

Improving the public's health

Local government delivers

Foreword

After almost six years, I hugely admire the way council leaders, cabinet members, chief executives, directors of public health and their teams remain full of commitment and inventiveness, despite the financial barriers they face. The data we present here demonstrates that the local authority delivery of public health is effective, accountable, efficient and offers great value for money.

Good public health, drawing imaginatively on all of local government's functions, can make a real, large-scale difference to: promoting the independence of people with long-term chronic conditions; preventing ill health and therefore to reducing pressures on social care and the NHS; improving people's lives and wellbeing and reducing health inequalities.

Public health teams, working with a 'health in all policies' approach across councils, are tackling persistent problems like adult and childhood obesity, mental illness, alcohol and drug misuse, sexually transmitted infections and the health impact of isolation and loneliness in old age, as well as addressing some of the serious health inequalities that still exist within and between communities. Despite these challenges, the changes to public health over the last six years should be seen as an exemplar of public sector reform.

Good practice from individual councils shows what potential there is for public health, if properly resourced, to make inroads into improving health and wellbeing, and to do it efficiently. We have, on a number of areas, delivered better outcomes at less cost than the NHS did when they controlled public health.

There is no silver bullet for England's main public health challenges, the immediate causes of which remain tobacco use, poor diet, mental health, physical inactivity and substance misuse. Each is driven by a complex web of socioeconomic circumstances that the NHS alone cannot address. But with comprehensive strategies we are making a difference as we have outlined in this report. Teenage conception rates have plummeted, and youth smoking and drinking rates are lower than they've been for decades. The NHS alone cannot deliver improvements in population health. They need what local authorities do to meet their objectives.

The reward of thriving early years for our children, improved incomes for the low paid, healthy and productive ageing, good quality work opportunities and high-quality places is at the core of the local government mission. The challenge for local councils is to now break the generational cycle of disadvantage that drives health inequalities. There is growing evidence that intervening in the first 1,000 days of a child's life can make a difference over their whole lifetime.

The rationale for a local government lead in public health is unchanged: that the greatest impacts on health are the circumstances in which we live, employment, education, environment and the effects of the social gradient of health, that is, equality or the lack of it. Local government can certainly impact more on these factors than the NHS.

As always with any change, some embrace it, some resist and many wait and see. After initial reluctance, many in public health are responding positively to the opportunity to influence population health.

However, despite all the excellent work, there have been significant reductions in the resources available for public health work. Councils' public health grant funding is being cut by £531 million in cash terms between 2015/16 and 2019/2020. Councils and their public health teams have put a brave face on the compromises they have had to make, working with their local NHS and voluntary sector, sharing public health initiatives and sometimes even public health teams across councils, reorganising in an attempt to achieve more with less.

They have also taken some decisions that the NHS simply could not or would not make. Significant modernisation of sexual health services, for example, have coped with the substantial increase in demand for services despite a reduction in funding. The same can be said for health visiting: outcomes have held up while funding has reduced. Local government relationships with providers and partners have helped achieve this.

The recognition that this was absolutely the right decision and that our confidence in local leaders was well placed was confirmed by the Health Select Committee in its report on the new public health system post-2013, in which local government was endorsed as the best home for the local leadership of the public's health.

More local, joined up and innovative ways of working are also inherently linked to the need for better fiscal discipline, and this is likely to continue. The way that we use our money cannot be constrained by history and what has been done before. Nor can we afford to experiment. We need to be led by experience and evidence of what works.

Of course, there remains an important role for national policy making but this cannot be a substitute for local leadership and local responsibility for improving the health of local people. It is right that those decisions are being made locally as this is where the action really happens.

Councillor Ian Hudspeth

Chairman, LGA Community Wellbeing Board

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Introduction

Public health – although it may be less visible to members of the public than hospitals and GPs – is absolutely crucial to improving individual and population health, reducing health inequalities and the future sustainability of the NHS and social care.

The public health challenges remain. As a society, people are living longer with life expectancy in England now reaching 79.6 years for men and 83.2 for women and we're healthier at every age group than ever before. However, inequalities persist and in the richest areas people enjoy 19 more years in good health than those in the poorest areas.¹

The relocation of public health to local authorities in England has been largely positive, allowing public health to become integrated into all policies and to take account of the wider determinants of health. This view was supported by the Health Select Committee in their 'Inquiry into public health post 2013'.²

The transfer of responsibility for public health coincided with reducing council budgets, but we have a strong track record of doing more with less. To ensure councils can effectively support the population in the future, partners need to work together to transform the way services are delivered.

This means doing things differently – not just becoming more efficient. We have proven experience of reshaping services and we understand that sometimes you need to invest to save.

Our greatest health challenges, for example, non-communicable diseases, health inequities and inequalities, poor air quality and spiralling health care costs, are highly complex and often linked through the social determinants of health.

One government sector alone will not have all the tools, knowledge or capacity, let alone the budget, to address this complexity.

For this report we have analysed the Public Health Outcomes Data, spend data held by the Ministry of Housing, Communities and Local Government (MHCLG) and other information held by Public Health England (PHE), and highlighted for local government where we have seen an improvement in delivery or in health outcomes. We know there is more work to be done to make sure improvements are consistent across all councils and that the data presented here should not mask the areas where we have seen a worsening in health outcomes and in performance.

Summary

- Data from Public Health England's spend and outcome tool (SPOT) demonstrates that a number of key health outcomes have improved since responsibility for public health transferred to local authorities, despite the spend in several areas falling, primarily due to government reductions to local authority budgets.
- Improved outcomes include reducing premature deaths, reducing new cases of sexually transmitted infections and a reduction in adult smoking prevalence. Other public health challenges have increased, however, including childhood obesity (which councils have prioritised and diverted additional resources to tackle) and the prevalence of depression.

- Ninety-eight per cent of adults were able to access drug treatment services within three weeks, and 100 per cent of children. Eighty-two per cent of first interventions had zero days waiting time.
- Spend per resident on public health is over three times higher in England's most deprived upper tier local authorities than in the least deprived, reflecting the poorer health status of its population. Even in the area of greatest need in the country spend per resident on public health in 2017 was less than a fifth of the combined spend per resident on children's and adults' social care.
- There has been considerable improvement, despite councils nationally having their funding cut by 49 per cent in real terms, between 2010/11 and 2017/18 and at the same time as increased demographic pressures and national policy changes.
- Data from Public Health England's Public Health Profiles show that, despite spending reductions, several key health outcomes have improved since responsibility for local public health transferred from the NHS to councils in 2013.
- The public health outcomes framework (PHOF) tracks 112 health indicators. In the last six years 80 per cent of those have been level or improving.

The move in 2013 of public health to local authorities

In April 2013, the responsibility and funding for many public health services were transferred from the NHS to councils. This included the transfer of funding and commissioning for sexual health services and services for drug or alcohol treatment. In 2015, responsibility for 0-5 public health services such as health visiting transferred across to local government.

Bringing public health back into local government was never a 'drag and drop' exercise. It was, and continues to be, about building a new and enhanced locally-led 21st century public health service, where innovation is fostered and promoted, supported by the expertise of professionals and key partners.

Local authorities have a statutory duty to improve the health of their populations. Councils are best placed to embed the health and wellbeing agenda within their local communities across all the policies for which they are responsible.

The transfer of public health from the NHS to local government remains one of the most significant extensions of local government powers and duties in decades. It has created huge opportunities for local authorities to make a stronger impact on improving the health of local communities and helped to re-frame public health to a social, rather than medical model of health and wellbeing.

The range of functions for which local councils are responsible, the fact that these functions are designed to serve all the people in an area and their responsibilities for the youngest, oldest and most vulnerable members of society, means that more or less everything councils do can make a difference

to people's health. This goes far beyond their specific public health and social care responsibilities – education, housing, leisure, economic development, environmental health, trading standards, etc all have a role to play.

Councils report that in some areas they inherited huge geographical inequities, a lack of service for some communities and poor facilities needing modernisation. This is because, in many parts of the country, public health was seen as the 'Cinderella service' of the NHS, operating as an add-on to their main business of treating sickness.

There was too much reliance on top-down targets that limited local initiative. Too many different organisations with a public health remit with confused, rather than clarified, core public health messages. It became clear very quickly, that public health services would have benefited from greater scrutiny by commissioners and the drive to offer value for money to the taxpayer. The net result was a system which did not deliver the step change in public health outcomes that the country needs or secure the common understanding that health is about much more than just hospitals and GPs.

What the data tells us

The findings on outcomes and outputs across key elements of the public health ring-fenced grant are summarised over the next pages. They demonstrate that the relocation of public health to local authorities in England has been largely successful, allowing public health to become integrated into many policies and importantly to take account of the wider determinants of health.

If you look at the public health outcomes for the nation, the trajectory is as good as, if not slightly better, than under the previous NHS arrangements.

The public health outcomes framework (PHOF) tracks 164 indicators. In the last six years 80 per cent of those have been level or improving. There are areas that we are concerned about, but the overall picture is of continuing improvements in health. We know that making a positive difference can be a long process and many of these indicators will take years to change.

In 2017/18 101 indicators either improved or showed no significant change, which is 76.5 per cent of indicators that can be tested for improvement.

	Overarching indicators	Wider determinants	Health improvement	Health Protection	Healthcare public health and premature mortality	Total
Improved since previous year	3	12	22	5	8	50
No significant change since previous year	11	7	16	4	13	51
Worsened since previous year	0	5	7	12	7	31
Not possible to compare	2	5	14	3	1	25
Not possible to judge if an increase/decrease is an improvement	0	6	1	0	0	7
Total	16	35	60	24	29	164
Number that have improved or stayed the same	14	19	38	9	21	101
Total where improvement can be compared	14	24	45	21	28	132
% that have improved or stayed the same	100%	79.2%	84.4%	42.9%	75%	76.5%

Source: Public Health England – PHOF Fingertips

Total public health spend: reducing premature mortality

- In 2017, the median spend on public health per resident in upper tier councils in England was £68.83 (an increase of around £18 since 2015 – the spend data for 2015 does not include children’s 0-5 services, the responsibility for which transferred to local authorities in October 2015).
- Between 2011-13 and 2014-16, rates of premature deaths from all causes, cancer, and cardiovascular disease in England fell steadily.
- Life expectancy at birth in England has increased in recent decades and provisional data for 2017 show that it has reached 79.6 years for males and 83.2 years for females. This is an increase of 0.1 years, since 2016, for both males and females. Male life expectancy has increased faster than that for females and the gap in life expectancy is now less than four years, whereas in 1981 it was six years.³
- Sexually transmitted infection (STI) testing and treatment: attendances up, new diagnoses down.

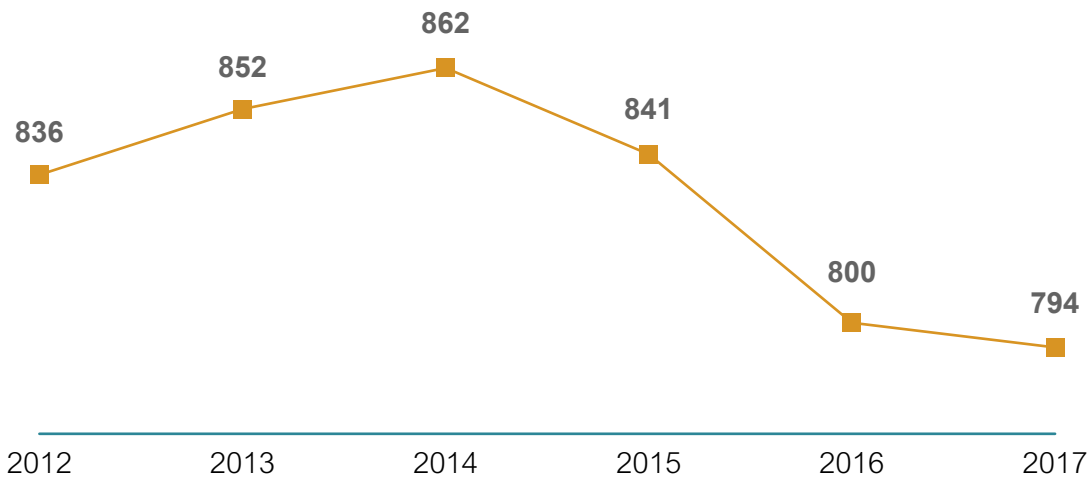
Sexually transmitted infection (STI) testing and treatment: attendances up, new diagnoses down

- In 2017, the median spend per resident in upper tier councils in England on STI testing and treatment was £5.66 (a reduction of £0.74 since 2015) and the median spend on sexual health prevention work was £0.81 (a reduction of £0.13 since 2015).
- Between 2012 and 2017, the rate of diagnoses for new STIs in England (excluding chlamydia in under 25 year olds) fell from 836 per 100,000 population to 794 per 100,000 population.
- The total number of new STI diagnoses in England fell slightly from 423,352 in 2016

to 422,147 in 2017. The total number of sexual health screens (tests for chlamydia, gonorrhoea, syphilis and HIV) has risen 18 per cent during this time, from 1,513,288 in 2013 to 1,778,306 in 2017.

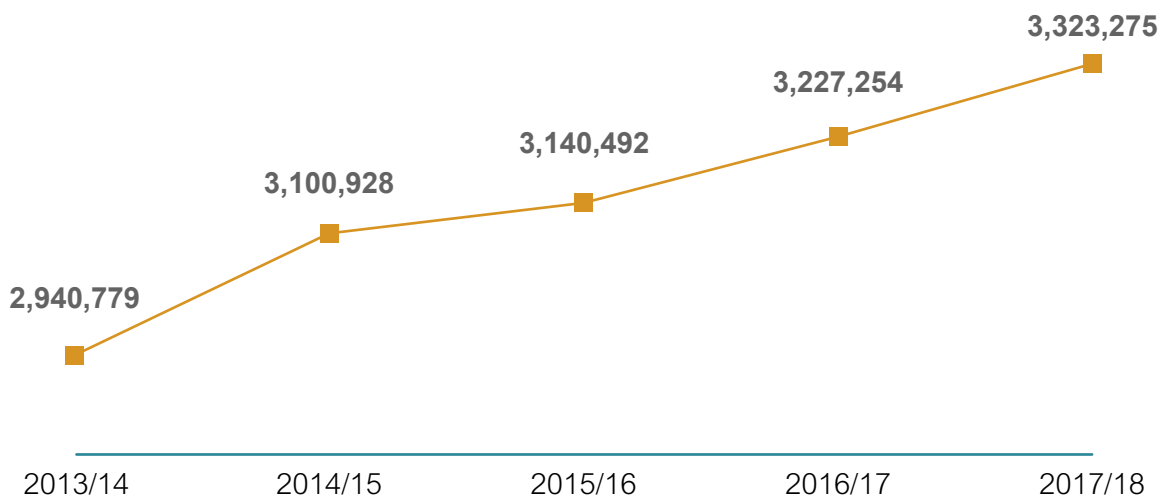
- The conception rate in teenagers has dropped by 23 per cent from 2013/14. Abortion and maternity rates are both declining in this age group. Rates are at the lowest level since record keeping began in the late 1960s. In 2016, there were an estimated 862,785 conceptions to women of all ages, compared with 876,934 in 2015, a decrease of 1.6 per cent.
- Addressing teenage pregnancy can save money, with £4 saved in welfare costs for every £1 spent. Furthermore every young mother returning to education, employment and training saves agencies £4,500 a year. For every child prevented from going into care, social services would save on average £65,000 a year.
- Latest figures show there were 3,323,275 attendances at sexual health clinics in England in 2017, up 13 per cent on the 2,940,779 attendances in 2013.
- The progress made in supporting people with HIV, enabling them to live independent, fulfilling lives and the fact that it no longer has the clear trajectory of decline to death which it once did, is a major public health success story.
- The report ‘Progress towards ending the HIV epidemic in the United Kingdom 2018’⁴ includes estimates which suggest that in 2017, 92 per cent of people living with HIV in the UK have been diagnosed, 98 per cent of those diagnosed were on treatment, and 97 per cent of those on treatment were virally suppressed.
- We do, however, accept that none of us should be complacent. Councils contributed to new HIV diagnoses amongst men who have sex with men falling by 17 per cent in England and a 28 per cent reduction since 2015. This saves the NHS a conservatively estimated £33 million in lifetime treatment costs. Last year NHS England spent £630 million on HIV treatment.

New STI diagnosis (excluding chlamydia) aged <25 per 100,000

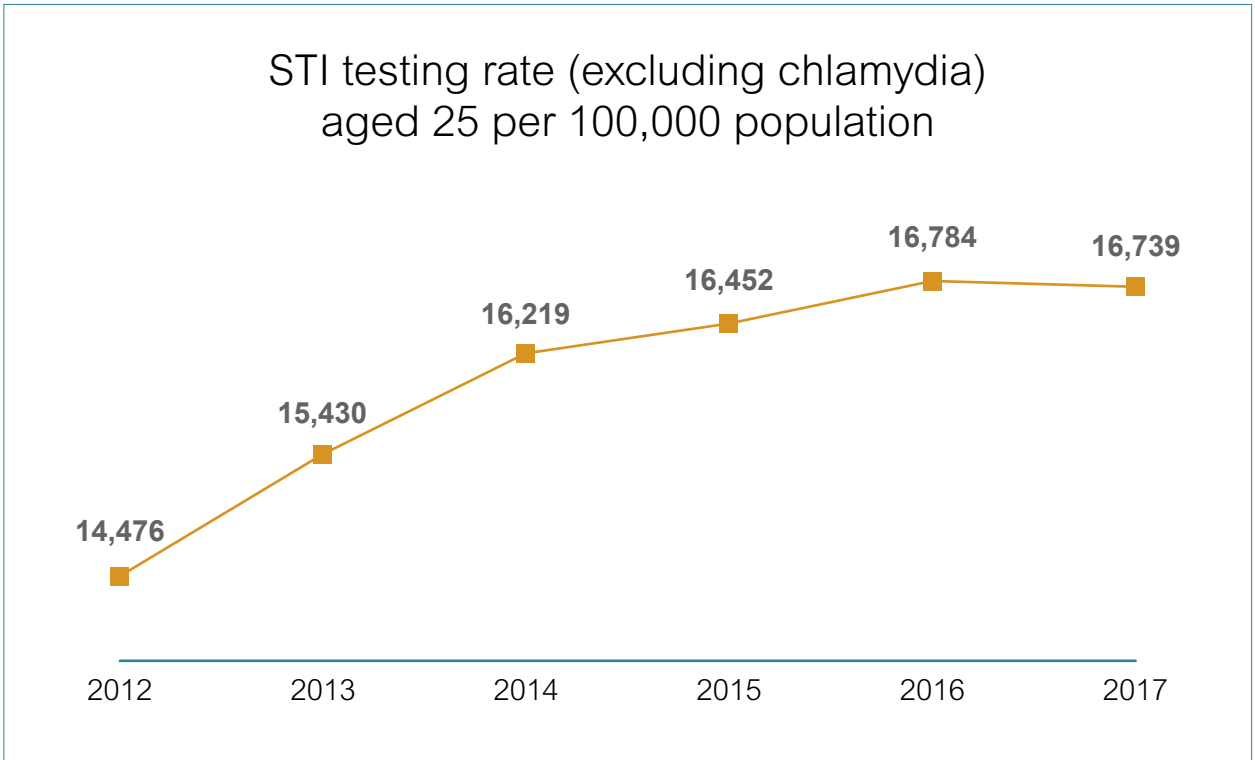


Data source: Public Health England

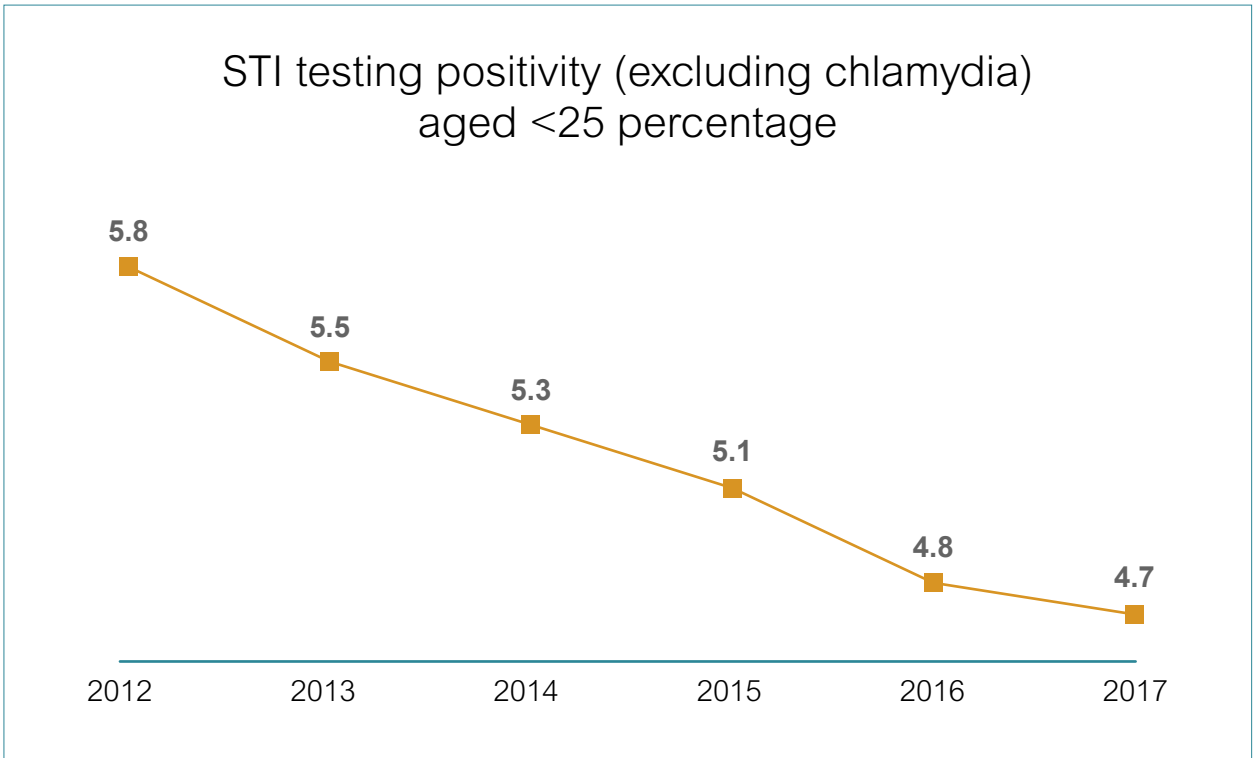
Total number of attendances at sexual health services 2013-17



Data source: Public Health England

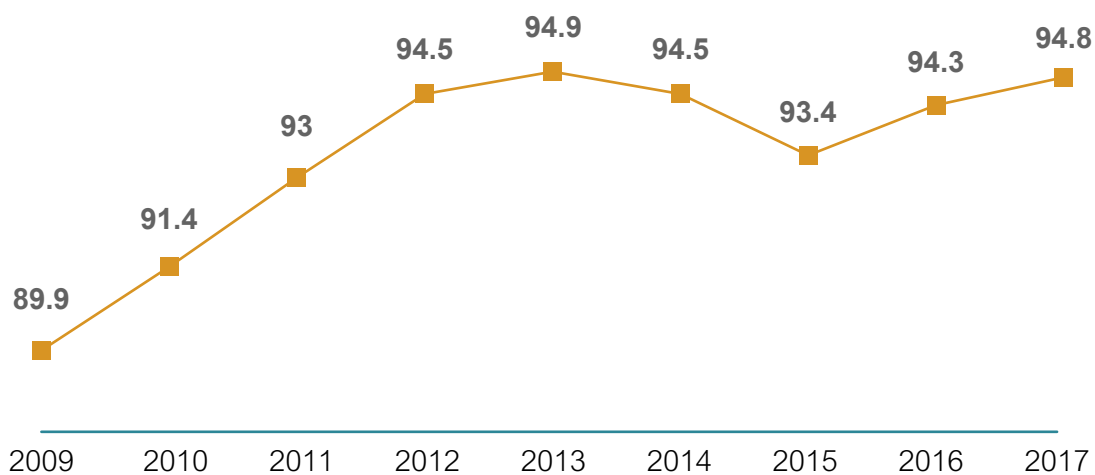


Data source: Public Health England



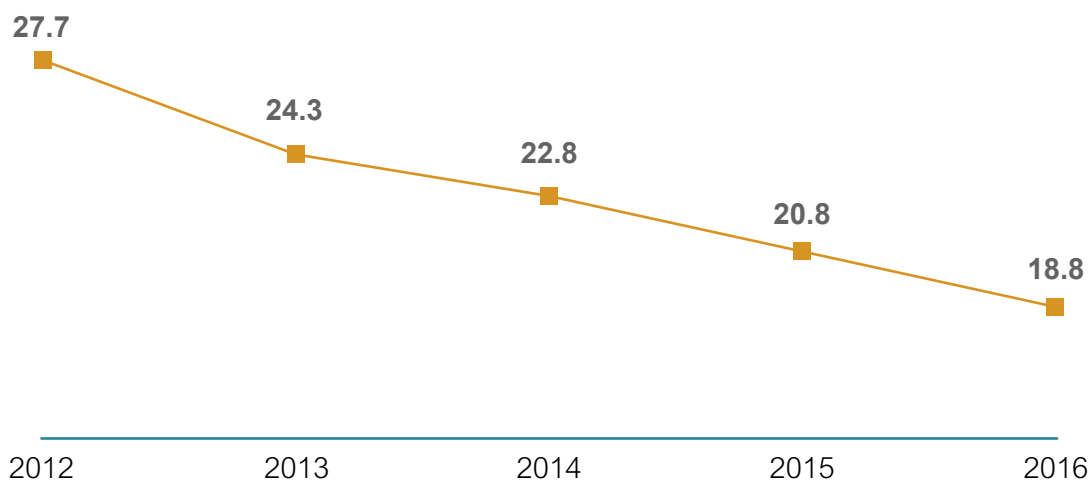
Data source: Public Health England

HIV testing uptake, MSM (per cent)

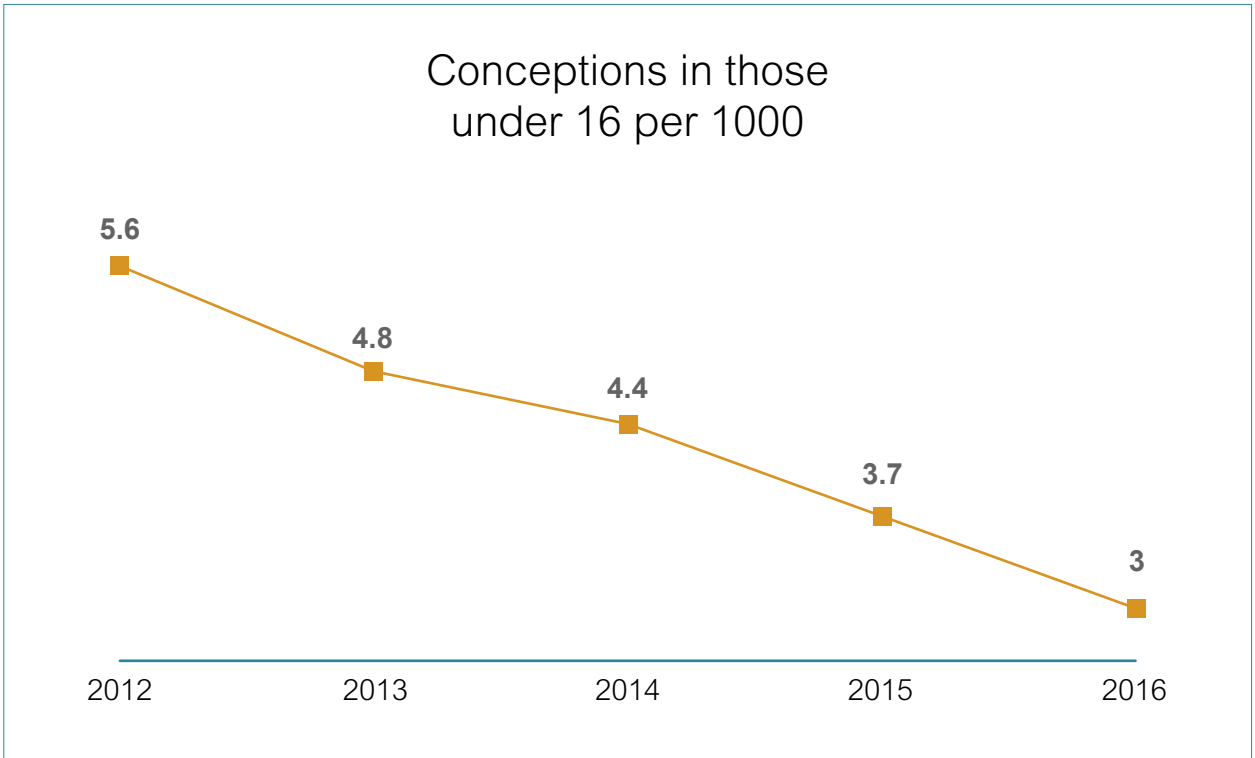


Data source: Public Health England

Under 18 conceptions per 1000



Data source: Public Health England

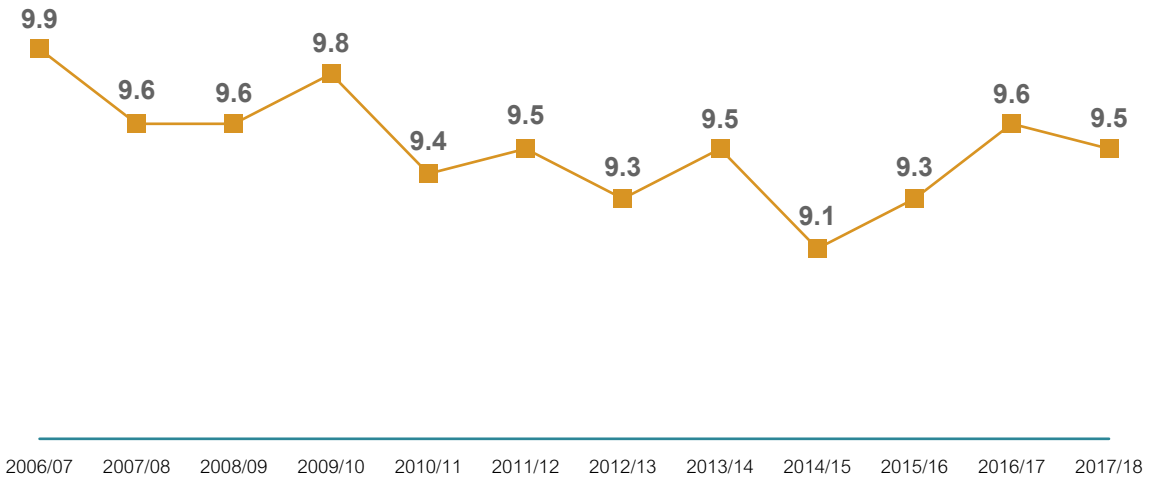


Data source: Public Health England

Childhood obesity: more children measured than ever

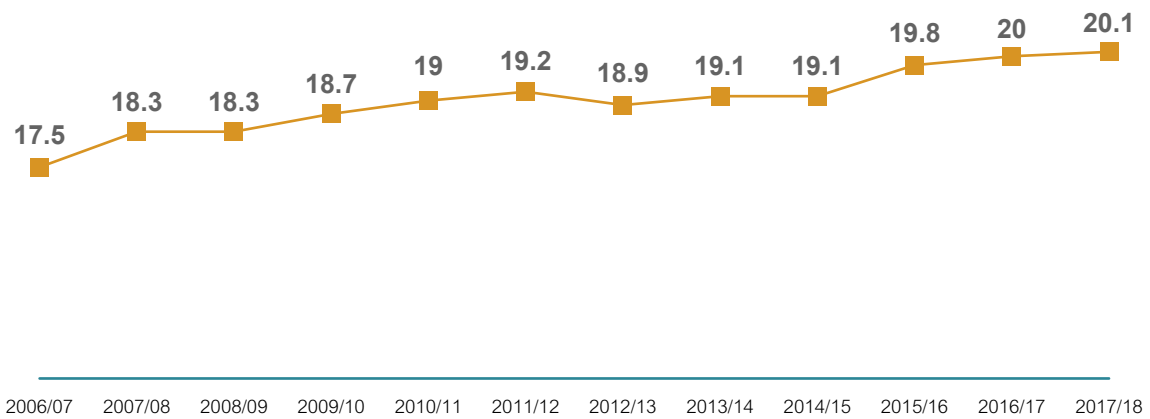
- In 2017 the median spend per resident in upper tier councils in England on the National Child Measurement Programme (NCMP) was £0.17 and on tackling childhood obesity it was £0.54 (a reduction of £0.04 and an increase of £0.10 respectively since 2015).
- Local authority commissioned services measured more children than at any time in the last ten years, at less cost than the NHS did, and put more money than the NHS did into tackling child obesity.
- Between 2012/13 and 2017/18 the proportion of Year 6 children in England who were obese rose from 18.9 per cent to 20.1 per cent. It has been rising since 2011.
- More children were measured in 2017/18 than at any other time in its 10 year history with over 1.18 million children in Reception and Year 6 combined. Of all eligible children 95 per cent were measured in the previous year. Councils spent £20.2 million delivering the NCMP last year around £1.3 million less than the previous year.
- The rate of childhood obesity has remained largely steady in England over the last 10 years. Clearly there is still more that needs to be done to tackle one of the most important public health challenges of our time. Over a longer time period, obesity prevalence is lower for Reception year compared to 2006/07, but it is higher for Year 6 compared to 2009/10.

Obese children (aged 4-5) proportion per cent



Data source: Public Health England – NCMP

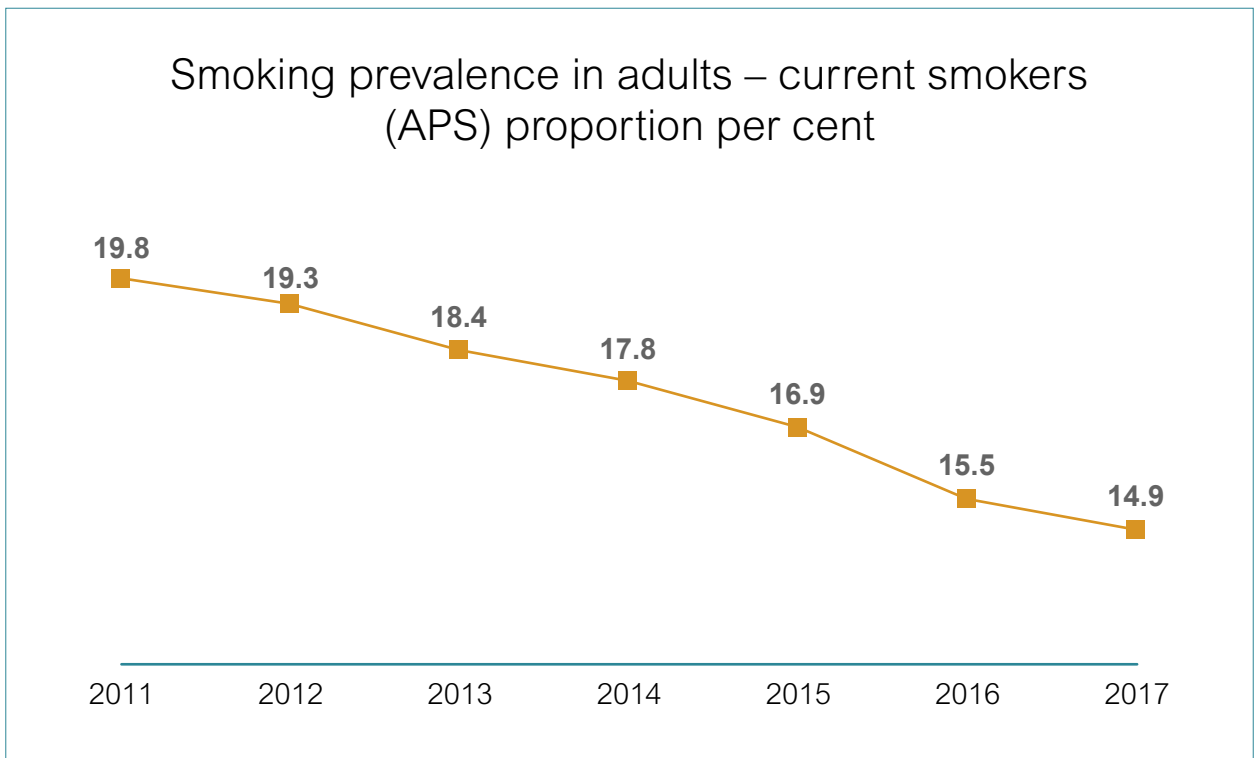
Obese children (aged 10-11) proportion per cent



Data source: Public Health England – NCMP

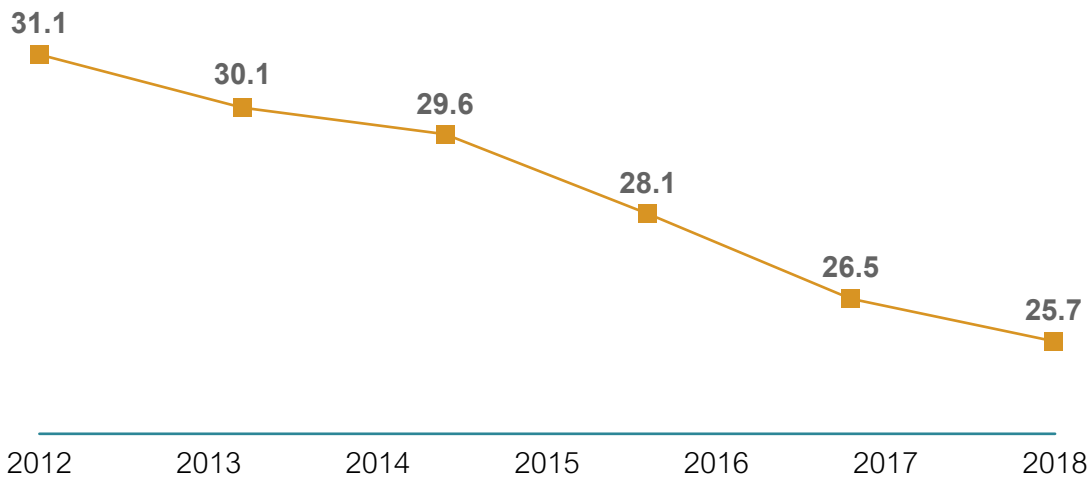
Smoking prevalence continues to reduce

- In 2017, the median spend on stop smoking services and interventions per resident in upper tier councils in England was £1.65 (a reduction of £0.55 since 2015).
- Between 2012 and 2017, the prevalence of smoking among adults in England fell from 19.3 per cent to 14.9 per cent. Time series analysis suggests that if this trend continues it will reduce to between 8.5 per cent and 11.7 per cent by 2023.
- Smoking prevalence in England dipped below 15 per cent in 2017. That makes 6.1 million smokers in England, one million fewer than in 2014.
- Councils are re-evaluating what they do on smoking cessation and tobacco control and how to be more effective, for example, reaching out to smokers with the greatest need such as routine and manual workers, pregnant smokers and those with mental illness.
- The overall number of adults smoking tobacco cigarettes in England fell by around 1.6 million to 6.1 million between 2011 and 2017.
- Smoking at the time of delivery has declined in recent years, with 13.6 per cent of women smoking at the time of delivery in the financial year 2010 to 2011, falling to 10.8 per cent in the financial year 2017 to 2018.
- Since 2013 a growing number of councils have introduced integrated wellbeing services as part of efforts to deliver cost effective preventative services. An integrated wellness service that offers a holistic approach (alcohol, weight, physical inactivity) are increasingly valued by service users and allow them to address complex issues simultaneously.
- NICE research suggests that stop smoking services are cost-effective with a return on investment of £2.36 for every £1 spent over a ten year period. This is a multi-sector return on investment (ROI) combining NHS and social care savings and gains resulting from increases in productivity.



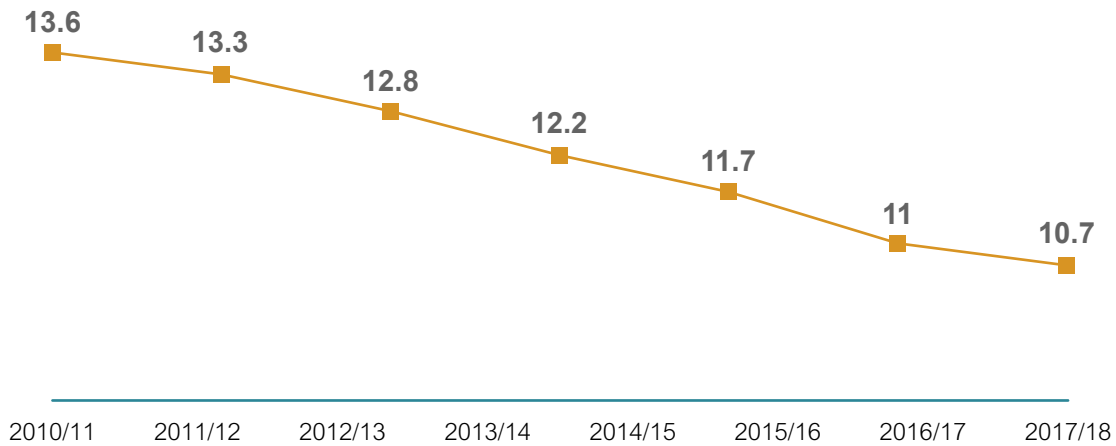
Data source: Public Health England

Smoking prevalence: routine and manual occupations – proportion per cent



Data source: Public Health England

Smoking status at time of delivery – proportion per cent pregnant women

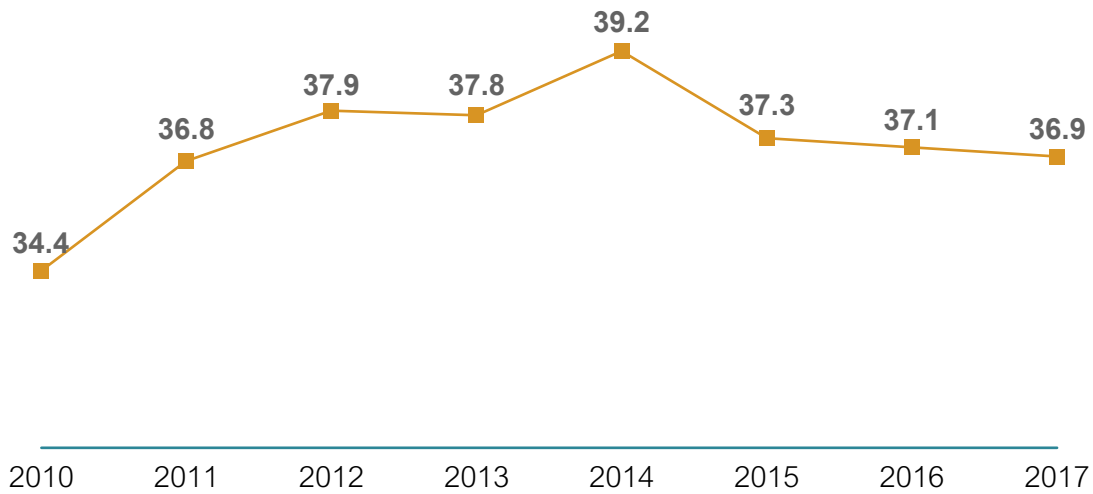


Data source: Public Health England

Drug misuse: treatment services performing highly

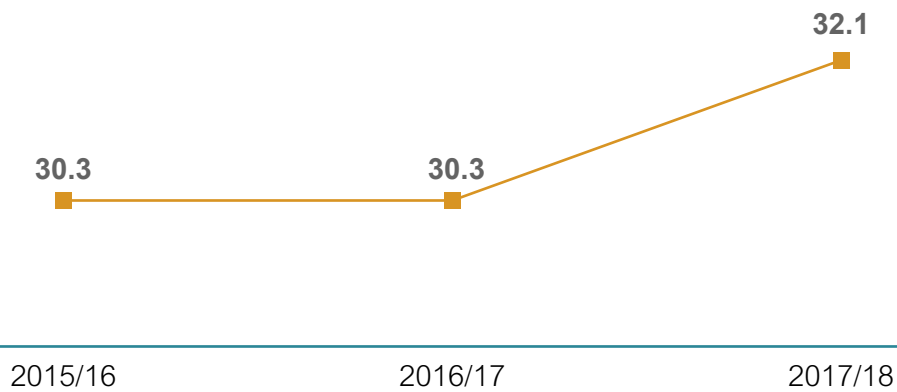
- In 2017, the median spend on drug misuse per resident in upper tier councils in England was £7.64 (a reduction of £2.60 since 2015).
- There has been a reduction in illicit drug use among adults aged 16 to 59 years in England and Wales compared with a decade ago, from 10.5 per cent using illegal drugs in the last year in financial year 2005/06, to 8.5 per cent in 2016/17.⁵
- In 2016/17, 280,000 individuals were in contact with drug and alcohol services. Overall, nearly all individuals (98 per cent) waited three weeks or less from first being identified as having a treatment need to being offered an appointment to start an intervention, with 82 per cent of first interventions having zero days waiting time.
- Waiting times to gain access to treatment were short. The average (mean) wait for young people to start their first specialist intervention was two days. Almost all (98 per cent) of the 17,445 first interventions starting in 2016/17 had waiting times of three weeks or under, with 81 per cent receiving a first intervention on the day they were referred.
- Between 2011-13 and 2015-17, the rate of deaths from drug misuse in England increased from 3.1 per 100,000 population to 4.3 per 100,000 population. The Government's own review concluded that the increase in drug related deaths started before the transfer to local government, that the causes are complex and that local government's proactive roll-out of naloxone is one of a number of factors contributing to addressing this rise. Ninety-five per cent of local authorities freely make the antidote drug Naloxone available to emergency services and those at the greatest risk.
- The Government's own review⁶ concluded that services are performing well. Drug treatment substantially reduces crime, HIV, Hepatitis B and C, and social costs associated with drug misuse and dependence. Current estimates suggest that the net benefit-cost ratio is approximately 2.5 to 1. Treatment penetration rates are amongst the highest of any country and successful treatment rates for opiate and non-opiate use have increased.
- Needle and syringe programmes (NSPs) are aimed at injecting drug users to reduce the transmission of infectious diseases through sharing injecting equipment. Research into the efficiency of these programmes suggests that increasing the number of injecting drug users using NSPs by 10 per cent leads to a 10 per cent reduction in the number of hepatitis C infections. This results in an annual saving to the NHS of £17.31 for every £1 spent.

Successful completion of drug treatment non-opiate users proportion per cent



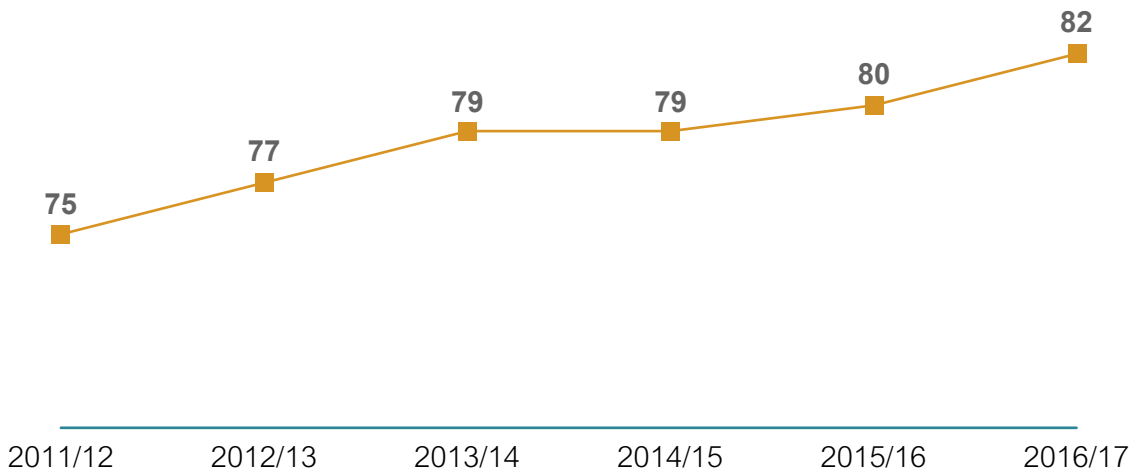
Data source: Public Health England

Adults with substance misuse treatment needs who successfully engage in community based structured treatment following release from prison (per cent)



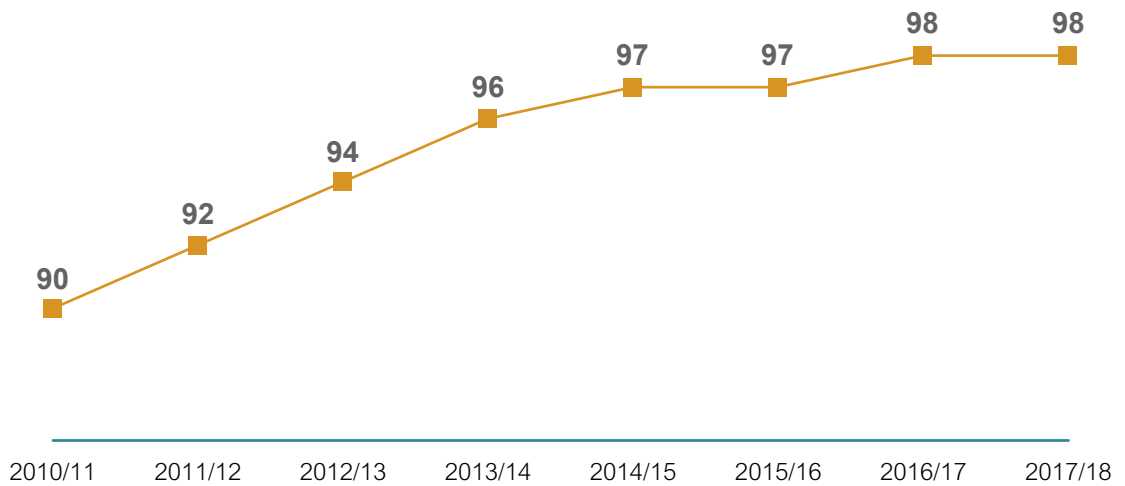
Data source: Public Health England

Percentage of young people completing drug and alcohol treatment (per cent)



Data source: Public Health England

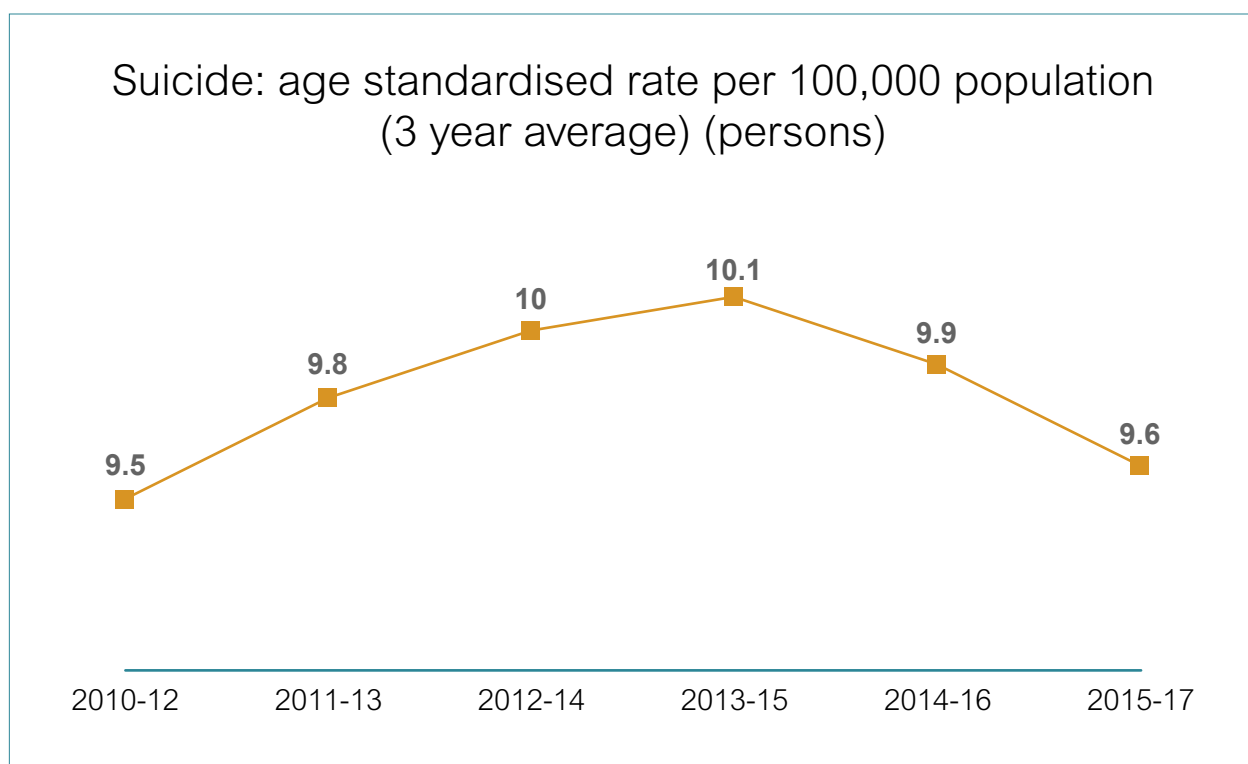
Trends in waiting times of three weeks and under for first intervention (Adults) (per cent)



Data source: Public Health England

Public mental health: suicides decreasing

- In 2017, the median spend on public mental health per resident in upper tier councils in England was £0.41 (2015 spend data not available).
- Between 2012/13 and 2016/17, suicides steadily decreased in England, with the male suicide rate of 15.5 deaths per 100,000 the lowest since 1981. Within a year of guidance being published, every local authority in England had prepared a suicide reduction plan.
- By contrast the prevalence of depression among adult GP patients in England increased from 5.8 per cent to 9.1 per cent.
- Evidence shows there are cost effective interventions for suicide and self-harm prevention programmes. Estimates suggest that every £1 spent yields benefits to the NHS of up to £2.93 over a ten year period.



Data source: Public Health England

NHS Health Checks: saving lives, saving treatment cost

- The median spend per resident in upper tier councils in England on NHS Health Checks fell from £1.11 in 2015 to £0.86 in 2017. This programme prevents around 390 premature deaths each year. It also results in an additional 1,000 people at age 80 years being free of cardiovascular diseases, dementia, and lung cancer each year in England, according to an independent analysis.⁷
- Councils have invited more than 14 million eligible people to have an NHS Health Check over the last five years, of which 6.8 million have taken up the offer.
- There is robust evidence that tackling both lifestyle and clinical risk factors is an effective method of preventing or reducing avoidable ill health, prevents 390 premature deaths a year, keeping an additional 1,000 people at age 80 years free of cardiovascular diseases, dementia, and lung cancer, and reducing cost for the NHS. The NHS health check provides several crucial means of addressing this, by identifying leading risk factors across populations, helping individuals understand their personal risk profile, and offering the opportunity to detect risk factors early.

Alcohol misuse spend steady

- In 2017, the median spend on alcohol misuse per resident in upper tier councils in England was £3.34.
- Between 2012/13 and 2016/17, the rate of alcohol-related harm hospital stays in England fluctuated but remained similar, with a slight increase from 630 per 100,000 population to 636 per 100,000 population.

- Research suggests investment in preventing alcohol misuse is a cost-effective way of reducing NHS costs. For example, identification and brief advice (IBA) comprises of identifying an 'at risk' drinker and offering brief advice on how to reduce alcohol consumption. PHE has estimated savings over five years of £19.13 to the NHS for every pound spent on IBA.

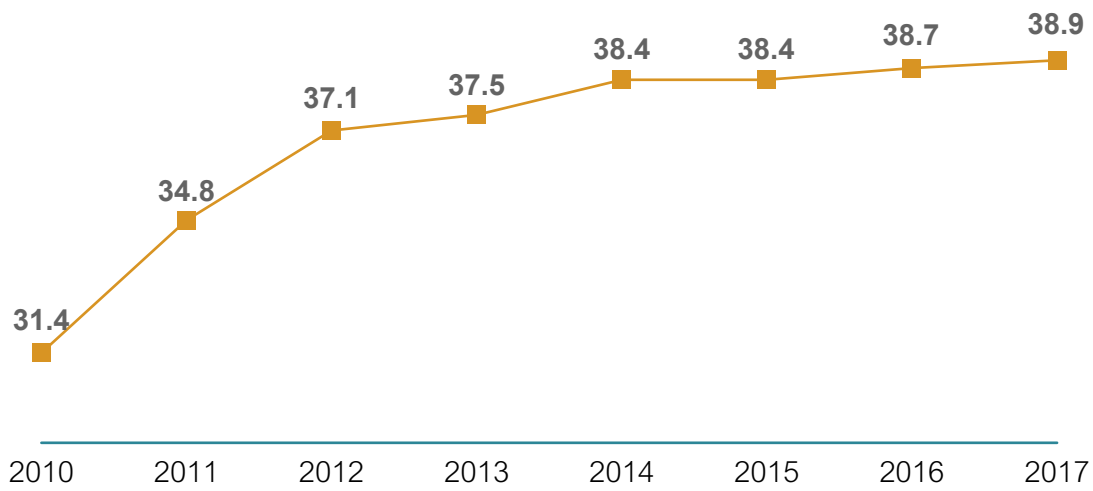
Public health advice: Helping the NHS commission effectively

- The median spend per resident in upper tier councils in England on public health advice fell from £0.85 in 2015 to £0.65 in 2017, despite directors of public health reporting in a 2017 survey that they had increased the number of advice to NHS projects, including advice to STPs and leading on prevention for STPs.

Children 0-5

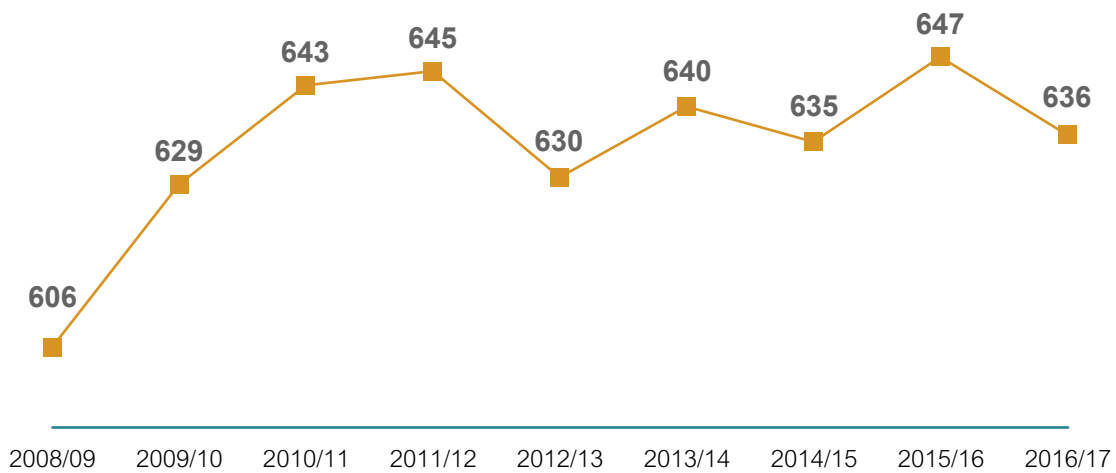
- The median spend per resident in upper tier councils in England on children's 0-5 prescribed services in 2017 was £13.81 (the median spend per resident on non-prescribed 0-5 services was £1.63).

Successful completion of alcohol treatment – proportion per cent



Data source: Public Health England

Admission episodes for alcohol related conditions per 100,000

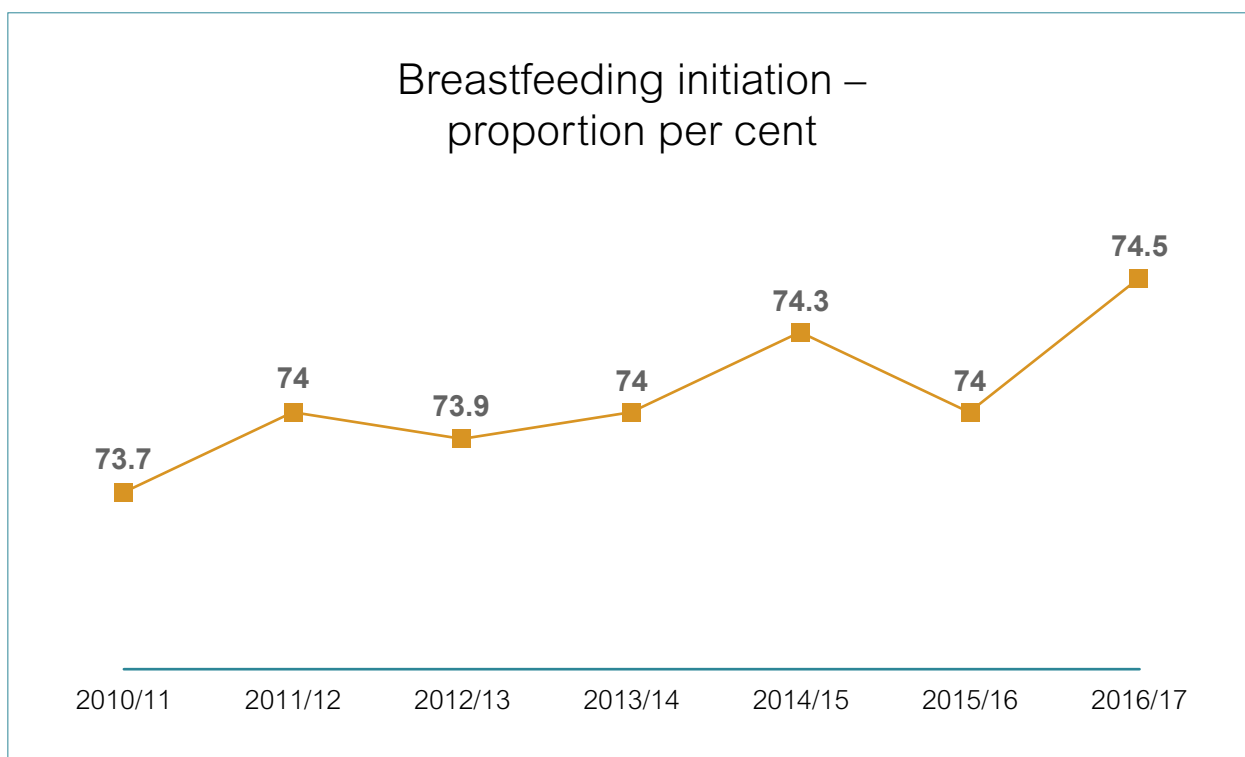


Data source: Public Health England

- There are a number of cost-effective health programmes. These include services aimed at improving child oral health which have a return of investment of up to £21.98 ten years after the intervention. Savings amount from increased school attendance due to avoided oral disease, subsequent decreased days off work for carers and reduced NHS costs.
- There were 3.9 infant deaths per 1,000 live births in England in the period 2014-2016. Among babies born at full term, 2.8 per cent had a low birthweight in 2016. Both of these indicators have shown improvement in recent years.
- Data from the oral health survey of 5 year old children⁸ for the academic year 2016/17 shows that 76.7 per cent were free from any dental decay. Figures show a continued increase in the proportion of children with no obvious dental decay from 72.1 per cent in 2012.

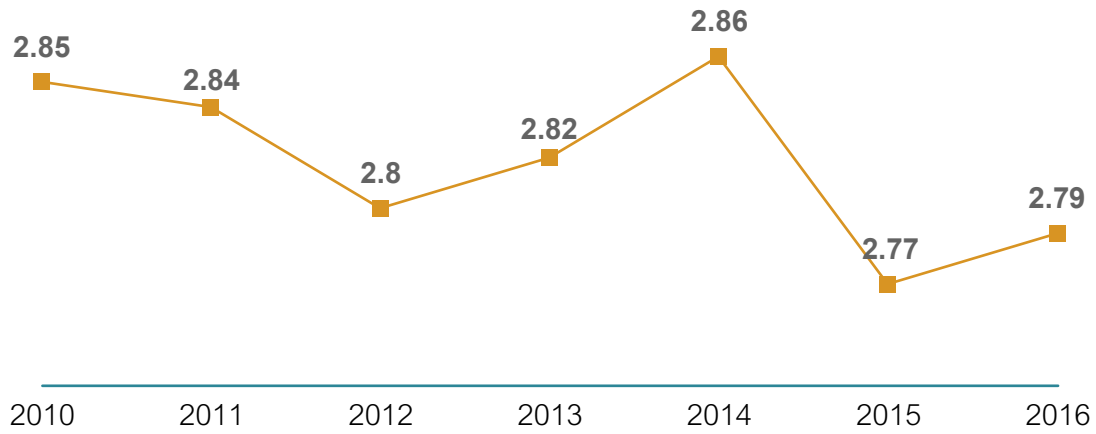
Children 5-19

- The median spend per resident in upper tier councils in England on children's 5-19 public health programmes in 2017 was £4.92.
- Evidence suggests that expenditure on programmes aimed at both supporting children with conduct disorders and preventing 'at risk' children from developing the condition has a return on investment of £45.45 over a child's lifetime. These savings stem from reduced rates of crime and mental illness, and increased lifetime earnings.



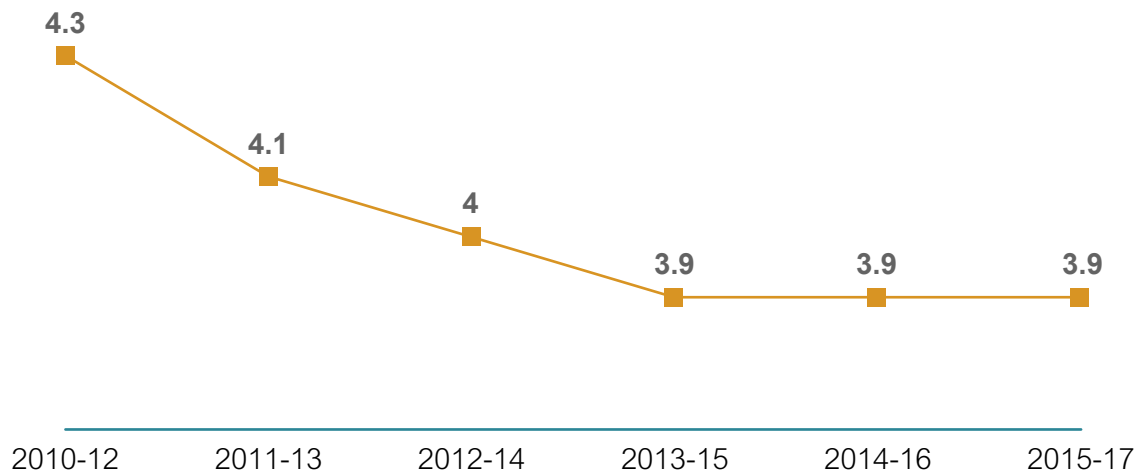
Data source: Public Health England

Percentage of low birth weight of term babies



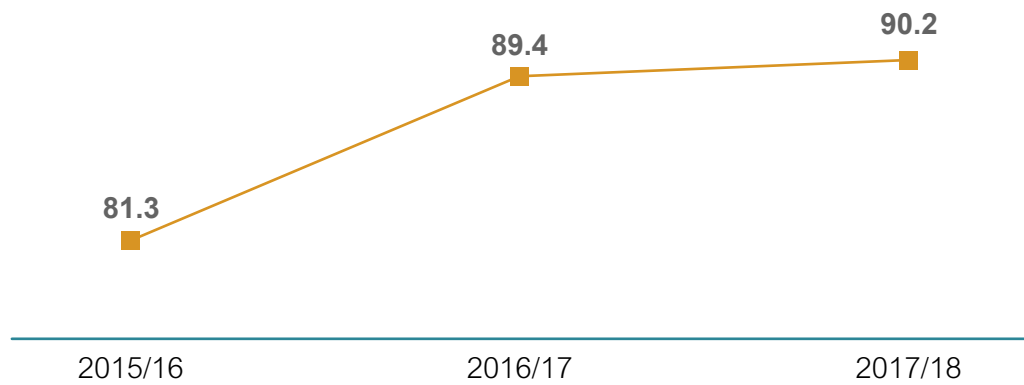
Data source: Public Health England

Infant mortality per 1,000



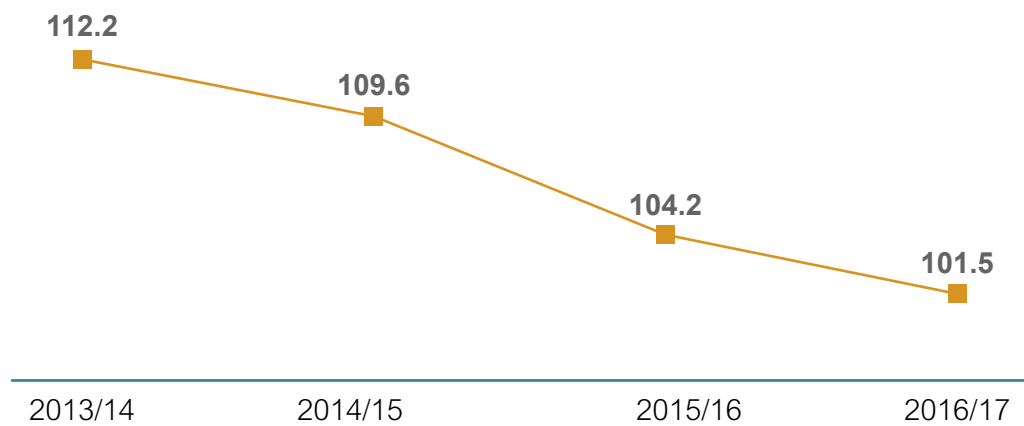
Data source: Public Health England

Proportion of children aged 2-2.5 receiving ASQ-3 as part of the Healthy Child programme or integrated review (per cent)



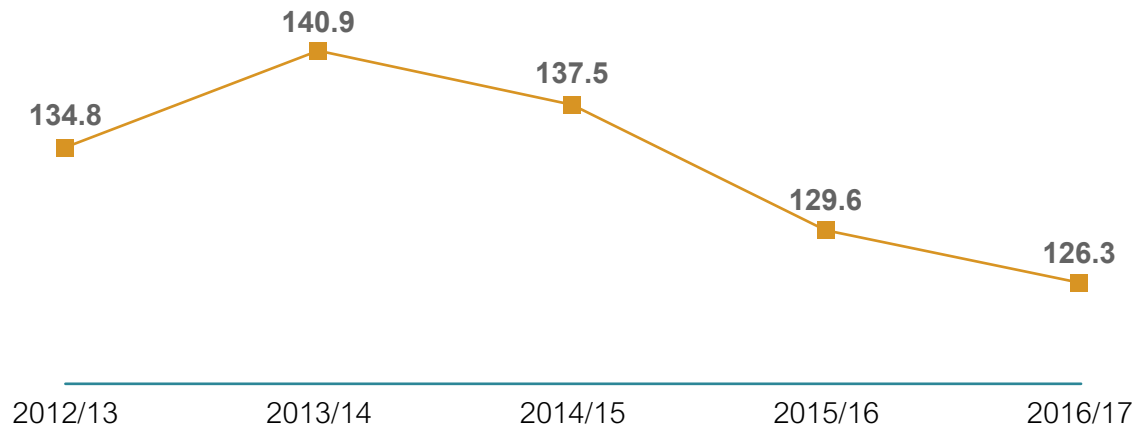
Data source: Public Health England

Hospital admissions caused by unintentional and deliberate injuries in children (aged 0-14) per 10,000



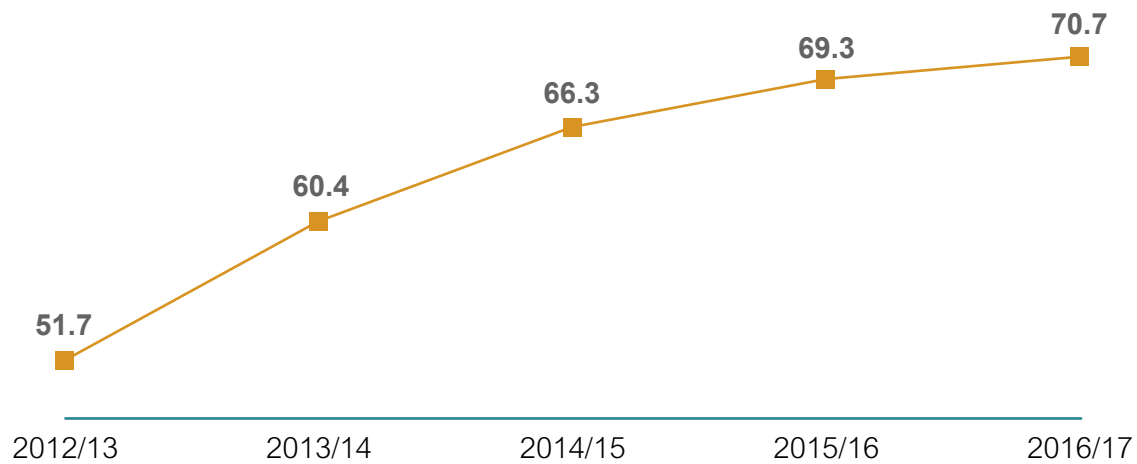
Data source: Public Health England

Hospital admissions caused by unintentional and deliberate injuries in children (aged 0-4) per 10,000



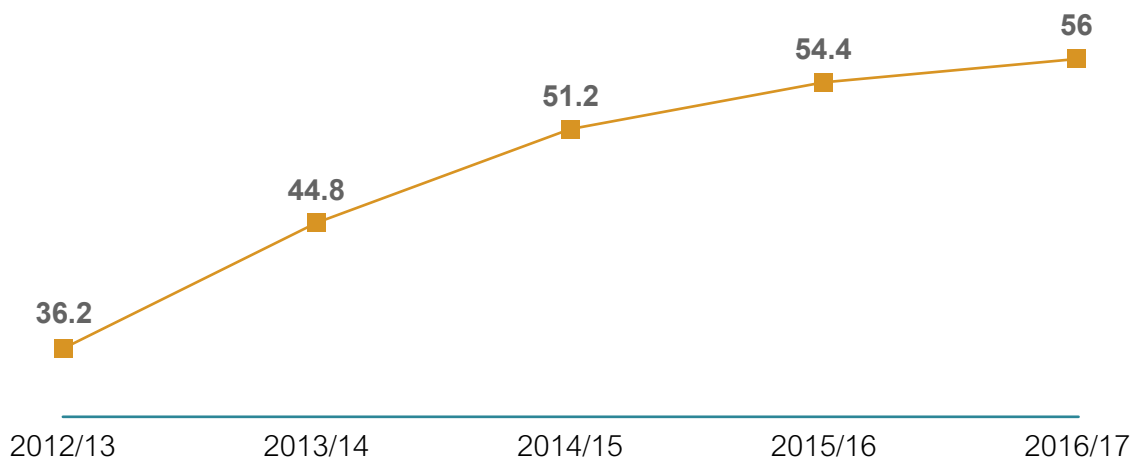
Data source: Public Health England

School readiness: the percentage of children achieving a good level of development at the end of reception



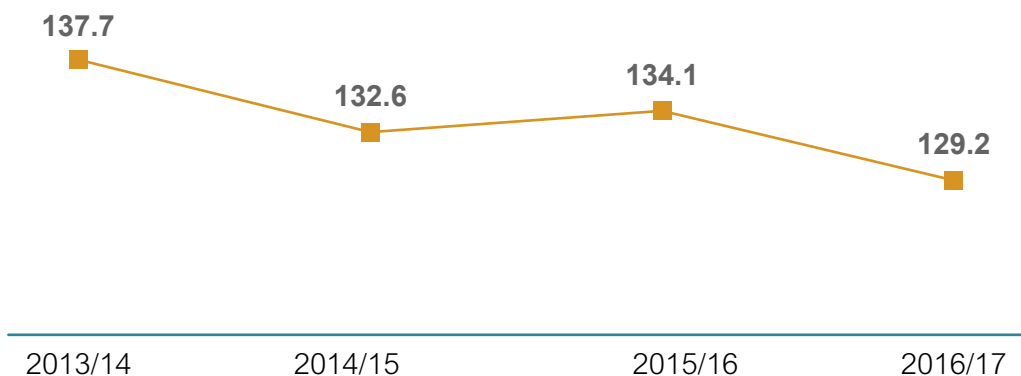
Data source: Public Health England

School readiness: the percentage of children with free school meals status achieving good level of development at the end of reception



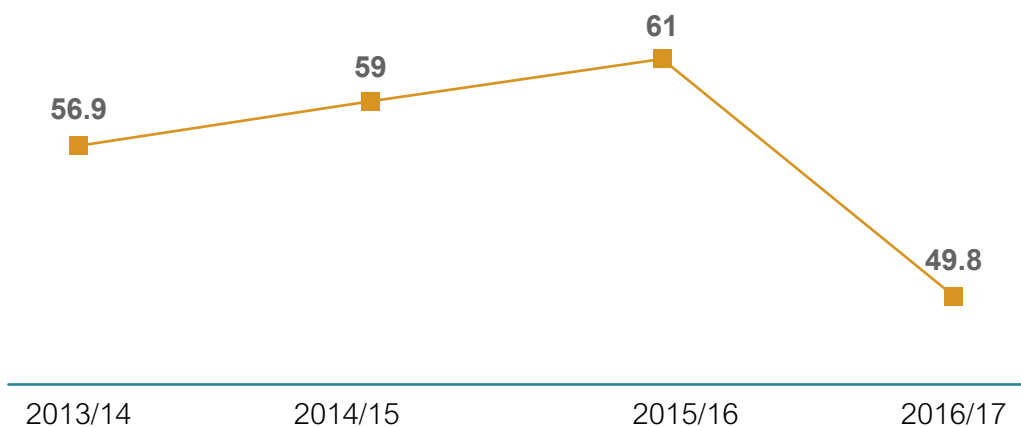
Data source: Public Health England

Hospital admissions caused by unintentional and deliberate injuries in young people (aged 15-24) per 10,000



Data source: Public Health England

Hospital admissions for alcohol-specific conditions, under 18s, crude rate per 100,000 population



Data source: Public Health England

Endnotes

- 1 Health profile for England: 2018, Public Health England 2018
www.gov.uk/government/publications/health-profile-for-england-2018
- 2 Inquiry into public health post 2013
www.parliament.uk/business/committees/committees-a-z/commons-select/health-committee/news-parliament-20151/public-health-report-published-16-17
- 3 Health profile for England: 2018, Public Health England 2018
www.gov.uk/government/publications/health-profile-for-england-2018
- 4 Progress towards ending the HIV epidemic in the United Kingdom: 2018 report
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/759408/HIV_annual_report_2018.pdf
- 5 Health profile for England: 2018, Public Health England 2018
www.gov.uk/government/publications/health-profile-for-england-2018
- 6 Public Health England (2017) An evidence review of the outcomes that can be expected of drug misuse treatment in England
- 7 Mytton et al (2018)
<https://journals.plos.org/plosmedicine/article?id=10.1371/journal.pmed.1002517>
- 8 Oral health survey of 5 year old children 2017
www.gov.uk/government/statistics/oral-health-survey-of-5-year-old-children-2017



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