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DATE: 22 November 2017

HEALTH AND WELLBEING BOARD INFORMATION BRIEFING

Meeting to be held on Thursday 30 November 2017

QUESTIONS ON THE INFORMATION BRIEFING

The Briefing comprises:

Members and Co-opted Members have been provided with advanced copies of the Part 1 (Public) briefing via email. The Part 1 (Public) briefing is also available on the Council website at the following link:

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

Printed copies of the briefing are available upon request by contacting Kerry Nicholls on 020 8313 4602 or by e-mail at kerry.nicholls@bromley.gov.uk.

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

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Update on Section 7a Screening and Immunisation Programmes August 2017

Update to ADPH on Section 7a Screening and Immunisation Programmes in London August 2017

Prepared by: Dr Catherine Heffernan, Principal Advisor for Commissioning Early Years, Immunisations and Vaccination Services ; Dr Jane Scarlett, Consultant Lead for Antenatal and Newborn Screening; Dr Josephine Ruwende, Consultant Lead for Cancer Screening

Classification: External

The NHS Commissioning Board (NHS CB) was established on 1 October 2012 as an executive non-departmental public body. Since 1 April 2013, the NHS Commissioning Board has used the name NHS England for operational purposes.

Contents

1 Aim

- This update is our quarterly update primarily intended for Directors of Public Health and CCGs in London by the joint NHSE (London) and PHE Public Health Commissioning Team.
- These updates comprise of news on the latest developments, new programmes or initiatives, challenges and progress made on improving uptake and delivery of screening and immunisation programmes in London.

2 Immunisations

2.1 Maternal & Targeted Neonatal Vaccinations

- NHSE (London) is piloting delivery of season 'flu and pertussis vaccination services within maternity units across London. This is a two year project and consists of a number of different models of delivery being trialled. It is envisioned that this programme will not only bring about an extension of patient choice (seasonal influenza vaccines are already offered in pharmacy and both pertussis and 'flu vaccine are offered in GP practices) but will help ensure that advice on and offer of vaccinations are part of the maternal pathway.
- The restrictions on BCG Intervax stock orders were lifted and PHE London TB team have communicated with London TB services about reinstating their access to BCG stocks. In a letter dated 3/8/2017, the Principal Advisor wrote to CCGs about vaccinating those children in the priority group C (previously unvaccinated children aged 1 to 5 years living in areas of the UK where the annual incidence of TB is 40/100,000 or greater; or with a parent or grandparent who was born in a country where the annual incidence of TB is 40/100,000 or greater). Whilst a more systematic approach is being developed, vaccination of overlooked eligible one year olds is being dealt with on a case by case basis. NHSE (London) remains committed to investing in and growing the BCG vaccinating workforce and continues to work with all maternity providers in providing universal access with targeted follow up in the community. The six high risk boroughs in 2016 – i.e. Newham, Ealing, Brent, Hounslow, Redbridge and Harrow remain receiving universal offer up to 12 months.
- The neonatal Hep B CHIS failsafe has been underway the past three months and the ordering and storage of dried blood spot kits (DBS) for London has been resolved with a community pharmacy (with a wholesale licence) holding the account for London. The London Neonatal Hep B protocol (formerly called pathway) was delayed whilst processes around these aspects were resolved. The protocol can now be released in September.

2.2 Childhood Immunisations

- Quarter 1 2017/18 COVER is the first submission by the 4 London CHIS Hubs. This production has uncovered a number of issues around the previous collation of data including a large proportion of GP practices that had not signed data sharing agreements nor submitted vaccination data to CHIS. This

number has been greatly reduced to <10 practices across London. This is being targeted through our CHIS operational and programme board meetings as well as a deep dive of a 10% audit. Overall, London's performance on the COVER indicators continues to remain stable.

- The Principal Advisor is a member of the National Immunisations Maintenance Board and through this is working with National PHE Immunisation team to undertake an analysis to explore factors affecting the timing of receipt of vaccinations in London and to update previous vaccine coverage by ethnicity analysis. She's also leading on use of Read codes by GP practices to better reflect children who were vaccinated abroad in order to reduce the number of children recorded as unvaccinated.
- From August 2017, the 6-in-1 (Hep B containing) vaccine will replace the 5-in-1 vaccine as the primaries in the routine childhood immunisation schedule. This has been widely prepared for and communicated across London.

2.3 School Age Vaccinations

- In July 2017, NHSE (London) hosted a workshop with all School Aged Vaccination (SAV) providers. The purpose of this workshop was to undertake a deep dive into the successes and challenges that were impacting on uptake in London. A number of actions came out of this workshop including improving the return of consent forms (the biggest barrier to uptake) and an escalation process for head teachers refusing entry of SAV teams. Both of these actions are in progress. It is intended to have a follow up workshop next year.
- This coming school year, the child 'flu programme will be extended to Reception and Year 4.

2.4 Adult Vaccinations

- The 2017/18 London Flu Plan has been drafted and Flu preparedness planning meetings have commenced. This year there is a focus on care home and hospice workers and mental health workers, continued focus on improving uptake of carers in pharmacy and clinical 'at risk' groups. We are also focusing on those areas of London that had frequent A&E attendances and ambulance call-outs. There is an added emphasis on improving PPV uptake, although current stock shortages have limitations for our plans.
- We've drafted a public health CQUIN for 2017/18 for ensuring all health care workers are vaccinated with MMR and pertussis (acute and community trusts).
- We're focusing on Men ACWY this summer. We've just finished a qualitative study of GP practices and SAV on why our uptake amongst 18 year olds was only 9.9% last year. These findings will be available later this year. Related to this is the pilot study with community pharmacy delivering Men ACWY to 18-25 year olds in a bid to increase access, patient choice and to bring it in line with the health seeking behaviours of this age group. This will include mobile units to universities and as pop ups at other relevant venues. This pilot will be closely monitored and evaluated.
- The joint project with the Office of CCGs for improving uptake of Shingles vaccine uptake continues. Early monitoring checks suggest improvement

above usual monthly cumulative increases in areas where vast majority of GP practices submitted data for surveillance in ImmForm. July figures overall saw a decrease in submission by practices which the Office for CCGs and NHSE are looking at to rectify for the August submissions.

2.5 London Immunisation Board

- The Quarterly Assurance Report plus updates on the Health Inequalities Strategy, London Immunisation Plan and the evaluation of local borough partnership and plans will be available in September 2017.

3 Antenatal & Newborn Screening

3.1 London ANNB Screening P&Q Boards

LA Public Health and CCG maternity commissioners are included in the membership of the Boards, and meeting papers are circulated prior to the meetings. Please contact the ANNB screening team in NHSEL if you are able to attend or send a representative to the meeting.

Meeting	Date and Time	Venue and commissioning lead
SWL ANNB Screening P&Q Board	Wednesday 6th September, 9.30-11.15 Tuesday 28th November, 9.30-11.30	Skipton House, Lucy Smith
SEL ANNB Screening P&Q Board	Wednesday 13th September, 9.30-11.15 Thursday 27th December, 9.30-11.30	Skipton House, Colette Scrace
NWL ANNB Screening P&Q Board	Thursday 14th September 2017, 2.30-4.30 Friday 8th December, 9.30-11.30	Skipton House, Brigitte Dingle
NCL ANNB Screening P&Q Board	Monday 11th September, 10.00-12.30 tbc	Skipton House, Shona Ash
NEL ANNB Screening P&Q Board	Monday 18th September, 10.00-12.30 Tuesday 28th November, 12.30-3.00	Skipton House, Petra Charlemagne

3.2 Foetal anomaly screening (FASP, includes Down's Syndrome, Edwards' Syndrome and Patau's Syndrome)

The two components to this programme were outlined in the Dec 2015 update. The FASP KPI measures the completeness of the information provided in the laboratory request form, which is needed for the risk calculation. The acceptable target for this is 97.0% and achievable is 100%. Four maternity providers did not meet the acceptable standard in Q3 2016/17.

KPI FA1 Satisfactory completion of laboratory request forms Q3 2016/17

Area	Performance %
England	97.5
London	98.3
Highest in London	99.6
Lowest in London	94.8

Source: https://www.gov.uk/government/publications/nhs-screening-programmes-kpi-reports-2016-to-2017

NHSEL is continuing to discuss with units the use of electronic request forms, with the aim of improving on the poor performance from those units which are consistently not able to meet even the minimum standard for this KPI. These discussions include the laboratories to encourage them to incorporate electronic forms in their IT systems. Nationally, laboratory QA is being moved from the Screening Quality

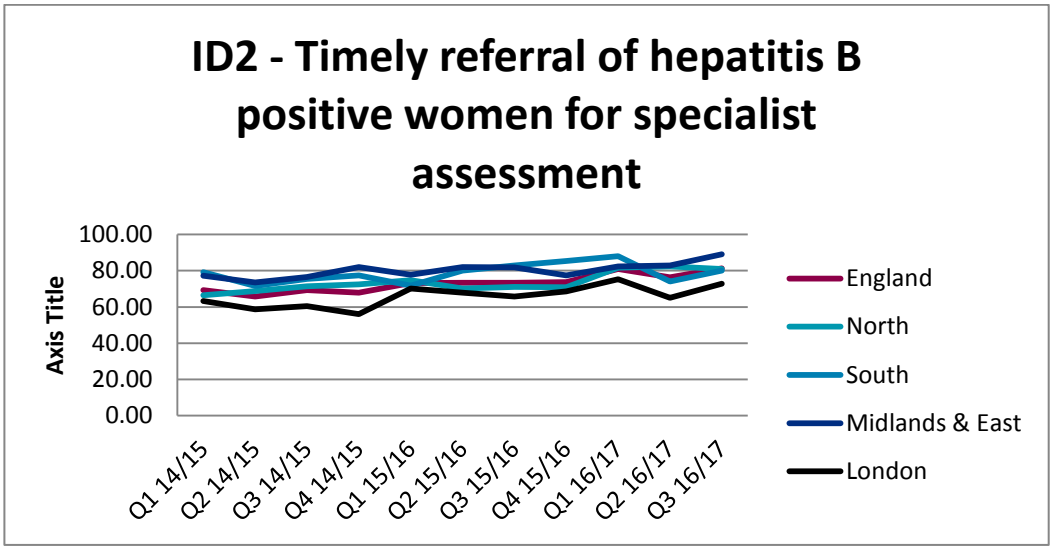
Assurance Service (SQAS) to the UK Accreditation Service (UKAS) and laboratory standards will be a focus for work in 2017/18.

Non-invasive Pre-natal Testing (NIPT) is being introduced as an evaluative roll-out from 2018. Several national groups have been established to plan this. The test will be available for women who have a primary screening risk calculation of 1 in 150 or higher. Maternity units have been asked to identify 3 leads per unit to attend national training from September, and to then cascade this training through their local maternity units.

A new KPI is being introduced from April 2016, and data collection is now being rolled out. This indicator looks at coverage of the fetal anomaly scan, which is carried out at 18 to 20 weeks gestation. The FA2 indicator measures the proportion of pregnant women eligible for fetal anomaly screening for whom a conclusive screening result is available within the designated timescale. This KPI is collected and presented 2 quarters in arrears. As a new KPI in the first year of collection, FA2 is being used by healthcare professionals and quality assurance services as an experimental indicator. In this period data quality and completeness is being improved, with the planned formal publication of data from 2017/18. Preliminary reporting across London shows 18 of the 25 (72%) maternity units were able to report on the KPI, compared to 67.6% of maternity units in England. This is a small improvement on Q2, where 16 units were able to report.

3.3 Infectious Disease Screening

Timely referral of hepatitis B positive women for specialist assessment
Women found to be Hep B positive should be referred to a liver disease specialist within 6 weeks, for full assessment, treatment if indicated, and to plan for the birth of the baby. This is a KPI, with the acceptable standard that 70% of women seen within 6 weeks and the achievable standard 90%. This standard and indicator changed in 2016 to include only women who are newly diagnosed hepatitis B positive or are already known to be hepatitis B positive with high infectivity markers detected in the current pregnancy. This means that from Q1 2016/17 the denominator is smaller, and so difficulties in achieving the target levels should be reduced. Due to small numbers, quarterly KPI data is not published for this indicator below regional level.



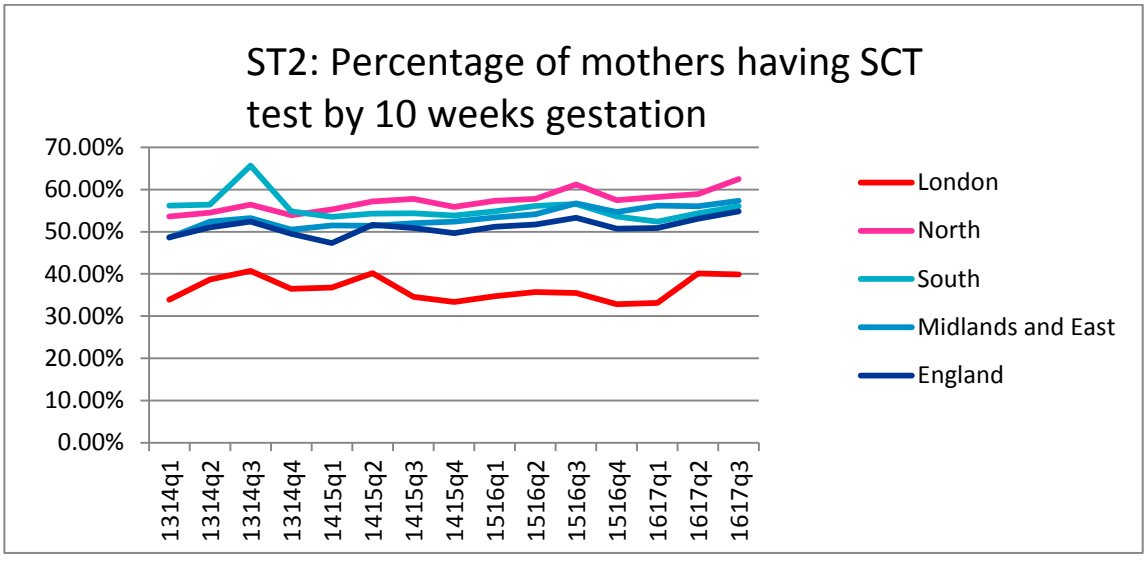
For Q3 2016/17, there were 17 women in North Region not seen within 6 weeks, 8 in South region, 11 in Midlands and East Region and 22 women in London. The new indicator does not show the total number of Hep B positive women by region, only those who need to be seen within six weeks. For the first time, this number for London is similar to other regions, with 26.0% of these women in London. Providers in London are asked to give exception reports including the reason for any woman not being seen within the 6 weeks deadline, and when those women are seen. Achieving this standard is a challenge for many units and improvement plans are in place with providers.

3.4 Sickle Cell and Thalassaemia Screening

Coverage of Sickle Cell and Thalassaemia (SCT) testing
Coverage of testing is good, with London the best performing of the four regions, and all maternity units able to meet the acceptable standard in Q3 of 2016/17.

Timeliness of Sickle Cell and Thalassaemia (SCT) testing
Timeliness of Sickle Cell and Thalassaemia screening is an ongoing issue across London. Performance is improving in some maternity providers, although this is masked by ongoing work to improve the accuracy of the reported data. One problem identified was maternity units using date of booking as a proxy for date of the result being available. This spuriously increases the proportion of women showing as having a result within the timescale, and work to improve on the data accuracy has led to a dip in the reported performance data across London.

The quarterly KPI for timeliness show improvement in performance across some trusts, with six trusts able to reach acceptable performance in Q3 2016-17, improved from 4 in Q1 and 5 in Q2. Many others are approaching the acceptable level. In contract, four trusts are below 20% of women with a result by 10 weeks, and the lowest performer has only 0.9% of women having a result by this gestation. The implication for couples of late diagnosis of affected pregnancies was discussed in the September 2016 update. London performs very poorly for this indicator compared to the other three regions, all of which are consistently able to meet the acceptable standard.



NHSEL have repeated the Health Equity Audit of early bookings in order to look more closely at the factors affecting this KPI. The report has been circulated to Directors of Public Health, and those in the boroughs served by the lowest performers will be contacted with the aim of increasing early bookings and so reducing inequalities in access to maternity care. Of the five maternity units not taking part in the audit, two had fewer than 20% of women with a result by 10 weeks gestation, and none had achieved the acceptable level. The health benefits to the mother and baby of early booking are well documented, and DsPH are asked to continue to encourage all women to book early for antenatal care.

Nationally, a new KPI will be introduced from next year which will measure the proportion of couples able to access diagnostic testing by 12 weeks gestation.

The quarterly KPI for completion of the family origin questionnaire shows variable performance across London. Some maternity units are able to consistently meet the achievable standard, while others consistently fail to reach even the acceptable standard. This is a similar issue to the Down's Syndrome laboratory request form, and again NHSEL are encouraging maternity units to commission their haematology laboratories to support use of electronic questionnaires.

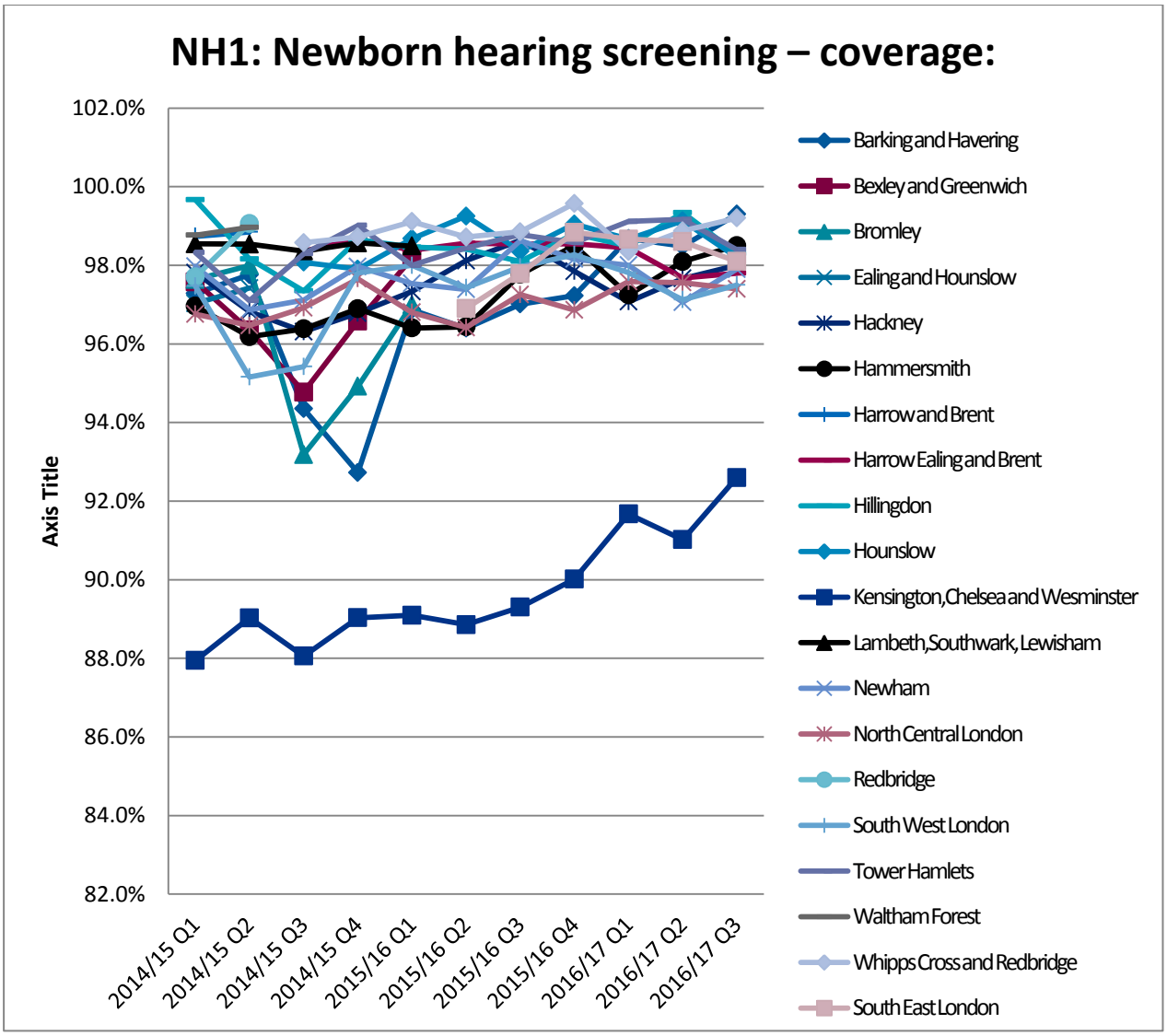
3.5 Newborn Hearing Screening

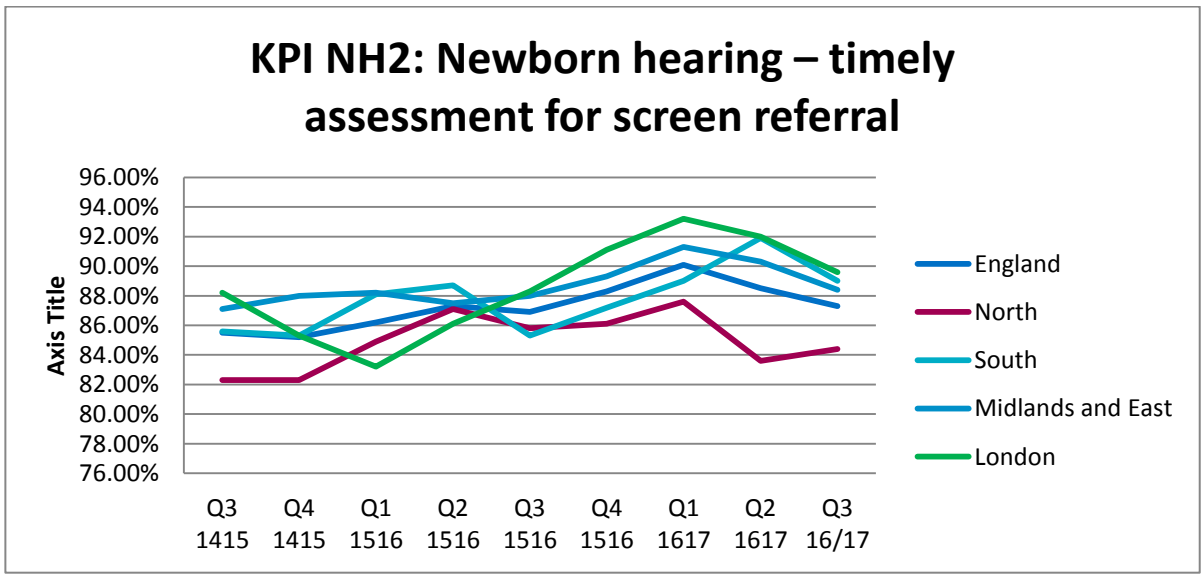
One KPI for newborn hearing screening is published quarterly by provider, KPI NH1, which measures the proportion of babies who receive a hearing screen within 4 weeks of birth. This KPI is collected by screening provider, and there have been several changes of provider sites across London.

The acceptable level for this KPI is 97%, and performance has consistently been adequate for this indicator, with the exception of Kensington, Chelsea and Westminster. This is due to the high proportion of babies born in a private maternity unit. As from October 2016, NHS South West London Newborn hearing screening programme will be contracted by the Portland Hospital to screen their babies, and national data collection will reflect this as of March 2017 (so will show from the Q3 2016/17 data, with full implementation showing from Q4). The figure below shows the coverage by provider unit, and shows how performance has become more consistent in the past year.

Since establishing a hub and spoke model of service across South East London, coverage across the area covered by that service has improved, and for the past four quarters has been above the acceptable threshold. This has had an appreciable impact on coverage across London as a whole.

KPI NH2 measures the timely assessment for screen referrals, with a requirement that babies receive audiological assessment either within 4 weeks of the decision that referral for assessment is required or by 44 weeks gestational age. This is reported quarterly by region but only annually by provider unit because of small numbers.


NH1: Newborn hearing screening – coverage:
102.0%
100.0%
98.0%
96.0%
94.0%
92.0%
90.0%
88.0%
86.0%
84.0%
82.0%
Axis Title
2014/15 Q1
2014/15 Q2
2014/15 Q3
2014/15 Q4
2015/16 Q1
2015/16 Q2
2015/16 Q3
2015/16 Q4
2016/17 Q1
2016/17 Q2
2016/17 Q3
Barking and Havering
Bexley and Greenwich
Bromley
Ealing and Hounslow
Hackney
Hammersmith
Harrow and Brent
Harrow Ealing and Brent
Hillingdon
Hounslow
Kensington,Chelsea and Wesminster
Lambeth,Southwark, Lewisham
Newham
North Central London
Redbridge
South West London
Tower Hamlets
Waltham Forest
Whipps Cross and Redbridge
South East London


KPI NH2: Newborn hearing – timely assessment for screen referral
96.00%
94.00%
92.00%
90.00%
88.00%
86.00%
84.00%
82.00%
80.00%
78.00%
76.00%
Axis Title
Q3 1415
Q4 1415
Q1 1516
Q2 1516
Q3 1516
Q4 1516
Q1 1617
Q2 1617
Q3 16/17
England
North
South
Midlands and East
London

3.6 Newborn Infant Physical Examination

The national NIPE screening programme covers the 72 hour examination of hips, heart, eyes and testes. Many maternity units also include other clinical examinations, but these are not a formal part of the NIPE screen. The NIPE handbook includes guidance on the 6-8 week NIPE examination, which GPs can work to, but this is not yet part of the screening programme. The handbook is available at https://www.gov.uk/government/publications/newborn-and-infant-physical-examination-programme-handbook

Reporting the NIPE KPIs is now mandatory, and overall for England there is now 93.8% completeness of reporting. Within London this is 96%, with only one trust in London which is not able to report the KPI. NHSE is now beginning to focus on the performance of those units able to report as well as on whether or not units are able to report, since many of the units reporting are not meeting acceptable standard for timely coverage of NIPE. The main difficulties for most unites are completeness of data capture rather than underlying performance, and action plans are in place.

KPI NP1 Newborn and infant physical examination – coverage Q3 2016/17

Area	Performance %
England	93.2
London	91.0
Highest in London	99.2%
Lowest in London	40.8%

Source: https://www.gov.uk/government/publications/nhs-screening-programmes-kpi-reports-2016-to-2017

KPI NP2, timely assessment of developmental dysplasia of the hip, measures the proportion of babies who have a positive screening test on newborn physical examination and undergo assessment by specialist hip ultrasound within 2 weeks of age. Due to small numbers this KPI will be publically reported annually by provider. For Q3 2016/17 three maternity units in London were not able to return data, so overall data completeness for London was 88%, compared to 84.8% for England as a whole. Quality of data collected is improving but is not yet sufficiently robust to allow interpretation.

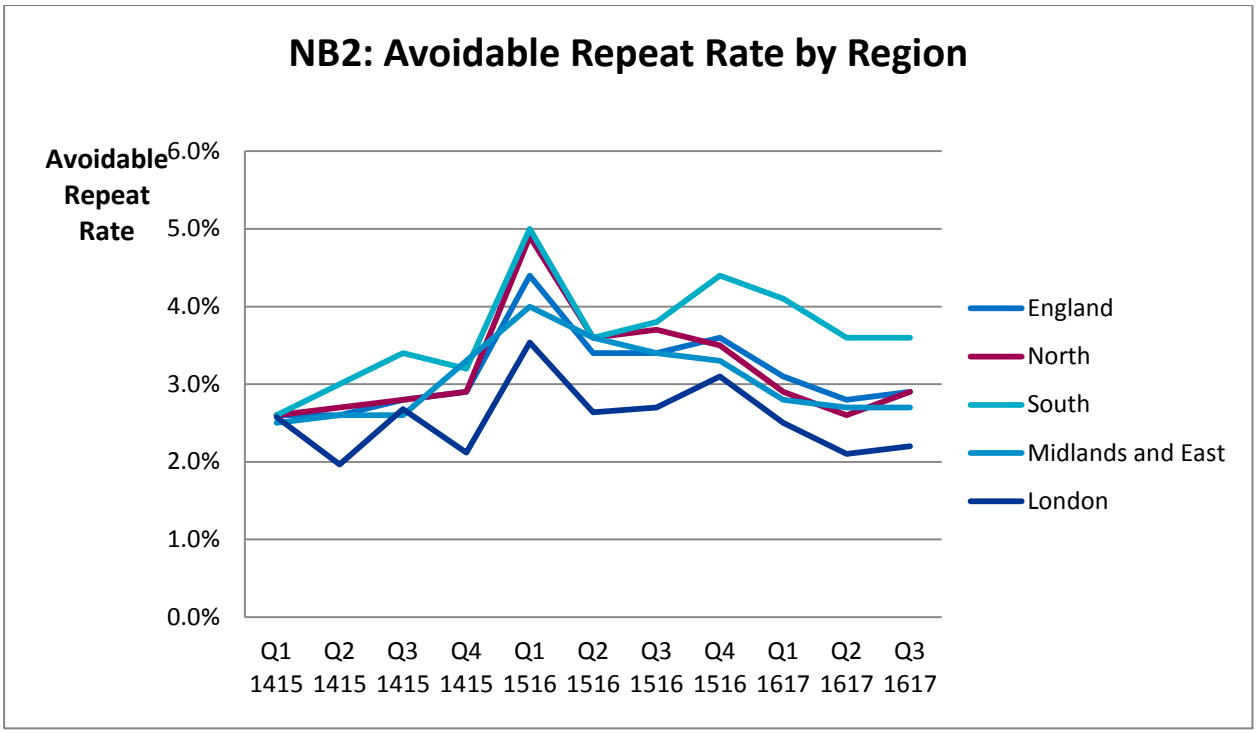
KPI NP2 Timely assessment of developmental dysplasia of the hip Q2 2016/17

Area	Performance %
England	50.4
North	57.2
South	33.7
Midlands and East	64.9
London	35.2

Source: https://www.gov.uk/government/publications/nhs-screening-programmes-kpi-reports-2016-to-2017

3.7 Newborn bloodspot screening

NHSEL has focused strongly on reducing the proportion of babies having an avoidable repeat bloodspot sample taken. Information on the reasons behind the avoidable repeats has been fed back to each provider, and revised trajectories will be agreed for 2017/18 with each to continue progress towards the acceptable standard of 2.0% for London as a whole, and towards the achievable standard of 1.0% for those trusts which already meet the acceptable standard.



In Q3 2016-17 there were 753 babies in London who had an avoidable blood sample, causing distress to the baby and family and cost to maternity services. The proportion of avoidable repeat samples by maternity unit varied from 0.5% in one maternity unit to 4.5%.

3.8 Incidents and Serious Incidents

The recent cyber attack has had an impact on antenatal and newborn screening programmes. The national programme leads considered risks following the attacks, in particular issues around generating NHS numbers for new babies. A decision was taken to temporarily allow newborn bloodspot cards to be processed without the babies NHS number. Some individual maternity units were also badly affected by the cyber attack, and are now reviewing lessons learned.

4 Cancer Screening

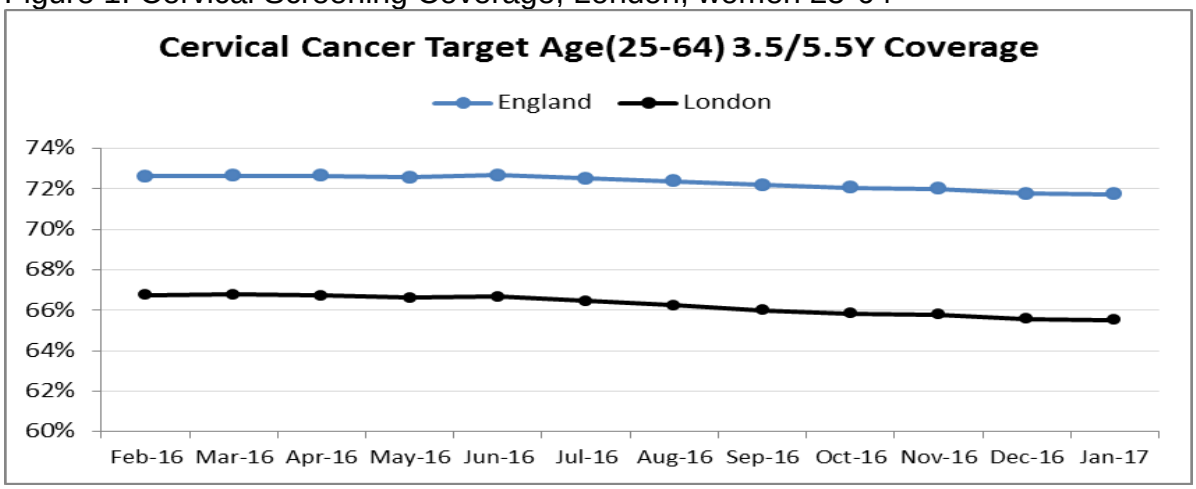
4.1 Cervical screening

4.1.1 Coverage

Cervical screening coverage declined by 1.3% between February 2016 and January 2017 (66.8 to 65.5%- Figure 1). This decline is seen in all age groups and all parts of the country. London continues to have the lowest coverage in England (65.5 vs 71.7%).

All boroughs in London fall below the 80% coverage target but rates vary from 74.8% in Bexley to 53.6% in Central London.

Figure 1: Cervical Screening Coverage, London, women 25-64



Source: Open Exeter NHSE OIC

4.1.2 Improving coverage

Texting

NHSE will be working with Primary Care Support England and a text provider to send GP Endorsed text reminders to all women invited for cervical screening in London. NHSE has taken advice from the NHS Information Commissioners Office on data protection and information governance requirements. It is anticipated that this intervention will improve uptake by up to 4%.

Survey

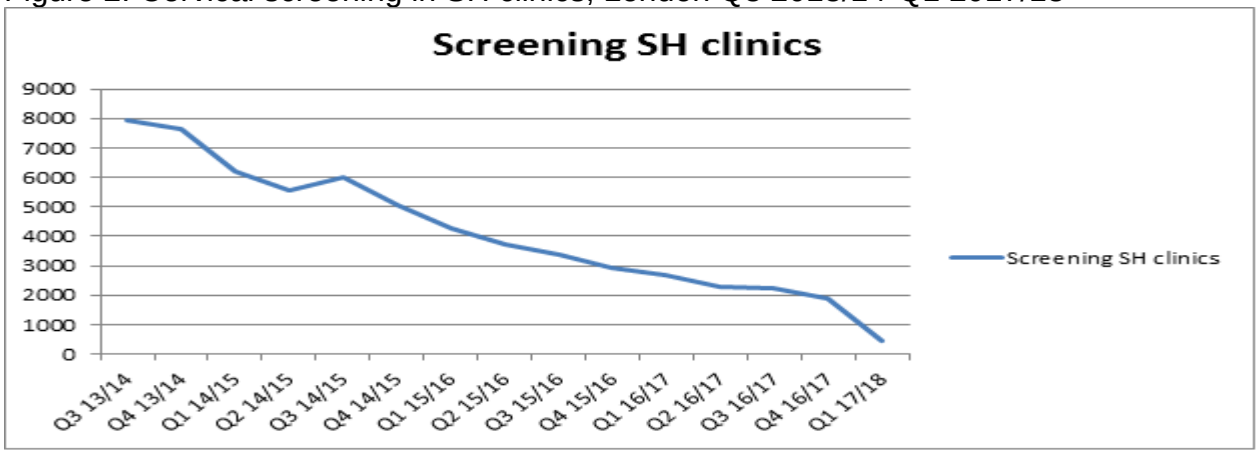
NHSE has funded Imperial University to undertake a survey to identify the barriers to attendance of cervical screening in London. It is hoped that the findings of the survey will inform future uptake improvement initiatives

Funding screening in SH clinics

To improve uptake, NHSE funded opportunistic cervical screening in sexual health clinics for women who were overdue screening[1]. Between October 2016 and June 2017, 4500 women were screened across London within sexual health clinics. This is less than the 7500 screens contracted for. This lower activity could be partly explained by the reconfiguration of SH services in London which limited provider engagement with this project. This also partly explains the continued decline in the volumes of women screened in SH services in London. (Figure 2)
NHSE is currently seeking additional funding to invest further funding for screening with new sexual health providers across London.

[1] Overdue screening- women aged 25-49 who have not been adequately screened in more than 3.5 years / women aged 50-64 who have not been adequately screened in more than 5.5 years

Figure 2: Cervical screening in SH clinics, London Q3 2013/14-Q1 2017/18



Source: Primary Care Support England

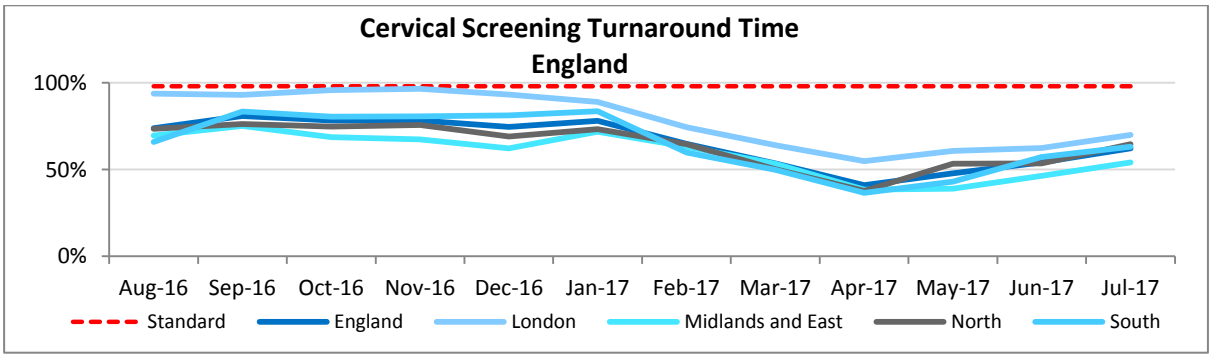
Learning Disability

NHSEL is working with Learning Disability (LD) nurses and GP practices across Barnet CCG on access issues for people with LD to improve coverage/uptake. The intention is to establish best practice and extend this work to all CCGs in London.

4.1.3 Provider Performance

Cytology performance- 14 day turnaround time vital signs
Ninety-eight percent (98%) of women should receive their results letter within 14 days of screening. Due to national shortage of cyto-screeners, cytology laboratories are struggling to process cervical samples in a timely manner resulting in large backlogs of samples. London has the best turnaround times in the country, but these fell to 55% in April but improved to 70% in July 2017. Barts (Royal London) and Barking, Havering Redbridge University Trust and Inner and Outer NE London CCGs have been most significantly affected. Both trusts have improvement plans in place so it is anticipated that the upward trajectory will continue. (Figure 3)

Figure 3: Cervical Screening Turnaround Times England



Source: Open Exeter NHSE OIC

4.1.4 Cervical screening in primary care

Sample Handling Guidelines
Implementation of the London Sample Handling Guidelines has resulted in a significant reduction in sample handling errors in primary care.

Between July 2015 and March 2017,

- Sample handling errors in London *reduced by 57%;* from 2.1% (1788) to 0.9% (516) of all samples.
- The number of out of programmes samples (women being screened too young, too early or inappropriately) *declined by 47%;* from 1.17% (663) to 0.62% (236)
- The number of women requiring a repeat screen *declined by 36%,* from 1.45% (824) to 356 (0.93%)

The effectiveness of the London Sample Handling Guidelines can be attributed to the following factors:

- the collaborative nature of the development process,
- localisation of the guidelines to London
- joint ownership by NHSE, laboratories and samples takers,
- extensive engagement with laboratories, primary care and cervical screening training providers,
- monitoring and reporting
- feedback to sample takers by laboratories
- NHSE screening team engagement with primary care staff across London

Cervical Sample Takers Database
The London Sample Takers Database was fully rolled out across London in August 2016, with 6,166 registered sample takers and 5,973 (97%) issued with unique sample taker codes.

4.1.5 Cervical screening Quality Assurance Visit themes

Cytology

- Ensure that screening safety incidents are reported in accordance with national guidance
- Annual staff screening numbers to reach minimum national standards

Colposcopy

- All colposcopists should attend at least 50% of MDT meetings to ensure the timely management of difficult cases and discordant results
- All colposcopists must see 50 new cases with ‘abnormal cytology’ (this may include normal cytology/HPV positive cases) each year in accordance with national standards
- Review clinical capacity to improve treatment of women with high grade CIN within 4 weeks, following receipt of diagnostic biopsy report
- To develop an SOP for the direct referral policy
- Ensure that screening safety incidents are reported in accordance with national guidance

4.1.6 HPV Primary Screening

The screening test
From April 2018, testing of high risk HPV (genotypes 16 and 18) will replace liquid based cytology as the screening test within the cervical screening programme. All

women will have a ‘smear’ taken as usual, which will be tested for HPV (HR HPV 16/18).

Evidence
High risk HPV is found in 99.7% of cervical cancers. Over three quarters of sexually active women will acquire the infection. It is most common in women under 35 years and most infections are transient
HPV testing is more sensitive than LBC. The test has a very high negative predictive value and therefore will be a more effective way to let women know whether they have any risk of developing cervical cancer. This will allow the screening interval to be extended.
HPV as a primary test will be cost effective, as it will save more lives, and reduce costs largely through extension of screening intervals, when confirmatory NHS Cervical Screening. HPV vaccination further strengthens the rationale for primary HPV screening as this will most accurately identify the falling proportion of HPV positive women who will remain at risk of cervical cancer

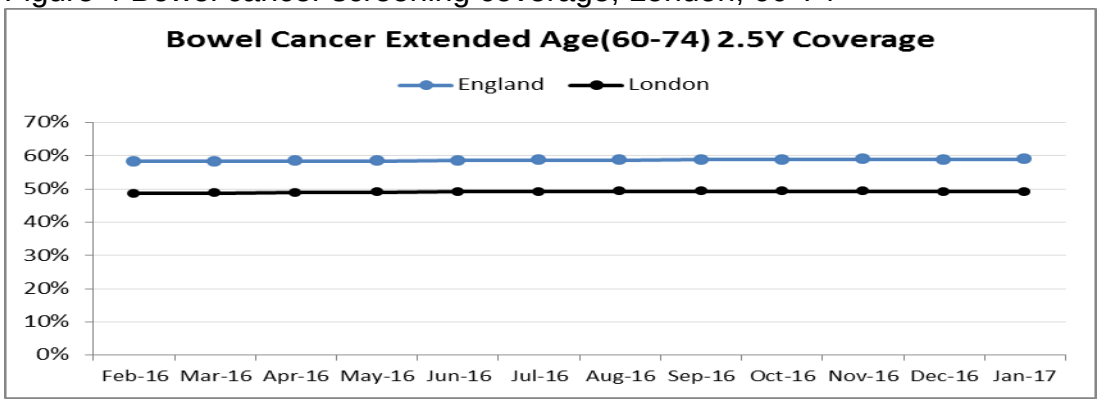
Implementation
HPV Primary Screening will be implemented across England from 2018. An 80% reduction in cytology activity is anticipated. This will require a reduction in cytology labs in London from ten (currently) to one or two. This will also require procurement of HPV/cytology labs across England.

4.2 Bowel screening

4.2.1 Uptake and coverage

Between February 2016 and January 2017, uptake increased by 2.2% (46.2% to 48.4%) and coverage increased from 48.5% to 49.2%. (Figure 4) Monthly fluctuations in uptake of +/- 2% are common in London and across the country. The higher the proportion of 60 year olds invited each month the lower the uptake. Coverage ranged from 39% in Barking and Dagenham to 58% in Bromley.

Figure 4 Bowel cancer screening coverage, London, 60-74



Source: Open Exeter NHSE OIC

4.2.2 Improving Uptake

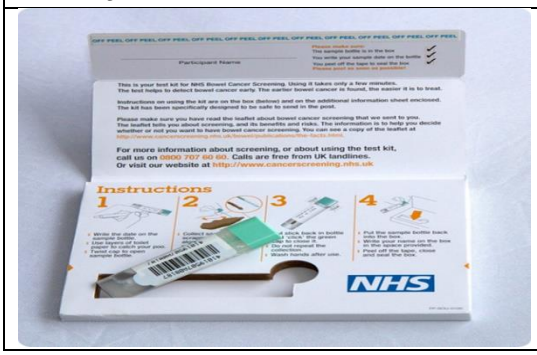
Subject to PHE Approval, NHSEL will implement text reminders within the bowel screening programme in London in 2017/18.
In 2018/19, faecal immunochemical testing will replace faecal occult blood testing within the bowel screening programme across England. Pilot studies have shown that uptake will increase by up to 7% (see section 2.4).

4.2.3 FIT

The test

From April 2018, faecal immunochemical testing will replace the faecal occult blood test within the bowel screening programme. Only one faecal sample is required for FIT as opposed to FOBt where three samples are taken on three different days.

Figure 5: NHSBCSP testing kits

FIT Kit	FOBT kit
	

Evidence
FIT is easier to use and can be measured more reliably using a machine rather than the human eye. FIT is sensitive to much smaller amount of blood than FOBt and therefore can detect cancers more reliably and at an earlier stage. The increased sensitivity enables FIT to detect more pre-cancer lesions (advanced adenomas). FIT requires a single faecal sample and is more acceptable to invited subjects which markedly increases participation rates. FIT is a cost effective alternative to FOBt.

Implementation
There is work underway across the country to determine the FIT threshold (the cut off for a positive test). This will be dependent on endoscopy capacity.

4.2.4. Bowel scope screening

Bowel scope screening (BSS) is rolling out across London. It is currently being offered in 53% of CCGs. Thirty four percent (34%) of practices and 33% of eligible men and women have been invited for screening.

4.3 Breast Screening

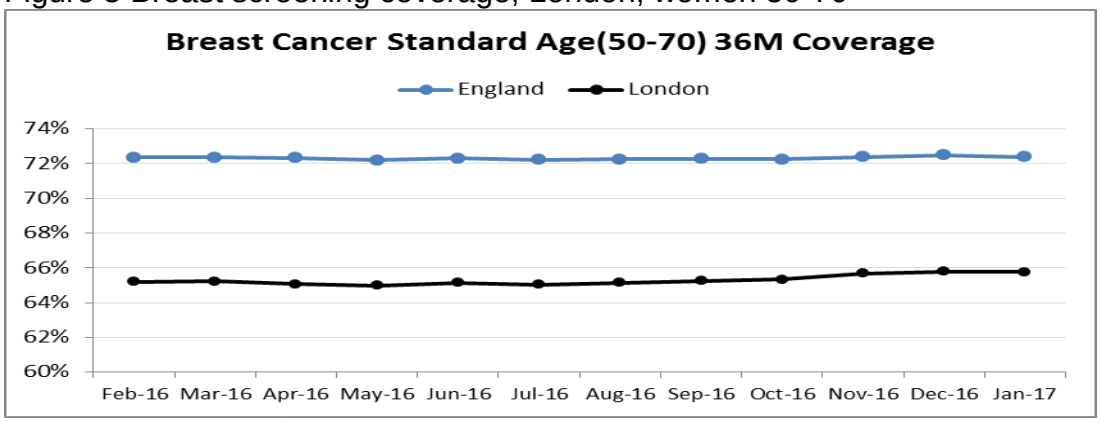
4.3.1 Uptake and coverage

Between February 2016 and January 2017 breast screening coverage in London increased by 0.6%. Coverage ranged from 57% in West London CCG to 76% in Bromley. (Figure 5)

4.3.2 Improving uptake and coverage

Expansion of text reminders using GP-held mobile phone numbers in Q4 2017/18

Figure 5 Breast screening coverage, London, women 50-70



Source: Open Exeter NHSE OIC

4.3.3 Provider performance and procurement update

The breast screening administrative functions has transferred from all units to the London Administration Hub (Royal Free). This will facilitate standardised processes and practices including but not limited to Round-Planning and Quality Management Systems.
Royal Free (NLBSS) awarded contract for delivering breast screening clinical services for Central and East London
There are concerns regarding performance and service delivery at South West London BSS (clinical); the service is currently under close observation and discussions are ongoing with PHE on the process to secure safe service delivery.
Mobilisation of clinical services from Bart's to Royal Free is challenging. Service delivery at Barts is compromised as a result of the loss of archive files. The Trust is currently working through a recovery and retrieval process. Outcome of recovery is currently unknown

5 Adult Screening

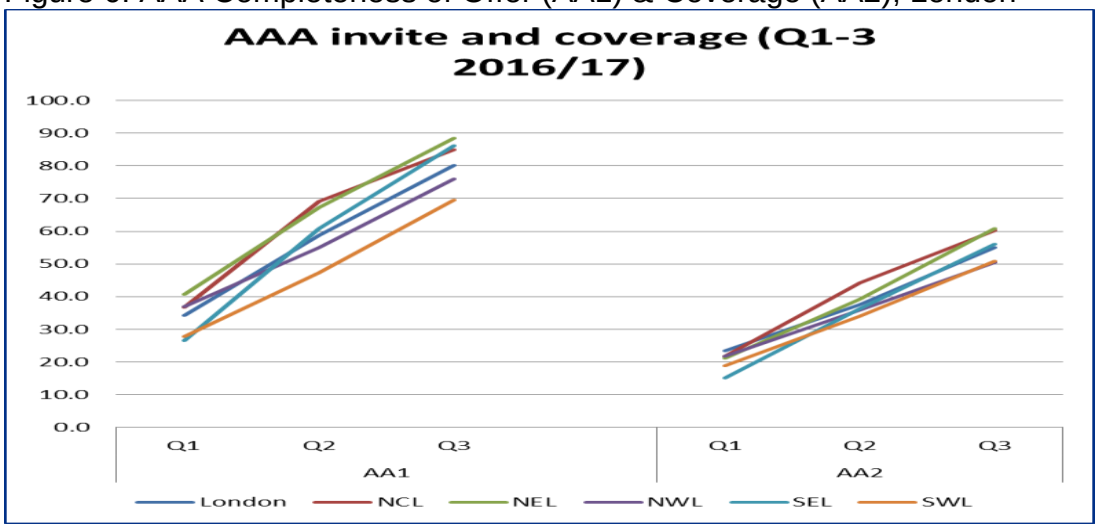
5.1 Abdominal Aortic Aneurysm Screening

5.1.1 Uptake and coverage

AAA is a one off screen for the majority of the population, as such uptake and coverage is measured cumulatively, throughout the year (Figure 6). Programmes

have different strategies and rates for inviting their cohort, making in year comparisons of uptake difficult.
Quarter 4 show uptake and coverage is comparable to 2015/16 with the exception of NWL. Uptake in NWL is anticipated to fall by approximately 10% for 2017/18. In 2016/17, significant gains were made due to a programme of promotional work that was deemed excessive and outside of the scope of the NAAASP, by the national team. Consequently a return to 2015/16 performance is anticipated. Confirmed full year uptake data will be available in September 2017

Figure 6: AAA Completeness of Offer (AA1) & Coverage (AA2), London



Source: PHE

5.1.2 Procurement

The five AAA services across London are aligned to STP borders (see Figure 7). NHSEL is currently procuring a single London-wide AAA service. Providers will be mobilised in December 2017 and the new service will commence in April 2018.

Figure 7: AAA Services in London

5.2 Diabetic Eye Screening Programme

5.2.1 The programme

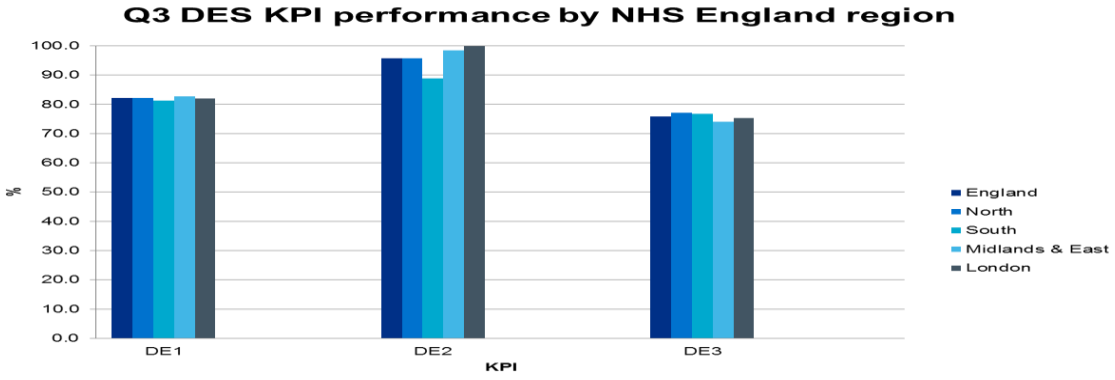
There are five DESP providers across London (Figure 8). Q3 reporting showed 425,000 individuals were eligible to receive an invitation to screening in the previous 12 months with 350,000 attending.

Figure 8: DESP Providers London

5.1.2 Provider performance

Performance of London providers compares well with the rest of country. (Figure 9) In 2015/16, a national project ran to standardise the delivery of the screening pathway and the methodology for reporting. As such accurate, validated performance data is only available from Q1 2016/17.

Figure 9: Provider performance



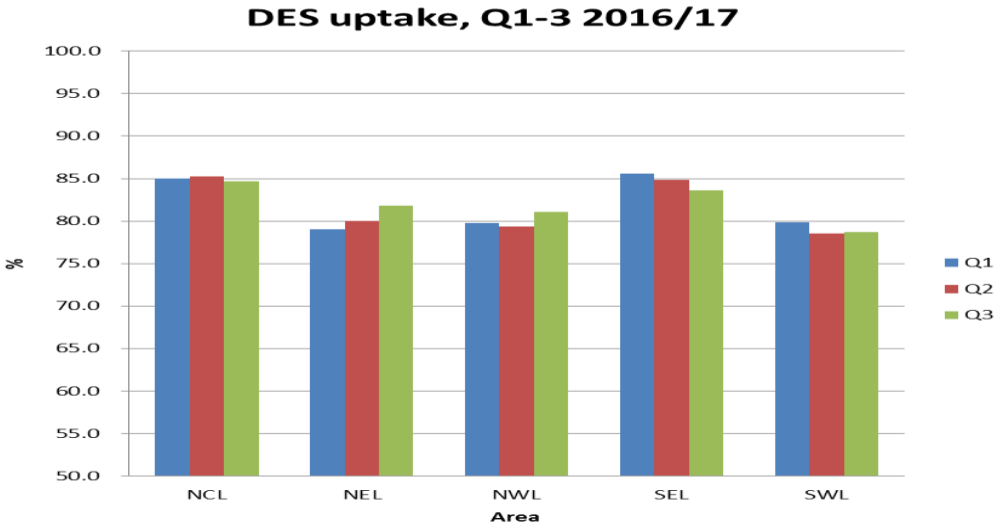
KPI	Description	Minimum Standard (%)	Achievable Standard (%)
DE1	Uptake of routine digital screening event	≥ 70.0%	≥ 80.0%
DE2	Results issued within 3 weeks of screening	≥ 70.0%	≥ 95.0%
DE3	Timely assessment for R3A screen positive		≥ 80.0%

Source: PHE

5.2.3 Uptake

Uptake across all London programmes is above acceptable standard and in most cases, equal to or greater than achievable standard. (Figure 8) Some services – i.e. SEL – have overseen a planned fall in uptake whilst the programme establishes its preferred infrastructure, to support ongoing service improvement and the capability to increase uptake further.

Figure 8: DESP Uptake London



Source: Open Exeter NHSE OIC

5.2.4 Improving Uptake

Looking forward, the implementation of the pregnancy pathway, the monitoring of performance in secure settings and the delivery of the 2017/18 CQUIN (enhanced surveillance in DESP) are the priority areas on which we will report to this Board. Services are currently undertaking HEA to understand where the area of focus is required to continue uptake and performance improvement

5.2.5 Improving quality

- Pan-London oversight and risk management group has been established with agreed ToR. The Group HAS identified work streams to support project delivery.
- EMIS - Some progress achieved with organisational restructure and key new appointments. Monthly full performance review meetings planned

6 Useful links

2017/18 NHSE Service Specifications are available at
https://www.england.nhs.uk/commissioning/pub-hlth-res/

PHE Screening professional briefing with high level national commentary on KPIs. https://www.gov.uk/government/publications/nhs-screening-programmes-kpi-reports-and-briefings-2016-to-2017

The KPI data for each programme is published online at https://www.gov.uk/government/collections/nhs-screening-programmes-national-data-reporting

Background information on cervical screening coverage and its relationship with other health data is available as well as top tips for actions that increase attendance. Data is available on the PHE Screening website and through a new interactive dashboard

Breast screening programme annual statistics 2015-16 http://content.digital.nhs.uk/article/2021/Website-Search?productid=24457&q=breast+screening+&sort=Relevance&size=10&page=1&area=both#top

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Public Health S7A Accountability Report

Supplementary DCO Report

August 2017

Prepared by:
NHS England Public Health Analyst Matrix

This report is based on performance indicators and baselines outlined in the NHS Public Health Functions Agreement, Public Health Functions to be exercised by NHS England. It is produced alongside the Public Health S7A Accountability Meeting Report for England.

Version number: 1.0

First published (internal):
11th August 2017

Updated: N/A

South London

Green indicates that current period meets or exceeds standard; amber indicates current period is below standard but meets or exceeds lower threshold; red indicates current period is below lower threshold

Childhood Immunisation Programmes

Rotavirus coverage (two dose, 12 mths)

Latest period	16-17 Q4
Lower threshold	90.0%
Standard	95.0%
Richmond upon Thames	77.0%
Croydon	85.3%
Lambeth	85.7%
Bromley	87.5%
Southwark	88.2%
Wandsworth	89.1%
Merton	92.3%
Sutton	92.4%
Greenwich	92.8%
Kingston upon Thames	93.3%
Lewisham	93.4%
Bexley	96.0%

Men B coverage (12 mths)

Latest period	16-17 Q4
Lower threshold	90.0%
Standard	95.0%
Lewisham	83.8%
Croydon	84.8%
Richmond upon Thames	85.2%
Lambeth	85.6%
Bexley	87.9%
Bromley	88.4%
Southwark	88.5%
Greenwich	92.2%
Kingston upon Thames	93.3%
Merton	98.0%
Sutton	98.0%
Wandsworth	No data

Dtap / IPV / Hib coverage (12 mths)

Latest period	16-17 Q4
Lower threshold	90.0%
Standard	95.0%
Richmond upon Thames	75.0%
Croydon	86.3%
Lambeth	88.4%
Bromley	88.7%
Greenwich	89.6%
Wandsworth	90.3%
Lewisham	91.1%
Southwark	91.9%
Bexley	92.7%
Merton	93.2%
Sutton	93.4%
Kingston upon Thames	95.3%

PCV coverage (12 mths)

Latest period	16-17 Q4
Lower threshold	90.0%
Standard	95.0%
Richmond upon Thames	75.3%
Croydon	86.4%
Bromley	88.7%
Lambeth	88.7%
Greenwich	89.3%
Wandsworth	90.8%
Lewisham	91.4%
Southwark	91.9%
Bexley	92.3%
Merton	93.6%
Sutton	93.6%
Kingston upon Thames	95.2%

Dtap / IPV / Hib coverage (2 years old)

Latest period	16-17 Q4
Lower threshold	90.0%
Standard	95.0%
Richmond upon Thames	82.9%
Croydon	90.1%
Bromley	90.3%
Wandsworth	90.7%
Greenwich	91.0%
Lambeth	91.5%
Lewisham	92.8%
Southwark	93.7%
Merton	94.1%
Sutton	94.3%
Bexley	94.5%
Kingston upon Thames	95.4%

MMR for one dose coverage (2 years old)

Latest period	16-17 Q4
Lower threshold	90.0%
Standard	95.0%
Richmond upon Thames	73.3%
Croydon	80.3%
Bromley	81.7%
Greenwich	82.8%
Lambeth	83.4%
Wandsworth	83.5%
Lewisham	85.0%
Bexley	87.5%
Southwark	88.3%
Merton	88.8%
Sutton	88.8%
Kingston upon Thames	90.5%

Hib/Men C booster coverage (2 years old)

Latest period	16-17 Q4
Lower threshold	90.0%
Standard	95.0%
Richmond upon Thames	72.4%
Croydon	80.2%
Lewisham	81.0%
Bromley	81.3%
Greenwich	82.4%
Lambeth	83.3%
Wandsworth	83.5%
Bexley	88.4%
Merton	88.6%
Sutton	88.7%
Southwark	89.3%
Kingston upon Thames	89.9%

PCV booster coverage (2 years old)

Latest period	16-17 Q4
Lower threshold	90.0%
Standard	95.0%
Richmond upon Thames	73.5%
Croydon	80.8%
Bromley	80.8%
Greenwich	82.5%
Lambeth	83.2%
Wandsworth	83.5%
Lewisham	84.0%
Bexley	88.2%
Merton	88.5%
Sutton	88.7%
Southwark	89.2%
Kingston upon Thames	89.9%

Hib / Men C booster coverage (5 years old)

Latest period	16-17 Q4
Lower threshold	90.0%
Standard	95.0%
Richmond upon Thames	84.5%
Croydon	84.7%
Lewisham	86.0%
Greenwich	86.2%
Wandsworth	87.8%
Merton	88.1%
Sutton	88.2%
Southwark	88.3%
Kingston upon Thames	90.2%
Lambeth	90.2%
Bexley	92.7%
Bromley	93.4%

MMR for one dose coverage (5 years old)

Latest period	16-17 Q4
Lower threshold	90.0%
Standard	95.0%
Richmond upon Thames	86.7%
Croydon	88.2%
Greenwich	89.0%
Merton	89.7%
Southwark	89.7%
Wandsworth	89.7%
Sutton	89.7%
Lewisham	90.8%
Lambeth	91.0%
Kingston upon Thames	93.4%
Bexley	94.1%
Bromley	95.2%

MMR for two doses coverage (5 years old)

Latest period	16-17 Q4
Lower threshold	90.0%
Standard	95.0%
Richmond upon Thames	65.8%
Croydon	71.3%
Bromley	77.4%
Merton	79.7%
Sutton	79.7%
Bexley	82.2%
Kingston upon Thames	82.5%
Wandsworth	83.2%
Greenwich	84.1%
Lambeth	85.3%
Lewisham	86.2%
Southwark	86.4%

DTaP/IPV/Hib coverage (5 years old)

Latest period	16-17 Q4
Lower threshold	90.0%
Standard	95.0%
Croydon	90.4%
Richmond upon Thames	91.8%
Greenwich	91.9%
Southwark	92.2%
Merton	92.7%
Sutton	92.8%
Wandsworth	93.4%
Lewisham	93.9%
Lambeth	94.2%
Kingston upon Thames	95.6%
Bexley	95.6%
Bromley	96.3%

DTaP/IPV booster coverage (5 years old)

Latest period	16-17 Q4
Lower threshold	90.0%
Standard	95.0%
Richmond upon Thames	31.8%
Wandsworth	68.2%
Croydon	70.7%
Greenwich	73.9%
Bexley	74.7%
Bromley	76.8%
Merton	76.9%
Lambeth	76.9%
Sutton	77.1%
Lewisham	77.4%
Southwark	77.5%
Kingston upon Thames	82.8%

South London

Green indicates that current period meets or exceeds standard; amber indicates current period is below standard but meets or exceeds lower threshold; red indicates current period is below lower threshold

Other Immunisation Programmes

HPV coverage one dose (females 12-13 year olds)

Latest period	2015/16
Lower threshold	80.0%
Standard	90.0%
Lewisham	74.9%
Croydon	78.5%
Greenwich	80.2%
Lambeth	86.2%
Richmond upon Thames	86.5%
Bromley	87.8%
Merton	88.6%
Bexley	89.0%
Southwark	89.7%
Sutton	89.8%
Kingston upon Thames	90.6%
Wandsworth	94.3%

HPV coverage two doses (females 13-14 year olds)

Latest period	2015/16
Lower threshold	80.0%
Standard	90.0%
Lewisham	75.8%
Richmond upon Thames	77.0%
Croydon	80.4%
Wandsworth	83.9%
Greenwich	84.0%
Lambeth	84.1%
Southwark	84.5%
Merton	86.4%
Bexley	86.5%
Bromley	86.9%
Kingston upon Thames	88.6%
Sutton	89.0%

Flu vaccination coverage (school age children) inc. those in risk groups

Latest period	2016/17
Lower threshold	50.0%
Standard	65.0%
Lambeth	42.6%
Croydon	46.6%
Southwark	46.9%
Lewisham	47.8%
Wandsworth	48.1%
Greenwich	50.6%
Bexley	53.3%
Merton	54.2%
Bromley	57.4%
Sutton	59.3%
Kingston upon Thames	61.6%
Richmond upon Thames	64.8%

3.03xv: Flu vaccination coverage (at risk individuals from age six months to under 65 years, excluding pregnant women)

Latest period	2016/17
Lower threshold	50.0%
Standard	55.0%
Richmond upon Thames	41.9%
Bexley	44.4%
Wandsworth	44.9%
Bromley	45.2%
Lambeth	45.2%
Croydon	46.0%
Sutton	46.3%
Merton	46.4%
Southwark	47.3%
Kingston upon Thames	47.5%
Lewisham	48.3%
Greenwich	50.0%

3.03xiv: Flu vaccination coverage (aged 65 and over)

Latest period	2016/17
Lower threshold	70.0%
Standard	75.0%
Merton	63.4%
Croydon	63.9%
Lambeth	63.9%
Bexley	64.3%
Southwark	65.3%
Wandsworth	65.3%
Sutton	65.4%
Richmond upon Thames	65.6%
Kingston upon Thames	66.2%
Bromley	67.0%
Lewisham	67.5%
Greenwich	68.1%

PPV coverage (aged 65 and over)

Latest period	2016/17
Lower threshold	65.0%
Standard	75.0%
NHS Southwark CCG	57.6%
NHS Lambeth CCG	61.1%
NHS Wandsworth CCG	61.4%
NHS Bromley CCG	62.9%
NHS Greenwich CCG	63.9%
NHS Kingston CCG	63.9%
NHS Croydon CCG	64.0%
NHS Merton CCG	64.4%
NHS Richmond CCG	65.2%
NHS Bexley CCG	65.2%
NHS Sutton CCG	70.3%
NHS Lewisham CCG	72.3%

Shingles vaccination coverage (70 years old)

Latest period	2015/16
Lower threshold	50.0%
Standard	60.0%
NHS Greenwich CCG	38.4%
NHS Lambeth CCG	41.7%
NHS Southwark CCG	42.3%
NHS Bexley CCG	45.8%
NHS Croydon CCG	47.0%
NHS Lewisham CCG	48.0%
NHS Merton CCG	48.2%
NHS Wandsworth CCG	48.4%
NHS Bromley CCG	48.8%
NHS Richmond CCG	50.5%
NHS Kingston CCG	50.9%
NHS Sutton CCG	58.0%

Shingles vaccination coverage (catch-up cohort 78-year olds)

Latest period	2015/16
Lower threshold	50.0%
Standard	60.0%
NHS Greenwich CCG	37.0%
NHS Southwark CCG	37.6%
NHS Lambeth CCG	40.5%
NHS Lewisham CCG	43.6%
NHS Bexley CCG	46.5%
NHS Wandsworth CCG	47.1%
NHS Merton CCG	47.2%
NHS Croydon CCG	47.6%
NHS Bromley CCG	49.7%
NHS Richmond CCG	56.3%
NHS Kingston CCG	56.8%
NHS Sutton CCG	58.3%

South London

Green indicates that current period meets or exceeds standard; amber indicates current period is below standard but meets or exceeds lower threshold; red indicates current period is below lower threshold

Cancer Screening Programmes

2.20i: Breast cancer screening coverage [50-70]

Latest period	Dec-16
Lower threshold	70.0%
Standard	80.0%

NHS Lambeth CCG	61.3%
NHS Wandsworth CCG	62.6%
NHS Greenwich CCG	62.7%
NHS Southwark CCG	63.6%
NHS Croydon CCG	65.3%
NHS Lewisham CCG	65.5%
NHS Kingston CCG	66.4%
NHS Richmond CCG	66.7%
NHS Merton CCG	67.6%
NHS Sutton CCG	70.3%
NHS Bromley CCG	75.4%
NHS Bexley CCG	75.8%

2.20ii: Cervical cancer screening coverage [25-64]

Latest period	Dec-16
Lower threshold	75.0%
Standard	80.0%

NHS Southwark CCG	66.3%
NHS Lambeth CCG	66.7%
NHS Wandsworth CCG	66.7%
NHS Merton CCG	67.0%
NHS Kingston CCG	67.2%
NHS Greenwich CCG	68.5%
NHS Lewisham CCG	68.6%
NHS Richmond CCG	70.0%
NHS Croydon CCG	70.2%
NHS Sutton CCG	73.0%
NHS Bromley CCG	73.7%
NHS Bexley CCG	74.8%

2.20iii - Bowel cancer screening coverage [60-74]

Latest period	Dec-16
Lower threshold	55.0%
Standard	60.0%

NHS Southwark CCG	42.0%
NHS Lambeth CCG	42.2%
NHS Lewisham CCG	46.3%
NHS Greenwich CCG	48.4%
NHS Wandsworth CCG	51.5%
NHS Croydon CCG	51.6%
NHS Merton CCG	52.0%
NHS Kingston CCG	55.7%
NHS Bexley CCG	56.0%
NHS Sutton CCG	56.5%
NHS Richmond CCG	57.2%
NHS Bromley CCG	57.7%

Screening Programmes

2.20v: Diabetic eye screening – uptake (DE1)

Latest period	16-17 Q3
Lower threshold	70.0%
Standard	80.0%

South West London Diabetic Eye Screening Programme	78.7%
South East London Diabetic Eye Screening Programme	83.6%

2.20vii: Infectious diseases in pregnancy screening – HIV coverage (ID1)

Latest period	16-17 Q3
Lower threshold	95.0%
Standard	99.0%

Lewisham and Greenwich NHS Trust (Lewisham)	99.6%
Epsom and St Helier University Hospitals NHS Trust	99.6%
King's College Hospital NHS Foundation Trust (PRUH)	99.9%
Croydon Health Services NHS Trust	99.9%
Guy's and St Thomas' NHS Foundation Trust	100.0%
King's College Hospital NHS Foundation Trust	100.0%
Kingston Hospital NHS Foundation Trust	100.0%
Lewisham and Greenwich NHS Trust (QEH)	100.0%
St George's University Hospitals NHS Foundation Trust	100.0%

2.20x: Sickle cell and thalassaemia screening – coverage (ST1)

Latest period	16-17 Q3
Lower threshold	95.0%
Standard	99.0%

Lewisham and Greenwich NHS Trust (Lewisham)	99.7%
King's College Hospital NHS Foundation Trust (PRUH)	99.9%
Croydon Health Services NHS Trust	99.9%
Epsom and St Helier University Hospitals NHS Trust	99.9%
Guy's and St Thomas' NHS Foundation Trust	99.9%
King's College Hospital NHS Foundation Trust	100.0%
Kingston Hospital NHS Foundation Trust	100.0%
Lewisham and Greenwich NHS Trust (QEH)	100.0%
St George's University Hospitals NHS Foundation Trust	100.0%

South London

Green indicates that current period meets or exceeds standard; amber indicates current period is below standard but meets or exceeds lower threshold; red indicates current period is below lower threshold

2.20xi: Newborn blood spot screening – coverage (CCG responsibility at birth) (NB1)

	Latest period	16-17 Q3
	Lower threshold	95.0%
	Standard	99.9%
NHS Richmond		96.5%
NHS Croydon		97.6%
NHS Bexley		98.2%
NHS Greenwich		98.5%
NHS Lewisham		98.8%
NHS Lambeth		98.8%
NHS Southwark		98.9%
NHS Bromley		98.9%
NHS Merton		98.9%
NHS Sutton		99.2%
NHS Kingston		99.3%
NHS Wandsworth		99.5%

2.20xii: Newborn hearing screening – coverage (NH1)

	Latest period	16-17 Q3
	Lower threshold	97.0%
	Standard	99.5%
South West London		97.5%
South East London		98.1%

2.20xiii: Newborn and infant physical examination screening – coverage (NP1)

	Latest period	16-17 Q3
	Lower threshold	95.0%
	Standard	99.5%
Lewisham and Greenwich NHS Trust (Lewisham)		91.7%
St George's University Hospitals NHS Foundation Trust		91.7%
Epsom and St Helier University Hospitals NHS Trust		92.5%
King's College Hospital NHS Foundation Trust		93.3%
Lewisham and Greenwich NHS Trust (QEH)		93.7%
Guy's and St Thomas' NHS Foundation Trust		94.1%
King's College Hospital NHS Foundation Trust (PRUH)		95.6%
Kingston Hospital NHS Foundation Trust		97.2%
Croydon Health Services NHS Trust		99.2%

2.20vi: Fetal anomaly screening (fetal anomaly ultrasound) – coverage (FA2)

	Latest period	16-17 Q2
	Lower threshold	90.0%
	Standard	95.0%
Lewisham and Greenwich NHS Trust (Lewisham)		88.9%
Kingston Hospital NHS Foundation Trust		90.5%
Epsom and St Helier University Hospitals NHS Trust		93.5%
Croydon Health Services NHS Trust		95.5%
Lewisham and Greenwich NHS Trust (QEH)		97.7%
Guy's and St Thomas' NHS Foundation Trust		99.9%
St George's University Hospitals NHS Foundation Trust		99.9%
King's College Hospital NHS Foundation Trust		No data
King's College Hospital NHS Foundation Trust (PRUH)		No data

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Briefing CS18103

London Borough of Bromley

PART 1 - PUBLIC

Briefing for Health and Wellbeing Board
30th November 2017

PUBLIC HEALTH PROGRAMMES PERFORMANCE UPDATE 2016/17

Contact Officer: Mimi Morris-Cotterill, Assistant Director, Public Health
Email: mimi.morriscotterill@bromley.gov.uk

Chief Officer: Director of Public Health

1. Summary

1.1 This Information Briefing provides an update on the performance of Public Health commissioned services in 2016-17 that was also considered at the meeting of Care Services PDS Committee on Tuesday 5th September 2017.

2. THE BRIEFING

2.1 The report is provided at Annex A.

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ANNEX A

Report No.
CS18061

London Borough of Bromley

PART ONE - PUBLIC

Decision Maker:	**CARE SERVICES POLICY DEVELOPMENT AND SCRUTINY COMMITTEE**
Date:	**Tuesday 5th September 2017**
Decision Type:	Non-Urgent Non-Executive Non-Key
Title:	**PUBLIC HEALTH PROGRAMMES PERFORMANCE UPDATE 2016/17**
Contact Officer:	Mimi Morris-Cotterill, Assistant Director, Public Health Email: mimi.morriscotterill@bromley.gov.uk
Chief Officer:	Director of Public Health
Ward:	Borough-wide

1. Reason for report

1.1 This report provides an update on the performance of Public Health commissioned services in 2016-17.

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2. RECOMMENDATION

2.1 The Care Services PDS Committee is requested to note the activity and performance of Public Health programmes during 2016/17.

Impact on Vulnerable Adults and Children

1. Summary of Impact: Public Health commissioned services benefit vulnerable adults and children.

Corporate Policy

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

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Financial

1. Cost of proposal: Not Applicable: All covered under existing Public Health Grant.
2. Ongoing costs: Recurring Cost: Contract management and financial support for Public Health will be part of 'Business as Usual' and will be covered through a general support recharge to Public Health.
3. Budget head/performance centre: Director of Public Health
4. Total current budget for this head: £15.1 million (2017/18)
5. Source of funding: Department of Health: Public Health Grant.

Personnel

1. Number of staff (current and additional): 25 FTE (2015/16) 19 FTE (2016/17)
2. If from existing staff resources, number of staff hours: See above.

Legal

1. Legal Requirement: Statutory Requirement
2. Call-in: Not Applicable: No Executive decision.

Procurement

1. Summary of Procurement Implications: Not Applicable

Customer Impact

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

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Ward Councillor Views

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

3. COMMENTARY

3.1 This paper reports on the 2016/17 contractual arrangements and provider performance of Public Health programmes which are grouped into three broad areas:

Adult Public Health Services

- NHS Health Checks
- Tier 2 Adult Weight Management
- Stop Smoking
- Healthy Lifestyle - Diabetes Prevention

Children and Young People Public Health Services

- National Childhood Measurement Programme (NCMP)
- Childhood Weight Management
- School Nursing
- Health Visiting
- Family Nurse Partnership

Risky Behaviour Programmes for Young People and Adults

- Sexual Health Services
- Substance Misuse

3.2 Third party organisations are commissioned to deliver the above public health services using a variety of contracting approaches, of which there are four categories:

- Category A: Standard Contracts with third party organisations
- Category B: Bromley CCG Community Block Contract with Bromley Healthcare
- Category C: Sexual Health Clinical Contracts with acute hospital providers
- Category D: Service Level Agreements with General Practitioners

Details of these are set out in Appendix 1.

Category A: Standard contracts

3.3 In 2016/17 there were 25 Category A Standard Contracts. 14 of these contracts were called off from the Council's Public Health Framework. The Framework was put in place in April 2014 with an estimated annual value of £800k. The actual spend in 2016/17 has risen to £319k, from £300k in 2015/16. The rise is due to the extension of a one-off arrangement to support those clients who remain in the system after the cessation of Stop Smoking Service.

3.4 There were 11 contracts outside the framework. Two of these, the Substance Misuse Service contracts (one for Adults and one for Young People), remain the most significant in terms of expenditure in this category. These two contracts will expire on 30 November 2017 and Executive approval was given to extend these contracts for a further year on 24 May 2017 (report CS18005).

3.5 The remaining 9 contracts have been put in place to support key Public Health outcomes.

Category B: Clinical Commissioning Group Community block contract

3.6 Bromley Clinical Commissioning Group (CCG) commissions a range of community services for Bromley residents through block contract with Bromley Healthcare (BHC), which includes Public Health Programmes.

3.7 These programmes have a total value of £6,301, in 2016/17 and are contractually managed within the block by the CCG through the section 75 agreement with the Council.

3.8 Grouped into three programmes of Sexual Health, Adult and Children and Young People, these services are tightly performance monitored directly by Public Health. There is an option to review and pull individual service lines out of the current block contract if performance problems are identified and appropriate notice is given.

3.9 The overall BHC community contract expired on 31 March 2017. The Public Health elements of the contract (Community Sexual Health services and Health Visiting service) were extended by 6 months to align them with the CCG procurement process as agreed by the Executive on 10 March 2016 (reports CS16008 and CS16025 respectively).

3.10 In addition, Oxleas NHS Foundation Trust was commissioned, through a block contract held by Bromley CCG, to provide a Dual Diagnosis Service to work alongside Substance Misuse Service with a block value of £64,000 per annum. This is a part of the Section 75 agreement with the CCG.

Category C: Sexual Health Clinical Contracts (acute)

3.11 Testing and treatment of Sexually Transmitted Infections (STIs) are statutory provision based on open access. This means Bromley residents can go for a check-up at a sexual health clinic anywhere in the country. That clinic invoices LBB based on a nationally agreed tariff. The open access nature of these 'contracts' continues to make this the most difficult of the budgets to manage.

3.12 For services in London, the Council continues the London collaborative commissioning approach with other London Boroughs in contract negotiations with London Hospital providers in each of the London sub-regions, to achieve lower unit prices and marginal rates. The negotiated contracts are held by the lead commissioner in each sub-region and in the south east London, this is Lambeth Council.

3.13 In addition, the Council is obliged to cover costs from providers who offer GUM services to any attending Bromley resident across the country. Outside London, service provisions are subject to Non-Contractual Arrangement (NCA) payable at rates negotiated by the provider's local authority commissioner in that area.

3.14 For 2016/17, the actual spend was £1,555k and despite continued growth in activities, this reflects a saving of £23k when compared to spend in 2015/16 of £1,578k and 2014/15 of £1,639k.

Table 1. Sexual Health contracts – acute GUM service

Contract	Service	14/15 Spend	15/16 Spend	16/17 Spend
In-Borough - King's College Hospital	**GUM**	**990**	**932**	**871**
Other London Providers	GUM	152	138	135
Other acute hospital providers	GUM	497	508	549
Total		**1,639**	**1,578**	**1,555**

3.15 The increased spend in other acute hospital providers in 2016/17, was due to activities at Lewisham and Greenwich NHS Trust. These activities were previously included in the block contract with their host commissioners and had since been disaggregated and charged to the appropriate commissioners, including Bromley.

Category D: Service Level Agreements with General Practices

3.16 In 2016/17 the Council continued with the Service Level Agreements (SLAs) with all 45 borough GP practices to support the delivery of Sexual Health and NHS Health Checks. The total value of the SLAs for 2016/17 was £550,000, with an actual spend of £455,490 compared to the SLA value of £603,000 and spend of £431,275 in 2015/16.

Performance and Risk Management

3.17 All public health contracts are recorded in the Council's Contract Register with regular updates as required. Performance management is through quarterly contract reviews with providers supported by performance reports. Where areas for improvement have been identified, appropriate performance measures are put in place with progress monitored until satisfactory performance is being met.

3.18 Overall, public health contracts have performed to a satisfactory level and continue to deliver efficiencies in 2016/17. A balanced position of budget against spend has also been achieved.

3.19 Details about individual programmes and performance of relevant contracts are set out in the attached Appendices 2 to 4.

3.20 In response to the overall Council savings requirement, the Exercise on Referral service was decommissioned when the contract expired on 31 March 2016 and is no longer included in this annual report.

3.21 The Stop Smoking Service, Tier 2 Adult Weight Management Services, Childhood Weight Management and School Nursing Service were also terminated when these contracts expired on 31 March 2017. However, performance of these contracts is being presented in this report for the last time.

3.22 For services that were decommissioned (except school nursing service), maintaining the health and wellbeing of the local population in these areas continue to be the responsibility of the Council. Given its financial position, the only financially viable option for the Council is to discharge these functions through "Making Every Contact Count" (MECC) [1]. This is only possible with the collaboration of Bromley CCG, who has agreed to incorporate MECC in their relevant service specifications, and MECC will be delivered through a range of providers.

3.23 Due to concerns associated with the decommissioning of school nursing service, Executive approval was given on 30 November 2016 to procure a Health Support to Schools Service for a period of one year plus an option to extend for a further year. This is a part of the section 75 agreement with the CCG.

[1] Making Every Contact Count is an approach to behaviour change that utilises the millions of day to day interactions that organisations and individuals have with other people to support them in making positive changes to their physical and mental health and wellbeing. MECC enables the opportunistic delivery of consistent and concise healthy lifestyle information and enables individuals to engage in conversations about their health at scale across organisations and populations.

http://www.makingeverycontactcount.co.uk/

4. POLICY IMPLICATIONS

4.1 This report is in relation to the business processes established to administer the existing contracted services. Authorisation to commissioning these services remains with Members working within the stipulations and statutory responsibilities set out in the Grant. The work is in accordance with the Health and Social Care Act 2012.

5. MARKET AND PROCUREMENT CONSIDERATIONS

5.1 All contracts that were due to expire were given due market considerations with reviews and appropriate amendments, where necessary, of the service specifications. These, in turn, helped to support and inform the appropriate procurement strategy in accordance with the Council's financial regulations and contract procedure rules.

5.2 During 2016/17, a number of services within the block contract with Bromley Healthcare were successfully re-procured.

6. FINANCIAL IMPLICATIONS

6.1 Public Health commissioners continue to work within the budget allocated for public health services. The Public Health Grant has been set by the Department of Health using estimates of public health baseline spending in 2011, along with a fair shares formula based on the recommendations of the Advisory Committee for Resource Allocation.

6.2 The Public Health Grant is a central government grant which is ring-fenced. The Department of Health grant allocation for Bromley was £15,478k in 2016/17. However, there will be a reduction in the Grant in 2017/18 to £15,096k. Work has been conducted by the Public Health team on identifying the savings towards these reductions.

6.3 The grant conditions require quarterly financial reporting to the Department of Health against a set of standardised budget reporting lines and the expenditure must be explicitly linked to the Health and Wellbeing Strategy, Public Health Outcomes Framework and the Joint Strategic Needs Assessment. The Council will need to show that it spends £15.1m on Public Health related expenditure. The reporting categories are sufficiently flexible to allow local decisions about what services are commissioned to be reflected sensibly. The Grant can be used for both revenue and capital purposes.

6.4 The expectation is that funds will be utilised in-year, but if at the end of the financial year there is any under spend this can be carried over, as part of a Public Health Reserve, into the next financial year. In utilising those funds the next year, the grant conditions will still need to be complied with.

6.5 There is also a statement of assurance that needs to be completed and signed off by the Chief Executive and Director of Public Health at year end. The expenditure for Public Health services will be included within the overall audit of the Council's statement of accounts and the Council needs to evidence that it spends the Grant on public health activities across the Council.

7. LEGAL IMPLICATIONS

7.1 This report uses existing legal frameworks, such as the scheme of delegation, to manage and administer the responsibilities placed on the Council.

7.2 The need to follow the guidance in paragraph 13 of the Ring Fenced Public health Grant letter is key:

(13) "*In giving funding for public health to local authorities, it remains important that funds are only spent on activities whose main or primary purpose is to improve the health and wellbeing of local populations (including restoring or protecting their health where appropriate) and reducing health inequalities."*

7.3 As are condition 3 and 9 of the grant:

"*the grant must be used only for meeting eligible expenditure incurred or to be incurred by local authorities for the purposes of their public health functions as specified in Section 73B(2) of the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012) ("the 2006 Act")".*

7.4 There is independent audit and provision for claw back if the money is not spent appropriately.

7.5 Education, care and health services are subject to the application of the "light touch" regime under the Public Contracts Regulations 2015.

Non-Applicable Sections:	Impact on Vulnerable Adults and Children, Procurement Implications and Personnel Implications
Background Documents: (Access via Contact Officer)	Gateway Review – Adults and Young People Substance Misuse Services (Report CS18005) Gateway Review of Sexual Health Services (Report CS16008) Gateway Review of Health Visiting and National Childhood Measurement Programme (Report CS16025)

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APPENDIX 1

CONTRACTS WITH THIRD PARTY ORGANISATIONS

Service	16/17 Contract Value/Budget £000	16/17 Actual Spend £000
Category A: Standard Contracts with Third Party Organisations		
Framework Agreements	338	319
Standard Contracts – Substance Misuse (Young People and Adults)	1,382	1,382
Sub-total	**1,720**	**1,701**
Category B: Clinical Commissioning Group Community Block Contracts using S75 Agreement		
Bromley Health Care		
Sexual Health		
• Contraception and Reproductive Health	722	722
• Sexual Health Improvement	228	228
• HIV Community Nurse Specialist Service	166	166
Adult		
• Health Improvement	176	176
• Stop Smoking Service	376	376
Children & Young People		
• School Nursing	698	698
• National Childhood Measurement Programme (NCMP)	131	131
• Childhood Weight Management	170	170
• Health Visiting Service	3,454	3,454
• Family Nurse Partnership	180	180
Oxleas NHS Foundation Trust	64	64
• Dual Diagnosis Service		
Sub-total	**6,365**	**6,365**
Category C: Sexual Health Clinical Contracts		
London Collaborative Commissioning Arrangement – In-borough provisions by King's College Hospital		871
London Collaborative Commissioning Arrangement – Other London Providers		135
All outside London non-contractual provision		549
Sub-total	**1,579**	**1,555**
Category D: Service Level Agreements with General Practices		
GP SLA	550	455
• Sexual Health		
• NHS Health Checks		
Sub-total	**550**	**455**

APPENDIX 2

ADULT PUBLIC HEALTH SERVICES

NHS Health Checks Programme

Brief Service Description

The NHS Health Check programme aims to prevent vascular diseases including: heart disease, stroke, diabetes and kidney disease, and raise awareness of dementia. Local authorities are responsible for making provision to offer an NHS Health Check to eligible individuals aged 40-74 years once every five years. In discharging this requirement, local authorities should act with a view to securing continuous improvement in the percentage of eligible persons in the area participating in health checks.

The programme uses various tests (blood pressure, cholesterol, body mass index) to assess individual's risk of developing CVD. Relevant lifestyle and medical approaches are then used to manage patients' risk factors, such as, diabetes prevention programme, smoking cessation, life prescription of medication to reduce blood pressure and cholesterol.

Evidence

Epidemiological studies show that a small number of well-known risk factors contribute the bulk of the population attributable risk for non-communicable diseases. These are poor diet, smoking, high blood pressure, obesity, physical inactivity, alcohol use and high cholesterol. Their contribution to ill health and premature mortality is so large that unless the numbers in the raised risk categories for these factors change substantially, national outcome measures cannot be expected to improve by much.[1]

In Bromley, the main causes of death are cardiovascular disease and cancer, with inequalities in life expectancy in key population and geographic areas. Based on strong evidence, NICE guidance recommends identification of individuals with the key risk factors for these diseases, and the use of evidence based interventions to manage them [4,5,6,7]. Early identification and intervention to reduce risk can prevent, delay and in some circumstances reverse the onset of cardiovascular diseases. The NHS Health Checks is the delivery model designed to address these seven risk factors.[2]

References

1. Murray CJL et al (2013) UK health performance: findings of the Global Burden of Disease Study 2010 The Lancet 381 No. 9871 p997-1020 23 March 2013 http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(13)60355-4/abstract
2. Public Health England (2015) NHS Health Check Best Practice Guidance. February 2015 http://www.healthcheck.nhs.uk/commissioners_and_healthcare_professionals/national_guidance/
3. NICE (2014). Lipid modification: cardiovascular risk assessment and the modification of blood lipids for the primary and secondary prevention of cardiovascular disease (CG67) http://www.nice.org.uk/guidance/cg181
4. NICE (2011) Hypertension. Clinical management of primary hypertension in adults CG127 http://publications.nice.org.uk/hypertension-cg127
5. NICE (2012) Preventing type 2 diabetes: risk identification and interventions for individuals at high risk http://publications.nice.org.uk/preventing-type-2-diabetes-risk-identification-and-interventions-for-individuals-at-high-risk-ph38

Epidemiology

The population of 40 -74year olds in Bromley is 133,164 with 93,511 of those eligible for an NHS Health Check. Modelling of this population would expect to find:

Expected findings in total 40-74year old population	Number	Percentage total
Ineligible for NHS Health Check due to pre-existing conditions	45,608	34%
Diagnosed with hypertension	23,719	18%
High risk of CVD >20% 10 year risk score	20,016	15%
Diagnosed with high risk of diabetes with high glucose result	3063	2%
Diagnosed with diabetes	1931	1%
Ref: National ready reckoner tool for NHS Health Checks		

It is estimated that each year of the first five years of the NHS Health Checks programme assuming a 40% uptake the programme should find:

- 225 people found to have hypertension
- 363 people at high risk of CVD with a risk score >20%
- 155 found to be at high risk of diabetes with raised blood glucose.
- 64 people found to have Type 2 diabetes

Commissioning and contracting arrangements

Eligible patients are identified through GP registers. GP Practices have been the only Provider of the NHS Health Checks for 2016-17 following the decommissioning of the Pharmacies and Outreach Service on the 31 March 2016. 44 out of a possible 45 GP Practices are participating in the NHS Health checks element of the Public Health Service Level Agreement (PH SLA)

A review of the PH SLA includes more detail about how this contract is functioning. This includes details of a pilot of additional NHS Health Checks being performed by the GP Alliance in order to support areas of lower uptake and to improve accessibility. The contract with the GP Alliance commenced in January 2017 but due to start up arrangements only commenced delivery of NHS Health Checks in March 2017. In addition, blood testing for cholesterol and HbA1c is provided through Point of Care Testing. A company called Alere is procured through the PH Framework to ensure delivery of this service in Bromley.

Contract History and Value

*As NHS Health Checks Providers are paid per Check completed, there is no absolute contract value as it varies depending on activity of the Providers. With no additional providers for 2016-17, underperformance by one Provider could not be picked up by the other Providers. There is a maximum number of NHS Health Checks set which Providers should offer which should not exceed which is 20% of Bromley's eligible population. For NHS Health checks completed, a cap was applied to 10% of the eligible population

Contract History	Estimated Contract Value*	Spend 2016-17
Pilot of the GP Alliance – commenced Jan 2017	• £84,360	£600
44 GP Practices –Service Level Agreements began on 01 April 2015 for one year, then extended for a further year to expire on 31 March 2017 with an option to extend for a further year.	estimated value • £ 176,110 per annum	£142,141
Alere – Point of Care Testing – Contract began on 01 April 2014 and will expire on 31 March 2016	• estimated value: £100,000 per annum (dependent on volumes)	£64,633
Total spend on contracts	£ 360,470	**£207,374**

Performance

National targets		Bromley 2014-15	Bromley 2015-16	Bromley 2016-17
Total eligible population	Target	93,215	94,312	95,190
The number and percentage of eligible population aged 40-74 eligible for an NHS Health Check who were offered an NHS Health Check	20%	21,400 (23%)	18,748 (19.9%)	17,524 (18.4%)
The number and percentage of eligible population aged 40-74years offered an NHS Health Check who received an NHS Health Check	50%	8,533 (39.9%)	8119 (43.3%)	6,738 (38.5%)
The percentage of eligible population aged 40-74years who received an NHS Health Check	10%	9.2%	8.6%	7%

Key Outcomes Measures

1. Identification of people with undiagnosed risk factors for CVD:
   - Hypertension: ➢ Current prevalence in Bromley is 13.6%, expected prevalence is 24.4%.[6]
   - Type 2 diabetes and people at high risk of developing diabetes
   - Increased cholesterol ≥7.5mmol/l
2. Identification of patients with 10 year risk of CVD ≥20%
3. Reduction in **CHD** mortality for people <75years.

Results

In 2016-17 From analysis of 6690 NHS Health Checks the findings measured 31.3.17 were as follows*

- Hypertension: 1203 (18%) were identified as having raised blood pressure at the time of the NHS Health Check. 237 (3.5%) people were prescribed antihypertensive medication following their NHS Health Check, 133(2%) people were diagnosed with hypertension following their NHS Health Check.
- Type 2 diabetes: 500 (7.5%) people had a raised blood glucose test indicating them to be at high risk of developing Type 2 Diabetes whilst 23 (0.3%) were diagnosed with Type 2 diabetes after the NHS Check.
- High cholesterol: 141 (2.5%) people had a very high cholesterol ≥7.5mmol/l
- High risk of CVD: 310 (4.6%) people were assessed to have a 10year Qrisk score of 20% or more. Of these, 83 (27%) were receiving statin therapy at the time of data collection.
  A further 1132 (17%) people had a 10year Qrisk score of 10-19% indicating moderate cardiovascular risk, Of these 134 (12%) were prescribed statin therapy.

(These figures should be considered with caution, as there may have been insufficient time for diagnoses and medication management to have been instigated at the time of data extraction. Therefore the figures would be expected to be higher on reaudit.)

- In the three year period 2013-15, the premature mortality rate for CHD in NHS Bromley CCG was 32.1 per 100,000. This continues the steady decrease from 42.2 pre 100.000 since 2004-6.

References

[6] National cardiovascular intelligence network (2015) Cardiovascular disease profiles www.ncvin.org.uk.

Tier 2 Adult Weight Management

Brief Service Description

The service delivers a 12 week evidence-based community weight management programme in a range of settings and venues which are available to patients with a BMI ≥35 (BMI ≥33 with comorbidities), who are motivated to change and registered with a GP practice in Bromley.

This service is an identified exit route from the statutory National Health Check Measurement Programme, for any patient with an increased health risk due to being overweight. There is a duty of care to offer a service to address a patient's condition if identified through screening.

This service contract expired on 31 March 2017, when this service was terminated. Performance from 2016-17 for this service is reported here.

Epidemiology

In Bromley, obesity has been identified as one of the four health priorities in the Joint Strategic Needs Assessment (JSNA) and in the Health & Wellbeing Strategy. It is a key risk factor for cardiovascular disease, diabetes and cancer. Bromley is the sixth fattest borough in London with 64.1% of the population either overweight or obese, this is higher than the prevalence for London (58.8%) and lower than the England prevalence (64.8%) (latest data 2015).

Evidence

NICE Public Health Guidance 53 recommends referral of overweight and obese adults to a lifestyle weight management programme.

A randomised controlled trial of weight loss programmes of 12 weeks' duration showed significant weight loss at both twelve weeks and at one year for both Weight Watchers and Slimming World, and showed that commercially provided weight management services are more effective and cheaper than primary care based services led by specially trained staff.

References

1. NICE Public Health Guidance PH53
2. Comparison of range of commercial or primary care led weight reduction programmes with minimal intervention control for weight loss in obesity: Lighten Up randomised controlled trial : *BMJ* 2011. Jolly K, Daley A, Adab P et al.

Commissioning and contracting arrangements

- **Current Commissioning**

This Tier 2 weight management service forms part of a healthy weight pathway. Tier 1 (covers universal services such as health promotion and primary care) and Tier 2 (covers lifestyle interventions) are commissioned by the Local Authority. Tier 3 (covers specialist weight management services) and Tier 4 (bariatric surgery) are the responsibility of the CCG.

This service was competitively tendered, new contracts were awarded to Slimming World and Weight Watchers providers, which started on 01 April 2014. These contracts expired on 31 March 2017.

Contract History

- **Contract Value**

Annual Contract Value (2013/14)	£113,750
Re-commissioned Annual Contract Value (2014/15)	£53,930
Re-commissioned Annual Contract Value (2015/16)	£53,930
Contract extension no additional funding allocated (2016/17)	£0
Whole Life Contract Value	£107,860

- **Actual Spend (2015/16)** £35,802. The approx. £20,000 difference between contract value and budget was used to offset the in year Public Health Grant reduction.
- **Actual Spend (2016/17)** £0
- **Voucher spend**

There were 1,100 pre-paid vouchers, purchased in 2015/16. They are utilised when the patient activates the referral by calling the weight management provider and attends the weight management programme. Patients referred to the service are eligible to attend a 12 week weight management programme, completed over a maximum period of 16 weeks. These vouchers were used throughout 2016/17.

Provider contractual performance of the Weight Management Service.

There were 621 referrals in 2016/17, compared to 676 referrals in 2015-16, 589 referrals in 2014-15.

Achievement on the 12 week programme is shown in the table below.

Performance: 38% achieved over 5% reduction in body weight, and 13% of people achieved over a 10% reduction in body weight. A 5% body mass reduction is clinically associated with improved health outcomes.

The service providers surpassed the performance target of 35% of participants achieving a reduction in at least 5% of original body weight.

Tier 2 Weight Management Service Performance, 2013-17.

Adult Weight Management	2016/17	2015/16	2014/15	2013/14
Total number of people enrolled on the programme.	Total = 621 Slimming World = 468 (95 still active) Weight Watchers = 153 (41 still active)	Total = 676 Slimming World = 459 (102 still active) Weight Watchers = 217 (3 still active)	Total = 917 Slimming World = 543 (90 still active) Weight Watchers = 374 (91 still active)	Total = 1,043 Slimming World = 649 (112 still active) Weight Watchers = 394 (173 still active)
No. of people that lost ≥5% and <10% body weight.	Total = 184 (38%) Slimming World = 149 (40%) Weight Watchers = 35 (31%)	Total = 189 (33%) Slimming World = 138 (39%) Weight Watchers = 51 (24%)	Total = 279 (38%) Slimming World = 186 (41%) Weight Watchers = 93 (33%)	Total = 266 (35%) Slimming World = 206 (38%) Weight Watchers = 60 (27%)
No. of people that lost >10% body weight.	Total = 50 (10%) Slimming World = 41 (11%) Weight Watchers = 9 (12%)	Total = 74 (13%) Slimming World = 38 (11%) Weight Watchers = 36 (17%)	Total = 52 (7%) Slimming World = 32 (7%) Weight Watchers = 20 (7%)	Total = 71 (9%) Slimming World = 49 (9%) Weight Watchers = 22 (9%)

Key Population Outcomes

- Severely obese people are 3 times more likely to need social care than those of a healthy weight.
- Obesity reduces life expectancy by an average of 3 years, severe obesity reduces life expectancy by 8-10years.
- Annual cost of obesity: Social Care £353 million and obesity attributed sick days £16 million. Every 1 person on this programme saves £230 over a lifetime.
- Evidence suggests that a moderate weight loss of between 5-10% of initial body weight is associated with substantial health benefits (improvements in lipid profile and blood sugar control, reduction in blood pressure).

Stop Smoking Service

Brief Service Description

The aim of this service is to provide a specialist, multi-component group and one to one, stop smoking service in Bromley provided by Bromley Healthcare, they also performance manage local providers (GPs and pharmacists) to additionally deliver stop smoking services.

This service is an identified exit route from the statutory National Health Check Measurement Programme, for any patient with an increased health risk due to smoking. There is a duty of care to offer a service to address a patient's condition if identified through screening.

The Bromley Healthcare Stop Smoking Service contract expired on 31 March 2017, when this service was terminated. Performance from 2016-17 for this service is reported here. Due to the termination of the Bromley Healthcare stop smoking service contract the provider significantly underperformed. The underperformance produced an associated underspend, which led to an additional short term stop smoking quitter contract procured with Solutions for Health to deliver additional quitters to increase the number of residents stopping smoking.

Evidence

One in two smokers die due to the effects of smoking[1]. Stopping smoking is always beneficial to heath and it is never too late to stop. Every cigarette smoked damages the lungs, which may not show up until later in life. Two major longitudinal studies have demonstrated the benefits of stopping smoking at an early age. The 50 year follow up of British doctors' study revealed that if smokers quit before the age of 30 they can avoid more than 90% of the smoking-attributable risk of lung cancer. The authors concluded that stopping smoking at age 60, 50, 40, or 30 gains, respectively, approximately 3, 6, 9, or 10 years of life expectancy[2]. A similar study of British women also found that stopping smoking before the age of 40 avoids more than 90% of the increased risk of dying caused by continuing to smoke, while stopping before the age of 30 avoid over 97% of the increased risk.

References

1. Doll R et al. Mortality in relation to smoking: 50 years' observations on male British doctors. British Medical Journal, 2004; 328: 1519.
2. Doll R, Peto R, Wheatley K, et al. Mortality in relation to smoking: 40 years' observations on male British doctors. British Medical Journal, 1994; 309: 901-911.
3. Hughes JR, Keely J, Naud S. Shape of the relapse curve and long-term abstinence among untreated smokers. Addiction. 2004; 99(1):29-38.
4. Bauld L et al. Effectiveness of NHS smoking cessation services: a systematic review. J Pub Health 2009; 1-2.
5. Pirie K, Peto R, Reeves G et al. The 21st century hazards of smoking and the benefits of stopping: a prospective study of one million women in the UK. The Lancet, 2012, 6736(12) 61720-6.

Epidemiology

Treating tobacco dependence is the single most cost effective lifesaving intervention. Smoking remains the principal cause of preventable premature death - killing more people than the combined total of the six next largest causes put together. Smoking is a major risk factor for cardiovascular disease, chronic obstructive pulmonary disease and many cancers.

Half of all long-term smokers will die of a smoking-related illness. The adult smoker population (18+ years) had risen over 4years, from 15.5% in 2009/10 to 18.1% in 2012/13. Prevalence has now reduced to 14.2% (latest data 2015). This is lower than the London (16.3%) and England (16.9%) prevalence. However, the prevalence of smoking in routine and manual occupational groups is consistently higher than that of the general population. Smoking whilst pregnant is still high in Bromley (5.3%) compared to London's (5.0%) prevalence at time of delivery.

Commissioning and contracting arrangements

- **Contract History - Bromley Healthcare**

The Stop Smoking Service forms part of Bromley Clinical Commissioning Group's (BCCG) Community Block Contract with Bromley Healthcare (BHC). The service was issued a contract query notice due to underperformance during 2016/17. BHC achieved 575 quits in 2016/17, compared to 1056 quits in 2015/16. The Bromley Healthcare Stop Smoking Service contract expired on 31 March 2017, when this service was terminated.

- **Contract Value 2016/17**

Annual Contract value: £385,750

- **Spend for 2016/17**

£376,431 BHC Stop Smoking service plus prescribing £207,704 (BHC and GPs).

- **Contract History - Solutions for Health**

Due to the underperformance of Bromley Healthcare an additional stop smoking quitter contract was procured from January to July 2017 with Solutions for Health to deliver 272 additional quitters to increase the number of residents stopping smoking.

- **Contract Value 2016/17**

Annual Contract value: £100,000.

- **Spend for 2016/17**

£95,200

Provider contractual performance of the Stop Smoking Service.
Bromley Healthcare performance

Year	Attempt to Quit	4 Week Quit	Efficacy
2011/12	2986	1413	47.3%
2012/13	3217	1521	47.3%
2013/14	2121	1027	48.4%
2014/15	2535	1346	53.1%
2015/16	2245	1056	47.0%
2016/17	1275	575	45.1%
Grand Total	**14,379**	**6,938**	**48.03%**

In addition, the service recorded the number of long term quitters in 2014/15. Of those followed up, 72.2% were still abstinent from smoking at 12 months.

Solutions for Health performance

Year	Attempt to Quit	4 Week Quit	Efficacy
2016/17	354	198 (51 still completing their quit attempt)*	56%

* Contract still in process.

Key Population Outcomes

- Stop smoking interventions are highly cost effective, for every £1 spent £10 is saved on future health care costs and health gains. A 20-a-day smoker saves around £3,000 per year by quitting. (Tobacco Control JSNA Support Pack. PHE 2015).
- The total annual cost of smoking in Bromley is £15,389,039*, which can be broken down as: NHS Costs: £9,753,958 Costs to businesses (productivity losses): £5,473,233 Passive smoking costs: £152,899 (adults: £108,649; children: £44,250). The number of accidental fires ignited by smoking related materials has fallen from 3,828 fires in 2009/10 to 3,143 fires in 2012/13, a fall of 18% in three years (NICE. Return on Investment Tool. September 2013).

Identified risk;

From April 2017, only 25 out of the 43 (58%) GP practices will continue to deliver stop smoking support for their patients. Only 5 out of the 59 (8%) pharmacies in Bromley will continue to deliver stop smoking support. There will be no services for smokers identified through NHS Health Checks and no outreach to priority target groups e.g. no training for maternity units and health visitors for pregnant women. The current smokers smoking prevalence at age 15 is 9.9% in Bromley, compared to 6.1% for London and 8.2% for England (PHOF, 2014-15).

Mitigating risk;

1. Public Health created a Bromley Healthcare decommissioning action plan to mitigate data management, communication, resource management, training, onward national reporting and reputational risk.
2. The decommissioning of the Stop Smoking Service has been added to the Public Health and departmental risk register.
3. LB Bromley will support the Pan Stop Smoking London telephone advice service initiative being delivered by Professor Robert West a leading consultant in stop smoking research and Public Health England (PHE). LB Bromley Public Health will still signpost patients from Kings the Acute trust to the Stop Smoking London telephone advice service.
4. Bromley CCG will be responsible for Nicotine Replacement Therapy and Champix prescribing costs.
5. PHE will continue to run their stop smoking national campaigns such as No Smoking Day in March and Stoptober the well recognised October campaign. LB Bromley will continue to publicise these effective campaigns, support and signpost residents to online support information and apps.
6. All councils are in charge of enforcing the Smoke Free law and LB Bromley will continue to reinforce legislation of smoke free public places and cars.

Diabetes Prevention Programme

Brief Service Description

Bromley took part in a Diabetes Prevention Programme pilot which was an intensive lifestyle intervention to prevent or delay the onset of Type 2 Diabetes Mellitus in 117 patients with non-diabetic hyperglycaemia (at high risk of developing diabetes). There is strong international evidence for this approach to diabetes prevention, this pilot tested the implementation of the programme via a UK primary care referral pathway.

Bromley was the first area in Europe to pilot this programme. The programme consisted of a two hour activation session, followed by weekly attendance at Weight Watchers meetings for 1 year, with additional email and telephone support. The pilot was subject to full evaluation, which was reported in the 2015/16 Care Services Policy Development and Scrutiny Committee Public Health Programme Update and has been published in the prestigious British Medical Journal Open Diabetes Research & Care publication.

Since then Bromley have been invited to present at the Public Health England scientific advisory board regarding how best to deliver the National Diabetes Prevention Programme (NDPP) and have spoken at the UK Congress on Obesity and the NHS England Health and Care Innovation Expo conference. Bromley have been successful as part of the South London bid to be the first wave sites in the UK to adopt the NDPP. Reed Momenta won the bid to deliver this programme which started in September 2016 and will continue until at least 2019.

Bromley has continued to successfully deliver Walking Away from Diabetes (WAFD) since 2012, a 3.5 hour diabetes education course to promote the prevention of developing type 2 diabetes.

Evidence

International evidence base;

The 2.8 years (1996-1999) US Diabetes Prevention Program (DPP) randomised clinical trial showed 58% reduction of diabetes incidence with intensive lifestyle intervention vs only 31% reduction with metformin, compared to placebo[1,2]. These beneficial effects were sustained in the subsequent 10-year follow up outcome study[3].

Bromley Weight Watchers Pilot results;

PHE's meta-analysis (2015)[4] stated that interventions which halt the upwards trajectory of blood glucose but show no overall change, represent considerable clinical success. Whilst, optimal interventions showed that a reduction in HbA1c of 2mmol/mol or a reduction in FPG of 0.2mmol/L or more could be achieved by lifestyle interventions. The Bromley Weight Watchers Pilot study reported above optimal results, there was a mean reduction in HbA1c of 2.81mmol/mol (±3.47, P<0.01) at 12 months. There was a mean reduction in fasting plasma glucose of 0.21mol/L (±0.83) at 12 months.

Which means of the 117 patients who had non-diabetic hyperglycaemia (at high risk of developing type 2 diabetes) at baseline;

- 54 (46%) patients returned to normoglycaemia at 6 months.
- 44 (38%) patients returned to normoglycaemia at 12 months.
- An additional, 15 (13%) and 18 (15%) reduced their risk at 6 and 12 months respectively.
- 4 (3%) developed T2D at 12 months.
- The reduction in risk of developing type 2 diabetes was due to the reduction in weight. 43% of patients achieved at least a reduction of 7% of starting weight.
- There was a mean reduction in weight of 10.0kg and mean reduction in BMI of 3.2kg/m2 at 12 months.

National Diabetes Prevention Programme.

Public Health England conducted a systematic review which demonstrated that modest weight loss, improvements in diet quality, and increases in physical activity levels can reduce incidence of type 2 diabetes by more than 50%, for individuals at high risk. They summarised that the intensive lifestyle intervention should last a minimum of 9 months and consist of at least 9 group based sessions[4].

Walking Away from Diabetes

WAFD was one of the first evidenced based programmes to be commissioned in the UK. The PREPARE study found that the WAFD course plus giving the patients a pedometer to increase the number of steps they walked per day produced a significant reduction in fasting glucose.

References

1. Translating the Diabetes Prevention Program into the Community. The DEPLOY Pilot Study Ronald T. Ackermann, MD, MPH, Emily A. Finch, MA, Edward Brizendine, MS, Honghong, Zhou, PhD, and David G Marrero, PhD *Am J Prev Med*. 2008 October ; 35(4): 357–363
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Epidemiology

A new diagnosis of T2D is made every 2 minutes in the UK (Diabetes UK, 2014). Diabetes is now the most prevalent chronic disease in Bromley; there are 14,493 people on the diabetes register in 2014/15 compared to 4,846 in 2002. A Diabetes Audit was undertaken in 42 out of the 45 GP Practices, which identified 11,451 patients at high risk of developing diabetes in only a 16 month period (from 1 April 2013 – 31 August 2014). Modelled prevalence of non-diabetic hyperglycemia was conducted in 2015 and identified 29,872 patients in Bromley (11.5% of the 16+ population) above the England average (11.4%).

Obesity is a key risk factor for developing Type 2 Diabetes, 80% of people with T2D are overweight or obese. 64.1% of Bromley's population is either overweight or obese.

People with diabetes are up to five times more likely to have cardiovascular disease and stroke, compared to those without diabetes. It is estimated that they die 10 years earlier than average, compared to those without the disease.

Provider contractual performance

Key outcome measures;

- Reduce the conversion from non-diabetic hyperglycaemia to type 2 diabetes in a group of high risk patients

National Diabetes Prevention Programme - Bromley to record;

- GPs to record the number of patients identified as eligible (inc offered, referred and declined to the NDPP)
- GPs to record the number of patients contacted or offered, referred and declined the NDPP in last month
- Report to NHS England

From September 2016 – April 2017 (8 months);

- 19,428 patients have non-diabetic hyperglycaemia and therefore eligible for the NDPP
- 1,530 patients have been offered the NDPP
- 753 patients (49%) have declined the NDPP

Walking Away from Diabetes

- 559 patients completed the WAFD course in 2016-17.
- Female 59% / Male 41%
- Mean age = 65 years old (Youngest 28 years old - Oldest 89 years old)
- Mean reduction in HbA1c 44 to 42 mmol/mol (284 results). Better than Public Health England meta-analysis results.
- 43% decreased their risk or are no longer at risk of diabetes.

Evaluation measures

NHS England measure the number of patients that go onto complete the NDPP. NHS England are undertaking a full national evaluation of the NDPP. Outcome data for the NDPP 9 month intensive lifestyle intervention will not be available until June 2017.

APPENDIX 3

CHILDREN AND YOUNG PEOPLE PUBLIC HEALTH SERVICES

National Childhood Measurement Programme (NCMP)

Brief Service Description

NCMP

This is a national programme and it is mandated 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 NCMP measures the weight and height of children in Reception class (aged 4 to 5 years) and Year 6 (aged 10 to 11 years).

Weight management

In 2016/17 there were two licensed evidenced-based healthy weight programmes for children and families commissioned in Bromley; HENRY and MEND.

HENRY (Health Exercise Nutrition for the Really Young)

The HENRY Programme has a strong evidence base in relation to the prevention of childhood obesity. There were two elements to Bromley's HENRY programme; 'Core Skills Training' for health and community practitioners and 'Let's Get Healthy with HENRY' family programmes. Training offered to health and community practitioners enabled them to work more effectively with parents of babies and pre-school children around healthy weight and lifestyle concerns. HENRY parenting courses were available to Bromley families and were delivered in the Children and Family Centres and a local primary school. Families participated in an eight week course supporting them to develop a healthier and more active lifestyle for the whole family. Participants in the HENRY core skills training included Family Support Workers, GP trainees and Health Visitors.

MEND (Mind Exercise Nutrition Do It!)

This multi-component weight management programme provided support for the families of children aged 4-13 years identified through National Childhood Measurement Programme as being overweight and obese. The programme 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. Sixty three families participated in Bromley programmes in 2016/17, compared to 64 families in 2015/16

Demographics and Epidemiology

The prevalence of obesity has trebled in the past 20 years. Across the country almost one third of children are either overweight or obese. In 2016 in England, one in five children in Reception, and over 1 in 3 children in Year 6 were obese or overweight. Being overweight or obese in childhood has consequences for health in both the short term and the longer term. Once established, obesity is extremely difficult to treat, so prevention and early intervention are very important. Obesity is a major contributory factor in diabetes, heart disease, musculo-skeletal disease, reproductive disorders, respiratory disorders, certain cancers and psychological illness.

The percentage of children in Bromley schools who are obese doubles from their first year in primary to their final year in primary school. For example with the latest cohort, 8.2% were obese in Reception, this increased to 16% by the time these children were in Year 6. In 2016 over 20% of children in Reception and almost 31% in Year 6 were either overweight or obese, this equates to 1,958 children in one year from Bromley schools. 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 table below illustrates NCMP data for Bromley from 2008 to 2016

Year Group	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Reception: Overweight	12.3%	13.2%	12.9%	12.9%	13.1%	13%	12.2%	12.6%
Reception: Obese	7.3%	8.2%	7.8%	7.4%	8%	8.3%	7.9%	8.2%
Year 6: Overweight	15.5%	14.3%	14.5%	15.7%	14.9%	14.5%	14.3%	13.3%
Year 6: Obese	16.0%	17.2%	16.4%	15.6%	17.1%	15.4%	16.5%	16%

Commissioning and contracting arrangements

Commissioning intentions
Going forward Public Health will commission a new Bromley Primary School Screening Programme. This will include vision screening for children in Reception and National Child Measurement Programme for Reception & Year 6 pupils in all state-maintained primary schools, including academies, within the local authority boundary in Bromley. Currently, there are no commissioning intentions to fund specific weight management programmes for children and young people. In the absence of support for families of children who have been identified as overweight or obese through NCMP, signposting to national weight management resources will be important. Colleagues in education, health and social care have been advised to signpost families to Change4life resources https://www.nhs.uk/change4life-beta/your-childs-weight

Contract History
As part of the block contract between Bromley CCG and Bromley Healthcare, this contract value was ring fenced up until end March 2017. After this time MEND and HENRY licenced programmes will no longer be commissioned via the Public Health grant.

Contract Value
£301,106

Provider contractual performance

Outcome measures were used to assess provider's performance. The 16/17 outcomes set out below demonstrates BHC has met all measures with some exceeding the annual targets.

Key outcome measures:
NCMP
All expected outcomes have been met in 2016-17

- 100% of eligible schools in Bromley are participating in the programme
- Participation rates of 98% Year Reception children
- Over 75% of schools report they are satisfied with the programme
- Families received their child's results within the 6 week target

HENRY
Outcomes were met in 2016-17.
- Sixty six health and community practitioners successfully completed the two day HENRY core skills training
- There were high change in confidence scores reported by trainees attending Core Skills training
- 100% of parents reported they would recommend the course to friends and family

MEND outcomes

- 100% 5-7 year olds completing the programme reduced or maintained BMI centile
- 97% 7-13 year olds completing the programme reduced or maintained BMI centile

Due to the saving requirements the childhood weight management programmes were decommissioned from 1 April 2017. Public Health will monitor the impact of this through NCMP annual data and will continue work with partners to ensure healthy eating and physical activity for children are promoted ubiquitously across the system. For example, by supporting Healthy Schools Award Programme and promoting the School Food Plan to all Bromley schools.

Health Visiting Service and Family Nurse Partnership (FNP)

Health Visiting Service Background

The Healthy Child Programme (HCP) 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, developmental reviews, information and guidance on parenting and healthy choices. The HCP is core to the specifications the Health Visiting and School Nursing Service delivered to. It has been universally available to all Bromley families and aimed to ensure that every child received 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

Service Description

From October 2015 the responsibility for commissioning public health services for children aged 0-5 transferred to local authorities. At this time the Government mandated certain elements of the Healthy Child Programme. 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 2½ 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 4 years

Demographics and Epidemiology

As Health Visiting is a universal service, the relevant population is all pregnant women and children under 5 years in Bromley. The live birth rate in Bromley has been rising since 2002, with the highest rates in Mottingham & Chislehurst North and Clock House wards. The number of births in Bromley has risen from 3500 in 2002, to over 4000 in 2012. The number of 0 to 4 year olds has gradually been increasing since 2006 and will peak in 2017 (21,196) but is projected to decrease to 21,016 by 2019 and then to 20,825 by 2024 (JSNA 2015). The Health Visiting Service are working with seventy seven families (70 families in 15/16) where there is a Child Protection Plan, seventy nine Child In Need cases (69 in 15/16) and thirty two Child Looked After cases (24 in 15/16).
This demonstrates the caseloads of the Health Visiting Service is not only increasing but also becoming more complex.

Commissioning and contracting arrangements

The table below illustrates coverage of mandated HV reviews 2016-17

Mandated contacts	Q1	Q2	Q3	Q4	Comments
Antenatal contact	514	454	406	488	This figure is the actual number of contacts. There are roughly 1000 births per quarter.
New birth visit	94%	94%	93%	92%	This is the % of the cohort of births in that quarter who received a New Birth Visit by a Health Visitor.
6 week review	80%	84%	90%	89%	This is the % of mothers reviewed by a HV 6 weeks after the birth. This review covers maternal mood and infant feeding.
12 month review	89%	90%	81%	88%	This is the % of children receiving their 1 year review before the age of 15 months.
2.5 yr review using Ages & Stages Questionnaire (ASQ)	69%	80%	78%	79%	ASQ is an evidence-based tool, developed in the US. Questionnaires are completed by parents, in conjunction with health visitors, and cover 5 domains of development: Communication, Gross Motor, Fine Motor, Problem Solving & Personal-Social development.

Contract history
As part of the block contract between Bromley CCG and Bromley Healthcare, this contract value has been ring fenced at its current value until 30 September 2017. The re-tendering process will be concluded in June 2017.

Commissioning Intentions
In line with LBB procedure Public Health are obliged to re-tender the Health Visiting Service Contract from 1 October 2017. Family Nurse Partnership (FNP) will be integrated into the new 0-4 Service and a three year contract will be awarded to the successful provider service.

Contract Value
£3,453,999

Family Nurse Partnership (FNP)
FNP is a highly effective programme designed to mitigate the risks of young parenthood. The licensed structured programme, delivered by specially trained family nurses, has been delivered in Bromley since September 2014. This intensive preventive and early intervention 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. The Bromley FNP programme has moved its focus from mother's age to broader vulnerability factors such as being a care leaver or known to Children's Social Care. 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.

Family Nurse Partnership Outcome Measures 2016/17

Metrics	Description	Target	Actual 2015/16	Actual 2016/17
Performance / KPIs	Take up of the offer of the programme by eligible young women	75%	76%	68.4%
	Percent of babies of low birth weight (under 2500g) at term	4.6%	7%	0%
	Completion rate of all recommended immunisations at 6 months	90%	94%	83.3%
	Clients registered with Children and Family Centres	100% of participants in FNP to register at Children & Family Centres	Data not available	42%

When comparing with the previous year's results it's clear that performance of the service earlier in the year was impacted negatively by significant staff changes within the small team. The service is now on track and is performing well.

FNP Safeguarding Data March 2017

Child Protection Plan	Child In Need	Child Looked After	Former CLA	Former CLA (mother)
8	3	1	1	1

Contract value: £180,000

School Nursing Service

Background

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.

Service Description

LBB has been responsible for commissioning School Nursing services since April 2013. The service mainly provided Tier 1 and 2 health interventions in community and education settings and has established relationships within primary and secondary care. This was a universal service, but most of the work was targeted work with children with medical conditions and children where there were safeguarding concerns.

The universal element of the service focused on:

- Vision Screening in reception year
- Health promotion – mostly in form of a whole day Sex and Relationship Education (SRE) to year 9s
- Co-ordination of the Healthy Schools Award Scheme, working with schools to improve children's well-being

Much of the service's work focused on supporting children where additional health needs were identified. Where a child does have an additional health need, School Nursing contributed to or even wrote the healthcare plans; signposted to other agencies as per the relevant pathway and provided training for school staff to support the child to access education.

Targeted

- Safeguarding lead for children aged 5-19: attendance at Case Conferences & participation in safeguarding processes
- Individualised Health Care Plan for children with complex health condition, including school support and staff training
- School management plans for common health conditions e.g. asthma
- Drop-in sessions weekly in some mainstream secondary schools
- Specialist School Nursing service to the Youth Offending Service

Demographics and Epidemiology

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. Three of the special schools are covered by the Community Nursing service commissioned by Bromley CCG. The Glebe School was covered by mainstream school nursing.

Commissioning and contracting arrangements

This service has been provided for many years under an NHS contract. The School Nursing Service was part of the block contract between Bromley CCG and Bromley Healthcare, this contract value was ring fenced up until the end March 2017.

Commissioning Intentions

From April 2017 a Health Support to Schools Service will to be funded for a period of up to two years from the Better Care Fund up to a maximum of £606k. Two key functions will be delivered through the Health Support to Schools Service; school nurse safeguarding support & strategic support to schools managing children with medical needs. A full evaluation of the service is being undertaken and a system is in place to record identified risks.

Contract Value
£698,233

Contract performance

The school nursing year runs from September to July, and many of the targets work to this timescale instead of April to March.

The service reduced significantly in 2016-17 due to uncertainty over future and is now improving again.

March 2016-17

Safeguarding	Prepare reports Attend Initial Case conferences Attend Review case conferences when appropriate Participate in multi professional meetings	Number of children subject to a CP plan	243
		Number of CP reports sent to QA prior to conference	195
		Number of invites received for conference	184
		Number of initial case conferences attended	53
		Number of review case conferences attended	2
		Number of 'All about Me'/'Teen questionnaire complete	34
		Number multi professional (CP) meetings attended	19
		Number CAF's contributed to by SN	
		Number of CAF's initiated by SN	
		Number of court reports submitted by SN	0
	All staff to access three monthly safeguarding supervision		100%
Screening	Vision screening offered to all children in mainstream schools in reception year	Number of children screened	2932
		Number of children who did not consent to be screened	58
		Number of children referred to orthoptist	141
		Number of children referred to WKEC consultant	35
YOS Nurse	Provide a school nursing service to the Youth Offending team (2 days)	Number of children seen for health review	16
		Number YP registered for C Card scheme	3
		Details of referrals to other services (service & no.YP) *Please note that both CAMHS and substance misuse have workers within the YOS so CYP would be signposted across to them as part of the YOS*	0
		Number Health Promotion sessions **Topic** — **No Students**	
		Healthy Eating	3
		Preparing for fatherhood	1
		Sex Education	2
Medical Needs	Known children in mainstream school with complex medical needs to have an individualised care plan School to be offered support and training Allergies – schools have up to date management plans Number of medical reviews of children with SSDP funding	Number of children with a complex medical care plan	31 (451)
		Number of children with an allergy care plan	15 (176)
		Number of medical reviews of children with SSDP funding	0

Staff Training – Primary / Secondary schools		
School	**Topic**	**Total**
24 schools – primary & secondary	Epipen, Asthma & Diabetes	716

Healthy Schools	Schools supported to become Healthy schools at level required by school	90% of all schools due to have Bronze renewed by the end of the academic year have reward renewed		20/3/17 87 Registered 59 Bronze 34 Silver 08 Gold
Drop Ins	Schools offered a drop-in service. Numbers of attending to be counted and reasons why	**Issues of concern** self-harm Issues, peer relationship issues, sex education, smoking, enuresis, healthy eating		**Number** 32
		School Nurse app Downloads		99
Health Promotion	Your Choice Your Voice (Relationship & Sex Education) delivered to a mainstream secondary schools	All secondary schools within the borough		17
		School	**Topic**	**Total no.**
	Support PSHE within mainstream schools	Primary schools & college	Puberty, Sex Education & Hygiene	328

Screening
All Bromley mainstream schools were offered vision screening for children in Reception Year. By the end of the school year 77% of eligible children had been screened. Of those who were screened, 6% of children were referred on to Orthoptist and Ophthalmologist services.

Healthy schools
In March 2017 87% of Bromley schools were participating in the Healthy Schools London Programme. The programme aims to improve children and young people's well-being by encouraging health promoting improvements at school level. Bromley school projects included; emotional resilience building, improved dining hall experiences, physical activity sessions that successfully engaged previously inactive children and healthier food options on breakfast club menus.

Children with medical needs in school
In the school year 2015-16, the service supported schools to write four hundred and fifty one complex individualised medical care plans.

APPENDIX 4

SEXUAL HEALTH SERVICES (OPEN ACCESS STATUTORY SERVICES)

Control of Sexually Transmitted Infections (STIs)

Brief Service Description

Sexually transmitted Infections (STIs) are communicable diseases that must be controlled. Once acquired, STIs need to be diagnosed and treated quickly to prevent onward transmission to partners. It is therefore essential to provide accessible screening, diagnosis and treatment management for those affected and their partners. Prevention methods and advice are a crucial part of the care pathway to minimise the re-infection rates within the community.
Screening programmes for Chlamydia[3] and Gonorrhoea for the under 25s along with target testing to detect undiagnosed and late diagnosis of HIV[4] are commissioned to avoid consequences of untreated infection and inadvertent onward transmission. Outreach programmes targeting those at risk population to promote condom use and early HIV testing are also commissioned to prevent transmission.
To minimise further transmission risks and progression rates, HIV clinical nursing and community specialist services are also commissioned to support people newly diagnosed and those living with HIV in managing their conditions effectively.

Evidence

Central to preventing onward transmission of STIs is early diagnosis through increased testing and screening (e.g. the National Chlamydia Screening Programme) as well as the promotion of safer sex, especially condom use. Early detection is therefore a proven and effective control method.
There is evidence that behaviour change interventions can increase condom use and reduce partner numbers[5] as well as showing delayed sexual initiation and reduction in STI incidence. [6]
Early diagnosis of HIV infection enables better treatment outcomes and reduces the risk of transmission. HIV testing is key to prevent its transmission. Increasing the number of tests in non-specialist healthcare setting[7] and the frequency of testing those groups at increased risk of HIV will play a key role in tackling HIV. [8] Outreach providing rapid point-of-care tests is recommended for increasing the uptake of HIV testing among Men having Sex with Men (MSM) [9]

Epidemiology[10]

STIs continue to represent an important public health problem in London, which has the highest rate of 5 listed STIs (chlamydia, gonorrhoea, genital herpes, genital warts and syphilis) in England. Bromley has a lower rate than London for all 5 listed STIs. It also has a lower rate than England for Chlamydia, Genital Warts, Genital Herpes and new STIs but has a higher rate than England for Gonorrhoea and slightly higher for Syphilis. In 2016, there were 1,828 new STIs diagnosed in residents of Bromley. This represents a 12.41% and 16.45% reduction in new STIs in Bromley when compare to 2,087 in 2015 and 2,188 in 2014. A sustainable downward trend in new STIs in Bromley is set to emerge. The at risk populations continues to be young people aged 15-24 who are at highest risk of chlamydia infection, MSM and Black African (BA)/Caribbean ethnic groups who have the highest rates of new STI infections in Bromley.

Chlamydia, Gonorrhoea and Syphilis[10]

- Chlamydia
  - In 2016/17, 6,274 (20%) young people (15-24 years old) were tested for chlamydia in Bromley with a positivity rate of 7.8%
  - These compared to 7262 (21.5%) in 2015/16, and 7689 (22.4%) in 2014/15 young people tested with a positivity rate of 7.75 % and 7.71% respectively. This suggests that despite a lower testing coverage rate, the programme continues to screen its population group at most risk of the infection which is indicated by the higher positivity rate.
- Gonorrhoea and Syphilis
  - Rates of gonorrhoea and syphilis in Bromley are now both above the national average, though below the London average.
  - Bromley's percentage change in diagnoses between 2014 and 2015 for these two infections are 47.2% for syphilis and 18.5% gonorrhoea compared to England averages of 20% and 11% respectively.
  - A particular concern nationally is the rapid rise in syphilis and gonorrhoea among MSM.
  - Improved test sensitivity and uptake may have contributed to the increase in gonorrhoea infections but increased transmission is also likely to play a major role. Minimizing onward transmission continues to be a Public Health priority due to growing threat of antibiotic resistance of this infection.
  - Public Health England data indicates that MSM account for a high number of new syphilis infections, with high risk sexual behaviours likely to be driving transmission rates.

- A targeted and focused prevention programmes such as promotion of condom use and early detection through frequent testing to minimise onward transmission of STIs with a particular focus on MSM is required.

- Genital Warts and Genital Herpes
  - Bromley has seen a 12% decrease in diagnoses of genital warts which follows a national trend (7% decrease).
  - There has been a small increase in diagnoses of genital herpes that follows national trend.
  -

HIV[10]

The number of Bromley residents living with HIV infection continues to rise with the latest available data continuing to show a year on year increase. The number has increased from 462 in 2011 to 475 in 2012, 508 in 2013 and 548 in 2014, **560** 2015 with a prevalence rate of 2.7 per 1000 population overall. When the prevalence rate reaches 2 per 1000 population, early testing to detect the infection is required.

This overall prevalence rate masks local variation with much higher rates of between 10-20 per 1000 population in areas such as Penge, Anerley, Beckenham and Mottingham.

These areas border on neighbouring boroughs with high prevalence rates i.e. Southwark, Croydon, Lewisham and Greenwich.

Bromley has continued to diagnose HIV infection at an earlier stage of infection, reducing onward transmission and improving outcomes for individuals with this infection but the rate for late and very late diagnosis of HIV infections is higher than should be expected in a lower prevalence area such as Bromley than the London average. Between 2013 -2015, 33% of HIV diagnoses were made at a late stage of infection compared to 42% in England. Target testing for HIV in varying community settings and primary care is a proven way of tackling late diagnosis and onward transmission of this infection in areas of high prevalence.[8 & 9]

The majority of Bromley HIV Infections are acquired in this country with half recorded as White British residents. Black African is the largest ethnic group among these. In Bromley, the most common probable routes of HIV transmission remain heterosexual contact and MSM.

Heterosexual contacts (48%, 261) account for the largest proportion of residents diagnosed with HIV who are accessing care. This is higher than London (44%) and England (45%).

MSM now accounts for 50% of PLWHIV in Bromley (276 in 2015) which is similar to London (50%) but higher than England (45%). This is 5% higher than previous year's probable route of infection data and suggests a change in Bromley's population demographic.

Commissioning and contracting arrangements

Socio-economic deprivation is a known determinant of poor health outcomes and sexual health data show a strong positive correlation between rates of new STIs and the index of multiple deprivations across Bromley. A universal approach to control STIs is neither cost effective nor delivering best value for Bromley. Targeting those hard to reach communities and those deemed to be high risk individuals are priority groups for controlling STIs in Bromley. As STIs proportionately affect young people and Chlamydia being the most commonly diagnosed STIs, priority is given to this detection programme.

Open Access GUM Service budget of £1,579k with spend of £1,556k.

During 2016/17, Bromley continued to collaborate with other London boroughs in contract negotiations with all London providers to achieve lower prices. This resulted in *a small underspend of £23k.*

Detection programmes value £172k with spend of 173,298

Chlamydia screening programme and target STI including HIV testing outside of GUM clinics were commissioned from approved providers under the Framework Agreement (Pharma BBG and other Community Pharmacies) and from eligible General Practices, using the Service Level Agreement.

HIV community clinical and specialist support services block contract values of £186k

HIV clinical nursing services are commissioned as part of the BCCG Community Block Contract and community specialist support was commissioned from Metro under the approved Framework Agreement. Health education along with condom distribution to hard-to-reach and high risk groups of men were commissioned and included in the BHC Block contract - Health Improvement Service (Sexual Health). In addition, Bromley also participated in the Pan London HIV Prevention Programme (PLHPP).

Provider contractual performances

Open access GUM Service

Over 13,000 contacts were delivered in 2016/17 of which 45% were provided by King's, our local provider. The lack of performance data (due to the confidential nature of GUM service) continues to make monitoring of this service a particular challenge. Commissioners continue to withhold payment until relevant data is submitted for validation.

Chlamydia Detection (under 25s)

Over 6,274 tests were carried out in all settings in 2016/17, covering 20% of all young people in Bromley compared to 7262 tests with a coverage rate of 21.5% in 2015/16. While this is below the level required for the PHOF indicator of 25%, our focus continues to be on striking the right balance between reaching the appropriate level of positivity rate that controls the spread of infection and cost effectiveness. During 2016/17 over 7.8% of all tests were found to be positive for infection, a rate that is within the National Chlamydia Screening Programme detection recommendations of between 5% to 12%. Over 95% of all partners were also tested with treatments completed. These figures show a year on year improvement on positivity rate and suggest that Bromley has sustained the detection rate, which is an effective method of controlling the spread of this silent infection. This has been achieved without compromising our financial position.

Settings	**Tests**
Symptomatic Screens in GUM Clinic settings	2309
Asymptomatic Screens in the following community settings	
• GPs	1238
• Pharmacies	542
• Contraception and Ante Natal	1002
• Colleges, Outreach and other Community settings (no outreach)	7
• Internet	1176
TOTAL	6274

HIV Prevention, Detection and Specialist Support

The Community Clinical Nurse Specialists team delivered 1,195 face to face contacts of support to 298 patients who are affected by HIV. There were 40 new referrals and 8 new diagnoses (3 males and 5 females) in 2016/17, with 2 late and 1 very late diagnoses. These are complex cases with age ranges from 18 to 82. Failure to detect and prevent these 24 new infections will have an economic implication of over £7.68 million in future direct lifetime costs. [11]

BHC Health Improvement Service continues to provide health education, advice and support to hard-to-reach and most at risk groups of population (MSM, Black African and Black Caribbean) at a number of venues in the community. The service distributed 5,643 and 13,020 condoms to these target groups in 2016-17 compared to 3,643 and 13,020 condoms in 2015/16.

References

[1] Open access means patients can self-refer and attend any clinics regardless of where they live.
[2] British Association of Sexual Health and HIV: Recommendations for Core Service Provision in Genitourinary Medicine. BASHH. 2005
[3] Public Health Outcomes Framework Indicator 3.2 Chlamydia detection rate (15-24 years old)
[4] Public Health Outcomes Framework Indicator 3.4 People presenting with HIV at a late stage of infection
[5] Clutterbuck D et al. UK National Guidelines on safer sex advice. The Clinical Effectiveness Group of the British Association for Sexual Health and HIV (BASHH) and the British HIV Association (BHIVA) July 2012
[6] Charamoa MR, Cre[az N, Guenther-Gray C, Henny K, Liau A, Willis L, et al. Efficacy of structural-level condom distribution interventions: a meta-analysis of U.S. and international studies, 1998-2007. AIDS and behaviour 2011; 15(7): 1283-1297
[7] Evidence and resources to commission expanded HIV testing in priority medical services in high prevalence areas, Health Protection Agency, 2012
[8] Increasing the uptake of HIV testing among black Africans in England (PH33), National Institute for Health and Clinical Excellence, 2011
[9] Increase the uptake of HIV testing among men who have sex with men (PH34), National Institute for Health and Clinical Excellence, 2011
[10] Based on Bromley Local Authority Sexual Health Epidemiology Report (LASER): 2013. Public Health England. 2015 Note - data in the report are based on calendar year rather than financial year as reported in other sections of this report.
[11] A study conducted by the Health Protection Agency and the National AIDS Trust estimates that the financial costs associated with HIV infection is around £320,000 in direct lifetime costs per HIV positive patient.

Reduce Unplanned Pregnancies including Teenage (Under 18) Conception Rate

Brief Service Description
Provision of an open access Contraception and Reproductive Health Service is a prescribed function of Local Authorities. Conception rate in under-18 year olds is an indicator in the PHOF.
Bromley commissions a range of community contraception services to reduce unintended pregnancies with a specific focus on reducing teenage (under 18) conception rate. 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.

Evidence
The Department of Health's "A Framework for Sexual Health Improvement in England" indicated that up to 50% of pregnancies are unplanned. While many unplanned pregnancies will become wanted, around half of the teenage pregnancies end in an abortion. [12]
Evidence shows that teenage pregnancy is associated with poorer health and social outcomes for both young parent and their children. Teenage mothers are less likely to finish their education, are more likely to bring up their child alone and in poverty. They have a higher risk of poor mental health than older mothers. Infant mortality rates for babies born to teenage mothers are around 60% higher than for babies born to older mothers. The children of teenage mothers have an increased risk of living in poor quality housing and are more likely to have accidents and poor emotional health and well-being, which impacts on their children's behaviour and achievement.
Good contraception services have been shown to lower rates of teenage conceptions.
According to NICE on effectiveness of contraception methods, LARC methods have a wider role in contraception and their increased uptake could help to reduce unintended pregnancy. [13] Both the Government and the Faculty of Sexual and Reproductive Healthcare highlight that knowledge, access and choice for all women and men to all methods of contraception are crucial elements that contribute to the reduction of unwanted pregnancies. Evidence also suggests that school-based sexual health services have positive effects on reductions in births to teenage mothers. [14]

Epidemiology
In 2015, Bromley shows teenage conceptions continue to fall to the lowest rate since 1998 :
Contraception rates -

- There were 82 under 18 conceptions, representing a rate of 15 per 1000 female in this age group, compared with 93 conceptions with rate of 16.7 in 2015.
- This is lower than both the London rate of 19.2 and the England rate of 21.
- This represents an overall reduction in the local teenage pregnancy rate of 53.3% since records started in 1998.
- The under 16 conception rate was down to 1.9 in 2015 compared to England rate of 3.7 and Outer London boroughs of 3.9. The local rate of 1.9 represents a drop of more than 65% when compared to 2013 rate of 5.5.

The continued reduction in teenage conception rates can be attributed to a more integrated way of service delivery. Concerted efforts were given to SRE delivery, supported by a young people specific website (information, advice and signposting to services), widely accessible Condom scheme with online registration and emergency hormonal contraception provision for young people across the borough.

Abortion rates

- Bromley rate was 19.1 2015 per 1000 female population aged 15-44 years while England rate was 16.7 and London 21.6. The highest rates are in women aged 20-24 in Bromley
- Bromley ranked 49th (1st has the highest rate) out of 147 within England for the total abortion rate
- 31.3% of women under 25 years who had an abortion in that year, had had a previous abortion compared to the England rate of 26.5%.
- Bromley ranked 42nd (1st has the highest rate) out of 147 within England for the repeat abortion carried out by women aged 25 and over, with rate of 16.4% compared to England rate of 14.4%.
- The highest number of unplanned pregnancies occur in the 20-34 year age group

Research evidence continues to show that it is teenage pregnancies that are associated with poorer outcomes for both the parents and children. More work is therefore needed to continue to tackle unintended pregnancies, especially in areas that have the highest rates of TP in Bromley. These continue to be found in Bromley wards that also have a higher level of deprivation such as Penge, Mottingham, Plaistow & Sundridge, The Crays and Darwin.

Commissioning and contracting arrangements
Contraception and Reproductive Health (£739k) and Health Improvement Service (£204k) were commissioned from Bromley Healthcare and included in the Bromley CCG Community Block Contract using S75 agreement.
LARC methods were commissioned from eligible General Practices (contract value up to £231k plus £120k prescribing costs) under the Public Health Service Level Agreement with actual spend for 15/16 is £223k plus £70k prescribing costs).

EHC were procured from Community Pharmacies (£14k) under the Framework Agreement with spend of £18k.

Provider contractual performances to include outcome measures and trends

Performance measures for services commissioned from BHC were primarily contact based, a measure applied to all services in the community block contract. Key performance indicators (KPIs) and other outcome measures have been developed and incorporated in the regular performance monitoring of the following BHC services.

Contraception and Reproductive Health Service

During 2015/16, the Service delivering a total of 6,910 face to face contacts against the target of 7,297, an under performance of 5%. Of these 6,910 contacts, 3,886 contacts (56.2%) were accessed by young people under 24 year olds and 176 contacts (2.55%) were accessed by male clients.

During these face to face contracts, the following were delivered:

- 7,178 contraceptive methods – main three methods were contraceptive sheath[15] (1,49: - Combined oral contraception (1,860) and Progestogen only oral contraceptive (1,358)
  (TOTAL oral contraception OC = 3,218)
- 2,402 LARC insertions (includes Depot Provera injections) were made, representing 33% of total activity, a significant improvement when compared to the number of insertions of 889 (12.6%) in 2013.
- 341 (322 EHC and 19 emergency IUD) Emergency contraception were provided

Quality Measures	Target	Outturn
YP under 16 have a Fraser Competency Assessment[16]	85%	85%
LARC fitting entered on current form and 80% offered appointment within 4/52	80%	80%

Health Improvement Service (Sexual Health)

Activity Measures	Target	Outturn
Sex and Relationships Education (SRE)		
Deliver Your Choice Your Voice programme to 17 Secondary Schools (P4)	17	22
Deliver Your Choice Your Voice Bitesize - No. of sessions (P7)	30	35
Deliver courses to promote sexual health with at risk groups	17	22
Promote condom use among higher risk groups		
wisDOM (previously called Ahead) - condoms distributed	11,519	13,020
Man-2-Man - condoms distributed	5,034	5,642
C-Card - condoms distributed	10,346	32,319
Run 3 individual campaigns (2 campaigns plus vending machine)	3	2
Distribute 2586 condoms through these campaigns	2,586	4,890

General Practices
In 2016/17, general practices in Bromley fitted 1,423 Long-Acting Reversible Contraception Methods (LARC). This compared with 1,446 LARC methods fitted in 2015/16. While there is a drop in the number of methods fitted in 15/16, these methods have a life span of 3 to 5 years so activities will fluctuate according to the "life" of the methods.
Community Pharmacies delivered 1,195 emergency contraception in 2015/16 with (16, 17 & 18 age groups are the largest users 2016)

References
[12] A Framework for Sexual Health Improvement in England, Department of Health. March 2003
[13] Clinical Guidance 30 Long-acting Reversible Contraception (Update), National Institute for Health and Clinical Excellence. September 2014
[14] Owen J, Carroll C, Cooke J, Formby E, Hayter M, Hirst J, Lloyd Jones M, Stapleton H, Stevenson M, Sutton A. School-linked sexual health services for young people (SSHYP): a survey and systematic review concerning current models, effectiveness, cost-effectiveness and research opportunities. Health Technol Assess. June 2010
[15] Contraceptive Sheath is often given as an addition to the main method of contraception.
[16] Fraser Competency Assessment is a universal assessment using a set of criteria which must apply when medical practitioners are offering contraceptive services to under 16's without parental knowledge or permission.

Substance Misuse Service

Brief Service Description

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.

Adults Substance Misuse Service
The aim of the Bromley Drugs and Alcohol service (BDAS) is to move a client from a position of problematic drugs and/or alcohol misuse, associated with poor physical health status, chaotic lifestyle and sometimes criminality to a position of stability, improved health and well-being, employment and positive engagement with the community. The substance misuse service model is a rapid assessment, integrated single point of access service, which includes assessment, prescribing and recovery services for people over 18 who require support or clinical interventions to enable them to reduce and become independent of substances. The service options include;

Stabilisation and Assessment: providing a single point of contact, assessment and care co-ordination for people requiring specialist drug and alcohol services.

Recovery Service: delivery of intervention programmes; such as; counselling, psychosocial interventions and peer mentoring. These form an integral part of the treatment and support service. The service also facilitates mutual aid groups to support their service users including Alcohol Anonymous, Narcotics Anonymous and Smart recovery. This includes return to employment programmes, to support people to maintain the abstinence or stability from substances.

Prescribing Services: service for people who require stabilisation of their chaotic drug use to reduce dependence on the illicit drug enabling engagement in a process towards abstinence and recovery. Only available via the substance misuse service in Bromley.

The service provides an individualised provision for high risk clients including; Pregnant, victims and perpetrators of domestic violence, clients discharged from hospital and/or prison. The service provides an holistic approach to client wellbeing including; working with Oxleas mental health trust and Princess Royal University Hospital providing satellite clinics and co-ordination of care pathways. The service ensures the Care Co-ordinator acts in a liaison capacity with services such as; GP, Probation Officer, Housing Officer, Job Centre Plus Manager and engages with family, and significant others in care programmes where appropriate. Hepatitis B&C screening and vaccination for all appropriate clients, promotion of maintaining physical health and ensuring clients are registered with primary care and smoking cessation referrals.

Needle Exchange
The aim of the service is to reduce the transmission of blood-borne viruses associated with injecting drug use. Pharmacies serve as a safe and secure point of collection and return of drug injecting paraphernalia by injecting drug users. The service seeks to increase referrals from healthcare professionals to BDAS.

Supervised Administration of Methadone.
Pharmacies provide supervised administration of methadone (SAM), a supervised community detoxification regime, which aims to reduce drug related morbidity/mortality. SAM is a harm reduction intervention which seeks to stabilise and maintain engagement in a prescribing regime, reducing the need for illicit opiates, the risk of blood borne virus transmission, and overdose. This also serves as a mechanism to reduce the diversion of medication onto local illicit markets.

The SAM service is for clients with chaotic lifestyles/drug using behaviour that could benefit from closer monitoring under supervised dispensing conditions until stabilised and those clients starting new episodes of substitute opiate treatment, where national guidelines recommend supervision for at least the first three months of treatment.

Dual Diagnosis
The Dual Diagnosis specialist service has a remit to provide services to mental health service users who are using any level of drugs and/or alcohol, with the overarching aim of supporting access into specialist drug and alcohol services and preventing/reducing the need for further substance use related contact with physical and mental health services.

Detoxification and Rehabilitation Placements
Spot purchasing of placements for inpatient detox and residential rehabilitation.

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 of substance misuse. 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.

Evidence

Bromley Drug and Alcohol Service provide an evidenced based programme of support.

Adults Substance Misuse Service
Drugs
The service provides a community opioid detoxification alongside longer psychological interventions for opiate users. Detoxification is the process by which opioid drugs are eliminated from dependent users in a safe and effective manner, either with opioid substitute treatment or gradual reduction in the illicit drug, such that withdrawal symptoms are minimised. It takes place either in community or residential settings. The evidence for the effectiveness of detoxification concerns its ability to achieve sustained abstinence in the user, and is based on detoxification plus psychological support. For example, detoxification together with contingency management has been shown to be cost-effective, with an estimated additional 1% of users being drug free at four months for every £12 spent on treatment.

Alcohol
The evidence base for the effectiveness of alcohol interventions is strong. UK and international research informs us that alcohol treatment such as screening, giving brief advice, motivational interviewing, cognition behavioural therapy, alcohol specialist treatment, detoxification and pharmacological treatment, self-help and mutual aid groups can be an effective and cost effective response to treating alcohol misuse. Alcohol misuse has a high impact on health, social care and criminal justice systems, for every £1 spent on treatment, £5 is saved elsewhere.

Young People
The benefits of specialist substance misuse interventions for young people's substance misuse are effective and provide value for money. A Department for Education cost-benefit analysis found that every £1 invested saved £1.93 within two years and up to £8.38 long term. Specialist services quickly engage young people, the majority of whom leave in a planned way and do not return to treatment services.

The strongest single predictor of the severity of young people's substance misuse problems is the age at which they start using substances. Effective commissioning of services lead to reductions in smoking, drinking and drug use, related offending, drug or alcohol-related deaths and hospital admissions and risk-taking behaviours more widely.

Needle Exchange
Injecting drug users are at greater risk of blood-borne infections, accounting for 90% of cases of Hepatitis C diagnosed in the UK. Rates of infection in drug users with Hepatitis B and HIV have declined as a result of needle and syringe programmes, vaccination and opportunistic testing and treatment. Evidence also suggests they increase the rate at which users enter treatment. The service protects the health of the local population by encouraging the safe disposal of injecting equipment and therefore minimises harm caused through contact with contaminated sharps.

Supervised Administration of Methadone.
This process replaces an illegal opioid with a longer acting but less euphoric opioid, usually methadone or buprenorphine, taken under pharmacy supervision. This treatment is recommended as an option for treating opioid dependency under a NICE technology appraisal (TA114). On average, 40-65% of patients maintain complete abstinence from illegal opioids while receiving opioid substitution therapy, and 70-95% are able to reduce their use substantially. Users also reduce risk-taking in injecting, experience improved mental health and relationships, and are less likely to be arrested. Opioid substitution therapy has also been associated with lower transmission of blood borne viruses.

Dual Diagnosis
Historically, people with co-occurring severe mental illness and substance misuse have been excluded from mental health treatment because of their substance misuse disorder. Likewise, they have been excluded from substance misuse services because of their severe mental health symptoms. As a result, patients have frequently not accessed services and experience some of the biggest health inequalities. The Dual Diagnosis Service provides the opportunity for service users to have both their mental health and substance misuse needs addressed at the same time.

Detoxification and Rehabilitation Placements
It is difficult to assess these programmes objectively because the people who receive residential care are not a typical group, tending to have more social, physical and mental health problems. However, what is known about these programmes is that completion rates are very high (75-80%), programmes of three months duration or longer work better than shorter programmes, and long-term outcomes are better if there is structured aftercare. NICE recommends that residential programmes be available as an option for clients who have significant physical, mental or social problems.

Epidemiology of substance misuse

The crime survey for England and Wales suggests that approximately 17,000 residents took illicit drugs in Bromley in 2014/15. The estimated prevalence of Class A drug use was 6,400 in Bromley in 2014/15, at a rate of 3.2% of the adult population. Nearly half of those taking drugs are in drug treatment. The most commonly used drugs in the UK, in order, are cannabis, cocaine and crack cocaine, and opioids. The substances most commonly misused by those in treatment in Bromley are opiates (44%) and alcohol (41%).

Demographics; Drug use is more common in males, single adults, white ethnic groups and those on low incomes. There is a relationship, however, between affluence and early use of cannabis. Nearly three quarters of drugs users in treatment in Bromley are male (64.2%) which decreased from 2015-16 (72.6%), and of White British ethnicity (84.3%). People in treatment in Bromley tend to be a little older than in other parts of the country, the highest proportion of substance misusers in treatment in Bromley are in the 35 to 49 year age group, in contrast to the national picture, which is 30 to 39 years. People in treatment in Bromley are more likely to be taking both opiates and crack (2016-17).

Impact on health; Mortality rates related to drug use have been increasing since 1993, with heroin and morphine the most commonly implicated drugs. There were 80 drug-related deaths in Bromley between 2006 and 2013 (43 male, and 37 female). The average age at death was 48 (ranging from 15 to 94 years old), more than thirty years lower than the average life expectancy for the borough. Deaths were most frequent in deprived wards. There is a strong association between drug use and mental health problems, with drug use occurring both as a result of mental illness, and as a cause. There were 518 drug-related hospital admissions in Bromley in 2013/14. Admission rates have been steadily increasing since 2009, the numbers greatest in the 25-44 age group.

Safeguarding; 20% of the drug users in treatment are parents but not living with their children, 21.7% live with children and 56.8% are not parents and/or have no access to children. 3.4% of the treatment population were pregnant. Employment and benefits; The number of drug users in treatment recorded as receiving any type of benefit was 60% of the total numbers in treatment (2016-17).

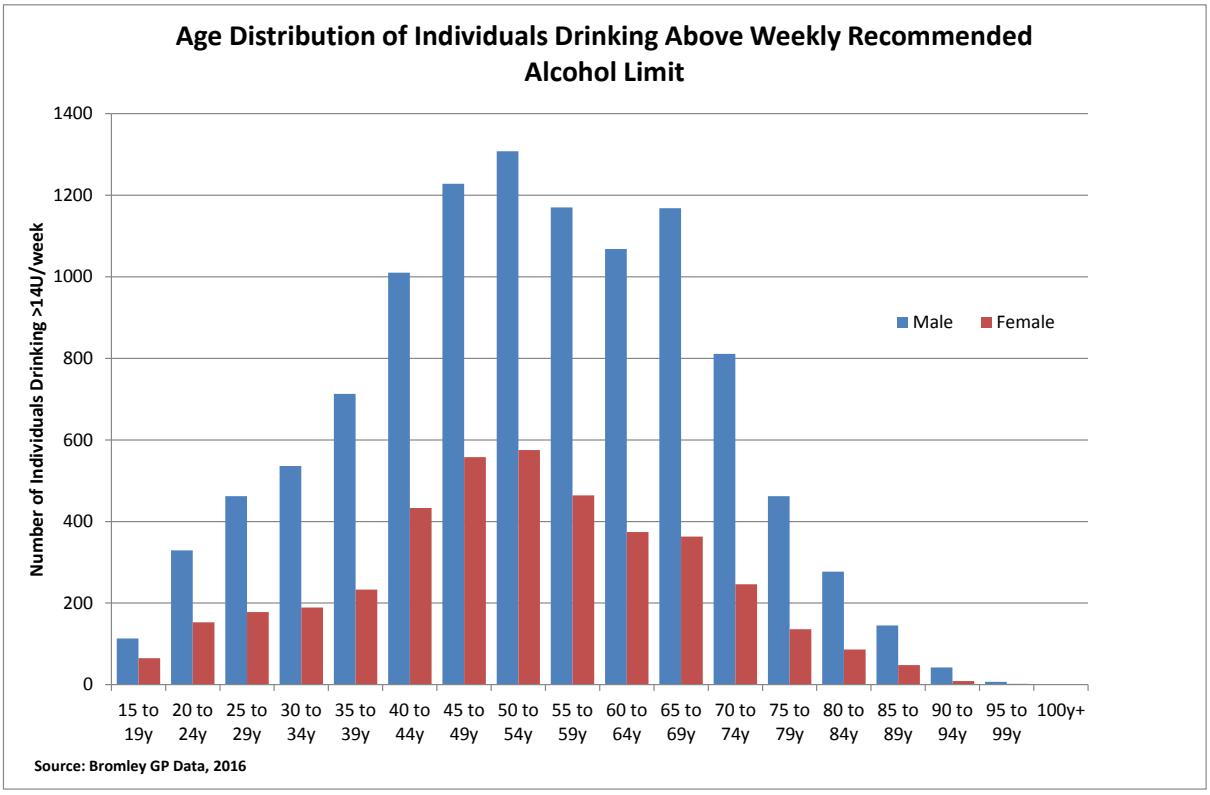
Epidemiology of alcohol use
Obtaining reliable information about drinking behaviour is difficult, and social surveys consistently record lower levels of consumption than would be expected from the data on alcohol sales. Estimates suggest that approximately 80% of adult population in Bromley drink alcohol. The majority (73.6%) are in a lower risk category and drink within recommended levels. 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. 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%). 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. This is likely to be an underestimate due to missing GP alcohol consumption data.

Table 1: 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

Figure 1. Age Distribution of Alcohol Consumption in Bromley, 2016



PHE prevalence estimates (2017) estimate there are 2,528 dependent drinkers in Bromley, and in 2016-17, the service saw 234 in structured treatment (less than 10%). Alcohol is a priority area for commissioning in 2017-18.

Impact on health; 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. 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. There were 2703 alcohol-related recorded crimes of which 1,269 were alcohol-related violent crimes and 31 alcohol-related sexual offences in Bromley in 2012-13.

Young People

The three substances most commonly misused by young people in treatment in Bromley was cannabis (92%), alcohol (59%) and cocaine (8%) in 2016-17 (some clients using more than one substance). Young people in substance misuse treatment also suffered from wider vulnerabilities including; Anti-social behavior / criminal act (25%), mental health problem (21%), self-harm (13%), and 13% were affected by others' substance misuse.

The alcohol-specific hospital 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.

Demographics – Age 2016-17

Age	Bromley (n)	Bromley %	National (%)
Under 13	0 / 51	0	2
Aged 13-14	8 / 51	16	21
Aged 15	19 / 51	37	27
Aged 16	9 / 51	18	25
Aged 17	15 / 51	29	25

Commissioning and contracting arrangements

- **Contract History**

The Substance Misuse Service is commissioned by the London Borough Bromley Public Health department. The adults and young person's substance misuse service was re-commissioned in 2015. The service was competitively tendered and a new contract was awarded to Change Grow Live (CGL) to deliver both adults and young person's contracts, which started on 01 November 2015.

Length of contract: 1st November 2015 – 31st October 2017 (optional 1 year extension).

On 24 May 2017, the LB Bromley Executive agreed to;

- Approve the extension of the Adults and Young People's Substance Misuse contracts with Change, Grow, Live for a period of one year from 1 December 2017 to 30 November 2018.
- Approve the exemption from tendering of the Community Pharmacy Needle Exchange and Supervised Administration of Methadone services for a period of eight months from 1 April 2018 to 30 November 2018 to align with the above Adults and Young People's Substance Misuse contracts.
- Agree to tender all Substance Misuse Contracts for a period of three years plus an optional two year extension from 1 December 2018 to 30 November 2021 (3+ 1 + 1 years).

- **Budget 2016-17**

Contract value: £1,755,060
Spend: £1,620,084

Service	Budget	Spend
Adults service	£1,216,490	£1,261,490
Young People's Service	£165,190	£165,190
In patient detox – spot service:	£129,140	£33,150
Prescribing	£124,380	£ 86,635
Dual diagnosis – Oxleas	£64,000	£64,770
Needle Exchange – Pharmacies	£47,000	45,108
Care Services support services	£8,860	£8,860
Total	**£1,755,060**	**£1,620,084**

Provider contractual performance
The most accurate data we have on drug users comes from the National Drug Treatment and Monitoring Service (NDTMS), as this is data collected diligently from those who attend drug treatment services. They provide an incomplete picture of drug use in the community, inevitably, as many drug users never access services, and the ones who do, tend to have more serious problems and to be taking opioids and/or crack. However, they do give indications of drug use in the wider community, with trends over time, and they also provide valuable information about who uses treatment services, and how effective that treatment is.

The numbers of people in alcohol and drug treatment have fallen again in the last year with 632 people in contact with alcohol and drug treatment services in Bromley in 2016-17 as compared with 675 in 2015-16, 730 in 2014-15 and 863 in 2013-14. In the year 2016-17, there were 345 new presentations for substance misuse treatment, as compared with 357 in 2015-16 and 381 in 2014-15.

Adults Attending Drug Treatment Services in Bromley
When engaged in treatment, people use less illegal drugs, commit less crime, improve their health, and manage their lives better, which also benefits the community.
A measure of effective treatment engagement is the number of people who have been in treatment for three months or more. In 2016-17, 392 people effectively engaged in treatment in Bromley, this represents 91% of the treatment population (429), which is higher than the national completion of treatment rate (89%). However, this represented a lower number of people in effective treatment than in 2015-16, 403 but it represented a higher percentage of people achieving successful completion of treatment (74%). Opiate users represent the largest group in treatment.

Treatment Outcomes for Adults
The key measure of successful treatment is the proportion of people who successfully completed treatment and did not return within 6 months. Bromley had a higher proportion of successful completers than the national value for local opiate clients 8.7% compared to 8.8% nationally and for non-opiate clients 43.2% compared to 43.2% nationally in 2016-17. The successful completed of treatment that did not re-present within 6 months is higher than the previous year.

Treatment Outcomes for Alcohol and non-opiate
The proportion of people who successfully completed treatment and did not return within 6 months is 95.4% compared to 87.0% nationally, this has improved from the previous year due to the PHE Alcohol Action Planning Toolkit completion.

Table 1 Adult Substance Misuse Service Performance

Performance Indicator	Substance	Q4 2015-16	Q4 2016-17	Top Quartile Range/National Average
Successful Completions	Opiate	17/314 (5.4%)	25/304 (8.2%)	9.89% - 18.53%
	Non-opiate	30/64 (46.9%)	26/50 (52.0%)	49.55% - 66.67%
	Alcohol	67/230 (29.1%)	79/195 (40.5%)	40.9%
	Alcohol & Non-opiate	24/67 (35.8%)	27/83 (32.5%)	46.07% - 57.22%
Representations	Opiate	3/14 (21.4%)	0/19 (0%)	11.1% - 0%
	Non-opiate	1/16 (6.3%)	1/17 (5.9%)	0%
	Alcohol	3/38 (7.9%)	1/41 (2.4%)	8.74%
	Alcohol & Non-opiate	0/7 (0%)	2/12 (16.7%)	4.35% - 0%

Source: NDTMS Diagnostic Outcomes Monitoring Executive Summary

Referral Sources
The highest proportions of presentations are made by self/family referrals (48.1%), 20.6% being referred by GPs, and 15.1% through the criminal justice system. Only 1.2% of referrals were from mental health or other health services, it is significant that there were only 0.9% of referrals from A&E in the year 2016-17.

Blood Borne Virus Vaccinations.
In 2016-17, 43.3% of eligible new presenters to drug services in Bromley accepted Hepatitis B vaccinations, down from 46.6% in 2015-16. However, only 12.8% completed the vaccination course. During the same period, 65.4% of new presenters to drug services in Bromley currently or previously injecting received a Hepatitis C test in 2016-17, as compared with 56% in 2015-16.

Treatment Outcomes for Young people
The performance of the Young People's Substance Misuse Service has improved considerably since the new provider took over the contract on 1st December 2015.

There is evidence that activity by the previous provider declined significantly in the months prior to the retendering process for the Young People's Substance Misuse Service, resulting in unmet need and potentially leaving young people at risk. It has taken the new provider several months to establish effective referral pathways with the numerous stakeholders involved. There was a total of 176 young people referrals into the service in 2016-17. There has been a 46% increase in the numbers of young people in treatment in Bromley in the last twelve months to end March 2017, compared to a national decrease of 4%. This is a welcome increase following large decreases in numbers in treatment last year.

The significant increase in the numbers of young people receiving treatment is due to the work undertaken by the service to promote and facilitate referrals from all stakeholders. The new young person's service have embedded an integrated pathway to substance misuse services ensuring young people have swift access to a high quality, evidence-based, integrated specialist treatment system. There is an increased awareness of the young people's service, they have visited 15 schools this academic year and 3 colleagues (4 of which are the Beacon academies which are pupil referral units – children who struggle in mainstream education), with 7 more schools and 2 colleagues planned. Schools have now referred 14 pupils. The highest number of referrals has been received from the youth Offending Service (YOS) with 60 referrals, 40 from A&E, 18 from social services, and the rest from CAMHS, housing, schools and parents. In 12 months of delivery and there are currently 51 young people in Tier 3 treatment.

Referral Source
Referrals to the young people's service need to be increased.

Referral Source	Bromley %	National (%)	Difference in referral rate
Children & Family Services	4	19	-15*
Education Services	12	28	-16*
Health & Mental Health	8	8	0*
Accident & Emergency	16	2	+14
Substance Misuse Services	0	3	-3
Youth Justice Services	40	25	+15
Self, Family & Friends	14	11	+3
Other (inc. blank)	6	3	+3

***** The Bromley Drugs and Alcohol service will concentrate on increasing referrals from these sources.

Key Population Outcomes
Alcohol and drug dependency leads to significant harms and places a financial burden on communities. Investment in prevention, treatment and recovery interventions reduces this burden.

Socioeconomic impact for alcohol in the UK;

- Alcohol is the third biggest risk factor for illness and death. A quarter of all deaths among 16-24 year old men are attributable to alcohol.
- Alcohol misuse harms families and communities; 27% of serious case reviews mention alcohol misuse. Almost half of violent assaults. 15% of road fatalities (PHE, 2016).

Socioeconomic impact for substance misuse in the UK;

- Deaths among heroin users are 10 times the death rate in the general population.
- 2248 drug misuse deaths were registered in 2014, the highest on record. Deaths involving heroin were 64% higher than in 2012.
- Parental drug use is a risk factor in 29% of all serious case reviews.
- A typical heroin user spends around £1,400 per month on drugs.
- Annual cost of drug addiction: Total cost to society is 15.4 billion; Any heroin or crack user not in treatment commits crime costing an average £26,074 a year. The National Treatment Outcomes Research Study (NTORS) found that 61% of a sample of people entering treatment had committed crimes other than drug possession in the three months prior to starting treatment, the most common being shoplifting. The main sources of illegal income required to fund an illicit drug habit were theft and fraud.
- The annual cost of looking after drug-using parents' children who have been taken into care is £42.5million. Often drug users are unemployed and claiming benefit. NHS cost: £488 million.

Return on Investment

- Every 100 alcohol dependent people treated can prevent 18 A&E visits and 22 hospital admissions.
- Providing adult drug treatment interventions prevents an estimated 4.9m crimes every year.
- Providing young people's drug and alcohol interventions result in £4.3m health savings and £100m crime savings per year.
- PHE evidenced that 82% of people surveyed said treatment's greatest benefit was improved community safety.

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Briefing CS18102

London Borough of Bromley

PART 1 - PUBLIC

Briefing for Health and Wellbeing Board
30th November 2017

PHARMACEUTICAL NEEDS ASSESSMENT UPDATE

Contact Officer: Dr Nada Lemic, Director: Public Health
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Chief Officer: Executive Director: Education, Care and Health Services

1. Summary

1.1 This Information Briefing provides an update on the pharmaceutical needs assessment update.

2. THE BRIEFING

2.1 The update is provided at Appendix A.

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PHARMACEUTICAL NEEDS ASSESSMENT UPDATE

The formal consultation for the draft Pharmaceutical Needs Assessment commenced on 18th October 2017 and is due to run until midnight on 20th December 2017.

The Health and Wellbeing Board will have an opportunity to discuss the draft Pharmaceutical Needs Assessment at its meeting on 30th November 2017; these comments will be captured and fed into the formal consultation process.

Consultation feedback will be collated and presented to the Pharmaceutical Needs Assessment Steering Group at its meeting on 8th January 2018. This will be discussed with a view to agreeing amendments to the draft Pharmaceutical Needs Assessment.

Webstar Lane will make the required amendments by 22nd January 2018 and the final Pharmaceutical Needs Assessment will be circulated to the Health and Wellbeing Board for approval at its meeting on 1st February 2018.

Webstar Lane will aim to ensure that the final Pharmaceutical Needs Assessment is ready for publication on 4th February 2018. This timescale assumes that there will be minor changes only following the meeting of the Health and Wellbeing Board on 1st February 2018.

The link to the consultation document:

http://www.bromley.gov.uk/news/article/297/pharmaceutical_needs_assessment_consultation

Dr Nada Lemic
25th October 2017

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