Report No.
CS13047

London Borough of Bromley

PART ONE - PUBLIC

Decision Maker:	**Executive**
	For Pre-Decision Scrutiny by the Care Services PDS Committee on 29th October 2013
Date:	**20th November 2013**
Decision Type:	Non-Urgent Executive Non-Key
Title:	**PUBLIC HEALTH PROCUREMENT FRAMEWORK**
Contact Officer:	Nada Lemic, Director of Public Health E-mail: Nada.lemic@bromley.gov.uk
Chief Officer:	Terry Parkin, Executive Director of Education, Care & Health Services
Ward:	ALL

1. Reason for report

1.1 The Executive in November 2013 and June 2013 agreed a strategic approach for dealing with Public Health contracts post transfer to the Local Authority. Following on from these decisions this paper focuses on the Category A: Standard contracts identified in the June report which come to an end in March 2014 and now require retendering.

1.2 These contracts cover the 5 key Public Health Improvement Programmes. The contracts are managed within our normal corporate procurement regulations and are therefore subject to be retendered accordingly under our Contract Procedure Rules.

1.3 This reports sets out the details of these programmes and the positive impact that they have had on service users. It also explains how Public Health intends to retender these services under a framework agreement that allows a great deal of flexibility during a period where Councillors and service heads are reviewing and making decisions around budget spend.

1.4 Other Boroughs have also taken a keen interest in how Bromley proposes to handle the retendering of these contracts as they are also looking at a flexible and innovative solution.

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2. RECOMMENDATIONS

2.1 The PDS Committee is asked to consider and note the impact of the existing services set out against the 5 key Public Health programmes and support the proposed procurement approach set out for the retendering of these services.

2.2 The Executive is asked to:

a) Approve the creation of a Public Health Framework which allows Public Health leads to commission services across these core programmes;

b) Approve this procurement approach as it provides the flexibility and assurance Members are seeking with regard to not committing a defined spend on these areas for 4 years, Instead it allows the Director of Public Health to prioritise spend and respond to baseline reviews and other corporate savings programmes;

c) Allow Public Health Leads to continue to work with other London Boroughs to achieve efficiencies through sharing best practice and opening up the framework to other local authorities.

Corporate Policy

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

Financial

1. Cost of proposal: Within existing officer capacity
2. Ongoing costs: Recurring Cost:
3. Budget head/performance centre: Director of Public Health
4. Total current budget for this head: £12.6 million
5. Source of funding: DoH Grant

Staff

1. Number of staff (current and additional): 23 FTE
2. If from existing staff resources, number of staff hours:

Legal

1. Legal Requirement: Statutory Requirement / Non Statutory
2. Call-in: 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? No
2. Summary of Ward Councillors comments: n/a

3. COMMENTARY

3.1 The report to Executive in June 2013 outlined the proposals for how the inherited Public Health contracts would be administered post transfer and Members approved the contracting approaches set out in the report across the 4 category types.

3.2 The current arrangements for the Category A - Standard contracts come to an end in March 2014 and require renewal in order to deliver the five key Public Health Improvement programmes namely;

1) NHS Checks

2) Sexual Health (including HIV care & support, Contraception outreach, Lab testing for Chlamydia)

3) Physical Activity

4) Smoking Cessation

5) Weight Management

3.4 Procurement Strategy

3.4.1 We have an obligation under our financial regulations and contract procedure rules to go through a full tendering exercise for these services. But there is also a need for a great deal of flexibility in how we commission these services because:

- The Council needs to find significant savings and we cannot lock ourselves into a set spend for a five year period
- The Director of Public Health needs the flexibility to be able to channel finding to priority areas of public health
- Public health leads run a number of projects and NHS health checks where they cannot promise providers set volumes of work
- There are a number of relatively small projects and activity that could be made very inefficient by requiring a separate tender for each

3.4.2 However, due to these factors the Procurement Manager within the Commissioning Division has proposed a framework solution. The argument is that with 5 key Public Health service areas being tendered simultaneously, each with multiple providers and well-developed markets, the best procurement solution would be to develop a framework with categories (or 'Lots') for each of the service areas. The Council has developed frameworks successfully in other service areas as a flexible means of delivering services.

3.4.3 Using a framework approach allows for simple tendering processes with an evaluated pool of providers for any future contracts within these Public Health service areas. The Council is not bound to use the framework, and if it considered the providers on the framework were unable to meet its requirements at any time, it could go back out to open tender as part of a separate tendering exercise.

3.4.4 Once a framework agreement has been established for two plus two years, specific call-offs can be made for specific services throughout the duration of the agreement, although there is no commitment to buy any services.

3.4.5 Within the framework arrangements there are two possible options for awarding contracts dependent on the requirements of an individual service:

- First, the Council can award a contract without reopening competition. As a framework agreement itself has already been competitively tendered, call-offs from the framework agreement can be made without going out to competition. The call off process will involve a Council awarding the contract to the most economically advantageous provider.

- Second, the contract can be awarded through a mini-competition with all the suppliers within the framework capable of meeting the particular need. This can be a quick process, based on a specific brief and prices/rates; the quality aspects will already have been evaluated at the time of establishing the framework.

3.4.6 An advantage of the framework will be to ensure that there is a range of potential providers available to provide these services, which should guard against the risks of over reliance on a single provider and the potential for any one provider to be over-extended.

3.4.7 The establishment of a framework should also ensure consistent and uniform quality controls and service specifications together with the delivery of competitive market rates.

3.4.8 The framework would be tendered using the Due North electronic tendering system. The system allows companies to submit their tenders on line providing the Council with greater visibility of market interest, reducing the administrative burden of the tendering process for all parties and giving the Council access to a potentially wider market of suppliers through on line advertising thereby increasing the potential for VFM from the procurement process. Registration on Due North is free for providers and would be a requirement for participation in the procurement exercise.

3.4.9 Councils can use the frameworks of other public sector bodies where it is clear that the framework was advertised on behalf of such other bodies. Officer discussions have taken place with Bexley Council on possible arrangements for a joint procurement exercise (led by Bromley) where Bexley would contribute to the procurement costs. Bexley have agreed to such an arrangement and are willing to contribute £10,000.

3.5 Indicative Timetable

3.5.1 An indicative timetable for the development of the framework would be:

Activity	**Target Dates**
Contacting existing providers to ensure registration on Due North	8th November 2013
Tender opportunity published through Due North	15th November 2013
Tender Return Date	3rd January 2014
Stage 1 Evaluation of PQQs completed	17th January 2014
Stage 2 Evaluation of tender submissions completed	31st January 2014
Possible clarification interview dates	w/c 10th February 2014
Evaluation of tenders completed	20th February 2014
Appointments to Framework	11th March 2014

5. POLICY IMPLICATIONS

5.1 This work continues to be in accordance with the transfer of responsibilities for Public Health as set out in the Health and Social Care Act 2012.

6. FINANCIAL IMPLICATIONS

6.1 This report specifically refers to the retendering of the Category A contracts, excluding the Substance Misuse contracts. The total 3rd party spend on these contracts stands at around £750k per annum across 15 different contracts. Commissioning leads for each of the 5 Public Health Programmes are required to monitor activity and to remain within their allocated budget as set out when the services were initially transferred.

	Current Contract Cost £'000
NHS Checks	150
Sexual Health	192
Physical Activity	74
Smoking Cessation	235
Weight Management	99
Total	**750**

6.2 The Framework arrangement allows for flexibility as it does not make any commitment to providers regarding volume of activity and so spend on these programmes can be reduced or increased accordingly in line with budget pressures and Member priorities e.g. there is no obligation to purchase any activity.

Non-Applicable Sections:	**LEGAL & PERSONNEL IMPLICATIONS**
Background Documents: (Access via Contact Officer)	Public Health Transfer of Contracts November 12 (Executive Report) Public Health Administration of Contracts June 13 (Executive Report)

Appendix One

Introduction – the appendix outlines the five public health programmes in more detail

1. NHS Health Checks - Value of current contracts: £150k per annum

The NHS Health Check, vascular risk assessment and management programme is a national primary prevention initiative targeting vascular disease, namely; heart disease, stroke, diabetes, kidney disease, peripheral arterial disease and some dementia. Vascular diseases are the main cause of death and disability in England and have common risk factors.

The NHS Health Check offers a confidential, free of charge consultation for adults aged 40-74 years old (without a previous diagnosis of one of the vascular diseases). The NHS Health Check will:

- Assess the individual's risk of developing vascular diseases through questions and measurements and blood tests.
- Offer advice and support with making healthy lifestyle changes based on the individuals risk factor profile and motivation to change.
- Signposting for further investigations or review at GP Practice as appropriate.
- Offer medical management to reduce their risks for those identified as higher risk.

By providing the NHS Health Checks through a structured programme all those who are eligible can be given the opportunity to have an NHS Health Check every 5 years.

In Bromley the invitations are sent by the GP Practice who have access to the patient's data and can identify the eligible population. The invitation may offer the opportunity to make an appointment for an NHS Health Check giving one of the following options depending in the Level of agreement with the GP Practice:

- Attending the GP Practice only
- A choice of attending the GP Practice or Alternative Provider
- A choice of attending an Alternative Provider

In past year we have also had short term contract with a provider who performs opportunistic NHS Health Checks in Community venues e.g. Libraries, community centres, supermarkets etc. We would wish future procurement to include this element.

Bromley uses **Point of Care testing** for cholesterol so the blood test result is available at the time of the check. This enables the DH Best Practice Guidance to be followed as the results are immediate and the required face to face communication of level of cardiovascular risk can be discussed with the individual along with support to reduce their level and risk and signpost for further services or intervention if required. This benefits participants as it limits the number of visits and ensures full checks are completed.

The cholesterol testing equipment is owned by Public Health and loaned to the pharmacists and GP Practices. There is a contract with the supplier which includes:

- The supply of consumables involved in the blood testing
- A service agreement (maintenance – replace broken equipment with new)
- An Internal Quality Control agreement for monthly testing of equipment to ensure accuracy of results.

The current system is working well in Bromley and we would wish to continue to commission this important element of the NHS Health Check which would include the on-going provision of consumables, provision of maintenance and quality assurance.

Evidence

The NHS Health Check programme is fully supported by Public Health England (PHE), NHS England (NHSE), the national Institute for Health and Care Excellence (NICE) and the Local Government Association (LGA). A paper entitled NHS Health Check: our approach to the evidence (PHE July 2013) makes the case for NHS Health Checks.

There is a multitude of evidence that the interventions incorporated into the NHS Health Check programme can reduce or slow the onset of vascular disease. Interventions to be included in the NHS Health Checks Programme were recommended by the UK National Screening Committee and incorporated into the Department of Health Best Practice Guidance[1,2,3] As the NHS Health Check is a relatively new model of working, the evidence on the actual model is not yet available to date, however national evaluation programmes are in progress.

With regard to the interventions, it is well documented that making lifestyle changes such as stopping smoking, weight management and appropriate levels of physical activity can reduce the risk of vascular diseases. NICE has produced evidence based guidelines on these three lifestyle risk factors highlighting best practice and the importance of addressing these risk factors in the population to reducing the prevalence of vascular disease. More specific interventions are targeted at those individuals found to be at increased risk of developing vascular disease.

Early identification of people with hypertension can most significantly prevent strokes and other vascular diseases.

Early identification of those at high risk of diabetes and targeting them with an intensive lifestyle change programme may prevent or delay the onset of diabetes. There is clear evidence that taking statin medication can help prevent cardiovascular disease and it is recommended to offer them to those at high risk of cardiovascular disease (CVD) (greater than 20% 10year risk)

Activity Levels and Measured Outcomes

The activity target relates to the number of the people defined as eligible for an NHS Health Check in the 40-74 year old population.

Being a 5 year programme, one fifth (20%) of the population should be offered an NHS Health Check each year. For 2013 -14 there is a national target for a year on year increase in the percentage uptake of people receiving an NHS Health Check from those who had received an offer. Table 1 shows the increase in numbers of NHS Health Checks offered and received since the programme was commenced.

Table 1. Performance figures complete to March 2013

NHS Health Checks Performance April 2009 - March 2013						
	Total numbers of 40-74yrs	**Total numbers of patients eligible for an NHS Health Check**	**Number of patients invited to have an NHS Health Check**	**Percentage of eligible population invited**	**Number of patients who received an NHS Health Check**	**Percentage take up of NHS Health Check of those invited**
Foundation Year 2009-10					2,649	
2010-11	139,361	100,363	5,706	6%	3,150	55%
2011-12	138,022	99,949	20,995	21%	7,617	36%
2012-13	-	100,037	23,033	23%	8,958	39%
TOTAL			**49,734**		**22,374**	

2. Sexual Health - Value of current contracts: £192k per annum

HIV Non-Clinical Care and Support Provision in Bromley

The transition of Public Health to the Borough has brought all HIV care and support commissioning responsibility together (except specialist treatment which continues to be commissioned by NHS England) with Public Health being the lead commissioner. A review of HIV Care and Support Provision in Bromley was commissioned to inform future commissioning intentions. The finding of the review confirms that there is a need to:

- Develop a sustainable model of care that addresses the changing needs of people living with HIV (PLHIV) in light of the changing face of HIV as a chronic manageable long-term condition.
- Re-specify and develop tighter service specifications for all services, focusing on impact and the outcomes to be delivered.

In response to the above, Public Health commissioners recommend to market test with a new service specification for a range of non-clinical care and support for PLHIV.

Bromley currently commissions a portfolio of non-clinical care and support services for people living with HIV in Bromley. The services mainly provide support, advice, counselling.

HIV Population Demographics

Treatment advances have transformed HIV from an almost universally fatal illness to a manageable chronic condition, if diagnosed early. Nevertheless, HIV remains a significant clinical and public health issue both worldwide and in the UK, especially in London.

The number of people living with HIV (PLHIV) in Bromley has increased by 68% in the last five years (compared with 48% for England) and by 7% from 2009 to 2010 (compared with 6% for England).

In 2010, there were 412 Bromley residents accessing HIV related care. This equates to a prevalence rate of 2.1 per 1,000 population aged 15-59. This compares with London rate of 5.4 per 1,000 and England rate of 1.9 per 1,000.

The median age of those accessing care for HIV was 41 (IQR: 35 to 49). There were fewer than five children under 15 years old with HIV.

The greatest numbers of patients accessing care were in the white (n=199, 48%) and black-African (n=148, 36%) ethnic groups.

The largest proportion of patients who were resident in Bromley were infected through sex between men and women (n=220, 53%). Infection via sex between men accounted for the next largest group (n=173, 42%) of residents receiving HIV care.

By 2011, the number in Bromley had increased to 458, an increase of 11% from previous year.

In terms of geographical spread, 33% of MSOAs in Bromley had prevalence rates higher than 2 per 1,000 - predominantly in wards located in the north of the borough which mirrors areas of central London and in wards either neighbours to boroughs that have high prevalence or where low cost housing is available.

Changing Face of HIV

Treatment advances in terms of effective antiretroviral therapy (ART) have reduced morbidity and mortality and increase life expectancy. Despite these advances, high rates of newly acquired HIV, often late presentation of HIV, continue to be reported.

In consequence, the overall numbers of people with HIV in the UK, largely working age adults (35 to 49 year olds), are increasing year on year (BHIVA 2013). This can have a significant economic

impact on individuals and families. Of particular concern, the number of older patients is likely to grow substantively over the next 5 to10 years, as the high numbers of patients in older age groups are ageing.

In addition, there is an increase in patients aged 15-24 years – this is likely to be a cohort effect from children with HIV growing older rather than new diagnosis. Transitional care planning (from child to adult HIV services) for this cohort is challenging and will require some consideration, particularly in Bromley where the numbers are small.

Men infected through sex with men (MSM) or black African people account for 85% of those living with HIV in the UK. There are differing care and support needs for MSM and heterosexual BA. Psychological support and substance abuse are important concerns for MSM, whereas the BA population is more affected by social isolation, access to housing, money concerns, unemployment and stigma.

Small numbers are infected through injecting drug use, received blood products or by mother to child transmission (MTCT).

HIV services must, therefore, primarily focus on prevention and enablement, be accessible, acceptable and respond to the needs of the differing groups, recognising the internal diversity of these groups.

Evidence

Undiagnosed, untreated and the more advanced stages of HIV infection facilitate onward transmission, compromising both individual wellbeing and the wider public health. However, if diagnosed early, HIV can be managed as a chronic long-term condition.

Living with HIV requires lifelong adjustments and management by people with the condition. Self-management approaches can help PLHIV to gain confidence, skills and knowledge to manage their own health, with resulting improvements in quality of life and independence (BHIVA Standards of Care for PLHIV 2013) and reduced transmission of HIV.

Review of evidence shows that the strongest evidence are case management, peer led programmes and psychological support. Advice and advocacy continues to demonstrate tangible and practical outcomes. However, the evidence is weakest regarding drop-in services.

Contraception & Sexual Health

Contraception and sexual health awareness is currently delivered through an outreach programme which includes health promotion and prevention and which aims to deliver behaviour change as an outcome that can be measured by using a Behaviour, Attitude, Skills and Knowledge (BASK) style questionnaire.

The programme targets those hard to reach young people (aged 15-24) in specific ward areas of Bromley and support them in maintaining their sexual wellbeing as they grow and develop sexually. Areas targeted are wards with the highest incidence of Chlamydia infection – BR1, BR5, BR6, SE20 and TN16. Outreach programme is conducted in educational settings in these areas.

Chlamydia testing the most vulnerable young people will continue to form a part of the focus, however targeting the most at risk communities in the identified areas and those young people will be a priority. This approach will focus on identifying those who are at great risk of poor sexual health and are likely to be tested positively and through appropriate treatment and behaviour change will reduce the overall prevalence that exists in the five key areas of Bromley Borough.

Specifically, the programme is to:

- Improve the knowledge of those who are most at risk of sexual ill health on access to specialised sexual health services.
- Reduce Chlamydia infection as well as other sexually transmitted infections (STIs) amongst those most at risk in the borough in line with the National Chlamydia Screening Programme (NCSP) guidelines
- Increase numbers of young people accessing Long Acting Reversible Contraception (LARC) and Emergency Hormonal Contraception (EHC) in the borough
- Develop young people's knowledge on STIs, transmission and treatment including Chlamydia, Gonorrhoea, Syphilis and Hepatitis
- Develop knowledge on HIV for all young people and encourage testing for HIV amongst young people most at risk
- Support positive attitudes and beliefs towards sexual health to reduce barriers.

Evidence

The recently published HPA figures showed that overall STI rates fell for the first time in 10 years, most notably among young people. Amongst those aged 15 to 19, Chlamydia diagnoses fell by 12% which indicates that efforts in recent years to intensify Chlamydia screening are now paying off. However, STI rates in gay men continue to rise. Gonorrhoea diagnoses went up by 33%, Chlamydia by 22% and genital herpes by 19% in a single year. Amongst all men, 40% of gonorrhoea and 64% of syphilis is in gay men.

The Bromley sexual health needs assessment conducted in October 2009 identified certain groups are at particular risk of poor sexual health: young people who live in deprived areas, those not in Education, LAC, Employment or Training (NEET), those who misuse drugs and/or alcohol, certain ethnic groups, men who have sex with men, youth offenders and travellers.

According to NICE guidance that is relevant to sexual health, focus should be given to behaviour change of the community or individual and especially being able to provide outcome evidence of the change when commissioning a service. It further recommends that, in the individual-level, interventions and programmes which motivate and support people to feel positive about the benefits of health-enhancing behaviours and changing their behaviour is a recommended action.

Evidence over the years of delivering the Chlamydia screening programme suggests that outreach is an effective ways of reaching out to young people, especially young males.

The model of the service commissioned is based on a successfully trialled project in a school in Greenwich. The aims of the project were to provide a confidential, dedicated 'drop in' primary health service and to assist young people to access quality, sympathetic health advice and services. They reported to have no teenage births at the school since the centre opened, pupils from ethnic backgrounds have used the services and the difference in numbers using the service compared to the demographics of school population are minimal and 87% of students who had used the services said that they would use the services again.

Expected Key Service Outcomes

- Overall change in Behaviour, Attitude, Skill and Knowledge as indicated by the BASK questionnaire
- Increase in testing of positivity rate of those young people who have been identified as particular at risk of poor sexual health screened for Chlamydia infection in outreach settings
- Increase in
    - knowledge of LARC amongst young people in Bromley
    - access of LARC amongst young women in Bromley
    - knowledge of EHC amongst young people in Bromley
    - access of EHC amongst young women in Bromley

- young people at risk assessing HIV testing in Bromley
- positive attitudes towards sexual health amongst young people in Bromley
- access to the borough wide Condom distribution scheme

Activity Levels and Method of Measurement

Activity Performance Indicators	***Method of measurement***	***Baseline Target***	***Threshold***
Chlamydia Screens - 600 young people aged 15-24 years who have been identified as at risk of infection with at least 12 positive results.	No. of screens achieved reported in the Bromley CSO Monthly and Quarterly Reports	600 but 10% can be out of area, meaning at least 540 should be Bromley residents 100% within correct age range	60 per month
Positivity rate of young people screened for Chlamydia infection in outreach settings	No. of positive results reported in Bromley CSO Quarterly Report	12 positive results per 600 young people screened	2 per month
Tutorial Presentations	Metro monthly report: Number of tutorial Presentations made within specific places/areas. Attendance at each tutorial and number of participants completed the BASK questionnaires	TBC	TBC per month
Baseline established for Change in Behaviour, Attitude, Skill and Knowledge as indicated by the BASK questionnaire.	BASK 1st Questionnaire completed BASK 2nd Questionnaire completed BASK 3rd Questionnaire completed	200 100 75	200 100 75
Service Provision – Educational establishments	Number of event per year per educational establishment.	100% of educational establishments assigned have at least one event per year and Fresher's Weeks are attended where applicable	
Allowance of 10% of the annual commissioned activity is allowed for out of area screens	Bromley CSO Report – Provider will also report back on screen obtained for Bromley in neighbouring boroughs	60	10 per month

Laboratory Testing for Chlamydia

Chlamydia is caused by a bacterial infection and is the most common sexually transmitted disease. It affects about 1 in 20 people between 15 and 50, with sexually active young people at highest risk. It is important to test for Chlamydia as the disease doesn't always produce symptoms but left untreated can cause infertility and ectopic pregnancy.

The National Chlamydia Screening Programme (NCSP) was established in 2003 and aims to control Chlamydia through early detection and treatment of asymptomatic infection, so reducing onward transmission and the consequences of untreated infection. It sets out a delivery programme to opportunistically screen those aged under 25 years of age in a range of healthcare and non-health care settings outside of GUM clinics at local level.

The control of Chlamydia infection and its associated complications remain a priority for Public Health England (PHE) and is one of the three key Sexual Health indicators of the Public Health Outcome Framework 2013/16.

The local Chlamydia Screening Office in Bromley commissioned a number of providers to offer chlamydia screening opportunistically in both healthcare and non-healthcare settings. These are general practices; community pharmacies; sexual and reproductive health services; abortion services and outreach services. In addition, there is an online facility for young people to order test kits remotely and anonymously.

Chlamydia screening involves taking a urine sample, which will be sent to the laboratory for investigation. The Urine Laboratory test (using nucleic acid amplification) will look for the presence of the bacteria, chlamydia trachomatis, in the urine. If the test result is positive, a course of treatment by antibiotics will then be prescribed. Where appropriate, partner notification will be given to the young person's sexual partner who, if consented, will be tested and treated appropriately.

Apart from analysing the samples, the laboratory testing service includes provision and dispatching of urine sample postal packs; patient request and screening forms; health promotional materials; processing and communication of test results; submission of national dataset (the Chlamydia Testing Activity Dataset, CTAD) to the Health Protection Agency at PHE and commissioner as well as provision of activity reports to the Commissioner.

The NCSP sets out clear standards for contracting laboratories, which must meet the following a set of mandatory requirements.

- Nucleic acid amplification tests (NATTS) must be used.
- Laboratories must be appropriately accredited with a nationally agreed accreditation scheme such as Clinical Pathology Accreditation (UK) Ltd.
- Commissioned laboratories must have capability to submit Chlamydia Testing Activity Data (CTAD) extracts to HPA on a quarterly basis.
- Commissioners should ensure that laboratories are registered with Care Quality Commission if they carry out regulated activities.

Evidence

In England, it has been estimated that between 26 and 43% of the 16-24 year old sexually active population needs to be tested annually to control chlamydia infection.

In 1998, the Chief Medical Officer's Expert Advisory Group on Chlamydia trachomatis considered the evidence-base associated with screening for genital chlamydia infection. This group concluded that chlamydia screening met the criteria for a screening programme and recommended that one be established.

In 2003, the Department of Health (DH) set up a national screening programme (NCSP) to opportunistically screen those aged under 25 years of age in a range of healthcare and non-health care settings outside of GUM clinics.

In 2013, the Public Health Outcome Framework 2013-16 includes the reporting of the diagnostic rates amongst the resident 14-24 years old population as the new indicator for monitoring the effectiveness of controlling chlamydia infection.

Expected Key Service Outcomes

Initially, a key measure of the success of the NCSP is the proportion of the target population tested annually. The policy has since changed and PHE recommends that local authorities should be working towards achieving a diagnosis rate of at least 2,300 per 100,000 in 15-24 years old population (Public Health Outcome Framework Indicator 2013/16), underlining the importance of reducing the prevalence of chlamydia infection in young adults in England.

Activity Levels and Method of Measurement

Providers must report the following according to NCSP core requirements:

- Total number of requests received by the laboratory
- Sample type totals (Urine or Swab)
- Patient gender
- Results (positive, negative and not reportable plus reason)
- Sample turnaround times

3. Physical Activity - Value of current contracts: £74,130 per annum

In an exercise referral scheme, a general practitioner (or other member of the primary care team) identifies and refers a sedentary individual with evidence of one or more of a prescribed set of medical conditions as detailed below, to the service.

- Arthritis
- Osteoporosis
- Type 1 or Type 2 diabetes
- BMI >30
- Hypertension
- Parkinson's disease
- Multiple Sclerosis
- Stroke
- Cancer
- >20% cardiovascular disease risk identified at NHS Health Check
- Non-diabetic hyperglycaemia

The service prescribes and monitors an exercise programme tailored to the individual needs of the patient with the objective of increasing participation levels in physical activity and structured exercise. The key features of the exercise referral scheme are:

- Provision of a specific range of appropriate and agreed physical activity for a defined period of time i.e. 12 sessions over a period of six months;
- information and advice on lifestyle risk factors and how such factors can be modified;
- the development of individual exercise plans;
- support for patients and carers to develop a plan for long-term management of physical activity and structured exercise;
- assessments and exercise programme are delivered by professionals with appropriate competencies and training which match the needs of the patient being referred;
- Support for black and minority ethnic groups, routine and manual workers, deprived communities, mental health patients, learning disability groups.

Evidence & Effectiveness

Physical activity contributes to the prevention and management of many medical conditions and diseases, including coronary heart disease, type 2 diabetes, some cancers, and mental illness such as dementia and depression. Despite recommendations that adults should undertake at least 30 minutes of exercise of moderate intensity at least five times per week, only about a third are active to this level.

Increasing levels of physical activity and structured exercise contributes to achieving reductions in risks of coronary heart disease and obesity, hypertension, cancer, osteoporosis, depression and anxiety.

People who are physically active reduce their risk of developing stroke and type 2 diabetes by up to 50%, and the risk of premature death by about 20–30%. Physical activity and structured exercise can help people lead healthier and even happier lives, irrespective of age (Be Active Be Healthy, 2009). Physical activity and structured exercise can also benefit the treatment of particular health conditions, for example in those recovering from coronary heart disease or for patients with long-term conditions such as chronic obstructive pulmonary disease and diabetes. In some cases physical activity and structured exercise can offer patient choice where outcomes are comparable to other more traditional treatments, for example as an alternative to pharmaceutical treatment for mild to moderate depression. Physical activity and structured exercise includes all forms of activity, such as 'everyday' walking or cycling to get from A to B, active recreation not undertaken competitively, such as working out in the gym, dancing, gardening or families playing together, as well as organised and competitive sport.

Activity Levels and Measured Outcomes

The exercise referral programme is commissioned on the basis of a certain level of activity, see table below:

Activity/Outcome	**Target Number**	**Target %**
Numbers Referred	1200	
Number of Initial Appointments	720	60%
Completers	180	25% of initial appointments
Improved Functional Limitation Profile	45	25% of completers
Self esteem Score		95% of completers
Patient Satisfaction (completers)	144	80% of completers
Patient Satisfaction Responses	144	100% of completers
7 Day Physical Activity Recall	100	56% of completers
Long Term Management Plan	90	50% of completers

4. Smoking Cessation - Value of current contract: £234,480 per annum

Bromley's Public Health provision of smoking services consists solely on smoking cessation work. The work is currently delivered through two main contracts of which one is Category A as described in the report.

This current contract is based on an annual target of 400 quitters. The provider offers intensive support to smokers who wish to give up, either referred by their GPs or other health professional or by themselves. Patients are normally seen weekly, either on a 1:1 basis or on a group therapy basis. The provider is also permitted to administer Nicotine Replacement Therapies (NRT).

For this contract, the provider is responsible for identifying locations from which to deliver the service. These include: areas of deprivation in wards such as Penge & Cator and Mottingham and

Chislehurst North; community settings including places of worship and homeless shelters; shopping centres; children's centres; healthcare settings and licensed venues such as pubs.

Evidence & Effectiveness

The JSNA (2012) demonstrates that smoking prevalence has increased year on year since 2009 in Bromley and whilst smoking related deaths have reduced both nationally and regionally in London, they have stayed the same locally. This evidence suggests that more targeted support is needed to encourage people to set quit dates and support them achieving this.

Table 1 - Smoking Prevalence Trend in Bromley *Source: LHO*

Year	Smoking Prevalence
2009-10	15.5%
2010-11	16.5%
2011-12	18.1%

The NHS Stop Smoking Service interventions are effective with 52.5% of those receiving interventions successfully quitting smoking at 4 weeks. Smokers attempting to stop without additional support would be expected to have a success rate of approx. 25% at 4 weeks.

Using the NICE Return on Investment Tool the estimated annual cost of smoking in Bromley is approximately £15.4 million (NHS costs £9.7 million, costs to businesses £5.5 million; passive smoking costs £153K). This tool predicts a considerable saving to be gained by investment in Stop Smoking Services and a sub-national tobacco control strategy of the order of £1.3 million in the first two years (mainly reductions in NHS costs but also nearly £0.5 million would be a cost saving to businesses).

5. Weight Management - Value of current Tier 2 Adult Weight Management Service contracts: £98,950 per annum

Tier 2 Adult Weight Management services provide a multi-component lifestyle weight management service that supports overweight and obese adults to lose weight and learn how to maintain a healthier weight. Patients are identified by the GP or other member of the primary healthcare team for referral to the weight management service.

Criteria for referral are:

- BMI >30 or
- BMI >28 with a comorbidity (such as hypertension, diabetes, coronary heart disease)

Exclusions are as follows:

- Pregnant women
- Housebound patients
- Age under 18 years
- Patients with eating disorders
- Patients who have attended a commercial weight management programme in the last three months
- Vulnerable patients without a carer

Patients are responsible for taking forward their own referral (as this ensures a level of motivation to proceed), and receive written information from the GP in order to manage the process. At present, patients are only eligible for one referral each.

Currently, the Tier 2 adult weight management service is delivered in Bromley by two commercial weight management providers.

It is important that this service is provided at multiple sites accessible to people across the whole borough throughout the week (including weekends) and at various times of day.

Evidence & Effectiveness

Obesity presents one of the major health challenges globally, nationally and locally. Obesity is a major risk factor for Type 2 diabetes, cardiovascular disease and cancer.

In Bromley, obesity has been identified as a key health priority in the JSNA and in the Health & Wellbeing Strategy. In Bromley, the estimated prevalence of obesity is 21.8% (2012 Health Profile), which represents approximately 54,200 adults.

GP obesity registers identify 25,168 people over the age of 16 years in Bromley with a BMI over 30 indicating obesity. However, the level of BMI recording in General Practice is relatively low (approximately 30%), supporting the likelihood that the disease register figure is a significant underestimate of the true value.

Notwithstanding the low level of BMI recording, the levels of obesity recorded on GP registers has been rising consistently over the last few years.

In tandem with the rising levels of obesity, there has been a consistent rise in the prevalence of diabetes in Bromley, with 13,307 cases on the GP registers in 2010, as compared with 4846 in 2002.

The prevention of diabetes has been identified as a key priority in the JSNA and in the Health & Wellbeing Strategy.

The key strategic objective of the adult weight management programme is to reduce the prevalence of obesity in Bromley and also to reduce the incidence of and complications from diabetes, hypertension, cardiovascular disease and cancer.

Although the proportion of obese individuals who are able to return to and maintain a healthy weight for the long term is relatively low, there is good evidence that a reduction of 5% in body weight in obese individuals results in reductions in cardiovascular risk.

There is good evidence that commercial weight management services are effective at supporting patients to achieve 5% weight loss. The Lighten Up randomised controlled trial published in the British Medical Journal in 2011 (*BMJ* 2011;343:d6500 doi: 10.1136/bmj.d6500) showed 46% of people achieving 5% weight loss at 12 weeks with Weight Watchers and 35% with Slimming World.

Activity Levels and Measured Outcomes

	Post Call Centre
Time period	Mid Feb 2013 to end Sept 2013
No. of People Receiving Vouchers	749
Proportion of men	125
No. of Completers (attended 10 or more session)	199(26.6%)
No. of Defaulters (attended fewer than 10 sessions)	132 (17.6%)
No. still active (attending sessions)	418 (55.8%)
Weight loss in completers and defaulters >5%	43%
Weight loss in completers and defaulters >10%	9%

Surveys were sent to 549 people who had attended the service, and 284 (51.7%) responded. Patient satisfaction has been good. The cost per course from current providers is approximately £54 per course.