Birmingham Lifestyle Services

Health Needs Assessment

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Chapter 1 Introduction

Addressing lifestyles services in Birmingham is an essential element of improving the public's health given that these services would individually and collectively have a significant impact on the health and well-being of our population. For the purposes of this document, "lifestyle services" were initially defined as smoking cessation, healthy eating/weight management, physical activity looking at the supportive function of health trainers and the NHS health checks programme.

If we look at smoking and tobacco consumption alone, we find that is the UK's greatest cause of preventable illness, disability, early death and health inequalities. More health gains would be achieved by stopping all smoking than from an increase to the NHS budget of 50%[i],

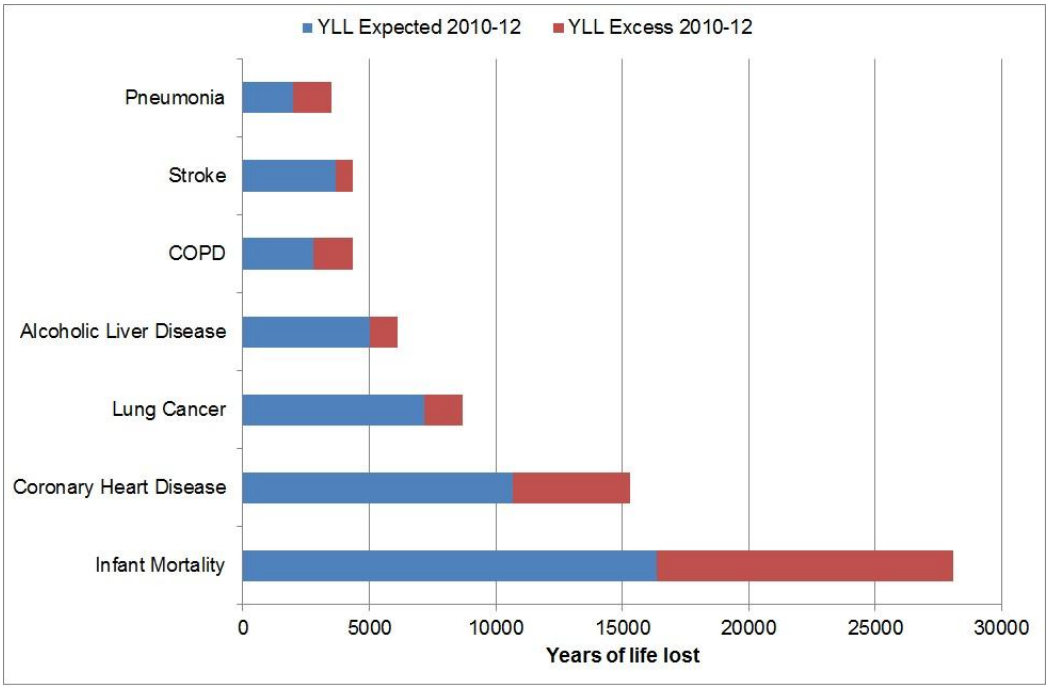
In terms of health eating, the Department of Health has estimated that if diets matched national nutritional guidelines, around 70,000 deaths in the UK could be prevented each year and that the health benefits would be as high as £20 billion each year [ii].

Lifestyle impact on Health

Positive lifestyle choices including physical activity, avoidance/cessation of smoking and healthy eating facilitate positive mental health, fitness for work, fitness for learning and social interaction both between individuals and between an individual and their community. In contrast, smoking, sedentary behaviour, unhealthy eating and associated obesity can facilitate low self esteem, sickness absence and a wide range of negative health outcomes including heart disease, cancer and stroke.

Years of life lost is defined as a measure of premature mortality. The major causes of excess years of life lost (YLL) in Birmingham are infant mortality, coronary heart disease (CHD), lung cancer, alcoholic liver disease, chronic obstructive pulmonary disease (COPD), stroke and pneumonia (see fig 1.1). All these conditions have links with lifestyle factors. Therefore we would infer that by addressing the lifestyle factors of the population this would have some effect on these conditions.

Figure 1.1 Excess life years lost in Birmingham (2010-2012)

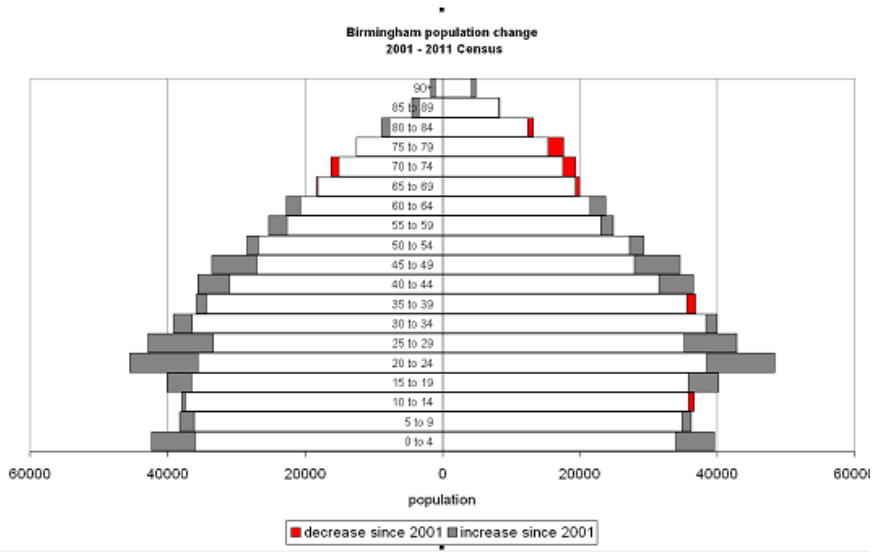


Chapter 2 Population profile

2.1 Demographics

The Census 2011 results estimated Birmingham to have a population of 1,073,045. This is an estimated increase of 95,958 people and a percentage increase of 9.8% compared to Census estimate of 2001. Birmingham has an estimate of 545,239 females and 527,806 males. Birmingham is growing at a faster rate than England & Wales (7%), West Midlands Region (6.3%) and the West Midlands Metropolitan area (7.1%).

Figure 2.1 Birmingham population change between 2001-2011



Households

Census 2011 reported a household estimate for Birmingham of 410,700. This is an increase of 19,900 (5.1%) compared to 2001. 32% of Birmingham households contained one person, compared to England 30.3% & West Midlands with 29.5%. 98% of Birmingham's population live in households & 2% live in Communal Establishments.

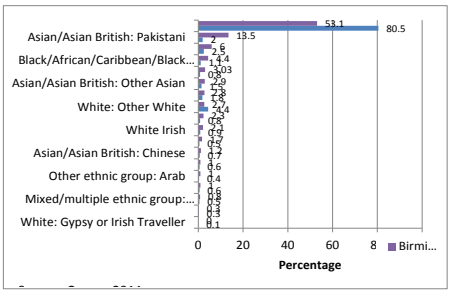
Population projections

By 2021 the population of Birmingham is projected to increase by 8% to 1.16 million. The biggest projected increase is in those aged 85+, which is expected to increase by 31% or 5,800. The number of children under 5 is projected to increase by 12.5% and people aged 20-24 by 6.5%.

2.2 Ethnicity

More than half of Birmingham population (53.1%) is made up of White: English/Welsh/Scottish/Northern Irish/British, 13.5% are Asian/Asian British: Pakistani, 6.0% are Asian/Asian British: Indian, 4.4% are Black/African/Caribbean/Black British: Caribbean.

Figure 2.2 Ethnicity distribution: Birmingham vs England & Wales (2011)



Source: Office for National Statistics

2.3 Deprivation

Birmingham has higher levels of deprivation compared to England & Wales, and the West Midlands Region. The dimensions of deprivation used to classify households 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).
- Housing (Household's accommodation is either 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.

Map 1. Deprivation across Birmingham

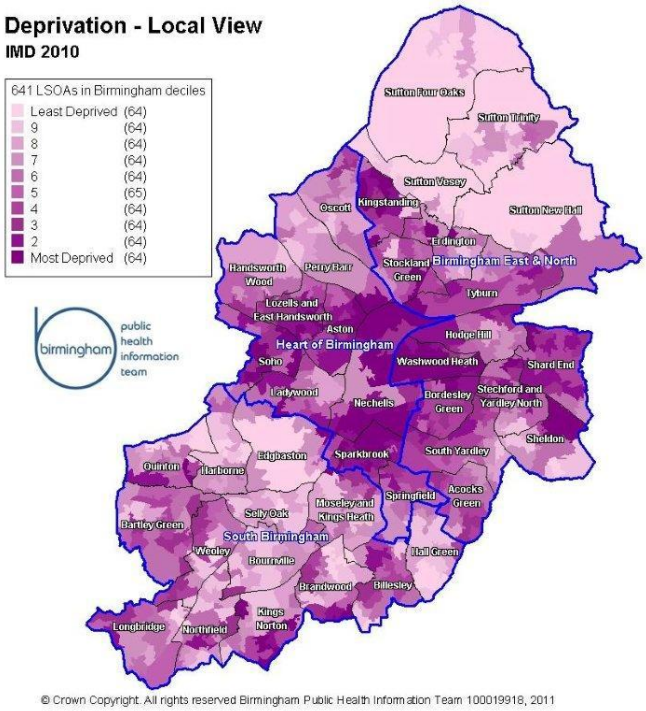
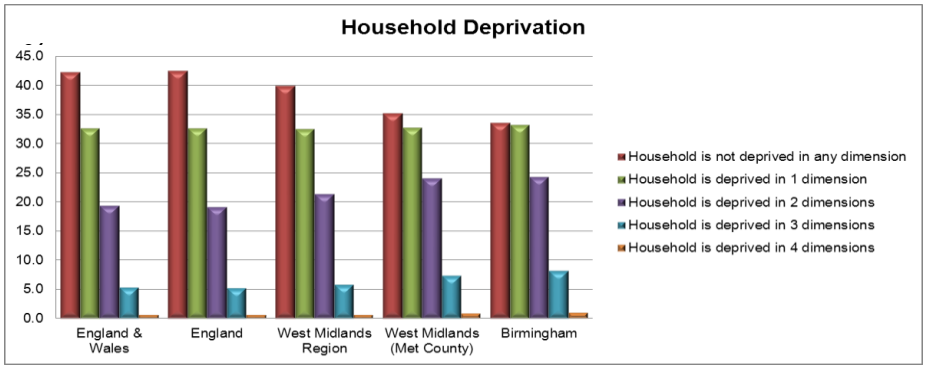


Figure 2.3 Levels of Deprivation in Birmingham



Source: Office for National Statistics

2.4 *Migration*

According to the 2011 Census the population of Birmingham was 1,073,045 which is a rise of 88445 (9%) residents in the past 10 years. Since 2001 the area has seen a significant change in the proportion of its residents who were born outside of the UK. This change has been driven by a number of factors, such as family migration, the dispersal of asylum seekers by the Home Office from 2000, refugee resettlement, economic migration and the enlargement of the European Union in 2004 and 2007.

Non UK-Born population

9.6% (103,682) of Birmingham's residents were born outside of the UK and arrived in the UK since 2001. This is the second highest proportion of non-UK born individuals arriving in the past 10 years, and significantly higher than the West Midlands average of 5.2% for this period.

The proportion of the non-UK born population in Birmingham who had arrived prior to 2001 was 12.5%, compared to 6 % for the West Midlands Region.

5.1% of Birmingham's population arrived from outside the UK in the past 5 years. This is significantly higher than the regional average for this period, which was 2.9%.

Long Term Migration

Long term migration estimates indicate that for the year 2011/12, 11,700 international migrants arrived in Birmingham whilst 7,000 individuals left. Net international migration for Birmingham on this ONS estimates has fluctuated between 4700 and 7000 in the period 2006 to 2012.

Migrants registering for health services

Migrant patients who have never previously registered with the NHS are given a marker for their first patient registration, known as a flag 4. Flag 4 registrations in the authority in 2012 was equivalent to 14.7 per every 1000 of the resident population.

This represents 15,944 new migrant patient registrations in 2011-12, a reduction of 1975 on the previous year. The Clinical Commissioning Group or Public Health department may be able to break this information down further info nationality, gender and age profiles by analysing GP patient registration data. Birmingham had the second highest level of new migrant GP registration per 1000 residents. The level of migrant new GP registrations is above than the average for the West Midlands Region of 8.3 per 1000 resident population in 2012.

Births to Non-UK born Mothers

Births have increased significantly in England over the past 10 years. The total number of Births in the Birmingham has increased from 14426 in 2001 to 17766 in 2012. Over 70% of the growth in number of births in the City during this period results from the increase in births to non-UK born mothers (2428).The number of births to non-UK born mothers increased from 30.5% in 2001 to 38.5% of all births for 2012, this is significantly higher than the regional average of 22.7% for 2012.

Chapter 3 Smoking

Introduction

Smoking is the leading cause of preventable death worldwide, and will cause approximately 10% of global deaths in 2015. Here in the UK, smoking remains the biggest single cause of preventable illness and premature death. It is responsible for over half the difference in life expectancy between the richest and poorest members of society.

Smoking increases the risks of stroke, heart disease, lung disease, asthma, chronic obstructive pulmonary disease (COPD) and a number of types of cancer. Smoking also harms non-smokers. Children exposed to smoke in the home have an increased risk of cot death, meningitis and increased frequency of lung infections and asthma attacks. Pregnant women who smoke also increase their risk of premature birth, having low birth weight babies and neonatal illness.

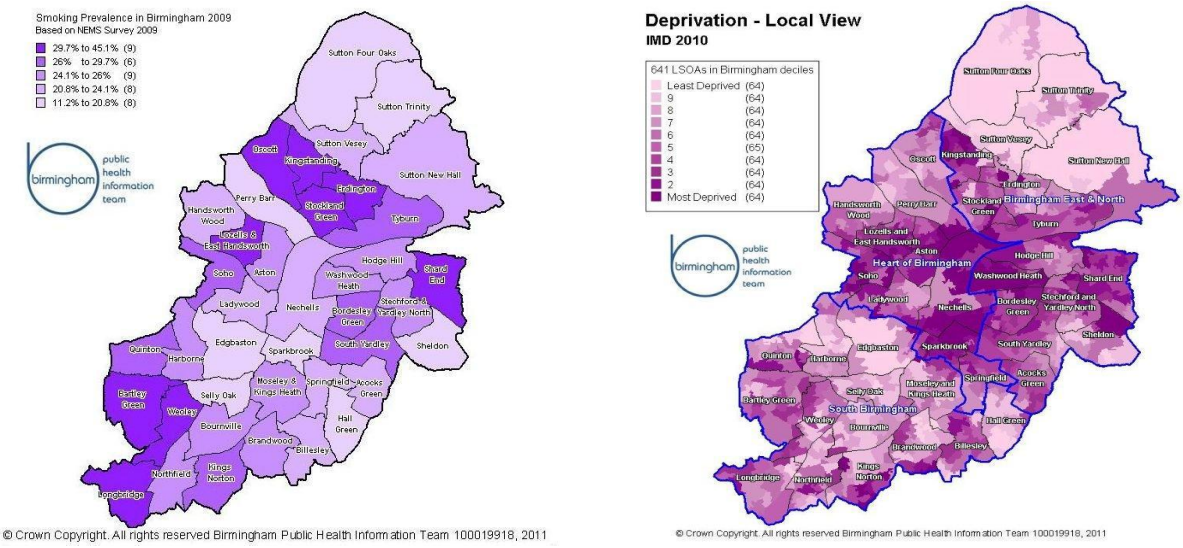
For smokers, quitting is often the single most effective method of improving health and preventing illness. There is a marked social gradient associated with smoking. Smoking is more prevalent in lower socio-economic and rates of decline in smoking are slower in these groups. Smokers who start smoking early in life are less likely to give up later in life and the greater the risk of developing lung cancer or heart disease.

Local Context

Across Birmingham there are approximately 190,000 adult smokers. Local survey data shows that smoking rates in Birmingham remain high at 25%, with those under 35 years of age accounting for a significant proportion (45%) of all smokers. Smoking is also a key driver of health inequalities and continues to be more prevalent in the most deprived areas (see Map 2).

In Birmingham an estimated 21% of those in the higher AB socio-economic groups are smokers in comparison with 30% in the lower DE groups. Reduction in the prevalence of smoking among routine and manual workers, some minority and ethnic groups and disadvantaged communities will help reduce health inequalities more than any other measure.

Map 2. Smoking prevalence in Birmingham with deprivation

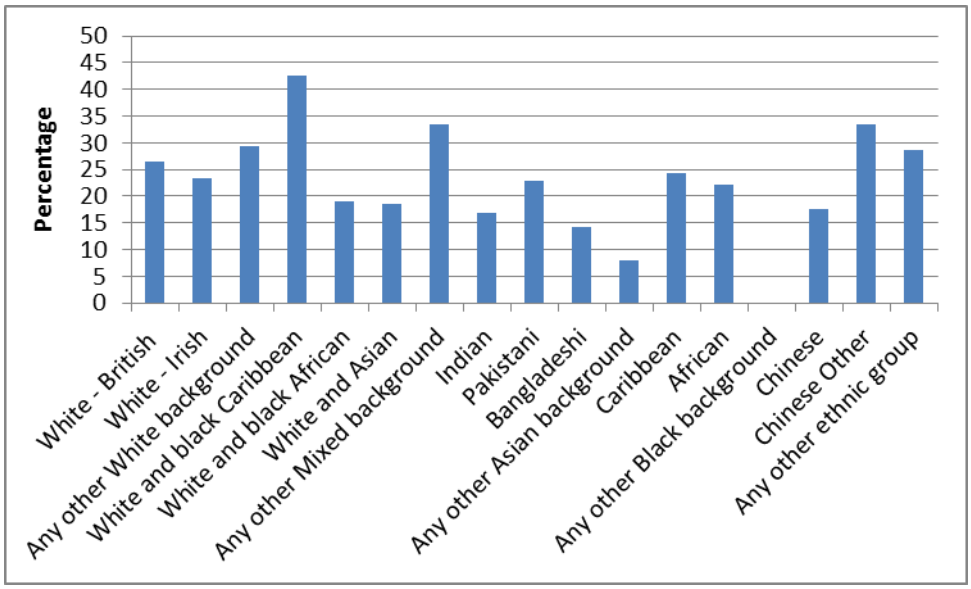


Ward level prevalence figures estimate that the highest rates of smoking are in Bordesley Green at 45.1%, Sutton New Hall at 35.6% and Bourneville at 33.3% (see Appendix A for full list).

Smoking prevalence by ethnicity

The figure below shows the ethnic differences in cigarette smoking, however these differences cannot be explained in the context of social class alone and does not take into account other forms of tobacco use such as chewing tobacco. There are also considerable age and sex variation in patterns of tobacco use within ethnic groups.

Figure 3.1 Proportion of people who smoke by ethnicity



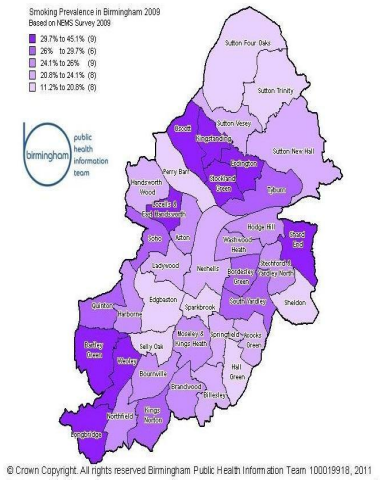
Coronary Heart Disease (CHD) and Chronic Obstructive Pulmonary Disease (COPD)

Smoking can contribute towards the development of many diseases, but is most commonly linked with coronary heart disease, stroke, lung cancer, asthma and chronic obstructive pulmonary disease. For those who smoke, quitting is often the single most effective thing they can do to improve health and prevent illness. The single largest risk factor for COPD is tobacco use; approximately 50% of COPD is thought to be directly caused by smoking.

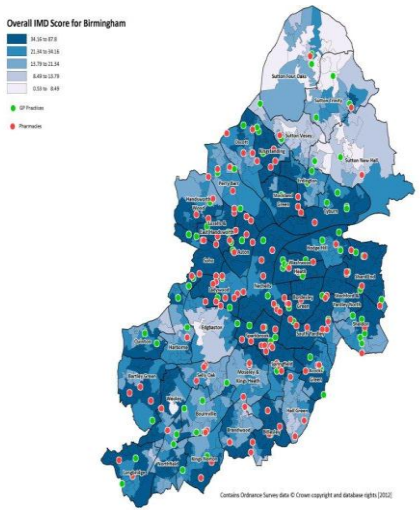
Map 3 highlights the links between smoking, CHD, COPD and deprivation across Birmingham. Stop Smoking services overlay the deprivation map.

Map 3. Smoking, CHD, COPD prevalence and Deprivation maps

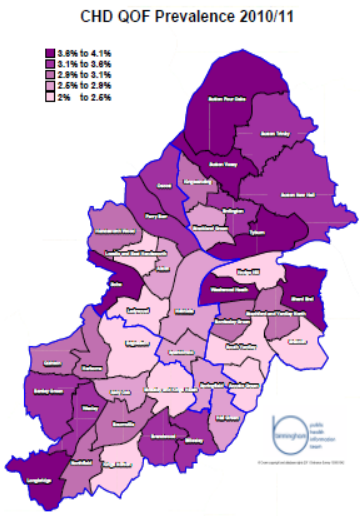
(a) Smoking prevalence



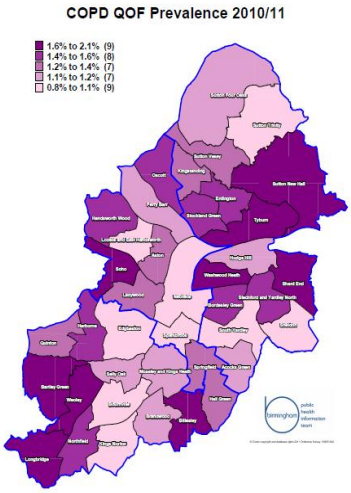
(b) Deprivation and smoking cessation services



(c) CHD prevalence



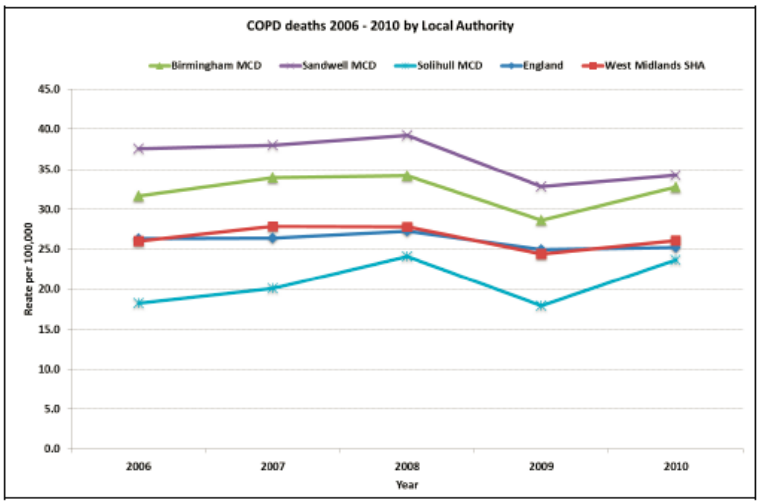
(c) COPD prevalence



Mortality due to COPD

The directly standardised death rate in Birmingham due to COPD was consistently higher than England and the West Midlands between 2006-2010.

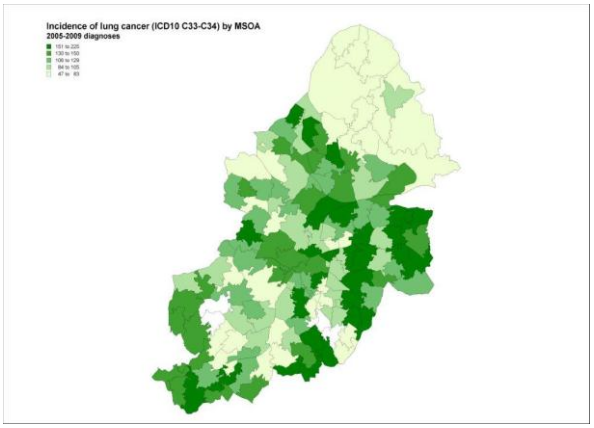
Figure 3.2 Directly standardised mortality rate for COPD



Lung cancer

From 2008-10, the overall lung cancer incidence for Birmingham was 55.9 per 100,000 and is markedly higher than the equivalent England figure of 47.7 per 100,000; which equates to more than 600 new cases each year.

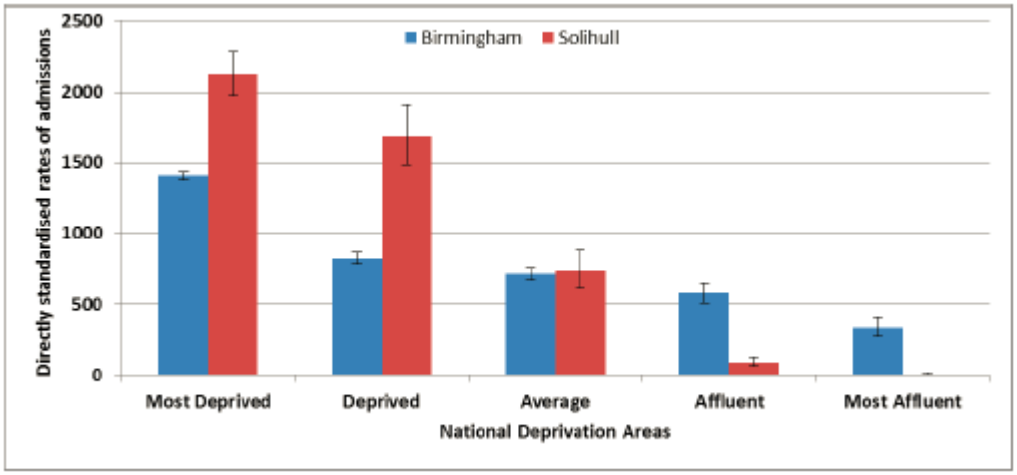
Map 4. Incidence of lung cancer across Birmingham.



Asthma

Admissions rates for asthma appear to be linked to the deprivation level of the area an individual resides. This trend is apparent in both Birmingham and Solihull, but is more pronounced in Solihull.

Figure 3.3 Standardised admission rates for asthma against deprivation quintiles (Apr09-Mar12)



Evidence base

NHS Smoking Cessation Services

These services, which support smokers to quit, use a combination of behavioural and pharmacological support, including Nicotine Replacement Therapy (NRT). Smokers who use these services are four times more likely to quit and ten times more likely to still be quit after a year than those who try to quit without support[iii].

Legislation

The coalition government has also carried out a public consultation on plain packaging as a possible measure to further reduce youth uptake and help smokers to quit[iv]. A systematic review of the evidence for this policy measure carried out by the University of Stirling concluded that the evidence was consistent in suggesting the introduction of plain packaging

would have a positive impact on reducing the harm caused by tobacco. This review is available at http://phrc.lshtm.ac.uk/project_2011-2016_006.html

Benefits of the current smoke-free legislation include:

- A reduction in emergency admissions for myocardial infarction (heart attack) in England in the first year following the introduction of smoke-free legislation in 2007[v]. This has resulted in estimated financial savings of £8.4 million saved in emergency hospital care for heart attacks[vi]. This figure does not include savings from the long-term effects of reduced second-hand smoke exposure.

- A reduction in exposure to second-hand smoke among children with an increase in the number of smoke-free homes. Banning smoking in public places has not resulted in smoking being displaced to homes and legislation appears to have encouraged parents who smoke to make their home smoke-free[vii].

Youth Prevention

Youth prevention is essential to reducing long-term smoking rates but there is limited evidence about what works. A randomised cluster trial of the peer support programme ASSIST (A Stop Smoking in Schools Trial) demonstrated a reduction in uptake among at risk groups two years post-intervention. This programme is recommended by NICE in its Public Health guidance 'School-based interventions to prevent smoking (PH23)'.

Strategies and Guidance

NICE Guidance

Brief Interventions and referral for smoking cessation (PH1) available at: http://publications.nice.org.uk/brief-interventions-and-referral-for-smoking-cessation-ph1

Workplace interventions to promote smoking cessation (PH5) available at: http://publications.nice.org.uk/workplace-interventions-to-promote-smoking-cessation-ph5

Smoking cessation services (PH 10) available at: http://publications.nice.org.uk/smoking-cessation-services-ph10

Preventing the uptake of smoking by children and young people (PH14) available at: http://publications.nice.org.uk/preventing-the-uptake-of-smoking-by-children-and-young-people-ph14

School-based interventions to prevent smoking (PH23) available at: http://www.nice.org.uk/guidance/index.jsp?action=bypublichealth&PUBLICHEALTH=Smoking+and+tobacco#/search/?reload

Quitting smoking in pregnancy and following childbirth (PH39) available at: http://publications.nice.org.uk/quitting-smoking-in-pregnancy-and-following-childbirth-ph26

Department of Health:

Healthy lives, healthy people: a tobacco control plan for England available at: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_124917

Local Stop Smoking Services: Key updates to the 2011/2012 service delivery and monitoring guidance for 2012/13 available at:

https://www.wp.dh.gov.uk/publications/files/2012/09/9193-TSO-2900254-NHS-Stop-Smoking_Accessible.pdf

Service Provision

Birmingham Public Health commissions a wide range of services through Birmingham Community Healthcare. The service is performance managed against a number of targets. Currently, these targets, including percentage of 4 week quits (actual 50%), percentage of smoking in pregnancy 4 week quits (actual 42%), proportion of 4 week quits from IMD quintiles 1 and 2 (actual 53%) and percentage of those setting a quit date who are long term unemployed (actual 21%) are being met. Although it should be noted that this data represents Quarter 1 only. In relation to the overall target of No of quits, this currently stands at 8119, although likely to be revised to 9376 in the following year. Again progress towards this target is currently being met.

Full year data covering the period 2012 to 2013 indicates the following:

- There were a total of 8,709 4 week quits. 53% of these were achieved by males.
- In relation to ethnicity, 75% of four week quits were achieved by White or White British individuals. Asian or Asian British equalled 13%, with Black or Black British equalling 4%.
- 75 pregnant women successfully quit at 4 weeks.
- In relation to deprivation indicated through occupation, 18% had never worked or had been unemployed for over 1 year, 16% were unable to work, 26% were routine and manual workers and 3% were prisoners.

Service Gaps/unmet need

Current service provision targets deprived communities across Birmingham with pathways into workplaces, schools and healthcare settings. However, there are a number of unmet needs which will impact upon the provision of an integrated lifestyles model which aims to predominantly meet the needs of those from priority groups:

Currently smoking is performance managed on a 4 week quit target. However, the evidence base indicates that 75% of those who quit at this stage will relapse within 6 months. As such, the service, instead of supporting long term maintenance, in effect facilitates a revolving door client with associated costs to BCC. As such, a focus on both 12 and 52 week quits with

associated performance management would generate an increased no of long term quits and as such generate the health benefits in reduced CHD and lung cancer that are desired.

The current service provides a universal offer to every client. Therefore although the service is targeted at specific groups, the content is not and as such, level of one to one contact in addition to pharmacological support is provided at the same level regardless of such factors as level of risk (both in terms of whether multiple lifestyle risk factors exist and whether the client is deprived etc). A change in this model would allow an increase in focus upon deprived communities and an increase in those who were unemployed/unable to work, from routine and manual employment and those who were homeless, where longer term support is likely to facilitate a sustained quit.

The current service does not respond to the fact that more than 60% of clients who attend a single lifestyle service, have more than a single lifestyle risk. As such opportunity to engage clients in relation to their multiple risk behaviours is missed. This is of particular relevance in light of the evidence which shows the interrelated nature of these risks, whether this be the perceived benefits of smoking in maintaining weight/weight loss or the strong cultural relationship between smoking and alcohol consumption.

Although the current service is targeted predominantly around deprivation, it does not have a specific remit regarding priority groups as identified within the Birmingham Health and Well Being Strategy. As such pathways and resources are not currently established to respond to the multiple needs (mental, physical and social) experienced by such groups as the homeless. Without a focus on both the social and health inequalities that are faced by such individuals, it is unlikely that the service will be successful in responding to their lifestyle needs. These groups are subject to the highest level of risk in relation to both prevalence and outcome but correspondingly have the highest level of gain to be made from contact with a service. In addition, services currently perform poorly regarding overall uptake by BME groups, which does not reflect the diversity in the city and potentially suggests that the services are not adapting to cultural differences in tobacco use, although this would need to be investigated further.

Individuals with the most to gain from lifestyle services are those who are less likely to engage with healthcare in general including registering with a GP. In contrast, they are more likely to engage with services relating to housing, employment and debt management (reflected in Local Authority services and databases). The pathways of current smoking cessation services predominantly focus on the former and as such, engage with individuals who already take positive steps in relation to their healthcare. Pathways into the latter services are weaker and as such SSS do not maximise the opportunity to engage with those who have the greatest potential gain.

Chapter 4 Health eating/Weight management

Introduction

Diet is inextricably linked to our health. Prevention and treatment of many diseases are linked to both the quantity and nutritional quality of the food we eat. A healthy diet begins at birth with good maternal nutrition and should continue throughout life.

As the pace of life gets faster and the availability of processed foods increases, our food patterns have changed for the worse; with fewer sit down meals, and more snacking, often on high calorie, high fat foods. Supporting a change in this food culture is a challenge and requires a national approach. Poor diet plays a role in coronary heart disease and cancer, as well as chronic conditions such as diabetes and osteoporosis. It is estimated that eating at least five portions of a variety of fruit and vegetables a day could lead to a reduction of up to 20% in overall deaths from chronic disease such as heart disease, stroke and cancer[viii]; and even an increase of one portion of fruit or vegetables a day lowers the risk of coronary heart disease by 4% and the risk of stroke by 6% and can help lower blood pressure.

The Scientific Advisory Committee on Nutrition has established dietary recommendations[ix] and highlighted the following concerns across the population:

- Fruit and vegetable intake below the five-a-day recommendation in all groups
- Oily fish consumption below the recommended one portion a week in all groups.
- High average salt consumption
- High consumption of soft drinks (particular in children and young people)
- High consumption of saturated fats (but around the recommended intake of total fat) in all groups.

- High intake of sugars in most groups (particular children and young people and elderly people living in institutions).
- A substantial proportion of adults exceeded the sensible drinking recommendations making a significant contribution to energy intake.
- Low fibre intakes in all groups.
- Low intakes of vitamins and minerals, including vitamin A, riboflavin, iron, potassium and magnesium in those under 25 years.
- Low intakes of some vitamins and minerals in older adults aged over 65 years.
- Evidence of low Vitamin D status in most population age groups

There is a need to focus on improving the diet of the whole population, but with a specific focus on specific groups at the most risk, namely:

- Children and young people aged 18 years and under, as they are going through a period of sustained growth and development
- Young adults aged 19-24 years who are often cooking for themselves for the first time
- Smokers, who tend to have a poor diet but increased requirement for some nutrients
- Adults aged 65 years and over living in institutions, who tend to have poorer appetite but increased requirement for nutrient-dense foods
- People in lower socio-economic groups

On average, low income households and those in the most deprived wards consume less fruit and vegetables, salads, wholemeal bread, wholegrain and high fibre cereals and oily fish and consume more white bread, full-fat milk, table sugar and processed meat products.

Both under and over-nutrition cause health problems, shown by the increasing rates of obesity in society alongside nutritionally inadequate diets that result in diet-related deficiencies and malnutrition in vulnerable infants, children and adults, such as rickets. Obesity has been identified as one of the most important preventable challenges to health, second only to smoking. The impact on health, its prevalence and its resistance to change are issues that make obesity an important public health problem. It is one however that can be reversed by developing a healthier environment where it is easier to make healthier choices and for people to manage their weight, control their diet and take part in physical activity.

Local context

Compared to England, the Birmingham population eats less healthily. Estimates suggest that 24.6% of our population eat healthily (at least 5 portions of fruit and veg per day) compared to 28.7% across England.

A person's inability to manage their weight can result in them becoming overweight or obese. Obesity has far reaching impacts both within the family, across the NHS and social care and in society as a whole. Treatments costs of diseases related to obesity are significant. Compared to England, there are a higher proportion of obese adults and children in Birmingham.

Adult Obesity

Adult (16 years and above) obesity for 2012/13 was estimated at 9.2% for Birmingham compared to 10.7% for England. But this data is an underestimation as it only takes into account GP registered patients on the registers as opposed to the total number of residents in the city.

Map 5. Adult obesity prevalence and Deprivation maps

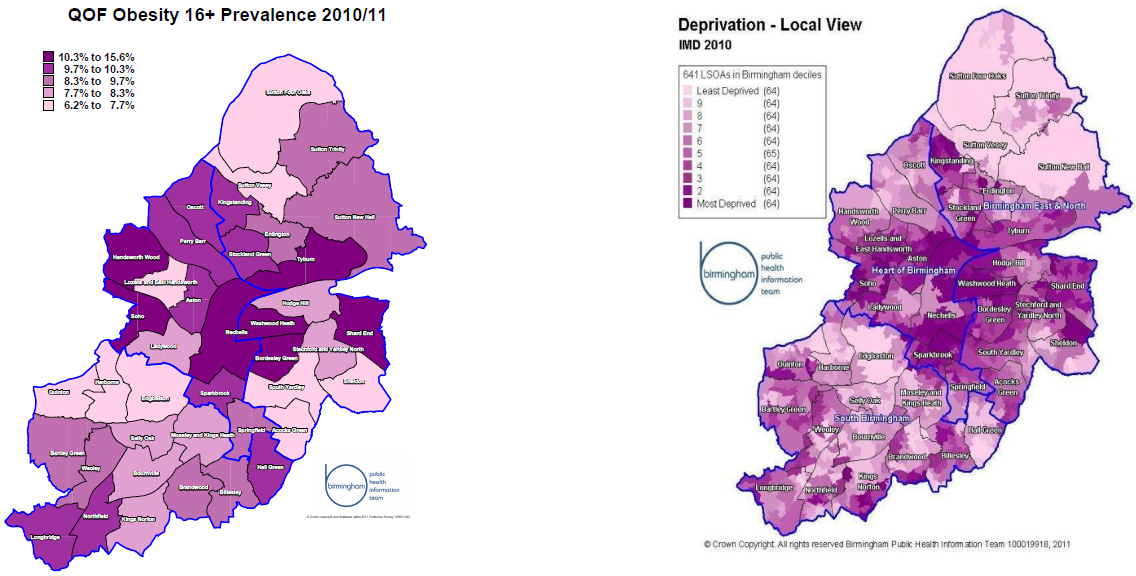
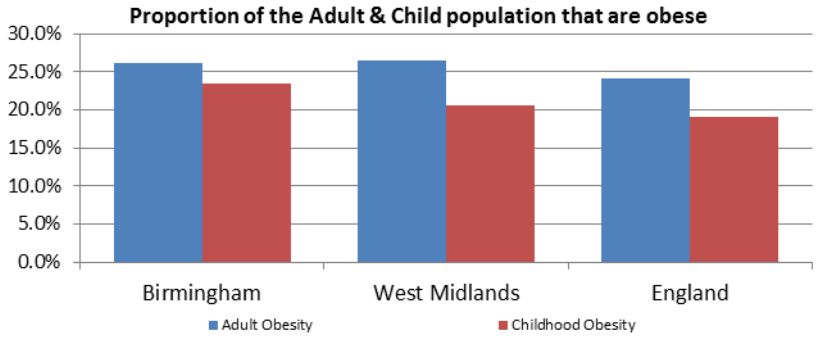


Figure 4.1 Obesity levels in Adult and Child population (2006-08 & 2010/11)



Source: Department of Health: Year: 2006-8 (adults) 2010/11 (children)

Childhood Obesity

An unacceptable number of children are classified as obese in Birmingham. The governments National Child Measurement Programme (NCMP) in 2012/13 shows the proportion of obese children in Birmingham are significantly more than England as a whole. A combined estimate of 35.5% of Year 6 children are overweight or obese.

Figure 4.2 Proportion of obese children in Birmingham and England (2012/13)

	Year 0	Year 6
Birmingham	11.3%	23.4%
England	9.3%	18.9%

The World Health Organization (WHO) regards childhood obesity as one of the most serious global public health challenges for the 21st century. Obese children and adolescents are at an increased risk of developing various health problems, and are also more likely to become obese adults.

The National Child Measurement Programme (NCMP) measures the height and weight of around one million school children in England every year, providing a detailed picture of the prevalence of childhood obesity. The latest figures, for Birmingham 2011/12, show that 24.4% of children in Year 6 (aged 10-11) were obese and a further 15.6% were overweight. Of children in Reception (aged 4-5), 12% were obese and another 12.3% were overweight. This means over a third of 10-11 year olds and nearly a quarter of 4-5 year olds were overweight or obese.

Data are also available from the Health Survey for England (HSE), which includes a smaller sample of children than the NCMP but covers a wider age range. Results from 2010 show that around 30% of children aged 2 to 15 were classed as either overweight or obese". National Obesity Observatory accessed online 20/1/13.

Diabetes

As mentioned previously, poor diet plays a role in coronary heart disease and cancer, as well as chronic conditions such as diabetes and osteoporosis. It is estimated that in 2012 8.5% of people aged 16 years and older had diabetes in Birmingham. The Diabetes Prevalence Model estimates that if current trends in population change and obesity persist the total prevalence of

diabetes is expected to rise to 9.6% by 2020 and 11% by 2030. 2014 figures for both type I and type II diabetes give an estimated prevalence of 8.8% of adults (over 16 years) in Birmingham compared to 7.5% across England.

Current Service Provision

BCHC Dietetic Weight Management Service (WMS) was commissioned to provide Dietitian-led weight management services to adults and children referred by their GP, Health Visitor or self-referral and who meet the referral criteria.

The WMS provides support to eligible individual adults to make changes resulting in clinically significant weight loss for adults; and to individual eligible children (and their families) to make changes to their diet in-line with their diagnosis, whilst ensuring they have optimal nutrition to support expected growth and development.

Both adult and children's services provide clinics at a variety of venues across the city with variable opening times. They operate an opt-in service for patients. All patients have an individual clinical assessment and care plan with patient-specific goals. A variety of resources and skills are available within these clinics.

All adults with a BMI greater than 30kgm-2 (27 kgm-2 for South Asian patients) where their primary medical condition is obesity will be eligible to access the adult service regardless of their age, culture or disability.

All adults with a BMI greater than 28 kgm-2 (25 kgm-2 for South Asian patients) with co-morbidities where their primary medical condition is obesity will be eligible to access the adult service regardless of their age, culture or disability. The likely co-morbidities of this group include:

- Diabetes
- Polycystic Ovary Syndrome with insulin resistance
- Gastroenterology conditions, e.g. Irritable Bowel Syndrome

- Mental health

Children with a BMI over 98th centile, who are aged between 0-5 years, or have a learning or physical disability which prevents them from joining the Children's Weight management programme.

The adult WMS is meeting the required performance target for the percentage of patients achieving 5% weight loss at 12 months and close to meeting the target for the percentage of patients achieving 15% weight loss at 18 months, as shown in Table 1. Graph 1 shows the mean average percentage weight loss of patients at each time point.

In terms of contacts, 458 (expected 630 end of year) new patient contacts and 990 (expected 1370 end of year) follow up contacts had been made in approx. the first 3 quarters of the year.

The paediatric WMS is meeting the required performance targets for mean changes in BMI z-scores, as shown in the following Table:

Mean changes in BMI z-scores

	Mean reduction in BMI z-score	**Contract Target**
Under 5s with Obesity	-0.27	-0.20
SEN Patients	-0.075	0

The service is currently not meeting targets around contact activity with only 274 contacts made in the first 2 quarters. The target for a full year is 652. At current levels, the service will reach 84% of its target.

The Lighten Up WMS provides a Call Centre and Patient Management System providing access to weight management programmes for the resident and registered population of NHS South Birmingham designed to cover the aspects of care given to patients aged over 16, who have not accessed a weight management service within the last three months and with a BMI:

- 28-39.9 with co morbidities (Diabetes, High blood pressure, CVD).
- 30-39.9 with NO co morbidities.
- 23.5 for Asian patients with co morbidities.
- 25 for Asian patients with NO co morbidities.
- 40 and have not previously accessed a weight management service.

And for pregnant women resident in or registered with a GP in Birmingham.

- pregnant women with a BMI of ≤ 18.5 or ≥ 30

In addition, the service negotiates and contracts with commercial and other weight management programme providers to deliver the weight management programmes. Agreed providers include:

Weight Watchers

Rosemary Conley

Slimming World

Any others to be agreed with commissioners

Birmingham Community Healthcare NHS Trust

Birmingham Maternal Health Trainers

There is currently no performance data relating to this service. A contract review to amend this situation is currently underway.

Child Weight Management Services

Performance Indicator	Threshold	Progress
Average reduction in BMI z-score at 12 weeks of the children's healthy weight programme	**Minimum of 0.2**	**First Steps (6 weeks) = -0.11** **Next Steps (12 weeks) = - 0.05** **Term average = - 0.1**

Measure	Target	Progress
Number of referrals to children's weight management programmes from GPs	**Increase in referrals of 15-20% above the same period last year** ***For comparison, Aug - Dec 2012*** ***First Steps = 26*** ***Next Steps = 34*** ***Total = 60***	**Target not met, increase of 6.6% achieved** **First Steps = 24** **Next Steps = 34** **Unallocated = 6** **Total = 64***

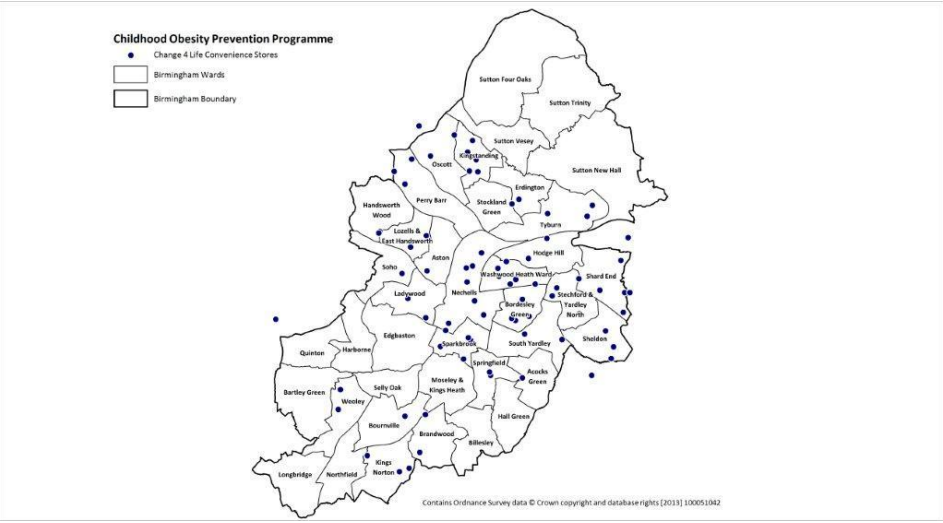
		*** 6 children were referred in this period but are not yet allocated to a programme**
Number of referrals to children's weight management programmes from self referral	**Increase in referrals of 5-10% above same period last year** ***For comparison, Aug- Dec 2012*** ***First Steps = 29*** ***Next Steps = 20*** ***Total = 49***	**Target not met, decrease of 20%** **First Steps = 26** **Next Steps = 11** **Unallocated = 2** **Total = 39*** *** 2 children were referred in this period but are not yet allocated to a programme**
Total number of referrals to the CWM Service	***For comparison*** ***August - December 2012*** ***Professional = 201***	**August - December 2013** **Professional = 310**

	Self = 49 ***Total = 250***	**Self = 39** **Total = 349** **Increase of 40% achieved**
Measure	**Target**	**Progress**
Number of families attending and completing the under 11's programme	**410 families attending and 307 families completing per annum** ***Breaks down to 136 families attending per term and 102 completing per term*** ***Previous term April - July 2013*** ***Number of families attending = 136*** ***Number of families completing = 62***	**Number of families attending this term = 87 (target not met)** **Number of families completing this term = 45 (target not met)**
Number of families attending the over 11's programme	**90 families attending and 68 families completing per annum** ***Breaks down to 30 families attending per term and 22 families completing per term***	**Number of families attending this term = 60 (Target exceeded)**

	Previous term April - July 2013 ***Number of families attending = 31*** ***Number of families completing = 12***	**Number of families completing this term = 11 (Target not met)**
Number of children attending 3, 6 and 12 month follow ups for both programmes	**188 families at 3 month, 131 families at 6 months and 113 families at 12 months per annum** ***Breaks down to 62 families at 3 months, 43 families at 6 months and 37 families at 12 months per term***	**First Steps** **3 months = 10** **6 months = 12** **12 months = 5** **Next Steps** **3 months = N/A** **6 months = 0** **12 months = 4** **Totals for both programmes** **3 months = 10** **6 months = 12** **12 months = 9** **(Target not met)**
Number of children maintaining or reducing their	**281 children per annum**	

BMI at 12 weeks	***Breaks down to 93 children per term*** ***For comparison April - July 2013*** ***First Steps= 51*** ***Next Steps = 12*** ***Total = 63*** **85% of completers (74) reduced or maintained their BMI**	**First Steps = 42** **Next Steps = 7** **Total = 49 (Target not met)** **However, 88% of completers (56) reduced or maintained their BMI**

Map 6. Childhood obesity services



Foodnet provides an assessment process for businesses relating to food to ensure they are meeting required standards. In relation to current target (current reporting period) of 175 businesses assesses, only 132 (75%) have been reached. Within this there is a target for 37% to

have been new assessments. Currently 125 of 132 are new which equates to 95% and therefore overachievement of this target.

Early Years Nutrition – Startwell, nutrition training and Kids on Track:

Measure	**Target**	**Progress**
Total number of early years settings completing each phase of the Startwell nutrition programme	18 settings per annum completing phase 1 14 settings per annum completing phase 2 8 settings per annum completing phase 3	18 settings engaged in phase 1 14 settings engaged in phase 2 8 settings engaged in phase 3
Startwell: These are annual targets, however the service undertook a in year redesign, that combined with the physical activity element of Startwell to provide a citywide service. This new offer has been operational since October and initial reports are due in March. Needs assessment and service analysis will be update following this.		
Number of Kids on Track settings supported or quality assured	16 settings per annum	5 settings have been observed Kids on Track training being delivered on the 11th February
Number of staff attending nutrition	300 staff per annum	444 staff attended training during this period.

training sessions		On average participants attending basic training increased their knowledge by 18% 72 % of participants attending basic training reported increasing their confidence in communicating messages as a result of the training by an average of 34%. 87% of participants attending activities training reported increasing their confidence in delivering nutrition workshops as a result of the training by an average of 32%.

Cooking courses (cooking with your kids and cook and taste):

Measure	**Target**	**Progress**
Number of cooking courses delivered	144 courses per annum	92 cooking courses delivered
Number of families attending and completing the	1026 families attending and 814 families completing	594 families attended cooking courses this term 530 families completed cooking

cooking courses	per annum	courses this term

Performance Indicator	***Threshold***	***Progress***
Reported behaviour change relating to fruit and vegetables, cooking skills and soft drinks and takeaways as applicable	Increase of 1 portion of fruit and vegetables and increase in confidence to cook of 1 (C&T only), reduction in takeaways and fizzy drinks.	• Average increase in fruit and vegetable consumption per person = 1.5 portions. • Average increase in confidence to cook (C&T only) = 1.7 points (on a 6 point scale) • Average decrease in takeaway consumption from 1 a week to 2-3 a month • Average decrease in family consumption of fizzy drinks per week = -1862 ml

Change 4 Life convenience Stores:

Measure	**Target**	**Progress**
Number of convenience stores engaged	77 stores maintained per annum	77 stores identified to be maintained. All stores have been visited at least twice..

Wellmoms:

Measure	Target	Progress
Number of children's centre clusters delivering a postnatal healthy living support service	16 clusters per annum	9 clusters are delivering a healthy living support service. The remaining 7 clusters should be delivering by the end of March
Number of children's centres running a weight management drop in service	32 children's centres per annum	25 Children's Centres are running a weight management drop in service 7 trained and planning to start
Number of people attending weigh-in's	600 direct beneficiaries per annum	498 direct beneficiaries. Total contacts are 1300.

Schools:

Measure	Target	Progress
Number of schools receiving policy support	33 schools per annum	33 schools engaged in the policy project
Number of Schools receiving classroom workshops	33 schools per annum	33 schools engaged in the classroom sessions.

		10 schools have completed the workshops. 23 schools have sessions booked and are currently receiving their workshops.
Number of direct[1] and indirect[2] beneficiaries from the classroom projects	990 direct[2] beneficiaries and 3960 indirect[3] beneficiaries per annum	677 direct beneficiaries from 12 schools 2584 indirect beneficiaries from 12 schools
Number of schools attending family cooking and packed lunch training and number of sessions implemented as a result	33 schools trained per annum with 27 sessions implemented	14 schools have been trained on packed lunches. 14 schools have been trained on family cooking. Total numbers of schools trained are 28. 2 implemented sessions as a result of training.

[1] Direct beneficiaries are those who the foodnet in schools team work with directly
[2] Indirect beneficiaries are those who the foodnet in schools team reach as a result of working directly with the direct beneficiaries, however they do not work with these people directly.

Oral Health:

Measure	Target	Progress
Number of settings attending oral health training level 1	60 settings per annum	96 settings have attended level 1 training
Number of staff attending oral health training level 1	180 staff per annum	192 staff have attended training On average participants increased their knowledge by 20% 95% of participants reported a self perceived increase in confidence communicating oral health messages. On average confidence increased by 2 1.5points (on a scale of 1-6)
Number of settings attending oral health training level 2	40 settings per annum	45 settings have attended level 2 training
Number of settings receiving at least one oral health workshop	20 settings per annum	12 workshops have been delivered
Number of settings who have set up tooth brushing regimes	20 settings per annum	Tooth brushing regimes will commence between January and March. Staff have received level 2 training and tooth brushes

Number of settings who have had a Bin the Bottle campaign	20 settings per annum	7 settings have had a Bin the Bottle campaign. 23 bottles/beakers binned and 2 dummies. 6 settings booked in Jan.

Maternal Nutrition

Measure	**Target**	**Progress** **Amount delivered 1/04/2013 to 22/07/2013**
Number of staff trained by maternal nutrition	50 staff per annum	29 staff trained
Number of checklists completed	6000	900 completed

Evidence base

There is a wide range of NICE guidance that includes diet and nutrition:

- NICE(2014): Obesity and Weight Management
- NICE (2008): Maternal and child and nutrition.
- NICE (2010) Physical activity and dietary intervention for weight management before, during and after pregnancy.
- NICE (2010) Prevention of cardiovascular disease

- NICE Guidance (2006) Obesity guidance on the prevention, identification, assessment and management of overweight and obesity in adults and children
- NICE (2008). Lipid Modification.

Key points in these documents include:

Large-scale interventions at national level working with the food industry

- Restrictions on marketing of foods and beverages high in salt, fats and sugar, especially to children.
- Introduction of food taxes and subsidies to promote healthy diets.
- Food industry changes to the formulation of ready-to-eat products with regard to salt, saturated fats and removal of trans-fats.
- In places where food services come into contact with a large number of people there are often good opportunities for making changes that affect more of the population e.g. workplace food, school meals, supermarket ready meals formulation.

Healthy eating interventions

- Improving school meals by making healthy food choices accessible, convenient and cheap. Interventions require some involvement of a parent or carer.
- Point of purchase schemes in supermarkets, restaurants and cafes such as healthy marketing or money-off incentives. Food labelling schemes, reduction in cost of low fat snacks.

Characteristics of healthy eating interventions that work include:

- Interventions focus on diet alone or diet and exercise. They include behaviour change theories, not just information.

- Personal contact with individuals, which is individually tailored and intensive for those at higher risks.
- Offer multiple contacts over a substantial period of time.
- Feedback to clients on individual changes in behaviour and level of risk.

National/local strategies:

Healthy Lives Healthy People: a call to action on obesity in England

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_130401

Lifestyle services commissioning review: strategic direction and future approach. Andy Wakeman

Unmet needs and service gaps

In relation to the community dietetic weight management service, it is essential to ensure that this is an entirely targeted service, focused upon those with greatest need and greatest likelihood of benefit and is therefore centred around those with existing comorbidities. Further data is required to understand exactly the nature of the patients who are accessing these services to ensure that there is not a lower level option that would be suited to some with less complex needs.

The paediatric WMS is currently not meeting contact targets, it is essential that this service publicise its existence to a greater extent and build stronger links with family support agencies. A review of this service should be carried out in 6 months to determine whether these changes have proved effective and to understand the nature of demand for this service and whether the current model is the right way to provide this service.

With regards to Lighten Up there is currently no performance data available to determine whether the service is meeting the targets established in the service specification. The referral

pathways to and from this service require review in light of the goal to now increase focus on priority groups. The main route of referral is still health professional and again this will automatically bias the sample of individuals who will be referred. A full review of performance data is required immediately.

With regards to child weight management services, the majority of targets have not been met and as such the health benefits of this service are not being realised. A full review of this service to determine whether its current structure, content and pathways are appropriate to the target audience is required.

With regard to maternal nutrition, early years settings and schools there are a considerable range of interventions taking place. Although the majority are on target (in relation to part year targets) there are three key weaknesses across all of these services. Firstly they are entirely focused upon process based outcomes such as training and not on whether a change has either been achieved or maintained. Secondly, where training then results in a service taking place within the early years setting itself there is no performance management of this service, again any data which does exist is process. It is therefore impossible to determine whether any immediate or long term behavioural change has taken place and therefore whether the services are either effective or cost effective. The final weakness is that services have the opportunity to engage with families and therefore maximise the connection to wider lifestyle services. However, there is no targets based around referrals / signposting to such services and the opportunity for MECC is therefore not being maximised.

Chapter 5 Physical activity

Introduction

Being active benefits both physical and mental wellbeing. It prevents the development of conditions such as stroke, heart disease and type-2 diabetes. In addition, there is also a reduction of hip fracture, osteoarthritis, some cancers; also risks of depression and Alzheimer's disease are reduced. In the UK levels of physical activity also vary considerably in relation to age, gender, ethnicity, socio-economic status and disability.

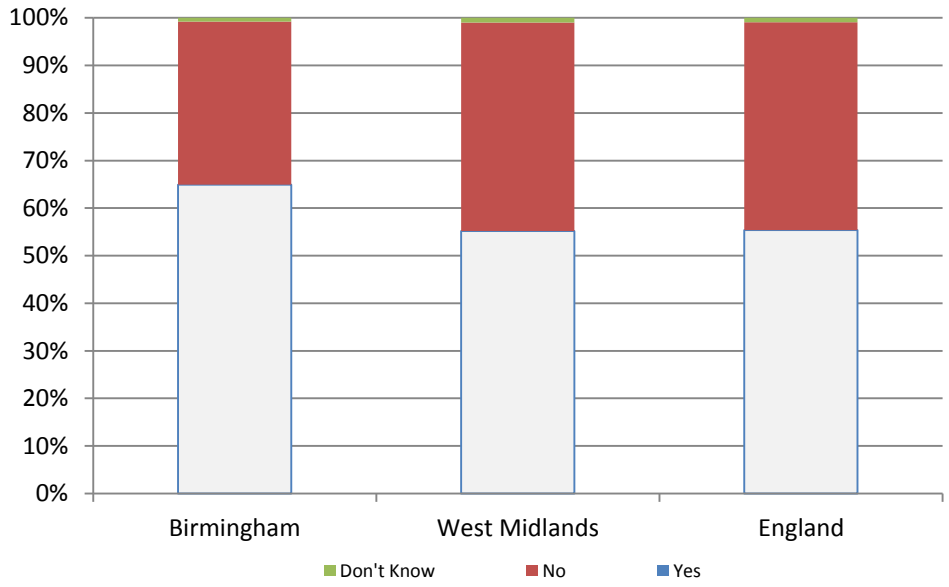
- Men are more active than women at all ages nationally
- Physical activity is less in lower income households.
- A noticeable decline in physical activity with increasing age, for both men and women.

Local Context

- Across Birmingham 52.2% of adults are completely inactive[x], doing less than 30min physical activity per week; with only 35.7% of adults participating in a sport once a week.

- Only 18.8% of the population do the recommended 3 x 30min of physical activity across the city, and yet 64.9% of adults surveyed wanted to do more sport[xi].

Figure 5.1 Proportion of adults (16+) wanting to do more sport



Source: Active People Survey 6, Population data: ONS Annual Population Survey 2012

The annual health costs of physical inactivity in Birmingham have been estimated to be £21, 937, 290.

Evidence Base for interventions that work

- Offer a range of physical activity and sports opportunities which are flexible and adaptable to the needs of the target group(s).
- GPs and other non-hospital-based health professionals support the programmes
- Refer residents to tailored physical activity programmes.
- Include organisational action: promoting activity in the workplace, and community action: Community-level activity programmes.
- BHF: Improving Health Through Participation in Sport: http://www.sportengland.org/research/understanding_participation/improving_health.aspx

- NICE: Intervention guidance on workplace health promotion with reference to physical activity http://www.nice.org.uk/PH13
- NICE: Promoting physical activity, active play and sport for pre-school and school-age children and young people in family, pre-school, school and community settings http://guidance.nice.org.uk/PH17
- NICE: Four commonly used methods to increase physical activity: brief interventions in primary care, exercise referral schemes, pedometers and community-based exercise programmes for walking and cycling http://www.nice.org.uk/PH2
- Physical activity and the environment http://guidance.nice.org.uk/PH8
- Swedish Institute of Public Health. Physical activity in the treatment and prevention of disease http://www.fhi.se/en/Publications/All-publications-in-english/Physical-Activity-in-the-Prevention-and-Treatment-of-Desease/

Current Service Provision

Age Group	***Percentage of Clients***
10 and Under	122,969 (13.2%)
11 – 20	214,115 (23.1%)
21 – 30	117,954 (12.7%)
31 – 40	141,970 (15.3%)
41 – 50	120,964 (13%)
51 – 60	85,394 (9.2%)

61 – 70	75,296 (8.1%)
70 and Over	49,575 (5.3%)
Unknown	7,935

Be active is a predominantly leisure centre based physical activity offer that is City wide with a key focus on deprived areas and BME groups. Although a range of activities are offered including gym, fitness classes, swimming, bowls, tennis, table tennis etc, the vast majority of activities undertaken are gym or swim based. In males, 94% of activity took place either within the gym or swimming pool. A similar pattern exists for females. With regards to health inequalities, 50% of clients are from deprivation quintiles 1 and 2, although it should be noted that 32% are from deprivation quintiles 4 and 5. The following Tables outlines percentage of clients by age and ethnicity:

In comparison to the recently proposed target of 35% in children, only 13.2% of those 10 and under are utilising the service (this further breaks down into only 1% of 0-4 year olds and 8.6% of 5-9 year olds). Additionally, there is very low uptake from older adults, with only 8.1% of individuals aged 61-70 years participating. More recent data suggests that the overall percentage of those who are engaging from the age group >65 years has dropped to 2%.

Ethnic Group	***Percentage of Clients***
White	39%
Asian or Asian British	34.8%
Black or Black British	16.2%
Chinese or Other	6%

Mixed Heritage	4%

Be Active Plus

Be Active Plus provides a supportive physical activity programme over a period of 12 weeks for those with a long term condition. During 2012/2013, 1726 individuals were referred, predominantly in relation to hypertension, diabetes and obesity. 1185 (69%) attended their first appointment, although considerable variation exists across location from 47% in Handsworth to 95% in Shard End. Similar variation can also be seen in number of individuals followed up. Overall 62% of attendees are female, 38% aged 45 to 59 and 25% aged over 60 years. In total 35% considered themselves disabled. Across all attendees, outcome data suggests an 84% increase in physical activity (including walking) and a 230% increase in physical activity (excluding walking). There was an overall reduction of 1.8% in Body Mass Index (although clients remained on average in the obese category) and a 6% increase in score on the WEMWBS mental health score, although no impact on number of alcohol free days. Although outcome data overall is positive, it varied considerably between sites with increases in BMI and reductions in mental health score in some areas. In total just over 100 clients were recorded as having quit smoking. Where data has been provided, the vast majority of clients are White British.

Unmet Needs and Gaps in Service

Be Active is extremely successful in engaging clients from across the population in terms of initial uptake of the service. It is also very successful in engaging with individuals from BME groups. However, the current data set that is available does not provide details around the number of attendances that an individual makes to the service. In line with the fact that an individual would be required to attend to a certain level on a weekly basis to then experience the health gains associated with physical activity including reduced risk/impact of such illnesses as diabetes and heart disease, it is currently not possible to determine whether the service is either effective or cost effective. Therefore although the service is one of the least expensive lifestyle services available at less than £3 per client, data weaknesses make it impossible to

determine whether this is actually cost effective. In addition, the majority of attendances that do take place still focus predominantly on gym and swimming pool. This is unlikely to be sustainable in current financial climates (and in light of recent reviews of leisure services) and as such the model must shift to respond to this, however, it must use an evidence based approach within this change to ensure that clients make a satisfactory transition to a new model without substantial losses in numbers. This will be particularly difficult in light of recent findings that Be Active services outside of gym, fitness classes and swim are not proving as popular in terms of uptake and have reduced geographical access. The service, in light of its scale is a prime opportunity to implement MECC, however, currently this opportunity is not being maximised and should be addressed. The service is not currently meeting its proposed targets in relation to children (35%). In light of the value of this focus particularly in terms of prevalence of childhood obesity and the positive impacts of physical activity on mental health and educational engagement, this should be prioritised within any review. Within this must be considered the reliance upon swimming pools for under 5 engagement and therefore the risk of disengagement from this group, should leisure centre/pool access be reduced. A future model which reflects a wider breadth and type of location for services including schools would provide greater opportunity for access. With regards to deprivation, although 50% of clients are from the most deprived areas in the city, there is still a substantial proportion of individuals from non deprived areas accessing this free offer. Future service models should consider a targeted or restricted as opposed to universal offer as both a cost effective and inequality focused approach. The Be Active model should be maximised to support disease prevention and management, however, uptake from the >65 age group is extremely poor. This suggests the need to both expand referral pathways (including those connected to LTC management) and the nature of programmes offered.

With regards to Be Active Plus, this programme is specifically associated with prevention (including tertiary prevention) of long term conditions. As such, greater data should be collected regarding long term behaviour change and well being associated outcome. Variation across locations should be investigated further to determine if this is caused by differences in demographics including patterns in long term conditions, quality of provision and/or wider determinants. Results of this investigation should then be responded to in future service reviews.

NHS Health Checks

The NHS Health Check programme aims to help prevent heart disease, stroke, diabetes, kidney disease and certain types of dementia. Everyone between the ages of 40 and 74, who has not already been diagnosed with one of these conditions or have certain risk factors, will be invited (once every five years) to have a check to assess their risk of heart disease, stroke, kidney disease and diabetes and will be given support and advice to help them reduce or manage that risk. 19.4% of registered patients were offered a health check in Birmingham and 43.5% of patients offered this health check took it up.

There is currently a 5% target per quarter. Birmingham has achieved 12% for the two quarters combined against a combined target of 10%.

Unmet Needs and Service Gaps

Although services are currently over performing regarding uptake, this rate is not equal across the city and as such there are pockets of poor uptake and service engagement with must be addressed. The service has extremely limited performance data, as such is it currently not possible to determine whether it responds to key health inequalities around deprivation/location, BME etc. In addition, limitations in data mean that it is ultimately not possible to determine whether engagement with service results in long term change and in particular avoidance of disease. The programme is preventive in nature but there is no data on either follow on service engagement such as lifestyle services or long term health. It is therefore also not possible to determine whether the current service model is the most cost effective available.

Health trainers

Health trainers are a nationally established programme and as such data collection is via a standardised format, collected on a quarterly basis. Health Trainers provide a lifestyle service offering up to 6 sessions of one-to-one support around a goal selected by the client. Clients

complete a personal health plan and are then monitored on whether they part achieve or fully achieve this goal. They can motivate, encourage and support clients to set goals and achieve changes to lifestyle, including losing weight, eating healthier, being more active, reducing alcohol or stopping smoking. Health Trainers can also signpost and/or refer clients to most other lifestyle services. The programme is run by two separate providers across Birmingham Health Exchange and Gateway family Services. It is also aligned to the NHS Health Check programme, where as a result of the Health Check clients may be referred to Health trainers to support lifestyle changes.

Current Service Provision/Performance

Jointly (the service is provided by two separate organisations), services have seen more than 4,500 clients. The majority of referrals, up to 84% have been from health professionals, predominantly GP. With regards to deprivation, over two thirds have been from the bottom 2 deprivation quintiles, this rate is similarly reflected in the percentage of those who achieve/part achieve goals from deprivation quintiles 1 and 2. The variation in demographic mix by provider is reflected in the rate of uptake by ethnicity from over 60% uptake in White British individuals within the gateway service to 63% uptake within Asian or Asian British individuals within the Health Exchange service. Across both services the vast majority of referrals are for weight management.

Unmet needs and service gaps

Although services are responding to current targets across the year, there are a number of weaknesses regarding their chosen targets. Currently the vast majority of clients are female and goals are centred around weight loss. As such, the service in many ways duplicates the goals within weight management services rather than supporting a distinct priority group with specific needs. One to one support is the most expensive form of support available across all lifestyle services when compared to online or telephone and as such should be targeted at those with greatest need and least current provision. In addition, even if services were to focus predominantly on obesity, they are not addressing the needs of male clients (only 26% are male – Q3 data 2014) who are the most vulnerable population regarding CVD. The vast majority of referrals are generated from GPs, yet is it understood that males engage to a lesser

extent with their GP and as such this referral route has an already established bias towards females. In addition, although deprivation targets are reached, the vast majority of clients are white (over 60% - Q3 data 2014), which does not reflect the diversity of Birmingham residents and avoids addressing some of the greatest health inequalities in the city. This in particular relates to the fact that the most negative health outcome associated with obesity is diabetes, a condition which is more prevalent in the Asian community.

Draft Recommendations

An improvement in pathways is required both in terms of expansion and also simplification to ensure ease of access. Referral pathways (both out and in) should represent all relevant services, in particular those relating to priority groups and wider determinants of healthcare. In addition and outside of medical requirements there should be a reduced reliance upon healthcare based referrals across all services as this creates a natural bias in those accessing.

Implementation of MECC across all providers and pathways should be carried out to maximise referrals into lifestyles with a particular focus on pathways linked to priority groups and wider determinants.

Improved performance management is required via contract management and service specifications that are centred around health inequalities, priority groups and groups identified as being of the greatest need with the maximum to gain from service access. This should be supported through improved and strengthened KPIs focused upon behaviour change and long term maintenance and an associated reduction in KPIs focusing upon process outcomes.

An overall shift in focus across all lifestyle services is required towards long term behaviour change and reduction in prevalence. A clear example of this exists in relation to smoking with the potential gains in moving from a 4 week quit target to 12 and or 52 weeks.

Lifestyle factors should no longer be addressed in silo but be addressed in contrast collectively via a triage system and risk assessment. This change will allow for consideration of the interactions between risk factors and how these can be managed as part of an overarching lifestyles plan.

An increased focus upon targeting as opposed to universal provision is required in light of both the findings of the current review and also the current financial climate. Targeting should include both access but also content so that the nature of service provided is in line with level of risk.

Chapter 6 References

[i] Mayhew. 2010. Increasing longevity and the economic value of healthy ageing and working longer. London: Cass Business School, City University

[ii] Cabinet Office. (2008). Food matters. Towards a strategy for the 21st century. The Strategy Unit. July 2008 (PDF, 2.26 MB - external link).

[iii] West, R. 2012. Stop smoking services: increased chances of quitting. NCSCT Briefing #8. London; National Centre for Smoking Cessation and Training.

[iv] Department of Health. 2010. Healthy Lives, Healthy People: A Tobacco Control Plan for England. London: DH.

[v] Sims M., Maxwell R., Bauld L. & Gilmore A. 2010, Short term impact of smoke-free legislation in England: retrospective analysis of hospital admissions for myocardial infarction. *British Medical Journal*, 340 c2161.

[vi] London Health Observatory. 2010. Heartsavers: Cost savings from a reduction of emergency admissions for myocardial infarction following smoke-free legislation in England [online]. Available at: http://www.apho.org.uk/resource/item.aspx?RID=91239 [accessed 22 June 2011].

[vii] Jarvis MJ., Sims M., Gilmore A., Mindell J. 2011. Impact of smokefree legislation on children's exposure to secondhand smoke: cotinine data from the Health Survey for England Tobacco Control. *Tobacco Control,* Apr 27.

[viii] WHO (2003) Diet Nutrition and the Prevention of Chronic Diseases

[ix] Scientific Advisory Committee on Nutrition (SACN). (2008). The Nutritional wellbeing of the British Population. Scientific Advisory Committee on Nutrition (PDF, 2.91 MB - external link).

[x] Active People Survey, Year:2010/12 (APS5/6)

[xi] Active People Survey 6, Population data: ONS Annual Population Survey 2012

Appendices

Appendix A. Ward level smoking prevalence estimate

Ward prevalence estimates are based on the original NEMS survey numbers and ONS 2010 population estimates

	Ward Population	% Prevalence NEMS	Estimated Smokers
Acocks Green	22,172	21.4%	4745
Aston	23,628	28.0%	6,616
Bartley Green	19,513	30.9%	6,030
Billesley	20,895	24.1%	5,036
Bordesley Green	23,425	45.1%	10,565
Bournville	20,853	33.3%	6,944
Brandwood	19,423	19.8%	3,846
Edgbaston	20,054	26.8%	5,374
Erdington	18,302	24.7%	4,521
Hall Green	19,917	32.1%	6,393
Handsworth Wood	21,821	18.9%	4,124
Harborne	19,505	20.8%	4,057
Hodge Hill	19,707	20.5%	4,040
Kings Norton	18,290	21.6%	3,951
Kingstanding	18,959	26.8%	5,081

Ladywood	20,969	24.3%	5,095
Longbridge	19,909	25.8%	5,137
Lozells and East Handsworth	21,722	23.8%	5,170
Moseley and Kings Heath	19,286	23.0%	4,436
Nechells	23,624	29.7%	7,016
Northfield	20,380	23.6%	4,810
Oscott	19,470	31.8%	6,191
Perry Barr	18,865	18.2%	3,433
Quinton	18,697	26.0%	4,861
Selly Oak	21,596	16.9%	3,650
Shard End	20,043	21.5%	4,309
Sheldon	16,866	33.4%	5,633
Soho	20,663	22.4%	4,629
South Yardley	21,966	25.8%	5,667
Sparkbrook	22,237	25.3%	5,626
Springfield	22,502	11.2%	2,520
Stechford and Yardley North	19,559	16.1%	3,149
Stockland Green	18,627	24.7%	4,601
Sutton Four Oaks	18,829	28.4%	5,347
Sutton New Hall	18,288	35.6%	6,511
Sutton Trinity	20,042	25.6%	5,131
Sutton Vesey	18,849	24.9%	4,693
Tyburn	19,674	26.4%	5,194
Washwood Heath	20,156	17.3%	3,487
Weoley	19,832	29.7%	5,890
Not known	Data Unavailable		
HMP			

Out of Birmingham	