Health Needs Assessment
Leeds Integrated Healthy Living Service

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Contents

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Executive summary

1. Introduction

This health needs assessment has been written to inform the commissioning of an integrated healthy living service for Leeds. The HNA forms part of the service review and should be read alongside two further reports, which provide an overview of a large scale consultation project and a review of how other authorities in England are developing integrated healthy living services.

2. Epidemiological data

There is a difference in life expectancy in Leeds of 10.8 years between people living in the most and least deprived wards. An analysis of census data compared an affluent and deprived ward and illustrated how people living in these wards experience contrasting environmental, economic and social circumstances which are likely to contribute to differences in health and life expectancy. Differences include age structures with the deprived ward being comprised of a younger population. The deprived ward also had much denser population with more people living in a smaller space, higher BME (Black and Minority Ethnic) community, more households with members who do not speak English, less owner occupied houses, more people living in overcrowded homes, more people with no qualifications, more people with limiting long term illness, less people in good health, more people claiming welfare benefits and more people unemployed.

2.1 Lifestyles

21.1% of people in Leeds smoke. There are differences between Clinical Commissioning Group (CCG) areas; the highest rates of smoking are in South and East CCG (25.9%) followed by West (20.1%) and lowest in the North CCG area (17.0%) however, the numbers of smokers are highest in the West.

Approximately 63.8% of people in Leeds are physically active, taking 150 minutes or more of activity per week. However approximately 23% of people in Leeds are inactive, taking 30 minutes or less of physical activity per week. There is a correlation between living in deprived areas and inactivity. Almost half of all children in Leeds fail to achieve the government recommendation of 7 hours of physical activity a week. Children of primary school age are significantly more active, 60.2% than those of high school age, 46.9%. Girls of high school age are the most inactive group with only 39.5% achieving 7 hours a week or more of physical activity. Primary aged children from deprived Leeds are more inactive than children in non-deprived Leeds however all children at high school age report lower physical activity levels. Physical activity levels are lowest amongst BME children, specifically Asian girls.

People in Leeds show lower levels of happiness, feelings of living a worthwhile life and higher levels of anxiety compared to Yorkshire and Humber and England. In Leeds in 2015 a mental wellbeing survey was undertaken in New Wortley. Those who were unemployed had a statistically significant lower wellbeing score than those in employment. This was also reflected in respondents reporting a disability having a

statistically lower wellbeing score than those not reporting disability. The lowest wellbeing scores were in the 18 – 24 year old age group across both genders.

2.2 Lifestyle related ill health

Many chronic diseases such as heart disease, diabetes and some cancers could be prevented by eliminating or modifying shared risk factors such as smoking, physical inactivity, poor diet and alcohol use. In addition, we know there is a two way relationship between how we think and feel and physical health, and the impact physical illness has on mental health; for example, people with a chronic medical condition have a 2.6 fold increase in the odds of having a mental illness, compared to those without a chronic medical condition.

The figures presented in the HNA for lifestyle related ill health are from GP audit data so only include diagnosed illness. Modelled estimates are far higher for Chronic Obstructive Pulmonary Disorder (COPD) and slightly higher for Cardiovascular Disease (CVD) and diabetes.

Across Leeds 21.6% of the population are obese. Rates of obesity are far higher in the deprived quintile of Leeds and significantly higher in Leeds South and East CCG area; however there are more obese people in the West than the South and East. Over the last three years obesity rates have remained steady, slightly rising in the West and slightly falling in the North. Nationally, childhood obesity rates rose 1% a year from 1995 to 2007. Rates have now levelled off but remain high with approximately 9% of reception age children and 20% of year 6 children being obese. Childhood obesity prevalence rates in Leeds are generally in line with national rates and lower than most core cities. Children from deprived Leeds are more likely to be obese than children from non-deprived Leeds.

Rates of GP recorded diabetes are far higher in deprived Leeds when compared to non-deprived Leeds. Between 2012 and 2015 diabetes rates have been rising in all areas. There are 39,282 people in Leeds diagnosed with diabetes, representing 4.65% of the population. In terms of numbers, 14,955 people are from West CCG, 14,168 from South and East CCG and 10,159 from North CCG representing 4.07%, 5.29% and 4.87% of their populations respectively.

Rates of GP recorded COPD are far higher in the deprived quintile of Leeds. Between 2012 and 2015 COPD rates have been gently rising in all areas. In Leeds in 2015 there were 15,934 people (1.89%) diagnosed with COPD; 6,003 in the West, 6,946 in the South and East and 2,985 in the North, representing 1.63%, 2.59% and 1.43% respectively.

Rates of GP recorded CVD are far higher in the deprived quintile of Leeds and significantly higher in Leeds South and East CCG. Between 2013 and 2015 CVD prevalence has remained steady. There are 67,656 people in Leeds diagnosed with CVD representing 8.01% of the population. There are 26,294 in the West, 24,175 in the South and East and 17,187 in the North representing 7.15%, 9.02% and 8.23% of the population respectively.

A higher number of Sexual Transmitted Infections (STIs) per 100,000 population are diagnosed in Leeds when compared to Yorkshire and the Humber and England. Leeds has also experienced the highest percentage increase in newly diagnosed STIs compared to England and Yorkshire and the Humber. This may be because there is a greater prevalence of STIs or better diagnosis of STIs.

The prevalence of diseased, missing or filled teeth (DMFT) in 3 year olds in Leeds is 19.4% and is significantly higher than England's prevalence of 12%. The prevalence of DMFT in five year olds in Leeds is 33.7%; this is 5% higher than the average for England. Only core cities and statistical neighbours with public fluoridated water schemes had a significantly lower average number of dental caries. The prevalence of DMFT in twelve year olds in Leeds is 45.8%, 12.4% higher than England's average prevalence. Children and young people living in areas of higher deprivation in Leeds have higher rates of tooth decay, children who are Looked After, or who have chronic and long term health conditions and children with additional physical and learning needs are at a higher risk of oral health inequalities. Over 50% of children and young people drink at least 2 sweetened drinks per day and 19% of the under 18 population did not attend a dentist at least once in 2012/13.

The total suicide rate for Leeds was the same as for Yorkshire and Humber region for 2006-2008 period, but slightly higher than the rate for England. Reported rates for Leeds were higher in the under 65 age group compared to the regional and England figure, but lower in the over 65s. Those taking their own life tend to be locally born white men between the ages of 30 and 50 years, with higher rates being seen within specific areas of Leeds. The findings for Leeds reflect the national picture and identified the highest number of recorded deaths was in the LS12 postcode, followed by LS11, LS14, LS15, LS8 and LS9 postcodes, many of which fall into areas of deprivation.

Self-harm related inpatient episodes continue to show a downward trend. A higher proportion of females than males in Leeds experienced a self-harm related episode. Females aged 15-19 had a significantly higher rate of self-harm related episodes than any other group in 2014/15. Between April 2014 and March 2015, 15-24 year olds accounted for almost 28% of individuals experiencing self-harm related episodes. Self-harm related episodes in 20-24 year old males have shown a significant downward trend. The most common primary diagnosis for self-harm related episodes in 2014/15 was paracetamol related poisoning. National benchmarking data shows that Leeds is now in line with other cities for self-harm related hospital admissions whereas in the past it was a negative outlier.

In terms of diagnosed mental ill health and young people, 3,120 young people in Leeds are in need of specialist mental health services. Self-harm is a key issue for children and young people with the highest rates identified amongst 15-19 year old girls. It is also estimated that 6.4% of young people have an emotional disorder that is not defined as a mental health problem.

2.3 Potential Years of Life Lost

An indicator used to measure the contribution public health initiatives and health care improvements in population health is 'avoidable mortality', which is a subset of Potential Years of Life Lost (PYLL). This is based on the concept that premature deaths, that is deaths of people younger than 75, from certain conditions should not occur in the presence of timely, preventative interventions and effective health care. Within the HNA, PYLL is calculated as the 3-year aggregate, directly standardised rates (DSR) per 100 000 population.

Deaths from cancer are the most common cause of PYLL in Leeds. The headline result is that Leeds PYLL shows an overall reduction over the three periods: 2009-11, 2010-12 and 2011-13. This reduction is being driven by a reduction in both deprived Leeds and the rest of the Leeds district. In deprived Leeds, the rate of avoidable PYLL in 2011-13 is over 9000, compared to less than 5000 in non-deprived Leeds. This is almost double the rate and shows the magnitude of health inequalities in the city. However the rate in deprived Leeds is reducing more quickly than Leeds as a whole; this means that we are demonstrably reducing health inequalities. For registered patients, compared with the Leeds rate, the gap in the rate of avoidable cancer PYLL is significantly greater for Leeds South and East CCG (14% above Leeds average); for Leeds West CCG (3% below Leeds average); Leeds North CCG (16% below Leeds average).

Deaths from Cardiovascular Disease (CVD) are the second single cause of PYLL in Leeds. There has been a reduction of almost 20% over 5 years in PYLL due to CVD, with a reduction noticeably in deprived Leeds due to reduced numbers of deaths and also an increase in the age at death (2011-13). This can be seen as evidence of a positive outcome of key public health programmes, leading to a decrease in smoking rates, the implementation of the NHS Health Check which had its initial focus on deprived Leeds, and effective management in primary and secondary care. For registered patients and compared with the Leeds rate, the gap in the rate of avoidable CVD PYLL is significantly greater for Leeds South and East CCG (11% above Leeds average). Leeds West CCG has a rate similar to the Leeds average. Leeds North CCG has a rate 19% below Leeds average. Whilst it is positive that there has been a significant reduction in Leeds South and East CCG rates since 2009, this reduction has not been reflected in the static rates of other two CCGs.

Deaths from respiratory disease are the third single cause of PYLL in Leeds. The rates are significantly higher in deprived Leeds than the non-deprived part of Leeds. Rates have decreased slightly but not statistically significantly over time. Smoking is the key contributor to respiratory disease, and historic smoking rates reflect this pattern. The rates for deprived Leeds are more than double those in the non-deprived part of Leeds. Registered CCG population rates vary around the Leeds rate; the gap in the rate in Leeds North CCG is substantially lower than Leeds (34%); the rate in Leeds West is also lower than Leeds rate by 7% and Leeds South and East significantly higher (36%). The rate in Leeds has declined overall with the greatest decline being seen in Leeds North CCG.

Overall, Leeds North and Leeds South and East CCGs registered and resident populations show a steady and statistically significant reduction in avoidable PYLL

which is falling faster in deprived resident populations. This trend is not replicated in Leeds West CCG population, where the trend appears to be static for the registered and resident populations, though the deprived resident population's rate is falling. It needs to be noted that the rates of a CCG registered population mask smaller area difference and that within each CCG there is great variation.

2.4 Clustering of unhealthy behaviours

Data from the Health Survey for England has been used to show how four lifestyle risk factors (smoking, excessive alcohol use, poor diet, and low levels of physical activity) co-occur in the population and how this distribution has changed over time. The overall proportion of the population that engages in three or four of these unhealthy behaviours has declined significantly, from around 33 per cent of the population in 2003 to around 25 per cent by 2008. However, these reductions have been seen mainly among those in higher socio-economic and educational groups. People with no qualifications were more than five times as likely as those with higher education to engage in all four poor behaviours in 2008, compared with only three times as likely in 2003. The health of the overall population will improve as a result of the improvement in these behaviours, but the poorest and those with least education will benefit least, leading to widening inequalities and avoidable pressure on the NHS. In Leeds there is a correlation between living in a deprived area and having an unhealthy behaviour.

3. Evidence of effective services and priorities for Leeds

All public health services should be based on best evidence where available and designed to meet need. The full HNA presents the evidence base around currently provided services to support healthy lifestyles, it reviews related services commissioned by partners and new approaches we are considering commissioning including: health coaching, health trainers, social prescribing, mental wellbeing, adult and child weight management, adult and child physical activity, smoking cessation, healthy eating, family approach to weight management and holistic assessment. Overarching evidence for behaviour change is provided by National Institute for Health and Care Excellence (NICE); specifically NICE Guidance PH6 around the principles for effective behaviour change interventions (2007) and NICE Guidance PH49 around individual approaches to behaviour change (2014).

Following a review of the evidence, priorities for Leeds have been identified which include:

Develop a robust evaluation framework that gathers information on longer-term outcomes and cost effectiveness. Ensure the LIHLS dovetails with the CCG commissioned social prescribing projects.

Develop a more holistic person centred approach to behaviour change where individuals can determine and prioritise their health goals using self-discovery and active learning, with help to work towards their goals by self-monitoring their behaviours to increase accountability. Support service users to navigate through a system of health improvement support and opportunities.

Develop a service which is assets based and considers broader determinants of health.

Ensure how people think and feel is considered whilst planning physical health improvement goal with a focus on improving mental health and wellbeing across the whole life-course.

Deliver effective communications programmes and campaigns with clear “calls to action” around healthy lifestyles.

Better support and enable those who want to lose weight but are not ready to enter a more structured weight loss programme. Whilst it is desirable to provide an effective weight management system that is led by a multi-disciplinary team, it is also effective to offer interventions focusing on wider skill development to enable people to achieve and maintain a healthy weight e.g. cooking skills, physical activity, and management of mood. Such activities will also provide an adjunct opportunity to support weight maintenance and prevent weight regain after a weight management intervention. Weight management interventions need to be varied to reach specific population groups for example men, which have historically not engaged with weight management services. Interventions would benefit from being integrated into a wider healthy living network of services and activities.

Better integrate child and family weight management interventions that develop approaches to proactively and effectively engage families, including those in a pre-contemplation stage, around their children’s overweight status. Increase the number of families taking up the offer of specialist support and completing weight management programmes.

Continue to focus on reducing inequalities in obesity levels for children from disadvantaged communities and ethnic minority groups. In addition to weight management interventions the LIHLS should work to increase the amount of opportunities for young people, particularly girls, and their families to participate in physical activity and therefore reducing sedentary behaviour as the default leisure time position. Work with partners to develop sustainable physical activity opportunities in disadvantaged communities using asset-based community development approaches and promote opportunities for active travel.

Continue to reduce smoking prevalence among adults in Leeds, especially in the most disadvantaged communities. Work with partners to increase referrals and access to our stop smoking services through incorporating smoking cessation interventions in health care pathways and increasing the number of effective interventions offering brief advice and referral. Explore the potential to roll out carbon monoxide monitoring to identify smokers following implementation in smoking in pregnancy and introduce new options within the smoking service for people who want to quit but are not suited to the current delivery model. Continue to support wider tobacco control initiatives to promote smoke free as the social norm, including reducing the impact and availability of illicit tobacco and increasing the number of smoke free areas in the city.

4. Effectiveness of currently commissioned services

Healthy living services in Leeds are generally of a high quality, however they are currently commissioned as individual services and as a result of this there has been a tendency for services to operate in isolation which has also resulted in some duplication. In addition, services deal with single health issues e.g. stopping smoking, losing weight, with the exception of the Health Trainers Service and Healthy Lifestyle Service meaning that a person requiring support around a number of lifestyle issues may need to access multiple services. .
The advantage of considering an integration of a range of individual lifestyle services together is that they can be planned as a whole, based around the needs of individuals and populations.

There are currently three commissioned services offering adult weight management support, Weigh Ahead offers exclusively weight management and is particularly focused on patients with a higher BMI, whilst the Healthy Lifestyle Service and the Health Trainer Service offer weight management within a menu of behavioural support programmes. Around 75% of the clients accessing the Healthy Lifestyle Service and Health Trainer Service do so for weight management purposes.
Whilst it is not possible to directly compare the services due to differing outcome measures, none of the services achieve the NICE guidance of 60% of clients achieving a 3% weight loss suggesting that individuals may need more support on motivation alongside skills development and goal setting. None attract a representative proportion of men into services, suggesting an alternative offer should be provided for that group.

The children's physical activity services are excellent at serving deprived communities and have an equal split between boys and girls accessing the range of activities; they are meeting targets set in terms of numbers accessing the services.

The stop smoking service has a high proportion of people who quit at 4 weeks however this represents just over a quarter of people who were originally referred again suggesting more work is required around motivation and readiness to quit. Unlike weight management services, a large number of men attend but are still slightly under represented, making up 43% of people accessing the service.

Ministry of Food is the only service attracting a higher number of 20 – 44 year olds. The service is accessed almost equally by men and women.

5. Integrated healthy living services in other areas of the UK

Integrated Healthy Living Services have been described as wellness services which promote health and well-being rather than diagnose and treat illness. Liverpool Public Health Observatory performed an evidence review of wellness services that had a bio-psychosocial / holistic approach to health and concluded that the majority of services are cost-effective and have shown the potential to bring a return on investment and to save on future costs of ill-health through early intervention.

Across the country, a number of Local Authorities are now commissioning "living well", "wellness", "healthy lifestyle" or "healthy living" services. The commissioning

process has shifted from commissioning separate services to an integrated service delivery model. Although there is difference in the specifics of the integrated service model, the commonality between the Local Authority models are outcomes: increasing life expectancy, reducing mortality from preventable causes, and service specific outcomes, e.g. reducing smoking prevalence, reducing excess weight. These service models include a range of healthy living services such as physical activity, healthy eating, smoking cessation, weight management, NHS Health checks, alcohol reduction, sexual health, and health trainers/community champions amongst others. The most common procurement model is one contract through one lead service provider who works as part of a collaborative or sub-contracts specialist services.

Some areas continue to procure through single “lots” and integration is achieved through establishment of a single point of access, co-location of services “under one roof”, integrated care pathways, and or effective onward signposting by a healthy living champion.

The commissioning of integrated healthy living services across the country is influenced not only by need but also by resources and as a consequence, there is variation in the model, scope, procurement options and variation in design such as integration of pathways.

6. Conclusion

The main theme emerging from the epidemiological data is of inequalities in health outcomes between the most and least deprived areas of the city. The LIHLS needs to respond to this by providing equitable services which improve the health of the poorest fastest.

There is clear evidence nationally that multiple unhealthy lifestyle behaviours of smoking, excessive alcohol intake, poor diet and low levels of physical activity are more common in deprived areas and this is mirrored in Leeds. The LIHLS needs to respond to this pattern, ensuring a holistic approach is taken with people accessing the service and that services are planned around individuals and communities rather than service specialisms.

Services in Leeds are generally of a high quality but tend to work in isolation. The advantage of considering a range of individual lifestyle services together is that they can be planned as a whole, based around the needs of individuals and populations. There is good evidence that integrated healthy living services which take a whole person, holistic approach to health are cost-effective and have shown the potential to bring a return on investment and to save on future costs of ill-health through early intervention.

In the UK there is a variation in spend per head of the population, ranging from £3 to £7Leeds City Council has one of the the lowest cost per head of the population to fund an Integrated Healthy Living Service currently £3.03 per head of population, however given recent announcements about budget cuts to public health, it is likely we may be required to reduce this further; this will influence what it is possible to commission in Leeds and how much change will be possible without additional investment.

7. Recommendations

1. Integrate existing healthy living services into a single system planned around an individual's and a community's needs. Consider if services should be commissioned as a single service, an integrated system or have elements of both.
2. Ensure the LIHLS provides a high quality service which is easily accessible for primary care colleagues to refer into, but also outreaches into the community to build relationships with targeted groups with the aim of encouraging behaviour change.
3. Ensure the LIHLS allocates capacity to provide an equitable service delivered using the principles of universal proportionalism. Ensure target groups are identified and the LIHLS is planned to meet their needs.
4. Focus on outreach and building motivation to change with the aim of improving weight management and smoking cessation outcomes specifically.
5. Develop a health coaching approach to behaviour change where individuals can determine their health goals using self-discovery and active learning, with help to work towards their goals by self-managing their behaviours to increase accountability.
6. Develop family based approaches to weight management. Consider the needs of adolescents.
7. Ensure how people think and feel is considered whilst planning physical health improvement goals.
8. Develop a service which is assets based and considers broader determinants of health and other community based healthy living activities. Ensure partnerships are in place with organisations that can provide additional input and opportunities to overcome barriers to change and to support and maintain change.
9. Develop an evaluation framework that gathers information on longer-term outcomes and cost effectiveness. Ensure robust data collection systems are in place including collection of demographic data. Consider how to incorporate ongoing evaluation to drive continuous service improvement. And how to embed return on investment tools and or economic evaluation.
10. Ensure the LIHLS dovetails with the CCG commissioned social prescribing projects and related services. Ensure CCGs understand the commissioning plans for the LIHLS and are provided with opportunities to co-commission where appropriate. Clearly negotiate who is responsible for which elements of weight management support with the Leeds CCGs.

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Glossary

Acorn	A nationwide population segmentation tool. It combines geography with demographics and lifestyle information and analyses where people live together with their underlying characteristics and behaviour, to create a tool for understanding the different types of people in different areas throughout the country
Alcohol attributable admission	A hospital admission which is partly caused by alcohol
Alcohol specific admission	A hospital admission solely caused by alcohol
Avoidable mortality	Deaths from potentially avoidable causes
BARCA	Bramley and Rodley Community Action
BME	Black and Minority Ethnic
BMI	Body Mass Index
BMI SD score	BMI thresholds based on single standard deviation spacing
COPD	Chronic Obstructive Pulmonary Disorder
CBT	Cognitive Behavioural Therapy
CCG	Clinical Commissioning Group
CHD	Coronary Heart Disease
CMO	Chief Medical Officer
CO	Carbon Monoxide
Core Cities	There are 10 Core Cities which are economically the largest areas outside of London in England, Wales and Scotland
CVD	Cardiovascular Disease
DAZL	Dance Action Zone Leeds
DCRS	Data Collection and Recording System
Deprived Leeds	The parts of Leeds which are amongst the 10% most deprived in England. This is worked out at Lower Super Output Area level, which gives a finer level of detail than Middle Super Output Areas. Almost 20% of the Leeds population live in these areas. This is a similar number to those living in the Deprived Quintile.
Deprived Quintile	The fifth most deprived parts within Leeds, calculated with the Index of Multiple deprivation. This is useful when working with MSOA based data
DMFT	Decayed Missing Filled Teeth
DNA	Did Not Attend
DPH	Director of Public Health
DSR	Directly Standardised Rate. Age standardising compensates for the fact that populations usually have different age profiles. DSR is usually expressed as a rate per 100,000 and means we can exclude differences in age structure when investigating the underlying causes of different rates
5YFV	5 Year Forward View is collective view of how the health service needs to change over the next five years if it is to close the widening gaps in the health of the population, quality of care and the funding of services

GP	General Practitioner
GUM	Genitourinary Medicine
HIV	Human Immunodeficiency Virus
HNA	Health Needs Assessment
HSCIC	Health and Social Care Information Centre
IAPT	Improving Access to Psychological Therapies
ICE	Integrated Commissioning Executive explores and negotiates opportunities for integrated commissioning of health and social care services in Leeds
IMD	Index of Multiple Deprivation
JSNA	Joint Strategic Needs Assessment
LCH	Leeds Community Healthcare is a NHS Trust
Leeds registered	Patients who belong to a practice which is within the Leeds health economy. Patients could live outside Leeds and still be Leeds registered
Life expectancy at birth	This indicator measures how many years a new-born baby is expected to live on average given current age-specific mortality rates.
LIHLS	Leeds Integrated Healthy Living System
LNCCG	Leeds North Clinical Commissioning Group
LSECCG	Leeds South East Clinical Commissioning Group
LSOA	Lower Super Output Area These are geographic areas designed nationally to improve the reporting of small area statistics in England. LSOAs when originally generated had between 1,000 and 3,000 people living in them, with an average population of 1,500 people.
LTC	Long Term Condition
LTHT	Leeds Teaching Hospital Trust
LWCCG	Leeds West Clinical Commissioning Group
LYPFT	Leeds and York Partnership Foundation Trust
MRC score	Medical Research Council score is used for grading the degree of a patient's breathlessness
MSM	Men who have sex with men
MSOA	Middle Super Output Area. These are geographic areas designed nationally to improve the reporting of small area statistics in England and Wales. MSOAs are built from groups of Lower Super Output Areas (LSOAs). The minimum population of an MSOA is 5,000 and the mean is 7,200 (when originally generated). There are 108 MSOAs in Leeds
NCMP	National Child Measurement Programme measures the weight and height of children in reception class (aged 4 to 5 years) and year 6 (aged 10 to 11 years)
NHSE	NHS England
NICE	National Institute for Health and Care Excellence
Non-OCUs	Non-Opiate and Cocaine Users
NRT	Nicotine Replacement Therapy
ONS	Office for National Statistics
PA	Physical Activity
Patient Activation	Describes the knowledge, skills and confidence a person

	has in managing their own health and health care. People who have low levels of activation are less likely to play an active role in staying healthy.
Patient Activation Measure (PAM)	This is a licensed tool that produces a patient-reported Measure of activation through the self-completion of thirteen statements. These statements are about beliefs, confidence in the management of health-related tasks and self-assessed knowledge.
PHE	Public Health England
PHP	Personal Health Plan
PHOF	Public Health Outcome Framework outlines desired outcomes for public health and how they will be measured
Prevalence	The number of cases divided by the population. In this report it can be thought of as the proportion of the relevant population with diabetes / CHD etc. Prevalence is expressed as a percentage. However an elderly population would be expected to have more cases (a higher prevalence) of certain conditions than a younger population. To compensate for variations in population ages, data can be directly age standardised (see above).
PYLL	Potential Years of Life Lost
Quintile	Refers to when a sample or population is divided into fifths
RCT	Randomised Control Trial
RSPH	The Royal Society for Public Health
STI	Sexual Transmitted Infection
Statistical neighbours	A tool for comparing data about children and young people across all local authorities in England
SOA	Super Output Areas are a set of geographical areas developed to facilitate the calculation of the Indices of Deprivation
TIA	Transient Ischaemic Attack is caused by a temporary disruption in the blood supply to part of the brain or referred to as a “mini stroke”.
WHO	World Health Organisation

1. Introduction

1.1 Leeds City Council Health Breakthrough

Leeds City Council is planning to build on the success of delivering the Tour de France in 2014, by delivering eight “Breakthrough” projects. These projects are Councillor led, high profile, and offer an opportunity to work across silos and innovate in order to deliver significant programmes of change. All breakthrough projects should contribute to the aim of Leeds being the best city.

One of the Breakthrough projects focuses on health, with a specific aim of reducing health inequalities through supporting healthier lifestyles.

Data from the World Health Organisation (WHO) atlas of heart disease and stroke provide estimates of how key risk factors contribute to the burden of disease across the globe. Figure 1 below shows the percentage contribution of seven top risk factors to the overall disease burden in developed countries:

Figure 1: Contribution of risk factors to disease
Source: WHO

Risk factor	% contribution to overall disease burden
Tobacco use	12.2
High blood pressure	10.9
Alcohol use	9.2
High cholesterol	7.6
Obesity	7.4
Low fruit and vegetable intake	3.9
Physical inactivity	3.3
Total	54.4

The health breakthrough will focus on three areas:

- Directly commissioning an integrated healthy living service which is person centred, solution focused and takes into account broader determinants of health.
- Working with partners to co-commission or agree service alignment in order to deliver healthy living services, in a way which maximises efficiencies and reduces duplication.
- To use the breakthrough status of this project to involve a broad range of partners in order to stimulate ideas and activity to support healthy living in Leeds.

The breakthrough also aims to answer the following questions:

- What are the specific geographical and population group needs particularly in deprived areas that lifestyle services should be designed around?
- How can the wider determinants of health be more integrated in the system to support people to improve health?

- What is the potential role of social prescribing in the system?
- How can we design services that support families to choose healthy lifestyles rather than developing services that are aimed at adults or children?
- Are there opportunities to co-commission with CCGs?
- How can we ensure that healthy lifestyle support is linked more closely to NHS Health Checks?
- What is the potential role of digital technology in enabling healthy lifestyles?
- How can the resources of the Council be better utilised including the customer access team and community hubs?
- How can other relevant Leeds City Council services be encouraged to refer into healthy lifestyle services e.g. housing, social care?

1.2 Healthy Living Services in Leeds

Currently there are a range of separate services commissioned by Leeds City Council which aim to promote healthy lifestyles in Leeds. These include:

- A healthy lifestyle service
- A health trainer programme
- Stop smoking services
- Weight management services for adults
- Weight management services for children and young people
- Healthy eating and cooking skills services
- Physical activity sessions for adults and children

Our aim is to use the opportunity of re-commissioning to build on the excellent work individual organisations have delivered, to work towards creating a system which supports people to live healthy lifestyles, with a focus on reducing inequalities. We plan to review how services to promote healthy living in Leeds can be delivered in a way that brings individual services together, addresses inequalities, are people centred and holistic, can support people with multiple unhealthy behaviours and co-morbidities, provide practical support to remove social barriers to health and increase motivation to make and sustain behaviour change.

1.3 Describing needs assessment

Health needs assessment (HNA) is as an essential tool to inform commissioning and service planning. HNA can be defined as a systematic method of identifying the unmet health and healthcare needs of a population, and making changes to address those unmet needs. This HNA also aims to record assets in terms of currently commissioned services and ideas which already support healthy lifestyles and can be built upon and to use the Breakthrough status of this project to maximise on broader assets in Leeds. HNA allows for appropriate targeting of resources. HNA involves gathering information to inform service planning with the aim of improving health. Current services may need to change for a number of reasons, including: inequalities in outcomes, local sensitivities, changing demographic patterns or disease trends, availability of new treatments and changing expectations.

There are three main approaches to HNA.

- Epidemiological: considers the epidemiology of the condition, current service provision and views of commissioners.
- Comparative: compares service provision between different populations.
- Corporate: is based on eliciting the views of stakeholders; these may include professionals and service-users, the public and politicians; on what services are needed.

1.4 What this report includes

This needs assessment focuses on an epidemiological approach. It provides:

- A summary of the policy context for this work.
- Data comparing the environmental and social context in the most and least deprived ward in Leeds.
- Data on healthy behaviours, health related morbidity, clustering of unhealthy behaviours and potential years of life lost.
- Evidence of effectiveness for healthy living services and interventions.
- Evidence of the effectiveness of currently commissioned services including commissioner's views of gaps in provision.

This HNA report provides one strand of the service review to inform the commission and should be read in conjunction with two further reports:

- Consultation in Leeds (Burkhardt et al, 2015) which summarises the huge amount of consultation activity that has been undertaken as part of the review.
- Review of Integrated Healthy Living Services in England (Squire, 2015), which documents how other areas in the UK have developed in delivered integrated healthy living services.

2. Policy Context

In general terms, over the last ten years the Government has adopted a target-driven approach to health policy around unhealthy lifestyle behaviours. Policies and plans often exist in silos with little recognition of how these lifestyle risks are jointly distributed across the population or how people actually experienced them which was mostly more than one at a time. The challenge when developing an integrated healthy living service is to develop a joined up response to these policies which takes a person centred focus. Nationally there are policies which focus on obesity, food, physical activity, play, drugs, alcohol, mental health, suicide prevention, sexual health and tobacco control.

However preventing ill health is a high priority nationally. In the NHS Five Year Forward View (2014) (5YFV), Simon Stevens set out his vision for the NHS; he stated concern that preventable illness is widespread and health inequalities are deep rooted. There is now broad consensus on what a "better future" should be. Stevens states that the future of millions of children, the sustainability of the NHS and the economic prosperity of Britain all now depend on radical upgrade in prevention and public health. Stephens made a commitment that the NHS will target action on obesity, smoking, alcohol and other major health risks. Other significant policy drivers are:

- The Public Health Outcomes Framework (2013) which sets high level outcomes of increasing healthy life expectancy and reducing differences in life expectancy.
- The Marmot Review (2010) which promotes a life course framework for tackling the wider social determinants of health.
- The Government's white paper Healthy Lives Healthy People (2010) which places importance on action that addresses the root causes of poor health and wellbeing, reaching out to the individuals and families who need the most support and be responsive, resourced, rigorous and resilient.
- The Care Act (2014) aims to provide a coherent approach to adult social care in England and sets out duties for local authorities and partners and new rights for service users and partners. There is a focus on the wellbeing of people who need care and their carers and local authorities and their partners must take steps to prevent, reduce or delay the need for care.

Leeds City Council is delivering against strategies focusing on obesity, sport, play, parks and green space, sustainable travel, drugs and alcohol and mental health. Public health activity in Leeds is coordinated through the Joint Health and Wellbeing Strategy (2013). The overarching aim is that the strategy will deliver a reduction in the differences in the life expectancy between communities with five outcomes:

- People will live longer and healthier lives
- People will live full, active and independent lives
- People's quality of life will be improved by access to quality services
- People will be involved in decisions made about them
- People will live in healthy sustainable communities

A full policy review is included in appendix a.

3. Epidemiological data

There is a range of data available to build a picture of health related lifestyles in Leeds, morbidity in part caused by unhealthy lifestyles, potential years of life lost due to these diseases and clustering of unhealthy behaviours. These data are described in turn in this chapter. As an introduction a general overview and analysis of inequality are included.

3.1 Overview of Leeds

The Public Health England health profile for Leeds provides a general overview of the status of health locally (PHE, 2015). The health profile states that the health of people in Leeds is varied compared with the England average. Deprivation is higher than average and about 21.6% (29,800) of children live in poverty. Life expectancy for both men and women is lower than the England average and within Leeds, life expectancy is 10.8 years lower for men and 8.5 years lower for women in the most deprived areas than in the least deprived areas. In Year 6, 19.3% (1,411) of children are classified as obese. The rate of alcohol-specific hospital stays among those under 18 was 34.7 per 100,000 population; this represents 55 stays per year. Levels of teenage pregnancy, GCSE attainment and smoking at time of delivery are worse than the England average. For adults, in 2012, 19.5% of adults were classified as obese. The rate of alcohol related harm hospital stays was 639 per 100,000 population; this represents 4,528 stays per year. The rate of self-harm hospital stays was 223.5 per 100,000 population, worse than the average for England. This represents 1,817 stays per year. Estimated levels of adult smoking are worse than the England average and the rate of smoking related deaths was 368 per 100,000 population, worse than the average for England. This represents 1,313 deaths per year. The rate of sexually transmitted infections is worse than average.

3.2 The role of place

People living in the most deprived areas of Leeds experience worse health outcomes when compared to more affluent areas. Whilst in part this is shaped by lifestyle behaviours, it is also imperative for commissioners to understand the impact of people's social, economic and environmental conditions in order to develop services that meet the needs of all communities and allocate resources equitably to reduce inequalities in outcomes between communities. Figures 2 and 3 show life expectancy and deprivation in Leeds. The correlation is clear; the most deprived communities also experience the lowest life expectancy as shown in figure 4 which plots where people live by deprivation and life expectancy. These data show that where you live has an impact on health. The gap in life expectancy between the most and least deprived ward is 10.8 years.

Figure 2: Life expectancy in Leeds by MSOA
Source: Public Health Information team LCC. Exeter populations and ONS mortality data

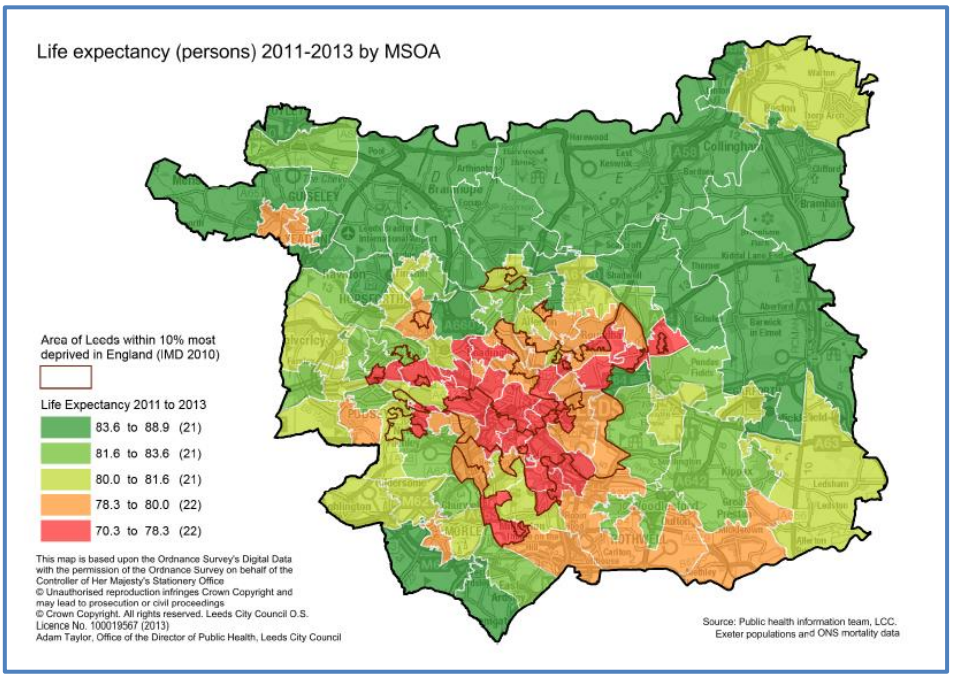


Figure 3: Deprivation in Leeds by MSOA
Source: Public Health Information team LCC. Exeter populations and ONS mortality data

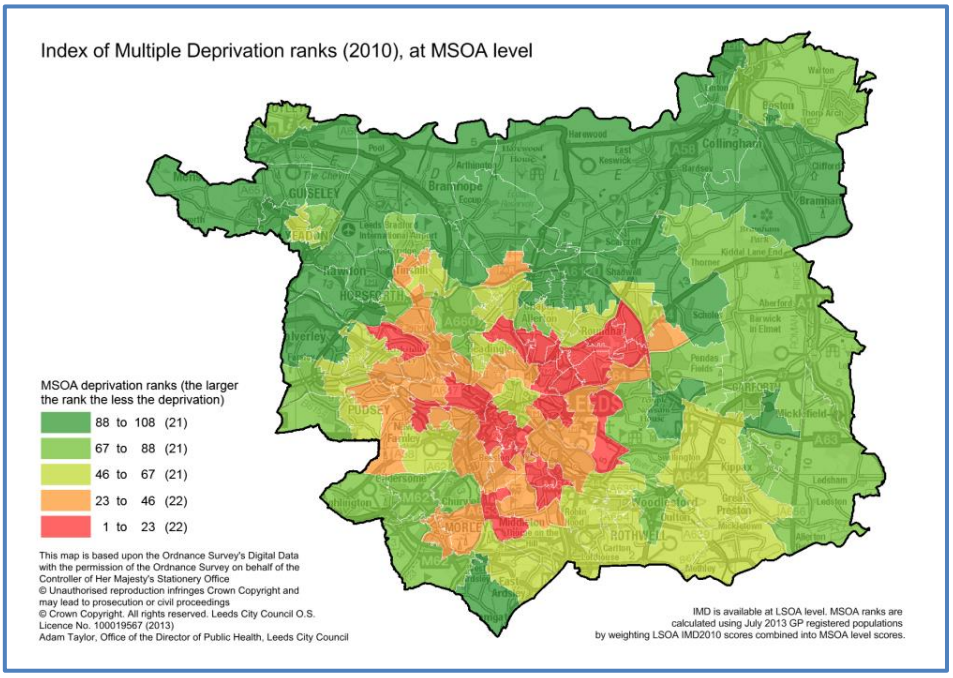
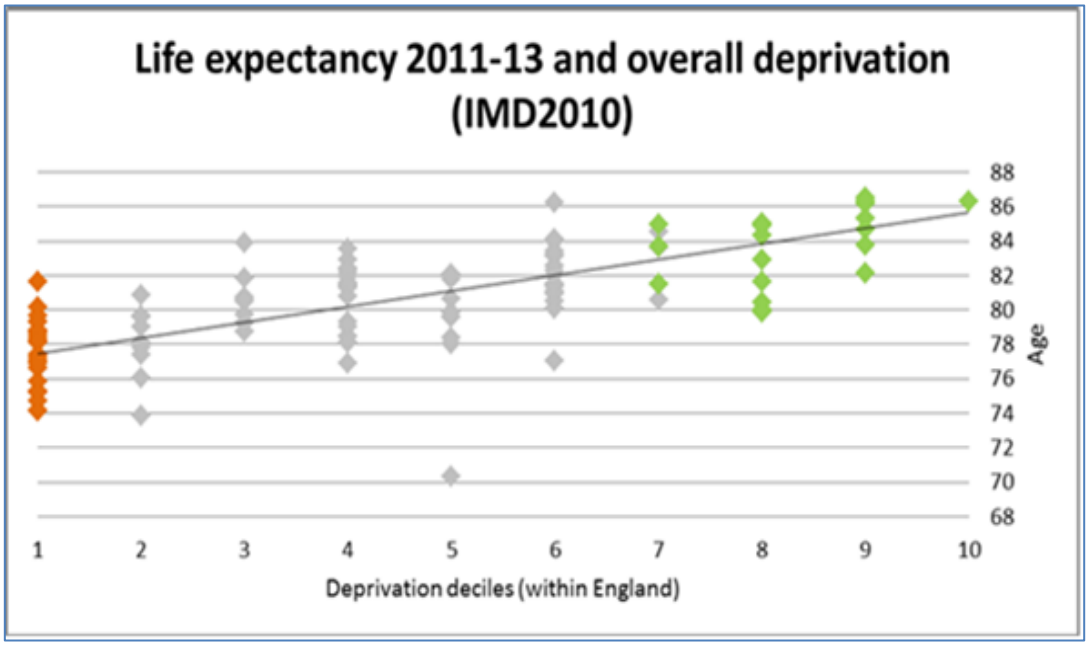
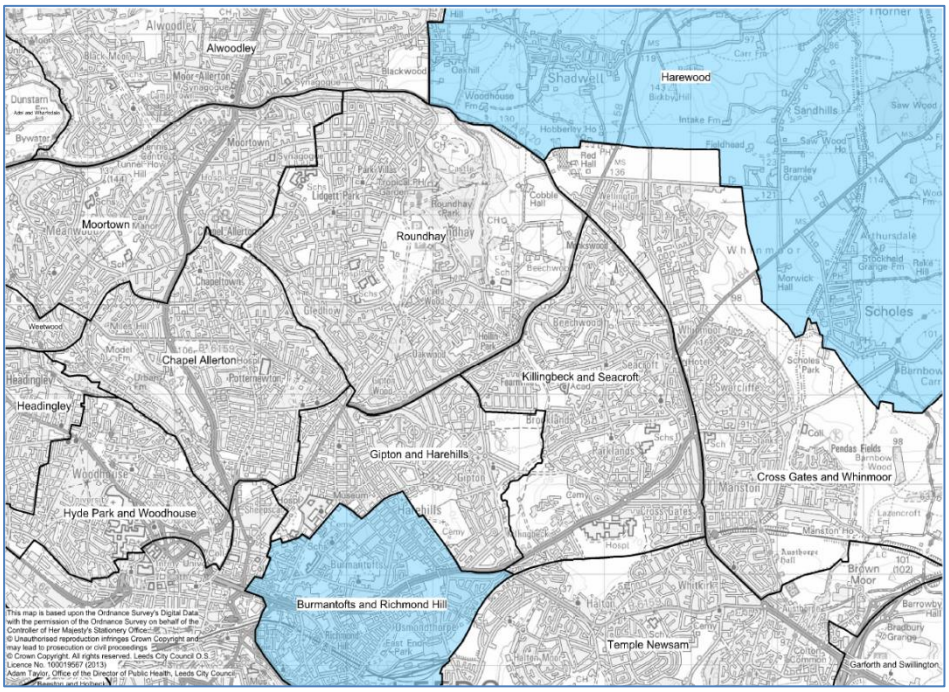


Figure 4: Life expectancy plotted against deprivation by MOSA in Leeds
Source: Public Health Information team LCC



As previously stated, whilst lifestyle factors can account for a proportion of the differences in life expectancy, there are also social, economic and environmental factors that need to be considered. Census data from a deprived and non-deprived ward can be compared to illustrate these factors which contribute to the gap in life expectancy in Leeds. Burmantofts and Richmond Hill is an inner urban ward located close to the city centre. Harewood ward is a rural ward located towards the north east of Leeds. The map below shows both wards, highlighted in blue. The distance between the outer perimeters is 4km at the closest point. The life expectancy in Burmantofts and Richmond Hill is 76.8 years, 10 years less than the life expectancy in Harewood ward which is 86.6.



Data from key domains reported in the 2011 census are pulled out in figure 5 below.

Figure 5: Data illustrating difference in determinants of health between a deprived and non-deprived ward
Source: 2011 Census

	Harewood	Burmantofts and Richmond Hill
Age and gender	• There are 18,363 people living in the ward, of which 51.5% are female and 48.5% are male • The ward has a higher proportion of people in the age bands from 45 years upwards than is average for the city	• There are 24,843 people living in the ward, of which 49.5% are female and 50.5% are male • The ward has a higher proportion of children and young people (aged 0-19) than is average for the city (28% compared 24.1%)
Population density	• There are 1.7 people per hectare (pph) in the ward, compared to a city population density of 13.6 pph	• There are 54.2 people per hectare (pph) in the ward, compared to a city population density of 13.6 pph
Ethnicity and nationality	• 94.8% of the population in the ward were born in the UK (compared to a city average of 88.6%) • 93.2% of the ward population are “White British” and 6.8% are from Black and Ethnic Minority (BME) communities, compared to a city BME rate of 18.9	• 77.6% of the population in the ward were born in the UK (compared to a city average of 88.6%) • 65.3% of the ward population are “White British” and 34.7% are from Black and Ethnic Minority (BME) communities, compared to a city BME rate of 18.9%
Household language	• In 12 households no adults but at least one child spoke English as a main language, and in 63 households there were no residents who spoke English as a main language	• In 255 households no adults but at least one child spoke English as a main language, and in 1,529 households there were no residents who spoke English as a main language
Accommodation type	• "Whole houses" or bungalows account for 94.2% of all households in the ward, (city average is 78.1%), however there are significantly more detached properties (53% compared to 14.5%) • The ward has a much lower proportion of households living in flats / maisonettes / apartments than is average for the city (5.7% compared to 21.8%)	• "Whole houses" or bungalows account for 63.8% of all households in the ward, (city average is 78.1%), however there are proportionately fewer detached and semi-detached properties (18.3% compared to 51.4%), and proportionately more terraced houses (42.5% compared to 26.7%) • The ward has a much higher proportion of households living in flats /maisonettes / apartments than is average for the city (36.2% compared to 21.8%)
Tenure	• 83% of occupied households in the ward are "owner occupied", compared to 58.6% for the city,	• 30.2% of occupied households in the ward are "owner occupied", compared to 58.6%

	although the rate for owner occupation has fallen slightly from 84.9% in 2001 (overall the city has seen a decrease in owner occupation) • 15.4% of occupied households in the ward are rented, compared to a city average of 39.9%	for the city, and the rate for owner occupation has fallen from 37.3% in 2001 (overall the city has seen a decrease in owner occupation) • 67.6% of occupied households in the ward are rented, compared to a city average of 39.9%
Rooms and Bedrooms	• The proportion of households deemed to be overcrowded has fallen slightly from 1.9% in 2001 to 1.5% in 2011 (while across the city the rate has increased from 7.8% in 2001 to 9.1% in 2011)	• The proportion of households deemed to be overcrowded has increased from 9.4% in 2001 to 14.8% in 2011 (across the city the rate has increased from 7.8% in 2001 to 9.1% in 2011)
Highest level of qualification	• 16.5% of adults in the ward have no qualifications, compared to 23.2% across the city • 39.1% of adults have level 4 or above qualifications (Bachelor's degree or equivalent, and higher qualifications), compared to a city rate of 26.9%	• 36.3% of adults in the ward have no qualifications, compared to 23.2% across the city • 14.9% of adults have level 4 or above qualifications (Bachelor's degree or equivalent, and higher qualifications), compared to a city rate of 26.9%
Limiting long term illness	• 2,781 people in the ward (15.2% of the total population) feel that they have a limiting long-term illness, lower than the city average of 16.8%	• 4,930 people in the ward (19.8% of the total population) feel that they have a limiting long-term illness, higher than the city average of 16.8%
General Health	• 3.5% of all people in the ward feel that their general health is "bad" or "very bad", compared to a city average of 5.4% • 52.5% of people feel that their general health is "very good", compared to 48.1%% for the city	• 8.3% of all people in the ward feel that their general health is "bad" or "very bad", compared to a city average of 5.4% • 43.1% of people feel that their general health is "very good", compared to 48.1%% for the city
Working age client group claimants composite figure of key benefits (source DWP) % based on working age (16-65) and not in FT education	• Working Age Client Group Claimants 5.5% (Leeds 14.2%) • Job seekers allowance (0.5%)	• Working Age Client Group Claimants 27.1% (Leeds 14.2%) • Job seekers allowance (6%)
Employment	• At the time of the 2011 Census 2.3% (304 people) of the population aged between 16 and 74 was unemployed (compared to 4.8% for the city) • The occupation with the highest number of respondents was the "professional occupations"	• At the time of the 2011 Census 9.3% (1,682 people) of the population aged between 16 and 74 was unemployed (compared to 4.8% for the city) • The occupation with the highest number of respondents was the "elementary occupations"

	(2,215 people, 25.2%) while "process, plant and machine operatives" had the lowest number (273, 3.1%)	(2,221 people, 22.1%) while "managers, directors and senior officials" had the lowest number (480, 4.8%)
Deprivation Dimension (see definition below)	• 56.3% of households are not deprived in any dimension (compared to 41.7% for the city as a whole) • 29.2% are deprived in respect of one of the above dimensions (compared to 32.2% for the city as a whole) • 12.4% are deprived in respect of two of the above dimensions (compared to 19.5% for the city as a whole) • 2% are deprived in respect of three of the above dimensions (compared to 5.9% for the city as a whole), and • 0.1% are deprived in respect of all four of the above dimensions (compared to 0.7% for the city as a whole)	• 23% of households are not deprived in any dimension (compared to 41.7% for the city as a whole) • 35% are deprived in respect of one of the above dimensions (compared to 32.2% for the city as a whole) • 28.5% are deprived in respect of two of the above dimensions (compared to 19.5% for the city as a whole) • 12.1% are deprived in respect of three of the above dimensions (compared to 5.9% for the city as a whole), and • 1.4% are deprived in respect of all four of the above dimensions (compared to 0.7% for the city as a whole)

Deprivation Dimension:

The 2011 Census provides a table that classifies households by deprivation dimension. The dimensions of deprivation are indicators based on the four selected household characteristics:

- Employment (any member of a household not a full-time student is either unemployed or long-term sick)
- Education (no person in the household has at least level 2 education, and no person aged 16-18 is a full-time student)
- Health and disability (any person in the household has general health 'bad or very bad' or has a long term health problem), and
- Housing (Household's accommodation is ether overcrowded, with an occupancy rating -1 or less, or is in a shared dwelling, or has no central heating)

A household is classified as being deprived in none, or one to four of these dimensions in any combination.

The data presented in figure 5 above show a very different picture in terms of the way people live in the two wards terms of their environment, experiences and potential opportunities. People living in the Burmantofts and Richmond Hill area generally live in more over crowded situations both in terms of housing and shared open space, properties are less likely to be owner occupied and more likely to be terraced or flats therefore without an area of exclusive household open space. Whilst there is a higher proportion of children in the Richmond Hill and Burmantofts area, education attainment at higher level is achieved by a smaller percentage of the population and a greater percentage of the population are unemployed or in

'elementary 'occupations, there is a higher proportion of people from BME groups and more households where English is not spoken as the main language.

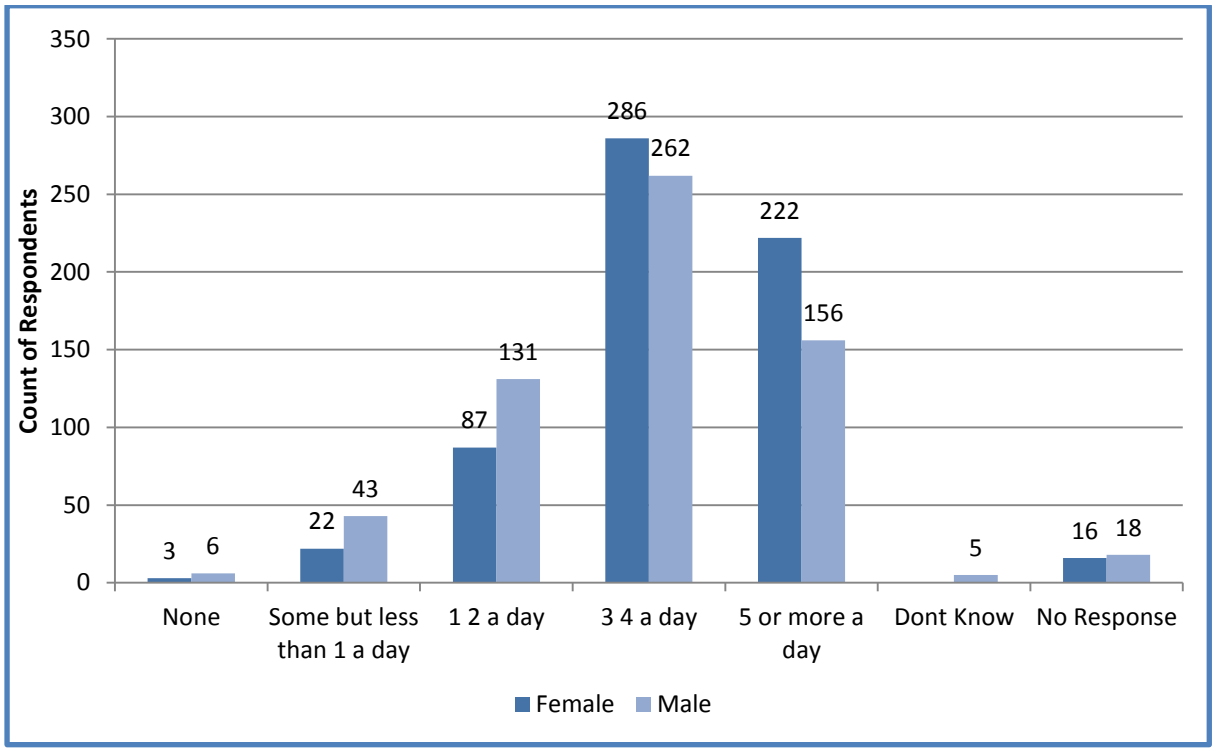
More detail about lifestyle, lifestyle related ill health, potential years of life list and clustering of unhealthy lifestyles and co-morbidities is included in this chapter.

3.3 Lifestyles

3.3.1 Five a day

Leeds Healthy Communities survey (2013) was commissioned by the Leeds City Council Public Health Intelligence Team and carried out through the Citizens Panel. The panel is made up of 3,833 people. 1,395 people responded to the survey (response rate 36%). The panel were asked "On average, how many portions of fruit and vegetables (including fresh, frozen, tinned and dried) do you eat each day? A portion is a handful. Fruit juice counts as a maximum of a portion a day". Figure 6 shows how many portions of fruit and vegetables were consumed by gender. The data suggest that more women than men eat five or more portions of fruit or vegetables and the majority of respondents ate more than three portions a day.

Figure 6: Fruit and vegetable consumption in Leeds
Source: Leeds Healthy Communities Survey 2014

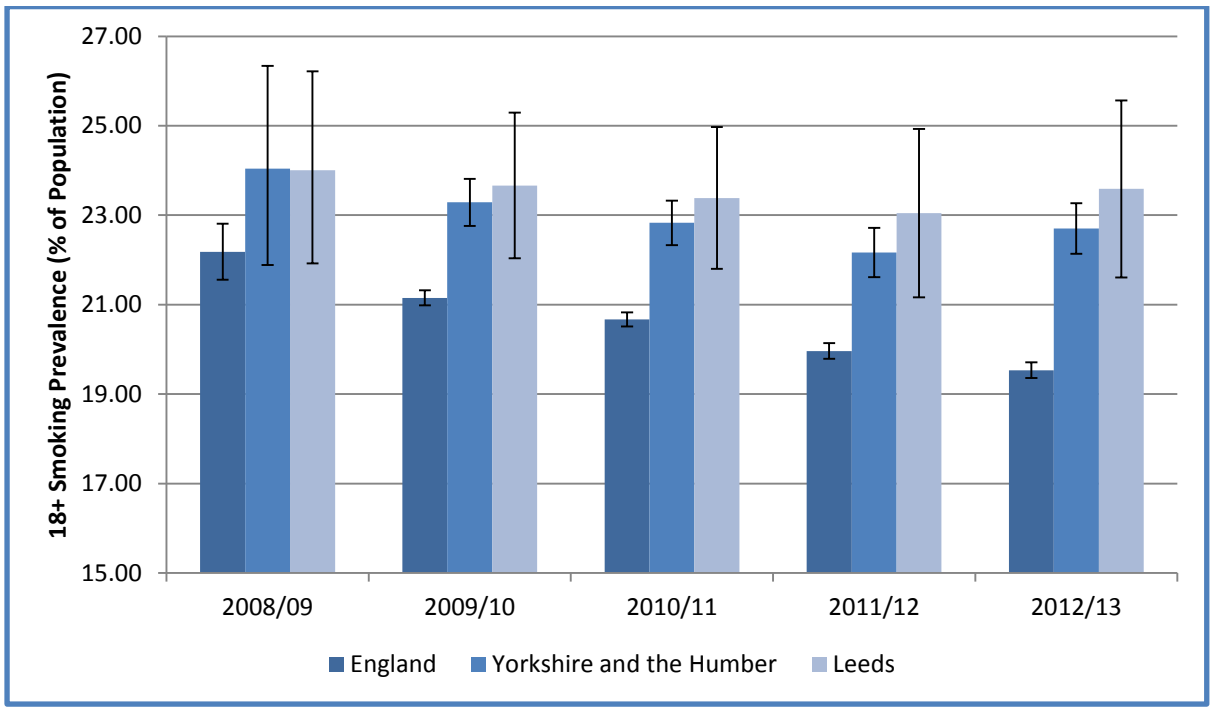


These data are from a small sample and likely to be biased as members of the Citizens Panel are probably unrepresentative of the whole population of Leeds. It is expected that the true pattern of consumption of fruit and vegetables in Leeds is less than figure 6 above shows.

3.3.2 Smoking prevalence

Smoking prevalence data are available from PHE. Figure 7 below is a bar chart illustrating smoking prevalence amongst people aged 18 and over from 2008 – 2013 comparing data from England, Yorkshire and the Humber and Leeds. The data show that the proportion of the population who smoke is higher than both England and the region. These data show that smoking prevalence in Leeds has changed from 24% in 2008/9 to 23.59% in 2012/13.

Figure 7 Smoking prevalence as a % of the population aged 18 and over in Leeds, West Yorkshire and England.
Source: PHE Health Profiles



Smoking data are also available from primary care audits conducted by Leeds City Council Intelligence Team. The audit data are relatively accurate with 96.1% of people aged 16 and over have their smoking status recorded, although this figure is for “ever recorded” so could be out of date. This figure is only for people who are registered with a GP.
The January 2015 audit showed that across Leeds, 21.1% of people aged 16 and over smoke, that is 146,245 smokers. There are differences between CCG areas. The highest rates of smoking are in South and East CCG, with 25.8% of the population smoking (54,900 people), lowest in North CCG area (17.0%, 29,046 people) and lower than average in the West CCG area (20.1%, 62,299 people). There are also differences between deprived and non-deprived Leeds. The audit shows the rate of smoking in deprived Leeds is 25.7% compared with the rate in non- deprived Leeds of 15.6%. Figure 8 and 9 below shows smoking prevalence by ward in Leeds. The ward with lowest prevalence is Harewood and the ward with highest prevalence is Burmantofts and Richmond Hill.

Figure 8: Percentage of population over 16 who are smokers, by ward in Leeds.
Source: Leeds City Council Public Health Intelligence Team, GP Audit, January 2015

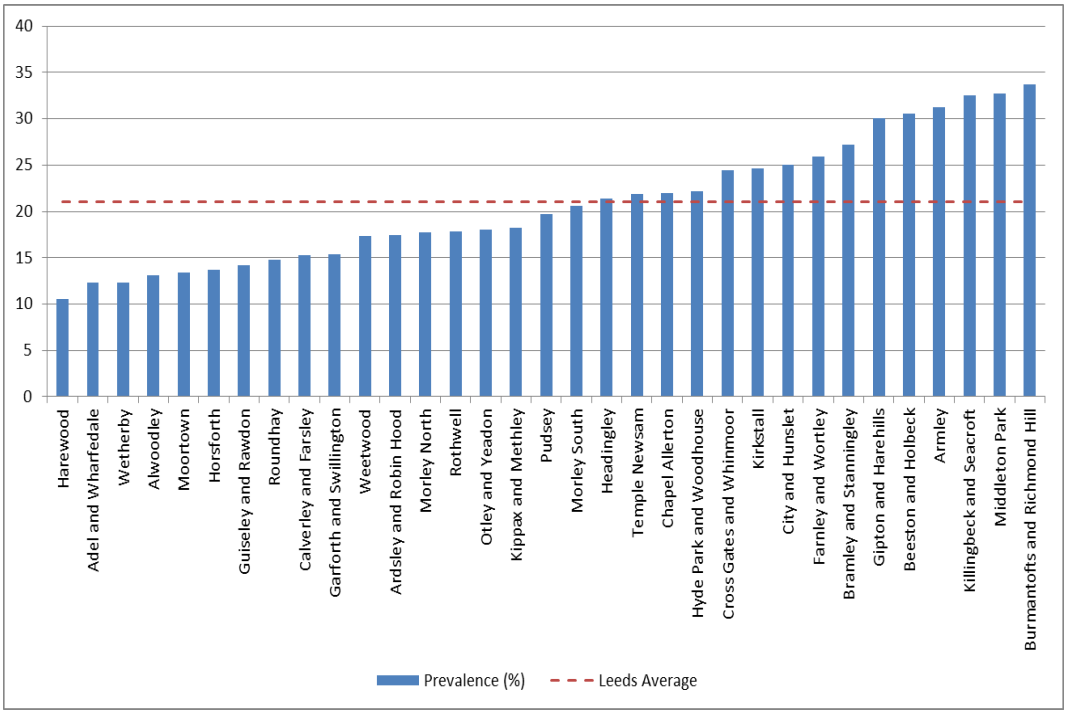
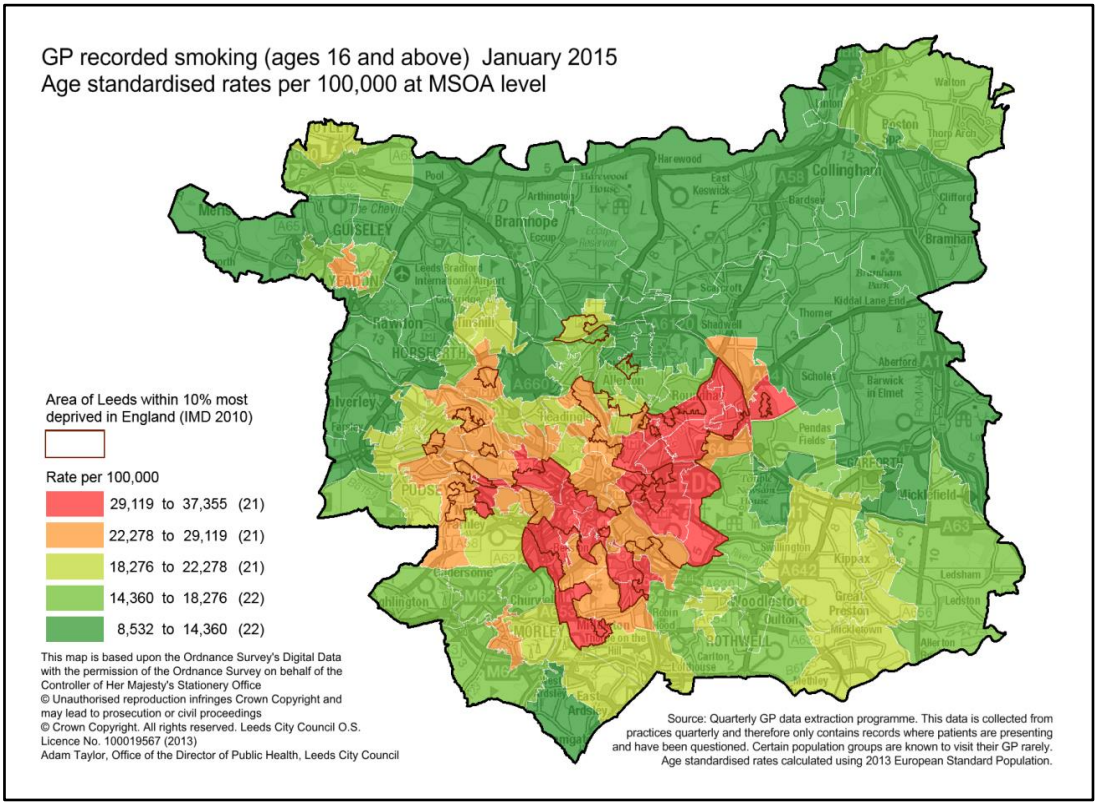


Figure 9 Map of standardised smoking rates per 100,000 age 16 and above by MSOA in Leeds
Source: Leeds City Council Public Health Intelligence Team, GP Audit, January 2015



While smoking rates have significantly fallen in the general population, rates remain higher amongst some subgroups. Figure 10 below shows smoking rates nationally, regionally and for Leeds where we have these data. In Leeds, smoking rates are highest among people with mental health problems (40.7%) and routine and manual workers (32.4%). Smoking rates are lower than general amongst BME groups, pregnant women and 15 year olds.

Figure 10: Percentage of people who smoke by subgroup.
Source: Leeds City Council GP Audit data*, 2015 and Tobacco Profiles**

	National	Regional	Leeds
Population**	18.4%	20.3%	21.6%
Smoking in pregnancy at time of delivery**	12%	16.2%	13.2%
Regular smoking aged 15 years (modelled estimates)**	8.7%	-	9.6%
Smoking in routine and manual workers**	28.6%	30.7%	32.4%
Smoking in BME groups*	-	-	11.5%
Smoking in people with mental health problems*	-	-	40.7%

3.3.3 Physical activity adults

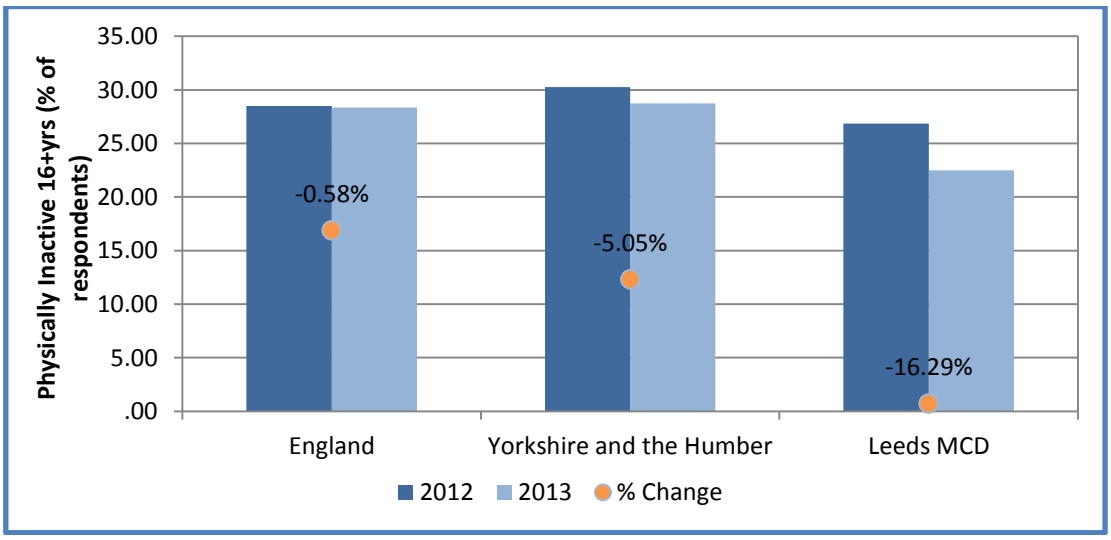
Data sources describing physical activity levels in Leeds are poor. There are many different measurements used, and no single source has a comprehensive sample size. The Chief Medical Officer guidance for physical activity levels for adults states that over a week, activity should add up to at least 150 minutes of moderate intensity activity in bouts of ten minutes or more. This can be achieved by exercising 30 minutes on at least five days a week.

The Public Health Outcomes Framework measure for physical activity in adults in Leeds shows that 57.7% of adults in Leeds are achieving 150 minutes of physical activity a week (see Figure 11 below). These figures are worked out using the Active People Survey with the additional inclusion of walking data, utility cycling and some extra dance forms.

Figure 11: Percentage of people aged 16 and over who undertake 150 minutes or more physical activity per week
Source: Public Health Outcomes Framework Data

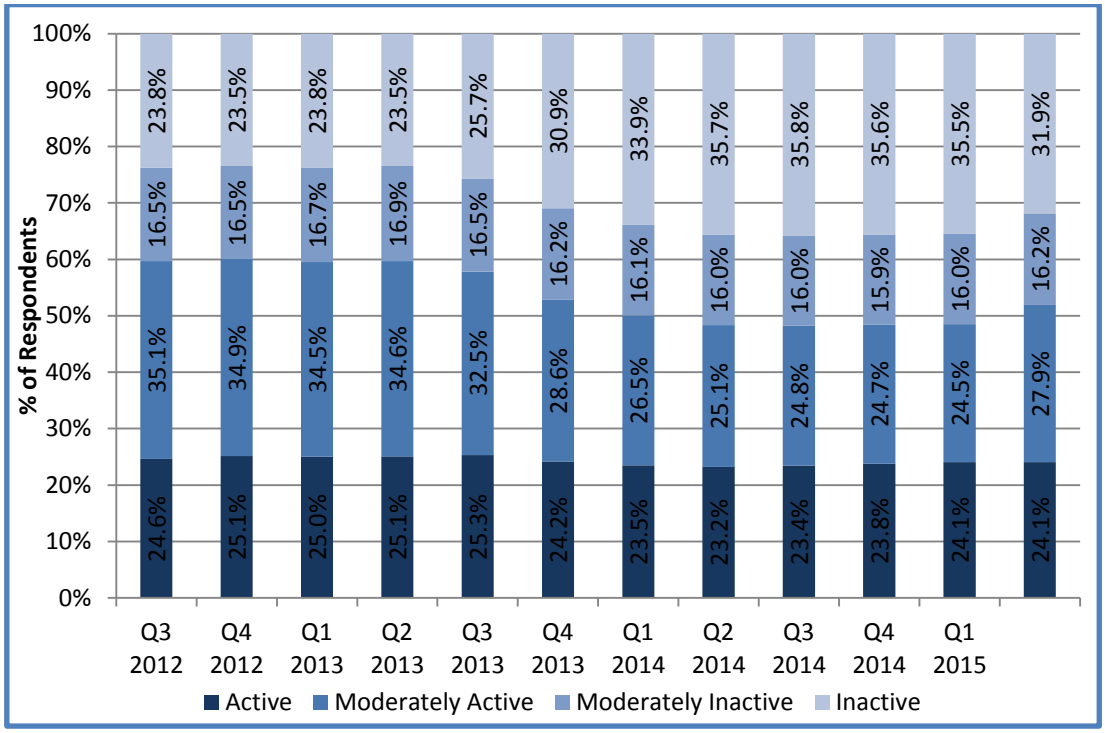
The Public Health Outcomes Framework also collects data on people aged 16 and above who are inactive. This is defined as people who take 30 minutes of less of physical activity per week. Figure 12 below shows that in 2012 and 2013 the percentage of people aged 16 and above in Leeds who were inactive was lower compared to Yorkshire and the Humber and England. Although there is a 6% drop in people taking more than 150 minutes of physical activity per week, there was also a 4% reduction in the percentage of people who take 30 minutes or less of physical activity per week. The Public Health Outcomes Framework measure for physical inactivity in adults in Leeds shows that 22.5% of adults in Leeds are achieving less than 30 minutes of physical activity a week.

Figure 12: Percentage of people aged 16 and over who undertake 30 minutes or less physical activity per week
Source: Public Health Outcomes Framework Data



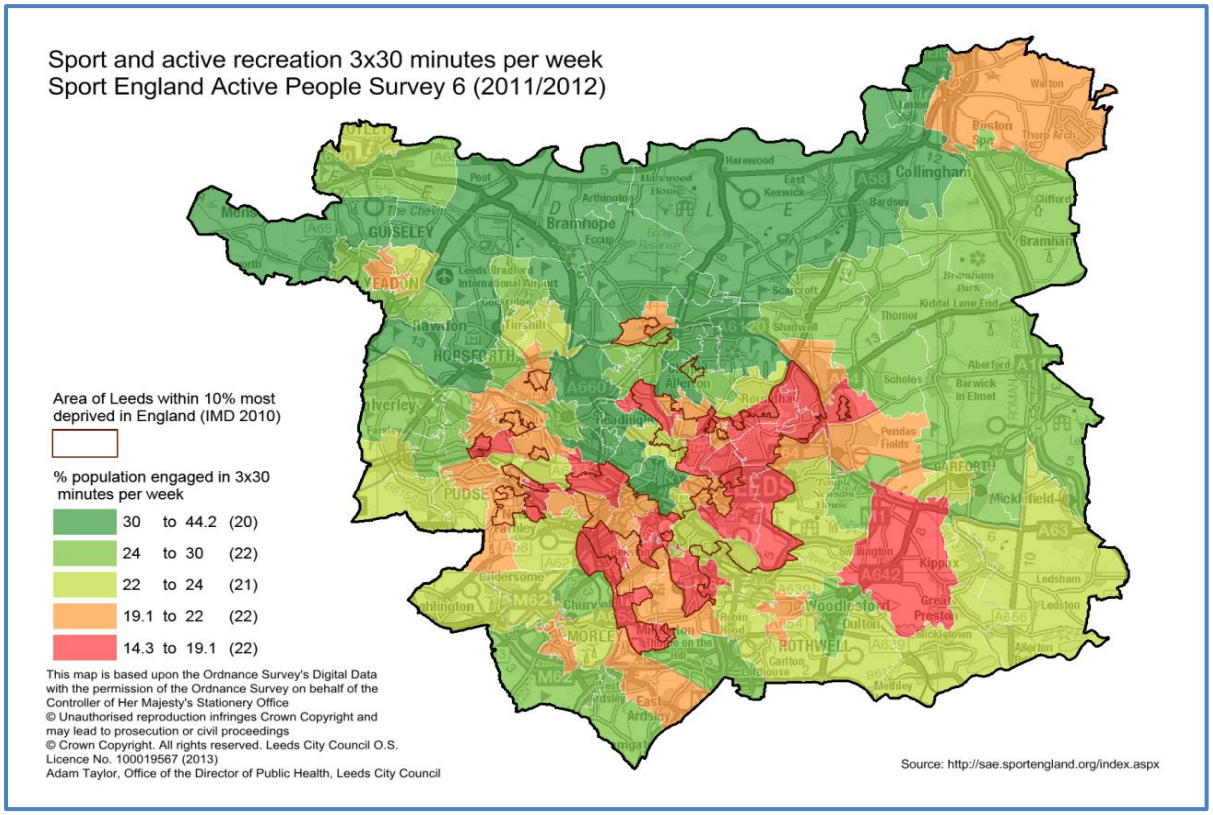
In Leeds we also have local data from GPs and the Sport England Active People Survey. Within primary care, physical activity level data are collected in one of two ways, either as part of the 40+ NHS Health Check, where attendees are invited to complete an audit of their physical activity or data are collected by GPs when patients attend the practice for weight management support. Figure 13 below shows results by quarter from mid-2012 to the beginning of 2015. These data show between 2012 and 2015 the percentage of active adults has fluctuated between 24.6% and 24.1% but not changed significantly. In the same time period the percentage of respondents who are inactive has increased from 23.8% to 31.9%.

Figure 13: GP Physical Activity Questionnaire results Leeds 2012 – 2015
Source: GP quarterly audit data, Leeds City Council Public Health Intelligence Team



The Active People Survey is conducted annually by Sports England. Approximately 500 people in Leeds are surveyed; therefore we would expect to see fluctuations in annual figures as these data are not statistically significant. It is included in this HNA as it is the only annual survey of physical activity in Leeds. The most recent Active People Survey (APS 9) found that 42.7% of Leeds residents participate in 30 minutes physical activity per week which represents a 6.3% increase from the baseline (APS 1 October 2005/6).

Figure 14: Map of participation in sport and active recreation 3 x 30 minutes per week by MSOA in Leeds
Source: Leeds City Council Public Health Intelligence Team, Sport England Active People Survey 6



3.3.4 Physical activity children

The Chief Medical Officer guidance for physical activity levels for all children and young people (aged 5 to 18 years) stated that they should engage in moderate to vigorous intensity physical activity for at least 60 minutes and up to several hours every day.

The Health Survey of England (2008) found that overall, 28% of children aged between 2 and 15 years met the government's recommendations for physical activity. A higher proportion of boys (32%) than girls (24%) were classified as meeting the government's recommendations for physical activity.
The Health Survey of England (2008) also showed that of girls aged between 13 and 15 years, only 8% met the government's recommendations for physical activity. Figure 15 below reports on 2 years aggregated data from the 2013/14 - 2014/15 'My School My Health' Survey and shows the percentage of children reporting doing 7 hours or more hours of physical activity per week.

Figure 15: Children reporting seven or more hours of physical activity per week by age, gender and banding in Leeds
Source: My School My Health Survey

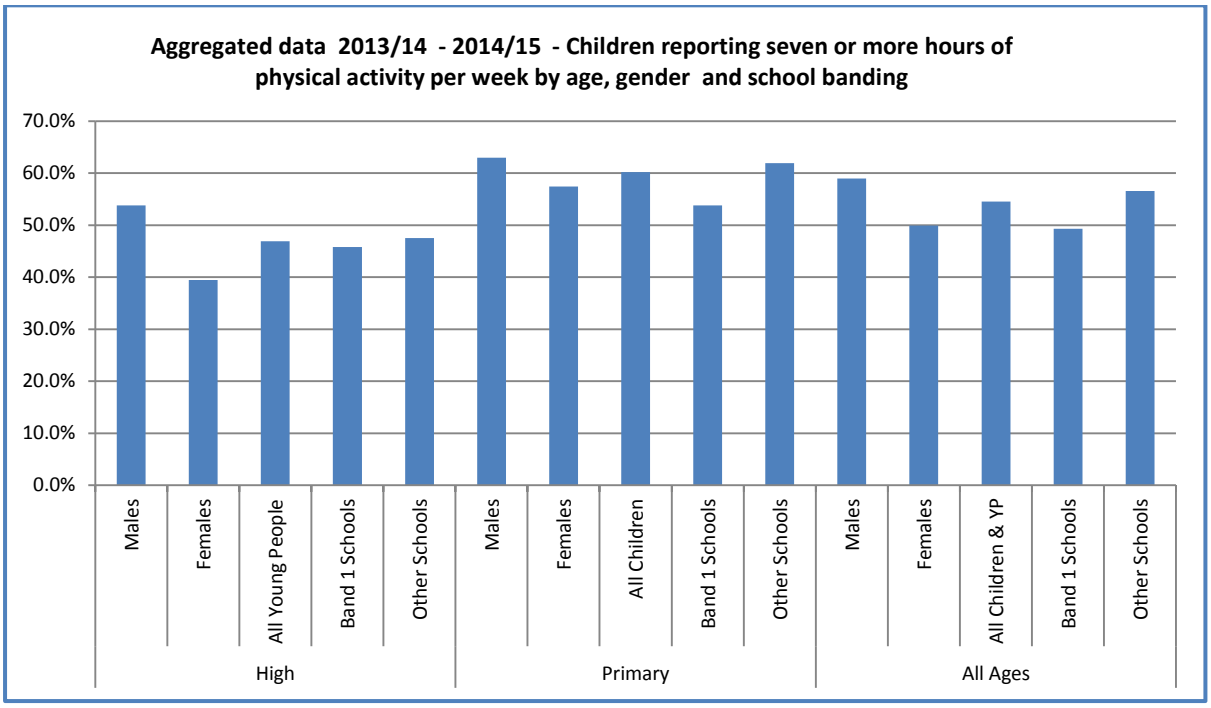
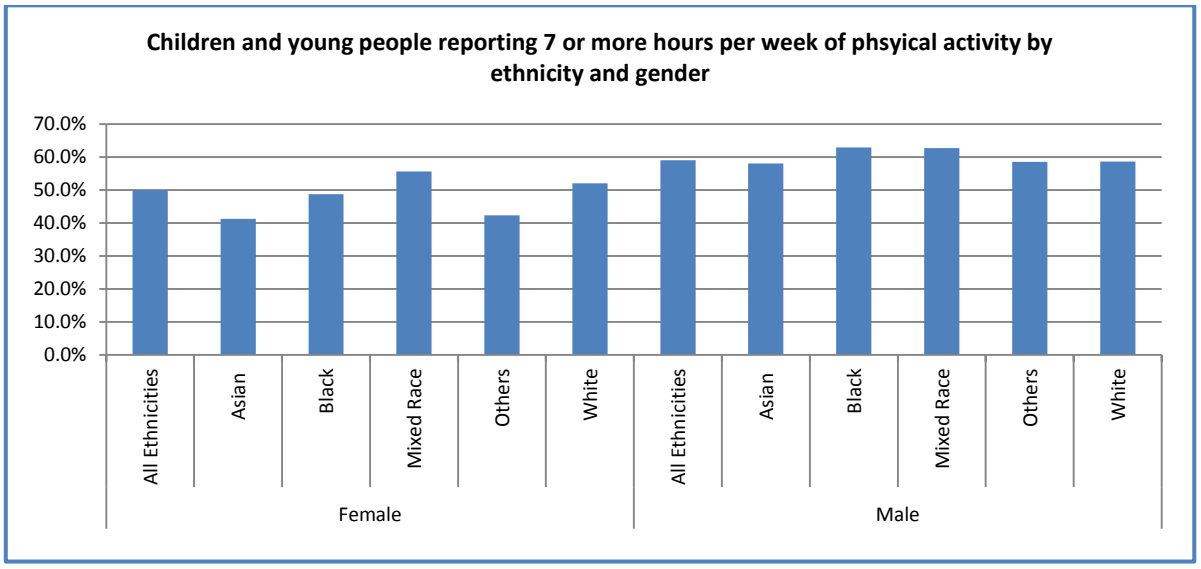


Figure 15 above shows that although there are differences between children of different socio-economic group and gender almost half of all children fail to achieve the government recommendation of 7 hours a week (one hour a day) regardless of their gender or background. The data shows that children of primary school age are significantly more active (60.2%) than those of high school age (46.9%). Girls of high school age are the most inactive group with only 39.5% achieving 7 hours a week or more of physical activity. Girls are more inactive (49.9%) than boys (59%) at all ages though this is not statistically significant at primary school age. Children from Band 1 schools (deprived Leeds) are significantly more inactive (53.8%) than those from other schools (61.9%) at primary school but at high school ages there is no longer a significant difference as all young people are reporting lower physical activity levels.

Figure 16 below shows physical activity levels by ethnicity and gender. There are statistically significant differences between the reported levels of physical activity of children from the “all ethnicities” group compared to children from white groups across both genders. Between males of different ethnicities there are no significant differences in the rates but between females of different ethnicities, Asian girls’ levels of physical activity are significantly lower than the white girls.

Children who are Looked After, have poorer health outcomes than average and while we lack data on their physical activity levels locally, national evidence suggests they have more barriers to accessing physical activity and are therefore more likely to be inactive.

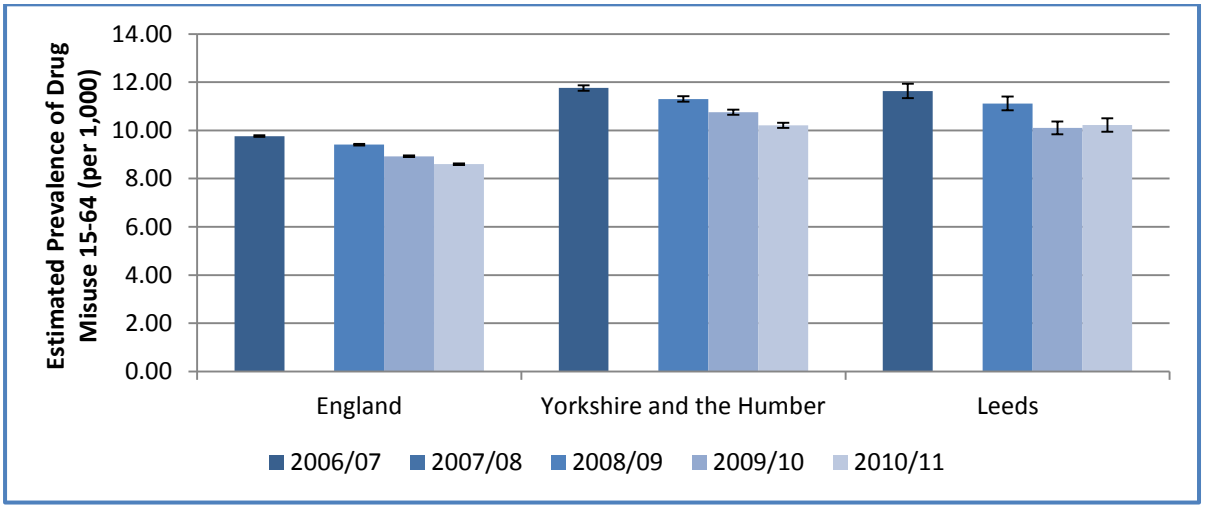
Figure 16: Children reporting seven or more hours of physical activity per week by ethnicity and gender in Leeds
Source: My School My Health Survey



3.3.5 Drug misuse

Figure 17 below shows PHE estimates for drug misuse amongst people aged 15 to 64 per 1,000 population. PHE define drug misuse as people who use opiates and or crack cocaine. Data are unavailable for 2007. These data show a downward trend for Leeds between 2006 and 2011, however there was a slight increase between 2009/10 and 2010/11. Prevalence is similar across Leeds and Yorkshire and the Humber; both areas have higher prevalence when compared to the data for England.

Figure 17: Estimated drug misuse 2006 – 11 (no data available 2007)
Source: PHE Health Profiles



Information was gathered by Public Health colleagues about drugs and alcohol use in Leeds to inform the recent re-commission of drugs and alcohol services. The drugs data was primarily from the Joint Strategic Needs Assessments 2012 and

2013, the Recovery Diagnostic Tool, the PHE Drug Treatment in England 2012-13 report and the National Drug Treatment Monitoring System (NDTMS), including the DOMES reports and Needs Assessment. Alcohol data are from drugs services. These data are summarised below:

3.3.5.1 Drugs

- Leeds has fewer non-Opiate and Crack Users (non-OCUs) in treatment compared with other cities in our cluster and nationally.
- There has been a steady improvement in the number of successful completions in Leeds since 2010; however there is a need to continue to improve in order to reach our top quartile and match the current national rate, in particular in relation to non-OCUs.
- Success rates are better for women than men in Leeds.
- Leeds has an ageing drug treatment population.
- People stay in drug treatment for longer in Leeds.
- When clients exit drug treatment in Leeds, the majority do not re-present within 6 months.
- The vast majority of people entering drug treatment in Leeds have a heroin or other opiate problem.
- Leeds has more people in drug treatment with children living with them than the national average.
- Waiting times for drug treatment in Leeds are good.
- Leeds has more 'complex' clients than the national average.
- Clients in drug treatment predominantly live in LS9, LS11 and LS12.

3.3.5.2 Alcohol

- There has been an increase in the number of people in alcohol treatment; however Leeds is still below the national target to have 15% of dependant drinkers in treatment.
- Waiting times for alcohol treatment in Leeds are not always in line with national averages, and re-presentations are higher.
- More than half of adults receiving alcohol treatment in Leeds are parents.
- The majority of people entering alcohol treatment are drinking at 'higher risk' levels.
- The alcohol treatment population in Leeds has a range of complexities.
- Most people in alcohol treatment in Leeds are White British, and very few are older people.

3.3.6 Wellbeing

3.3.6.1 Mental Well-being in Leeds

The ONS recommend using the Warwick Edinburgh Mental Well-being Scale (WEMWBS) when measuring wellbeing. The WEMWBS aims to measure mental wellbeing itself and not the determinants of mental wellbeing, which include resilience, skills in relationship, conflict management and problem solving, as well as socioeconomic factors such as poverty, domestic violence, bullying, unemployment, stigma, racism and other forms of social exclusion.

In Leeds, the WEMWBS tool has been used for the New Wortley Wellbeing Survey April-June 2015 which was commissioned by Leeds West CCG and undertaken by Yorkshire and Humber Commissioning Support Unit. As part of the identification of health needs in Leeds West, particularly the New Wortley area, it was realised that there was a gap in regards to understanding the mental wellbeing of residents. This prompted the New Wortley wellbeing survey which aimed to provide a snapshot of mental wellbeing for the area and help to target interventions, particularly in relation to the mental health planning and commissioning agenda.

The short version of the Warwick Edinburgh Mental Wellbeing Scale (SWEMWBS) was used to measure wellbeing, in a survey alongside demographic questions. An appropriate sample was calculated and stratified by age and gender by the Public Health team, the survey was undertaken by the Healthy Living Network and the analysis and reporting of results was undertaken by the Health Economics, Evidence and Evaluation Service (HEEES).

Despite some caveats, some of the key results include the overall New Wortley scores being similar to the national average wellbeing scores (Health Survey, 2011). Those who were unemployed have a statistically significant lower wellbeing score than those in employment. This is also reflected in respondents reporting a disability having a statistically lower wellbeing score than those not reporting disability. The lowest wellbeing scores were in the 18 – 24 year old age group across both genders and this age group had the highest proportion of respondents with a score of < 20.

When considering the survey results with the findings of local engagement work there are some similarities emerging in that for those who participated in the engagement project. Despite hardships and deprivation in the area the engagement project stated ‘a tangible community spirit shone through’ and this possibly reflects in the wellbeing of participants willing to engage and interact to participate in the survey. This emphasises the importance of targeting interventions at those who are less likely to engage and may be more isolated from this community spirit culture. This is reflected in the demographic of those with wellbeing scores of < 20, LS12 Patient Empowerment Project (PEP) clients and the under representation of a similar group in the survey.

The key recommendation from this report is that these results should be considered and triangulated further with other health and social care intelligence and population demographic data to help identify potentially vulnerable groups and target appropriate interventions to those who need them, when they need these most.

However, the concept of ‘mental well-being’ as it is currently used in this field is still characterised by a lack of clarity over boundaries, definitions and tools for evaluation and by a lack of evidence of ‘what works’.

3.3.6.2 Happiness, Satisfaction and Anxiety

Figure 18 below shows the percentage of respondents to the ONS Annual Population Survey who report low levels of happiness. In 2011/12 and 2013/14, survey respondents in Leeds showed lower levels of happiness compared to

Yorkshire and the Humber and England. In 2012/13 a smaller percentage of respondents from Leeds stated they had low levels of happiness.

Figure 18: Percentage of respondents reporting a low level of happiness in Leeds, West Yorkshire and England 2011 – 2014
Source: Public Health Outcomes Framework

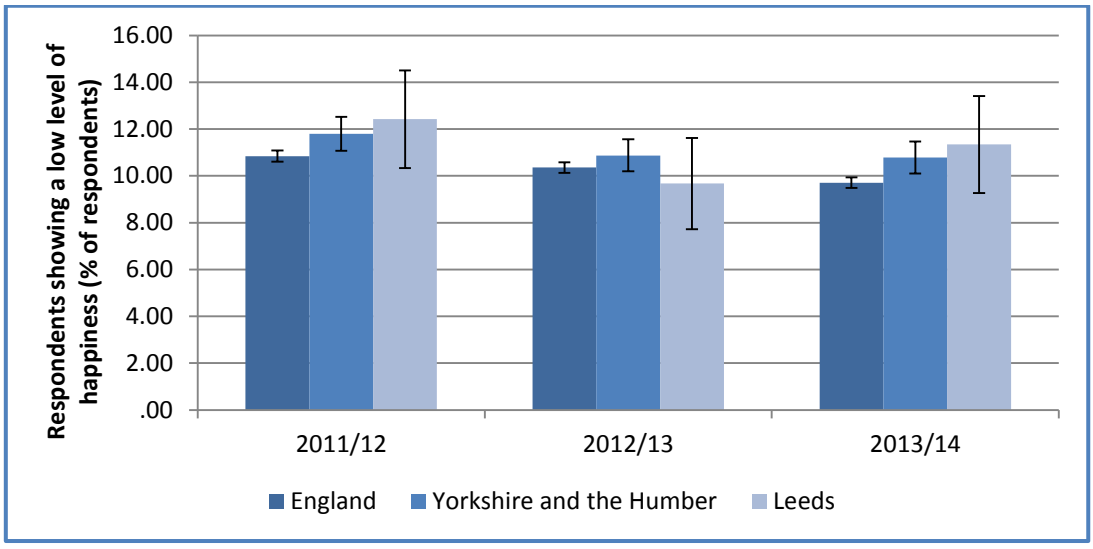


Figure 19 shows percentage of respondents to the ONS Annual Population Survey who score 0-4 report to the question "Overall, to what extent do you feel the things you do in your life are worthwhile?" In 2013/14, the survey respondents in Leeds showed lower levels of satisfaction (5.5%) compared to Yorkshire and the Humber (6.0%) and England (5.6%). Low levels of worthwhile scores have decreased in Leeds when compared to 2011/12.

Figure 19: Percentage of respondents reporting low worthwhile scores in Leeds, West Yorkshire and England 2011 – 2014
Source: Public Health Outcomes Framework

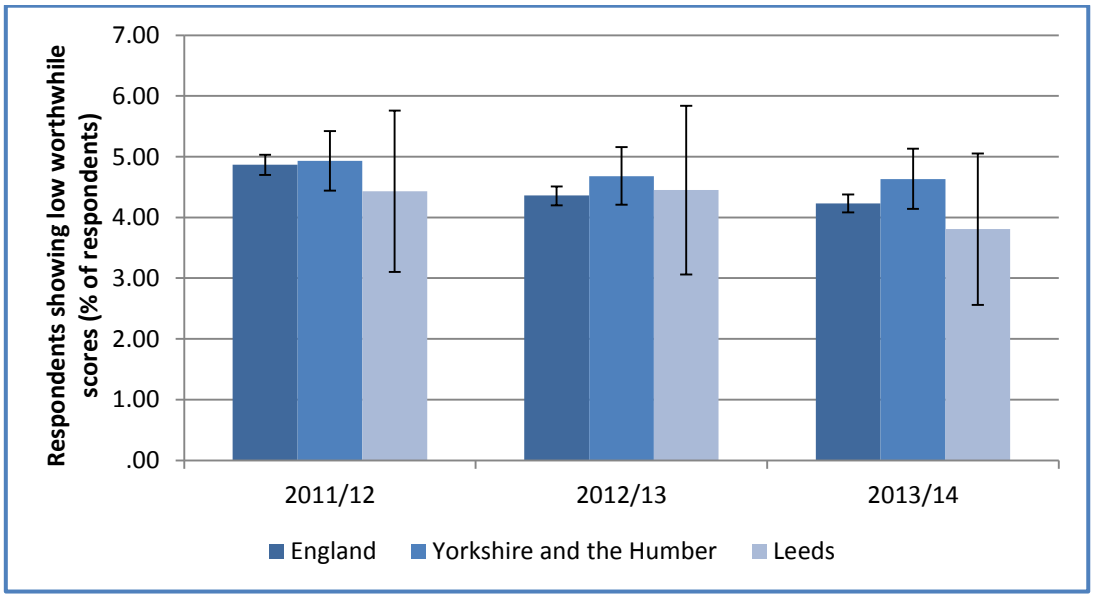
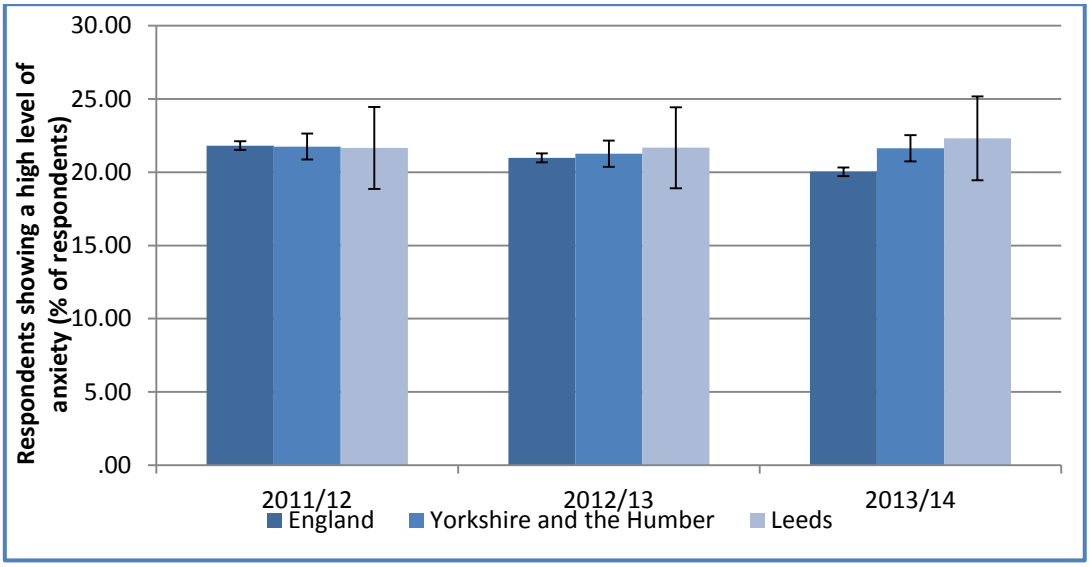


Figure 20 shows the percentage of respondents to the ONS Integrated Household Survey scoring 6-10 to the question "Overall, how anxious did you feel yesterday?" In 2013/14, the survey respondents in Leeds (22.3%) showed a higher anxiety score compared to Yorkshire and the Humber (21.6%) and England (20.0%). Levels of anxiety in Leeds have shown an increase when compared to 2011/12.

Figure 20: Percentage of respondents reporting high levels of anxiety in Leeds, West Yorkshire and England 2011 – 2014
Source: Public Health Outcomes Framework



3.4 Lifestyle related ill health

Many of the chronic diseases such as heart disease, diabetes and some cancers could be prevented by eliminating or modifying shared risk factors such as smoking, lack of physical activity, poor diet and alcohol use (WHO, 2008). These shared risk factors are illustrated in Figure 21 below. In addition, there is a two way relationship between how we think and feel and physical health, and the impact physical illness has on mental health. The CMO report (2013) cites that people with a chronic medical condition have a 2.6-fold increase in the odds of having a mental illness, compared to those without a chronic medical condition.

Figure 21: Shared risk factors for preventable illness
Source: WHO 2008

Risk Factor	Diabetes	Heart Disease	COPD	Cancer
Smoking	High risk	High risk	High risk	High risk
Drinking	High risk	High risk		High risk
Diet	High risk	Risk		Risk
Obesity	High risk	Risk		High risk
Lack of exercise	High risk	High risk	Risk	High risk

We have used GP audit data to share an epidemiological picture of lifestyle related ill health in Leeds as it is the most reliable and up to date data source available. However GP data are only able to provide intelligence on diagnosed illness. The Leeds City Council Public Health Intelligence team have compared modelled data which calculates and expected prevalence, with the actual prevalence recorded on GP systems for COPD, CVD and Diabetes. The modelled data are an estimate, often based on old data but is included to illustrate the complexity of assessing need based on diagnosed illness.

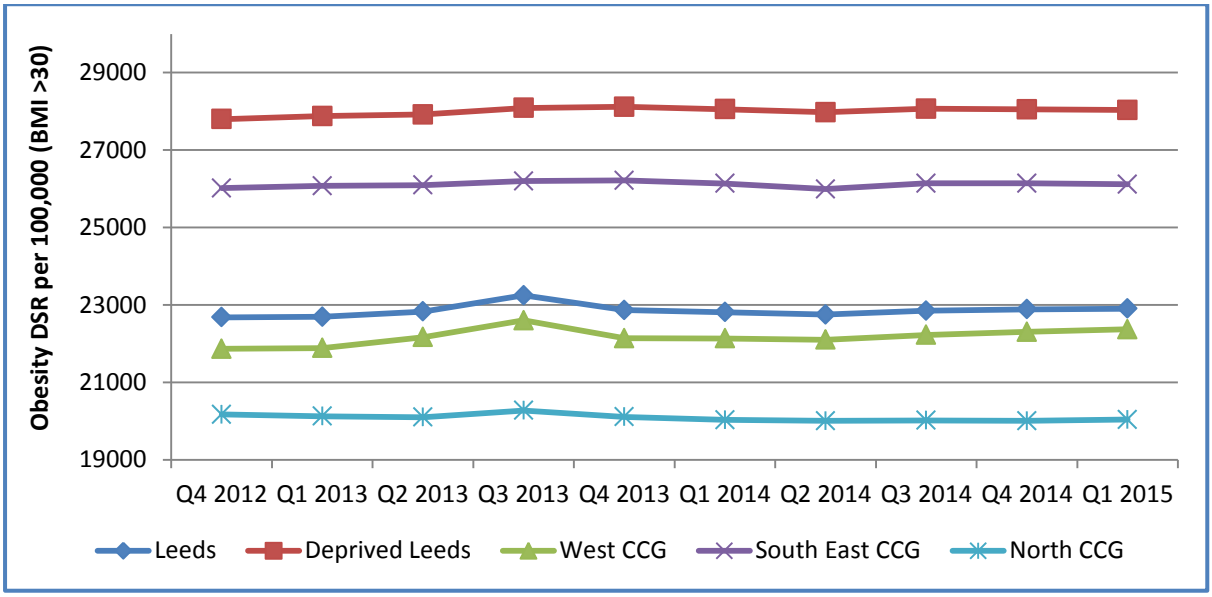
Figure 22: Modelled versus diagnosed prevalence of illness in Leeds
Source: National Diabetes Information Service, APHO, ERPHO, GP Audit January 2015

Condition	Modelled prevalence (%)	GP recorded prevalence (%)	Difference (n)
COPD	4.36	2.30	14,373
CVD	10.61	9.71	6,240
Diabetes	7.04	5.62	9.855

3.4.1 Obesity in adults

Figure 23 below shows the prevalence of obesity (BMI 30 and above) using GP audit data. The number of people with a Body Mass Index (BMI) recorded is 671,503 or 79.35%. 85.14% of people aged 16 and over have their BMI recorded. As with smoking, we do not know when the BMI was recorded. Figure 19 shows the rates of obesity are far higher in the deprived quintile of Leeds and significantly higher in Leeds South and East CCG area. Between 2012 and 2015 obesity rates have remained steady, slightly rising in the West and slightly falling in the North.

Figure 23: Directly standardised prevalence of people with a BMI of 30 and above in Leeds 2012 – 2015
Source: GP quarterly audit data, Leeds City Council Public Health Intelligence Team



GP audit data can also be analysed by Ward. Figure 24 shows that the ward with the lowest percentage of population aged 16 and above who are obese (BMI of 30 or above) is Headingley and the ward with the highest percentage is Middleton Park. Across Leeds, 21.6% of people aged 16 and over have a BMI of 30 and above; that equates to 130,114 people. The proportion is higher in South and East CCG area (25.68% and 48,361 people) and lower in the North (19.57% and 28,775 people) and West (19.88% and 52,978 people).

Figure 24: Percentage of people aged 16 and above with a BMI of 30 or over by ward.
Source: Leeds City Council Public Health Intelligence Team GP Audit, January 2015

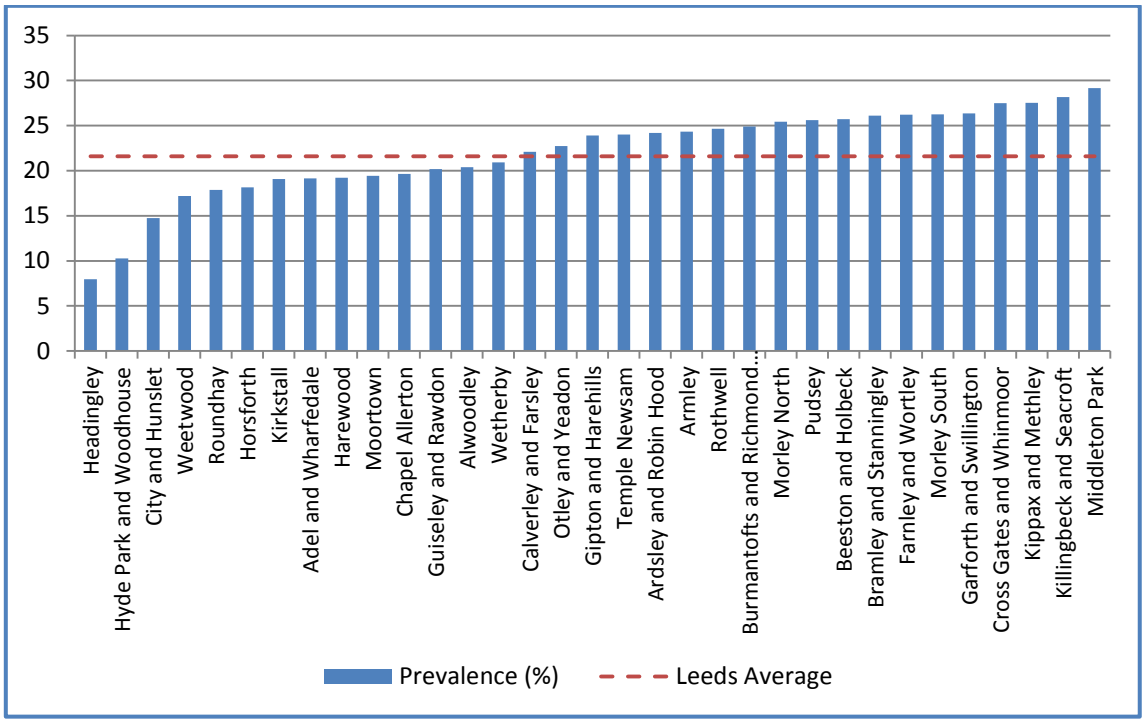
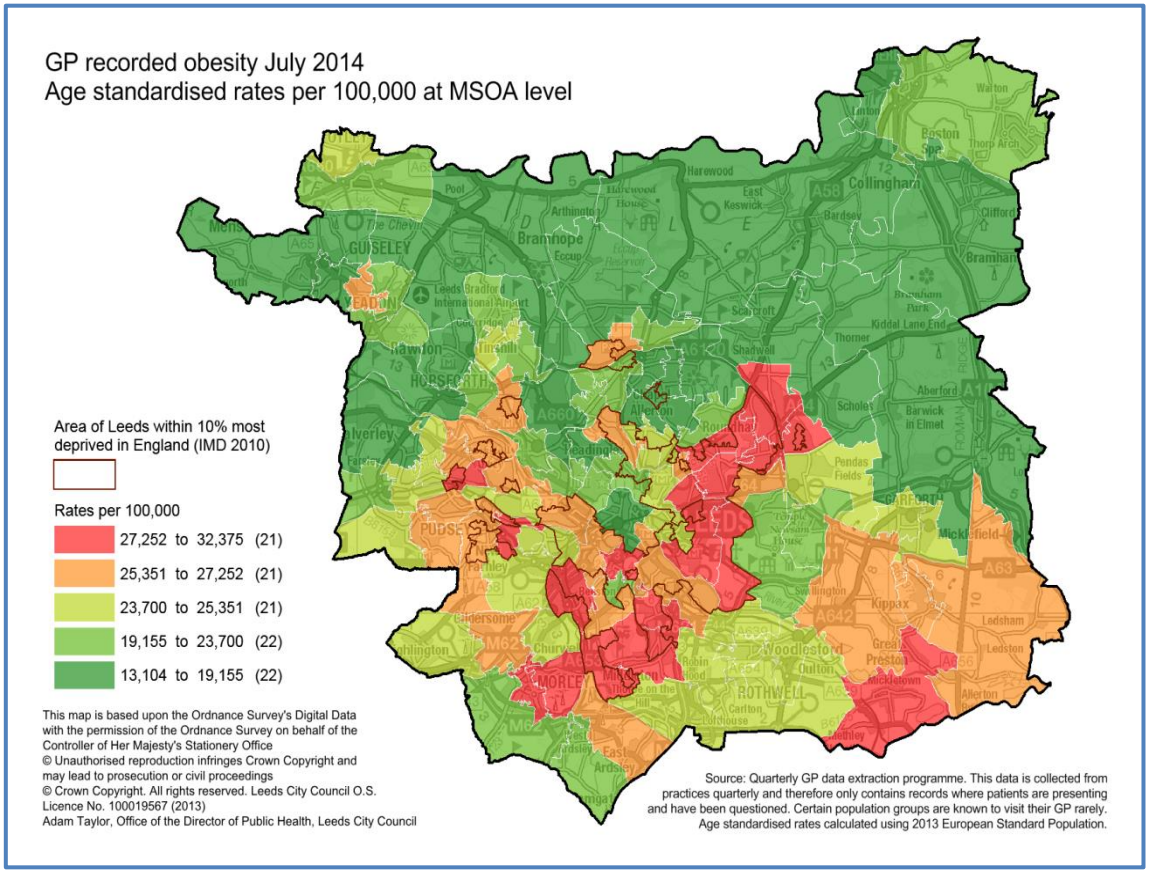


Figure 25 below shows GP recorded obesity presented in a map. There appears to be a correlation between deprivation and obesity however this pattern is not as clear as with other lifestyle related morbidities.

Figure 25: Map showing the spread of GP recorded obesity age standardised rates per 100,000 at MSOA level
Source: Public Health Intelligence Team LCC – July 2014 data extracted from GP systems

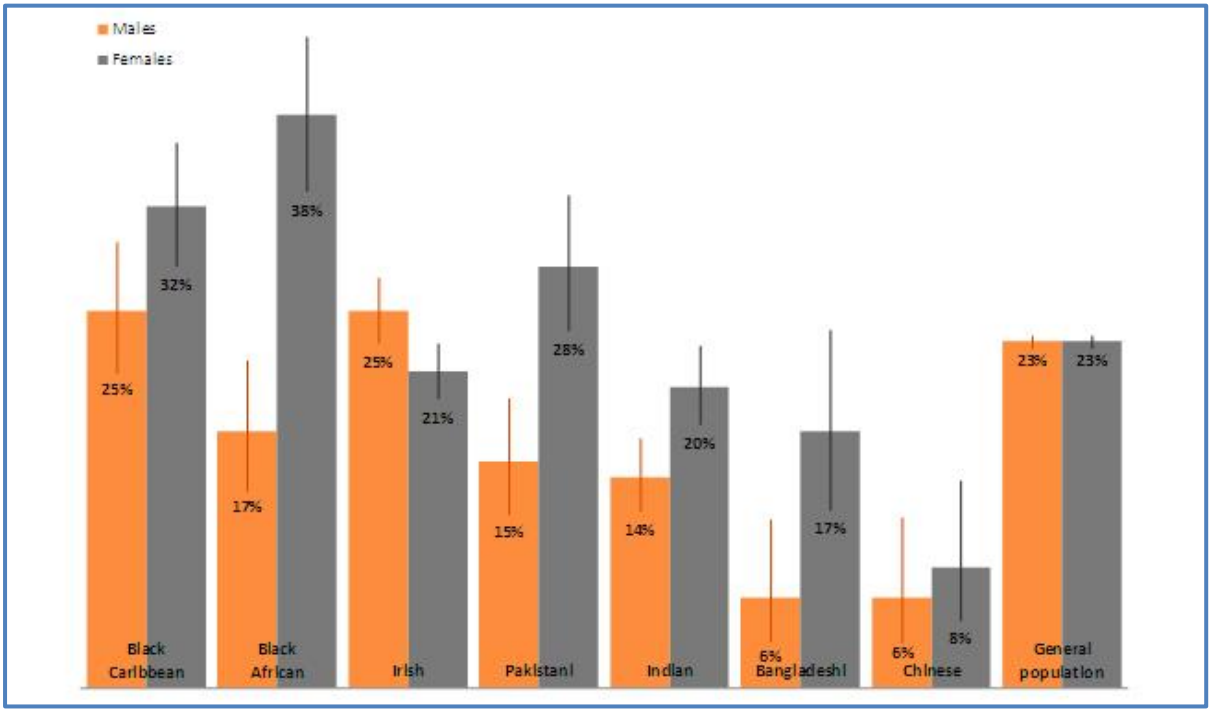


There is not a straightforward relationship between obesity and ethnicity. There is debate about the validity of using current definitions of obesity for non-white ethnic groups, for both adults and children. Different ethnic groups are associated with a range of different body shapes and different physiological responses to fat storage (Gatineau & Mathrani, 2011). There are little national data on obesity prevalence in adults from minority ethnic groups in the UK.

An exception to this is the Health Survey for England in 2004 (NHS HSIC, 2005). The Health Survey for England stated that 22.7% of men and 23.2% of women in the general population were obese (a BMI over 30). With the exception of Black Caribbean and Irish men (25.2%), men from minority ethnic groups had markedly lower obesity prevalence rates than those in the general population. Bangladeshi and Chinese men had the lowest obesity rates (5.8% and 6.0% respectively). Among women, obesity prevalence was highest in the Black Caribbean (32.1%), Black African (38.5%) and Pakistani (28.1%) groups, and lowest (7.6%) among the Chinese group.

The prevalence of obesity-related conditions such as cardiovascular disease and type 2 diabetes varies by ethnic group. NICE Public Health Guidance 46 suggests that in the UK Black, Asian and other minority ethnic groups are at a higher risk of diabetes than white populations with the same body mass index (BMI) and waist circumference values. The guidance states that there is limited evidence that suggests a BMI threshold of 23 in Black and Chinese populations may be approximately equivalent to an overweight cut-off point of 25 in white European populations. Limited evidence also suggests that a BMI of 24 among South Asian and Chinese populations, and 26 for Black populations, may be approximately equivalent to an obesity cut-off point of 30 in white European populations. These suggested revised body mass index thresholds recognise that people from Black, Asian and other minority ethnic groups are at equivalent risk for diabetes and mortality at a lower BMI than White people.

Figure 26: Adult obesity (aged 16+) BMI ≥ 30 by ethnicity in England
Source: Health Survey for England 2004



In 2013, PHE examined the relationship between obesity and disability. They found a two-way relationship between obesity and disability in adults and the following outlines their findings. Obesity is associated with the four most prevalent disabling conditions in the UK: arthritis, back pain, mental health disorders and learning disabilities. Obesity may lead to disability as a consequence of increased body weight, associated co-morbidities, environmental factors, or a combination of these. Among people with severe obesity, limitations in mobility-related activities have been reported to be between five and nine times greater than for healthy weight subjects. A recent UK cohort study of adults with severe obesity found that the prevalence of self-reported disability was strongly associated with BMI, age, the presence of type 2 diabetes, metabolic syndrome and clinical depression.

One third of obese adults in England have a limiting long term illness or disability compared to a quarter of adults in the general population. The prevalence of obesity-related disabilities among adults is increasing. Adults with disabilities have higher rates of obesity than adults without disabilities. For those adults who are disabled and obese, social and health inequalities relating to both conditions may be compounded. This can lead to socioeconomic disadvantage and discrimination. The combination of rising obesity and disability has significant implications for health and social care services in England.

Mental health disorders are the second greatest cause of disability in the UK. According to the Office for National Statistics, 16.2% of people in England have a common mental health problem such as depression or anxiety (19.7% of women and 12.5% of men), and 0.5% of people experience psychotic or bipolar disorders (0.3% of men, 0.5% of women). Obesity has been linked to common mental health problems such as depression and anxiety. A systematic review of longitudinal studies revealed associations in both directions between depression and obesity; people who were obese had a 55% increased risk of developing depression over time, while people who were depressed had a 58% increased risk of becoming obese. A recent systematic review and meta-analysis found a positive but weak association between obesity and anxiety disorders.

People with severe mental illness are also at increased risk of obesity. An American study found that obesity was more prevalent in any individuals with serious mental illness (50% of women and 41% of men) than in the demographically matched comparison population (27% of women and 20% of men). Other clinical studies have reported rates of obesity of up to 60% in people with schizophrenia or bipolar disorder. Many antipsychotic, mood-stabilizing, and antidepressant medications commonly used to treat severe mental illness are associated with weight gain.

Around 2% of the UK population has a learning disability and less than a quarter of this group are known to local health and social services. People with learning disabilities are more likely to be either underweight or obese than the general population. A report by the Sainsbury's Centre for Mental Health in 2005 found that the rate of obesity among people with a learning disability was significantly different to those without such a disability (28.3% compared to 20.4%). Genetic disorders such as Prader-Willi syndrome carry a high risk of severe obesity and it has been estimated that 24–48% of adults with Down's syndrome are obese. Again, psychotropic medication, used by 30–50% of adults with learning disabilities, can also lead to weight gain. People with learning disabilities are at risk of obesity at an earlier age than the general population and as a consequence are likely to experience obesity-related health problems at a younger age.

3.4.2 Obesity in children

Childhood obesity is a major public health concern and one which has grown in importance over the last few decades. From the mid-1990s until 2007 childhood obesity rose by around one percentage point every two years showing an upward trend. Trend data show rates have been relatively similar over the last seven years but though the rise in obesity rates has been halted prevalence still remains high particularly in comparison to other European countries.

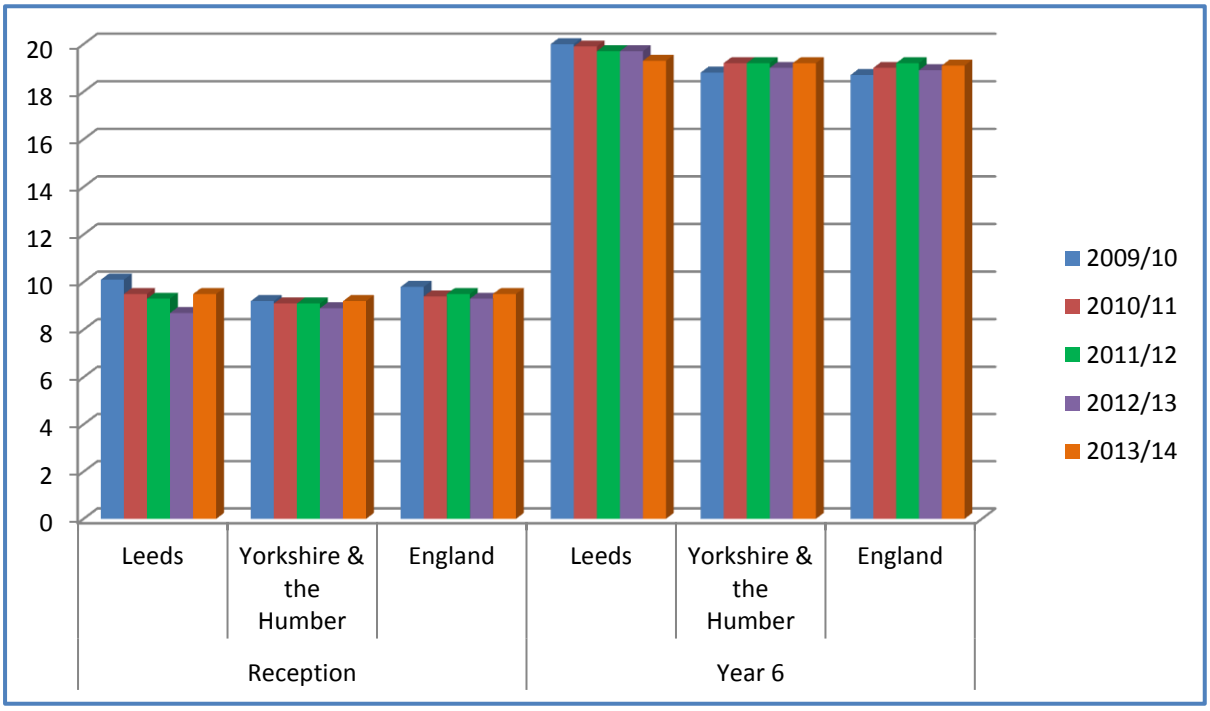
Prevalence rates are calculated using the age and sex-specific UK National Body Mass Index (BMI) centiles classification.

- 'Underweight' is defined as less than or equal to the 2nd centile.
- 'Overweight' is defined as greater than or equal to the 85th centile but less than the 95th centile.
- 'Obese' is defined as greater or equal to the 95th centile.

The National Child Measurement Programme (NCMP) data are a robust data set and shows approximately 27% of children surveyed in Leeds are overweight or obese.

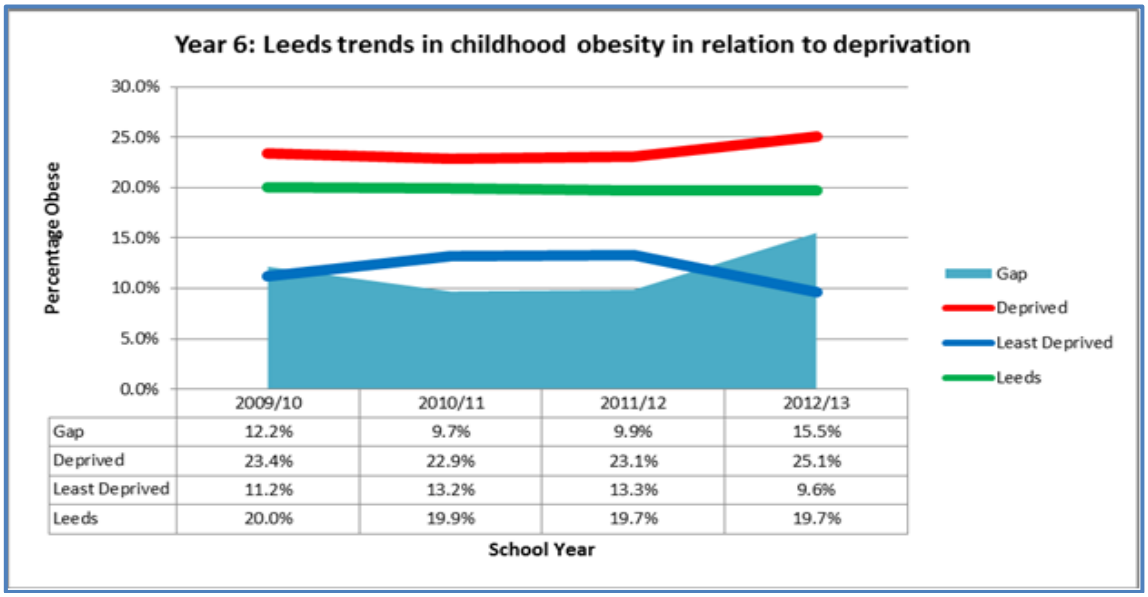
- Just less than one in eleven children in reception is obese (8.7%, 755 children)
- Just less than one in five children in Year 6 (10 – 11 year olds) is obese (19.7%, 1022 children), which is double the proportion for reception (4 – 5 year olds) and this level has remained static over the last two years.
- Underweight prevalence remains low with the rate for reception being 1% and for Year 6 is 1.6%.

Figure 27: Prevalence of obesity in Year 6 and Reception children 2009/10 to 2013/14 Source: National Child Measurement Programme Survey



Childhood obesity prevalence rates in Leeds are generally in line with national rates and lower than most core cities.

Figure 28: Leeds trends in childhood obesity in relation to deprivation
Source: National Child Measurement Survey



	2009/10	2010/11	2011/12	2012/13
Gap	12.2%	9.7%	9.9%	15.5%
Deprived	23.4%	22.9%	23.1%	25.1%
Least Deprived	11.2%	13.2%	13.3%	9.6%
Leeds	20.0%	19.9%	19.7%	19.7%

Children from 'Deprived Leeds' are significantly more obese (12.1%) than from 'Non-deprived Leeds' (8.4%). While the size of the gap between 'Deprived Leeds' and 'Non-deprived Leeds' can be seen to have fluctuated for both age groups over the 4 year period, it has reduced for reception children and widened for children in Year 6.

Figure 29: Map of recorded childhood obesity at school reception year in Leeds by MSOA
Source: Public Health Intelligence Team LCC – data source National Childhood Measurement Programme 12/13

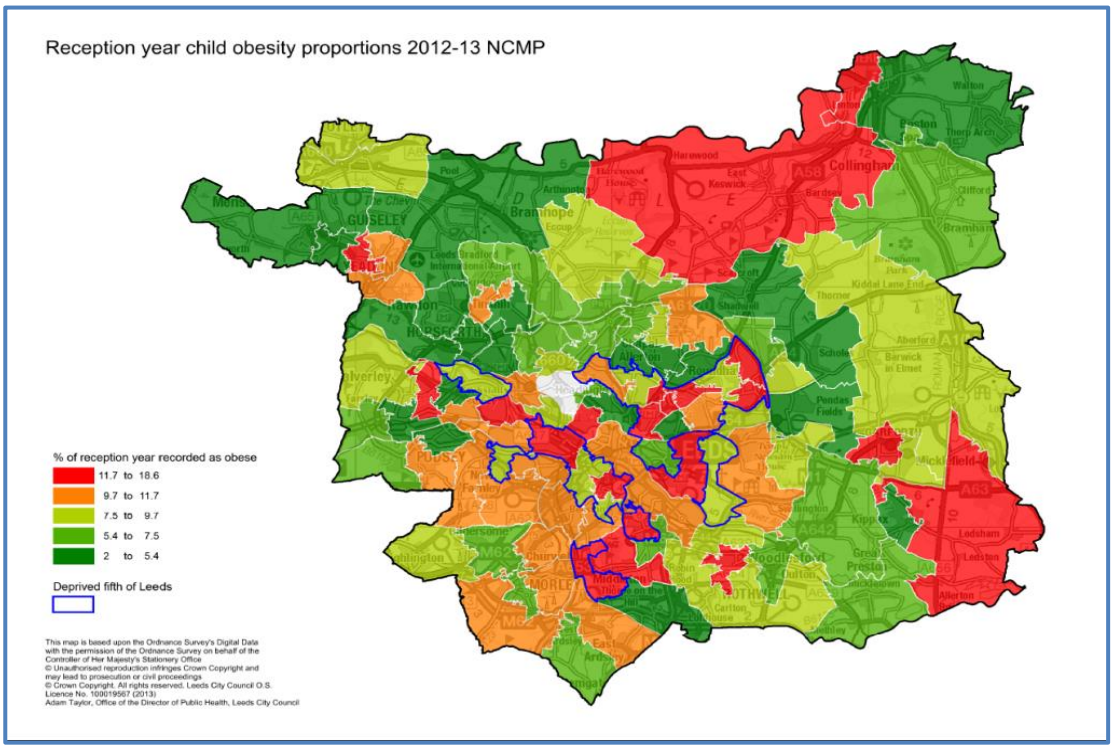


Figure 30: Map of recorded childhood obesity at school year six in Leeds by MSOA
Source: Public Health Intelligence Team LCC – data source National Childhood Measurement Programme 12/13

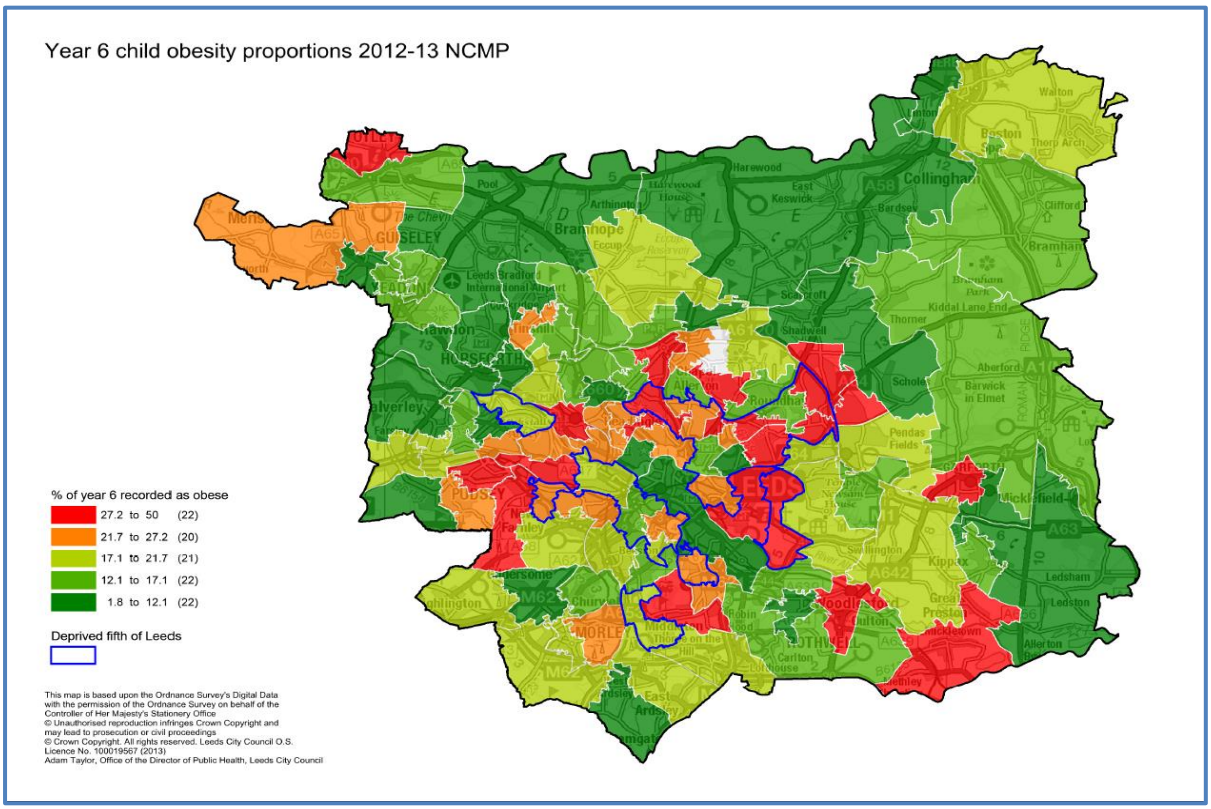
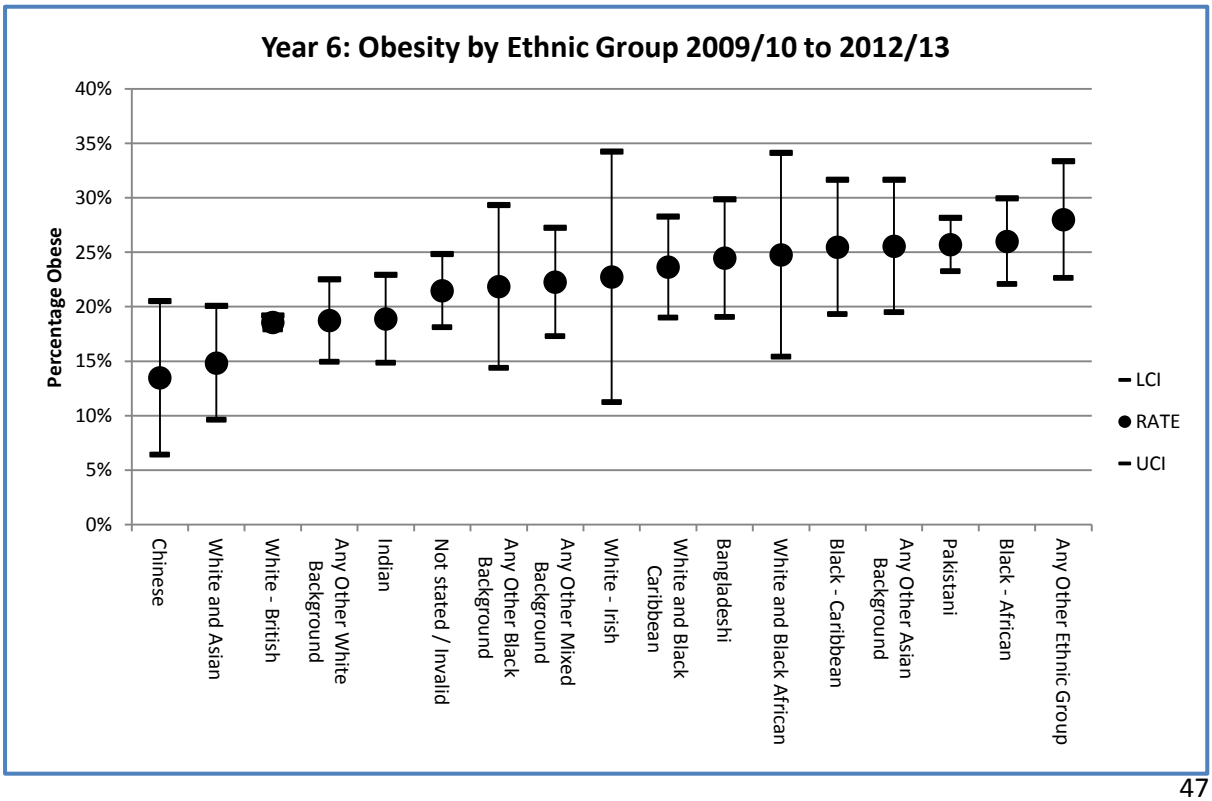


Figure 31: Year 6 Obesity rates by ethnic group 2009/10 to 2012/13
Source: National Child Measurement Programme Report 2012/2013



There are higher levels of obesity amongst most ethnic populations, as compared to the White British population and data on children in reception shows similar trends to the year 6 data above. Children with Black and Asian lineage show significantly higher rates of obesity than white British children and this is in line with national findings. The findings however need to be treated with some caution as there is some uncertainty as to whether UK growth charts can be used to accurately determine the BMI of all ethnic groups and likely confounding factors between ethnicity and deprivation.

3.4.3 Diabetes

Diabetes is a major cause of premature death and disability and greatly increases the risk of heart disease and stroke, kidney failure, amputations and blindness. Eighty percent of NHS spending on diabetes goes on managing these complications, most of which could be prevented.

There are currently approximately 40,000 people living with diabetes in Leeds which costs a total of £115,589,789 per year which is an average cost of £2,836.14 per person. About 90% of people diagnosed with diabetes have type 2 diabetes and the risk factors associated with it are family history, age, and/or ethnicity. However, being overweight or obese is a significant risk factor for type 2 diabetes. The correlation between weight and type 2 diabetes has been made clear in that 80% of people with type 2 diabetes are overweight or obese (International Diabetes Federation, 2014).

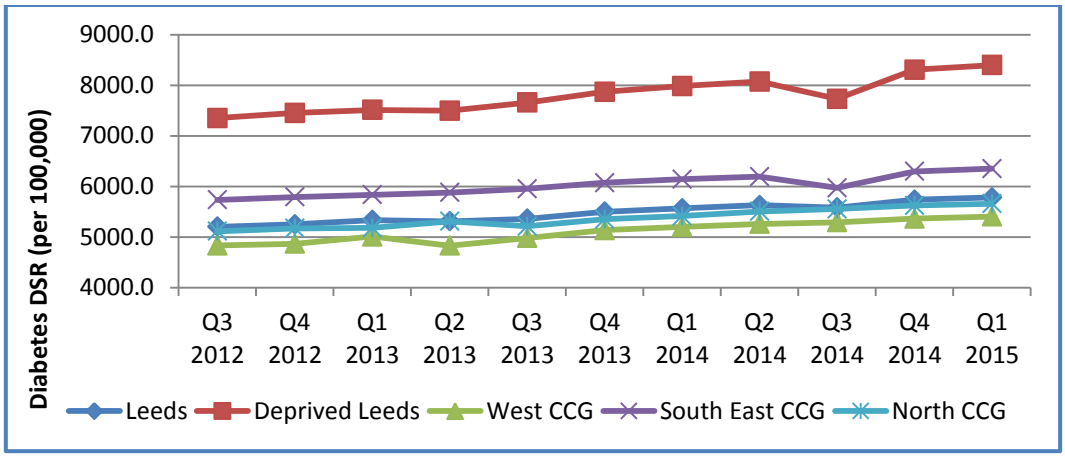
The Quality and Outcomes Framework (QOF) rewards contractors for the provision of quality care and helps to standardise improvements in the delivery of primary medical services. Diabetes management is one area that is part of QOF. Contractors are rewarded for managing blood pressure, cholesterol, kidneys, blood glucose monitoring, foot examination, offer of influenza vaccination and the offer of a referral to structured education. In addition NICE recommends that all people with diabetes should receive nine key tests at their annual review. These important markers ensure diabetes is well controlled and are designed to prevent long-term complications. The nine key tests are: weight, blood pressure, smoking status, HbA1c, urinary albumin, serum creatinine, cholesterol, eye examinations, and foot examinations.

Diabetes is a priority for Leeds to ensure that people are identified, and receive high quality care that is integrated between primary care, LCH and LTHT. To achieve this, a diabetes network group has recently being established with representation from CCG's, LCH, LTHT and the third sector. The Leeds Institute of Quality Healthcare (LIQH) has been funded by the 3 CCGs and agreed across all the NHS organisations in Leeds to provide a professional leadership programme which brings together an understanding of quality improvement science; systems leadership and co-production and shared decision making with people and their carers. It is owned by the Leeds Clinical Senate and Leeds City Council and the University of Leeds are partners. There is also strong international evidence and a belief that developing a systematic quality improvement approach will bring us the best value. Diabetes has been identified as an area to focus on in relation to quality improvement and as such

is now part of the LIQH, and work commenced on this in July 2015, with key stakeholders from LTHT, LCH, CCGs and Leeds City Council.

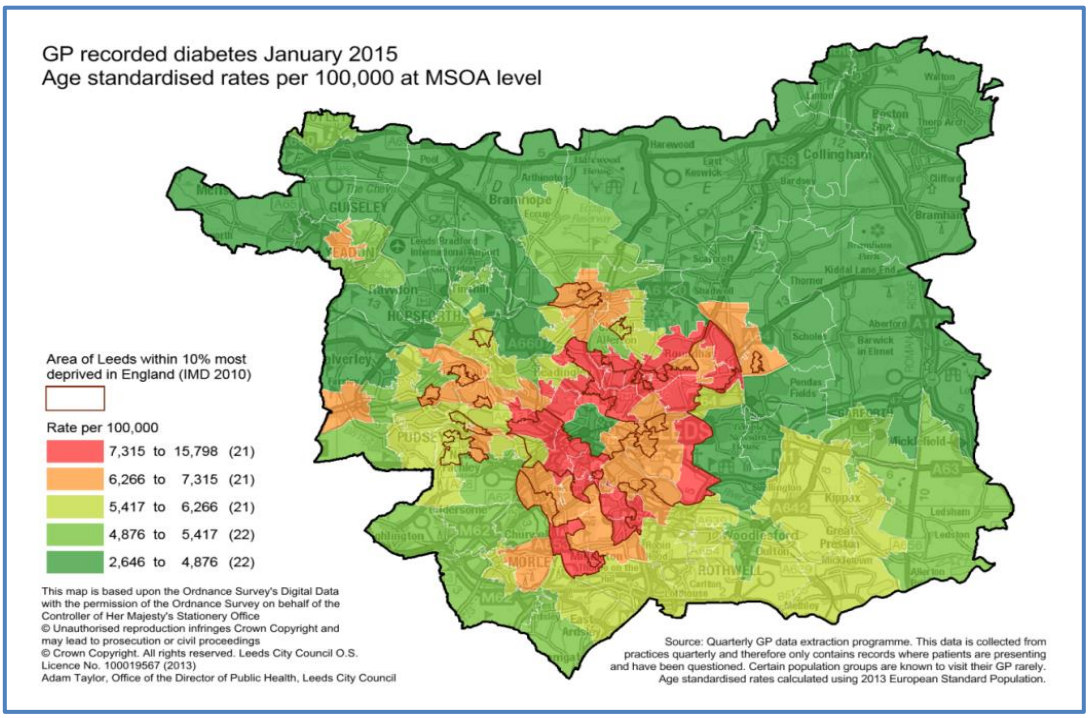
Figure 32 below shows the prevalence of diabetes using GP audit data and allows local analysis by CCG and deprivation. Figure 33 shows the rates of diabetes are far higher in the deprived quintile of Leeds and that between 2012 and 2015 diabetes rates have been rising in all areas.

Figure 32: Directly standardised prevalence of diabetes in Leeds 2012 – 2015
Source: GP quarterly audit data, Leeds City Council Public Health Intelligence Team



These data can also be showed in map form as in Figure 33 below.

Figure 33: Map of age standardised rates of GP recorded diabetes in Leeds by MSOA
Source: Public Health Intelligence Team LCC - data extracted from GP records from patients who have presented and have been questioned



In terms of numbers, GP audit data from January 2015 found there are 39,282 people diagnosed with diabetes representing 4.65% of the population. Of these, 14,955 people are from West CCG, 14,168 from South and East CCG and 10,159 from North CCG representing 4.07%, 5.29% and 4.87% of their populations respectively.

Figure 34 shows the prevalence of diagnosed diabetes in Leeds compared to West Yorkshire and England between 2008 and 2013. The chart shows a steady increase in Leeds. The percentage of the population in Leeds with diabetes is lower when compared to England and West Yorkshire. It is not certain that diabetes rates are lower in Leeds; the data could be highlighting underdiagnoses of diabetes.

Figure 34: Percentage of the population of Leeds aged 17 and over with diagnosed diabetes in England, West Yorkshire and Leeds
Source: PHE Health profiles

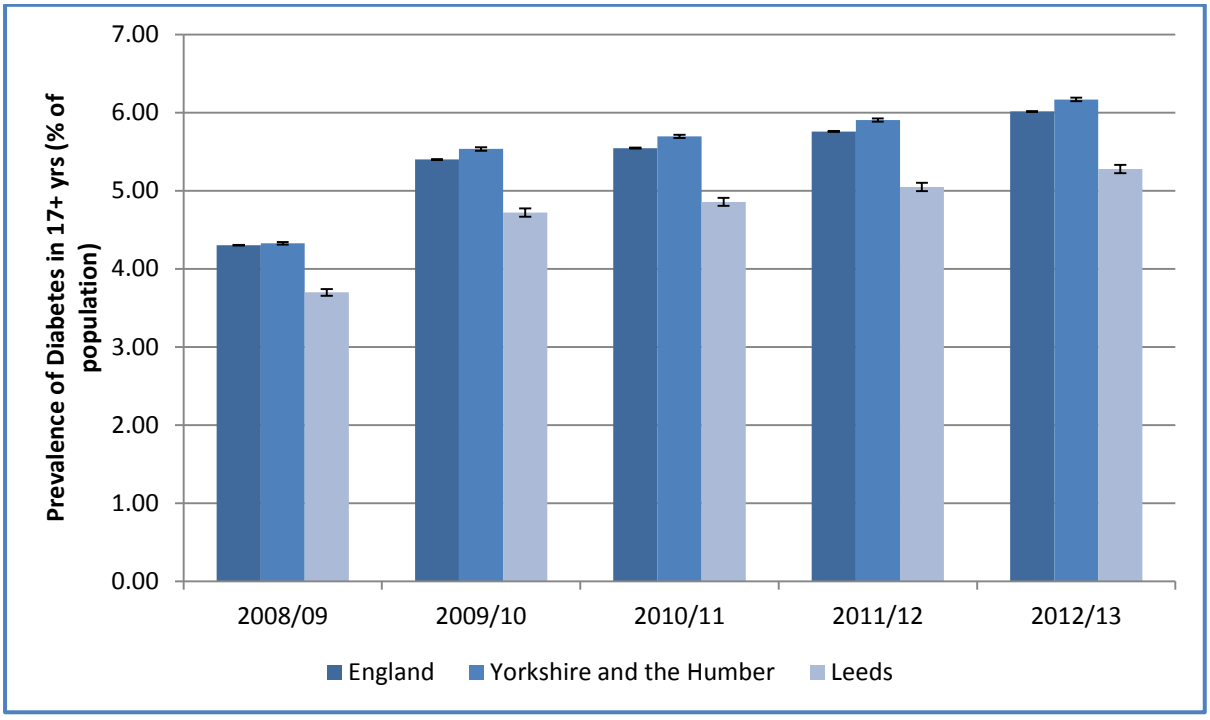
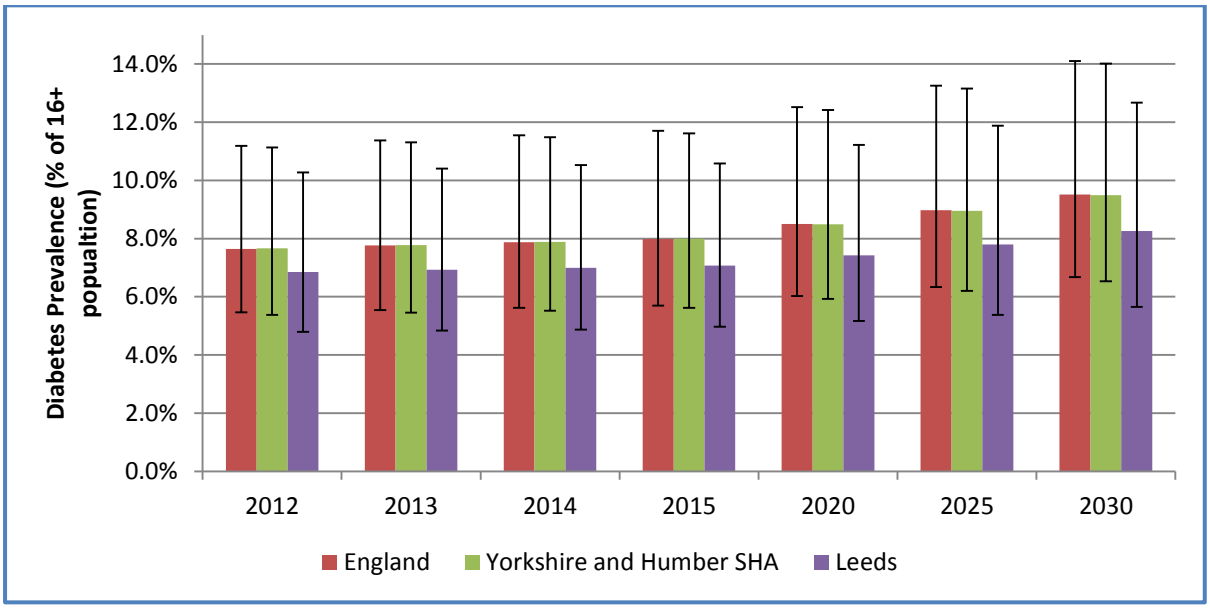


Figure 35 shows an analysis undertaken by Association of Public Health Observatory modelling diabetes prevalence until 2030. The model shows that rates of diabetes will increase in Leeds but rates will remain lower when compared to Yorkshire and the Humber and England.

Figure 35 Modelled data estimating diabetes prevalence in Leeds, Yorkshire and the Humber and England 2012 – 2030
Source: APHO 2010



3.4.3.1 High risk of developing diabetes

The number of people considered at high risk of diabetes is a growing global problem closely linked to obesity. If undiagnosed or untreated, it can lead to the development of type 2 diabetes and associated complications (Diabetes UK, 2014). Seven million people in the UK currently are estimated to be at high risk of developing type 2 diabetes. Between 2003 and 2011 the prevalence of high risk of diabetes tripled with 35.3% of the adult population known to have it.

Once a person has been found to be at high risk of developing diabetes they can often reverse both the condition and their chances of developing type 2 diabetes by as much as 60% by implementing lifestyle changes including losing weight, adopting a healthy balanced diet and increasing physical activity levels.

The NHS Diabetes Prevention Programme is a joint commitment from NHS England, Public Health England and Diabetes UK to deliver at scale an evidence based behaviour change programme focused on lowering weight, increasing physical activity and improving the diet of those individuals identified as being at high risk of developing type 2 diabetes. It is about supporting people to take control of their own health to reduce the risk of developing type 2 diabetes.

There are seven demonstrator sites across the UK to learn practical lessons from delivery, testing and evaluation approaches to improve uptake of the behavioural intervention. The overall plan is for a full roll-out of the programme. During 2015/16 there is an aim to sign up 10,000 people at high risk of developing diabetes and will then begin a national rollout programme in 2016/17.

In the US, there has been a RCT diabetes prevention programme over the past 10 years and it has highlighted that the incidence of diabetes was reduced by 34% in

the lifestyle group compared to the placebo group. Weight Watchers are currently piloting an intensive lifestyle programme in Bromley for people identified as high risk of developing diabetes and the results of the programme will be available in November 2016.

High risk of developing diabetes is a key priority of the Leeds Integrated Care and Prevention Programme and a key deliverable of the Targeted Prevention work stream. The aim is to ensure people are identified early and are offered an intensive lifestyle programme to reduce their risk of developing diabetes with a key focus on structured education, obesity, healthy eating and physical activity.

3.4.5 Chronic Obstructive Pulmonary Disorder

Chronic obstructive pulmonary disease (COPD) is the name for a collection of lung diseases including chronic bronchitis, emphysema and chronic obstructive airways disease. The main symptoms include shortness of breath, persistent cough, and frequent chest infections. The main cause of COPD is smoking, it usually starts to affect people over the age of 35, but diagnosis does not usually take place until people are in their 50s. The main reason for this is that people usually dismiss their symptoms as a result of smoking and therefore do not seek medical help. It is thought that there are more than 3 million people living with the disease in the UK of which only about 900,000 have been diagnosed.
Figure 36 below shows the prevalence of Chronic Obstructive Pulmonary Disorder (COPD) using GP audit data which is up to date and allows local analysis by CCG and deprivation. Figure 37 shows the rates of COPD are far higher in the deprived quintile of Leeds and that between 2012 and 2015 COPD rates have been gently rising in all areas. In Leeds in 2015 there were 15,934 people (1.89%) diagnosed with COPD: 6003 in the West, 6946 in the South and East and 2,985 in the North, representing 1.63%, 2.59% and 1.43% respectively.

Figure 36: Directly standardised prevalence of COPD in Leeds 2012 – 2015
Source: GP quarterly audit data, Leeds City Council Public Health Intelligence Team

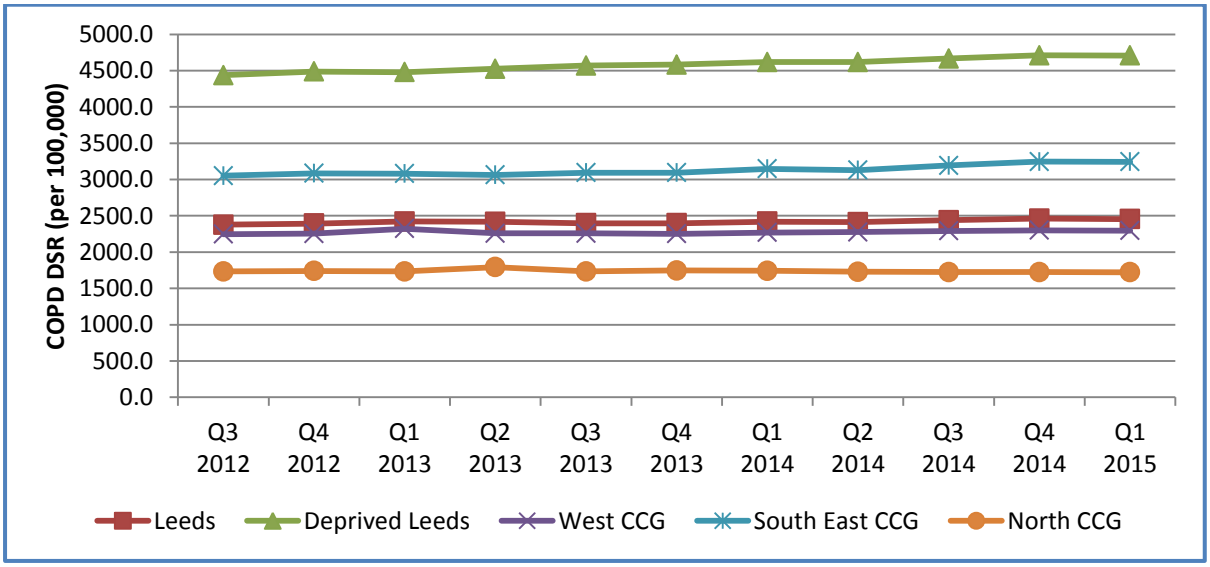
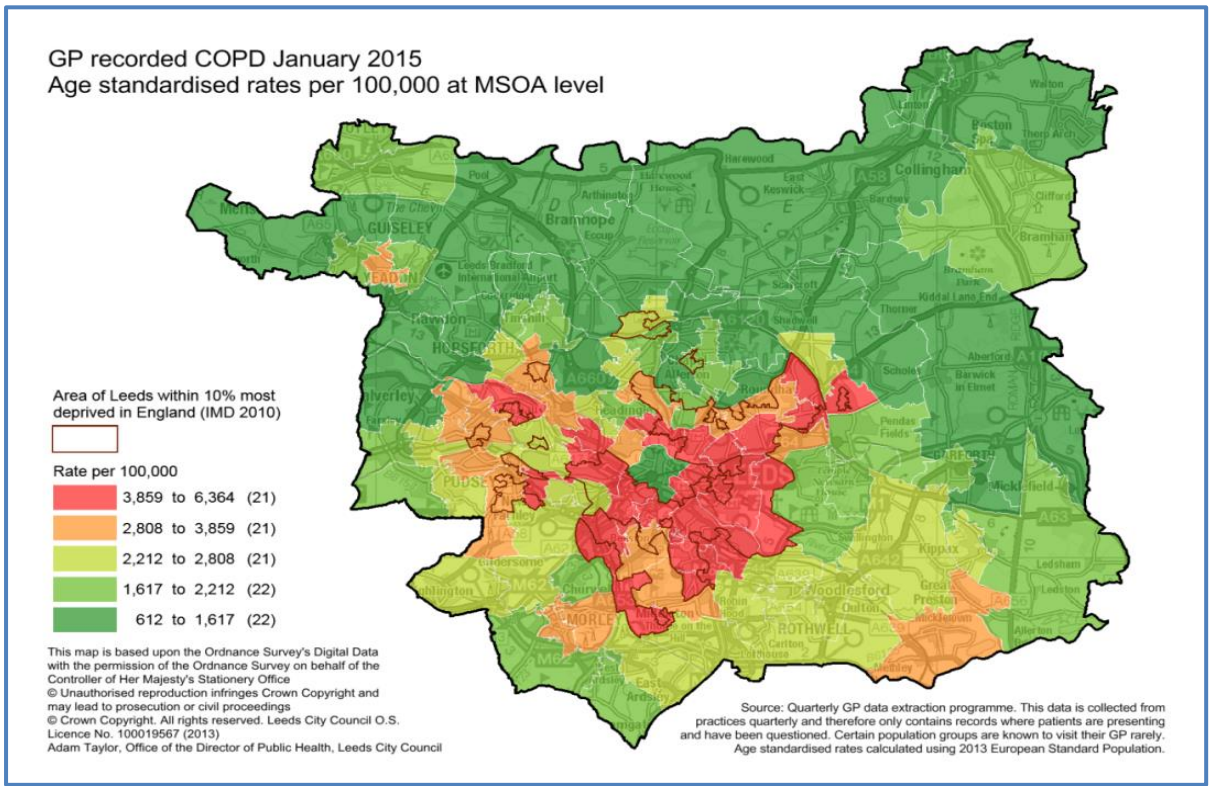


Figure 37 Age standardised rates GP recorded COPD in Leeds by MSOA
Source: Public Health Intelligence Team LCC



3.4.6 Cardiovascular disease (CVD)

Cardiovascular disease (CVD) includes all the diseases of the heart and circulation including coronary heart disease (CHD), angina, heart attack, congenital heart disease and stroke. Figure 38 shows the rates of CVD are far higher in the deprived quintile of Leeds and significantly higher in Leeds South and East CCG. Between 2013 and 2015 CVD prevalence has remained steady. There are 67,656 people in Leeds diagnosed with CVD representing 8.01% of the population. There are 26,294 in the West, 24,175 in the South and East and 17,187 in the North representing 7.15%, 9.02% and 8.23% of the population respectively.

Figure 38: Directly standardised prevalence of CHD in Leeds 2013 – 2015
Source: GP quarterly audit data, Leeds City Council Public Health Intelligence Team

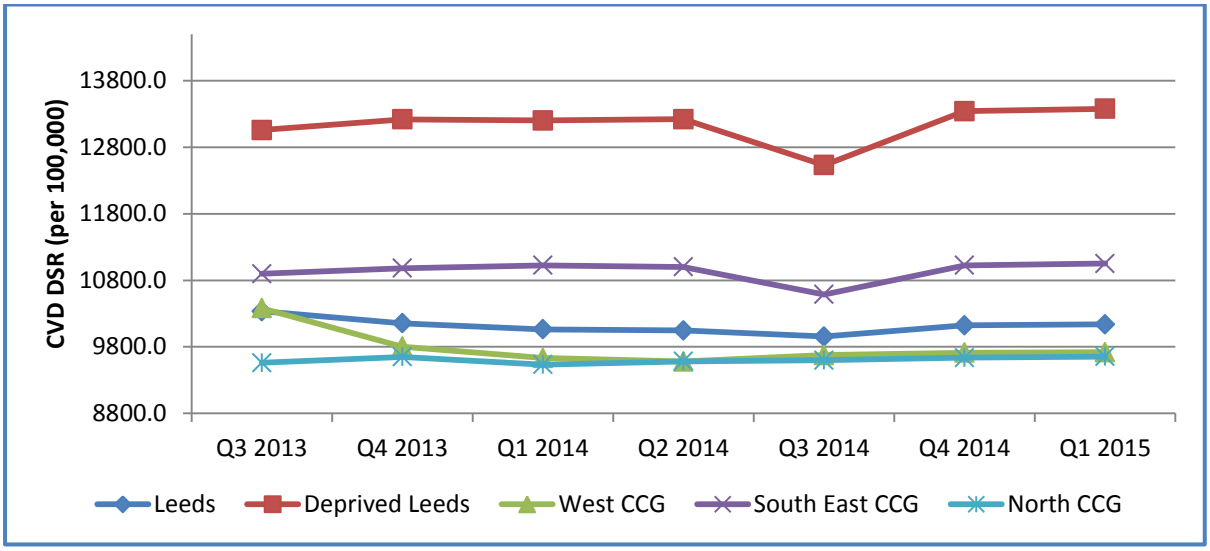
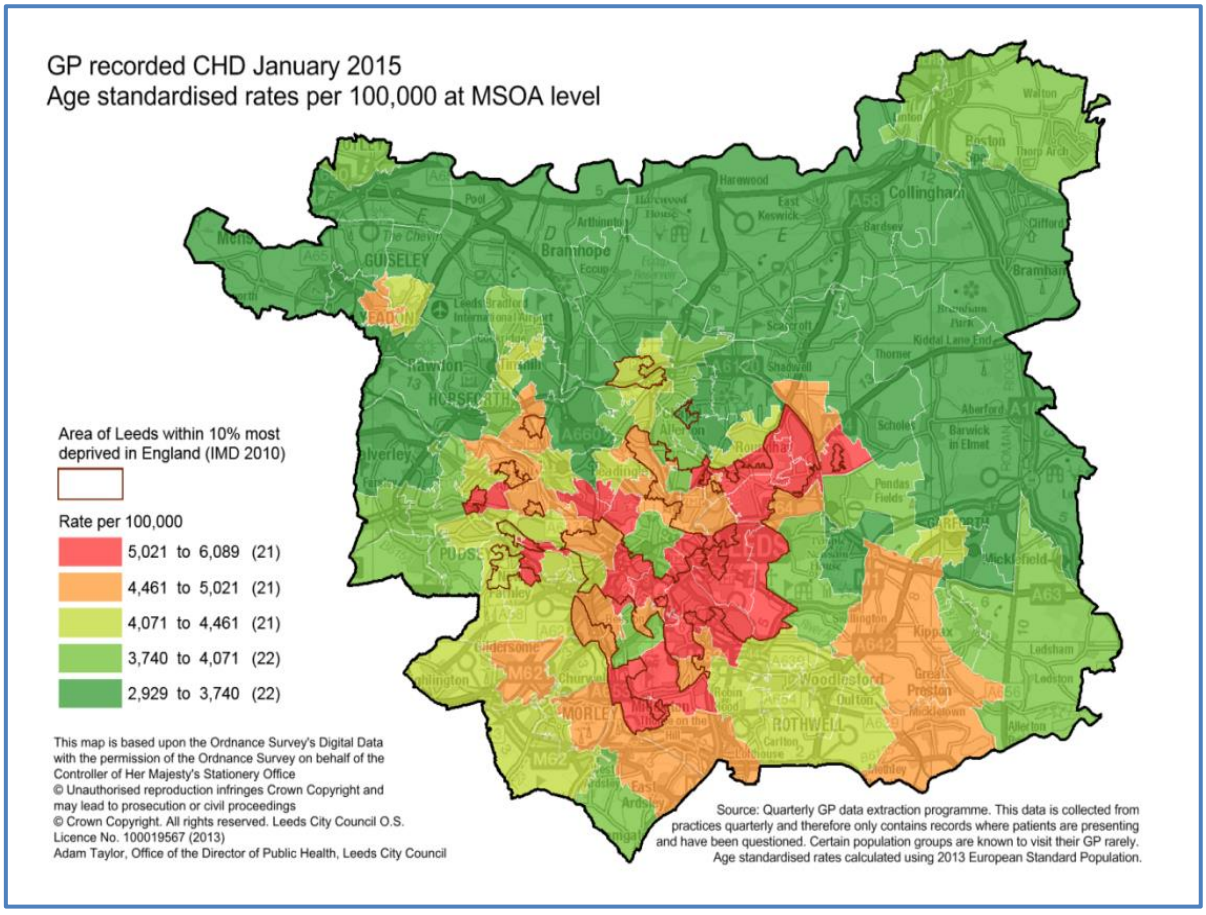


Figure 39 Map of age standardised rates CHD in Leeds by MSOA
Source: Public Health Intelligence Team LCC – Data extracted from GP records

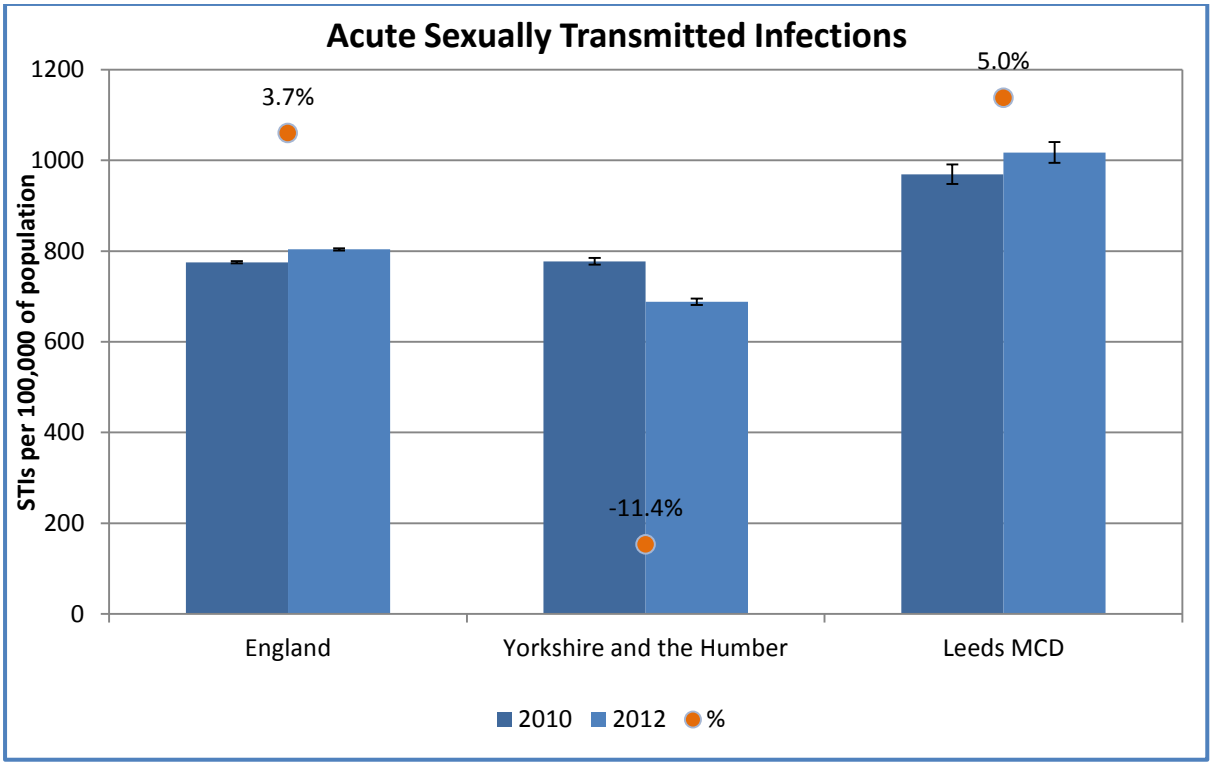


Figures 38 and 39 above shows that as with COPD, CVD rates are highest rates in the more deprived areas of the city

3.4.7 Acute Sexually Transmitted Infections

Figure 40 below shows newly diagnosed sexually transmitted infections (STIs) per 100,000 population for all ages. A higher number of STIs per 100,000 population are diagnosed in Leeds when compared to Yorkshire and the Humber and England. Leeds has also had the highest percentage increase in newly diagnosed STIs when compared to England and Yorkshire and the Humber. This may be because there is a greater prevalence of STIs or better diagnosis of STIs.

Figure 40: Newly diagnosed STIs per 100,000 population in Leeds, West Yorkshire and England 2010 and 2012
Source: PHE health profiles



Data were collated to inform the recent commission of the Leeds Integrated Sexual Health Service. In Leeds, sexual health services serve a large and diverse population and improving the sexual health of the population remains a public health priority. Leeds has a uniquely young population as well as hosting students in three universities. This young population coupled with the impact of deprivation, urbanisation and migration as the largest city in Yorkshire and the Humber produces a disproportionate STI burden and need for sexual health services. In Leeds, as with other areas, there is a strong association between deprivation and STIs, teenage conceptions and abortions, with the highest burden borne by women, men who have sex with men, teenagers, young adults and black and minority ethnic groups.

3.4.7.1 HIV

- In 2010, there were 102 new HIV diagnoses in Leeds residents.
- Between 2010-2012, 51.6% of people newly diagnosed with HIV were classed as late diagnoses.
- In 2011, 1,062 residents of Leeds received HIV treatment and care. This figure is broken down into acquired infection routes as 27% sex between men and 69% heterosexual. Leeds has a small number of infections via intravenous drug use, blood products and mother to child transmission routes.
- Of the 1,062 Leeds residents diagnosed with HIV it is estimated a further 19-30% percent of this figure are living with undiagnosed HIV. In 2012, Leeds reached a HIV prevalence rate of 2.21 per 1,000 (15-59 year old population), indicating a need to increase HIV testing in the city.

3.4.7.2 Sexually Transmitted Infections 2011

- Leeds is ranked 46 (out of 326 local authorities, first in the rank has highest rates) in England for rates of STIs.
- Acute STI diagnoses in Leeds have risen to 966.7 per 100,000.
- Rates of diagnoses for most acute sexually transmitted infections were highest among residents from deprived areas of the city. The rate in the most deprived areas was 952 per 100,000 and 325 per 100,000 for the least deprived areas.
- Chlamydia is the most commonly diagnosed STI. The chlamydia diagnosis rate in 15-24 year olds in Leeds was 2163.6 per 100,000.
- 70% diagnoses of acute STIs were in young people aged 15-24 years old.
- Young people are also more likely to become re-infected with STIs, contributing to infection persistence and health service workload. In Leeds, an estimated 13.4% of 16 to 19 year old women and 14.1% of 16 to 19 year old men presenting with an acute STI at the GUM clinic during the three year period from 2009 to 2011 became re-infected with an STI within twelve months.
- In Leeds Genitourinary Medicine (GUM) clinic in 2009 to 2011, 13.1% of acute STIs were among men who have sex with men (MSM).
- 80% of STIs diagnosed were in the White population and 20% in ethnic groups of which 8.2% were Black or Black British, 3.6% Asian and 6.2% mixed.

3.4.7.3 Conceptions

- Leeds teenage conception rates remain higher than the national average.
- Leeds has a higher repeat abortion rate in women aged 25 years and over.
- Leeds had been experiencing a downward trend in conceptions in 15-17 year olds. The lowest rate in September 2011 was 35 per 1,000 females. The rate at June 2012 reached 44.4 per 1,000 females.
- The percentage of conceptions in 15-17 year olds leading to an abortion has slightly increased from 52.6% to 56.4% in Leeds.
- In 2012, there were 2711 abortion procedures in Leeds residents which is a rate of 15.3 per 1,000 females (aged 15-44), the largest number of procedures were in the 20-24, then 25-29 year age groups.

3.4.8 Oral health

Oral health is integral to general health and is essential for well-being and a good quality of life. Dental caries (tooth decay), erosion of the dental hard tissue and gum disease are the most common forms of dental disease in children. Since 1973 and the introduction of fluoride toothpaste, the rate of tooth decay has been declining in the UK. Currently England's 12 year olds have the lowest decay rates in Europe, however there are many inequalities within England. Children and young people who experience caries may experience pain, loss of appetite, be unable to attend school, and suffer low self-esteem. It may start a lifetime of fearing dental treatment and non-attendance for treatment. Children with caries are more likely to have tooth decay as adults. Dental caries are entirely preventable for most people (Jorysz, 2014).

- Three year olds' dental health in Leeds: There are no plans to repeat the three year old survey 2011/12. The early results of the survey show the prevalence of diseased, missing or filled teeth (DMFT) in 3 year olds in Leeds is 19.4% and is significantly higher than England's prevalence of 12%.
- Five year olds' dental health in Leeds: The prevalence of DMFT in five year olds in Leeds is 33.7%. This is 5% higher than the average for England (27.9%) and is a similar prevalence to the region. Only core cities and statistical neighbours with public fluoridated water schemes had a significantly lower average number of dental caries. The proportion of five year old children with 1 or more teeth extracted on one or more occasions in Yorkshire and the Humber was 4.6%. In England it was 3.1%. Extractions in this age group usually require a hospital admission and a general anaesthetic. Tooth extraction is the most common reason that children are admitted to hospital.
- Twelve year olds' dental health in Leeds: The prevalence of DMFT in twelve year olds in Leeds is 45.8% which is 12.4% higher than England's average prevalence (33.4%) and higher than the regional prevalence (44.7%).

Children and young people living in areas of higher deprivation in Leeds have higher rates of tooth decay. The four wards in Leeds with the highest mean DMFT in five year old children are Gipton and Harehills (2.35), Beeston and Holbeck (2.24), Middleton Park (2.13), Armley (2.08). Three of the wards with the highest mean DMFT (Gipton and Harehills, Beeston and Holbeck and Middleton Park) have Index of Multiple Deprivation (IMD) rankings in the highest 20% in Leeds. The next four wards with the highest mean DMFT are Killingbeck and Seacroft (1.92), Burmantofts (1.55) and Richmond Hill, Chapel Allerton (1.18), Farnley and Wortley (1.5). These wards all have IMD rankings in the highest 40% of the city. In contrast the four areas with the lowest DMFT were Guiseley and Rawdon (0.33), Wetherby (0.52), Harewood (0.53), Kippax and Methley (0.35); three of these wards, Guiseley and Rawdon, Wetherby and Harewood, have IMD rankings among the 20% least deprived nationally (Jorysz, 2014).

Research shows that there is an association between ethnicity and tooth decay but the associations are not straightforward and link to: socioeconomic status, amount of time lived in the UK, English speaking, culture and diet. The largest group of children by ethnic origin in Leeds is 'White'. Asian groups are the 2nd largest with approximately 16,000 children and young people. Studies show higher levels of

dental caries are generally seen in the primary teeth of children of South Asian children even after adjusting for socio-economic status. Gipton and Harehills ward has the highest number of South Asian people in Leeds. 25% of Leeds Pakistani community and 40.6% of the Bangladeshi population live in Gipton and Harehills. The ward has the highest DMFT in all of Leeds wards. Some groups such as Gypsy, Roma and Travellers are thought to have very poor oral health but there are no clear data to show this (Jorysz, 2014).

Children who are 'Looked After' or who have chronic and long term health conditions; children with additional physical and learning needs are at a higher risk of oral health inequalities. Services are not always appropriate to their needs (Jorysz, 2014).

A diet high in sugary foods and drinks means that the teeth are being bombarded by an acid attack throughout the day. A healthy diet that is low in sugary foods and drinks supports good oral health. Children and young people in Leeds report low rates of eating five portions of fruit and vegetables per day. Over 50% of children and young people drink at least 2 sweetened drinks per day (Jorysz, 2014).

19% of the under 18 population did not attend a dentist at least once in 2012/13. Reasons why people do not attend a dentist include not finding it easy to access a local dentist, long waiting lists for dentists, fear of painful dental treatments, poor English, disorganised at making appointments (Jorysz, 2014).

3.4.9 Mental health

3.4.9.1 Mental illness

Mental illness represents 28% of the national disease burden in the UK. It is the leading cause of sickness absence in the UK, accounting for 70 million sick days in 2007. There is a large premature mortality gap, people with mental illness die on average 15 to 20 years earlier than those without, often from avoidable causes.

Higher levels of poor mental health and wellbeing and mental illness are inextricably linked with deprivation within Leeds. Local mapping highlights these issues and emphasises the social gradient of mental health and wellbeing. This was informed by a Mental Health and Wellbeing Needs Assessment for Leeds, completed in May 2011, as one part of a Joint Strategic Needs Assessment.

The needs assessment identified a strong link between levels of socio-economic deprivation and higher levels of poor mental health and wellbeing. Within this, key population groups have higher prevalence and incidence of different mental health and wellbeing issues, e.g. girls and young women have the highest incidence of self-harm, men from low socio-economic background experiencing social isolation have highest incident of suicide and key issues around stigma and discrimination in some BME communities.

Other issues included increased dual diagnosis; people experiencing poor mental health and substance and alcohol use; and increase in common mental health problems in older people. In relation to children and young people, there is a an

increasing evidence base accumulating of how experience in these critical first few years of life impacts on mental and physical health throughout the life span.

3.4.9.2 Suicide

Suicide is not the result of a single disease process. Factors are complex and no one organisation is able to directly influence them all. Rates of suicide tell us so much about the health and wellbeing of our local communities. The impact of a suicide can, and often is, felt by a whole community. According to the recently released World Health Organization (WHO) report: 'Preventing Suicide: A Global Imperative', over 800,000 people die as a result of suicide across the world each year. The report notes that this estimate is conservative, with the real figure likely to be higher because of the stigma associated with suicide, lack of reliable death recording procedures, and religious or legal sanctions against suicide in some countries. In the UK the suicide rate has risen since 2008 and rates are continuing to rise despite improvement in some economic indicators. Middle-aged male suicide rates have risen most since 2008. This group are traditionally least likely to seek help, which presents a challenge to services to be creative about improving access. The fall over the previous decade in the suicide rates among younger men has stalled, and suicide remains a leading cause of death for this group.

Men are at greater risk of suicide for a number of reasons. Many of the clinical and social risk factors for suicide are more common in men. Cultural expectations that men will be decisive and strong can make them more vulnerable to psychological factors associated with suicide, such as impulsiveness and humiliation. Men are more likely to be reluctant to seek help from friends, family and services. Linked with this, providing services appropriate for men requires a move away from traditional health settings. Men are also more likely than women to choose more dangerous methods of self-harm, meaning that a suicide attempt is more likely to result in death.

The Leeds Mental Health and Wellbeing Needs Assessment (2011) identified the need to undertake a suicide audit for Leeds to provide more up to date intelligence on the factors affecting suicides across the city. The purpose of the audit (2008-10) was to increase understanding of local suicide data and patterns in order to shape local decisions and priorities around suicide prevention. Three years of data (2008-10) was reviewed and completed in 2012.

The total suicide rate for Leeds was the same as for Yorkshire and Humber region for 2006-2008 period but slightly higher than the rate for England. Reported rates for Leeds were higher in the under 65 age group compared to the regional and England figure but lower in the over 65's. The audit highlighted those taking their own life tend to be locally born White men between the ages of 30 and 50 years, with higher rates within specific areas of Leeds. The findings for Leeds reflect a national picture and identified the highest number of recorded deaths was in the LS12 postcode area, followed by LS11, LS14, LS15, LS8 and LS9 postcodes, many of which fall into areas of deprivation.

3.4.9.3 Self-harm

The latest data from the Yorkshire and Humber Clinical Support Unit was published in June 2015 for Leeds shows:

- Self-harm related inpatient episodes continue to show a downward trend.
- A higher proportion of females than males in Leeds experienced a self-harm related episode.
- Females aged 15-19 had a significantly higher rate of self-harm related episodes than any other group in 2014/15.
- Between April 14 and March 15, 15-24 year olds accounted for almost 28% of individuals experiencing self-harm related episodes.
- Self-harm related episodes in 20-24 year old males have shown a significant downward trend.
- The most common primary diagnosis for self-harm related episodes in 2014/15 was paracetamol related poisoning ("Poisoning: 4-Aminophenol derivatives").
- National benchmarking data shows that Leeds is now in line with other cities for self-harm related hospital admissions whereas in the past it was a negative outlier.

It should be noted that the data used throughout the report relates to admissions for self-harm, i.e. self-harm events serious enough to warrant hospital admission, and is likely to represent only a small proportion of general self-harm prevalence. In order to get a more complete picture of self-harm related hospital activity, analysis of A&E activity would be recommended. Locally data has also shown an increase in referral to the CAMHS service for self-harm in the previous 3 years. In addition to the increasing need there has been a reported increase in the complexity of cases, particularly for self-harm cases. Work across the life course in relation to self-harm awareness, prevention, early intervention acute and ongoing support continues to strengthen in Leeds.

3.4.9.4 Children and Young People's Mental Health

There is a major body of evidence accumulating on how experience in the critical first few years impacts on mental and physical health throughout the life span. Over half of mental health problems in adult life (excluding dementia) start by the age of 14 and seventy-five per cent by age 18. Although mental health issues are relatively common, it is often the case that children and young people don't get the help they need as quickly as they should. As a result, mental health difficulties such as anxiety, low mood, depression, conduct disorders and eating disorders can stop some young people achieving what they want in life and making a full contribution to society (Department of Health, 2015).

Prevalence analysis by Public Health England estimates that prevalence for any mental health disorder for ages 5-16 in Leeds is 9.5%. This is slightly below the Yorkshire and Humber estimated prevalence. Improved data will be available following the commissioning of a national prevalence report due in 2016/17.

As part of the Whole System Review of children and young people's Emotional Wellbeing and Mental Health Services in Leeds, it was modelled that 6.4% of young people have an emotional disorder that is not defined as a mental health, therefore needing targeted services in schools or voluntary sector support; 3,000 young people are in need of specialist Tier 3 services and 120 young people in need of Tier 4 services. Section 3.9.3 clearer demonstrates that self-harm is a key issue for children and young people with the highest rates identified amongst 15-19 year old girls.

Local data about emotional wellbeing can be drawn from the My Health My School survey 2014/15. Secondary school pupils were asked how often they felt a particular emotion with the following responses displayed in Figure 41 below (n: 2482);

Figure 41: High School Pupils Emotional Wellbeing in Leeds
Source: My Health My School Survey 2014/15

	Sad or upset	Stressed or anxious
Every day	4.87%	9.95%
Most days	11.97%	16.16%
Some days	41,42%	32.23%
Hardly ever	35.33%	27.88%
Never	6.41%	13.78%

Primary school children completed the same question (n: 3361), results are shown in Figure 42 below

Figure 42: Primary School Pupils Emotional Wellbeing in Leeds
Source: My Health My School Survey 2014/15

	Sad or upset	Stressed or anxious
Every day	2.80%	4.55%
Most days	10.21%	10.21%
Some days	44.45%	29.60%
Hardly ever	35.50%	33.09%
Never	7.05%	21.75%

3.5 Potential years of life lost

3.5.1 What are potential years of life lost?

The following information about PYLL is taken from an analysis of Leeds data written by Fiona Day and Lucy Jackson.

Potential years of life lost (PYLL) is a measure of the potential number of years lost when a person dies prematurely from any cause. The basic concept underpinning PYLL is that deaths at younger ages are weighted more heavily than those at older ages. It is widely accepted that the contributions of public health initiatives and of health care to improvements in population health ought to be quantified. An indicator widely used in measuring this contribution is 'avoidable mortality' (which is a subset

of PYLL), which is based on the concept that premature (defined as being under age 75) deaths from certain conditions should not occur in the presence of timely, preventative interventions and effective health care. PYLL is calculated as a 3 year aggregate directly standardised rate (DSR) per 100,000 population.

We have traditionally looked at the main causes of death in the population both under 75, and all ages. The advantage of using PYLL is that deaths at younger ages may be perceived to be of less importance if cause-specific death rates alone (traditional mortality methods) were used in highlighting the burden of disease and injury, since conditions such as cancer and heart disease often occur at older ages and have relatively high mortality rates.

PYLL analysis for Leeds has been performed by the Public Health Intelligence team at Leeds City Council. Five years of data were analysed and built into three, 3-year aggregate rates, 2009-11, 2010-12 and 2011-13, to establish a trend of avoidable PYLL for various geographies.

Avoidable Mortality according to Office for National Statistics (ONS) is defined as a death that could be amenable to healthcare or preventable by public health interventions. Various organisations, including the Health and Social Care Information Centre, Public Health England and ONS have been producing PYLL analyses in recent years. Although the methodologies vary slightly, all use the same groupings of diseases to facilitate discussion about PYLL.

The headline result is that Leeds PYLL, as calculated in the 3-year aggregate, directly standardised rates (DSR) per 100 000, shows an overall reduction over the three periods: 2009-11, 2010-12 and 2011-13. This reduction is being driven by a reduction in both deprived Leeds, as defined by the IMD 2010, within the worst 10% deprivation band nationally, and the rest of the Leeds district.

In deprived Leeds, the rate of avoidable PYLL in 2011-13 is over 9000, compared to less than 5000 in non-deprived Leeds. This is almost double the rate and shows the magnitude of health inequalities in the city.

It should be noted that the rate in deprived Leeds is reducing more quickly than Leeds as a whole; this means that we are demonstrably reducing health inequalities. During the period 2011-13, 93.2% of All Causes PYLL for Leeds residents were due to the top 6 causes. The top 6 causes in descending order are: cancers; cardiovascular diseases; respiratory diseases; deliberate injuries; drug and alcohol related disorders and unintentional injuries. The top 6 causes also account for similar proportions of All Avoidable Causes PYLL for Leeds deprived, the non-deprived part of Leeds and the Leeds CCG registered populations.

The top 2 causes (cancers and cardiovascular disease) account for over 60% of all PYLL for Leeds residents, Leeds deprived, the non-deprived part of Leeds, and the Leeds CCG registered populations. The two causes account for proportionately less of the PYLL in Leeds deprived (57.6%) than the non-deprived part of Leeds (64.1%); this is because Leeds deprived has a higher proportion of PYLL caused by respiratory disease.

3.5.2 PYLL from Cancer

In this context “Cancers” are growths or tumours which, when they are malignant, can be described as “Cancers”. This is a wider definition than Cancer would be because it includes non-malignant growths that have been the underlying cause of death of a person.

Deaths from cancer are the largest single cause of PYLL across the city, accounting for 36.3% of PYLL. The trend is that rates of PYLL have remained static over the time covered by Public Health analysis. The PYLL rate from cancer in Leeds deprived is 1.5 times higher than the non-deprived part of Leeds. However the proportion of total PYLL caused by cancer is lower in deprived Leeds than in the non-deprived part of Leeds at 32.7% and 38.0% respectively. Cancer deaths remain a key driver of health inequalities, accounting for over 30% of the life expectancy gap between Leeds as a whole and England as a whole.

At CCG level and compared with the overall Leeds rate, the gap in the rate of avoidable cancer PYLL is significantly greater for Leeds South and East CCG (14% above Leeds average); for Leeds West CCG (3% below Leeds average); Leeds North CCG (16% below Leeds average). There is an early indication of a possible reduction in PYLL due to avoidable cancer in Leeds South and East CCG however this needs to be sustained over time; the trend for Leeds North and Leeds West is static. It needs to be noted that the rates of a CCG population mask smaller area difference and that within each CCG there is great variation.

At the ward level, there has been a narrowing of the range of scores in the most recent 3-year aggregate rates, and a general reduction in the rate for the worst wards in Leeds. Beeston and Holbeck Ward is the exception to this rule and with small year on year increases is now the highest scoring ward in the district.

Cancer incidence is more common in older people. Although the cut-off point for PYLL analysis is deaths before 75, this still makes higher rates more likely in an area with an older population. However, because the PYLL rates are based on a standardised population, this should not affect the results of the analysis.

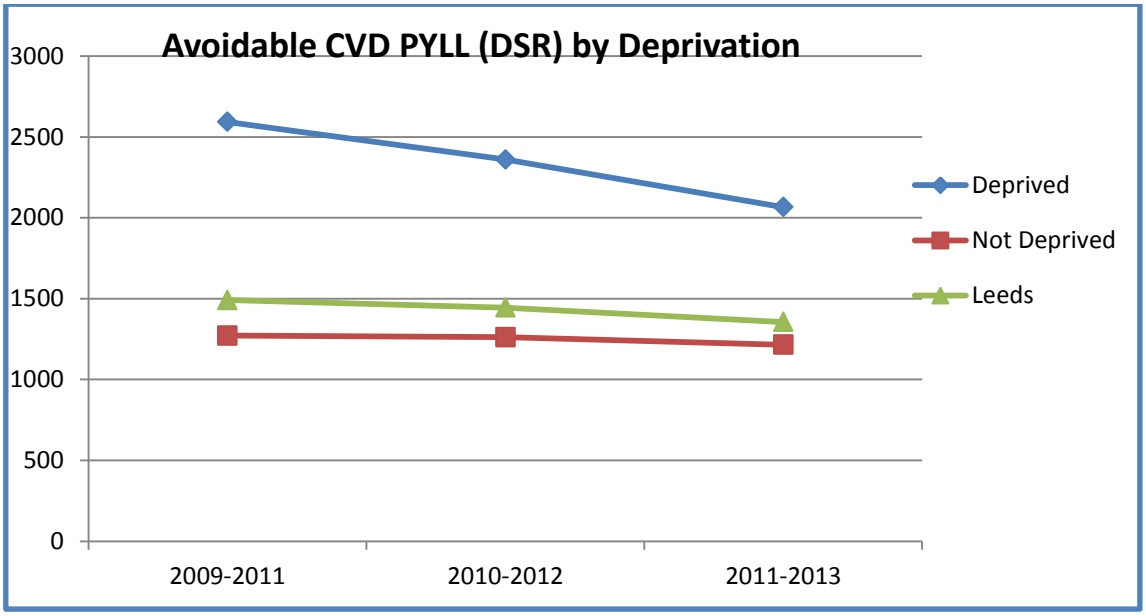
Cases of cancer in Leeds are likely to increase as the population grows and ages, so cancer must continue to be a local strategic priority for prevention, early intervention, treatment and recovery. Cancer is a significant cause of health inequalities, and risk factors for cancer incidence and mortality include: smoking; alcohol use; obesity; and a lack of awareness of and/or uptake of cancer screening programmes and cancer symptoms and signs. Inequalities also exist within cancer treatment itself. These risks are linked to poverty and deprivation, and to cultural and language barriers to accessing prevention, screening and treatment.

3.5.3 PYLL from Cardiovascular Disease

Cardiovascular Diseases (CVD) covers a range of diseases including coronary heart disease (CHD) but also diseases of the circulatory system such as strokes. Deaths from cardiovascular diseases (CVD) are the second largest cause of PYLL across the city. They account for around a quarter of all deaths. There has been a reduction

of almost 20% over 5 years in PYLL due to CVD, with a reduction noticeably in deprived Leeds due to reduced numbers of deaths and also an increase in the age at death (2011-13). This can be seen as evidence of a positive outcome of key public health programmes, leading to a decrease in smoking rates, the implementation of the NHS Health Check which had its initial focus on deprived Leeds, and effective management in primary and secondary care.

Figure 43: Avoidable PYLL from CVD by deprivation in Leeds
Source: Leeds City Council Public Health Information Team



CVD accounts for a quarter of all deaths. Although the gap in CVD PYLL between deprived Leeds and the rest of Leeds is reducing, the gap remains large. The gap in the rate in deprived Leeds is over 60% higher than Leeds overall. Therefore the focus remains on the early detection and prevention of CVD as a key component in preventing premature mortality and reducing health inequalities.

The lowest ward for avoidable CVD PYLL is Harewood, the highest ward is Richmond Hill which has a rate, almost 4 times higher. The lowest rate for a Community Committee is Outer North, the highest is Inner East.

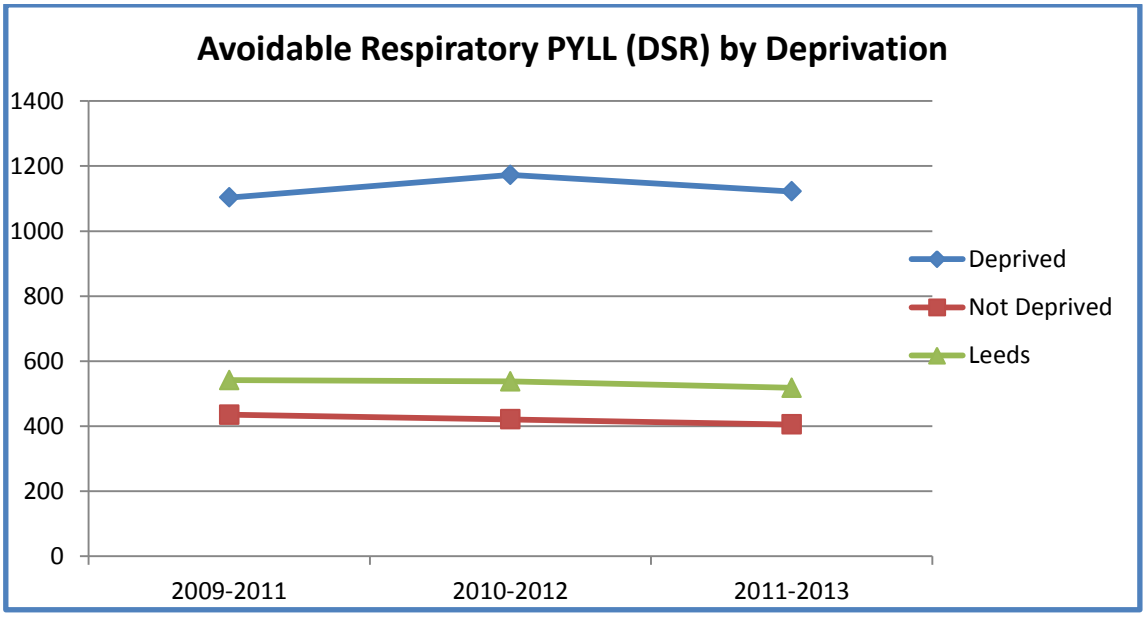
For registered patients of Leeds CCGs and compared with the Leeds average, the gap in the rate of avoidable CVD PYLL is significantly greater for Leeds South and East CCG, 11% above Leeds average, Leeds West CCG has a rate similar to the Leeds average and Leeds North CCG has a rate 19% below Leeds average. However it is positive that there has been a significant reduction in Leeds South and East CCG rates since 2009; unfortunately, this reduction has not been reflected in the static rates of other two CCGs. It should be noted that rates shown at the CCG registered population level of aggregation mask the variation of rates within their geographical populations.

3.5.4 PYLL from avoidable respiratory disease

Deaths from respiratory disease are the third single cause of PYLL in Leeds. The rates are significantly higher in deprived Leeds than the non-deprived part of Leeds. Rates have decreased slightly but not statistically significantly over time. Smoking is the key contributor to respiratory disease, and historic and current smoking rates reflect this pattern.

The rates for deprived Leeds are more than double those in the non-deprived part of Leeds. The rate of PYLL in Inner West Community Committee is significantly higher than any other community committee and is seven times the rate of the Outer North West (the lowest). The highest ward rate is Cross Gates, the lowest ward is Garforth.

Figure 44: Avoidable PYLL from respiratory disease by deprivation in Leeds
Source: Leeds City Council Public Health Information Team



Registered CCG population rates vary around the Leeds rate; the gap in the rate in Leeds North CCG is substantially lower than Leeds (34%); the rate in Leeds West is also lower than Leeds rate (7%) and Leeds South and East significantly higher (36%). The rate in Leeds has declined overall with the greatest decline being seen in Leeds North CCG.

3.5.5 All Avoidable Causes PYLL

Leeds North and Leeds South and East CCG registered and resident populations show a steady and statistically significant reduction in avoidable PYLL which is falling faster in deprived resident populations. This trend is not replicated in Leeds West CCG population, where the trend appears to be static for the registered and resident populations, though the deprived resident population's rate is falling.
Look at all avoidable causes of PYLL in Leeds, City and Hunslet ward appears to be improving its position on the basis of a year on year improvement in PYLL for cardiovascular disease (CVD). Burmantofts and Richmond Hill ward has seen a

small rise and then an overall reduction in CVD PYLL but has not kept pace with Hyde Park and is now the highest scoring ward. Alwoodley and Harewood have the lowest scoring rates for avoidable PYLL recorded. All three CCGs are recommended to use this new PYLL analysis to inform their strategic plans with a focus on improving CVD and cancer outcomes in areas of high deprivation as priorities.

Figure 45: All Avoidable causes of PYLL by deprivation in Leeds
Source: Leeds City Council Public Health Information Team

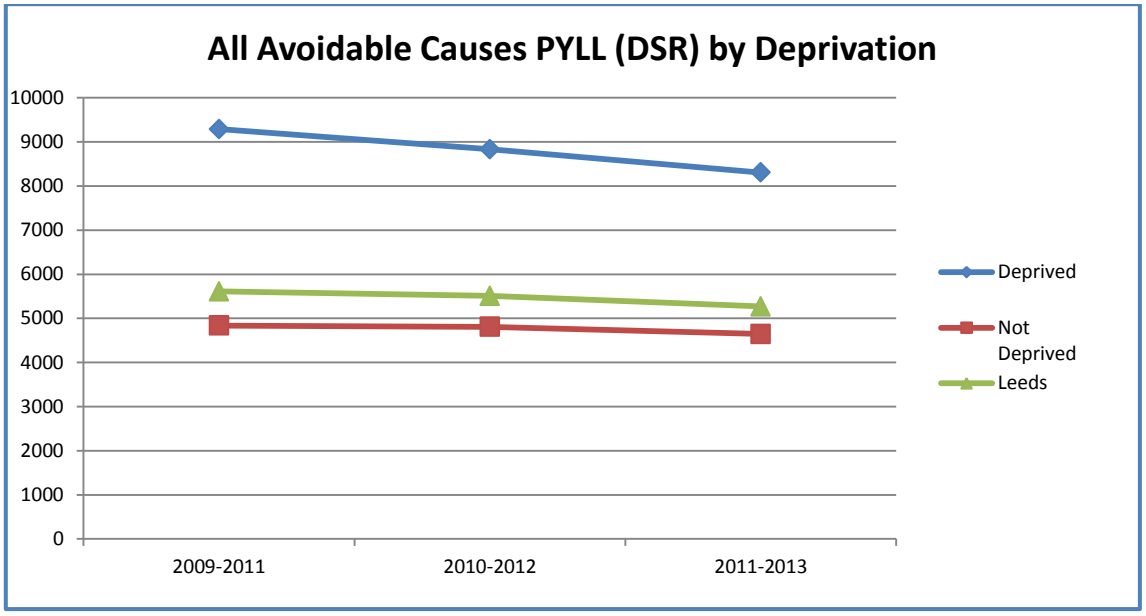
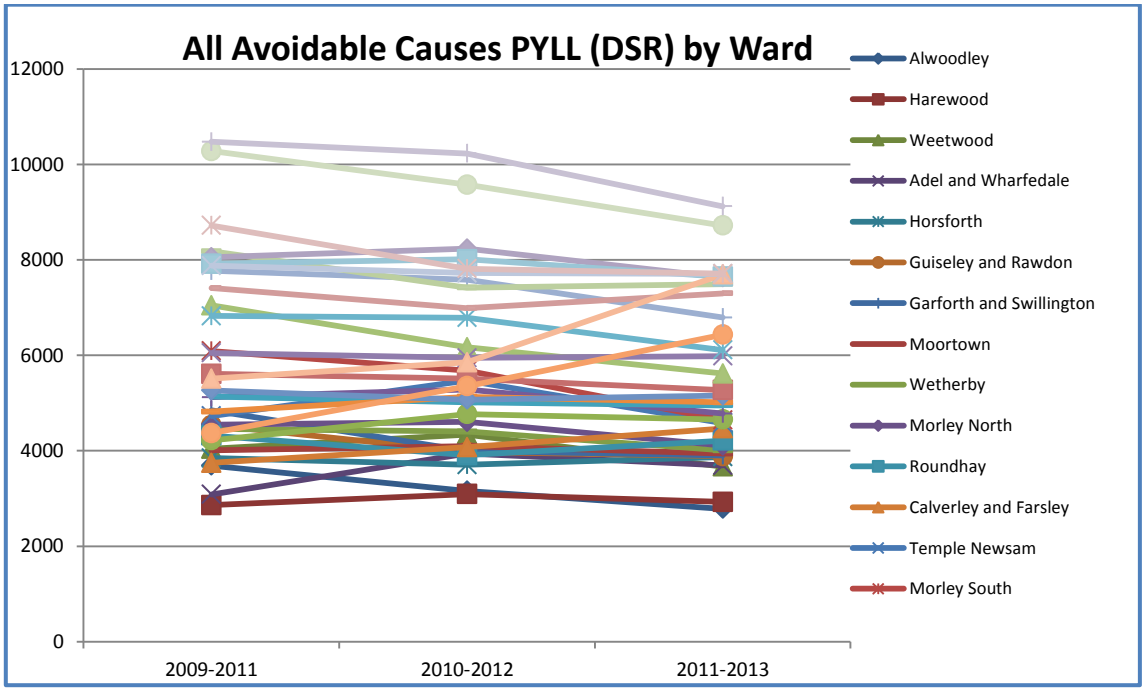


Figure 46: All avoidable causes of PYLL by ward in Leeds
Source: Leeds City Council Public Health Information Team



3.6 Clustering of unhealthy lifestyles and co-morbidities

In Leeds services are currently set up to support individuals make lifestyle changes based on a single health behaviour e.g. smoking or weight loss. However, often unhealthy behaviours are clustered.

The Kings Fund (Buck and Frosini, 2012) explored this idea. They noted that people's lifestyle behaviours are widely known to affect their health and risk of mortality but less is known about how these behaviours cluster together in the population and how multiple lifestyle risk patterns have changed over time between different population groups. Buck and Frosini used data from the Health Survey for England and examined how four lifestyle risk factors (smoking, excessive alcohol use, poor diet, and low levels of physical activity) co-occur in the population and how this distribution has changed over time. They found that the overall proportion of the population that engages in three or four of these unhealthy behaviours has declined significantly, from around 33 per cent of the population in 2003 to around 25 per cent by 2008. However, these reductions have been seen mainly among those in higher socio-economic and educational groups; people with no qualifications were more than five times as likely as those with higher education to engage in all four poor behaviours in 2008, compared with only three times as likely in 2003. They conclude that the health of the overall population will improve as a result of the improvement in these behaviours, but the poorest and those with least education will benefit least, leading to widening inequalities and avoidable pressure on the NHS.

In Leeds there is a correlation between living in a deprived area and having an unhealthy behaviour. Figure 47 below shows what proportion of the population who are living in deprived and non-deprived Leeds have either no, 1, 2 or 3 unhealthy behaviours; defined as currently smoking, having a BMI 30 or over and excessive alcohol intake (alcohol intake score of 8 or above).

Figure 47: Multiple unhealthy behaviours by deprivation in Leeds
Source: Leeds City Council Public Health Intelligence Team

Number of Lifestyles	Deprived	Non Deprived
0	60.9%	71.6%
1	33.5%	26.0%
2	5.5%	2.4%
3	0.2%	0.0%
Total	100.0%	100.0%

In addition to clustering of lifestyle behaviours, there is a pattern to co-morbidities. Obesity in Leeds can be used as an example to illustrate this point. There is an increased risk of co-morbidities for adults who are overweight and obese. Leeds City Council Public Health Intelligence team cross referenced the GP records for those with a Body Mass index over 40 against ten key co-morbidities. Figure 44 below presents the co-morbidity data for those with a BMI>40. Individuals may have more than one co-morbidity recorded.

Figure 48: People in Leeds with a BMI over 40 and a co-morbidity
Source: Leeds City Council Intelligence Team GP Audit January 2015

Co-morbidity	Number of people
Hypertension	5475
Diabetes	3263
Depression	2822
Anxiety	2818
CKD	907
CHD	884
Cancer	612
COPD	518
Stroke/TIA	399
Heart Failure	319
Total counts	18017

Public Health Intelligence also identified a range of 0 to 9 co-morbidities in the 16,236 individuals with a BMI>40. It is found that 58% of these individuals have 1 or more co-morbidity and 32% have two co-morbidities or more.

Figure 49: People with a BMI over 40 and number of comorbidities
Source: Leeds City Council Intelligence Team GP Audit January 2015

How many co-morbidities	Number	%
0 comorbidity	6751	41.6
1 comorbidity	4342	26.7
2 comorbidities	2939	18.1
3 comorbidities	1390	8.6
4 comorbidities	544	3.4
5 comorbidities	190	1.2
6 comorbidities	64	0.4
7 comorbidities	12	0.1
8 comorbidities	3	0.0
9 comorbidities	1	0.0

4. Evidence of effective services

All public health services should be based on best evidence where available and designed to meet need. This following section sets out the evidence base around currently provided services to support healthy lifestyles, services commissioned by partners and new approaches we are considering commissioning including:

- Health coaching
- Health trainers
- Social prescribing
- Mental wellbeing
- Adult and child weight management
- Adult and child physical activity
- Smoking cessation
- Healthy eating
- Family approach to weight management
- Holistic assessment.

Overarching evidence for behaviour change is provided by NICE. Specifically NICE Guidance PH6 around the principles for effective behaviour change interventions (2007) and NICE Guidance PH49 around individual approaches to behaviour change (2014).

NICE guidance around principles for effective behaviour change recommends:

- Base interventions on a proper assessment of the target group, where they are located and the behaviour which is to be changed: careful planning is the cornerstone of success.
- Work with other organisations and the community itself to decide on and develop initiatives.
- Build on the skills and knowledge that already exists in the community, for example, by encouraging networks of people who can support each other.
- Take account of, and resolve, problems that prevent people changing their behaviour; for example, the costs involved in taking part in exercise programmes or buying fresh fruit and vegetables, or lack of knowledge about how to make changes.
- Base all interventions on evidence of what works.
- Train staff to help people change their behaviour.
- Evaluate all interventions.

NICE guidance around individual approaches to behaviour change recommends:

- Develop a local behaviour change policy and strategy.
- Ensure organisation policies, strategies, resources and training all support behaviour change.
- Commission interventions from services that are willing to share intervention details and data.
- Commission high quality, effective behaviour change interventions.

- Plan behaviour change interventions and programmes taking local needs into account.
- Develop acceptable, practical and sustainable behaviour change interventions and programmes.
- Use proven behaviour change techniques when designing interventions.
- Ensure interventions meet individual needs.
- Deliver very brief, brief, extended brief and high intensity behaviour change interventions and programmes.
- Follow up service users to ensure behaviour change is maintained for at least a year.
- Commission training for all staff involved in helping to change people's behaviour.
- Provide training for behaviour change practitioners.
- Provide training for health and social care practitioners.
- Assess behaviour change practitioners and provide feedback.
- Monitor behaviour change interventions.
- Evaluate behaviour change interventions.

4.1 Health coaching

4.1.1 Summary of evidence

Health coaching has been defined as helping patients to gain knowledge, skills, tools and confidence to become active participants in their care so that they can reach their self-identified health goals (Bennet et al, 2010). There are numerous definitions as health coaching is an umbrella term for multiple applications:

- For health improvement: Health coaching is a behavioural intervention that facilitates participants in establishing and attaining health-promoting goals in order to change lifestyle related behaviours with the intention of reducing health risks, improving self-management of chronic conditions, and increasing health-quality of life (Van Ryn and Heaney, 1997).
- As a decision making aid: Health coaching is based on strong provider communication and negotiation skills, informed patient-defined goals, conscious patient choices, exploration of the consequences of decisions, and patient acceptance of accountability for decisions made (NHS Health Education East of England and The Evidence Centre, 2014).
- For wellness coaching: Wellness coaches promote optimal physical and mental health, or an ability to thrive in presence of disease, through facilitating a partnership and change process that enables clients to change their mind-sets, and develop and sustain behaviours proven to improve health and wellbeing (NHS Health Education East of England and The Evidence Centre, 2014). This takes the client beyond what they have been able to achieve alone, moving from where they are to where they want to be.

It is reported that half of patients leave primary care not understanding what their doctor has told them; only 9% of patients participate in decisions, the average adherence rates for prescribed medication is about 50% and for lifestyle changes they are below 10% (Bennet et al, 2010). Locally, only 10% of referrals into adult

weight management services successfully achieve 3% weight loss or more. This may be because the current medical model treats patients as passive recipients of care that supports learnt helplessness rather than supporting patients to be active managers and experts of their own circumstances, needs, preferences and capabilities with solutions to their own health concerns.

New approaches for working with patients are required to address the challenges associated with the need to increase patient confidence, improve decision making, improve compliance and encourage lifestyle change to improve outcomes and reduced health care costs (Health Education East of England NHS, 2014). At the heart of the 'House of Care' model, locally used to support those with long term conditions, is a coordinated patient consultation that is supported by activated professionals and patients, system change, and commissioning. Central to the 'House of Care' is personalised care planning which is consistent with a health coaching approach.

Health coaching encompasses five principal roles:

- Providing self-management support.
- Bridging the gap between the practitioner and client.
- Helping clients navigate the health and social care system.
- Offering emotional support.
- Serving as a continuity figure.

Coaching supports clients in seven domains of self-management support to enable their care to be extended into their real lives. This includes providing information, teaching specific skills, promoting healthy behaviours, imparting problem-solving skills, assisting with the emotional impact on health, providing regular follow-up and encouraging clients to be active participants in their care (Bennet et al, 2012). Health coaches can bridge the gap by following up clients and asking about needs and barriers, and addressing health literacy, cultural issues and social-class barriers. Health coaches are useful navigators of the health and social care system and can advocate for clients when their voices are not heard. Well-intentioned but rushed clinicians may fail to address patients' emotional needs, but as trust and familiarity grows, coaches can offer support to help patients emotionally cope with their illness. Coaches can also connect with patients at visits and between visits to create familiarity and continuity.

Health coaching approaches use a range of evidence based tools and models that include behaviour change theory, patient activation, motivational interviewing, stages of change, mindfulness, positive psychology, and cognitive behaviour therapy alongside coaching models and competencies. Health coaching is a framework or an approach rather than a specific technique. The intention is for clients to resolve ambivalence to their health goal, move through the stages of change, and follow through on lifestyle change that leads to improved outcomes. The process assumes that people are resourceful and have potential to change health behaviours.

The Evidence Centre at the Health Education East of England NHS (2014) performed a rapid review of the evidence for health coaching. This document outlines the findings from this review. The caveat to this evidence is that there is no

clear definition of what health coaching is and there are varying approaches and interventions. There are few randomised control trials or comparative studies. As most of the evidence comes from a US context, it is difficult to make generalisations on cost effectiveness.

There is some evidence that health coaching can support people's motivation to self-manage or to change their behaviours, and increase their confidence in their ability to do so. The feasibility and acceptance of health coaching is generally reported as high. In addition health coaching has some positive impacts on patients' attitudes towards their own health and studies from many parts of the world suggest health coaching improves people's confidence in making change and it increases self-efficacy. It has also been found to improve the self-efficacy of those caring for someone with a health problem.

There is some evidence that health coaching can support people to adopt healthy behaviours and lifestyle choices. Research has most commonly cited benefits in increasing physical activity, eating more healthily, reducing smoking, weight loss, improving perceived mental health and pain management amongst others. Health coaching which is integrated into routine care and signposts people to other community resources is well received.

Many studies have identified that the people who appear to benefit most from health coaching are those who have the most to improve, e.g. greatest amount of weight to lose, or have the most severe symptoms. Health coaching may also work best when people have already decided they want to do something differently, and health coaching provides a tool to help people achieve this.

There is no clear evidence that in-person health coaching is more effective than telephone coaching or that that individual health coaching is more effective than group health coaching. There is no clear evidence that a peer coach is more effective than a health professional trained in health coaching. This is due to a lack of studies comparing different approaches. There is no clear evidence on the frequency of health coaching, but health coaching every one to two weeks for several months has been found to work well to establish and build relationships to support behaviour change. The overall message from the evidence base is that providing health coaching has many benefits, but in order to be effective, health coaching may need to be implemented as part of a wider programme supporting education and behaviour change.

London Deanery (2011) has a number of quotes from patients as part of the evaluation of their health coaching programme for GPs which include:

"It made me think about why I do the things I do and about how smoking is affecting my life … I have a plan. I liked the style. I felt I could say what I really thought."

"I didn't feel judged and felt listened too. It is nice someone else believing in me. Makes me think I can do it."

"At first I wasn't sure how coaching would help me lose weight, but taking the time to explore the pros and cons of changing what I'm doing really helped to put things in perspective. I felt more ready to make a change … at home I noticed what I was eating much more and what I need to change … I feel much more confident and motivated to succeed."

Research by Wolver et al (2011) has shown that individuals desiring to better their health often face obstacles when it comes to initiating and maintaining changes in behaviour. An integrated (holistic) health model may help to overcome these hurdles through offering supportive patient partnerships that focus on identifying and implementing lifestyle changes based upon personal values and goals. Health professionals trained in health coaching can support and promote this process by building trusting relationships with patients that encourage personal growth, enhance motivation and promote self-efficacy. This process significantly improved patient activation scores and consequently improved self-management of health and endorsed greater readiness to change.

A randomised control trial (RCT) conducted by Thom et al (2014) reviewed health coaches as a member of the primary care team versus usual care and the impact on patients' trust of their primary care provider. The health coaches met with patients before their medical visits to support agenda setting, then attended the medical appointment and discussed with the patient afterwards the care plan and their understanding. The health coach also assisted the patient to develop action plans to increase physical activity, improve healthy eating, reduce stress, or improve medication adherence. The health coach also phoned the patients monthly and referred on to other services as appropriate. The mean level of patient trust was significantly more at 12 months in patients who received health coaching and their satisfaction of their primary care provider also significantly increased when compared to the usual care group. The researchers proposed that the health coaches improved communication between patients and the primary care provider which consequently improved interpersonal trust.

A systematic review of coaching to improve health outcomes established that the aim is to improve self-efficacy and self-empowerment (Ammentrop, et al, 2013). Consequently, the studies including disadvantaged groups had the most convincing results. This suggests that some patients may benefit from an alternative approach and a different type of communication than what they are used to from their health care professional.

The Kings Fund (2014) supports health coaching as a tool to increase patient activation, which is closely associated with improved clinical outcomes. The Kings Fund describes patient activation as the knowledge, skills and confidence a person has in managing their own health and health care. People who have low levels of activation are less likely to play an active role in staying healthy. They are less good at seeking help when they need it, following a doctor's advice and managing their health when they are no longer being treated. Their lack of confidence and their experience of failing to manage their health often means that they prefer not to think about it. NHS England is exploring the feasibility of the licence for Patient Activation Measure as a tool to support self-management in pilot sites. The Patient Activation Measure (PAM) is a patient-reported measure that was first validated in the United

States. It is a powerful and reliable measure of patient activation. The PAM contains a series of thirteen statements designed to assess the extent of a patient's activation. These statements are about beliefs, confidence in the management of health-related tasks and self-assessed knowledge. Patients are asked to rate the degree to which they agree or disagree with each statement. These answers are combined to provide a single score of between 0 and 100, which represents the person's concept of themselves as an active manager of their health and health care. The score is associated with four sub-domains of patient activation ranging from low activation to high activation.

Studies have demonstrated that coaching tailored to the patient's level of activation significantly improves outcomes than when patients are coached in the usual way. The Kings Fund (2014) continues to explain that people with high levels of activation and health literacy may only require an initial conversation, signposting them to relevant information or guided support. For those with low levels of activation, tailored coaching approaches have proved most effective at supporting behaviour change. In addition, it is important for those with low levels of health literacy to be provided with information in different formats and the support necessary for them to understand and use that information.

The Health Foundation (2011) suggests the most promising way of supporting self-management appears to involve approaches which empower and activate people so they feel more confident about managing their conditions and are more likely to alter their behaviours. There is strong evidence suggesting that improved self-efficacy is associated with better clinical outcomes. These approaches include motivational interviewing, education programmes with an active component, coaching with proactive goal setting and follow up, and programmes based on psychological and emotional support that acknowledge people's stage of change.

4.1.2 Key target groups

- Most successful for those in contemplation, preparation, action, maintenance and relapse stages of change.
- People with risky lifestyle style behaviours.
- People with long term conditions.
- Disadvantaged groups.

4.1.3 Priorities for Leeds

- Leeds develops a person centred approach where individuals can determine their health goals using self-discovery and active learning, with help to work towards their goals by self-monitoring their behaviours to increase accountability.
- For providers of a person centred service to be trained in health coaching approaches that includes behaviour change theory, motivational strategies, and communication techniques which are used to assist individuals to develop intrinsic motivation and obtain skills for improved health.
- The provider of a person centred service supports the organisational context for health coaching that includes support for supervision and further development.

- Leeds develops a health coaching approach for a holistic assessment that identifies goals for physical health, emotional health, personal relationships, employment, finance, learning and leisure etc.
- Leeds develops a robust evaluation framework that gathers information on longer-term outcomes and cost effectiveness.
- Leeds, as a health system, agrees the strategic approach to embed better conversations and a health coaching culture across organisations to improve health outcomes.

4.2 Health trainers

4.2.1 Summary of evidence

A Kings Fund Report (Buck and Frostini, 2012) argues there is a need for a shift in focus in public health initiatives, from targeting single behaviours to reducing multiple unhealthy behaviours, and concludes the report has unearthed 'there is great potential in the existing health trainer and community champions networks to make a real impact on reducing the evident inequalities in the clustering of behaviours and currently represent an under-used and ready-made workforce'.

A Royal Society of Public Health report (2014), evaluating the social and economic impact of health trainers demonstrates that such interventions produce benefits on a wide scale including improved mental wellbeing, increased social interaction, higher levels of community cohesion and improved career prospects. It concludes that the qualitative evidence clearly indicates that the non-professional, client-led, personal approach is popular amongst target audiences. In 2015, a RSPH report added 'to tackle the major public health challenges, it is vital that commissioners recognise the importance of embedding healthy lifestyles within communities, and our research demonstrates that when commissioned effectively, the health trainer service could be instrumental in achieving this' (2015).

A recent (2015) RSPH report looking at the link between mental wellbeing and healthier lifestyles evaluated the impact of the health trainer service. Using data from the Data Collection and Recording System that is used by approximately 60% of health trainer services across the country, the report demonstrates the success of health trainer services in supporting clients, regardless of deprivation quintile, to achieve substantial improvements across a range of wellbeing measures, as well as positive behaviour change. The report concludes that health trainers provide time and support offered by no other service, they are a trusted community resource and as shown by the DCRS data, hugely successful in reaching those typically seen as 'hard to engage'; the role of health trainer should be protected.

Research around stakeholder perspectives on the role of health trainers concludes that this role is a significant development for the public health workforce; offering something quite distinctive and separate from professional advice (South et al, 2007).

The NICE Commissioning Guide CMG45: Services for the prevention of cardiovascular disease (2012a) offers examples of service models for the identification and assessment of cardiovascular disease risk for commissioners. Four commonly used behaviour change and lifestyle interventions are smoking cessation

services; dietary interventions; physical activity and alcohol services. The guidance suggests these services can be delivered for patients under a 'one-stop-shop' service provided by health trainers. There is an emphasis on health trainers' ability to effectively engage with people as they are recruited for their communication skills and equipped with generic skills to motivate behaviour and lifestyle change (NICE, 2014).

NICE public health guidance 42 Obesity: working with local communities (2012) suggests that health trainers have the potential to support effective, sustainable and community-wide action on obesity and should be part of integrated health and wellbeing strategy's at a local level.

A qualitative study in two primary care trusts in northern and central England concludes that the health trainer service appears to be not only 'fit for purpose', but also to bring with it certain 'added value'. A critical factor in this success appears to be the unique combination of time, the 'person next door' and a 'one-to-one' approach, which facilitated an innovative and highly productive connection between the health trainer and client (Ball and Nasr, 2011).

The findings from a study by Michie et al (2012) reports pre-post changes in body mass index (BMI), associated behaviours and cognitions among service users who set dietary or physical activity goals during a 12-month period (2008-2009; n = 4418). Sixty-nine percent of clients were from the two most deprived population quintiles and 94.7% were overweight or obese. Mean BMI decreased from 34.03 to 32.26, with overweight/obesity prevalence decreasing by 3.7%. There were increases in fruit and vegetable consumption, reductions in fried snack consumption, increases in frequency of moderate or intensive activity and gains in self-efficacy and perceived health and wellbeing. Clients with higher BMI, poorer diet or less activity at baseline achieved greater change. Findings suggest that the health trainer service has the potential to improve population health and reduce health inequalities through behaviour change.

The Department of Health have developed a national training guide for health trainers titled Improving Health: Changing Behaviour; NHS Health Trainer Handbook. It outlines evidence around a range of theories and approaches grounded in psychological science that help people change behaviours. The health trainer develops competencies that support people to: learn how to watch for things around them that can trigger or reinforce the behaviour they want to change; teach people how to take control of their health and related behaviours; set goals and plan how to achieve them; build confidence to make the changes that they want to and self-monitor them and build social support.

4.2.2 Key target groups

- People living in the 20% most deprived communities in Leeds.
- People who smoke.
- People with a BMI over 30.
- Families with overweight children.
- People who are inactive.
- People from black or ethnic minority communities.

- People at high risk of diabetes and with long term conditions.
- Those not engaging with traditional NHS provision and will benefit from an alternative peer approach.

4.2.3 Priorities for Leeds

- To embed the health trainer approach into the integrated healthy living service to enable the service to be person centred, have a strengths or asset based approach, and be holistic through addressing wider determinants of health.
- To ensure health trainers support local communities and deliver a range of healthy living activities and interventions in addition to their role as navigators and advocates.
- To consider how the health coaching approach can be embraced through the health trainer approach.
- To consider how health trainers can support a service user's journey within an integrated healthy living service that supports and compliments access to other healthy living activities and interventions across the system.
- To target the health trainer provision for the most deprived communities and vulnerable groups of Leeds.

4.3 Social prescribing

4.3.1 Summary of evidence

Social prescribing is a term which broadly refers to a process linking patients seen by general practitioners and other primary health care workers to community services. It has been defined as 'a means of enabling primary care services to refer patients with social, emotional or practical needs related to their health and well-being to a range of local, non-clinical services, often provided by the voluntary and community sector, and to broader universal services' Age Concern (2011).

However this is by no means a universally accepted definition. There is a huge range of interventions which have been labelled as social prescribing including exercise on referral, gym-based activities, craft clubs, dance classes, befriending, aqua-therapy, signposting information and guidance and self-help groups (Centre for Reviews and Dissemination, 2015). Kimberlee (2015) recently categorised social prescribing programmes into four different types; the most comprehensive of these is 'Social prescribing holistic'; in this model the client is managed holistically taking into account all their needs, not only the one they were referred for. Clients are supported over multiple sessions with the aim of improving overall wellbeing and encouraging autonomy in managing their own care. The least comprehensive model was 'social prescribing as signposting'; in this model the service does little more than refer clients to a community service. There is very limited social or emotional support or follow-up. Almost all social prescribing services have an element of signposting. Most services fall somewhere in between simple signposting and a comprehensive holistic service.

There is a lack of high quality evidence investigating the effectiveness of social prescribing. There have been three systematic reviews but these look specifically at the prescription of physical activity and not at the full range of social prescribing

activities currently available. These reviews all found there was no evidence of effectiveness for social prescribing of physical activity (Pavey et al 2011, Washburn et al 2013 and Orrow et al 2012).

There has been a recently published review of social prescribing services within a CCG in Bristol. This was mainly a qualitative study categorising the various social prescribing programmes into separate models. There was only one quantitative assessment carried out as part of this review. This was of a holistic social prescribing programme and showed statistically significant reductions in anxiety, depression, social isolation and GP attendance. In addition, wellbeing and moderate exercise were increased (Kimberlee 2015). However this data was based on only 70 patients with no control group; no information was provided as to how the analysis was conducted which greatly limits the applicability of the report.

There has been one randomised control trial conducted on a social prescribing program. This was a liaison service between primary care and voluntary organisations ran over 26 different GP surgeries in Avon. It was found that the group of patients in the social prescribing arm showed significant improvements in anxiety, other emotional feelings, ability to carry out everyday activities, feelings about general health and quality of life. There was no significant difference found in perceived social support or depression. A cost comparison found that social prescribing was more expensive then GP care alone (Grant et al 2000).

Most of the evidence in support of social prescribing comes from evaluations of local small scale pilots. One of the most robust is the evaluation of the Rotherham social prescribing pilot. This programme has been widely recognised and received an ‘Excellence in Individual Participation Commissioner’ award at NHS England’s ‘Excellence in Participation Awards’ 2014. The evaluation found that there was a reduction in patient’s use of secondary health care services including A and E attendances in the twelve months following the social prescribing intervention compared to the twelve months before it. An improvement in wellbeing was also found. This evaluation attempted to calculate return on investments, these were estimated at 1.41 – 3.38; that is a return of £1.41 - £3.38 for each pound invested; indicating a significant long term cost saving. However, this evaluation was an uncontrolled before and after study and so has a high risk of bias. No statistical tests of significance were conducted to assess reduction in demand for secondary health care services and wellbeing was measured using a new, non-validated scale.

The centre for reviews and dissemination at the University of York has produced a rapid appraisal and summary of existing evidence of the efficacy of social prescribing. It concludes that there is little evidence to inform the commissioning of social prescribing services. It recommends that evaluations of social prescribing schemes should be rigorous and have a comparative study design (Centre for Reviews and Dissemination).

4.3.2 Key target groups

The importance of communities in tackling health inequalities is highlighted in the Marmot Review (2010). This review also suggests that primary care has a crucial role in integrating services and promoting healthier communities. The need for NHS

organisations to develop different ways of utilising community assets is highlighted in the NHS Five Year Forward View and the Department of Health has suggested that social prescribing should be introduced for those with long term conditions (Department of Health, 2006). Though social prescribing is clearly on the national agenda, there is no national policy and schemes tend to be developed individually by Clinical Commissioning Groups.

Information taken from the Leeds Joint Strategic Needs Assessment (2013) (JSNA) highlights several areas of need for which social prescribing services may offer a solution:

- Over 150,000 people in Leeds are amongst the most deprived 10% of people in England. Life expectancy for men is 12.4 years and for women 8.2 years lower in areas of most deprivation compared to the least deprived areas of the city. Average health is lower in Leeds compared to national average.
- Deprivation is associated with higher levels of poor mental health and poor wellbeing, higher rates of obesity and higher smoking rates.
- The Leeds JSNA highlights that actions needed for change are not just the responsibility of government services but also the responsibility of all partner agencies and communities in Leeds.
- There is evidence that mental health problems are becoming more widespread. Mental health problems, particularly depression are more common in people with a physical illness including those living with long term conditions.
- The JSNA suggests there is a need to continue and develop work with people with mental health problems by addressing their physical needs. There is also a need for screening for mental health problems in many settings including the voluntary sector.
- The JSNA has suggested that to facilitate life-style behaviour change there is a need to develop large scale systematic multi-agency sustainable programmes that cover all ages, tailored to particular population groups and localities.
- The JSNA has suggested work needs to continue to develop a menu of interventions and opportunities that promote physical activity and healthier eating in localities. There also should be continued investment in weight management services supporting people to manage their weight in order to prevent and manage long term conditions.
- The JSNA suggests there needs to be a move towards holistic management of people with long term conditions, focusing on individual and their mental as well as physical needs rather than specific disease pathways.
- The 2001 census showed just over 43,000 older people living alone in Leeds; this is predicted to increase by 37% by 2030. Living alone is linked to social isolation.

In addition, social prescribing has the potential to help address the five overall outcomes from the Leeds Joint Health and Wellbeing Strategy 2013-2015. These are:

- People will live longer and have healthier lives

- People will live full, active and independent lives
- People will enjoy the best possible quality of life
- People are involved in decisions made about them
- People will live in healthy and sustainable communities

4.3.3 Priorities for Leeds

In Leeds social prescribing services are commissioned by each CCG separately. One of these (the West CCG) has a program which is already running and has had an initial evaluation. The other two CCGs are in the process of commissioning social prescribing services.

Leeds South and East CCG is currently in the process of commissioning a social prescribing service. Funding of 1.5 million pounds has been secured to develop and run the service for three years. This funding has been secured from the CCG. The new service will provide a pathway for general practice and other providers to refer individuals into community activity provision with ease. A provider of this service is currently in the process of being commissioned and it is hoped the service will commence in October 2015.

The service will consist of individuals referred in from primary care, other providers and self-referral. Individuals will receive information about local community provision via the social prescribing hub. There is also the option to have a one-to-one session with a community activity advisor with the aim of supporting individuals to access community based activities which meet their identified needs. There is funding held by the Leeds Community Foundation and available through the Third Sector Grant Agreement (£300,000 for the South East CCG) for the development of services if community provision gaps are identified.

This service is being developed with the aim of addressing several social problems. These include social isolation, mental health, physical ill health and management of long-term conditions. Intended outcomes of the service include: reduction in GP attendance, reduction in use of secondary health care and social health care, improvement in physical and mental health and reduction in social isolation and loneliness. The intended outcomes and evaluation of the service are in the process of being formalised. It is hoped an academic partner can be brought in to perform a rigorous, high quality evaluation of this programme but this is yet to be commissioned. Funding for the evaluation has already been allocated from the overall budget.

Leeds North CCG is also in the process of commissioning a social prescribing service. This service is based on two standalone pilots within the CCG. These pilots involve the placements of individual wellbeing co-ordinators within GP practices. These coordinators perform an assessment and link a person to the support they need. They also based their model on the social prescribing service in Rotherham and will have a ‘hub and spoke’ approach. The intended role of the new service is to undertake assessment of individuals and then navigate them to the support they need. Individuals can access the service either through self-referral or referral from GP’s or other health care workers. This service is intended to target the wider

determinants of ill health, long-term conditions, financial inclusion and social isolation amongst other issues.

A launch event was held recently with multiple potential providers attending. It is hoped that the contract will be awarded in June 2015 and it is intended that the service will open in March 2016, if not earlier. Funding of £900,000 in total has been secured from Leeds North CCG and the Public Health department within Leeds City Council. Funding of £100,000 has already been allocated to pay for an evaluation of this service by the University of York.

Leeds West CCG has the most established social prescribing service within Leeds. It is called the Patient Empowerment Project (PEP). It was recognised by GP's at a locality development session within the West CCG that there was a need for better communication with voluntary services. With many reporting they were unaware what services were available for patients in the community. BARCA-Leeds were commissioned to deliver the program and the service commenced in September 2014. The service is funded non-recurrently at £300,000 a year by the Leeds West CCG; funding has been confirmed for a second year. At present patients can only access the service though a referral from their GP, however, it is intended that patient's will ultimately be able to self-refer into the service. Once referred, the patient has an initial meeting with the PEP workers during which they are assessed to determine their needs and advised of the community groups and activities which would be suitable for them. This includes referral to other services such as financial advisers. If necessary, PEP workers will initially accompany patients to groups. Patients can be seen multiple times until they are integrated into the community services they need. This is a holistic service which has six aims. These are:

- Improve the wider health and wellbeing of patients.
- Improvement in patient's self-reported wellbeing and inability to self-manage their condition.
- Make it easier for primary care to access local services and therefore reduce service fragmentation.
- Increase uptake of prevention/support/self-care management groups.
- Promote social inclusion in local communities.
- Provide a link to primary care to help approach a patient's needs in a holistic manner leading to improved patient experience.

A comprehensive evaluation was carried out six months into the PEP (Johnson 2015); this was carried out by the Yorkshire and the Humber Commissioning Support (YHCS) Health Economics, Evaluation and Evidence Service (HEES). A mixed methods study design was used with both qualitative and quantitative elements. The evaluation aimed to find evidence to see if the PEP was meeting the six main outcomes. Assessment was undertaken at the initial social prescribing consultation and again at three month review. At the time of evaluation the service had received 299 referrals, 182 participants had been initially assessed and 24 participants had undergone the three month review. Assessment at baseline shows that those participating in the PEP have a lower than average Shortened Warwick-Edinburgh Mental Well-being Scale (SWEMWBS) than the national average. In addition, on three well-being questions (Overall, how happy did you feel yesterday? overall, how anxious did you feel yesterday? overall, how satisfied are you with your life

nowadays?) taken from the ONS and used in the UK Annual Population survey, the average results for those in the PEP were markedly worse than the national averages. This was taken as evidence to show that the patients attending PEP are those that potentially offer the biggest challenge to the health and social care system.

There was a meaningful, positive change in the mean score of the SWEMWBS; a measure of wellbeing, 22 patients out of the 24 had a positive change. Improvements were also made in the EQ-5D-5L, a measure of self-reported health status and in the three well-being questions taken from the ONS. For the SWEMWBS and the ONS questions, t-tests produced P values of less than 0.05, however, due to the low number of participants (24) they did not consider these as statistically significant, it does however indicate that the PEP seems to be performing very well, and is likely, with a larger number of participants to show statistically significant changes. Patient's rated the service well, with a mean sore of 8.04 (10 being a really good experience, 0 a poor one) and 83.3% of people reported they would contact PEP again if they found themselves in the same situation.

The results of this evaluation are extremely positive, improvements have been made in well-being, self-reported health and the service is rated highly by patients. In addition, representatives of the West CCG report that the most recent analysis of data has shown that robust statistically significant positive changes have now been shown in two of the ONS questions (Overall, how happy did you feel yesterday? Overall, how satisfied are you with your life nowadays?) (Personal Communication, June, 2015).

The main limitation of this evaluation is that the participant results were based on a very small group of only 24 patients who had been assessed at three months meaning the results may not be generalisable to all the patients that will go through PEP. However, this was only a preliminary evaluation, a full evaluation will be carried out at a later date including assessment of management of long term conditions using medical markers (e.g. blood pressure, MRC score) to assess improvements via comparison with a control group not within the PEP.

4.4 Mental wellbeing

4.4.1 Summary of evidence

Good mental health is fundamental to physical health and wellbeing, relationships, work, achieving potential; as well as bringing wider social and economic benefits. Mental health and wellbeing is shaped and influenced by many underlying factors, including the way in which we organise ourselves as a society, how we distribute our resources and what we value.

There have been a number of recent attempts to define the concept and to measure the well-being of the population. However, such attempts have tended to assume a relationship between mental illness and well-being before such a relationship has been defined and widely agreed. In 2013 the focus for the Annual Chief Medical Officer's (CMO) report focused on the evidence for public mental health work. The report focused on:

- defining wellbeing
- the epidemiology of public mental health
- the quality of the evidence base
- the economic case for good mental health
- the importance of both treating mental health as equal to physical health and
- the needs and safety of people with mental illness.

Paul Farmer, Chief Executive of the national Mind Charity responded stating 'The overwhelming evidence from the report is that the evidence base for wellbeing services isn't as strong as it ought to be, which in itself can suggest an example of how far mental wellbeing lags behind physical health. We have come to understand a great deal over many years about preventing heart disease and stroke, with robust evidence that underpins a national public health programme. We need to see the same sort of investment for research into the impact of public mental health programmes.' Although mental health problems account for a quarter of all ill health, they receive less than 6% of all health research funding (UK Clinical Research Collaboration, 2012). Much of the commonly cited evidence base for well-being intervention evaluations in England as related to mental health is found in the 'grey' literature.

Public Health England welcomed the report but challenged the CMO's conclusion made in the report that there is a lack of evidence around the "Five Ways of Wellbeing". The Five Ways to Wellbeing are a set of evidence-based actions which promote people's wellbeing. They are: Connect, Be Active, Take Notice, Keep Learning and Give. These activities are simple things individuals can do in their everyday lives. The Five Ways to Wellbeing were developed by New Economics Foundation (NEF) from evidence gathered in the UK government's Foresight Project on Mental Capital and Wellbeing. The Project, published in 2008 (Government Office for Science), drew on research about mental capital and mental wellbeing through life. It asked NEF to develop the Five Ways to Wellbeing to communicate its key findings. The Five Ways have been used by health organisations, schools and community projects across the UK and around the world to help people take action to improve their wellbeing. They have been effectively applied in a range of ways and settings, for example to encourage people to start thinking about wellbeing, to develop organisational strategy, to measure impact, to assess need, for staff development, and to help people to incorporate more wellbeing-promoting activities into their lives. There is a concern that the CMO's challenge to the evidence around Five Ways to Wellbeing signals a return to a narrow and definition of mental health which focuses on mental illness rather than public mental health.

The World Health Organization which has suggested a useful model for public mental health. This illustrates the three evidence based approaches and opportunities set out in three main themes that overlap for which there is a sufficient evidence base to make a real and sustained public health impact:

- Mental health promotion which includes primary prevention, stopping mental health problems occurring in the first place by using "upstream approaches".
- Mental illness prevention which includes identifying early signs and ensuring early intervention to minimise progression into more serious ill health.

- Treatment of and recovery from mental illness which includes working with people with established mental health problems to ensure an early path to sustainable recovery.

PHE advocate that we must recognise that there are overlaps between the concepts of wellbeing and mental health: both have been defined as 'feeling good and functioning well', and are influenced by personal psychological resources, physical health and social determinants. Whilst clarity of language is important, recognising community preferences is important for health promotion.

In 2010 the Prime Minister launched a national “wellbeing programme” which aimed to measure progress in quality of life. In response the Office for National Statistics (ONS) published a measurement framework comprising 10 domains and 38 measures of wellbeing including objective measures of wellbeing such as life expectancy and levels of unemployment, as well as subjective measures such as feeling safe to walk alone after dark, overall satisfaction with life and levels of anxiety. Progress is reported annually in “Life in the UK” reports. The first was published in 2012. The latest report (2015) showed that people with higher levels of personal wellbeing make better health and lifestyle choices; they are more likely to eat healthily, be physically active and are less likely to smoke.

4.4.2 Key target groups

- Those at risk of developing poor mental health across the life course particularly those living in the most deprived areas of Leeds.
- Older people.
- People at risk of taking their own life, predominantly White British males aged 30-50 usually but not exclusively living in the more deprived areas of Leeds including LS12, LS11, LS14 and LS15 and people bereaved through losing someone close to them as a result of suicide.

4.4.3 Priorities for Leeds

- More emphasis on population wellbeing, including addressing underlying factors across all partners (e.g. housing, debt, employment).
- To improve mental health and wellbeing across the life-course approach.
- Achieving parity between mental and physical health.
- Children and young people’s emotional health.

4.5 Adult weight management

4.5.1 Summary of evidence

There is little UK-based evidence on the effectiveness of adult multicomponent weight management interventions. There is also limited evidence on cost-effectiveness due to the lack of follow up data. The NICE Guidance (2014) Public Health 53: Managing overweight and obesity in adults, lifestyle weight management services identified that: there is a lack of long-term review of lifestyle weight management programmes to determine cost effectiveness; there is a lack of studies directly comparing lifestyle weight management programmes in the UK; there is a

lack of evidence on whether there are any unintended effects associated with long-term weight management programmes; there is also a lack of evidence on 'weight cycling' (repeated attempts to lose weight) in relation to these programmes; and there is a general lack of evidence on which specific components of a lifestyle weight management programme ensure effectiveness. NICE (2014) recommends multi-component lifestyle interventions to change behaviours that lead to a reduction in energy intake and an increase in physical activity levels.

In response to this, and despite the range of NICE guidance available, there is a range of variability in adult weight management interventions across the country. The key components of weight management interventions recommended in NICE Guidance (2014) Public Health 53: Managing overweight and obesity in adults – lifestyle weight management services include the following:

- Multi-component interventions that address dietary intake, physical activity levels and behaviour change.
- Interventions that are developed by a multidisciplinary team. This includes input from a registered dietician, registered practitioner psychologist and a qualified physical activity instructor.
- Interventions that focus on life-long lifestyle change and the prevention of future weight gain.
- Interventions last at least 3 months, and that sessions are offered at least on a fortnightly basis and include a 'weigh-in' at each session.
- Agreement of achievable goals for weight loss with the client at different stages, including within the first few weeks, for the end of the programme and at 12 months.
- Agreement of specific dietary targets with the client that are tailored to individual needs and goals.
- Discussion on increasing physical activity that can be easily integrated into everyday life and maintained in the long term (for example, walking).

4.5.2 Key target groups

- Weight maintenance and preventing weight gain: people with a BMI over 25.
- Lifestyle weight management: people with a BMI of over 27 with co-morbidities or from BME communities or with a BMI over 30.
- Specialist medical and surgical weight management interventions: people with a BMI of over 35 with co-morbidities or from BME communities or with a BMI over 40.
- Men.
- Pregnant women.
- People with long term conditions.
- High risk groups identified from NHS Health Check.
- People living in areas of deprivation.
- BME groups.
- People with mental health problems.
- People with physical and learning disabilities.

4.5.3 Priorities for Leeds

- To better support and enable those who want to lose weight but are not ready to change.
- To develop an effective weight management system that provides a range of interventions governed by a medical led multi-disciplinary team.
- Better integration with child and family weight management.
- Better integration with other skill development opportunities e.g. cooking skills, physical activity, management of mood.
- Specific weight management interventions for men in line with findings from the systematic review (Robertson et al, 2014).
- Better opportunities to support weight maintenance and prevent weight regain after a weight management intervention – long term follow up and support.

4.6 Child weight management

4.6.1 Summary of evidence

The Epstein studies provide some of the best long term data available on the treatment of childhood obesity. There is limited evidence to support the selection of any one specific programme but the evidence does indicate that the following principles are core elements of an effective weight management programme:

- Multi-faceted approach targeted at specific behaviours.
- A reduction in energy intake from food.
- An increase in physical activity.
- A reduction in sedentary behaviours.
- Behaviour modification strategies.
- Parental involvement.
- Communication style.
- Frequent appointments.
- Support over a prolonged period.

The above approaches are generally in line with recent NICE guidelines. Recent evidence supports the effectiveness of interventions focussed primarily on parents as they have a pivotal role in deciding what children eat and what physical activity they do. There is evidence for longer term, resource intensive and multi-faceted approaches so it has been suggested that services staffed by community health workers, employed for their time, communication and motivation skills, rather than by health professionals, will be more effective (BMA 200536). The importance of developing and delivering high quality holistic support to children, young people and their families as close to home as possible is well recognised nationally (ECM1 NSF2, Health Select Committee Report 200420).

There is an established referral pathway for those children identified as being obese through the statutory National Child Measurement Programme. The weight management service in Leeds is evidence based and follows NICE guidance and provides a community based specialised treatment that supports elements of the 5-17 years general childhood obesity care pathway. Weight management services for children and young people accept referral through school nursing, wider partners and self-referral for overweight and obese children aged between 5th and 19th

birthdays with a BMI ≥ 91th centile and with carers who are willing to engage and support a weight reduction intervention.

4.6.2 Key target groups

- Children and young people aged 5-19 and their families.
- Children from lower socio-economic groups.
- Children from black and minority ethnic groups.

4.6.3 Priorities for Leeds

- Integrate programmes into wider healthy living network of services.
- Develop approaches that proactivity and effectively engage families including those in a pre-contemplation stage around their children's overweight status.
- Extend weight management programmes that are focussed on parents and carers.
- Increase the numbers of families taking up the offer of specialist support.
- Increase the number of families completing weight management programmes.
- Reduce inequalities in obesity levels for children from disadvantaged communities and ethnic minority groups.

4.7 Adult physical activity

4.7.1 Summary of evidence

Inactivity is the fourth greatest cause of ill health burden costing an estimated £7.4 billion a year in the UK. Physical inactivity directly contributes to one in six deaths in the UK, the same number as smoking. The UK is more inactive than comparative countries. Being active can reduce the risk of developing diabetes by 30-40%. People with diabetes can reduce their need for medication and the risk of complications by being more active. Persuading inactive people to become more active could prevent one in ten cases of stroke and heart disease in the UK. Being active every day can reduce the risk of breast cancer by up to 20% and also improve the lives of those living with cancer. Staying active can reduce the risk of vascular dementia and also have a positive impact on non-vascular dementia. People who are inactive have three times the rate of moderate to severe depression of active people. Being active is central to mental health. People are more likely to be active if it is seen as 'normal', and if their friends and peers are also active. Large, community-wide campaigns have been effective in increasing physical activity, but only when supported by local level community activities. Increasing social support for physical activity within communities, specific neighbourhoods and worksites can effectively promote physical activity. A child active from an early age establishes good habits for life, and being active should begin in babyhood. As people age, it can be argued that activity is more, not less important.

Public Health England (2014) set out the evidence base for physical activity in the context of settings and life stages within the 'Everybody Active Everyday physical activity framework'. It recommends the following to ensure improved health through physical activity interventions:

The physical environment: ensure environments are safe and supportive of health and wellbeing. This could mean, for example, re-allocation of road space to support

walking and/ or cycling, restricting motor vehicle access, introducing road user charging, safe routes to school, walking-friendly street layouts, improving green space. Such changes have prompted substantial shifts from car transport to walking and cycling. In addition people who have close access to green space live longer and having open space in which to exercise also alleviates stress and depression and has been shown to aid mental health. Activities such as ‘ trim trails’ and ensuring resources such as school playing fields are available to communities impact on physical activity levels. Schools need active playgrounds, safe routes to school and high quality, safe bicycle parking and there is strong evidence for the effectiveness of interventions to increase stair use in improving health within the workplace.

The social environment: People are more likely to be active if it is seen as normal and if their friends and peers are also active. Large community wide campaigns have been effective in increasing physical activity, but only when supported by local level activities. Site specific communication can work well at key community sites such as churches, schools, centres for older people etc. Social marketing has a lot of potential for promoting to younger people, but this area is new and not well evaluated.

Community-wide interventions: Increasing social support for physical activity within communities, specific neighbourhoods and worksites can effectively promote physical activity. For example, free community classes, fun sessions for children and young people. These are particularly good for underserved populations such as women, older people and lower socioeconomic groups. Town walking and cycling programmes have also proved effective, for example, maps and route signage, fun rides, group rides and cycle hire schemes. Group led walks at community level are also successful at increasing physical activity levels.

Group interventions: Evidence suggests that the social element behind physical activity aids enjoyment and encourages sustained behaviour change. Led walking groups are recommended by NICE. Other successful facilitated group sessions include guided bike rides and ‘Park Run’. It is important to target leisure opportunities for those new to sport and activity.

One-to-one interventions: There is strong evidence for the effectiveness of counselling and brief advice in primary care to increase an individual’s physical activity. NICE recommends that primary care practitioners identify those who are inactive, deliver brief advice with follow up, incorporate brief advice in commissioning and implement systems to support brief advice. NICE recommends only funding exercise referral programmes for people who are sedentary, inactive or have existing health conditions.

‘Everybody Active Everyday’ also suggests activities are targets across the life course; Starting Well; Living Well and Ageing well. The school setting is extremely important and evidence supports a ‘whole school’ approach including physical education, classroom activities, after-school sports and active travel to and from school. Interventions that work include staff training, increase in quality PE classes, interventions for targeted populations, increased break times, equipment and material provision. The ‘Inactivity Time Bomb’ Street Games report also demonstrates evidence to show that sport can contribute to significant improvements

in children's literacy and numeracy skills. Young people who participate in sport see their numeracy scores improve by 8% on average. This effect on underachieving young people is 29%. NICE provide specific guidance on how to promote physical activity to children and young people with specific evidence based recommendations for interventions. Promoting activity to adults can be challenging and wider social settings need to be looked at i.e. housing, social centres, supermarkets, mosques and churches. Workplace polices that show successful increases in physical activity include flexible working policies, health checks, and policies to encourage walking and cycling to work. NICE provide further guidance on delivering successful, evidence based physical activity interventions in the workplace. In terms of older people the evidence shows that physical activity can also tackle social isolation as well as giving health benefits. Targeted and tailored interventions are most likely to be successful with older people.

4.7.2 Key target groups

- People who are inactive.
- People with long term conditions.
- People at risk of poorer mental health specifically unemployed adults.
- Using physical activity to raise educational attainment.

4.7.3 Priorities for Leeds

- Develop a shared vision and strategy for physical activity in the city of Leeds.
- Work through other services and organisations to explore how they could help build physical activity into their systems, pathways and contacts e.g. workforces and localities.
- Complete the Strategic Commissioning project through Sport and Active Lifestyles.
- Use 'Leeds Let's Get Active' research to better understand if activity can be effective in triggering behavioral change where people have multiple unhealthy lifestyles, what impact can physical activity have on people with long term health conditions; is 'Leeds Let's Get Active' cost effective?

  Develop plans to answer identified research questions:

  - Long term impacts of physical activity interventions, including built environment interventions, at individual, group and population level.
  - Evaluation of interventions to establish sustained behaviour change targeted at specific key groups.
  - Cost-effectiveness studies which reflect cost-benefits for health, social care and other societal impacts such as educational attainment, productivity and sickness absence.
  - Large-scale population evaluation of built environment and transport infrastructure interventions.
  - Insight studies into different communities to address inequalities.
  - How best to support those with long-term mental health conditions to sustain exercise and activity.

- The effectiveness of new technologies (e.g., social media) in changing behaviours over longer terms.

4.8 Child physical activity

4.8.1 Summary of evidence

Evidence shows that physical activity behaviours are often established in childhood. It is critical therefore to engage children in physical activity from early years onwards to establish healthy physically activity levels for life and thereby prevent and reduce child obesity. Physical activity in children is crucial in reducing the effects of risk factors for disease; including avoiding raised blood pressure, avoiding weight gain and achieving high peak bone mass. Evidence also shows physical activity can improve educational attainment and increase self-esteem, self-efficacy and confidence in children.

Recommendations on minimum physical activity levels to benefit health from Chief Medical Officer are that all children and young people should engage in moderate to vigorous intensity physical activity for at least 60 minutes and up to several hours every day (Department of Health, 2011). Most children do not achieve the recommended physical activity levels and addressing this is a key government priority. Latest robust research using accelerometers shows that only 51% of children met the recommendation of at least one hour of physical activity a day, with girls (38%) less active than boys (63%) (Griffiths et al., 2013).

4.8.2 Key target groups

Groups most at risk of inactivity as identified by NICE and reflected in local data:

- Children from lower socio-economic groups.
- Adolescent girls (aged 10+).
- Children from black and minority ethnic groups.
- Overweight and obese children.

4.8.3 Priorities for Leeds

- Reduce inequalities in children's physical activity for children from BME and disadvantaged communities.
- Reduce sedentary behaviours of children and families, particularly reducing TV and screen time.
- Increase physical activity levels in early year's settings and the family environment.
- Increase girl's engagement in physical activity.
- Develop sustainable physical activity opportunities in disadvantaged communities using asset-based community development approaches.

4.9 Smoking

4.9.1 Summary of evidence for smoking and nicotine containing devices

Smoking remains the leading cause of preventable death in England and is estimated to be responsible for approximately 80,000 deaths per year (HSCIC, 2014a). The smoking related costs to society are approximately £12.9 billion per year (ASH, 2014), which includes costs to the NHS in treating smoking related diseases, as well as other costs including:

- Loss in productivity due to premature deaths (£3bn).
- Cost to businesses of smoking breaks (£5bn).
- Smoking-related sick days (£1bn).
- Social care costs of older smokers (£1.1bn).
- Costs of fires caused by smokers' materials (£391m).

In 2013/14, smokers in Leeds spent approximately £125.9M in duty on tobacco products, but the estimated cost to the city was £209.5m, meaning that Leeds has an annual shortfall of about £84M each year (ASH Ready Reckoner, 2015c).

Nationally the prevalence of smoking has declined in the general population to 19.5% (ASH, 2014); in Leeds it is approximately 23% (Joint Strategic Needs Assessment 2013-15). However smoking rates are significantly higher in several wards across Leeds and in some particular groups. These include 20-34 year olds, members of some minority ethnic communities (particularly men), and those from lower socioeconomic groups. Smoking rates are markedly higher among the more deprived areas of the city. In 2012, 14% of adults in managerial and professional occupations smoked compared with 33% in routine and manual occupations (ASH, 2015b).

The provision of stop smoking services and interventions is a high priority for reducing health inequalities and improving the health of local populations. The 2014 NICE guidance on service and delivery for smoking cessation services, and the Department of Health Service and Monitoring Guidance 2015, provides comprehensive guidance for commissioners and providers of stop smoking services. These documents present the latest evidence base to inform service design and delivery, such as providing all licensed stop smoking medication as a first line intervention, including varenicline and combination nicotine replacement therapy.

Nationally there has been a significant reduction in smokers accessing stop smoking services. The number of people that set a quit date (586,340) through the NHS Stop Smoking Services in 2013/14 declined by 19 per cent since 2012-13 (724,250) (HSCIC, 2014a). This is the first time the number has fallen for two consecutive years since NHS Stop Smoking Services were set up in all Health Authorities in England in 2000-01. The number of people that successfully quit having set a quit date stood at 300,540 (51 per cent) in 2013/14.

Despite the reducing numbers accessing stop smoking support, findings from a systematic review suggests that NHS stop smoking services continue to be effective in supporting smokers to quit in the short and longer term, with group interventions being more effective compared to other formats e.g. one to one interventions (Bauld, 2009). However many clients express a clear preference for one to one support.
The smoking cessation model adopted by Leeds consists of the specialist stop smoking service and a network of intermediate registered stop smoking advisors.

Currently registered stop smoking advisors, (typically practice nurses and pharmacists) are an important setting for smoking cessation support which ensures good service provision across Leeds. Both local and national data highlight that while primary care stop smoking services are a good setting for smoking cessation support they are less effective compared to the specialist service.

Nicotine containing devices commonly referred to as e-cigarettes or vaporisers have substantially increased in popularity over the past few years and are mainly used by smokers and ex-smokers (Ash, 2015a). According to Ash (2015a) 2.6 million adults in Great Britain are using e-cigarettes, most of whom are using the devices to help them quit smoking or to prevent them going back to cigarettes. Despite no official encouragement, subsidies or prescriptions and with little regulation they have overtaken nicotine replacement therapy sales and have provoked extensive debate on their impact on smoking prevalence and health.

Despite the name commonly used for these devices, they are not cigarettes, they do not burn tobacco. The three main components of an e-cigarette are the battery, a vaporising chamber and electronic cigarette liquid. Since they first came to market, the devices have developed in design, appearance and functionality, with early models of e-cigarettes having a very similar look to cigarettes, while in contrast more recent innovative designs are larger, approximately the size of a fountain pen, with others having larger chambers for liquids and various voltages so the user can adjust levels of vapour.

E-cigarettes are being marketed as a lifestyle product and there are concerns that this could encourage non-smokers to try them, which could lead to nicotine addiction and a possibly act as a gateway into smoking. However, despite the current marketing practices of companies to promote the use of e-cigarettes through a plethora of marketing channels such as print, social media, television and celebrity endorsements to name a few (Cancer Research, 2015), current UK data doesn't support these concerns that they may re-normalise smoking, be appealing to children or act as gateway into smoking (West et al, 2015). Rather than a gateway into smoking, e-cigarette may offer a gateway out of it with current data showing that smokers are making more quit attempts (West et al, 2015) although these are largely self-managed rather than supported quit attempts. This may not necessarily be as a result of an increase use of e-cigarettes but a range of other factors; it is still encouraging news for public health.

The most effective way to reduce the health impact of tobacco is to completely stop smoking in one go, however only a small percentage of smokers achieve this (Hughes et al, 2004). In these circumstances a harm reduction approach may be the most viable way to reduce the harm that smoking causes and e-cigarettes appear to be a popular alternative. It has been widely acknowledge that it is the tar and toxins such as cyanide, arsenic and carbon monoxide from tobacco smoke which is attributed to the damaging effects on the body and clean alternative forms of nicotine can be used with little or no long term impact (Cancer Research, 2015). Currently there are no studies available that have investigated the long term effects of e-cigarettes use or vaping, however many of the leading researchers in the field of tobacco agree that e-cigarettes offer a substantially less harmful product when compared to tobacco. A comprehensive review commissioned by PHE (2015)

concluded that e-cigarettes are significantly less harmful to health by approximately 95% based on the toxicological evidence compared to tobacco and offer the potential to help smokers quit. At the moment e-cigarettes are unlicensed products and fall under consumer protection legislation and as such are not regulated by the MHRA and are not subject to medicines regulation. From 2016 e-cigarettes that contained 20mg or more nicotine will need to apply for a medical license, e-cigarettes containing less than 20 mg of nicotine will come under the European Tobacco Products Directive and classed as a tobacco containing products and have similar marketing and advertising restrictions (BMA, 2015).

Despite some unsubstantiated health claims and no long term data readily available on their impact on health, there is a general consensus from PHE and other UK health organisations, e-cigarettes offer significantly less harmful method for smokers to inhale nicotine compared to traditional smoked tobacco (PHE, 2015). Their use has increased greatly in a short space of time and they have become more appealing and acceptable by smokers compared to current licensed pharmacological treatment such of nicotine replacement therapy. However the key strategy will be to ensure that any future regulation works for the benefit of public health. In practice this would support those smokers who are unwilling or unable to quit tobacco to switch to a less harmful product, while also ensuring they do not appeal to non-nicotine users.

4.9.2 Key target groups

- Routine and manual workers.
- People living in areas of the city where prevalence is highest.
- Pregnant women.
- People with mental health problems.
- People from BME groups.

4.9.3 Priorities for Leeds

- Reduce smoking prevalence among adults in Leeds; especially in the most disadvantaged communities.
- Increase referrals and access to our stop smoking services through incorporating smoking cessation interventions in other health care pathways.
- Increasing the number of effective interventions offering ‘brief advice and referral’.
- Employing a more targeted approach to smoking cessation interventions.
- Explore the roll out of CO monitoring to identify smokers following implementation in smoking in pregnancy.
- Introducing new options within the smoking service for people who want to quit but are not suited to the sudden abstinence model.
- Deliver effective communications programmes and campaigns with clear “calls to action” around healthy lifestyles.
- Reduce the impact and availability of illicit tobacco
- Increasing the number of smoke free areas in the city

4.10 Healthy eating

4.10.1 Summary of evidence

Poor diet is known to influence the risk of cancer, diabetes, heart disease and other conditions. Around 70,000 fewer people would die prematurely each year in the UK if diets matched the nutritional guidelines on fruit and vegetable consumption, and saturated fat, added sugar and salt intake. There are social inequalities within diet-related ill health that demand attention. Consumer awareness of the importance of healthy eating is rising, but major behavioural changes and shifts in cultural norms are required before healthy diets are the norm (HM Government, 2008).

UK policies on diet have relied heavily on providing information and education to support people to make healthier choices (Jebb 2012). However results from the Health Survey for England (2007) highlight that although the majority of adults are aware of healthy eating messages such as the governments “5 a day” target, the percentage of adults who actually consume “5 a day” remains low at only 26% (Health and Social Care Information Centre 2015). Information and knowledge about what constitutes a healthy diet is only one aspect of a more complex problem (Lobstein, 2004).

There are a number of factors which have an impact on food choice including availability, access, knowledge, skills and personal choice. Single issue solutions such as providing information fail to recognise that poor diets are the product of a complex web of determinants and are found to be ineffective in enabling long term behaviour change.

NICE Obesity: Guidance on the prevention of overweight and obesity in adults and children CG43 (2006) recommends that interventions to improve diet and reduce energy intake, should be multicomponent; including for example, dietary modification, targeted advice, family involvement and goal setting, be tailored to the individual and provide ongoing support.

Cooking skills courses have been shown to have the unique ability to influence dietary knowledge, attitudes and behaviours (Caraher and Lang 1999). Cooking courses are able to promote healthy eating key messages in a way that is meaningful to people’s daily lives. The S.W.I.T.C.H study (2010) investigated approaches to help women to make informed health choices highlighted that evidence based healthy eating messages were more likely to be acted upon, if the messages were delivered via a practical activity such as a cooking class.

4.10.2 Key target groups

Diet is well recognised as an inequalities issue with people from low incomes more likely to consume a poorer quality diet. Action to improve diet in Leeds has focused on working with people with low incomes. This is a key component of the Leeds Food Strategy which was developed to improve the public’s ability to choose and obtain food that meets their nutritional requirements and are right for their stage of life.

NICE Obesity: Guidance on the prevention of overweight and obesity in adults and children CG43 (2006) further suggests a gender focus for dietary interventions working with women from disadvantaged groups. Women are often the family's food gatekeeper with the responsibility for purchasing, preparing and supporting food choices. Other groups who have been identified as key target groups for dietary interventions include people with learning disabilities and children with a particular focus on family interventions.

In regards to cooking skills interventions, Caraher and Lang (1999) has urged caution when trying to identify certain groups of the population who could benefit from cooking skills education, as all groups of society would benefit from cooking skills, helping to create a cultural norm where people actively use cooking skills to prepare meals.

4.10.3 Priorities for Leeds

The vision for food work in Leeds is that every adult will be able to make food choices right for their stage of life, to benefit health and well-being. The principles with this vision are that:

- All adults will understand the basic principles of a balanced diet (as guided by the PHE "eat-well" plate).
- All adults will feel confident and able to eat a balanced diet.
- Leeds will have a skilled workforce able to deliver consistent food messages and identify nutritional risks.

The outcomes and priorities agreed to work towards this vision can be found in the Public Health Food and Nutrition Plan.

It is important to note that the development of a new food strategy is planned. This will involve cross-council action to take forward a number of priorities across the food system. The Public Health Food and Nutrition plan outlines the Office of Public Health's contribution to a food strategy.

4.11 Family approach to weight management

4.11.1 Summary of evidence

There is limited evidence to support family-based programmes designed specifically to deliver weight management to both adults and children simultaneously. The benefits of a holistic family approach, aimed to tackle both parents/carers and children's weight together, has been largely unexplored. What is known is summarised below.

A review assessing family-based interventions for child obesity included some studies where both parents and their children were targeted for weight loss. Results showed that interventions in which parents and children were seen together, weight loss occurred in parents, parent and children, or the child alone. The authors stated however that it was difficult to draw conclusions since most of the studies had methodological flaws. (Berry, 2004) A family-based program aimed at increasing steps and cereal consumption (for breakfast and snacks) to reduce weight gain in

children and adults had positive, significant effects on percentage BMI-for-age for children and adults and most positive effects were with girls and mothers (Rodearmel, 2006). A study to compare a family-based intervention with a traditional program oriented to the individual for achieving weight loss by obese Mexican American women showed significant linear trend in both body mass index and weight reduction across the groups, with losses greatest in the family group, followed by the individual group, and least in the comparison group (Cousins, 1997).

Locally, findings are available from 'Leeds Watch It Together' draft evaluation report. A South Leeds healthy weight review, demonstrated a need for a family-based programme studies where both parents and their children were targeted for weight loss so the 'Watch It Together' pilot was set up with 'Watch It' (children's weight management service) and 'Weigh Ahead' (adult weight management service) working together on the programme. Despite extensive promotion low numbers of referrals were received, with only a group of 6 parents/ carers and 7 children/ young people participating in the pilot. Despite the issue with recruitment and other challenges the report showed some positives: "physical activity session worked well as parents / carers and children / young people had fun together. It provided an opportunity to build relationships while engaging in a healthy activity. Sessions were focused on fun games rather than exercise. The family activity session should be included in future groups".

The report concluded that parents and carers lost an average of 2.28% body weight on the group with half the group achieving the target of 3% weight loss. Children / young people showed some reduction in their BMI with 43% achieving the "Watch It" target. Parents and carers had improved on 4 out of 10 health behaviours post intervention and children and young people improved on 8 out of 10 health behaviours post intervention. The overall evaluation and feedback provided by parents/carers on completion of the group was very positive with 100% of parents and carers rating the programme at least 7 out of 10 on the friends and family test post intervention, exceeding the initial objective of 75%.

There is significant evidence to show that weight-related health interventions that require parent participation are more effective than those without parental participation (Neimeyer et al, 2012). Interventions to prevent childhood obesity that involve parental support and home activities that encourage children to be more active, eat more nutritious foods and spend less time in screen based activities are found to be effective (Waters 2011). The Epstein studies on effective treatment of childhood obesity suggest that parental involvement is important. Recent evidence supports targeting parents exclusively in the treatment of childhood obesity (Golan, 2004). Interventions focussed primarily on parents are effective as they have a pivotal role in deciding what children eat and what physical activity they do. In terms of targeting new mothers, there limited evidence on the promotion of physical activity and healthy eating in new mothers (Hartman, 2011) the local Fit Together programme found this group particularly responsive to their weight management programme.

4.11.2 Key target groups

- Families from lower socio-economic groups

- Families from black and minority ethnic groups

4.11.3 Priorities for Leeds

- Integrate programmes into wider healthy living network of services.
- Ensure adults and children maintain a healthy weight.
- Supporting adults and children with effective weight management programmes where needed.
- Develop approaches that proactivity and effectively engage families including those in a pre-contemplation stage around their children's overweight status.
- Extend weight management programmes that are focussed on parents.
- Reduce inequalities in obesity levels for children from disadvantaged communities and ethnic minority groups.

4.12 Holistic approaches to wellbeing

4.12.1 Summary of evidence

Wellbeing is a widely used term and there are currently no universally accepted definition or measurement tools despite the growing body of academic research. In 2006, the Department for Environment and Rural Affairs (DEFRA's) 'Whitehall Wellbeing Working Group'; with membership including government departments, devolved administrations, the Environment Agency, Improvement and Development Agency for Local Government and the Sustainable Development Commission, agreed a statement of common understanding of wellbeing for policy makers; "Wellbeing is a positive, social and mental state; it is not just the absence of pain, discomfort and incapacity. It arises not only from the action of individuals, but from a host of collective goods and relationships with other people. It requires that basic needs are met, that individuals have a sense of purpose, and that they feel able to achieve important personal goals and participate in society. It is enhanced by conditions that include supportive personal relationships, involvement in empowered communities, good health, financial security, rewarding employment and a healthy and attractive environment."

This statement recognises two aspects of wellbeing: the wellbeing of individuals and the conditions, such as a healthy and attractive environment, that enhance individual wellbeing. The following components: involvement in empowered communities, supportive personal relationships, good health, financial security, rewarding employment, and a healthy and attractive environment were included to illustrate indicators, datasets, and research and government department policy objectives at that time.

When this is considered against the Leeds Integrated Healthy Living System, the physical and mental health wellbeing is achieved through the provision of healthy living services. This wellbeing definition emphasises the importance of what people feel and their purpose. A holistic approach to wellbeing ensures an individual's personal goals can be met while understanding the impact of the wider determinants of health.

What is not available is a universal tool to assess someone's wellbeing in this broadest sense. The Warwick-Edinburgh Mental Well-being Scale (WEMWBS) is commonly used and available as a self-assessment tool on NHS Choices. Warwick and Edinburgh Universities were commissioned to develop it in 2006 for NHS Health Scotland. The WEMWBS is a scale of 14 positively worded items, with five response categories from 'none of the time' to 'all of the time'. It is used to assess a population´s mental wellbeing. It covers most aspects of positive mental health such as: positive affect (feelings of optimism, cheerfulness, and relaxation), satisfying interpersonal relationships and positive functioning (energy, clear thinking, self-acceptance, personal development, mastery and autonomy). The tool provides an overall score that can be used as a baseline for subsequent follow up.

Another tool to assess wellness and wellbeing is the Wheel of Wellness. The Wheel of Wellness was first introduced in the early 1990's (Witmer and Sweeney, 1992) as a counselling tool which focused on five interrelated life tasks: spirituality, self-direction, work and leisure, friendship, and love. Many adaptations of the Wheel of Wellness have been made as tools to explore the concept of wellness and wellbeing. These are predominately used in psychology and counselling. The Wheel of Life is another adaption that is commonly used in coaching. An adaption of the Wheel of Life has been used by NHS Lancashire and Sefton through the "get the most out of life tool" and by Public Health Leeds with the Wellbeing Wheel. The commonality of these tools is that scaling is used to establish a subjective score for each area of the wheel. The use of a scale as a subjective measurement tool is evidence based and originates from pain management as a way to quantify something that is subjective, such as acute pain.

NHS Sefton had an independent evaluation of the Wellbeing Sefton Coordinator that was based within the CAB service and who coordinated access to a range of social prescribing opportunities across Sefton. Wellbeing Sefton used WEMWBS and their Life Balance Assessment tool (adapted from the Wheel of Life) as part of their initial holistic assessment. The LBA tool is based on the "get the most out of life" developed by Lancashire Help Direct. The tool covers eight areas: health and fitness, home and garden, learning and leisure, mobility and transport, community groups and involvement, employment, volunteering and training, relationships and families, and managing finances. Clients are asked to score each area on a scale of 1 to 5 over the previous 2 weeks (1 = very unhappy, and 5 = very happy). The tool includes a wellbeing wheel as a visual representation of all 8 areas with a scale to rate satisfaction in each area. An hour appointment is used to go through the WEMWBS and LBA tools with the client. The evaluation identified that 88% of clients had low mental wellbeing in their initial assessment. Follow up WEMWBS and LBA assessment at 3 months have shown significant improvements in both scores. A criticism of the LBA is that the scale is too narrow to monitor slight changes in satisfaction levels and a 10 point scale would have been more beneficial.
The evaluation expressed that the initial consultation and LBA was proved to be useful in empowering clients to identify their specific needs and in tailoring recommendations to the clients' needs. The ability of the Well-being Coordinator to spend time with clients and enable them to reflect on their personal situation was viewed as an important and unique aspect of the service and suitability of the service for vulnerable clients was appreciated. The main barriers for clients to engage with their tailored recommendations were lack of confidence and financial issues. These

barriers were articulated by clients interviewed as part of the evaluation process. Lack of confidence also had an impact on the number of clients who do not attend their initial appointment. It was viewed that those who did attend are those ready to make a change.

The Big Lottery Fund used quantitative questionnaires that included WEMWBS to evaluate their national well-being projects that had a focus on improving mental health, physical activity and healthy eating which demonstrated that:

- Gaining new skills, either interpersonal skills or vocational skills, was found to be important for improving participants' personal wellbeing and self-esteem.
- The opportunity for social activities that help form and maintain friendships outside the projects contributed to significant improvements in social wellbeing scores.
- There is a strong correlation between improved personal well-being and improved mental health. Improved mental health and personal wellbeing were very important factors in enabling people to make and sustain changes to their eating and exercise habits.
- Increased confidence was found to be central to improving all areas of an individuals' wellbeing. Self-confidence increased as a result of increased social well-being, improved mental health, or a sense of personal progress. Increased self-confidence, motivation and determination are all necessary to adopt and maintain healthier behaviours and to access other opportunities to improve their health and well-being.
- To enable healthy behaviour change, you first need to improve personal well-being and mental health.
- Addressing multiple aspects of wellbeing is important to improve peoples' knowledge, enjoyment and behaviour which can in in turn support lasting improvements to their well-being (CLES and nef, 2013).

The NHS Health Trainers Handbook (2008) developed by the British Psychology Society includes a variety of tools that help clients to change their behaviour based on evidence based psychological science and theory. The handbook suggests that changing behaviour is more effective if people are engaged in thinking about their own solutions and setting their own goals based on these. The approach of the health trainer is to help people decide how they would like to change and teach them skills to help them achieve their aim. This includes helping people think through how their social and cultural circumstances can help or hinder change. This is also based on the principles of health coaching.

The handbook recommends the use of a Health Behaviour Check (HBC) as an assessment tool to help people think about their health, their behaviours, and what changes they might like to make. It is intended that the Health Behaviour Check provides a baseline measure of current health behaviours for the client. This is then used to assess progress over subsequent meetings so that clients are aware of their progress and what they have achieved. The HBC includes questions on physical activity levels, dietary intake, alcohol intake, smoking status, scaling approach to describe current health, and demographic status. The assessment ends by asking the client what they would like to focus on (what problem to be addressed) and ascertaining the level of importance, confidence and motivation to make that change

using scaling approaches. This is part of the process of developing a personal health plan. A number of other positive psychology tools can be used to support the client during the action planning, goal setting and action phase. An advantage of this approach is that it gathers a lot of information that can be used as baseline measures to establish a health status on the key healthy living issues which can be used to measure outcomes. A criticism of this tool is that despite the capture of demographics it doesn't explore the social context of the client and the wider determinants of health that may be impacting on someone's health. Nor is it a pictorial representation of a client's life, such as the Wheel of Life, that may be helpful for a client to identify their health goal. However, the Health Trainers Handbook includes a variety of tools that can be used to explore this as subsequent sessions.

14.12.2 Key target groups

If the purpose for a holistic wellbeing assessment is to enable a client to prioritise, goal set and action plan, the target groups that would benefit the most from this approach are:

- Those in contemplation, preparation, action, maintenance and relapse stages of change
- Vulnerable people and those from disadvantaged groups
- Those with lower levels of mental health
- Those with low levels of confidence and self-efficacy

4.12.3 Priorities for Leeds

It is important that the Leeds integrated healthy living service has a consistent approach to assessing health and wellbeing. This may be a mixed methods approach that includes information gathering on risky lifestyle factors (e.g. Health Trainer health behaviour check) in addition to a health and wellbeing wheel as a holistic approach to explore the whole person and identify next steps to improving their health and wellbeing. It is recommended that the commissioning of the Community Health Development Services use the same approach to assessing health and wellbeing.

As there is already a Leeds Wellbeing Wheel in operation, it important that the use of this wheel is reviewed to identify the successes and challenges of this approach and to ensure learning can be embedded to ensure suitability for the LIHLS. It is anticipated that training is important to ensure the Wellbeing Wheel is used consistently across organisations and between frontline workers.

As rapport develops between a client and a practitioner, it is common that barriers to behaviour change and other social concerns will become apparent over time. It is important that the LIHLS holistic assessment tool is not a static process in the first appointment but is continually reviewed with the client to demonstrate progress but also to capture awareness as new barriers come to light and identify solutions. As a system, it is important that Leeds have a range of opportunities to ensure that those using the holistic assessment can act as social prescribers and connect clients to activities to meet their goals and needs. In order for a holistic assessment to be

developed, it is essential that outcomes are identified to ensure this tool can be developed to ascertain baseline and follow up measures for effectiveness.

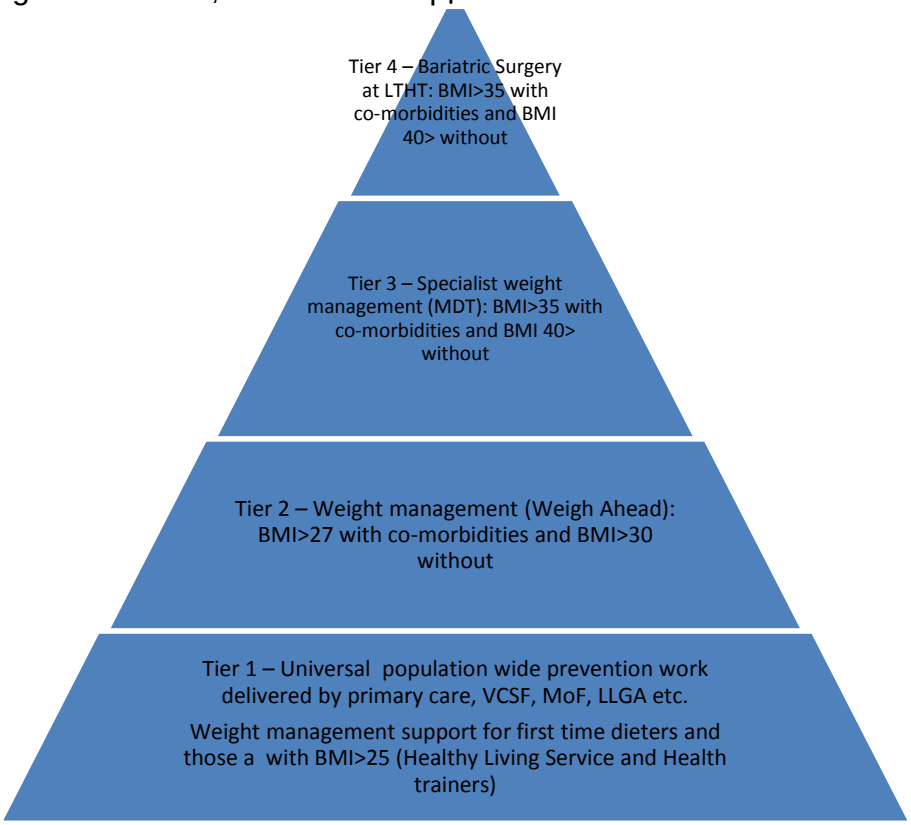
5. Effectiveness of currently commissioned services

The following section provides information about services currently commissioned. This includes a summary of what the service does the activity in the financial year 2014 – 15 and commissioner's perspectives on strengths, weaknesses and gaps. This will be triangulated with current service provider's reflections and insight based on their frontline and management experiences, as part of this project's consultation work.

Demographic monitoring data describing the age, ethnicity and gender of service users has been compared to the demographics of Leeds (Census, 2011). The completeness of age, ethnicity and data recorded varies by service.

Weight management is currently delivered across three services. An overview of weight management in Leeds is provided below, and the effectiveness of each service is presented in more detail later in this chapter.

In Leeds, there is a range of services that support weight management that may be universal for all adults, targeted for a specific BMI, or specialist medical or surgical interventions to address the underlying causes of obesity, for example metabolic diseases. As indicated by the diagram below, weight management services are part of a four tier system. Clients are expected to move up and down the tier system depending on their BMI, clinical and support needs.



Tier 1 includes a range of health promoting activities for the whole population that include cooking skills, physical activity opportunities, community development,

amongst others to reduce the risk of being overweight plus brief interventions, support and signposting by primary care and other health and social care professionals into relevant services to meet the clients need. This range of services may target specific groups such as deprived communities. In Leeds, there are prevention services to maintain weight and prevent weight gain in addition to weight management support for overweight clients who are first time dieters or for those who will not engage with mainstream services.

Tier 2 includes healthy living services that provide brief and extended brief interventions for weight management to those who are obese. The Healthy Lifestyle Service sees clients for up to 12 weeks; the Health Trainer Service see clients up to 8 contacts and the Weight Management Service (Weigh Ahead) see clients for 20 weeks plus ongoing support. These services achieve the outcome to increase physical activity by promoting access to physical activity opportunities through Leeds Let's Get Active and the "I want to get active" scheme. The Healthy Lifestyle Service does not meet the 3% or the 5% NICE weight loss targets. Weigh Ahead only achieves the 5% weight loss targets for those with 6 or more recorded weights (classed as completers). In 2014/15, for all clients in the Health Trainer service who had 2 or more weights recorded, regardless of the personal health goal, 77.1% had lost some weight (although this cannot be broken down into the NICE 3% and 5% categories). For clients in the Healthy Lifestyle Service with a weight loss goal, 76.4% had lost some weight (44% achieved a 3% weight loss and 22% achieved a 5% weight loss). In the Weigh Ahead service, 68% of all clients achieved some weight loss. For the clients who had 6 or more weights, 76% had lost some weight, 50% achieved a 3% weight loss and 35% achieved a 5% weight loss.

There are concerns at the level of clients who drop out of the weight management service. From 2245 referrals, only 1058 attended their first appointment (47%) during 2014/15. Of these 1058 clients, only 159 clients (19%) have 6 or weights recorded and are classed as completers. Therefore, only 7% of referrals (n=2245) end in a completed weight management intervention (n=35). This questions whether the majority of referrals are for clients who are in the pre-contemplation and contemplation stage and not ready to take action, in addition to those who will relapse as part of the programme. It also questions whether the interventions are meeting client need.

Tier 3 is a specialist weight management service that provides non-surgical interventions 12 to 24 months prior to a surgical review. This service also provides post-surgical support following bariatric surgery up to 2 years. An Endocrinologist and a dietician at Leeds Teaching Hospitals Trust currently review patients eligible for bariatric surgery. Currently there isn't a range of interventions for obese clients who require specialist weight management interventions. This is being supported by Weigh Ahead and commercial slimming companies. There is also no outcome data for this service. This is a CCG commissioning responsibility and a gap in the weight management system across the country.

Tier 4 is bariatric surgery. In Leeds, bariatric surgery is currently available at LTHT. Through Choose and Book, Leeds residents can choose any bariatric surgical provider in the region. NHS England is aware that the surgical unit is not compliant

with the competency requirements for each surgeon and the unit. This is because of the limited throughput from Tier 3 services. This is a similar picture nationally.

5.1 Health trainers (Health for All)

5.1.1 Summary of service and activity between April 2014 and March 2015

The Health Trainers service is provided by Health for All. The service employs a diverse team to provide information, persuasive messages and increase people's knowledge of health risk. Moving away from 'advice from on high' to 'advice from next door' approach, local people have been recruited and trained as Health Trainers to support positive behaviour change and prevent ill health due to poor lifestyle choices. Using a coaching model and motivational interviewing techniques, individuals are supported to increase healthy behaviour through setting small goals and understanding the triggers that can reinforce behaviours they are trying to change and developing strategies to address those triggers. Individuals connect with a health trainer over 6-8 sessions on a one to one basis, which can include setting and reviewing a personal health plan, accompanying people to a new organisation for the first time where confidence may be low, accompanying people to a supermarket to understand food labelling and make better food choices and signposting/referring people into other local services. Health Trainers are largely based in GP practices but have started to expand their presence in community based venues, since April 2015.

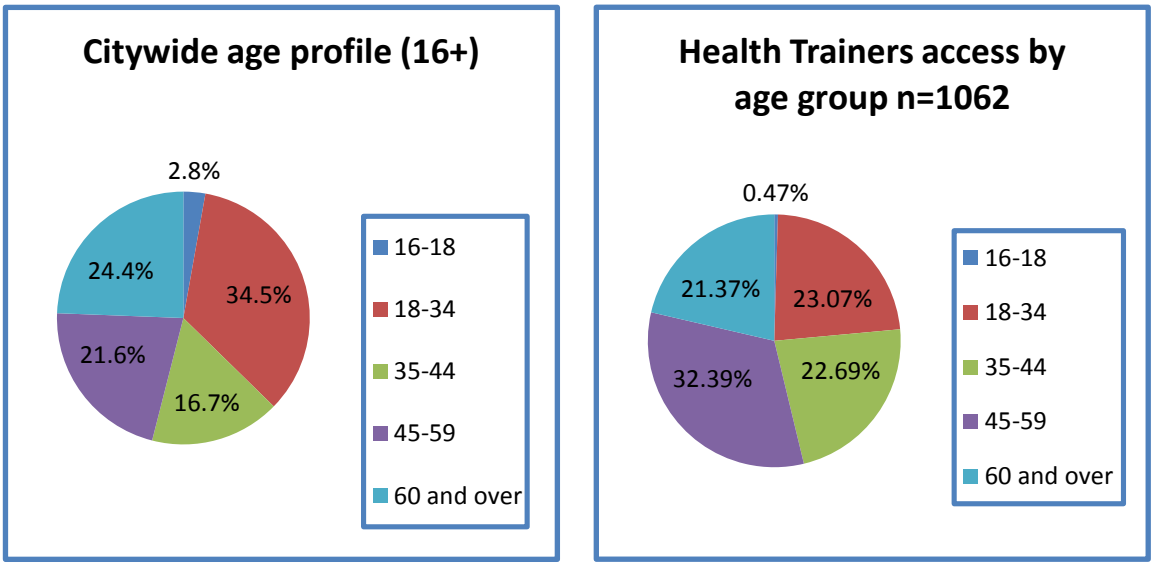
Performance data April 2014– March 2015

- The service received 1,365 referrals of which 1,066 accessed the service on at least 1 occasion (78.1%). There was an increase of 6.8% on the number of people seen in 2013/14, the majority of referrals were by GPs (83.3%).
- The largest proportion of clients came from the most deprived areas of Leeds; 749 people were from a Quintile 1 area (70.3%).
- 801 people (75% of the total people who accessed the service) had a healthy eating or weight loss focus.
- 776 individuals (72.8% of all who accessed the service) set a Personal Health Plan (PHP) and were supported by a Health Trainer to achieve a health improvement goal, 322 people (41.5%) achieved the goals in their PHP and 217 people (28%) part achieved their goals 44 people (5.7%) did not achieve their goal and 193 (24.9%) were lost to follow up.
- Of the 303 people who followed a weight management programme and had an end point BMI was recorded for 280 people of these, 43 (14.2%) maintained their weight (BMI change <1) and 221 people (79%) achieved some weight loss (BMI reduction range 1 to 10) .
- Of the 290 people who did not set a PHP, 48 were signposted into other services, with the largest activity around the following services and activities: 'Leeds Let's Get Active' Programme - 16 clients and 'Weigh Ahead' – Adult weight management service 10 clients.

5.1.2 Health Trainer Service access by age, ethnicity and gender (2014 – 2015)

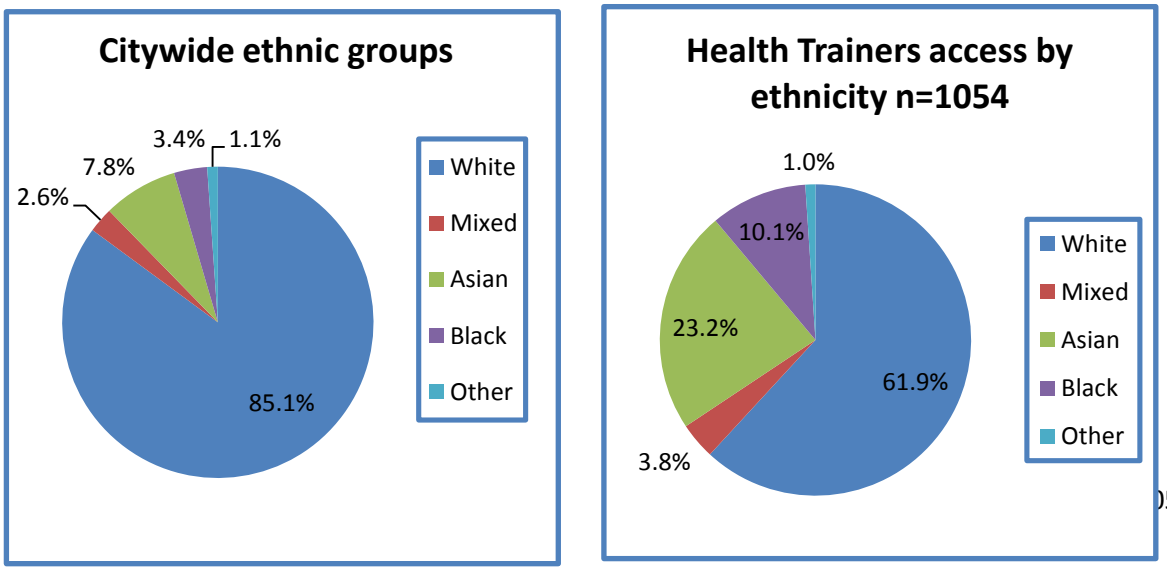
	Number of records	% of all records
Total number of records received	1064	
Number of records with age recorded	1062	99.8%
Number of records with ethnicity recorded	1054	99.1%
Number of records with gender recorded	1064	100%

Figure 50: Age profile of Health Trainer Service users compared with citywide age profile (16+)
Data Source: Census 2011 and service activity data 14/15



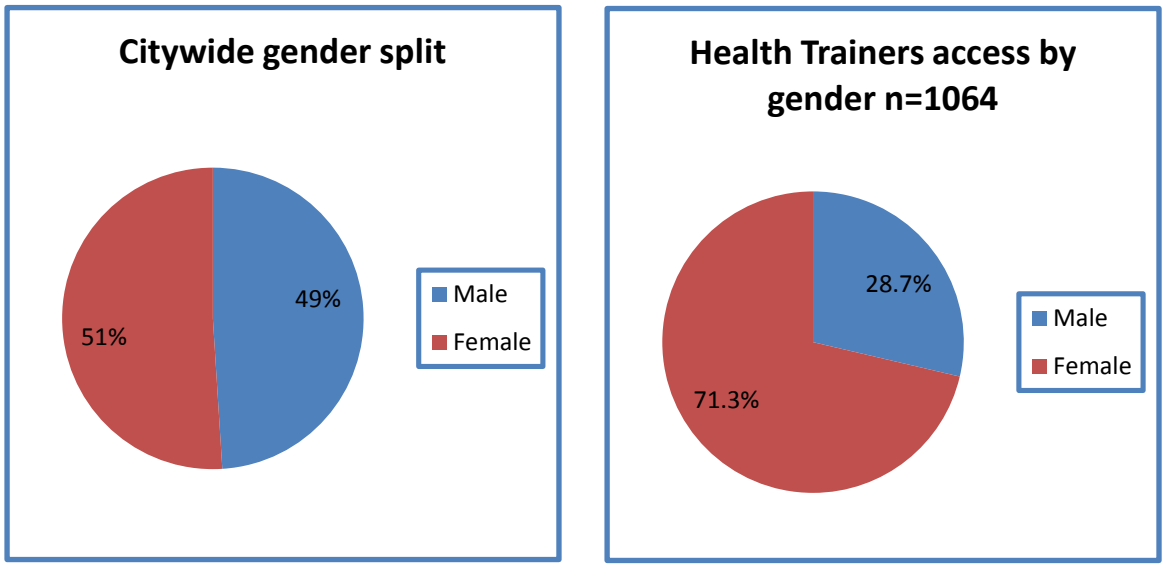
The age profile of the Health Trainer Service users is similar to the Adult Weight Management and HLS service with the majority of clients attending from the 45-59 age group (32.4%). The proportion of service users aged 16-34 represent 23.5% of total service users. The proportion of people attending from the 60+ age group is 21.4% which compares well with the city wide profile of 24.4%.

Figure 51: Ethnicity profile of Health Trainer Service users compared with citywide ethnicity profile
Data Source: Census 2011 and service activity data 14/15



As people from ethnic minority backgrounds are at higher risk of ill health, with poor lifestyle choices being a huge contributing factor, it is encouraging that 38.9% of service users accessing the service are from a non-white background, compared with the citywide profile of 14.9%. There are a greater proportion of service users who are of Asian origin, particularly those belonging to a Pakistani background.

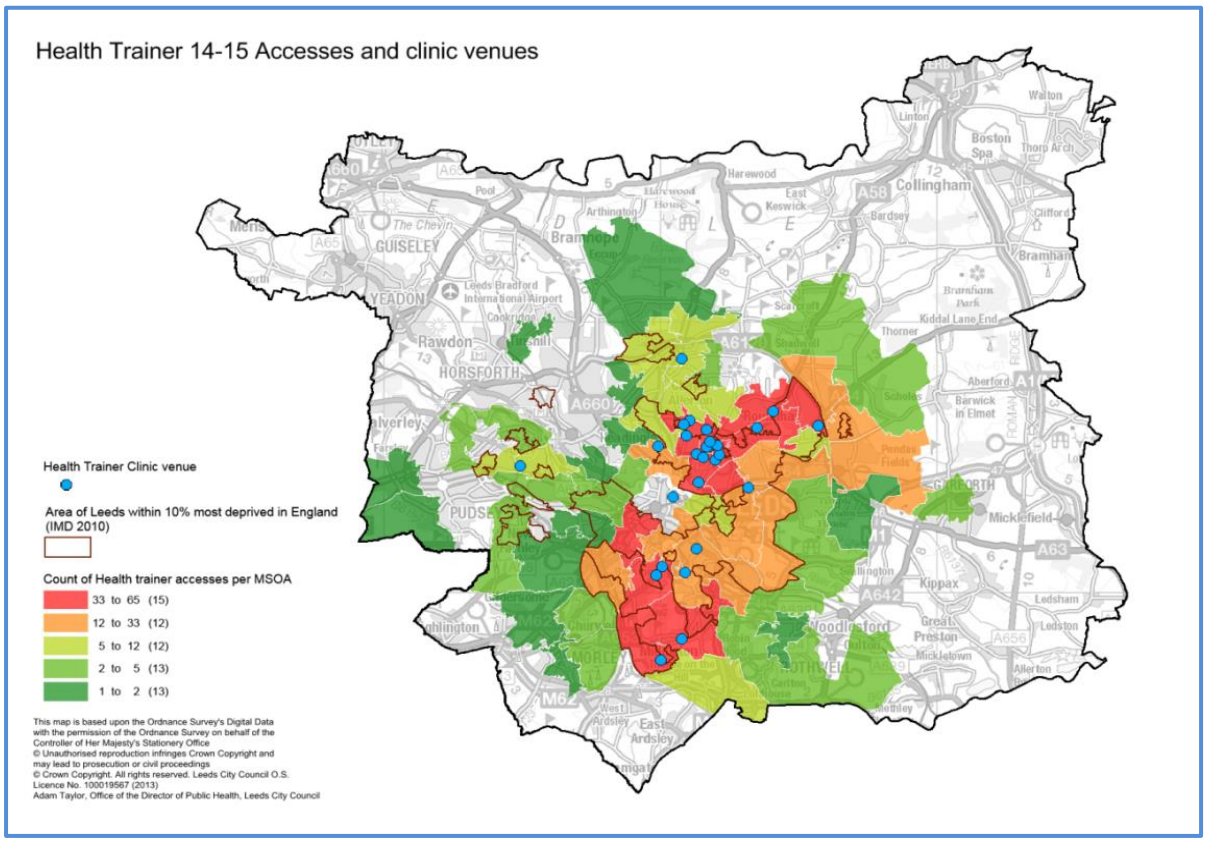
Figure 52: Gender profile of Health Trainer Service users compared with citywide gender profile
Data Source: Census 2011 and service activity data 14/15



There are a greater proportion of women (71.3%) who access the service compared with men (28.7%) which is very similar to the pattern seen in the Adult Weight Management and HLS service.

5.1.3 Health Trainer Service usage by geography

Figure 53: Map showing location of the Health Trainer clinics and the number of people by postcode sector who have accessed the service
Data source: Postcode data collected from the service and mapped by Public Health Intelligence Team LCC



The Health Trainers service targets areas with highest deprivation across Leeds, to support lifestyle behaviour change and promote wellbeing for those most vulnerable to poor health. It has been successful in reaching its target audience with over 80% of service users who access the service coming from the top 20% Super Output Areas; this is also where prevalence of obesity, Long Term Conditions (LTCs) and diabetes is highest. The small number of clinics outside of the most deprived areas of Leeds is based on historical agreements where there had been seven contract providers across the city.

5.1.4 Commissioners views of strengths, weaknesses and gaps

One of the strengths of the service is the commitment health trainers make in supporting the client throughout their journey, which includes contact outside of sessions that further motivates people towards achievement of their goals. Recruiting local people from the communities helps deliver a health improvement service that is accessible, offer easy to understand information and an empathetic and non-judgmental approach. Changing behaviours can be a complex task and providing information and persuasive message alone is sometimes not enough. Health trainers accompany people to new services if confidence is low, such as a

leisure centre or supermarket if they want help to understand food labels/make healthier food choices. The service has received interest from a number of organisations recently. The Leeds South and East CCG have recently awarded them with funds to increase service capacity over the next two years from April 2015. IAPT are also setting up referral pathways with the service as part of this increase. LCH have invested funds to host two whole time equivalent posts over the next two years covering all three CCGS areas, working as part of integrated neighbourhood teams, offering social prescription for people with LTCs. LTHT are funding a 0.20 whole time equivalent post to work with employees who are on lower grade pay scales to address their health and wellbeing. The service has historically received the majority of its referrals from GP practice staff. Since April 2015, the service has started to increase its presence in community based venues to access people who do not engage with primary care. The service has a robust monitoring system in place that collects data around ethnicity, age, postcode, and measures wellbeing and service outcome data. It attempts to follow up clients 3 and 6 months post intervention to check maintenance of health goal, progress and offer referral into another service if required.

Weaknesses

The service needs to engage people who do not currently access primary care services; efforts are being made to expand the health trainer's presence in community venues. There are a high number of people who did not attend appointments in the service; health trainers need to clarify with referrers that they must assess client's readiness to change before a referral is made to them.

Gaps

To improve referral pathways and communications across other healthy living services in Leeds.

5.2 Healthy Lifestyle Service (Leeds Community Health Care)

5.2.1 Summary of service and activity between April 2014 and March 2015

The programme aims to improve the health and wellbeing of individuals and communities in Leeds through supporting people to change unhealthy behaviour, with a specific focus on: reducing alcohol consumption, stopping smoking, losing weight, increasing physical activity and eating healthily.

This service was designed to provide a more universal offer of healthy living interventions across the less deprived areas of the city and to allow more focusing of the specialist services in the most deprived areas. Initially working to support people who had attended an NHS Health Check via a GP / practice nurse referral, the service has now extended its' referral route to include self-referral and not limited to NHS Health Check clients.

The service is typically delivered in a range of healthcare settings and offers out of hours appointments.

Staff have been trained in basic motivational interviewing techniques and some topic specific (stop smoking, weight management, physical activity and healthy eating) application of behaviour change techniques; all staff offering smoking cessation with pharmacotherapy have completed the relevant National Centre for Smoking Cessation and Training assessment

Between 1/4/14 and 31/3/15, there were:

- A total of 1589 referrals to the service
- A total of 1062 first appointments (conversion rate 66.8%) and an increase of 39.1% from the previous year

Smoking Cessation

- A total of 230 clients contacted the healthy living service for smoking cessation (21.7% of first appointments)
    - 68 clients were referred onto specialist smoking services and 162 commenced a smoking cessation programme with the Healthy Living Service
    - Of the remaining 162, 119 clients attended a first appointment (73.5% retention to first appointment) and 67 went on to set a quit day (56.3%)
    - 44 clients who set a quit day were quit at 4 weeks (65.7% success rate) (minimum DH standard 35%)

Weight Management

- A total of 792 clients accessed Healthy Living Service for a weight management intervention (74.6% of first appointments)
- Of these,
    - 674 clients commenced a weight management intervention and 108 were referred to specialist weight management services (13.6% referred on)
    - 233 clients had a final assessment date (41.1% of those who commenced weight management intervention with HLS)
    - Of these 10.3% maintained their current weight (change of <1% weight loss)
    - 72.1% achieved some weight loss (>1% reduction in BMI)
    - 43.7% achieved 3% weight loss – NICE target 60%
    - 21.5% achieved 5% weight loss – NICE target 30%

Longer term weight management outcomes

- From clients seen the previous year (13/14)
    - 66% of clients (n=132) completed were followed up at 6 months:
        - 52% achieved further weight loss
        - 7% maintained weight
    - 60% of these clients (n=79) were followed up again at 12 months
        - 32% lost further weight
        - 38% maintained weight

Alcohol reduction

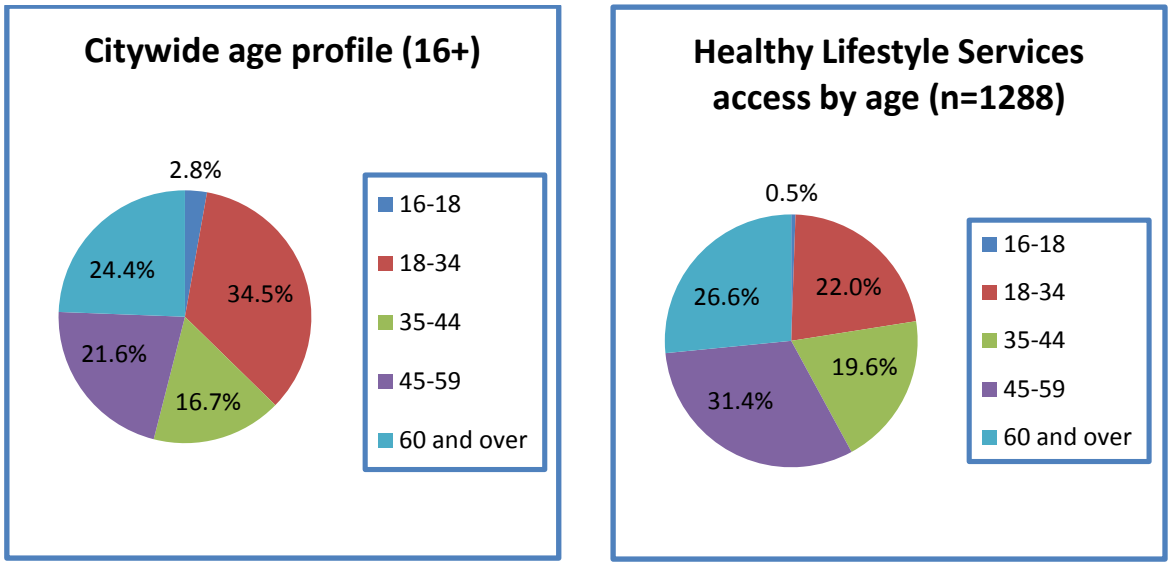
- A total of 23 clients accessed Healthy Living Service for alcohol reduction (2.2% of first appointments (n=1062))
    - 5 clients were referred to specialist alcohol services
    - 13 clients commenced an alcohol reduction intervention (56.5% of 23 clients)
    - 11 clients were lost to follow up (85% of 13 clients)
    - 2 clients (43% of 13 clients) achieved a reduced alcohol consumption by 50%

In addition, 265 people (25% of first appointments (n=1062)) accessed the service for support and advice about increasing their levels of physical activity and healthy eating.

5.2.2 Healthy Lifestyle Service access by age, ethnicity and gender

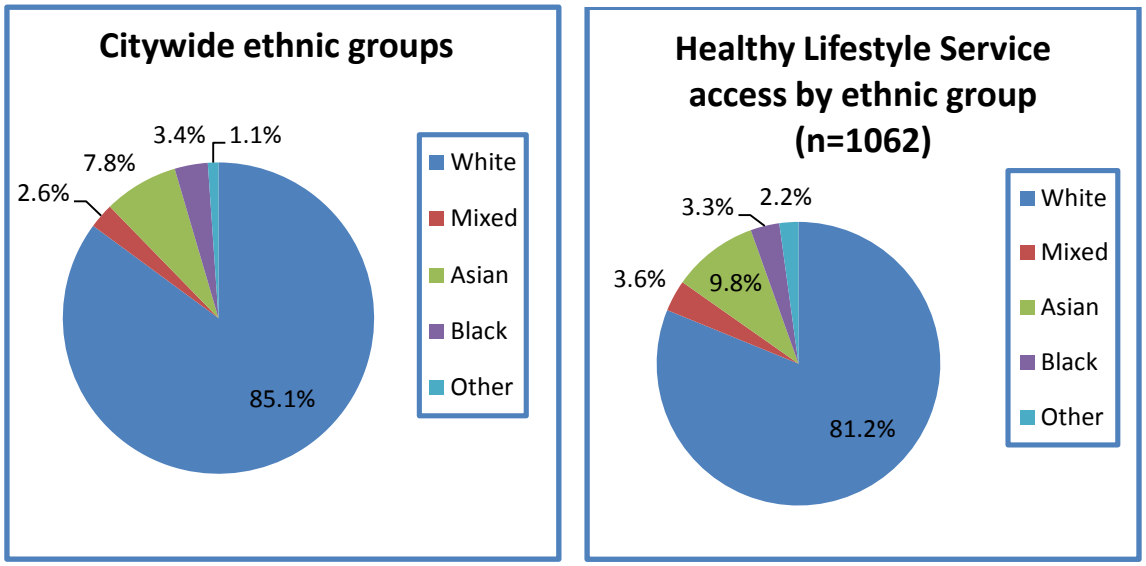
	Number of records	% of all records
Total number of records received	1290	
Number of records with age recorded	1288	99.8%
Number of records with ethnicity recorded	1062	82.3%
Number of records with gender recorded	1290	100%

Figure 54: Healthy Lifestyle Service age profile of service users compared with citywide age profile (16+)
Data Source: Census 2011 and service activity data 14/15



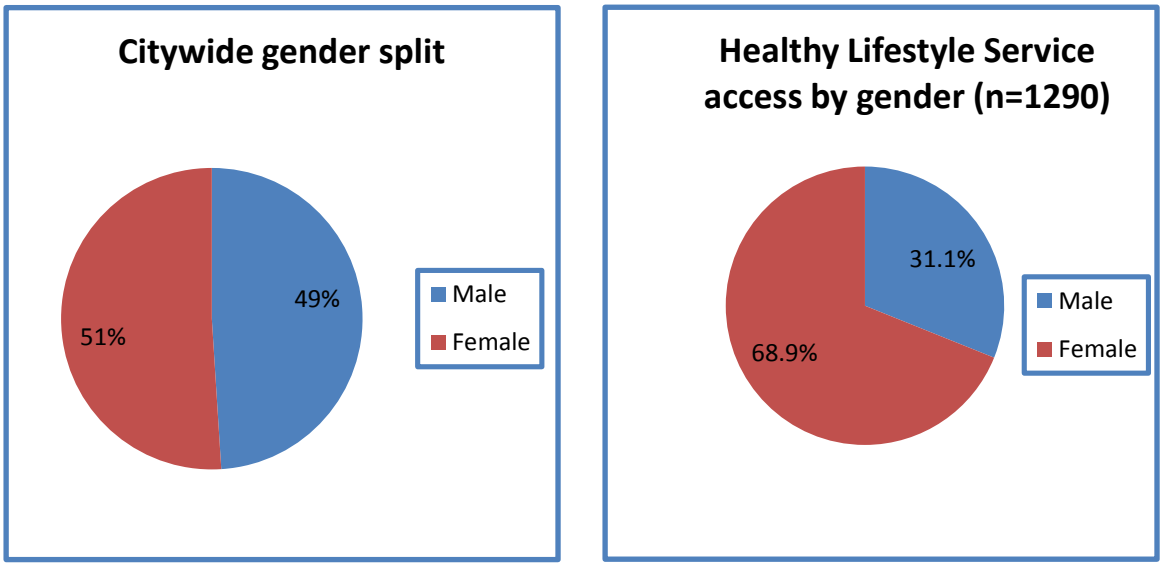
2014/15 data shows there is a much greater proportion of total service users in the 45-59 age group (31.4%) c/w the citywide proportion of people in that age range (21.6%). The proportion of people aged over 60 and between 35-44 who use the service is similar to the citywide split, however the proportion of service users aged 18-34 is a lower proportion of all service users (22.0%) compared with that age group in the general population (34.5%).

Figure 55: Healthy Living Service ethnicity profile of service users compared with citywide ethnicity profile
Data Source: Census 2011 and service activity data 14/15



Access to the service is broadly representative of the Leeds population in terms of ethnicity. There is a slightly smaller proportion of white people and a slightly greater proportion of people who are of Asian, mixed or other ethnic origin, particularly those of Pakistani origin. Total percentage of people accessing the service from a non-white background is 18.8% compared with the citywide profile of 14.9%

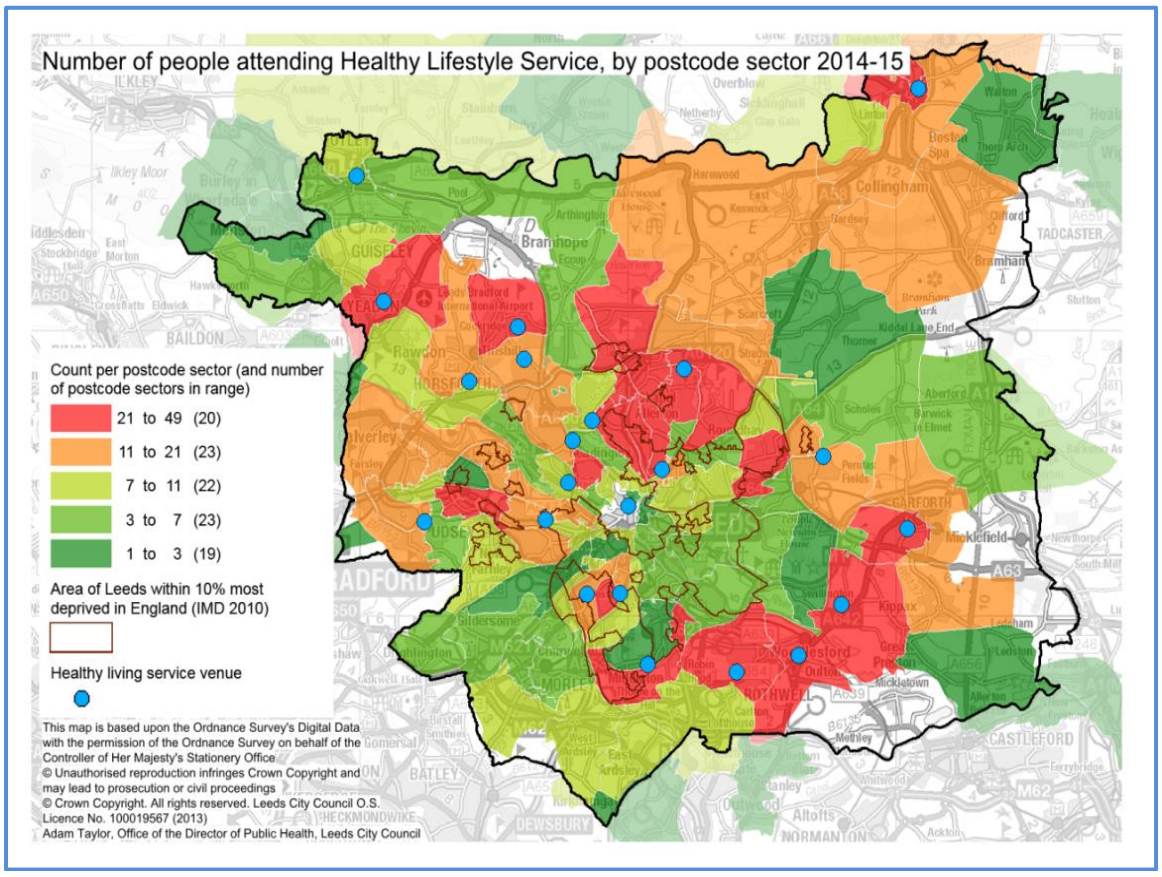
Figure 56: Healthy Lifestyle Service gender profile of service users compared with citywide gender profile
Data Source: Census 2011 and service activity data 14/15



There are a greater proportion of women (68.9%) who access the service compared with men (31.1%) Leeds split (2011 census 51% women 49% men)

5.2.3 Healthy Lifestyle Service by geography

Figure 57: Map of the location of the Healthy Lifestyle Service clinics and the number of people by postcode sector who have accessed the service
Data source: Postcode data collected from the service and mapped by Public Health Intelligence Team LCC



The HLS service was commissioned to provide a service to complement the Stop Smoking Service, Weigh Ahead and Health Trainer Service by offering healthy living interventions for the areas of Leeds outside the 10% most deprived. It has largely been successful in achieving this geographical reach with the highest number of service users attending from areas, outside those that are most deprived, but where evidence of ill health, GP recorded data around smoking prevalence and obesity is higher. The service complements, in particular, the Health Trainer Service providing good citywide access to healthy living interventions. Access to the HLS in certain areas of the city such as Wetherby and the surrounding area appears to be greater than to topic specific services such as smoking and weight ahead, however numbers are relatively small for all the services.

5.2.4 Commissioner views on strengths, weaknesses and gaps

Strengths

- A range of healthy living provision under one-roof with a single point of access and information.

- The service is looking at an integrated offer with smoking cessation and weight management.
- Initial smoking cessation results have been promising with over 50% quit rates and high levels of CO validation.
- As the advisors are trained to deliver interventions across a range of topic areas, this has allowed adaptation of interventions for example; clients wishing to lose weight may also be encouraged to reduce their alcohol intake through monitoring calories rather than units.
- The service has allowed an extension of the geographical coverage of healthy living interventions to enable the more specialist services to focus on the areas of the city where more intensive interventions are more suited to need.

Weaknesses

- Inaccurate data collection – number of clients accessing services is different to number of first appointments.
- Is not achieving weight loss targets; performance is worse than evidence from commercial slimming companies with a similar 12 week programme.
- The BMI range of the service suggests that some clients would be better served in a specialist weight management service, it is assumed that Healthy Living Service is used to manage the Weigh Ahead waiting list.
- It is thought that some goals agreed are outcome led rather than client led due to the poor success rates across some topics.

Gaps

- Lack of flexibility in provision, only 1:1s are available and clients are seen for 12 weeks only.
- Specialist skill set or skills on wider determinants of health.
- The team has varying results among staff members, with some team members being considered motivating and helpful. Perhaps more structured training and peer supervision could help.
- The service was initially designed to also support people who had attended the specialist smoking and weight management services on a longer term basis to help prevent relapse of changed behaviour, however there is little evidence that people are specifically attending for relapse prevention appointments. The service is however working alongside the weight management service and the smoking service to offer complementary additional ‘weigh ins’ and CO readings.
- There has been a lot of confusion with the establishment of this service and with the health trainer service which has, to a certain extent, resolved over time. Consideration to service scope and eligibility will need to be given to any further integration.

5.3 Adult weight management – Weigh Ahead (Leeds Community Healthcare)

5.3.1 Summary of service and activity between April 2014 and March 2015

Adult Weight Management Services are part of the Community Nutrition and Dietetics Service run by Leeds Community Healthcare. The service employs a team

of dieticians who provide weight management programmes and care plans for people who are obese (BMI over 30 or BMI 27 with comorbidities) and who want to lose weight. Sessions are held in health centres and leisure centres. The service accepts both self and health professional referrals from GP practice, Leeds Community Healthcare and Leeds Teaching Hospitals Trust. Both group work and one to one support is provided. The service sub-contracts Leeds City Council Leisure Services to provide the physical activity element to those attending group-work.

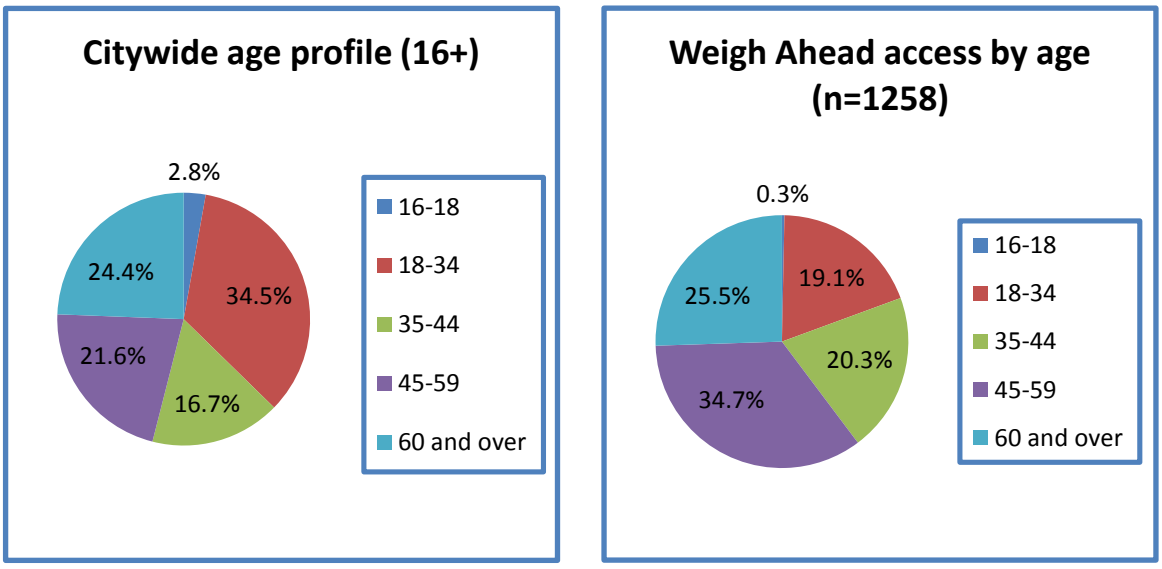
Between 1 April 2014 and 31 March 2015, there were:

- 2245 referrals leading to 1058 first appointments (conversion rate 47%)
- A total of 550 clients have 2 or more weights recorded (52% of those attending a first appointment).
- A total of 308 clients had only one weight recorded (29%)
- Of the 550 clients that commence a weight management programme, 159 clients (29%) have 6 or more weights recorded (classified as completers)
- Of those who complete :
  - 50% achieve 3% weight loss. The NICE target is 60%
  - 35% achieve 5% weight loss. The NICE target is 30%

5.3.2 Weight Management Service access by age, ethnicity and gender

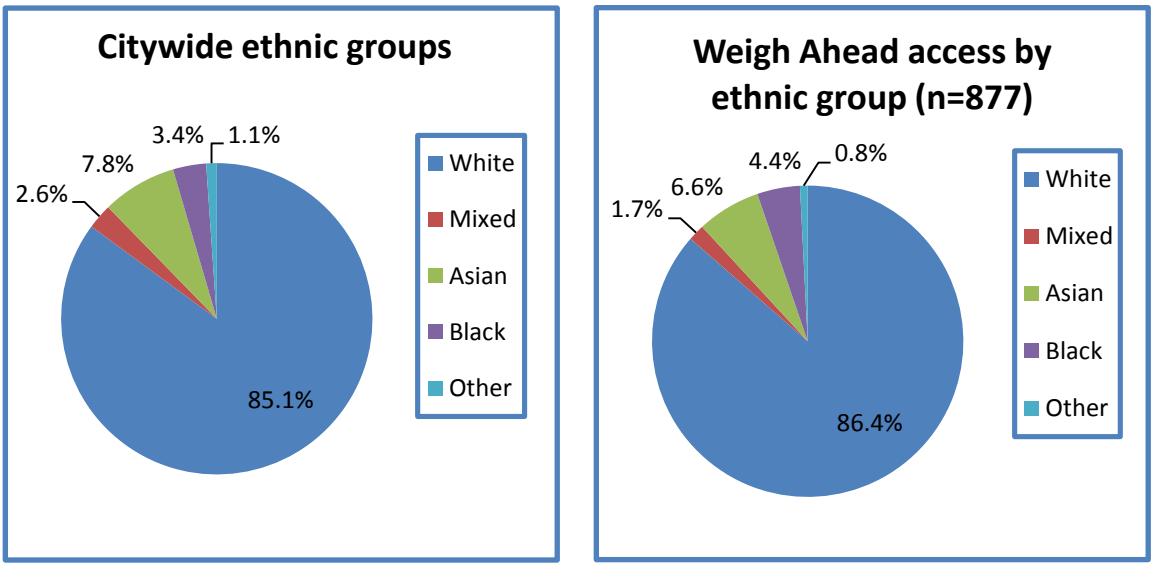
	Number of records	% of all records
Total number of records received	1258	
Number of records with age recorded	1258	100%
Number of records with ethnicity recorded	877	69.7%
Number of records with gender recorded	1258	100%

Figure 58: Weight Management Service age profile of service users compared with citywide age profile (16+)
Data Source: Census 2011 and service activity data 14/15



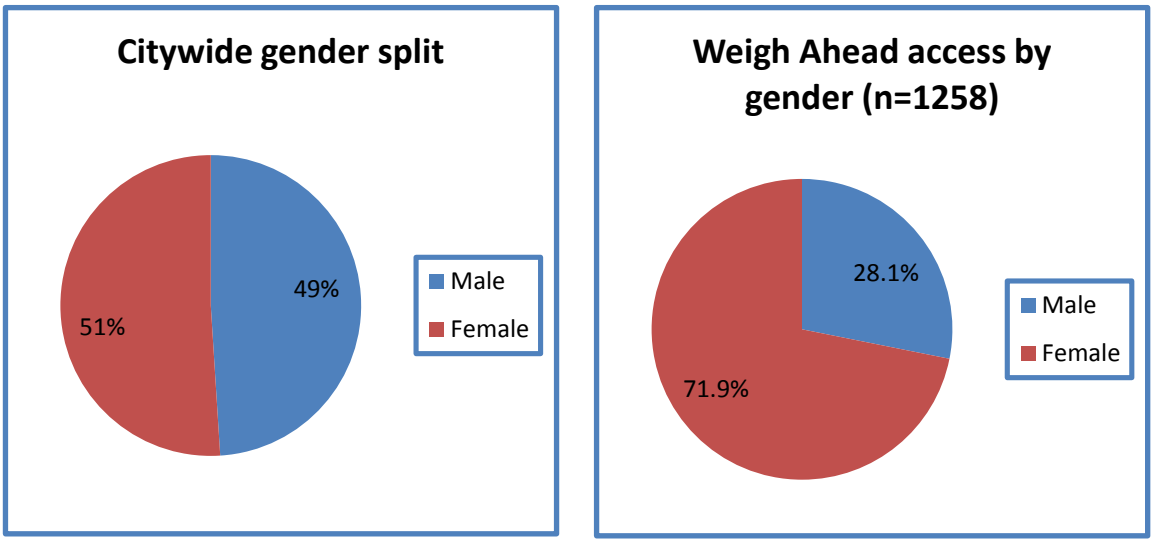
The age profile for Weigh Ahead service users differs from the city wide profile with most service services users falling with in the 45-59 age group (34.7% c/w 21.6%). The data would suggest that the service is more appealing to older age groups with 60.2% of service users being over 45. Younger age groups (16-34) are underrepresented at 19.4% (16-34) compared with the citywide profile of 37.3% for the same age group.

Figure 59: Weight Management Service ethnicity profile of service users compared with citywide ethnicity profile
Data Source: Census 2011 and service activity data 14/15



People from minority ethnic backgrounds are more likely to experience obesity related ill health. The profile of service users is extremely close to the city wide profile regarding ethnicity. The service sees a slightly higher proportion of people (particularly women) of Black Caribbean origin compared with the citywide percentage where rates of obesity are higher, but these are small numbers.

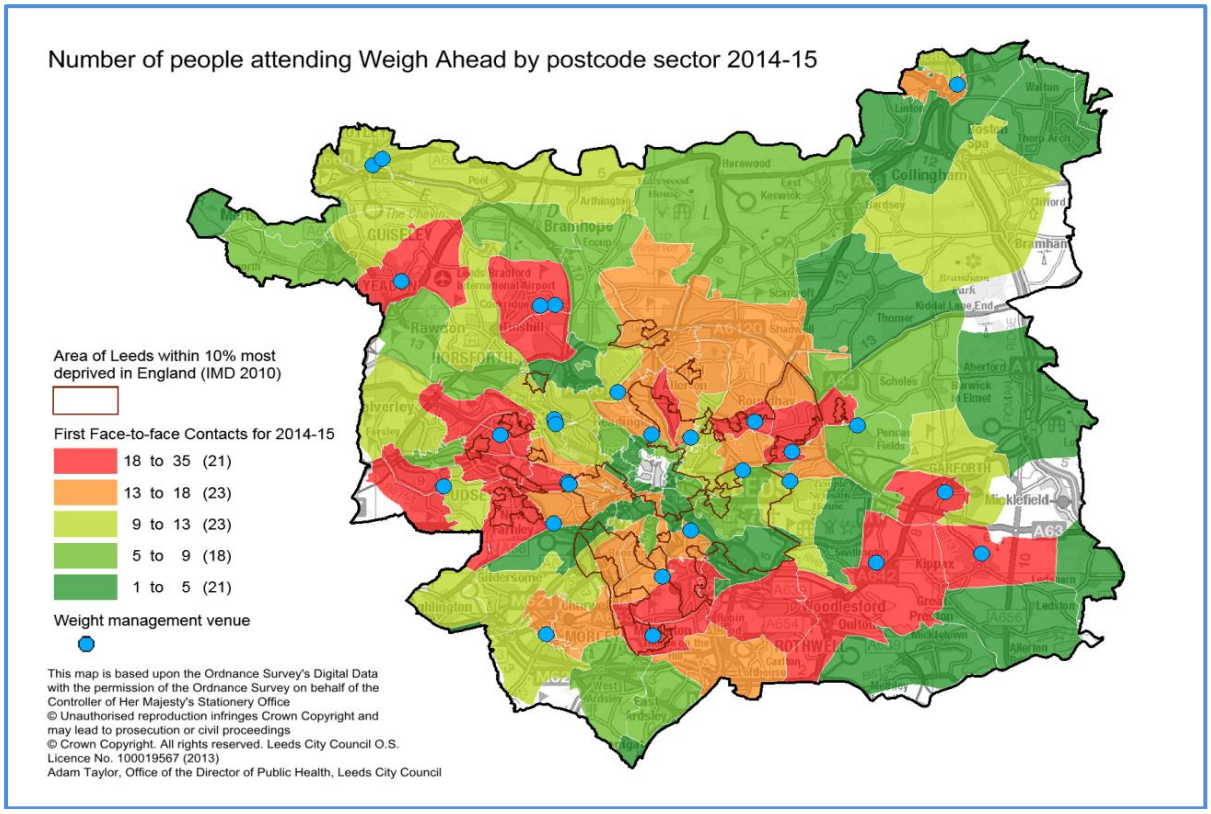
Figure 60: Weight Management Service gender profile of service users compared with citywide gender profile
Data Source: Census 2011 and service activity data 14/15



Access to Weigh Ahead is predominately by female clients. When compared to the citywide profile, it is clear that the service is being under-utilised by men.

5.3.3 Weigh Ahead Service usage by geography

Figure 61: Map showing the location of the Weigh Ahead service clinics and the number of people by postcode sector who have accessed the service
Data source: Postcode data collected from the service and mapped by Public Health Intelligence Team LCC



Service clinic locations would suggest that a number of historically established clinics are still well used (the service was first established in NW Leeds). However despite a disproportionate number of clinics in those areas, this does not correspond to obesity prevalence, deprivation, or incidence of long term conditions associated with obesity (e.g. diabetes) (with the exception for Yeadon, although this is not amongst the very worst in the city). There is a strong association between deprivation and obesity (ref: Figure 25); this is particularly evident from the area stretching from inner North East to outer South, however despite modest service provision across that area, there is a suggestion that people from inner east Leeds in particular are not using the current provision.

The majority of clinic provision does not fall within the 10% most deprived areas therefore it could be suggested that this corresponds to the low number of people accessing from deprived communities despite high prevalence of obesity in those areas.

5.3.4 Commissioner views on strengths, weaknesses and gaps

Strengths

- Service provides a disordered eating clinic. There are 3.0 wte dieticians currently trained in disordered eating underpinned by cognitive behavioural therapy (CBT). This is not commissioned as part of the service specification but is supported as the commissioner recognises the psychosocial relationships that exist with food and body image.
- Provides specialist dietetic services such as pharmacology and very low energy diets.
- Provision of group sessions in evenings at leisure centres.
- The service is looking at an integrated offer with smoking cessation and Healthy Lifestyles Service.

Weaknesses

- The cost per client who completes a weight management programme is approx. £2,719. This is due to the loss of clients from referral to first appointment to completion of intervention.
- The service is not achieving the 3% weight loss target.
- There is inconsistent data recording in relation to BME groups – 30% of ethnicity data are unknown.
- The service offers an option of one-to-one sessions or group work. The group sessions are closed groups. This means that a client needs to wait to join a new group and the waiting is often managed by support offered by Healthy Living Service and Weigh Ahead. Commercial slimming companies have a rolling group format that is successful.
- Supervised physical activity sessions supervised by Leeds City Council Leisure Services are not available to those who have a 1:1 intervention except signposting to other physical activity opportunities.
- Lack of integration with Tier 3 services – complex clients do not get escalated up and non-complex tier 3 patients do not get de-escalated down.
- Lack of integration with Tier 1 services to support maintenance and relapse prevention.
- Poor uptake by men which is compounded by a lack of men specific services that respond to best practice.
- Service has access to subsidised places to Ministry of Food, this opportunity is not used effectively to support skill development.
- Limited links with child weight management, previous attempts to provide a family weight management service has failed due to poor attendance.

Gaps

The service is performance managed against numbers entering the service. This instead should be numbers completing the intervention and achieving 6 or more weights (i.e. having their weight measured and recorded at least 6 times). To achieve a cost per client below £300, 1,500 clients need to complete the service.

More needs to be done to engage clients and keep them in the service. Other areas which need addressing include:

- Physical activity opportunities for all.
- Men specific weight management programme.
- Use of NICE recommended validated tools to monitor changes in diet, mood and physical activity.
- Integration with other weight management services and other tier 1 services for maintenance and relapse prevention. Need to develop a range of interventions for weight management and maximise the skill mix across the city more effectively. Need to consider a family approach for both child and adults.
- Measuring waist circumference with those with a BMI less than 35 to articulate risk to client of co-morbidities as a potential motivator to lose weight.
- Links with cooking skills provision with a focus on cooking for weight loss, cooking for diabetics etc. It is important to help clients to develop life skills to manage their dietary intake through what they can cook for themselves and their families.
- Lack of additional support for those with complex needs.

5.4 Child weight management - Watch It (Leeds Community Health Care)

5.4.1 Summary of service and activity between April 2014 and March 2015

Watch It is run by Leeds Community Healthcare. The service employs a small team of staff who provide weight management programmes for overweight and obese children aged 5-19 years with a BMI ≥ 91th centile, who are willing to engage with their primary caregivers.

Sessions are held in schools and leisure centres and include one to one support for parents and young people plus physical activity sessions for children and young people. The service accepts both self and health professional referrals, primarily from school nurses as part of the NCMP programme.

The Watch It programme is open to children 5-19 citywide, and is commissioned to target families from the most deprived areas and children with higher BMI.

The service offers 3 different programmes.

- Watch It Classic Programme, for secondary school age children and young people (11 to 18 years) and their families. The programme addresses eating behaviours, nutrition and physical activity. The programme is 16 weeks with the opportunity to opt in for more support for up to one year.

- Healthy Families Programme, for parents and carers of primary school children (5 to 11 years) to support them to achieve and maintain a healthy weight for their children. The programme is designed to be delivered over 10 weeks during term time.

- Watch It Choices Programme which is targeted for young people with moderate learning or physical disabilities who are aged between 12 and 19

years; to support them to achieve and maintain a healthy weight. This 8 week programme is delivered once a year at each of four Leeds Specialist Inclusive Learning Centres during term time. In addition the service piloted a family programme with adult weight management in 2013/14

Watch it received 410 referrals between April 2014 and March 2015

Classic programme

- 279 children/ young people enrolled on the classic programme during this year.
- 84 children/ young people completed the core phase of the programme this year. The mean reduction in BMI standard deviation score (sds) was 0.13.
- 34 children/ young people completed the consolidation phase this year. The mean reduction in BMI sds was 0.25.
- 35 children/ young people completed the wellbeing phase this year. The mean reduction in BMI sds was 0.35

Healthy families

- 30 families completed the healthy families programme
- The mean reduction in BMI sds was 0.17.

Choices

- 26 out of 27 children/ young people successfully completed the choices programme this year. Given the complex needs of these children the service does not have a target relating to their weight status.

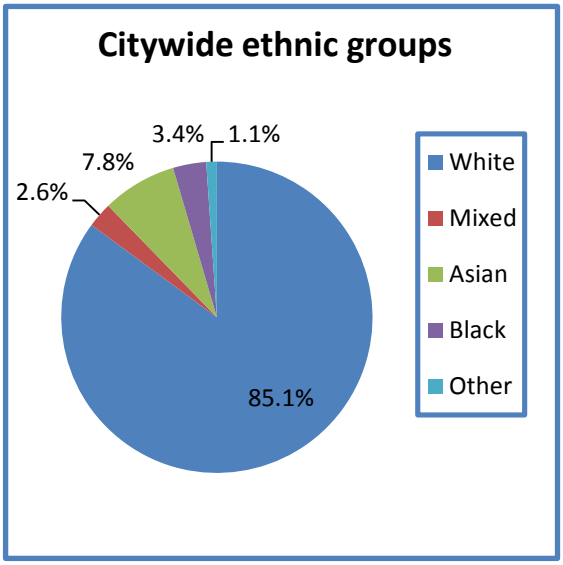
BMI for children

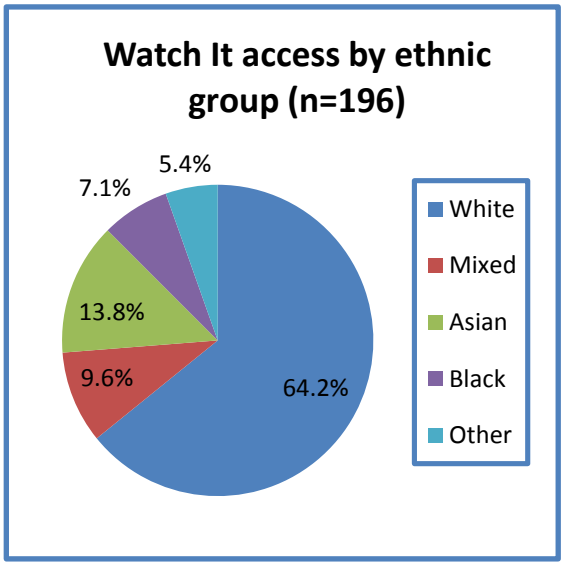
Fixed measures such as those used to measure adults BMI cannot be used for children as they would provide misleading information. Measuring BMI in children is more complicated than that for adults because a child's BMI changes as they mature, therefore BMI for children is recorded using growth thresholds that take into account a child's age and sex. Each growth reference group have set thresholds defined by statistical conventions and a child's BMI score or standard deviation scores (BMI sds) indicates how many units a child's BMI is above or below the average BMI value for their age and sex.

5.4.2 Watch It usage by ethnicity and gender

	Number of records	% of all records
Total number of records received	218	
Number of records with age recorded	Information not provided	
Number of records with ethnicity recorded	196	89.9%
Number of records with gender recorded	218	100%

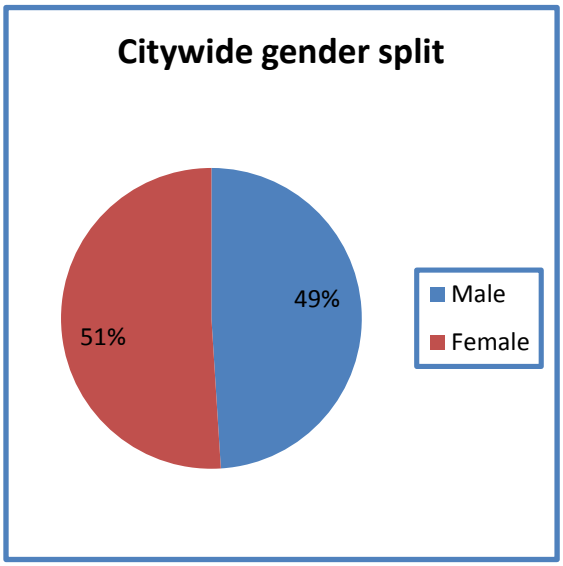
Figure 62: Watch It ethnicity profile of service users compared with citywide ethnicity profile
Data Source: Census 2011 and service activity data 14/15

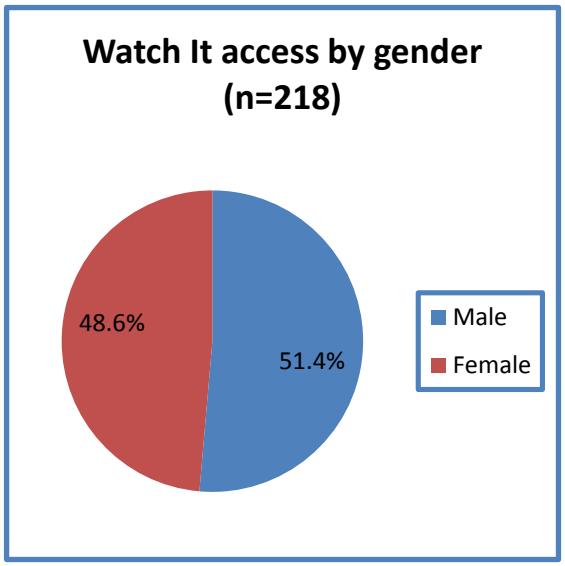




Compared with adult weight management, the service has done extremely well to attract children from ethnic groups which are predisposed to weight gain i.e. Asian and Black.
There were a slightly greater number of Asian boys compared to Asian girls who used this service which may have suggested a culture gender bias though this was not seen in the previous year data.

Figure 63: Watch It gender profile of service users
Data Source: Census 2011 and service activity data 14/15

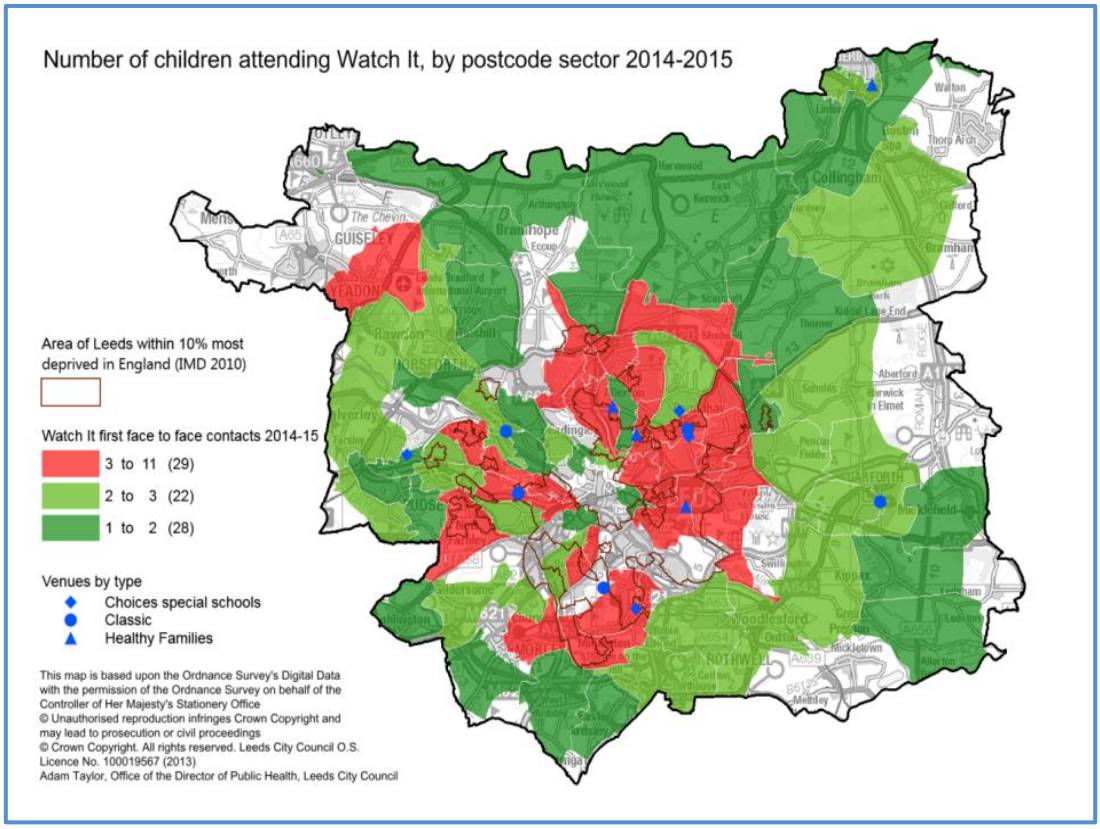




The service has been successful in attracting both boys and girls onto the service and reflects the citywide profile. Compared with access by adults of weight management services the gender of a child does not appear to be a factor in service access.

5.4.3 Watch It usage by geography

Figure 64: Map showing the location of the Watch It service clinics and the number of children by postcode sector who have accessed the service
Data source: Postcode data collected from the service and mapped by Public Health Intelligence Team LCC



5.4.4 Commissioner views on strengths, weaknesses and gaps

Strengths

- Specialist child weight management services are achieving their target in relation to weight reduction, and use family based models. Service user feedback is positive. Service users report positive shifts in related health behaviours e.g. reduction in consumption of sugary drinks, increasing consumption of 5 a day and increased levels of physical activity.
- Research indicates that Watch It is a relatively cost effective approach to managing childhood obesity.

Weaknesses

- 186 children completed Watch It programmes which represents a small fraction of the population of children who are over the 91st centile and therefore eligible for support.

- Current services are not operating at capacity as there are not enough children and families choosing to attend or practitioners referring families into the service.

Gaps

- There is an established referral pathway for those children identified as being obese through the statutory National Child Measurement Programme. However too few of these families take up the offer of specialist support. Too many families do not go on to complete the programme following the introductory session.
- There is a need to extend the involvement of parents given the pivotal role they have in deciding what children eat and what physical activity they do and the developing evidence in relation to the effectiveness of interventions focussed on parents
- Current services are not well integrated into wider healthy living network of services.
- Approaches that proactivity and effectively engage families are required, including those in a pre-contemplation stage around their children's overweight status

5.5 Change4life Service (Health for All)

5.5.1 Summary of service and activity between April 2014 and March 2015

The Change4Life service supports families living in South Leeds, whose children aged 5-11 years old are at risk of being overweight and obese. The aim of the service is to increase the opportunities for children and their families to become involved in physical activity and healthy eating, increase the demand for the uptake of such instances and create sustainability within communities for these opportunities. The Change4Life service also delivers a range of activities locally to enable these and other local families to achieve the Change4Life eight messages e.g. weekly play in the park sessions, family stay and play sessions.

Children and their families can be referred by any agency working with the child or family and parents and carers can also refer themselves to the service. The family will then receive between six and eight meetings (dependent on need) which take place in the family home which is a unique approach to engaging families around the issue of obesity. These meetings will be one hour long on average and will aim to make changes in line with the national Change4Life eight key behaviour messages.
The Change4Life Service this year, for the first time provided group sessions, bringing some families on the one-to-one case load together to address certain issues and Change4Life messages in a group setting. This worked best with families used to a group setting and for many was a positive and powerful experience.

The Service does not routinely weigh children, although will do so if requested and is appropriate. Instead the progress made by the family is measured using a scaling ladder, families self-score and this is done verbally with the Change4Life worker throughout the process and the majority of families have reported that they feel more confident, have increased motivation to change, have a better understanding of

basic health messages, increased practical skill set and are aware about where else to get help. In addition the service piloted a family programme with adult weight management in 2013/14

Summary of Activity 1/4/14 - 31/03/15

- The service delivered 36 activity sessions exceeding the target number of activity sessions.
- In 2014/15 the Change4Life Service exceeded the target number of one-to-one families to work with and has supported over 28 families with children who are overweight or obese in LS10 & LS11 (Inner South Leeds) with families receiving more than 135 one-to-one sessions.

5.5.2 Commissioner views on strengths, weaknesses and gaps

Strengths

- Workers meet clients in their home and will often cook together with the family.
- The service have a very proactive approach and engage with children and families through school cooking sessions, assemblies and community events such as galas and fun days.
- It delivers physical activity sessions alongside the service.
- It has skilled, experienced and dynamic staff.

Weaknesses

- Change4life service is a small funded project so is restricted to the number of families it can support and how it can develop.

Gaps

- The approach with teenagers needs to be investigated as this model will be different and it will have some family contribution but requires other interventions as individual and peer influence is key to their behaviour change.
- Inclusion of the parent/carers role and their own weight needs to be addressed and acknowledged as well as that of their child's.
- Greater inclusion of physical activity sessions integrated within the services.
- Only a small percentage of overweight families are accessing this service compared to the actual number of overweight children there are.

5.6 Child physical activity

There are four services currently delivering children's physical activity: Active Clubs Experience (ACE), Dance Action Zone Leeds (DAZL), Leeds United Foundation and The Works Skatepark. All four services are commissioned to increase involvement of inactive/overweight children in regular physical activity from the 20% most disadvantaged communities. The primary aim of the services is to increase activity levels of 5 – 11 year olds and contribute to preventing child obesity in children under

11 years. The aim is to build the confidence of children to get involved in active recreation and ultimately to inspire an enthusiasm for being active throughout life.

5.6.1 Active Clubs Experience - ACE (Health for All)

5.6.1.1 Summary of service and activity between April 2013 and March 2014

ACE provides multi sports activity to increase involvement of inactive/overweight children in regular physical activity. They offer a range of fun based games and activities delivered with an inclusive ethos. The aim is to build the confidence of children to take part in team games and a wide range of sports and enjoy these in a playful engaging environment. The programme also engages parents and families from disadvantaged communities in healthy lifestyle messages.
ACE employs a manager and an extensive team of freelance staff delivering the sessions. The service includes:

- Regular after school sessions in primary schools.
- Regular community provision and support for the children and their families to feed into this when skills and confidence are developed.
- Multi sports events and holiday programmes.
- Change4life fun days in schools and communities to engage parents and families in healthy lifestyle messages using the Change4life campaign and local resources.

In order to increase the capacity of the programme, schools make a financial contribution to the after school programme enabling the project to reach more children.

ACE's primary target is to engage inactive children. Children reporting doing less than 2 hours sports/active recreation beyond the school day were defined as "inactive"

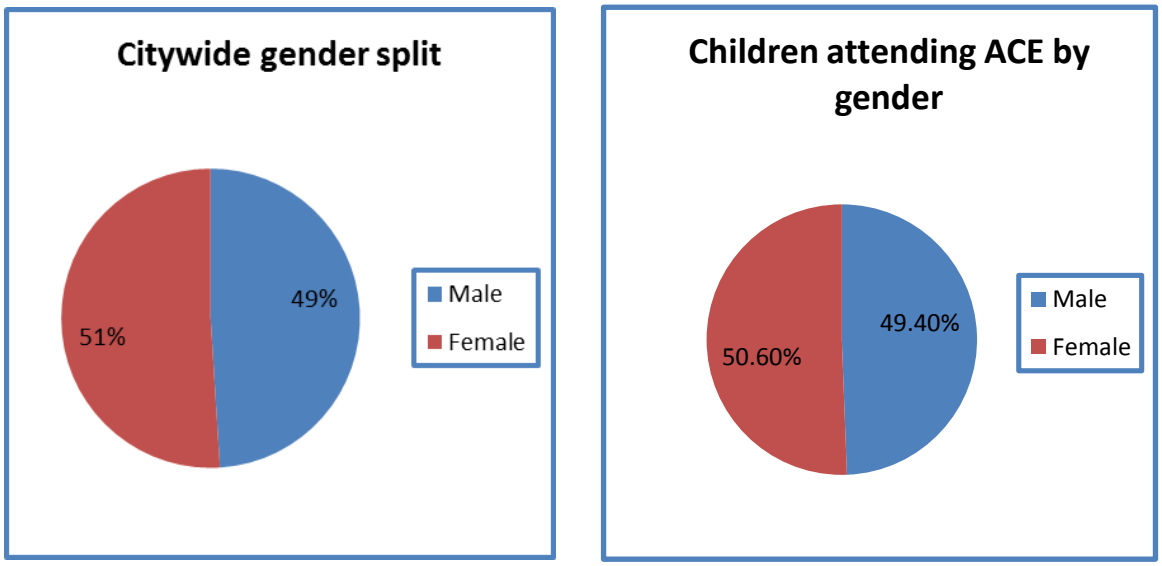
Between April 2014 and March 2015 the following numbers of children were engaged in the programme are shown in figure 65.

Figure 65: Number of children engaged in the ACE programme
Source: contract management data

Children engaged in regular sessions				
Inactive children	Active children	Total children	Other sessions	Total children engaged
1726	947	2673	4378	7051

- This shows 2673 children and young people were engaged in regular physical activity sessions of which 1726 were "inactive"
- A further 4378 children or parents/carers engaged were engaged in physical activity including tasters, short projects and holiday programmes.
- ACE exceeded targets on all aspects of the programme.

Figure 66: ACE gender profile of service users compared with citywide gender profile
Data Source: Census 2011 and service activity data 14/15



The ACE programme engaged equal numbers of girls and boys in the programme

5.6.1.2 Commissioner views on strengths, weaknesses and gaps

Strengths

- Engagement of high numbers of children from disadvantaged areas in after school multi-sports provision and good retention in the programmes.
- Engagement of high numbers of children in change4life fun day activity.
- Indicates a successfully run programme that is inclusive and well engaged with by disadvantaged inactive children.
- Positive feedback from head teachers and school staff. Schools willing to contribute to the costs of the service.
- Effectively engages girls (approx. equal numbers of and boys which is higher than traditional sports).
- ACE have performed well, broadening out the services they provide and securing other sources of funding to enable them to develop and do more
- Programme is successful at engaging as it focuses on fun rather than health. Once relationships are built health messages can be incorporated more successfully. Change4Life insight shows that families at risk of obesity are generally motivated by happiness of their children rather than health.

Weaknesses

- Engagement of children and families in community provision is not as successful as the after school provision.
- Maintaining long term engagement of children in community provision is unsuccessful.
- Developing young leaders and other asset based community development approaches are secondary aim and could be a stronger aspect of the programme.

5.6.2 Dance Action Zone Leeds (DAZL)

5.6.2.1 Summary of service and activity between April 2013 and March 2014

DAZL provide dance activity to increase involvement of inactive/overweight children in regular physical activity. They offer a range of fun based dance programmes delivered with an inclusive ethos. The aim is to build the confidence of children to get involved and ultimately to inspire an enthusiasm for being active throughout life.

The programme uses asset based community development approaches engaging and empowering local communities to deliver dance programmes in their own communities. This includes volunteering and dance leadership programmes. DAZL works holistically with children and families supporting them with a range of issues in their lives. It has strong partnerships with health, education and social care attending multiagency meetings in the locality and signposting young people into services. Pathways are also in place to offer progression into vocational dance and artistic dance programmes through partnerships with the dance sector.

An extensive programme of dance shows and performances bring communities together to celebrate the achievements of children and young people and they provide a positive and celebrational focus for disadvantaged communities where often the focus is on problems. Performances and dance competitions provide opportunities for children and young people to aspire and achieve, and allows their families opportunities to witness and celebrate their successes.
DAZL also engages parents and families in healthy lifestyle messages and promotion at the shows and dance class. Health education is delivered through issue based work creating dance productions on themes such as alcohol, smoking and emotional wellbeing.

DAZL employs a Director and 2 staff plus an extensive team of freelance staff to deliver the sessions. The service includes:

- Regular after school sessions in primary schools.
- Regular community provision and support the children and their families to feed into this when skills and confidence are developed.
- Dance leadership training and qualifications.
- Holiday programmes and taster sessions.
- Health education through performance projects and fun days in schools and communities to engage parents and families in healthy lifestyle messages.

Between April 2014 and March 2015 the following numbers of children were engaged in the DAZL programme.

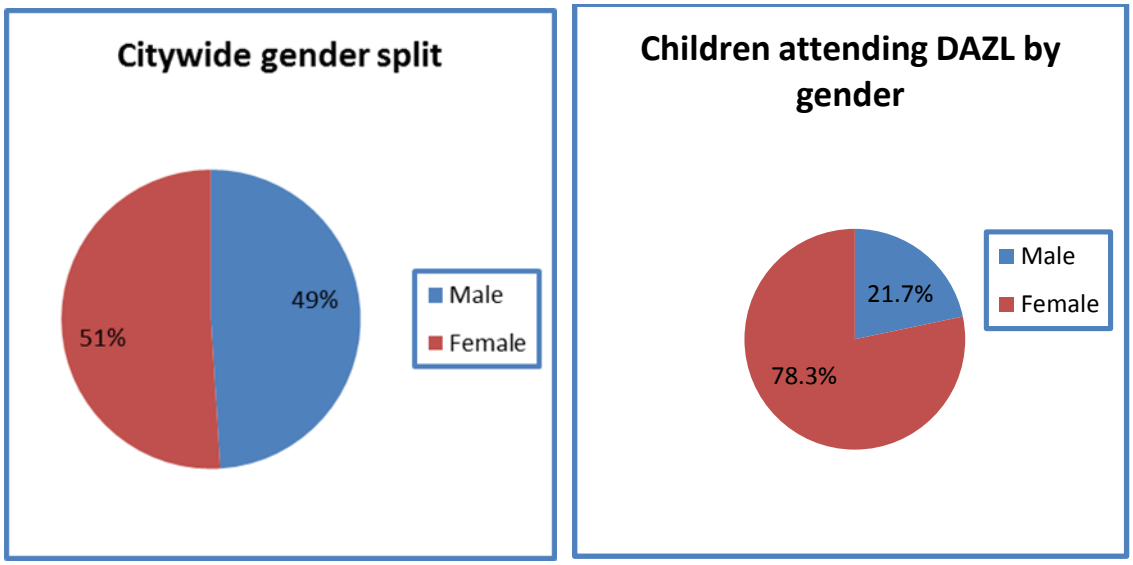
Figure 67: Number of children engaged in the DAZL programme
Source: Contract management data

Children engaged in regular sessions				
Inactive children	Active children	Total children	Other sessions	Total children engaged
2195	627	2822	3247	7051

- This shows 2822 children and young people were engaged in regular physical activity sessions of which 2195 were “inactive”.
- A further 3247 children or parents/carers were engaged in dance activity including tasters, short projects and holiday programmes.
- 139,668 people attending dance shows and performances.

DAZL far exceeded targets on all aspects of the programme

Figure 68: DAZL gender profile of service users compared with citywide gender profile.
Data Source: Census 2011 and service activity data 14/15



In 2014-2015, the DAZL programme engaged significantly more girls than boys in the programme which is a positive of the programme as girls are more inactive than boys at all ages.

5.6.2.2 Commissioner views on strengths, weaknesses and gaps

Strengths

- Engagement of high numbers of children from disadvantaged areas in after school and community dance provision and good retention in the programmes.

- Engagement of high numbers of girls in physical activity - 79% attending are girls
- Community development approaches provide excellent reach into most disadvantaged communities; building confidence, self-esteem and leadership skills.
- Holistic approach provides support for children and families across a wide range of health education and social issues and strong partnerships lead to effective hand holding and signposting to services where needed.
- Dance shows and performances build resilience in children and young people and the events provide social cohesion and positive focus for communities.
- Of all the children's physical activity programmes DAZL approach offers the greatest impact on the health and wellbeing of children and families and can provide a model for the wider services. It meets both physical activity outcomes in a highly cost effective way as well as improving health and wellbeing more widely.

Weaknesses

- Project currently relies on inspirational leadership and the organisation needs to make sure it is sustainable and not too dependent on one individual.

5.6.3 Leeds United Foundation

5.6.3.1 Summary of service and activity between April 2013 and March 2014

Leeds United Foundation (LUF) provides football activity to increase involvement of inactive/overweight children in regular physical activity. They offer a range of fun based games and activities delivered with an inclusive ethos. The aim is to build the confidence of children to get involved and ultimately to inspire an enthusiasm for being active throughout life. The programme also engages parents and families in healthy lifestyle messages. LUF employs a coach to deliver the sessions. The service includes:

- Regular after school sessions in primary schools.
- Regular community provision and support the children and their families to feed into this when skills and confidence are developed.
- Football events and holiday programmes plus fun days in schools and communities to engage parents and families in healthy lifestyle messages.

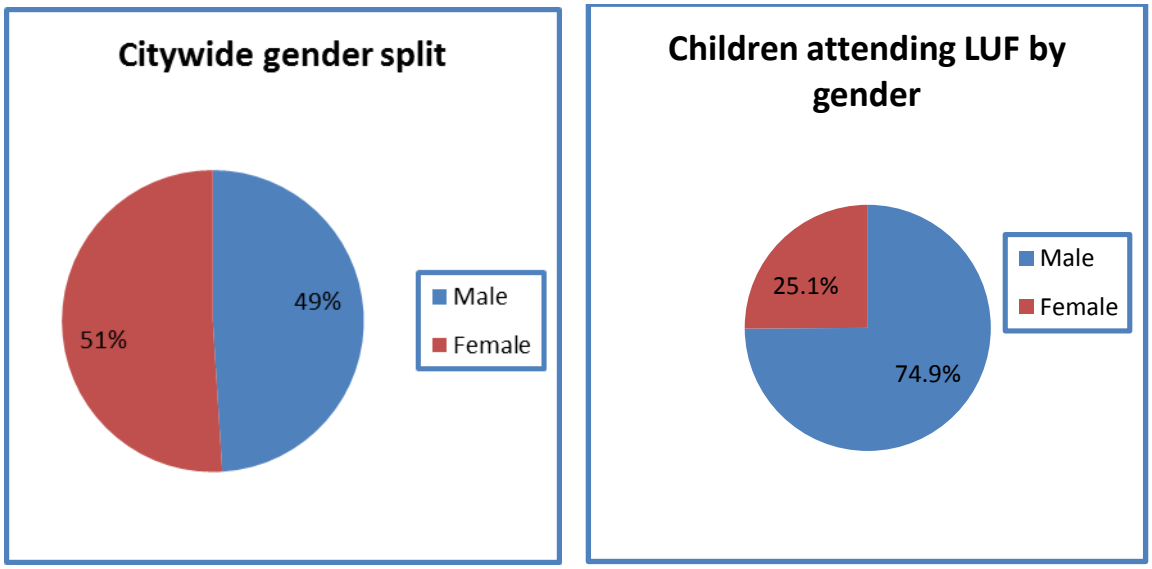
Between April 2014 and March 2015 the following numbers of children were engaged in the LUF programme:

Figure 69 Number of children engaged in the LUF programme
Source: contract management data

Children engaged in regular sessions				
Inactive children	Active children	Total children	Other sessions	Total children engaged
365	139	504	1001	1505

- This shows 504 children and young people were engaged in regular physical activity sessions of which 365 were “inactive”.
- A further 1001 children or parents/carers engaged were engaged in physical activity including tasters, short projects and holiday programmes.
- Leeds United Foundation has met or exceeded targets for delivery of the programme.

Figure 70: LUF gender profile of service users compared with citywide gender profile
Data Source: Census 2011 and service activity data 14/15



The programme engaged significantly more boys than girls in the regular sessions.

5.6.3.2 Commissioner views on strengths, weaknesses and gaps

Strengths

- Good engagement of children from disadvantaged areas in regular football provision including good retention.
- Indicates a successfully run programme that is inclusive and well engaged with by disadvantaged inactive children.
- Programme is successful at engaging as it focuses on fun rather than health messages which once relationships are built can be incorporated more successfully. Change4Life insight shows that families at risk of obesity are motivated by happiness of their children rather than health.

Weaknesses

- Engagement of children and young people in community provision is not as successful as the after school provision.
- Low engagement of girls who are more inactive than boys.
- Developing young leaders and other asset based community development approaches are secondary aims and could be a stronger aspect of the programme

5.6.4 The Works Skatepark

5.6.4.1 Summary of service and activity between April 2013 and March 2014

The Works Skatepark provides freesports activity including skateboarding, BMX and scooters; to increase involvement of inactive/overweight children in regular physical activity. They offer a range of fun based activities delivered with an inclusive ethos. The aim is to build the confidence of children to get involved and ultimately to inspire an enthusiasm for being active throughout life. The programme also engages parents and families in healthy lifestyle messages. The service includes:

- Engaging children and young people in five week courses of regular freesports sessions and tasters to encourage ongoing independent freesports activity.
- Subsidised access to The Works indoor skatepark in summer holidays.
- Support the development of freesports and cycling opportunities for children and young people in Leeds local parks and community settings.
- In partnership with other agencies engage parents and families in healthy lifestyle messages and healthy living fun days.

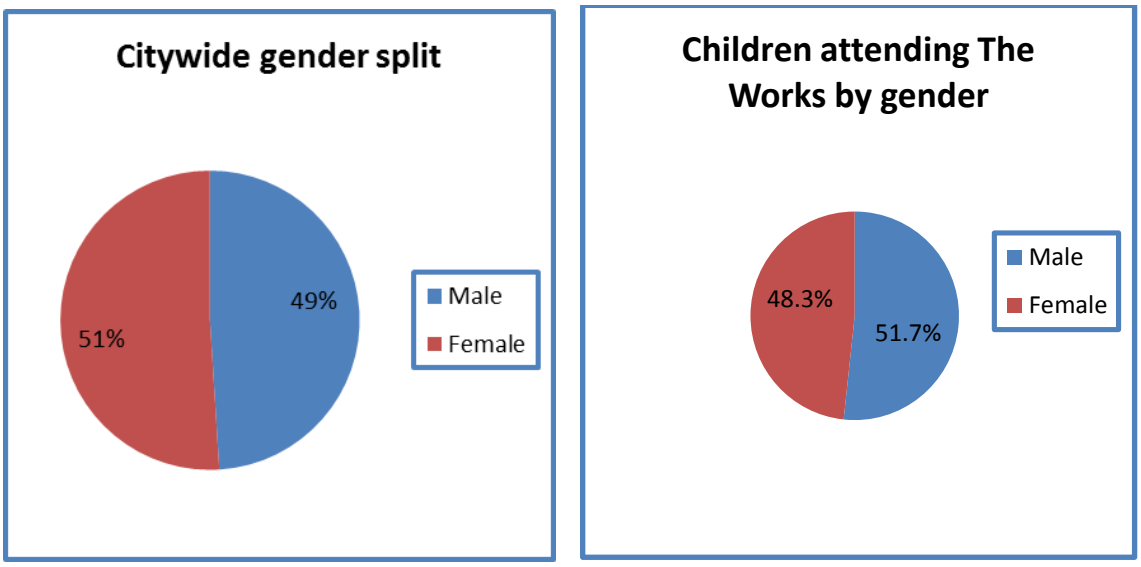
Between April 2014 and March 2015 the following numbers of children were engaged in The Works programme.

Figure 71: Number of children engaged in The Works programme
Source: Contract management data

Children engaged in regular sessions				
Inactive children	Active children	Total children	Other sessions	Total children engaged
139	146	288	7076	7364

- This shows 288 children and young people were engaged in regular physical activity sessions of which 139 were “inactive”.
- A further 7076 children or parents/carers engaged were engaged in physical activity mainly the subsidised summer holiday programme at The Works skatepark which attracts over 600 children per year.
- The Works exceeded the targets for the programme.

Figure 72: The Works gender profile of service users compared with citywide gender profile
Data Source: Census 2011 and service activity data 14/15



The programme engaged similar numbers of boys to girls in the regular sessions.

5.6.4.2 Commissioner views on strengths, weaknesses and gaps

Strengths

- Engagement of high numbers of children from disadvantaged areas in freesports activity including children with behavioural problems and disabilities.
- Engagement of high numbers of children in the summer programme who attend this independently.
- Positive feedback from head teachers and school staff. Schools willing to contribute to the costs of the service and keen to engage.
- Programme is successful at engaging as it focuses on fun rather than health. Once relationships are built health messages can be incorporated more successfully. Change4Life insight shows that families at risk of obesity are generally motivated by happiness of their children rather than health.

Weaknesses

- Encouraging children's independent freesports activity beyond the courses needs further evaluation as to its effectiveness and then possibly strengthening this element.
- Freesports have a tendency to appeal to boys so uptake by girls is lower.
- Developing young leaders and other asset based community development approaches are secondary aim and though underway could be a stronger aspect of the programme.

5.6.5 Summary of access to the current children's physical activity opportunities and identified gaps across the children's physical activity programme

5.6.5.1 Age

The Children's physical activity programme was commissioned to provide a service to children aged 5 – 11 years and as they work mostly in primary schools they reach this target group. As a secondary target group they work with a small number of young people aged 12 – 19 years. This is within the scope of the service but may be slightly ad hoc.

5.6.5.2 Ethnicity

The programme does not collect detailed data on ethnicity of children participating due to the sensitivity of collecting these data from children. However as the programme targets disadvantaged communities with high BME numbers there is like to be high levels of engagement of children from BME communities. More could be done to increase intelligence about this area however, particularly as Asian girls are the most at risk of inactivity and may have barriers to accessing the programme.

5.6.5.3 Gender

Across the 4 providers the programme engages similar number of girls and boys. Given girls are more inactive than boys it could be argued that the programme should reflect this by engaging more girls than boys.

5.6.5.4 Geographical reach

The children's physical activity programme was commissioned to provide a service to areas of Leeds in the 10% most deprived nationally. It has largely been successful in achieving this geographical reach with high numbers of children attending. Most of the service is delivered in inner city Leeds but some provision takes place in outer South Leeds pockets of deprivation. The gaps generally equate to industrial areas with a small population or no schools. There may be one or two small projects in less deprived areas that are not meeting the targets.

5.6.5.5. Gaps

The ever changing landscape of funding for children's physical activity (PA) means it is hard to predict the gaps in the longer term. Community PA provision for children and young people has currently diminished due to the lack of funding in universal children's services such as extended services and youth services. This is an area where provision needs to currently focus. The HNA being carried out may indicate which population groups and areas of Leeds we should focus on. Initial insight shows Asian girls as particularly inactive. The Active4life programme is providing an excellent preventative programme and it is a provision that needs sustaining. However public health might also benefit from having some more flexibility to drive change and transformation in children's PA going forward. The ability to respond to changing landscapes and look at other ways of providing PA provision would be helpful. Commissioning a programme for example with enough flexibility in its service specification would be beneficial so it can respond to the changing landscape of resource and need over the lifetime of a contract. Children's PA programmes may provide effective settings for healthy living work for children and families. They offer

opportunities for engagement and relationship building and access to families in pre contemplation stages around healthy living.

5.7 Stop Smoking Services (Leeds Community Healthcare)

5.7.1 Summary of service and activity between April 2014 and March 2015

The smoking service is provided by Leeds Community Healthcare. The service employs a team of smoking cessation advisors who provide a diverse range of smoking cessation interventions for adults including: 1:1, groups, rolling / drop in clinics, telephone support and home visits, young people are also supported in appropriate settings. The service provides some specialist support for people with severe mental illness and pregnant women. Clinics are held in a range of settings including community venues, health facilities and the workplace setting. The service accepts both self and professional referrals e.g. from GP practice, other NHS Trusts in the city, third sector organisations etc. In line with Department of Health requirements, the service monitors the numbers of people who set a quit day and are quit at 4 weeks following the quit day (using the Russell standard). The service should aim to have at least 85% of all quits validated by a carbon monoxide measure. All advisors in the service are trained and assessed as competent by the National Centre for Smoking Cessation and Training. All smoking cessation treatments are offered first line and are obtained either via a prescription or direct from the pharmacists via a Nicotine Replacement Therapy (NRT) voucher scheme. In addition to providing smoking cessation interventions, the service is also responsible for training and providing on-going support for primary care based smoking advisors (registered advisors), data collection for smoking cessation activity across the city and data collection for the NRT voucher scheme. The service also supports delivery of smoking cessation interventions via brief advice training for a range of providers e.g. GPs, midwives and working with others to establish referral routes e.g. midwifery services. The service is responsible for the delivery of campaigns and marketing materials.

A range of front line healthcare staff deliver the registered smoking advisors in primary care service. These are usually practice nurses or health care assistants who have attended a minimum of 2 days training with the specialist service. All those who attend the training are given a unique registration number with the service. The service is delivered under a ‘locally enhanced service agreement’ with payment released on the return of paperwork to evidence the number of clients who have been seen and successfully quit smoking. Clients are usually seen on a 1:1 basis with all smoking cessation treatments being offered as an adjunct to behaviour change support based on the NCSCT standard treatment programme.

Between April 2014 and March 2015:

- 5947 referrals leading to 5692 people making a first appointment (conversion rate 95.7%)
- Of those that booked, a total of 4261 attended a first appointment (conversion rate 74.9%)

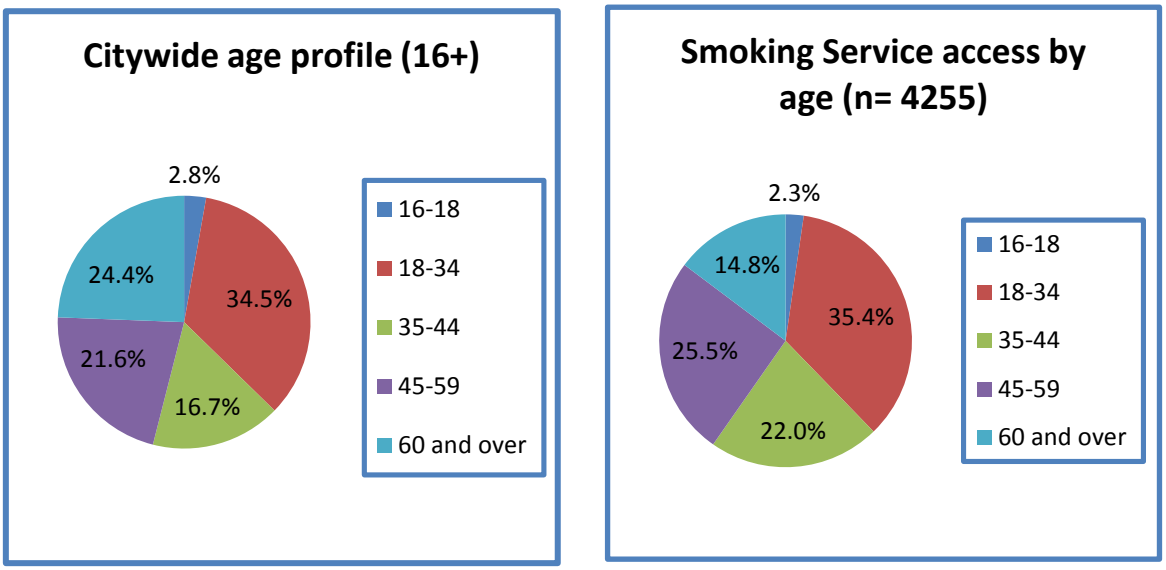
- Of those attending 2409 people set a quit date (retention from first appointment 56.5%)
- Of those setting a quit date 1548 people were quit at 4 weeks (64.3% success rate)
- Number of quits validated by CO 1139 (73.6% validation rate)

Turning to registered advisors, due to the data collection methods and the non-return of information for clients who do not quit smoking at 4 weeks it is not possible to present a full data set to compare. Between April 2014 and March 2015 the total number of people who quit smoking with support from a registered advisor was 425.

5.7.2 Smoking service access by age, ethnicity and gender

	Number of records	% of all records
Total number of records received	4260	
Number of records with age recorded	4255	99.8%
Number of records with ethnicity recorded	4099	96.2%
Number of records with gender recorded	4260	100%

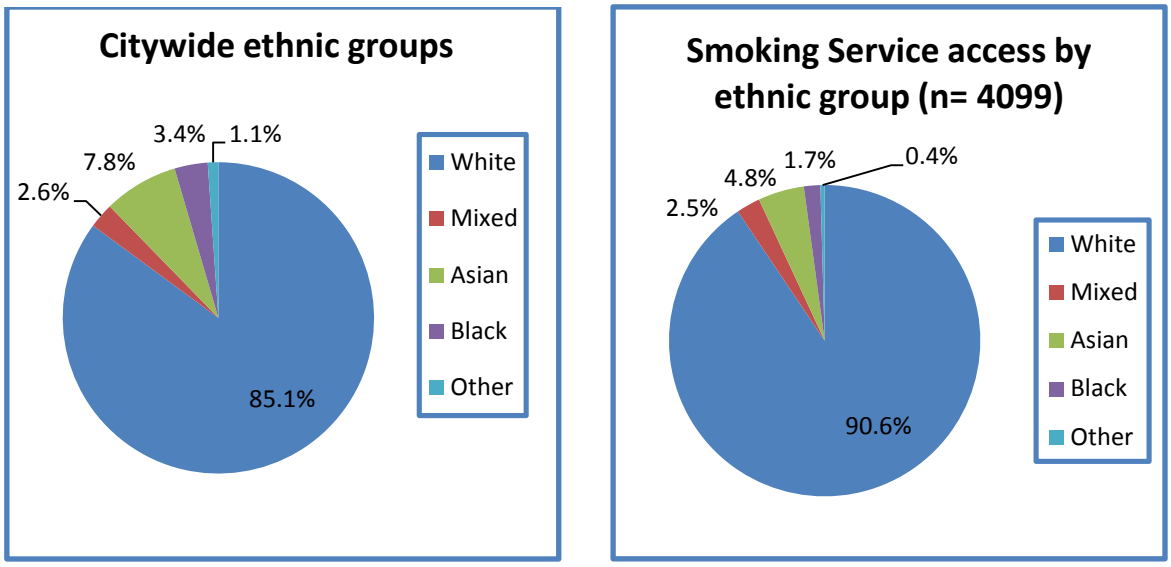
Figure 73: Smoking service age profile of service users compared with citywide age profile (16+).
Source: Census data 2011 and service activity data 2014-15.



The smoking service has been successful in engaging service users across all ages. The age profile is virtually the same as the citywide profile when comparing service use of 16-34 year olds. From 35 upwards the majority of clients attending are from the 35-59 age group 47.5% c/w city profile of 38.3% with less people attending from the 60+ group (14.8% c/w citywide profile of 24.4%). Due to the decreased life expectancy of smokers it could be that those people who live beyond 60 years old are more likely to be non-smokers.

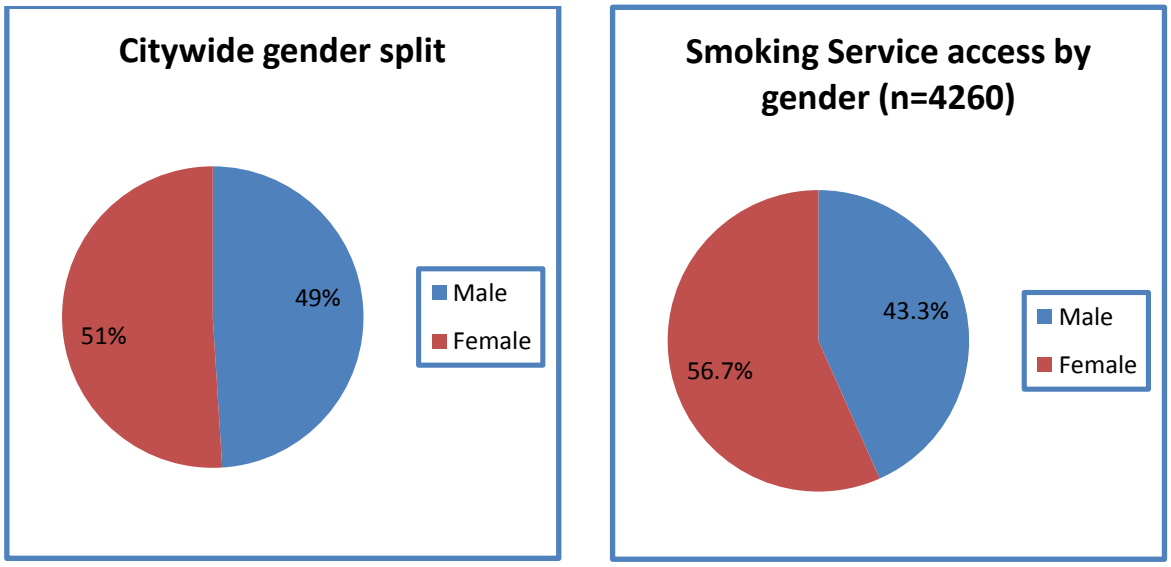
Figure 74: Smoking service ethnicity profile of service users compared with citywide ethnicity profile.

Data Source: Census 2011 and service activity data 14/15.



The service users profile shows an under representation of people from Asian and Black groups compared with the citywide profile. However further detailed analysis does show that men of Asian origin are more likely to access the service than females which mirrors the recorded higher rates of smoking in that group.

Figure 75: Smoking service gender profile of service users compared with citywide gender profile.
Data Source: Census 2011 and service activity data 14/15.

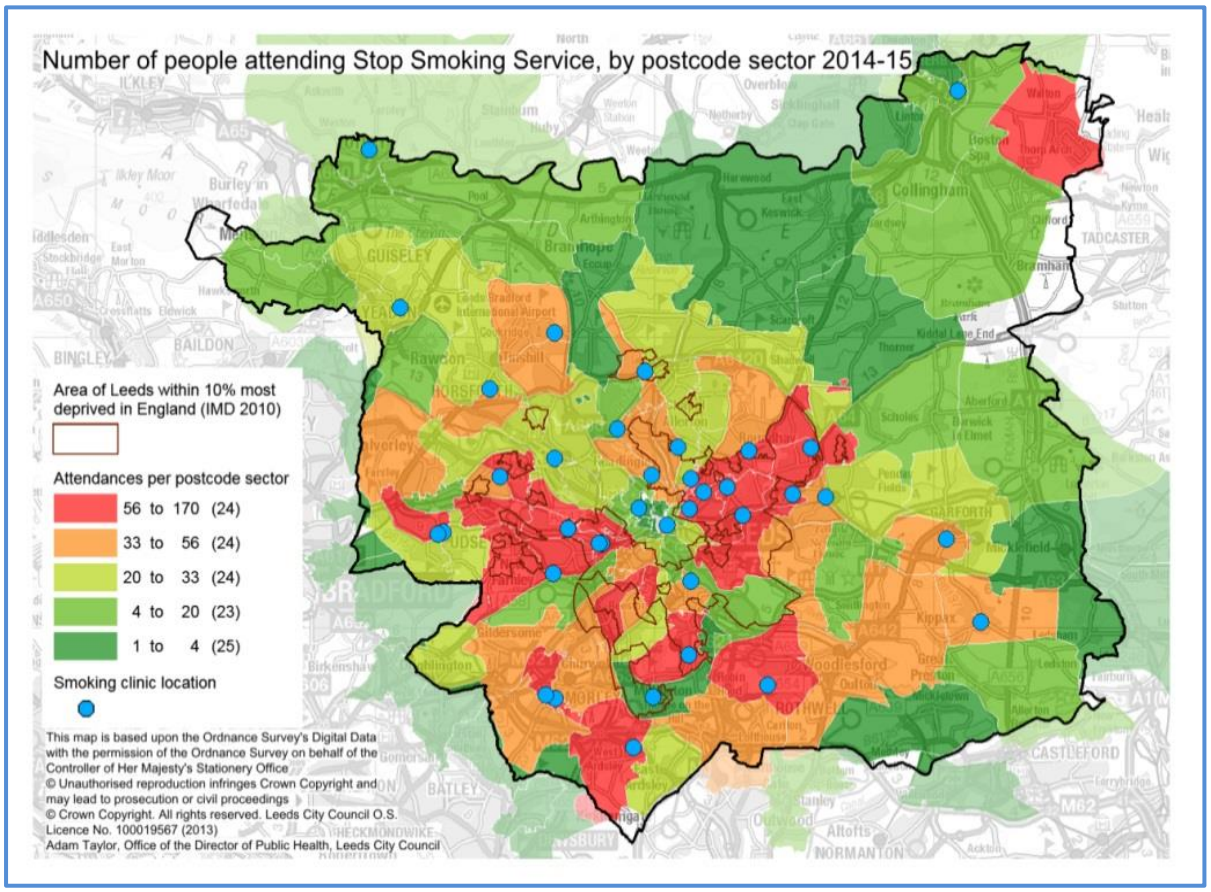


The split of the gender profile for service users show a greater proportion are female (56.7%) this is slightly higher than the citywide split of 51%. However, compared with other lifestyle services (e.g. weight management or health trainers) the gender

balance is closer to the citywide profile showing that the service does have an appeal to male users.

5.7.3 Smoking service usage by geography

Figure 76: Map of location of the smoking service clinics and the number of people by postcode sector who have accessed the service
Data source: Postcode data collected from the service and mapped by Public Health Intelligence Team LCC



The stop smoking clinics are predominantly offered in the areas of the city where smoking prevalence is highest and deprivation is worst, with the exception of the LS23 area where the service is delivered in HMP Wealstun. The greatest access to the service tends to be from the more deprived areas, exceptions being seen in Ardsley and Robin Hood and a small pocket within Pudsey (NW).

Compared with the maps showing the incidence of long term conditions associated with smoking (figures 33, 37 and 39), the service is tending to attract people from the areas which experience the greatest incidence of these conditions in the city. There is, however a small pocket in South East Leeds where COPD rates are high, but access to services is low. There are three clinic in particular (Yeadon, Otley and Wetherby) where access to services is low as is smoking prevalence and incidence of long term conditions related to smoking.

5.7.4 Commissioner views on strengths, weaknesses and gaps

Strengths

- The service has staff with specific expertise around working with people with mental health issues and pregnant women who smoke and have created close working partnerships with Leeds and York Partnership Foundation Trust (LYPFT) and maternity services. However, whilst a strength, capacity is limited.
- The service collects data for the entire city and as such, maintains a data base of all active advisors. This enables the service to inform other providers of smoking cessation support (mainly primary care) of any new information relevant to the field. The service delivers an annual update session for the citywide network of smoking cessation advisors.
- The service offers smoking cessation clinics in a range of venues and out of hours (evenings and weekends).
- The service has historically ranked in the top 5 services in the country for success rates at 4weeks.
- The service is looking at an integrated offer with smoking cessation and Healthy Lifestyles Service.
- The service attempts to follow up all clients who set a quit date at 52 weeks. Although the data received indicates that many clients are lost to follow up, of those that are contacted, the longer term abstinence rates remain consistent with nationally predicted outcomes (25%) – The service is one of the only ones nationally to collect this data.
- The service provides training linked to national standards to ensure consistency across all providers.
- The service has good data collection and good monitoring of ethnicity, age, gender and socio economic status (based on employment status).
- The registered advisor service provides additional smoking cessation capacity especially in the non-deprived areas of the city.

Weaknesses

- Whilst continuing to provide a cost effective intervention, the service is experiencing a lower through put of clients with declining referrals and self-referrals, therefore resulting in an increased cost per quitter – however, this is a trend which has been experienced nationally.
- Whilst the service is maintaining a quit rate well above the national minimum standard (35%) it is concerning that following a service review by the provider organisation in early 14/15 that quit rates have declined, however this may be a temporary situation as Q4 14/15 has shown an improvement.
- The service has not achieved the expected 85% CO validation.
- Over the last few years, the service appears to have an increasing percentage of people who are accessing the service and attending a first appointment, but not setting a quit day. This would suggest that the service is seeing people who have moderate levels of motivation in that they have attended, but are not yet ready to set a quit day. The service model is currently a total abstinence model which is possibly not suited to all smokers, suggesting an alternative quit method, such as ‘Cut Down to Quit’ should be offered along with further motivational interventions

to those smokers not yet ready to quit. This would mean that clients would be in contact with the service for a longer period of time, but retention rates could possibly be improved.

- It is difficult for registered advisors to maintain their skills and competences given the small numbers of people being seen by individual advisors. In addition, not all advisors have completed the NCSCT assessment process and are unable to be released to attend update sessions
- Due to registered advisors being paid by quitter, it is difficult to compare quit rates between the services and also to accurately monitor the number of times a client has been seen.

Gaps

- The main gap in the service provision is offering alternative methods of quitting complementing the current total abstinence model. Although an evidence based standard treatment programme is provided, this is mostly suitable for smokers who have relatively high levels of motivation to quit.
- It would also be useful to consider the access to pharmacological treatment directly from the service where appropriate. The service uses an NRT voucher scheme which requires the patient to visit their pharmacist to obtain treatment this dates back to requirements, given previous classification i.e. prescription only medicine (POM), pharmacy (P) or general sales listed (GSL). All NRT products are now GSL and could potentially be supplied direct to the client; this would be more convenient for the client. In addition it would potentially save costs on the NRT voucher scheme as treatment could be issued on a weekly basis and pharmacy administration costs avoided. However, as other treatments are POM this may result in clients selecting a product for convenience rather than what they believe will be effective.
- Although, clients are seen for support for cessation of other nicotine containing products including nicotine vaporisers (E cigarettes) and smokeless tobacco products, this is not included in the service specification; consideration should be given to these products and any evidence of effective interventions as they increase in popularity.

5.8 Ministry of Food (Zest Health for Life)

5.8.1 Summary of service and activity between April 2014 and March 2015

Jamie Oliver's Ministry of Food Leeds (MoF) aims to contribute to improvements in health and well-being by influencing food choice. The service runs from a Food Centre based in Leeds Kirkgate Market providing cooking courses to teach adults 16+ with no or limited cooking skills how to prepare tasty, healthy meals on a budget. Each cooking session promotes a key healthy eating message to educate service users on a wide range of healthy eating messages from understanding food labels to reducing salt, fat and sugar.

The service delivers a wide range of activities including:

- Standard 8 week cooking courses (following the Jamie Oliver quality assured model).
- One off taster for service users who would like to experience one session prior to booking onto a course, or possibly lack confidence
- Outreach cooking opportunities working in deprived communities

The service is expected to evidence sustained behaviour changes in eating habits and cooking skills service desired outcomes include:

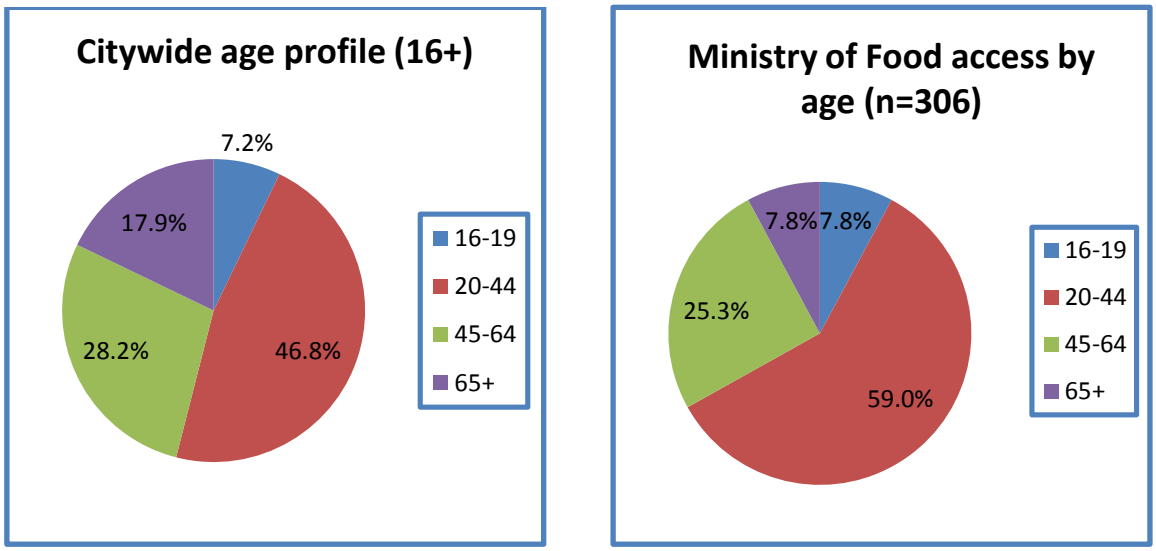
- To increase and improve cooking skills.
- To increase the consumption of fruit and vegetables.
- To decrease the consumption of high fat and high sugar foods and takeaways.
- To decrease the intake of salt.
- To increase confidence in cooking from scratch.

During the 2014-15 period, 310 people accessed the standard 8 week cooking course delivered by the service. Service outcomes data shows that 57% of attendees increase their consumption of fruit and vegetables by 1 portion or more. Increasing consumption by 1 portion has been shown to have positive impacts on health.

5.8.2 Ministry of Food access by age ethnicity and gender

	Number of records	% of all records
Total number of records received	306	
Number of records with age recorded	293	95.8%
Number of records with ethnicity recorded	292	95.4%
Number of records with gender recorded	304	99.3%

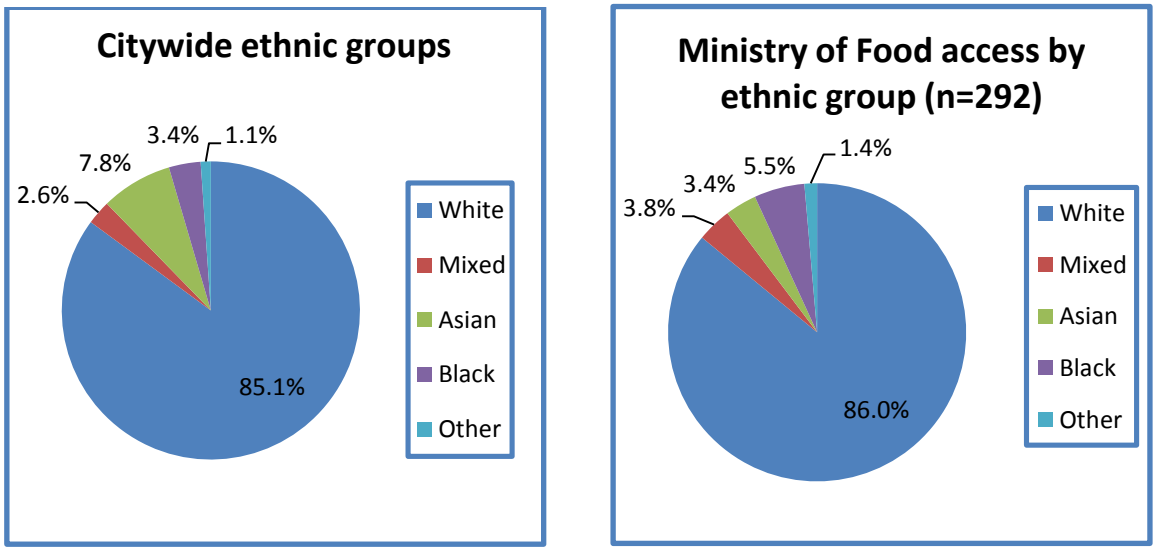
Figure 77: Ministry of Food age profile of service users compared with citywide age profile.
Data Source: Census 2011 and service activity data 14/15.



MoF has an interesting age profile in that it is the only healthy living adult activity in scope that has the majority of its users within the 20-44 age bracket (59% c/w 46.8% citywide profile). The other age categories are similar to the citywide profile with the exception of the 65+ age group.

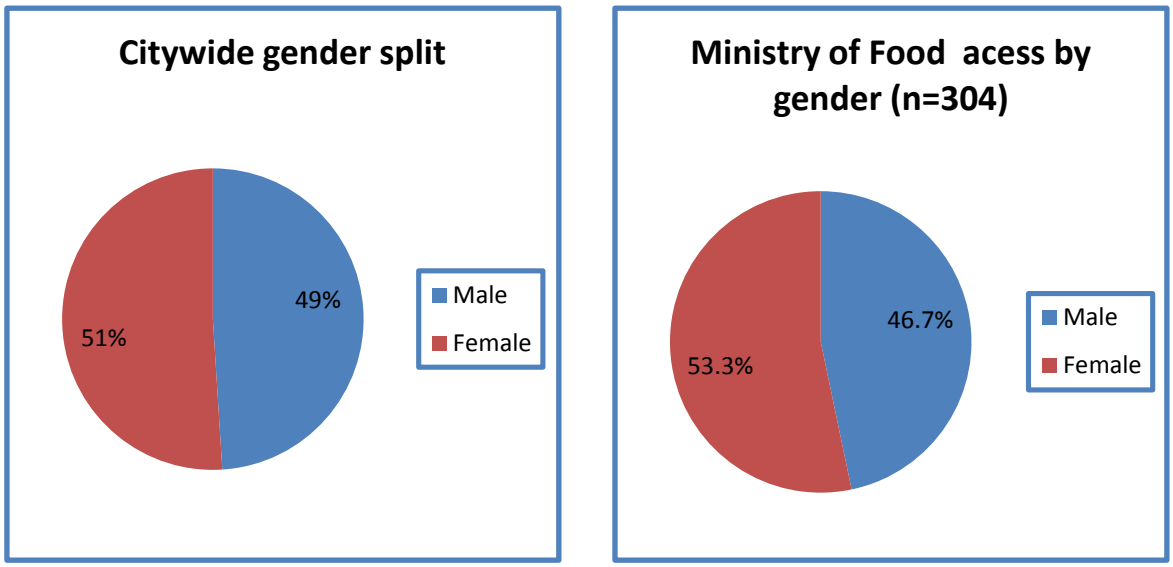
Having a younger majority age group may be a result of changes to the national curriculum which removed the home economics / cookery lessons as part of design and technology (1996-2013); this has now been reintroduced. With the highest proportion of people attending from the 20-44 age group, it is possible that people in this group may be likely to have young families which would show that MoF can impact on family eating behaviours and food habits.

Figure 78: Ministry of Food ethnicity profile of service users compared with citywide ethnicity profile.
Data Source: Census 2011 and service activity data 14/15.



Generally the ethnicity split of attendees of MoF is similar to the citywide profile with a slight under-representation of people form Asian origin, which is a group which tends to be more susceptible to certain long term conditions including diabetes and coronary heart disease. Local insight suggest that the service is appropriate for these groups however there may be a variety of factors which may discourage people of Asian descent attending including, having male trainers, the location in the market and the range of dishes provided.

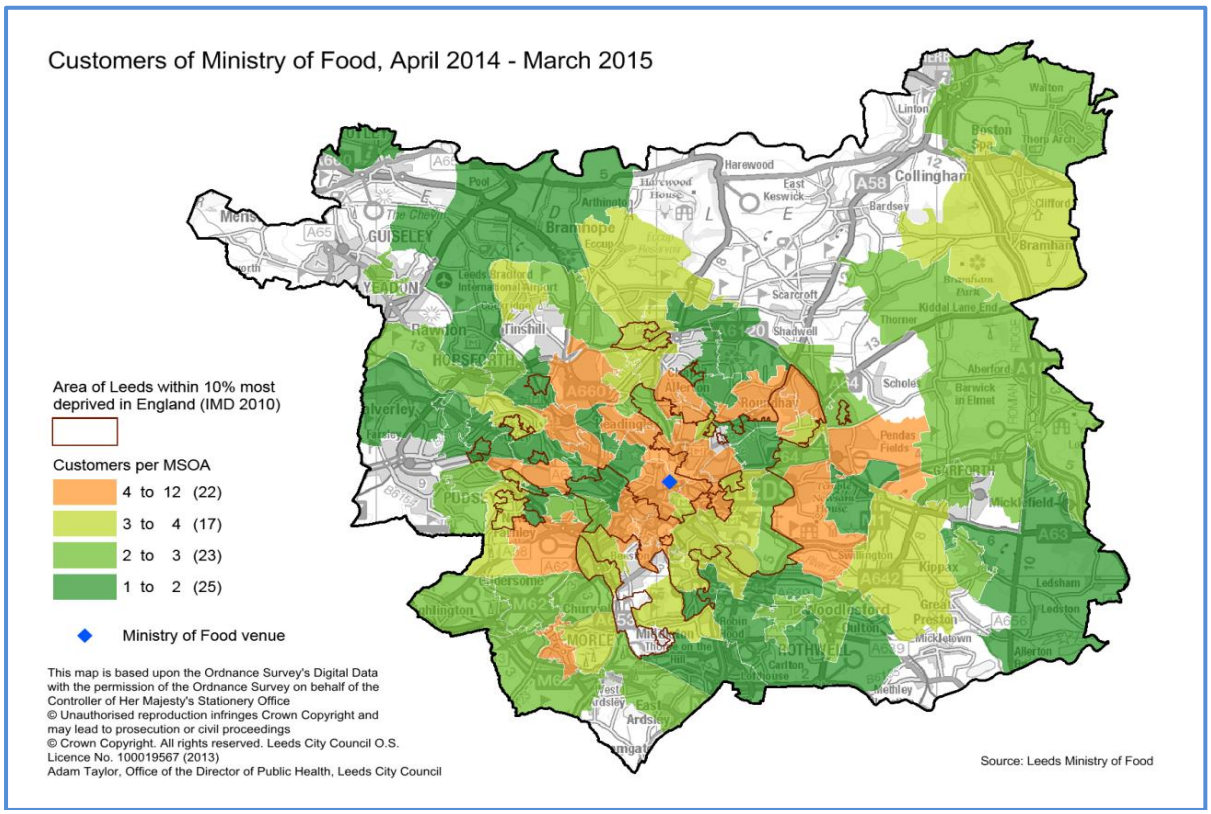
Figure 79: Ministry of Food gender profile of service users compared with citywide gender profile.
Data Source: Census 2011 and service activity data 14/15.



The profile of MoF shows that the gender split is similar to the citywide split which shows that unlike the other behaviour change interventions (e.g. weight management, smoking) it is particularly successful in attracting male attendees providing a valuable opportunity to engage with men around healthy living.

5.8.3 Ministry of Food usage by geography

Figure 80: Map showing the location of the Ministry of Food and the number of people by postcode sector who have accessed the service
Data source: Postcode data collected from the service and mapped by Public Health Intelligence Team LCC



The service is offered at one venue which is based in Leeds Kirkgate Market. The service has attracted a diverse geographical range. Although the service charges for attending, this is means tested so people from more deprived areas are allocated subsidised places (either via a free bursary or £35 per course compare to £60).
MoF service reach shows that the service is attractive to communities within deprived areas; however some areas are underrepresented particularly in the South area of the city (e.g. Beeston, Middleton). The areas which have a higher representation are predominantly focused around the city centre and include several areas of high deprivation.

Comparing the service user data with long term conditions which are associated with poor diet e.g. Diabetes and Obesity, show that MoF has been successful in attracting people from those areas where the incidence of these conditions is highest.

5.8.4 Commissioner views on strengths, weaknesses and gaps

Strengths

- Ministry of Food delivers a quality assured model via the Jamie Oliver Foundation.
- Ministry of Food pro-actively delivers a range of activities to engage adults to access the provision including outreach events, taster sessions and cooking courses off site.
- Ministry of Food provides a food centre which offers a referral point to enable appropriate signposting from a range of services.
- Ministry of Food has developed good working relationships with a wide range of services and the number of services referring in has increased year on year.
- Ministry of Food has good data collection and good monitoring of ethnicity, age, gender, disability and socio economic status (based on postcode).
- Ministry of Food is very acceptable to men with a nearly an equal balance of men and women accessing the service.
- Ministry of Food is able to demonstrate sustainable changes to dietary behaviours by using an evaluation form which meets the National Obesity Observatory (NOO) Standard Evaluation Framework for Dietary Interventions guidance, measuring outcomes before, after and 6 months following the intervention.
- Ministry of Food has an excellent staff team with a range of cooking and community development skills. The staff are consistently sited in public feedback as a key strength of the service.
- Ministry of Food has successfully included their provision into other Healthy Living Service Pathways such as Weight Management and Alcohol Services (outcomes to evidence available).
- Ministry of Food is able to engage a range of different service users.
- Ministry of Food offers provision 6 days per week (Mon – Sat).
- Commissioning arrangements also include the Leeds Lets Change centre which enables MoF users to be signposted into other services as appropriate

Weaknesses

- Ministry of Food is unable to offer evening sessions at the venue due to the closing times of the market. Delivery of a satellite project in another area of the city has highlighted a need for evening sessions.
- There is a cost to the public, recent insight has shown that people who are shown the costs of the service see this as a barrier to attending. Conversely those who attend the service feel it is value for money. If Leeds Market were to reduce the rent for the stall in the market this would enable the service to be provided free of charge to people in receipt of means tested benefits.
- The majority of the service provision is delivered onsite at Leeds Kirkgate Market which could require transport costs for service users to access and reduces the services reach across deprived communities
- Ministry of Food was commissioned at a time when other cooking skills providers were having their contracts reviewed. This has led to some negative views about the service and reduced the amount of expected referrals from other cooking

providers. Furthermore insight with providers has shown that they perceive the service to be more appropriate for the middle class.

- Insight from the public has suggested that the course may be too basic and could have a stronger focus on food budgeting.

Gaps

The main challenge for Ministry of Food is the growing number of people accessing the service with learning difficulties. The evaluation form used by the service is inappropriate for some service users to complete. Furthermore it is questionable that the outcomes the service is commissioned to generate are not achievable for people with learning difficulties who report more social based outcomes such as maintaining independence, improving confidence and developing a sense of achievement. The service has seen a year on year increase in the number of people accessing with learning difficulties and there is a gap in staff knowledge to provide an appropriate service. The service is currently part of a fragmented model for food work in which locality providers deliver some cooking skills alongside the city based MOF offer. The recent insight review concluded that the public require both basic and progressive cooking opportunities in the community which isn't part of the existing contract. The service is consistently approached to deliver children and family based activities which is not part of the current contract, although assessment of need would be required to identify this target audience as a clear gap.

5.9 Equity

There is a clear correlation between deprivation, unhealthy lifestyles, lifestyle related illness and potential years of life lost. There are also additional challenges faced by defined groups of people who face greater discrimination and therefore require consideration when assessing need. The Equality Act 2010 protects people from discrimination and defines target groups on the basis of 'protected characteristics'. The relevant characteristics for services and public functions are:

- Age
- Disability
- Gender reassignment
- Marriage and civil partnership
- Pregnancy and maternity (includes breastfeeding)
- Race – this includes ethnic or national origins, colour and nationality
- Religion or belief
- Sex and,
- Sexual orientation

Appendix b contains a summary of briefing sheets which were produced by Leeds City Council Equality team; focusing on information about some of the potential barriers that are faced by individuals from the different protected characteristics.

This HNA focuses on lifestyles, lifestyle related ill health, potential years of life lost and inequality in life expectancy. However there is a recognition that taking an epidemiological approach such as this, focusing on the lifestyle element as a cause of ill health, comes at the expense of understanding the broader impacts on

population health. This HNA needs to be read in conjunction with other needs assessments for the city which focus on issues of equality, specifically the HNA which has been written to support Leeds City Council Commissioning of Community Health Development projects. The Community Health Development HNA starts with communities and contains a broad range of information including emerging migrant communities. In addition there are HNAs published for Leeds which explore the needs of Gypsies and Traveler communities, central and eastern European communities.

In Leeds "The Vulnerability Model" was developed (Bruhn, 2013) to describe three key factors that contribute towards poor health outcomes and enables consideration to be given to how these different factors synergise to create risk. The model is intended to be used when planning services to ensure the needs of vulnerable groups are considered. The three factors are:

- Who you are: the link between demographics / population groups including the increased risk of higher prevalence or incidence rates for certain conditions in specific population groups and illnesses. For example there are higher rates of diabetes in South Asian communities and higher rates of respiratory disease in people with learning disabilities.
- Where you live: the importance of geography and the impact of socio-economic factors such as poverty, housing, worklessness and education on health outcomes. It also includes how geography can impact on opportunities to access and adopt healthy lifestyle choices. As poverty is a key factor in health inequalities, geography is an important factor to consider.
- How people treat you: the impact on self-efficacy and self-esteem of stigma and discrimination both at an individual and institutional level. This can have a particular impact on real and perceived access to services, patient experience and mental health and wellbeing.

The more factors you have, the increased vulnerability populations have to the risk of poor health outcomes and lower life expectancy. The model can be used to analyse needs of different population groups in the light of the circumstances that surround them and that may affect their health. This may lead to different groups emerging as priority or at a higher risk depending on the specific circumstances. This vulnerability may change in a different neighbourhood or with time.

Ongoing equality impact assessment and proper consideration of prioritisation and target groups for future commissioned services alongside practical and effective diversity monitoring are key.

6. Review of Integrated Healthy Living Service Models in the UK

Different procurement approaches and models have been used to commission integrated health and wellbeing services across the UK. This chapter aims to highlight the evidence base for Integrated Healthy Living Services (IHLS) or wellness services; and to summarise different models used to procurement IHLS across England.

6.1 What is an Integrated Healthy Living Service?

Integrated Healthy Living Services has been defined by the Liverpool Public Health Observatory (2010) and subsequently the NHS Confederation (2011) as "Wellness Services" that are the preferred model to "promote health and well-being rather than diagnose and treat illness. This could be via healthy lifestyles and psycho-social interventions, and might include a combination of smoking cessation, weight management, brief alcohol interventions, physical activity pathways, health trainer provision, social prescribing/referral and psychological well-being interventions such as mindfulness and stress management. Wellness services aim to encompass and integrate both mental and physical health issues in order to improve a person's overall health and wellbeing".

Liverpool Public Health Observatory (2010) performed an evidence review of wellness services that had a bio-psychosocial/holistic approach to health and concluded that the "majority of services reviewed… are cost-effective and have shown the potential to bring a return on investment and to save on future costs of ill-health through early intervention… Wellness services that facilitate true community engagement can build on what individuals themselves identify as supporting them to improve wellbeing. Therefore the demand for complex health and social care services will be reduced. As lifestyle factors are interconnected, providing an integrated holistic lifestyle person-centred service is potentially more cost-effective, by aligning services thus reducing duplication of service support structures".

The Liverpool Public Health Observatory recommended a model and standards for Wellness Services that were endorsed by the NHS Confederation (2011).

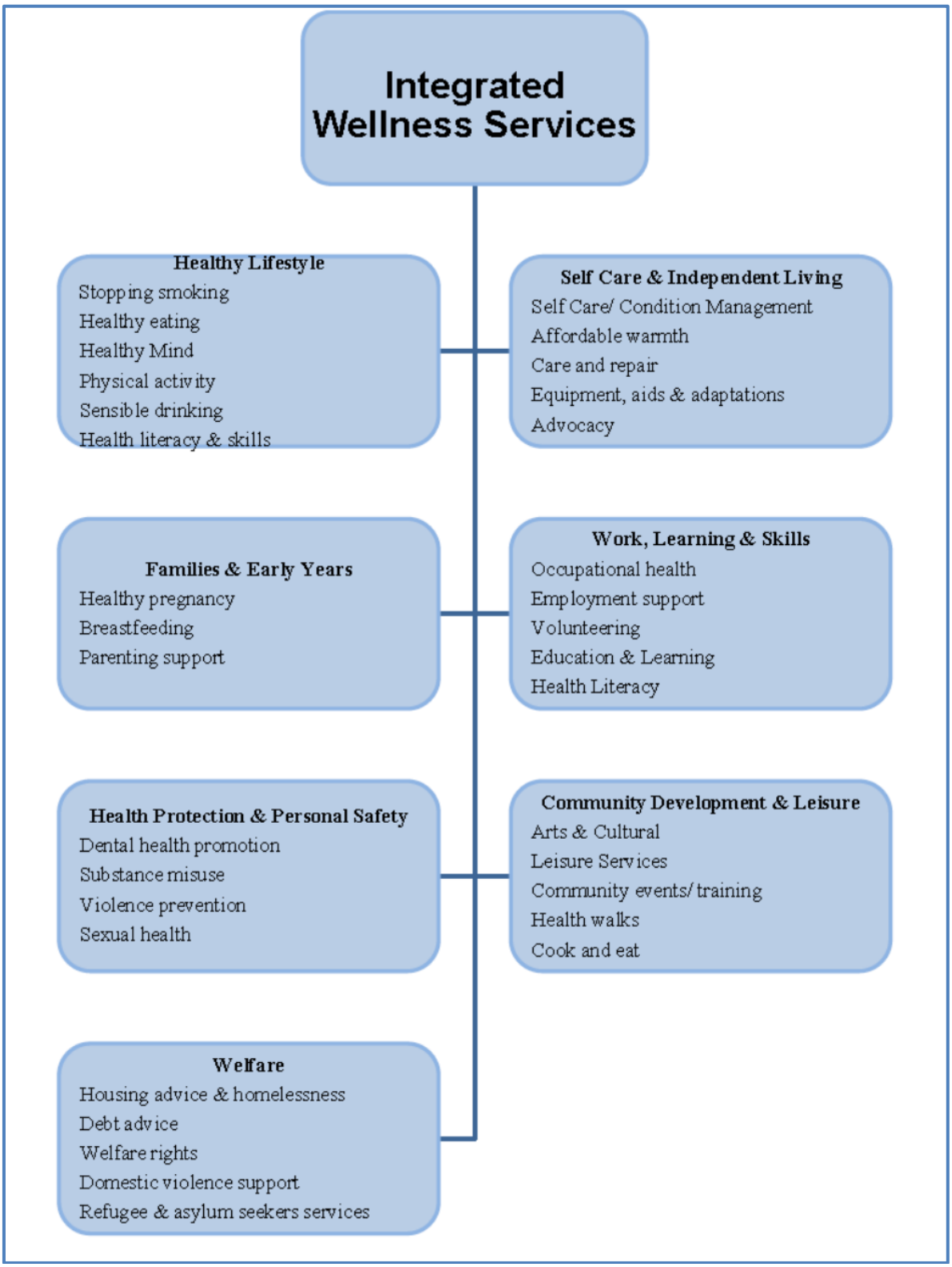
The standards proposed for Wellness Services are:

- Improving outcomes
- Improving quality
- Service integration
- Stakeholder engagement and whole system fit
- Efficiency improvements and
- Sustainability.

This model for a Wellness Service is illustrated in Figure 81. It is important to note that the model is much broader than the procurement of smoking, weight management, physical activity and healthy eating services that is applicable to Leeds.

Figure 81 is helpful to demonstrate what is meant by a “whole system fit”. The model recognises the scope to integrate across the system which does not necessarily require commissioning all parts of the system.

Figure 81: NHS Confederation (2011) Wellness Service Model



6.2 Integrated Health Living Services across England

Across the country, Local Authorities are commissioning what are known as “living well”, “wellness”, “healthy lifestyle” or “healthy living” services. The commissioning process has shifted from commissioning separate services to an integrated service delivery model. This document presents information and learning received from the following Local Authorities:

- Barnsley Metropolitan Borough Council
- Blackburn with Darwen Council
- Cheshire West and Chester Council
- Derbyshire County Council
- Derby City Council
- Knowsley Council
- Luton Borough Council
- Rochdale Borough Council
- Salford City Council
- Suffolk County Council
- Sunderland City Council

A brief description of the services commissioned by these Local Authorities can be found in the full report.

6.3 Procurement model, scope and funding

Although there is difference in the specifics of the integrated service model, the commonality between the Local Authority models are outcomes: increasing life expectancy, reducing mortality from preventable causes and service specific outcomes e.g. reducing smoking prevalence, reducing excess weight. These service models include a range of healthy living services such as physical activity, healthy eating, smoking cessation, weight management, NHS Health checks, alcohol reduction, sexual health and health trainers/community champions amongst others. The most common procurement model is one contract through one lead service provider who works as part of a collaborative or sub-contracts specialist services. Some areas continue to procure through single lots and integration is achieved through procurement of a single point of access, co-location of services “under one roof”, integrated care pathways and /or effective onward signposting by a healthy living champion.

When reviewing integrated healthy living service models across the country, it became clear there is a variation in spend per head of the population. This is at a range of £3 to £7. Leeds City Council has the lowest cost per head of the population to fund an Integrated Healthy Living Service currently at £3.03 per head of population. This needs to be considered to ensure the new service meets expectations and is realistic to deliver within the financial envelope. The cost per head has been calculated using procurement values only and does not include any costs associated with integrated care pathways, for example integration with local authority services.

6.4 Fit against the NHS Confederation model and standards for Wellness Services

From reviewing different models, it is apparent that there are common elements within the integrated service model that support the Liverpool Public Health Observatory Wellness Service standards. It is acknowledged that not all services developed have fulfilled all aspects of the Wellness Service standards. Below highlights operational specifics, principles and objectives of wellness services reviewed against the NHS Confederation Wellness standards. These include:

Standard 1: Improving outcomes
Robust outcome measures are noted in the service specifications reviewed in relation to:

- Population health, e.g. reducing mortality.
- Wellbeing, e.g. tackling wider determinants of health.
- Inequalities, e.g. demonstrable targeted approach to those greatest in need.
- Customer defined health and wellbeing outcomes developed in response to consultation, e.g. self-reported wellbeing scores.

Business cases have identified that this has been achieved through:

- Public consultation on their needs and preferences for service delivery acknowledging existing assets.
- Consultation and equity audits to ensure services are targeted to specific groups and communities, and are accessible by those in greatest need.
- Development of a service with a principle to support capacity building and skill sets for health and well-being, for both practitioners and service users that move beyond management of lifestyle risk factors, to enabling resilience and independence to live well.

Standard 2: Improving quality
The service specifications have all been developed against NICE guidance, other quality standards and outline the following expectations:

- The provider demonstrates a clear commitment to self-care and co-production of health related goals and plans.
- The service is person centred and uses a strength based approach that acknowledges and develops the experience, skills, and potential of people to live healthy lives alongside the assets in their community.
- The service creates opportunities for service users and community members to be involved in local delivery e.g. development of community volunteers, community champions etc.

Standard 3: Service integration
The service specifications reviewed outline some specific operational elements of the service to ensure service integration, and these include:

- The service offers a single, integrated, and coordinated approach to support people to live healthier lives.
- The service has a single point of access and is contactable electronically 24 hours per day, 7 days per week, and 52 weeks per year.
- The service has a central hub for referrals, bookings and holistic assessments.
- The service provides a common, holistic assessment that incorporates psychosocial wellbeing, physical health, and lifestyle behaviours.
- The service proactively takes into consideration the impact of the wider determinants of health on wellbeing and supports health change through goal setting, promoting self-efficacy, increasing motivation, increasing social value, and access to social networks and support.
- There is seamless integration with other health and wellbeing related services through clearly defined care pathways and coordinated referrals or social prescribing across the system.
- The service provides access to specialist interventions e.g. smoking, weight management, with coordinated care plans.
- The service is flexible and adaptable and provides a range of approaches to meet service user need e.g. provision of information, health coaching, brief advice, extended brief advice, peer support, group work, one-to one support, self-help, signposting, social prescribing, social marketing and campaigns, outreach and community development.
- Services are accessible to meet the needs of the community and embrace new technologies.

Standard 4: Stakeholder engagement and whole system fit

The business cases reviewed identified that the commissioning process is aligned to the joint vision and strategic plan for healthy lifestyles and services via Health and Wellbeing Boards. As a consequence, the service is developed as part of the whole system for health improvement.

From the information reviewed, the elements of this standard that are not as clearly embedded include the presence of the following:

- Multi-agency partnership that oversees partnership development and improves alignment with the service.
- Communication processes and partnership arrangements to inform and to develop the service with CCGs, other local authority provision, other NHS organisations, community service providers and the third sector.
- Jointly commissioning with CCGs and for integrated services to have joint outcome accountability.

Standard 5: Efficiency improvements

The commissioning of integrated wellness services is a relatively new way of providing services and therefore there is limited evidence of effectiveness, efficiencies and cost effectiveness except the outcome of the review by the Liverpool Public Health Observatory. Therefore, the following elements of this standard have been difficult to demonstrate from the information reviewed:

- Value for money is ensured by benchmarking the service with other areas

- Whole system cost efficiencies have been modelled and are monitored e.g. reduced admissions to secondary care.

Standard 6: Sustainability
The services that have been commissioned are responsible to train other front line workers to support the delivery of brief interventions to improve health and reduce lifestyle risk factors. This is a key element of ensuring sustainability. The business cases and service specifications reviewed also promote sustainability through addressing the wider determinants of health. Another element of this standard to ensure sustainability is to monitor outcomes through appropriate follow-up of service users, for example at 6 and 12 months post intervention.

6.5 Conclusions

From reviewing the information, it is clear that the direction of travel across local authorities is to design and procure integrated healthy living or wellness services. The process for this has varied across Local Authorities and it is important to acknowledge that integration of services can be achieved through services being co-located, integrating care pathways, or through access to a single point of access that holistically assesses clients and signposts onto relevant services. This holistic approach has been noted in areas who have taken time to integrate health and wellbeing approaches and subsequent access to services.

The scope of integrated healthy living services across the country is influenced not only by need but also by resources. As a consequence, there is variation in the scope of integrated healthy living services and models, variation in procurement options, and variation in design such as integration of pathways.

7. Discussion and recommendations

7.1 Discussion

The data presented in this HNA is to inform the commissioning of an integrated healthy living service for Leeds.

The main theme emerging from the epidemiological data is of inequalities. There is a 10.8 year gap in life expectancy in Leeds. The LIHLS needs to respond to this inequality by providing equitable services which improve the health of the poorest fastest. The LIHLS therefore needs to take into account broader determinants of health and the role of place which was illustrated through the comparison of data measuring the factors which influence health when comparing Richmond Hill and Burmantofts ward to Harewood ward.

The data show a clear relationship between deprivation and unhealthy lifestyles and lifestyle related ill health. The proportion of the population who are obese, have diabetes, COPD and CVD is higher in the South and East CCG areas of the city compared to the West and North. However in terms of numbers, which are sourced from the GP audit data, the West of the city has more people who are obese, diabetic, have COPD and CVD. The population covered by the West CCG is larger with 355,000 patients compared to 258,000 in the South and East and 211,000 in the North.

Deaths from cancer are the most common cause of potential years of life lost in Leeds. Although deaths from cancer are reducing in Leeds, the rate of cancer for deprived Leeds for PYLL is almost double that of non-deprived Leeds. Deaths from CVD are the second most common cause of PYLL. Deaths from respiratory disease are the third single highest cause of PYLL in Leeds and again are significantly higher in deprived than non- deprived Leeds. Therefore the LIHLS needs to be effective in reducing smoking, excessive drinking, obesity and increasing physical activity with a focus on deprived Leeds.

However, it is encouraging that overall PYLL in Leeds is reducing fastest in the most deprived areas and the commissioning of the LIHLS should ensure there is not a detrimental impact on the interventions that have contributed to this improvement.

There is clear evidence nationally that unhealthy lifestyle behaviours of smoking, excessive alcohol intake, poor diet and low levels of physical activity are more commonly in deprived areas. This pattern is mirrored in Leeds. National data show improvements have been made faster in more affluent communities. The LIHLS needs to respond to this pattern, ensuring a holistic approach is taken with people accessing the service and that services are planned around individuals and communities rather than service specialisms.

Services in Leeds are generally high quality; however, procurement law dictates the need to periodically re-commission services. This provides an opportunity to redesign our current healthy living provision to increase effectiveness and ensure it is integrated with other related services and activities to better meet the needs of service users.

The advantage of considering a range of individual lifestyle services together is that they can be planned as a whole, based around the needs of individuals and populations. The main criticism of services as they are currently configured is that apart from the Health Trainers Service and Healthy Lifestyle Service, they deal with single health issues.

There are currently three commissioned services offering adult weight management support, Weigh Ahead offers exclusively weight management and is particularly focused on patients with a higher BMI, whilst the Healthy Lifestyle Service and the Health Trainer Service offer weight management within a menu of behavioural support programmes. Around 75% of the clients accessing the Healthy Lifestyle Service and Health Trainer Service do so for weight management purposes.
Whilst it is not possible to directly compare the services due to differing outcome measures, none of the services achieve the NICE guidance of 60% of clients achieving a 3% weight loss suggesting that individuals may need more support on motivation alongside skills development and goal setting. None attract a representative proportion of men into services, suggesting an alternative offer should be provided for that group.

The children's physical activity services are excellent at serving BME communities and having an equal split between boys and girls accessing the service and are meeting targets set in terms of numbers accessing the services.

The stop smoking service has a high number of people who quit at 4 weeks however this represents just over a quarter of people who were originally referred again suggesting more work is required around motivation and readiness to quit. Unlike weight management services a large number of men attend but are still slightly under represented, making up 43% of people accessing the service.

Ministry of Food is the only service attracting a higher number of 20 – 44 year olds. The service is accessed by men and women almost equally.

There is good evidence that integrated healthy living services which have a bio-psychosocial / holistic approach to health are cost-effective and have shown the potential to bring a return on investment and to save on future costs of ill-health through early intervention. Across the country, Local Authorities are commissioning "living well", "wellness", "healthy lifestyle" or "healthy living" services, moving from commissioning separate services to an integrated service delivery model.

In the UK there is a variation in spend per head of the population, ranging from £3 to £7. Leeds City Council has the lowest cost per head of the population to fund an Integrated Healthy Living Service currently £3.03 per head of population, however given recent announcements about budget cuts to public health, it is likely we may be required to reduce this further; this will influence what it is possible to commission in Leeds and how much change will be possible without additional investment.

7.2 Recommendations

1. Integrate existing healthy living services into a single system planned around an individual's and a community's needs. Consider if services should be

commissioned as a single service, an integrated system or have elements of both.

2. Ensure the LIHLS provides a high quality service which is easily accessible for primary care colleagues to refer into, but also outreaches into the community to build relationships with targeted groups with the aim of encouraging behaviour change.
3. Ensure the LIHLS allocates capacity to provide an equitable service delivered using the principles of universal proportionalism. Ensure target groups are identified and the LIHLS is planned to meet their needs.
4. Focus on outreach and building motivation to change with the aim of improving weight management and smoking cessation outcomes specifically.
5. Develop a health coaching approach to behaviour change where individuals can determine their health goals using self-discovery and active learning, with help to work towards their goals by self-managing their behaviours to increase accountability.
6. Develop family based approaches to weight management. Consider the needs of adolescents.
7. Ensure how people think and feel is considered whilst planning physical health improvement goals.
8. Develop a service which is assets based and considers broader determinants of health and other community based healthy living activities. Ensure partnerships are in place with organisations that can provide additional input and opportunities to overcome barriers to change and to support and maintain change.
9. Develop an evaluation framework that gathers information on longer-term outcomes and cost effectiveness. Ensure robust data collection systems are in place including collection of demographic data. Consider how to incorporate ongoing evaluation to drive continuous service improvement. And how to embed return on investment tools and or economic evaluation.
10. Ensure the LIHLS dovetails with the CCG commissioned social prescribing projects and related services. Ensure CCGs understand the commissioning plans for the LIHLS and are provided with opportunities to co-commission where appropriate. Clearly negotiate who is responsible for which elements of weight management support with the Leeds CCGs.

Appendix a

Review of policy related to healthy living services

National policy

The Five Year Forward View
NHS England, 2014
Stevens explains that although the NHS has dramatically improved over the past fifteen years, quality of care can be variable, preventable illness is widespread and health inequalities is deep rooted. There is now broad consensus on what a "better future" should be. Stevens states that the future of millions of children, the sustainability of the NHS and the economic prosperity of Britain all now depend on radical upgrade in prevention and public health. The NHS will target action on obesity, smoking, alcohol and other major health risks. The NHS should be involved in developing and supporting new workplace initiatives to promote employee health and cut sickness-related unemployment. When people do need health services, patients should gain far greater control of their own care and the NHS will become a better partner with voluntary organisations and local communities. Decisive steps will be taken to break down the barriers in how care is provided. The future will see far more care delivered locally, organised in a way which supports people with multiple health conditions not just single diseases. Stevens suggests there are viable options for sustaining the NHS over the next five years provided the NHS does its part allied with the support of government and other national and local partners

Improving outcomes and supporting transparency: A public health outcomes framework for England, 2013-2016
Department of Health, 2013
The Public Health Outcomes Framework (PHOF) is the overarching framework for public health work in England. It has two high level outcomes: Increased health life expectancy and reduced differences in life expectancy and healthy life expectancy between communities. These outcomes reflect the focus not only on how long we live- our life expectancy but on how well we live – our healthy life expectancy at all stages of the life course. The second outcome focuses attention on reducing health inequalities between people, communities and areas in society. The PHOF uses both a measure of life expectancy and healthy life expectancy so that they are able to use the most reliable information available to understand the nature of health inequalities both within areas and between areas. The Department of Health acknowledges that the improvements in these outcomes will take years sometimes-even decades to see marked change.
The Department of Health has developed a set of supporting public health indicators that help focus our understanding of how public health teams are performing annually nationally and locally against agreed outcomes. These indicators are grouped into four domains:

- Improving the wider determinants of health
- Health improvement
- Health protection
- Healthcare public health and preventing premature mortality

In domain 1 there is a range of indicators that reflect factors that can have a significant impact on our health and wellbeing and reflect the recommendations in the Marmot review. Domain 2 focuses on actions to help people make healthy choices and lead healthy lifestyles. Domain 3 includes a critical range of indicators focusing on those essential actions to be taken to protect the public's health. Indicators hosted in domain 4 are being delivered by the whole public health system.

Fair Society, Healthy Lives: The Marmot Review
The Marmot Review, 2010
Marmot sets out the impact of health inequality on health outcomes. Marmot describes the link between social status and health, the lower a person's social position the worse his or her health. Action should focus on reducing the gradient in health. The existing inequalities in health result from social inequalities, therefore action on health inequalities requires action across all the social determinants of health. To reduce the steepness of the social gradient in health, actions must be universal but with the scale of and the intensity that is proportionate to the level of disadvantage. The review suggests economic growth is not the most important measure of a country's success. The fair distribution of health, wellbeing and sustainability are important social goals. Tackling social inequalities in health and tackling climate change should be tackled together. The Marmot states that reducing health inequalities will require action on six policy objectives:

- Give every child the best start in life
- Enable all children and young people and adults to maximise their capabilities and have control over their lives
- Create fair employment and good work for all
- Ensure a healthy standard of living for all
- Create and develop healthy and sustainable places and communities
- Strengthen the role and impact of ill health prevention

Marmot acknowledges that delivering these policy objectives will require action by central and local government, the NHS, the third and private sectors and community groups. National policies will not work without effective local delivery systems focused on health equity in all policies. Effective local delivery requires effective participatory decision-making at local level

Healthy Lives, Healthy People: our strategy for public health in England
Department of Health, 2010
The pubic white paper outlines a commitment to protecting the population from serious health threats, helping people live longer, healthier and more fulfilling lives and improving the health of the poorest, fastest. It adopts a life course framework for tackling the wider social determinants of health. The government outlines a new approach which aims to build people's self-esteem, confidence and resilience right from infancy – with stronger support for early years. It emphasises more personalised, preventive services that are focused on delivering the best outcomes for citizens and that help to build the 'Big Society'. The Department of Health states that the goal is a public health service that achieves excellent results, unleashing innovation and liberating professional leadership. The government emphasises the need for local government and local communities to be at the heart of improving health and wellbeing for their populations and tackling inequalities. A new integrated

public health service – Public Health England – will be created to ensure excellence, expertise and responsiveness, particularly on health protection, where a national response is vital. The government states that this new approach will: reach across and reach out – addressing the root causes of poor health and wellbeing, reaching out to the individuals and families who need the most support and be responsive, resourced, rigorous and resilient.

Healthy Lives, Healthy People: A call to action on obesity in England
The Department of Health, 2011
The Department of Health states that overweight and obesity represent probably the most widespread threat to health and wellbeing in this country. England along with the rest of the UK ranks one of the most obese nations in Europe with no evidence of a sustained decline. Obesity is also linked to inequality. Excess weight is also a major risk factor for diseases such as type 2 diabetes, cancer and cardiovascular diseases. The strategy states that the environment now makes it much harder for individuals to maintain a healthy lifestyle and there is a role for government and key partners to act to change the environment to support individuals to change their behaviour. The Department of Health suggests that action needs to encompass an appropriate balance of investment and effort between prevention, treatment and support.
The strategy makes the case for an ongoing focus on equipping people to make the best possible choices. There is a need for a spectrum of interventions from preventative to weight loss surgery, commissioned and provided in an integrated way which makes efficient use of different routes into support and different kinds of provision, backed by an agreed local pathway. The strategy sets out opportunities for local government to work with local CCG's and the local commissioning board to build on best practice.

Food Matters: Towards a Strategy for the 21st Century
The Strategy Unit, 2008
This strategy was written in 2008 by the previous government and outlined the government's vision for the food system. It describes a food system that is more sustainable economically, socially and environmentally. The strategy outlines the future strategic policy objectives for food should be fair prices, choice, access to food and food security through open and competitive markets, continuous improvement in the safety of food, a further transition to healthier diets and a more environmentally sustainable food chain.

Poor diet is known to influence the risk of cancer, heart disease and other conditions. The importance of nutrition for mental health and well-being is gradually becoming clearer. Around 70,000 fewer people would die prematurely each year in the UK if diets matched the nutritional guidelines on fruit and vegetable consumption and saturated fat, added sugar and salt intake. There are social inequalities within diet-related ill health that demand attention. Consumer awareness of the importance of healthy eating is rising but major behavioural changes and shifts in cultural norms are required before healthy diets are the norm. The policy document references the need to align marketing and communications campaigns about food and increasing consumption of fruit and vegetables so that more people reach and exceed the 5 a day target.

Everybody Active, Every Day: An evidence-based approach to physical activity
Public Health England, 2014
Public Health England states that being active everyday needs to be embedded across every community in every aspect of life- not something where cost, access or cultural barriers are an issue. The association between physical activity and a healthy, happy life means an active life needs to be made easy and accessible for all. Public Health England states what needs to be done is simple – be more active. The policy argues for the need to create cultural change, the need for activity to be fun, easy and affordable to all. In order to deliver on this vision Public Health England states that action across four areas at a national and local level is needed:

- Active society- creating a social movement
- Moving professionals- activating networks of expertise
- Active lives- creating the right environments
- Moving at scale- scaling up interventions that make us active

Sport England Strategy 2012-2017: A sporting habit for life
Sport England, 2012
In 2017 Sport England wants to have transformed sport in England so that sport becomes a habit for life for more people and a regular choice for the majority. Sport England is seeking a year on year increase in the proportion of people who play sport once a week for at least 30 minutes. In particular, Sport England aims to raise the percentage of 14-25 year olds playing sport once a week and reduce the proportion dropping out of sport. The strategy has highlighted six priorities:

- See more people taking on and keeping a sporting habit or life
- Create more opportunities for young people
- Nurture and develop talent
- Provide the right facilities in the right places
- Support local authorities and unlock local funding
- Ensure real opportunities for communities

Healthy Weight, Healthy Lives: A cross-government strategy for England
Department of Health/Department of Children, Schools and Families, 2008
The government state that halting the obesity epidemic is about individual's behaviour and responsibility and the responsibility of the private and voluntary sectors too. However it acknowledges that the government has a significant role to play, in expanding the opportunities people have to make the right choices for themselves and their families. The government has therefore a new ambition 'of being the first major country to reverse the rising tide of obesity and overweight in the population by ensuring that all individuals are able to maintain a healthy weight' Their focus is on children 'by 2020 we will have reduced the proportion of overweight and obese children to 2000 levels'. To make this ambition a reality the government will focus on five policy areas:

- To promote children's health
- To promote healthy food
- To build physical activity into our lives

- To support health at work and provide incentives more widely to promote health
- To provide effective treatment and support when people become overweight or obese

The government also commits to invest in research to deepen our understanding of the causes and consequences of the rise in excess weight, along with what works in terms of tackling it. The government states it has committed significant funds to make the strategy a reality.

The Play Strategy
Play England, 2008
The strategy focus is not just on the places where children play, including parks and green spaces, schools and children's centres, but it also considers how communities and neighbourhoods can become more child-friendly. The strategy sets out a vision for play, which sees:

- Supervised and unsupervised places for play areas in every residential area, free of charge.
- Local neighbourhoods that are safe, interesting places to play.
- Routes to children's play spaces that are safe and accessible for all.
- Parks and open spaces that are attractive, well maintained and well used.
- Children and young people have a clear stake in public space and their play is accepted by their neighbours.
- Children and young people play in a way that respects other people and property.
- Children and young people and their families take an active role in the development of local play spaces.
- Play spaces are attractive, welcoming, engaging and accessible for all local children.

Drug Strategy: Reducing Demand, Restricting Supply, Building Recovery, Supporting people to live a drug free life.
The Home Office, 2010
The government's strategy states that the UK has amongst the highest rates of cannabis use and binge drinking amongst younger people in Europe. There are approximately 13,000 hospital admissions linked to young people's drinking each year. Early drug and alcohol use is related to a range of educational, health and social problems. One third of adults receiving treatment for drug or alcohol issues have parental responsibilities for a child.
The government's policy states that drugs matter to the whole of society as the whole population is impacted upon; including crime in local neighbourhoods, families forced apart by dependency and the corrupting effect of international organised crime. The strategy suggests that drugs have a profound and negative effect on communities, families and individuals. This strategy is structured around 3 themes:

- Reducing demand
- Restricting supply
- Supporting individuals to recover

These three priorities will enable individuals and their families to live their lives to the full, local areas will be safer places to live and raise our families and public investment will deliver greater value for money. A fundamental difference between this strategy and preceding strategies is that instead of focusing primarily on reducing the harms caused by drug misuse, this strategy aims to offer every support for people to choose recovery as an achievable way out of dependency. The solutions should be holistic and centred around the individual, with the expectation that full recovery is possible and desirable.

The Government's Alcohol Strategy
HM Government, 2012
This strategy aims to provide radical change in the approach towards "irresponsible drinking". This strategy sets out how harmful drinking will be tackled using a range of approaches from every angle. These approaches include:

- More powers to stop serving alcohol to people who are already drunk.
- More powers for local areas to restrict opening and closing times.
- Control the density of licensed premises and charge a late night levy to support policing.
- More powers for hospitals not just to tackle the drunks turning up in A&E but also the problem clubs that send them there night after night.

This strategy prioritises the need to address cheap alcohol and aims to work with a broad range of partners which will require long-term and sustained action by local agencies, industry, communities and Government.

No health without mental health: A cross government mental health outcomes strategy for people of all ages
Department of Health, 2011
This cross government strategy states that the cost of mental health problems to the economy in England is approximately £105 billion and treatment costs are expected to double in the next 20 years. This policy aims to streamline mental health in England. At least one in four of us will experience a mental health problem at some point in our life and around half of people with lifetime mental health problems experience their first symptoms by the age of 14. The policy takes a life course approach and prioritises early intervention across all ages. A wide range of partner organisations have worked with the Department of Health to agree a set of shared objectives to improve mental health outcomes for individuals and the population as a whole:

- More people will have good mental health.
- More people with mental health problems will recover.
- More people with mental health problems will have good mental health.
- More people will have a positive experience of care and support.
- Fewer people will suffer avoidable harm and
- Fewer people will experience stigma and discrimination.

Closing the Gap: Priorities for essential change in mental health
Department of Health, 2014

Within this document the Department of Health state that a number of related and relevant documents address long term change at a population level and therefore this policy document aims to bridge the gap between the long-term ambition and short-term action. The Policy highlights five priorities for short term action:

- Increasing access to mental health services
- Integrating physical and mental health care
- Starting early to promote mental wellbeing and prevent mental health problems
- Improving the quality of life of people with mental health problems
- Mental health is everybody's business

Preventing suicide in England- A cross-government outcomes strategy to save lives
HM Government, 2012

The government states that suicide is a major issue for society and a leading cause of life lost. Within the suicide prevention strategy the government have identified two overall overarching objectives:

- A reduction in the suicide rate in the general population in England.
- Better support for those for those bereaved or affected by suicide.

The government have highlighted six key areas for action to support delivery of the two overarching objectives:

- Reduce the risk of suicide in key high-risk groups.
- Tailor approaches to improve mental health in specific groups.
- Reduce access to the means of suicide.
- Provide better information and support to those bereaved of affected by suicide.
- Support the media in delivering sensitive approaches to suicide and suicidal behaviour.
- Support research, data collection and monitoring.

A Framework for Sexual Health Improvement in England
Department of Health, 2013
The government ambition is to improve sexual health and wellbeing of the whole population. To enable this to become a reality the Department of Health states there must be a reduction in inequalities, an improvement in sexual health outcomes, the need to build an honest and open culture where everyone is able to make informed and responsible choices about relationships and sex and recognise that sexual ill health can affect all parts of society. The framework accepts that individual needs vary but there are certain core needs that are common to everyone. The Department of Health suggests that there is ample evidence that sexual health outcomes can be improved by:

- Accurate, high-quality and timely information that helps people to make informed decisions about relationships, sex and sexual health.

- Preventative interventions that build personal resilience and self-esteem and promote healthy choices.
- The framework also acknowledges there is a need for rapid access to confidential, open access, integrated sexual health services in a range of settings.

Healthy Lives, Healthy People: A Tobacco Control Plan for England
Department of Health, 2011
The Department of Health states that tobacco use remains one of the most significant public health challenges, with approximately 21% of adults in England still smoking. The policy highlights the fact that smoking is the primary cause of preventable morbidity and premature death. The policy acknowledges smoking rates are much higher in some social groups, including those with the lowest incomes, suffering the highest burden of smoking-relates illness and death. The policy focuses specifically on the action that the government will take nationally to drive down the prevalence of smoking and to support comprehensive tobacco control in local areas. The government has set three national ambitions to focus tobacco control work across the whole system:

- To reduce smoking prevalence among adults in England.
- To reduce smoking prevalence among young people in England.
- To reduce smoking during pregnancy in England.
-

Through this plan, the government supports comprehensive tobacco control in England across six internationally recognised strands:

- Stopping the promotion of tobacco.
- Making tobacco less affordable.
- Effective regulation of tobacco products.
- Helping tobacco users to quit.
- Reducing exposer to second-hand smoke.
- Effective communications for tobacco control.

Local policy

Leeds Joint Health and Wellbeing Strategy 2013-2015
Leeds City Council, 2013
Leeds City Council and NHS Leeds Clinical Commissioning Groups (North, South and East, West) have a new shared legal duty to prepare and publish a Joint Health and Wellbeing Strategy (JHWS) through the Health and Wellbeing Board. The Joint Health and Wellbeing Board is the result of commissioners coming together to provide the strategic direction and sets out how they will make the best use of the collective resources. The JHWS spans the NHS social care and public health across all ages and considers wider issues such as housing, education and employment. The aim is that it will support partners to achieve the vision that Leeds will be a health and caring City for all ages, where people are the poorest will improve their health the fastest. The plan sets out five outcomes supported by a number of priorities and indicators. The five outcomes are:

- People will live longer and healthier lives.
- People will live full, active and independent lives.
- People's quality of life will be improved by access to quality services.
- People will be involved in decisions made about them.
- People will live in healthy sustainable communities.

The overarching aim is that the strategy will deliver a reduction in the differences in the life expectancy between communities.

The Best Council Plan 2015-2020: Update 2015-16
Leeds City Council, 2015
The Best Council Plan explains that over the coming years, the projected growth and changes in the Leeds population continue to present a range of challenges. Inequalities persist: for example the life expectancy for a man living in a deprived Leeds neighbourhood is 12 years lower than a man living in an affluent part of Leeds. For 2015/16 LCC's net budget had been reduced by £44m, the majority of which is a reduction in core funding from the national government. Further reductions provide a challenge to LCC's capacity to maintain council services and will impact on the way the Council will work. Leeds City Council has five council values which will continue to underpin activity:

- Working as part of a team for Leeds City Council.
- Being open, honest and trusted.
- Working with communities.
- Treating people fairly.
- Spending money wisely.

The six objectives for 2015/16 are:

- Supporting communities and tackling poverty.
- Promoting sustainable and inclusive economic growth.
- Building a child friendly city.
- Delivering the better lives programme.
- Dealing effectively with the City's waste.
- Becoming a more efficient and enterprising council.

To accelerate pace the council has established a new way of working that will break through traditional boundaries and engage partners and communities differently, with a clear focus on outcomes. The council has moved to a more collaborative way of working, empowering people to influence decisions where they live. The council is becoming better connected with citizens of Leeds and tackling the challenges of poverty, deprivation and inequality through the community hubs, integrating essential services for those who need them most.

Core Strategy Leeds Local Development Framework
Leeds City Council, 2014
The Core Strategy sets out the overall vision and strategic level policies that guide the delivery of development and investment decisions, and the overall future for the

District. The Core Strategy seeks to provide an overall balance in managing the competing demands, challenges and opportunities facing the District.

Can't wait to be healthy- Leeds Childhood Obesity Prevention and Weight Management Strategy 2006-2016
Leeds City Council, 2006
The strategy describes key issues and actions needed at a local level over ten years to bring about a comprehensive, well-co-ordinated and sustained response, to the complex problem of childhood obesity among 0-19 year olds. The strategy hosts five key principles and values that the actions are based upon:

- The rights and needs of the whole child will be the main drivers to service development.
- Strong communication and partnership working will enable the development of the most appropriate services.
- The active participation of children, young people parents and carers will enable the development of the most appropriate services.
- Parents and carers have a role in determining the health outcomes.
- Prevention and early intervention will be prioritised.

A Strategy for sports and active lifestyles in Leeds 2013-2018
Sport Leeds and Leeds City Council, 2013
The Leeds Sport and Active Lifestyles Strategy 2013-2018 is a strategy for the whole city providing an overarching vision for the development of sport and active lifestyles over the next six years. The remit of the strategy covers more than just organised sport. The strategy covers active sport, active recreation and some forms of active travel. The Sport Leeds vision is for Leeds to be the most active big city in England. The strategy hosts three core outcomes:

- Improving health and wellbeing through more active lifestyles.
- Widening access to sport.
- Nurturing success in sport across the City.

Equally the strategy states it will contribute towards a number of wider population outcomes:

- Tackling health inequalities.
- A child friendly City.
- Raising the profile of Leeds nationally and internationally.
- Building cohesive and harmonious communities.

The Leeds Play Strategy Playing our part: Creating the play friendly city
Children Leeds and Leeds City Council, 2005
Children Leeds state that the purpose of the pay strategy is to help engage local services, organisations and communities in playing their part in improving opportunities for play in Leeds. A key aim of the strategy is to create common culture in the city where everyone recognises the importance of play in their work and for children, young people and their families. The strategy outlines a number of key actions:

- Promote play friendly neighbourhoods.
- Promote high quality places for freely chosen play.
- Develop small neighbourhood play spaces.
- Develop small neighbourhood youth zones.
- Develop community playgrounds.
- Make parks and open spaces child and play friendly.
- Develop community adventure playgrounds.
- Support the development of open access play schemes.
- Support schools in improving the range and quality of play opportunities in school.
- Improve access to quality outdoor play environments in school.
- Extend community use of school grounds.
- Support hospitals and other medical settings.

A Parks and Green Spaces Strategy for Leeds
Leeds City Council, 2009
The Parks and Green Space Strategy sets out the key priorities to 2020 in achieving a vision where quality, accessible parks and green spaces are at the heart of the community, designed to meet the needs of everyone who lives, works, visits or invests in Leeds, both now and in the future. The strategy is centred on six overriding aims and themes:

- Places for people: To engage the community in promoting parks and green spaces as accessible places for everyone to experience and enjoy.
- Quality places: To provide good quality parks and green spaces that are well managed and provides a range of attractive facilities.
- Sustaining the green realm: To plan for the development of new and to protect existing parks and green spaces that will offer lasting social, cultural and environmental benefits for the people of Leeds.
- Creating a healthier city: To promote parks and green spaces as places to improve health and well-being and prevent disease through physical activity, play, relaxation, and contemplation.
- An enabler for regeneration: To promote liveability and the economic benefits of quality parks and green space provision as an integral part of major regeneration projects.
- Delivering the strategy: To engage partners in supporting and delivering the Parks and Green Space Strategy.

Leeds Sustainable Education Travel Strategy 2008-2012
Leeds City Council, 2008
The overall aim of the Sustainable Education Travel Strategy for Leeds is to “Create a way in which children and young people travel to education and training establishments sustainably. More specifically, the strategy aims to increase the number of young people walking, cycling and using public transport to access schools and FE establishments; and to enable pupils, parents and carers to access sustainable travel information for schools and FE establishments.

Leeds Drug and Alcohol Strategy and Action Plan-2013-2016
Leeds City Council, 2013
This strategy aims to promote a responsible attitude to alcohol and enable individuals, families and communities affected by the use of drugs and alcohol to reach their potential and lead safer, healthier and happier lives. The strategy hosts four key outcomes:

- People choose not to misuse drugs and/or alcohol.
- More people recover from drug and alcohol misuse.
- Fewer children, young people and families are affected by drug and alcohol misuse.
- Fewer people experience crime and disorder related to the misuse of drugs and alcohol.

This strategy will harness the efforts of individuals, people in recovery, families, communities, treatment agencies, faith organisations, and public, private and third sector organisations.

Leeds Mental Health Framework
Leeds City Council, 2014
Leeds is a City that values people's mental wellbeing equally with their physical health. The City's ambition is for people to be confident that others will respond to their needs without prejudice or discrimination and with positive and hopeful approach to future recovery, wellbeing and ability. The framework sets out a common set of outcomes and priorities for mental health services aimed at improving the quality and integration of services. Although primarily focused on adults, the framework aims to take a life course approach as set out in the national mental health strategy. Equally it mirrors the six objectives set out in the national strategy. Improving the mental health of citizens is the responsibility of all- employers, council services, housing and health but the framework suggests currently the drive to address mental health concerns is not equally shared.

NHS Leeds West CCG Clinical Commissioning Strategy 2013/14 to 2015/16- refreshed April 2014.
NHS Leeds West CCG Clinical Commissioning Strategy 2014
NHS Leeds West Clinical Commissioning group (LWCCG) is an organisation established in April 2013 which serves a diverse population of approximately 350,000 people living in West Leeds. LWCCG has committed to uphold core values set out in the NHS. LWCCG has identified eight priority health goals:

- Promoting healthy living to tackle the wider determinants of health.
- Improving the sexual health of the population.
- Proactive management for people with long term conditions.
- Improving the mental health of the population.
- Improving outcomes for those diagnosed with cancer.
- Improving access to elective care services.
- Commissioning an effective response to urgent care needs.
- Improving end of life care.

NHS Leeds South and East Plan on a Page.
NHS Leeds South and East Clinical Commissioning Group, 2014
The five year strategic plan sets out how the NHS in Leeds along with Leeds City Council are working together to improve the health and wellbeing of local people. The vision for NHS Leeds South and East (LSECCG) is to be “a healthy and caring city for all ages, now and in the future, where people who are the poorest, improve their health the fastest”. Success for SECCG is when the people of Leeds:

- Live longer and healthier lives.
- Live full active and independent lives.
- Have a quality of life improved by access to quality services.
- Are involved in decisions made about them.
- Live in healthy and sustainable communities.

NHS Leeds North Clinical Commissioning Group Clear and Credible Plan 2013/14-2015/16
NHS Leeds North Clinical Commissioning Group, 2013
In the next three years Leeds North Clinical Commissioning Group (LNCCG) will reduce health inequalities and deliver improvements in health for local people with the available resources, this will be enabled through effective partnerships with communities, patients and partners. LNCCG has identified a number of health imperatives:

- Life Expectancy
- Mental Health
- Dementia
- Supporting more people to manage their own condition
- Long term conditions
- Urgent care
- Cancer
- End of life

Appendix b: people with protected characteristics in Leeds

Disability

The Equality Act 2010 defines disability as 'A person has a disability if s/he has a physical or mental impairment which has a substantial and long-term adverse effect on that person's ability to carry out normal day-to-day activities.' The social model has been developed by disabled people in response to the perceived negative impact the medical model has had on their lives. The medical model views disability as a 'problem' that belongs to the disabled individual. It is not seen as an issue to concern anyone other than the individual. Under the social model, disability is caused by the society in which we live and is not the 'fault' of an individual disabled person. The social model can be explained using a simple example, this is that of a wheelchair user who has a mobility impairment. S/he is not actually disabled in an environment where s/he can use public transport and gain full access to buildings and their facilities in the same way that someone without his/her impairment would do.

The Census in 2001 showed that 128,000 people in Leeds (18% of the total population) indicated that they had a long term illness, health problem or disability which limits their daily activities or work. Over one-third of all households in Leeds have one or more people with a limiting long-term illness.

Barriers include

Built environment

Buildings and premises might not be easy for everyone to use, visit or work in. You will need to think about the inside and outside of the building, including entrances and doors, getting around, furniture, toilets, lifts, car parks, paths and public areas. Things to consider might include is your building wheelchair accessible? Are there disabled toilets? Are there changing places toilets? Is there an induction loop? What is the signage like outside and inside the building? If your building or premises are not accessible and you are not able to make significant changes how will you offer alternative provision? Is the lighting in the office appropriate, it should not be too low.

Location of premises and services

Some places are easier to get to or more welcoming than others. It might be difficult for you to change your location, but if you are planning services from new or different buildings think about the location. Things to consider could be: is your venue easy to access using public transport? Are there any disabled parking bays? Are there any safety issues for disabled people as many disabled people have a fear of harassment and victimisation based on their impairment?

Information and communication

Our communications with the public and with colleagues should be as accessible to as many people as possible. Things to consider could be how you use Braille, large print, British Sign Language Interpreters and easy read documents? It would also be useful to consider how you market your services to disabled users. Do you monitor service users? Do you know the makeup of the community your services or policy is targeted at?

Customer care and staff training
The staff team is the most important part of a service and policy implementation: how they treat people can make the difference between a positive and negative experience of using a service or policy. Does any customer care training cover equality and diversity? Also consider are staff aware how to book BSL interpreters and order Braille versions of documents. Do staff understand your customers' access requirements? Do staff know how to report hate crime related to disability? Are staff aware of mental health issues and is this covered in any training they receive.

Timing
Timing can relate to the availability of a service, for example, the One Stop Centre opening times. An example of something to consider would be if there is an appointment system does this take into account extra time required when using BSL interpreters.

Costs
If people have to pay for your service, or if your service leads to particular benefits, is this fair for everyone? Are there any potential hidden costs? Would a disabled person have to cover the cost of a carer, support worker, advocate or transport? This may be an issue for disabled people who are in receipt of benefits as they could have lower than average incomes.

Stereotypes and assumptions
The way services have been designed or have developed over time might exclude some people. This might have happened because assumptions have been made about the way people live or the values that people have. Assumptions should not be made based on a person's impairment. People with the same impairment may have differing needs.

Consultation and involvement
When you consult and involve people who use services, or employees, make sure you involve disabled people with a variety of impairments. Think about different ways to consult and involve people and make sure this is accessible to everyone. Involving people who do not use services could give you some useful information as well.

Sexual orientation
The Equality Act 2010 defines Sexual Orientation within law as a person's sexual orientation towards:

- persons of the same sex (i.e. the person is a gay man or lesbian)
- persons of the opposite sex (i.e. the person is heterosexual)
- persons of either sex (i.e. the person is bisexual)

Lesbian, gay and bisexual describe different sexual orientations. Lesbian and gay men are attracted to members of their own sex, whilst bisexual people are attracted to members of both sexes. People who are attracted to the opposite sex are described as heterosexual.

General demographics
We have very little information about lesbian, gay and bisexual people in Leeds. Understanding this community's specific issues and needs presents Leeds with a

significant future challenge. Stonewall, the lesbian, gay and bisexual charity, estimates that large cities such as Leeds with an established gay scene, businesses and support network may be made up of at least 10 per cent lesbian, gay and bisexual people. Like other local authorities, Leeds continues to build its understanding of and adjust its approach to changing demographics in the city. Our challenge is to ensure that council services are able to adapt and respond to emerging needs.

Barriers include

Built environment
Is the building and surrounding area well lit? LGB customers and staff may have an increased awareness of their personal safety, due to the fear of victimisation and harassment due to their sexual orientation. Is there room for privacy or separate meeting rooms for customers wanting to discuss confidential issues?

Location of premises and services
How safe and welcoming is the area? Will everyone feel safe coming there? Homophobic hate crimes and incidents occur commonly in the everyday lives of LGB people. Many LGB people worry about being the victim of crime and feel at risk of being a victim of hate crime. Both the experience and fear of homophobic hate crimes and incidents have a dramatic impact on the quality of life of many LGB people.

Information and communication
Our communications with the public and with colleagues should be as accessible to as many people as possible. Things to consider could include making sure information is confidential. Also, if sending information specifically to the LGB community, think about what the title is - does LGB need to be in the title? You should be aware that family or colleagues who may see the correspondence may not know that the individual is LGB.

Staff care and training
The staff team is the most important part of a service and policy implementation: how they treat people can make the difference between a positive and negative experience of using a service or policy. Does any customer care training cover equality and diversity? Are staff aware of the use of appropriate language? Do staff know of or know how to contact LGB organisations? Do staff know how to record hate incidents?

Timing
Is your service available at different times of the day and days of the week?

Costs
Are there costs related to your service? If there is a means test, does it take into account the circumstances of same sex couples?

Stereotypes and assumptions
While many in the general population believe that they have no contact with lesbian, gay or bisexual people, it is easy for negative stereotypes to develop, particularly if

they are reinforced through the media. Common stereotypes portray all lesbians as being masculine and gay men as being effeminate. Lesbian, gay and bisexual people come from all walks of life, all ethnicities, all economic levels, all religions and all political perspectives. They may be disabled, can be young or old and may be married or parents. Are your services based around a particular type of family unit? Does this exclude, for example, same sex couples/parents?

Consultation and involvement
Gaining information from different communities can be useful when developing services or policies. There may be a perception of irrelevance - the idea that public services are not 'for' LGB people. You should have very specific aims and make them immediately relevant to LGB people. LGB people may be more comfortable in specific LGB settings (such as an LGB community centre, for example, or other meeting spaces that LGB groups might regularly use). LGB people might feel more apprehensive about attending a planning meeting in, for example, the community room of a church or other religious organisations because of a fear of discrimination. Using neutral venues such as council buildings even if you are not running an LGB-specific event is a good option. (This is also relevant to location).

Age

Age is defined within the Equality Act, by a reference to a person's age group. Where people fall into the same age group they share the same protected characteristic of age. An age group can mean people of the same age or people of a range of ages, and can include people of the same age, people of a range of ages, children, young people or older people.

Barriers include

Built environment
Is your building well lit? Will customers feel safe inside and outside your building? Do you provide seating areas while customers are waiting? Are there are any play areas for children and families whilst they wait for services?

Location of premises and services
Can your service be offered from different locations such as schools or youth centres where younger people could access them easily and might feel more comfortable? Can your service be easily accessed by public transport, as public transport is used most by 17-20 year olds? Do you provide adequate parking nearby which older customers might find useful? Information and communication: is your service only available to people over or under a certain age? Is there a genuine reason for this? It can sometimes be justifiable to adopt an age-specific approach to the delivery – provided this is a fair means of achieving a genuine aim.

Staff care and training
If dealing with young people there will need to be consideration given around data protection and also possibly the consent of parents/carers? Things to think about would be do you need consent from parents/carers before you provide a service? Are your staff aware of child protection/safe guarding policies and practices? Have your staff been on any age equality awareness training?

Timing
Is your service flexible? Could young people access it after school hours? Is your service available at different times of the day? Public transport often provides concessions at certain times in the day for older and younger customers. Is there an appointments system so people taking time away from school or work know how long they will be away for?

Cost
Does your service provide concessions or benefits based on age? Is there a genuine reason for this? Do you ensure everyone is aware of any concessions or benefits?

Stereotypes and assumptions
Assumptions should not be made based on the age of employees or customers. Not all people over a certain age will be retired and not all people under a certain age will be in full time education.

Consultation and involvement
Do you undertake specific consultation when designing or changing services with older or younger customers?

Carers

Carers are addressed within the law as someone who, without payment, provides help and support to a friend, neighbour or relative who could not manage otherwise because of frailty, illness or disability.

General demographics
The Census 2011 provided information on carers in Leeds. It indicated that there were 71,598 people in Leeds who identified themselves as providing unpaid care. Of these:

- 16,441 provide 50 hours or more of unpaid care per week
- 9,473 provide between 20 and 49 hours of unpaid care per week
- 45,684 provide up to 20 hours of unpaid care per week

Barriers include

Built environment
Buildings and premises might not be easy for everyone to use, visit or work in. Do you have or know where a customer can find a changing place toilet or disabled toilets?

Location of premises and services
Are your premises easily accessible through public transport? Are you able to provide your service at other locations on some occasions? How close are you located to other facilities or services such as shops and health centres? Being close to other facilities can help carers to make one journey for a number of reasons and therefore save time and reduce concerns about the person they care for.

Information and communication
Our communications with the public and with colleagues should be as accessible and timely, to as many people as possible. Providing enough information and providing it in good time is important, for example the cancellation of a day trip for services users may impact on carers who may have made alternative plans.

Customer care and staff training: does any staff and customer care training cover an understanding of 'carers'? Often any decisions made on services provided for people who are cared for, such as a reduction in services or re-location in service will impact on the lives and incomes of their carers.

Timing
Many carers have limited time in the day they can go places. These are usually after the person they are caring for has either gone to a day centre or is accessing a social care service or when they are able to get some help to look after the person they are caring for. Things to think about could be can your services only be accessed at certain times? Can you offer appointments rather than a drop in basis, so that carers are aware of how long they will be away from home?

Cost
If people have to pay for your service, or if your service leads to particular benefits, is this fair for everyone? Are there any potential hidden costs? Do your services offer discounts for carers? Many carers face additional expenses due to their caring responsibilities which can include extra costs for transport, heating etc.

Stereotypes and assumptions
Carers come from all walks of life and can face many barriers of their own. Although carers are entitled to some benefits only approximately 1% of the total UK population is receiving some financial help. Many carers provide unpaid care to their friends or relatives. Carers can be younger, older, men, women and from any background. Consultation and involvement: involving carers when planning service changes can be very useful however it may not always be practical, due to caring responsibilities for carers to attend meetings at certain times Think about alternative ways of including carers such as questionnaires, letters, email and phone calls.

Gender reassignment

Gender reassignment often referred to by the inclusive term 'trans people' is defined within the Act as people who are proposing to undergo, are undergoing or have undergone a process (or part of a process) to reassign their sex by changing physiological or other attributes of sex. Transvestite or cross-dressing people (people who wear clothing traditionally associated with the other gender either occasionally or more regularly).

General demographics

The Census 2011 showed the population of Leeds was 51% female and 49% male. At present, there is no official estimate of the trans population but studies indicate between 65,000 and 300,000 in the UK i.e. 0.1% and 0.5%.

Barriers include

Built environment
Buildings and premises might not be easy for everyone to use, visit or work in. Are baby changing facilities accessible to both men and women? Is there a room for privacy or separate meeting rooms, for example to use for breastfeeding or to discuss confidential issues for example domestic violence or health related issues? If there are changing areas, do they include private areas?

Location of premises and services
Some places are easier to get to or more welcoming than others. It might be difficult for you to change your location, but if you are planning services from new or different buildings think about the location. Are your services close to any other local facilities such as shops and health centres? Being close to other facilities can help people to make one journey for a number of reasons and help employees to feel welcome and safe within communities. Do you provide services or information from different buildings such as day centres or nurseries? Do you know the gender profile of customers who access these services, are there any gaps in your information?
Information and communication - our communications with the public and with colleagues should be as accessible and timely, to as many people as possible. Are your services aimed at all members of the public or to a specific gender? Is there a low take up from a particular gender? Have you analysed why this is? Is your information and communication clear about who the service or facility is for? Does your service require people to disclose personal information? Is there service provision where a trans person may disclose their trans status raises issues of confidentiality.
You can contact the equality team for guidance on how to record information on Trans status appropriately.

Customer care and training
The staff team is the most important part of a service and policy implementation: how they treat people can make the difference between a positive and negative experience of using a service or policy. Are staff able to deal with requests for female only space or a request for someone to be spoken to by a male or female member of staff? Do your services provide ‘men or women only’ sessions? If they do have you promoted the reason for these to ensure customers and staff are aware.

Timing
Is your service available at different times of the day and days of the week? Can people make appointments that would suit them? If people have to wait for a long time or in a queue may cause difficulties for people with children or pregnant women for example.

Stereotypes and assumptions
Are your services based around a particular type of family unit? Does this exclude for example families where the father is the main carer? Are your flexible working policies available for fathers?

Cost
Are there costs related to your service? Are there any extra costs or hidden costs to access your service such as parents having to pay for childcare?

Consultation and involvement
Gaining information from different communities can be useful when developing services or policies. Addressing any identified gender-specific barriers to employment, service and participation in decision-making processes, for example by developing and promoting policies to support work life balance or not scheduling meetings at unsociable hours will be useful.

Genuine Occupation requirement (GOR)
In very limited circumstances it will be lawful for an employer to treat people differently if it is a genuine occupational requirement that the job holder must be of a particular gender. When deciding if this applies, it is necessary to consider the nature of the work and the context in which it is carried out. Always seek advice and guidance from human resources in these circumstances.

Race

The Equality Act 2010 defines Race as 'a group of people defined by their race, colour, and nationality (including citizenship) ethnic or national origins. It aims to eliminate discrimination, advance equality of opportunity and foster good relations. It relates to a number of protected characteristics, of which race is one.

General demographics
Leeds is home to over 130 nationalities. The 2011 Census shows that 18.9% of the total population for Leeds comprised people from Black and Minority Ethnic (BME) communities (Including Irish and other white populations), a rise of 8.8% from the 2001 Census. Leeds Black and Minority Ethnic communities are largely concentrated in three wards; Gipton and Harehills, Chapel Allerton and Hyde Park and Woodhouse. However people from BME communities live in all areas of Leeds.
There will be significant changes in the size and profile of Black and Minority Ethnic communities in the coming years. By 2030 the BME population in Leeds is estimated to increase by 55 per cent.

Barriers include

Built environment
Buildings and premises might not be easy for everyone to use, visit or work in. Consider what the signage is like outside and inside the building, are they easy to read and understand, written in plain English and where required, in appropriate community languages? Is there room for privacy or separate meeting rooms which could be used as a prayer room, for example?

Location of premises and services
Some places are easier to get to or more welcoming than others. It might be difficult for you to change your location, but if you are planning services from new or different buildings think about the location. Things to consider could be, is your venue easy to

access through public transport. Who is your service targeted at? Are some communities served better or worse by the location, for example Gypsy and Traveller sites? What do you know about the local demographics of the area your services are targeted at? Do you know if local people are accessing your services, if they are not do you know why?

Information and communication
Our communications with the public and with colleagues should be as accessible to as many people as possible. Things to consider could be whether there is a need for publications to be available in alternative languages or easy read, or does the customer need a face to face interpreter. Is your website easy to use for people whose first language is not English?

Customer care and staff training
The staff team is the most important part of a service and policy implementation: how they treat people can make the difference between a positive and negative experience of using a service or policy. Does any customer care training cover equality and diversity? Does training for staff give them the skills and knowledge they need to provide services to a diverse population? Also consider whether staff are aware of how to book interpreters and order alternative versions of documents. Do staff know how to deal with and record incidents of racial harassment or other hate incidents? Do staff have an understanding of the local demographics? Do you have any information on BME perceptions of the service?

Timing
Timing can relate to either the availability of a service, for example, the One Stop Centre opening times. Things to consider would be if there is an appointment system does this take into account extra time required if using language interpreters? Do you know or have you asked what customers from different ethnic backgrounds would prefer?

Costs
If people have to pay for your service, or if your service leads to particular benefits, is this fair for everyone? Are there any potential hidden costs? For example will finding services that are culturally sensitive have more costs for the customer? Research shows that people from BME backgrounds are more likely to be unemployed or living in income poverty than the wider population.

Stereotypes and assumptions
The way services have been designed or have developed over time might exclude some people. This might have happened because assumptions have been made about the way people live or the values that people have. Assumptions should not be made based on the way someone dresses or speaks. Does your service cater for different family units? For example many, but not all BME people have extended families.

Consultation and involvement
When you consult and involve people who use services, or employees, make sure you involve different groups and communities. Do you need to do some outreach work rather than sending out written material, will you need interpreters to do this?

Can you use local community venues to share information about your service or policy?

Genuine Occupation requirement (GOR)
In very limited circumstances it will be lawful for an employer to treat people differently if it is a genuine occupational requirement that the job holder must be of a particular race. When deciding if this applies, it is necessary to consider the nature of the work and the context in which it is carried out. Always seek advice and guidance from human resources in these circumstances.

Religion
Religion or belief is defined within the law as any religion and any religious or philosophical belief, any lack of such religion or belief. We live in a multi-racial and multi-cultural society and faith and religion are increasingly recognised as being important on civil society and cultural renewal.

General demographics
The Census in 2011 monitored religion or belief. These data are shown in the table below

Religion	Community size (Number)	Percentage of Leeds Population %
Buddhist	2,772	0.4
Christian	419,790	55.9
Hindu	7,048	0.9
Jewish	6,847	0.9
Muslim	40,772	5.4
Sikh	8,914	1.2
Other	2,396	0.3
No religion	212,229	28.2
Religion not stated	50,717	6.7

Barriers include

Built environment
Buildings and premises might not be easy or practical for everyone to use, visit or work in. Is there, for example, a room for privacy in a separate room to use as a prayer room if required by staff or a visitor?

Location of premises and services

Some places are easier to get to or more welcoming than others. It might be difficult for you to change your location, but if you are planning services from new or different buildings think about the location. If you are using a religious building will your staff be comfortable using it? Would all members of the public feel comfortable using the religious building? Think about the potential impact on all parts of the community.

Information and communication

Our communications with the public and with colleagues should be as accessible to as many people as possible. If you are targeting particular communities, religious organisations have many community facilities where information about services could be displayed. This could help provide information to members of the community who are not current service users.

Staff care and training

How much do your staff know about different religions? Basic information such as dietary requirements should be asked when providing refreshments. Some religious or cultural traditions require particular dress for example, not cutting the hair, wearing head coverings such as the hijab, turbans and skull cap. The council has guidance on providing uniforms for staff that includes equality considerations. There may also be a requirement to wear long or modest clothing and/or the wearing of particular jewellery like the Sikh kara (bracelet). Sensitivity and flexibility should be shown and every effort made to accommodate the wearing of religious dress. If you are not sure if something causes a health and safety concern, always seek guidance.

Timing

Are your services available at different times of the day and days of the week? Are there any clashes with religious or cultural festivals, holidays or major events? Also staff should be aware dates for some religious festivals are approximate as they are based on lunar observation and may change from year to year. The Equality team provide a calendar of religious and other equality related dates.

Cost

Are there any hidden costs for you or the customer? For example if you are providing refreshments there may be an extra cost involved to ensure dietary requirements are met, who will be responsible for the cost? If you will be charging customers consider if it is fair to charge more for individuals who ask for specific requirements? Alternatively do you have enough in your budget to meet these needs?

Stereotypes and assumptions

It is important to remember that all faiths are practised by people from differing backgrounds and traditions and with varying degrees of adherence. For example, not all Muslims you meet offer their prayers five times a day, just like not all Sikhs wear turbans and not all Christians go to church on Sunday. Assumptions should not be made about a person's faith, simply from things such as names, colour, race or country or origin. Some people do not adopt a faith at all. Requests or representation from people with less known religious belief should be treated with the same sensitivity as those with more well-known or mainstream religions or beliefs.

Consultation and involvement

Gaining information from different communities can be useful when developing services or policies. When involving communities it would be useful to think about whether there are any clashes with religious or cultural festivals, holidays or major events? Some religions have a holy day in the week where spiritual/religious observance or particular duties are expected. It would be useful to consider trying to avoid these days or providing alternative ways such as email or phone or a number of days/events where people could be involved.

Genuine Occupation requirement (GOR)

In very limited circumstances it will be lawful for an employer to treat people differently if it is a genuine occupational requirement that the job holder must be of a particular religion or belief. When deciding if this applies, it is necessary to consider the nature of the work and the context in which it is carried out. Always seek advice and guidance from human resources in these circumstances.

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