PUBLIC HEALTH INTEGRATED SERVICE CONTRACTS

Committee name	Families, Health and Wellbeing Select Committee
Officer reporting	Sharon Daye, Social Care & Health
Papers with report	N/A
Ward	N/A

HEADLINES

The aim of this report is to provide the Families Health and Wellbeing Select Committee with an update on the following commissioned Public Health contracts:

- NHS Health Checks
- Adult and Children's Weight Management Services
- Integrated Sexual and Reproductive Health Services
- Integrated Specialist Community Substance Misuse Services
- Smoking Cessation Services
- Healthy Start Scheme

RECOMMENDATIONS:

That the Committee note the contents of the report.

SUPPORTING INFORMATION

1.0 The Strategic Context:

Public Health – A Population Focus

1.1 Local authorities are democratically accountable 'stewards' of their local populations' wellbeing. They understand the crucial importance of 'place' in promoting wellbeing ie:

- The built and natural environment within which residents live, work and play,
- The housing they live in
- The green spaces around them
- Their opportunities for work and leisure

All of these factors are crucial to the population's health and wellbeing. Taking a 'population' perspective, is at the heart of public health, and is a natural part of the role of local government.[i]

1.2 As a local authority, the Council is well placed to try new and different ways of tackling intractable public health problems. The local authority has considerable expertise in building and sustaining strong relationships with residents and service users through community and public involvement arrangements. This undoubtedly helps to extend the engagement of local people in the broader health improvement agenda.[ii]

1.3 The Faculty of Public Health defines public health as being:

> "*The science and art of promoting and protecting health and wellbeing, preventing ill health and prolonging life through organised efforts in society."*

What does this mean for us in Hillingdon? Put simply our priority is to help support the residents of Hillingdon (in collaboration with our partners in health, education, the police, the voluntary sector, business and communities) **to stay well, live longer and lead productive lives**.

1.4 Overarching Public Health Outcomes: There are two overarching public health outcomes which local authorities were tasked with achieving in 2013:

- **Outcome A:** Increasing the healthy life expectancy of residents. Taking account of health quality as well as the length of life.

- **Outcome B:** Reducing differences in life expectancy and healthy life expectancy between communities.

These two outcomes reflect a focus not only on how long people live, but on 'how well' they live at all stages of life.

1.5 Three domains of Public Health: The three domains of public health practice provide a useful framework around which to organise and deliver the above 'overarching public health outcomes' for Hillingdon's residents:

Table 1: Three Key Domains of Public Health Practice[iii]

Domain 1	Domain 2	Domain 3
Health Improvement: ▪ Disparities/Inequalities ▪ Wider factors that affect health and well-being: - Education - Housing - Employment - Family - Community - Environment - Lifestyles ▪ Surveillance and monitoring of specific diseases and risk factors.	**Healthcare Public Health:** ▪ Disease prevention ▪ Evidenced-based practice ▪ Clinical effectiveness ▪ Efficiency ▪ Service planning ▪ Clinical governance ▪ Disparities ▪ Equity of provision ▪ Audit and evaluation	**Health Protection:** ▪ Infectious diseases ▪ Emergency response ▪ Environmental health hazards ▪ Chemicals, poisons and Radiation ▪ Disparities

1.6 An outcomes-focused approach

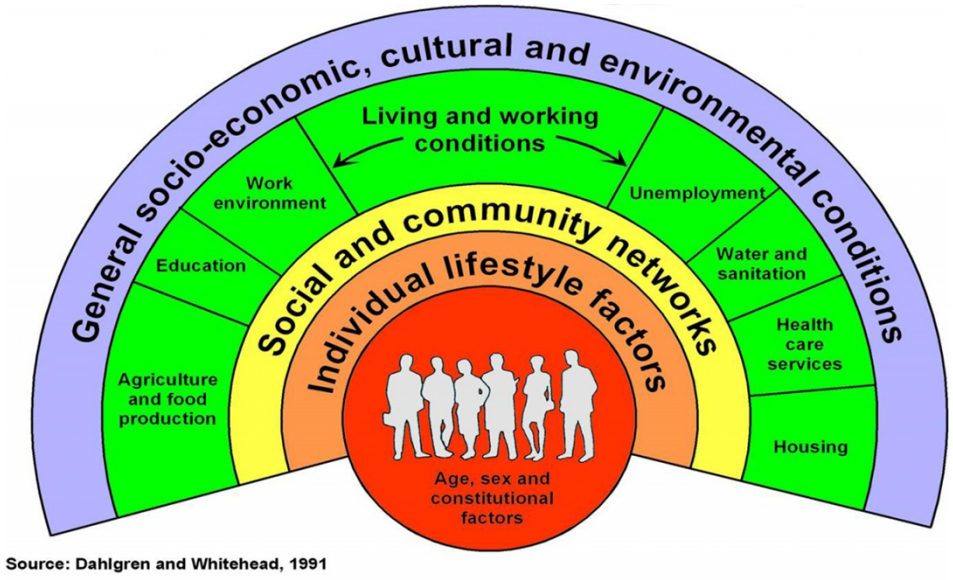
The Public Health Outcomes Framework (PHOF):[iv] The PHOF, from which the 'overarching outcomes' (section 2.1 above) were taken, have a set of supporting public health indicators which are 'designed' to help local authorities understand what progress they are making locally to

improve the lives of their residents. The indicators are based around the three domains of Public Health practice (as outlined above), with the addition of a fourth domain entitled: *'Improving the Wider Determinants of Health'*. The PHOF is refreshed[1] every three years, most recently in 2019, following user consultation.

Published on a quarterly update cycle, the PHOF is not a performance management tool for local authorities. Rather, it enables local authorities to benchmark and compare their own outcomes with that of other local authorities.

1.7 Wider Determinants of Health: As individuals, our health is influenced by a wide range of social, economic and environmental factors. We are not always able control them and they can influence and often constrain the 'choices' that we make and the lifestyle that we lead. The term wider determinants of health is usefully explained by **Figure 1** below:

Figure 1: The Wider Determinants of Health[v] in our Neighbourhoods



Source: Dahlgren and Whitehead, 1991

1.8 These indicators are used to build up a picture of the health and care needs of Hillingdon residents, as part of the ongoing development of our Joint Strategic Needs Assessment (JSNA). This 'picture' of Hillingdon is used to inform the commissioning and procurement of both health and social care services, as well as planning, housing, leisure services and so on.

2.0 PUBLIC HEALTH CONTRACTS

2.1 Table 1, below, provides details of both the 'mandated' and 'specified non-mandated' public health services contracts which are commissioned by the London Borough of Hillingdon

[1] PHOF is refreshed every three years by Public Health England. [Note: As of as of 1st October 2021 PHE became (a) The Office of Health Improvement & Disparities (OHID) and The UK Health Security Agency (UKSHA)]. The responsibility for refreshing the PHOF rests with the OHID.

Table 1: Mandated and specified non-mandated public health services commissioned by the London Borough of Hillingdon

Mandated Public Health Services	Specified Non-mandated Public Health Services
▪ Integrated Sexual and Reproductive Health Services (PH) ▪ Weighing and Measuring Children (PH) ▪ NHS Health Checks Programme (PH) ▪ Healthy Child Programme 0 to 19: health visitor and school nursing service (SC)	▪ Integrated Substance Misuse (drugs and alcohol) Services (PH) ▪ Smoking Cessation Services (PH) ▪ Adult Weight Management (PH)

Key: PH – Public Health led.
SC – Social Care led

Not all commissioned public health services sit within the 'direct' remit of the Director of Public Health function. This report focuses on those areas for which 'Public Health' is the lead.

2.2 The NHS Health Check

Context:

The NHS Health Check is a national risk assessment, awareness and management programme for people aged 40 to 74 who do not have an existing cardiovascular condition. The programme is aimed at preventing heart disease, stroke, type 2 diabetes, kidney disease and some types of dementia. All eligible individuals are entitled to receive an NHS Health Check once every five years. The NHS Health Check is one of the five mandated Public Health functions for local authorities.

Cardiovascular disease (CVD) is responsible for more than a quarter (25.4%) of all deaths in England. Between 50% and 80% of cases of heart disease and stroke are estimated to be caused by modifiable risk factors such as smoking, obesity, high blood pressure, high cholesterol, atrial fibrillation (AF), excessive alcohol consumption and physical inactivity, so therefore could be prevented from occurring (Gov.UK, 2018).

The NHS Five Year Forward View (NHSE, 2017) outlines the Office for Health Improvement and Disparities (OHID) – formally Public Health England (PHE) - ambition to reach over 2.8 million more people with an NHS Health Check. Nationally, it is estimated that this will identify around 280,000 people at high risk of CVD and facilitate follow up, preventative care for 70,000 patients with high blood pressure, 14,000 patients with type 2 diabetes and over 4,600 patients with CKD who will be diagnosed earlier and treated by the NHS.

Over a five-year period, based on the current population of Hillingdon, the NHS Heath Check Programme could potentially identify 9,580 people with a high risk of CVD and 1,920 people with hypertension (PHE, 2018). The earlier identification and subsequent treatment of these

people should lead to a reduction in premature death from CVD and narrow inequalities. There will be associated savings in both NHS and social care costs.

***The commissioned service (Contract Value:* £280,000)**

Currently, the London Borough of Hillingdon (the local authority) has a separate contract with each Hillingdon GP practice for them to provide an NHS Health Check service for their eligible patients. These 45 contracts are due to expire on 31st July 2022. The Public Health Team is exploring possible options for future commissioning arrangements which could facilitate an increase in the number of NHS Health Checks carried out and reduce variation in activity between individual GP practices.

In addition to the standard Hillingdon contract terms and conditions, the NHS Health Check contract includes:

- A detailed service specification;
- A list of national service standards and guidance which much be adhered to;
- A set of quality outcome indicators;
- Information on reporting and performance monitorin

Outcomes

The commissioned Hillingdon NHS Health Check programme contributes towards improved performance against the following national indicators set out in the Public Health Outcomes Framework (PHOF) including:

- Indicator E03 – Under 75 mortality rate from causes considered preventable;
- Indicator E04a – Under 75 mortality rate from all cardiovascular diseases;
- Indicator E04b – Under 75 mortality rate from cardiovascular diseases considered preventable;

And specifically:

- People invited for an NHS Health Check per year;
- People receiving an NHS Health Check per year;
- People taking up an NHS Health Check invite per year.

In Hillingdon, around 81,500 people are eligible for an NHS Health Check. 20% of this eligible population (16,300 people in 2021/22) should be invited each year to ensure that the entire cohort are offered an NHS Health Check every five years. At least 13.3% (aspiring to 15%) of the eligible population should receive an NHS Health Check each year. For 2021/22, this is nearly 10,900 checks (aspiring to 12,200 checks) which is equivalent to a take-up rate of 66.6% (aspiring to 75%).

The **Table 2** below shows how Hillingdon compares against the London and England benchmarks for the period 2020/21. (Note: Hillingdon NHS Health Check services, as elsewhere, were severely impacted by the Covid-19 pandemic during 2020/21).

Table 2: NHS Health Check Performance for the period 2020/21 for Hillingdon, London and England

Indicator	Hillingdon percentage of eligible cohort	London percentage of eligible cohort	Hillingdon's position out of 33 London local authorities	London percentage of eligible cohort	Hillingdon's position out of 151 England local authorities
People invited for an NHS Health Check	2.3%	3.6%	22nd	3.1%	77th
People receiving an NHS Health Check	1.2%	2.2%	22nd	1.2%	62nd
People taking up an NHS Health Check invite	53.0%	62.5%	16th	39.0%	48th

Source: https://fingertips.phe.org.uk as at 11 November 2021

Current Challenges:

In addition to the ongoing challenge of COVID-19 recovery, there are several other key issues facing the Hillingdon NHS Health Check programme. These are:

- Increasing NHS Health Check uptake and improving access: a range of approaches should be considered to improve take-up among the eligible population, target higher risk and under-served groups, and raise awareness of the NHS Health Check among the general public;
- Increasing the uptake of preventative interventions**:** increasing referrals to and the uptake of preventative interventions such as smoking cessation, weight management and exercise services would enable more individuals to be supported in making behaviour changes to reduce their risk of cardiovascular illness;

- Potential forthcoming changes to the NHS Health Check programme: OHID will shortly publish its National NHS Health Check Review report. It is anticipated that this report will include recommendations to:

    - Lower the age at which people will be able to receive their first NHS Health Check;
    - Broaden the scope of the NHS Health Check by introducing both a mental health and a musculo-skeletal component;
    - Use digital technology to support the delivery of NHS Health Checks;

- Cost pressures: At present, the NHS Health Check budget can accommodate around 7,850 checks each year, which is 9.6% of the current eligible population. Hillingdon's target number of checks and its aspirational target are 10,875 (13.3% of the eligible population) and 12,234 (15.0%) respectively. ***If the age range for the programme is expanded, these targets will increase significantly.***

Once the National NHS Health Check Review report has been published, the Hillingdon NHS Health Check contract will need to be reviewed and revised to reflect the recommendations arising from the report, and also address the issues of uptake and improving access. If there are significant changes in expectations as to what needs to be delivered, ie. increased numbers of checks, additional tests and new digital requirements, the Public Health Team will need to prepare a business case to seek further funding for the programme.

By increasing the number of NHS Health Checks that are carried out each year, we will be able to identify more people who are at a higher risk of CVD and detect more undiagnosed disease. Early identification of higher CVD risk or previously undiagnosed disease means the risk or condition can be better managed, leading to improved health outcomes for more people, and reduced health and social care costs.

2.3 Adults and Children's Weight Management Services

Context:

Levels of overweight and obesity in England are high and increasing. Almost two-thirds (62.8%) of adults in England carry excess weight and 1 in 3 children leaving primary school are either overweight or obese. Such high levels of excess weight in our population, combined with sedentary lifestyles, high availability of convenient energy dense foods are leading to an increase in the prevalence of serious long term conditions and early deaths from strokes, cancers and COVID-19.

Obesity is a strong and complex contributor to poor outcomes in COVID-19 that the experts have called out for urgent multidisciplinary action for dealing with these two pandemics converging into a 'syndemic'. The impact of social lockdowns have added further concerns owing to reported drops in physical activity among adults and children, increased snacking and reduced consumption of fresh fruit and veg due to disruption in supply chains leading to what is colloquially referred to as 'lockdown bellies'.

In March 2021, the government announced £100 million funding to support the population lose weight. Out of this:

- £30 million was distributed to local authorities for providing *Tier 2* (lifestyle based) weight loss services. *The rest of the funding was allocated for establishing:*

    - a national digital weight management service
    - Enhanced service for GPs to refer those suffering from certain LTCs
    - NHS commissioning of *Tier 3* weight-loss (clinical service) and *Tier 4 (bariatric surgery)*
    - Pilot a small number of multi-component programmes for children

<u>Prevalence of overweight and obesity in adults and children:</u> In 2019/20, 65.3% of adults (aged 18+) in Hillingdon were classified as overweight or obese compared with 55.7% in London and 62.8% in England. This equates to approximately 158,000 adults with excess weight, while on GP registers, the recording of obesity is only 8.3% (21,028), because it includes only those adults who were weighed and measured at the GP practice.

For children, data from the National Child Measurement Programme shows that in the 2019/20 academic year, 21.8% of reception age school children in Hillingdon were overweight or obese, rising to 36.3% for year 6 pupils. Although Hillingdon is not among the boroughs with worst childhood obesity and overweight rates in London, our rates have been persistent / worsening. Year 6 obesity rate has been significantly higher than the national rate in previous years and the obesity rate more than doubles between the Reception Year and Year 6.

<u>Health Disparities:</u> Obesity and overweight prevalence is higher in more deprived communities. Obesity rates are also higher in women than in men, and in some minority ethnic groups

compared to the white British ethnicity. Children from deprived neighbourhoods and from minority ethnic communities are more likely to be overweight and obese.

Health Impacts: Obesity is associated with reduced life expectancy and is a risk factor for a range of chronic diseases including cardiovascular disease, type 2 diabetes, at least 12 types of cancers, liver and respiratory disease, and can also impact on mental health.

While obesity is not something that can be changed overnight, a healthy lifestyle (maintaining a healthy weight, eating a healthy diet and being physically active) not only lowers the risk of cancer and other non-communicable diseases but also ensures better functioning of immune system.

COVID-19 and Obesity: Obesity is known to increase a person's risk of becoming severely ill or dying from COVID-19. Studies have shown that obesity increases the risk of being admitted to hospital with COVID-19 by 113%, of being admitted to intensive care by 74%, and of dying by 48%. In people with BMI over 40, the risk of death from COVID-19 had increased by 90% as compared to people with healthy weight.

Apart from the health risks of the coronavirus, the food we eat, the way we work and how physically active we are have all been changed and impacted in ways hardly imaginable a year ago, which compounded by factors like loneliness, has added further challenges to maintaining a healthy weight.

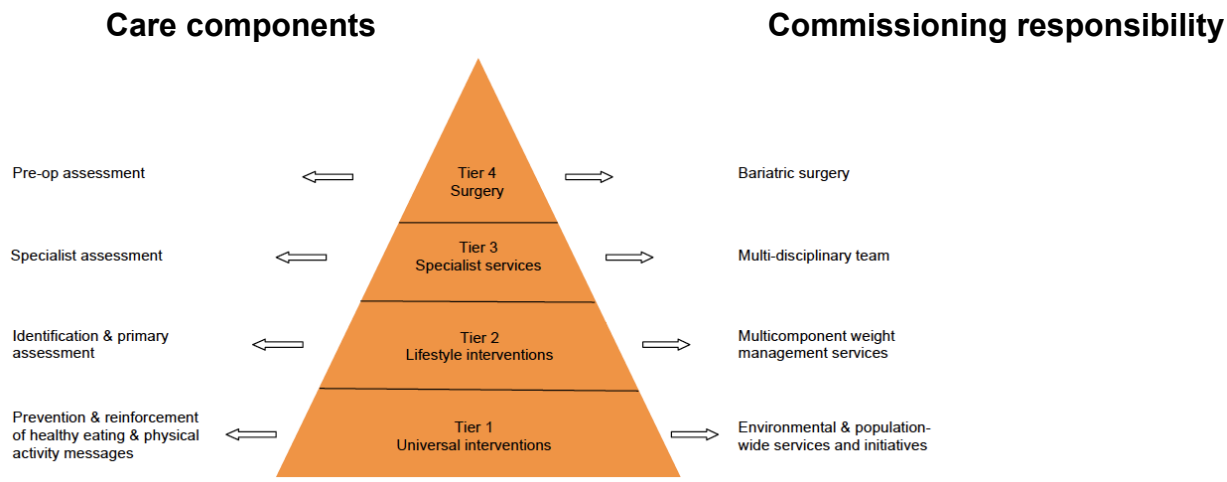
The cost of obesity: The overall cost of obesity to the society as a whole was estimated in 2012 to be £49.9 billion per year. It is expected to increase as levels of obesity in the population increase, and those with excess weight become older.

Building a Collaborative Approach: Obesity is a complex issue which requires actions at many levels by the government, local agencies and organisations, businesses, the NHS, communities, families and individuals.

At the local level, Hillingdon council provides a multiagency partnership chaired by public health to co-ordinate actions by stakeholders to tackle the issue of obesity across the 'life-course' from maternity, early years, schools, adults and older age using a variety of settings.

Procuring a weight management service is important, however wider preventative approaches *(ie. Tier 1*) across the system are equally essential to tackling the impacts of the modern 'obesogenic' environmental factors. **Figure 2** below illustrates the different tiers of service and commissioning responsibilities. Local authorities are responsible for the bottom tiers (*Tier 1 and Tier2*), while the NHS is responsible for the top two tiers (*Tier 3 and Tier 4*)

Figure 2: Tiers of weight management services



Source: BOSS and RCS Tier 3 guidance

Tier 1 is crucial for preventing the 'conveyor belt' of adults and children contributing to increasing rates. However, contracts for Tier 1 services are not commissioned by the public health team and hence are out of the scope of this report.

Commissioned Tier 2 services (Contract Value: £107,035)

Adults Weight Management:

In 2018, the local authority commissioned, The Hillingdon (GP) Confederation to provide an Adults Weight Management Programme (£25k). The service provides a 12-week weight management programme for approximately 200 adult residents. The programme, which started as a face-to-face service, had to be transformed - with the introduction of the COVID-19 lockdowns in 2020 - to an 'online offer'. Going forward the aim will be to provide some face-to-face sessions during times of reduced COVID-19 transmission.

This year, we are building upon the success of the adult weight management programme with an additional £82,035 government grant. This has enabled us to extending the 'reach' of the service to 800 adults. The original programme has been 'revamped' and relaunched as the 'Health, Lifestyle, Action' programme with apps, blogs and expert input from local doctors and pharmacists. Criteria for accessing the services are as follows:

- Adults who have Body Mass Index (BMI) greater than 30 Kg/M2 (or 27.5 Kg/M2 in Asian population) and no comorbidities.

- BMI greater than 27.5 Kg/m2 and co-morbidities, such as diabetes, hypertension, etc.;

There are plans to enhance efforts to tackle disparities through the provision of specialist services for men, people from certain high risk black and minority ethnic groups, people with learning disabilities and, those with mental illness.

We shall be working closely with Hillingdon Health & Care Partnership and NWL NHS Integrated Care System colleagues to help develop effective Tier 3 and Tier 4 services, so that Hillingdon residents with severe and complex obesity can access those services to reduce their risk of serious diseases through quality assured and safe clinical weight management services.

Going forward, the Government has kept their promise in the recent spending review announcing their decision for:

- Maintaining the Public Health Grant in real terms over the Spending Review 2021 period, enabling local authorities to invest in prevention and frontline services like child health visits.

- Continuing the £100 million investment per year announced at Spending Review 2020 to help people achieve and maintain a healthy weight.

- Investing in the Start for Life offer for families.

Children's weight Management:

Children's weight measurement is a ***mandatory*** responsibility of the local authorities which involves weighing and measuring ALL school children at age 4-5 and age 10-11 years as part of the National Child Measurement Programme (NCMP).

The National Child Measurement Programme (NCMP) has been provided in Hillingdon since 2005 by the school nursing service. Since 2013, Hillingdon Council has commissioned Central and North West London (CNWL) to provide a weighing and measurement service for all children at entry (Reception Year) and exit level (Year 6) of primary schools, via the 0-19 children's services contract.
(This contract is managed by Head of Child and Family Development.)*

The (Children's weight management contract is also managed by Head of Child and Family Development as part of 0-19 service.) CNWL has been commissioned to provide Tier 2 weight management service as part of the wider 0-19 contract for around 180 children. Children identified via the NCMP as being 'very overweight' (obese) at KS1 (5-7 years) and KS2 (aged 7-12 years) attended a 10-week family based intervention. Prior to the first lockdown, CNWL was developing a revamped 'My CHOICE' programme. However, in spring term 2020, the delivery of the very first programme was disrupted due to the first lockdown. CNWL is in the process of restarting My Choice.

Outcomes:

The commissioned adults and children's weight management services contribute to the following metrics:

- National - PHOF indicators
- PHE Adult Weight Management Services Outcomes
- DHSC grant condition outcomes specified as part of the grant allocation including data submission using the specified Digital Data Capture Tool

2.4 Integrated Sexual & Reproductive Health Services

Context

Sexual health is an important and wide-ranging area of public health. Most of the adult population of England are sexually active. Sexual ill health can affect all parts of society – often when it is least expected.[vi] Having the correct sexual health interventions and services can have a positive

effect on population health and wellbeing as well as individuals at risk. Some groups at higher risk of poor sexual health face stigma and discrimination which can impact on their ability to access services. Groups at highest risk of acquiring sexually transmitted infections (STIs) include young people, some black and ethnic minority groups, and gay and bisexual men.

Unmet Need: A lot of people, including health professionals, are not comfortable talking about sexual health issues. Many STI cases are not reported and therefore remain undiagnosed, either because they are asymptomatic, have non-specific symptoms or because infected individuals do not seek care because of the social stigma attached to STIs. Consequently, the numbers of STI cases reported may substantially underestimate the total number of cases.

Sexual ill health can be detrimental to the overall health and wellbeing of residents. These can include loss of earnings, loss of fertility due to undiagnosed and/or untreated pelvic inflammatory disease. Long term complications from unplanned pregnancies which may lead to deprivation and increasing inequalities such as stigma, long term psychological effects and includes the effects not only on the mother and child but also on the wider family and community.

Markers for sexual health need in Hillingdon include, in particular: STIs, late diagnosis of HIV, abortions (including repeat abortions) and teenage pregnancy. The position in Hillingdon mirrors the national picture whereby increasing levels of STI transmission in the population is likely to be linked to long term changes in sexual behaviour such as: unsafe/risky sexual behaviour, the average number of sexual partners and patterns of contraceptive use

***Commissioned Service: Integrated Sexual & Reproductive Health Services (Contract Value:* £3,300,000)**

Local authorities have a statutory responsibility for commissioning comprehensive, open access, sexual (ie. testing for and treatment of sexually transmitted diseases) and reproductive (ie. contraception) health services for their residents. Services currently commissioned as part of the Integrated Sexual and Reproductive Health Service include:

- Genitourinary Medicine (GUM) services to meet the healthcare needs of those who have acquired sexually transmitted infections (STIs);
- Community Contraception & Sexual Health Services (CASH) – including young people friendly clinics;
- Chlamydia screening of those aged 15 to 24 years;
- HIV Support Services;
- Health promotion;
- Condom distribution;
- Emergency Hormonal Contraception

- The HIV prevention drug pre-exposure prophylaxis (PrEP)
- Chlamydia screening.

Hillingdon's Integrated Reproductive and Sexual Health contract was awarded to London North West Healthcare Trust in July 2017. The current contract is due to end on 31st July 2022. It has recently been amended to include the provision of Pre-Exposure Prophylaxis[2] (PrEP) which is funded by NHS England.

[2] Pre-Exposure Prophylaxis[2] (PrEP) is medicine people at risk for HIV take to prevent getting HIV from sex or injection drug use. When taken as prescribed, PrEP is highly effective for preventing HIV.

The **NHS** is responsible for commissioning the following sexual and reproductive health services:

- The General Medical Services Contract (for GPs), which includes Level 1 sexual health provision from general practitioners (GPs)such as uncomplicated contraception and referral to abortion services;
- HIV treatment, care,
- Sexual Assault Referral Centres (SARCs).
- Abortion services
- Psychosexual services for sexual dysfunction.

Outcomes:

The Public Health Outcomes Framework contains a number of specific indicators for sexual health:

- Syphilis diagnostic rate / 100,000
- Gonorrhoea diagnostic rate / 100,000
- Chlamydia detection rate / 100,000 aged 15 to 24 <1900 1900 to <2300 ≥2300
- Chlamydia proportion aged 15 to 24 screened
- New STI diagnoses (exc chlamydia aged <25) / 100,000
- HIV testing coverage, total (%)
- HIV late diagnosis (%)
- New HIV diagnosis rate / 100,000 aged 15+
- HIV diagnosed prevalence rate / 1,000 aged 15-59 <2 2 to 5 ≥5
- HIV late diagnosis (%)
- New HIV diagnosis rate / 100,000 aged 15+
- HIV diagnosed prevalence rate / 1,000 aged 15-59 <2 2 to 5 ≥5
- Under 25s repeat abortions (%)
- Abortions under 10 weeks (%)
- Total prescribed LARC excluding injections rate / 1,000
- Under 18s conception rate / 1,000
- Under 18s conceptions leading to abortion (%)

Performance against the teenage conception indicator improved significantly from 2018, as the teenage conception rate dropped to 14.8 per 1,000 girls under 18 years, compared to 36.5 in 2010. Hillingdon has performed less well in meeting needs in relation to the following indicators: Chlamydia screening, new STI diagnoses and total prescribed long acting reversible contraception (LARC).

Challenges

Long Acting Reversible Contraception (LARC): More work needs to be done to investigate and audit the duration and variable use of Long Acting Reversible Contraception (LARC), removal rates and its variable uptake across the Borough. This should also include pre-conception and maternity.

One of the challenges for the IRSH provider is working in partnership with the maternity service provider to ensure that all, especially vulnerable women, receive a form of LARC prior to discharge from hospital ie. at the time of a caesarean section or at the very least receive a "bridging method" of contraception, such a progesterone only pill, which is suitable for breast feeding mothers, until they are able to access their usual contraceptive services in the usual way either online or via a triage service by ISRH or at the 6 week postnatal check-up in primary care.

Abortions: Early intervention and prevention is key, as such the commissioned services will need to work with a range of other services to help prevent at risk groups from developing more complex problems:

- Targeting 'unreached communities' and those adopting ‘risky’ behaviours’/ making 'risky' lifestyle choices.
- Improving approaches to harm reduction (ie. in relation to the use of New Psychoactive Substances (NPS) also referred to as club drugs, legal highs.

Community Sexual Health Promotion:

- Need for effective coordinated general sexual health promotion programme (to tackle lack of awareness about STIs and routes of transmission.
- Limited number of Hillingdon residents reached through the Pan-London HIV Prevention Programme. Improved links with local area required to ensure effective engagement with residents.
- Lack of clarity regarding the impact of current health promotion programmes which target young people through eg. Chlamydia Screening Programme.

Male Service Users: The existing community sexual health service is predominantly used by women and is perceived to be a service for women. Engaging, in particular, young men in 'sexual health self-care' is key. Evidence suggests that: (a) young men are unlikely to actively seek out information or advice on sex health and (b) re-infection rates of Chlamydia in young women is often driven by partners. Successful work with men needs to see behind the 'macho mask' to consider vulnerabilities that hide behind such behaviour. Targeted service for boys and young men through outreach services to locations used by young men and dedicated clinic sessions to increase service uptake.[3]

Over Fifties: There are gaps in the provision of sexual and reproductive health services for an increasing population of over 50s:

- Over 50s and Stigma: There is a need to raise awareness amongst over 50s regarding. the need to understand the risks they face and how to protect themselves. (Note: Many medical /care professionals avoid discussing sexual health issues with the older community as they may be embarrassed to broach the subject, or don’t ask questions around sexual health as they assume older patients are not sexually active. Stigma around older people’s sexuality can stop people from seeking professional advice – including older LGBT people.

- Young People Focused: As reported in the 'Adult Health Watch Mystery Shopper Focus Group' in 2020, over 50s believe that the existing ISRH service is focused on meeting the needs of young people, with less attention being paid to the needs of the over 50s population. The challenge would be how to ensure that the service meets the sexual health and contraceptive needs of the middle-aged service users.

[3] Sex Education Forum Factsheet II. “Supporting the Needs of Boys and Young Men in Sex and Relationship Education”.

2.5 Integrated Substance Misuse Services

Context

Substance (both drugs and alcohol) misuse is an important public health issue. It is complex in nature and can have a significant impact not only on the lives of those directly involved but also on those close to them - their families, friends, as well as the communities within which they live. In addition, drugs and alcohol misuse represent a significant underlying contributor to health care costs, crime, homelessness, spouse and child abuse, as well as on-the-job safety and productivity losses.

Drugs Misuse:

Drug addiction is defined as a chronic, relapsing disorder characterized by compulsive drug seeking and use, despite adverse consequences.

The cost of drug misuse: The total cost of the illicit drugs trade to the NHS and criminal justice service together (alongside associated costs to families and society), is estimated to be over £19 billion a year, which is more than double the estimated value of the illicit drugs market itself.

Drug-related morbidity and mortality: Although drug misuse exists in most parts in the UK, it is more prevalent in areas that are characterised by social deprivation, which in turn is associated with poorer health. The majority of drug misusers also smoke cigarettes, and many have lifestyles which are not conducive to good health. People in treatment or in the criminal justice system, who have used opiates are six times more likely to die prematurely than people in the general population. They are particularly at risk soon after leaving treatment or prison. Some people who use opiates and have never been in treatment are at greatest risk of drug-related death.[vii]

The impact of drug misuse on families and communities[viii]: Protecting children from the potential impact of drug misuse is an important issue. Drug misuse often places an immense strain on the families of drug misusers including the children of drug-using parents, and can has a serious negative impact on the long-term health and wellbeing of family members. Problem drug use in parents can, and does, cause serious harm to children at every age. Effective treatment of the parent can have major benefits for the child. Services and clinicians need to work together to protect and improve the health and wellbeing of affected children. Drug treatment can also improve the quality of life for families and carers.

Alcohol Misuse:

The cost of alcohol misuse: Alcohol misuse is estimated to cost the NHS approximately £3.5 billion per year and society, as a whole, £21 billion annually. Most people enjoy alcohol without causing harm to themselves or to others. Alcohol misuse is when a person drinks levels of alcohol that can cause them physical, psychological, and social problems - both in the short and long-term. Alcohol misuse contributes to a wide range of serious health problems and accidents which require health care that include:

- *Physical and mental health harms:* Physical problems include liver diseases (hepatitis and cirrhosis), heart diseases and stroke. Psychological problems include depression, loss of memory and impaired judgment. Misuse of alcohol can be fatal, contributing to sudden deaths through acute alcoholic poisoning or accidents while people are intoxicated, as well as deaths due to long-term abuse of alcohol.

- *Crime/public disorders:* Alcohol misuse has close links to crime, disorder, anti-social behavior, and other crime types such as domestic and sexual violence and drink driving.
- *Loss of workplace productivity:* Working days lost due to alcohol related sickness and reduced employment.
- *Social harms:* Including problems within families, young people and communities.[ix]

The profile of primary alcohol misusers is different to that of drug clients, as they tend to be older: over a fifth are aged between 40 and 44 years of age. Most alcohol misusers enter treatment via self-referrals or referrals from mental health services. The position is similar for Hillingdon. Outreach findings for Hillingdon suggest that there is a cohort of substance misusers who are not known to any services, who commonly have problems of homelessness, alcohol dependency, inability to claim benefits, loss of employment, lack of access to a GP and a consequent inability to access prescribed medication.

Categories of alcohol misuse: There are four main categories of "alcohol misusers":

- *Hazardous drinkers:* those who drink at levels over the sensible drinking limits, either regularly or through less frequent sessions of heavy drinking, but have so far avoided significant alcohol related problems.
- *Harmful drinkers:* those who drink above sensible levels, usually more than hazardous drinkers and show clear evidence of some alcohol-related health problems.
- *Moderately dependent drinkers:* are likely to have increased tolerance of alcohol, suffer withdrawal symptoms, and have lost some degree of control over their drinking. They may recognise they have a problem with drinking but do not have severe dependence.
- *Severely dependent drinkers:* may have withdrawal fits (delirium tremens: e.g. confusion or hallucinations usually starting between two or three days after the last drink); and may drink to escape from or avoid these symptoms.

Patterns of drinking vary according to gender, age and other factors such as lifestyle and income. For example, men are more likely than women to drink more than 'sensible' amounts, while young people aged 16-24 years are more likely than older people to 'binge drink'.

Commissioned Substance Misuse Services (Contract Value: £2,974,509)

Local Authority commissioned substance misuse services are provided by ARCH (Addictions Recovery Community Hillingdon), which is a part of Central & North West London NHS Foundation Trust (CNWL). ARCH currently provides a range of ***clinical and psychosocial interventions*** for the clients who may reside or have a GP within the London Borough of Hillingdon.

As of Quarter 4 2020/21 the service had approximately **1,193** clients of which approximately **600** clients have an alcohol-related problem within the service. The clients attending the service cover a broad spectrum and typology of drug misuse and drinkers including mild to moderate or severe dependence or problem drinking. A large proportion of these clients will have a range of complex presentations and physical and mental health comorbidities.

ARCH provides a range of service for the most vulnerable to serious harm from others. Priority groups will also include:

- Pregnant women and those with parenting responsibilities
- Service Users who are also offending

- Clients with co-existing mental health and alcohol or drug misuse problems (dual diagnosis)
- Service Users who are injecting
- Those in inappropriate accommodation or at risk of eviction, or homeless
- Sex workers
- Treatment naïve – individuals who have not previously accessed services
- Those receiving support from multiple organisations and support services
- Young People in transition
- Service Users leaving prisons

Pathways of Care for drug and alcohol misuse clients: **Table 3** below details the pathways of care that are available at ARCH for substance misusers of all ages (Note: Young people in the main are seen from 18+ years).

Table 3: Pathways of Care for drug and alcohol misuse clients:

PATHWAYS OF CARE
▪ Assessment and individual personal recovery plans ▪ Advice and information on reducing harm, including blood borne virus interventions ▪ Needle exchange ▪ Specialist psychosocial interventions ▪ Specialist pharmacological treatments for help with drug and alcohol problems ▪ Specialist detoxification programmes to manage withdrawal symptoms and safely wean clients off drugs and alcohol ▪ Emerald Pathway – For alcohol dependent older people who have multiple barriers to engagement with mainstream services ▪ One-to-one and group therapies aimed at getting to the core of the problem ▪ GP Shared Care Scheme for clients stable on opiate substitute treatment ▪ Motivation and support from those that have previously had problems with alcohol or drugs ▪ Group activities and social networks, including men and women's groups, relapse prevention and life skills advice ▪ Joint working with employment agencies, training providers and housing associations to help you get back on track ▪ Evening and weekend social drop-in and activities with the opportunity to volunteer and build new social networks to help with client's recovery.

Grant Monies: Since 2019/20 ARCH has been successful in obtaining grants from the former Public Health England to undertake project work regarding rough sleepers and criminal justice clients – see **Table 4**

Table 4: Grant Allocation for Substance Misuse 2019/20 to 2021/22

Project Title	Project Description	Allocated Grant
1) Alcohol treatment capital grant 2019-20 Welfare Pathway for Street Homeless Dependent Drinkers	To provide a comprehensive physical health and wellbeing plan for street homeless dependent drinker clients, by providing a 'Health Passport' for each client to ensure they have access to the nursing and medical team at ARCH. As part of the comprehensive physical and wellbeing offer for these clients, ARCH have sought to enable these clients to have access to Fibroscan. FibroScan is a rapid and non-invasive method to assess alcohol liver disease. Access to this service is particularly significant for ARCH clients with alcohol problems, who may be homeless or rough sleepers, as their engagement with other health care providers is poor. The Fibroscan has enabled early identification of liver disease and early implementation of disease management programs. The aim has been to help to reduce emergency hospital admissions and improve mortality rates within the local population.	**£69,660.00**
2) Rough sleeping drug and alcohol treatment grant 2020/21	ARCH Homeless Outreach team will be community based and predominantly focus on outreach activities, this means visit hostels and accommodation projects to target these individuals, build a therapeutic relationship and refer on to specialist services. This will also include in-reach to community groups, soup kitchens and locations where need is greatest need. The outreach workers and specialist nurses will provide NICE compliant interventions with the aim to reduce health inequalities. Outreach to: ▪ Known hotspots of street drinkers – Olympic House and Heathrow Airport ▪ Liaison with Salvation Army, Winter Night Shelters and Housing ▪ Joint targeting and liaison in areas of high social deprivation. - Safe neighbourhood teams - Police - crack house closures - Community events - Hillingdon's largest ethnic groups - Emerging populations ▪ Re-engaging SUs who dis-engage or miss appointments ▪ Engaging repeat attenders to A&E	**£171,655**

Project Title	Project Description	Allocated Grant
3) **Universal Grant (2021/22)**	To improve treatment pathways from the criminal justice system including courts, prisons and police custody, through a range of intervention to include: In-reach into Prisons to meet and jointly run groups for those due for release and known. Create more personal release plan and ahead of time. Creating pathways from prison to rehab /RDP Build into roles to sit in within the MDT – sit in and know the people who are going to be released – Through the gate/link workers to meet prisoners on day of release and support navigation to appointments – ensuring have harm reductions packs and detailed support plan in place. Active engagement with social prescriber to link into asset map Support and partnership work with ETE and housing Areas of need prison releases during first week – lots appointments e.g. probation substance misuse, benefits housing etc – Developing a co-ordinated multi partnership approach to release planning Robust packages of care package in the community and assertive follow-up Support prison to do segmentation exercise of addictions caseload Identify clients who also have pain management issues and those prescribed pregabalin and gabapentin Prescribing / mental and physical health and wellbeing assessments. Ensure referrals into secondary care is in place where needed. Court nurse to work with the courts to ensure correct application of ATRs DRRSs Identify GP to work with prison releases Multi-agency working - link with probation and where possible better co-production and communication Use of contingency management vouchers /incentives Group work program criminal justice clients an option/ reducing re-offending program – linking in with probation Clear sign posting and partnership working to get into volunteering and employment Robust systems in place for data capture Interventions need to target re-offending.	**£355,000.00**

Outcomes:

The commissioned substance misuse service contributes towards improved performance against the following national outcome indicators set out in the PHOF and National Drug Treatment Monitoring System (NDTMS), namely:

- Successful completion of treatment
- Early / unplanned exits
- Drug-related deaths
- Hospital admissions due to drug poisoning
- Alcohol-related admissions to hospital
- Mortality from causes considered preventable
- Adults new to treatment in eligible for a HBV vaccination who accepted one
- Take home Naloxone and overdose training
- Clients identified as having a mental health treatment need and receiving treatment for their mental health
- Employment outcomes
- Length of time in treatment
- Successful completions

Challenges

Prevention: We recognise that there is more to be done around the issue of *prevention*. Identifying drug misuse and intervening early, can build resilience, reduce risks, and help to avoid further health and social harms and dependence. It is also acknowledged that the prevention of substance misuse needs to move more upstream - both from the perspective of:

- Preventing substance misuse amongst children and young adults/adults;

- Amongst cohorts of adults who are at risk of developing more serious problems (eg. older people, MSM, or those for whom new psychoactive substances may represent a 'gate way' to stronger stimulants).

- The commissioned service will be expected to fully engage in working with the local authority and strategic partners in the development of evidenced-based approaches to the prevention of substance misuse.

Emerging Needs: The changing and emerging needs of local populations such as that of Hillingdon[4] are likely to include issues such as:

- Complex/multiple needs, including domestic violence, co-existing substance misuse with mental health issues, criminal justice involvement and homelessness
- Safeguarding for children, young adults and vulnerable adults
- Pathways for harmful/hazardous drinkers
- Interventions for dependent and binge drinkers
- Flexible responses to novel psychoactive substances (NPS)
- Links to end of life pathways/palliative care

[4] Public Health England - Quality governance guidance for local authority commissioners of alcohol and drug services (2015) https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/669622/Alcohol_and_drug_treatment_quality_governance_guidance.pdf

Tackling issues such as these will require effective partnership working by the specialist community substance misuse service providers, across the local Integrated Care System - including: primary healthcare, secondary/acute healthcare, mental health services for common and more severe mental illness, sexual health clinics, social services as well as prison healthcare.

Impact of COVID-19 - Young People's Mental Health: Unfortunately, COVID-19 has had a detrimental impact on young people's mental health. The young person worker at ARCH is offering more individual psychological support as part of her Counselling Psychologist pathway than in previous years. Young people are experiencing higher rates of anxiety, low mood, isolation, feeling overwhelmed, self-harming behaviours and self-medicating their mental health difficulties. Referrals to ARCH from A&E department have increased considerably since last year and the pattern of these referrals are more likely to require CAMHS or social services input for complex needs, than in previous years where referrals from A&E were, at that time, more suited for brief educational support.

The Emerald Pathway – Alcohol dependent older people: The 'Emerald Pathway', was launched in August 2016. The pathway targets elderly clients who are alcohol dependent, who have multiple barriers to engagement with mainstream services - such as physical or mobility issues. 'Emerald pathway' clients are unable or unsuitable to be seen within the mainstream service but have need of brief alcohol intervention. All 'Emerald Pathway' clients are seen by the outreach team in their home for the entirety of their treatment journey.

The outreach team has established good working links with the A&E alcohol liaison nurse, that serves to ensure firstly, that appropriate referrals reach the outreach team and secondly, that vulnerable and elderly clients are able to access support services that meet their needs. ARCH is currently reviewing the service with a view to modifying the pathway to target clients with lower-level needs that otherwise would not access treatment but are at risk of escalating needs. This client group (ie. older or less mobile clients that have attended A&E possibly following an alcohol-related injury) would be able to access a brief alcohol intervention model.

2.6 Smoking Cessation Services

Context

Smoking is the primary cause of preventable illness and premature death, accounting for approximately 74,600 deaths a year in England. It harms nearly every organ of the body and dramatically reduces both quality of life and life expectancy. Smoking causes lung cancer, respiratory disease, and heart disease as well as numerous cancers in other organs including the lip, mouth, throat, bladder, kidney, stomach, liver and cervix.

There is no risk-free level of exposure to tobacco smoke, and there is no safe tobacco product.[5] About half of all lifelong smokers will die prematurely, losing on average about 10 years of life. Smoking kills more people each year than the following preventable causes of death combined:

- Obesity (34,100)
- Alcohol (6,669)
- Road traffic accidents (1,850)
- Illegal drugs (1,605)
- HIV infection (504)

[5] US Surgeon General - 'How Tobacco Smoke Causes Disease', The 2010 US Surgeon General report,

Professor Chris Whitty - Chief Medical Officer for England, has stated that:

> *"Smoking is one of the biggest causes of a very large number of diseases, of which lung cancer is only one. It is likely that by the end of this year, that at least as many and probably more people will have died of a smoking related disease than of COVID-19. It also has a very significant impact on hospitalisation as a result."*

The impact of smoking places a severe strain on hospital services. In 2019/20 there were estimated to be 506,100 hospital admissions attributable to smoking.

Commissioned Services (Contract Value: £135,382)

The Hillingdon Local Authority has commissioned CNWL - ARCH (Addictions Recovery Community Hillingdon) to provide a high quality, targeted and evidenced-based approach to smoking cessation. The provider delivers a service that adheres to guidance from Office of Health & Disparities (OHID), the Department of Health, the National Institute of Health and Care Excellence (NICE) as well as recommendations provided by the National Centre for Smoking Cessation and Training (NCSCT) and Action on Smoking and Health (ASH).

Eligibility Criteria: To facilitate a quit attempt, a combination of behavioural support with appropriate licensed smoking cessation pharmacotherapy is provided to eligible residents who fit into the following agreed priority groups:

- Children and young people under 18 years.
- Pregnancy and after childbirth - including partners.
- Those with mental health issues including substance misuse.
- People with disabilities and long-term conditions.
- Routine and manual occupations.

With the primary aim being to reduce smoking prevalence among these priority groups, specialist core smoking cessation advisors, based at ARCH, provide support to residents through a variety of mechanisms including and where possible (in the light of the COVID-19 pandemic), face to face and telephonic consultations. Within the community, community pharmacies are also available to provide behavioural support and pharmacotherapy through appropriately trained and registered smoking cessation advisors. GP practices are equipped to direct their patients to the core service or a suitable pharmacy to engage in an intervention.

Within the secondary care setting (ie. Hillingdon Hospital) the service provider works with the hospital (ie. with colleagues in both the Maternity Unit and Respiratory Medicines Services) to implement the CQUIN (Commissioning for Quality and Innovation) scheme, which is delivering clinical improvements in smoking cessation. This has been achieved by identifying, treating and/or referring patients to the core smoking cessation service. Working in partnership with the local hospital, the core team of advisors are also available within this setting to provide smoking cessation support to inpatients, outpatients and patients attending A&E.

The Service has largely maintained a conversion to quit rate above 35% as recommended by the Institute for Health & Care Excellence (NICE) and following the service specification outcomes expectations.

Outcomes

The commissioned smoking cessation service contributes towards improved performance against the following national outcome indicators set out in the PHOF:

- Smokers that have successfully quit at 4 weeks
- Smoking in early pregnancy
- Smoking status at time of delivery

Challenges:

The Impact of COVID-19: ARCH has reported that COVID-19 has seriously disrupted the provision of stop smoking support and supplies of pharmacotherapy to eligible residents of Hillingdon. There has been a notable reduction in residents accessing the provision especially during major campaigns - pre- and post-No Smoking Day and Stoptober where the service was unable to participate in outreach across the borough due to the lockdown restrictions. Historically, this intervention has always succeeded in awareness and driving footfall into the service and therefore quit attempts.

Due to social distancing and factoring in the expulsion of air, the format of this intervention including the use of the motivational Carbon Monoxide tool to validate a client quit attempt was not utilised during the pandemic. However, this has been reverted with the gradual ease of the lockdown.

ARCH have made contingency plans in line with Government guidelines and have continued to operate mainly through the borough Community Pharmacy provision and telephonic consultations by the core smoking cessation team. During the pandemic, it has also been noted that the number of Community Pharmacies engaged in smoking cessation clinics has seriously fallen due to staff capacity and other urgent pharmaceutical services taking precedent.

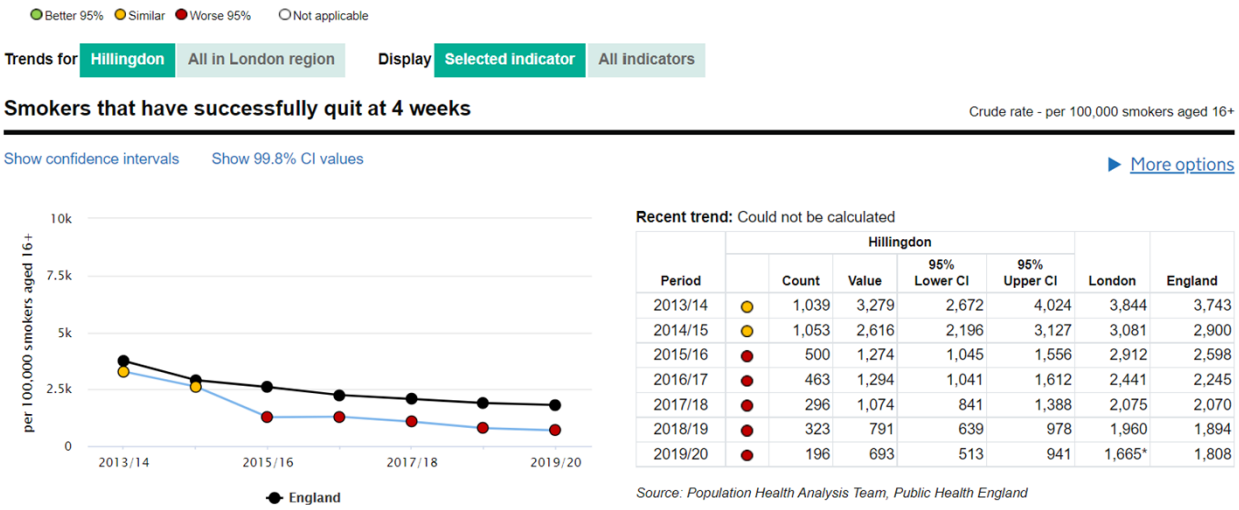
Pan London Smoking Cessation Transformation Project (LSCTP): Since April 2021, the local authority has invested just over £10,000 to be part of the LSCTP programme. The anticipated benefits include:

- Engaging with the LSCTP will add an extra layer of service and capacity on top of what the core service provides. Residents will have the flexibility to either access the core service or engage with specialist advisors employed by LSCTP through phone, text, and online platforms.
- ARCH will be able to count those who quit using the Pan-London service against their figures.
- Membership will also facilitate sign posting into the core service.
- Membership will provide ARCH with the opportunity to engage in network meetings with other London Boroughs. The meetings will provide a platform to share examples of good practice in smoking cessation.

With collaborative working, and investment into the Pan-London LSCTP, it is envisaged that the ARCH Stop Smoking Service will experience a rise in resident footfall, engagement levels and importantly quits.

Capacity: Currently the core service has limited members of staff who are fully trained, and this has led to difficulties in providing a seamless smoking cessation service. There remains scope to build on opportunities to provide outreach in community settings, such as places of worship, community halls and libraries in order to achieve much needed improvement in the 4-week quit rate – see **Figure 3 below**:

Figure 3:



Recent trend: Could not be calculated

Period		Hillingdon Count	Value	95% Lower CI	95% Upper CI	London	England
2013/14	●	1,039	3,279	2,672	4,024	3,844	3,743
2014/15	●	1,053	2,616	2,196	3,127	3,081	2,900
2015/16	●	500	1,274	1,045	1,556	2,912	2,598
2016/17	●	463	1,294	1,041	1,612	2,441	2,245
2017/18	●	296	1,074	841	1,388	2,075	2,070
2018/19	●	323	791	639	978	1,960	1,894
2019/20	●	196	693	513	941	1,665*	1,808

Source: Population Health Analysis Team, Public Health England

Eligibility: Historically the stop smoking service has accepted all residents of Hillingdon to access an evidenced-based quit attempt. However, since April 2019, the service has been restructured and provides motivational support in combination with medication only to those residents of Hillingdon who fit into the agreed eligible priority groups . Residents who are not eligible are directed to fund their own medication, but can still receive a course of motivational and behavioural change support.

2.7 Healthy Start

Context

The Department of Health and Social Care (DHSC) Healthy Start Scheme (HSS) is a statutory, UK-wide means-tested scheme to improve the health of low-income pregnant women and families on benefits and tax credits. Through the issuing of the Healthy Start Card/vouchers both adults and children are able to access vitamin supplements, milk, fresh fruit and vegetables.

The HSS aims to encourage breastfeeding and healthy eating for vulnerable pregnant women, breastfeeding women and children up to age four in low income and disadvantaged families across the UK. Women are supposed to receive information about Healthy Start when they attend for their first antenatal appointment.

Tackling Disparities: This statutory scheme is regarded as being key to reducing health inequalities, as it provides targeted support to the nutritionally vulnerable and tackles the key issue of weight management particularly in children.

Vitamin Deficiency: One of the key benefits of the HSS is that it aims to address the significant public health issue of vitamin D insufficiency and deficiency. Those at risk of vitamin D deficiency include for example: pregnant and breastfeeding women, breast fed babies whose mothers are deficient, people whose skin is covered when outside, the housebound and those with a family history of vitamin D deficiency.

Commissioned Services (Vitamins - £1,000)

Responsibility for the issue of vitamin tablets and drops to Healthy Start beneficiaries transitioned to the London Borough of Hillingdon on 1st April 2013. The vitamins are purchased by Public Health from the approved supplier - NHS Supplies.

Eligibility: Women qualify for the Healthy Start scheme if they are at least 10 weeks pregnant or have at least one child that's under 4. In addition, they must be receiving any of the following benefits:

- Child Tax Credit (only if the family's annual income is £16,190 or less).
- Income Support.
- Income-based Jobseeker's Allowance.
- Pension Credit (which includes the child addition).
- Universal Credit (only if the family's take-home pay is £408 or less per month from employment)

Eligibility for the Healthy Start Scheme also pertains extends if:

- Those under 18 years of age and pregnant, even if they do not receive any of the above benefits.
- Those who claim income-related Employment and Support Allowance (ESA) and are over 10 weeks pregnant.
- Those in receipt of working Tax Credit 'run-on' (this is the payment someone may receive for a further four weeks after they stop qualifying for Working Tax Credit)

Amount received: Once approved, Healthy Start Vouchers are received by post every 4 weeks or alternatively, money is added onto a Healthy Start Card every 4 weeks to spend on milk, infant formula milk, fruit, and vegetables:

- £4.25 or one voucher each week of the pregnancy from the 10th week.
- £8.50 or two vouchers each week for children from birth to 1 year.
- £4.25 or one voucher each week for children between 1 and 4 years.

The money will stop when the child is 4, or benefits are no longer received.

The pre-paid card or paper voucher is redeemable in a wide variety of local shops (e.g. supermarkets, news dealers, convenience and grocery stores, pharmacies), and milkmen who have registered to take part in the scheme.

Healthy Start Vitamins: Currently, beneficiaries also receive vitamin vouchers every eight weeks, or they can present their Healthy Start pre-paid card, which they can exchange for Healthy Start vitamins in their local children's center. Children's drops containing Vitamins A, C and D and Adult Tablets containing Vitamins C, D and folic acid are the vitamins that women and children may not be getting in adequate quantities from their dietary intake. This arrangement provides an ideal opportunity to engage with a priority group who can be linked into further support and services within the Children Centres.

On a quarterly basis, Children's Centres submit to the Public Health Team the number of Vitamin vouchers redeemed by residents. This information is submitted to NHS Business Services Authority.

Outcomes

The Healthy Start Scheme does not have any specific metrics attributed to it in the PHOF. The effectiveness of local uptake of the scheme is 'measured' in terms of our position in relation to the national average. The NHS Business Services Authority publish dataon the uptake of the Healthy Start Scheme on a quarterly basis. Take-up is calculated as a percentage of entitled beneficiaries over eligible beneficiaries. **Table 5** below shows a combined total of women and children who are entitled and eligible for the HSS. (Note: The table does not include eligible pregnant women, as they are not in receipt of a specific benefit). As shown in **Table 1** Hillingdon's average uptake of 53.3% is higher than the London average (52.3%), but slightly lower than the national average (55.0%).

Table 5: National and local data comparison on take up of the Healthy Start Scheme

Healthy Start Vouchers - Hillingdon Local Authority average take up for the period September 2020 to September 2021	
Location	**% Average take up September 2020 to September 2021**
Hillingdon	**53.3%**
London	**52.3%**
National	**55.0%**

https://www.healthystart.nhs.uk/wp-content/uploads/2021/04/Healthy-Start-vouchers-uptake-data-england.xlsx

Challenges

The uptake of Healthy Start Vitamins: There are some concerns that many eligible women in Hillingdon are not exchanging their vitamin vouchers for the drops/tablets, even though they are 'spending' their vouchers on milk, fresh or frozen fruit and vegetables or infant formula milk. The reasons for the current levels of uptake of the vitamins are not fully understood. It is apparent from the literature that the reasons for poor levels of uptake of the Healthy Start Vitamins can often be related to:

- Confusion among many health practitioners and families about where Healthy Start vitamins can be accessed in the local area.
- Midwives not being able to allocate adequate time for discussion within clinics due to competing priorities regarding the importance of vitamin D for both their children and their health.
- Training for health and other professionals working with children and families.
- Public awareness raising.
- Historical problems of supply.

The Impact of COVID-19: The COVID-19 pandemic has had a significant impact on many services throughout the London Borough of Hillingdon including the Healthy Start Scheme.

Mandatory lockdowns to control the spread of the virus, have inhibited the HS vitamins component of the scheme.

Mitigation: A Healthy Start training / Re-launch online event was completed on 28th June 2021. The purpose of this exercise was to enhance the skills, knowledge and confidence of colleagues from existing and new partner organisations such libraries, housing, job centres and food banks, to enable them to identify and share information about the HSS with those individuals and families who would be eligible to sign up to the scheme. The online event was well attended by over 40 colleagues.

The training event has served to promote the scheme in Hillingdon, targeting areas of greatest deprivation and going beyond that to ensure the widest distribution of key messages regarding the scheme. To facilitate advertising, materials such as posters and banners were produced by the Local Authority.
Feedback has confirmed that the training has also increased the confidence of our colleagues to be able to engage in a positive conversation about the Healthy Start Vitamins and the health benefits in particular of Vitamin D for maternal and child health.

3.0 Service Transformation

All commissioned public health contracts are under review, as part of ongoing service transformation. The aim will be to ensure that commissioned services are 'fit for purpose', designed to meet the health needs of our residents and are aligned with the strategic direction of the health and care partnership.

4.0 How this report benefits Hillingdon residents

This report benefits the residents of Hillingdon because it highlights the commissioned public health interventions which seek to improve both their physical and mental health and well-being.

5.0 Financial Implications

There are no direct financial implications arising from this report.

6.0 Legal Implications

The Borough Solicitor confirms that there are no specific legal implications arising from this report.

7.0 BACKGROUND PAPERS

None.

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[iii] Faculty of Public Health – 'What is Public' Health?' http://www.fph.org.uk/what_is_public_health
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[viii] Ibid

[ix] National Audit Office - 2008, *Department of Health Reducing Alcohol Harm: health services in England for alcohol misuse*, Report by the Comptroller and Auditor General.