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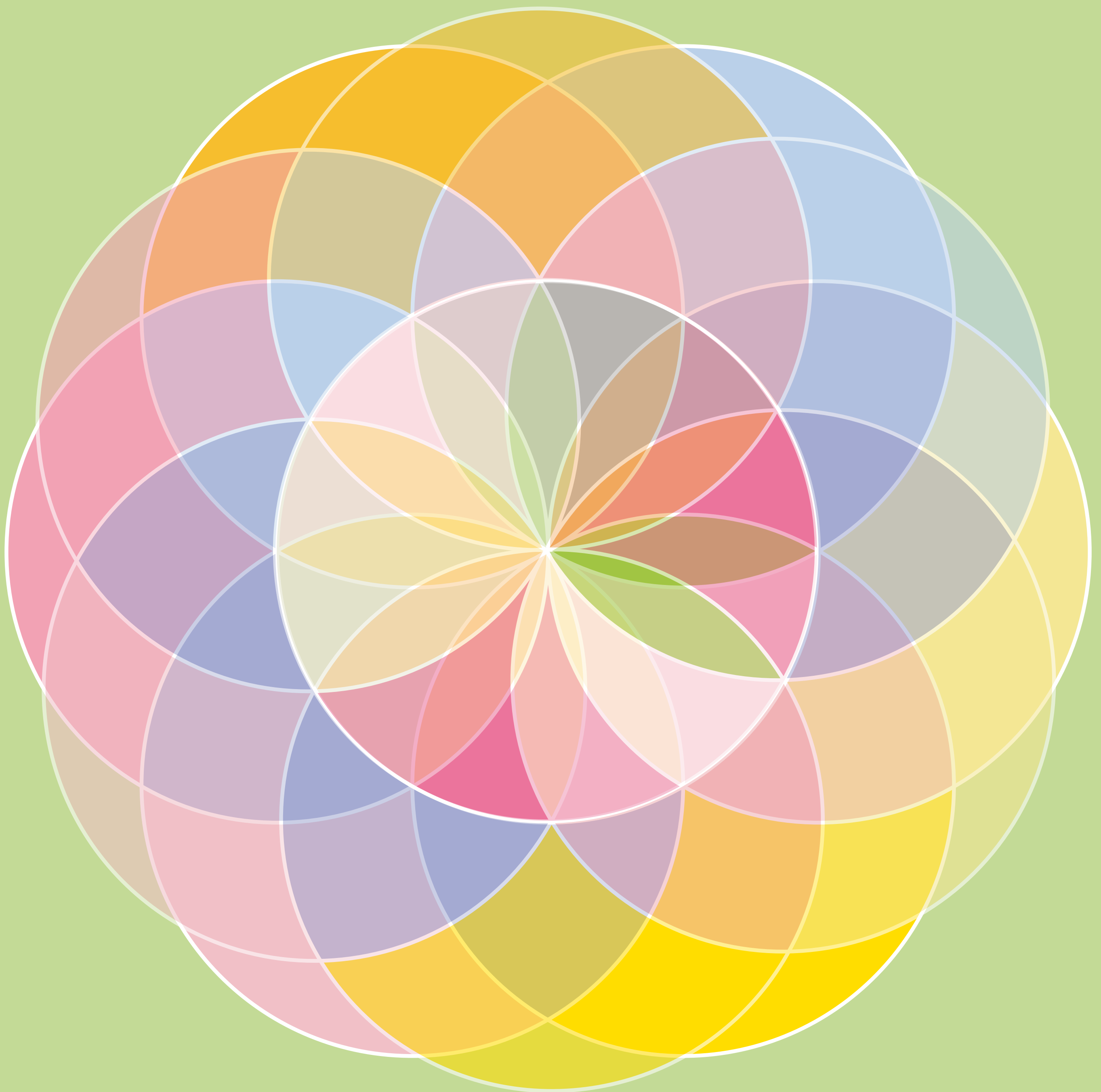
Ensuring action on Health and Wellbeing

Opportunities for local authority catering and sport and leisure services to contribute to tackling obesity and promote physical activity



Ensuring action on Health and Wellbeing

Opportunities for local authority catering and sport and leisure services to contribute to tackling obesity and promote physical activity

Rob Bailey

APSE's principal advisor for catering and sport and leisure services.

email: rbailey@apse.org.uk

tel: 0161 772 1810

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The Association for Public Service Excellence (APSE) is a not-for-profit local government body working with over 300 councils throughout the UK promoting excellence in public services. APSE is the foremost specialist in local authority frontline service provision in areas such as waste and refuse collection, parks and environmental services, leisure, school meals, cleaning, housing and building maintenance and energy services. APSE leads a research programme exploring a range of issues which impact upon both local authority frontline services as well as strategic public policy issues.

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Foreword

Councils took responsibility for public health in England in April 2013 and local government's health and wellbeing role is expanding across the UK. APSE believes this presents exciting opportunities for directly delivered services to make a positive contribution to the lives of local people.

There are clear links between a range of local government front-line activities and achieving better health and well-being outcomes. This research focuses on catering and sport and leisure as these two services have very direct connections with health and well-being. There is strong evidence that tackling obesity and promoting physical activity in particular are key to preventing and addressing conditions that are blighting people's lives and costing the public purse billions of pounds in treatment and associated costs.

This publication has been produced to assist providers of catering and sport and leisure services in thinking about ways in which they can best contribute to this exciting new agenda. It sets out the current context and describes the important actions local authority catering and sport and leisure services can take towards achieving health and wellbeing objectives. It discusses ways in which they can engage with Health and Wellbeing Boards, which have been established to drive public health improvement. It also offers valuable help in navigating the current commissioning environment and includes case study examples of schemes run by these services, which have been successful in improving health and wellbeing.

Over the past two years, APSE has worked with research partner De Montfort University to develop the Ensuring Council as a positive model for meeting the challenges facing local government. The 'ensuring ethos' we have developed helps link strategic objectives with delivery of services and advocates the retention of in-house capacity. It also emphasises collaboration, innovation and democratic accountability.

These Ensuring Council principles all chime perfectly with the holistic approaches required by the new public health agenda. Councils have a strategic overview and also operate services that impact upon health. Taking forward opportunities to contribute to health and wellbeing objectives is a perfect example of the ensuring ethos in action. We hope this publication helps catering and sport and leisure services grasp those opportunities.

Paul O'Brien

Chief Executive, APSE

Executive summary

It is now widely recognised that holistic and preventative approaches are fundamental for improving the health and well-being of local communities. Local authorities are well placed to make those holistic and preventative interventions as they sit at the strategic centre of communities and also operate a vast range of services that impact upon public health and can mitigate health inequalities.

The Ensuring Council model has been developed by APSE to articulate connections between strategy and delivery and the role front-line service providers can play in the new public health agenda is an example of the ensuring ethos in action. Other principles of the ensuring ethos, which also underpin successful activities to improve health and wellbeing and reduce health inequalities, include accountability, collaboration and innovation.

Front-line service providers understand the needs of their local communities and are best placed to respond to those needs and this publication examines the important contribution local authority catering and sport and leisure services can make towards health and well-being goals. It suggests ways in which these services can best engage with and contribute towards the public health agenda and demonstrate their value to commissioners.

Section 1 sets out New Framework for Public Health. Since April 2013, top tier English local authorities have had public health powers restored following the Health and Social Care Act 2012. Each of these councils has established a Health and Wellbeing Board, which acts as the key forum for leaders from the health and care system to work together to improve the health and wellbeing of their local population and reduce health inequalities. Working in partnership with Clinical Commissioning Groups and others, Health and Wellbeing Boards are responsible for commissioning and collaborating on a range of public health services and for advising the commissioners of local NHS services.

Much of public health was previously delivered by Primary Care Trusts (PCTs) and other NHS bodies. Whilst many former PCT employees have transferred to the local authority or other NHS bodies, the local authority has wide discretion on future commissioning. In terms of public health, councils themselves are often able to efficiently deliver the services and have successfully commissioned catering teams and sport and leisure teams to deliver significant aspects of the new duties.

Section 2 discusses the role of Health and Wellbeing Boards and ways in which providers of services can engage with them. Whilst these Boards have now been operating for almost two years, many inherited contracts that are currently reaching their term. This is a perfect opportunity for councils to take a fresh look at the nature of services and determine the best outcomes for their locality.

This section assists in-house service providers in identifying opportunities for providing additional services in ways that help fulfil councils' health and wellbeing objectives and in developing strengths to deliver effectively. Of specific interest to catering and sport and leisure services are the areas of obesity, physical nutrition and health checks. These offer opportunities to deliver related services but also the change to sign-post people to other services through the health checks and measurement programmes.

Section 3 explores the new national framework for public health in England, the responsibilities of local authorities and the requirement to gather local health intelligence to guide commissioning decisions. Priorities and a national set of indicators are grouped in four domains: improving the wider determinants of health; health improvement; health protection; and healthcare public health and preventing premature mortality.

Section 4 examines opportunities that exist for catering and sport and leisure services to contribute to health and well-being within this new framework. It focuses in particular on the potential for interventions by front-line services in tackling obesity and promoting physical activity. These are two areas highlighted within this framework where local authorities have existing skills and strengths to deliver many health

interventions. The causes and relationships between obesity and physical activity and their health outcomes are explored and potential health interventions in these areas are considered.

Section 5 sets out the clear invest to save argument for maximising the role of front-line services in risk prevention and promotion of healthier lifestyles. In-house providers understand the needs of their local communities and their role in encouraging healthier lifestyles can help save public resources.

For example, a quarter of all adults are obese and 67% of men and 57% of women are overweight. Even at school level, 20% of pupils in year 6 are classified as obese. The long term health problems and costs associated with this are substantial. The cost to the NHS exceeds £5 billion and over £15 billion in the wider economy. Similarly, no more than 40% of men and 28% of women are sufficiently physically active with 1 in 5 considered to have very low physical activity levels. The cost to health services are huge, including almost £500 million spent dealing with coronary heart disease alone.

Section 6 provides insights into the tendering process for services wishing to contribute to health and wellbeing objectives. It shows the importance of providing evidence of the value interventions can bring when preparing a tender bid or funding submission. It also stresses the importance of understanding the needs of the target groups and wider areas of health. Evidence of behaviour change and health improvement outcomes should be provided where possible, which mean looking at wider impacts. Innovation is essential, as is willingness to work as a multi-agency partner. A cost benefit analysis should show savings to the public purse in its broadest sense.

On a practical and financial level it is important to demonstrate: readiness to deliver at scale; projected efficiencies; and the medium and long term vision for the organisation. The evidence base should include information on previous successes, learning, knowledge, skills and stakeholder engagement. It is important to be proactive in identifying improvements, challenges, risks and projected financial efficiencies.

Health comes with a different set of guiding principles and terminology than within existing local authority services. In-house providers must therefore position themselves effectively to enable Health and Wellbeing Boards to commission their services. This requires that they communicate using the same language and build the processes needed to gather data and demonstrate outcomes. Examples of commissioning documents and tenders are included in this section.

Section 7 discusses different approaches to delivering public health in Scotland, Northern Ireland and Wales. While these countries still favour NHS boards, the local authority can still play a significant part in delivery.

Section 8 features examples of good practice where catering and sport and leisure services are making a valuable contribution to public health and well-being. Due to the different starting points, some authorities are further advanced in commissioning and integrating health services within the local authority, which means lessons can be shared between authorities. Successful case study examples are included here from: Blackpool, East Riding of Yorkshire, Telford and Wrekin, Wandsworth and Wigan.

Conclusions and Recommendations for maximising potential of service providers to contribute towards health and wellbeing outcomes for local communities and overcoming barriers that exist at central and local level are offered in the final section.

1. The new framework for public health

The Health and Social Care Act 2012 established Health and Wellbeing Boards as a forum where key leaders from the health and care system work together to improve the health and wellbeing of their local population and reduce health inequalities.

Since April 2013, each English top tier and unitary authority has its own Health and Wellbeing board. Board members are encouraged to collaborate to understand their local community's needs, agree priorities and encourage commissioners to work in a more joined up way. As a result, patients and the public should experience more joined-up services from the NHS and local councils in the future.

1.1 Local government's new public health functions

From April 2013 local authorities in England have had an enhanced role in improving the health of their local population, working in partnership with clinical commissioning groups, and others, through health and wellbeing boards in their localities. They are responsible for commissioning and collaborating on a range of public health services and for advising the commissioners of local NHS services. In addition they need to ensure they have appropriate health intelligence and evidence input needed to discharge these new duties effectively.

Public Health was previously a local government responsibility until 1974 when most of its functions were passed to the NHS. The 1875 Public Health Act consolidated a range of Acts covering sewerage and drains, water supply, housing and disease. Councils had to appoint Medical Officers in charge of public health and were ordered to cover sewers, keep them in good condition, supply fresh water to their citizens, collect rubbish and provide street lighting. Local sanitary inspectors were appointed to look after slaughterhouses and prevent contaminated food being sold. In the Education (Provision of Meals) Act 1906 local councils were told to provide free school meals for poor children and in 1907 (Administrative Provisions Act) school medical examinations were ordered for all children

Health and Wellbeing Boards have now been established by local authorities in partnership with NHS clinical commissioning groups and others. The boards are responsible for preparing comprehensive joint strategic needs assessments and joint health and wellbeing strategies, and have a role in commissioning plans taking into account those assessments and strategies.

These new responsibilities for local government join existing roles that substantially influence the health of local people, for example environment, housing, economic development and regeneration, education and care services. It is intended that local authorities will be able to improve significantly the health of their local populations, as measured by the Public Health Outcomes Framework.

These new functions rest with councils as a whole but are usually supported by specialist public health staff transferred into local government, including specialist leadership from directors of public health supported by their teams, including, in many cases, some public health intelligence staff.

Beyond upper-tier and unitary local authorities, it is intended that local partners such as district councils, NHS and voluntary agencies, and local businesses will make significant contributions to local health and wellbeing strategies. At this point in time, collaboration with other partners remains in its infancy and underdeveloped.

Public Health England is to work closely alongside local authorities both as the national leadership body for public health (including working with councils on the joint appointments process for directors of public health) and as an active partner in local initiatives, where appropriate.

1.2 Local public health intelligence

While many responsibilities for public health transfer from the NHS to local authorities, healthcare commissioning responsibilities have transferred to new NHS Clinical Commissioning Groups and the NHS Commissioning Board. The business intelligence functions supporting these commissioning responsibilities are, in the main, transferring into new commissioning support units or other NHS bodies.

To deliver their public health functions, local authorities need to obtain and use relevant data and evidence to both inform their public health advice to the NHS and to shape their own strategic health activities. Depending on local circumstances this work may best be organised 'in-house' by the local authority, or it may be a commissioned service – purchased partly or wholly from other bodies, or collaborative arrangements with other local authorities.

In addition, commissioning support units may assist in providing data on behalf of clinical commissioning groups, to assist local authorities in providing public health advice to the NHS. Access to an effective and robust local health intelligence function is essential for local authorities to discharge their new duties effectively. Many of the new health functions in councils critically depend on the use of data and evidence, including strategic leadership for health, developing health and wellbeing strategies and publishing director of public health annual reports.

Local clinical commissioning groups may also ask the local authority to undertake specific tasks to support local NHS commissioning. Examples of work that might require sophisticated use of data and evidence include:

- developing and using the joint strategic needs assessment and the joint strategic assets assessment to inform commissioning or service delivery plans for local authorities and for clinical commissioning groups
- developing and interpreting neighbourhood, locality and/or local GP-practice profiles
- identifying vulnerable local populations, marginalised groups and describing local health inequalities, and supporting equality and diversity analyses
- offering public health advice on the commissioning cycle, including understanding local performance and key drivers against indicators set out in the Public Health Outcomes Framework, the NHS Outcomes Framework and the Commissioning Outcomes Framework
- supporting clinical commissioning groups in interpreting and understanding data on variation in levels of service use in both primary and secondary care
- assisting in developing evidence-based care pathways, service specifications and quality indicators to monitor patient outcomes
- preparing the director of public health's annual health report
- providing critical evidence appraisals to support development of clinical prioritisation policies for both populations and individuals.

A number of specialist intelligence staff have transferred to local authorities from the NHS, bringing with them significant and relevant experience and expertise. It will be important for councils to consider whether the health intelligence capacity and capability available to transfer in from the NHS will be sufficient to discharge new public health responsibilities, especially because:

- health intelligence capacity is highly variable around the country, both in existing public health teams and in local authorities
- although many councils already employ information and intelligence staff to support existing duties, such as in housing, planning and the environment, the specialist nature of health intelligence means it is unlikely all existing council teams would be able to fully absorb new public health responsibilities
- health intelligence expertise is also highly sought after and some staff may choose to move toward a commissioning support unit-type organisation and to focus on the business intelligence aspects of their role.

The most obvious example where Public Health England is working in direct support locally is in health protection, but increasingly Public Health England will support health improvement responsibilities while the local strategic leadership function remains with councils.

2. Health and Wellbeing Boards

Health and Wellbeing Boards are regarded as a key part of broader plans to modernise the NHS to:

- ensure stronger democratic legitimacy and involvement
- strengthen working relationships between health and social care, and,
- encourage the development of more integrated commissioning of services

The boards aim to give communities a greater say in understanding and addressing their local health and social care needs.

2.1 Function

Health and Wellbeing Boards have strategic influence over commissioning decisions across health, public health and social care.

- Boards are intended to strengthen democratic legitimacy by involving democratically elected representatives and patient representatives in commissioning decisions alongside commissioners across health and social care. The boards provide a forum for challenge, discussion, and the involvement of local people.
- Boards bring together clinical commissioning groups and councils to develop a shared understanding of the health and wellbeing needs of the community. They undertake the Joint Strategic Needs Assessment (JSNA) and develop a joint strategy for how these needs can be best addressed. This includes recommendations for joint commissioning and integrating services across health and care.
- Through undertaking the JSNA, the board can drive local commissioning of health care, social care and public health and create a more effective and responsive local health and care system. Other services that impact on health and wellbeing such as housing and education provision may also be addressed.

2.2 Board Membership

The Health and Social Care Bill mandates a minimum membership of:

- one local elected representative
- a representative of local Healthwatch organisation
- a representative of each local clinical commissioning group
- the local authority director for adult social services
- the local authority director for children's services
- the director of public health for the local authority

Local boards are free to expand their membership to include a wide range of perspectives and expertise, such as representatives from the charity or voluntary sectors.

2.3 Community Involvement

- Boards are under a statutory duty to involve local people in the preparation of JSNAs and the development of joint health and wellbeing strategies.
- Each health and wellbeing board has a local Healthwatch representative member. Local Healthwatch have a formal role of involving the public in major decision-making around health and social care and its work is expected to feed into that of Health and Wellbeing Boards.
- All Health and Wellbeing Boards are accountable to local people through having local councillors as members of the board.

2.4 Local authorities are responsible for:

- tobacco control and smoking cessation services
- alcohol and drug misuse services
- public health services for children and young people aged 5-19 including Healthy Child Programme and in the longer term all public health services for children and young people
- the National Child Measurement Programme
- interventions to tackle obesity such as community lifestyle and weight management services
- locally-led nutrition initiatives
- increasing levels of physical activity in the local population
- NHS Health Check assessments
- public mental health services
- dental public health services
- accidental injury prevention
- population level interventions to reduce and prevent birth defects
- behavioural and lifestyle campaigns to prevent cancer and long-term conditions
- local initiatives on workplace health
- supporting, reviewing and challenging delivery of key public health funded and NHS delivered services such as immunisation and screening programmes
- comprehensive sexual health services including testing and treatment for sexually transmitted infections,
- contraception outside of the GP contract and sexual health promotion and disease prevention
- local initiatives to reduce excess deaths as a result of seasonal mortality
- the local authority role in dealing with health protection incidents, outbreaks and emergencies
- public health aspects of promotion of community safety, violence prevention and response
- public health aspects of local initiatives to tackle social exclusion
- local initiatives that reduce public health impacts of environmental risks

(Department of Health 'Commissioning Responsibilities', 2011)

2.5 Budgets

Whilst significant, the amounts devolved to local authorities for public health are dwarfed in comparison to those provided to Clinical Commissioning Groups. For example, in Lancashire, a county with a population of 1.17 million people, the amount provided to the council for public health in 2103-14 was £48 per head, whilst that to the CCG, £1,194. The average across England was £56 per head (equating to 5% of CCG budget) to the local authority, but £1,150 to the CCG. This compares with an average council tax per head of around £550.

2.6 Current issues

Health and Wellbeing Boards usually only meet on a quarterly basis. The meetings are therefore only able to assess a limited agenda, usually covering the main functions of Public Health but at a typically strategic level. In two tier areas, where district councils look after leisure and environmental health, there is a split between the county and the district. Often the District Council is represented indirectly by a single councillor who may be from another authority.

Health and Wellbeing Boards of unitary councils often have a direct representation, through the director of public health and directors for children's and adults services, on behalf of the council as a whole. This offers to potential for a service to put together a proposal which will be championed at the Board and has a significantly higher chance of success. For instance, Lancashire Contains six Clinical Commissioning Group areas and 12 District Councils. The boundaries of Districts and CCGs are not coterminous. Leisure services are delivered through a variety of direct provision, leisure trusts and the districts have representation through three district councillors representing the 12 boroughs.

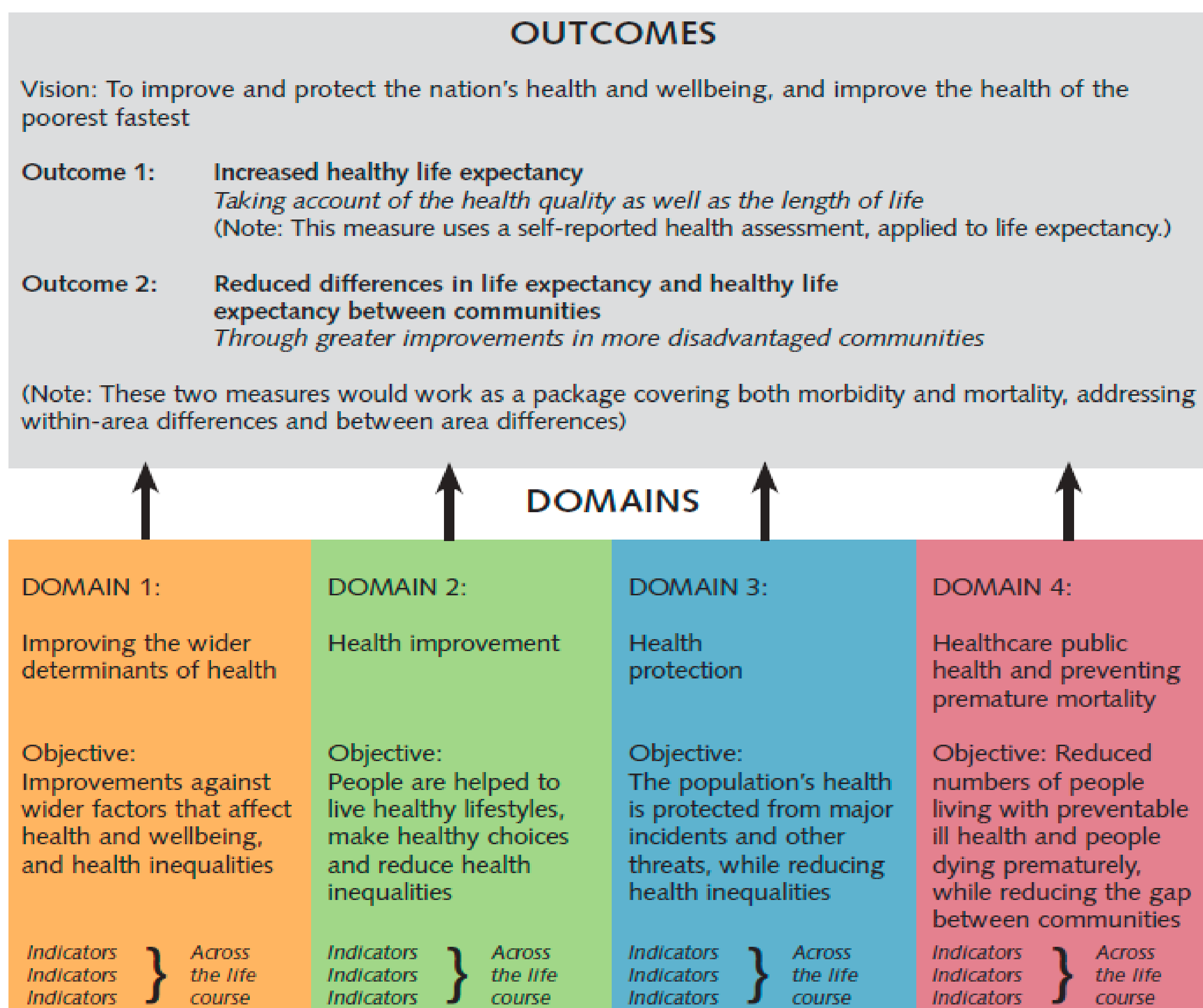
3. The National Framework for England

Understanding the national framework enables providers of council services to determine where they can make valuable interventions on health and wellbeing. The Public Health Outcomes Framework for England 2013-2016 sets the context for the system from local to national level.

3.1 The Public Health Outcomes Framework

The framework focuses on the respective role of local government, the NHS and Public Health England, and their delivery of improved health and wellbeing outcomes for the people and communities they serve.

The framework sets out the broad range of opportunities to improve and protect health across the life course and to reduce inequalities in health that still persist, as shown in the diagram below.



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3.2 High-level outcomes

The framework focuses on the two high-level outcomes across the public health system and beyond. These are:

- increased healthy life expectancy
- reduced differences in life expectancy and healthy life expectancy between communities.

These outcomes reflect the focus, not only on life expectancy, but on 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 our society. Measures of both life expectancy and healthy life expectancy are used so that the most reliable information is available to understand the nature of health inequalities both within areas and between areas.

It is acknowledged that whilst it will be possible to provide information on the performance against both these outcomes, the nature of public health is such that the improvements in these outcomes will take years – sometimes even decades – to show marked change. A set of supporting public health indicators has been developed, that are intended to provide a yearly update both nationally and locally on those things that matter most to public health, and improve the outcomes stated above. These indicators cover the full spectrum of public health and are ones that can realistically be measured at the moment.

These indicators are grouped into four domains:

- improving the wider determinants of health
- health improvement
- health protection
- healthcare public health and preventing premature mortality

(A public health outcomes framework for England, 2013-2016, 2012)

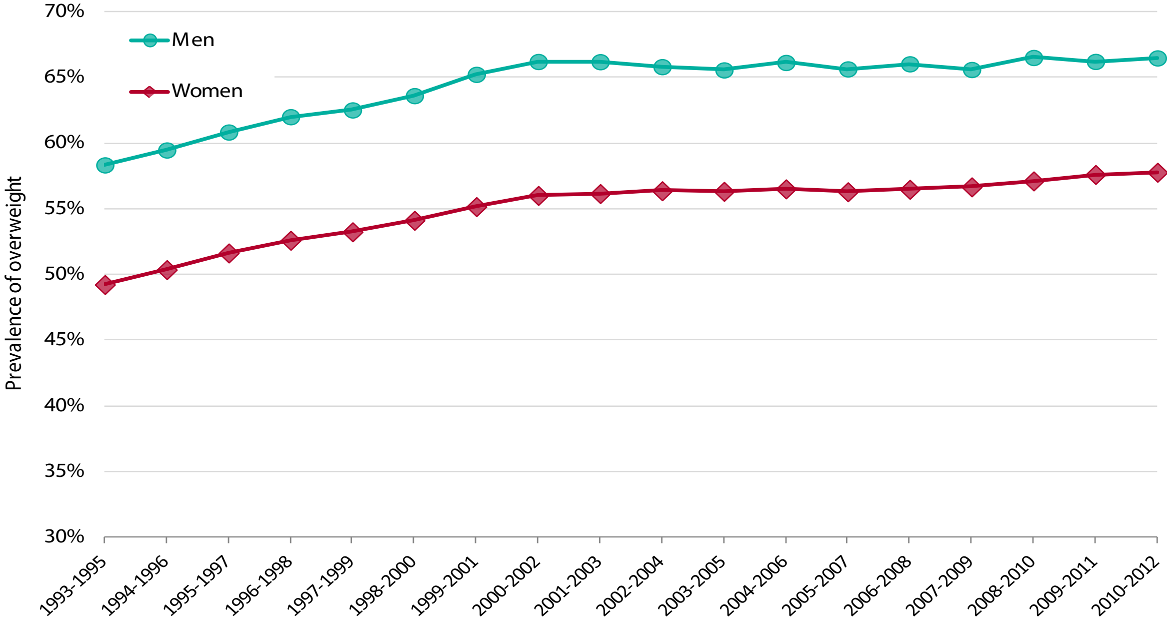
4. The context for interventions for obesity and physical activity

Local authority in-house teams responsible for catering services and sport and leisure services are well placed to make interventions that support Health and Wellbeing Boards to address obesity and promote physical activity. There is an array of evidence to demonstrate both the importance of these areas in efforts to improve public health and the contribution that local authority services can make to reducing obesity and increasing physical activity among local residents.

4.1 Obesity

The prevalence of obesity among adults increased sharply during the 1990s and early 2000s. The proportion who were categorised as obese increased from 13.2% of men in 1993 to 24.4% in 2012 and from 16.4% of women in 1993 to 25.1% in 2012 (Health Survey for England). In adults, obesity is commonly defined as a body mass index (BMI) of 30 or more.

Trend in excess weight among adults



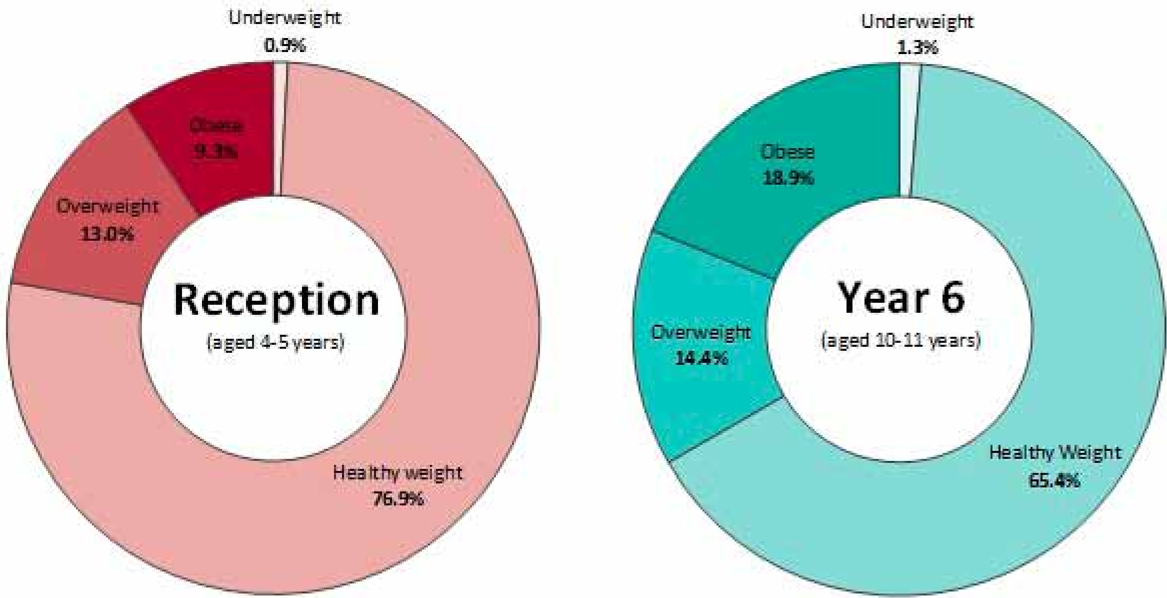
***Adult (aged 16+) overweight including obese: BMI ≥ 25kg/m* Health Survey for England 1993-2012 (3-year average)**

In addition, 9.7% of boys and 8.8% of girls (all children 9.3%) in Reception year (aged 4-5 years) and 20.4% of boys and 17.4% of girls (all children 18.9%) in Year 6 (aged 10-11 years) are also classified as obese according to the British 1990 population monitoring definition of obesity (≥95th centile) (National Child Measurement Programme 2012/13). It is predicted that obesity will affect 60% of adult men, 50% of adult women and 25% of children (Foresight 2007). One in 10 children start school obese whilst 1 in 5 leave obese and 1 in 5 start overweight whilst 1 in 3 leave overweight

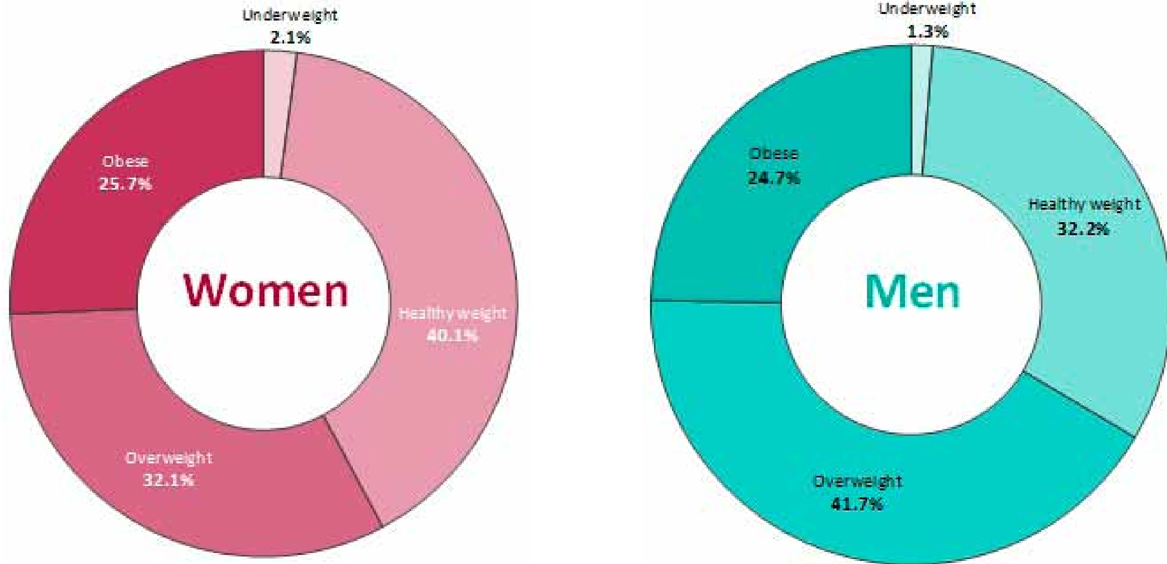
Obesity is associated with a range of health problems including type 2 diabetes, cardiovascular disease and cancer. The resulting NHS costs attributable to being overweight and obesity are projected to reach £9.7 billion by 2050, with wider costs to society estimated to reach £49.9 billion per year (Foresight 2007). These factors combine to make the prevention of obesity a major public health challenge.

(Public Health England 'About Obesity' 2011)

School children obesity 2012



Adult obesity 2012



Causes of obesity

Obesity occurs when energy intake from food and drink consumption is greater than energy expenditure through the body's metabolism and physical activity over a prolonged period, resulting in the accumulation of excess body fat. There are however many complex behavioural and societal factors that combine to contribute to the causes of obesity. The Foresight report (2007) refers to a "complex web of societal and biological factors that have, in recent decades, exposed our inherent human vulnerability to weight gain". The report identified over 100 variables directly or indirectly influence energy balance.

The Foresight report map identifies seven cross-cutting predominant themes:

- Biology: an individual's starting point - the influence of genetics and ill health
- Activity environment: the influence of the environment on an individual's activity behaviour, for

example a decision to cycle to work may be influenced by road safety, air pollution or provision of a cycle shelter and showers

- Physical Activity: the type, frequency and intensity of activities an individual carries out, such as cycling vigorously to work every day
- Societal influences: the impact of society, for example the influence of the media, education, peer pressure or culture
- Individual psychology: for example a person's individual psychological drive for particular foods and consumption patterns, or physical activity patterns or preferences
- Food environment: the influence of the food environment on an individual's food choices, for example a decision to eat more fruit and vegetables may be influenced by the availability and quality of fruit and vegetables near home
- Food consumption: the quality, quantity (portion sizes) and frequency (snacking patterns) of an individual's diet

4.2 Physical activity and the prevention of chronic disease

Physical inactivity is the fourth leading risk factor for global mortality (accounting for 6% of deaths globally). This follows high blood pressure (13%), tobacco use (9%) and high blood glucose (6%). Overweight and obesity are responsible for 5% of global mortality.

The benefits of regular physical activity are proven at all ages. In particular, for adults, doing 30 minutes of at least moderate intensity physical activity on at least 5 days a week helps to prevent and manage over 20 chronic conditions, including coronary heart disease, stroke, type 2 diabetes, cancer, obesity, mental health problems and musculoskeletal conditions. The strength of the relationship between physical activity and health outcomes persists throughout people's lives, highlighting the potential health gains that could be achieved if more people become more active throughout their life.

There is a clear causal relationship between the amount of physical activity people do and all-cause mortality. While increasing the activity levels of all adults who are not meeting the recommendations is important, targeting those adults who are significantly inactive (i.e. engaging in less than 30 minutes of activity per week) will produce the greatest reduction in chronic disease.

(DoH, "Start Active, Stay Active" 2011)

Participation rates across the UK are detailed below, although these are self reported rates and the real rates are likely to be much lower.

Country	Men	Women
England	40%	28%
Northern Ireland	33%	28%
Wales	36%	23%
Scotland	43%	32%

4.3 Physical activity levels in Scotland and Wales

The Scottish Health Survey 2012 contains information on the self-reported physical activity levels of adults in Scotland. The key findings are:

- In Scotland, in 2012, 62% of adults (aged 16 and over) were active at the recommended level, whereas 21% had very low activity levels.
- Men were more likely than women to meet the guideline (67% versus 58%).
- In contrast, the proportions of men and women with very low activity levels were much more closely aligned (19% and 23%, respectively).

(The Scottish Health Survey 2012)

Table 1. The relationship between physical activity and health outcomes

Health outcome	Nature of association with physical activity	Effect size	Strength of evidence
All-cause mortality	Clear inverse relationship between physical activity and all-cause mortality.	There is an approximately 30% risk reduction across all studies, when comparing the most active with the least active.	Strong
Cardio-respiratory health	Clear inverse relationship between physical activity and cardiorespiratory risk.	There is a 20% to 35% lower risk of cardiovascular disease, coronary heart disease and stroke.	Strong
Metabolic health	Clear inverse relationship between physical activity and risk of type 2 diabetes and metabolic syndrome.	There is a 30% to 40% lower risk of metabolic syndrome and type 2 diabetes in at least moderately active people compared with those who are sedentary.	Strong
Energy balance	There is a favourable and consistent effect of aerobic physical activity on achieving weight maintenance.	Aerobic physical activity has a consistent effect on achieving weight maintenance (less than 3%change in weight).	Strong
		Physical activity alone has no effect on achieving 5% weight loss, except for exceptionally large volumes of physical activity, or when an isocalorific diet is maintained throughout the physical activity intervention.	Strong
		Following weight loss, aerobic physical activity has a reasonably consistent effect on weight maintenance.	Moderate
Musculo-skeletal health	***Bone***: There is an inverse association of physical activity with relative risk of hip fracture and vertebral fracture. Exercise and training can increase spine and hip bone marrow density (and can also minimise reduction in spine and hip bone density).	***Bone***: Risk reduction of hip fracture is 36% to 68% at the highest level of physical activity. The magnitude of the effect of physical activity on bone mineral density is 1% to 2%.	Moderate (weak for vertebral fracture)
	Joint: In the absence of a major joint injury, there is no evidence that regular moderate physical activity promotes the development of osteoarthritis.	***Joint***: Risk reduction of incident osteoarthritis for various measures of walking ranges from 22% to 83%.	Weak
	Participation in moderate intensity, low-impact physical activity has disease-specific benefits in terms of pain, function, quality of life and mental health for people with osteoarthritis, rheumatoid arthritis and fibromyalgia.	Among adults with osteoarthritis, pooled effect sizes (ES) for pain relief are small to moderate, i.e. 0.25 to 0.52. Function and disability ES are small: function ES = 0.14 to 0.49 and disability ES = 0.32 to 0.46.	Strong
	Muscular: Increases in exercise training enhance skeletal muscle mass, strength, power and intrinsic neuromuscular activation.	***Muscular*** The effect of resistance types of physical activity on muscle mass and function is highly variable and dose-dependent.	Strong
Functional health	There is observational evidence that mid-life and older adults who participate in regular physical activity have reduced risk of moderate/severe functional limitations and role limitations.	There is an approximately 30% risk reduction in terms of the prevention or delay in function and/or role limitations with physical activity.	Moderate to strong
	There is evidence that regular physical activity is safe and reduces the risk of falls.	Older adults who participate in regular physical activity have an approximately 30% lower risk of falls.	Strong
Cancer	There is an inverse association between physical activity and risk of breast and colon cancer.	There is an approximately 30% lower risk of colon cancer and approximately 20% lower risk of breast cancer for adults participating in daily physical activity.	Strong
Mental health	There is clear evidence that physical activity reduces the risk of depression and cognitive decline in adults and older adults.	There is an approximately 20% to 30% lower risk for depression and dementia, for adults participating in daily physical activity.	Strong
	There is some evidence that physical activity improves sleep.		Moderate
	There is limited evidence that physical activity reduces distress and anxiety.	There is an approximately 20% to 30% lower risk for distress for adults participating in daily physical activity.	Limited

Adapted from Department of Health and Human Services (2008) Physical Activity Guidelines Advisory Committee Report, Washington, DC: US Department of Health and Services by Start Active, Stay Active – A report on physical activity for health from the four home countries' Chief Medical Officers

The Welsh Health Survey 2012 contains information on the self-reported physical activity levels of adults in Wales. The key findings are:

- 29% of adults reported doing at least 30 minutes of at least moderate intensity physical activity, on five or more days a week
- Overall, a higher proportion of men (36%) than women (23%) were physically active on 5 or more days a week
- The proportion of people who were physically active on 5 or more days a week decreased with age, particularly for men
- Some adults (13%) reported that they had done no exercise or physical activity in the past week, and a further 21% had done no more than light activity

(Welsh Health Survey 2012)

4.4 Nutrition

Whilst malnutrition is now rare, there are significant benefits to a healthy diet, especially amongst the young and over 65s. Good nutrition has the following benefits:

- Healthy Heart (Mitigates against heart disease. Diets rich in fruits, vegetables, whole grains and low fat dairy)
- Bone and Teeth Strength (Protects against Osteoporosis, Calcium rich diet)
- Energy levels (Unprocessed carbohydrates, whole grains, fruits and vegetables)
- Brain Function (Protects against Alzheimer's Disease with diet containing nuts, vegetables and fruits, high in vitamin E)
- Weight Control (Reduced risk of type-2 diabetes, clogged arteries and thyroid dysfunction)

For local authorities nutrition offers a range of opportunities to influence local wellbeing. The main one being school meals and extensions to that including school breakfasts. Others include cooking skills for adults to give people the skills to prepare fresh food and reduce the reliance on processed and fatty meals.

4.5 School meals

There has been a huge change in the perception of school meals since Jamie Oliver's School Meals campaign started in 2005. There have been several pilots to determine the benefits of free school meals and the Government has introduced Universal Infant Free School Meals in England from September 2014 followed by the Scottish Government in January 2015. In addition breakfast clubs have increased substantially with 85% of schools now offering breakfast (APSE, Kellogg's 2014).

In addition to Universal Infant Free School Meals, there have been significant changes to the curriculum to ensure that children leave school with the ability to cook at least 6 savoury meals, a skill lost to many of the current generation of parents.

Public Health England has reviewed the literature and determined that there is currently insufficient evidence to determine a direct link between free school meals and specific health benefits.

However in children the benefits in schools have been proven in terms of improvements to:

- SAT results and KS1 & KS2, especially in those from low income families
- Attendance
- Improved concentration

The main long term benefits are:

- Increasing the cooking skills of the next generation
- Increased use and consumption of fresh food and away from processed
- Changing food knowledge and eating habits to a more healthy diet
- Removing disadvantage for children who currently attend school hungry

4.6 Free School Meal pilots

The Free School Meals (FSM) pilot was a two-year programme operating in three local authorities between the autumn of 2009 and summer of 2011, to extend entitlement to free school meals. Under the current rules, pupils are entitled to free school meals if their parents claim means-tested out-of-work benefits (such as Income Support) or Child Tax Credit (and not Working Tax Credit) with an annual income of no more than £16,190. Children who receive a qualifying benefit in their own right are also entitled to receive FSM. Around 80% of children currently eligible for FSM live in out-of work households or with earned income of less than £1,000.

An earlier scheme at Hull Council suggested that the learning environment for all children is supported by the provision of free, healthy school meals. Headteachers remarked that schools were calmer places within which to learn and socialise.

The FSM pilot also included a range of supporting activities in each area to encourage take-up of school meals and to make parents aware of the pilot such as holding talks and taster sessions. The findings of the evaluation should therefore be considered in relation to the whole pilot approach rather than just the provision of free school meals.

Key findings

- In the universal pilot areas, the increased take-up of school meals led to a shift in the types of food that pupils ate at lunchtime, away from foods typically associated with packed lunches towards those associated with hot meals. Children were less likely to report eating crisps at least once a day.
- The universal pilot had a significant positive impact on attainment for primary school pupils at Key Stages 1 and 2, with pupils in the pilot areas making between four and eight weeks' more progress than similar pupils in comparison areas.
- The improvements in attainment tend to be strongest amongst pupils from less affluent families and amongst those with lower prior attainment, although it should be noted that the effects for different types of pupils are not always significantly different from one another.
- There was no evidence that the FSM pilot led to significant health benefits during the two year pilot period. For example, there was no evidence of any change in children's Body Mass Index.

(DofE, Evaluation of the Free School Meals Pilot, 2013)

4.7 Breakfast clubs

In 2011, The British Nutrition Foundation determined that there is a concern that a substantial proportion of pupils are not eating breakfast and arrive at school hungry, impacting negatively on their diet and school performance. This resulted in voluntary breakfast clubs at schools across the country. Breakfast clubs can help develop social skills and provide opportunity for additional learning. Research has shown breakfast clubs to have significantly improved social skills, punctuality and health and concentration levels in children. These benefits are particularly seen in deprived areas.

5. The cost of ill-health

The costs of ill-health to the NHS and to the wider economy is substantial but difficult to quantify and likely to under-estimate the actual costs if reliant on reported information. Examples are included from a variety of sources to consider direct and associated costs to the public purse as a whole.

5.1 Context

Within the wider context, local authorities have a role to play in reducing the costs of a range of local issues. Investing resources to tackle youth unemployment, youth crime and educational underachievement will have huge long term savings according to the Department of Health:

Youth unemployment	£133 million per week
Youth crime	£1.2 billion per year
Educational underachievement	£22 billon per generation
One year in a children's residential home	£149,240
One year in foster care	£35,152
Admission to inpatient child and adolescent mental health services	£24,482 (median)

(DoH, Our Children Deserve Better, 2013)

The Yearly Health Survey for England (HSE) is part of a programme of surveys commissioned by the Health and Social Care Information Centre. The survey highlights a range of issues affecting the health and wellbeing of the general population.

Social Care

- Among people aged 65 and over, a third of women (36 per cent) and just over a quarter of men (27 per cent) reported a need for help in the last month with at least one Activity of Daily Living. Help was needed most often with getting up and down stairs (21 per cent and 36 per cent respectively).
- The majority of people aged 65 and over who received help in the last month were helped by an informal helper, rather than a formal one. For Activities of Daily Living (ADLs), 75 per cent of men and 71 per cent of women had informal helpers only, and the equivalent proportions for Instrumental Activities of Daily Living (IADLs) were 78 per cent and 74 per cent respectively.

Physical Activity

- The average sedentary time per weekday decreased from 5.0 hours in 2008 to 4.9 hours in 2012 in men and from 5.0 to 4.7 hours in women. On weekend days, the average sedentary time decreased from 5.6 hours in 2008 to 5.4 hours in 2012 in men and from 5.3 to 5.1 hours in women.
- A higher proportion of boys than girls aged 5 to15 (21 per cent and 16 per cent respectively) were classified as meeting current guidelines for children and young people of at least one hour of moderately intensive physical activity per day. Among both sexes, the proportion meeting guidelines was lower in older children. The proportion of boys meeting guidelines decreased from 24 per cent in those aged 5 to 7 to 14 per cent aged 13 to 15. Among girls the decrease was from 23 per cent to 8 per cent respectively.

Wellbeing

- Participants who met government guidelines for the recommended levels of physical activity had higher well-being scores, on average, than others. Average well-being scores for those who met the government guidelines were 53.6 for men and 53.5 for women, compared with an average score of 50.0 and 49.1 respectively for those who were inactive.

Gambling

- In the last 12 months, 68 per cent of men and 61 per cent of women had participated in gambling activity; with men being more likely than women to do so. The most popular forms of gambling were purchase of tickets for the National Lottery (men 56 per cent, women 49 per cent); purchase of scratch cards (19 per cent and 20 per cent respectively), participation in other lotteries (14 per cent for both men and women) and betting on horse racing (12 per cent and 8 per cent respectively).

Drinking habits

- Among adults who had drunk alcohol in the last week, 55 per cent of men and 53 per cent of women drank more than the recommended daily amounts, including 31 per cent of men and 24 per cent of women who drank more than twice the recommended amounts.

Children's weight and obesity

- Among children aged 2 to 15, 14 per cent of both boys and girls were classed as obese, and 28 per cent of both boys and girls were classed as either overweight or obese. Children aged 11 to 15 were more likely to be obese (19 per cent of both boys and girls) than those aged 2 to 10 (11 per cent and 10 per cent respectively).
- The majority of parents of boys and girls aged 4 to15 were able to accurately judge if their child was too heavy. However, just under a quarter of parents who thought that their child was about the right weight in fact had a child who was overweight or obese (23 per cent among both fathers and mothers). The mean Body Mass Index (BMI) at which fathers reported that children were overweight was lower than for mothers (23.6 kg/m2 for fathers and 24.7 kg/m2 for mothers).

(HSIC, Health Survey of England 2012, 2013)

5.2 Mental Health

The wider economic cost of mental illness in England has been estimated at £105.2 billion each year. This includes direct costs of services, lost productivity at work, and reduced quality of life. The cost of poor mental health to businesses is just over £1,000 per employee per year, or almost £26 billion across the UK economy.

In 2008/9, the NHS spent 10.8% of its annual secondary healthcare budget on mental health services, which amounted to £10.4 billion. Service costs, which include NHS, social, and informal care costs amounted to £22.5 billion in 2007 in England.

Over the last four years, overall investment in psychological therapy services has increased by 96%, from £197 million in 2008/09 to £386 million in 2011/12. IAPT investment increased to £213 million and now exceeds investment in non-IAPT services.

In 2010/11 the total money invested in adult mental health services for working age adults was £6.550 billion or £195.8 per head of weighted working age population. In the same year, £11.91 billion was spent on all age mental health disorders, compared to £11.26 billion in 2009/10.

There has been significant investment in inpatient environments, with over £2 billion invested in new and refurbished mental health facilities since 2001.

(NHS, Mental Health, 2013)

5.3 Obesity

Being overweight and obesity represent probably the most widespread threat to health and wellbeing in this country. A total of 23 per cent of adults are obese (with a body mass index – BMI – of over 30); 61.3 per cent are either overweight or obese (with a BMI of over 25). For children, 23.1% of 4–5-year-olds are overweight or obese, and 33.3 per cent of 10–11-year-olds. The trend has been upward over the

past decades, although it appears to have now levelled off in children and there are signs of levelling off among younger adults. However, the absolute level of obesity is very high – England, along with the rest of the UK, ranks as one of the most obese nations in Europe – and there are few signs yet of a sustained decline. We also continue to see clear health inequalities with regard to obesity.

People who are overweight have a higher risk of getting type 2 diabetes, heart disease and certain cancers. Excess weight can also make it more difficult for people to find and keep work, and it can affect self-esteem and mental health.

By 2020, the NHS aim to see:

- a downward trend in the level of excess weight in adults
- a sustained downward trend in the level of excess weight in children

(NHS, "Healthy Lives, Healthy People", 2012)

The cost to the UK economy of overweight and obesity was estimated at £15.8 billion per year in 2007, including £4.2 billion in costs to the NHS.(UK health forum 2007) and estimated at over £5 billion in 2012

5.4 Inactivity

The costs to the state of physical inactivity are high as can be seen from the Sport England / British Heart Foundation figure below.

National Programme Budget Project/Cost of physical inactivity data (Sport England 2009-10)

The costs of inactivity

A 2012 study for Sport England by the British Heart Foundation Health Promotion Research Group (BHF, 2013) found the cost of physical inactivity to NHS providers in England more than £900 million in 2009/10. The same report attempted a cost breakdown by individual authority. It represented an average cost of inactivity to each primary care trust of £6.2 million. Local breakdowns are available in the Local Sports Profile Tool from Sport England. Separate research for the CASE (Culture and Sport Evidence) programme found that the lifetime cost saving generated by taking part in regular sport varies between £1,750 and £6,900 per person, depending on the type and intensity of sport.

Table 2: Health costs of physical inactivity

Disease category	West Lancashire	NorthWest	England
Cancer lower GI e.g. bowel cancer	£123,849	£10,000,041	£67,816,189
Breast Cancer	£76,560	£7,919,863	£60,357,887
Diabetes	£461,082	£29,733,783	£190,660,420
Coronary heart disease	£1,099,680	£81,670,410	£491,095,943
Cerebrovascular disease e.g. stroke	£299,150	£20,181,189	£134,359,285
Total Cost	£2,060,321	£149,505,285	£944,289,723
Cost per 100,000 population	£1,915,996	£2,145,919	£1,817,285

Sport England commissioned data from British heart Foundation Health Promotion Research Groupfor PCTs, reworked into estimates by TBR. Year: 2009/10

An example of potential savings determined by the British Heart Foundation estimated the following:

Savings to a single country

The Scottish Physical Activity Task Force estimated that if physical inactivity in Scotland decreased by 1 per cent each year for the next five years: the economic benefit associated with the number of life years saved due to preventing these deaths is estimated to be £85.2 million yearly hospital admissions for coronary heart disease, colon cancer and stroke would fall by around 2,231 cases NHS Scotland could have a possible yearly cost saving of £3.5 million.

Increasing physical activity in the workplace

Physical activity programmes in the workplace have varying success rates at reducing employee absences. Even if a programme was only one per cent effective at reducing the number of employee absences over a year, employers have the potential to save between £2,870 and £6,244 each year. If a programme was considered 50 per cent effective in increasing physical activity, an employer could see a potential saving of up to £312,217 each year.

(BHF, "Economic costs of physical inactivity", 2013)

6. The commissioning process

Since 2007, the NHS and upper-tier local authorities have had a statutory duty to produce an annual Joint Strategic Needs Assessment (JSNA). The JSNA aims to analyse the health needs of populations to inform and guide commissioning of health, well-being and social care services within local authority areas. The main goal of a JSNA is to accurately assess the health needs of a local population in order to improve the physical and mental health and well-being of individuals and communities.

The JSNA therefore provides the high level objectives from which decisions are taken as to the best services to commission within the budgets available to maximise improvement across the local population.

From these objectives, each Health and Wellbeing Board must then develop its priorities and break these down into a series of targets, outcomes, actions and responsibilities (see Appendix A for an example from Manchester City Council). The Health and Wellbeing Board must then decide whether to tender the work or has the option to award it internally to the authority. An example of a Telford and Wrekin Council funding bid is included as Appendix B.

By way of example, Manchester's priorities are:

1. Getting the youngest people in our communities off to the best start
2. Educating, informing and involving the community in improving their own health and wellbeing
3. Moving more health provision into the community
4. Providing the best treatment we can to people in the right place and at the right time
5. Turning round the lives of troubled families
6. Improving people's mental health and wellbeing
7. Bringing people into employment and leading productive lives
8. Enabling older people to keep well and live independently in their community

6.1 World Class Commissioning

Much of the groundwork for the changes can be traced back to changes made by the last Government. In 2008, it launched its World Class Commissioning (WCC) initiative, which sought to make NHS commissioning more professional and effective. This was an attempt to significantly improve NHS commissioning which had been previously weak and inconsistent.

The WCC programme included the following four strands:

1. A vision for World Class Commissioning;

2. Eleven organisational competencies:

- Locally lead the NHS
- Work with community partners
- Engage with public and patients
- Collaborate with clinicians
- Manage knowledge and assess needs
- Prioritise investment
- Stimulate the market
- Promote improvement and innovation
- Secure procurement skills
- Manage the local health system
- Make sound financial investments;

3. An assurance system to hold commissioners to account and reward performance and development; and

4. Support and development tools.

The first results from the commissioning assurance system were published in 2009, uncovered a number of weaknesses, particularly in respect of the role of stimulating and developing a provider market.

Courtesy of The NHS Information Centre for health and social care. Full diagram available at: www.ic.nhs.uk/commissioning

6.2 Local authority rôle

The local authority now has a responsibility for a range of services listed below. Some of the services are mandatory for local authorities and the commissioning of other services will be discretionary.

Of specific interest to catering and sport services are the areas of Physical Activity, Obesity, Nutrition and Health Checks. These offer opportunities to deliver related service but also through the health checks and measurement programmes, the opportunity to sign-post people to other services.

Table 3: Local authority responsibilities

	Local authority commissioning	Related CCG commissioning	Related NHS CB commissioning
Children's public health 5-19	Healthy Child Programme for school-age children, including school nursing	Treatment services for children, including child and adolescent mental health services (CAMHS)	Healthy Child programme (pregnancy to five years old), including health visiting and family nurse partnership Immunisation programmes
Sexual health	Contraception over and above GP contract Testing and treatment of sexually transmitted infections (excluding HIV treatment) Sexual health advice, prevention and promotion	Promotion of opportunistic testing and treatment Termination of pregnancy services (with consultation on longer-term arrangements) Sterilisation and vasectomy services	Contraceptive services commissioned through GP contract Sexual assault referral centres HIV treatment
Public mental health	Mental health promotion, mental illness prevention and suicide prevention	Treatment for mental ill health	Mental health interventions under GP contract Some specialised mental health services
Physical activity	Local programmes to address inactivity and other interventions to promote physical activity	Advice as part of other healthcare contacts	Brief interventions in primary care
Obesity programmes	Local programmes to prevent and address obesity, e.g. National Child Measurement Programme and weight management services	Advice as part of other healthcare contacts NHS treatment of overweight and obese patients	Brief interventions in primary care Some specialist morbid obesity services
Drug misuse	Drug misuse services, prevention and treatment	Advice as part of other healthcare contacts	Brief interventions in primary
Alcohol misuse	Alcohol misuse services, prevention and treatment	Alcohol health workers in a variety of healthcare settings	Brief interventions in primary care
Tobacco control	Local activity, including stop smoking services, prevention activity, enforcement and communications	Brief interventions in secondary care and maternity care	Brief interventions in primary care
Nutrition	Any locally-led initiatives	Nutrition as part of treatment services, dietary advice in healthcare settings	Brief interventions in primary care
NHS Health Check Programme	Assessment and lifestyle interventions	NHS treatment following NHS Health Check assessments and ongoing risk management	Support in primary care for people with long term conditions identified through NHS Health Checks
Reducing and preventing birth defects	Population level interventions to reduce and prevent birth defects (with PHE)	Maternity services	Interventions in primary care such as pre-pregnancy counselling or smoking cessation programmes Some specialist genetic services Antenatal and newborn screening aspects of maternity services
Health at work	Any local initiatives on workplace health	NHS occupational health services	
Dental public health	Epidemiology, dental screening and oral health improvement, including water fluoridation (subject to consultation)		Oral health as part of dental contracts
Accidental injury prevention	Local initiatives such as falls prevention services		
Seasonal mortality	Local initiatives to reduce excess deaths		Flu and pneumococcal vaccination programmes

(NHS Commissioning Board 2012)

6.3 NICE public health guidance recommendations

Many options exist to tackle the problems of obesity. The guidance from the National Institute for Clinical Excellence below, highlights the opportunities for commissioning of small innovative projects for which there may not be a current evidence base.

- Commissioners should allocate some of their budget to help establish and sustain local community engagement activities such as small community projects or local community groups. This can be done by, for example, funding the expenses of the leaders of community walking groups, or providing small grants to hire meeting spaces.
- Commissioners should allocate some of their budget to innovative approaches to obesity prevention that are based on sound principles, have the support of the local community and are likely to be effective, but for which there is limited evidence. Funds for innovative approaches should be allocated within a framework of action learning and evaluation.
- All contracts should include requirements for regular monitoring or evaluation. Commissioners should ensure some flexibility in contracts to allow programmes or services to be adapted and improved, based on early or ongoing monitoring. Any changes should be clearly documented and carefully monitored. Clear processes should be put in place for learning and evaluation, especially for new approaches.
- Commissioners should ensure service specifications and contracts encourage local partnership working and reduce unnecessary duplication and overlap, particularly for local services provided by the voluntary and community sector (for example, by specifying a joint rather than separate approach for physical activity and food and nutrition initiatives).
- Where possible, commissioners should consider extending effective programmes or services, re-commissioning effective small-scale projects and commissioning small-scale projects or prototypes that fill a gap in provision. (Such actions should be based on local experience, monitoring and evaluation.)
- Commissioners should consider redesigning or decommissioning programmes or services that are identified by local Healthwatch or other local bodies with a scrutiny function (such as health overview and scrutiny committees) as ineffective or not meeting the community's needs.

The table below provides a range of interventions that should be considered and the majority are well within the capabilities of most local authorities:

Table 4: Interventions that should be considered by local authorities

Local commissioning on obesity	NICE guidance	
	Adults	Children
Community engagement and workforce development	Behaviour change: the principles for effective interventions Community engagement Preventing type 2 diabetes – population and community interventions	
Prevention	Promoting physical activity in the workplace Alcohol-use disorders – preventing harmful drinking Prevention of cardiovascular disease Weight management before, during and after pregnancy Preventing type 2 diabetes – population and community interventions Obesity Walking and cycling	Physical activity and the environment Maternal and child nutrition Promoting physical activity for children and young people Prevention of cardiovascular disease Obesity
Lifestyle weight management	Weight management before, during and after pregnancy	
Wider local policies	Physical activity and the environment Prevention of cardiovascular disease Preventing type 2 diabetes – population and community interventions	
Evaluation and monitoring	Prevention of cardiovascular disease Preventing type 2 diabetes – population and community interventions Obesity	

(NICE 2013)

6.4 Tender process

At this point in time, most Health and Wellbeing Boards are still operating contracts that were often agreed with their predecessor PCT's. However most of these will end within the next 12 to 18 months. Many feel obliged to tender new work although in many cases in-house organisations offering value for money are being awarded work directly once confidence is established.

Main requirements of health commissioners

When preparing a tender bid or funding submission, it is important to demonstrate the following:

- Value of / addition to the evidence – service level and research etc.
- Understanding of the needs of the target groups and recognition that delivery may need to be amended appropriately (need-led)
- Understanding of wider areas of health and of any overlap.
- Evidence of behaviour change / health improvement – outcomes (not outputs) where possible.
- Willingness to look outside service to evidence wider impact e.g. with parents.
- Willingness to be a multi-agency partner.
- Innovation is essential
- Cost Benefit Analysis – savings to the wider system

On a practical and financial level it is important to demonstrate:

- Readiness to deliver at scale.
- VFM with projected efficiencies.
- The vision for the organisation & service now & in 3 / 5 / 10 years

- Recognition of the evidence base.
- Evidence of previous successes (& failures = learning) / Knowledge / skills / Stakeholder engagement etc
- Proactive identification of improvements / challenges / risks / projected financial efficiencies etc.

Many projects have a defined time scale and will be assessed to determine whether they achieve their objectives and outcomes are proven. Successful programmes are likely to be re-commissioned, whilst those that fail to meet targets will be discontinued or refocused.

To that end there is a pressing need to evidence success (the ' So what?' Question). The project will need to include provision for:

- Robust and timely reporting
- Quantitative and qualitative data
- Building evaluation into planning
- Agreed and appropriate KPIs / outcomes

And once successful in obtaining work, it is imperative that the relationship with the 'commissioner' is managed proactively:

- Involve right people from the start
- Manage expectations.
- Share your knowledge – providers are the experts.
- Ongoing effective service user feedback to help commissioners plan service dev./ investment

6.5 Examples of tender documents

Tender documents used by Manchester City Council and Telford and Wrekin Council are provided as Appendices A and B.

7. Public Health in Wales, Scotland and Northern Ireland

While councils in England now have a statutory new health and wellbeing role, Scotland, Northern Ireland and Wales have different approaches to delivering public health. Authorities in these countries play a significant non-statutory role in public health and there are opportunities for providers of front-line services to contribute towards health and wellbeing outcomes.

7.1 Wales

The recent Williams report from the Commission on Public Service Governance and Delivery accepted the principle that, 'prevention is better than cure' but the practical difficulties of transferring resources from reactive to preventative services, particularly where this is cross sector or anticipatory, have slowed policy development. It is widely recognised that increasing physical activity for example, would have a positive impact on the clinical consequences of obesity. However, translating that into a transfer of resources from the NHS to local authority leisure centres or parks departments is difficult to achieve when health budgets are under immediate pressure.

Public Health is Wales is delivered by seven Health Boards. For example Aneurin Bevan Local Health Board covers the areas of Blaenau Gwent, Caerphilly, Monmouthshire, Newport, Torfaen and South Powys.

The Local Health Board delivers a variety of programmes including those covering cardiac, respiratory and weight management. Many of the schemes are delivered at local authority leisure facilities or outdoor parks. Lessons are paid for by the Health board but any income (typically £1.50 per session) is retained by the local authority. Referrals can be made by GPs, practice nurses and consultants.

The Wales National Exercise Referral Scheme

Overview

The National Exercise Referral Scheme is a Welsh Assembly Government funded scheme which has been developed over the last four years to standardise exercise referral opportunities across all Local Authorities and Local health Boards in Wales. The Scheme targets clients who have a chronic disease or are at risk of developing chronic disease.

Principal aims

- To offer a high quality National Exercise Referral Scheme across Wales.
- To increase the long term adherence in physical activity of clients.
- To improve physical and mental health of clients.
- To determine the effectiveness of the intervention in increasing activity levels and improving health.

The programme

The Scheme operates in all 22 local authorities and runs for 16 consecutive weeks and consists of 2 fully supervised group-based sessions each week. Each session lasts for approximately one-hour and cost £1.50. The sessions are usually run in leisure or community centres but there are some outdoor opportunities available in most areas

Quality standards

All protocols used on the Scheme represent the best current known practice and meet with current national guidance. All exercise professionals operating the Scheme are trained to NVQ level 3, have a qualification that meets occupational standard D449 working with referred patients, and are appropriately insured. All protocols went through ethical approval, and the British Medical Association in Wales was consulted as part of the development of the Scheme.

The evaluation

The evaluation was conducted by the Cardiff Institute of Society, Health and Ethics, Cardiff University in partnership with the North Wales Clinical School, Cardiff University and the Institute of Medical and Social Care Research, Bangor University.

(WAG, "The evaluation of the National Exercise Referral Scheme in Wales", 2010)

Main findings of the evaluation:

- All participants in the scheme had higher levels of physical activity than the control group, with this difference being significant for patients referred for coronary heart disease risk factors
- There were positive effects on depression and anxiety
- The economic evaluation demonstrated a cost per Quality Augmented Life Year (QALY) of £12,111. For those who adhere to the full programme the scheme there is a marginal cost saving (£-367 per QALY)

The Welsh Local Government Association appointed a Coordinator in August 2008. The national coordinator's role is to: monitor the day to day running of the scheme; mentor and support the coordinators and exercise professionals across Wales to improve and develop their schemes performance; commission training and develop standard protocols for each of these chronic conditions based on best practice from across the UK.

The physical benefits include:

- The heart and lungs become stronger and more efficient
- Muscular strength increases
- Joints become stronger
- The onset of osteoporosis can be delayed
- Body fat and excess weight may be reduced
- Relaxation and sleep might be improved
- Being better able to carry out the activities of daily living
- Feeling more alert and energetic
- Maintaining good posture
- Helping to normalise blood pressure
- Reduce risk of developing diabetes
- A reduced risk of blood clotting
- Helping to maintain independence, rather than becoming dependant

Psychological benefit - comments by participants include:

- "I feel less anxious and stressed"
- "My confidence and self-esteem are better"
- "Being more active helped me to to give up smoking"
- "The activity sessions gave me time for myself"
- "My wife says I look a lot happier"
- "I took more responsibility for my own health"

Social benefits - comments by participants include:

- "It was a good opportunity to meet other people who had the same worries as I did"
- "The sessions made me get out of the house and gave me a new interest"
- "I made new friends and enjoyed the conversations we had"
- "I feel much fitter and can play with my grandchildren for longer now"

7.2 Scotland

Heath in Scotland is delivered by 14 regional NHS Boards, seven Special NHS Boards and one public health body. The relationship between local authorities and Public Health in Scotland is consensual with few powers, but duties imposed on both parties in legislation to cooperate. These duties are outlined in the Public Health etc (Scotland) Act 2008.

The act contains the following clauses

(4) Duty of local authorities to protect public health

- "Each local authority is to continue to make provision, or secure that provision is made, for the purpose of protecting public health in its area."

(6) Duty of health boards and local authorities to co-operate

- In exercising the functions conferred on them by virtue of this Act, each health board and local authority must co-operate with any relevant person that appears to the board or, as the case may be, authority to have an interest in or a function relating to the protection of public health.

(7) Joint public health protection plans

- (1) Each health board must prepare such plans relating to the protection of public health in its area as the board considers appropriate.
- (2) In preparing a plan under subsection (1), a health board must consult the relevant local authority

In addition there is the ***Schools (Health Promotion and Nutrition) Scotland Act*** – health promotion guidance. This guidance has been devised to support local authorities and schools.in working with partner agencies to meet the duty to ensure that all schools are health promoting. The guidance contains sections on physical education, activity and sport, 'Food and health' including school meals in Scotland and dental health.

7.3 Northern Ireland

The Public Health Agency (PHA) was established in April 2009 as part of the reforms to Health and Social Care (HSC) in Northern Ireland as the major regional organisation for health protection and health and social wellbeing improvement. Their role commits them to addressing the causes and associated inequalities of preventable ill-health and lack of wellbeing.

In fulfilling its mandate to protect public health, improve public health and social wellbeing, and reduce inequalities in health and social wellbeing, the PHA works within an operational framework of three areas: Public Health, Nursing and Allied Health Professionals, and Operations.

The PHA run a GP referral scheme in conjunction with local authority partners to encourage people with specific health conditions to join the Healthwise scheme – a free 12 week physical activity programme. The scheme is available at registered leisure centres and Healthy Living Centres (HLCs) within the Belfast and South Eastern Health and Social Care Trust areas and is for people with certain health conditions who have been referred by their GP, nurse or other health professionals.

The scheme is suitable for those with:

- high blood pressure
- a body mass index (BMI) of more than 25
- asthma or chronic obstructive pulmonary disease (COPD)
- diabetes
- osteoporosis
- hypertension
- coronary heart disease and associated risk factors

- anxiety
- stress
- depression

Trained health and fitness staff at each centre are available to take people through the scheme over the 12 weeks. They will develop a physical activity referral programme to suit a person's health needs and monitor any improvements to the person's health. Some activities include walking, swimming, group activities and training in a fitness suite.

8. Case studies

The following are just a small selection of examples of good practice around the UK, where councils' in-house teams and leisure partners are making a positive contribution towards health and wellbeing objectives.

Blackpool

As a response to significant levels of deprivation in the borough, Blackpool Council took the decision from January 2013 to provide daily breakfasts within 33 schools, delivering up to 11,000 breakfasts per day. The children have a choice of a drink and two items from a selection of in the main, malt loaf, bagels - plain and cinnamon, fruit, chopped fruit, raisins, yoghurt and smoothies. Some schools have also chosen toast and cereal on certain days.

The £1.3m scheme was initially fully funded by the local authority and free to all pupils. Breakfast is delivered in the classroom, usually prior to registration, by teaching staff. The benefits to the children are such that recently public health funds have been ring-fenced to provide a continuing service. The Health & Wellbeing board have since taken over most of the responsibility for funding

The programme has been assessed by Dr Greta Defeyter of Northumbria University, who said: "Blackpool's Free School Breakfast Scheme is one of the largest school breakfast schemes operating within the UK. The overall findings of the evaluation of the Blackpool Free School Breakfast scheme presented in the current report are very positive and based on these findings I strongly recommend that the scheme continues"

The School Breakfast Programme has a number of objectives, which are specifically:

- To contribute to reducing health inequalities (chronic disease morbidity and life expectancy) by improving health among those communities that demonstrate the worse health outcomes.
- To improve the nutritional status of primary school children in Blackpool
- To increase the awareness of healthy eating
- To support and embed healthy eating practices within schools and the local community, particularly amongst children
- To improve punctuality, attendance, educational attainment of primary school children

East Riding of Yorkshire

East Riding Leisure Team has developed a range of programmes that are commissioned by health. These services have not only generated income for the service, but have also brought new members into the gyms. Customer retention as a result is estimated at £200k per year.

East Riding has been especially innovative in designing an online software system that links into GP surgeries and is also available for pharmacies. All can book patients directly onto the programmes. Services include:

- Live Well - £120k per year
- Young Live Well - £50k per year
- Health Checks (partners) - up to £100k
- Stroke free and rely on retention
- Cardiac rehab free and rely on retention
- GP referral - £100k per year

LiveWell is part of the Bariatric Care Pathway. It works with patients to support them to lose weight, get fit and improve their health over a 26 week period. Fitness instructors trained in physical activity, nutrition, motivational interviewing and cognitive behavioural therapy support individuals on a one to one basis to address their lifestyle and behaviour to lose weight and maintain weight loss.

Patients are referred to the programme by their GP. After initial assessment of their BMI and fitness levels participants are offered a choice of physical activities, tailored to their needs and abilities, at a location of their choice. They are encouraged to set goals in line with NICE guidelines which suggest that even a small weight loss of 5% can have health benefits for most people.

The results of the LiveWell programme are particularly striking. There has been a 84% completion rate, when the expectation was 20%. Health improvements among participants include:

- 87.5% feel healthier
- 81.3% feel fitter
- 81.3% feel more energetic
- 75% feel more relaxed
- 62% feel better about themselves
- 56.3% have made new friends
- 43.8% helped with medical condition

East Riding used to have up to 85 bariatric operations per annum – this is now down to between 15 -20. It is estimated that the cost of the operation and pre and post care averages around £25-30k. The savings to the NHS are therefore substantial.

The leisure service currently charges the NHS £600 per patient for the 26 week intervention programme. However, it is not this that provides the greater return it is the fact that they stay loyal to the service and become core members. The programme has been audited by the University of Hull, which provides the evidence base but also external validation of the results.

Telford and Wrekin

In 2008, Telford and Wrekin Council purchased a Cooking Bus which allows it to have a mobile kitchen and teaching space to deliver workshops in all areas of the Borough including promotional events. This purchase was possible through one off grant funding and partner contributions. The running costs for the bus (garaging, fuel, servicing) are covered from the Education Catering budget.

The Cooking Bus provides a facility to deliver a range of healthy eating based initiatives for frontline staff, volunteers, children and young people, NEETs, families, carers and foster carers. Projects that have previously benefited from the Cooking Bus include the Lets Cook Project (primary schools) & Lets Cook minis (Early Years). These projects raised awareness and demonstrated healthy cooking and education on nutrition and the importance and benefits of a good well balanced diet.

During the operation of the project, it accessed all primary schools, some children's centres and hard to reach groups (Shortwood School with cultural diet needs). We reported on all activities demographic areas linked to obesity, gender, feedback from participants. Attendance which was 98% of those who signed up.

The change4life eat well project is currently being delivered from the Cooking Bus. This is a new Healthy Eating Project for families with children under 11. The funding for this project is from Public Health as part of the Excess Weight Priority, this covers the 2 part time tutors who have been appointed. They have skills and expertise to take the project further and continue to educate residents of the Borough and assist to improve the health and wellbeing of the local population.

A second project for cares, which funded by Public Health, is run successfully from the Cooking Bus. This project provides workshop sessions to meet the needs of:

- Young Carers - cooking skills including dishes which are nutritious and quick to prepare, sessions will also include social engagement
- Male Carers – half day workshops to teach cookery skills, nutrition and cookery terms following recipes confidence in cooking
- Female carers – based more on social engagement and networking

The Carers sessions are to assist with having a well-balanced diet, cooking for one and preventing social isolation due to the nature of caring for a family member and supports independent living. The project will provide supporting information to attendees – recipe cards, nutrition based around the eat well plate and links to Change 4 Life campaign.

The Cooking Bus will also attend community events to raise awareness of healthy eating and facilitate road show workshops with in the borough and is used for one off sessions and is available for use by other service areas such as Family Learning, Neighbourhoods, Leisure, Youth and Cohesion

An important impact is that the authority is able to work with all sectors of the population. Outcome data from a previous project run between 2008 – 2013 from the cooking bus called Lets Cook is available.

Wandsworth

Wandsworth Council handed out hundreds of weight-loss vouchers in a bid to tackle rising obesity levels. The scheme is part of a drive to improve the health of residents on the Winstanley and York Road estates, Battersea. A similar scheme in Roehampton saw 460 people take up the challenge.

Those involved are taking part in weight loss classes, a stop smoking service, or cooking lessons for 12 weeks to earn gym access for six months at either Latchmere Leisure Centre or Battersea Sports Centre. Studies from 2012/2013 show, within Wandsworth, 9.8& of children at reception age were obese. Levels doubled to 20.2% for year six children.

Leader of Wandsworth Council, Ravi Govinda, said: "The council wants to give people on the Winstanley and York Road Estates the tools to transform their lives. This extends way beyond the council's aim to see physical improvements on the estates to a much bigger desire to support more people to make the most of all the opportunities around them."

Weight loss company Slimming World is playing a large part in the initiative, having been approached by Wandsworth Council to accept pre-paid vouchers so residents can participate for free. More than 100 people have signed up to slim down since March, and the council plans to buy 600 vouchers from Slimming World at a cost of £4.95 each. The programme has been so successful there are plans for classes to be held in six more venues in addition to those at Dimson Lodge, Battersea Church Road. To join the weight loss classes you must have a BMI above 25, not be pregnant, and have not been on the programme within the past six months.

Wigan

Three innovative projects in Wigan - Metrofresh, Let's Get Movin' and Back to Sport - are making positive contributions to health and wellbeing objectives for the borough.

Metrofresh

There are lots of changes happening with school food, but the outcomes and impacts are much wider than just food on a plate. Working collaboratively, MetroFresh and the Wigan Startwell team want to ensure that every child has the best start on life, enabling all children and young people to maximise their capabilities and have control over their lives and their attitude and behaviour towards food is a significant part of this

There are a number of relevant indicators in the Public Health outcomes framework, such as children in Poverty (links to FSM Uptake) and Pupil Absence (link with good health) that revolve around food and getting the implementation of Universal Infant Free School Meals and outcomes of the School Food Plan right can potentially influence this.

The partners are working together to map and understand the evidence base at local and national level around improved long term health following the introduction of Universal Infant Free School Meals. The

culture and ethos around school food needs to have a collaborative approach, from the School Leadership Team, School Governors, Metrofresh and Public Health.

Working together we can ensure that we maximise the take up of School food, making sure food is appetizing, nutritious; making the dining hall a welcome place; keeping queues down; getting the right price; allowing children to eat with their friends and getting them interested and excited in cooking and growing food. To this end Public Health Wigan have funded a development chef to £50k over two years. This is an exciting opportunity to drive cultural change.

Let's Get Movin'

Let's Get Movin' is a Children's Healthy Weight Service provided through a three year contract from August 2013 to 2016.

This service is aimed at delivering healthy weight interventions for referred children, young people and families, to reduce BMI, improve health outcomes and prevent further weight gain. Health improvements will be achieved through the delivery of a multi-component weight management programme (nutrition/diet, physical activity, behavioural modification and support) to address the needs of overweight and/or obese children up to 17 years old. The service is aimed at increasing the number of children and young people that adopt a healthy lifestyle and maintain a healthy weight across the Wigan Borough by providing the following:

Early Years

- Deliver weaning courses for 400 parents with babies 2-6 months old;
- Deliver pre-school Healthy Lifestyles Programme to 100 settings;
- Weight Management Service for 200 overweight/obese children 2-4 years.

Primary School Aged Children

- 5-7 years (KS1) Weight Management Programme for 300 overweight/obese children;
- 8-11 years (KS2) Weight Management Programme for 200 overweight/obese children;
- Delivery of the National Childhood Measurement Programme for Reception and Year 6 children in all schools;
- Healthy Lifestyles programme for children in Year 4 in 100 schools per year

Secondary School Aged Children

- 12-14 years (KS3) Weight Management Programme for 75 obese children and young people.
- 15-17 years (KS4) Weight Management Programme for 50 obese young people

Wigan youngsters tackle weighty issue of childhood obesity

Many Year 5 children are currently taking part in a six-week programme - The Healthy Lifestyle Award – which is delivered by Wigan Council's Fit 4 Fun Academy team.

Each week the team covers a different topic including the balance of good health, eating five portions of fruit and veg a day, snack swaps, physical activity and the facts about fats and sugars. The children take part in a different activity each week including active games, circuits and basketball skills, wearing pedometers throughout and recording their scores.

While the programme is designed to be fun for the children, it supports the National Child Measurement Programme (NCMP), a statutory measurement that is undertaken with all Reception and Year 6 children on an annual basis. The programme aims to encourage children to make changes to adopt a healthier lifestyle by being more active and making healthier choices around food.

Participants also have various health and fitness measurements taken at the start of the programme, and again six weeks later. Parents whose children are identified as being above a healthy BMI (body mass index) and want additional support can go on to access Fit 4 Fun Academy's community family healthy lifestyle programmes.

The NCMP data for 2011/12 shows that 8.5 per cent of Wigan's Reception children are obese and 12.9 per cent are overweight, which is in line with the average for England, however, more Year 6 children are classified as obese or overweight compared with the England average, with 19.5 per cent regarded as obese and 16.2 per cent being overweight.

Wigan Council lead commissioner for early intervention and prevention, Emma Edwards, said: "As a borough we have made significant improvements and developments in children's healthy weight services that will have a gradual impact on the percentage of healthy weight children in the coming years. Encouragingly, a small decrease has been seen in overweight and obese Reception aged children from the baseline in 2006.

"Programmes such as the Healthy Lifestyles Award delivered by Fit 4 Fun, plus the other healthy weight resources operational across the borough are working to reduce the prevalence of obesity in children in Wigan. This is done by making children aware of the importance of eating a healthy, balanced diet and taking part in regular physical exercise. The programme enables children to make informed choices about how they live their lives. The NCMP figures have shown that we have made real progress in reducing obesity and overweight levels and we are committed to giving every child in the borough a healthy start in life by supporting them to be a healthy weight and lead a healthy lifestyle."

Back to Sport

Back to Sport, a three year contract which ran until the end of January 2015, was part of a suite of physical activity commissions which aim to develop a public health infrastructure sufficiently robust to anchor and sustain effective physical activity promotion in relation to sporting opportunities in the Wigan Borough.

The service aims to provide and further develop a range of sport and physical activity opportunities by linking with local sports clubs, national governing bodies and other physical activity providers, to support and enable sedentary adults, or those not involved in active lifestyles to become more active by returning to sport, or trying a new sport, thus improving health outcomes.

The programme is aimed at increasing participation in sport and physical activity, and achieve the best wellbeing outcomes for individuals referred into the service by:

- Supporting behaviour change in order to reduce levels of sedentary3 behaviour, by enabling access to sport and physical activity opportunities in a range of sporting, workplace and community settings.
- Building individual, organisational and community capacity for physical activity behaviour change.
- Building capacity within service delivery through the development of sustainable, volunteer led sports activity.
- Motivating, empowering and supporting individuals to make healthy lifestyle changes, which result in health improvement, an increase in self confidence and self efficacy.
- Providing effective post intervention follow up support to enable individuals to sustain long term physical activity and maintain health and wellbeing outcomes.
- Maximise upon the existing sporting heritage within Wigan Borough.

At population level the expected outcomes include:

- Higher levels of physical activity, particularly amongst those who are currently inactive.
- Reduce mortality and morbidity from heart disease, diabetes and other disorders associated with inactivity.
- Improvements in the Boroughs overall life expectancy.
- A reduction in health inequalities.

At a service level, the key outcomes anticipated include:

- Increased participation in physical activity/sport– measured at baseline, post intervention and 6 months.
- Capacity to deliver a programme for 500 new participants per year.

- Delivery of a range of Back to Sport activity sessions by core provider staff, freelancers, partners and/or trained volunteers.
- An increase in the number of sustainable sessions delivered across the borough.

9. Conclusion and recommendations

Conclusion

The new framework for public health and wellbeing offers new opportunities for providers of catering and sport and leisure services. The holistic approach to public health advocated by the current framework chimes with many of the principles of APSE's Ensuring Council model.

In-house service providers need to be fully aware of this new framework and engage with Health and Well-being Boards and commissioners. They need to demonstrate the value of these services to Health and Well-being Boards and Commissioners. They need to show that investing in local services can save resources spent on dealing with ill-health. There is a wealth of information to draw upon and examples of good practice are available.

Recommendations

While there are considerable opportunities for in-house providers to make a positive contribution to health and wellbeing objectives, there are also barriers at central, local authority and service delivery level.

APSE recommends the following ways in which central government departments, local authorities' senior management teams, Health and Wellbeing Boards, and managers responsible for delivering these services, can maximise their contribution to the health and well-being of their local communities.

- Actively look beyond the silos that constrained past working. Much of public health around obesity and physical activity can be delivered well by non-clinicians
- Seek community based solutions, located locally and easily accessible
- Encourage interventions that deliver a pathway into physical activity
- In two-tier areas, utilise the existing leisure infrastructure
- Actively consider approaches individualised to each CCG area
- Promote schemes that enable referrals from a variety of partners, such as the model used by East Riding of Yorkshire Council

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NICE 2014: Obesity: working with local communities pathway

Appendix A

Example of Health & Wellbeing Board Priority Statement (Manchester)

Strategic priority 2

Educating, informing and involving the community in improving their own health and wellbeing

Background

Manchester has some of the poorest health in England, and even within Manchester people die younger and experience higher levels of illness in some parts of the city than others. This alone is a reason to act to improve health; the fact that poor health also prevents people from reaching their full potential and holds back the development of the city provides further reasons for acting to improve health. In addition, changes to the population and to expectations of good health lead to ever-increasing demands on health, social care and health services. This pattern is clearly not sustainable in the long term.

These problems will not be solved by the development of ever increasing services. Instead we need to prevent people from getting to the stage where they need expensive treatments or services, whether in the NHS or in social care; and where people do need support, we need to reduce their dependency on services. This can only be done in partnership with people themselves and the whole strategy will only be successful if we can completely change the relationship between communities and services and adopt a more assertive approach.

Together we need to build strong communities that are able to take action themselves in support of their own health and wellbeing. Such communities are built on a high quality physical environment, and supported by appropriate universal services. Three main strategies are needed. The first is to work with individuals, challenging them to change their behaviour and take more responsibility for their own health and wellbeing – including making appropriate use of services. The second is to improve the environment people live in: not just their housing, but their neighbourhood, social circumstances and experiences, tackling anti-health forces that make it more difficult for people to take responsibility for their own wellbeing. The third is to ensure a life course approach is adopted, that embeds healthy behaviours in children and young people that continue into adulthood and old age and there are obviously strong links and interdependencies with priority one (children's health) and priority eight (health ageing) . We are committed to action across all three.

Over the next two years we will transform the way in which health, care and public health services engage with people and communities. The new model will be based on co-production – recognising people as assets and powerful agents of change themselves; working with communities and individuals; and seeing our services as facilitating the change that people want to make for themselves rather than simply delivering the things we have always delivered. This will need service providers to think very differently about their roles and the way services are currently delivered.

Target group(s) for 2013 – 2015

- People and families living in a number of priority neighbourhoods (to be defined, prioritised by deprivation and levels of ill health)
- People aged 40-74 who are eligible for an NHS Health Check
- People and families identified as needing support to make appropriate use of local services.

Headline outcomes by 2015

- People and communities will do more themselves to improve their own health and wellbeing.

- More people will be leading healthier lifestyles across the risk factors of smoking, physical activity, diet, alcohol and fewer children and young people will be taking up risky behaviours
- People will be using the right services for their needs

Preferred headline indicators

Premature mortality rate from cardiovascular diseases, cancers, cancers considered preventable, liver diseases, liver diseases considered preventable, respiratory diseases, respiratory diseases considered preventable - age-standardised rate of mortality in persons less than 75 years of age per 100,000 population

Actions

Over the next two years:

9) Health, care and public health services will work with people, families and communities to improve independence and self reliance

10) We will work with local communities to:

- create new urban spaces that support people's health and wellbeing
- protect and enhance existing green space
- encourage development and urban design that is accessible and promotes physical activity

From April 2014 we will:

11) Integrate existing Healthy Living Network approaches into new neighbourhood services that support families and communities to take action to improve their own health and wellbeing

12) Have reviewed our approach to implementing the NHS Health Check and increased uptake of this service

13) Ensure specialist services are targeted to those who most need specialist support and we will have identified a new approach to running healthy lifestyles services that will help people across the life course to change their own lifestyles Have identified a new model for services that help individuals and families to reach and maintain a healthy weight

14) Have established and promoted "Choose Well", a web based tool to support people in deciding which service is most appropriate for their needs.

By April 2015:

15) We will have trained an agreed number of front-line workers from the City Council and local NHS Trusts to motivate clients or patients to change their lifestyles

Who will be accountable for achieving these results?

- Responsibility for leading and co-ordinating action on healthy lifestyles outcomes sits with Public Health Manchester within Manchester City Council.
- Responsibility for encouraging appropriate service use sits with the Clinical Commissioning Groups.

However achieving results across all three will require action by a wide range of partners, including the voluntary and community sector, GPs and other primary care staff, social care, and neighbourhood delivery teams.

Appendix B

Example funding application to Commissioning Board

Application form for public health outcomes fund 2014-15 (Telford and Wrekin)

The Public Health Outcomes Fund is designed to support existing services/proposals that will make a positive impact on the health and wellbeing of the Telford & Wrekin population. It should be linked to the achievement of Public Health outcomes and in line with Public Health commissioning intentions.

1. Name of Proposal

Change for Life Eat Well Project

2. State the Public Health Outcome Framework indicators that this proposal contribute towards together with the rationale [Refer to Appendix)]

PH Outcome Indicator	PH Outcome description	Rationale
2.06i	*Excess weight in 4 – 5 year olds*	*To support and educate families to cook and eat healthy food , giving basic cooking skills , nutritional information to encourage healthy eating, social engagement through food and increase confidence to cook fresh food* *Assist them to have a balanced diet – early intervention and education to raise diet awareness*
2.06ii	*Excess weight in 10- 11 year olds*	*As above*
1.01	*Children in poverty*	*Educating families to cook on a budget , links to the Food bank and assisting to provide a healthy diet* *Increase uptake in Free School Meals* *Promote uptake of Healthy Start*

Priorities this Proposal Supports

Local Priorities

Health and Wellbeing Board identified Excess Weight as a Priority

Health and Wellbeing Board identified Carers as a Priority

Excess Weight has been selected as a priority in all 3 Children's Centre Localities

Supports delivery of excess weight vision and action plan

Supports delivery of Change 4 Life campaign

National Policy

Supports delivery of the 5 a day campaign

NICE(National Institute for Health and Clinical Excellence) Public Health

PH11 – Maternal and Child Nutrition

PH27 – Weight Management before and after pregnancy

PH42 – Obesity – working with Local communities

PH47 – Managing overweight among children and young people

3. Description of Proposal – outline the entire key elements/aspects/evidence base etc. using the prompts below. What is the proposal?

In 2008 the Council purchased a Cooking Bus which allows us to have a mobile kitchen and teaching space to deliver workshops in all areas of the Borough including promotional events. This purchase was possible through one off grant funding and partner contributions. The running costs for the bus (garaging, fuel, servicing etc) are covered from the Education Catering budget.

The Cooking Bus provides a facility to deliver a range of healthy eating based initiatives for frontline staff, volunteers, children and young people, NEETs, families, carers and foster carers

Projects that have previously benefited from the Cooking Bus include the Lets Cook Project (primary schools) & Lets Cook minis (Eraly Years) . These projects raised awareness and demonstrated healthy cooking and education on nutrition and the importance and benefits of a good well balanced diet.

During the Operation of the project we accessed all Primary schools, some children's centres and hard to reach groups (Shortwood School with cultural diet needs). We reported on all activities demographic areas linked to obesity, gender, feedback from

participants. Attendance which was 98% of those who signed up.

The change4life eat well project is currently being delivered from the Cooking Bus. This is a new Healthy Eating Project for families with children under 11 (including Early Years). The funding for this project is from Public Health as part of the Excess Weight Priority, this covers the 2 part time tutors who have been appointed. They have skills and expertise to take the project further and continue to educate residents of the Borough and assist to improve the health and wellbeing of the local population.

A second project which is run successfully from the Cooking Bus, but is not funded by Public Health, is for Carers. This project provides workshop sessions to meet the needs of:

Young Carers - cooking skills including dishes which are nutritious and quick to prepare, sessions will also include social engagement

Male Carers – half day workshops to teach cookery skills, nutrition and cookery terms following recipes confidence in cooking

Female carers – based more on social engagement and networking

The Carers sessions are to assist with having a well-balanced diet, cooking for one and preventing social isolation due to the nature of caring for a family member and supports independent living

The project will provide supporting information to attendees – recipe cards, nutrition based around the eat well plate and links to Change 4 Life campaign.

The Cooking Bus will also would attend community events to raise awareness of healthy eating and facilitate road show workshops with in the Borough

The Bus is also used for one off sessions and is available for use by other service areas such as Family Learning, Neighbourhoods, Leisure, Youth and Cohesion

Impact is that we are able to work with all sectors of the population

Outcome data from a previous project run 2008 – 2013 from the cooking bus (Lets Cook) is available

4. Which Category of public health spends is this application against?

Nutrition
Food Poverty
Reducing Social Isolation
Ageing Well Offer – Carers Wellbeing

5a. What will be the detailed outcomes of this proposal?

Educating and Raising awareness to all areas of the Borough , to enable residence to have diet awareness linked to healthy life styles

5b. How will these outcomes be measured and the impact

We would produce a quarterly report of all activity, areas of the borough delivered, attendees, group mix age & gender. Session feed back

5. Overview of proposed budget lines

14-15 £	Total £	Description
20k	*20k*	*For the operational costs of the Cooking Bus , garaging, fuel etc*
		Food for demonstrations , supporting material recipe cards
10k	*10k*	*To deliver the project to Carers, to support healthy living, reduce social isolation and support independent living*
		Total 30k

The change4life Eat Well project is funded by Public Health.

This application is to pay for the £20,000 operating costs of the Cooking bus , Garaging , fuel and promotional material which is currently funded from the catering budget

The Carers cooking project is currently funded (£10,000) by Adult Social Care

NAME OF LEAD			
POST:	*Catering Service Delivery Manager*	TEL:	
EMAIL:		DATE	

Please provide the name of the Assistant Director who you have liaised with prior to submitting your application and who supports your proposal.

NAME OF ASSISTANT DIRECTOR SPONSOR		POST	*Customer & People Services*

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fax: 0161 772 1811