

**Annual Report of the
Director of Public Health**
Gloucestershire County Council
2013-14

Published 2015

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1 Introductions

1.1 Foreword -

Councillor Dorcas Binns and Councillor Andrew Gravells

It has been our privilege to lead the public health team since its transfer from the NHS to the County Council in April 2013.

Public health has been defined by the coalition government as *'the science and art of promoting and protecting health and well-being, preventing ill-health and prolonging life through the organised efforts of society'*.

As cabinet leads we see our role as promoting both the science and the art of Public Health, while supporting the development of the team and its integration into the wider work of the Council and its partners.

This report gives an introduction to team members and an account of their stewardship of the public health grant of £21.7 million. A significant element of the resource is deployed in commissioning of public health services.

Partnerships, networks, inter-dependencies and common purpose are crucial to the work. These are the focus of the Health and Wellbeing Board which has also undergone considerable development in the past year. All this effort is directed towards protection of good health and prevention of ill health by supporting individual and community resilience, while providing a safety net for those less able to help themselves.

The report is a map of progress so far, but it is not the map that matters, it is the journey.

We have taken our first steps on the journey with the new public health team.

We look forward to the adventure ahead.

1.2 Executive Summary

Dr Peter Brambleby, DCH, FRCP (Edin), FFPH.
Interim Director of Public Health (from June 2014)

In their foreword the cabinet leads for Health and Wellbeing and Public Health make reference to both the science and art of public health.

The **science** of public health incorporates several disciplines. These are directed chiefly towards finding and interpreting evidence to support decisions by cabinet and elected members. Scientific disciplines include:

- epidemiology (the study of the distribution and determinants of health and wellbeing, and evaluation of services);
- economic appraisal;
- health impact assessment;
- commissioning and contract management;
- psychology and behavioural change.

The **art** of public health is to come up with new questions, new solutions, new ideas, new ways of getting messages across and new ways of bringing about change. Albert Einstein (1879-1955) wrote that: *“Logic takes you from A to B, but imagination takes you anywhere.”* Georges Braque (1882-1963) wrote that: *“Science reassures, art disrupts”*.

Both science and art are featured in this report.

2014 was the centenary year of the outbreak of the Great War. This report opens with a brief review of how much the health and wellbeing of the people of Gloucestershire has improved since then. Advances were not solely, or even mainly, due to progress in medicine and the introduction of the NHS, but rather to strides in sanitation, housing, clean air and nutrition. The role of the Local Authority always was, and always will be, fundamental to the health of the public.

Thereafter, the substantive report is in four main parts.

The first part is an account of the stewardship of the 2013-14 public health grant of £21.7m. It describes where that money went, what it achieved, who was responsible and what has been learnt along the way.

The public health approach is congruent with the Council’s values of helping people and communities to help themselves. It focuses on getting a favourable return on investment in terms of health and wellbeing. Since this is the first report under full Council management, it introduces the core team members and explains their roles.

Public Health sees its principal role within the council as one of decision support to elected members. All council decisions have an impact on health and wellbeing.

A decision is *“a choice that is made when the way forward is not self-evident”*. Decision support covers all stages of council work:

- making the case for change,
- helping bring about change,
- evaluating outcomes and value for money after the change.

Tough decisions will need to be made about the best use of resources, and that means resources in the widest sense, not just the money. This brings us to new ideas in “asset-based community development (ABCD)”, “social capital”, “active communities”, and “social return on investment”. Our partners in the NHS are facing similar challenges and we are collaborating closely. The new thinking about community assets is not only helpful in meeting need and managing expectation within tight financial constraints but also often more effective and sustainable in the long run.

When it comes to efficiency, public health aims to be both **technically efficient** with its budget (achieving objectives at least cost – “doing things right”) and **allocatively efficient** (deploying resources between competing claims to maximise population health gain – “doing the right things”).

The true cost of inefficiency is not borne in taxes alone but also in avoidable disability, distress, missed life chances or even dying before one’s time. The pursuit of efficiency is therefore deadly serious – literally.

The second part of the report gives a snapshot of health and wellbeing in Gloucestershire. It begins with a quiz. How much do you know about the current state of health and wellbeing in Gloucestershire? Find out! This section does not attempt to replicate the Joint Strategic Needs Assessment (JSNA), nor the Health and Wellbeing Implementation Plan, but it does make reference to both.

The JSNA is being revised and collated in a format that will be more easily accessed by members of the public on-line, an arranged in a library of topics organised by stages of life, needs and districts of residence.

Gloucestershire’s health and wellbeing priorities are:

1. Reducing obesity
2. Reducing the harm caused by alcohol
3. Improving mental health
4. Improving health and wellbeing into older age
5. Tackling health inequalities.

The third part of the report looks into the current year and beyond. It describes how the public health team is re-organising itself to meet the new challenges and opportunities. There is a brief account of the anticipated risks and how these might be mitigated.

The fourth part of the report is a summary of challenges. The overwhelming conclusion from the appraisal of need and scarcity of resources is the case for a shift towards prevention, personal responsibility, domiciliary and community care, and full use of activity and arts to help people to be all they can be, which is the essence of health and wellbeing. For those whose needs cannot be met except through the caring agencies, there needs to be an effective safety net of care in place.

Improving the life chances and health of 600,000 people is a huge responsibility, a fantastic opportunity and an immensely rewarding task.

Few jobs offer a better chance to combine science and art, and both are integral to the definition of public health.

As a public health team we look forward to playing our part. This report is a summary of that aspiration.

2 100 years ago

As we reflect on the centenary of the Great War, what issues confronted public health at that time?

Extracts from the Report of the Medical Officer of Health for Gloucestershire for 1913 (published 1914)

The primary concerns of Public Health in Gloucestershire a hundred years ago were very different to those we focus on today. Rather than targeting the behaviour and lifestyle choices of the general population, the key aims related to external, environmental factors.

In 1913 the county had a population of 330,800, nearly half the 605,654 population of today. The leading employment groups were agriculture for males (24.3%) and domestic service for females (48.1%). A century on, this has changed to banking, finance and insurance for males (18.5%), and public administration, education, and health for females (40.1%).

Regarding maternity, there were 6,493 births in 1913, almost the same as the 6,465 in 2013. This means the birth rate a century ago, of 19.6 per 1,000, was twice that of today. Infant mortality has fallen dramatically from 73 deaths in the first year of life per 1,000 births to 3.9 deaths per 1,000 births. Looking at that in numbers, it is a drop from 477 infant deaths in 1913 to just 27 infant deaths in 2013. Inequalities were wide at locality level: Stow had an infant mortality rate of 263 per 1,000 whereas Tetbury's was only 11 per 1,000.

Overall mortality rates have dropped from 13.1 per 1,000 to 9.5 per 1,000 in the past century, but in 1913 most people (56%) died before their 65th birthday. Now only 13% die before that age. The leading causes of death in 1913 were, in order, respiratory, cancer, and tuberculosis. Circulatory disease (heart attacks and strokes) has replaced tuberculosis, but the other two remain significant. Now the top three are cancer, circulatory, and respiratory diseases.

The 1913 report contains an extensive chapter on notifiable

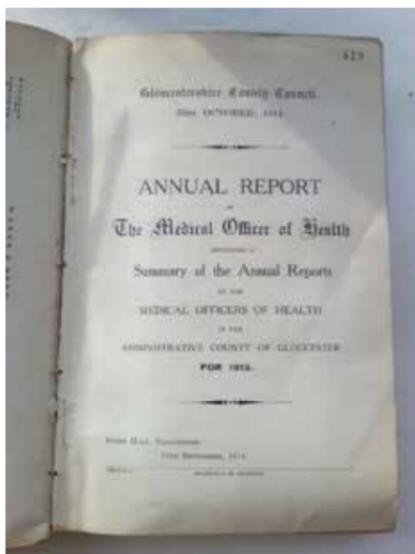
diseases. The top three were scarlet fever (490 cases), pulmonary tuberculosis (239), and diphtheria (150). Though it is difficult to compare these with today's notifiable diseases due to advancements in diagnosis, the top three in 2013 were campylobacter food poisoning (602), scarlet fever (151), and hepatitis C (84). It may come as a surprise to some that scarlet fever is still prevalent, but today's antibiotics have blunted its severity. In 1913 there were 12 isolation hospitals in Gloucestershire for patients with communicable diseases, and it was recommended that more of these were needed. Now we have no isolation hospitals. Certain diseases that concern us today, like HIV, Ebola and legionnaire's were unknown then. Antibiotics were unknown and very few immunisations existed.

Overcrowding of housing was a key issue in 1913, with more than 5% of people living in accommodation that housed more than two people per room. The Council addressed this issue by placing orders for new houses to be built in industrial areas. With respect to the housing stock, the local authority had carried out an increased number of inspections, which often found issues such as dampness and lack of opening windows.

The public water supply of 1913 was still developing, with large areas of the county facing contamination and shortages. The local authorities were looking to address these by extending the mains supply and adding concrete floors to reservoirs. Sewerage was problematic and described as "a danger and a menace to health" in parts of the Forest of Dean, where it was discharged into a local brook.

Nowhere in the report were the cornerstones of modern public health mentioned: smoking, alcohol, diet or physical activity. The clean air act would not be passed for another four decades.

There is also a post scripted note on the report apologising for the delay in publishing; this was caused by four out of five clerks departing at short notice for duties related to the outbreak of the First World War.



3 Looking back at 2013/14

This section is about stewardship of the public health grant for 2013/14.

It shows the major areas of investment, what they were for and who was responsible. It is only a snapshot, but is an introduction to what we do and who we are. Please use it to build networks and get in touch.

The table of investments below is dominated by services for which we contract, for example substance misuse, sexual health, public health children's services and tobacco control, but the core of the public health 'offer' is its staff, and this is where our description starts.

Table 3.0 Breakdown of the public health grant 2013/14

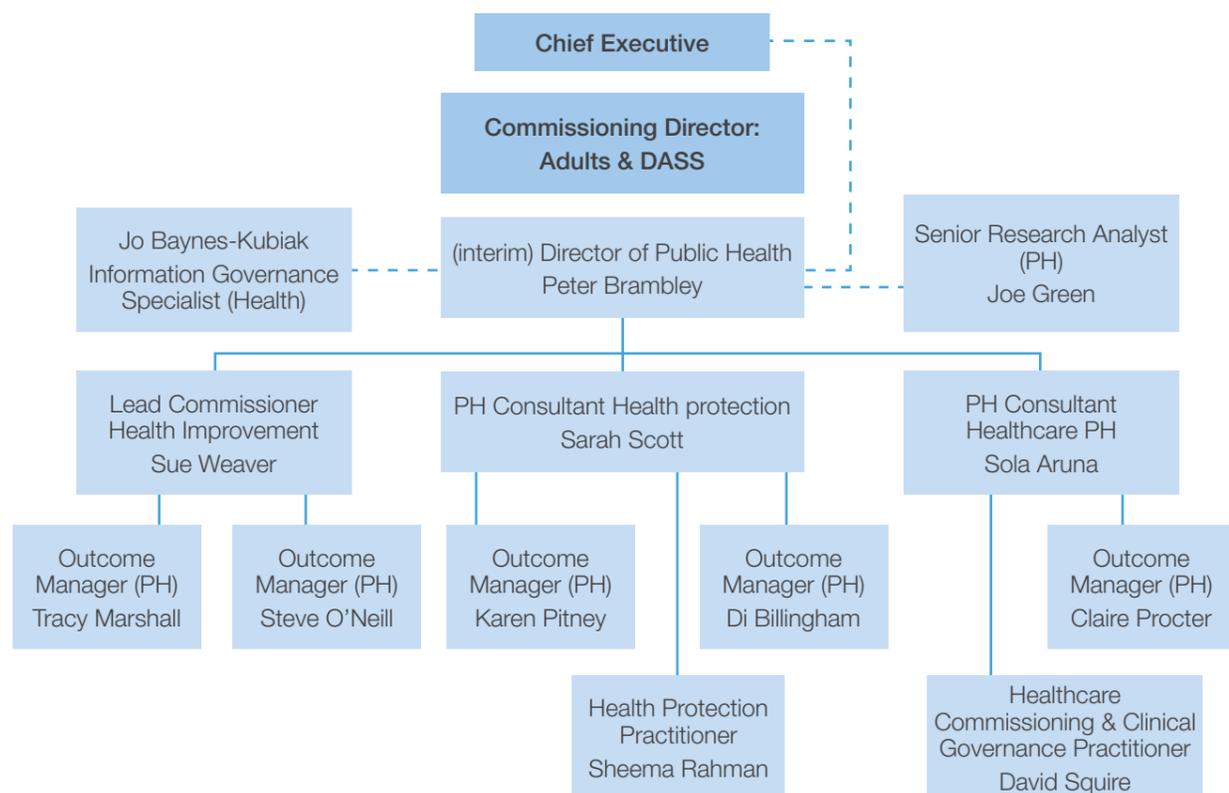
3.1	Core public health staff and pay budget	£ 1,827,000
3.2	Substance misuse and alcohol	£ 6,711,000
3.3	Sexual health	£ 4,176,000
3.4	Public health - children	£ 1,918,000
3.5	Tobacco control and smoking cessation	£ 1,490,000
3.6	Weight and nutrition	£ 773,000
3.7	NHS Health Checks	£ 817,000
3.8	Healthy Ageing	£ 905,000
3.9	Public mental health	£ 228,000
3.10	Health protection	£ 14,000
3.11	Active Together, Healthy Together and other carry-forwards	£ 2,267,000
	Total	£ 21,126,000

3.1 Public Health Core Team

(Investment: £1.827m)

Contact: Dr Peter Brambleby

This budget covers salaries for staff and associated costs such as travel and training.



Wider team funded by the public health grant (matrix management)

- Senior Analysts (includes Joe Green, above)
- 8 Commissioning Officers
- 1 Commissioning Support Officer
- 1 Administration Support Post
- 1 Information Governance Post (Jo Baynes-Kubiak, above, fixed term)
- 1 Programme Manager for Domestic Abuse
- 0.5 Support Officer for Domestic Abuse

This dispersed model of workforce has the advantage of spreading public health output across the commissioning work of the council. Those listed are accountable to other teams, not the director of public health. In order to keep a sense of 'team' and ensure that public health skills and knowledge are kept up to date, a fortnightly programme of continuing professional development (CPD) has been instigated. In a recent inspection by the Severn Deanery for Postgraduate Medical Education, the CPD programme was commended and Gloucestershire's training status for public health upgraded from C ("needs improvement") to B ("satisfactory, with areas of good practice").

Meet the Public Health team



Dr Peter Brambley has been Interim Director of Public Health since June 2014. His background was in child health before coming into public health. He spent 10 years as a Director of Public Health in the NHS before going freelance in 2010, with a portfolio

of woodland management, training and consultancy. He has contributed to public health textbooks and is a past examiner for the Faculty of Public Health.



Dr Sola Aruna is consultant in Public Health. She has a background of clinical medicine in Nigeria and the West Indies, in general medicine and paediatrics, and full public health training for the UK Faculty of Public Health. She is our principle source of

advice to the clinical commissioning group and the joint strategic needs assessment, and covers screening assurance and suicide prevention.



Sarah Scott is a Consultant in Public Health. She worked as an Environmental Health Officer and Public Health Manager before undergoing full public health training for the UK Faculty of Public Health. Her portfolio includes health protection, sexual health, wider determinants of health, Active Together and Healthy Together, public health nursing and continuing professional development.



Sue Weaver is the Lead Commissioner for Health Improvement. She is a dietician, with previous experience in hospital-based specialties and more recently has worked as health promotion specialist in obesity, nutrition and physical activity. She is currently studying for a Master's Degree in Public Health.



David Squire is a Healthcare Commissioning and Clinical Governance Practitioner. He has a background in nursing, a degree in economics and is currently completing a Master's Degree in Public Health. He keeps an eye on the public health budget and risk register, amongst other things.



Claire Procter is an outcomes manager for public health. She has a degree in politics and a masters in political economy; and is currently studying for a Masters in Public Health. Prior to moving into public health Claire spent 10 years in government communications with DCLG and Cabinet Office. Her portfolio includes public health support to the clinical commissioning group.



Steve O'Neill is a Public Health Outcome Manager. He worked as a volunteer young people's counsellor and benefits adviser. He trained in social work and has post graduate qualifications in substance misuse, commissioning and public sector management and leadership. He has worked as provider and commissioner in community, criminal justice and residential drugs and alcohol services.



Karen Pitney is a Public Health Outcome Manager. She has a background in primary health care, working as a GP practice manager in Gloucestershire and member of the practice-based commissioning team before moving into public health in 2010 with a particular focus on sexual health.



Tracy Marshall is a Public Health Outcome Manager. She has a degree in Social Policy and a Master's degree in Public Health. She has worked in the voluntary sector and been in public health for the last 14 years, chiefly transport, environment and physical activity.



Diana Billingham is a Public Health Outcome Manager. She has a degree in Hospitality Management and a post graduate qualification in Recreation Management. She worked for 12 years in local government leisure management before moving to the NHS. Since working in Public Health her portfolio has included developing the health and wellbeing partnership; working with the voluntary and community sector and promoting volunteering; carers support services and fuel poverty. She has been involved with voluntary sector organisations and is currently vice-chair of Carers Gloucestershire. She is a qualified coach and mentor.



Sheema Rahman is a health protection practitioner. She has an MSc in nutrition, physical activity and public health, and a certificate in management. She gained experience in Scotland in the fields of drugs, alcohol, smoking and dental public health. Her current portfolio includes sexual health.

3.2 Substance misuse and alcohol

(Investment £6.711m)
Contact: Steve O'Neill

The primary objectives of this work are to:

- Prevent alcohol-related and drug-related problems
- Reduce harm when drugs and alcohol are being used, including impact on carers, family members and wider society
- Direct treatment towards best chance of full abstinence from drugs and sensible levels of drinking.

Alcohol

Alcohol is the third biggest risk factor for illness and premature death, after smoking and obesity. It is often a key factor in anti-social behaviour, domestic abuse and safeguarding.

In Gloucestershire roughly one in four people are estimated to be drinking above the recommended safe number of units per week.

In 2012-13, there were 3,934 alcohol-specific hospital admissions (where alcohol was the main factor) and a further 10,853 alcohol-related hospital admissions (where alcohol was a contributory

The annual cost of alcohol-related harm



factor) in Gloucestershire. Looking back over the previous five years we see a steady increase.

Gloucester and Cheltenham see the greatest amount of comparable harm and have rates of admission higher than the national average.

There is good news. The large local on-line pupil survey shows that fewer children aged 11-15 years are drinking alcohol than they were a decade ago. In 2014 43% of 11-15 year olds surveyed in school said that they had drunk alcohol at least once, compared to 61% in 2004. However, those young people who are drinking alcohol seem to be drinking a great deal more.

Drugs

We know problem drug use tends not to happen in isolation and is often linked to other factors

including mental health problems, alcohol misuse, domestic violence and homelessness.

National Prevalence estimates suggest that there are approximately 2,500 Opiate (largely heroin) and users of crack cocaine within the county.

Stopping people using drugs can save money, Public Health England estimate that for every £1 spent there is £3.36 return to public purse. Our own estimates, taking in wider social return on investment, put that as high as £9 benefit for every £1 invested.

The cost of drug use:

- The crime associated with drug use is estimated to cost £445,000 over the lifetime of one person who takes drugs
- Providing health services to someone who injects drugs costs an estimated £35,000 or more over their lifetime.

There were a total of 1,495 adults in 2013/14 reported as being in effective treatment within the Gloucestershire drug treatment system.

What is Gloucestershire County Council doing to combat drug and alcohol misuse?

We commission a range of programmes and services to prevent, reduce harm, provides structured treatment and help with full recovery.

Following a major commissioning exercise in 2012 the main community service is now offered through a single provider, Turning Point, to have 'one front door' for anyone with alcohol and drug problems to go through.

Key to the delivery is the use of local hubs and mobile outreach vehicles, making it easier for people to access the support they need. Gloucestershire has seven hubs in; Gloucester, Cheltenham, Cinderford, Stroud, Tewkesbury, Cirencester and Moreton-in-Marsh.

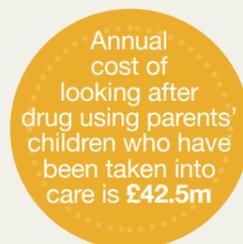
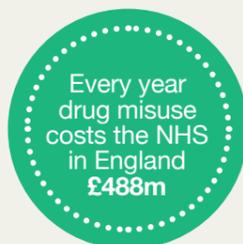
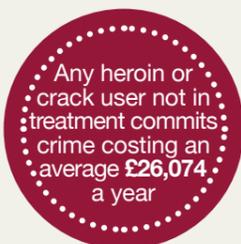
The services provided by Turning Point address all elements to prevent problematic drug and alcohol use. It worked with over 2,000 people in 2013-14.

For more information or support contact
www.turning-point.co.uk

The annual cost of drug addiction

Every year it costs society

£15.4bn



Case studies:

Jane went into treatment at Christmas time. *'I was drinking every day and my children had been removed temporarily because of my drinking. I went to see Turning Point every two weeks, keeping drinks diaries and a recovery diary. I managed to stop drinking with their support. I have been abstinent for seven months for the first time since I was 12. I have now done an 8 week parenting workshop in full and was able to celebrate with the children, peers and staff. I am currently working on providing a positive future for myself and children'*.

Gary. *'Before I attended the Turning Point drop in service I was drinking around two litres of vodka a day. I'd lost everything; my friends, family, money employment and my home. With the support I got from the team I'm now living with my partner and back in work'*.

Pete *'I was drinking about three litres of cider every day, I was working full time running my own business, but I had started to isolate myself from friends and family. I attended one to one sessions with a key worker twice a month and with the support of my family and the nurses from Turning Point I am now leading a new life, enjoying work and enjoying seeing my children flourish'*.

Natalie works in a critical safety environment and was drug tested at work positive for cannabis and was suspended. She reduced her cannabis use gradually by using a cannabis workbook and sessions with a worker. She is now abstinent from cannabis and had managed to save £860 during her time in treatment. She is now back at work and has been discharged from the service.

Alan was using heroin and had poor physical health including Hepatitis C. He has three children aged between three and seven and is their main carer. Since stopping his heroin use, he has secured stable accommodation for his family. He is now a peer mentor to other drug users.

3.3 Sexual Health

(Investment £4.176m)
Contact: Karen Pitney

Sexual Health

Efforts to improve sexual health in Gloucestershire are aimed at reducing the rates of unwanted teenage pregnancy and sexually transmitted infections for example Chlamydia, Gonorrhoea, Syphilis and human immunodeficiency virus (HIV).

Since April 2013, Public Health in local authorities have had responsibility for commissioning sexual health services. Gloucestershire's sexual health services are delivered throughout the county with each service contributing to the joint aims of:

- Preventing sexual ill health and promoting healthy relationships and good access to contraceptive choices strength and contraception access, and,
- Supporting and treating those who have acquired a sexually transmitted infection, including HIV, or who find themselves with an unplanned pregnancy.

Sexual health services are provided from specialist clinics, in each district, from GP Practices, community pharmacies, within schools and colleges, youth services and, where appropriate, in bespoke settings appropriate to the needs of the client.

Contraception

The under-18 conception rate fell by almost 50% since measurement began in 1998. There were 20.9 conceptions per 1,000 females aged 15-17 in 2012. This is the fourth lowest rate in the South West.

To contribute to this achievement Gloucestershire County Council commissions:

- Specialist contraception clinics within each district of the County.
- Weekly clinics delivered from every college site.
- Extended sexual health drop in sessions within some secondary schools.

- Emergency hormonal contraception provision from community pharmacy.
- Extended young people sexual health drop in services from targeted GP surgeries.
- A specialist teenage pregnancy midwifery service.
- A free condom distribution service to under 25's.
- Specialist sexual health support from the youth service.

Sexually Transmitted Infection and HIV

The trend of Herpes, Genital Warts and Gonorrhoea within Gloucestershire has remained in line with the picture nationally since the current method of data collection began in 2008.

Gloucestershire is part of the National Chlamydia Screening Programme (NCSP) which aims to achieve a rate of 2,300 positive diagnoses of Chlamydia for every 100,000 young people aged 15-24 living in the county. 22.4% of Gloucestershire 15-24 year olds were screened for Chlamydia in 2013. This is significantly lower than the national rate of 24.9%, and therefore an area on which we need to focus more attention. Source: Chlamydia Testing Activity Dataset, Public Health England

Gloucestershire has seen a year on year increase in the number of people living with HIV since 2002. In 2012 there were 341 people living with HIV with the increase made up of new diagnoses plus the movement of people in and out of county living.

As regards HIV, early work following the move of the public health team into the LA included a brief review of services currently commissioned within the authority. This led to a streamlined service being developed which brought prevention, testing, social care and carer support into a single unit of management. The tender was won by the Eddystone Trust, providers of specialised HIV support for over 25 years, who began delivering support on April 1st 2014. Eddystone offer services which are bespoke to the needs of each individual and early indications show the number of people accessing their services is increasing month on month.

Late diagnosis of HIV remains a concern for Gloucestershire with 52.5% of people receiving their diagnosis of HIV after the point treatment would normally have begun. Late HIV diagnosis is calculated on a rolling three year basis which, for Gloucestershire, has remained at the same level since 2009. Increased access to HIV testing and improved prevention and awareness initiatives as part of the new contract are expected to reduce levels of late diagnosis and give an improved quality and length of life to those with HIV.

The new approach with young people acknowledges natural curiosity and encourages openness, whilst promoting self respect. It addresses relationships and self-esteem as well as the physiological issues around sex. This work is carried out in schools and colleges across the County and gives young people access to drop in sessions to get help and advice. Call 0800 328 3508 for more information.

Tackling sexually transmitted infections (STIs) in young people

Gloucestershire County Council commissions a range of weekly drop in sessions at colleges across the county to give testing and advice on STIs and contraception. It operates a free condom services for under 25's. In addition, 21 schools and 16 GP surgeries offer extended support on STIs and relationships.

Another service available to under-25s is the C-card scheme. This is a way of ensuring that young people not only have access to contraception, but also have access to clear and reliable information to support making the right choices.

A joint project between NHS Gloucestershire and Gloucestershire County Council's Youth Support Service team helps under-25s with free contraception and sexual health advice. The scheme offers a safe 'space' for young people to talk about sexual health concerns with trained professionals and acts as a referral point to other contraception and sexual health services. Sessions include support on how to use condoms safely and advice on other sexual health services, including free Chlamydia testing.

To find out more about how to register for the C-card scheme or to find out where to receive help, visit www.sexhelpglos.nhs.uk

3.4 Public Health - Children

(Investment £1.918m)
Contact: Karen Pitney

Public Health Nursing (5 - 19 years)

The public health nursing service is available for all school aged children aged 5-19 across the county, whether they are in school, excluded or educated at home. Their responsibilities include safety and emotional wellbeing as well as physical health and immunisation.

Immunising children, measuring their height and weight, running drop-in clinics and teaching part of the PSHE (personal, social and health education) curriculum are amongst their contracted activities. This is a major area of overlap between public health and children's services in the Gloucestershire County Council commissioning network.

Gloucestershire has participated in a large annual pupil survey which gives rich data on need and response. This is featured in section 4.

Health Visiting (0 - 4 years)

Plans are being put in place, led by the Children's Services team, to take on commissioning responsibility for health visiting (pre-school children, 0-4 years) during 2015.

The team consists of 50 qualified nurses (36 whole time equivalents), a health and well-being team of 12 (eight whole time equivalents) who deliver school entry screening and the national child measurement programme along with health promotion and support. Immunisation is delivered by another specialist team of nurses.

Gloucestershire Healthy Living and Learning (GHLL)

Commissioned by Gloucestershire County Council, Gloucestershire Healthy Living and Learning (GHLL) helps schools and colleges support pupils to make healthy choices. The GHLL programme also helps teachers and tutors to identify pupils who need targeted, specialised help, and develops peer supporters from within the student body. Since its launch in July 2012 twenty schools have registered and reviewed their health and wellbeing provisions and 569 peer supporters have been trained.



“Contraception should be used on every conceivable occasion.” Spike Milligan

3.5 Tobacco control and smoking cessation

(Investment £1.49m)
Contact: Tracy Marshall

Tobacco Control

Does giving up smoking make a difference?

Yes!

- After 20 minutes pulse rate and blood pressure fall measurably.
- After 8 hours nicotine and carbon monoxide levels in blood fall by half and oxygen levels return to normal.
- After 24 hours carbon monoxide is eliminated from the body, lungs start to clear out mucus and other lung debris.
- After 48 hours there is no nicotine in the body. Ability to taste and smell is greatly improved.
- After 72 hours breathing is easier, bronchial tubes relax and energy levels increase.
- After 2-12 weeks circulation to limbs and organs improves.
- After 3 to 9 months coughs, wheezing and breathing problems improve as lung function improves by up to 10%.
- After 5 years risk of heart attacks falls to half that of someone still smoking.
- After 10 years risk of heart attacks falls to that of someone who has never smoked, and risk of lung cancer falls to half of that of a smoker.

Gloucestershire has around 84,000 smokers, which is around 2,000 smokers fewer than would be expected by the national average, but the aim is to get this figure to drop further year on year. Enhanced targets have been set for our smoking cessation providers for three groups; manual workers, pregnant mothers and people with long-term mental health issues. This is in an attempt to tackle inequalities in health driven by smoking-related diseases.

Half of all smokers die of a smoking-related disease.

Giving up doesn't just benefit smokers' health and finances, but also helps reduce pressure on the NHS and social care. Each long-term quitter is estimated to save the NHS £658.22 per year and last year the service helped 3,302 smokers

in the county quit. This could save the NHS over £2 million as well as the benefits to individuals and families.

Research evidence endorsed by NICE (National Institute for Health and Care Excellence) shows the best way to stop smoking for most people is to draw on support from a trained expert. The Quit shop in Southgate Street, Gloucester, and trained GPs and pharmacists, offer choice to those who want help. Since 2001, the Stop Smoking Service, GPs and pharmacies have provided support to 65,812 people and 36,485 of them have quit. Others may have quit under their own efforts, perhaps prompted by health promotion campaigns.

The county's hospitals help their patients to stop smoking on an opportunistic basis, offering nicotine replacement therapy (NCT) on the wards and referral on to the stop smoking service.

For more information on stopping smoking visit www.stopsmoking.glos.nhg.uk

Controlling illegal sales

To help combat illegal tobacco we are working with colleagues in trading standards to cut down on the amount of illegal tobacco available in the county. Not only is selling it illegal but often smokers don't know how much tar is in the product, or what other chemicals may have been added.

3.6 Weight and nutrition

(Investment £773k)
Contact: Tracy Marshall

There is overwhelming evidence of the costs of obesity to individuals, families and wider society. Yet, despite over a decade of local intervention to encourage healthy lifestyles, obesity levels have continued to rise, particularly among our most disadvantaged communities.

It is a complex issue influenced by many factors. While at an individual level the main causes are poor diet and sedentary lifestyles, there are also wider influences such as people's income; education; occupation and mental health.

The county rate of obesity has been steadily increasing in recent years in line with national trends. In Gloucestershire:

- 9.9% of 4-5 year olds are obese

- 17.5% of 10-11 year olds are obese
- 24.4% of adults are obese

Taking steps to tackle obesity is important because, it can lead to a number of serious and potentially life-threatening conditions, such as; type 2 diabetes, coronary heart disease and some types of cancer.

Obesity is identified as a priority area for action in the Gloucestershire the Health and Wellbeing strategy.

Health Exercise Nutrition for the Really Young (HENRY)

HENRY focuses on 0-5 year olds, enabling parents and carers to provide a healthy start for babies and young children and trains those within the early years' workforce to support families with young children at high risk of obesity.

In 2013/14 a total of nine training courses were delivered targeting areas with high levels of childhood obesity identified using National Child Measurement Programme (NCMP) data. By December 2013, 111 Public Health Nursing staff and 73 Children Centre staff had received HENRY Core Training. HENRY training will continue to be delivered and targeted in this way in 2014/15.

Figures from 2010 show that obesity costs NHS Gloucestershire £149.1 million. HENRY costs only £30,000.

Eat Better, Start Better

Our Eat Better, Start Better programme helps young children to eat well. The county council spent £60,000 to support children's centres to embed healthy eating and promote healthy foods.

Children start learning about food at a very early age. The messages they receive during this time lay the foundations for the choices they make about food as they grow up. With more than one in five children overweight or obese as they start their school reception year, it's never been more important to help them get a healthy start in life.

We're helping early years providers meet children's nutritional needs more consistently, and to help families with young children develop the cooking skills and confidence they need to cook and eat more healthily.

Breastfeeding peer support:

To increase and support breastfeeding up to six months the council commissions breastfeeding

peer supporters working on a one-to-one basis with women in areas with low breastfeeding rates. Peer supporters are linked to children's centres and support is provided by trained volunteer mothers who have had a positive experience of breastfeeding.

In 2013/14, 407 mothers were supported by the service. Of these, 97.5% initiated breastfeeding, and 58% were breastfeeding at six weeks - compared with the county data where 79.9% of mothers initiated breastfeeding and 51.5% were still breastfeeding at six weeks.

Tackling Adult obesity

Tier 2 Weight Management

In 2013/14 Slimming World was commissioned to provide 12-weeks of support to help people achieve 5% weight loss and encourage longer term adoption of a healthy lifestyle to sustain their weight loss. In the first year of the programme (September 2013-September 2014) 5,225 patients have been supported to lose weight, with 37% losing at least 5% of their body weight.

Healthy Eating Coaching

A pilot project is currently taking place working with staff in supported living settings for people with learning disabilities. Staff are offered free coaching sessions with a nutritional therapist to support them to help people with LD to make healthier eating choices. There are currently 20 coaching places available and sessions include:

- Menu planning and meal ideas
- Budgeting
- Practical cooking demonstrations

The pilot will be completed early in 2015 and an evaluation will inform future work.

"Health Trainers" are recruited from local communities and work with people that are at a greater risk of poor health. The service support adults who want to make a change towards a healthier lifestyle but are unlikely to make and maintain these changes without some help. They offer one-to-one support as well as working with groups and communities to develop and increase skills, knowledge and capacity within local communities and communities of interest.

3.7 NHS Health Checks

(Investment £817k)

Contact: Tracy Marshall, Sue Weaver

One of the legacies of the hand-over of public health from NHS to local authorities was the promise of free NHS health checks to those aged 40-74 who were otherwise fit and well.

Checks are aimed at those without a pre-existing condition and screens for circulatory and vascular risk factors. Those in the 40-74 age group without a pre-existing condition are sent a letter from their GP to invite them along.

By the end of September 2014, 33.6% of eligible people in Gloucestershire had been invited to an NHS Health Check as part of Public Health's measuring scheme from 2013-18. This means that Gloucestershire is ahead of schedule and significantly above the national invite rate of 28.3%.

Uptake is only 36.8% of invitees; significantly lower than the national uptake rate of 47.7%. (Source: *Public Health England NHS Health Checks Portal*)

Following the Health Check, the healthcare professional will discuss the results and give advice or treatment to lower risk of vascular disease.

For more information visit www.gloucestershire.gov.uk/nhshealthchecks

3.8 Healthy Ageing

(Investment £905k)
Contact: Diana Billingham

Healthy Ageing

Although people are living longer not everyone spends their later years in good health. The impact of previous and current lifestyle choices, experiences and wider social circumstances can result in a rise in the number of people with higher levels of health and social care needs. Similarly to the rest of the UK, Gloucestershire has an ageing population.

'Healthy Ageing' is about ensuring people enter later life in the best possible physical and mental health and wellbeing, able to maintain control and independence for as long as possible and live their lives with dignity and to their full potential. It is also about ensuring the resilience to cope with adversity and the chance to feel that they have a positive role in their local community. It is important

to harness the potential and opportunities that older people can offer as well as ensuring that the services and resources are available to allow people to maintain health and wellbeing.

The **Gloucestershire Village and Community Agents** are an excellent example of the type of service that we commission to provide information and support to people aged over 50 in their communities. The aims of the Village and Community Agents are to help older people feel more independent, secure, cared for and have a better quality of life and to promote local services and groups enabling the agents to provide clients with a community based solution where appropriate. There are 38 Agents working across the whole county.

More details can be found at Gloucestershire Village Agents www.villageagents.org.uk

Fuel poverty

In 2012, 8.9% of Gloucestershire households were classified as being in fuel poverty (more than 10% of household expenditure on heat and light). The distribution is fairly even across the county, with every district being slightly better than the national average of 10.4%.

Other determinants that influence our health and wellbeing are housing, employment and the environment we live in both built and natural. An example of a service we commission to improve the homes we live in is the **Warm and Well Fuel Poverty Advice Project**. Gloucestershire residents are facing the challenge of affordable warmth issues. The aim of the Warm and Well project is to provide advice and support, particularly to vulnerable households to reduce the occurrence of harms associated with fuel poverty and cold damp homes. We work in partnership with the six district councils and the voluntary and community sector to target those householders most at risk.

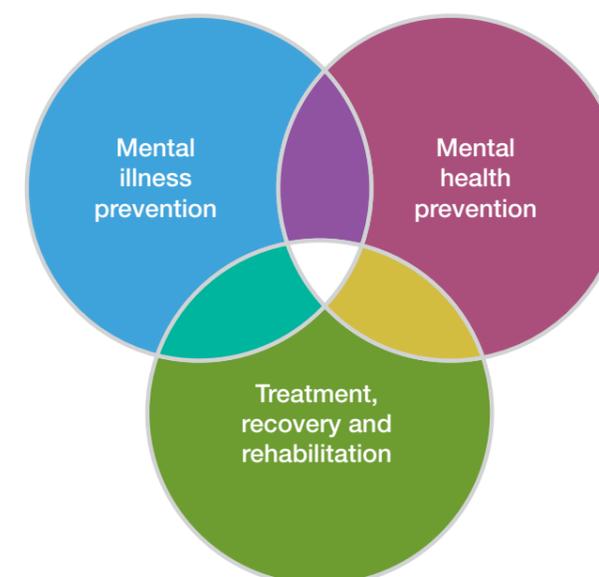
Warm and Well | Severn Wye Energy Agency
www.warmandwell.co.uk

Source: *Public Health Outcomes Framework and Department of Energy and Climate Change.*

3.9 Public Mental Health

Investment £228k)
Contact: Steve O'Neill

Public mental health focuses on wider prevention of mental illness and promotion of mental health across the life course. It also includes suicide (and self harm) prevention.



Mental illness is the largest single source of burden of disease in the UK. It not only has a human and social cost, but also an economic one, with costs in England amounting to £105 billion a year. The NHS in Gloucestershire spent an estimated £116,140,000 on mental health disorders in 2012/13 (11.7% of its total spend). Over three-quarters of psychiatric disorders develop below the age of 25.

The 2013/14 budget for Public Mental health was spent on the following:

MenTalk (£15,000): a programme delivered by Cheltenham Town Football Club through the medium of football. It is designed to:

- Encourage young men to discuss mental health issues
- Assist young men to seek help should they experience mental health problems
- Identify ways in which young men can improve their own mental health.

This programme was available to all secondary schools in Gloucestershire and an independent evaluation has shown it was successful at increasing the understanding amongst young men of mental health problems. It has also led to a more understanding attitude to those with mental health issues and a greater willingness of participants to talk about their own difficulties.

Peer mentoring (£35,000): a pilot programme aimed at pupils aged 15-19 years who may be experiencing emotional distress, including self harm and suicidal thoughts.

Work Programme Returners (£60,000): aims to improve the mental wellbeing and day-to-day functioning of those who are out of work and are at risk of poor mental wellbeing and mental ill health, due to economic inactivity.

ArtLift (£30,000 interim funding with additional funding from the CCG): a primary care based art intervention where health professionals refer NHS patients for a 10 week art programme, usually delivered in a primary care setting. Patients are referred for a range of reasons such as to reduce stress, anxiety or depression; to improve self-esteem or confidence; to increase social networks; alleviate symptom of chronic pain or illness; distract from behaviour related health issues and to improve overall wellbeing.

Volunteer Buddying (£20,000): this provides support for people who have had a diagnosis of psychosis. It enables them to engage in activities that improve their mental wellbeing, reduce isolation, improve physical activity levels, and engagement in purposeful activities.

Mental Health First Aid (MHFA) Training (£32,000): a training programme which equips people with the skills to provide "first aid" for mental health issues. The local offer consists of a two-day programme available to public and voluntary sector organisations and carers, a half-day 'lite' programme (suitable for line managers in the work place) and Youth MHFA which is specifically targeted at professionals in contact with children and young people.



Comments from attendees on mental health first aid training event

"The two day course has developed my confidence in working with all clients, family and friends and to understand many types of mental health issues"

"I am in my main job dealing with employees who have tried to complete suicide and other with a social phobia which I have only realised by attending the workshop"

"With a better perspective of my wife's mental health problems, I hope to be able to cope better with the domestic situation"

"It is quite important to realise that this group myself included have been trying to cope with a family member with mental health issues for quite long periods of time (myself for 15 years) the course was especially good because of the experiences of other courses members"

Applied Suicide Intervention Skills Training – ASIST (£21,720): a training programme for frontline staff that improves capacity for suicide prevention.

Self harm helpline (£50,000): a confidential helpline (telephone, text and online) service that provides listening support for people who are self harming, or friends or family. Local evaluation has shown that the service is effective in reducing the impulse to self harm and suicidal ideation.

Countywide mental health strategy implementation plan (£15,000 with additional funding from the CCG): the funding helped provide the infrastructural support for the development of an all-age implementation plan to support the mental health strategy approved by the Health and Wellbeing Board.

Other work undertaken during the year which focused on/impacted on public mental health includes:

- Health visiting and school nursing support to vulnerable families and school children. The health visiting service worked, amongst other things, to identify maternal and infant mental health needs and to provide appropriate advice,

intervention and onward referral. Health visitors also worked to support the emotional wellbeing of children in care. School nurses provided direct care, information and advice to vulnerable school children as well as support to teachers.

- Welfare advice in GP surgeries was piloted in four primary care sites in Gloucester. It aimed to increase the accessibility of welfare advice in areas of deprivation especially for those who would not usually access the service including people with mental ill health, disabilities and older people.
- Coordinating and supporting the work of the Gloucestershire Suicide Prevention Partnership Forum (GSPPF) and its members.
- Working with Samaritans, multi-storey car park operators, Gloucestershire Constabulary, British Transport Police, Survivors of Bereavement by Suicide and Network Rail to improve preventive activities and interventions around suicide 'hotspots' in the county.
- Working to support and drive forward the work of the Children's Safeguarding Board on suicides in children through a dedicated Children and Young People's Task and Finish sub-group of the GSPPF. Outcomes include:
 - Gloucestershire healthy Living and learning (GHLL) working with secondary school lead teachers, the police schools unit and Samaritans to produce a Key Stage 4 resource for teachers that helps them address the difficult subject of suicide in the young.
 - GCC safeguarding lead heads the work on a referral pathway for professionals regarding vulnerable children and young people. This pathway will now be aligned with work on reviewing the clinical pathways for self-harm (in accident and emergency as well as in Primary Care) being led by the Clinical Commissioning Group.
 - Promotion of the Samaritans' step-by-step service and their suicide prevention guides to schools and colleges, as well as establishing links with schools affected by suicide. The step-by-step service provides support following a suicide and helps with prevention of further incidents.

3.10 Health Protection

(Investment £14k)

(Special thanks to Dr Toyin Ejidokun of Public Health England for contribution to this section)

Contact: Sheema Rahman, Sarah Scott

Health protection seeks to prevent or reduce the harm caused by communicable diseases and minimise the health impact from environmental and outbreaks such as chemicals and radiation. This function is delivered by a range of organisations including Public Health England, Public Health in GCC and district councils.

Notifiable diseases are infectious diseases that registered medical practitioners have a statutory duty to notify to the 'proper officer' at their local council or the local health protection unit on suspicion in order that appropriate public health actions can be implemented to prevent further spread of disease. The table below details the types of notifiable diseases that occurred in Gloucestershire during 2013/14.

Gastrointestinal diseases, acute hepatitis A and hepatitis E affected a significant number of Gloucestershire residents. These infections can be prevented by practising good hand hygiene (washing hands thoroughly with soap and warm water) especially those who provide care to others

	Organisms / diseases	Number of (suspected) or confirmed cases
Gastrointestinal	Campylobacter	602
	Giardia	80
	Cryptosporidium	60
	Salmonella enteritidis	21
	Shigella	16
	Salmonella typhimurium	15
	E.coli O157	11
Respiratory	Scarlet fever	151
	Whooping cough	(128) 60
	Mumps	(112) 28
	Measles	(109) 18
	Tuberculosis	(54) 47
	Rubella	10
	Diphtheria	2
	Legionnaires disease	2
Hepatitis	Chickenpox	2
	Hepatitis C	84
	Hepatitis B	35
	Hepatitis E	12
Others	Acute hepatitis A	4
	PVL - Staphylococcal infection	35
	Meningococcal meningitis	6
	Pneumococcal meningitis	5
	Meningococcal septicaemia	2
	Viral meningitis	2
	Haemophilus influenza meningitis	1

Source: PHE

and persons who handle food. Special care should also be taken by those who visit farms particularly after contact with animals. Every effort should be made to ensure that food is cooked properly.

Scarlet fever is a mild childhood infection which occurs in cycles every four years and shows a seasonal pattern. An increase in cases of scarlet fever was observed in late February 2014. Rarely, the bacterium that causes it can also cause serious infections such as bacteraemia, necrotising fasciitis, pneumonia and meningitis. Scarlet fever is highly contagious with transmission occurring through direct inhalation of contaminated respiratory droplets or through environmental sources. The disease is controlled by exclusion, adequate infection control and hygiene practices.

Staphylococcus aureus (SA) is a germ that commonly lives on healthy skin. Some types produce a toxin called Panton-Valentine Leukocidin (PVL) which destroys white blood cells. The germ can cause harm if it gets an opportunity to enter the body through a cut or graze. PVL-SA causes boils or skin abscesses and occasionally more serious infections of the lungs, blood, joints and bones. PVL-SA can be picked up from skin-to-skin contact with someone who is already infected for example close family, during contact sports, or contact with an item or surface that has PVL-SA on it, for example shared gym equipment, razors or towels. The disease can be prevented by practising good hand and respiratory hygiene and ensuring that infected areas of the body are covered with clean, dry dressings or plasters.

Hepatitis B and C are blood borne viral infections spread mainly through contact with blood or body fluids from an infected person. There is a vaccine available for preventing hepatitis B disease but none for hepatitis C.

Measles, mumps and rubella (MMR): These are vaccine preventable diseases that are no longer common in the UK because of the effectiveness of the MMR vaccine. Children receive two doses of the combined MMR vaccine as part of the routine UK childhood immunisation schedule. To confirm the diagnosis of these diseases, a salivary test kit is often sent to the patient and tested in the laboratory. There were a number of cases of other vaccine preventable diseases, for example pertussis (whooping cough), pneumococcal and meningococcal meningitis. The numbers of these diseases are again much lower than in previous years due to the success of the vaccination programme implemented, the most recent being

the vaccination of pregnant women against pertussis.

Legionnaires disease is an uncommon form of community acquired pneumonia. The disease can be prevented by ensuring that water systems and those using water devices such as air conditioning systems do not harbour the legionella bacteria.

Tuberculosis is an infectious disease caused by Mycobacterium tuberculosis. It commonly affects the lungs, but can affect any part of the body. It is usually spread by coughs or sneezes, but is not highly contagious. It requires prolonged close contact to spread from one person to another. The most important part of controlling the disease is quickly identifying and treating those who already have the disease, to shorten their infection and to stop it being passed on.

Chickenpox is a highly infectious disease transmitted by personal contact or droplet spread. The disease can be more serious in adults, particularly pregnant women and those who smoke. Pregnant women appear to be at greatest risk late in the second or early in the third trimester. Those who are most at risk may need to be given immunoglobulin to prevent them becoming infected.

Action points

General practitioners should continue to notify and investigate all suspected cases of notifiable diseases such as measles, mumps and rubella so that diagnosis can be confirmed.

Health professionals involved in childhood immunisations should continue to work with parents to ensure that a high uptake for the vaccines is sustained.

Every opportunity should be used to reinforce the importance of good hand hygiene in preventing both gastrointestinal diseases as well as respiratory diseases such as coughs and colds.

During the past year (1 April 2013 to 31 March 2014), a total of 90 incidents were successfully managed in the Gloucestershire locality. The health protection team worked closely with Environmental and public health colleagues, NHS England, acute care and NHS Area Teams, to deliver an appropriate co-ordinated response to these incidents. The majority of the situations were in care homes (58%). Of these, 60% were suspected/confirmed Norovirus; 36% were respiratory tract infections/influenza like illnesses. We had one

outbreak of scabies and one of Pertussis. Other incidents were linked with schools, nurseries and other settings included:

- Three confirmed cases of measles at a school in the Forest of Dean
- A chlorine leak at a school in Cheltenham
- Ten cases of cryptosporidium linked to a farm park. Common factors were lamb feeding and the play area.
- Outbreak of food poisoning in attendees at a charity event. A total of 165 people attended the event and evidence suggested a 70% attack rate.
- Campylobacter outbreak in 30 out of 40 attendees of a wedding. The proprietors later accepted liability.
- Bovine tuberculosis in dogs. Two of the dogs with active TB were put down and all contacts were screened.
- A protracted multi-agency response to an exposure to a person who acquired TB at an office. Five of the six contacts screened had positive results suggesting latent TB. Cramped conditions in the office may have been a contributory factor.

The section below summarises some of the health protection activities of the GCC Public Health team:

Seasonal Flu

Flu is a viral infection. Symptoms are more severe and last longer than a common cold and include a sudden high temperature, headache and general aches and pains, tiredness and a sore throat. It can result in serious complications, such as

hospitalisation, disability and death, for older people, infants, pregnant women and people with certain underlying health conditions. In recognition of this each year vulnerable groups are offered a free flu vaccination. The viruses that cause flu differs from year to year therefore it is essential that those most vulnerable to the disease receive their vaccination every year. This vaccination programme is commissioned by NHS England with support from Gloucestershire County Council and Gloucestershire Clinical Commissioning Group. In 2013 the Public Health team worked alongside Adult Social Service to promote the uptake of the flu vaccination in front line social care staff. This joint working has continued into 2014 where a new delivery model using pre-paid vouchers and community pharmacies has been trialled.

In 2013 a flu vaccination programme was introduced for all children aged two and three years. This was extended in 2014 to include four year olds. The programme will continue to expand to include children up to the age of 16. Although seldom very ill with flu, children play a major part in its spread to more vulnerable groups, and that is the rationale for this policy.

Table 3.10.1 Uptake of flu vaccination by pre-school children in Gloucestershire.
Source: PHE

Indicator: Flu vaccine coverage	Gloucestershire - Sept 2013 - Dec 2014 (%)
Children: 2 years	50.0
Children: 3 years	46.3

Table 3.10.2 Flu vaccine uptake by the other at risk groups in Gloucestershire (where the programme has been running for longer).

Indicator:	Target (%)	Winter 2010/11 (%)	Winter 2011/12 (%)	Winter 2012/13 (%)	Winter 2013/14 (%)
Aged 65 and over	75.0	75.0	75.1	74.9	74.3
At risk, aged six months to under 65 years	None	53.6	54.5	53.0	52.3
Pregnant women	None	-	30.6	42.3	37.2

Measles and the MMR catch up campaign

On average there are five cases of measles a year in Gloucestershire, but in from January 2012 to April 2013 there were 83 confirmed cases. This mirrored a rise in cases seen across England and Wales. In response, an MMR catch up campaign was launched in April 2013. This focused on children aged 10 to 16 who might have missed MMR vaccinations. The GCC Public Health team worked closely with NHS England and Public Health England to deliver the vaccination campaign which ran from 1/9/2013 – 31/8/2014. Following the campaign 82% of 10-16 years olds had received the both MMR vaccinations. Work continues to promote MMR uptake in this group. The incidence of measles is falling again.

Screening and Immunisations

In April 2013 NHS England assumed commissioning responsibility for national screening and immunisation programmes. The Bath, Gloucestershire, Swindon and Wiltshire (BGSW) Area Team works closely with the GCC Public Health team to maximise the uptake of these programmes.

Gloucestershire's health services performed well during 2013/14 for all vaccinations offered to children aged up to two years old.

School aged immunisation programmes (HPV, school leaver booster and Men C booster) are provided by the school nursing service and as necessary by general practice. Provisional uptake for 2013/14 indicates that by June 2014 90.3% of all 12-13 yr old girls have received three doses of HPV. This is nearly 10% more than the uptake across England

During 2014 62% of Gloucestershire residents aged 65-74 took up the offer of bowel screening, exceeding the target of 60%.

The Breast Screening Programme invites all eligible women aged 50-70 years registered with a GP for mammographic (X-ray) screening every three years. During 2013/14 the round length defined as the percentage of eligible women whose first offered appointment is within 36 months of their previous screen dropped below the required target of 90%. This is due to unexpected staff absenteeism and has since been rectified.

The Cervical Screening Programme invites all eligible women registered with a GP aged between 25 to 64 years for a cervical screen every three

or five years (depending on age). Gloucestershire is consistently meeting the 80% target for the percentage of eligible women screened within five years

(Data sourced from NHSE AT Screening and Immunisations reports for the HP Assurance Group.)

Ebola

Ebola is a type of viral haemorrhagic fever spread through contact with bodily fluids from an infected person or animal (especially bats). There is no cure but the risk of spread can be prevented if front line health staff in the community take a good travel history, seek advice over the phone before moving the patient, follow personal infection control protection procedures and cleaning up properly afterwards.

The likelihood of catching Ebola in the UK remains very low.

The UK has had plans for dealing with Ebola and other viral haemorrhagic fevers for some years and since the outbreak in Africa these plans have been constantly revised. Public Health England (PHE) is leading this work on both a national and local level, working across the government and with the NHS.

At a local level we tested our Ebola plans with an exercise in October 2014, and have had monthly teleconferences since. This involves County Council, District Councils, Public Health England, NHS England, Police, Ministry of Defence, Gloucestershire Clinical Commissioning Group, Gloucestershire Hospitals Trust, Gloucestershire Care Services, SW Ambulance Trust and others such as schools or airports as required.

Further information on Ebola can be found at www.nhs.uk/Ebola

3.11 Active Together and Healthy Together

(Investment: £2,600,000)

Contact: Diana Billingham

The Active Together and Healthy Together grant schemes have the broad purpose of promoting the wellbeing of people of all ages by helping them to stay active and healthy through increased opportunities for community and locally based activities; "More people, more active, more often".

Active Together was launched in June 2014. It is a two-year programme, and around 30% of the fund was allocated by December. Under this scheme each councillor has discretion over £40,000 to encourage activity schemes in their patch, using local knowledge. A further £10,000 per councillor goes into a pooled fund called Healthy Together, which focuses on each district respectively, and aims to reduce the underlying causes of health inequality. The closing date for the first round of applications for the Healthy Together grant was 31 December 2014.

The grants help people to help themselves to create or extend opportunities for staying active and healthy in their neighbourhoods and localities. As well as improving health and wellbeing we anticipate it should also bring people together and strengthen communities.

An evaluation has been commissioned from the University of Gloucester who have experience in the techniques of "Social Return on Investment". They will help us assess effectiveness and value for money. Part of the exercise is to share the learning and help our staff develop their own competencies in evaluative techniques.

For more details go to the GCC website

Active Together grants - Gloucestershire County Council www.gloucestershire.gov.uk/activetogether

Healthy Together Grant Fund - Gloucestershire County Council www.gloucestershire.gov.uk/healthytogether

3.12 What have we learned from our first year in the local authority?

With regard to public mental health, the children's and families teams in the council already do a lot of work around preventing mental illness and promoting mental wellbeing in vulnerable children and families. This includes early years and parenting support for families whose children may be at risk of developing mental health problems, intensive support for families with drug and substance misuse problems and support for children in care, amongst others. There is the potential for public health to further enhance these and other areas of work, especially when one considers the enormous opportunity presented by

prevention, early intervention in the life course and targeted support with regard to development of mental health disorders in the community.

A snapshot of health and wellbeing in Gloucestershire

4.1 What do you know about health in Gloucestershire? Try this simple quiz:

1) What is the average male and female life expectancy in Gloucestershire (2010-12)?

- a) 70 years (men) and 75 years (women)
- b) 80 years (men) and 84 years (women)
- c) 82 years (men) and 81 years (women)

Answer

The correct answer is b. Men living in Gloucestershire can expect to live for an average of 80 years, while the average woman can expect to live to 84 years. Life expectancy for both men and women in Gloucestershire is higher than the national average.

2) On average, how much longer will men living in the least deprived parts of the county live compared to men living in the most deprived areas (2010-12)?

- a) Three and a half years
- b) Six years
- c) Almost eight years.

Answer

The correct answer is c. Life expectancy is 7.9 years lower for men in the most deprived areas of Gloucestershire than the least deprived areas. This is known as the 'life expectancy gap'. The life expectancy gap for women is 5.8 years.

A man living in Gloucester for example can expect to live to 78 years, significantly below the national average, compared to a life expectancy of 81.2 years for a man living in the Cotswolds.

3) In the 2011 census, what percentage of Gloucestershire residents rated their health as 'good' or 'very good'?

- a) 75%
- b) 90%
- c) 83%

Answer

The correct answer is c. A total of 82.8% of residents in the County felt they were in good or very good health, higher than the national average of 81.2%. The proportion feeling they were in bad or very bad health was 4.5%, lower than the national average of 5.6%.

4) What are the main causes of early deaths in Gloucestershire; that is deaths under the age of 75?

Answer

The main causes of premature deaths in Gloucestershire are cancer, cardiovascular diseases (such as heart disease and stroke) and respiratory diseases.

The good news is that early deaths in the county from these conditions have been steadily falling over the last decade and are below the national average.

Lifestyle choices can make a major difference to your chance of developing diseases like cancer and heart disease. The four main risk factors are smoking, poor diet and lack of physical activity (which can lead to weight gain) and excess alcohol.

5) Caring for people with long term conditions, such as high blood pressure, diabetes, and asthma, accounts for £7 out of every £10 spent on health and care in England.

In Gloucestershire and England as whole, one of the most prevalent long term conditions is diabetes; but how many people were registered as having diabetes in the county in 2012/13?

- a) 21,356
- b) 25,670
- c) 30,682

Answer

The correct answer is c. A total of 30,682 people in Gloucestershire were registered with their GP as having diabetes in 2012/13. This figure is likely to be an underestimation, as not everyone with the condition will have been diagnosed.

Diabetes rates are projected to increase nationally and locally. The increase is largely caused by increasing rates of obesity; one of the main risk factors for type 2 diabetes. Diabetes is associated with an increased risk of a range of other chronic health conditions, including cardiovascular disease, blindness, amputation, kidney disease and depression.

6) Obesity is a key risk factor for a range of health conditions. What proportion of adults was estimated to be obese in the county in 2012?

- a) 23%
- b) 10%
- c) 16%

Answer

The correct answer is a; 22.9% of adults in Gloucestershire are estimated to be obese - a little over one in five, which is similar to the national average.

Childhood obesity is also a growing cause for concern nationally and locally.

In 2012/13, almost one in four of the county's children was overweight or obese when they started school, which is higher than the national average.

7) Smoking rates have been steadily falling over the last ten years, but how many adults in Gloucestershire are estimated to still smoke (2013)?

- a) 10%
- b) 16%
- c) 25%

Answer

The correct answer is b. The proportion of adults who smoke in Gloucestershire was 16% in 2013; better than the national average.

8) How many adults in the county were admitted to hospital with an alcohol related condition in 2012/13?

- a) 2,150
- b) 5,678
- c) 3,934

Answer

The correct answer is c. A total of 3,934 people were admitted to hospital with an alcohol related condition in 2012/13. The rate of admissions in the county is similar to the national average. Nationally, alcohol misuse is estimated to cost the NHS £3.5 billion a year.

9) Gloucestershire carries out a regular survey of its school pupils to help understand more about their health and wellbeing. In the most recent survey, what proportion of secondary school pupils reported that they don't drink alcohol, or don't often drink alcohol?

- a) 70.7%
- b) 56.2%
- c) 33.1 %

Answer

The correct answer is a. Over seven out of ten secondary school pupils in Gloucestershire now report they that don't drink, or seldom drink alcohol. This is up from 46.3% in 2006.

10) Your emotional wellbeing can have a major impact on your health. In a 2012/13 national survey of wellbeing, what proportion of Gloucestershire residents recorded a 'low happiness' score?

- a) 5%
- b) 19%
- c) 12%

Answer

The correct answer is 12% reporting a low happiness score in the county. Evidence shows that people with higher wellbeing have lower rates of illness, recover more quickly, and generally have better physical and mental health. Evidence also shows that as many as one in four of us will have a mental health issue at some point in our lifetime.

4.2 Joint Strategic Needs Assessment

The Gloucestershire Joint Strategic Needs Assessment was the subject of a major review during 2014, and the recommendations are now being put into place.

In summary, the main elements of that review were:

A new, “off the shelf” software platform to replace the older bespoke system that was expensive to maintain. The JSNA would be open to internal and public access. Procurement of that system is now well in hand. Costs will be met from the public health grant.

The SharePoint platform for the JSNA will be decommissioned but the council’s existing SharePoint capability will be rolled out across Commissioning to enable confidential document sharing within GCC and potentially between organisations.

A JSNA summary document will be produced annually – ‘Understanding Gloucestershire: A Summary Joint Strategic Needs Assessment’. This will not be a huge document but will point to the JSNA website for relevant background data (including qualitative data). The first such summary is due in June 2015.

An Information and Analysis Group will be set up, reporting into the Strategic Implementation Group of the Gloucestershire Health and Wellbeing Board. It will oversee a rolling programme of analyses, “deep dives” and quality checks. The CCG have requested strong CCG/Primary Care representation on this group. Topics for analysis may come from the Board or the SIG may recommend to the Board that it would like more information on a topic.

Any substantial needs assessment in a topic area will bring together numerical, narrative and published evidence, and not rely on a single approach alone.

There will also be an asset-based approach to need, looking not just at deficits but at the capabilities of individuals and communities to draw on their own resources to achieve results that were more appropriate, enabling, sustainable and affordable.

4.3 Health and Wellbeing Board

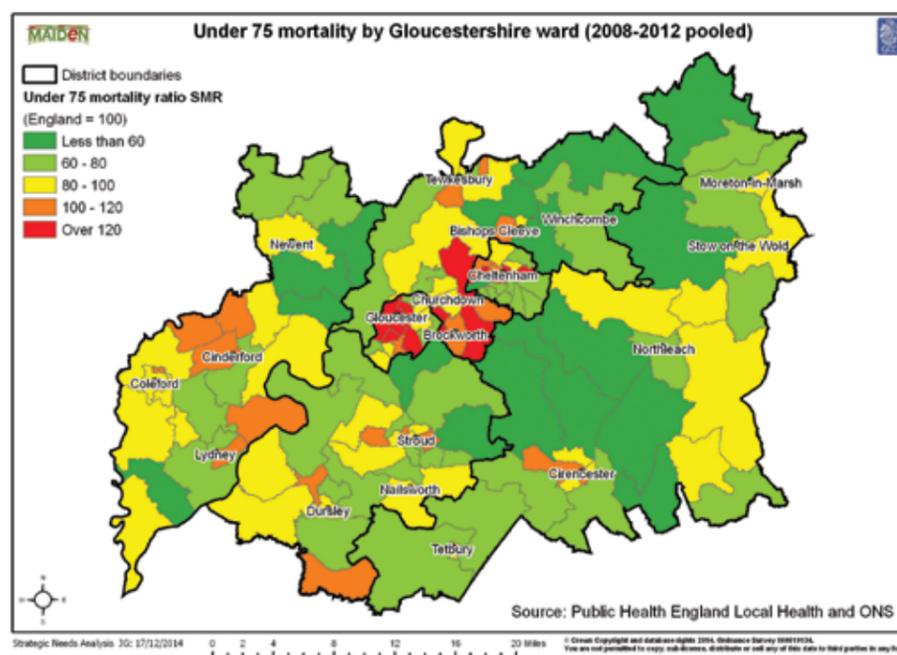
Gloucestershire’s health and wellbeing priorities are:

1. Reducing obesity
2. Reducing the harm caused by alcohol
3. Improving mental health
4. Improving health and wellbeing into older age
5. Tackling health inequalities.

The ways in which the first four items are being tackled were addressed in chapter 3. Inequalities are a major theme of the JSNA, and deserve a special mention.

For example: inequalities in “dying before our time”

The map below takes the age of 75 years as an arbitrary cut-off for “dying before one’s time”. Five years’ data are aggregated to give the stability of greater numbers. Each electoral ward is coloured according to whether it is above (poor mortality rates) or below (favourable mortality rate) the rate



for England. Inequality is wide, and the “hot spots” are in Gloucester and Cheltenham. Even at this level there are concealed pockets of poor health within electoral wards and there is no substitute for local knowledge.

Evidence from the business world suggests that sponsors are a key to the success or failure of projects. At its July 2014 meeting the GHWB agreed to the suggestion that each Action Card should have a Board level Sponsor.

Responsibilities of the sponsor include:

- To provide board level accountability for development and delivery of their specified Joint Health and Wellbeing Delivery Plan Action Card.
- To liaise with the commissioning lead for their topic on a regular basis to receive briefings and provide clear direction for the strategy and how it links with the overall goals of the Health and Wellbeing Board.
- To report progress to the Board on a six monthly basis.
- To alert the Board to any risks to delivery of the specified Action Card as early as possible.
- To champion the Card at Executive level to secure buy-in from stakeholders and partners, using their influence to overcome challenges and remove obstacles.

The role of the Commissioning Lead is to:

- Lead on the development of the Action Card in their specified area
- Work with partners to influence and agree their specific contributions to delivering the outcomes on the card
- Identify the relevant local strategies and delivery partnerships/groups to help deliver outcomes as effectively and efficiently as possible, being clear about who is accountable for delivery of tasks
- Identify and report any gaps/duplications in countywide strategies, action plans and work-streams in their specified area
- Put in place effective mechanisms to monitor progress, report achievement of milestones and any changes to delivery of the strategy in their area
- Report on an agreed basis to the Sponsor and brief them appropriately when performance reports are due to Board
- Liaise with the card Sponsor and agree:
 - The time commitment each person can expect

from the other and how often you will meet

- The frequency and nature of reports that the Sponsor will expect from the Commissioning Lead
- How the Sponsor expects the Commissioning Lead to deal with problems and issues and when they will be escalated to the Sponsor.

Provider Engagement Plan

The Health and Wellbeing Board has always had a responsibility to engage with Providers and other stakeholders in Gloucestershire but at the beginning of October Jeremy Hunt wrote to Boards and major healthcare Providers to stress the importance of working together and engaging in an effective, timely and meaningful way.

Gloucestershire had already started the process of developing a provider engagement plan and following the successful Provider Engagement event held in July 2014 at Kingsholm Stadium the Board has agreed a programme of events for 2015. Three meetings are planned with the whole Board invited to attend alongside health and social care providers. Topics for the meetings in 2015 will be as follows:

February 26th 2015 – Understanding the JSNA

- To develop a shared understanding of ‘Joint Strategic Needs Assessment’ in Gloucestershire, including both the process and the product
- To agree a systematic process for engaging those who provide front-line services in shaping the understanding of “needs” and “assets” in the Gloucestershire population.

September 10th 2015 – Reshaping Our Offer (with Providers)

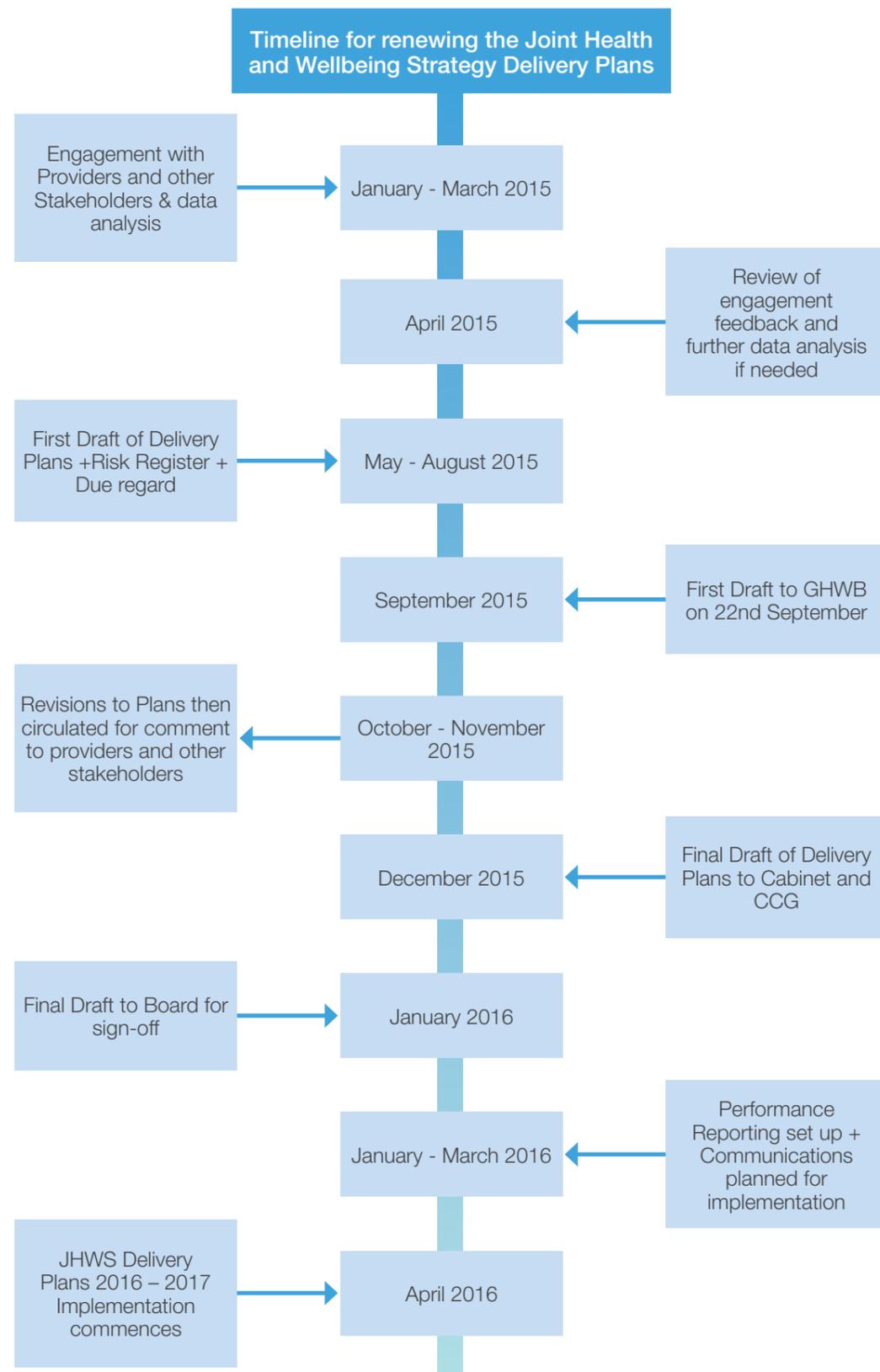
- Building on February’s JSNA session, to take stock together of the opportunities and constraints of the new health and social care landscape in Gloucestershire
- To develop a clearer view of what we mean by “shift to a community setting”, “earlier interventions” and “social capital”.

November 5th 2015 – Evaluation (with Providers)

- To understand what we mean by “evaluation”, “outcomes”, “user experience”, “Well-being” and “value for money”, and the role of providers in demonstrating progress.
- To explore how we can develop an evaluative, entrepreneurial, learning culture

Invitations have been circulated directly to Providers on our distribution list and via partners who hold databases or distribute newsletters to colleagues such as the Voluntary and Community Services Alliance, Healthwatch, and Local Medical

Committee. Regular communication and an opportunity for providers to shape the agendas of the above sessions is important if we are to keep people engaged.



5

Looking forward into 2014/15 and beyond

5.1

What are the main duties for the year ahead?

The following is a summary of the draft business plan and its associated risk register for public health, based on seven main categories.

Corporate public health offer

- Developing a delivery plan that supports the priorities within the Health & Wellbeing Strategy and ensures that public health responsibilities under the Health & Social Care Act 2012 are fully embedded into council business.
- Leading the production and publication of the Joint Strategic Needs Assessment
- Supporting the Gloucestershire Health and Wellbeing Board, its Strategic Implementation Group and its outreach programme to providers of health and social care.
- Supporting the work of Gloucestershire Clinical Commissioning Group
- Supporting the transfer of child health commissioning responsibilities from the NHS.
- Contributing to assessment (up front) and evaluation (post hoc) of health impact and effect on inequalities of any decision of the County Council or District Councils.
- Maintaining the professional competencies of public health staff.

Finance and value

- Reviewing public health services and contracts to ensure that public health investment has the maximum possible impact on public health outcomes.

Health protection and safeguarding

- Providing assurance that robust procedures are in place to provide appropriate public health population level advice in the event of a major incident, that infectious and chemical hazards are minimised, and to reduce risks from healthcare-acquired infections.

Information governance

- Improving information sharing arrangements to ensure that necessary public health data sets and performance indicators are available, up to date and secure.

Mandated and legal responsibilities

- Consolidating the capability and capacity of the public health team to ensure that functions mandated under the terms of the public health grant, and other discretionary services, can continue to be delivered.
- Delivering obligations under the memorandum of understanding with the Clinical Commissioning Group.

Performance

- Conducting regular performance monitoring of contracts and maintaining relationships with providers to ensure that activity and quality standards are met, and that early action is taken where targets are in danger of not being met.

Quality and safety

- Establishing a robust clinical governance framework for all public health commissioning to ensure that all professional standards are maintained and services are safe and of good quality.

5.2

How might public health shape up to meet the new opportunities?

Health needs are multi-faceted, and to really understand and deal with them a number of perspectives have to be taken. It is like confronting an unusual object from an unfamiliar angle and having to walk all round it to work out what it really is.

There is a danger in taking too simplistic a view, for example simply looking from a medical model, sociological approach or personal experience. We need to bring as many perspectives as possible to bear.

There are many ways in which the 'offer' of the public health team can be shaped, but we are looking at three main headings for business planning purposes; age, place and need.

5.2.1 Age

Why age? This relates to stages of life. Everybody falls into an age category, so it means no individual is overlooked. Age is a major determinant of the need for services, whether that is health, social care, housing, education or employment. We can predict that the numbers of people in each age group will rise or fall by different amounts in the years ahead, and ought to plan our investment and interventions accordingly.

The three main groups are: children and young people, adults, and older people. These each break down in pairs, leaving us with six principal categories:

Children and young people

0-4 years - pre-school children.

Needs include health visiting, screening and immunisations, making the best start in life.

“Starting well” - getting ready for school

5-19 years school age children, school leavers, further education and training.

Needs include school nursing, child measurement, immunisation, educational attainment,

“Developing well” - getting ready for adulthood

Adults

20-44 - young working age

Needs include family planning, occupational health, health promotion, career development, employment, leisure and housing.

“Living well” - getting ready for parenthood and sustainable work-life balance.

45- 64 older working age

Needs include health checks, rising incidence of life-style associated diseases, premature mortality, employment (including retraining if redundancy strikes).

“Working well” - getting ready for active retirement

Older people

65-84 early retirement age

Needs include rising demand for health care, warmth, safeguarding, active older age, companionship, independent living.

“Ageing well” - getting ready for a well-managed death at a place of their choosing.

85+ old age

Needs as for 65-84, but with higher degrees of dependency with rising age, aiming at staying at home or a community setting with minimum admissions to hospital.

“Celebrating life”. Dying is the final common step in every personal journey. We do it only once, so we should do it well.

The public health team is mapping its current resource deployment against these six age groups with a view to tracking and refining investment in each group so as to be explicit about “fair shares” and to maximise health outcomes.

When this work is complete it will be available on the Joint Strategic Needs Assessment website.

5.2.2 Place

Why place?

Public health has been described as “the study of denominators”. This makes reference to the importance of understanding groups of individuals by where they live, their characteristics and their environment, and not just the individuals themselves.

There are essentially two ways of looking at populations. The first is based on resident population – where they live. In Gloucestershire there are six districts, made up of 142 electoral wards and 373 “lower super output areas” (LSOA). The LSOA is the smallest residential population building block for public health denominators – any smaller than that and there is a risk of identifying individuals.

The other way of building population profiles is by registered population – which GP practice they are registered with. There are 83 GP practices in Gloucestershire. Practice populations overlap in terms of where the people live, (sometimes even across county boundaries), but are useful in understanding health data such as trends or inequalities in diagnosis, prescribing, use of hospitals and health outcomes.

We know that inequalities exist between different localities:

- inequalities in the causes of ill health,
- inequalities in travel times to services,
- inequalities in quality of services, and inequalities in measurable health outcomes, to name a few.

We know that environmental factors, both indoors and outdoors, have a profound effect on health and wellbeing.

We also know that people identify with localities and that certain organisations such as district councils, GP surgeries, hospitals, towns and villages have a formal responsibility for a defined place or catchment population.

For these reasons, in addition to offering public health support to stages of life we also want to identify with local areas.

The obvious way to align this is by district council, which also maps closely to how the clinical commissioning groups are clustered, so this is what we will do. (The Cotswolds district is divided into north and south for CCG purposes.)

5.2.3 Need (for health or social care)

Why need?

A simple definition of “need” for health or social care is: “The ability to benefit from a health or social care intervention, where benefit is a measurable change attributable to that intervention.”

The public health team was handed down primary responsibility for certain need groups when it was created. Examples include drug and alcohol dependency, smoking, sexual health and obesity.

The Clinical Commissioning Group with whom we work divides its population’s needs by clinical programme groups, such as respiratory, musculoskeletal and vision (based on the chapters of the international classification of diseases).

The local authority recognises certain disability groups such as physical, sensory and learning difficulty.

Describing the work of the public health team by need for health or social care is important because it relates most closely to services. It is our intention

that in time every such service will be underpinned by a needs assessment and subjected to systematic monitoring and evaluation.

5.2.4 By all three categories simultaneously: age, place and need

Imagine a Rubik’s cube with its three dimensions, and the challenge of lining up the colours.

The three categories described above are the facets by which we build up a rounded picture of need and response.

Imagine the four-year old girl in Stroud with dental decay; the 18-year old boy in Tewkesbury with heroin addiction; the 45 year man in Cheltenham with a heart attack; the 78 year old woman in Gloucester with dementia, the 30 year old man in the Forest of Dean who needs to re-train for employment, and the 85 year old terminally ill woman in the Cotswolds who needs palliative care at home, and so on. They all fall into all three categories simultaneously: age, place and need.

In our upcoming business plan, part of the GCC “meeting the challenge” initiative, we will describe our business and allocate indicative budgets to all three dimensions.

Our joint strategic needs assessments will also tell the story of need in all three categories.

5.2.5 Need, demand and supply in caring services

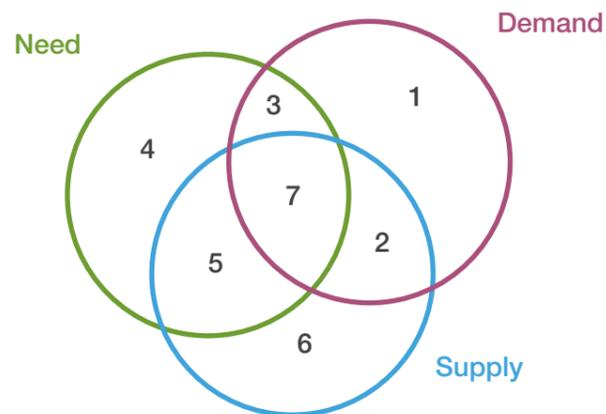
(Based on a model by Rafferty J and Stevens A. DH, May 1990)

Think of the commissioning challenge as three circles, usually of different sizes, that overlap imperfectly. The commissioning challenge is to get a better degree of overlap between all three.

“Need” is the eligibility for the service as defined by commissioners, based on the ability to achieve measurable benefit, sometimes following national standards, guidelines or published evidence.

“Demand” is what people ask for or their caring professional refers them for.

“Supply” is what is provided and budgeted for in the local area.



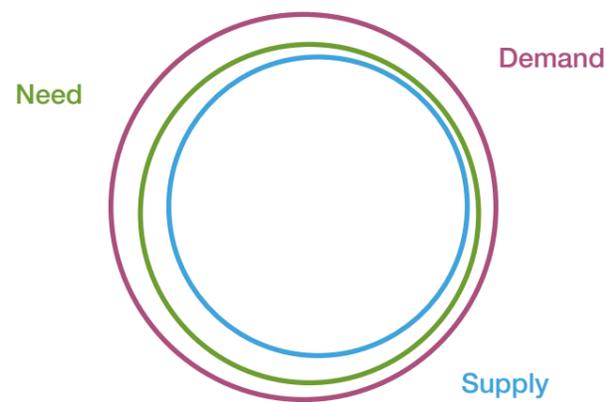
Key to numbers

1. Demand does not meet criteria of need, so is not supplied (e.g. antibiotics for sore throat). Action: public and patient information to manage expectation appropriately
2. Demand does not meet need criteria but is supplied (e.g. elective surgery performed outside of agreed guidelines). Action: professional education so as not to waste scarce resources where the need criteria are not met
3. Needed service is demanded but not supplied (e.g. patient access is inappropriately denied, or there is a waiting list). Action: professional education about eligibility and/or increased capacity
4. Needed services are neither demanded nor supplied (e.g. unsuspected and undiagnosed high blood cholesterol). Action: Case finding, screening, disease management registers, public and professional awareness campaigns
5. Needed service is supplied without patient having to demand (e.g. immunisation, screening, services to vulnerable people). Action: proactive outreach in the community.
6. Resources are supplied without need or demand (e.g. wasted medicines and spare

capacity in hospitals). Action: continual drive to eliminate such waste and spare capacity.

7. Needed services are demanded and supplied – this is the ideal position and overall aim of commissioning.

This is where we want to be:



There is still not a perfect fit, there never will be, but the picture is much better than where it began.

In order to get this better fit we need to address each of the numbered stages on the previous page.

Managing demand is chiefly about managing expectation.

Expectation is best managed if need and entitlement are clearly expressed and there is an honest and open discussion about the resources available.

Where there are significant areas of unmet need it may be necessary to generate awareness and raise demand. Demand management does not mean reducing demand: it means channelling it to equate most closely with need. Examples of where demand may need to go up are screening, immunisation and health checks where the service is available but uptake is less than optimal – meaning a loss of benefit and a waste of resources.

One of the objectives of commissioning is to achieve “equity of marginal met need.” This is where no-one who is without a service has a greater need (ability to benefit) than anyone receiving a service.

6

Summary of main questions and ideas

The future is not what it used to be! Expectations and national policies can change.

The future may not be evenly distributed! We may need local solutions for local problems.

Some aspects of the future may be here already! Not everything has to change – we may need to keep doing what we do well.

The future is not an accident! We are not passive victims of external forces – there is a great deal we can do for ourselves.

residents and of the Clinical Commissioning Group to its patients.

6.2

Where is it possible to intervene for greater health and wellbeing?

- With individuals – lifestyle, aspiration, opportunity, addictive behaviours, health care needs
- With families and households – family nutrition, activities, domestic violence, poverty, parental role models; health visitors, social workers, GPs, volunteers
- Wider social networks – healthy schools, workplaces, clubs, communities; village agents, community safety officers, health promotion advisors, teachers, librarians

6.1

A shift in expectations

Table 6.1 looks at the shift in values and approaches that will shape our future. These are a simplification of complex cultural changes between the old dispensation and the new. They are shared here to shape the new offer of the Council to its

Table 6.1

Old dispensation	New dispensation
Services provided largely reactively according to demand	Services provided proactively for need, seeking out unmet need and shaping realistic expectations
Starts by asking “What do you need”. In that way was sometimes unintentionally patronising or promoted undue dependence	Starts by asking “what can you do?” Recognises and respects the inherent resources of individuals and communities and builds resilience for those who are able to meet their own needs with help, and provides a safety net for those who are unable
Clients and patients are passive recipients of the state’s benevolence, with professional carers calling the shots	Clients and patients are active participants in their own care, with professional carers advising on choices
Focus on entitlements	Focus on responsibilities
Professionals working in rigid hierarchies (with the patient or client at the bottom)	Professionals working in networks, where any node in the network might be dominant at any point: doctors, nurses, social workers, patients, etc all have equal status.
Hospitals are the pivot of the local health and wellbeing economy	Community and domiciliary services, including health and social care, are the pivots of the local health and wellbeing economy
Challenge met by new investment	Challenge met by transformation – since there is little or no new money change is driven by drawing more heavily on community social capital

- With large organisations and local government: hospitals, businesses, Councils, armed forces and police.
- With national government – national policies on health, welfare, work and pensions, defence, transport and agriculture.

6.3 How might we intervene? A ladder of intervention

This checklist is ladder of escalating assertiveness of intervention.

In general, our offer should start at the lowest effective rung on the ladder.

- Information – signposting in public places, leaflets, on-line joint strategic needs assessments, public web sites, press releases, campaigns, special event days
- Training and enablement - pre-school, school age, colleges, employers
- Support and services – getting alongside and helping
- Incentives – payments or vouchers? There is a small but growing evidence base for incentive schemes and behavioural change, for example encouraging children to read and new mothers to breast feed – such incentives may have a place in future plans.
- Sanctions – fines, penalties, withdrawal of benefits, delays in surgery while patients lose weight or quit smoking?
- Enforcement – greater use of existing regulatory powers, licensing, trading standards, hygiene laws?

6.4 Whose responsibility is it to intervene, and when?

- People - (public, patients) – public health is everybody's business.
- Policy makers - (national, local)
- Payers - (Commissioners at CCG, GCC, Public Health)
- Providers – GPs, hospital and community trusts, adult social services, children's services, voluntary sector, private sector, leisure and outdoor sectors

6.5 How can we promote innovation and learning?

- A culture from the top that encourages it
- Management to make it happen
- Governance to keep it safe
- Evaluation to assess its efficacy and value for money
- Dissemination to share the learning

6.6 Conclusion

The Health and Social Care Act of 2012 transferred responsibility for the specialist public health function from the NHS to Local Authorities.

The definition of Public Health is: 'the science and art of promoting and protecting health and well-being, preventing ill-health and prolonging life through the organised efforts of society'.

This report is an account of the first full year of the work of the public health team and the deployment of the public health grant. It describes both the science and art of public health and emphasises the need for organised efforts of society. It contains some ideas for the way ahead.

The public health team looks forward to making an ever greater contribution to health and wellbeing each year, in support of members, officers and the wider partnerships.

There is a particularly strong overlap with the work of the Clinical Commissioning Group and closer integration on investment, intervention and evaluation with them and the other partners on the Health and Wellbeing Board.

