LBHF PAC 20th JANUARY 2015

OVERVIEW OF THE PUBLIC HEALTH SERVICE FOR THE THREE BOROUGHS

1. INTRODUCTION

1.1 This paper describes both the mandatory and non-mandatory public health responsibilities, functions and services delivered in LBHF.

1.2 Under Section 12 of the Health & Social Care Act 2012 [i], from 1 April 2013, unitary local authorities have a duty to improve the health of the public, including for example: [ii]

- providing information and advice (for example giving information to the public about healthy eating and exercise); and
- providing or making arrangements for the provision of services for the management of health risk factors such as such smoking, and overweight and obesity).

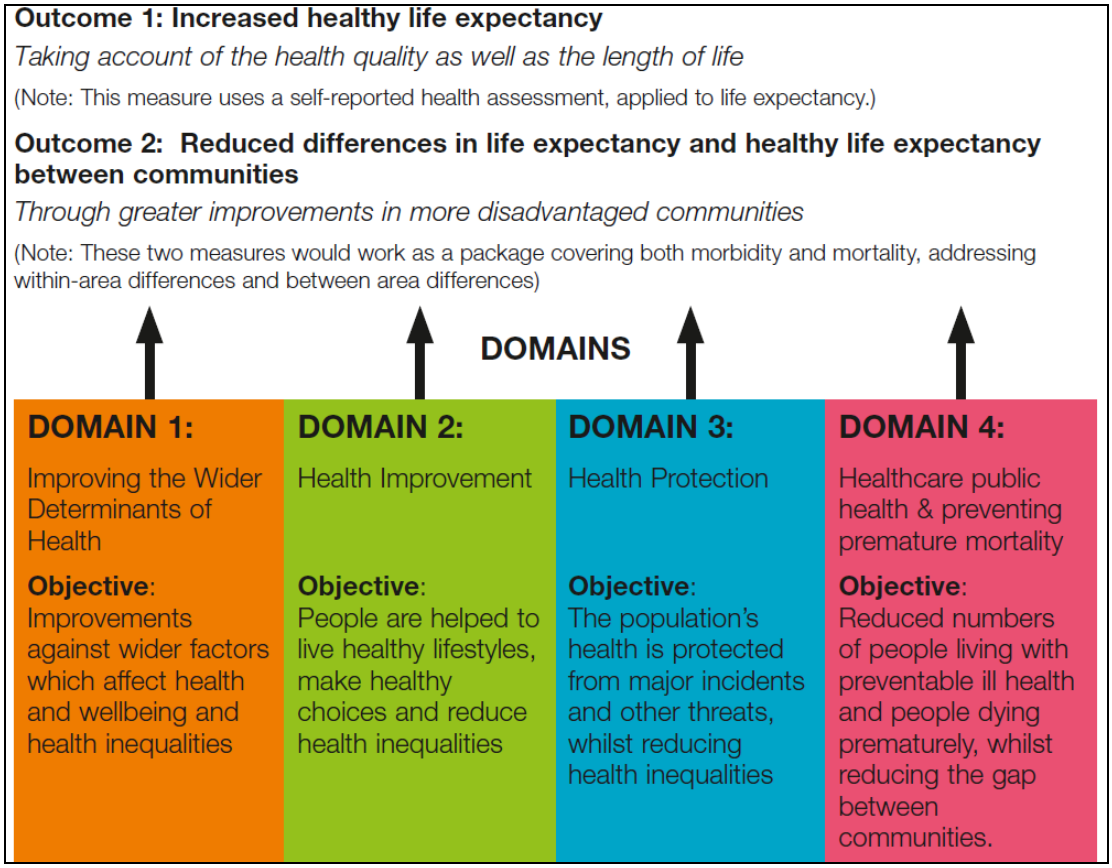
1.3 Regulations [iii] made under Section 6c of the NHS Act 2006 mandate local authorities to:

- provide for the weighing and measuring of children in reception classes and Year-6 (the National Child Measurement Programme);
- provide for the provision of health checks for people aged 40-74 years;
- provide for the provision of open access sexual health services;
- provide or make arrangements for the provision of a public health advice service to CCGs in their area; and
- provide information and advice on the preparation for and the management of threats to people's health such as infectious diseases, environmental hazards and extreme weather conditions.

1.4 The Health & Social Care Act 2012 also requires unitary authorities to have regard to the Department of Health's Public Health Outcome Framework (PHOF)[iv] which includes a range of measures across two key outcomes and four domains:

---

[i] http://www.legislation.gov.uk/ukpga/2012/7/contents/enacted/data.htm
[ii] Local authorities' public health responsibilities
http://www.parliament.uk/business/publications/research/briefing-papers/SN06844/local-authorities-public-health-responsibilities-england
[iii] http://www.legislation.gov.uk/ukdsi/2012/9780111531679
[iv] http://www.phoutcomes.info/



The public health team provides leadership on these outcomes through working closely with colleagues across Council departments and with external partners, such as the NHS and voluntary sector.

Further detail on the indicators is provided in appendix 1.

2. FUNDING AND CAPACITY

2.1 Public health currently has a stand-alone ring-fenced public health grant, which is required to be used for health improvement, health protection, reducing health inequalities and for providing public health advice to CCGs [v].

Further detail on the public health budget may be found in Appendix 2.

2.2 The public health team is currently structured as follows:

- Intelligence, including – data analysis and evidence, public health advice service to CCGs, JSNA process
- Children and families, including – childhood obesity, school nursing, health visiting transfer

---

v https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/388172/final_PH_grant_determination_and_conditions_2015_16.pdf

- Behaviour change, including – commissioning of health checks, community champions, diabetes champions, smoking cessation
- Substance misuse and sexual health - service commissioning
- Health protection, including advice and assurance on infectious disease
- Social determinants, including supporting collaboration across council functions to deliver public health outcomes

The structure of the public health team is currently under review.

3. THE DRAFT PUBLIC HEALTH STRATEGY

2.1 A Public Health Strategy is currently being developed, which aims to help the three councils focus on their joint and individual priorities for improving health outcomes.

There are six proposed joint priorities:

- reducing smoking rates
- reducing levels of obesity in adults and children
- improving sexual health
- reducing substance misuse
- improving preventative health care
- improving mental well-being

2.2 Each of these priority areas, in addition to other work, will contribute to the council's mandatory public health duties and to its wider public health duty to improve the health of the local population.

2.2.1 *Smoking* is the primary cause of preventable illness and premature death[1] and smokers are twice as likely to die before the age of 70 years as are life-long non-smokers.[2] Some 65% of adult smokers start smoking before the age of 18 years; only 6% start aged over 25 years.[3] LBHF has higher rates of smokers (21.4%) than the other two boroughs and more than the average for England (19.5%).

An important public health priority therefore is to both help people to quit and reduce the likelihood of children starting to smoke.

2.2.2 *Overweight and obesity* are major problems because they substantially increase the risk of developing a number of long-term conditions. Principal among these is type 2 diabetes because it substantially increases the risk of heart disease, blindness, kidney failure and early death.[4] Overweight and obesity also substantially increase the risk of developing high blood pressure, raised blood cholesterol levels, osteoarthritis, sleep apnoea (an interruption of breathing during sleep that increases the risk of sudden cardiac death), stroke, a number of

cancers, and dementia.

Our priority therefore should be helping people of all ages to avoid becoming overweight and obese and reducing the risks of disease by helping people to reduce excess weight.

2.2.3 *Sexual health* is significant because of the propensity of sexually-transmitted infections to be spread easily and amongst many people (the number of people infected increases year-on-year), leading to a variety of different health problems requiring treatment, and the very substantial cost of HIV treatment. In addition, 'unsafe' sex can not only lead to infection but also to unplanned pregnancy. In 2012, Hammersmith and Fulham had the 5th highest rate of STIs in England.

The treatment of sexually-transmitted infections is now the responsibility of local councils. The LBHF budget for this alone in 2015/16 is £6.4m. Unless we do more to identify people with such infections at an earlier stage (enabling treatment and thus reduced risk of infection of others) and encourage greater condom use (for example through the development of condom negotiation skills) the need for such treatment services will continue to rise.

2.2.4 *Substance misuse* includes the use of illicit drugs and so-called legal highs as well as alcohol. The contribution of drug-use disorders to mortality has increased very substantially in the last 20 years[5] as has the number of people admitted to hospital because of alcohol misuse and deaths due to alcohol-related non-violent causes (such as liver failure).[6] Hammersmith and Fulham has the 3rd highest rate of deaths due to chronic liver disease in London and alcohol-related hospital admissions have more than doubled over the last decade.

It is also significant that whilst drug use is likely to have a proportionately much greater deleterious impact on the life and health of the user, the number of people drinking alcohol in excess of recommended guidelines presents a much larger problem overall. Substance misuse is one of the largest areas of expenditure from the public health budget at £5.5m for 2015/16 in LBHF.

2.2.5 *Improving preventive health care* includes promoting screening (for example, health checks) and assuring adequate immunisation coverage.

Currently, there is conflicting evidence on the effectiveness of health checks, but our experience so far is that we are identifying a moderately high proportion of people with previously unknown remediable risk factors for heart disease, stroke, diabetes and kidney failure. Health checks are mandatory services for local councils to provide. We are likely to improve people's health most by concentrating our health check activity more in deprived areas.

Immunisation is second only to a clean water supply in reducing the burden of ill-health.[7] The council role in immunisation is principally to

assure the process which is commissioned solely by NHS England.

2.2.6 *Improving mental well-being* is of particular importance in LBHF. There is a clear link between loneliness and poor mental and physical health (i.e. tackling loneliness and social isolation, supporting people to remain connected to their communities and to develop and maintain connections to their friends and family). In 2013/14, 38.4% of Hammersmith and Fulham residents who use services reported that they had as much social contact as they would like, which was significantly lower than England (44.5%).

3. KEY WORK AREAS TO MEET OUR MANDATORY DUTIES AND TO IMPROVE HEALTH

3.1 *Smoking cessation* is particularly cost-effective[8] and has short-term benefits (such as a statistically significant risk reduction of planned surgery within 4-8 weeks of quitting[9]), medium term benefits (such as reducing the risk of heart attack within 12 months[10]) and long-term benefits (such as reducing the risk of cancer over several years[11]).

We are working with Hammersmith & Fulham CCG to develop ways to encourage patients who smoke to quit whilst they are receiving treatments and to help patients quit smoking before elective surgery.

We commission a local provider, *Thrive Tri*be, to deliver stop smoking services and training to GP practices and pharmacies so they can deliver stop smoking advice. The contract prioritises residents in the top two quintiles of deprivation, where prevalence rates on a ward basis can reach 25%.

In addition we commission the local provider to deliver the three national campaigns and three local campaigns each year, as well as a service which aims to stop young people from starting to smoke.

3.2 *Health checks*, a mandated service for local councils, help identify people at risk of conditions such as heart disease, stroke, diabetes and kidney failure before symptoms develop. We are concentrating our efforts particularly in the borough's more deprived areas where disease rates are higher and the consequences more significant. Health Trainers have been commissioned to deliver health checks in community settings.

We also intend to tender for cardiovascular disease (CVD) prevention services, concentrating on family-level interventions as well as individual ones. The service will be for people identified as at medium or high risk of developing CVD in the next ten years. Major referral sources for this are GP and community pharmacy health checks. We are amending the key performance indicators away from process measures to health outcomes.

3.3 *Community Champions* are a valuable way of influencing people's health behaviour at a 'street level'. Community champions deliver work

across a broad range of public health outcomes, including mental health, employment and employability, weight loss, increased physical activity and community cohesion.

We currently have three community champion projects, in Edward Woods, Old Oak and in the Parkview Centre in White City. The SROI (Social Return on Investment) evaluation of the projects revealed that for every £1 invested in the project, there is a return of £5.05.

In addition we have a Maternity Champions project in Old Oak, to support expectant parents in accessing services at an early stage and to make sure every child gets the best start in life. The project is working closely with midwives, health visitors and children's centres.

Working in collaboration with housing associations, we plan to extend these projects to include new ones in Shepherds Bush Green, North end Road and Lillie Road.

3.4 *Diabetes Champions* are volunteers affected by diabetes who work in communities to raise awareness of diabetes risks and how to reduce them. With the continuing rise in the prevalence of overweight and obesity, this is an especially important subject. In the first two quarters of this year our provider ran 38 events involving 636 people. An evaluation of similar work locally in 2012 showed 95% of event attendees improved their knowledge of diabetes; 80% made changes to increase their physical activity, and 75% made changes to improve their diet.

3.5 *Child obesity prevention and healthy family weight services* are a key component of councils' responsibilities to deal with wider determinants of poor health. We are currently procuring services to help establish 'healthy habits for life' in the context of eating, cooking and physical activity. The wider child obesity prevention strategy is working with NHS services, Schools, Children & Family services, and parks, sport and leisure services.

We will continue our statutory duty to deliver the National Child Measurement Programme (NCMP), which includes providing feedback to parents and supporting access to obesity prevention and management programmes.

3.6 *Genito-urinary medicine (GUM) and other sexual health service commissioning* will also continue but we are looking to reduce the cost of both GUM and contraceptive services; decommission some services related to HIV that are not part of our obligation under the Health & Social Care Act 2012; increase the range and reach of prevention services and advice; and, as much as possible, move contract key performance indicators away from service provision measures to hard outcome and proxy outcome measures.

3.7 *Substance misuse service* funding will be shifted from the General Fund to Public Health Grant monies.

3.8 *Mental health* problems are common, with some 30% of people who see their GP having a mental health component to their illness,[12] and about one in four experiencing a mental health illness at least once.[13]

We are exploring ways in which we might improve people's mental health wellbeing, particularly in terms of identifying potential problems at an early stage.

3.9 *Health protection* work will continue. For example, one role of councils is now to provide assurance that immunisation rates are adequate. Immunisations are commissioned from primary care by NHS England and we are working with them to see how we can obtain more accurate data on immunisation uptake as well as contribute to increasing uptake.

We have also provided advice on Ebola virus infection for staff and local GP practices and keep this up to date.

4. SERVICE PROVIDERS

4.1 We have a large number of contracts with a wide range of providers to deliver various public health interventions. These include several individual GP surgeries, some community pharmacies, third sector organisations, NHS community services providers and NHS acute trusts.

4.2 This diversity of provision enables better service access both in terms of choice, and, importantly, in terms of sensitivity to and appeal for different population groups.

5. RISKS

5.1 The NHS public health function was moved to local councils in 2013 because the majority of the key 'upstream' determinants of health, such as education, employment, housing and environment, lie outside the NHS remit and fit more closely with local authority functions.[14]

A number of other functions, such as the treatment of sexually-transmitted diseases and school nursing services, were transferred at the same time.

5.2 Local councils face a reputational risk should they not be seen to improve people's health and reduce health inequalities. Mitigating this will require effective integration of the public health function into council working and adequate investment in key areas affecting people's health.

APPENDIX 1
Public Health Outcomes Framework (PHOF) key indicators

1 Improving the wider determinants of health
Objective Improvements against wider factors that affect health and wellbeing and health inequalities
Indicators • Children in poverty • School readiness • Pupil absence • First-time entrants to the youth justice system • 16-18 year olds not in education, employment or training • Adults with a learning disability / in contact with secondary mental health services who live in stable and appropriate accommodation • People in prison who have a mental illness or a significant mental illness • Employment for those with long-term health conditions including adults with a learning disability or who are in contact with secondary mental health services • Sickness absence rate • Killed and seriously injured casualties on England's roads • Domestic abuse • Violent crime (including sexual violence) • Re-offending levels • The percentage of the population affected by noise • Statutory homelessness • Utilisation of green space for exercise/health reasons • Fuel poverty • Social isolation • Older people's perception of community safety

2 Health improvement

Objective

People are helped to live healthy lifestyles, make healthy choices and reduce health inequalities

Indicators

- Low birth weight of term babies
- Breastfeeding
- Smoking status at time of delivery
- Under 18 conceptions*
- *Child development at 2-2½ years (under development)*
- Excess weight in 4-5 and 10-11 year olds*
- Hospital admissions caused by unintentional and deliberate injuries in children and young people aged 0-14 and 15-24 years
- Emotional well-being of looked after children
- *Smoking prevalence – 15 year olds (placeholder)*
- Self-harm
- Diet
- Excess weight in adults
- Proportion of physically active and inactive adults
- Smoking prevalence – adult (over 18s)
- Successful completion of drug treatment
- People entering prison with substance dependence issues who are previously not known to community treatment
- Recorded diabetes
- Alcohol-related admissions to hospital
- Cancer diagnosed at stage 1 and 2
- Cancer screening coverage
- Access to non-cancer screening programmes
- Take up of the NHS Health Check Programme – by those eligible*
- Self-reported wellbeing
- Falls and injuries in people aged 65 and over

3 Health protection

Objective

The population's health is protected from major incidents and other threats, while reducing health inequalities

Indicators

- Fraction of mortality attributable to particulate air pollution
- Chlamydia diagnoses (15-24 year olds)*
- Population vaccination coverage
- People presenting with HIV at a late stage of infection
- Treatment completion for Tuberculosis (TB)
- Public sector organisations with board-approved sustainable development management plan
- Comprehensive, agreed inter-agency plans for responding to health protection incidents and emergencies*

4 Healthcare public health and preventing premature mortality

Objective

Reduced numbers of people living with preventable ill health and people dying prematurely, while reducing the gap between communities.

Indicators

- Infant mortality
- Tooth decay in children aged 5
- Mortality from causes considered preventable
- Mortality from all cardiovascular diseases (including heart disease and stroke)
- Mortality from cancer
- Mortality from liver disease
- Mortality from respiratory diseases
- Mortality from communicable diseases
- Excess under 75 mortality in adults with serious mental illness
- Suicide rate
- Emergency readmissions within 30 days of discharge from hospital
- Preventable sight loss
- Health-related quality of life for older people
- Hip fractures in people aged 65 and over
- Excess winter deaths
- Estimated diagnosis rate for people with dementia

APPENDIX 2
The LBHF public health budget

	Actual Budget 2014/15 £'000	Proposed Budget 2015/16 £'000	Estimated Budget 2016/17 £'000	Estimated Budget 2017/18 £'000
Income/ Funding				
Public Health Grant Income	(15,228)	(15,228)	(15,228)	(15,228)
Substance Misuse Grant	(5,627)	(5,627)	(5,627)	(5,627)
0-5 Programme incl Health Visiting (from Oct 2015)	-	(1,833)	(3,667)	(3,667)
Drawdown from PH Reserves	-	(783)	(327)	-
Total Income	**(20,855)**	**(23,471)**	**(24,849)**	**(24,522)**
Contract Expenditure				
Substance Misuse	5,464	5,464	5,191	4,931
Sexual Health	6,978	6,410	6,169	5,986
Behaviour Change	2,110	2,753	2,953	2,953
Families and Children's Services	2,607	5,135	6,968	6,968
Intel & Social Determinants	41	89	89	89
Total Contract Expenditure	**17,200**	**19,851**	**21,370**	**20,927**
Overheads and Other Expenditure				
Salaries and overheads	1,431	1,435	1,435	1,435
Unallocated budget	2,570	-	-	116
PHIF projects	-	1,817	1,676	1,676
Children's services funding	-	368	368	368
Total net expenditure (General Fund)	**346**	**0**	**0**	**0**

Contract Expenditure	2014/15 Budget £'000	Budget 2015/16 £'000	Budget 2016/17 £'000	Budget 2017/18 £'000
Detox & Residential Placements	590	590	561	532
Community Based Services	3,518	3,518	3,342	3,175
Reducing Reoffending	280	280	266	253
Dual Diagnosis	100	100	95	90
other	976	976	927	881
Substance misuse	**5,464**	**5,464**	**5,191**	**4,931**
			-	-
GUM	4,300	4,026	4,026	3,870
Chlamydia Screening	375	375	375	375
HIV Contracts	764	562	351	351
Contraception	1,165	1,072	1,050	1,030
Other	374	375	367	360
Sexual Health	**6,978**	**6,410**	**6,169**	**5,986**
			-	
Health Checks	414	414	414	414
Smoking Cessation	901	924	924	924
Heath Trainers	503	777	777	777
Community Champions	257	403	403	403
Cardiovascular risk management programme	-	200	400	400
Other	35	35	35	35
Behaviour Change	**2,110**	**2,753**	**2,953**	**2,953**
			-	
Obesity & Dietetics	395	944	944	944
School Nursing	1,920	1,920	1,920	1,920
Healthy Schools	60	60	60	60
Domestic violence	127	127	127	127
Dental health	41	41	41	41
Mental Health	33	33	33	33
Healthy Start Vitamins	31	31	31	31
Tackling Childhood Obesity program/ pilot	-	145	145	145
0-5 Programme incl Health Visiting	-	1,834	3,667	3,667
Families and Children	**2,607**	**5,135**	**6,968**	**6,968**
Libraries work around health	17	17	17	17
Health Promotion Recource Centre	24	23	23	23
PublicHealth Leadership Forum	-	6	6	6
Making Every contract count	-	15	15	15
Specialist project work	-	15	15	15
Software	-	5	5	5
JSNA Website	-	1	1	1
NHS Data access	-	7	7	7
Intel & Social Determinants	**41**	**89**	**89**	**89**
Total	**17,200**	**19,851**	**21,370**	**20,927**

REFERENCES

1 National Institute for Health and Care Excellence. *NICE guidance and public health outcomes.* National Institute for Health and Care Excellence. London. 2012. See: http://www.nice.org.uk/advice/lgb5/chapter/rationale-for-the-indicators (accessed 22 December 2014)

2 Doll R, Peto R, Boreham J, Sutherland I. Mortality in relation to smoking: 50 years' observations on male British doctors. *Br Med J 2004: 328: 1519*

3 See: http://www.lho.org.uk/LHO_Topics/National_Lead_Areas/NationalSmoking.aspx

4 Carson JL, Scholtz PM, Chen AY, Peterson ED et al. Diabetes mellitus increases short-term mortality and morbidity in patients undergoing coronary artery bypass graft surgery. *J Am Coll Cardiology* doi:10.1016/S0735-1097(02)01969-1

5 Murray CJL, Richards MA, Newton JN, Fenton KA, Anderson HR et al. UK health performance: findings of the Global Burden of Disease Study 2010. *Lancet* DOI: http://dx.doi.org/10.1016/S0140-6736(13)60355-4 See: http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(13)60355-4/abstract (accessed 23 December 2014)

6 Hospital Episode Statistics. The NHS Information Centre for Health and Social Care. 2014. See: http://www.hscic.gov.uk/article/2021/Website-Search?productid=14775&q=alcohol&sort=Relevance&size=10&page=1&area=both#top (accessed 23 December 2014)

7 World Health Organisation. *Vaccination greatly reduces disease, disability, death and inequity worldwide.* World Health Organisation. Geneva. 2008 See: http://www.who.int/bulletin/volumes/86/2/07-040089/en/ (accessed 22 December 2014)

8 National Institute for Health and Care Excellence. *Smoking cessation services.* National Institute for Health and Care Excellence. London. 2013. See: http://www.nice.org.uk/guidance/ph10/resources/guidance-smoking-cessation-services-pdf (accessed 17 December 2014)

9 Moller AM, Villebro N et al. Effect of pre-operative smoking intervention on post-operative complications: a randomised clinical trial. *Lancet* 2002; 359: 114-7

10 Sims M, Maxwell R, Bauld L, Gilmore A. Short-term impact of smoke-free legislation in England: retrospective analysis of hospital admissions for myocardial infarction. *Br Med J* 2010; 340: c2161

11 Parkin DM, Boyd L, Darby SC, Mesher D, Saisieni P, Walker P. The fraction of cancer attributable to lifestyle and environmental factors in the UK in 2010. *Br J Cancer* 2011; 105:S1-S82

12 Royal College of General Practitioners. *Care of People with Mental Health Problems*. *Curriculum Statement 13.* Royal College of General Practitioners. London. 2007

13 See http://www.nhs.uk/NHSEngland/AboutNHSservices/mentalhealthservices/Pages/Overview.aspx *Mental health services*. NHS Choices (accessed 22 December 2014)

14 Madelin T. The Lancet: UK Policy Matters. *Transfer of local public health functions from NHS to local authorities.* Lancet. London. 2011. See: http://ukpolicymatters.thelancet.com/policy-summary-transfer-of-local-public-health-functions-from-the-nhs-to-local-authorities/ (accessed 23 December 2014)