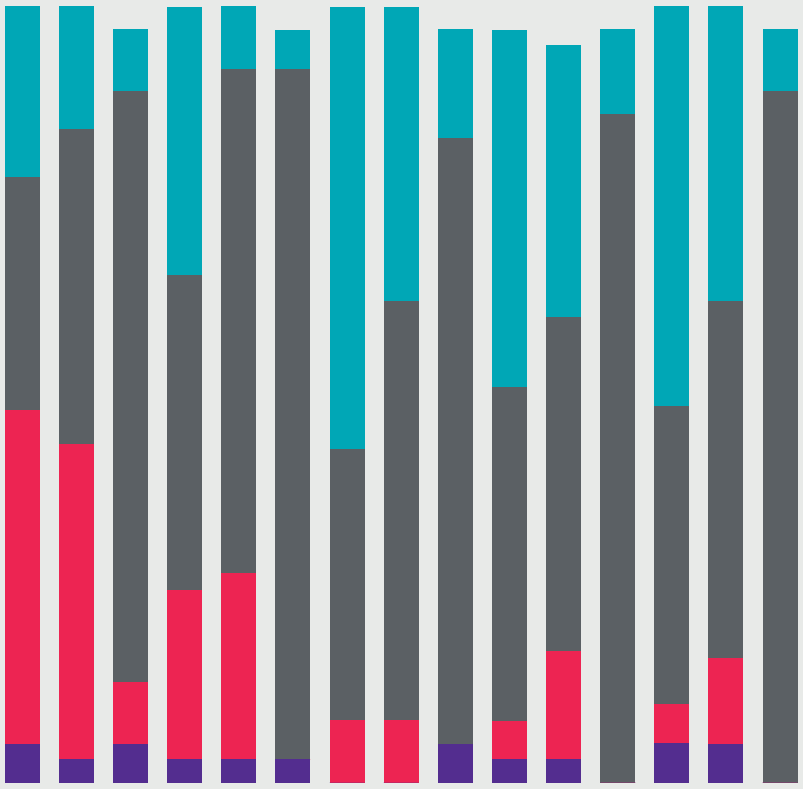
QualityWatch

Focus on: Public health and prevention

Has the quality of services changed over recent years?

Research report



Alisha Davies, Eilís Keeble,
Tazeem Bhatia and
Elizabeth Fisher

April 2016

The Health Foundation | nuffieldtrust

About QualityWatch

QualityWatch is a major research programme providing independent scrutiny into how the quality of health and social care is changing. Developed in partnership by the Nuffield Trust and the Health Foundation, the programme provides in-depth analysis of key topics and tracks an extensive range of quality indicators. It aims to provide an independent picture of the quality of care, and is designed to help those working in health and social care to identify priority areas for improvement. The programme is primarily focused on the NHS and social care in England, but also draws on evidence from other UK and international health systems.

The QualityWatch website **www.qualitywatch.org.uk** presents key indicators by area of quality and sector of care, together with analysis of the data. This free online resource also provides research reports, interactive charts and expert commentary.

About this report

QualityWatch Focus On reports are regular, in-depth analyses of key topics. These studies exploit new and innovative methodologies to provide a fresh view of quality in specific aspects of health and social care. This QualityWatch Focus On provides an overview of public health outcomes in recent years and considers the opportunities and challenges presented as efforts are made to maintain the quality of services in the light of recent reforms and financial pressures. Download and view other resources on this topic area at **www.qualitywatch.org.uk/public-health**.

Acknowledgements

We thank the following people who have contributed to the report or commented on earlier drafts: Alessandra Giusti (Nuffield Trust), Dr Andrew Furber (Association of Directors of Public Health) and Professor John Newton (Public Health England). We also thank all the Directors of Public Health and Public Health Consultants who took part in our survey, especially those that provided us with quotes or took part in further interviews, as well as the service provider and advocacy organisations for public health and prevention who provided us with information for this report. Finally, we thank the QualityWatch project team who have provided useful insight during the review phase.

Contents

List of figures, tables and boxes

Figures

Tables

Boxes

List of acronyms used in the report

ADPH	Association of Directors of Public Health
APPGSRH	All-Party Parliamentary Group on Sexual and Reproductive Health in the UK
BASH	British Association of Sexual Health and HIV
BMI	Body mass index
CCG	Clinical commissioning group
CI	95% confidence intervals
DH	Department of Health
DsPH	Directors of Public Health
FSRH	Faculty of Sexual and Reproductive Healthcare
GP	General Practitioner
GUM	Genitourinary Medicine
H&SCA 2012	Health and Social Care Act 2012
HSCIC	Health and Social Care Information Centre
HWB	Health and wellbeing board
IMD	Indices of multiple deprivation
JHWS	Joint Health and Wellbeing Strategy
JSNA	Joint Strategic Needs Assessment
LA	Local authority
LARC	Long acting reversible contraception
LGA	Local Government Association
MMR	Measles, mumps and rubella
MSM	Men who have sex with men
NDTMS	National Drug Treatment Monitoring System
NICE	National Institute for Health and Care Excellence
ONS	Office for National Statistics
PHE	Public Health England
PHOF	Public Health Outcomes Framework
SRE	Sex and relationships education
SRH	Sexual and reproductive health
STI	Sexually transmitted infection
WHO	World Health Organization

Executive summary

This QualityWatch report provides an overview of public health outcomes in recent years. The report also considers the opportunities and challenges presented as efforts are made to maintain the quality of services in the light of these recent reforms and financial pressures.

We examine trends in 20 indicators across sexual and reproductive health (SRH) and HIV, substance misuse, smoking, childhood obesity and immunisations. In order to provide a more nuanced view we also gathered reflections from senior public health professionals (37 responses to a survey and 11 interviews), and other provider and advocacy organisations (11 interviews).

Indicators in public health

From 2009 to 2015, six indicators showed continued deterioration: reduction in the number of people setting a quit date with NHS stop smoking services; increasing rates of four common sexually transmitted infections (STIs); and alcohol-related hospital admissions.

There were 10 indicators that showed continued improvement (including provision of long acting reversible contraception [LARC] by general practitioners [GPs], reduction in genital warts, drug treatment waiting times, smoking in pregnancy, and childhood obesity at age 4–5 years), but in five of these there was an indication that progress may have slowed (reductions in smoking prevalence, teenage pregnancy and late diagnosis rate for HIV; completion of substances misuse treatment; and measles, mumps and rubella [MMR] immunisation uptake). It is too early to tell if this reflects a true change in these indicators. Changes in the remaining indicators were either unclear (proportion of smokers who quit and numbers of substance misuse in treatment) or constant (childhood obesity at age 10–11 years and uptake of the 5-in-1 vaccine* in babies).

The most socioeconomically deprived areas of England were disproportionately affected by worsening trends in STI rates, but a greater proportion of these local authorities showed improvement in teenage pregnancy rates compared to what was expected based on the national trend.

New opportunities to improve quality…

Senior public health professionals that we surveyed/interviewed felt that local government procurement processes were contributing towards improving effectiveness, equity and access to services commissioned. Examples of how this is occurring include placing greater emphasis on integrated service models, alignment to quality standards, addressing the needs of vulnerable populations and enhanced performance management. However, some interviewees highlighted the significant burden the re-tendering process places on providers.

Some of the respondents/interviewees suggested that there is now greater opportunity for integration across council services to improve access and

* Diphtheria, tetanus, whooping cough (pertussis), polio, and Hib (Haemophilus influenzae type B).

outcomes. But some respondents raised concerns about fragmentation in some areas (particularly sexual health services), loss of local knowledge and influence in others (immunisation and screening programmes), and loss of public health input in NHS commissioning.

…But increasing pressure from financial challenges

System-wide financial pressures and uncertainty were identified as key challenges. Senior public health professionals and provider and advocacy organisations reflected that more difficult local prioritisation decisions are likely, and maintaining effective and equitable access with decreasing funds is a concern. One survey respondent said: "It is impossible to reconcile the rhetoric of the NHS and the government with regard to prevention with cuts in public health budgets and wider local authority budgets."

Conclusion

The Health and Social Care Act 2012 resulted in significant restructuring of the public health system and was followed by cuts in public health and local government funding. As yet, there is little evidence of a marked change in outcomes, but where there is change it is difficult to ascertain whether this has been a consequence of the system reforms, budget cuts, or wider societal factors.

Strengthening the arguments for prioritising public health, along with scrutiny of local commissioning decisions, may help to ensure the rhetoric of greater focus on prevention becomes a reality. Monitoring future public health outcomes is warranted to ensure improvements are sustained and emerging challenges are addressed.

1

Introduction

Why preventing poor health is important

The top three causes of premature death in the UK (heart disease, lung cancer and stroke) are placing significant burden on the NHS, social care and wider society, but all are largely preventable. The Department of Health (DH) estimates that 70% of the total health and social care spend in England is for the treatment and care of people with long-term conditions such as diabetes and heart disease (Department of Health, 2010a). Yet, many of the behaviours which contribute towards the development of long-term illnesses such as these are also preventable, including smoking, excessive alcohol consumption, lack of physical exercise and obesity.

Investing to improve the population's health makes economic sense. It is estimated that, in the UK, people being overweight or obese costs the NHS £5.1 billion, smoking costs £3.3 billion, alcohol costs £3.3 billion, and physical inactivity costs £0.9 billion (2006/07 figures; Scarborough and others, 2011). Two large reviews of economic analyses of preventative interventions found that 80–85% were sufficiently cost effective to be recommended by the National Institute for Health and Care Excellence (NICE), including interventions such as stop smoking services, increasing physical exercise and prevention of sexually transmitted infections (STIs; Van Gils and others, 2011; Owen and others, 2012). However, it is estimated that only 5.29% of the NHS budget in England was spent on prevention in 2014/15.*

Pausing or changing the direction of the rising burden of preventable ill health is imperative, given estimates that the number of people with at least one long-term condition will increase by 20% by 2025, reaching 18 million in total (Department of Health, 2010a).

How services and functions to improve the public's health are organised

In 2010 the white paper *Equity and Excellence: Liberating the NHS* set out the Coalition Government's vision for reforming the NHS, including a greater focus on improving public health (Department of Health, 2010b), alongside a new public health service in England (HM Government, 2010). This was followed by the Health and Social Care Act 2012 (H&SCA 2012), which

*Estimated percentage based on summarised financial position for DH arm's length bodies and RDEL outturn total in 2014/15 in DH annual reports and accounts (https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/447002/DH_accounts_14-15_web.pdf) and based on projected spending on public health budgets set out in NHS public health functions agreement 2014-15 (https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/256502/nhs_public_health_functions_agreement_2014-15.pdf).

resulted in significant changes to the organisation of the NHS, along with the public health system (HM Government, 2012a).

The H&SCA 2012 established NHS England, a new national organisation to commission primary care and some specialised NHS services. NHS England began allocating resources to the newly developed local clinical commissioning groups (CCGs) to commission local NHS services. At a national level, disparate public health organisations were brought together as Public Health England (PHE), a new executive agency of the DH. PHE's role is to provide leadership, and deliver some services (health protection, and public health information and intelligence) to protect and promote the public's health (HM Government (HM Government, 2012b; Department of Health, 2011a).

At a local level, local authorities (LAs) became responsible for improving the health of their population, supported by ring-fenced public health budgets and new statutory duties to improve the health of the people in their area (HM Government, 2012a). Directors of public health (DsPH) are now statutory roles leading public health within local government, providing opportunities to develop co-ordinated approaches to preventing ill health across council functions (from housing to leisure) and with social care and the local NHS. The H&SCA 2012 also created new statutory health and wellbeing boards (HWBs) within each upper tier LA. HWBs bring together local commissioners of health and social care, elected representatives and Healthwatch (the local consumer organisations) to agree an integrated way to improve local health and wellbeing (HM Government, 2012c). A key role of the HWBs is to produce Joint Strategic Needs Assessments (JSNAs) to identify the current and future health and social care needs of the local community, which will feed into a Joint Health and Wellbeing Strategy (JHWS) setting out joint priorities for local commissioning (Heath, 2014). These priorities are also informed by the Public Health Outcomes Framework (PHOF), which highlights key areas of focus to reduce premature mortality and inequalities in health (Department of Health, 2013a).

These changes meant that from 1 April 2013, local government took over responsibility for over 20 public health services and functions, including stop smoking services drugs and alcohol misuse services, physical activity programmes and child health (Table 1.1). The Secretary of State for Health can prescribe that LAs commission or provide certain public health functions. Prescribed functions include national programmes that were previously the responsibility of the Secretary of State for Health and services where greater national uniformity is needed, such as health protection and the National Child Measurement Programme. Other services are not prescribed in regulations, but the government states that prescribed services are not intended to be seen as being more or less important than services that are not prescribed (Department of Health, 2011b). LAs have a statutory duty to take appropriate steps to improve the health of their populations and must also give regard to any relevant statutory guidance in decisions about commissioning and providing services.

NHS England also commissions certain public health functions that remain the responsibility of the Secretary of State for Health under section 7A of the NHS Act 2006 (Department of Health and NHS England, 2015). These include the responsibility for the delivery of immunisation and screening programmes, along with specialist services including prison health and sexual assault services.

Table 1.1: Public health services and functions which transferred to local government, or remained within the NHS following the Health and Social Care Act 2012

Transferred to local government	Remained within the NHS
Child Measurement Programme*	Child health information systems
Prescribed children (0–5 years) services*†	Cancer screening programmes
Child (5–19 years) public health programmes	Immunisation programmes
NHS Health Check programme*	Non-cancer screening programmes (e.g. newborn hearing screening programme)
Sexual health services (STI testing and treatment, contraceptives and advice on preventing unintended pregnancy)*	Prison health services for adults and children
Sexual health services (advice, prevention and promotion)	Sexual assault referral services
Obesity programmes (adults and children)	
Physical activity programmes (adults and children)	
Public health advice and support for NHS commissioning*	
Stop smoking services and interventions	
Wider tobacco control	
Substance misuse (drugs and alcohol services)	
Local authority role in health protection*	

*Prescribed functions. †Came into effect on 1 October 2015 – includes universal health visiting services and targeted support such as the Family Nurse Partnership (HM Government, 2013; for a full list see Appendices A and B).

Prevention and public health in the wider context

In 2014, the NHS Five Year Forward View – published jointly by the main NHS national bodies and PHE – emphasised the need for prevention, stating: "The future health of millions of children, the sustainability of the NHS, and the economic prosperity of Britain all now depend on a radical upgrade in prevention and public health" (NHS England and others, 2014). Furthermore, the Five Year Forward View committed the NHS to help deliver PHE's priorities, including tackling obesity, reducing smoking and harmful drinking, reducing dementia risk and antimicrobial resistance, and being an

"activist agent of health-related social change" (Public Health England, 2014a).

In June 2015, as part of a package of measures to 'bring down debt' the Chancellor of the Exchequer announced non NHS DH savings, which amount to £200 million (7%) cuts to the public health budget (Department of Health, 2015a, HM Government 2015). This was followed in the 2015 spending review with the announcement of a 3.9% per year cut over the next five years to LA public health budgets (HM Treasury, 2015).

This report

The purpose of this report is to provide an overview of changes to public health outcomes over recent years. It also considers the opportunities and challenges presented as efforts are made to maintain the quality of public health services in light of the system reforms and current and future funding pressures.

2

Methods

We used a mixed-methods approach. We examined trends and regional differences in 20 indicators of quality across five relevant public health topics. We also carried out an online survey of DsPH (details on methods and cohort shown below), supplemented by in-depth interviews with 11 DsPH and 11 individuals from other service provider and advocacy organisations for public health and prevention. Further details on the qualitative and quantitative approaches used are available in the Appendix document, which is available on the QualityWatch website at www.qualitywatch.org.uk/public-health

Qualitative methods

We carried out an online survey (Appendix C) to obtain the views of DsPH on the impact of the system reforms on the quality of public health services and functions (Table 1.1). Quality was defined drawing on definitions by Maxwell (Maxwell, 1984) and Darzi (Darzi, 2008), and included consideration of access, effectiveness, safety and equity. A question on capacity was also included in light of the structural changes and impact on personnel. We also asked the DsPH for their views on the challenges for public health over the next five years, and potential solutions.

As of 29 September 2015, there were 133 DsPH across 152 LAs in England (Public Health England, 2015a). In November 2015, the online survey was sent to DsPH for whom valid email addresses could be found (n=120/133). The survey remained open for two weeks, with two reminders sent to non-responders. The survey was also distributed via the Faculty of Public Health and the Association of Directors of Public Health networks. Responses were anonymous, but individuals could indicate whether they were willing to be contacted directly for follow up. The survey response rate was 28% (34/120). A small number of public health consultants also responded to the survey. Although we were not expecting respondents from this group of professionals, we assume that these respondents were directed to the survey by a DPH. Their views have been taken into account and responses are therefore collectively referred to as 'senior public health professionals' in this report.

We completed semi-structured telephone interviews with 11 DsPH who agreed to be contacted (Appendix D). The purpose was to review the findings from the survey, and to delve into more detail in areas where there is no quantitative data (specifically the availability of public health advice to support NHS commissioning).

We also carried out 11 semi-structured telephone interviews with service provider and advocacy organisations (identified during discussions with the DsPH or within relevant literature) with a regional or national overview within a specific topic area (Appendix E). The purpose was to triangulate the findings from the DsPH survey and indicators within each area of interest.

We presented the preliminary themes at a regional event on public health in austerity attended by over 45 individuals from local government, PHE,

academia and CCGs. Views expressed by those who attended also helped inform this report.

Quantitative methods

We selected five topics to explore in more detail in the quantitative analysis, based on the areas of concern identified in the survey, alongside the availability of data, and a range of prescribed and other public health functions commissioned by LAs and the NHS. The five topics were:

- sexual and reproductive health (SRH) and HIV
- substance misuse (drugs and alcohol)
- smoking
- childhood obesity
- immunisations.

A full description and data sources for each of the indicators are provided in Appendix F.

For the majority of indicators (n=14) we calculated the average annual change from 2009 to 2014, or 2009/10 to 2014/15. However, owing to a lack of data, the average annual change was calculated over a shorter period for a small number of indicators (provision of long-acting contraceptives by GPs (2011–14); chlamydia rates (2012–14); smoking in pregnancy (2010/11–2014/15); adult smoking prevalence (2010–14); and immunisation uptake (2010/11–2014/15). Depending on the structure and availability of the original data source, trends are expressed over calendar or financial year, and 95% confidence intervals (CI) are provided.

We also explored regional variation in trends for the 150 upper tier LAs in England (excluding City of London and Isles of Scilly) by calculating the difference in observed to expected values. Expected values were calculated by applying the national rate of change over the period of interest to the LA value. Outliers were identified as those LAs whose change was greater than two standard deviations above and below the mean. We then identified the proportion of LAs within each quintile of deprivation (Indices of Multiple Deprivation [IMD], 2015 data; Department for Communities and Local Government, 2015) where the trend was significantly better or worse than the national average.

3

Findings

This report firstly explores the following issues across the five topics:

- Why is this topic important?
- What recent changes have there been to service commissioning and provision?
- What has happened to the indicators over recent years?

We then draw out the key themes from the survey and interviews on the opportunities and challenges to maintaining the quality of public health services, in light of the system reforms and current and future funding challenges.

3.1. Sexual and reproductive health and HIV

Why is this topic important?

Sexual health promotion, alongside the provision of SRH and HIV services, make an important contribution to individual and population health. STIs are often asymptomatic and if left untreated may cause pelvic inflammatory disease and infertility, and be transmitted to others. There is therefore a need for early detection and treatment (National Institute for Health and Care Excellence, 2014a).

SRH services are highly cost effective. NICE estimated that about 30% of pregnancies are unplanned, at an estimated cost to the NHS of £193 million in 2010 (Montouchet and Trussell, 2013), yet £1 invested in contraception can save £11 in averted outcomes (Bayer Healthcare, 2013). In the case of HIV, if the person is diagnosed late*, costs to the health economy are twice as high in the first year after diagnosis. Implementing NICE guidance on increasing uptake of HIV testing among at-risk groups would prevent 3,500 cases of HIV transmission within five years and save £18 million in treatment costs alone, each year (National Institute for Health and Care Excellence, 2011).

What recent changes have there been to service commissioning and provision?

NICE recommends that local commissioners ensure that sexual health services, including contraceptive and abortion services, are in place to meet local needs and include arrangements for the notification, testing, treatment and follow-up of partners of people who have an STI (NICE, 2007).

* Late diagnosis of HIV is defined as a diagnosis with a CD4 cell count below 350 cells per mm^3, and at the point at which anti-retroviral treatment would normally have begun. CD4 cells are an essential part of the human immune system, if they become depleted the body is left vulnerable to a wide range of infections that it would otherwise have been able to fight.

Following the H&SCA 2012, the commissioning arrangements for SRH and HIV services now span three different commissioners (LAs, CCGs and NHS England; Table 3.1). For example, local government now commissions all community and pharmacy contraceptive services (apart from services provided by GPs), whereas CCGs are responsible for commissioning termination of pregnancy services. Concerns have been raised in other reports about the fragmentation of services: for example, in the case of HIV, treatment is commissioned by NHS England and comprehensive sexual health services are commissioned by LAs. The government recognised that this was not ideal and sought to "examine ways to ensure that prevention work does not become isolated from treatment services" (HM Government, 2011).

Table 3.1: Sexual health commissioning responsibilities in England from April 2013

NHS England	Clinical commissioning groups	Local authorities
Contraception services provided as an 'additional service' under GP contract HIV treatment and care under specialist commissioning Promotion of opportunistic testing and treatment for STIs Prison sexual health services Sexual assault referral centres Cervical screening Specialist foetal medicine services Human papilloma virus immunisation programmes	Termination of pregnancy services Contraception for gynaecological purposes Non-sexual health psychosexual counselling Female sterilisation and vasectomy HIV testing when clinically indicated in CCG-commissioned services	Contraception services primarily delivered in the community (GP and pharmacy, including long acting reversible contraception [LARC]) STI testing and treatment, and partner notification National Chlamydia Screening Programme HIV testing and prevention Sexual health aspects of psychosexual counselling Sexual health specialist services (e.g. teenage pregnancy services, school outreach programmes, young people's sexual health services, and services in colleges and pharmacies)

Source: Public Health England, 2014b

In March 2013, the DH *Framework for Sexual Health Improvement* recognised that a concerted effort was needed across commissioning organisations and providers to ensure a co-ordinated approach to improving knowledge, reducing stigma and increasing access to services (Department of Health, 2013b). There are best practice guidance and tools available to support local commissioning (Public Health England, 2014b; Hind, 2013; Local Government Association, Public Health England and Association of Directors of Public Health, 2013).

Many recognise that within local government there exists the opportunity to think more broadly about sexual health promotion and services, and to work across partners to deliver an integrated, council-wide approach to SRH (Public Health England, 2014b; Local Government Association, Public Health England and Association of Directors of Public Health, 2013; British Association of Sexual Health and HIV, Faculty of Sexual and Reproductive Healthcare, 2012; Local Government Association, 2013a; Wilkinson, 2015; All-Party Parliamentary Group on Sexual and Reproductive Health in the UK, 2015). However, some of these reports have also raised concerns that the new commissioning structures have resulted in more fragmented service provision, and that services may come under pressure due to wider funding challenges.

In 2013, the British Association of Sexual Health and HIV (BASHH) and the Faculty of Sexual and Reproductive Healthcare (FSRH) highlighted concerns about the structural and financial arrangements for sexual health services, maintaining access to services, and the impact on service standards and training (Local Government Association, 2013a). In August 2014, the All-Party Parliamentary Group on Sexual and Reproductive Health in the UK (APPGSRH) inquiry included submissions from commissioners, providers, policy-makers and service users, and described the structural changes as "leading to services being commissioned in new silos built around the commissioning structures and not service users" (All-Party Parliamentary Group on Sexual and Reproductive Health in the UK, 2015). The inquiry also highlighted concerns about loss of responsibility for commissioning comprehensive SRH care for the entire population, maintaining provision of LARCs through GP contracts, changes to payment methods incentivising STI care over contraceptive services, continuation of specialist training, and wider system fragmentation with a potential detrimental impact on the availability of services and patient care (Wilkinson, 2015; All-Party Parliamentary Group on Sexual and Reproductive Health in the UK, 2015). For example, despite being mandated to provide comprehensive, open-access STI testing and treatment and contraceptive services for everyone present in their area, some LAs were restricting access to some services based on age or place of residence (All-Party Parliamentary Group on Sexual and Reproductive Health in the UK, 2015).

Concerns about cuts to SRH services have also been highlighted elsewhere, including: the need to ensure co-ordinated commissioning of contraception and sexual health services to meet local needs; the unintended adverse consequences of re-tendering services; the threat posed by cuts to prevention and sexual health promotion; and continuing concerns about accountability (Wilkinson, 2015; White, 2016; Faculty of Sexual and Reproductive Healthcare, 2015; Primary Care Women's Health Forum, 2014).

What has happened to the indicators over recent years?

We looked at the following indicators of SRH and HIV to examine changes over time in measures of prevention and access to services:

- provision of LARC
- teenage pregnancy rates
- rates of common STIs (gonorrhoea, genital warts, genital herpes, chlamydia and syphilis)

- late diagnosis of HIV.

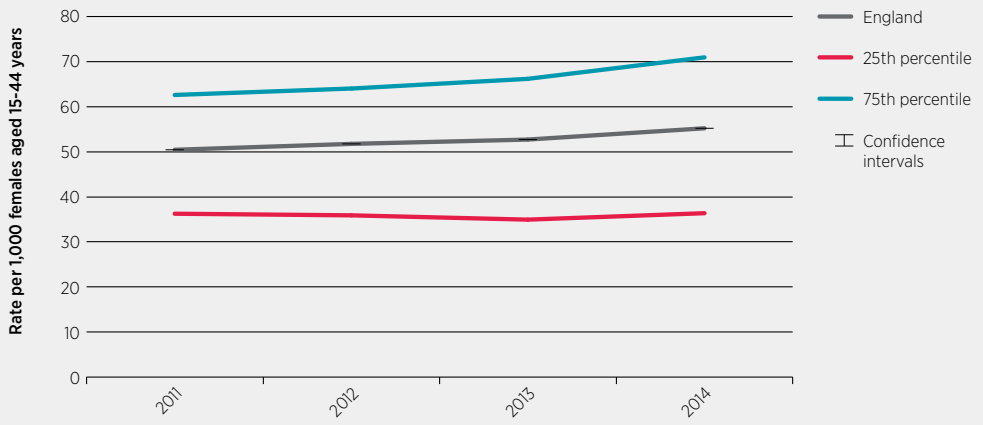
Provision of LARC

Ensuring women of all ages have access to the full range of contraception and can obtain their chosen method quickly and easily can prevent unplanned pregnancies (Department of Health, 2013b). LARC methods* are considered more effective forms of contraception as they are not as user dependent as condoms and oral contraceptive pills (National Institute for Health and Care Excellence, 2005a). A NICE cost impact assessment estimated that fully implementing the 2005 clinical guidance for LARC in England would deliver a saving of £102 million as a result of a reduction in unplanned pregnancies (National Institute for Health and Care Excellence, 2005b).

It is difficult to ascertain uptake of different contraception methods across the population as they can be obtained from GPs, community services and pharmacies, and data are not collated centrally. Uptake of LARC is highest among women attending SRH services, and increased by 22.6%, from 232.7 per 1,000 women in 2009/10 to 285.3 per 1,000 women in 2013/14. Data from SRH services suggest that the proportion of women using LARCs as their main form of contraception increased from 26% in 2009/10 to 31% in 2013/14. However, in 2013/14 user-dependent contraceptives were still the most common form of contraception in use (69% of women; HSCIC, 2015a).

Within primary care settings, the prescription rate for LARC in England increased by 9.3%, from 50.5 per 1,000 resident women aged 15–44 (95% CI 50.3, 50.6) in 2011, to 55.2 per 1,000 resident women (95% CI 55.0, 55.3) in 2014 (Figure 3.1).

Figure 3.1: Rate of GP prescribed long-acting reversible contraceptives per 1,000 resident women aged 15 to 44 years, England, 2011–2014



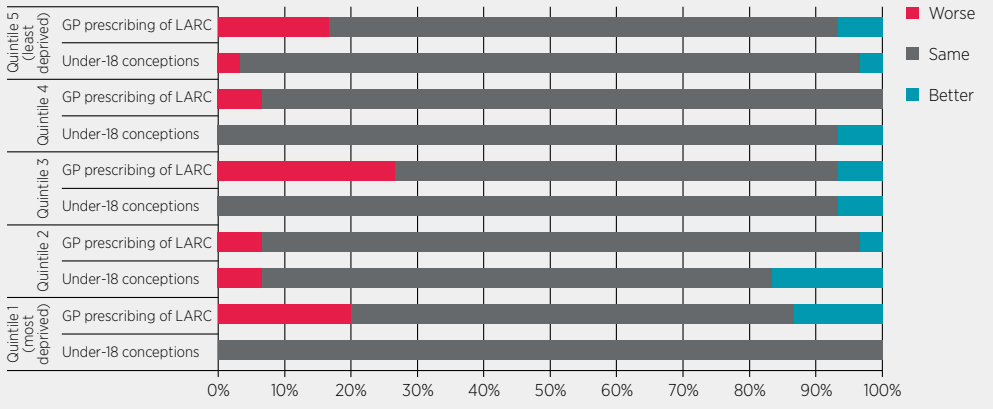
Source: Public Health England Sexual and Reproductive Health Profiles (Public Health England, 2015b). 95% confiden ce interval small so not visible.

* LARC is defined in this guideline as contraceptive methods that require administration less than once per cycle or month. Included in the category of LARC are: copper intrauterine devices (coil), progestogen-only intrauterine systems, progestogen-only injectable contraceptives and progestogen-only subdermal implants (National Institute for Health and Care Excellence, 2005a).

Regional variation

Regional trends are only available for GP prescribing of LARC. The national pattern of increasing prescription of LARC was not consistent across LAs in England. From 2011 to 2014, nine LAs improved significantly compared to what was expected based on the national trend, but in 23 LAs the GP prescribing rate deteriorated significantly compared to what was expected. There was no clear pattern across the LA deprivation quintiles (Figure 3.2). Reductions in provision may reflect a reduction in funding for LARC in primary care in some areas (Primary Care Women's Health Forum, 2014), or women obtaining LARC from other settings.

Figure 3.2: Percentage of local authorities by deprivation quintile that had significantly better, the same or worse outcomes compared to expected, based on the England trend (GP prescribing of LARC from 2011 to 2014; under-18 conception rate from 2009 to 2014)



Source: Public Health England (2015b); Office for National Statistics (2013a). LARC = long-acting reversible contraceptives

Teenage pregnancy

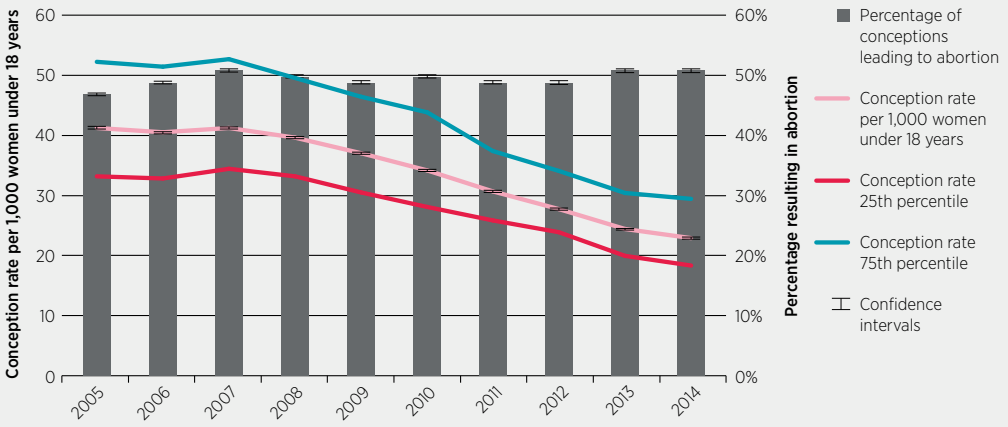
The UK has one of the highest teenage pregnancy rates in Europe (Office for National Statistics, 2014). Teenage pregnancy is a significant public health issue in England and places significant pressures on the NHS, LA social care, and housing and education services. In 1999, the Teenage Pregnancy Strategy for England was launched, with the aim of halving the under-18 conception rate* by 2010, from a baseline of 46.6 per 1,000 women. The evidence-based whole-system approach, alongside investment in contraceptive services, helped achieve success in many local areas (Department of Education, 2010).

From 2009 to 2014, the under-18 conception rate decreased by 38.5%, from 37.1 (95% CI 36.7, 37.5) per 1,000 women in 2009, to 22.8 (95% CI 18.2, 29.4) in 2014 (Figure 3.3).

In 2014, there were 21,282 conceptions to those aged under 18, equating to 22.8 (95% CI 22.5, 23.1) conceptions per 1,000 women. Of these, 51.1% resulted in abortion, and this has remained around this level for the past five years (Figure 3.3). This suggests that more needs to be done to prevent unwanted pregnancy through better sexual education for young people, promoting effective contraception methods (including the use of LARC) and continuing to improve access to SRH services.

* Defined as the number of conceptions per 1,000 women aged 15 to 17 years.

Figure 3.3: Under-18 conception rate and percentage of conceptions resulting in abortion from 2005 to 2014



Source: Office for National Statistics, 2013a

Regional variation

From 2009 to 2014, the decline in teenage pregnancy was significantly better than what was expected based on the national trend in 10 LAs, and worse than expected in three. Encouragingly, a greater proportion of those LAs that improved better than expected were found in the more deprived areas, reflecting greater progress in areas with higher need (Figure 3.2). Marked regional variation in progress on teenage pregnancy has been highlighted elsewhere (Department of Education, 2010).

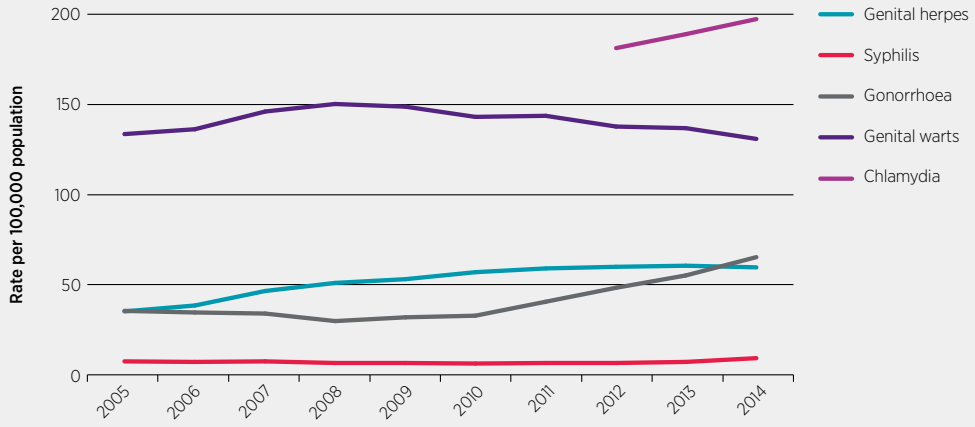
Rates of common STIs

In 2014 there were over 2.5 million attendances at genitourinary medicine (GUM) services – an increase from 2.2 million in 2010. In 2014, there were also approximately 440,000 diagnoses of STIs in England, the most common being chlamydia (198.4 per 100,000) and genital warts (131.1 per 100,000; Public Health England, 2014c; 2016a).

Between 2009 and 2014, the greatest increases in incidence rates of new STI diagnoses were in gonorrhoea (a 109.8% increase from 30.9 to 64.9 per 100,000 population), syphilis (a 46.9% increase from 5.5 to 8.0 per 100,000 population) and genital herpes (a 12.2% from 52.6 to 59.0 per 100,000 population). Over the same period, there has been a decline in genital warts (a 12.1% decrease from 149.2 to 131.1 per 100,000 population) (Figure 3.4). From 2012 to 2014 the incidence rate of chlamydia increased by 8.9% from 182.1 per 100,000 population to 198.4 per 100,000 population (Public Health England, 2014c).

Increasing trends in STIs may be attributed to more routine testing and case finding in GUM and SRH services, but also to ongoing unsafe sexual behaviour. For example, it is likely that condom-less sex associated with HIV seroadaptive behaviours* is contributing to the increases in syphilis among men who have sex with men (MSM) (Public Health England, 2016a). Of increasing concern is the rise in gonorrhoea diagnoses, especially within the context of antimicrobial resistance with regard to this STI (Public Health England, 2014d).

Figure 3.4: Rates of new STI diagnoses in England in GUM clinics and integrated GUM and sexual and reproductive health services from 2005 to 2014, both sexes combined



Source: Public Health England (2016a). STI = sexually transmitted infection; GUM = genitourinary medicine.

Regional variation

There is marked regional variation in the distribution of STIs, with rates higher in urban areas, especially London. Improvements in STIs rates were significantly better than expected based on the national trend in a small number of LAs (seven for genital herpes and gonorrhoea, 10 for syphilis and six for genital warts), and these LAs were spread across the deprivation quintiles. However, a greater proportion of LAs whose deterioration was significantly worse than expected (18 for genital herpes, 11 for gonorrhoea, 10 for syphilis and 14 for genital warts) were in the top 20% of LAs by level of deprivation (Figure 3.5).

Late diagnosis of HIV

In 2014, an estimated 103,700 people were living with HIV in the UK, of whom an estimated 17% (18,100) were unaware of their infection – a decline from 25% (22,800) in 2010 (Public Health England, 2015c).

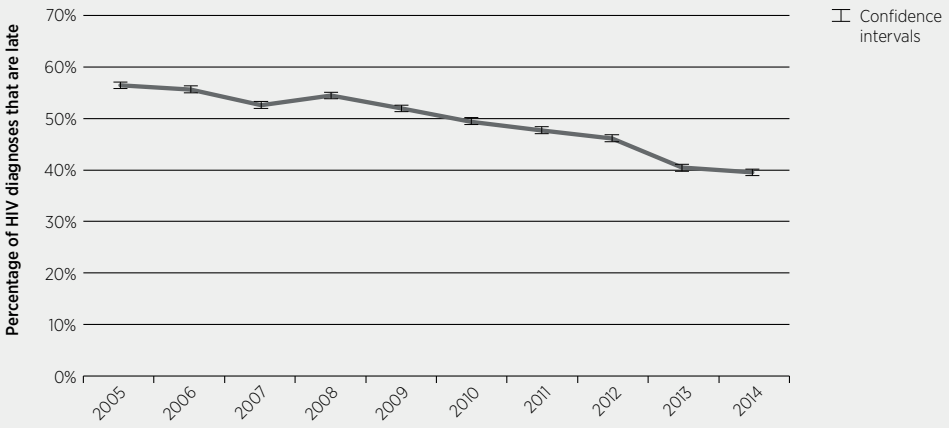
* Strategies undertaken by men who have sex with men to reduce risk of HIV transmission or acquisition. Examples include selecting sexual partners of the same HIV serostatus, or modifying sexual practices depending on knowledge of one's own and one's partner's serostatus.

Figure 3.5: Percentage of local authorities by deprivation quintile and STI that had significantly better, the same or worse outcomes compared to expected, based on the England trend, from 2009 to 2014

Source: Public Health England (2015b)

From 2009 to 2014 in England, the proportion of new HIV diagnoses, in adults aged 15 years or above, that were diagnosed late decreased from 52% to 40% – a reduction from 2,710 to 1,748 (Figure 3.6). The rate of decline slowed from 2013 to 2014, but it is too early to confirm whether this reflects a true change in late diagnoses.

Figure 3.6: Percentage of newly diagnosed HIV infections that are late (CD4 < 350mm^3) in England, 2005–2014



Source: Public Health England (2015d). Late diagnosis of HIV is defined as a diagnosis with a CD4 cell count below 350 cells per mm^3, and at the point at which anti-retroviral treatment would normally have begun.

For the UK overall, figures suggest that the decline over the period 2009 to 2014 is mostly attributable to reductions in late diagnoses among MSM (from 40% in 2009 to 29% in 2014), with a smaller decline among heterosexual men (66% to 61%) and women (59% to 52%). In contrast, the proportion of late diagnoses among injecting drug users increased from 48% to 65% over the same period. Although MSM are the highest absolute number of people diagnosed late, being newly diagnosed at a late stage of infection remains of significant concern among heterosexuals, and disproportionately among black Africans (Public Health England, 2015c).

Regional variation

The numbers are too small to explore regional differences in trends in late HIV diagnosis. Data from PHE suggest that although HIV testing in STI clinic attendees continues to increase throughout most of England, there is marked variation across the country, especially for HIV test coverage among heterosexual populations – only 15% of STI clinics achieved the recommended 80% of eligible attendees having an HIV test in 2014 (Public Health England, 2015c).

3.2. Substance misuse (drugs and alcohol)

Why is this topic important?

Prevention of substance misuse and the provision of substance misuse services for those in need are essential for addressing the detrimental impact of drugs and alcohol on the health of individuals, those around them and wider society. Drugs alone are estimated to cost the UK £15 billion each year, of which £13.9 billion is attributed to crime committed by drug-dependent offenders (Gordon and others, 2006). Estimates suggest that alcohol costs the UK NHS £3.3 billion a year (2006/07 figures; Scarborough and others 2011). In England alone, estimates suggest that over 15,000 people die from alcohol-related illnesses each year (Home Office, 2013).

There is a strong evidence base for a range of interventions that address substance misuse prevention and treatment. Home Office findings suggest that every £1 spent on drug treatment services saves £2.50 in crime and health costs of drug addiction (Home Office, 2009). In addition, every £1 spent on young people's drug and alcohol interventions is estimated to save between £5 and £8 to society – largely in health, crime and welfare costs (Public Health England, 2013).

What recent changes have there been to service commissioning and provision?

In April 2013, LAs in England became responsible for the commissioning of local alcohol and drug treatment services. Public health teams within local government have the opportunity to integrate prevention, treatment and support with other council functions, including housing, crime, employment and education, to address the wider determinants of substance misuse and improve an individual's recovery from substance dependence (Joint Commissioning Panel for Mental Health, 2013; Local Government Association, 2013b; 2014; Public Health England, 2015e).

In 2014, a review carried out by PHE alongside the Association of Directors of Public Health (ADPH) found that the transfer into local government had gone well, with the opportunity to work across the wider council responsibilities and external partners thought to better address prevention. But there were challenges, including budget transfers, lack of clear service specifications, contractual arrangements that needed resolving and potential impact on commissioning staff capacity (Public Health England and Association of Directors of Public Health, 2014). Concerns have also been raised about service quality and sustainability within a testing financial climate. The DrugScope (now DrugWise) *State of the Sector* report (2015) found that over half of 189 substance misuse services studied had been through a re-tendering process since September 2013, with mixed views on the potential impact of this for driving improvements in quality, best practice or addressing local needs. Some providers reported experiencing reductions

in service funding, changes to service delivery (with a loss of frontline staff and an increasing use of volunteers), and continued gaps in links with housing, education and mental wellbeing (DrugScope, 2015).

Alcohol Concern completed a review of the funding and prioritisation of alcohol misuse services across a sample of 30 LAs* in England between 2013/14 and 2014/15. Alcohol remained a high priority in the majority of areas and in 2014/15, one third of LAs reported an increase in funding for alcohol services. But the report also highlighted reductions in funding in some areas, and disproportionately in those areas with the highest levels of alcohol harm, which are often also the most socioeconomically deprived (Alcohol Concern, 2015).

What has happened to the indicators over recent years?

We looked at the following indicators of substance misuse to examine changes over time in measures of prevention and access to services:

- number receiving treatment
- waiting times for first intervention/treatment
- treatment completion rates
- alcohol-related hospital admissions.

Number receiving treatment

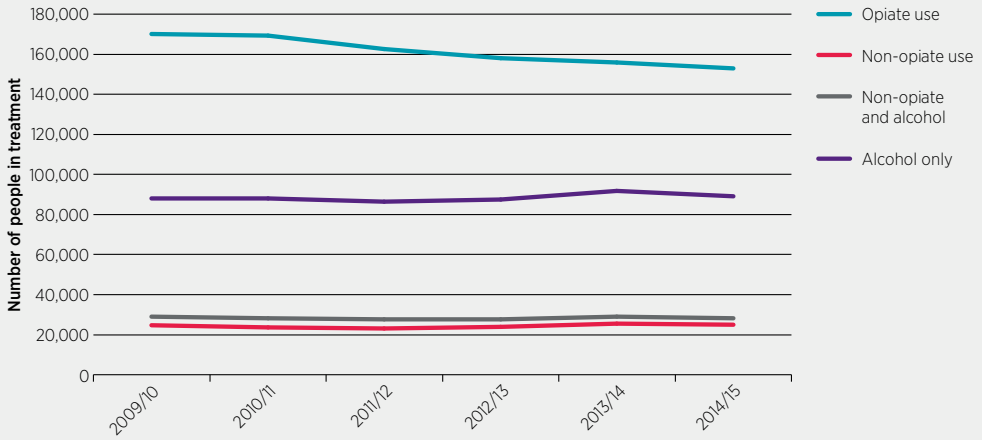
In England in 2014/15 there were 295,224 individuals in contact with drug and alcohol services. Treatment for opiate use accounted for 52% of those in treatment, while alcohol accounted for 30%.

From 2009/10 to 2014/15, the total number of individuals in treatment for opiates decreased by 10.0%, reflecting a decline in heroin use over this period, whereas the number in treatment for alcohol increased by 1.2% (Figure 3.7; Public Health England, 2015f).

The age profile of those in treatment is increasing, with 44% of those in treatment for opiates and 68% of those in treatment for alcohol in 2014/15 aged 40 years or more. This has an important impact on the treatment needed, as older age groups tend to have more complex health and social care needs as a result of longer-term substance misuse (Public Health England, 2015f).

* Response rate 2013/14 78%; 2014/15 66%.

Figure 3.7: Number of people in treatment for substance misuse in England, 2009/10 to 2014/15



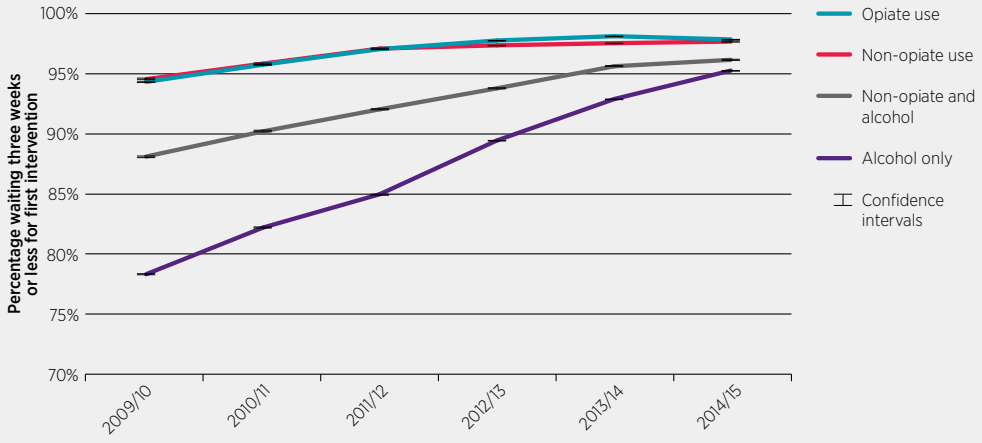
Source: Public Health England (2015f)

The number of younger people (aged 18 to 24 years) presenting for treatment has fallen by 32.7% since 2009/10 (from 21,080 to 14,178). The decline has been greater for opiate use (59.9% decline), compared with alcohol (34.3% decline), and reflects downward trends in the estimated prevalence of opiate use (Gordon and others, 2012) and drinking alcohol (Office for National Statistics, 2013b) by young people. It is recognised that while the number of young people drinking is decreasing, those who do are drinking alcohol in much greater quantities and experiencing more alcohol-related harm (Healey and others, 2014).

Waiting times for first intervention/treatment

Between 2009/10 and 2014/15, waiting times to treatment improved, with over 95% of first interventions starting within three weeks and under of referral; in 2014/15 the average waiting time was 3.3 days to access services (Public Health England, 2015f). The greatest improvement in waiting times has been in alcohol treatment: from 78.2% waiting three weeks and under for treatment in 2009/10 to 95.4% in 2013/14 (Figure 3.8).

Figure 3.8: Percentage of people waiting three weeks or less for first substance misuse intervention, England, 2009/10 to 2014/15



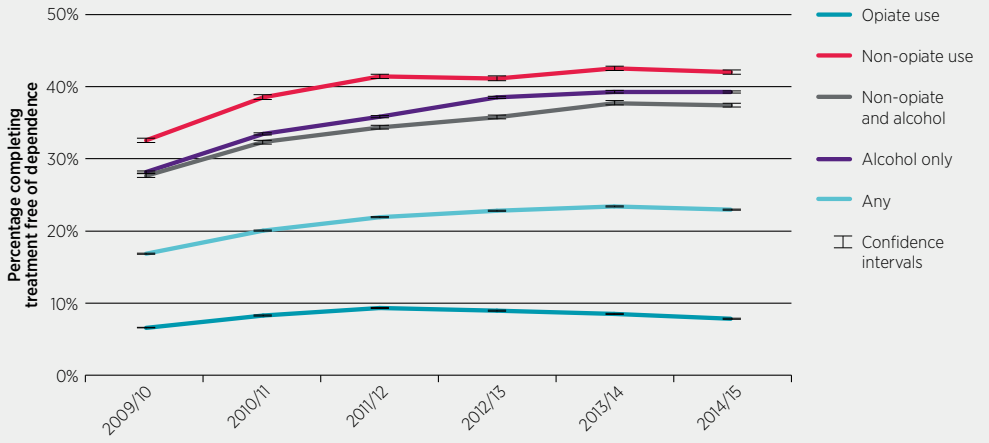
Source: Public Health England (2015f)

Treatment completion

Of those in substance misuse treatment, the percentage of people completing treatment free of dependence* increased from 17% in 2009/10 to 23% in 2012/13, and then remained stable. The percentage of those in treatment who dropped out or left decreased from 11.7% in 2009/10 to 10.3% in 2011/12, but then increased to 12.1% in 2014/15.

The patterns are different for drug and alcohol use, with a small decline in the proportion of opiate users leaving drug free (from 8.8% in 2012/13 to 7.6% in 2014/15). This is thought to reflect the increasingly complex needs of these patients. In contrast, the proportion of alcohol users who left free of dependence increased from 28.2% in 2009/10 to 39.5% in 2014/15. Overall, the upward trends in treatment completion have slowed in recent years (Figure 3.9).

Figure 3.9: Percentage of people completing treatment free of dependence, England, 2009/10 to 2014/15



Source: Public Health England (2015f).

Regional variation

The patterns of increasing completion of treatment from 2009/10 to 2014/15 were largely consistent across England. However, in some LAs improvements in treatment completion rates for opiates (six LAs), and non-opiates (15 LAs) were significantly better than expected based on the national trend, whereas 11 LAs were significantly worse than expected. There was no clear pattern across the quintiles of deprivation (Figure 3.10).

* Defined as the number of users that left substance misuse treatment successfully and who do not then re-present to treatment again within six months, as a percentage of the total number of users in treatment.

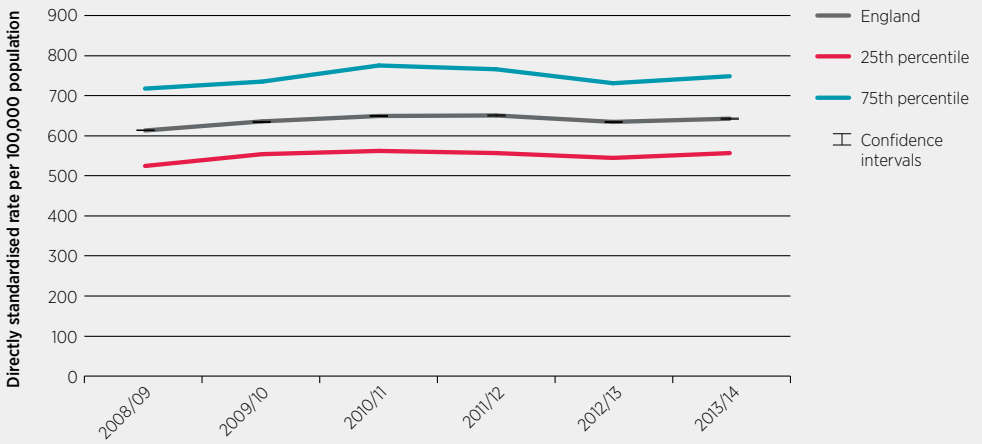
Figure 3.10: Percentage of local authorities, by deprivation quintile and drug type, that had significantly better, the same or worse outcomes in treatment completion compared to expected based on the England trend, 2010 to 2014

Source: Public Health England (2016b)

Alcohol-related hospital admissions

From 2008/09 to 2013/14, alcohol-related hospital admissions in England increased by 5.0%, from 614.6 (95% CI 612.4, 616.8) per 100,000 population to 645.1 (95% CI 642.9, 647.3) per 100,000 population (Figure 3.11). The increasing burden of alcohol on hospitals is of concern and has been highlighted in a recent Nuffield Trust report (Currie and others, 2015).

Figure 3.11: Rate of admissions for alcohol-related conditions per 100,000 population, 2008/09 to 2013/14



Source: Public Health England (2016b)

Regional variation

In 21 LAs the increase in alcohol-related admissions had deteriorated significantly more compared to what was expected based on the national trend, with only one LA improving significantly better than expected. There was no clear pattern across the quintiles of deprivation (data not shown).

3.3. Smoking

Why is this topic important?

Smoking is the leading cause of preventable death and disease in England, responsible for 17% of all deaths in people aged 35 and over, and contributing to the development of coronary heart disease, cancer and respiratory disease (HSCIC, 2015b). Despite a steady reduction in smoking rates, nearly 7.8 million people in England are smokers, including approximately 90,000 young people (aged 11 to 15 years). Smoking is the main contributor to health inequalities in England (Jarvis and Wardle, 2005), and is estimated to cost the UK NHS £3.3 billion per year (2006/07 figures, Scarborough and others, 2011).

Smoking cessation and tobacco control interventions are the most cost effective of all public health interventions (Owen and others, 2012; National Institute for Health and Care Excellence, 2008; All Parliamentary Group on Smoking and Health, 2015). A number of tools have been developed to support commissioners to estimate potential savings from investments in tobacco-control interventions (National Institute for Health and Care Excellence, 2015).

What recent changes have there been to service commissioning and provision?

Following the H&SCA 2012, responsibility for the commissioning of stop smoking services and wider tobacco control transferred from the NHS to public health in local government.

In January 2016, a report by Action on Smoking and Health commissioned by Cancer Research UK highlighted the benefits of the transfer to local government, with 86% of tobacco leads and commissioners surveyed* across England valuing more constructive relationships with colleagues in other council departments, and 60% reporting better integration of tobacco control into the wider council strategy (Anderson and Cheeseman, 2016). The integration of tobacco control with the broader interests of LAs has led to the development of new alliances and strengthened relationships across councils, highlighting tobacco control issues within broader policy discussions, and increasing local political support and prioritisation for tobacco control. Approximately half of the tobacco control leads who responded to the Action on Smoking and Health survey also reported improved relationships with parts of the NHS, including mental health services and maternity services.

However, three quarters of tobacco leads were concerned about the impact of budget pressures on service provision (Anderson and Cheeseman, 2016). The need to find efficiencies, or increased emphasis on integration of services, were thought to be contributing towards a move away from the traditional model of specialist services for stop smoking, with dedicated advisers, towards more community-based provision, delivered for example via pharmacists or in more integrated lifestyle improvement programmes (Anderson and Cheeseman, 2016; National Centre for Smoking Cessation and Training and Public Health England, 2014). However, research has shown that an integrated approach to tackling multiple behaviour change is not necessarily more effective than targeted supportive options (Grandes and others, 2008; Prochaska, 2011; O'Connor, 2015).

* Survey had 118 responses and an 86% response rate.

What has happened to the indicators over recent years?

We looked at the following smoking-related indicators to examine changes over time in measures of prevention and access to services:

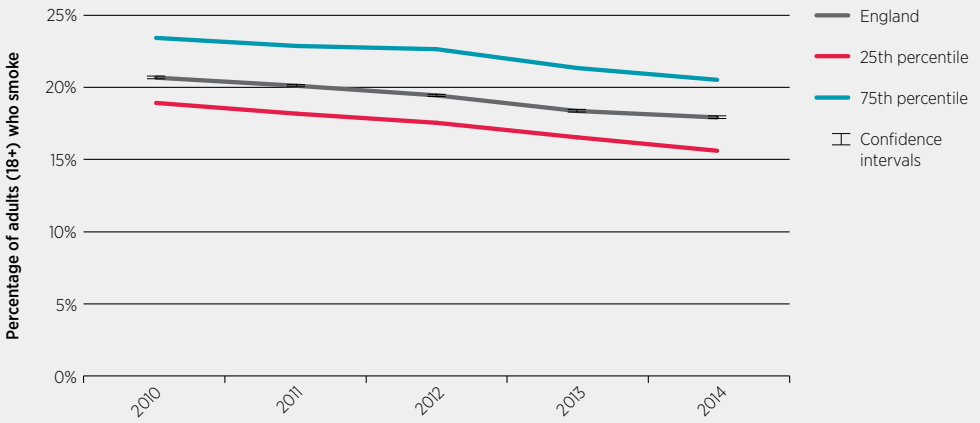
- prevalence of smoking among adults (18 years and over)
- smoking in pregnancy
- setting a quit date and successful quitters
- percentage of successful quitters.

Prevalence of smoking among adults

Between 2010 and 2014, there was a steady decline in the prevalence of smoking among adults in England from 20.8% (95% CI 20.6%, 21.0%) to 18.0% (95% CI 17.8%, 18.2%) (Figure 3.12).

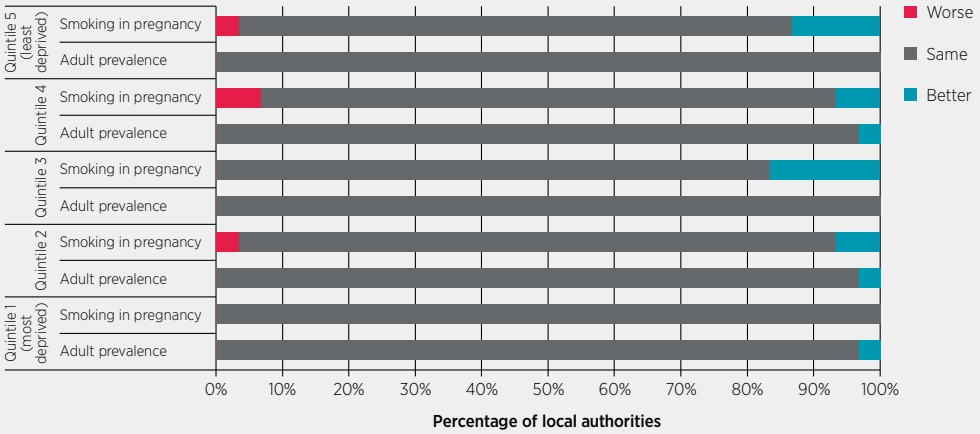
In the regional analysis, three LAs were found to have improved significantly better compared to what was expected based on the national trend and none were found to have deteriorated significantly compared to what would be expected (Figure 3.13).

Figure 3.12: Prevalence of smoking in adults (aged 18 and over) in England, 2010 to 2014



Source: Public Health England (2016b)

Figure 3.13: Percentage of local authorities by deprivation quintile that had significantly better, the same or worse outcomes in smoking prevalence (2010 to 2014) and smoking in pregnancy (2010/11 to 2014/15) compared to expected, based on the England trend



Source: Public Health England (2016b)

Smoking in pregnancy

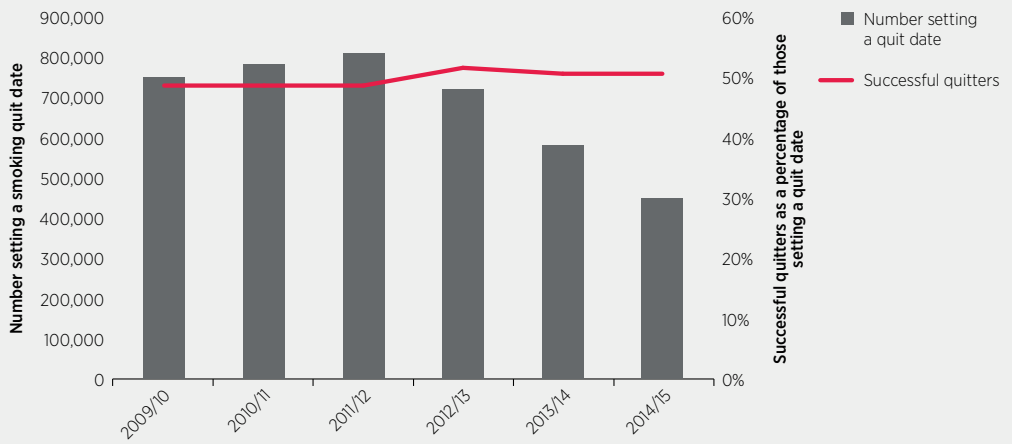
From 2010/11 to 2014/15, the percentage of mothers who reported smoking at the time of delivery declined from 13.5% (95% CI 13.4%, 13.6%) to 11.4% (95% CI 11.3%, 11.5%). This is also reflected in a decline in the number of pregnant women who set a quit date with NHS stop smoking services, from 21,839 in 2010/11 to 18,887 in 2014/15 (HSCIC, 2015b).

In the regional analysis, 13 LAs were found to have improved significantly better compared to what was expected based on the national trend, and four were found to have a deteriorated significantly compared to what was expected. There was no clear pattern with deprivation (Figure 3.13).

Setting a quit smoking date and successful quitters

From 2009/10 to 2011/12 the number of individuals who set a quit date in NHS stop smoking services increased from 757,537 to 816,444, but then declined by 44.8% to 450,582 in 2014/15. The percentage of those who set a quit date and who had successfully quit smoking at four weeks has remained at approximately 50% (Figure 3.14).

Figure 3.14: Number of people setting a smoking quit date and the percentage of those who successfully quit in England, 2009/10 to 2014/15



Source: HSCIC (2015b)

However, the proportion of smokers who successfully quit smoking at four weeks is not consistent across all socio-economic groups, with the percentage of successful quitters in 'routine and manual occupations' consistently 4–5% lower than for 'managerial occupations' (HSCIC, 2015b).

There are a number of different factors which may have contributed to the decline in the number of people setting a quit date through stop smoking services. These may include less awareness of local services following a shift in the focus of national mass media campaigns from directing smokers to stop smoking services, to encouraging quitting attempts at population-level via Stoptober or provision of Quit Kits. There may also be a reduction in the number GP referrals to stop smoking services. Data from the Smoking Toolkit Study suggest that the number of smokers receiving an offer of support to quit smoking from their GP has declined over this period (O'Connor, 2015). The decline in stop smoking service utilisation may also

reflect a decrease in smoking prevalence, or, more likely, increasing use of electronic cigarettes as individuals try to stop smoking independently.*

Smokers have a significantly greater chance of quitting smoking permanently when they are supported or have medication (National Centre for Smoking Cessation and Training and Public Health England, 2014), so continued decline in these services would be of concern.

3.4. Childhood obesity

Why is this important?

Obese children are at increased risk of stigmatisation, bullying and low self-esteem (Rees and others, 2009), and obesity has significant consequences for children's mental and physical health (Griffiths and others, 2011; Wijga and others, 2010; Gardner and others, 2009; World Health Organization, 2015). There is strong evidence that, once established, obesity is difficult to reverse through interventions and tracks through into adulthood (Waters and others, 2011). Overweight children are at increased risk of being overweight in adulthood and therefore at risk of premature mortality and physical morbidity in later years (Reilly and Kelly, 2011).

The complications of obesity cost the UK NHS more than £5.1 billion a year (Scarborough and others, 2011). They also cost English LAs £352 million in social care (Public Health England, 2014d) and the estimated cost to the wider economy could be as much as £27 billion (Butland and others, 2007). By 2034, one in three people will be obese and one in 10 will develop type 2 diabetes. It is estimated that reverting the prevalence of obesity back to 1993 levels has the potential to avoid up to five million cases of disease (diabetes, hypertension, cancer and cardiovascular disease; UK Health Forum, 2014).

But tackling obesity cannot be achieved through targeting only those at risk. It requires a population-level strategy that addresses both the environment in which people make their choices and the structural determinants of health across the whole population (Butland and others, 2007). Economic modelling of individualised interventions to reduce body mass index (BMI) show that even a modest 5% reduction in BMI in childhood is cost effective, if the intervention costs less than £600 per person and the reduction in BMI is sustained into adulthood where most of the benefits of weight loss are realised (Brown and others, 2013). PHE has developed tools for demonstrating the cost effectiveness of interventions to tackle obesity, but the period over which they measure benefit is often too short to demonstrate value in children (Public Health England, 2015g).

What recent changes have there been to service commissioning and provision?

Following the implementation of the H&SCA 2012, in April 2013 LAs became responsible for delivery of the National Child Measurement Programme,

* *The Independent*. 'Smokers turn their backs on NHS as they opt for e-cigarettes to help quit smoking'. www.independent.co.uk/life-style/health-and-families/health-news/smokers-turn-their-backs-on-nhs-as-they-opt-for-ecigarettes-to-help-quit-smoking-9679239.html. *Nursing in Practice*, 'E-cig uptake linked to official drop in quitters'. www.nursinginpractice.com/article/e-cig-uptake-linked-official-drop-quitters; Health Survey for England. www.hscic.gov.uk/pubs/healthsurveyeng13

obesity programmes in adult and childhood, and for commissioning public health services and other services for children aged 5–19 years. In October 2015 this was followed by children's services for 0–5 year olds, including health visiting functions and the Family Nurse Partnerships (Department of Health, 2015b).

The transfer of public health to local government also provided the opportunity to better influence the local obesity environment through, for example, influencing planning applications for the locations of fast food outlets near schools, or encouraging physical activity through the planning of the built environment and leisure opportunities (Local Government Association, Public Health England and Town and Country Planning Association, 2016). A pilot programme to support councils in designing a whole-system approach to reducing obesity was recently announced,[*] alongside a joint NHS England, PHE and ADPH programme.

Weight management programmes can benefit children and young people who are overweight or obese (National Institute for Health and Care Excellence, 2013). In November 2014, PHE found that 73% of LAs and 18% of CCGs who responded to their survey across England commissioned a weight management service for children and young people and/or adults. Common barriers to local commissioning included: the need for evidence to support long-term outcomes; lack of clear national guidance and leadership on obesity; challenging funding and lack of resources; the need for a joint approach across commissioners; and disjointed obesity pathways and service models (Coulton and others, 2015).

What has happened to the indicators over recent years?

We looked at the following indicators of childhood obesity to examine the changes over time as a measure of prevention and access to services:

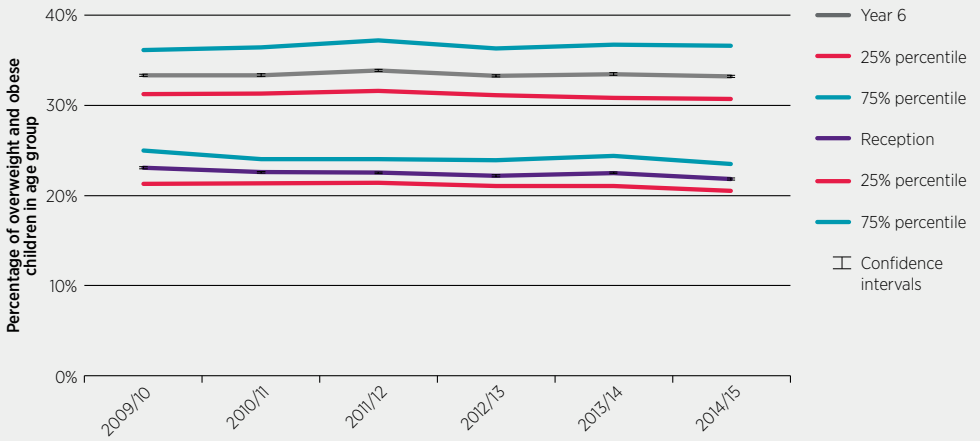
- overweight and obese children aged 4 to 5 years (reception)
- overweight and obese children aged 10 to 11 years (year 6).

From 2009/10 to 2014/15 the prevalence of overweight and obese children in England aged 4–5 years decreased from 23.1% (95% CI 23.0%, 23.2%) to 21.9% (95% CI 21.8%, 22.0%) (Figure 3.15). This declining trend has been observed since 2006.

Over the same period (2009/10 to 2014/15), the prevalence of overweight and obese children in England aged 10–11 years has fluctuated at around 33%, and was 33.2% (95% CI 33.1, 33.4) in 2014/15 (Figure 3.15).

[*] http://www.leedsbeckett.ac.uk/wholesystemsobesity/

Figure 3.15: Percentage of overweight and obese children in England aged 4–5 years (reception) and 10–11 years (Year 6), 2009/10 to 2014/15



Source: Public Health England (2016b)

Regional variation

In the regional analysis, eight LAs were found to have deteriorated significantly more than expected based on the national trend for overweight and obese children aged 4–5 years, and 12 LAs were found to have deteriorated more than expected for children aged 10–11 years. There was no clear pattern with deprivation (Figure 3.16).

However, more in-depth analysis from PHE found differing trends in childhood obesity by levels of deprivation. In the least deprived areas trends in childhood obesity have declined since 2006/07. In contrast, in the most deprived areas the declining trend in obesity among children aged 4–5 years has faltered, and obesity in children aged 10–11 years has increased (Public Health England, 2016b).

Figure 3.16: Percentage of local authorities by deprivation quintile that had significantly better, the same or worse outcomes in obese and overweight children in reception (4–5 years) and Year 6 (10–11 years) compared to expected based on the England trend, 2009/10 to 2014/15

Source: Public Health England, 2016b

3.5. Immunisations

Why is this important?

All children in the UK are offered protection against a range of vaccine-preventable diseases, including the 5-in-1 vaccine (diphtheria, pertussis [whooping cough], polio, tetanus, Haemophilus influenzae type B; DTaP/IPV/Hib), meningitis C, MMR and pneumococcal infection. To be fully effective, and to prevent the spread of these diseases, the World Health Organization (WHO) recommends that at least 95% of children within a given population should be immunised.

What recent changes have there been to service commissioning and provision?

Following the implementation of the H&SCA 2012, responsibilities for commissioning and delivery of immunisation programmes were delegated from the Secretary of State for Health to NHS England under section 7A of the NHS Act 2006 (Department of Health and NHS England, 2015). The programmes are now delivered over larger geographical teams than when the service was commissioned by the primary care trusts. At a local level, DsPH are responsible for providing assurance to the local HWB on local immunisation levels.

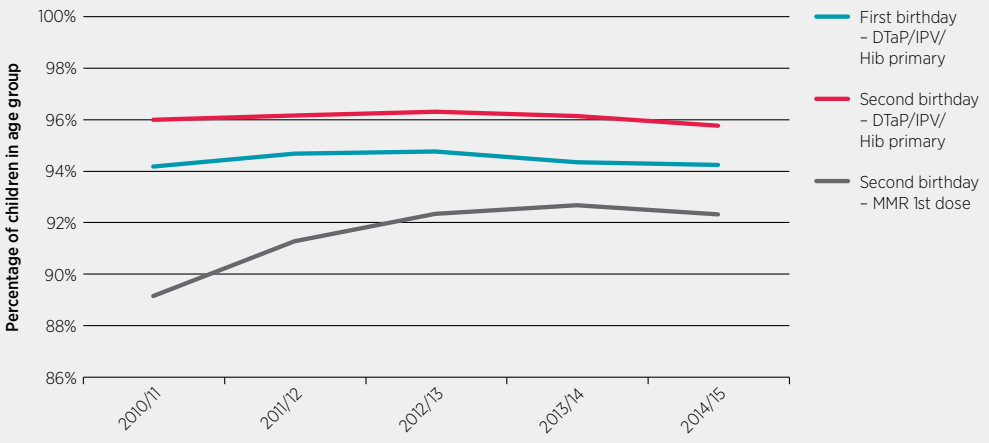
What has happened to the indicators over recent years?

We looked at the following indicators to examine the change over time in uptake of childhood immunisations:

- DTaP/IPV/Hib at first and second birthday
- MMR at two years of age.

From 2010/11 to 2014/15 the immunisation uptake for childhood immunisations remained around 94% coverage for DTaP/IPV/Hib at first birthday, and 96% at second birthday. The coverage of MMR at two years of age has improved over recent years, reaching 92.3% in 2014/15, but the upward trend has slowed and needs to improve in order to meet the WHO recommended level of coverage (Figure 3.17).

Figure 3.17: Childhood immunisation uptake in England, 2010/11 to 2014/15



Source: Health and Social Care Information Centre (2015c)

Regional variation

Overall, a number of LAs improved significantly better than expected based on the national trend for DTaP/IPV/Hib at first (n=6 LAs) and second birthdays (n=10 LAs), and for MMR (n=12 LAs). However, in 15 LAs the DTaP/IPV/Hib at first birthday and in five LAs the MMR uptake deteriorated significantly more than expected. There was no clear pattern by deprivation (data not shown).

3.6. Quality of public health services: qualitative responses

The overall response rate among DsPH invited to participate in the QualityWatch public health survey was 28% (34/120). An additional three public health consultants completed the survey, and their views have been taken into account to provide a total of 37 responses from senior public health professionals working in local government across England (Table 3.2).

Table 3.2: Number of responses from senior public health professionals to the QualityWatch public health survey (November 2015)

Public Health England	Number of responses (% of total)
North of England	12 (32%)
Midlands and East of England	9 (24%)
South of England	10 (27%)
London	6 (16%)
Total	**37**

Here we bring together the survey responses, along with the more in-depth interviews with 11 of the senior public health professionals who responded, and 11 other provider and advocacy organisations representing the areas of interest. Due to the small sample size, the views expressed may reflect each interviewee's perspective and may not be representative of all public health professionals and organisations. However, the reflections do provide useful context for this report.

Opportunities and difficulties in maintaining the quality of public health services following the H&SCA 2012

Greater opportunity for integration across council services to improve access and outcomes

Some of the senior public health professionals reflected that, following the H&SCA 2012, there are now better opportunities to work across local government and influence the wider council agenda and therefore have a positive impact on the wider determinants of health, from housing to transport (five responses). Wider partnerships have developed, such as working with leisure services to emphasise prevention and health; working

with trading standards to enhance tobacco control; and better integration across housing and substance misuse services to support recovery.

> *"Public health is now at the heart of all council services"*
> **(Survey respondent)**

> *"The main improvement that has happened through moving to councils is not in commissioned services, but in opportunities to influence wider council areas such as transport, leisure, planning, regeneration etc."*
> **(Survey respondent)**

For example, situated within local government, public health has the opportunity to work across the council to tackle teenage pregnancy; from commissioning effective SRE in schools, to ensuring access to contraceptive services and targeting programmes for those most vulnerable, such as young people in care and the criminal justice system (Local Government Association, 2013a). One interviewee reflected that:

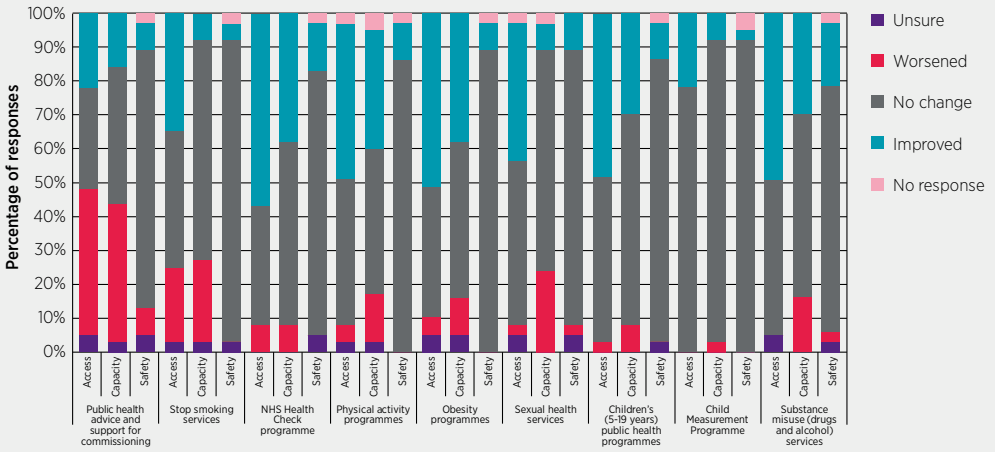
> *"The solution to teenage pregnancy was not the gift of any one agency."*

The transfer of smoking cessation and tobacco control to provision outside of the NHS has, in some areas, also enabled better links. As expressed by an interviewee:

> *"Being within local government has given tobacco control/smoking cessation an ability to have a different conversation with different parts of the NHS – because they are external stakeholders now. So we are seeing significant positive development of links with mental health trusts and maternity services – both areas where there has also been recent national policy attention."*

Furthermore, survey respondents suggested that access to many public health services which are now commissioned by local government had improved, including NHS health checks (56.8%, 21 responses), obesity (51.4%, 19 responses), substance misuse (48.6%, 18 responses), children's public health services (48.6%, 18 responses), and physical activity programmes (45.9%, 17 responses) (Figure 3.18).

Figure 3.18: Percentage of survey respondents reporting change in access, capacity and safety of public health functions transferred to local government



Source: DsPH survey (November 2015) n=37 responses

Across those interviewed there was a strong desire to deliver a whole-system approach to health, and recognition of the potential to work across

local government to improve health. But the interviews with providers and advocacy organisations showed that ongoing financial pressures were detrimental to encouraging people to work together, since the majority tended to look inward trying to sustain the current service.

Differing experiences of procurement within local government

In the survey of senior public health professionals, 12 respondents felt that the transition to local government provided an opportunity for public health commissioners to revisit existing contracts and that it is an opportunity to improve quality, and deliver more effective and efficient services (especially some existing alcohol and drugs misuse services). While recognising that it may be too early to tell what the impact on quality has been, senior public health professionals considered local government to be much better at procurement and contract management, by providing:

- greater transparency and increased scrutiny as a result of needing to engage with lead members for health and the public to justify decisions
- greater freedoms within local government to address local needs rather than a top-down approach:

  "Local government is much better at procurement and contract management than the NHS; once out of the NHS system it becomes apparent how stifling the top-down NHS approach to this is." **(Survey respondent)**
- greater focus on outcomes and stronger performance management of providers:

  "The increased discipline around commissioning and contracting, particularly the legal aspects, has been positive and in my view contributed to some increase in quality in large contracted services." **(Survey respondent)**
- greater emphasis on procuring services against specifications and opportunities to encourage partnership working:

  "Improved effectiveness through more appropriate commissioning and alignment with other services (e.g. recovery-based drug services, stop smoking services, more focused on disadvantaged groups, sexual health services integrated)." **(Survey respondent)**
- a stronger emphasis on equity, addressing the needs of more vulnerable groups:

  "The greater focus of council on protected characteristics monitoring has provided some drive. Also, application of the social value act[*] to council commissioning impacts on local benefit." **(Survey respondent)**

The perspective from the providers and advocacy organisations was more mixed. While recognising that some prevention services were in need of improvement or that the "quality of commissioning prior to transition was not brilliant", they highlighted that the re-tendering process had been a burden in some areas and disruptive:

[*] One respondent also highlighted the potential to think about securing wider community benefits when commissioning services, such as environmental, economic and employment benefits for the local population through the Public Services (Social Value) Act 2012 (HM Government, 2012c).

> *"We have people who spent half their clinical time in a year doing nothing but working on the contract. That takes away from patient care."* **(Interviewee)**

It will be difficult to demonstrate whether and how procurement of public health services within local government has had a positive impact on quality because this system reform has taken place alongside marked reductions in budgets, which will have an impact on the scope and quality of services provided.

System fragmentation

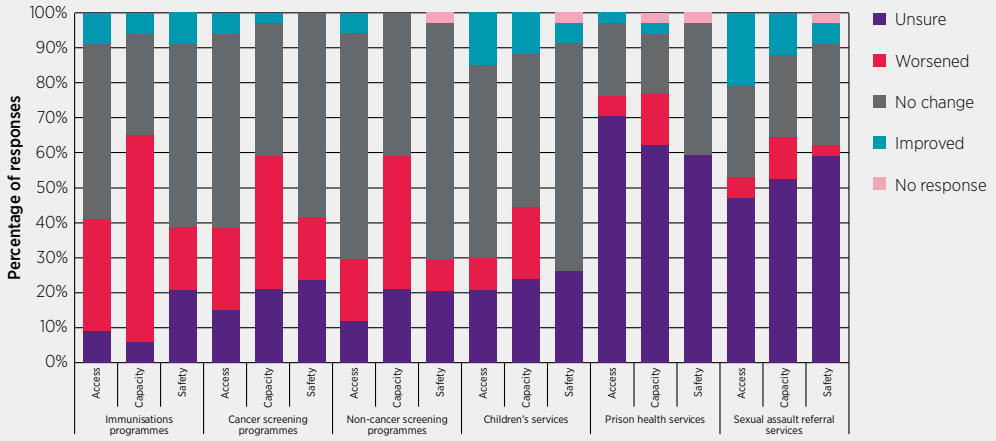
Across all the interviews conducted there was a broad consensus that the changes brought about by the H&SCA 2012 had resulted in fragmentation of services and care pathways across multiple commissioners (in particular for SRH and HIV) and that this has been further confounded by budget cuts, resulting in the loss of supportive services which were able to signpost individuals, especially young people, into prevention pathways. For example:

> *"In some areas abortion and maternity services are commissioned through the CCG, so it would be in their interest to contribute to prevention, reducing abortions and maternities, particularly those with higher risk such as young parents; but in some areas contraception has fallen into a silo."* **(Interviewee)**

> *"In addition, the infrastructure network of practitioners in local areas which supported young people into services like youth workers and Connexions, have been cut, so the pathways into sexual and reproductive services in many areas have been fractured."* **(Interviewee)**

Changes to the commissioning and provision of immunisation and screening programmes were highlighted by some as an area for concern. Over 50% of senior public health professionals surveyed felt that access for immunisation and cancer programmes was unchanged following the H&SCA 2012. However, some felt that access and capacity had worsened (worsened access: immunisation 32% (11 responses); cancer screening 24% (8 responses); worsened capacity: immunisation 59% (20 responses), cancer screening 38% (13 responses) (Figure 3.19).

Figure 3.19: Percentage of survey respondents reporting change in access, capacity and safety of public health functions which remained within the NHS



Source: DsPH survey (Nov 2015) n=34 responses

Following the H&SCA 2012, the Secretary of State for Health now delegates responsibility for the delivery of immunisation and screening programmes to NHS England under the Section 7A of the NHS Act 2006 (Department of Health and NHS England, 2015). At a local level, DsPH, in their new roles within local government, are responsible for providing assurance to the local HWB on immunisation and screening uptake levels. In the survey and interviews, some senior public health professionals felt that their ability to provide assurance on local screening and immunisation rates was limited due to their lack of access to local NHS data at general practice level, and the loss of understanding and influence to address local barriers to uptake and address local inequalities.

> *"There is still a lot of confusion in the system about how public health services operate and who is responsible for what. The public health system feels quite weak and fragmented and there is a lot of work still to be done to really develop place-based leadership for public health. [There are] initiatives such as local Health Protection Committees that are attempting to pull some of this together [but] these have some way to go. The new role of the DsPH as a public health systems leader is starting to emerge and there are some great examples of people doing this well but this is not universal."* **(Survey respondent)**

> *"Most of these services, particularly screening and immunisation, operate on a much wider footprint than they used to. This has probably helped to professionalise the way these services are run and improved standardisation of programmes, but there has been some loss of local focus."* **(Survey respondent)**

> *"It is difficult to ensure appropriate targeting of programmes to meet the needs of disadvantaged groups when the programmes are commissioned regionally and in isolation from local PH teams."* **(Survey respondent)**

Others felt that local screening and immunisation co-ordination and assurance meetings were working well, possibly reflecting variation in local capacity and relationships between stakeholders. One respondent highlighted that there was a lot of confusion over the complex data-sharing agreements, and this has been recognised at a national level:

"There has been a shock to the system and subsequent fragmentation – it may be that with some stability going forward and the redevelopment of links between the local areas and sectoral NHS England teams this may recover and issues such as screening uptake may return to levels pre-transition" (Survey respondent)

Loss of public health input into NHS commissioning

The H&SCA 2012 stipulated that each CCG was under a duty to "obtain advice appropriate for enabling it effectively to discharge its functions from persons who have a broad range of professional expertise in the prevention, diagnosis or treatment of illness, and the protection or improvement of public health" (HM Government, 2012a). The extent and the precise content of the service is not prescribed nationally, but the DH did provide guidance on suggested memorandum of understanding between CCGs and LAs (Department of Health, 2012).

Responses to the survey on this topic were mixed, with 45% (16 responses) of senior public health professionals reporting that the public health input into local NHS commissioning had worsened following the H&SCA 2012; whereas 30% (11 responses) felt there had been no change, and 22% (eight responses) felt it had improved. Although the total responses are small, the variability of the views expressed is likely to reflect differences in capacity, and relationships between the different partners involved.

In areas where there had been no change or improvement in public health input, senior public health professionals felt that well integrated teams and good engagement across public health and the CCG had helped: one interviewee noted that "public health input if anything tends to be stronger [at a local level]".

In those areas where a reduction in public health input into commissioning was reported, this was due to a combination of factors, including no access to NHS data to support commissioning within local government, and the loss of experience and reduced capacity within public health teams. One respondent suggested that:

"[The] information and intelligence function has deteriorated through lack of local provision and inadequacy and irrelevance of PHE['s] offer" **(Survey respondent)**

One respondent said that a loss of public health input and a population approach to commissioning would result in "little focus on prevention, service developments won't be delivered against need, resources will be used less effectively" (Interviewee). This is of particular concern, given the emphasis on planning services for local populations, closing the gap in quality of care, health and wellbeing, and costs within the NHS planning guidance to deliver the Five Year Forward View (NHS England and others, 2016).

Future challenges facing services to improve the public's health

Financial pressures

The most challenging issues facing services to improve the public's health, as expressed by senior public health professionals responding to our survey are the detrimental impact of increasing financial pressures across local government and the NHS on service provision and quality; uncertainty over financial planning for public health; and concerns about the loss of skilled public health workforce (Table 3.3).

Table 3.3: Challenges facing public health over the next five years as expressed by senior public health professionals in the QualityWatch public health survey (November 2015)

Challenges	Percentage of respondents citing challenge as relevant (*N*)
Challenging financial situation across wider local government	93.9% (31)
Insufficient public health resources	72.7 % (24)
Uncertainty over financial planning for public health (e.g. ring fence, current and future cuts)	72.7% (24)
Challenging financial situation across local NHS	69.7% (23)
Loss of skilled public health workforce	54.5% (18)
Loss of local control over public health budget	45.5% (15)
Ring-fenced budget being used for non-public health functions	42.4% (14)
Mismatch between local and central government priorities	39.4% (13)
Loss of focus on non-statutory functions	30.3% (10)
Public health continues to be considered on the periphery	21.2% (7)

Notes: 33 responses in total; multiple responses permitted.

There were also concerns expressed that the continued financial difficulties would have a detrimental effect on the working relationships across partners in prevention and public health, and challenge the sustainability of services:

> *"Local relationships [are] currently very good but could be threatened by constant pressure on all parties. The council has shown great interest in public health and willingness to engage across all directorates, but financial pressure is huge and even with [a] ring fence councils across the region have sought to use public health funds to prop up other services."* **(Interviewee)**

> *"The risk is as money is tight people do not collaborate and share, but it is in everyone's interest to get prevention right"* **(Interviewee)**

> *"Budget cuts are beginning to impact on quality of services, particularly services targeting at-risk groups."* **(Interviewee)**

Greater uncertainty

Uncertainty about public health funding was considered a key challenge among those interviewed. For example, £200 million in-year cuts from the 2015/16 public health budget was announced in June 2015 (HM Government, 2015; Nuffield Trust, The Health Foundation and The King's Fund, 2015) with a decision on how they would be implemented announced

five months later in November 2015 (Department of Health, 2015c). In some areas the cuts were difficult to implement where services had already been commissioned for the 2015/16 financial year. There is concern that continued uncertainty will result in more short-term contracts with providers, affecting the sustainability of provision. One interviewee reflected on the potentially negative consequences to continuation of service as a result of dealing with much greater uncertainty, with future funding decisions in some LAs being made close to the end of existing contracts – something which did not happen previously with rolling NHS contracts.

> *"[This is] unsettling for staff because they cannot be kept on if the service is likely to be cut – in the NHS that never happened. By the time the decision is made [to keep the service] many experienced nurses may have voted with their feet and disappeared, because they do not want to face that uncertainty" (Interviewee)*

Difficult prioritisation decisions are needed

Among the senior public health professionals we surveyed and interviewed, the importance of prioritisation, investing to save, and commissioning to meet local needs, were strong themes. But some also raised concerns that more challenging budgets will result in more difficult prioritisation decisions locally. Reflections from all those interviewed on how these decisions will evolve locally included (Box 3.1):

- competing tensions between delivery of prescribed (such as the National Child Measurement Programme) and non-prescribed functions (such as stop smoking services)
- decisions over whether to continue to fund clinical services (such as treatment services) or not, potentially seeing such services as an NHS function
- questions over the provision of services addressing perceived poor health choices by individuals (such as substance misuse services) compared to those supporting frail elderly populations
- decisions evolving through political will.

Box 3.1: More challenging budgets resulting in more difficult prioritisation decisions: quotes from provider and advocacy organisation interviews

"DsPH are in the unenviable position of having to address a range of different priorities"

"Increasingly everyone needs to prioritise: 'what are you going to stop doing?'"

"The return on investment from obesity will not be seen for many years. In reality, this goes down like a lead balloon"

"Many local councils have been genuinely working really hard, both the elected councillors and the officers, and the public health teams, to try and sustain a responsible model of sexual health care in their community"

"[The] decision that this is a lifestyle choice so no need to fund these services to 'just stop'– but it is not as easy as that"

"Substance misuse cut across every agenda, crime, health, troubled families – addressing the issues and dealing with the addiction problem will have much wider gains, for politicians it is not a vote winner and when you only have one pot of money for communities… Our service are competing against funding for support for [a] frail elderly lady who may have broken her arm, or housing for people with learning disabilities – the drugs agenda is far from glamorous, it does not win votes."

"There is a clear correlation between level of political support and investment in these [stop smoking] services. Political support is important to activity moving forward through the council"

Alongside best practice guidance and evidence of cost effectiveness, there is an awareness that different types of evidence from local politicians, and the public, may be drawn on to inform these decisions within local government.

> *"The service was under threat but after a very vigorous service user led campaign councillors relented and said it will remain with a 5% cut"* **(Interviewee)**

Different models of public health services

Three of the senior public health professionals we interviewed reflected that working within a reduced budget had contributed towards increased "rigour around considerations of cost effectiveness", and emphasis on "achiev[ing] the best possible outcome from reducing budgets". In the drive to achieve greater efficiencies, other interviewees reflected on the development of new models of delivery, but some were concerned that this may have unintended consequences on outcomes. For example, some noted a move towards single consultant-led and nurse-delivered models of SRH care, but at the potential loss of specialist input across the complexities of SRH. There was concern that the emphasis would be on sustaining clinical aspects, at the potential loss of health promotion and educational elements, or that moving towards combining multiple behaviours within one lifestyle model or

behaviour change, or more remote methods of delivery, may not be as effective.

> *"The risk is not necessarily about tackling multiple behaviours in one go, but the potential dilution of the methods used, e.g. telephone and texting support for smoking cessation are cheaper but not proven to be as effective. Texting and telephone support, rather than face-to-face and group support, when tackling more than one issue has also not been proven to provide the level of support and motivation that someone who is struggling with all of those things would need to change their behaviour."* **(Interviewee)**

One interviewee felt that:

> *"The ethos in local government to do things in a more integrated way, and treat the whole person, is in some ways in conflict with the evidence base".*

Mitigating these challenges

When we asked senior public health professionals their views on the best ways of mitigating the challenges facing public health, the most frequent responses were: joint public health commissioning across local government and the NHS (79%, 26 responses); placing greater responsibility on CCGs for prevention and population health (70%, 23 responses); and stronger leadership (70%, 23 responses).

Two thirds (66.7%, 22 responses) of the senior public health professionals surveyed highlighted the need to strengthen the return on investment evidence to support public health commissioning – for example the claim that that £1 investment in contraception saves £11 in averted outcomes in teenage pregnancy.

Overall, responses emphasised that the rhetoric around prevention needs to translate into practice, with strong leadership at both a local and national level, a joint approach across local government and the NHS to deliver on prevention, and a focus on strengthening the evidence base for prevention:

> *"Everything is driven by a need for savings and an overwhelming demand for acute care, both emergency and elective so prevention is always on the margins when it comes to resourcing even though there is much rhetorical support."* **(Survey respondent)**

Five senior public health professionals commented on the lack of consistent joint messages on prevention, both at a national and local level; with prevention not being taken seriously by NHS commissioners, or the local government not understanding their role in all areas:

> *"The NHS has a commitment to 'prevention' in the Five Year Forward View – however national government has cut public health budgets – but much worse, the main purpose of transferring public health to local government was to address wider determinants of health and well-being. The cuts to general local government budgets is frankly making this impossible and indeed worsening the situation. It is impossible to reconcile the rhetoric of the NHS and the government with regard to prevention with cuts in public health budgets and wider local authority budgets."* **(Survey respondent)**

4

Discussion and conclusion

This report is a timely exploration of the quality of public health services, in light of the significant changes made to the public health system following the H&SCA 2012, the emphasis on prevention in the recent Five Year Forward View, and the recent cuts to public health funding.

We have explored trends in 20 indicators across five key public health areas, with reflections from senior public health professionals and representatives of provider and advocacy organisations on the impact of the system reforms and funding challenges on quality of public health services. In doing so, we hope this report will be an important reference point when looking to the challenges ahead and within the context of the increased emphasis on prevention and public health.

Changes across public health indicators

Overall, for the majority the 20 public health indicators we looked at, trends have generally followed past trajectories over the period 2009 to 2015. Six indicators showed continuing worsening trends (reduction in the number of people setting a quit date with NHS stop smoking services; increasing rates of the STIs gonorrhoea, chlamydia, genital herpes and syphilis, and alcohol-related hospital admissions). Ten indicators showed continued improvement (including provision of LARC by GPs, prevalence of genital warts, drug treatment waiting times, smoking in pregnancy, and childhood obesity at age 4–5 years), but in five of these there was an indication progress may have slowed (smoking prevalence, teenage pregnancy, late diagnosis rate for HIV, completion of substance misuse treatment and MMR uptake) – but it is too early to tell if this reflects a true change in these indicators. Trends in the remaining four indicators were either unclear (proportion of smokers who quit, numbers of substance misuse in treatment) or had stayed the same (childhood obesity at age 10–11 years, and DTaP/IPV/Hib immunisations).

Trends were variable across the country, with the most socioeconomically deprived areas disproportionately affected by worsening trends in STI rates, compared to the national average. However, more deprived areas did demonstrate significantly better improvement in teenage pregnancy rates, compared to the national trend, possibly reflecting greater awareness and continued support to address this issue locally.

Fragmentation of public health services and functions

In our study, interviewees raised concerns about fragmentation of existing public health services following the implementation of the H&SCA 2012, with a potential detrimental effect on the availability of services and patient care. The potential loss of existing referral routes and links with organisations that would signpost individuals to prevention services, in particular youth services, was also noted. Prior to the H&SCA 2012, the system to commission and deliver public health services and functions was also arguably somewhat fragmented. Nonetheless, further fragmentation of the

public health system has been raised as a concern by others and has a potential negative impact on the quality of services and outcomes (British Association of Sexual Health and HIV and Faculty of Sexual and Reproductive Healthcare, 2012; Wilkinson, 2015; All-Party Parliamentary Group on Sexual and Reproductive Health in the UK, 2015; White, 2016; Faculty of Sexual and Reproductive Healthcare, 2014). The APPGSRH report in July 2015 described the division of commissioning responsibilities across organisations as "leading to services being commissioned in new silos built around the commissioning structures and not service users", failing to reflect the interdependencies between different services (All-Party Parliamentary Group on Sexual and Reproductive Health in the UK, 2015). For example, contraception services are commissioned by LAs, yet termination of pregnancy services are commissioned by CCGs, and the commissioning arrangements for HIV and other sexual health services do not reflect the co-dependency between them.

The importance of links between HIV and sexual health services has been recognised at a national level: PHE, the LGA and DH have published guidelines to help inform a co-ordinated approach across the different commissioners in the new system for sexual health (Department of Health, 2013b; Public Health England, 2014b; Hind, 2013) and substance misuse (Joint Commissioning Panel for Mental Health, 2013; Local Government Association, 2013b; 2014; Public Health England, 2015e), and there are examples where joined-up models of commissioning are being put in place. For example, Norfolk County Council and NHS England's East of England Specialised Commissioning Team have used a section 75 agreement to jointly commission an integrated sexual health and HIV service for the county (Local Government Association, Public Health England and Association of Directors of Public Health, 2013).

In the survey and interviews, some senior public health professionals highlighted concerns about the consequences of the major reorganisation of immunisation and screening programmes, which remained within the NHS but are now delivered over larger geographic areas then they previously were under primary care trusts. In some areas, it has been difficult to provide assurance on local screening and immunisation rates due to data-sharing restrictions, and the loss of influence to address local barriers to uptake. At a national level, indicators on immunisations did not indicate a marked change in uptake, but the data available at a population level are not sensitive enough to be able to explore uptake within specific high-risk groups.

Providing healthcare-related public health advice to local CCGs is a prescribed function of LAs, but the extent and the precise content of the service is to be agreed locally (Department of Health, 2012). Views on the provision of public health input into NHS commissioning was mixed, with some reporting this had reduced as a consequence of limited access to NHS data within local government systems, and the loss of experience and reduced capacity within public health teams; whereas others, where prior engagement across public health and the CCG worked well, had maintained this input. A recent survey by the ADPH on funding challenges found that 50% of the DsPH who responded (87 responses, response rate 66%) felt that the level of healthcare-related public health advice to CCGs would be unchanged in 2016/17; but approximately 35% felt that this would be reduced (Association of Directors of Public Health, 2016). It may be that CCGs are able to access this advice internally or from other sources, but given the emphasis within NHS guidance to deliver the Five Year Forward View on planning services for local populations, access to specialist advice

and support in these areas to inform commissioning decisions is important (NHS England and others, 2016).

Commissioning for quality in a new environment

Among the senior public health professionals surveyed there was a general consensus that the transition of public health into local government has acted as an impetus to revisit service provision in some areas and to improve quality and deliver more effective and efficient services (especially existing alcohol and drug misuse services). The need to reassess provision in substance misuse services has also been reported in a larger survey of DsPH (Public Health England and Association of Directors of Public Health, 2014). Some of our interviewees viewed re-tendering as a significant burden on providers, diverting attention away from patient care. This is supported by the findings from another survey of substance misuse providers, over half of whom had been through a re-tendering process since September 2013 (DrugScope, 2015), and another cautioning that short-term commissioning may be counterproductive to long-term planning of care (Public Health England and Association of Directors of Public Health, 2014).

The senior public health professionals we interviewed felt that procurement processes within local government are more robust compared with within the NHS, with greater emphasis on aligning services to needs, especially of the most vulnerable populations; commissioning integrated service models, aligning to quality standards and holding providers to account through stronger performance management mechanisms; and greater transparency and increased scrutiny of local decisions. All of these can potentially contribute to improving the effectiveness, equity and access to services commissioned. However, these views may not be representative of the experience across all LAs. For example, the APPGSRH found that over a third (35%) of LAs did not issue a service specification as part of their procurement of potential sexual health providers in 2013/14 (All-Party Parliamentary Group on Sexual and Reproductive Health in the UK, 2015).

Prevention across local government – achieving its aspirations?

Many of our survey respondents recognised that the recent changes to the public health system offer opportunities to think more broadly about how to link public health services with other council functions – something that has been reflected in other reports (Public Health England, 2014b; Local Government Association, Public Health England and Association of Directors of Public Health, 2013; British Association of Sexual Health and HIV and Faculty of Sexual and Reproductive Healthcare, 2012; Local Government Association, 2013a; Wilkinson, 2015; All-Party Parliamentary Group on Sexual and Reproductive Health in the UK, 2015). There is evidence to suggest that there may be better progress in some areas (e.g. tobacco control; Anderson and Cheeseman, 2016) than others (e.g. continued gaps in links with housing, education and mental wellbeing; DrugScope, 2015). Among those we interviewed, there is also a concern that continued financial pressures may prove detrimental to this collaborative approach, as both providers and commissioners look inwards with a focus on sustaining their current functions and services in times of austerity.

Who is accountable for outcomes?

The H&SCA 2012 moved away from a top-down directive approach to facilitating greater local control and accountability, enabling a focus of funds and services based on local population needs rather than meeting enforced

targets. At a local level, the HWBs (including representation from public health (DsPH), elected members, CCGs, local Healthwatch and others) have strategic oversight of the delivery of services to meet local health needs, as set out in the JSNA and JHWS. This will include progress against the PHOF – nationally set indicators which highlight key areas of focus to reduce premature mortality and inequalities in health (Department of Health, 2013a). In addition to the HWBs, the council Health Scrutiny Committees can hold the LA and partners to account in relation to commissioning and delivery of services, and have a proactive role in understanding communities and tackling health inequalities (Association of Directors of Public Health, 2016). The local Healthwatch has a role to play too, gathering information and responding to the views of the communities about health and services. The DsPH, along with the chief executive or the finance director, must account to PHE for their compliance with the conditions attached to their public health grant through spending returns – an important consideration given concerns from others that the grant may not always be spent appropriately in some areas (National Audit Office, 2014; Iacobucci, 2014).

Concerns about accountability for public health outcomes have been raised as an area of concern in reports by the APPGSRH and others (All-Party Parliamentary Group on Sexual and Reproductive Health in the UK, 2015; Barker, 2014). In our survey and interviews, many senior public health professionals felt that there is greater local scrutiny than previously when public health was within the NHS. This view was reflected in the National Audit Office review of public health spending (National Audit Office, 2014).

In this report we also considered the national picture, highlighting that more deprived areas are disproportionately affected by increasing trends in STI rates. There are many reasons for differences in outcomes across England, but variation in service provision and outcomes may be exacerbated by continued financial pressures and difficult prioritisation decisions. PHE publishes the PHOF enabling LAs to compare their progress against others, along with health profiles for specific areas (e.g. sexual health; Public Health England, 2016b), and comparative spend against outcomes tools (Public Health England, 2016c). The LGA Health and Wellbeing peer review process (Local Government Association, 2015a) may also help local areas to self-assess and learn from others to improve outcomes. Within the context of increased devolution and greater powers at a local government level, there may need to be further thought on how to help strengthen and empower local accountability for both spend and outcomes.

Prioritising public health in times of austerity – a key challenge

In our survey, senior public health professionals were asked about the most challenging issues facing services to improve the public's health. Respondents highlighted the detrimental impact of increasing financial pressures on service provision and quality across local government (94%, 31 responses) and the NHS (70%, 23 responses), uncertainty over financial planning for public health (73%, 24 responses), alongside concerns about the loss of skilled public health workforce (55%, 18 responses).

In 2015/16, the total public health grant to LAs amounted to £2.8 billion (with an additional £480 million for children services [0–5 years]). In June 2015, the Chancellor of the Exchequer announced a £200 million (7%) cut to the public health budget, applied as a flat rate reduction across LAs, on the basis that this approach was more transparent and offered greater certainty for LAs as the financial year was progressing (Department of Health; 2015a, HM Government, 2015). This was followed in the 2015

Spending Review with the announcement of a 3.9% per year cut over the next five years to LA public health budgets – a real-terms reduction of at least £600 million in public health spending by 2020/21 (Nuffield Trust, The Health Foundation and The Kings Fund, 2015). The ring fence around the public health budget is intended to remain in place until 2018. However, there are then greater uncertainties, especially within the wider context of the potential replacement of central government funding with revenue generated from local business rates towards the end of the Parliament (HM Treasury, 2015).

There is concern among the ADPH that continued cuts will negatively impact on public health and exacerbate inequalities. For example, there are already cuts in public health services in place for smoking cessation (budgets were cut in 39% of LAs in England in 2015/16) and wider tobacco control (28% of LAs; Association of Directors of Public Health, 2016). A report by Alcohol Concern found reductions in funding for alcohol misuse services were experienced disproportionately in areas with the highest levels of alcohol harm, which were often the most socioeconomically deprived as well (Alcohol Concern, 2015). A *BMJ* survey found 10 LAs had cut or restricted access to sexual health services over the past two years (White, 2016), and other reports highlight threats to sexual health promotion (Wilkinson, 2016; White, 2016; Faculty of Sexual and Reproductive Healthcare, 2015), and provision of LARC and training for new clinicians to provide LARC (Primary Care Women's Health Forum, 2014). In the longer term, a move towards funding services through local business rates needs careful consideration to ensure that this is not detrimental to deprived areas, where the opportunities for income generation may be lower, but need is higher.

Themes arising from the interviews with senior public health professionals were the need to invest to save, and commissioning to meet the needs of the local population. However, senior public health professionals and provider and advocacy organisations expressed views that reduced budgets are likely to result in increasingly difficult prioritisation decisions for public health services.

Although it was not the intention of the H&SCA 2012 to identify prescribed services as being more important (Department of Health, 2011b), some expressed views that discussions on which areas to fund may also include whether the function is prescribed or not. One example of this potentially occurring is evidenced by comparing two related sexual health services, one of which is prescribed and one of which is not: estimated net expenditure in England on the prescribed functions of STI testing/treatment, contraceptives, and advice on preventing unintended pregnancy increased by 6% (from £367 million to £390 million) between 2013/14 and 2015/16 (Local Government Association, 2015b). In contrast, the non-prescribed function of sexual health advice, prevention and promotion had a 25.6% estimated reduction over the same period (from £114 million to £82.6 million) (Local Government Association, 2015b).

However, this is not the case for all non-prescribed functions, and expenditure has gone up over the same time period in some cases, such as physical activity programmes and childhood obesity. Whether these non-prescribed functions continue to see expenditure increases could be at risk based on the views of those we surveyed and interviewed.

Additional views also included taking into account whether a service is available elsewhere – such as in the NHS. This could result in greater emphasis on clinical elements of public health services, with a loss of focus on health promotion (e.g. funding for specialist treatment services for

alcohol but not health promotion initiatives to address alcohol misuse). A further consequence could be the reduction of some functions (e.g. contraception services).

Provider and advocacy organisations also highlighted tensions in the provision of services addressing perceived poor health choices by individuals – for example, funding for substance misuse services – when compared to those seen as incontrovertible – such as supporting frail elderly populations.

There was also recognition of the need to find efficiencies, through increased emphasis on services which seek to address multiple behaviours, and new methods of delivering care which may be at the expense of maintaining effectiveness (Grandes and others, 2008, Prochaska, 2011; O'Connor, 2015).

What is needed?

Senior public health professionals were asked about their views on how to mitigate the challenges facing public health. The most frequent responses were for a joint approach to commissioning of public health across local government and the NHS, alongside strong public health leadership and placing greater responsibility on CCGs for prevention and population health at a local level. At a national level, further development of return on investment evidence to support public health commissioning was felt to be needed.

The future

Prevention and public health are key components to the delivery of the Five Year Forward View, yet the potential detrimental impact of cuts to public health services and functions on population health (and consequently the NHS and social care services which support those in ill health) needs careful consideration. Disinvesting in public health and social care in the short-term is cost-increasing in the long term (Owen and others, 2012).

Local investment in public health also needs to be supported by national levers of change and political will. For example, there is a risk that without continued focus on teenage pregnancy, supported by investment and targeted local services, continuation of the positive downward trend would stall, despite a clear economic rationale for investment. The Family Planning Association suggests that a 10% cut in spending on contraception and sexual health services could cost up to an extra £8.3 billion in health and non-health (social welfare, housing and education) related costs due to unwanted pregnancies, and £363 million in STIs by 2020. Progress in addressing teenage pregnancy would be lost without continued investment, with rates potentially reverting to the 2003 levels (Lucas, 2015).

In relation to alcohol, one study suggests that up to 77,000 deaths from liver disease could be prevented over 20 years with national change in alcohol policy (Sheron and others, 2012). An analysis carried out by the UK Health Forum estimated that if smoking prevalence rates stall at the levels seen in 2014, there would be an additional 25,126 cases of lung cancer (and estimated £7 million extra costs) by 2034, whereas if smoking prevalence fell to 5% in the population, then an estimated 4,290 cases of lung cancer could be avoided (an estimated saving of £2 million) by 2034 (compared to steady progress over this period) (UK Health Forum, 2014).

A costing tool by NICE suggests that, in England, a shift of 1% of patients being diagnosed with HIV at an earlier stage of disease could produce

savings from treatment alone of around £212,000 a year for MSM, and £265,000 a year for black Africans (National Institute for Health and Care Excellence, 2011). Overall, NICE estimates that 3,500 cases of onward transmission could be prevented within five years, saving £18 million per year in treatment costs alone, without taking into account the wider costs or savings to society (National Institute for Health and Care Excellence, 2014b).

The evidence to support prevention is strong in many areas, so the question is how this can be better translated into practice. Return on investment tools will help, but the difficulty is that the return is often not to the commissioner directly or within the electoral cycle (Taylor-Robinson, 2008; Pokhrel, 2015). Looking beyond the public health grant, to achieve its aspirations to address the wider determinants of health, public health needs to influence decisions across the entire local government budget, and to better understand how to develop the evidence base to influence a non-NHS environment (Woolf and others, 2015).

Strengths and limitations

The mixed methods approach used in this study– bringing together a quantitative review of key indicators of public health outcomes and qualitative views of senior public health professionals and provider and advocacy organisations within public health – is a key strength. However, the sample sizes for the survey and interviews were small, and so views expressed may not be representative of all LAs across England, nor the opinions of all those working in these areas. Even with this limitation, the reflections do provide valuable context when considering the changes within the public health system and funding cuts, and highlight important issues which would not have been evident in examination of the population-level indicators alone.

The interpretation of trends in any public health indicator is challenging, and our exploration of regional variations in trends in public health indicators, compared to the national average, was limited to only those indicators available at LA level.

Difficulties occur as any change is likely to be a consequence of many different factors which influence poor health behaviours, including societal factors, system change, alongside legislative and regulatory changes affecting service provision.

Within LAs, marked population changes over the period of interest may account for some of the change in the indicators, compared to the national average. However, given the short follow-up period (2009 to 2015), this is unlikely to have a marked impact.

The H&SCA 2012 was implemented in April 2013, and as such the follow-up time for the indicators is short. It will take time for organisational changes and funding cuts to have an impact on outcomes at a population level, so continued oversight of indicators for prevention and public health is highly important.

Conclusion

The H&SCA 2012 resulted in significant restructuring of the public health system and was followed by cuts in public health and local government funding. As yet, there is little evidence of a marked change in outcomes, but where there is change it is difficult to ascertain whether this has been a consequence of the system reforms, budget cuts, or wider societal factors.

Views expressed by those we surveyed and interviewed suggest that the transfer of public health to local government has resulted in greater emphasis on commissioning to improve quality and outcomes, and aspirations to better link prevention across council functions. But continued cuts to public health and local government budgets places a strain on work across provider organisations and commissioners to realise the potential of an integrated approach to health, greater focus on prevention, and addressing the wider determinants of health. Financial pressures are likely to result in difficult prioritisation decisions within local government, with a potential detrimental impact on public health services, especially those serving vulnerable groups.

Strengthening the argument for prioritising public health, along with local scrutiny of local commissioning decisions, may help to ensure the rhetoric of greater focus on prevention becomes a reality. Monitoring future population health outcomes is warranted in order to ensure previous improvements are sustained and emerging challenges are addressed.

References

Alcohol Concern (2015) *A Measure of Change: The impact of the public health transfer on local alcohol provision*.

All Parliamentary Group on Smoking and Health (2015) All Party Parliamentary Group on Smoking and Health. Representation to the 2015 Spending Review.

All-Party Parliamentary Group on Sexual and Reproductive Health in the UK (2015) *Breaking down the Barriers: The need for accountability and integration in sexual health, reproductive health and HIV services in England*.

Anderson W, Cheeseman H (2016) *Reading between the Lines. The results of a survey of tobacco control leads in local authorities in England*. A report by Action on Smoking and Health commissioned by Cancer Research UK, January 2016. doi:10.1017/CBO9781107415324.004

Association of Directors of Public Health (2016) *Impact of Funding Reductions on Public Health.*

Barker K (2014) *A New Settlement for Health and Social care*. The King's Fund

Bayer Healthcare (2013) Contraception Atlas, 2013.

British Association of Sexual Health and HIV, and Faculty of Sexual and Reproductive Healthcare (2012) The Role of Local Authorities in Health Issues – Communities and Local Government Committee. Written submission by the British Association of Sexual Health and HIV (BASHH) and the Faculty of Sexual and Reproductive Healthcare (FSRH). www.publications.parliament.uk/pa/cm201213/cmselect/cmcomloc/694/694vw19.htm Accessed 1 February 2016.

Brown M, Marsh T, Rtveladze K, Fordham R, Suhrucke M, Turner D, Little R and Filani O (2013) Managing overweight and obesity among children: Report on economic modelling and cost consequence analysis. National Heart Foundation and University of East Anglia. https://www.nice.org.uk/guidance/ph47/evidence/economic-modelling-report-430357501

Butland B, Jebb S, Kopelman P and others (2007) *Tackling obesities: future choices – project report (2nd edition)*. Government Office for Science

Coulton V, Dodhia S, Ells L, Blackshaw J and Tedstone A (2015) *National Mapping of Weight Management Services: Provision of tier 2 and tier 3 services in England*. Public Health England.

Currie C, Davies A, Blunt I, Ariti C and Bardsley M (2015) *Alcohol-specific Activity in Hospitals in England*. Nuffield Trust.

Darzi A (2008) *High Quality Care for All: NHS Next Stage Review final report*.

Department for Communities and Local Government (2015) English Indices of Mulitple Deprivation, 2015. www.gov.uk/government/statistics/english-indices-of-deprivation-2015 Accessed 1 February 2016.

Department for Communities and Local Government (2014) Local Authority Revenue Expenditure and Financing. https://www.gov.uk/government/collections/local-authority-revenue-expenditure-and-financing Accessed 23 March 2016.

Department of Education (2010) *The Teenage Pregnancy Strategy: Beyond 2010.*

Department of Health (2010a) *Improving the Health and Well-being of People with Long-term Conditions*.

Department of Health (2010b) *Equity and Excellence: Liberating the NHS.*

Department of Health (2011a) *The New Public Health System: summary.*

Department of Health (2011b) *Public Health in Local Government: Local government's new public health functions*.

Department of Health (2012) *Guidance to Support the Provision of Healthcare Public Health Advice to Clinical Commissioning Groups*.

Department of Health (2013a) *Improving Outcomes and Supporting Transparency Part 1A: A public health outcomes framework for England, 2013-2016.*

Department of Health (2013b) *A Framework for Sexual Health Improvement in England.*

Department of Health (2015a) Local Authority Public Health Allocations 2015/16: In-year savings. A consultation. https://www.gov.uk/government/consultations/local-authority-public-health-allocations-2015-to-2016 Accessed 1 February 2016.

Department of Health (2015b) *Overview 3: Changes to how 0-5 services are commissioned.*

Department of Health (2015c) Local Authority Public Health Grant Allocation 2015/16. Government response to public consultation on in-year savings and Equality and health inequalities analysis.

Department of Health and NHS England (2015) NHS Public Health Functions Agreement 2016-17. Public health functions to be exercised by NHS England.

DrugScope (2015) *State of the sector report*. www.drugwise.org.uk/state-of-the-sector/ Accessed 1 February 2016.

Faculty of Sexual and Reproductive Healthcare (2014) *Faculty of Sexual and Reproductive Healthcare Survey. An analysis of the key issues for local sexual health services.*

Faculty of Sexual and Reproductive Healthcare (2015) Statement on Cuts to Sexual and Reproductive Health Services.

Gardner DS, Hosking J, Metcalf BS, Jeffery AN, Voss LD and Wilkin TJ (2009) 'Contribution of early weight gain to childhood overweight and metabolic health: a longitudinal study (EarlyBird 36)', *Pediatrics* 123(1): e67–73

Gordon H, Anderson Rael dos S and Joanne W (2012) *Estimates of the Prevalence of Opiate Use and/or Crack Cocaine Use, 2011/12: Sweep 8 Summary Report*.

Gordon L, Tinsley L, Godfrey C and Parrott S (2006) The Economic and Social Costs of Class A Drug Use in England and Wales, 2003/04. In: Singleton N, Murray R, Tinsley L, eds. *Measuring different aspects of problem drug use: methodological developments*. Home Office Online Report 16.

Grandes G, Sanchez A, Cortada JM, Balague L, Calderon C, Arrazola A, Vergara I, Millan E (2008) Is integration of healthy lifestyle promotion into primary care feasible? Discussion and consensus sessions between clinicians and researchers. *BMC Health Serv Res*, 8, 213. doi:10.1186/1472-6963-8-213.

Griffiths LJ, Dezateux C and Hill A (2011) 'Is obesity associated with emotional and behavioural problems in children? Findings from the Millennuim Cohort Study', *International Journal of Paediatric Obesity* 6: e423–32

Healey C, Rahman A, Faizal M and Kinderman P (2014) Underage drinking in the UK: changing trends, impact and interventions. A rapid evidence synthesis. *Int J Drug Policy*, 25, 124–32. doi:10.1016/j.drugpo.2013.07.008.

Heath S (2014) Health and Wellbeing Boards (England) Local authorities' public health responsibilities (England). Parliamentary briefing. www.parliament.uk/briefing-papers/SN06844.pdf

Hind J (2013) Commissioning Sexual Health Services and Interventions. Best practice guidance for local authorities. Department of Health. www.gov.uk/government/uploads/system/uploads/attachment_data/file/144184/Sexual_Health_best_practice_guidance_for_local_authorities_with_IRB.pdf

HM Government (2010) *Healthy Lives, Healthy People: Our strategy for public health in England*.

HM Government (2011) Healthy Lives, Healthy People: Update and the way forward. https://www.gov.uk/government/publications/healthy-lives-healthy-people-update-and-way-forward Accessed 1 February 2016.

HM Government (2012a) *Health and Social Care Act 2012.* http://www.legislation.gov.uk/ukpga/2012/7/contents/enacted Accessed 17 March 2016.

HM Government (2012b) *Overview of Health and Care Structures – The Health and Social Care Act 2012*.

HM Government (2012c) *New Focus for Public Health – The Health and Social Care Act 2012.*

HM Government (2012d) *Public Services (Social Value) Act 2012*. http://www.legislation.gov.uk/ukpga/2012/3/enacted Accessed 18 March 2016.

HM Government (2013) The Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2013. No. 351. www.legislation.gov.uk/uksi/2013/351/made Accessed 21 March 2016.

HM Government (2015) Chancellor announces £4½ billion of measures to bring down debt. https://www.gov.uk/government/news/chancellor-announces-4-billion-of-measures-to-bring-down-debt Accessed 1 February 2016.

HM Treasury (2015) Spending Review and Autumn Statement 2015. https://www.gov.uk/government/publications/spending-review-and-autumn-statement-2015-documents Accessed 1 February 2016.

Home Office (2009) The Drug Treatment Outcomes Research study (DTORS): Cost-effectiveness analysis. Home Office Research Report 25.

Home Office (2013) Next steps following the consultation on delivering the Government's alcohol strategy. http://www.webcitation.org/6LZKJa6fQ Accessed 1 February 2016.

HSCIC (2015a) Sexual and Reproductive Health Services, England 2014-15. Table 6. Women using sexual and reproductive health services by main method of contraception. www.hscic.gov.uk/searchcatalogue?productid=18929&topics=2%2fPublic+health%2fLifestyle%2fContraception&sort=Relevance&size=10&page=1#top Accessed 27 January 2016.

HSCIC (2015b) Statistics on Smoking. England 2015.

HSCIC (2015c) NHS Immunisation Statistics 2015. http://www.hscic.gov.uk/searchcatalogue?topics=2%2fPublic+health%2fHealth+protection%2fImmunisation&sort=Relevance&size=10&page=1#top Accessed February 2016

Jarvis MJ and Wardle J (2005) Social Patterning of Health Behaviours: The case for cigarette smoking. In: Marmot M, Wilkinson R, eds. *Social Determinants of Health*. Oxford University Press Inc.

Joint Commissioning Panel for Mental Health (2013) *Guidance for Commissioners of Drug and Alcohol Services*.

Iacobucci G (2014) 'Raiding the public health budget', *BMJ* 348: g2274

Local Government Association (2013a) *Tackling Teenage Pregnancy. Local government's new public health role*.

Local Government Association (2013b) *Tackling Drugs and Alcohol. Local government's new public health role*.

Local Government Association (2014) *Tackling the Causes and Effects of Alcohol Misuse.*

Local Government Association (2015a) Health and Wellbeing Peer Challenge. http://www.local.gov.uk/peer-challenges/-/journal_content/56/10180/3511124/ARTICLE Accessed 23 March 2016.

Local Government Association (2015b) Estimated budget net expenditure - Sexual health services - Advice, prevention and promotion (non-prescribed functions) in England. http://lginform.local.gov.uk/reports/lgastandard?mod-metric=3999&mod-period=3&mod-area=E92000001&mod-group=AllLaInCountry_England

Local Government Association (2013) Public Health England and Association of Directors of Public Health. Sexual health commissioning: Frequently asked questions. http://www.local.gov.uk/c/document_library/get_file?uuid=de86daf2-19e3-42f4-95c8-29bb6cc80a65&groupId=10180 Accessed 1 February 2016.

Local Government Association, Public Health England, Town and Country Planning Association (2016) *Building the Foundations: Tackling obesity through planning and development.*

Lucas S (2015) Unprotected Nation. An Update on the Financial and Economic Impacts of Restricted Contraceptive and Sexual Health Services. www.fpa.org.uk/sites/default/files/unprotected-nation-2015-full-report.pdf Accessed 1 February 2016.

Maxwell R (1984) Quality Assessment in Health. BMJ, 288, 1470–2.

Montouchet C and Trussell J (2013) Unintended Pregnancies in England in 2010: Costs to the National Health Service (NHS). *Contraception*, 87, 149–53.

Murphy L and Turner S (2012) Local Healthwatch, Health and Wellbeing Boards and Health Scrutiny: Roles, relationships and adding value. http://cfps.org.uk/publications?item=7195 Accessed 1 February 2016.

National Audit Office (2014) Public Health England's Grant to Local Authorities.

National Centre for Smoking Cessation and Training, and Public Health England (2014) Local Stop Smoking Services. Service and delivery guidance 2014.

National Institute for Health and Care Excellence (2005a) Long-acting Reversible Contraception. Clinical guideline 30.

National Institute for Health and Care Excellence (2005b) National Cost-impact Report: Implementing the NICE clinical guideline on long-acting reversible contraception.

National Institute of Health and Care Excellence (2007) Sexually Transmitted Infections and Under-18 Conceptions: Prevention. Public health guidance 3.

National Institute of Health and Care Excellence (2008) Stop Smoking Services. Public health guidance 10.

National Institute of Health and Care Excellence (2011) Increasing the Uptake of HIV Testing among Black Africans, in Increasing the uptake of HIV testing among men who have sex with men.

National Institute of Health and Care Excellence (2013) Weight Management: Lifestyle services for overweight or obese children and young people.

National Institute for Health and Care Excellence (2014a) Contraceptive Services for Under 25s. Public health guidance 51.

National Institute for Health and Care Excellence (2014b) HIV Testing. LGB21.

National Institute for Health and Care Excellence (2015) Tobacco Return on Investment Tool. www.nice.org.uk/about/what-we-do/into-practice/return-on-investment-tools/tobacco-return-on-investment-tool Accessed 29 February 2016.

NHS England (2014) *Five Year Forward View*. https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf Accessed 1 February 2016.

NHS England, NHS Improvement Development, Care Quality Commission and others (2016) *Delivering the Forward View: NHS planning guidance*. www.england.nhs.uk/wp-content/uploads/2015/12/planning-guid-16-17-20-21.pdf Accessed 1 February 2016.

Nuffield Trust, The Health Foundation, The Kings Fund (2015) *The Spending Review: What does it mean for health and social care?*

O'Connor R (2015) Health Matters: The importance of creating sustainable stop smoking services. Public Health. England. https://publichealthmatters.blog.gov.uk/2015/10/16/health-matters-the-importance-of-creating-sustainable-stop-smoking-services/ Accessed 26 February 2016.

Office for National Statistics (2013a) Conception Statistics, England and Wales, 2013. www.ons.gov.uk/ons/rel/vsob1/conception-statistics--england-and-wales/2013/index.html Accessed 29 January 2016.

Office for National Statistics (2013b) Drinking Habits amongst Adults, 2012. www.ons.gov.uk/ons/dcp171778_338863.pdf?format=hi-vis Accessed 1 February 2016.

Office for National Statistics (2014) International Comparisons of Teenage Births. www.ons.gov.uk/ons/rel/vsob1/births-by-area-of-usual-residence-of-mother--england-and-wales/2012/sty-international-comparisons-of-teenage-pregnancy.html Accessed 29 January 2016.

Owen L, Morgan A, Fischer A, Ellis S, Hoy A and Kelly MP (2012) The cost-effectiveness of public health interventions. *J Public Health* (Bangkok), 34, 37–45. doi:10.1093/pubmed/fdr075

Pokhrel S (2015) Return on investment (ROI) modelling in public health: strengths and limitations. *Eur J Public Health*.doi:10.1093/eurpub/ckv136

Primary Care Women's Health Forum (2014) Primary Care Women's Health Forum Survey on Primary Care LARC services. http://events4healthcare.com/PCWHF_Survey.html Accessed 15 January 2016.

Prochaska J (2011) A Review of Multiple Health Behavior Change Interventions for Primary Prevention. *Am J Lifestyle Med,* 5. doi:10.1177/1559827610391883. doi:10.1016/j.surg.2006.10.010.Use

Public Health England (2013) *Alcohol and Drugs Prevention, Treatment and Recovery: Why invest?*

Public Health England (2014a) From Evidence into Action: Opportunities to protect and improve the nation's health. https://www.gov.uk/government/publications/from-evidence-into-action-opportunities-to-protect-and-improve-the-nations-health Accessed 1 February 2016.

Public Health England (2014b) Making it Work: A guide to whole system commissioning for sexual health, reproductive health and HIV. https://www.gov.uk/government/publications/commissioning-sexual-health-reproductive-health-and-hiv-services Accessed 1 February 2016.

Public Health England (2014c) Health Protection Report: Sexually transmitted infections and chlamydia screening in England.

Public Health England (2014d) Surveillance of Antimicrobial Resistance in Neisseria Gonorrhoeae. Key findings from the 'Gonococcal resistance to antimicrobials surveillance programme' (GRASP) and related surveillance data 2014.

Public Health England (2014d) Preliminary analysis of Health Survey for England combined data 2011 and 2012. Obesity Knowledge and Intelligence. https://www.noo.org.uk/LA/impact/economic

Public Health England (2015a) Directors of Public Health in England. 2015. https://www.gov.uk/government/publications/directors-of-public-health-in-england--2 Accessed 1 February 2016.

Public Health England (2015b) Sexual and Reproductive Health Profiles. http://fingertips.phe.org.uk/profile/sexualhealth/data#page/0 Accessed 29 January 2016.

Public Health England (2015c) HIV in the UK – Situation Report 2015. Incidence, prevalence and prevention.

Public Health England (2015d) National HIV Surveillance data tables. No. 1: 2015. 2015. https://www.gov.uk/government/statistics/hiv-data-tables Accessed 1 February 2016.

Public Health England (2015e) Quality Governance Guidance for Local Authority Commissioners of Alcohol and Drug Services.

Public Health England (2015f) Adult Substance Misuse Statistics from the National Drug Treatment Monitoring System (NDTMS). 1 April 2014 to 31 March 2015.

Public Health England (2015g) Health Economics to Support the Case for Prevention.

Public Health England (2016a) Sexually Transmitted Infections (STIs): annual data tables. 2016. https://www.gov.uk/government/statistics/sexually-transmitted-infections-stis-annual-data-tables Accessed 29 January 2016.

Public Health England (2016b) Public Health Outcomes Framework. http://www.phoutcomes.info/ Accessed 23 March 2016.

Public Health England (2016c) Spend and Outcomes tool (SPOT). http://www.yhpho.org.uk/default.aspx?RID=49488 Accessed 23 March 2016.

Public Health England, Association of Directors of Public Health (2014) Review of Drug and Alcohol Commissioning.

Public Health England. Patterns and trends in child obesity (slide set) (2016) https://www.noo.org.uk/slide_sets Accessed 14th April 2016.

Rees R, Oliver K, Woodman J and Thomas J (2009) *Children's views about obesity, body size, shape and weight: a systematic review.* EPPI Centre, Social Science Research Unit, Institute of Education, University of London.

Reilly JJ and Kelly J (2011) 'Long-term impact of overweight and obesity in childhood and adolescence on morbidity and premature mortality in adulthood: systematic review', *Int J Obes* 35(7): 891–8

Scarborough P, Bhatnagar P, Wickramasinghe KK, Allender S, Foster C and Rayner M (2011) The Economic Burden of Ill Health due to Diet, Physical Inactivity, Smoking, Alcohol and Obesity in the UK: An update to 2006-07 NHS costs. *J Public Health* (Bangkok), 33, 527–35. doi:10.1093/pubmed/fdr033

Sheron N, Gilmore I, Parsons C, Hawkey C and Rhodes J (2012) Projections of alcohol-related deaths in England and Wales – Tragic toll or potential prize? *Lancet* 379, 687–8. doi:10.1016/S0140-6736(12)60244-X

Taylor-Robinson DC, Milton B, Lloyd-Williams F, O'Flaherty M and Capewell S (2008) 'Planning ahead in public health? A qualitative study of the time horizons used in public health decision-making', *BMC Public Health* 8(1), 415. doi:10.1186/1471-2458-8-415

UK Health Forum (2014) Risk factor based modelling for Public Health England. www.ukhealthforum.org.uk/prevention/pie/?entryid43=38207 Accessed 23 March 2016.

Van Gils PF, Tariq L, Verschuuren M and van den Berg M (2011) Cost-effectiveness research on preventive interventions: A survey of the publications in 2008. *Eur J Public Health*, 21, 260–4. doi:10.1093/eurpub/ckq069

Waters E, de Silva-Sanigorski A, Burford B, Brown T, Campbell K, Gao Y, Armstrong R, Prosser L, Summerbell C (2011) 'Interventions for preventing obesity in children', *Cochrane Database Syst Rev* 12: CD001871

White C (2016) Sexual Health Services: Divided and unprotected. *BMJ*, 309, 10–1. doi:10.1136/bmj.i309

Wijga A, Scholtens S, Bemelans W, de Jongste J, Kerkhof M, Schipper M and others (2010) 'Comorbidities of obesity in school aged children: a cross sectional study in the PIAMA birth cohort', *BMC Public Health* 10(1): 184

Wilkinson C (2015) SRH Commissioning in England: Moving beyond transition. *J Fam Plann Reprod Health Care*, 41, 5–7. doi:10.1136/jfprhc-2014-101145

World Health Organization (2015) Obesity and overweight. Factsheet No. 311. http://www.who.int/mediacentre/factsheets/fs311/en/

Woolf SH, Purnell JQ, Simon SM, Zimmerman EB, Camberos GJ, Haley A, Fields RP (2015) Translating evidence into population health improvement: strategies and barriers. Annual Review of Public Health 36: 463-482 doi: 10.1146/annurev-publhealth-082214-110901.

About the authors

Alisha Davies is a Fellow of the Faculty of Public Health and a Senior Research Analyst at the Nuffield Trust. She joined the Trust in 2014 and has a particular interest in evaluation of innovative models of health and social care, with a focus on prevention and quality improvement. Prior to joining the Nuffield Trust, Alisha worked in public health roles in a primary care trust, a local authority and an acute trust supporting service redesign and evaluation in practice. Since completing the report Alisha has taken up the post of Head of Research and Development at Public Health Wales.

Eilís Keeble joined the Nuffield Trust as a Research Analyst in October 2015 and is working on a range of quantitative projects relating to health and social care. Prior to joining the Trust, Eilís worked in the Census Transformation Programme at the Office for National Statistics. While there, she worked on developing methods to produce population statistics from administrative datasets. She was also seconded part time to HM Revenue & Customs as part of this project to assess the suitability of their data for statistical purposes. Eilís holds an MSc in Demography and Health from the London School of Hygiene and Tropical Medicine and a BSc in Human Sciences from University College London.

Tazeem Bhatia is a Specialty Registrar in Public Health and joined the Nuffield Trust in January 2015 as a Public Health Trainee. Tazeem is particularly interested in access to services and patient centred systems. As a Public Health Registrar, she previously worked at West Kent PCT on a health equity audit for HIV, Greenwich Local Authority on improving cardiovascular disease outcomes and auditing their NHS health check programme and South East London Health Protection team. Prior to joining the Nuffield Trust, Tazeem trained as a GP in the UK and then worked for several years in Afghanistan and Myanmar. Her work in Afghanistan concentrated on health system strengthening, improving access to healthcare and service provision. In Myanmar, she worked on improving the access of marginalised, oppressed populations to healthcare; HIV service provision and setting up an HIV clinic in the largest prison in Yangon. Tazeem has an MPhil in Public Health from Humbolt University, Berlin. Her thesis studied the factors influencing Tuberculosis medication adherence.

Elizabeth Fisher joined the Nuffield Trust in May 2012 from the Care Quality Commission, where she was an Analyst Team Leader. In this role, she worked on the development and continued production of Quality and Risk Profiles (QRPs) for NHS, independent health care, adult social care and primary medical care organisations, which use information to help target regulatory inspection activity. Prior to that, Liz worked at the Healthcare Commission where she supported the Core Standards Assessment – a major component of the Annual Health Check – for many years. Liz has a PhD in Cell Physiology and Pharmacology, which she obtained from Leicester University. Liz graduated from Manchester University with a first-class degree in Pharmacology, which included a year's work placement at the pharmaceutical company Novartis.

Nuffield Trust

The Nuffield Trust is an independent health charity. We aim to improve the quality of health care in the UK by providing evidence-based research and policy analysis and informing and generating debate.

The Health Foundation

The Health Foundation is an independent charity committed to bringing about better health and health care for people in the UK. Our aim is a healthier population, supported by high quality health care.

QualityWatch

QualityWatch, a Nuffield Trust and Health Foundation research programme, is providing independent scrutiny into how the quality of health and social care is changing over time.

Download this publication from our website:
www.qualitywatch.org.uk/public-health

Find out more:
www.qualitywatch.org.uk

Subscribe to our newsletter:
www.qualitywatch.org.uk/newsletter

Follow us at:
Twitter.com/Quality_Watch

Tell us your views:
feedback@qualitywatch.org.uk

The Health Foundation
90 Long Acre
London WC2E 9RA

020 7257 8000
info@health.org.uk

www.health.org.uk

Nuffield Trust
59 New Cavendish Street
London W1G 7LP

020 7631 8450
info@nuffieldtrust.org.uk

www.nuffieldtrust.org.uk