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East Sussex
County Council

Enabling people of all ages to live healthy lives and have healthy lifestyles

Foreword

The first of April 2013 saw the successful completion of the transfer of Public Health Services from the Primary Care Trusts to the County Council, and the Health and Wellbeing Board, established in shadow form in 2011, take on its full statutory powers and duties.

The Health and Wellbeing Board has developed its first Health and Wellbeing Strategy – *Healthy Lives, Healthy People, The East Sussex Health and Wellbeing Strategy 2013-2016* – which aims to protect and improve people's health and wellbeing and reduce inequalities. The Strategy sets out the seven key priorities for improvement over the next three years:

1. The best possible start for all babies and young children
2. Safe, resilient and secure parenting for all children and young people
3. Enabling people of all ages to live healthy lives and have healthy lifestyles
4. Preventing and reducing falls, accidents and injuries
5. Enabling people to manage and maintain their mental health and wellbeing
6. Supporting those with special educational needs, disabilities and long term conditions
7. High quality and choice of end of life care

These priorities are areas where the Board can make a real difference and the strategy sets out how this will be achieved through the commissioning of services, joint working and collective action.

The Annual Report of the Director of Public Health 2013/14 was produced to inform delivery of the Health and Wellbeing Strategy. Whilst the full Annual Report covers all seven priority areas, a series of booklets have also been produced which focus on each of the priority areas in turn. Each booklet reproduces what is contained in the Annual Report for that area.

This booklet presents the results for priority 3: Enabling people of all ages to live healthy lives and have healthy lifestyles.

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Chapter 1: Introduction

The Director of Public Health is required by statute to prepare and publish an annual report. This year's report provides the evidence to help commissioners identify the interventions that will deliver the priorities which have been agreed in the East Sussex Health and Wellbeing Board's Health and Wellbeing Strategy for 2013-2016 "Healthy Lives, Healthy People".

The report presents the results from a series of rapid evidence and literature reviews aligned to the seven priority areas identified in Healthy Lives, Healthy People and the recommendations will help service commissioners to ensure that they make the best investment of the resources they have available and to weigh the return on that investment against other competing priorities.

For each of the seven priority areas, sub-topics have been identified which are important for delivery. Recommendations from the evidence reviews have been included in the appendices, and the full evidence review reports are included on the East Sussex Joint Strategic Needs Assessment website **www.eastsussexjsna.org.uk.**

To make the recommendations more easily accessible a series of booklets have been produced. Each booklet focuses on one of the priority areas in Healthy Lives, Healthy People, and reproduces what is contained in the full annual report for that area, including all the recommendations contained in the appropriate appendix.

Booklet 1:	The best possible start for all babies and young children
Booklet 2:	Safe, resilient and secure parenting for all children and young people
Booklet 3:	Enabling people of all ages to live healthy lives and have healthy lifestyles
Booklet 4:	Preventing and reducing falls, accidents and injuries

Booklet 5: Enabling people to manage and maintain their mental health and wellbeing
Booklet 6: Supporting those with special educational needs, disabilities and long term conditions
Booklet 7: High quality and choice of end of life care

Commissioners can use the booklets to prioritise the key recommendations for implementation. Recommendations should be prioritised where they:

- are not part of current practice;
- highlight the need for practice to change;
- require retraining or the development of new skills;
- require implementation by a broad range of agencies or across a range of settings;
- may be viewed as potentially contentious or difficult to implement for other reasons.

The Health and Wellbeing Strategy Action Plan

Healthy Lives, Health People is supported by an action plan setting out high level actions, outcomes, indicators and targets including those aimed at 'narrowing the gap' between the best and worst performing areas in the county. Table 1.1 presents the targets and indicators for priority area 3: Enabling people of all ages to live healthy lives and have healthy lifestyles.

The Structure of this Booklet

This booklet outlines the approach taken to review the literature and evidence, identifies the sub-topics that are important for delivery, presents some of the key facts and figures for and then identifies evidence based recommendations for implementation.

The full evidence review report for this priority area is included on the East Sussex Joint Strategic Needs Assessment website **www.eastsussexjsna.org.uk.**

Table 1.1 The Health and Wellbeing Strategy Action Plan: Priority Area 3 – Enabling people of all ages to live healthy lives and have healthy lifestyles

OUTCOMES	ACTIONS AND OUTPUTS	OBJECTIVES
Priority 3: Enabling people of all ages to live healthy lives and ha		
More people will have healthy lifestyles to improve their prospect of a longer, healthier life.	• Enhance the alcohol care pathway - from prevention through to recovery and involving a range of health, care and other partners. • Develop and implement a cross-sector multi-agency Tobacco Control Plan. • Develop and implement a cross-sector multi-agency Obesity Prevention Plan. • Enable frontline staff to offer residents brief advice and signposting to relevant services.	• Fewer young drinking at i risk levels. • Lower rates young peop and others i population. • Increase in t population a recommend activity (all a • More people portions of f day. • Reduction in

	STRATEGIC OUTCOME INDICATORS
ave healthy lifestyles	
g people and adults ncreasing and higher of smoking amongst le, pregnant women n the general the proportion of the achieving the minimum ed rates of physical ages). e of all ages eating five fruit and vegetables a n alcohol related crime.	3.1 Reduce rates of mortality from causes considered preventable. Indicator definition: Age-standardised rate of mortality from causes considered preventable per 100,000 population. Baselines: (2010) England average 149; (2010 to 2012) East Sussex average 135.3; Eastbourne 154.0; Hastings 175.6; Lewes 121.4; Rother 133.3; Wealden 112.6. Targets by 2016: 10% reduction between 2010-2012 and 2015-2017 for East Sussex County based on a steady reduction of 2% per year; and by 2015-2017 reduce the gap between Hastings Borough and Wealden District to the gap measured in 2003-2005 (59.5 deaths per 100,000). 3.2 Increase both the percentage offered NHS Health Checks and the take up by those in the eligible population. Indicator definition: Percentage of eligible population aged 40-74 offered an NHS Health Check who received an NHS Health Check in the financial year. Baselines: (2011/12) England average 14% offered and 51.2% received; East Sussex average 9.6% offered and 43.5% received. NB: district and borough level data not available. Targets by 2016: 2013/14 = 10% offered and 50% received; 2014/15 = 20% offered and 50% received 2015/16 = 20% offered, 70% received.

Chapter 2: Evidence based commissioning

2.1 The approach – identifying the evidence

Within each of the seven priority areas of the Health and Wellbeing Strategy several sub-topics were identified as important for delivery. These were reviewed for evidence to support health and social care interventions and services.

The reviews focused on systematic reviews and meta-analyses, but where there was a lack of evidence, randomised controlled trials were also included. Each review aimed to identify the most important and relevant message supported by the scientific literature. They deliver a summary of clear and concise evidence statements based on the 5-10 most recent and relevant systematic reviews or meta-analyses.

Table 2.1: Sub-topics for the overall literature review of priority area 3: Enabling people of all ages to live healthy lives and have healthy lifestyles

Priority area	Sub-topic
Enabling people of all ages to live healthy lives and have healthy lifestyles	a. Interventions to reduce the number of young people/adults drinking alcohol at a high risk level
	b. Interventions to lower rates of smoking amongst young people/adults
	c. Interventions to support primary prevention of smoking in children/young adults
	d. Interventions to support people to change behaviour (all ages)
	e. Interventions to promote physical activity (all ages)
	f. Interventions to promote healthy eating (all ages)

Evidence was classified based on the Scottish Intercollegiate Guidelines Network (SIGN) methodology. These reviews did not include a full systematic assessment of study quality, perceived levels of bias and probabilities of causal relationships were scored based on an assessment of each source's methodology. Scorings were indicative rather than definitive.

Table 2.2: Study Quality Classification

1++	High quality meta-analyses, systematic reviews of Randomised Control Trials (RCTs), or RCTs with a very low risk of bias.
1+	Well-conducted meta-analyses, systematic reviews, or RCTs with a low risk of bias.
1-	Meta-analyses, systematic reviews, or RCTs with a high risk of bias.
2++	High quality systematic reviews of case control or cohort or studies. High quality case control or cohort studies with a very low risk of confounding or bias and a high probability that the relationship is causal.
2+	Well-conducted case control or cohort studies with a low risk of confounding or bias and a moderate probability that the relationship is causal.
2-	Case control or cohort studies with a high risk of confounding or bias and a significant risk that the relationship is not causal.
3	Non-analytic studies, e.g. case reports, case series.
4	Expert opinion.

The recommendations for each topic were classified using a system based on the overall quality of the evidence. Recommendations graded 'A' are based on the highest quality evidence and those graded 'D' the lowest.

Table 2.3: Recommendation Strength Classification

A	At least one meta-analysis, systematic review, or RCT rated as 1++, and directly applicable to the target population; or a body of evidence consisting principally of studies rated as 1+, directly applicable to the target population, and demonstrating overall consistency of results.
B	A body of evidence including studies rated as 2++, directly applicable to the target population, and demonstrating overall consistency of results; or extrapolated evidence from studies rated as 1++ or 1+.
C	A body of evidence including studies rated as 2+, directly applicable to the target population and demonstrating overall consistency of results; or extrapolated evidence from studies rated as 2++.
D	Evidence level 3 or 4; or extrapolated evidence from studies rated as 2+.

2.2 Commissioning prioritisation

This booklet aims to provide commissioners and multi-agency partnerships with a checklist against which commissioning plans and strategies can be compared to ensure they are based on current best evidence.

The evidence review includes some interventions that are well established within local services. However, it is recommended that commissioners and multi-agency partnerships review the full list of recommendations against strategies.

A process of prioritisation and building recommendations into work plans is recommended using the following criteria to identify interventions which:

- are not part of current practice;
- highlight the need for practice to change;
- require retraining or the development of new skills;
- require implementation by a broad range of agencies or across a range of settings; and
- may be viewed as potentially contentious or difficult to implement for other reasons.

Chapter 3: Enabling people of all ages to live healthy lives and have healthy lifestyles

Focus on

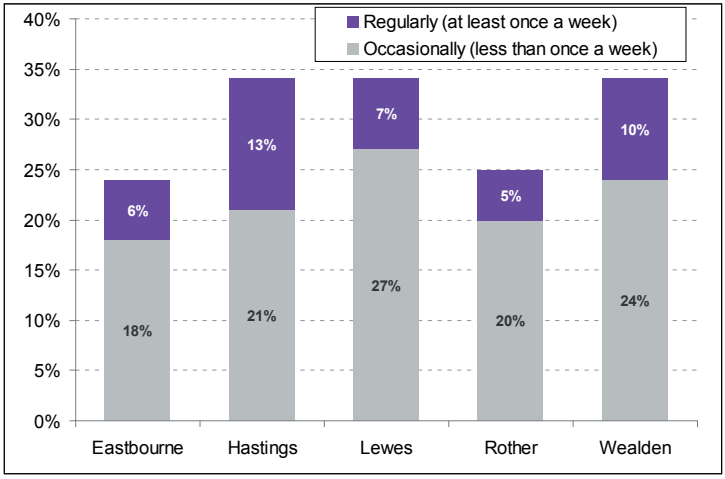
3.1 Interventions to reduce the number of young people/adults drinking alcohol at a high risk level
3.2 Interventions to lower rates of smoking amongst young people/adults
3.3 Interventions to support primary prevention of smoking in children/ young adults
3.4 Interventions to support people to change behaviour (all ages)
3.5 Interventions to promote physical activity (all ages)
3.6 Interventions to promote healthy eating (all ages)

Public Health Outcome Framework indicators relevant to this key area and their East Sussex rating in comparison to the England Average, November 2013.

	Public Health Outcome Indicator	Comparison to England
1.16	Utilisation of outdoor space for exercise/health reasons	Significantly better
2.14	Smoking prevalence – adults (over 18s)	Better
2.22	Take up of NHS Health Check Programme by those eligible	
	i health check offered	Significantly worse
	ii health check take up	Significantly better

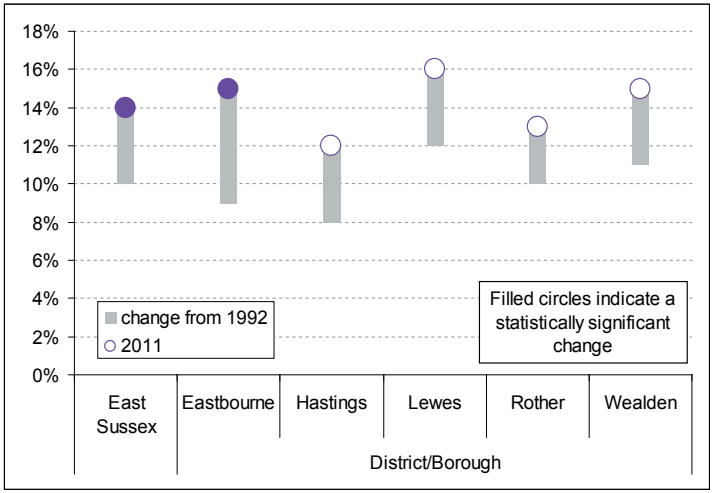
3.1 Key facts and figures: young people and adults drinking alcohol at high risk level

Figure 3.1a: Frequency with which 14-15 year old pupils describe how often they drink alcohol, 2012



Source: East Sussex JSNA, The 2012 East Sussex health related behaviour survey of year 10 pupils, January 2013
www.eastsussexjsna.org.uk/evidencelinks/evidence

Figure 3.1b: Change in percentage of drinkers who are increasing risk and higher risk drinkers, 1992 and 2011



Source: East Sussex JSNA, Health and Lifestyle in East Sussex 1992-2011, January 2012
www.eastsussexjsna.org.uk/evidencelinks/evidence

What is increasing and higher risk drinking? Increasing risk drinkers are at an increasing risk of alcohol-related illness. They are defined as:

- men who regularly drink more than 3 to 4 units a day but less than the higher risk levels
- women who regularly drink more than 2 to 3 units a day but less than the higher risk levels

Higher risk drinkers have a high risk of alcohol-related illness. They are defined as:

- men who regularly drink more than 8 units a day or more than 50 units of alcohol per week
- women who regularly drink more than 6 units a day or more than 35 units of alcohol per week

In a recent survey of drinking habits in young people between a quarter and a third of 14-15 year olds said they drank alcohol occasionally or regularly, for young people drinking alcohol at any level can be harmful to health.

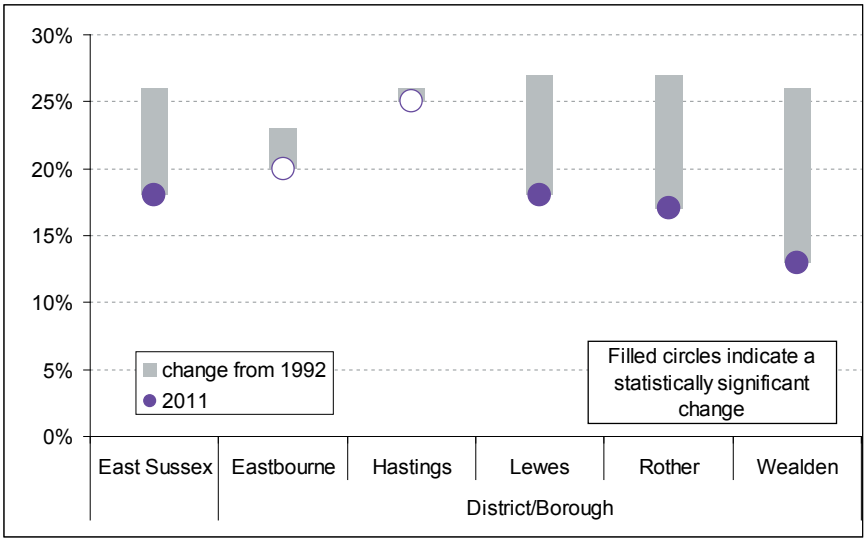
The proportion of adults drinking at increasing risk levels has significantly increased in recent year across East Sussex (Fig 5.1b). This is due to a significant increase in Eastbourne. People who drink at these levels have a greater risk of developing conditions such as reduced fertility, high blood pressure, some cancers and heart disease.

3.2 Key facts and figures: smoking amongst young people and adults

Figure 3.2a: Percentage of 14-15 year old pupils who describe themselves as occasional or regular smokers, 2012

Source: East Sussex JSNA, The 2012 East Sussex health related behaviour survey of year 10 pupils, January 2013
www.eastsussexjsna.org.uk/evidencelinks/evidence

Figure 3.2b: Change in percentage of smokers, 1992 and 2011



Source: East Sussex JSNA, Health and Lifestyle in East Sussex 1992-2011, January 2012
www.eastsussexjsna.org.uk/evidencelinks/evidence

In line with national trends smoking rates for adults across East Sussex as a whole have decreased in recent years. However in some areas despite more than 20 years of tobacco control activity rates remain virtually the same as they were in 1992.

The proportion of young people who say that they are occasional or regular smokers remains worryingly high across the county and in some areas almost 1/3 (30%) of girls say that they smoke occasionally or regularly.

3.3 Key facts and figures: primary prevention of smoking in children and young adults

Figure 3.3 Percentage of 14-15 year old pupils answering that at least one person smokes on most days indoors at home

Source: East Sussex JSNA, The 2012 East Sussex health related behaviour survey of year 10 pupils, January 2013
www.eastsussexjsna.org.uk/evidencelinks/evidence

Between 37% and 52% of 14-15 year olds in East Sussex live in a home where someone smokes inside the home on most days.

Young people whose parents smoke are more likely to take up smoking themselves. In addition exposure to second hand tobacco smoke is associated with an increased risk of poorer health outcomes for children and young people.

3.4 Key facts and figures: supporting behaviour change (all ages)

Healthy Foundations is a lifestyle segmentation model which aims to ensure that all public health interventions are informed by our understanding of what motivates people and how these motivations are affected by their social and material circumstances. It classifies people according to their attitudes to life and health, demographic characteristics and their health-related behaviours. The Segmentation Model consists of five core motivational segments: Health Conscious Realists; Balanced Compensators; Live for Todays; Hedonistic Immortals; and Unconfident Fatalists.

<table>
<tr><th colspan="2">Health Conscious Realists (HCR)</th></tr>
<tr><td rowspan="2">What are they like
They are motivated people who feel in control of their lives and their health. They generally feel good about themselves, but have more internally focused aspirations to better themselves, learn more and have good relationships, rather than just aspiring to looking good. They tend not to take risks and take a longer term view of life, and that applies to their health too. Their health is very important to them and they feel that a healthy lifestyle is easy to achieve and enjoyable. They also take a realistic view of their health: of all the segments they are the least fatalistic about their health, and don't think they are any more or less likely than other people to get ill.</td><td>Profile
• Female bias in this segment
• They are more likely to live in less deprived areas but significant numbers do live in deprived areas
• Segment with an older than average age (47 compared to 43 years for the study sample)</td></tr>
<tr><td>Behaviours
• Display positive health behaviours
• Highly motivated
• In control of their lives and their health
• Low prevalence of smoking and drug use
• Eat healthily</td></tr>
</table>

Balanced Compensators (BC)

What are they like

They are positive and like to look and feel good about themselves. They get some pleasure from taking risks. However, they don't take risks with health. Health is very important to them, and something they feel in control of. A healthy lifestyle is generally easy and enjoyable. They are not fatalists when it comes to health and understand that their actions impact on their health both now and in the future. If they do take some health risks, they will use compensatory mechanisms to make up for this, such as going for a run in the morning having eaten a big meal or drunk too much the night before.

Profile

- Stronger male bias within this segment
- Highest proportion of people in full time work
- Segment with a slightly younger than average age (41 compared to 43 years for the study sample)

Behaviours

- Generally positive health behaviours
- Exercise regularly
- Eat healthily
- Low prevalence of smoking and drug use

Live for Today (LFT)

What are they like

They definitely like to "live for today" and take a short term view of life. They believe that whatever they do is unlikely to have an impact on their health, so what's the point? They tend to believe in fate, both where their health is concerned, but also for other things in life. They value their health but believe that leading a healthy lifestyle doesn't sound like much fun, and think it would be difficult. They don't think they are any more likely than anyone else to get ill in the future. They tend to live in deprived areas which gets them down and they don't feel that good about themselves, but feel more positive about life than the "Unconfident Fatalists". They are the segment who are most resistant to change and don't acknowledge that their health needs to change, unlike the "Unconfident Fatalists".

Profile

- Tend to live in more deprived areas
- Segment average age (42 compared to 43 years for the study sample)

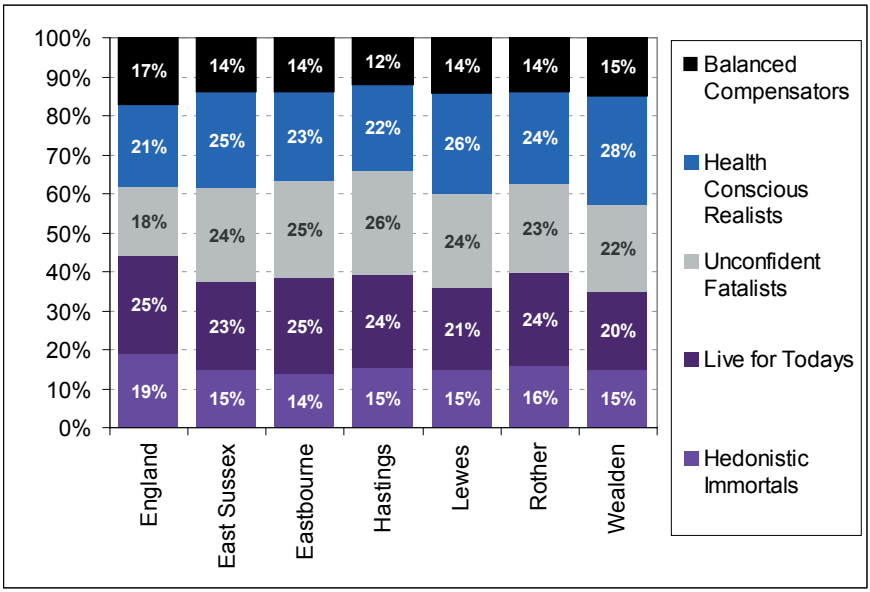
Behaviours

- Exhibit fairly poor health behaviours
- Hold short-term view of life
- Fatalistic about life
- More likely to smoke and drink heavily
- Little concern for their future wellbeing

Hedonistic Immortals (HI)	
What are they like They are people who want to get the most from life. They do not mind taking risks – as this is part of leading a full life. They feel good about themselves and are not that motivated by material wealth or possessions. They know that their health is important to avoid getting ill in the future, but feel pretty positive about their own health at the moment and don't think they will be getting ill any time soon. Maybe because of that they do not really value their health right now. They do not have a problem with leading a healthy lifestyle: it would be fairly easy and enjoyable to do so, and they certainly intend to live healthily. However they feel that anything which is enjoyable, such as smoking and drinking, cannot be all bad.	**Profile** • Segment with a younger average age • More likely to come from less deprived areas • Segment with a younger than average age (36 compared to 43 years for the study sample) Behaviours • Motivated by enjoyment and taking risks • Display lack of concern for their health and wellbeing • Most likely to drink heavily • Higher-than-average incidence of drug taking

Unconfident Fatalists (UF)	
What are they like Overall, they feel fairly negative about things, and don't feel good about themselves. A significant proportion feel depressed. They feel that a healthy lifestyle would not be easy or in their control. Generally they don't feel in control of their health anyway. They are quite fatalistic about health and think that they are more likely than other people of the same age to get ill. Their current lifestyles are not that healthy, and their health isn't currently as good as it could be. They know their health is bad, and that they should do something about it, but they are de-motivated.	**Profile** • Segment with an older average age (47 compared to 43 years for the study sample) • Tend to live in more deprived areas • Least likely to be in paid work • More likely to be retired Behaviours • Exhibit the most negative health behaviours • Hold negative perceptions of a healthy lifestyle • Often fatalistic about their own health

Figure 3.4: Percentage of the adult population by Healthy Foundations segmentation, 2011



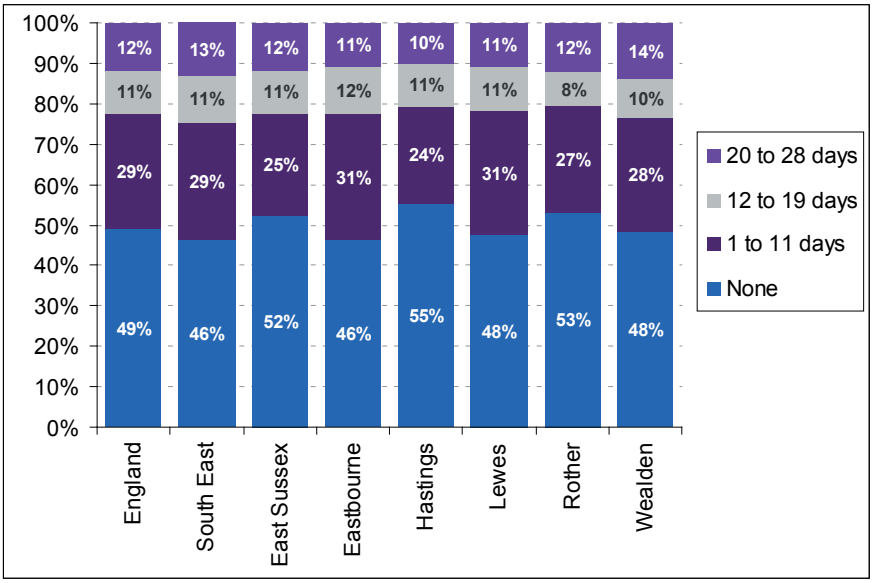
Source: East Sussex JSNA, Health and Lifestyle in East Sussex 1992-2011, January 2012
www.eastsussexjsna.org.uk/evidencelinks/evidence

Understanding motivational and communication preferences in the population can help to target support and services. Healthy Foundations segmentation of East Sussex show that we have a significantly higher proportion of 'unconfident fatalists', people who may find it more difficult to make behaviour changes and need more intensive support to do this than the England average. Hastings has an even higher proportion of 'unconfident fatalists' than East Sussex.

3.5 Key facts and figures: physical activity

East Sussex has higher proportion of adults reporting that they did no sport or active recreation in the past month than the England and South East averages.

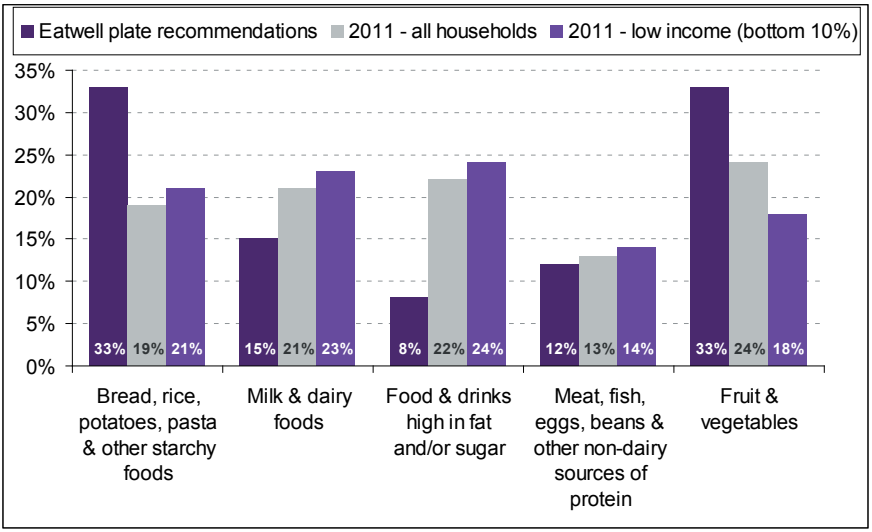
Figure 3.5: Days of adult participation in sport and active recreation in the last 28 days, 2010/12



Source: Source: Local Sport Profile Tool from Sport England based on Active People Survey Data
http://www.sportengland.org/our-work/local-work/local-government/local-sport-profile/

3.6 Key facts and figures: healthy eating (all ages)

Figure 3.6: Eatwell plate comparison for low income and all households in England, 2011



Source: Family Food 2011, Department for Environment, Food and Rural Affairs
www.gov.uk/government/publications/family-food-2011

The Eatwell plate describes the proportions of food from the different food groups that adults are recommended to eat to achieve a healthy and balanced diet. Nationally most households are not eating close to the eatwell plate. Low income households tend to buy much less fruit and vegetables and much more food and drinks high in fat and/or sugar.

Recommendation: commissioners and multi-agency partnerships delivering in this area should review current commissioning plans and strategies against evidence recommendations laid out in Chapter 4. Where gaps or weaknesses are identified, interventions for implementation should be prioritised using criteria outlined in Chapter 2.

Chapter 4: Evidence based recommendations for priority area 3

The objective of this section is to make evidenced based recommendations that support commissioners with a robust basis for decision making.

Recommendations are based on evidence from systematic reviews and meta-analyses. Scoring of recommendations is based on the SIGN methodology as set out in Chapter 2. Recommendations graded 'A' are based on the highest quality evidence and those graded 'D' the lowest. These reviews were carried out at a specific point in time and we acknowledge there are further caveats commissioners must take into consideration:

- NICE guidance is being updated on a continuous cycle, and some of the evidence presented here may not have been reviewed by NICE at this time. Commissioners need to ensure interventions do not conflict with current NICE guidance.
- East Sussex CCGs operate a 'Low Priorities Procedures' process whereby some procedures are not ordinarily commissioned and requests for treatment are referred to an 'individual treatment panel'. It is important to recognise that the agreed processes should be followed for these interventions.
- Locally, new pathways to treatment for patients for a wide range of conditions are being developed by GPs, commissioners and secondary care clinicians. It is important to ensure agreed treatment pathways are followed.

It is recommended that commissioners review the entire evidence base set out in the evidence review for this priority area, but that service planning focuses on those issues highlighted in this recommendations section.

RECOMMENDATION NUMBERS LISTED ARE THOSE FROM THE FULL EVIDENCE REVIEW FOR THIS PRIORITY AREA. FULL EVIDENCE REVIEWS ARE AVAILABLE ON THE EAST SUSSEX JOINT STRATEGIC NEEDS ASSESSMENT WEBSITE WWW.EASTSUSSEXJSNA.ORG.UK

2.2 Recommendations for interventions to reduce the number of young peopl

This evidence review recommends:

Intervention	
2.2.1	Commissioners should maintain and develop partnerships to monitor and ev into planning.
2.2.3	Include formal evaluation within the commissioning framework so that alcoh
Ensure:	
2.2.2	a local joint alcohol needs assessment is carried out in accordance with 'Wor integrated care pathways for alcohol treatment are reviewed.
2.2.4	alcohol education is tailored for different age groups and takes different lear
2.2.13	there are appropriate referral systems to specialist treatment for anyone who
2.2.14	there are sufficient resources to ensure all alcohol intervention providers hav governance structures and supervision to those providing screening and brie
2.2.19	there are appropriate referral pathways to child and adolescent mental healt appropriate and available. For young people at a significant risk of alcohol-re
2.2.5	education programmes to reduce the number of young people drinking alcoh knowledge attitudes and skills training included.
Promote:	
2.2.6	education programmes that begin early in childhood; combine a school-base problem behaviours including alcohol use.
2.2.7	partnerships to support alcohol education in schools as part of the educatio to reduce alcohol use and to involve them in those initiatives.
2.2.8	a 'whole school' approach to alcohol, in line with DCSF guidance. It should in and the school environment to the professional development of staff.
2.2.10	brief interventions delivered by appropriately trained staff to children and yo alcohol and/or make a direct referral to external services.
2.2.11	brief interventions with the adolescent and a parent.

e/adults drinking alcohol at a high risk level

	Grade
valuate alcohol reduction partnership working and incorporate good practice	A
ol interventions and treatment are routinely evaluated and followed up.	A
rld Class Commissioning' and ' Signs for improvement', that locally defined	A
rning needs into account.	A
o is dependent on alcohol.	A
ve appropriately trained professionals who can provide strategic direction, ef interventions for alcohol reduction.	A
th services, social care or to young people's alcohol services for treatment, as elated harm, consider referral.	A
ol at a high risk level are integrated into to the school curriculum and	A B
ed curriculum intervention with parent education, which target a range of	A
n curricula. Engage with parents, children and young people about initiatives	A
nvolve staff, parents and pupils and cover everything from policy development	A
oung people in schools who are thought to be drinking harmful amounts of	A
	B

Intervention	
2.2.16	audit in primary care to identify hazardous and harmful drinking.
2.2.17	alcohol screening as an integral part of practice. Where screening everyone i may be at an increased risk of harm from alcohol.
2.2.18	alcohol screening questions that are sensitive to people's culture and faith a
2.2.9	Follow best practice on child protection, consent and confidentiality. Where a external services for children and young people in schools who are thought t
Consider:	
2.2.12	delivering brief interventions to heavy alcohol users admitted to general hos
2.2.15	providing E-self-help alcohol awareness/reduction interventions without pro
2.2.20	reviewing policies on pricing to reduce the affordability of alcohol.

This evidence review does not recommend:

Intervention	
2.2.21	intensive brief interventions over less intensive interventions.
2.2.22	longer counselling over brief intervention.

	Grade
	B
s not feasible or practicable, NHS professionals should focus on groups that	A
nd tailored to their needs.	A
appropriate, involve parents or carers in the consultation and any referral to o be drinking harmful amounts of alcohol.	A
pital wards.	A B
fessional contact.	B
	A

	Grade
	B
	B

2.3 Recommendations for interventions to lower rates of smoking amongst y

This evidence review recommends:

Intervention	
2.3.1	Review of smoking cessation policies and practices at strategic and provide
Ensure:	
2.3.2	smoking cessation advice and support is available in community, primary a
2.3.5	health professionals have monitoring systems set up to ensure they have a
2.3.6	all those offering smoking cessation services are offering one or more interv
2.3.8	smoking cessation support and treatment is delivered only by staff who hav Cessation Treatments'.
2.3.11	all health professions have access to smoking cessation training.
2.3.3	local policy makers and commissioners should target hard to reach and dep attention to their needs.
2.3.4	reduction interventions can be carried out using self-help materials or aide
Promote:	
2.3.7	interventions that offer either advice to stop smoking or assistance with sto
2.3.12	high intensity behavioural interventions in conjunction with nicotine replac month of supportive contact after discharge.
2.3.14	interventions that combine pharmacotherapy and behavioural support.
2.3.15	intervening with older smokers.
Encourage:	
2.3.9	primary care professionals to advise all patients who smoke to quit when th to an intensive support service. If they are unwilling or unable to accept this
2.3.10	other health professionals, such as hospital clinicians, pharmacists and de support service.
2.3.13	employers to develop a smoking cessation policy in collaboration with staff policy

oung people/adults

	Grade
level.	A
nd secondary care settings for everyone who smokes.	A
ccess to information on the current smoking status of their patients.	A
entions that have been proven to be effective.	A
e received training that complies with the 'Standards for Training in Smoking	A
	A
rived communities including minority ethnic groups, paying particular	A
d by behavioural support, and can be carried out with the aid of pre-quit NRT.	A
pping, including text messaging.	A
ement therapy that begins during a hospital stay and includes at least one	A
	A
	B
ey attend a consultation. Those who want to stop should be offered a referral referral they should be offered pharmacotherapy in line with NICE guidance.	A
ntists and community workers to refer people who smoke to an intensive	A
and their representatives as one element of an overall smoke-free workplace	A

This evidence review does not recommend:

Intervention	
2.3.16	There is not strong evidence from indirect comparisons that offering more int

2.4 Recommendations for interventions to support primary prevention of smo

This evidence review recommends:

Intervention	
Ensure:	
2.4.1	smoking prevention interventions in schools and other educational establ
2.4.2	schools and other educational establishments deliver evidence-based sm
2.4.10	interventions to prevent the uptake of smoking as part of PSHE are linked t children and young people in their design.
2.4.11	head teachers, school governors, public health commissioners, teacher tra partnership and provide training for all staff who will be involved in smoki
2.4.4	interventions are integrated into the curriculum, PSHE education and work
Promote:	
2.4.3	smoke free policies consistent with regional and national tobacco control s
2.4.8	interventions that are culturally sensitive and begun in early adolescence w
2.4.13	national, regional or local mass-media campaigns to prevent the uptake o
2.4.16	community multi-sectorial interventions to reduce smoking rates among ch
2.4.5	Work with local partners involved in smoking prevention and cessation act

	Grade
tensive behavioural support was associated with larger treatment effects.	A

oking in children/ young adults

	Grade
ishments are part of a local tobacco control strategy.	A
oking prevention interventions.	A
to the whole-school or organisation-wide smoke-free policy and involve	A
aining bodies and providers of continuing professional development work in ng prevention work.	A
k associated with healthy further education and healthy schools status.	A
strategies.	A
when susceptibility to smoking is highest.	C
f smoking among young people under 18.	A
nildren and youth.	B
tivities to deliver interventions.	A

Intervention	
Local authorities and trading standards bodies:	
2.4.6	should work with other agencies to identify areas where under-age tobacc
2.4.7	should ensure retailers are aware of legislation prohibiting under-age toba and ensure enforcement efforts are sustained.
Encourage:	
2.4.9	head teachers, school governors, teachers, support staff and others who w develop a whole-school or organisation-wide smoke free policy in consulta
2.4.12	parents and carers to become involved, in school based smoking preventi
2.4.14	Effective practice, including effective local and regional media messages,
2.4.15	Use process and outcome measures to ensure campaigns are being delive

This evidence review does not recommend:

Intervention	
2.4.17	Media campaigns delivered in conjunction with or supported by the tobac

2.5 Recommendations for interventions to support people to change behavio

This evidence review recommends:

Intervention	
2.5.1	Deliver population-level policies, interventions and programmes tailored information gathered about the context, needs and behaviours of the tar
Ensure:	
2.5.2	population-level interventions and programmes aiming to change behav
2.5.5	fair and equitable access to education and training, to enable practitione develop their skills and competencies.
2.5.8	that, wherever possible, the following elements of behaviour change inte outcome measures: effectiveness; acceptability; feasibility; equity and sa

	Grade
o sales are a particular problem.	A
acco sales and support better enforcement of existing tobacco sales legislation	A
work with primary and secondary schools and further education colleges to ation with young people and staff.	A
on initiatives.	A
should be shared locally, regionally and nationally.	A
red correctly and effectively.	A

	Grade
co industry.	A

ur

	Grade
l to change specific, health-related behaviours. These should be based on rget population.	A
iour are consistent with those delivered to individuals and communities.	A
ers and volunteers who help people to change their health-related behaviour to	A
erventions and programmes are evaluated using appropriate process or afety.	A

Intervention	
2.5.2	population-level interventions and programmes aiming to change behav
2.5.3	Work in partnership with individuals, communities, organisations and po behaviour.
2.5.4	Provide training and support for those involved in changing people's hea required.
2.5.6	Equip practitioners with the necessary competencies and skills to suppo
2.5.7	Evaluate all behaviour change interventions and programmes, either loca an economic component.
2.5.9	Promote health behaviours that include physician advice or individual co
2.5.10	Consider mass media campaigns and legislative interventions to promot
2.5.11	Take into account the local and national context and working in partnersh changing behaviour.
Prioritise behaviour change interventions and programmes:	
2.5.12	developed in collaboration with the target population, community or grou
2.5.13	using key life stages or times when people are more likely to be open to c the workforce.

	Grade
iour are consistent with those delivered to individuals and communities.	A
opulations to plan interventions and programmes to change health-related	A
lth-related behaviour so that they can develop the full range of competencies	A
rt behaviour change, using evidence-based tools.	A
ally or as part of a larger project. Wherever possible, evaluation should include	A
ounselling, and workplace and school-based activities.	A
e changing health behaviours.	A
hip with recipients when planning interventions and programmes aimed at	A
up and take account of lay wisdom about barriers and change.	A
change such as pregnancy, starting or leaving school and entering or leaving	A

2.6 Recommendations for interventions to promote physical activity

This evidence review recommends:

Intervention	
Ensure:	
2.6.1	the joint strategic needs assessment, the joint health and wellbeing strate opportunities to increase walking and cycling and also consider how impe
2.6.6	walking and cycling projects are evaluated, including their impact on healt
Promote:	
2.6.2	coordinated, cross-sector working and ensure NICE's recommendations on
2.6.3	multi-component physical activity school and community programmes for
2.6.4	physical activity sessions for children and young people are led by staff or working with children and have the skills to design, plan and deliver sessi
2.6.13	community based interventions in increasing physical activity in socio-eco
2.6.8	an exercise referral scheme that directs someone to a service offering an a monitoring of progress and a follow-up.
2.6.5	Offer high level support from the health sector for walking and cycling.
2.6.7	Address the needs of hard to reach and disadvantaged communities, inclu promote physical activity.
2.6.9	work with public health to foster an integrated approach to local commissi
2.6.10	fund both targeted and universal services that can help people achieve or
2.6.11	introduce and monitor an organisation-wide programme that encourages a
2.6.12	raise awareness of the importance of physical activity for children and you physical activity initiatives aimed at children and young people are regular and young people's physical activity.

	Grade
egy and other local needs assessments and strategies take into account diments to walking and cycling can be addressed.	A
th inequalities.	A
n physical activity and the environment are implemented.	A
children and young people.	A B
volunteers who have achieved the relevant sector standards/ qualifications for ons.	A
nomically disadvantaged communities.	B
ssessment of need, development of a tailored physical activity programme,	A
	A
uding minority ethnic groups, when developing service infrastructures to	A
oning that supports a long term system-wide health and wellbeing strategy.	A
maintain a healthy weight.	A
and supports staff and, where appropriate, service users, to be physically active.	A
ng people that includes: ensuring there is a coordinated local strategy; ensuring rly evaluated; identifying a senior council member to be a champion for children	A

2.7 Recommendations for interventions to promote healthy eating

This evidence review recommends:

Commissioners	
Intervention	
2.7.1	Focus on all of the following areas: • raising awareness of the health problems caused by obesity and • training to meet the needs of staff and volunteers; • influencing the wider determinants of health; • aiming activities at both adults and children in a broad range of s • providing lifestyle weight management services for adults, childre • providing clinical services for treating obesity.
2.7.2	Working with public health teams to foster an integrated approach to local and wellbeing strategy.
2.7.8	Ensure all monitoring and evaluation considers the impact of strategies, p
2.7.5	Preventing and managing obesity is a priority for action, at both strategic a
2.7.6	Engage with the local community, to identify environmental barriers to phy

Strategic leadership	
Intervention	
2.7.3	Ensure through the health and wellbeing board a coherent, community-wi management. Activities should be integrated within the joint health and w
2.7.4	Health and wellbeing boards, supported by directors of public health, sho should ensure JSNAs consider the full range of factors that may influence w local evidence on obesity.
2.7.7	Public health teams should ensure commissioners understand the demog characteristics of subgroups within local communities that may impact on
2.7.9	Consider extending effective programmes or services, recommissioning eff prototypes that fill a gap in provision.

	Grade
	A
the benefits of being a healthier weight;	
settings;	
en and families;	
commissioning supporting a long-term (beyond 5 years) system-wide health	A
olicies and activities on inequalities in obesity and related health issues.	A
and delivery levels, through community interventions, policies and objectives.	A
ysical activity and healthy eating.	A

	Grade
de, multi-agency approach is in place to address obesity prevention and wellbeing strategy and broader regeneration and environmental strategies.	A
uld ensure JSNAs address the prevention and management of obesity. They weight, consider inequalities and the social determinants of obesity, consider	A
raphics of their local area, and consider local insight on the motivations and obesity levels.	A
fective small-scale projects and commissioning small-scale projects or	A

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