Agenda Item 6c: APPENDIX

Committee Name	**FAMILIES HEALTH AND WELLBEING SELECT COMMITTEE: APRIL 2022**
Officer Reporting	**Kelly O'Neill: Interim DPH**
Papers with report	**Public Health Integrated Service Contracts**

1. Headline Information

This report provides an update on the current Public Health Grant (PHG) funded contracts:

- Universal 0-19 Healthy Child Programme
- Integrated Sexual and Reproductive Health
- Integrated Community Substance Misuse (Drugs and Alcohol)
- Stop Smoking

The scope includes information on current public health funding, what each service is commissioned to deliver, headline performance 2021/22, and commissioning intentions to maintain continual improvement for each service in 2022/23.

2. PH Grant Funding: Investment into borough residents heath:

Each year DHSC allocates a public health grant (PHG) to each local authority on a principal-agent basis that is invested into truly needed services/ programmes that prevent ill health, promote healthier lives and address health disparities.

There are stated conditions on how the grant can be spent, this is referred to as prescribed and non-prescribed functions and the allocation of spend is monitored annually by the Office for Inequalities and Disparities (OHID). A responsibility of the Director of Public Health is to provide assurance that the conditions through which the borough public health grant is applied is being met and to demonstrate how investment has achieved health improvements for borough residents. These improvements are measured through data and evaluation, for example, the Public Health Outcome Framework (PHOF).

The PHG investment supports the achieving of two main longitudinal health outcomes for Hillingdon resident population, including those people who are temporarily in our borough. These outcomes are:

- **Increasing the healthy life expectancy of residents**: taking account of health quality and the length of life – achieved through children starting well, having a healthy birth and development, staying healthy as adults and as life progresses maintaining a healthy, autonomous, and independent life where health and care needs are met when they are needed.
- **Tackling health inequalities in our borough:** Proactively taking action to reduce unfair and avoidable differences in health and life outcomes experienced by one individual and community when compared to another.

To achieve these overarching outcomes and the wider public health measures set out in PHOF, LB Hillingdon determines based on data of need how the grant is spent wider than the key contracts this report focuses on.

Table 1: An outline of the current grant financial position (April 2022) for Hillingdon

Annual Public Health Grant 2022/23	£18.539M – this is an increase of £506,563 from 2021/22
PH Reserve Status	£2.54M
LBH Investment to support PH outcomes	£5.1M
Total current PH contracts value	£11.923M • Integrated sexual health - £3.566M (LNW provider)

	• NHS Health Checks - £280K (GP Confed provider) • Substance Misuse services - £3.027M (CNWL provider) • 0-19 Health Child Programme - £4.917M (managed through resident services – CNWL provider) • Stop Smoking services £133K (CNWL provider)
PH team staffing allocation	£413,959

3. Process for oversight of PH Grant investment into LBH

As part of the PHG oversight and assurance, a process for review of allocation of public health grant against aligned PH outcomes is carried out and now at year end this process will restart. This process brings together the components of where funding has been allocated to give an overall understanding of the outcomes from the investment and the impact this is having in improving residents' health and wellbeing.

As part of this process the Public Health team will agree with funded services, any changes that could be made to achieve even better improvements for financial year 2022/23. Each funding investment allocation will be agreed with progress against planned activity, profiled budget spend, and outcomes will be reviewed on a quarterly basis.

4. Procurement plans for PHG funded external contracts:

The three main PHG funded service contracts have been extended for 18 months to ensure the council meets its duty to provide statutory services – and a future commissioning and procurement options paper presented for each contract. The three contracts included in this options paper are:

1. Integrated sexual health
2. Substance misuse contracts
3. Integrated services – 0-19 (led by Social Care)

Regardless of the procurement option all three contracts will need to be extended to ensure the council meets its duty to provide statutory services, and a need assessment should be completed to ensure services are addressing access to, and benefit from all communities. Given what we have learnt from the pandemic this is a timely opportunity to ensure services address our need and address the differences in health and wellbeing experienced by our residents and communities.

5. Integrated Public Health Grant Funded Contracts:

The scope, performance and commissioning intentions for each contract is presented separately.

5.1 Integrated Sexual and Relationship Health Contract

Contract Name	Provider	Contract Value
Integrated Sexual and Relationship Health (IRSH)	LNWH provider	£3.566M

The service is commissioned as a block contract 'Prime Provider' model with the contract lead provider London North West Healthcare Trust (LNWH) with sub-contracted providers to support service elements:

- Integrated sexual health and contraception service for residents of all ages from 13 to 90 years of age North West London Sexual Health (nwlondonsexualhealth.nhs.uk)
- Online Sexual Transmitted Infection (STI) testing service - delivered by SH24 Order a STI test kit | SH:24 (sh24.org.uk)
- Online Contraception & Emergency Hormonal Contraception Contraception information, tools and advice | SH:24 (sh24.org.uk)

The service offers face to face appointments and drop-in services through three clinics, the main clinic being the Wakely Centre, Hayes with two satellite clinics. Supporting the clinics are outreach services into educational settings:

- Secondary school aged student service - delivered by Brook via, assemblies, 1:1 course, Healthy Relationship courses. This service is also delivered at the Pupil Referral Unit, and in special schools.
- Outreach HIV education, information, signposting, point of care testing, peer mentoring and support is delivered by the Terrence Higgins Trust in partnership with Spectra.

Local need for this service is comparable to that experienced in other areas of London and neighbouring local authority areas. Most service users are women seeking information and treatment for contraception or EHC (emergency hormonal contraception), men who have sex with men for STI & HIV testing, and this is available as a face-to-face HIV clinic at Northwick Park Hospital that offers PREP. The priority focus for the service is to support the sexual health need, including prevention services for:

- **High Risk and Vulnerable groups:** Increasing uptake of early intervention and prevention services amongst high-risk and vulnerable groups which include:
    - Under 18s
    - Adults at risk of STIs and HIV infection including people not born in the UK arriving from countries where there are higher prevalence of HIV and Hepatitis
    - Women attending for pregnancy terminations and repeated attendance for the same need
    - Users of sexual health services who experience repeat STI infections.
    - Individuals who may be vulnerable because of other life circumstances, where they live, relationships they have and risks related to behaviour, which may be without choice.

- **Hardly reached individuals, groups and communities -** Some groups find accessing services more difficult because of concerns regarding stigma or perceived service limitations (e.g., LGBT+ groups), or may be at additional risk of exploitation because of life circumstances, for example residents with:
    - mental health need,
    - learning disabilities,
    - victims of sexual assault, domestic violence and/or trafficking)

- **Male service users:** The current community sexual health service is predominantly used by women, and so is perceived to be a service 'for women'. Evidence suggests that young men are unlikely to actively seek out information or advice on sex – the service is taking action to challenge this perception and make the service understood by men as relevant to their needs

Throughout the pandemic many of these services were delivered mainly through SH24 the Hillingdon online Sexual Health with limited service available in person.

5.1.1 Contract performance data shows the strength of the IRSH to be:

- Led by SH24, providing a comprehensive and unique online offer that predates many other virtual offers
- Weekly Young People drop in at the main clinic site that allows immediate access without booking
- Provision of a service that meets quality standards, including access to and experience by service users, within budget

To demonstrate service activity Table 2 shows the online SH 24 service has between the period Q1—3 2021/22 for Hillingdon residents.

Table 2: Online activity provided by SH 24 (April – December 2021)

Intervention Measure	Performance
Number of orders for sexual health kits	7,911
% Of sexual health kits returned	68.2%
Of the kits returned % that were within 24 hours	83.4%
Total reactive/ positive results for an STI	414
Chlamydia Tests	311

Gonorrhoea Tests	49
Chlamydia treatments delivered	269
Chlamydia Diagnosis rate	5.5%
Gonorrhoea Diagnosis rate	0.9%
Syphilis reactive rate	1%
HIV reactive rate	0.5%

5.1.2. Changes to the service post-Covid:

There has been efficient working and improved service provision during Covid despite face-to-face activity being significantly reduced. This includes:

- All residents telephone triaged prior to a face-to-face appointment being offered. Commissioners are working with the provider to maintain this as a hybrid service model combined with a digital technology-based offer. This takes account of the digital poverty that creates exclusion to service access that was highlighted by the YP Healthwatch feedback to the IRSH
- There have been changes to some providers service offer for varied reasons, these changes are being reviewed to determine whether there are any access gaps that need to be addressed through commissioning intentions
- The use of Telemedicine – for some residents this has been a benefit, but for others, telemedicine is not suitable, particularly for some young people and people with low literacy skills. This service approach will not be offered in isolation of other access as this risks increasing inequalities amongst some residents who are identified as priority service users
- Commissioners are working with the IRSH providers to increase the number of Pharmacies to at least 7 who can offer the Chlamydia Screening programme

5.1.3 Service Improvements for 2022/23:

The following actions are being developed to improve the service offer for borough residents:

- Improving the offer of LARC in PCN's based on a similar model to cervical smear tests.
- Prevention of unplanned pregnancy – the borough is an outlier for abortion rates in the older age group 25-35 years of age, and for repeat abortions (PHOF 2020)
- Supporting more residents with learning disabilities to be aware of and use sexual health services
- Increase outreach to target sex workers in the borough – this would have greater effectiveness working across other NWL boroughs
- Improve referral pathway from Abortion services into IRSH, the pathway is too complex, and as NWL CCG commission abortion services, there is a risk of fragmentation or low referrals numbers to local services
- To relocate the IRSH service hub site

5.2 Substance Misuse (Drug and Alcohol) Service Contract

Contract Name	Provider	Contract Value
Substance Misuse Services	CNWL	£3.027M

This service provides an essential support and treatment offer to vulnerable residents experiencing drug and alcohol addictions, many of whom have complex health, wellbeing and social needs. There has been an increase in the number of people who are accessing this service post the pandemic lockdowns. This is likely to continue due to a reported increase in harmful alcohol use which may result in more people seeking treatment in the future.

Recognising the continuous rise in drug related deaths since 2012, the Government commissioned Dame Carol Black to carry out a 'Review of Drugs'. This two-part report examined both the drug markets and criminal networks involved in drug dealing, as well as treatment and recovery provision. Published in July 2021, part two of the report

laid out 32 recommendations for Government and local authorities, which included investing more into treatment services and strengthening partnerships. The three priorities set out are:

- Delivering a world-class **treatment** and recovery system
- Achieving a generational **shift in the demand** for recreational drugs
- Breaking **drug supply** chains

National targets have been set out for the first three years including increasing the numbers accessing treatment services by 20%. Local authorities will be expected to contribute towards these aims and will be receiving enhanced funding during 2022/23 to 2024/25 to enable them to do so.

There is a need to work closely with CNWL, the service provider, alongside key partners to ensure a comprehensive response is agreed and outcomes for both residents and their families are maximised. Through a joint needs assessment and partnership liaison, Hillingdon will target those groups and areas where people are most at risk or are not accessing services. A treatment plan will be required and will be signed off and monitored by OHID, ensuring improved governance as well as investment for this agenda.

Based on National Drug Treatment Monitoring System (NDTMS) data Hillingdon has the 12th highest prevalence of opiate user and 17th highest rate of cocaine (crack) use in London. Men aged between 19 and 59 years of age account for 92.1% of the service users accessing the service. Table 3 below is used to illustrate the range of drugs used by those attending the service (data 19/20).

Table 3: Drugs used by service users accessing the service

Substances	Male	Female
Opiate and/or Crack Users	410	125
Opiate without Crack Users	201	72
Crack without Opiate Users	10	*
Cocaine Users	81	34
Amphetamine Users	13	*
Cannabis Users	105	39
Benzodiazepine Users	43	24
Alcohol Users	280	112
Other drugs Users	7	6

*Data has been suppressed due to low numbers

The Substance Misuse Service offer is broad and includes:

- Comprehensive assessment and care planning with one-to-one tailored psychosocial support
- Clinical interventions including opiate substitute prescribing
- A range of psychology informed and peer support groups
- Drug, alcohol and dual diagnosis support and treatment services delivered by a specialist multi-disciplinary team that includes Psychiatrists, Nurses, Psychologists, Social Workers, Key Workers, Outreach Workers, and Smoking Cessation staff.
- In-patient drug rehabilitation service which is funded by CNWL – residential funding is supported by the LA
- Homeless and Rough Sleeper programme delivered as a partnership with Homelessness and Housing teams
- Criminal Justice Service in-reach to Prisons to co-ordinate discharge of an offender into local services and supporting access to Naloxone (drug used to reverse the effects of opioids, and prevent overdose)
- Partnership work with the Probation Service to get those people in recovery services back into employment and help with housing
- Tier 4 Young Persons Drug and Alcohol support workers – tier 4 services are aimed at individuals with a very high level of need of services to stabilise them – this can include abstinence and detoxification programmes
- Addiction's worker located in hospital A&E service to support the care of people presenting with specialist drug and alcohol emergency needs
- Emerald Pathway – this is an outreach worker supporting service users aged 55 years plus, that supports service users who have fallen due to alcohol use
- Peer, carers and extended friends and family support group

- Substance Misuse Supervised Consumption / Needle exchange, accessed through six pharmacies across the borough
- Fibro scan service to detect liver disease/cirrhosis early and refer to hospital services for assessment and treatment
- Stop smoking support

5.2.1 Contract Performance Data: Q1-3 2021/22

Outcomes for all groups had improved and are within, or near to the top quartile for Hillingdon's comparator group, apart from opiate users. However, this is currently the priority area for focus and clinical pathways are being reviewed aiming to achieve improved outcomes. Reporting of successful completions of structured treatment, in Quarter 3 2021/22 covers the period 01.01.21 to 31.12.21.

Table 4: Successful Completions in Treatment: Q1-3 2021/22

Quarter 1- 3 (period 01.01.21-31.12.21)	Hillingdon Successful Completions	Top Quartile Comparator Range
Opiate Users	4.8%	6.41-10.70%
Non-Opiate Users	41.4%	40.36-60.58%
Alcohol Users	43.1%	44.93-57.23%
Alcohol and Non-Opiate Users	38.5%	37.01-51.52%

Of the 1184 people in treatment during this period, 301 successfully completed treatment. However, it should be noted that as successful completion measures show those completing treatment in a planned way, out of all of those still in treatment, they do not illustrate the many 'in treatment' benefits gained from those engaged and does not mean that people are dropping out of the service.

For example, Treatment Outcome Profiles (TOPs) measures look at 'softer' measures, comparing at the start, in treatment (at six months as a minimum standard) and exiting treatment. The six months TOPs reviews in Hillingdon in Quarter 3, shows that abstinence rates for all categories were well within, or above the expected range.

Table 5: Abstinence Rates at 6 Months in Treatment

Quarter 3 2021/22	Abstinence Rates at 6 Month Review Hillingdon	Expected Range
Opiate Users	41.4%	27.8-64.1%
Crack Users	37.5%	20.3-59.5%
Cocaine Users	56.3%	20.9-69.6%
Alcohol Users	35.3%	10.2-29%

Evidence suggests that people will gain meaningful benefits from engaging in treatment for 12 weeks or more, even before they have completed treatment, hence OHID measure the proportion in treatment who are retained for this period (or successfully complete within this period).

Hillingdon performs in line with, or above the national average for this measure.

Table 6: Retention Rates in Treatment for 12 Weeks or More

Quarter 3 2021/22	Retained in Treatment in Hillingdon for 12 Weeks or More	National Average
Opiate Users	95%	95.8%
Non Opiate Users	96.8%	85.8%
Alcohol and Non-Opiate Users	96.6%	87.2%

A further indicator that a treatment service is delivering meaningful, quality treatment is showing low unplanned early exits. Relapse and reengaement is a normal part of addiction, however, maximising opportunities to engage people when they first enter treatment is important.

Hillingdon performs better than average in all groups, except the opiate cohort. As described above, that is the current focus for commissioner and provider.

Table 7: Early Exit Rates From Treatment

Quarter 2 2021/22	Proportion Exiting in an Unplanned Way Before 12 Weeks in Hillingdon	National Average
Opiate Users	21.1%	15.8%
Non Opiate Users	4.7%	17.8%
Alcohol Users	11.8%	13%
Alcohol and Non Opiate Users	3.9%	16.7%

5.2.2 Improvements planned for 2022/23

The priority commissioning intention is to more effectively work with the service provider to implement the From Harm to Hope national strategy. This will include aiming for a 20% increase in drug and alcohol treatment and review the recommendations from the 2020 for outstanding actions that were not implemented due to the pandemic focus.

To achieve these improvements, we will:

- Establish a forum where the action plan for the national strategy will be oversee
- Implement a universal offer to schools potentially free or chargeable depending on the model chosen that is quality assured
- Increase prevention and early intervention work with Sorted the young people's universal and Tier 2/3 drug services
- Improve the training to build capacity and capability amongst referral organisations
- Increase the uptake of services by women.
- To establish a pilot programme for Dual Diagnosis Mental Health Teams in 2 PCNs based on the programme in Ealing
- Timely and planned referrals from the Prison service in partnership with ARCH

5.3 0-19 Healthy Child Universal Programme Contract

Contract Name	Provider	Contract Value
0-19 Health Child Programme	CNWL	£4.917M

The 0-19 Healthy Child Programme is a universal offer to all families with children who live in the borough. Through health surveillance pre-birth and at developmental stages especially up to the age of 5 years a child and family are supported so that they are ready, able and willing to learn by the time they start schools. The service also provides a school and home-based nurse support for school aged children attending schools and schooled at home.

There has been a programme of ongoing transformation between LBH as the commissioner and CNWL as the service provider which has allowed greater alignment of services that support families. The transformation objectives aim to develop a 0-19 contracted service based on local family need, that can flex to changes in the population, their needs, including emerging priorities at scale, develop a robust prevention and early intervention offer that reduces means we tackle local needs at the earliest opportunity and to be able to respond effectively. This includes the development of Family Hubs and aligned outreach spokes where system-wide borough professionals work together in a neighbourhood, and together focus on better outcomes for families.

5.3.1 Current Performance of the service

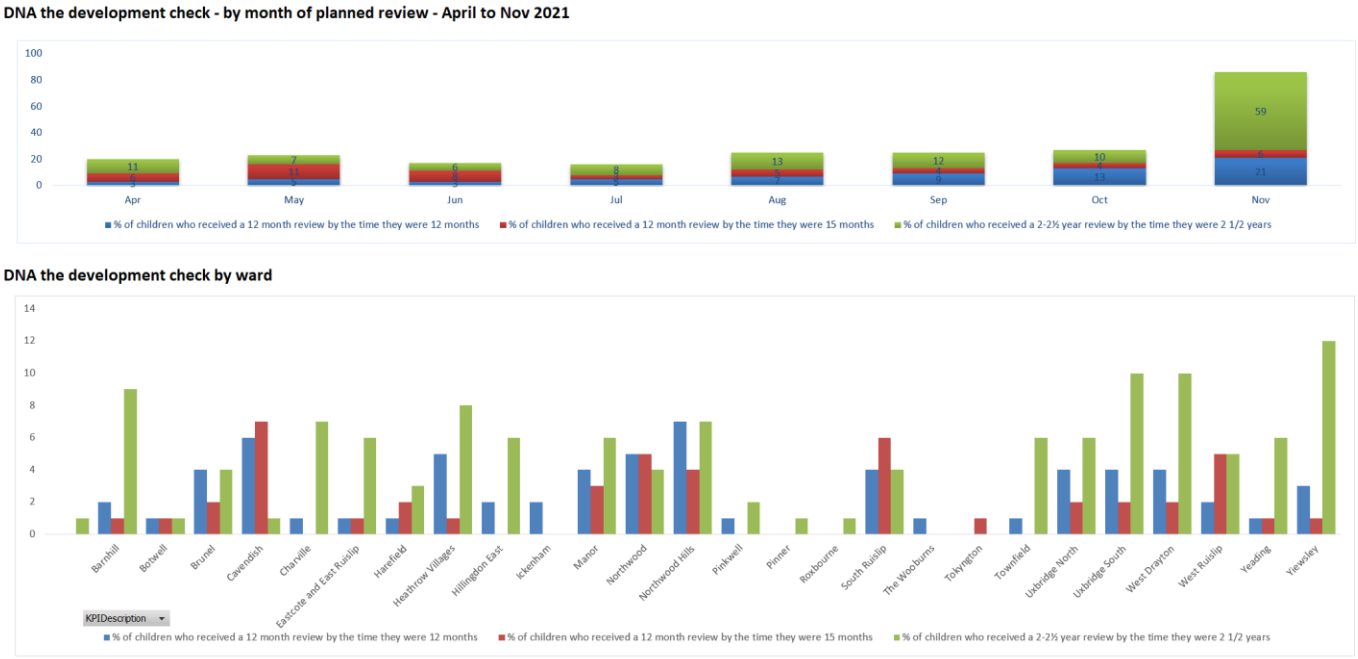
As a universal service it is important that all children are seen by a professional regularly. Service performance is based on national measures. Performance for Q1 – 3 2021/22 where outputs are consistent have been averaged for paper brevity and are set out in the Table 8 below.

Table 8: Headline contract performance measures

Target Met	Target not met	Improvement Focus
% Of new births that receive a face-to-face new birth visit by a HV within 14 days (target 85%) – 93%	No of mothers who receive a face-to-face antenatal contact with a HV at 28 weeks (target 85%) – 75%	Breastfeeding uptake – 65% (no target is set)
% Of children that receive a face to face 6–8-week review by a HV (target 95%) – 94%	NCMP consented Reception (target 95%) – 51%	Recording breastfeeding status at 6–8-week review (target for publishing 95%) – 92%
% Of children who receive a 12-month review by the time they are 15 months (target 75%) – 85%	NCMP consented Year 6 (target 95%) – 64%	Follow up and intervention for all children identified through NCMP as overweight/ obese
% Of children who received a 2-2.5-year check (target 70%) – 72%		LAC assessments completed – improvements seen
All schools have a designated named school nurse		

CNWL has reviewed the number of children who have not attended for one of three milestone checks. Figure 1 is the number of DNA by month for each of the checks and the total DNA by ward – we are progressing through the transformation board how we can reach out to these families and support improved access.

Figure 1: DNA service activity against three mandated child surveillance checks: April – November 2021



The 0-19 HCP contract has effectively been managed through Social Care Services.

5.3.2 Improvements planned for 2022/23

There are greater opportunities for the PH team to be more engaged in this programme and wider public health support of children and young people in the borough – particularly to help support the prevention and early intervention areas of focus where outcomes are poorer for our children and their families.

In this commissioning year w will work with Social Care contract lead and CNWL as part of the transformation programme and align investment in:

- Whole System approach to obesity – supported through the London Community of Interest in partnership with LB Hounslow
- Invest in evidence-based interventions that support healthy weight, oral health, and increased physical activity.

5.4 NHS Health Checks Programme:

Contract Name	Provider	Contract Value
NHS Health Checks	GP Confederation	£280K

The NHS Health Check is one of the 5 mandated PH functions for a local authority. The national programme offers a risk assessment, awareness and management programme for people aged 40 to 74 who do not have an existing diagnosed cardiovascular illness. The programme is aimed at preventing heart disease, stroke, type 2 diabetes, kidney disease and vascular 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.

In Hillingdon, NHS Health Checks are provided by the 45 GP practices. Eligible patients are contacted by their GP practice (by letter, telephone, text message or face-to-face) and invited to book an appointment. Appointments usually take 15-20 minutes.

At an NHS Health Check appointment, an assessor will measure a person's height, weight and waist circumference, pulse rhythm is checked, and blood pressure measured. If the person has not had a venous blood test for cholesterol and blood glucose (or HbA1c) prior to their appointment, they will also receive a point of care finger stick blood test for these. The individual will be asked to confirm any family history of vascular disease, smoking status, alcohol consumption and physical activity levels. People aged 65-74 will be given information about the signs and symptoms of dementia, and local memory services. The assessor will then calculate the person's risk of developing a vascular disease over the next 10 years, will explain this to the person and then given healthy lifestyle advice to help them reduce their risk level, and signposted to local services such as leisure centres and health walks.

If a person has results that are outside normal parameters or if there are any other concerns, they will be referred to a GP for further investigations and / or treatment. Patients are also referred to local healthy lifestyle services such as smoking cessation, exercise-on-referral, weight management and the NWL Diabetes Prevention Programme where appropriate.

Table 9: Uptake of Health Checks at borough level

Year	Total eligible population	Number of first offers of an NHS Health Check (in a five-year period)	Number of NHS Health Checks received	Uptake (%)
2018/19	77,949	10,423 (13.4%)	6,645 (8.5%)	63.8
2019/20	78,665	13,214 (16.8%)	6,029 (7.7%)	45.6
2020/21	79,859	1,825 (2.3%)	967 (1.2%)	53.0
Q1-Q3, 2021/22	81,561	5,530 (6.8%)	2,723 (3.3%)	49.2

Data is collated on uptake by gender, age and ethnicity. We know that there are under-screened groups which data confirms for the borough:

- Men in all age groups.
- Those eligible from Black, Mixed race and other ethnic groups are less likely to attend for screening.
- Patients registered to practices where uptake is lower.

The national analysis indicates that deprivation is the most significant factor for under-screening in NHS Health Checks with the most deprived being the least screened. More analysis for this programme is required using a population health management approach to analyse and address gaps in service provision.

The priority for this contract as part of the population health management approach will be to:

1. Increase NHS Health Check uptake by:

    - Improving our understanding of whom those most at risk are and will benefit most, and target the service to those people and groups identified
    - Reducing variation amongst GP providers though increased training; greater support for the lower performing GP practices and greater collaboration at PCN level between practices
    - More effective publicity and marketing of NHS Health Checks as an important health intervention

2. Improve access to an NHS Health Check by:
    - Increasing access through locations and times when appointments can be made – including workplace health offer

3. Effective referral to a health improvement intervention is increased by:

    - Ensuring that part of the immediate post HC discussion care plans about how risk can be reduced, and directs the individual to the most appropriate service that can support this
    - Increase referrals which commute to attendances in preventative services such as smoking cessation, weight management and exercise services that maximises the support offer to individuals
    - Follow up those people identified as at risk to determine what worked, and how services can be more responsive

4. Improve digital technology by:

    - Looking at the NHS Health Check offer in other areas and where there has been successful digitalisation of the service that increases uptake and improve individuals' NHS Health Check experience in line with the new digital NHS Health Check offer that is currently being developed by NHSX

5. Greater evaluation and alignment to wider HHCP focused workstreams where NHS Health Checks could contribute to improving health outcomes for residents by:

    - Having clear measures for evaluation such as access to, experience of, benefit from the service
    - Share what works to improve system ownership of the programme and recognition of the value the service offers for preventing long term conditions as part of a process of investment into prevention.

5.4.1 Local Public Health action for this contract 2022/23:

- Cost of NHS Health Check programme:

  The current budget is based on completion of circa 7,500 – 8,000 checks each year, which accounts for approximately 9.5% of the current eligible population. Increasing uptake is an effective return on investment for increased funding as a prevent to save and the expansion of the programme to people aged 30-39 and activity to an annual target of 10,875 (13.3%) of the eligible population in 2022/23 and 12,234 (15.0%) in 2023/24 would make a significant step towards increasing our ambitions to reduce chronic LTC through earlier detection of risk amongst younger people

- Data:

  This service generates significant amounts of data that would be able to better inform system prevention and early intervention planning – the action is to embed this work within HHCP as part of the LTC prevention programme.

5.5 Stop Smoking Services Contract:

Contract Name	Provider	Contract Value
Stop Smoking services	Addictions Recovery Community Hillingdon (ARCH) – CNWL NHS Trust	£133K

The adult smoking prevalence in Hillingdon is 10.1% of the total population, lower than London (11.1%) and England (12.1%). Smoking disproportionately affects the most disadvantaged in the community and is a significant contributor to health inequalities in the borough, for example 2019 data shows that in LBH people who are in routine and manual occupations have a smoking prevalence of 15.9% (London 20.7%/ England 23.2%).

The borough service is provided by ARCH with clinics available in locations around the borough. The service model is working to the NICE: Tobacco: preventing uptake, promoting quitting and treating dependence guidelines (November 2021) with local performance indicators that demonstrate improved outcomes for service users. Data is presented for 2021/2022 quarter 1-3. Q4 data will be available in May.

The service has focused on:

1: Improving campaigns strategies to increase referrals to smoking cessation services

- Promoting and supporting stop smoking in a range of settings in line with the priority indicators.
- Joint work with LBH Communications Team so that the stop smoking website is relevant with advertisements for services in 'Hillingdon People'.

2: Support for targeted stop smoking interventions at Hillingdon Hospital: Regular weekly clinics running within Hillingdon Hospital advertised through hospital departments, especially cardiology and respiratory services.

5.5.1 Targeted Priority Activity:

1. **'Stop before the Op':** This is linked to the Pre-Assessment Department at HHFT with promotion of screening for tobacco use and referral to the service. There are effective referral pathways with access to stop smoking level 1 training for hospital staff. The benefits of this intervention are significant: less anaesthetic is required, less risk of peri and post operative oxygen support, quicker recovery period, faster wound healing with less risk of infection, reduced risk of heart attack and operation complications.

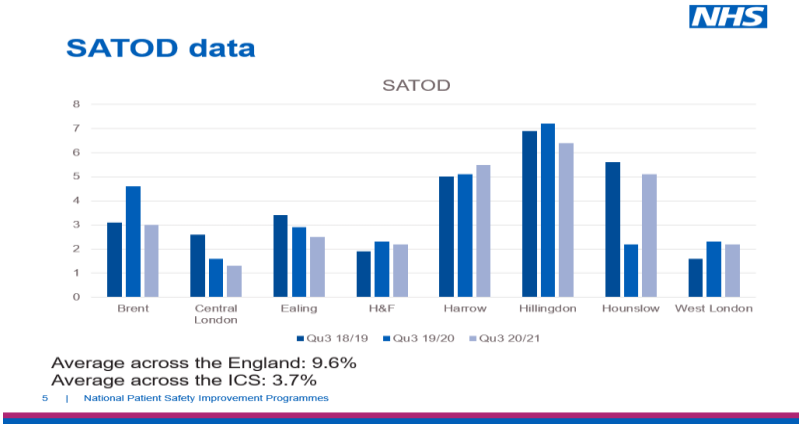
2. **Primary Care /GPs:** Review carried out of stop smoking services in General Practice and wider primary care settings. New virtual models for stop smoking service delivery are being trialled at a small number of GP surgeries for a 3-month period started in April 2022 have been initiated including virtual groups.

3. **Mental Health:** 2019 PHE data shows that residents with a long-term mental health condition in Hillingdon have a higher smoking prevalence 29.2% (London 26.6%/ England 25.8%), for those with a serious mental illness in Hillingdon this is higher still - 37.2% compared to London (38.9%) and England (40.5%). Targeted support delivered through satellite clinics held at hostels for people who experience mental ill health. The target group focuses on residents with complex mental health needs including harm reduction approach to smoking cessation using psychosocial and behavioural interventions.

4. **Maternity services and pregnant women:** This are an important intervention for women who are smoking at the time of maternity booking using CO testing validation. This programme is in the early stage of service development to support NW London Local Neonatal and Maternity System (LMNS) aim to offer smoke free services to 100% of birthing people and any smokers in their household by March 2024. The current target is to achieve at least 40% with services offered face to face with a specialist midwife/ support worker by the end of the 21/22 financial year.
   Targeted interventions for pregnant woman and their partners are essential for the best in-utero infant development and many women are continuing to regularly smoke throughout their pregnancy. SATOD (Smoking at Time of Delivery) data indicates that whilst rates for the Borough are lower than the England

average (9.6%) there are higher % of women who report they are smoking when they give birth. Figure 2 below compares Hillingdon with other NWL boroughs by comparing the percentage of women at one Quarter (Q3) data point across 3 years – 18/19 – 20/21 who are smoking at the time they give birth:

Figure 2: Smoking at the time of delivery – SATOD 18/19 – 20/21



Overall stop smoking data for Q1-3 shows that there is more scope for improved engagement with smokers and improve the quit rate as well as understand how effective stop smoking services in different settings are. Between April 2021 – Dec 2021 326 people set a stop smoking quit date of whom 144 (44%) quit smoking. This means they were not smoking 4 weeks after their quit date.

Table 10 shows the quitter outcomes for different settings where smoking cessation services are offered and the variable quitter numbers. There are clearly opportunities to increase uptake in some services.

Table 10: Outcomes from stop smoking service by setting Q1-3 2021/22:

Service Setting (Total 144)	No. set a quit date	No. of quitters	% Quitters in period
Community	55	34	61%
Pharmacy	263	104	39.5%
Hospital	8	6	75%
Pregnant women	12	9	75%

There is current 13 pharmacies in the borough offering stop smoking services of whom 4 are providing most of the activity (Nuchem in Hayes, Mango in Cowley, Grosvenor in Hayes and Carters in Eastcote).

A review of these settings and how we increase uptake and quitter numbers especially in the target groups set out in Table 11 will be carried out with the service in 2022/23.

Table 11: Outcome by Target Group from stop smoking service by setting Q1-3 2021/22

Priority Group (Total 326)	No. set a quit date	No. of quitters	% Quitters in period
Pregnant Women (37 referrals)	12	9	75%
People with MH need*	8	3	37%
Young People	10	5	50%
People in Routine/ Manual Occupations	43	18	41%
Non-priority group smokers	253	145	57%

62 clients with a mental health need had a brief intervention for a harm reduction approach and received support to motivate them towards quitting smoking as part of overall health and wellbeing assessment.

Additional Stop Smoking resource is funded by LBH as part of a Pan-London approach to increase the number of people accessing services. There have been too few referrals between the London Service and the local provider which will also be part of the scope of a local Stop Smoking review.

The prevalence of smoking in the borough has reduced, and Figure 3 below shows that there has been a year-on-year decline in the number of people in the borough who are quitting – this is contributed to by the development of vaping technology which is considered as a 'harm reduction intervention'.

Figure 3: Smoking Quitters in Hillingdon 2011/12 – 2020/21:

Source: OHID - Local Tobacco Control Profiles

6. **Public Health Planning for 2022/23**

There are areas of each contract that need improvement, more focus on prevention and early intervention, service delivery, and especially how we weight service delivery to target individuals and groups we know to be at higher risk and more vulnerable.

We recognise that as we develop options behind our procurement plans, it is important that we more effectively build in robust evaluation methods that do not focus solely on activity and outputs but measure outcomes and impact of the services for our residents. This links with the new health and wellbeing strategic outcome that our residents get better access, experience of and benefit from our services, and we are clear that those people we hardly reach are focused on, and we can evidence this.

These contracts all make a significant contribution to health inequalities, tackling unfair and avoidable differences in health and wellbeing. Procurement plans, new contracts and variations on existing contracts need to be more understanding of weighted need, become outcome focused and are driven through working in partnership with wider services; improving the health of our most vulnerable residents, those with the greatest needs requires combined and joined up efforts. This programme of work is included as part of the public health service plan for 2022/23.