trading Standards. More than 100 people attended, with representatives from partner organisations, faith groups, health sector. Around a third of people who attended were service users or carers.

4.3. The recommendations made in this report have resulted from the workshop discussions at the Conference.

5. RECOMMENDATIONS FROM THE CONFERENCE

5.1. Discussions from the workshops at the Conference yielded a number of recommendations These are as follows:

1) London Borough of Bromley to develop a new 'social isolation' resource on the Bromley MyLife website (by Summer 2017) which would:

- provide support for the local third sector in planning services e.g collate existing data and resources relating to who in our local community is most vulnerable to social isolation.

- provide detailed information for individuals, and organisations involved in signposting people, relating to activities and support which can help tackle social isolation. This information would be tailored according to peoples' interests, age, location.

2) A campaign to signpost resources to people who may be experiencing social isolation which would be rolled out through members of the Health and Wellbeing Board and other partner organisations in Bromley. The purpose of this campaign, which would be developed by the London Borough of Bromley, would be to raise awareness of the new resources available at Bromley MyLife.

Partner organisations (including members of the Health and Well Being Board) would be asked as part of this campaign:

- To promote and disseminate materials to their service users which promote the new Bromley MyLife resource

- To support an awareness week in the Autumn, through hosting or participating in activities, designed to highlight the issue of social isolation

3) Make sure that the issue of social isolation is reflected in the future Health and Wellbeing strategy and priorities, including the pilot project for social prescribing in Bromley – led by Broley Healthcare and Community Links as part of the Integrated Care Networks.

5.2. Members of the Health and Wellbeing Board are asked to consider 'sponsoring' the campaign approach outlined in 5.1 with each partner agreeing to support the development of a campaign plan. If this is agreed, the detailed campaign plan will be presented at the next Health and Wellbeing Board meeting on 30 March.

6. IMPACT ON VULNERABLE PEOPLE AND CHILDREN

Vulnerable people and children are more likely to be abused if they are socially isolated. The recommendations outlined in this report, will help partner organisations and individuals find local support which can help prevent social isolation and so reduce the risk of abuse.

7. FINANCIAL IMPLICATIONS

Not applicable.

8. LEGAL IMPLICATIONS

Not applicable.

9. COMMENT FROM THE DIRECTOR OF AUTHOR ORGANISATION

Click here and start typing - *Please include a short comment from your respective organisation director.*

Adult Services Stakeholder Conference

Not on your own – be safer together
- Tackling social isolation in Bromley

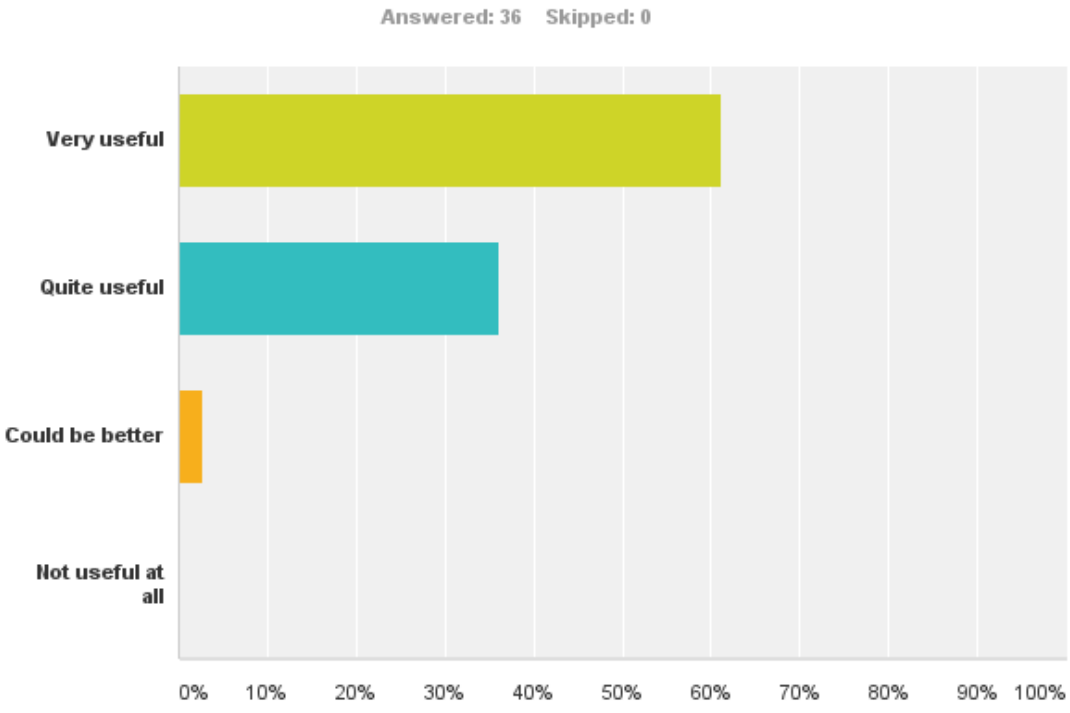
Conference Evaluation

In total 100 people attended the Adult Services Stakeholder Conference on 23 November 2016. 36 people completed the evaluation form, the vast majority completing the form at the event.
The total cost for the event was £321 (including refreshments and venue hire), or £3.21 per person.

Overall summary

- The vast majority of delegates found the Conference including the workshops and presentations useful or very useful and informative.
- People found the event well-organised and liked the venue
- A very small number of people suggested areas of improvement in terms of organisation of the event including:
    - smaller workshop area rooms
    - one set of presentations available to everyone and suitable for easy read
    - all day event rather than half day
    - Remove the mid-afternoon coffee break

Q.1 How useful did you find this Conference?



Summary
• 35 respondents (97%) found the event quite useful or very useful.
• 1 respondent (1%) felt that the event could be better

When asked to explain their answer, people were positive about the presentations and the workshops

1.1 Additional Comments
When asked to explain their answer, the qualitative responses can be divided into the following themes:

i) **Sharing information on this issue was really helpful**
• Useful to see what other organisations do in Bromley to support who can be isolated. It was also great to hear people's personal experiences
• Met a lot of people who could be very useful in helping with the Dementia club I want to start
• Got a better insight into social isolation

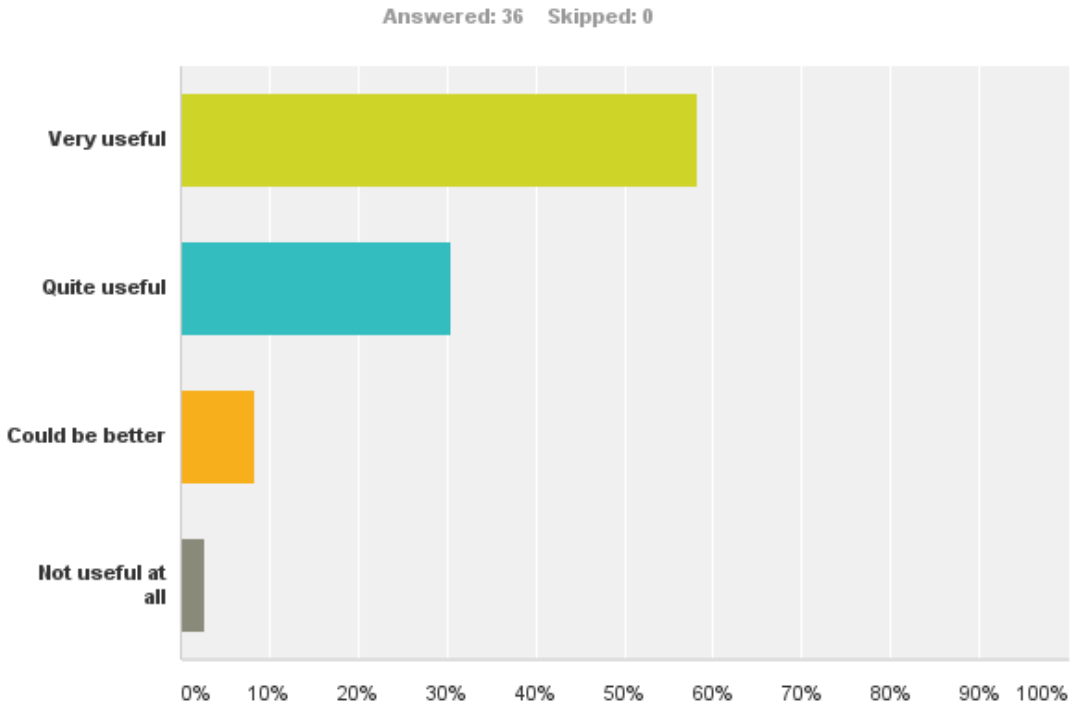
ii) Was a good networking opportunity
• It was really helpful to network with other providers – the workshops were very helpful
• Good to talk to people. Stalls interesting.
• Good to network with local people and organisations
• Made some new connections with organisations working in the community
• Great networking opportunity and made some useful links. Learnt more about social isolation and how it manifests/impacts on lives.

iii) Made me more aware of social isolation as a problem affecting the local community and what we can do about it
• The event was thought provoking and will be borne in mind whilst developing/ commissioning services
• Added to my current knowledge and experience on subjects discussed. Made useful contacts
• Early stages so hopefully a good starting point
• I like listening to the speakers
• Brought awareness that many different groups can be isolated. Previously I focused on the elderly and those with learning difficulties but now aware that social isolation affects many more people.

iv) Sharing information in this way was beneficial

v) Thoughts on how we can make the event more useful
• It was useful to hear the presentations and the workshops but wonder how much of the 'talk' will translate into actions
• More information stalls would be helpful
• Found it a bit drawn out – did we need the break in the middle?

Q 2) How useful did you find the presentations?

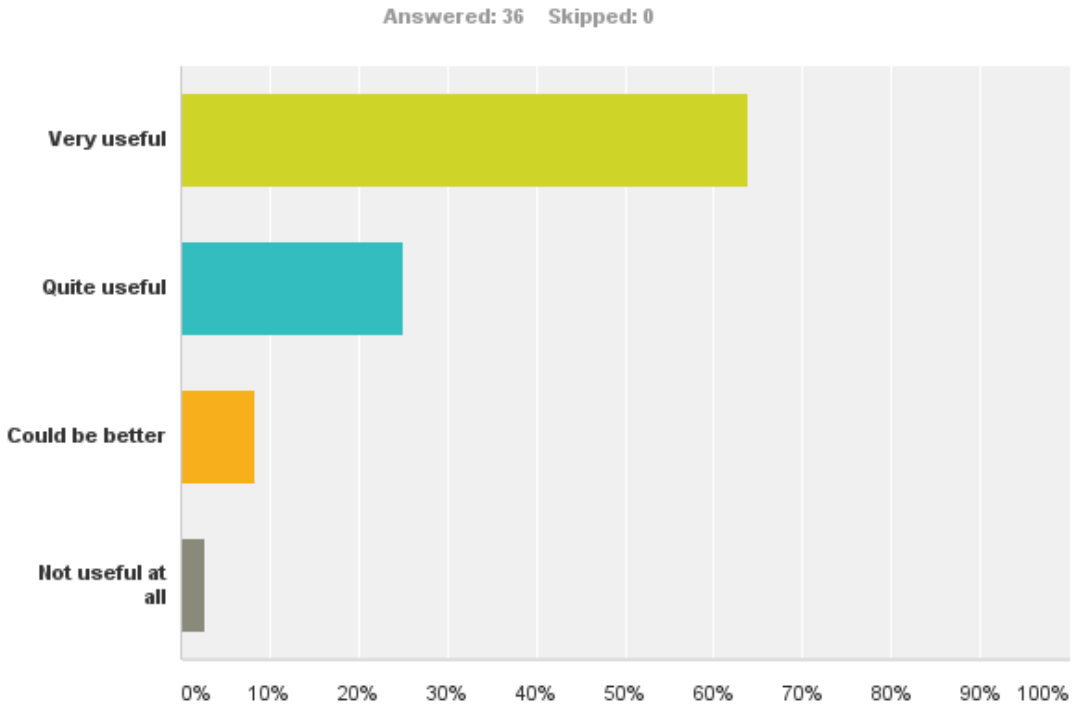


Summary
• 21 respondents found the presentations very useful or quite useful (88%)
• 3 respondents felt that the presentations could be better
• 1 respondent found that the presentations were not useful at all

i) Comments
When asked to explain their answer, people gave the following comments
• Relevant and useful lead into workshops
• I could see the presentations and hear them!
• Good insight to different organisations that I can contact on behalf of trading standards and work together
• Very informative presentations
• All the presentations were well done and clear.
• Presentation from Advocacy for All was brilliant, thought provoking. Information is powerful and has enabled the individuals to have confidence in changing lives.

ii) Room for improvement
When suggesting areas for improvement, the following comments were made
• It was sometimes difficult to hear due to problems with the microphone
• Could the Sparks crowd (Advocacy for All) be higher up so we all could have seen them?
• Accessibility could be improved – my clients could not read the easy read material quickly enough
• Rather than easy read versions, one version should be printed for all. One presentation was done with music and no words and was difficult to follow – not good for people with visual impairment or find it difficult to read.

Q 3) How useful did you find the workshops?



Summary
More than ¾ of respondents found the workshops useful
22 out of 26 respondentsfound the workshops very useful or useful (89%)
3 people felt that the workshops could be better
And 1 person felt that the workshops were not useful at all

Comments
Only one person gave an additional comment – reflecting that only four out of seven people expected in their group turned up

Q 4) Would you suggest that we do anything differently at the next conference? Or do you have any other comments?

Overwhelming number of responses were positive in response to these two linked questions.

Example of the responses are printed below:
- Learnt a lot
- This was my first time. It made me think of more ways of linking into different groups in as community to combat isolation.
- I liked the fact that young people and adults had a focus – it does make sense to have themed conferences of importance to all
- Good venue, well thought out layout and it was good that coffee was also brought into main church

When suggesting areas for improvement, the following comments were made:
- Have sweeteners
- Workshops need to be in quieter rooms and our room was cold

- Would it be too much to have an all day event? Then after the workshops there could be a Q and A
- Send out questions beforehand so we have more time to think and prepare
- Have one version of speeches/ presentations which is all easy read for everyone – one version for everyone would be more inclusive and promote equality rather than have two versions

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THE LONDON BOROUGH
www.bromley.gov.uk

Adult Services Stakeholder Conference

Not on your own – be safer together - Tackling social isolation in Bromley

What is social isolation? A briefing

The purpose of this briefing is to give delegates some background information about social isolation and also highlight what we do know about social isolation for people living in Bromley.

Definition of social isolation
According to the Campaign to End Loneliness, we can be clear when we talk about social isolation that we mean the absence of any social contact e.g contact with friends, families or community involvement or access to services.

National picture
We know that feeling isolated can affect people at different stages of their life. National figure tell us that social isolation can significantly affect following groups of people.

For example:
people with learning disabilities

- Nearly half of young people aged 18-35 (47%) surveyed by Mencap with a learning disability would like to spend more time outside their house. (Mencap, 2016)

carers

- Research by Carers UK in 2015 found that 83% of carers surveyed felt lonely or isolated due to their caring role.
- In a survey carried out by the London Borough of Bromley in 2014 (Your future, your support and your say) revealed that a third of carers who responded (total 105) do not have any friends or family close by to support them.

older people

- It is estimated that more than 1 million older people (aged over 65) say that they always or often feel lonely (Age UK, 2016)

young people leaving care

- 77% of the care leavers surveyed by the Centre for Social Justice highlighted their feelings of loneliness or social isolation when leaving care

What is the impact of social isolation?
Safeguarding and social isolation
If you are socially isolated, you can be more vulnerable to abuse, whether this be physical, domestic abuse or violence, sexual abuse, psychological or emotional, financial or material, modern slavery, discrimination, organisational, neglect or self neglect. Being isolated can make you a target for an abuser.
Not only can being isolated make you a target but if you have little contact with other people, it can make it really difficult to report. The work of our community organisations in Bromley, many of whom are represented here is vital in bridging the gap for many, many people.

Excess Winter deaths
More people die during the winter months. The cold of winter is hazardous to health especially to the elderly and the sick but the latest figures for Bromley show that the number of excess winter deaths in Bromley is worse than elsewhere in England and that there are around 150 potentially preventable winter deaths each year, accounting for 6% of all Bromley deaths. People especially at risk include those living in poorly heated or expensive to heat homes, and those with underlying chest conditions (breathing). Obviously social isolation can be a factor in identifying people who cannot afford to heat their homes or are not aware that their home is too cold – but currently we don't know how much a factor it can play.

Falls – people falling at home
It is estimated that more than 1000 older people (1214) living in Bromley will be admitted to hospital as a result of an unintentioned fall. If you are socially isolated, and don't have friends or family to call on, you may not found quickly and may not get prompt hospital treatment (often A and E) to get you back on your feet.
Research carried out in Devon and Cornwall which has a growing elderly population due to the numbers of older people that choose to retire there, found out of all older people admitted to A and E, a third had little social contact (less than one contact a month) .

Costs, social, psychological, financial
The impact of social isolation can be equivalent to obesity or smoking and thus can have a real impact on health and social care budgets. Age UK estimated that being isolated can be more damaging than smoking 15 cigarettes a day, and also cites a study that found that lonely people have a 64% increased chance of developing clinical dementia.

People who are socially isolated have higher blood pressure than their less lonely peers. A recent study from York University found that lonely people are around 30% more likely to suffer a stroke or heart disease, two of the leading causes of death in Britain.

In Bromley, the 2011 Census showed that 31, 012 people (10% of the population) are unpaid carers. Carers who feel socially isolated are more likely to experience depression or other impact on their mental health and potentially be unable to carry on their caring role – obviously any increase in the number of people who can no longer be supported by their carer would lead to increasing pressure on health and social care budgets.

What about social isolation in Bromley? What is happening here? What do we know?
We know in Bromley from the most recent Adult Social Care Users Survey that more people in Bromley compared to other London Boroughs and other areas in England tell us that they feel socially isolated or lonely. Out of 680 people that answered the survey, we know that 23% of people have some social contact but do not feel that it is enough or feel socially isolated. (This is a higher percentage compared to other London Boroughs/ rest of England figures) Out of this group of people who felt that they needed more social contact, 62% of people were over 65 years old.
This is an important figure because we know that Bromley's population of older people is growing over the next few years thus more people in the future may experience social isolation.
 Facts and figures: The proportion of older people in Bromley (aged 65 and over) is expected to increase gradually from 17.7% of the population in 2015 (56, 500) to 17.9% by 2020 (58,600) and 18.7% by 2025 (62, 800).

What is already happening in Bromley?
Bromley has a wealth of community organisations which connect people who may be feeling isolated. The Conference is an opportunity to find out more about what is going on in the local area, and delegates will also have the chance to see maps which show where services are located in the borough.

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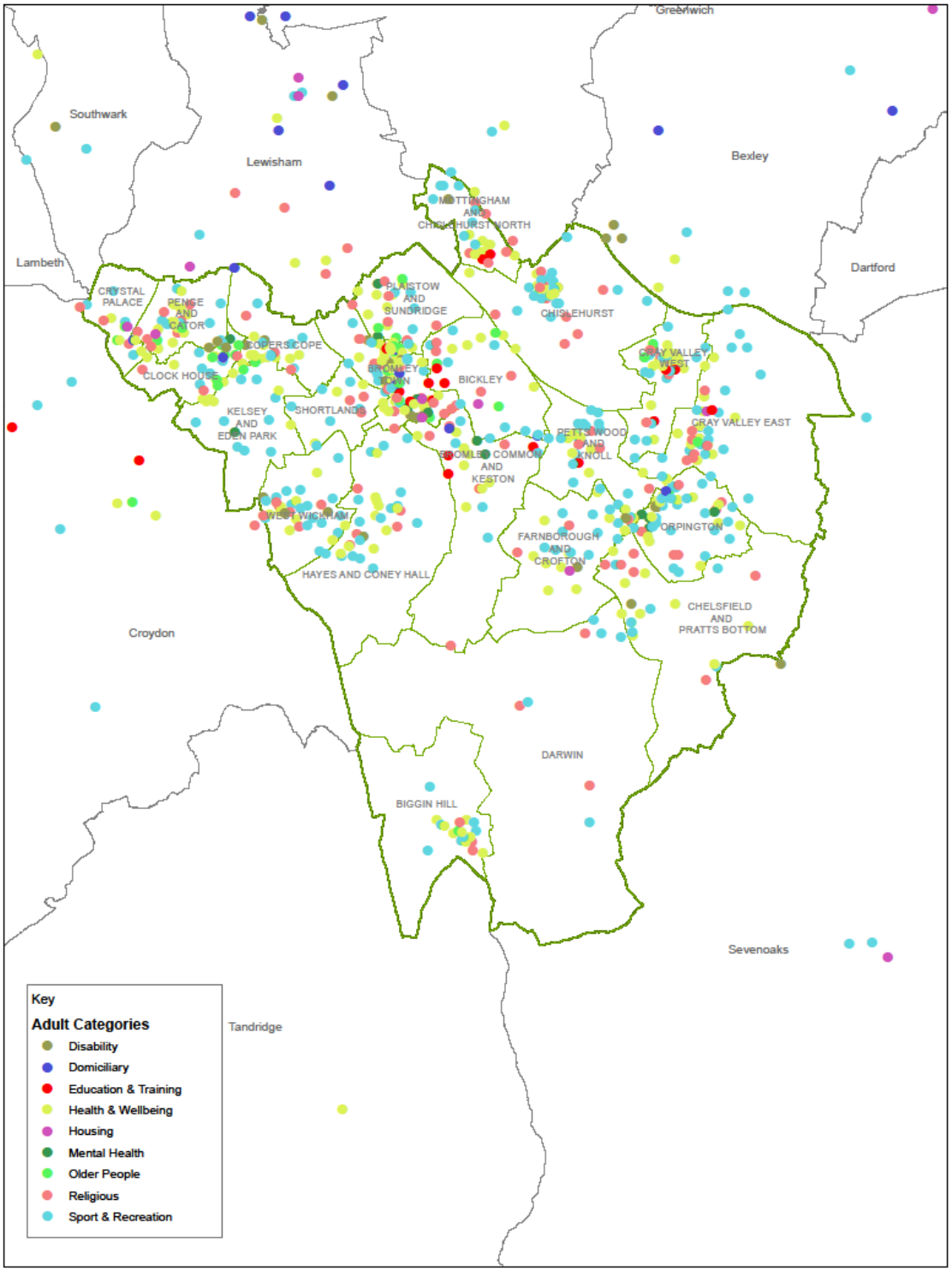
MAPS

What do we know about where support services in Bromley are located?

Adult Support Services in Bromley – from Bromley MyLife website

The purpose of this map is to show a snapshot of services aimed at adults in Bromley (as of October 2016)
The data has been drawn from the Bromley MyLife website and gives an idea of where many services and support is concentrated.
The data has been categorised to give an idea of the kind of support that is available for adults and where it is located.
More detailed information about individual services can be found at bromley.mylifeportal.co.uk



Adult Support Services in Bromley Town Centre – from Bromley MyLife website

The purpose of this map is to show a snapshot of services aimed at adults in Bromley (as of October 2016)
The data has been drawn from the Bromley MyLife website and gives an idea of where many services and support is concentrated.
The data has been categorised to give an idea of the kind of support that is available for adults and where it is located.
More detailed information about individual services can be found at bromley.mylifeportal.co.uk

Report No.
Please obtain a report number

London Borough of Bromley

Decision Maker: **HEALTH AND WELLBEING BOARD**

Date: **2nd February 2017**

Decision Type: Non-Urgent Non-Executive Non-Key

Title: **Primary Care Commissioning, Access and Resilience**

Contact Officer: Jessica Arnold, Head of Primary and Community Care,
Bromley CCG

Tel: 01689 866 172
E-mail: Jessica.arnold1@nhs.net

Chief Officer: Dr. Angela Bhan, Chief Officer, Bromley CCG

Ward: All wards of Bromley

1. Summary

The attached report provides an update to the Health and Wellbeing Board, relating to three critical areas of primary care:

A. Moving from co-commissioning of general practice with NHS England (level 2) to fully delegated commissioning by the CCG (Level 3) from 1st April 2017

B. Recent improvements in access to primary care in Bromley, in particular at evenings and weekends

C. Investments being planned into primary care as part of the GP Forward View plan

The report also includes a general update on primary care for information.

2. Reason for Report going to Health and Wellbeing Board

For information, comment and discussion.

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

Specific actions are noting and discussing, and incorporation of primary care matters into the future business of the Health and Wellbeing Board as appropriate.

Health & Wellbeing Strategy

1. Related priority: Not Applicable

Financial

1. Cost of proposal: No Cost:

2. Ongoing costs: No Cost:

3. Total savings: Not Applicable:

4. Budget host organisation: Bromley CCG

5. Source of funding: Various

6. Beneficiary/beneficiaries of any savings: Not applicable

Supporting Public Health Outcome Indicator(s)

Not Applicable:

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4. COMMENTARY

Please see enclosed report from Bromley CCG, entitled '*Primary care commissioning, access and resilience*'.

5. IMPACT ON VULNERABLE PEOPLE AND CHILDREN

General practice accounts for 90% of contacts with the NHS and is the first port of call for many people experiencing ill health and wellbeing. Therefore, ensuring we have well-run, resilient and accessible primary care in Bromley is a top priority for the CCG and its partners to ensure the best possible health and wellbeing outcomes of our whole population.

6. FINANCIAL IMPLICATIONS

The investments required are outlined in the enclosed report. Investments will come from either the CCG baseline budget or from additional monies devolved to the CCG by NHS England as part of the GP Forward View programme.

7. LEGAL IMPLICATIONS

Not applicable.

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

General and specific matters relating to primary care are taken for information or for decision as appropriate to the CCG Clinical Executive Group, the CCG Primary Care Programme Board, the CCG governing body, the SEL Community Based Care Board and the SEL Primary Care Joint Committee.

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Bromley Health and Wellbeing Board
Thursday, 2nd February 2017

ENCLOSURE XX

PRIMARY CARE COMMISSIONING, ACCESS AND RESILIENCE

DIRECTOR RESPONSIBLE: Angela Bhan, Chief Officer

CLINICAL LEAD: All Clinical Leads

AUTHOR: Jessica Arnold, Head of Primary and Community Care

INTRODUCTION AND SUMMARY:

This paper sets out key updates from the primary care function of Bromley CCG, in particular:

A) Moving from co-commissioning of general practice with NHS England towards fully delegated commissioning from 1st April
B) Recent improvements to primary care access, in particular during evenings and weekends
C) Investments into general practice planned as part of the local GP Forward View programme

The paper also gives a brief summary of other progress in primary care for information.

KEY UPDATES:

A) Level 3 full delegation of Primary Care Commissioning

All CCGs in London that are currently at level 2, co-commissioners of primary care, were asked in summer 2016 by NHS England to consider taking on level 3, fully delegated commissioning of primary care from 1st April 2017. Bromley CCG submitted our application for level 3 delegated commissioning for the December national deadline following a 67% majority vote and general support by the CCG's GP membership. The CCG was notified shortly before Christmas that our application had been forwarded for national approval without any conditions or caveats. A decision is expected in mid February.

The advantages of delegated commissioning are expected to be:

- Empower and enable CCGs to improve primary care services for the benefit of patients and local communities
- Enable clinically led, optimal local solutions to local needs
- Enable commissioning and service design across the whole patient pathway
- Allow greater control over local decisions affecting primary care informed by local knowledge of services and practices
- Enable CCGs to shift investment from acute to primary and community services

- Key enabler of developing seamless integrated out-of-hospital services
- Opportunity to design local incentive schemes as an alternative to QOF or DESs
- Drive outcomes based commissioning in primary care by aligning outcome measures and incentives used in primary care
- Mitigate risks around status quo of NHS England currently covering a large geographical patch and all independent contractors (GP practices, dental, optometry, pharmacy) while facing considerable staffing and financial challenges

Possible disadvantages of delegated commissioning:

- Workload for the CCG will increase. For example, the CCG will need to provide assurance that it is discharging NHS England's statutory functions effectively. This could be onerous in terms of monitoring and intervention. It will be important to ensure that there are adequate resources (funding and staff), and this is being considered as part of the NHS England devolution into seconded STP-based teams
- Real and perceived conflicts of interest will increase, and governance rules about GPs making decisions where conflict of interest applies must be adhered to. However, strengthened and transparent processes for decision-making have been developed in preparation for delegation
- There is a risk of inconsistency of approach in areas where national consistency is clearly desirable; therefore, the CCG will continue to work with NHS England on national priorities and with other CCGs to learn from best practice and experience elsewhere

Approval will permit Bromley CCG to commence the transition to level 3 from 1st April 2017. This will include establishing a new Primary Care Commissioning Committee (replacing the former SEL Joint Committee meetings and becoming the CCG's highest level of governance for primary care matters); adopting new Conflict of Interest arrangements; and working alongside a devolved NHS England team that is being seconded to SEL level to support local delivery. For information, all six SEL CCGs are expecting to be approved for fully delegated commissioning of primary care from April.

B) GP Forward View: Plan development and implementation

In April 2016, NHS England launched the General Practice Forward View (GPFV), a plan to stabilise and transform general practice backed by a multi-billion pound investment to start to redress historic underinvestment. It clearly stated that if general practice fails, the NHS fails, recognising the increasing pressure that general practice is under every day.

In Bromley, the GPFV investments are as follows:

- £185,000 for vulnerable practices, practice resilience and workforce, of which £30,000 must be spent on admin-clerical staff training
- £89,000 for online consultations
- £1,183,000 for improving access (see section C of this report)
- Over £3,000,000 under the Estates and Technology Transformation Fund for a Bromley Wellbeing Centre (see section 3 of this report)
- Funding for a Primary Care Development Manager (0.5WTE) to deliver the GP Forward View; we have recruited successfully and the postholder is expected to start in April 2017

In addition, each CCG is required to spend a further £3 per head non-recurrently in primary care, from their baseline allocations, over the two years 2017/18 and 2018/19. In Bromley, this will be focused on practice resilience and development, and reducing variation in services.

Bromley CCG is currently in the process of developing a detailed prioritisation and action plan for the resilience and workforce elements of our local GPFV plan, informed by robust engagement with our GP membership and local stakeholders. In September 2016, we submitted a high level draft plan to NHS England for assurance purposes that included:

- Plans for supporting vulnerable practices with diagnostics and sustainability planning (a requirement of the funding);
- Schemes to attract and retain more practice nurses in the borough;
- Attracting GPs into the area through a range of measures that include educational events, clinical leadership opportunities and returning doctor retainers;
- Re-developing the locum bank and exploring options to extend into a nurse bank;
- Working with practices on initiatives to release capacity in general practice, including improved efficiency and back office functioning and introducing new roles into primary care;
- Support to practices that are considering merging (not required but encouraged through this funding); and
- Admin and clerical training and practice manager development opportunities.

Once the GPFV local plan is drafted upon conclusion of planned engagement activity and approved internally and by NHS England, it can be published and implemented at pace.

C) Primary care access hubs and 8-8, 7/7 access

Bromley CCG has commissioned primary care access hubs since 1st December 2015 to offer additional GP appointments during late afternoons, evenings and weekends as an 'overflow' for routine and semi-urgent cases when patients' registered GP practice appointments are already taken. Hub appointments can be booked via GP practices, NHS 111, or re-directions from the UCC; they are not however, available for walk-ins. GPs working in the hubs have electronic access to patient records and are able to prescribe and make referrals. The access hubs are run by the Bromley GP Alliance.

The service began with two hubs (Beckenham and St Mary Cray) opening 4pm-8pm on weekdays and 9am-1pm at weekends. However, as part of the evaluation and development of the primary care access hub model, and additional investment available through the CCG baseline and the GP Forward View, we expanded the service to include:

- a third hub location (Bromley Common) from December 2016
- additional appointments on weekdays and four hours of additional opening on Saturdays to manage winter pressure from December 2016
- nurse wound dressing appointments to manage winter pressures from early January 2017

…and will be expending the service further in coming months to include:

- 8am-8pm opening of access hubs on Saturdays and Sundays from 28th January
- nurse appointments as part of the 'business as usual' provision after winter
- promotion to the general public to ensure good utilisation at weekends once 8-8 is offered
- online access to booking hub appointments (details TBC)

From our evaluation of the primary care access hubs to date, there are very high levels of satisfaction from both patients and GP practices, and utilisation of appointments has been maintained above 90% following the pilot period.

A new contract for the access hubs is due to be issued to Bromley GP Alliance in late January 2017 covering the 15 month period up to 31st March 2018. During this time, we will be undertaking a competitive procurement process as we are legally obligated to do so.

OTHER AREAS OF INTEREST:

1) **PMS contract review and GMS equalisation**

In November 2015, the CCG began a process to review the additional services we commission from general practice (on top of the core GP contract) and ensure these services are aligned to our strategic priorities and primary care strategy. There are two parts to this review: refresh of the contracts with our 24 PMS practices that already provide additional services, and equalisation with our 19 GMS practices who do not currently offer additional services.

We developed commissioning intentions to offer additional services around: screening and immunisation, patient satisfaction, use of technology, End of Life care planning, wound care, additional hours, integrated working, carers, housebound visiting and sustainability planning.

In March 2016, local contract negotiations across all London CCGs were paused for a period of eight months to resolve conflicts at London level, and the pause was eventually lifted in November 2016. Bromley CCG has now re-commenced local discussions about these priority services. Engagement with the CCG governing body, our GP practices and the Bromley LMC has been ongoing and the final commissioning intentions are likely to be agreed by the end of March and implemented from 1st July 2017. These will be in line with the original commissioning intentions outlined here, although service specifications will be updated to reflect progress during the pause.

The investment made into general practice under the PMS contract and planned GMS equalisation will be £12.26 per weighted patient; totalling £3.5million per annum.

2) **Integrated Case Management local improvement scheme (LIS)**

Bromley CCG implemented an Integrated Case Management Local Improvement Scheme from 1st December 2016. The LIS pilots a model of multidisciplinary care planning around a small but complex caseload of vulnerable people. The scheme asks GPs to identify patients who are at risk of deteriorating health and would benefit from a multidisciplinary approach, and participate in MDT conferences to agree and deliver a care plan. This is supported by a GP Chair, a non-clinical MDT liaison officer, and professional support from community services, mental health services, hospice, the voluntary sector and social care where appropriate.

The scheme went live on 1st December 2016 and provides an important early step in implementing Bromley's new Integrated Care Networks. To date, 37 of Bromley's 45 practices are participating in Integrated Case Management.

3) **Development of a Bromley Health and Wellbeing Centre**

Funding has been received by Bromley CCG through the national Estates and Technology Transformation Fund (ETTF) for development of a Bromley Health and Wellbeing Centre. The business case and early plans for the Centre are currently in development, including using patient engagement and working with our partners to scope location and potential services to be run from the Centre. It is likely to house at least one GP practice.

4) Homelessness and health: *Banking on a Meal,* Healthwatch report

In response to the HealthWatch report, *Banking on a Meal*, in autumn 2016, the CCG has been looking at barriers to accessing GP services for homeless people. The report was based on interviews and input from staff and users of food banks around Bromley borough and identified a common experience amongst homeless people of being told they cannot register with a GP practice because they have no fixed address. As this is incorrect – practices can use a friend/relative's address, a community building such as a church or the GP practice itself to register the patient – the CCG have emphasised this message to our GP practices. Further work is being undertaken by Healthwatch with the council and CCG to look at the quantum of homelessness in the borough and prevention action.

5) Quality and Performance Report

Highlights from the most recent (July 2016) Quality and Performance Report from NHS England relating to Bromley primary care include:

- Overall patient satisfaction with their surgery was 83% (compared with 85% nationally, but second highest for SEL)
- Patient confidence and trust in the GP was 95% (the same as nationally)
- Patient satisfaction with opening hours was 72% (compared with 76% nationally and the lowest in SEL)
- Friends and Family Test saw 83% recommending their GP surgery (compared with 88% nationally and 86% average for SEL)
- 40.9% of Bromley practices received a 'good' rating; 2.3% were outstanding; 6.8% required improvement; 50% have not yet had ratings published
- Bromley had no contractual breaches
- Only 2014/15 Quality Outcomes Framework (QOF) data was available

6) CQC inspection outcomes

The Care Quality Commission (CQC; health regulator) are midway through a programme of inspection of all London GP practices. In Bromley, the outcomes to date are:

- 1 practice was rated 'outstanding'
- 18 practices were rated 'good'
- 3 practices were rated as 'requires improvement'
- 23 have not yet been inspected

The CCG is working closely with practices that have a 'requires improvement' or 'inadequate' rating, including through the GP Forward View plan and it's focus on practice resilience.

PUBLIC AND USER INVOLVEMENT:

The CCG held a patient engagement event in Bromley on 13th December 2016. The event gave an update on primary care developments, allowed for Q&A and included three discussion groups on access, technology and the voluntary sector. The event was attended by 34 patients and HealthWatch. Feedback from the event was very good. The CCG has produced a 'you said, we did' from the patient event and incorporated the feedback and ideas of patients into our work planning.

ACRONYMS

- → CCG – Clinical Commissioning Group
- → CQC – Care Quality Commission
- → ETTF – Estates and Technology Transformation Fund
- → GMS – General Medical Services
- → GP – General Practitioner
- → IT – Information Technology
- → MDT – Multidisciplinary Team
- → NHSE – NHS England
- → PCJC – Primary Care Joint Committee
- → PCPB – Primary Care Programme Board
- → PMS – Personal Medical Services
- → QOF - Quality Outcomes Framework
- → SEL – South East London
- → SOP – Standard Operating Procedure

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REVIEW OF PUBLIC HEALTH AND JOINTLY COMMISSONED CHILDREN SERVICES

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[1] National Child Measurement Programme

1. BACKGROUND

During 2015/16 the Council reviewed its provision of both public health services for children (school nursing, health visiting, family nurse partnership, obesity services) and children's residential respite and therapeutic services provided jointly with the CCG (Hollybank, speech and language therapy and occupational health).

The CCG is re-commissioning community health services from October 2017 and has set up a programme to retender services.

A working group has been set up with representation from LBB (Public Health and Health Integration Programme) and the CCG to:

- review Public Health Children's services (0-19) with a particular focus on services for the 5-19 year group

- make recommendations for the future delivery of speech and language and occupational therapy services to schools

- make recommendations for the future delivery of provision for children with long term conditions and disabled children's residential respite

- establish the impact of the proposed changes to services commissioned by LBB on community health services and to determine whether there are any functions which need to be included in the specification for the community contract

This report provides information in the following areas:

- What is the need for well-being service in children 5-19 years?
- What works in relation to preventative and well-being services for this group? This section seems to be describing at present elements of what works rather than actual interventions/programmes known to work
- What is currently commissioned or provided/
- What are the legal and statutory responsibilities of different agencies in relation to child well-being and safeguarding?
- What are the identified gaps in service provision?

2. ASSESSMENT OF NEED

2.1. Child Well-being Needs Assessment: Executive Summary

This report describes the population of children and young people aged 0-18 in Bromley in terms of size of population and the ethnic make-up of that population, together with estimates of projected changes to that population.

The report then describes how prevention could affect the health and wellbeing of the children and young people of Bromley. Prevention can be primary, secondary or tertiary.

Primary prevention aims to prevent a problem before it occurs by identifying families within the population who are more likely to suffer poor outcomes for their children. Section A uses evidence to identify risk factors in families in Bromley.

Secondary prevention aims to identify a potential or emerging problem in a child or young person at an early stage in order to minimise the impact of that problem. Section B reviews what we know about emerging health, education and social care needs of children and young people in Bromley. This section will focus on children with identified low level needs, for example those known to Children's Social Care from Early Intervention Family Support or those identified as having Special Educational Needs but who do not have a statement or EHC Plan.

Tertiary prevention aims to minimise the impact of a known need.. Some information about tertiary prevention will be set out in Section C. Information in this section will include those CYP known to the school nursing service as needing an individualised Healthcare Plan in school, those children with EHC Plans or statement of SEN, Looked After Children and young people known to the Youth Offending Service, and those on a Child Protection Plan.

Key findings on demography

- The greatest population growth 2015 to 2025 will be in secondary school age children.
- Certain wards have a higher concentration of ethnic minorities than others. The North-West of Bromley has the highest proportion of ethnic minority population and the North-East of the borough has the highest proportion of Gypsy Travellers, in particular the wards of Cray Valley East and West.
- There may be a higher disease burden due to the increased risk amongst certain BME groups, and evidence suggests a lower life expectancy amongst Gypsy Travellers as well as higher prevalence of long term illness.

Key findings from Section A: Risk factors in families in Bromley

- Mental health issues in parents in Bromley is at least as common as national rates
- Illness and disability of parents is of concern, especially in areas of higher deprivation

- Smoking in pregnancy is more common in Bromley than in London, and is particularly high in pregnant young people under the age of 20 and pregnant women in routine and manual occupations.
- Recorded drug and alcohol misuse in Bromley is below the national average. However the proportion of pregnant women in substance misuse services and hospital admissions for substance misuse are both higher than national and London averages. These should be reviewed after an update of the data in 2016.
- Domestic violence is recorded more frequently in Cray Valley wards and Mottingham and Chislehurst North
- Homelessness of families with children is higher than national rates. There are increasing numbers of households with children residing in temporary accommodation and outside Bromley
- Families affected by unemployment, housing and financial difficulties and require support are more likely to live in the Crays, Mottingham or Penge
- Teenage pregnancy rates are reducing significantly, although still more frequent in areas of higher deprivation. Late booking for antenatal care in pregnant teenagers is of concern.

Key findings from Section B: Emerging health, educational and social care needs

- The distribution of children with Special Educational Needs across the borough is higher in some wards, notably the Cray Valley wards, Bromley Common and Keston, Orpington, and Plaistow and Sundridge.
- Smoking rates in young people in Bromley are higher than London and national rates.
- Young people between 15 and 24 years old continue to have the highest rates of new STIs. Males of all ages are more affected by new STIs than females
- Of the 90 young people in treatment in Bromley in 2014-15, 70% were using two or more substances (this may include alcohol) and 97% began using their main problem substance before the age of 15 years.
- Nearly a third of children in Year 6 in Bromley are either overweight or obese. Pupils obese in reception year were more likely to remain obese at year 6 in Crystal Palace, Mottingham and Chislehurst North, Cray Valley East and Cray Valley West
- Some wards have a higher proportion of children living in families who are receiving support: Biggin Hill, Cray Valley West, Plaistow and Sundridge, and Mottingham and Chislehurst North
- Community and hospital services indicate that young people in Bromley have a high level of need for support around self harming behaviour. A brief survey of emotional health concerns in secondary schools in Bromley in 2015 confirms this.
- A quarter of young people in contact with the YOS have health needs.

- The number of exclusions of primary school pupils is very high.
- There is no data on LGBT in young people in Bromley, although this is a known risk factor for several adverse outcomes in this age group.
- Vulnerability and safeguarding concerns in EHE children and young people may not be identified. This is of particular concern for young people who may be EHE for longer periods of time.
- There appears to be significant under-reporting or lack of identification of CSE in Bromley, particularly by health services

Key findings from Section C: minimising the impact of a known need

- At least 200 children and young people with complex health needs but no EHC Plan or Statement require support to attend school, and this number is increasing. A total of 600 children and young people in Bromley schools require some nursing support to access school.
- Compared to similar areas there are higher rates in Bromley of children with speech, language and communication needs, children with severe, profound and multiple learning difficulties, and pupils on the autistic spectrum. Pupils with behavioural, emotional or mental health needs are more likely to attend independent schools
- Some indicators, for example on substance use in Bromley Looked After Children, are reassuring. Others raise concerns:
  - Exclusions from school and persistent absence of Bromley LAC are higher than statistical neighbours, London and national data.
  - The proportion of LAC who are Not in Education, Employment or Training is also higher than comparators. This may be due in part to the relatively high rates of LAC with Special Educational Needs in Bromley.
  - The proportion of LAC who have been convicted or subject to a final warning or reprimand during 2014 was also higher than comparators, although the numbers are small.
  - The predicted increase in the number of UASC will require support from health as well as social care agencies.
- Initial contacts to assessments by children's social care services have begun to level off and in the case of referrals decrease significantly based on levels prior to 2011. This is likely to be due to the success of the targeted approach of the MASH service

These key findings are discussed in more detail in Section 6 of this paper.

2.2. Evidence of Effectiveness of Preventative Services

Background

The following provides a brief overview evidencing 'what works' in terms of prevention. The Chief Medical Officer illustrates a strong case for a shift to prevention in her Annual Report 'Our Children Deserve Better: Prevention Pays' (2012). Early intervention and preventive measures have a significant impact on health outcomes. Furthermore, improving the lives of children and young people brings significant economic benefits.

The evidence presented to date highlights that the life course approach matters (Marmot 2012). Evidence for the life course approach is strong; each stage of life affects the next. In particular, events in the early period of life have a profound effect on the future health and wellbeing of children and young people (CMO 2012). A staggering 80% of children showing behavioural problems at the age of five go on to develop more serious forms of anti-social behaviour (Mental Health of Children and Adolescents in Great Britain, 2004). It is now very well documented that the environment of a child's earliest years can have effects that last a lifetime. Between conception and age three, a child's brain undergoes an incredible amount of change. At birth, the child's brain will already have the majority of the neurons it will have for life. It doubles in size in the first year, and by age three it has reached 80 percent of its adult volume (Lipina 2009).

We know that, when necessary, early intervention for a child at a very young age can be most effective. There are other times too when interventions are highly effective and appropriate. This may be because clinically they will have the most significant impact (e.g. people who give up smoking by the age of 30 will avoid some of the risks of dying early from tobacco-related diseases); or because a person is highly motivated and confident to successfully make behaviour changes that will impact their health and wellbeing. Pregnancy and early parenthood are often identified as stages in life when many people are especially motivated and interventions are particularly successful. Furthermore, there is some evidence that groups provided with information and support at timely points in the development of given types of illness, such as shortly after a first myocardial infarction, may be more motivated to change their behaviours than other populations (Van Berkel 1999, Newsom et al 2015).

Pregnancy and Early Childhood

Key risk factors associated with poorer developmental outcomes in children

Parental Smoking and Drugs and Alcohol use

- There is a need for specific interventions that can access 'hard-to-reach' groups. Smoking prevalence remains high amongst young pregnant women and standard interventions tend not to work

- Front line health practitioners working with families should complete National Centre for Smoking Cessation and Training (NCSCT) specialist training modules such as 'Pregnancy & the Post-Partum Period' to enable them to provide effective cessation support and/or brief advice on: 1. the risks of smoking to women & children/unborn babies; 2. The significant role of partners 3. What NHS Stop Smoking Services provide and how to refer to them them (Healthy Child Programme 2015)

- Randomised Controlled Trials provide substantial evidence for the efficacy of incentives for smoking cessation in pregnancy (BMJ 2015)

- Parental problem drug use has been shown to be one of the commonest reasons for children being received into the care system (NICE guideline No.52). Effective treatment programmes for parents supported by robust referral pathways are key to minimising the risk to families (refer to Bromley's Drugs Misuse Needs Assessment 2015)

- There is some evidence that both integrated services, that is a holistic service that addresses substance misuse as well as maternal and child wellbeing, parenting programmes, child care and other child-centred services in one setting; as well as non-integrated programmes can improve some birth outcomes for infants of women who have substance misuse problems during pregnancy

- Evidence suggests that the more holistic integrated programmes lead to a small improvement in parenting, but not on child protection outcomes (Healthy Child Programme 2015)

- NICE recommends parents who are using drugs are offered behavioural couples therapy as the evidence illustrates that it is more successful that individual-based treatment where one or both parents are misusing drugs

Obesity Prevention in Early Childhood

- Increasing evidence points to the possible impact of interventions targeting early life, such as in utero and infancy, including breastfeeding (CMO 2012)

- Effective components of interventions: decreasing pre-schoolers' screen time; decreasing consumption of high fat/calorie drinks/foods; increasing physical exercise; increasing sleep; modifying parental attitudes to feeding; and promoting authoritative parenting through programmes, such as HENRY(Health, Exercise, Nutrition for the Really Young)

Support for families who need additional support

- There is evidence for the effectiveness of a range of different types of Domestic Violence (DV) interventions concerned with prevention, re-abuse, and the adverse consequences of DV (e.g. impact on mental health). The range of interventions include; advocacy services, skill

building, counselling and therapy. In terms of prevention and an early intervention approach it is paramount that frontline staff are equipped with training and skills so they can spot the signs of abuse in family members and intervene as early as possible

- Young females need gender-sensitive and specific responses acknowledging the importance of experiences of victimisation, positive relationships and improved self-esteem as an exit from crime and violence

- NICE (2014b) recommends providing specialist domestic violence and abuse services for children affected by domestic violence and abuse, matching the support to the child's developmental stage and seeking to address the emotional, psychological and physical harms arising from a child or young person being affected by domestic violence and abuse, as well as their safety. The Bromley Children's Group Work Programme is an evidence based programme that has successful reach and outcomes working with Bromley families

- The Rapid Review of the Healthy Child Programme (2015) purports that there is good evidence to support the commissioning of home visiting interventions in early childhood for at-risk families. They lead to reductions in Child Protection Services (CPS) reports, accident and emergency visits, hospitalisations and self-reports of abuse, as well as an increase in the uptake of immunisations. Home visitation by paraprofessionals holds promise for socially high-risk families with young children, including in the area of reducing harsh parenting

- There is consistently strong evidence to support the use of Family Nurse Partnership (HCP 2015). A recently published randomised controlled trial in the UK of FNP found evidence of better cognitive and language development in the baby, improved attachment between mother and baby, and fewer symptoms of depression in the mother

Positive Parenting & Attachment

- Evidence from a number of longitudinal studies has demonstrated that securely attached children function better across a range of domains including emotional, social and behavioural adjustment, as well as peer-rated social status and school achievement (CMO 2012). Implementing evidence-based interventions to promote secure attachment may limit children developing major social, educational and behavioural problems

- There is evidence to support the use of massage with disadvantaged and depressed mothers of babies (HCP 2015)

- Families may be reluctant to access some types of support because service users are stigmatised in some communities (Becher and Hussain 2003). CFCs in Bromley are careful in the enrolment process for programmes such as HENRY, ensuring that the group is made up of targeted (i.e. any families identified as needing additional support) and

universal (i.e. all families). Providers who recently gave evidence to the APPG (2016) stressed the significance of maintaining an element of universal service provision – open to all rather than just targeted on the most disadvantaged. A universal approach helps to prevent support from being stigmatised as something for "failing families". Furthermore the evidence is that it often enables service providers to identify parents who are dealing with more complex issues at an early stage. This is particularly the case when dealing with problems do not discriminate on the basis of income or geographic location, such as mental health

- NICE guidance recommends the use of evidence-based parenting programmes as a secondary prevention measure for parents of children who have oppositional defiant disorder or conduct disorder or who have been identified as at high risk of developing these disorders

  'Good evidence exists that high-quality programmes focused on strengthening support systems around children and young people (particularly parenting) in combination with developing children and young people's internal resilience have the best chance of improving multiple outcomes'
  (CMO 2012:211).

Older Children and Young People

Obesity treatment

- School-based programmes are effective when diet and physical activity components are included

- There is strong evidence that the involvement of whole families (parents and children) in interventions that promote both healthier diet and more exercise can have an impact on reduction of BMI(NICE 2015, Obesity in children and young people: prevention and lifestyle weight management programmes). There is International recommendations that the core elements of any initiative to address obesity should involve the whole family and include nutrition education, behaviour modification and promotion of physical activity (Sacher, 2010). There is some evidence supporting the effectiveness of specific programmes such as MEND (Swain 2009, Sacher et al 2010)

Emotional Health

- The contribution of schools to developing resilience and enhancing wellbeing as a component of the curriculum is grounded in an extensive evidence base

- The Healthy Schools programme along with SEAL (Social and Emotional Aspects of Learning) for primary schools are whole-school initiatives

designed to develop emotional wellbeing and healthy positive behaviours among school students

- There is evidence that specialist teachers trained in PSHE (Personal Social & Health Education) deliver the most effective health-related teaching, especially in relation to the topics that children are reported to be most likely to want information about, including health exploratory behaviours and sexual health (CMO 2012)

- School support is a protective factor for mental health. A recent Cochrane systematic review of psychological or educational prevention programmes for young people aged 5–19 found some evidence of effectiveness of interventions in reducing the risk of having a depressive disorder.

- There is evidence that approaches focusing on the building of young people's social and emotional skills have greater long-term impacts than deficit-based programmes. Strengthening protective factors or health assets in schools, in the home and in local communities can make an important contribution to reducing risk for those who are vulnerable and in so doing promote their chances of leading healthy and successful lives (CMO 2012)

Specific prevention strategies for targeted groups including; Young People Not In Education, Employment or Training (NEET), Electively Home Educated, Children In Need, Young Carers and Young People known to the Youth Offending Team (YOT) and those with Special Educational Needs (SEN)

- Commission a range community based health services which enable access to young people who might not otherwise attend health services in Primary Care. There is evidence that, in general, many young people are not satisfied with GP services

- National evidence shows that significant numbers of vulnerable and 'hard to reach' groups of young people who had not previously accessed health provision within mainstream services did access the school nurse service

- Compelling evidence illustrates the benefits of vulnerable groups receiving targeted health and wellbeing support as they are likely to experience physical and emotional problems at school, such as disruptive behaviour, difficulty making friends and being bullied

- Implement the 'Foundation Pathway for Young Carers'

- Commission a Health Advisor Role to support clients with specific health needs and to liaise with other professionals within YOT

- Increasing evidence exists which highlights the success of new technologies in engaging young people in healthcare issues

Preventing young people engaging in risk behaviours (including smoking, sexual heath & the use alcohol and drugs)

- Once young people start smoking there is little evidence illustrating successful cessation approaches. The evidence is stronger in relation to stopping them smoking in the first place. There needs to be easily understood tobacco policies in learning environments

- Education content implemented in learning environments inform young people about short and long-term health, and the economic and societal consequences of tobacco use

- There is evidence of success of targeted peer mentoring programmes in areas of greater need (PHE 2016)

- The Chief Medical Officer has called for an alcohol-free childhood up to the age of 15 because evidence suggests that there are no safe drinking limits for childhood

- Promoting prevention measures builds resilience among young people and improves awareness of alcohol harm and delay the age of first use (PHE 2014)

- A review of the effectiveness of school based interventions found evidence that some class room based programmes (life skills approach and skills-based activities) can reduce alcohol use in the medium-term and one produced long term reductions (greater than 3 years) in alcohol use (for further information refer to Bromley's Alcohol Misuse Needs Assessment 2014)

- Training for teachers to conduct age-appropriate participatory sexuality and HIV education can improve students' knowledge and skills

- Offering education about healthy, respectful relationships in schools means that the learning takes place in the context of the peer group, with the potential to learn together. There has been an increasing focus on the call for compulsory sex and relationship education in schools

- Very few young people develop dependency. Those who use drugs or alcohol problematically are likely to be vulnerable and experiencing a range of problems, of which substance misuse is one. This means that the commissioning and delivery of specialist drug and alcohol interventions for young people should take place within the wider children and young people's agenda. The aim is that all needs are met, rather than addressing substance misuse in isolation; and that intervention is successful before problematic use becomes entrenched

- There is evidence that programmes that aim to improve young children's self-control are effective for improving self-control and reducing problem

behaviours. A recent review of the evidence highlighted the success of the *'RisKit Intervention'. The success of the programme included* improvements in relationships, self-perception, discussion / articulation of feelings, emotional expression & anger management *('What works in enhancing social and emotional skills development during childhood and adolescence'2015)*

- Promoting good communication in families (through parenting programmes), feeling connected and having a sense of belonging reduces the chances of young people engaging in high risk behaviours

- Although it's known that risk behaviours in adolescent years are usually a normal part of development, the later the on-set of any risk behaviour the less likely it seems to have a long-term impact on health. It is known that risk behaviours tend to co-occur

- Implement interventions of proportionate universalism (Marmot 2008), as targeted interventions can result in stigmatisation and may increase the risk of 'reactive' risk behaviours (Jackson et al 2012)

Health support to Safeguarding function for children aged 5-18

- Evidenced based approach to safeguarding is set out in *"Best start in life and beyond: Improving public health outcomes for children, young people and families."* Public Health England, January 2016. It involves:
- working in partnership with other key stakeholders to help promote the welfare and safety of children and young people
- working collaboratively to support children and young people where there are identified health needs, or where they are in the child protection system, providing therapeutic public health interventions for the child and family, and referring children and families to specialist medical support, where appropriate
- deliver safeguarding policies and procedures as determined by the Safeguarding Children Board
- Working with the designated school safeguarding lead and local authority services, providing assessments and reports as required
- Contributing to multi-agency decision-making, assessments, planning and interventions, relating to children in need, children at risk of harm and Looked After Children. This includes providing Review Looked After Child health assessments (in accordance with Promoting the Health and Wellbeing of Looked After Children Statutory Guidance 2015) and reports in accordance with the local Safeguarding Children Board policies and procedures and national guidance such as Working Together to Safeguard Children (HM Government, 2015)
- where appropriate and the child or young person is known to the provider, senior team members attend child protection conferences or meetings when

they are the most appropriate health representative and there is a specific outcome to contribute towards

- working within inter-agency and single agency protocols, policies and procedures and in accordance with Working Together to Safeguard Children (HM Government, 2015)

This work identifies potential gaps with resource implications. These are summarised in the Appendix.

3. DESCRIPTION OF CURRENTLY COMMISSIONED SERVICES

3.1. Public Health Services

3.1.1 National Childhood Measurement Programme (NCMP)

3.1.2 Healthy Child Programme – Health Visiting Service, Family Nurse Partnership & School Nursing Service

3.1.3 Drug and Alcohol services for young people

3.1.4 Sexual health services for young people

3.1.1 National Childhood Measurement Programme (NCMP)

Contract value	**£120,746**
Type of contract	**Part of PH in CCG block contract**
Provider	**BHC**
End date of contract	**30th September 2017**

The NCMP measures the weight and height of children in Reception class (aged 4 to 5 years) and Year 6 (aged 10 to 11 years). This is a mandated programme for Public Health. The programme has two key purposes:

1. to provide robust public health surveillance data on child weight status, to understand obesity prevalence and trends at local and national levels, to inform obesity planning and commissioning and underpin the Public Health Outcomes Framework indicator on excess weight in 4-5 and 10-11 year olds

2. to provide parents with feedback on their child's weight status: to help them understand their child's health status, support and encourage behaviour change and provide a mechanism for direct engagement with families with overweight, underweight and obese children.

The Public Health Outcomes Framework (PHOF) indicators illustrate that obesity rates vary considerably across London. In 2015 in year 6 the range was from 10.5 per cent in Richmond upon Thames, to 27.8 per cent in Southwark. Bromley has one of the lowest childhood obesity rates of all London boroughs. However the prevalence of obesity is far more apparent in deprived wards in the borough. Household income data illustrates child obesity prevalence rises as household income falls, and is significantly higher in the lowest income group than in the highest. Childhood obesity is a significant health inequalities issue. The percentage of children in Bromley schools who are obese in their first year in primary school, doubles by the time they reach their final year in primary school. For example with the latest cohort, 7.3% were obese in Reception, this increased to 16.5% by the time these children were in Year 6. Currently over 20% of children in Reception and almost 31% in Year 6 are either overweight or obese, this equates to 1,774 children in one year from Bromley schools.

Table 1. NCMP data for overweight and obese children in Bromley

Year Group	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
Reception: Overweight	12.3%	13.2%	12.9%	12.9%	13.1%	13%	12.2%
Reception: Obese	7.3%	8.2%	7.8%	7.4%	8%	8.3%	7.9%
Year 6: Overweight	15.5%	14.3%	14.5%	15.7%	14.9%	14.5%	14.3%
Year 6: Obese	16.0%	17.2%	16.4%	15.6%	17.1%	15.4%	16.5%

Weight management

Contract value	**£187,820**
Type of contract	**Part of PH in CCG block contract**
Provider	**BHC**
End date of contract	**31st March 2017**

There are currently two licensed evidenced-based healthy weight programmes for children and families in Bromley; HENRY and MEND.

HENRY (Health Exercise Nutrition for the Really Young)
The HENRY Programme plays a key role in preventing childhood obesity. There are two elements to Bromley's HENRY programme; training for health and community practitioners and 'Let's Get Healthy with HENRY' family programmes. Training is offered to health and community practitioners to enable them to work more effectively with parents of babies and pre-school children around healthy weight and lifestyle concerns. HENRY parenting courses are available to Bromley families and are delivered in the Children and Family Centres. This year the delivery of the programme will be trialled in one of the borough's larger Primary schools. Families participate in an eight week course supporting them to develop a healthier and more active lifestyle for the whole family.

MEND (Mind Exercise Nutrition Do It!)
This multi-component weight management programme provides support for the families of children aged 4-13 years identified through National Childhood Measurement Programme (NCMP) as being overweight and obese. It meets the NICE *'Managing overweight and obesity among children and young people: lifestyle weight management services'* (PH45) recommendations for children's Tier 2 weight management support; combining healthy eating/nutrition advice, physical activity and behaviour change. Ninety nine children and their families participated in Bromley programmes in 2015-16. Sixty four of these children and their families are defined as completers of the programme. Of those who did complete the programme, 86% maintained or decreased their BMI.

3.1.2 The Healthy Child Programme (HCP)

The Healthy Child Programme is a public health programme for children, young people and families, which focuses on early intervention and prevention. It offers a programme of screening tests, immunisations, developmental reviews, information and guidance on parenting and healthy choices. The HCP is core to the specifications the Health Visiting and School Nursing Service deliver to. It is universally available to all Bromley families and aims to ensure that every child gets the good start they need to lay the foundations of a healthy life.

The Healthy Child Programme aims to:

• Help parents develop and sustain a strong bond with children
• Encourage care that keeps children healthy and safe
• Protect children from serious disease, through screening and immunisation
• Reduce childhood obesity by promoting healthy eating and physical activity
• Identify issues early, so support can be provided in a timely manner
• Make sure children are prepared for and supported in education settings
• Identify and help children, young people and families with problems that might affect their chances later in life

Health Visiting Service

Contract value	**£3,454,000**
Type of contract	**Standard contract**
Provider	**BHC**
End date of contract	**30th[t] September 2017**

In 2015 the Government mandated certain elements of the Healthy Child Programme. This mandation was designed to support a smooth transfer to allow local authorities to provide universal services that give parents and their babies the best start in life. The mandated elements are the five universal health visitor assessments that form part of the '4-5-6 Model for Health Visiting'. This model offers a framework for health visiting teams to provide universal and non-stigmatising services to all families with children under 5 years of age. The model includes a four level service model (Community, Universal, Universal Plus and Universal Partnership Plus) and five mandated elements include;

- Antenatal health promoting visits
- New baby review
- 6-8 week assessment
- 1 year assessment
- 2 to 21/2 year review

Nationally six High Impact Areas were identified. The intention is for these areas to be prioritised and ensure resources are targeted appropriately, according to health need and to maximise health outcomes. They describe the areas where the 0-5 workforce can and should have a significant impact on health outcomes. The 6 High Impact Areas are:

1. Transition to parenthood and the early weeks

2. Maternal (perinatal) mental health
3. Breastfeeding
4. Healthy weight (healthy diet and being active)
5. Managing minor illnesses & reducing accidents
6. Health, wellbeing & development at 2 years & support to be 'ready for school' at 5 years

The Health Visiting Service is universally available to all families living in Bromley who have a child under the age of five years old. The remit includes the mandated checks but also includes a wide range of issues relating to the health and development of pre-school aged children. There is a strong focus on prevention, health promotion, early identification and early intervention. Through direct contact with all families, the service identifies and supports those who need additional support and targeted interventions, for example, parents who need support with their emotional or mental health The service works with families on positive parenting through motivational interviewing and evidence based approaches, and to support behaviour change leading to positive lifestyle choices.

The Health Visiting Service forms part of multi-agency teams that support families that have complex needs e.g. a child with special educational needs or disability, or where there are identified safeguarding concerns. The Health Visiting Service currently works in close partnership with LBB's Early Intervention Service to support families with additional needs, e.g. to participate in parenting programmes. There are plans to further integrate the services over the coming years to minimise duplication and to ensure early, appropriate and holistic support is offered to families most in need.

Health visitors provide health input to safeguarding processes for children aged 0-4 years (see section 3.3).

Family Nurse Partnership (FNP)

Contract value	**£180,000**
Type of contract	**Standard contract**
Provider	**BHC**
End date of contract	**30th September 2017**

FNP is a highly effective programme designed to mitigate the risks of young parenthood. The licensed structured programme, delivered by specially trained family nurses, went live in Bromley in September 2014. This intensive preventive programme for vulnerable first time young parents begins in early pregnancy and ends when the child reaches 24 months. This service is based on good evidence that intensive support to vulnerable families can have a significant impact on outcomes. By improving the attachment between the baby and the mother and supporting young mothers in their parenting role, many of the long term outcomes related to poor attachment can be reduced or avoided. These adverse outcomes include behaviour and mental health problems in the child, poor education outcomes and involvement of Children's Social Care. Bromley currently has two

Family Nurses (FNs) who provide support up to 50 vulnerable mothers. The Bromley FNP programme is moving its focus from mother's age to broader vulnerability factors such as being a care leaver or known to Children's Social Care. A recently published randomised controlled trial in the UK of FNP found evidence of better cognitive and language development in the baby, improved attachment between mother and baby, and fewer symptoms of depression in the mother. Locally, strong attachment between FNP babies and their young parents, with good levels of child development for those babies have been observed and ASQ's are evidencing good early child development outcomes.

School Nursing Service

Contract value	**£960,066**
Type of contract	**Part of PH in CCG block contract**
Provider	**BHC**
End date of contract	**31st March 2017**

LBB has been responsible for commissioning School Nursing services since April 2013. The current service mainly provides Tier 1 and 2 health interventions in community and education settings and has established relationships within primary and secondary care. This is a universal service, but most of the work is targeted work with children with medical conditions and children where there are safeguarding concerns. Schools within the borough work with over 48,000 school aged children within the state funded sector, which comprises Academies, maintained schools, a Pupil Referral Unit and 2 Further Education Colleges. The Community Nursing service commissioned by Bromley CCG, provides support to Bromley's Special Schools other thanThe Glebe which is covered by Bromley Healthcare's School Nursing Service, currently commissioned by Public Health.

The number of pupils in schools which School Nursing supports is increasing year on year. Targeted groups of children and young people who are a priority for the School Nursing service include Children Looked After, Children in Need, children with statements of Special Educational Need, young people known to the YOT, young carers, and children with long-standing illness.

School Nursing Services are a core part of the Healthy Child Programme (HCP) building on the support in the early years and sustaining this for school-aged children and young people to improve outcomes and reduce inequalities through targeted support.

Universal:

- **Screening**
  Vision screening is offered to all children in Reception Year in maintained schools and Academy schools.

- **Personal, Social & Health Education (PSHE)**
  PSHE support is mostly offered in the form of a whole day to year 9s focused on healthy relationships, sexual health and risk behavior. Also

talks on issues such as puberty or hand hygiene to Year 5 & 6 and secondary school groups

- **Healthy Schools Award Scheme**
  The service co-ordinates the Healthy Schools Award Scheme; working with schools to improve specific aspects of health & well-being in their school communities. Bromley has one of the highest number of awards of all London boroughs

Targeted

- **Safeguarding**
  See Section 3.3

- **Health Care Plans and training**
  Nurses ensure individualised Health Care Plan (add number here with School Nurse input) for children with complex health condition are written and updated. They provide support to the school support and staff training. In 2015-16 approximately 353 staff across the school system received training from the School Nursing Service to enable them to support access to education for children/ young people with medical needs. One to one teaching of school staff on a range of health issues is provided by the nurses e.g. buccal midazolam administration, gastrostomy feeds, EpiPen use

- **School management plans**
  The service works with schools to develop and maintain up to date management plans for common health conditions such as diabetes, asthma, epilepsy and allergies

- **One to one support for students**
  This is delivered mainly through drop-in sessions in a number of secondary schools across the borough. Students go and see the school nurse to discuss a range of issues e.g. stopping smoking, peer relationship issues, self-harm issues. The service often does an initial assessment with a young person and can then refer and/or signpost students to the relevant service that can provide on-going support

- **Specialist School Nursing support to specific groups**
  See section 3.3

3.1.3 Drug and alcohol services for young people

Contract value	**£1,600,000**
Type of contract	**Standard contract**
Provider	
End date of contract	**31st March 2018**

The aim is to commission an integrated, recovery oriented treatment service for people with alcohol and/or drug misuse to meet the following objectives.

- To reduce health and social harm related to substance misuse.
- To support individuals in achieving long-term abstinence or reduce individual's levels of substance misuse.
- Achieve harm reduction including reduction in anti-social behaviour, reduction in domestic violence and reduction in substance misuse related crime.
- Improvement in physical and mental health and well-being of people affected by substance misuse including a reduction in deaths related to substance misuse and a reduction in hospital admissions related to substance misuse, improvement in measurable mental health outcomes, reduction in blood-borne infections.
- Long-term abstinence as measured by successful completion of treatment and a reduction in relapse rate.

Young Persons Substance Misuse Service

The overarching aim of the service is to increase opportunities for identification of young people with substance misuse and prevention. The service provides an integrated pathway to substance misuse services ensuring young people are always supported and have swift access to a high quality, evidence-based, integrated specialist treatment system. The service works with a range of partners providing advice and information and signposting to young people and families, community members, professionals and community workers.

3.1.4 Sexual Health Services for young people

Contract value	**£1,112,983**
Types of contract	**Framework, standard and Part of PH in CCG block contract**
Provider	**BHC**
End date of contract	**31st September 2017**

Bromley commissions a range of community contraception services to reduce unintended pregnancies with a specific focus on reducing teenage (under 18) conception rate and controlling sexually transmitted infections (Chlamydia and HIV). These include contraception advice and methods such as long-acting reversible contraception (LARC), Emergency Hormonal contraception (EHC) and condom scheme along with a range of health education and advice for young people in local schools and colleges.

These services are:

Contract	Annual Value
Contraceptive and Reproductive Health Services	£719,562
Health Improvement Service that includes: - Sex Relationship Education (SRE) - Associated Training Programmes - Outreach Programmes - Condom Distribution Schemes	£227,812
HIV Community Nurse Specialist Service	£165,609
TOTAL	**£1,112,983**

Contraception and Reproductive Health Services provide all methods of contraception along with health promotion and advice for all age groups, including male clients, from a number of health clinics in the community.

There are three components to **Health Improvement Services** – Sex and Relationship Education (SRE), Outreach and Condom Distribution Schemes.

The local SRE programme (Your Choice Your Voice) is a universal programme and is delivered to year 9 pupils in schools in Bromley. The programme aims at empowering young people by building their knowledge, confidence and resilience to make the right decision about their sex and wellbeing. An associated training

programme is available to support professionals, parents and carers regarding SRE.

The two condom distribution schemes, one for young people and one for Men having sex with Men (MSM) and Black African/Caribbean Communities are effective and value for money programmes. They help to prevent unplanned pregnancies and transmissions of STIs. Outreach programmes that deliver health promotion and safe sex messages are designed to target those particularly hard to reach high risk population such as young people outside of school setting, gay men and Black African communities.

HIV Community Nurse Specialist Service is to support people newly diagnosed and those living with HIV in managing their conditions effectively. It aims at preventing late and very late HIV diagnosis. It also enables people affected by HIV to protect themselves from acquiring new STIs and avoiding onward transmission through regular screening and prevention interventions; to increase focus on self-management approaches and live independently. thereby reducing demand on costly health and social care.

3.2. Jointly commissioned services

3.2.1 Speech and Language Therapy

Contract value	**£1,451,000**
Type of contract	**LA & CCG contracts (see below)**
Provider	**BHC**
End date of contract	**30th September 2017**

Introduction
A large number of children and young people with speech, language and communication needs (SLCN) will not need specialist intervention but those that do need quick and efficient access to the appropriate expertise.

The benefits of early identification and intervention are widely recognised. It is particularly important that in the early years there is no delay in making provision as identifying needs at the earliest point and making effective provision is acknowledged to improve long term outcomes for children. A key challenge is therefore to ensure that all children and young people who have SLCN are identified and able to access appropriate therapy provision as early as possible.

Estimates suggest that around 10% of all children may have long-term and persistent SLCN, and 7% of children and young people have significant speech and language impairment likely to need special or targeted interventions at some stage in their development.

Table 1: Bromley's Projection of need based on prevalence estimate of 7%

Age	2015	2020	2025
0 - 4 years	1470	1421	1407
5 – 10 years	1701	1771	1729
11 – 18 years	2030	2100	2317

SEN local authority data notes that 27.3% of Bromley primary school pupils with an SEN have SLCN listed as their primary need.

- Special schools - 5.1%
- Primary schools - 27.3%
- Secondary schools - 13.3%

SLCN is also most often identified as a need for children & young people with ASD. 649 children in Bromley have ASD listed as their primary SEN need. However, this only reflects those with ASD as a *primary* need. Many children will have another primary need listed, such as specific learning difficulty or moderate learning difficulty, but will also have an ASD diagnosis, meaning the true figure will be much higher than 649. SLCN is extremely high among Bromley pupils.

Current Spend

Agency	Annual spend	
CCG	£1.148m	
LBB	£303,000 (within CCG block contract since September 2015)	
LBB	School place funding (increased)	
LBB	Funding out of borough school placements awarded by Tribunals	
Schools	A number of schools have commissioned Service Level Agreements (SLAs) with BHC or independent providers funded from the schools own resources	

Current Provision

Bromley Healthcare (BHC) is commissioned by Bromley CCG within the terms of the CCG Community Contract to provide the SLT service. BHC undertakes the majority of assessments for Bromley's children and young people, to identify the level of need and determine whether that need can be met, or partially met, within existing resources.

Bromley has seen an increase in demand for speech and language services meaning that the current commissioned resource cannot meet demand.

Similar pressures are also seen in the Occupational Therapy (OT) service.

Key Pressures

- The number of new pre school aged referrals has doubled since 2011.
- SLT staff recruitment issues across the UK.
- Schools need to consider and understand models that enable effective and cost efficient allocation of resources to support SLCN, including specialists within the classroom, effective training and professional development, targeted interventions and direct specialist support

3.2.2. Overnight residential short breaks (respite) provision

Contract value	**£1,419,305**
Type of contract	**CCG block contract**
Provider	**BHC**
End date of contract	**30th September 2017**

Introduction
Hollybank is an overnight residential short break provision for disabled children and young people which is jointly funded by Bromley Clinical Commissioning Group (BCCG) and London Borough of Bromley. The current OFSTED rating is 'good' in every category (November 2015).

The service purpose is to offer regular planned overnight short breaks with the highest standard of care for children and young people with multiple disabilities, including behaviours that challenge associated with a disability, and complex health care needs, working in partnership with their families and other carers, helping to maintain the disabled child or young person within their family whilst the child enjoys the short break experience

Sevice Users
There are currently 57 service users. The average number of nights per service user is 2.13 per child. The breakdown of primary needs of these children & young people is:-

Autistic Spectrum Disorder	Global Developmental Delay	Physical Disability	Learning Disability	Complex Health Needs
34	**4**	**6**	**7**	**6**

'**High need' service users**
Some service users have exceptionally high needs, most typically in terms of managing their challenging behaviour or managing their complex medial regime and therefore require an exceptional staffing ratio in order to ensure their own safety and the safety of other children and staff. Typically, these children/young people present with a primary diagnosis of Autistic Spectrum Disorder (ASD). Currently 65% of all service users are regarded as 'high need'. This percentage has increased over time.

KEY ISSUES

Value for Money
There is currently more capacity than demand, and the unit costs are higher than the London average, particularly when the provider's 'double occupancy' model is taken into account. The cost per bed per night is £445.67

OFSTED Registration
The current terms of registration restrict the maximum number of nights to 75 per annum. The borough has limited ‘step up’ provision beyond 6 nights per month and therefore has to typically resort to longer term out of borough placements, i.e. weekly residential as a minimum, as the step up.

Children attending out of borough boarding school placements
The local authority’s most recent policy directive is to offer a local education placement to pupils with SEN rather than a day/residential out of borough placement wherever possible. LBB’s recent school place planning report for SEND highlights the growing needs for specialist education places. This will inevitably require the provision of Short Breaks for some of those pupils in order to support their social care and health needs, and to support their families to maintain an in borough day school placement. This supports a view that an overnight residential short break provision will continue to be required, demand for which may increase.

4. STATUTORY AND LEGAL RESPONSIBILITIES

Agency		Legal responsibilities	Legal responsibilities	Statutory guidance
CCG		Children Act 1989: Section 10 & 11 Children Act 2004 Equality Act 2010	Children & Families Act 2014 Health and Social Care Act 2012 NHS Act 2006	Working Together to Safeguard Children, 2015
LBB	**Child social care**		Children & Families Act 2014 Health and Social Care Act 2012	
	Public Health		Children & Families Act 2014 Health and Social Care Act 2012	
	Education		Children & Families Act 2014 Education Act 2002: *Section 175*	Section 100 of the Children and Families Act 2014

Children & Families Act 2014

The Children & Families Act 2014 requires education, health and social care to work jointly and collaboratively to commission support for children & young people with SEND.

NHS Act 2006, 2014 Mandate and 2014 NHS Outcomes determine that CCGs are responsible for commissioning services to meet health needs.

Health and Social Care Act 2012

It was the Health and Social Care Act that effected the transfer of responsibility from the NHS to Local Authorities. This Act also specifies that services are prescribed by the Secretary of State which is generally done through subsequent statutory guidance and strategies.

Part 2, Section 17 of the Act outlines the transfer of NCMP and School Nursing to local authorities. Section 22 outlines Immunisation and screening plans, for

which Public Health have overview responsibilities and some of these functions are carried out by Public Health nurses.

Part 5, Section 195 of the Act outlines the duty for integrated working between the NHS, Public Health and social care

The Act is also the basis for the ring-fenced Public Health Grant to Local Authorities to meet the responsibilities under this Act.

Children's Act 1989

The Local Authority has the responsibility to "safeguard and promote the welfare of children within their area who are in need and so far as is consistent with that duty, to promote the upbringing of such children by their families by providing a range and level of services appropriate to those children's needs".

Children Act 2004

Section 10. Local Authorities have a duty to promote cooperation between relevant partners such as governing bodies of maintained schools, proprietors of academies, clinical commissioning groups and NHS England, with a view to improving the well-being of children so far as relating to their physical and mental health, and their education, training and recreation. The arrangements are also to include protection from harm and neglect.

Section 11 places duties on a range of organisations and individuals to make arrangements for ensuring that their functions, and any services that they contract out to others, are discharged with regard to the need to safeguard and promote the welfare of children.

Education Acts

Education Act 2002: *Section 175* places a duty on:

a) local authorities in relation to their education functions; and

b) the governing bodies of maintained schools and the governing bodies of further education institutions (which include sixth-form colleges) in relation to their functions relating to the conduct of the school or the institution.

to make arrangements for ensuring that such functions are exercised with a view to safeguarding and promoting the welfare of children (in the case of the school or institution, being those children who are either pupils at the school or who are students under 18 years of age attending the further education institution).

A similar duty applies to proprietors of independent schools (which include academies/free schools) by virtue of regulations made under ***sections 94(1) and (2)*** of the **Education and Skills Act 2008**. Regulations made under ***Section 342*** of the **Education Act 1996**, set out the requirements for a non-maintained special school to be approved and continue to be approved by the Secretary of State.

Equality Act 2010
This Act puts a responsibility on public authorities to have due regard to the need to eliminate discrimination and promote equality of opportunity. This applies to the process of identification of need and risk faced by the individual child and the process of assessment. No child or group of children must be treated any less favourably than others in being able to access effective services which meet their particular needs.

The council should always consider its 3 duties in section 149 and they apply to people with protected characteristics and their relationship with the other groups and generally. Age is a protected characteristic.

The United Nations Convention on the Rights of the Child (UNCRC).
This is an international agreement that protects the rights of children and provides a child-centred framework for the development of services to children. The UK Government ratified the UNCRC in 1991 and, by doing so, recognises children's rights to expression and receiving information.

Safeguarding
The legislation relevant to safeguarding and promoting the welfare of children is set out above and summarised in the following table.

Table 1: Bodies covered by key safeguarding duties

Body	**CA 2004 Section 10 - duty to cooperate**	**CA 2004 Section 11 - duty to safeguard & promote welfare**	**Education Legislation - duty to safeguard & promote welfare**	**Commissioning Implications**
Local authorities	Duty to promote cooperation under Section 10 of the Children Act 2004	Ensure their functions and those they commission safeguard children	X In relation to their education functions under section 175 of the Education Act 2002	
Clinical commissioning groups	Reciprocal duty to cooperate under Section 10 of the Children Act 2004		X	
Maintained schools	Reciprocal duty to cooperate under Section 10 of the		X under section 175 of the Education Act 2002 (maintained schools) & via regulations made under section 342 of the	

	Children Act 2004		Education Act 1996 (nonmaintained special schools)	
FE colleges	X		X under section 175 of the Education Act 2002	
Independent schools	X		X Via regulations made under sections 94(1) and (2) of the Education and Skills Act 2008	
Academies and free schools	Reciprocal duty to cooperate under Section 10 of the Children Act 2004		X Via regulations made under sections 94(1) and (2) of the Education and Skills Act 2008	

Statutory Guidance

Working Together to Safeguard Children (WTSC) was updated in 2015. This document outlines the responsibilities of local agencies with regard to safeguarding. Both Health Visitors and School Nurses have a key role in safeguarding as universal services.

The role of Health Visitors is particularly crucial as they conduct the universal reviews in the 0-5 year olds:

"Local agencies should have in place effective ways to identify emerging problems and potential unmet needs for individual children and families. This requires all professionals, including those in universal services and those providing services to adults with children, to understand their role in identifying emerging problems and to share information with other professionals to support early identification and assessment."

"Professionals working in universal services have a responsibility to identify the symptoms and triggers of abuse and neglect, to share that information and work together to provide children and young people with the help they need."

"The early help assessment should be undertaken by a lead professional who should provide support to the child and family, act as an advocate on their behalf and coordinate the delivery of support services. The lead professional role could be undertaken by a General Practitioner (GP), family support worker, teacher, health visitor and/or special educational needs coordinator."

Both Health Visitors and School Nurses have responsibility to assist with identified health issues:

"Local areas should have a range of effective, evidence-based services in place to address assessed needs early. The early help on offer should draw upon the local assessment of need and the latest evidence of the effectiveness of early help and early intervention programmes. In addition to high quality support in universal services, specific local early help services will typically include family and parenting programmes, assistance with health issues and help for problems relating to drugs, alcohol and domestic violence."

Supporting pupils at school with medical conditions (2014).

Statutory guidance under Section 100 of the Children and Families Act 2014.

1. This places a duty on governing bodies of maintained schools, proprietors of academies and management committees of PRUs to make arrangements for supporting pupils at their school with medical conditions.

2. This places a duty on local authorities to be ready to make arrangements when it is clear that a child will be away from schools for 15 days or more because of health needs (whether consecutive or cumulative across the school year).

Non-statutory guidance under Section 100 of the Children and Families Act 2014.

1. School nurses are responsible for notifying the school when a child has been identified as having a medical condition which will require support in school. Wherever possible, they should do this before the child starts at the school. They would not usually have an extensive role in ensuring that schools are taking appropriate steps to support children with medical conditions, but may support staff on implementing a child's individual healthcare plan and provide advice and liaison, for example on training. School nurses can liaise with lead clinicians locally on appropriate support for the child and associated staff training needs – for example there are good models of local specialist nursing teams offering training to local school staff, hosted by a local school. Community nursing teams will also be a valuable potential resource for a school seeking advice and support in relation to children with a medical condition.

2. Other healthcare professionals, including GPs and paediatricians - should notify the school nurse when a child has been identified as having a medical condition that will require support at school. They may provide advice on developing healthcare plans. Specialist local health teams may be able to provide support in schools for children with particular conditions (eg asthma, diabetes).

3. Local authorities:

- should provide support, advice and guidance, including suitable training for school staff, to ensure that the support specified within individual healthcare plans can be delivered effectively.
- should work with schools to support pupils with medical conditions to attend full time. Where pupils would not receive a suitable education in a mainstream school

because of their health needs, the local authority has a duty to make other arrangements.

4. Providers of health services - should co-operate with schools that are supporting children with a medical condition, including appropriate communication, liaison with school nurses and other healthcare professionals such as specialist and children's community nurses, as well as participation in locally developed outreach and training. Health services can provide valuable support, information, advice and guidance to schools, and their staff, to support children with medical conditions at school.

5. Clinical commissioning groups (CCGs) – commission other healthcare professionals such as specialist nurses. They should ensure that commissioning is responsive to children's needs, and that health services are able to co-operate with schools supporting children with medical conditions. They have a reciprocal duty to cooperate under Section 10 of the Children Act 2004 (as described above for local authorities). Clinical commissioning groups should be responsive to local authorities and schools seeking to strengthen links between health services and schools, and consider how to encourage health services in providing support and advice, (and can help with any potential issues or obstacles in relation to this). The local Health and Wellbeing Board will also provide a forum for local authorities and CCGs to consider with other partners, including locally elected representatives, how to strengthen links between education, health and care settings.

Statutory Duties relating to Short Breaks

The Children and Families Act 2014 requires education, health and social care to work jointly and collaboratively to commission support for children and young people with SEND.

Childrens Act 1989 requires that local authorities provide breaks from caring for carers of disabled children to support them to care for their children at home and to allow them to do so more effectively, and Short Breaks for Carers of Disabled Children 2011 details the 1989 responsibilities more specifically.

NHS Act 2006, 2014 NHS Mandate and 2014 NHS Outcomes determine that CCGs are responsible for commissioning services to meet health needs

The legislation specifically imposes a duty on local authorities to provide short breaks. This duty is not imposed on CCGs.

Joint commissioning agreements must set out:-

- The Education, Health and Social Care provision reasonably required by local children and young people with SEND aged 0 – 25, both with and without EHC plans. This should draw upon local information and data.
- How this provision will be secured and by whom
- What advice and information about Education, Health and Social Care provision is available, and who is responsible for providing advice

- How children and young people with SEND are identified

Health and Education need to work together to design and commission needs-led services that consider universal, targeted and specialist approaches to improve children and young people's communication skills.

For school-aged children, speech and language therapy (SLT) is largely considered to be part of special educational needs provision, rather than a health provision, which places a duty on the local authority to take a lead in providing the service.

Statutory Duties relating to Speech and Language therapy

The Children & Families Act 2014 requires education, health and social care to work jointly and collaboratively to commission support for children & young people with SEND.

It states that 'speech and language therapy and other therapy provision can be regarded as either education or health care provision, or both. It could therefore be included in the EHC Plan as education or health provision. However, since communication is so fundamental in education, addressing speech and language impairment should normally be recorded as special educational provision unless there are exceptional reasons for not doing so. In cases where health care provision or social care provision is to be treated as educational provision, ultimate responsibility for ensuring that the provision is made rests with the local authority'

NHS Act 2206, 2014 Mandate and 2014 NHS Outcomes determine that CCGs are responsible for commissioning services to meet health needs.

Statutory guidance relating to the health of Looked After Children

The statutory guidance, *Promoting the health and well-being of looked after children (March 2015)* and The Intercollegiate Framework 'Looked after Children; knowledge, skills and competencies of healthcare staff' (2015) details how looked after children should be supported by competent healthcare professionals to support LAC to fulfil their potential. Evidence highlights that where looked after children have access to specialist health practitioners their health outcomes improved (Mooney et al).

The initial LAC health assessment must be undertaken by a registered medical practitioner. The statutory guidance, *Promoting the health and well-being of looked after children (March 2015)* states that this practitioner should have skills in assessing development, emotional and behavioural difficulties, and the ability to recognise underlying conditions such as foetal alcohol syndrome. It is therefore best practice that this initial health assessment is conducted by a paediatrician. The review health assessments may be carried out by a registered nurse or registered midwife. A specialist nurse with associated skills and competencies should carry out these LAC reviews.

The Statutory Guidance 2015 states that there should be a named/lead health professional for each child in care who can work as a key contact point for the child and link between health professionals, social worker and carer. Addressing the identified health needs of LAC, including input from local CAMHS services for LAC placed out of Borough, is also one of the key areas that the Statutory and NICE Guidance recommends.

5. RECOMMENDATIONS

This document summarises the information on need, evidence of effectiveness, current services and legal and statutory framework around the health of children and young people.

This document is intended to support the commissioning of health services for children and young people in Bromley from October 2017.

Appendix. Child Wellbeing Needs Assessment: Key Findings

Key finding	Commissioned service	Potential gap	Recommendation	Cost
Demography				
The greatest population growth 2015 to 2025 will be in secondary school age children.				
The North-West of Bromley has the highest proportion of ethnic minority population and the North-East of the borough has the highest proportion of Gypsy Travellers (GT), in particular the wards of Cray Valley East and West. This may be linked to higher prevalence of long term illness	Targeted services to GT are already in place within maternity and HV services	Targeted services to GT for children aged 5-19	Schools Partnership Board (SPB) to take forward targeted education. Strategic School Health team (SSHT) to include expertise in GT health issues	tbc 0.1WTE Band 7
Section A				
Mental health issues in parents in Bromley is at least as common as national rates	Wellbeing Service for adults	? accessible to most vulnerable	Ensure accessible to most vulnerable. Audit wellbeing service use	None
Illness and disability of parents is of concern, especially in areas of higher deprivation	EIFS service targeted in these areas	? accessible to most vulnerable	EIFS already monitor access by deprivation indicators. Review with Public Health could determine possible additional indicators	None
Smoking in pregnancy is more common in Bromley than in London, and is particularly high in pregnant young people under the age of 20 and pregnant women in routine and manual occupations	Smoking Cessation service commissioned by Public Health	Service de-commissioned from April 2017	Staff training in smoking cessation advice and Skilled Motivational Interviewing in all services working with young people. To be delivered to current staff and added to all future service specifications	Training costs for current staff
Recorded drug and alcohol misuse in Bromley is below the national average. However the proportion of pregnant women in substance misuse services and hospital admissions for substance misuse are both higher than national and London averages.	Drug and Alcohol service commissioned by Public Health		These should be reviewed after an update of the data in 2016 by service provider and Public Health.	None
Domestic violence is recorded more frequently in Cray Valley wards and Mottingham and Chislehurst North	DVA work led by LBB	?Schools engaged fully in DVA work	?Role of SSHT in linking schools to LBB-led work	

Key finding	Commissioned service	Potential gap	Recommendation	Cost
Homelessness of families with children is higher than national rates. There are increasing numbers of households with children residing in temporary accommodation and outside Bromley	Housing work led by LBB, with health implications being reviewed in partnership with PH	tbc	tbc	tbc
Families affected by unemployment, housing and financial difficulties and require support are more likely to live in the Crays, Mottingham or Penge	EIFS service targeted to these areas			None
Teenage pregnancy rates are reducing significantly, although still more frequent in areas of higher deprivation. Late booking for antenatal care in pregnant teenagers is of concern.	Sexual health services commissioned by Public Health	SRE service de-commissioned from April 2017	Strategic School Health team (SSHT) to support schools to deliver SRE, including promoting access to maternity services	0.2WTE Band 5
Section B				
The distribution of children with Special Educational Needs across the borough is higher in some wards, notably the Cray Valley wards, Bromley Common and Keston, Orpington, and Plaistow and Sundridge.	SEND services commissioned by LBB and Bromley CCG			
Smoking rates in young people in Bromley are higher than London and national rates.	See section A			
Young people between 15 and 24 years old continue to have the highest rates of new STIs. Males of all ages are more affected by new STIs than females	Sexual health services commissioned by Public Health			
Of the 90 young people in treatment in Bromley in 2014-15, 70% were using two or more substances (this may include alcohol) and 97% began using their main problem substance before the age of 15 years	Drug and Alcohol service commissioned by Public Health		This work will be led by service provider and Public Health	None
Nearly a third of children in Year 6 in Bromley are either overweight or obese. Pupils obese in reception year were more likely to remain obese at year 6 in Crystal Palace, Mottingham and Chislehurst North, Cray Valley East and Cray Valley West	Weight Management services and Healthy Schools Scheme are commissioned by Public Health	Both services to be de-commissioned from April 2017	Strategic School Health team (SSHT) should include support for the Healthy Schools Scheme and for PSHE in schools	0.2WTE Band 5 nurse
Some wards have a higher proportion of children living in families who are receiving support: Biggin Hill, Cray	EIFS service targeted to these areas		SSHT to support EIFS with specialist health expertise as	0.1WTE

Key finding	Commissioned service	Potential gap	Recommendation	Cost
Valley West, Plaistow and Sundridge, and Mottingham and Chislehurst North			required	Band 7
Community and hospital services indicate that young people in Bromley have a high level of need for support around self harming behaviour. A brief survey of emotional health concerns in secondary schools in Bromley in 2015 confirms this	Wellbeing Service for CYP commissioned by LBB. School CAMHS support pilot commissioned by Bromley CCG.		Transformation Plan led by CCG is key vehicle for this work. SSHT to link closely with this work and schools to ensure optimal support	
A quarter of young people in contact with the YOS have health needs	School Nurse service commissioned by Public Health	SN service de-commissioned from April 2017	SSHT to support this role	0.4WTE Band 7
The number of exclusions of primary school pupils is very high	EWO		Schools Partnership Board (SPB) to take forward. SSHT to support this work	0.1WTE Band 8a
There is no data on LGBT in young people in Bromley, although this is a known risk factor for several adverse outcomes in this age group			SSHT to support schools in collecting this data	
Vulnerability and safeguarding concerns in EHE children and young people may not be identified. This is of particular concern for young people who may be EHE for longer periods of time	EWO		SSHT to support the EWO EHE team with expert advice and some outreach to families of concern	0.1WTE Band 7
There appears to be significant under-reporting or lack of identification of CSE in Bromley, particularly by health services	Health services commissioned by LBB and CCG		Vulnerable Children Panel to take forward supported by SSHT.	0.2WTE Band 7
Section C				
At least 200 children and young people with complex health needs but no EHC Plan or Statement require support to attend school, and this number is increasing. . A total of 600 children and young people in Bromley schools require some nursing support to access school.	CCG commission health services.	Support to schools to enable access to school, including training	SSHT to support this role with: 1. Specialist advice and support to schools 2. Overview of health needs in schools to inform CCG commissioning 3. Training to schools	0.9WTE Band 8a 0.6WTE Band 7 1.0WTE Band 5
Compared to similar areas there are higher rates in				

Key finding	Commissioned service	Potential gap	Recommendation	Cost
Bromley of children with speech, language and communication needs, children with severe, profound and multiple learning difficulties, and pupils on the autistic spectrum. Pupils with behavioural, emotional or mental health needs are more likely to attend independent schools				
Exclusions from school and persistent absence of Bromley LAC are higher than statistical neighbours, London and England.	See Section B		Schools Partnership Board (SPB) to take forward. SSHT to support this work	
The proportion of LAC who are Not in Education, Employment or Training is also higher than comparators. This may be due in part to the relatively high rates of LAC with Special Educational Needs in Bromley			Schools Partnership Board (SPB) to take forward. SSHT to support this work	
The proportion of LAC who have been convicted or subject to a final warning or reprimand during 2014 was also higher than comparators, although the numbers are small	LAC Nurses commissioned by Bromley CCG		SSHT to work closely with LAC nurses	
The predicted increase in the number of UASC will require support from health as well as social care agencies	CCG commission health services		SSHT to work closely with LAC nurses	
Initial contacts to assessments by children's social care services have begun to level off and in the case of referrals decrease significantly based on levels prior to 2011. This is likely to be due to the success of the targeted approach of the MASH service	Safeguarding is function of School Nursing service	SN service de-commissioned from April 2017. No health input to safeguarding function for CYP 5-19 yrs	Working group CCG and LBB to agree health input to safeguarding function for 5-19 year olds	1.5 WTE Band 7

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Report No.
CSD 17031

London Borough of Bromley

Decision Maker:	**HEALTH AND WELLBEING BOARD**
Date:	**2nd February 2017**
Decision Type:	Non-Urgent Non-Executive Non-Key
Title:	**Alcohol Abuse In Bromley**
Contact Officer:	Stephen Wood, Democratic Services Officer
	Tel: 020 8 313 4316 E-mail: stephen.wood@bromley.gov.uk
Chief Officer:	Mark Bowen, Director of Corporate Services
Ward:	N/A

1. Summary

Report ES 16069 on Alcohol Abuse In Bromley was submitted for scrutiny to the Public Protection and Safety PDS Committee on 29thth November 2016.

The report provides an update on Alcolhol abuse in Bromley

2. Reason for Report going to Health and Wellbeing Board

The report is going to the Health and Wellbeing Board for their attention and information.

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

The Board is asked to consider and comment on the issues raised in the report.

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Report No.
ES16069

London Borough of Bromley

PART ONE - PUBLIC

Decision Maker:	**PUBLIC PROTECTION AND SAFETY POLICY DEVELOPMENT AND SCRUTINY COMMITTEE**
Date:	**29th November 2016**
Decision Type:	Non-Urgent Non-Executive Non-Key
Title:	**ALCOHOL USE IN BROMLEY**
Contact Officer:	Dr Agnes Marossy, Consultant in Public Health E-mail: agnes.marossy@bromley.gov.uk
Chief Officer:	Dr Nada Lemic, Director of Public Health
Ward:	All Wards

1. Reason for report

This report provides information on alcohol use in Bromley/

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2. RECOMMENDATION(S)

2.1 **To consider and comment on issues identified within the report.**

Corporate Policy

1. Policy Status: Existing Policy
2. BBB Priority: Healthy Bromley Children and Young People Excellent Council Quality Environment Safer Bromley Supporting Independence

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Financial

1. Cost of proposal: Not Applicable
2. Ongoing costs: Not Applicable
3. Budget head/performance centre: N/A
4. Total current budget for this head: £N/A
5. Source of funding: N/A

Personnel

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

Legal

1. Legal Requirement: Statutory Requirement
2. Call-in: Applicable

Customer Impact

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

Ward Councillor Views

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

Alcohol Use in Bromley

1. Introduction

In many parts of the world, drinking alcoholic beverages is a common feature of social gatherings. Nevertheless, the consumption of alcohol carries a risk of adverse health and social consequences related to its intoxicating, toxic and dependence-producing properties.

In addition to the chronic diseases that may develop in those who drink large amounts of alcohol over a number of years, alcohol use is also associated with an increased risk of acute health conditions, such as injuries, including from traffic accidents.

According to the World Health Organisation[1]:

- Worldwide, 3.3 million deaths every year result from harmful use of alcohol, this represent 5.9% of all deaths.
- The harmful use of alcohol is a causal factor in more than 200 disease and injury conditions.
- Overall 5.1% of the global burden of disease and injury is attributable to alcohol, as measured in disability- adjusted life years (DALYs).
- Alcohol consumption causes death and disability relatively early in life. In the age group 20 – 39 years approximately 25% of the total deaths are alcohol-attributable.
- There is a causal relationship between harmful use of alcohol and a range of mental and behavioural disorders, other non-communicable conditions as well as injuries.
- Causal relationships have been established between harmful drinking and incidence of infectious diseases such as tuberculosis as well as the course of HIV/AIDS.
- Beyond health consequences, the harmful use of alcohol brings significant social and economic losses to individuals and society at large.

2. Epidemiology of Alcohol Misuse[1]

Alcohol is a psychoactive substance with dependence-producing properties. Alcohol consumption can have an impact not only on the incidence of diseases, injuries and other health conditions, but also on the course of disorders and their outcomes in individuals. Alcohol-related harm is determined, apart from environmental factors, by three related dimensions of drinking:

- the volume of alcohol consumed
- the pattern of drinking
- and, on rare occasions also the quality of alcohol consumed.

[1] World Health Organisation Global Status Report on Alcohol and Health, 2014.

Alcohol Consumption has been identified as a component cause for more than 200 diseases, injuries and other health conditions.
A component cause may be one among a number of components, none of which alone is sufficient to cause the disease. When all the components are present, the sufficient cause is formed.
For most diseases and injuries causally impacted by alcohol, there is a dose–response relationship. For example, for all alcohol-attributable cancers, the higher the consumption of alcohol, the larger the risk for these cancers.

Pattern of Drinking also affects the risk of harm. For example, a pattern of drinking while eating seems to be associated with less harm from chronic diseases than the same pattern of drinking at other times.
The cardio protective effect of low-risk patterns of alcohol consumption disappears completely in the presence of heavy episodic drinking (HED).
HED is the consumption of 60 or more grams of alcohol (7.5 units) on at least one single occasion at least monthly. The volume of alcohol consumed on a single occasion is important for many acute consequences of drinking such as alcohol poisoning, injury and violence, and is also important wherever intoxication is socially disapproved of. HED is associated with detrimental consequences even if the average level of alcohol consumption of the person concerned is relatively low.

Quality of Alcohol Consumed may impact on health and mortality for instance when home-made or illegally produced alcoholic beverages are contaminated with methanol or other very toxic substances, such as disinfectants.

2.1 Mechanisms of Harm in an Individual

There are three main direct mechanisms of harm caused by alcohol consumption in an individual. These three mechanisms are:

- toxic effects on organs and tissues;
- intoxication, leading to impairment of physical coordination, consciousness, cognition, perception, affect or behaviour;
- dependence, whereby the drinker's self-control over his or her drinking behaviour is impaired

2.2. Factors Affecting Alcohol Consumption and Alcohol-Related Harm[1]

A variety of factors have been identified at individual and societal levels, which affect the magnitude and patterns of consumption and can increase the risk of alcohol use disorders and other alcohol-related problems in drinkers and others.
Environmental factors such as economic development, culture, availability of alcohol and the level and effectiveness of alcohol policies are relevant factors in explaining differences in vulnerability between societies, historical trends in alcohol consumption and alcohol-related harm.

Age

Children, adolescents and elderly people are typically more vulnerable to alcohol-related harm from a given volume of alcohol than other age groups.

Early initiation of alcohol use (before 14 years of age) is a predictor of impaired health status because it is associated with increased risk of alcohol dependence and abuse at later ages, alcohol-related motor vehicle accidents, and other unintentional injuries. At least part of the excess risk among young people is related to the fact that, typically, a greater proportion of the total alcohol is consumed during heavy drinking episodes. Also, young people appear to be less risk-averse and may engage in more reckless behaviour while drunk.

While alcohol consumption generally declines with age, older drinkers typically consume alcohol more frequently than other age groups. Also, as people grow older, their bodies are typically less able to handle the same levels and patterns of alcohol consumption as when they were younger, leading to a high burden from unintentional injuries, such as alcohol-related falls.

Gender

Harmful use of alcohol is the leading risk factor for death in males aged 15–59 years, yet there is evidence that women may be more vulnerable to alcohol-related harm from a given level of alcohol use or a particular drinking pattern. The vulnerability of females to alcohol-related harm is a major public health concern because alcohol use among women has been increasing steadily in line with economic development and changing gender roles and because it can have severe health and social consequences for newborns.

There is a higher burden of alcohol-related disease among men than women because men are less often abstainers, drink more frequently and in larger quantities.

However, the same level of alcohol consumption leads to more pronounced outcomes for women because women typically have lower bodyweight, smaller liver capacity to metabolise alcohol and a higher proportion of body fat, so achieve higher blood alcohol concentrations than men.

Women are also affected by interpersonal violence and risky sexual behaviour as a result of the drinking problems and drinking behaviour of male partners.

Women who drink during pregnancy may increase the risk of fetal alcohol spectrum disorder and other preventable health conditions in their newborns.

Familial Risk Factors

A family history of alcohol use disorders is considered a major vulnerability factor for both genetic and environmental reasons.

Multiple genes influence alcohol use initiation, metabolism and reinforcing properties in different ways, contributing to the increased susceptibility to toxic, psychoactive and dependence-producing properties of alcohol in some vulnerable groups and individuals.

Parental alcohol use disorders have been found to negatively affect the family situation during childhood. Parents with alcohol use disorders display particular patterns of alcohol consumption and thereby increase the likelihood that their children will develop drinking patterns associated with high risk of alcohol use disorders when they are introduced to alcohol. Heavy drinking by parents affects family functioning, the parent–child relationship and parenting practices, which in turn affects child development adversely. The mistreatment of children, including sexual abuse, physical abuse and neglect, may also lead to childhood psychopathology and later to problem drinking.

2.3 Socioeconomic Status[1]

Surveys and mortality studies, particularly from the developed world, suggest that there are more drinkers, more drinking occasions and more drinkers with low-risk drinking patterns in higher socioeconomic groups, while abstainers are more common in the poorest social groups. However, people with lower socioeconomic status (SES) appear to be more vulnerable to tangible problems and consequences of alcohol consumption. For example, manual workers seem more vulnerable to severe alcohol-related health outcomes, including mortality, than non-manual workers for a given pattern of drinking.

One explanation for the potentially greater vulnerability among lower SES groups is that they are less able to avoid adverse consequences of their behaviour due to a lack of resources. For example, individuals with higher SES may be more able to choose safer environments in which to drink, purchase social or spatial buffering of their behaviour and have better access to high-quality health care services.
A second explanation could be that individuals in lower SES groups have a less extensive support network, i.e., fewer factors or persons to motivate them to address alcohol problems before severe consequences occur.
A third, contested, explanation that has been proposed in the past is that of an “all or nothing” pattern of behaviour in lower SES groups, i.e. poor people drink less often, but when they drink, they drink a lot.

3. Guidelines on Alcohol Use

In August 2016, the UK Chief Medical Officers issued guidelines and recommendations on regular drinking, single episodes of drinking and on pregnancy and drinking[2].

Weekly Drinking Guideline

This applies to adults who drink regularly or frequently i.e. most weeks

The Chief Medical Officers' guideline for both men and women is that:

- To keep health risks from alcohol to a low level it is safest not to drink more than 14 units a week on a regular basis.
- If you regularly drink as much as 14 units per week, it is best to spread your drinking evenly over 3 or more days. If you have one or two heavy drinking episodes a week, you increase your risks of death from long term illness and from accidents and injuries.
- The risk of developing a range of health problems (including cancers of the mouth, throat and breast) increases the more you drink on a regular basis.
- If you wish to cut down the amount you drink, a good way to help achieve this is to have several drink-free days each week.

Single Occasion Drinking Episodes

This applies to drinking on any single occasion (not regular drinking, which is covered by the weekly guideline)

The Chief Medical Officers' advice for men and women who wish to keep their short term health risks from single occasion drinking episodes to a low level is to reduce them by:

- limiting the total amount of alcohol you drink on any single occasion
- drinking more slowly, drinking with food, and alternating with water
- planning ahead to avoid problems e.g. by making sure you can get home safely or that you have people you trust with you.

The sorts of things that are more likely to happen if you do not understand and judge correctly the risks of drinking too much on a single occasion can include:

- accidents resulting in injury, causing death in some cases
- misjudging risky situations, and
- losing self-control (e.g. engaging in unprotected sex).

Some groups of people are more likely to be affected by alcohol and should be more careful of their level of drinking on any one occasion for example those at risk of falls, those on medication that may interact with alcohol or where it may exacerbate pre-existing physical and mental health problems.

[2] UK Chief Medical Officers' Low Risk Drinking Guidelines, August 2016

If you are a regular weekly drinker and you wish to keep both your short- and long term health risks from drinking low, this single episode drinking advice is also relevant for you.

Pregnancy and drinking

The Chief Medical Officers' guideline is that:

If you are pregnant or think you could become pregnant, the safest approach is not to drink alcohol at all, to keep risks to your baby to a minimum.

Drinking in pregnancy can lead to long-term harm to the baby, with the more you drink the greater the risk.

The risk of harm to the baby is likely to be low if you have drunk only small amounts of alcohol before you knew you were pregnant or during pregnancy.

If you find out you are pregnant after you have drunk alcohol during early pregnancy, you should avoid further drinking. You should be aware that it is unlikely in most cases that your baby has been affected. If you are worried about alcohol use during pregnancy do talk to your doctor or midwife.

4. Classification of drinking behaviours

The most common classifications of alcohol consumption are based on quantity. The World Health Organisation and the National Institute of Health & Care Excellence (NICE) refer to classifications as follows:

Table 1: Classification of Drinking Behaviours[3]

RISK			Men	Women
1	**Lower risk** This level of drinking means that in most circumstances you have a low risk of causing yourself future harm.	**Sensible drinking** Drinking within the recommended limits.	No more than 3-4 units a day on a regular* basis	No more than 2-3 units a day on a regular* basis
2	**Increasing risk** Drinking at a level that increases the risk of damaging your health and could lead to serious medical conditions.	**Hazardous drinking** A pattern of alcohol consumption that increases risk of harm.	More than 3-4 units a day on a regular* basis	More than 2-3 units a day on a regular* basis
3	**Higher risk** This level of drinking has the greatest risk of health problems.	**Harmful drinking** A pattern of alcohol consumption that is causing mental and physical damage.	More than 50 units per week (or more than 8 units per day) on a regular* basis	More than 35 units per week (or more than 6 units per day) on a regular* basis

*Regular in this context means drinking at this sort of level every day or most days of the week; whilst for weekly drinking, it refers to the amounts drunk most weeks of the year.

[3] Adapted from Gravesham County NHS. http://www.gravesham.gov.uk/__data/assets/pdf_file/0007/62359/Units_Poster.pdf last accessed 16/09/14

4.1 Binge drinking

The new guidelines allow estimates to be made of the amounts of alcohol likely to be harmful when consumed on a single drinking day.

Table 2 Risks in a Single Drinking Day

Amount of Alcohol in One Day	Risk
Up to 4.67 units	This value is a third of the recommended weekly limit. This is the value you would drink if you drank 14 units spread evenly over three days.
More than 4.67 and up to 7 units	Evidence in the new guidelines suggests that the risk of accident or injury increases when drinking this amount of units over 3 to 6 hours.
More than 7 and up to 14 units	Up to the level that men and women are advised not to regularly drink in a week.
More than 14 units	The equivalent of drinking more than the low risk guidelines recommend for regular drinking in a week, in one day.

Source: Opinions & Lifestyle Survey 2016

4.2 Dependence

Drinkers can also be classified by their addiction to alcohol, known as dependence. Alcohol dependence is characterised by craving, tolerance, a preoccupation with alcohol and continued drinking in spite of harmful consequences (for example, liver disease or depression caused by drinking). Someone who is alcohol-dependent may persist in drinking, despite harmful consequences. They will also give alcohol a higher priority than other activities and obligations.

- **Mild dependence:**
  May crave an alcoholic drink when it is not available or find it difficult to stop drinking.
- **Moderate dependence:**
  Likely to have increased tolerance of alcohol, suffer withdrawal symptoms, and have lost some degree of control over their drinking.
- **Severe dependence:**
  May have withdrawal fits (delirium tremens: e.g. confusion or hallucinations usually starting between two or three days after the last drink); may drink to escape from or avoid these symptoms.

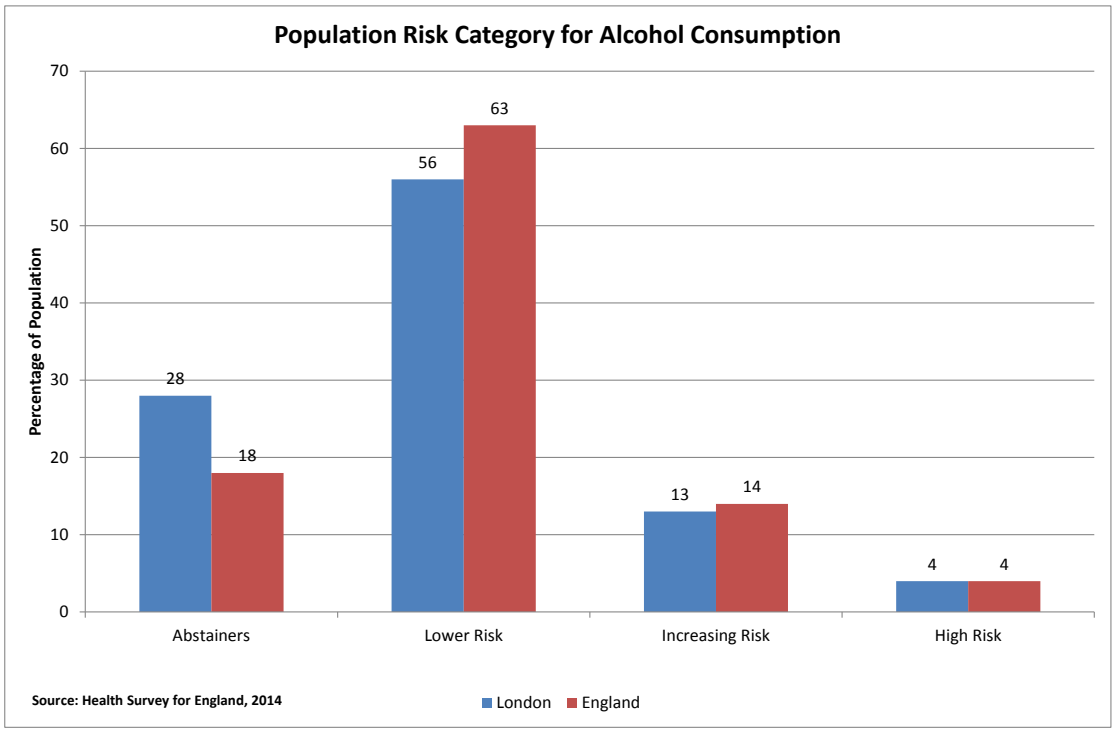
Abstainers are considered to be people who have reported not consuming alcohol in the previous 12 months. This may include people who have once been dependent on alcohol but are no longer consuming it.

5. Alcohol Consumption in Bromley

Obtaining reliable information about drinking behaviour is difficult, and social surveys consistently record lower levels of consumption than would be expected from the data on alcohol sales. However, a range of data sources which are available locally were extracted and analysed to understand patterns and trends in alcohol consumption in the Bromley population.

People in Bromley are not thought to drink any more than the average for London or England. In 2012 an estimated 73.6% of all drinkers in Bromley were in the lower risk category and drinking within the recommended levels, compared to 73.4% for London. There were 19.5% of drinkers at increasing risk, and a further 6.9% at high risk, which was no different to the London average. Figure 1 shows the most recent estimates of people consuming alcohol regionally and nationally.

Figure 1: Health Survey for England Estimates of Alcohol Consumption 2014



* Abstainers include people who may have had harmful or dependent drinking patterns in the past but may have stopped drinking since. They are not included in the estimation of lower risk drinkers.

Data collected from GP systems in June 2016 shows that of the 274,935 people aged 16 years and over registered with Bromley GPs, 42.2% have been asked about their alcohol consumption within the last three years. As this proportion is quite low, it is not possible to draw definite conclusions about alcohol consumption in the population. It should also be noted that information on the volume of alcohol consumption alone will not identify all those at risk, as some patterns of consumption e.g. heavy episodic drinking cause harm at lower levels of consumption.

The following data relates to those who have a record of their alcohol consumption within the last three years:
Almost 13% of people in Bromley reported drinking above the recommended weekly limit, with more men than women exceeding the recommendations (21.3% vs 6.3%). This is lower than Health Survey for England estimates for London.

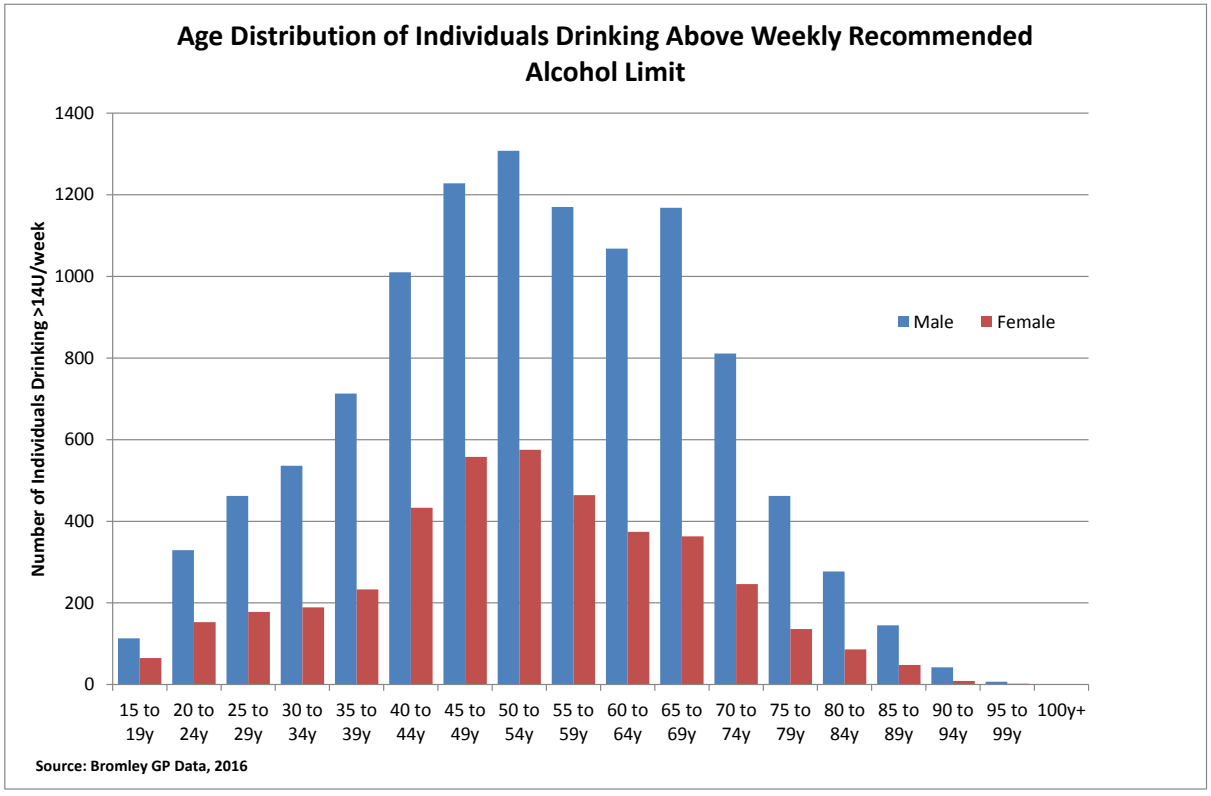
Table 3 Alcohol Consumption in Bromley

No. of Units Weekly	Persons	Male	Female
Zero	33%	25.1%	39.7%
Up to 14 units	53.9%	53.7%	54%
Over 14 units	12.9%	21.3%	6.3%

Source: Bromley GP Data, 2016

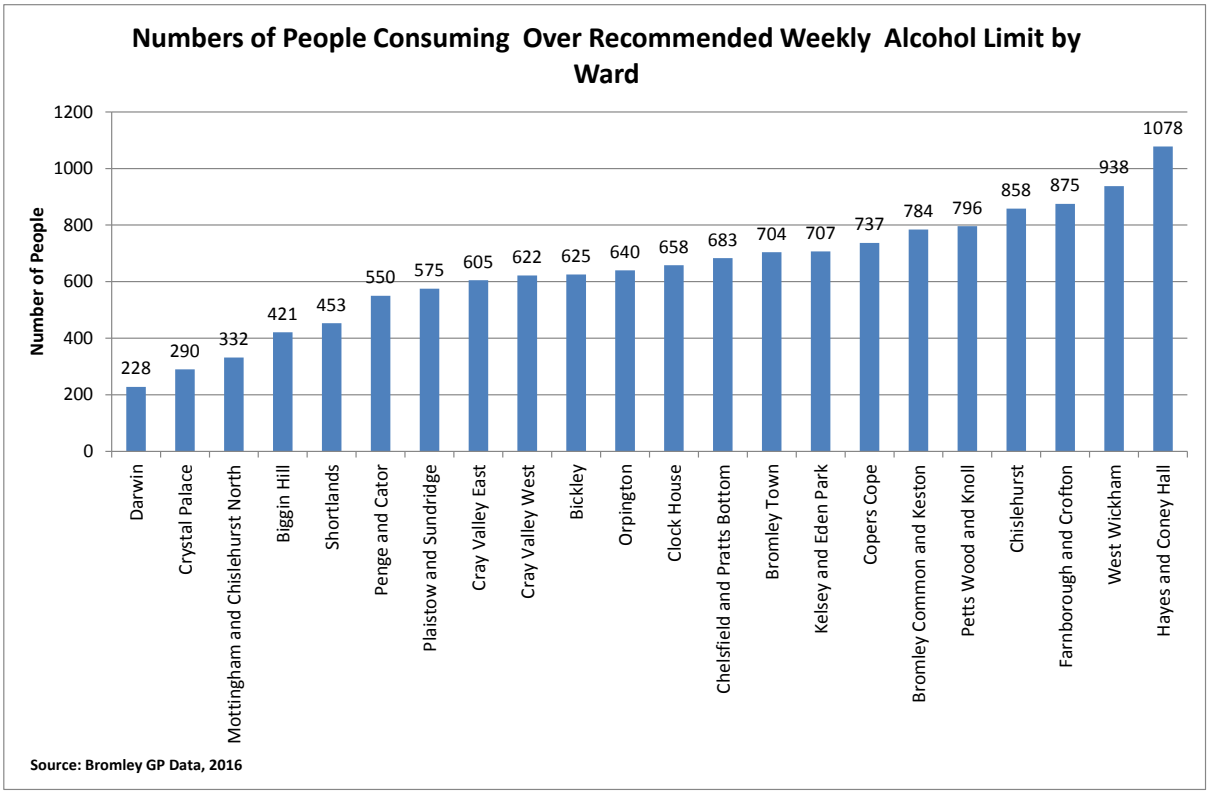
The numbers of men and women drinking above the recommended limit of 14 units per week rises with age to a peak at age 50 to 54 years, and declines again thereafter.

Figure 2 Age Distribution of Alcohol Consumption in Bromley, 2016



The numbers of people drinking above the recommended weekly limits varies with ward of residence, Hayes & Coney Hall ward having the highest number, and Darwin having the lowest number.

Figure 3: Harmful Alcohol Consumption in Bromley by Ward, 2016



Patients registered with Bromley GPs who are aged between 40 and 74 years and do not have existing cardiovascular disease are eligible for an NHS Health Check every five years. As part of the NHS Health Check, patients complete a short questionnaire relating to their alcohol consumption, the Audit C questionnaire (see Appendix).

In 2015-16, of the 6,868 people who had an NHS Health Check, 95% completed the Audit C questionnaire. 736 of these (10.7%) had a score of 8 or more, indicating an increasing risk from their volume and pattern of alcohol consumption (16.1% of men and 7.1% of women). This level is slightly lower overall and particularly for men than that expected for this age group compared to the reported consumption in the GP data.

5.1 Prevalence of binge drinking

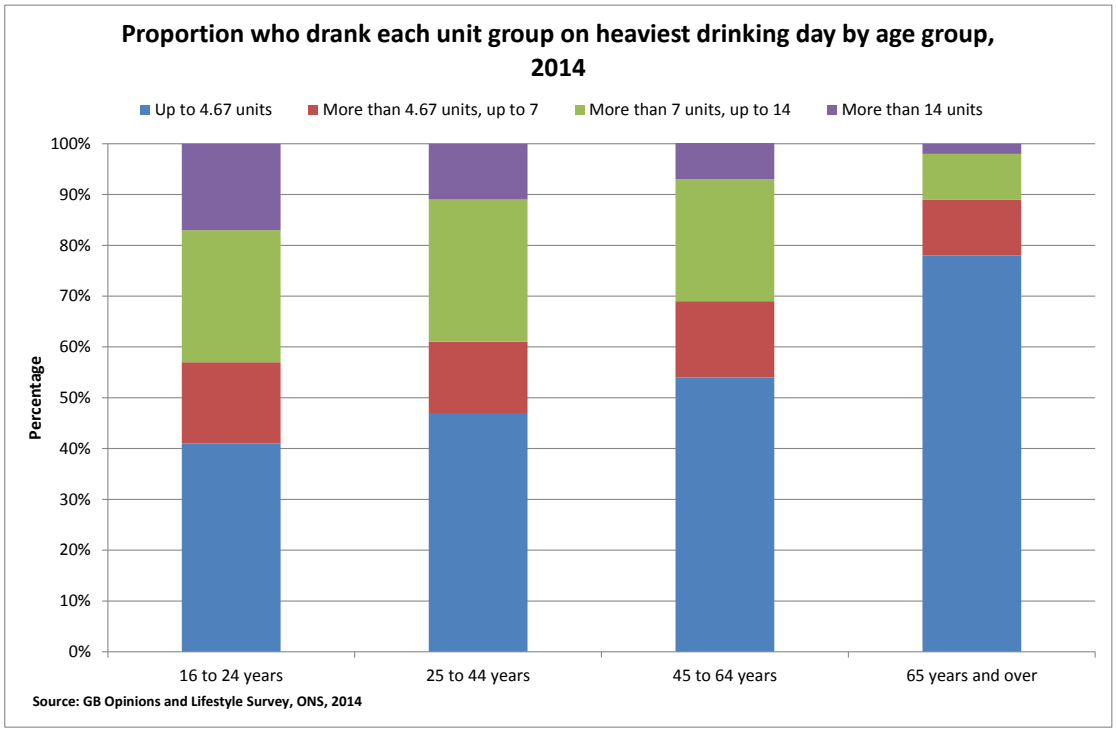
In 2014, the GB Opinions and Lifestyle Survey found that 58% of the population had drunk alcohol in the week before being interviewed.

Of these, 45% drank more than 4.67 units on their heaviest drinking day (i.e. over a third of the weekly limit) and 9% drank more than the recommended weekly amount of 14 units in one day.

Although young people were less likely to have consumed alcohol (48% of those aged 16 to 24 years as compared with 66% of those aged 45 to 64 years), they were more likely to consume more than the recommended weekly limit in one day (17% of 16 to 24 year olds as compared with 2% of those aged 65 years and over).

There are no recent local Bromley estimates for the level of binge drinking available.

Figure 4 National Estimates for Alcohol Consumption on a Single Drinking Day



6. Impact on Health & Wellbeing

The Chief Medical Officer's Alcohol Guidelines published in 2016 state that drinking any level of alcohol regularly carries a health risk for everyone.

An analysis of 67 risk factors and risk factor clusters for death and disability found that alcohol is the 3rd leading risk factor for death and disability after smoking and obesity.

Among the conditions for which alcohol is a causal factor are:

- Mouth, throat, stomach, liver and breast cancers
- Cirrhosis of the liver
- Heart disease
- Depression
- Stroke
- Pancreatitis

The lifetime risk of cancer increases with increasing alcohol consumption, as illustrated in the table below:

Table 4 Alcohol Consumption and Cancer Risk

Weekly Alcohol Consumption (Units)	Lifetime Risk (per 1000)	
	Breast Cancer	Bowel Cancer
35+	206	115
14	126	64
0	109	64

Alcohol misuse is also associated with mental health problems. A number of large epidemiological surveys demonstrate the high prevalence of co-morbidity in those attending mental health services and both drug and alcohol treatment services.
An estimated 44% of community mental health patients have reported problem drug use or harmful alcohol use in the previous year.
There is a strong association between alcohol misuse and suicide. The National confidential inquiry into suicide and homicide by people with mental illness found that there was a history of alcohol misuse in 45% of suicides among the patient population during period 2002 to 2011.

6.1 Alcohol Related Mortality

Excessive alcohol consumption is a major cause of preventable premature death. Liver disease is one of the leading causes of death in England and people are dying from it at younger ages. Alcohol accounts for over a third of all cases of liver disease. Most liver disease is preventable.
Liver disease has more than doubled since 1980 and is the only major killer disease on the increase during that period in the UK [4].

National

In England, in 2014 there were 22,966 alcohol-related deaths. Males accounted for a larger proportion of all alcohol-related deaths than women in England (66% in 2014). Between 2012 and 2014, the rate of deaths related to chronic liver disease in England was 15.21 per 100,000 population, and the rate of alcohol-related cancer deaths was 38.04 per 100,000 population.

Local

In 2014 there were 121 alcohol-related deaths in Bromley. The mortality rate from alcohol-related causes in Bromley appears to be on a rising trend for women whilst remaining level for men in the period between 2009 and 2013.
The alcohol-related mortality rate for men and women in Bromley is lower than the national levels, but the rate for women is slightly higher than the London regional

[4] PHE, Health Matters: harmful drinking and alcohol dependence, January 2016

rate. The alcohol-related mortality rate for men in Bromley is approximately twice that for women.
Between 2012 and 2014, the rate of deaths related to chronic liver disease in Bromley was 10.00 per 100,000 population, and the rate of alcohol-related cancer deaths was 34.3 per 100,000 population.
Figures 5 and 6 show the trend in alcohol-related deaths in Bromley, London and England by gender.

Figure 5: Alcohol-related deaths. Directly Standardised Rate - Males

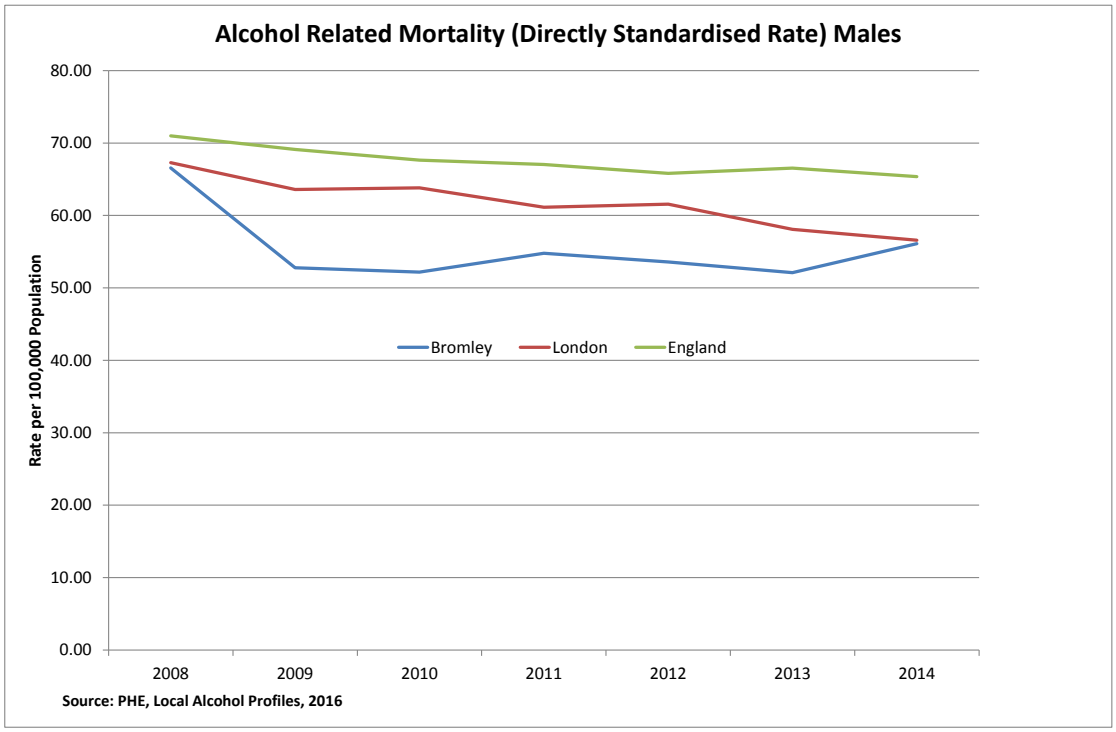
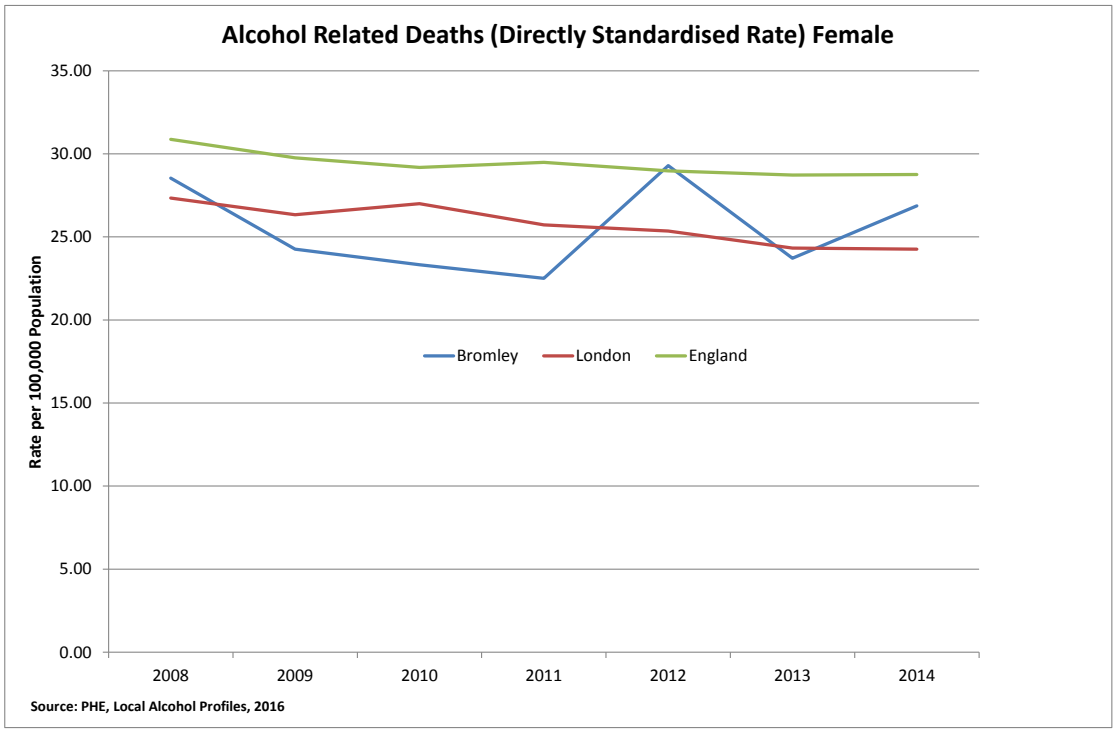


Figure 6: Alcohol-related deaths. Directly Standardised Rated - Females



6.2 Hospital Admissions - burden of ill-health due to alcohol[5]

Alcohol-related hospital admissions can be due to regular alcohol use that is above lower-risk levels and are most likely to involve increasing-risk drinkers, dependent drinkers and binge drinkers.

Alcohol dependence can be a long-term condition, which may involve relapses even after good quality treatment. Dependent individuals also experience many health problems and are frequent users of health services.

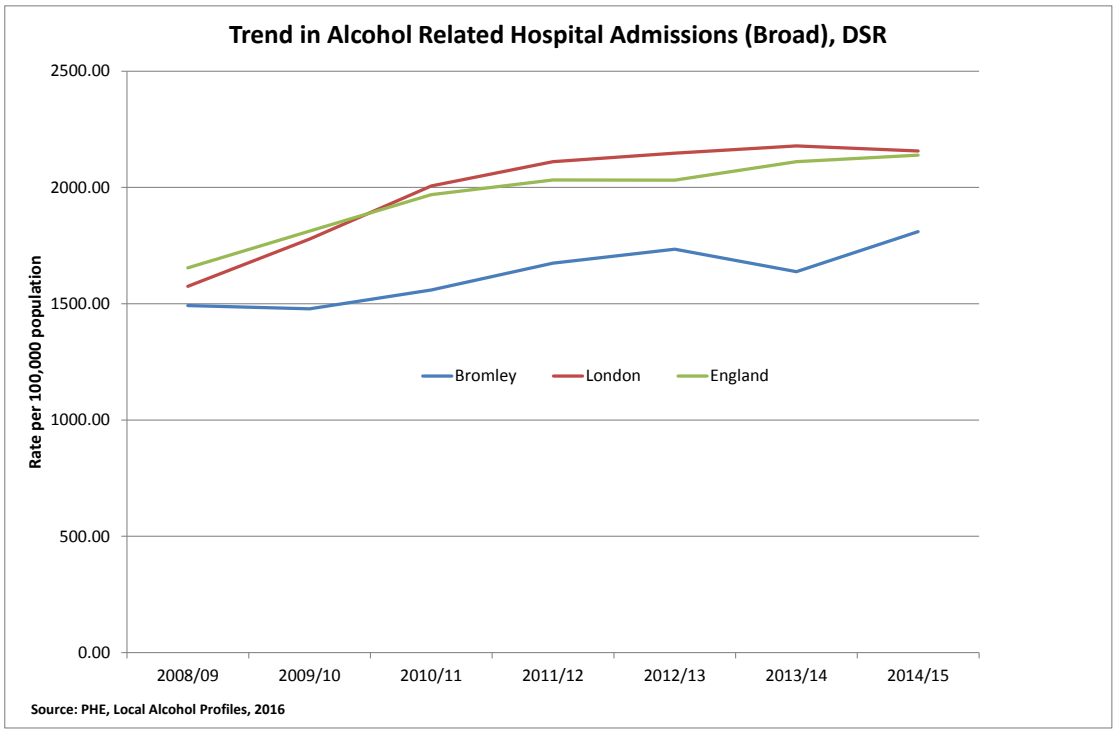
Health conditions in which alcohol plays a causative role can be classified as either "alcohol-specific" or "alcohol-related". For alcohol-specific conditions, alcohol is causally implicated in all cases e.g. alcohol poisoning or alcoholic liver disease. Alcohol-related conditions include all alcohol-specific conditions plus those where alcohol is causally implicated in some, but not all cases, e.g. high blood pressure, various cancers and falls.

There are two types of measure for alcohol-related admissions. The broad measure is an indication of the totality of alcohol health harm in the local adult population. The narrow measure shows the number of admissions where an alcohol-related illness was the main reason for admission or was identified as an external cause. The narrow measure is more responsive to change resulting from local action on alcohol.

[5] PHE, JSNA Support Pack 2016

The rate of alcohol-related hospital admissions whilst increasing at national, regional and local levels, remains lower in Bromley than for London and England as shown in figure 7 below.

Figure 7: Alcohol-related NHS hospital admissions 2008/09 to 2014/15



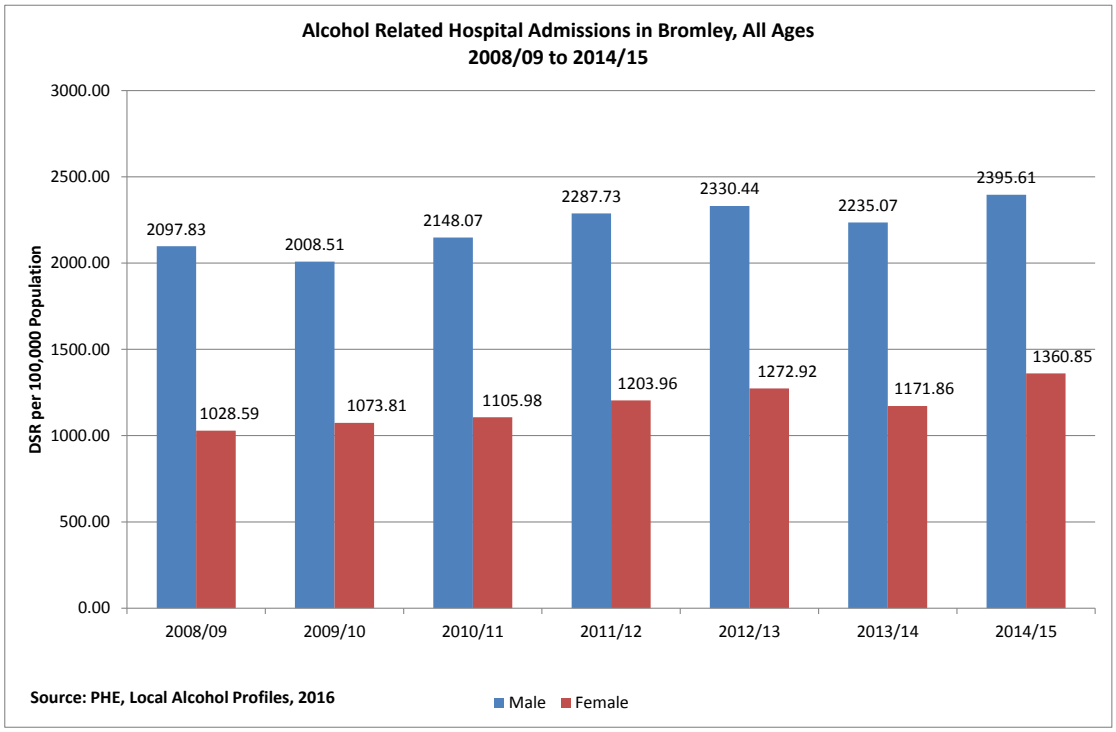
In 2014/15, there were an estimated 1,085,830 hospital admissions in England where the primary diagnosis or any of the secondary diagnoses are an alcohol-attributable code (the broad measure).

Nationally, more males than females are admitted to hospital with alcohol-related conditions.

The hospital admission rate for males is almost twice the rate for females in Bromley. The rates are shown in Figure 8.

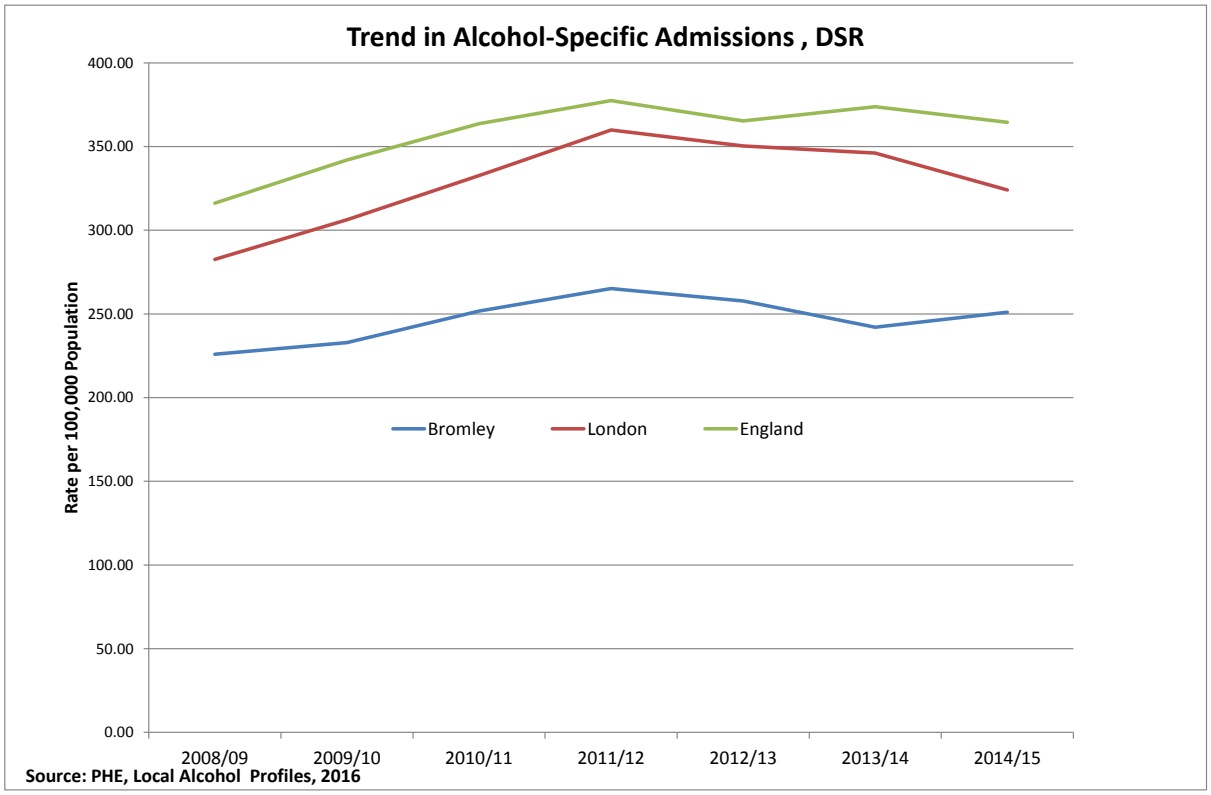
In 2014-15, nearly half of the alcohol-related hospital admissions nationally were for cardiovascular disease, and 19% were for mental and behavioural disorders due to alcohol.

Figure 8: Alcohol-related hospital admissions for men and women in Bromley 2008/09 - 2014/15



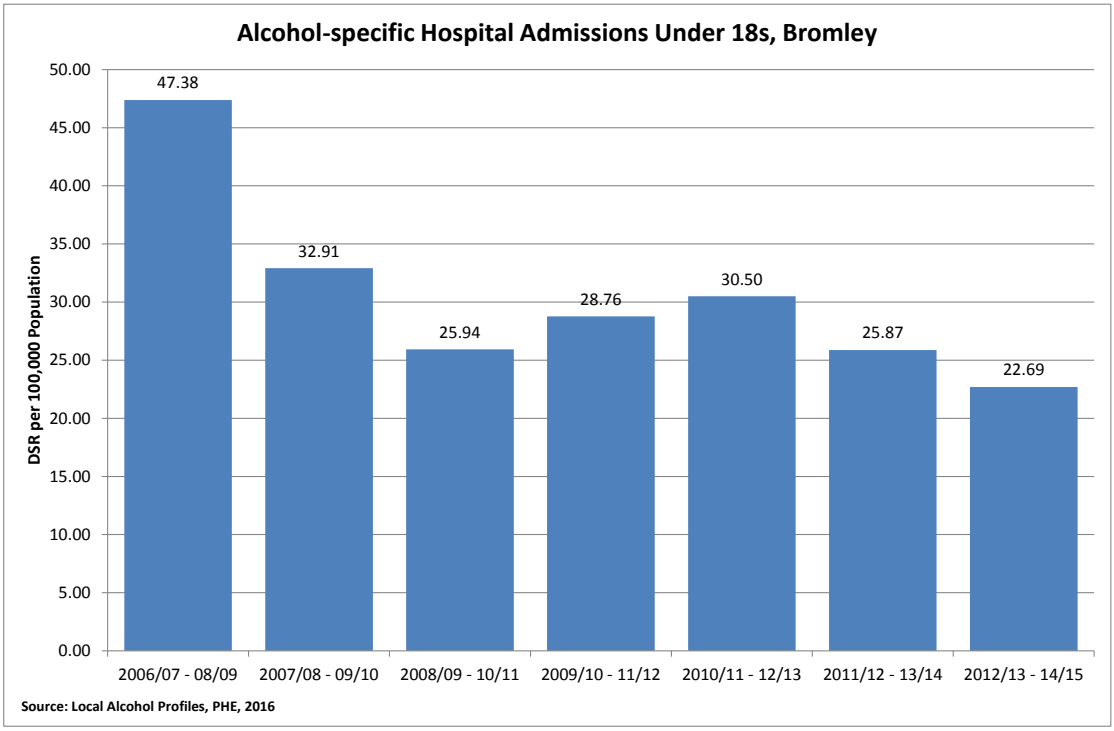
Alcohol-specific hospital admissions have been lower in Bromley than in London and England over the last seven years, but overall, there has been an increase in the rate of admissions over this period.

Figure 9 Trend in Alcohol Specific Admissions



The alcohol-specific admission rate for under 18 year olds in Bromley has been gradually decreasing over the last two years, and is comparable with the rate for London (23.73 per 100,000), but significantly lower than the rate for England (36.61 per 100,000 population).

Figure 10: Alcohol-specific hospital admissions for young people in Bromley 2006/07 to 2014/15



7. Socioeconomic Impact[1]

In addition to harm to the physical (e.g., liver disease) and/or mental health (e.g., episodes of depressive disorder) of the drinkers, alcohol consumption is often associated with socioeconomic consequences.

Alcohol is typically a valued commodity, which means that drinking usually uses resources which would otherwise be available for other purposes. Where earnings are low, heavy drinking may further impoverish the drinker, the drinker's family, or a whole community, thus increasing health or social harm.

Intoxication, dependence or alcohol withdrawal states can result in poor performance in major social roles – in functioning at work, in parenting, in relationship and friendship roles. Both the drinker and others may be affected by the consequences, such as job or productivity loss, break-up and dysfunction in family life, including domestic violence. This in turn can result in harm to physical or mental health.

The reputational drinking history of an individual, i.e., how the pattern of drinking is interpreted by others, is crucial in social judgements, both those made in the moment and in the longer term. There is a clear tendency in many cultures to marginalize and

socially exclude habitually intoxicated persons and their families, even more so than "dirty or unkempt" persons.

Marginalisation related to alcohol use can affect health status through diminished access to good health care. Studies on health services show that the care given is likely to be inferior, or the access to health care worsened, if the patient is seen as a run-down drinker or a similarly degraded status.

Harm to Other Individuals
In addition to harm to the drinker from their alcohol consumption, there are also harms to others by various means:

- **Injury** to other individuals can be intentional, e.g., assault or homicide, or unintentional, e.g., a traffic crash, workplace accident or scalding of a child.
- **Neglect or abuse** can affect, for example, a child, a partner or a person in the drinker's care.
- **Default on social role** can involve the drinker's role as a family member, as a friend and/or as a worker.
- **Property damage** can involve damage, for example, to clothing, a car or a building.
- **Toxic effects** on other individuals include most notably fetal alcohol syndrome (FAS) and preterm birth complications.
- **Loss of amenity or peace of mind** can influence family members (including children), friends, co-workers and strangers, who may, for example, be kept awake or frightened by the actions of the drinker.

Harm to Society at Large
The harmful use of alcohol results in a significant health, social and economic burden on society at large through:

- The increased burden of disease
- Social and economic costs

5.9% of all deaths and 5.1 % of the global burden of disease and injury in 2012, as measured in DALYs (Disability Adjusted Life Years), is attributable to alcohol. Beyond the population-level burden of diseases and injuries, it is important to note that harmful use of alcohol kills or disables people at a relatively young age, resulting in the loss of many years of life to death and disability.
There are three major categories of alcohol-attributable social and economic costs.

1. Direct economic costs of alcohol consumption. Direct costs encompass costs for multiple types of health-care services, such as hospitalisations, ambulatory care, nursing home care, prescription medicines or home health care. Direct costs also include significant costs in the justice sector caused, for example,

by damage to property from vehicle crashes and arrests for being “drunk and disorderly” as well as increased crime. Depending on the society, many of the direct costs are borne by governments.

2. Indirect costs. Indirect costs result, for example, from lost productivity due to absenteeism, unemployment, decreased output, reduced earnings potential and lost working years due to premature pension or death. These indirect costs are typically borne by society at large, because the alcohol-attributable loss in workforce productivity can affect the economic viability of an entire community.
3. Intangible costs. Intangible costs are the costs assigned to pain and suffering, and more generally to a diminished quality of life. Such intangible costs are borne by the drinkers, as well as their families and potentially by other individuals linked to the drinker.

8. Treatment and Management of Alcohol Misuse

The management of alcohol misuse at a population level falls into three categories:

- **Primary Prevention** which seeks to prevent the onset of disease. This takes place when the individual is still in good health, before there are any signs and symptoms of disease. It is chiefly concerned with maintaining a healthy lifestyle and avoiding adverse environmental influences. In this case primary prevention is concerned with preventing harmful alcohol use.

- **Secondary Prevention** aims to halt the progression of a disease once it is established. It takes place when the individual has developed early indicators of the development of disease. Lifestyle changes can still have a beneficial effect at this stage. In this case secondary prevention is concerned with identifying harmful alcohol use and harm reduction in individuals who are not yet alcohol dependent.

- **Tertiary Prevention** is concerned with the rehabilitation of people with an established disease to minimise residual disabilities and complications. In this case, tertiary prevention is concerned with managing individuals who are dependent on alcohol.

Management of the physical consequences of harmful alcohol use is not considered here, as this is in the NHS domain and management is not specifically related to alcohol.

8.1 Primary Prevention

Population approaches help reduce the aggregate level of alcohol consumed and therefore lower the whole population’s risk of alcohol related harm.

Population approaches can help by creating an environment that supports lower risk drinking. Examples of population approaches include those that seek to control the availability of alcohol through pricing, licensing controls, and preventing under age sales.
International evidence suggests that making it less easy to buy alcohol, (by reducing the number of outlets selling it in a given area and the days and hours when it can be sold), is an effective way of reducing alcohol related harm. The research base also supports the use of local crime and related trauma data to map the extent of alcohol related problems before developing or reviewing a licensing policy. The Council is responsible under the Licensing Act 2003 for granting licences for the retail sale/supply of alcohol in the borough. If an area is saturated with licensed premises, and the evidence suggests that additional premises may affect the licensing objectives, the Council can then adopt a cumulative impact policy which can be used to limit the number of new premises. The Council has identified two Cumulative Impact Areas (Bromley and Beckenham Town Centres), however, the policy can only be considered where there are relevant representations made against an application. If no one objects to an application, then the Council must grant it.

In addition, effective interventions on preventing under age sales, sales to people who are intoxicated or proxy sales (that is, illegal purchases for someone who is under-age or intoxicated) have been effective in reducing harm, in particular to young people. Ensuring that action is taken against premises that regularly sell alcohol to people who are under age, intoxicated or making illegal purchases for others is important in reducing harm. NICE and other studies support undertaking test purchases (using mystery shoppers) to ensure compliance with the law on under age sales.

Supporting people in understanding how much alcohol they are drinking is key to promoting sensible drinking as the social norm.

Primary prevention strategies include national programmes such as Change for Life, which highlight safe levels of alcohol consumption, the harms of drinking and suggest alternatives and tracking devices.
More locally, Bromley Changes (the Young Person's Substance Misuse Service) offers an annual session at each of Bromley's secondary schools for 13 to 15 year olds talking about safe levels of drinking, the journey of alcohol through the body, and the effects of alcohol.
For nine secondary schools, there is also a monthly drop in session, where pupils can ask for information about issues relating to alcohol.
During the week of 17th to 23rd November – Alcohol Awareness Week, assemblies are offered at schools for pupils aged 14 to 16 years.

The Licensing Act 2003 covers retail sales and the supply of alcohol, the provision of various forms of entertainment and the provision of late night refreshment.

There are four statutory objectives which must be addressed when any licensing functions are undertaken. The licensing objectives are:

- the prevention of crime and disorder
- public safety
- the prevention of public nuisance and
- the protection of children from harm.

There is currently no public health objective in the Act, but since April 2013, the Director of Public Health has been designated a Responsible Authority and as such is entitled to make representations to the licensing authority. Within Bromley's Statement of Licensing Policy, there is a section on Public Health. However, at present, the role of Public Health information in relation to licensing decisions in Bromley is unclear.

Table 5 Licenced Premises in Bromley

Year	Number of licenced premises	Number of licenced Clubs	No of 24hr licences
2009	815	90	4
2012	839	81	5
2013	731	81	5
2014	712	97	5
2016	774	77	10

Source: Bromley DCMS/Home Office Returns

In Bromley three alcohol exclusion zones have been established, in Beckenham Town Centre, Bromley Town Centre and in Penge. Within an alcohol exclusion zone it is an offence under the Criminal Justice and Police Act 2001 to consume alcohol in 'public' - any open space other than that which forms part of licensed premises. These zones have been established primarily to reduce problems relating to alcohol crime and disorder, but also serve a primary prevention function.
The police collect information about violent crime/drunkenness incidents related to the night-time economy (between 8 pm and 5 am) on Beckenham and Bromley High Streets and on East Street in Bromley.
There is quite a lot of variation in the incident figures from month to month (Figures 11 to 13) because of the small numbers involved, however, these stay largely within the control limits (set at +/- 2 standard deviations).

Figure 11

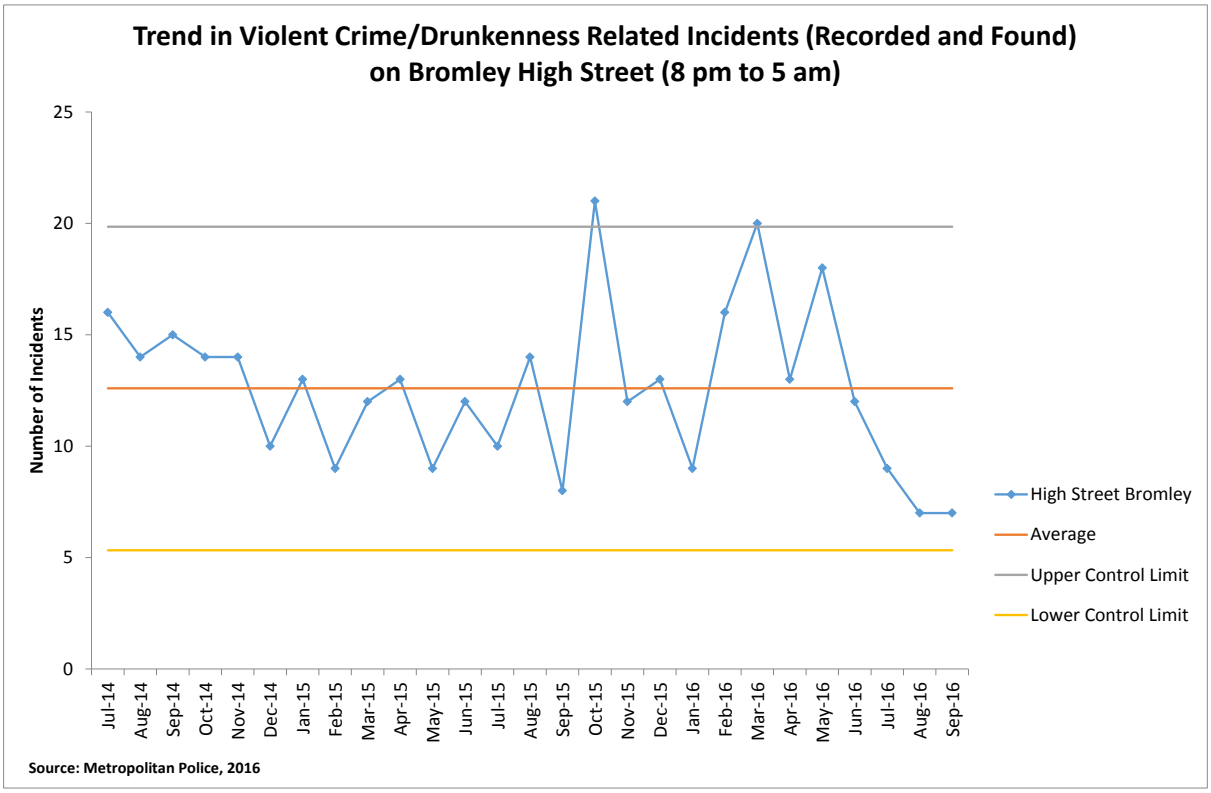


Figure 12

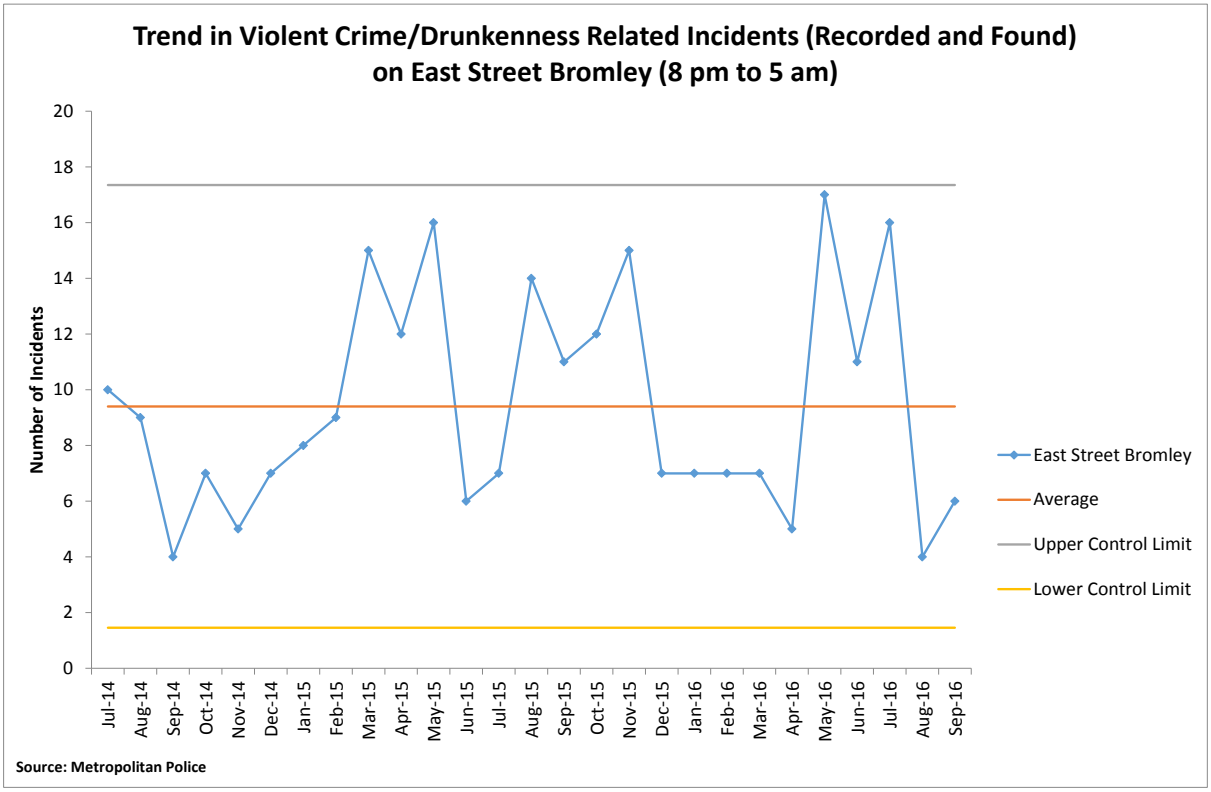
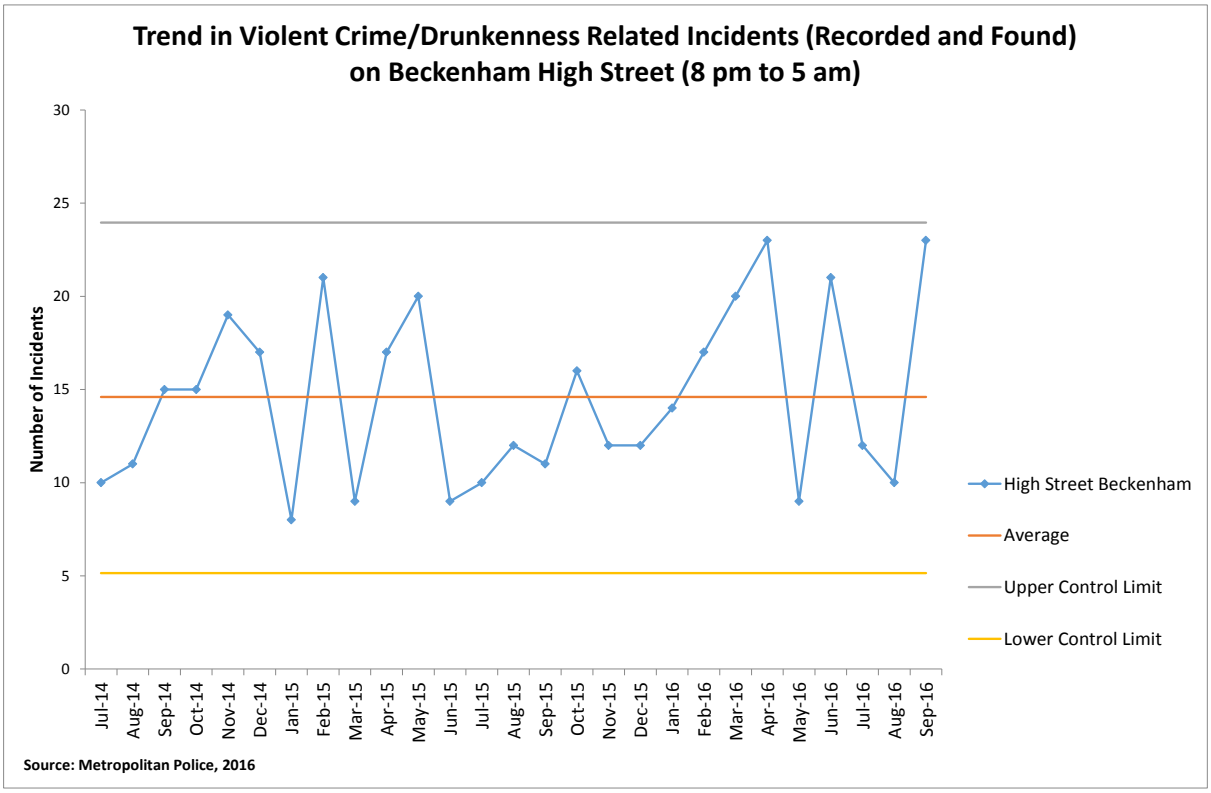


Figure 13



Trading Standards have a role to play in the primary prevention of alcohol misuse by enforcing the law and restricting alcohol sales.
It is against the law:

- To sell alcohol to someone under 18 anywhere.
- For an adult to buy or attempt to buy alcohol on behalf of someone under 18.
- For someone under 18 to buy alcohol, attempt to buy alcohol or to be sold alcohol.

Trading Standards carry out test purchases using under age volunteers, often police cadets. Premises targeted are those where we have received an allegation of under age sales, or as a result of visits by officers who have carried out a risk assessment of the management of the business. In some cases, a previous visit with an 18 year old volunteer would have been conducted to test whether or not the business was complying with voluntary age verification systems, for example Challenge 25, where we would expect the business to ask for proof of age.
Compliance levels for alcohol test purchasing are as follows:

In 2015-16 the proportion of premises who refused the sale was 85%. This compares to previous years where the compliance level was 88% in 2014-15, 70% in 2013-14 and 77% in 2012-13.

8.2 Secondary Prevention

Secondary prevention includes screening of individuals to detect whether their consumption of alcohol is at a harmful level, and giving brief advice.
This takes place in Primary Care as part of the NHS Health Checks for people aged between 40 and 74 years, and also at the Princess Royal University Hospital (PRUH) as part of the Health Promoting Hospital Local Incentive Scheme commissioned by the CCG.
All patients admitted to participating wards at the PRUH should be screened using the FAST Questionnaire (see Appendix) offered a brief intervention and referral to the Bromley Drug and Alcohol Service as appropriate. This scheme (part of the Health Promoting Hospital Incentive Scheme commissioned by the CCG) started in 2014-15 and each year more wards are enrolled onto the scheme, and currently 10 wards are participating.

Table 6 Alcohol Screening Results at the PRUH

Time Period	No. of Admissions	Screened	FAST Score >3	Brief Advice
Q1 2015-16	2736	82.7%	4.7%	99.1%
Q2 2015-16	3713	81.1%	4.9%	99.3%
Q3 2015-16	3923	86.2%	6.3%	90.6%
Q4 2015-16	3909	85.8%	5.0%	78.7%
Q1 2016-17	3986	90.5%	5.5%	76.0%
Q2 2016-17	3780	84.0%	6.3%	37.7%

The level of screening is high, but there are a lower than expected proportion of FAST scores above 3 (compared to alcohol consumption levels in the general population). Work is ongoing to support this initiative, as performance is affected by staff turnover. From 2018-19, alcohol screening in hospitals will be part of a National CQUIN.
In parallel with this, work has been ongoing to strengthen awareness of alcohol services and of referral pathways amongst hospital staff.

Harm reduction interventions by the Specialist Substance Misuse Service for both adults and young people are considered in the section on tertiary prevention.

8.3 Tertiary Prevention

Tertiary prevention is the management of individuals who are dependent on alcohol. This management is delivered by the specialist substance misuse provider.
Included in this section is information on harm reduction for non-dependent drinkers, as this is also delivered by the specialist service.

The main aim of treatment is to move a client from a position of problematic drugs and/or alcohol misuse, with possible poor physical health status, chaotic lifestyle and

criminality to a position of stability, improved health and well-being, employment and positive engagement with the community.
This may be achieved through:

- harm reduction – reducing the alcohol consumption to achieve “controlled drinking” i.e. reducing alcohol consumption to a moderate level.
- Abstinence oriented treatments using a range of interventions including community or inpatient detoxification, medication, psychosocial interventions and residential rehabilitation.

Treatments are more effective if given in combination. However, it should be understood that dependency is a chronic illness for which there is no cure. Abstinence is a lifelong battle.

8.3.1 Treatment in Bromley

Bromley Drug and Alcohol Service provides services at different levels based on the level of dependency determined at initial assessment, as shown in the Alcohol Model Pathway diagram.

Beyond brief intervention, each level includes:

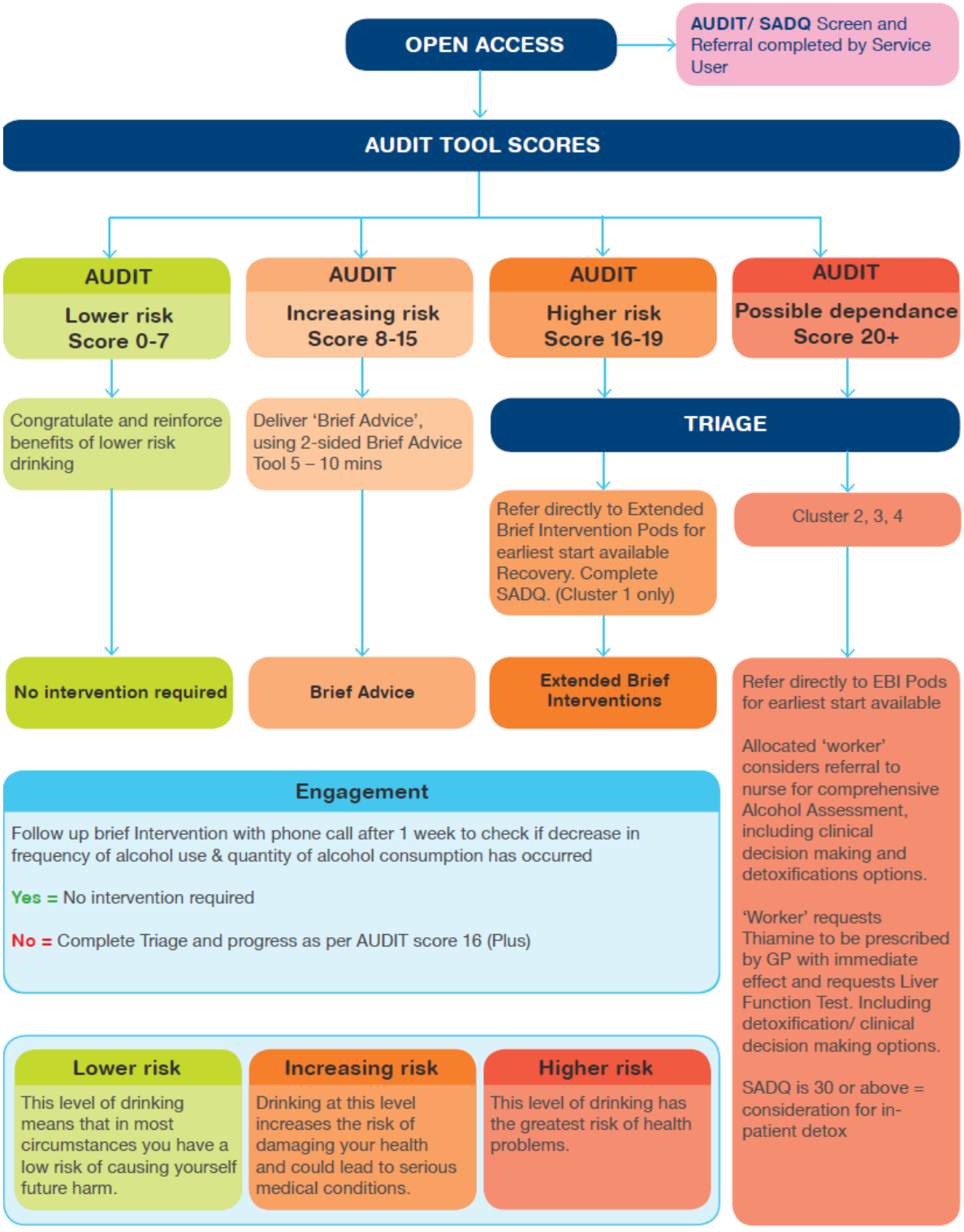
- Assessment/Engagement
- Extended Brief Intervention Pods (groups)
- Care Planning/Care Co-ordination and case management
- Withdrawal management
- Psychosocial interventions
- Pharmacotherapy
- Aftercare/Reintegration/Recovery

The length of treatment is determined by the level of dependency:

- Harmful/Mild Dependence 12 weeks
- Moderate Dependence 24 weeks
- Severe Dependence (without complex needs) approx. 12 months
- Moderate/Severe Dependence (with complex needs) at least 12 months

In addition, for complex patients who require it, there is spot purchasing from specialist providers for inpatient detoxification (for patients for whom there are medical risks) and for residential rehabilitation (where there is a need for complete separation from established patterns of behaviour and social networks).

CGL Alcohol Model Pathway

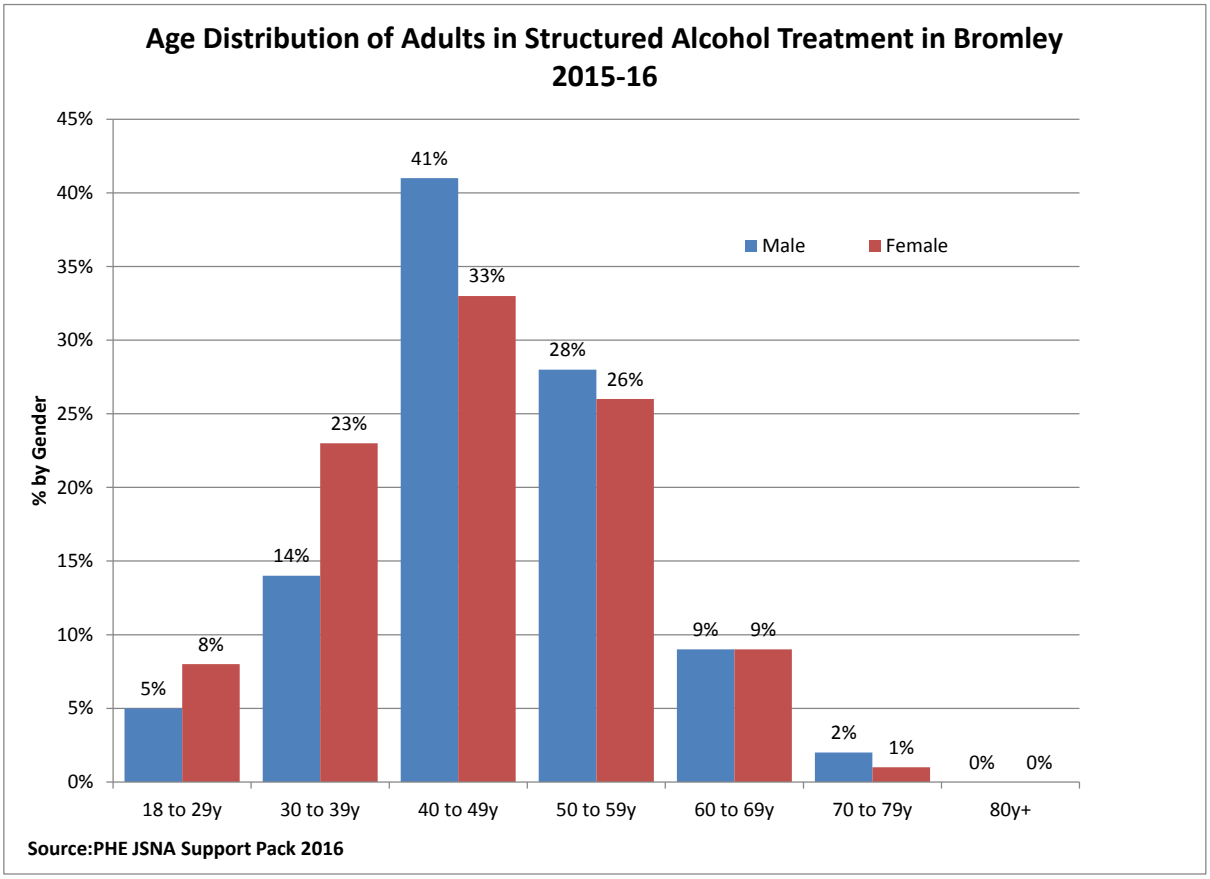


8.3.2 Adults Attending Structured Alcohol Treatment Services in Bromley

Evidence shows that, when individuals are engaged in treatment, they consume less alcohol, improve their health, manage their lives better and cause less harm to themselves, those close to them and to the wider community.

During 2015-16, 238 adults were engaged in structured alcohol treatment services in Bromley, of these 58% were men and 42% women.

Figure 14: Age of Individuals Receiving Alcohol Treatment



The average age of adults in alcohol treatment is 45 years, and the age distribution for both genders is very similar, although more females than males under the age of 40 years present for alcohol treatment.

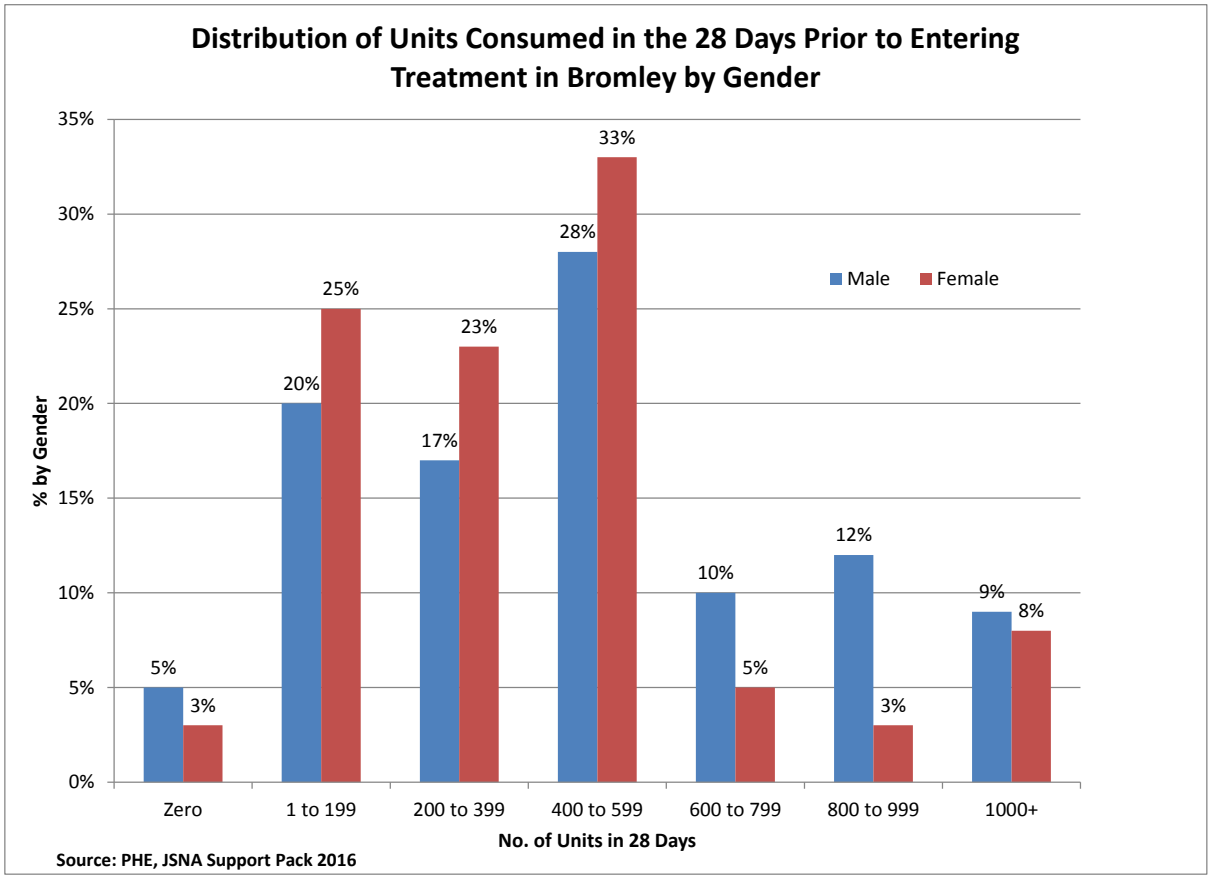
Of the 158 new presentations to treatment in Bromley in 2015-16, 5% were pregnant, as compared with 1% nationally.

The new presentation cohort also included 16% who were currently receiving care from mental health services for reasons other than substance misuse, this is lower than the national figure of 20%.

Most people who require structured treatment for alcohol dependence will be drinking at higher risk levels. There is no direct correlation between regular consumption levels and dependence, but the levels of alcohol consumed by individuals in the 28 days prior to entering treatment may give some indication of the severity of dependency and potential harm among the treatment population.

Although the majority of adults cite using alcohol in the month prior to treatment, 7% nationally (and 5% locally) cite no alcohol use. This may be because they have been referred to treatment directly from the criminal justice system or they may be in treatment to maintain abstinence and prevent relapse.

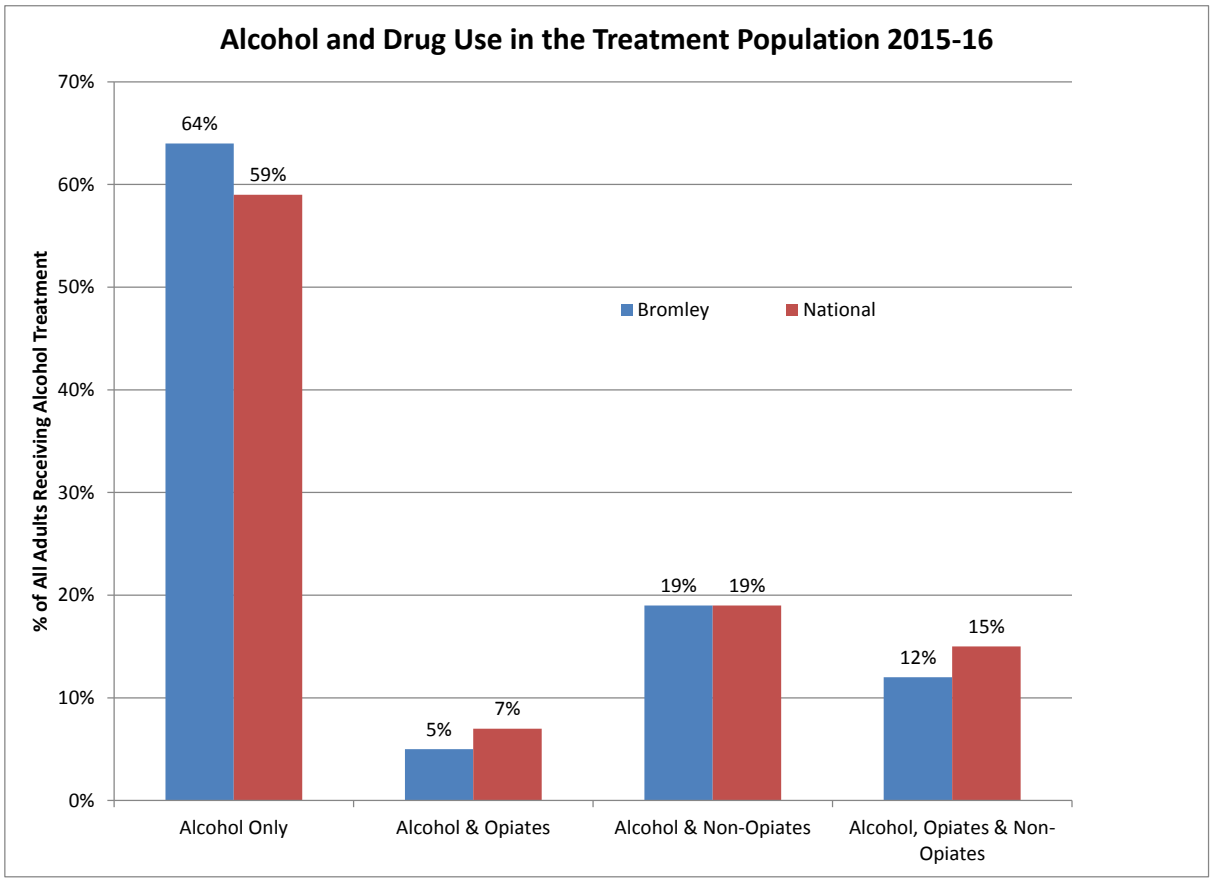
Figure 15: Alcohol Consumption Levels Prior to Treatment



In the chart above, it can be seen that a greater proportion of men than women were consuming above 600 units in the 28 day period, however, it should be remembered that women suffer harm at lower alcohol consumption levels than men.

In addition to the 238 adults in structured treatment for alcohol only, there were additionally 132 adults who were in treatment for alcohol and drug use.
The proportion of adults in alcohol treatment also using opiates is lower for Bromley than nationally. The most commonly cited additional drugs were crack (12%), cocaine (15%) and cannabis (11%).

Figure 16: Additional Substance Use



Recovery from alcohol dependence relies to some extent on the social, physical and financial assets of the individual; so called recovery capital.

Improving job outcomes is key to sustaining recovery. In Bromley, many of those requiring structured treatment for alcohol misuse are in regular employment, 37%, as compared with 29% nationally.

A safe, stable home environment also enables people to sustain their recovery. In Bromley, a much higher proportion of adults starting treatment (20%) report a housing problem compared with nationally (11%), although the proportion with an urgent housing problem is the same as the national figure.

Figure 17: Employment Status

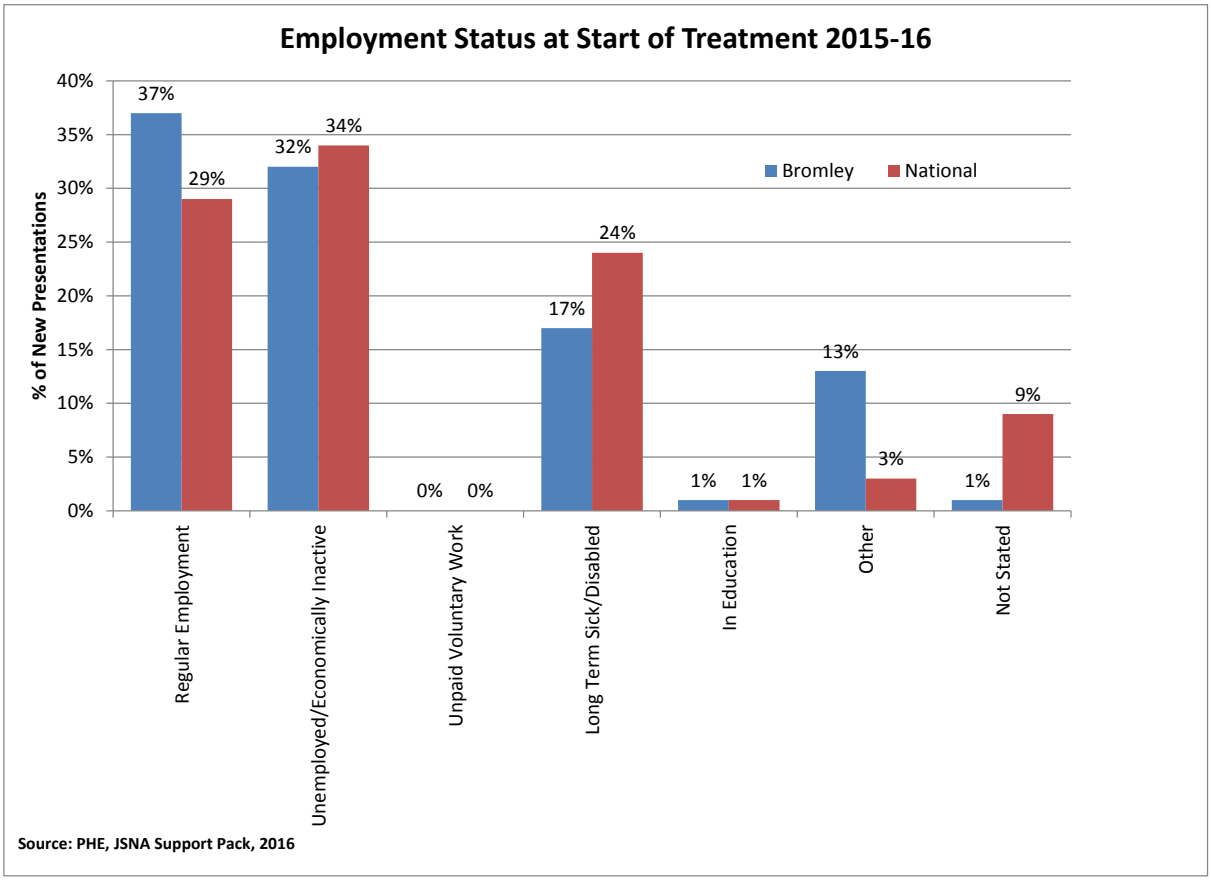
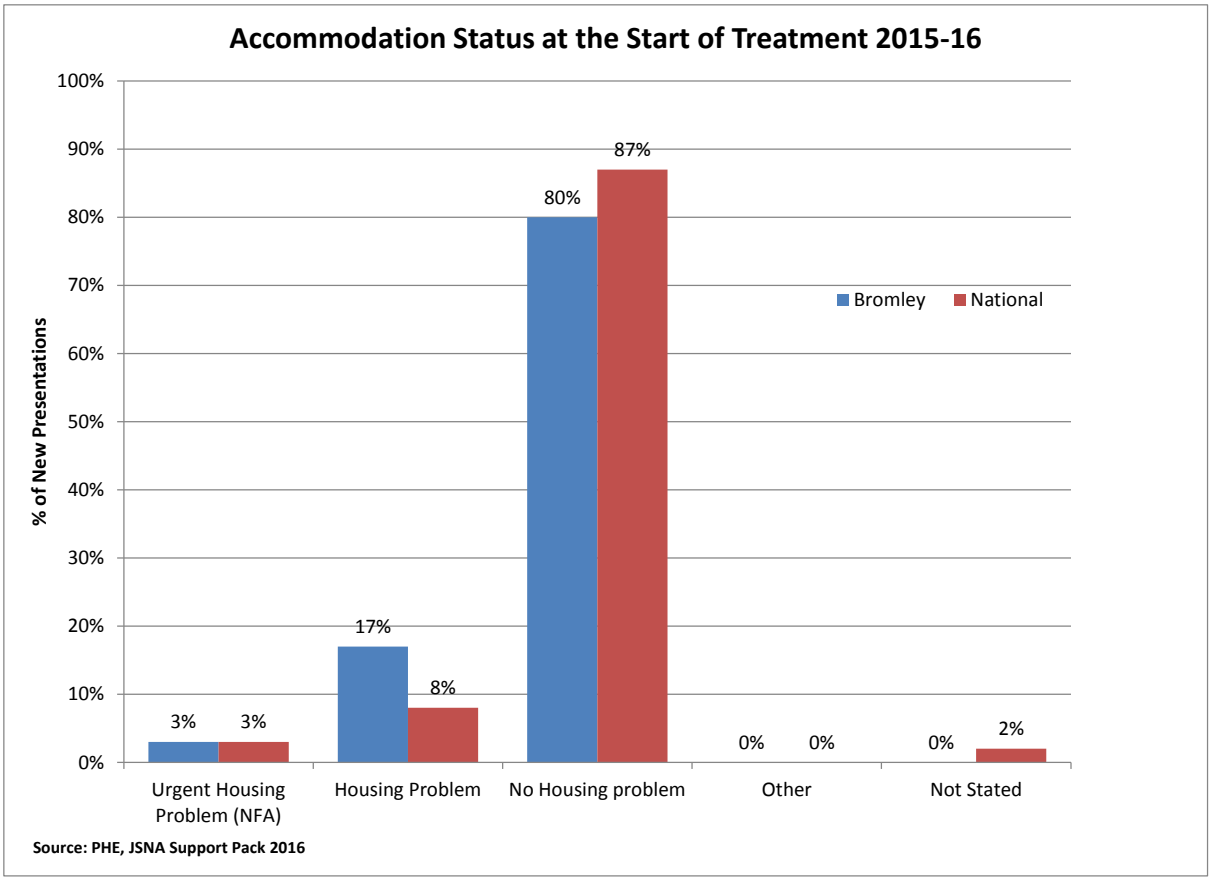


Figure 18: Housing Status



8.3.3. Adults in Non-Structured Treatment

The alcohol treatment service provides support not only for those who are dependent on alcohol, but also for individuals who have harmful levels of drinking and need support to reduce their alcohol consumption (i.e. harm reduction).

Those whose level of drinking places them at higher risk are offered an extended brief intervention over a course of twelve weeks.

Between July 2015 and June 2016, there were 74 individuals drinking at higher risk levels who received support from the service.

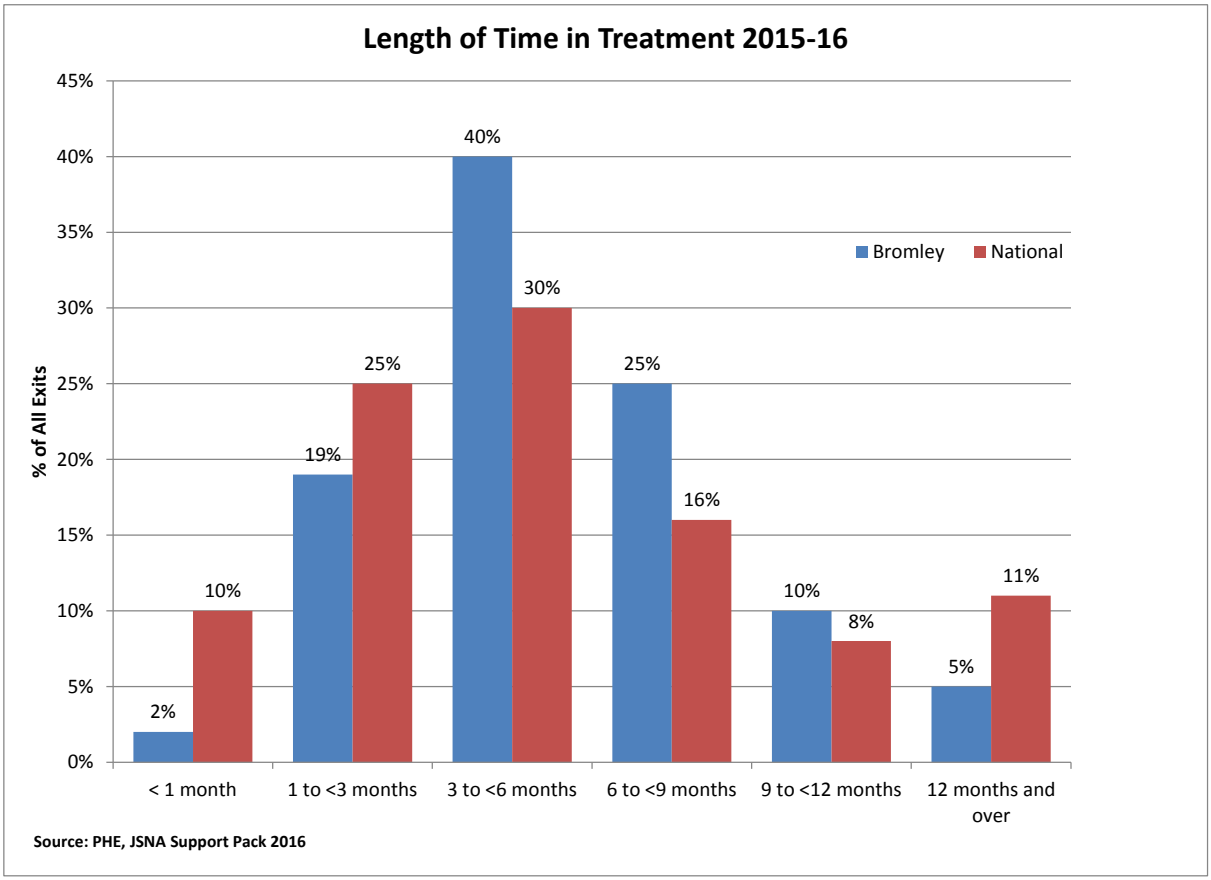
Of these 64.9% were male and two thirds were between 35 and 54 years of age. Many of this group have stable backgrounds, i.e. stable housing (75.7%), a stable employment situation (44.6%), and no identified safeguarding issues (51.4%). Referrals are mainly from the GP (37.8%) or self-referrals (31.1%).

9. Treatment Outcomes in Adults

NICE Guidelines suggest that harmful drinkers and those with mild alcohol dependence might benefit from a package of care lasting three months, while those with moderate dependence might need a six month package and those with severe dependence or those with complex needs may need a package of care lasting up to a year.
The length of a typical treatment period is around six months, although nationally 11% of clients remained in treatment for at least a year. Retaining individuals for their full course of treatment is important in order to increase the chances of recovery and reduce rates of early treatment drop out. Conversely, having a high proportion of individuals in treatment for more than a year may indicate that they are not moving effectively through and out of the treatment system.

In Bromley, a higher proportion of individuals than nationally are retained in treatment for over three months, and a lower proportion are retained beyond 12 months.

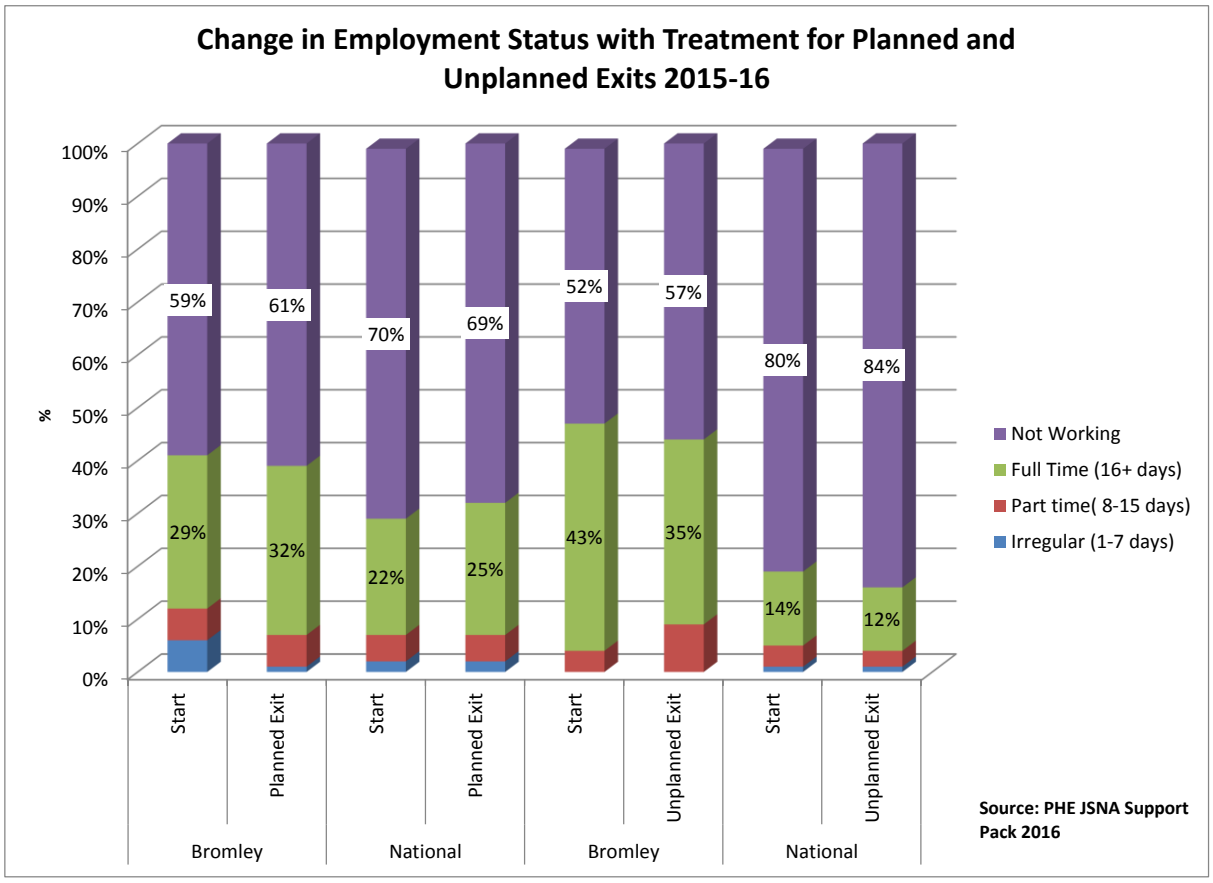
Figure 19: Length of Time in Treatment



The key measure of successful treatment is the proportion of people who successfully completed treatment and did not return within six months.
In the calendar year 2015, 28% of individuals left alcohol treatment successfully and did not return within 6 months as compared with 38% nationally.

For those still in treatment, there are a number of indicators at six month review which are predictors of continued recovery. These are rates of abstinence from alcohol, and changes in average days use, secure housing at planned exit and employment status at planned and unplanned exit.
In 2015-16, 65% of individuals reported abstinence at planned exit, as compared with 48% nationally.
There was a reduction in average drinking days from 21.7 days to 11.7 days in Bromley, compared with from 20.6 days to 12.4 days nationally.
A lower proportion of individuals (78%) no longer reported a housing need in Bromley than nationally (84%).
Although there was an improvement in the proportion of individuals working fulltime at planned treatment exit as compared with at start of treatment, there was also an increase in the percentage not working at all in Bromley. For unplanned exits, the employment status worsened between start and exit both in Bromley and nationally.

Figure 20: Change in Employment Status



10. Young People

Young people are more prone to harmful health effects from alcohol use, and misuse of alcohol can have a major impact on their education, and their long-term chances in life.

Official data for the year 2015-16 relating to alcohol and substance misuse treatment in young people is not yet available, although the numbers appear to be much lower than would be expected.

Of the 35 young people aged between 13 and 17 years treated in the Young People's Substance Misuse Service during 2015-16, 23 (65.7%) reported alcohol use in combination with other substances (34 of the 35 reported cannabis use).

Since the current Young Person's service was awarded the contract in December 2015, there has been a great deal of work to establish referral pathways to the service from children's social care, the acute hospital trust, youth offending services and mental health services, thus increasing access for young people.

11. Strategic Review

Bromley has been identified by Public Health England as a priority partnership which would benefit from support to address alcohol harm.

It was agreed at a meeting with the Head of the London Alcohol and Drugs Team that Bromley would complete Public Health England's Alcohol CLeaR Assessment Tool.

CLeaR is an evidence-based improvement model which stimulates discussion among partners about local opportunities for improving outcomes through effective collaborative working. It allows partnerships to **C**hallenge services, provide **Lea**dership and examine **R**esults (CLeaR).
The areas to be considered are summarised in Table 7.

Table 7 CLeaR Domains

	Domain	**Content of Sub-sections**
1	Setting the Context	Defining local priorities
2.	Leadership	Vision and governance
		Planning and commissioning
		Partnership
3.	Challenge services	Communications and social marketing
		Primary prevention (reducing availability)
		Secondary prevention (targeting those at risk)
		Tertiary prevention (treatment provision)
4.	Results	Nationally reported data
		Locally collected intelligence
		Progress against local alcohol objectives

The CLeaR tool was launched on 16th September; therefore this strategic review is just starting. It will involve discussions with all the partners involved in the prevention and management of alcohol misuse: community safety partnership representatives, licensing, trading standards, planning, housing, the clinical commissioning group, the substance misuse treatment provider, an elected member with responsibility for the alcohol, licensing, and/or community safety portfolios, representatives from primary care and the Kings College Hospital NHS Foundation trust and Oxleas NHS Foundation trust. The process will include a wider consultation with adult and children's social care, Jobcentre Plus, third sector agencies working with vulnerable groups, housing providers, schools and colleges and service users.

What this means for residents and children in Bromley

Estimates suggest that the level of drinking in people in Bromley is similar to that for London and England, with 17% of people in the increasing and high risk categories. Local GP data suggests that 21% of men and 6% of women drink above the recommended levels of alcohol each week and this is most prevalent in those aged between 40 and 69 years.

In 2014 there were 121 alcohol-related deaths in Bromley. The mortality rate from alcohol-related causes in Bromley appears to be on a rising trend for women whilst remaining level for men in the period between 2009 and 2013. The alcohol-related mortality rate for men in Bromley is approximately twice that for women.

The rate of alcohol-related hospital admissions has been increasing at national, regional and local levels, but remains lower in Bromley than for London and England. The hospital admission rate for males (2,396 per 100,000 population) is almost twice the rate for females (1,361 per 100,000 population) in Bromley.
The alcohol-specific admission rate for under 18 year olds in Bromley (22.7 per 100,000 population) has been gradually decreasing over the last two years, and is comparable with the rate for London, but significantly lower than the rate for England.

Availability of alcohol in Bromley is controlled through the Licensing Act 2003 and the Council's Licensing Policy; however, this is only relevant where objections to an application are made. If no objections are made, then the Council must grant the licence. Trading Standards work to ensure that alcohol is not sold or available to under 18 year olds. There is also a programme of education on alcohol for 13 to 15 year olds.

Screening and advice on alcohol use are delivered in both primary care (for new patients and at NHS Health Checks) and secondary care (PRUH).

During 2015-16, there were 238 adults engaged in structured alcohol treatment services in Bromley, of these 58% were men and 42% women.

The average age of adults in alcohol treatment is 45 years, and the age distribution for both genders is very similar.

Of the 158 new presentations to treatment in Bromley in 2015-16, 5% were pregnant, as compared with 1% nationally.

The new presentation cohort also included 16% who were currently receiving care from mental health services for reasons other than substance misuse.

In addition to the 238 adults in structured treatment for alcohol only, there were additionally 132 adults who were in treatment for alcohol and drug use.

In Bromley, many of those requiring structured treatment for alcohol misuse are in regular employment, 37%, as compared with 29% nationally.

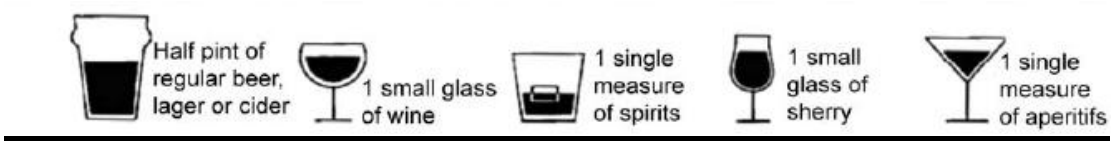
In Bromley, a much higher proportion of adults starting treatment (20%) report a housing problem compared with nationally (11%), although the proportion with an urgent housing problem is the same as the national figure.

Bromley had a lower proportion of successful treatment completers in 2015 than the national value. 28% of individuals left alcohol treatment successfully and did not return within 6 months as compared with 38% nationally.

Fewer than expected young people have accessed the Young person's Substance Misuse Service in the last year. Of those who access the service, the majority are cannabis users, with 66% additionally using alcohol.

A strategic review of alcohol services is currently underway. Prevention, early identification and intervention will be the focus, particularly in the highest risk group (aged 40 to 69 years). There will also be an emphasis on strengthening the referral pathways.

This is one unit of alcohol…



…and each of these is more than one unit

AUDIT – C

Questions	Scoring system					Your score
	0	1	2	3	4	
How often do you have a drink containing alcohol?	Never	Monthly or less	2 - 4 times per month	2 - 3 times per week	4+ times per week	
How many units of alcohol do you drink on a typical day when you are drinking?	1 -2	3 - 4	5 - 6	7 - 9	10+	
How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	

Scoring:
A total of 5+ indicates increasing or higher risk drinking.
An overall total score of 5 or above is AUDIT-C positive.

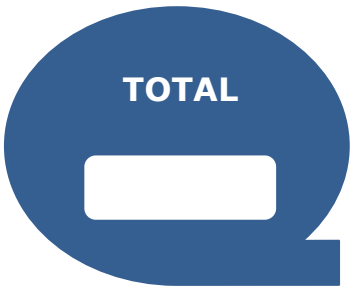
Score from AUDIT- C (other side)

Remaining AUDIT questions

Questions	Scoring system					Your score
	0	1	2	3	4	
How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you failed to do what was normally expected from you because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you been unable to remember what happened the night before because you had been drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Have you or somebody else been injured as a result of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down?	No		Yes, but not in the last year		Yes, during the last year	

Scoring: 0 – 7 Lower risk, 8 – 15 Increasing risk,
16 – 19 Higher risk, 20+ Possible dependence

TOTAL Score equals

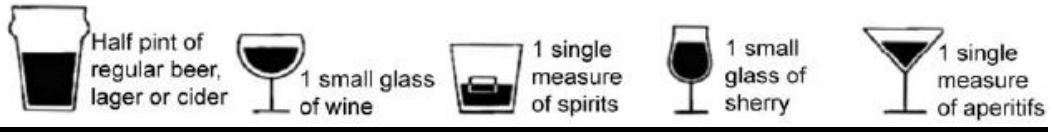


AUDIT C Score (above) +

Score of remaining questions

FAST Questionnaire

This is one unit of alcohol…



…and each of these is more than one unit

FAST	Scoring system					Your score
	0	1	2	3	4	
How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Only answer the following questions if the answer above is Never (0), Less than monthly (1) or Monthly (2). Stop here if the answer is Weekly (3) or Daily (4).						
How often during the last year have you failed to do what was normally expected from you because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you been unable to remember what happened the night before because you had been drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down?	No		Yes, but not in the last year		Yes, during the last year	

Scoring:

If score is 0, 1 or 2 on the first question continue with the next three questions

If score is 3 or 4 on the first question – stop here.

An overall total score of 3 or more is FAST positive.

What to do next?

If FAST positive, complete remaining AUDIT questions (this may include the three remaining questions above as well as the six questions on the second page) to obtain a full AUDIT score.

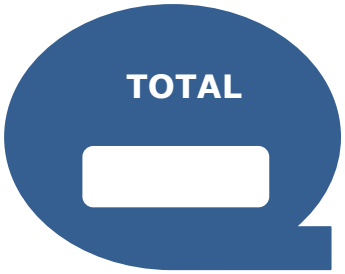
Score from FAST (other side)

Remaining AUDIT questions

Questions	Scoring system					Your score
	0	1	2	3	4	
How often do you have a drink containing alcohol?	Never	Monthly or less	2 - 4 times per month	2 - 3 times per week	4+ times per week	
How many units of alcohol do you drink on a typical day when you are drinking?	1 -2	3 - 4	5 - 6	7 - 8	10+	
How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Have you or somebody else been injured as a result of your drinking?	No		Yes, but not in the last year		Yes, during the last year	

TOTAL AUDIT Score (all 10 questions completed):

0 – 7 Lower risk,
8 – 15 Increasing risk,
16 – 19 Higher risk,
20+ Possible dependence



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Department of Health

From David Mowat MP
Parliamentary Under Secretary of State for Community Health and Care

Richmond House
79 Whitehall
London
SW1A 2NS

Tel: 020 7210 4850

FAO Health and Wellbeing Board Chairs

Dear Chair,

14 DEC 2016

I am writing to you in your capacity as local Health and Wellbeing Board Chair to highlight the Government response to the independent Review of Choice in End of Life Care.

This document set out the Government's commitment to everyone approaching the end of life, and I ask you to consider this commitment at this important time for your local area as Sustainability and Transformation Plans (STPs) are further developed, and Clinical Commissioning Groups (CCGs) finalise Operational Plans for the coming years.

Our ambition is for everyone approaching the end of life to receive high quality care that reflects their individual needs, choices and preferences, regardless of where they live.

On 5th July, we set out plans to improve end of life care in England. Our proposals were based on a commitment to high quality, personalised end of life care that we are making to all people at, or approaching the end of life. The commitment states that everyone should be able to expect:

- honest discussions between care professionals and dying people;
- dying people making informed choices about their care;
- personalised care plans for all;
- the discussion of personalised care plans with care professionals;
- the involvement of family and carers in dying people's care;
- a key contact so dying people know who to contact at any time of day.

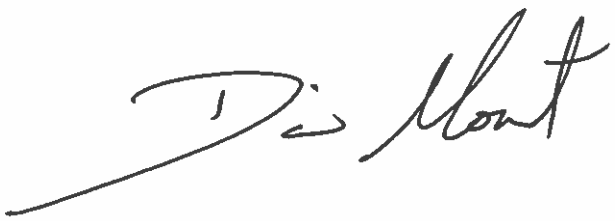
I am aware of the many priorities you have at a local level, but I am asking you to consider how you can encourage your colleagues locally to consider the importance of end of life care as local strategies and priorities are finalised.

A key element of the commitment is bringing together the NHS, social care and the voluntary sector to deliver seamless, person-centred care. Good end of life care is not the responsibility of one person or organisation: it happens because professionals and organisations work together.

There is a real opportunity over the coming years to ensure innovative ideas are put to work to deliver better outcomes for dying people. The Government fully supports the Ambitions for Palliative and End of Life Care Framework, which encourages local health leaders to develop strategies for palliative and end of life care which involve all providers and relevant stakeholders.

NHS England and the National Council for Palliative Care have launched a *Palliative and End of Life Care Knowledge Hub* bringing together resources and tools to support commissioners and providers to drive delivery of the Ambitions Framework. More information is available at: http://endoflifecareambitions.org.uk/.

In summary, I am asking you and your colleagues to consider how you can encourage action to improve end of life care, specifically through Operational Plans and STPs, to ensure everyone receives the high quality, personalised care at the end of life they deserve.



DAVID MOWAT

THE LONDON BOROUGH

Chief Executive's Department
Civic Centre, Stockwell Close, Bromley BR1 3UH

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DX5727 Bromley

David Mowatt MP
Under Secretary of State for Community Health & Care
Richmond House
79 Whitehall
London
SW1A 2NS

16th January 2017

Dear David Mowatt MP

Re: Choice in End of Life Care

Thank you for your letter to Chairs of Health & Wellbeing Boards dated 20 December 2016 asking us to consider how we can encourage action to ensure everyone receives high quality, personal care at the end of life. I welcome the opportunity to highlight the good work that is being done in Bromley borough.

Bromley has an established Personalised Care Service delivered by St Christopher's Hospice as well as a Bromley Care Coordination Service, which coordinates Health and Social care services. These provide personalised care plans for end of life patients, which are discussed with them and their family and allow them to make choices about their care and where they wish to die. Patients also have a key contact and access to advice 24 hours a day.

Despite the strengths of these local services we are always aiming to improve the quality of personalised care and the JSNA identified the need for more consistency in the care patients get when dying from conditions other than cancer, especially dementia. This was reflected in the Bromley Clinical Commissioning Group commissioning intentions for 2016/17 and is a priority again for the coming 17/18 year. (These commissioning intentions are aligned to the STP and feed into the CCG operational plans).

The aims are:

- To commission high quality, coordinated end of life care where we work to help patients and their families, so that they do not have to worry about who provides what service
- To make services available to support people in their last year of life, allowing individuals to be comfortable and die with dignity
- To improve end of life care particularly for people with non-cancer related conditions
- To commission services that identify end of life care patients earlier
- To address inequalities in end of life care such as increasing care for patients with dementia

The work underway to achieve these aims includes:

- Improvements to existing services such as increased funding for specialist palliative care staff, and improving overnight care for terminally ill patients.
- Joint working between the local hospice, hospital cardiologists and palliative care team and primary care to pilot a new integrated care model for heart failure patients nearing the end of life
- Increased workforce training to develop skills in identifying patients who are at end of life
- Linking the existing Personal Care Service closely to the new Integrated Care Networks

We have an End of Life Steering Group with members drawn from across health and social care including the CCG, Local Authority, Acute Hospital and Mental Health Trusts, voluntary sector (St Christophers Hospice, Carers, Marie Curie), London Ambulance Service and Healthwatch. The CCG also holds Advanced Dementia workshops which bring together representatives from across the system to link end of life and dementia work.

We are also committed to knowledge sharing, having contributed to the regional knowledge hub at SE London level where our locally developed resources and tools have been shared across all SE London CCGs.

To build on the excellent work already going on I have scheduled a discussion on End of Life care at the Health & Wellbeing Board in the near future to review our strategic approach and additional partnership opportunities.

Yours sincerely

Cllr David Jefferys

CSD17032

London Borough of Bromley

Decision Maker:	**HEALTH AND WELL BEING BOARD**
Date:	**2nd February 2017**
Decision Type:	Non Urgent Non-Executive Non-Key
Title:	**Health and Wellbeing Board Matters Arising and Work Programme**
Contact Officer:	Stephen Wood, Democratic Services Officer Tel: 0208 313 4316 E-mail Stephen.wood@bromley.gov.uk
Chief Officer:	Mark Bowen, Director of Corporate Services
Ward:	N/A

1. Reason for report

1.1 Board Members are asked to review the Health and Wellbeing Board's current Work Programme 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 attached.

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2. RECOMMENDATION

2.1 The Board is asked to review its Work Programme and progress on matters arising from previous meetings.

2.2 The Board is asked to consider what items (if any) need to be removed from "Outstanding Items for Possible Consideration".

2.3 The Board is encouraged to suggest new items for the Work Programme and for the next meeting.

Non-Applicable Sections:	Policy/Financial/Legal/Personnel
Background Documents:	Previous matters arising reports and minutes of meetings.

Corporate Policy

1. Policy Status: Existing Policy:

2. BBB Priority: Excellent Council; Supporting our Children and Young People; Supporting Independence; Healthy Bromley

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Financial

1. Cost of proposal: No Cost for providing this report

2. Ongoing costs: N/A

3. Budget head/performance centre: Democratic Services

4. Total current budget for this head: **£335,590**

5. Source of funding: 2015/16 revenue budget

Staff

1. Number of staff (current and additional): There are 8 posts (7.27) in the Democratic Services Team

2. If from existing staff resources, number of staff hours: Maintaining the Board's work programme takes less than an hour per meeting

---

Legal

1. Legal Requirement: Matters Arising and the Work Programme should be actioned in accordance with statutory obligations.

2. Call-in: Not Applicable

Customer Impact

1. Estimated number of users/beneficiaries (current and projected): This report is intended primarily for Members of the Health and Well Being Board.

Ward Councillor Views

1. Have Ward Councillors been asked for comments? No

2. Summary of Ward Councillors comments: N/A

3. COMMENTARY

3.1 The Matters Arising table is attached at **Appendix 1.** This report updates Members on matters arising from previous meetings which are ongoing.

3.2 The current Work Programme is attached as **Appendix 2.** The Work Programme is fluid and evolving. Meetings are scheduled so that generally speaking they will be held approximately two weeks after CCG Board meetings which will facilitate more current feedback from the CCG to the HWB.

In approving the Work Programme members of the Board will need to be satisfied that priority issues are being addressed, in line with the priorities set out in the Board's Health and Wellbeing Strategy and Terms of Reference which were approved by Council in April 2013.

3.4 The Chairman proposes to reduce the frequency of Board meetings, given the establishment of Task and Finish Groups around Health & Wellbeing priorities and the related work and time commitment to attend meetings for all Board Members in between.

3.5 For Information, **Appendix 3** shows dates of Meetings and report deadline dates.

3.6 For Information, **Appendix 4** outlines the Constitution of the Health and Well Being Board.

3.7 **Appendix 5** is the updated Glossary.

APPENDIX 1

Health and Wellbeing Board

Matters Arising/Action List

Agenda Item	Action	Officer	Notes	Status
Minute 65 02/06/16 **HWB Strategy Update**	Resolved that the existing HWB Strategy be maintained for the present time, and that the Strategy be reviewed after fresh JSNA data is available.	**Dr Lemic and Dr Marossy**	The HWB Strategy will be updated in due course. It needs to be decided at which meeting the matter will be reviewed. Will be reviewed at the meeting on February 2nd in the update from Dr Marossy.	**Completed**
Minute 65 02/06/16 **HWB Strategy**	Resolved that the issue of Falls be discussed at a future meeting.	**TBC**	Speaker to be identified and asked to attend a future meeting to update the Board.	**Ongoing**
Minute 79 06/10/16 **Health and Social Care Integration Update**	Resolved that the ICN update be noted and that a further update be brought to the next meeting of the Board, which would include an update on the development of the Frailty Unit.	**Dr Bhan**	Item has been included on the February agenda.	**Completed**
Minute 96 01/12/16 **BCF Performance Update**	Resolved that Mark Cheung and the LBB Director for Adult Social Care report back to the HWB on the anomaly around the TOCB data	**Mark Cheung** **Stephen John**	An update will be provided at the February 2017 meeting.	**Ongoing**
Minute 99 01/12/16 **Bromley Winter Plan** **Minute 102**	Resolved that the Winter/Escalation Plan be noted, and that a report on the performance against the Winter Plan be provided to the next meeting of the HWB	**Michael Maynard**	An update report will be available to the HWB for the February 2017 meeting.	**Completed**

01/12/16 **Healthwatch Inequalities Report**	Resolved that the report be noted, and that an update on the development of the Homelessness Strategy be brought back to a future Board meeting	**TBC**	An update will be brought to the HWB in due course	**Ongoing**
Minute 103 **01/12/16** **BSAB Annual Report for 2015-2016**	Resolved that the report be noted and that a more detailed discussion of the report take place in February 2017	**Board Members**	This is currently scheduled on the Work Programme for the meeting in March 2017. TBC.	**Ongoing**
Minute 106 **01/12/16** **Any other Business**	Resolved that the issue of Isolationism be reviewed at a future meeting, and that consideration be given to inviting the leaders of the stakeholder conference to address the HWB	**Jenny Manchester**	A report on the effects of Social Isolation Is being presented to the HWB at the February meeting.	**Completed**

Appendix 2

HEALTH AND WELLBEING BOARD
WORK PROGRAMME 2015/16

Title	Notes
Health and Wellbeing Board—February 2nd 2017	
ICN and Frailty Unit Verbal Update	Dr Bhan/Mark Cheung/Dr Parson
Update from Mental Health Sub Group on Joint Working with Mental Health Partnership	Harvey Guntrip
Work Programme and Matters Arising	Steve Wood
JSNA 2016 Presentation and an update on the HWB Strategy	Agnes Marossy
Alcohol Mis-Use Report (For Information)	Agnes Marossy
Children's JSNA	Jenny Selway
Performance against the Winter Plan	Michael Maynard
Phlebotomy Update-Verbal Update	Dr Bhan
Elective Orthopaedic Centres-Verbal Update	Dr Bhan or Dr Parson
Primary Care Commissioning Update Report	
Update on Emerging Issues	
Update or Presentation on Isolationism	Jenny Manchester
Presentation from the Local Pharmaceutical Committee	Raj Matharu
Letter from David Mowat-Personalised End of Life Care	Jackie Peake and Jackie Goad
Review of the General Practice Forward View Document and the role of HWBs in developing partnerships between primary care and wider local services.	Jessica Arnold
Health and Wellbeing Board—30th March 2017	
ICN and Frailty Unit Update	Dr Bhan
Update from Mental Health Sub Group	Harvey Guntrip
Work Programme and Matters Arising	Steve Wood
Phlebotomy Update	Dr Bhan
Elective Orthopaedic Centres	Dr Bhan or Dr Parson
Development of the Transfer of Care Bureau	Dr Bhan/Parson
Primary Care Commissioning Update	Dr Bhan/Parson
Bromley Safeguarding Adults Annual report-2015-2016	For detailed discussion/TBC
BCF Plan Sign Off	Jackie Goad
CAHMS Co-Production Report (TBC)	
CCG Annual Report	Dr Bhan/Dr Parson
Transforming Care (Winterbourne View) Programme Update	Andrew Royle

Outstanding Items for Possible Consideration:	
Obesity and Promoting Exercise	
NHS Self-Care Programme	
Falls	
Update from Bromley Third Sector Enterprise	
Health and Social Care Integration and the Self-Assessment Tool	
Presentation from Community Links with emphasis on Social Prescribing	
BSCB Action Plan Update (subsequent to Ofsted Report)	
Update on Bromley Third Sector Enterprise	
Healthwatch Project to Explore Sexual Health and Gender Identity	
IRIS System	Ste

Appendix 3

Dates of Meetings and Report Deadline Dates

The Agenda for meetings MUST be published five clear days before the meeting. Agendas are only dispatched on a Tuesday.

Report Deadlines are the final date by which the report can be submitted to Democratic Services. Report Authors will need to ensure that their report has been signed off by the relevant chief officers before submission.

Date of Meeting	**Report Deadline**	**Agenda Published**
2nd February 2017	January 24th 1.00pm	January 25th 2017
30th March 2017	March 21st 1.00pm	March 22nd 2017

A link to the agenda is emailed to the Board on the publication date. Hard copies are available on request.

Questions
Questions from members of the public to the meeting will be referred directly to the relevant policy development and scrutiny (PDS) committee of the Council, or to other meetings as appropriate, at the next available opportunity unless they relate directly to the work of the Board.

A list of the questions and answers will be appended to the corresponding minutes.

Minutes
The minutes are drafted as soon as possible after the meeting has finished. They are then sent to officers for checking. Once any amendments have been made, they are sent to the Chairman, and once he has cleared them, they are sent, in draft format, to Members of the board. Please note that this process can take up to two weeks.

The draft minutes are then incorporated on the agenda for the following meeting and are confirmed. Following this approval they are published on the web.

London Borough of Bromley

Constitution

Health & Wellbeing Board

(11 Elected Members, including one representative from each of the two Opposition Parties; the two statutory Chief Officers (without voting rights); two representatives from the Clinical Commissioning Group (with voting rights); a Health Watch representative (with voting rights) and a representative from the Voluntary Sector (with voting rights). The Chairman of the Board will be an Elected Member appointed by the Leader. The quorum is one-third of Members of the Board providing that elected Members represent at least one half of those present. Substitution is permitted. Other members without voting rights can be co-opted as necessary.

1. Providing borough-wide strategic leadership to public health, health commissioning and adults and children's social care commissioning, acting as a focal point for determining and agreeing health and wellbeing outcomes and resolving any related conflicts.

2. Commissioning and publishing the Joint Strategic Needs Assessment (JSNA) under the Health and Social Care Act.

3. Commissioning and publishing a Joint Health & Wellbeing Strategy (JHWS) – a high level strategic plan that identifies, from the JSNA and the national outcomes frameworks, needs and priority outcomes across the local population, which it will expect to see, reflected in local commissioning plans.

4. Receiving the annual CCG commissioning plan for comment, with the reserved powers to refer the CCG commissioning plan to the NHS Commissioning Board should it not address sufficiently the priorities given by the JSNA.

5. Holding to account all areas of the Council, and other stakeholders as appropriate, to ensure their annual plans reflect the priorities identified within the JSNA.

6. Supporting joint commissioning and pooled budget arrangements where it is agreed by the Board that this is appropriate.

7. Promoting integration and joint working in health and social care across the borough.

8. Involving users and the public, including to communicate and explain the JHWS to local organisations and residents.

9. Monitor the outcomes and goals set out in the JHWS and use its authority to ensure that the public health, health commissioning and adults and children's commissioning and delivery plans of member organisations accurately reflect the Strategy and are integrated across the Borough.

10. Undertaking and overseeing mandatory duties on behalf of the Secretary of State for Health and given to Health and Wellbeing Boards as required by Parliament.

11. Other such functions as may be delegated to the Board by the Council or Executive as appropriate.

Appendix 5

GLOSSARY:

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)
Bromley Safeguarding Children Board	(BSCB)
Cardiovascular Disease	(CVD)
Care Programme Approach	(CPA)
Care Quality Commission	(CQC)
Children & Adolescent Mental Health Service	(CAMHS)
Child Sexual Exploitation	(CSE)
Chlamydia Testing Activity Dataset	(CTAD)
Clinical Commissioning Group	(CCG)
Clinical Decision Unit	(CDU)
Clinical Executive Group	(CEG)
Clinical Leadership Groups	(CLG)
Common Assessment Framework	(CAF)
Community Learning Disability Team	(CLDT)
Community Psychological Services	(CPS)
Delayed Transfer of Care	(DTOC)
Director of Adult Social Services	(DASS)
Director of Children's Services	(DCS)
Disability Discrimination Act 1995	(DDA)
Dispensing Appliance Contractors	(DAC)
Emergency Hormonal Contraception	(EHC)
Essential Small Pharmacy Local Pharmaceutical Services	(ESPLPS)
Female Genital Mutilation	(FGM)
Florence – telehealth system using SMS messaging	(FLO)

Health & Wellbeing Board	(HWB)
Health & Wellbeing Strategy	(HWS)
Health of the Nation Outcome Scales	(HoNOS)
Hypertension Action Group	(HAG)
Improving Access to Psychological Therapies programme	(IAPT)
In Depth Review	(IDR)
Integrated Care Network	(ICN)
Integration Transformation Fund	(ITF)
Intensive Support Unit	(ISU)
Joint Health & Wellbeing Strategy	(JHWS)
Joint Integrated Commissioning Executive	(JICE)
Joint Strategic Needs Assessment	(JSNA)
Kings College Hospital	(KCH)
Local Medical Committee	(LMC)
Local Pharmaceutical Committee	(LPC)
Local Pharmaceutical Services	(LPS)
Local Safeguarding Children's Boards	(LSCB)
Long Acting Reversible Contraception	(LARC)
Mental Health Champion	(MHC)
Multi Agency Planning	(MAP)
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)
Multi-Agency Sexual Exploitation	(MASE)
National Chlamydia Screening Programme	(NCSP)
National Institute for Clinical Excellence	(NICE)
Nicotine Replacement Therapies	(NRT)
National Reporting and Learning Service	(NRLS)
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 and Outcomes Framework	(QOF)
Quality, Innovation, Productivity and Prevention programme	(QIPP)
Queen Mary's, Sidcup	(QMS)
Secure Treatment Unit	(STU)
Serious Case Review	(SCR)
Sex and Relationship Education	(SRE)
Sexually transmitted infections	(STIs)
South London Healthcare Trust	(SLHT)
Special Educational Needs	(SEN)
Summary Care Record	(SCR)
Supported Improvement Adviser	(SIA)
Sustainability and Transformation Plans	(STP)
Tailored Dispensing Service	(TDS)
Unitary Tract Infections	(UTI)
Urgent Care Centre	(UCC)
Voluntary Sector Strategic network	(VSSN)
Winterbourne View Joint Improvement Programme	(WVJIP)

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