

# APPENDIX 1: HLWBS EQUALITY IMPACT ASSESSMENT (EIA)

## Healthy Lifestyles and Wellbeing Service August 2018

### SECTION 1 – INTRODUCTION

Lifestyle risk behaviours, such as smoking, excessive alcohol intake, poor diet and physical inactivity, are important contributors to illness, physical health and premature death. Supporting people to make changes to their lifestyle can make a difference to the health of people in South Gloucestershire and reduce demand on health and social care services. Mental health is also integral to wellbeing and the importance of mental wellbeing should not be overlooked. Improved mental health is associated with a range of positive outcomes including better physical health and life expectancy, better educational achievement and improved employment rates.

In terms of prevention, a Case for Change has been developed for Bristol, North Somerset and South Gloucestershire (BNSSG) comprising of a comprehensive analysis of the sociodemographic profile and of the main health needs facing the population. This has identified five priority areas of prevention to address the health and wellbeing needs:

- Tobacco
- Alcohol
- Obesity and physical activity
- Vascular disease risk factors
- Mental health

In South Gloucestershire we currently have a mixed model of service delivery. Our services are designed to address individual lifestyle and wellbeing issues with some commissioned from primary care (GP Practices and community pharmacies), some from the voluntary and community sector and others delivered by staff employed within the Council. The local authority funds these services via the Public Health team, Social Care and the Cultural Services team.

In order to increase the reach and effectiveness of services, a new model for a Healthy Lifestyle Service has been developed. The objective of developing a new model is to provide a healthy lifestyle and wellbeing offer which supports individuals to modify the five leading risk factors that contribute to early death and reduced quality of life in South Gloucestershire listed above. It is currently proposed that the budget for this new service is reduced in comparison to current spend.

It is proposed that the new service is based on the provision of a high quality service that embeds prevention and reduces health inequalities. It is proposed that the new service takes a targeted approach where required to ensure that inequalities are reduced. The new service would be able to achieve financial efficiencies through the integration of provision and expansion of self-care options and being underpinned by a digital offer of websites and apps, signposting to evidence based services already available online.

It is proposed that the new service be available from 1<sup>st</sup> April 2019.

## **SECTION 2 – RESEARCH AND CONSULTATION**

Data in this section is based on national data, local data, service information and results of the consultations we have conducted to date. Please see appendix 1 for the detailed data accompanying this information.

### **Research Information**

#### **Prevalence of smoking, obesity, physical activity, poor mental wellbeing and alcohol use.**

Equalities data for the following risk factors are based on nationally collected data.

#### **Smoking**

- Smoking prevalence is highest for the age group 25 -34 and then begins to decline.
- Whilst smoking has declined annually since 2010, the rate remains higher in men than women.
- Smoking rates are higher in people who are of “Mixed” heritage, followed by “White” and those of “Other” ethnicity. Rates are lower for “Black” and “Asian” people.
- People who identify as gay, lesbian or bisexual are more likely to smoke than those who identify as heterosexual.

#### **Obesity**

- The age group most likely to be obese are those aged 55 – 64 but only by a small margin and obesity affects all age groups once adulthood has been established.
- Throughout adulthood men are more likely to be overweight and obese although, it is important to note the high proportion of women who are overweight and obese as well.
- The rates of excess weight are higher for people from “Black” and “White” groups. The rates are lowest for “Asian” people and “Chinese” people.
- 44% of gay and bisexual men are overweight or obese compared to 70% of men in general.
- UK research has found similar BMI levels for lesbian and bisexual women and heterosexual women.

#### **Physical Activity**

- 21% of men and 25% of women are classed as inactive.
- 72% of adults aged 25 – 34 are active but this drops to below 60% for people aged 55 and over and sharply drops to 30% for adults over 75.
- Women have lower activity levels than men and are more likely to report that they are inactive.
- People from “Black”, “Asian” and “Other” ethnic backgrounds are more likely to be inactive.
- 55.5% of LGBTQ+ people were not active enough to maintain good health

- 64% of LGBTQ+ people who identified as something other than male or female (e.g. genderfluid or genderqueer) were not active enough to maintain good health

## **Mental Wellbeing**

This section is concerned with mental wellbeing as defined as a state of well-being in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community rather than to describe mental illness.

- People report lower life satisfaction in mid-life whilst older people are more likely to report higher life satisfaction, feeling worthwhile and happiness. Anxiety seems to peak between ages 50 – 59.
- People from a “Black” ethnicity report lower life satisfaction and feeling worthwhile than other ethnicities. “Asian” people report lower scores than “White” people.
- On every measure of wellbeing, people who are gay, lesbian, bisexual or other report worse wellbeing than those who identify as heterosexual.
- Group at high risk of mental ill-health in South Gloucestershire also includes people living in Priority Neighbourhoods, unemployed people, people with disabilities, prisoners, Gypsies and Travelers, substance misusers (including alcohol misusers), smokers, people with long term conditions, and victims of domestic abuse.

## **Alcohol**

- Women aged 16-24 were more likely to report binge drinking
- By age 45, men were more likely to report drinking more than 8 units and this difference is more pronounced by age 65.
- Overall, men are more likely than women to drink more than the recommended amount on a particular day.
- “White” people are more likely to drink than any other ethnic group.
- Binge drinking is high across all genders, ages and sexual orientations in the LGB group, with 34% of males and 29% of females reporting binge drinking at least once or twice a week.

## **Services**

There are a number of services under review which may be part of the proposed new service. For each, where data is available, service usage has been reported by protected characteristics, age, gender, ethnicity and sexual orientation. Services collect other data related to health inequalities which is not recorded here.

### Community Connectors

Community connectors is a service which provides social prescribing services to people who are isolated

- Two thirds of services users were female.
- No service users identified as transgender or non-heterosexual, although many people declined to answer this question.
- The majority of service users were white.
- Accurate assessment of the diversity of service users difficult as responses to some of these questions have not been recorded.

### Specialist Stop Smoking Service

The stop smoking service provides one to one and group support to people who wish to stop smoking and prescribes nicotine replacement therapy to help people quit.

- More women than men accessed the service, despite more men being smokers than women.
- 86% of people setting a quit date were “White British”, 6% were not stated and 4% were “White Other”.
- The ethnicity of the remaining 4% of people were non-white backgrounds, the largest being Indian at 0.7%.
- The age group most likely to use the service was 45 – 64.
- The group most likely to stop smoking was the over 65s, with the quit rate decreasing in each descending age band.
- For women, the age group most represented in services were the 18 – 34s, and the group most likely to stop smoking were the over 65s, but the quit rate was similar in the other age groups.

### Life shape

Life shape is a service for people who want to lose weight. It consists of vouchers for Weight Watchers and SportsPound

- 76% of service users were female
- 60% of service users did not have an ethnicity recorded
- 34% were white
- Age 50 – 54 was the most common age group.

### **NHS Health Checks**

NHS Health Checks is a national programme to prevent cardiovascular disease by screening people aged 40 – 74 every 5 years for risk factors for CVD such as blood pressure, cholesterol, BMI and smoking status. 23 of 24 GPs surgeries take part in the programme.

- Across all age groups more women had health checks than men.
- The majority of the NHS health checks are taken by people from a white background, as you would expect in South Gloucestershire.
- However, there is a large percentage where the ethnicity is not recorded.

## **Sports Pound**

Sports pound is a scheme which aims to help people become more physically active. People can receive vouchers to attend a course or activity free of charge or they can attend the council run leisure centres for free for a month.

- 81% of service users were white.
- 20% of service users had a disability.
- 75% of service users were female
- 90% were adults over 26.

## **Wellbeing College**

The Wellbeing College is a service offering free wellbeing courses and taster sessions to people in South Gloucestershire.

The Wellbeing College collects a comprehensive set of demographic data from those using the service and then proactively plans the programme to address gaps in provision. This includes outreach sessions with local priority communities.

Some headlines from the latest Wellbeing College report include.

- 70% of service users were females
- 6% of the service users belong to the Black and Minority Ethnic (BME) community
- 53% of people accessing the college self-reported having a disability

## **Consultation information (to date)**

The council has undertaken a series of research and consultation exercises to inform the development of this proposal.

- In January 2018 there were a series of stakeholder events, organised by the care forum designed to test out some assumptions underlying this proposal
- There was a public survey, available on line and in print in libraries, from 28<sup>th</sup> February to 14<sup>th</sup> March 2018 which was promoted through social media with 467 responses, asking people what they needed from services to improve their health and wellbeing
- We commissioned a specialist organisation to do some in-depth telephone interviews with people less likely to respond to online surveys to get their views on how best to improve their health and wellbeing. Recruitment was completed the week beginning 26<sup>th</sup> March with the interviews taking place from 3<sup>rd</sup> April to the 13<sup>th</sup> April 2018.
- As the model developed we ran further stakeholder events on the 25<sup>th</sup> and 26<sup>th</sup> April 2018 to ensure that we were developing in line with the views expressed at the first events.
- We have conducted focus groups in May 2018 with specific groups to gather their views and will continue to do so throughout the consultation period.

We intend to do further public engagement work. As part of this consultation we will promote the consultation on social media. We are doing a series of three outreach events where we will invite people to share their views which will be backed up by a poll on twitter for those unable to attend or don't want to answer all the questions on the full consultation. We will also undertake further focus groups with services for people with a range of issues. There will be outreach events on the morning of 14<sup>th</sup> June at Kings Chase shopping centre, 20<sup>th</sup> June in Yate Shopping centre and 28<sup>th</sup> June, in Willow Brook shopping centre.

### *Summary of Stakeholder feedback*

The key messages from the stakeholder events were:

- People wanted a holistic service which allowed people to address more than one lifestyle issue at a time
- Joined up services so that people did not have to go to lots of places and repeat their story to get their needs met
- Mental health and wellbeing is a vitally important part of health
- The whole health community needs to be engaged in promoting healthier lifestyles and signposting to services who can offer further help
- Single access point will help other services refer in
- Tiered approach to target intensity of interventions according to need
- Digital technology supports the offer
- Strengthen the role of advocates, peer and community support

### *Summary of public engagement survey*

A public engagement survey was designed to gather the views of the community about healthy lifestyles and services. The full report is in the appendix.

The survey was available on line for 2 weeks in March 2018 and was promoted by Facebook and Twitter. There were 467 responses to the survey. The demographics of the survey responses are below.

Our survey respondents were typically female and heterosexual and white. 17% had a disability and most were either employed part time, full time or self-employed.

- People aged 45- 64 and 65 – 74 reported worse health.
- Men are more likely to report very poor health (although very small numbers)
- People with disabilities are more likely to say they have poor or very poor health than those without.

We asked people how important improving their health was. 97% of the respondents said it was important or very important and consequently this was the same for all categories of people.

- People aged 25 – 44, 45 – 64 and over 75 wanted to be more active.
- People from a BAME group also were more likely to say this.
- People aged 25 – 74 were more likely to want to lose weight than other ages
- Women were also more likely to want to lose weight than men.
- Younger people and people with a disability wanted to feel less stressed or anxious.

- People with a disability and people from LGBTQ+ groups were more likely to want to stop smoking.
- The younger age groups also reported wanting to eat more healthily as did women.
- Men were more likely than women to want to drink less alcohol.

There was an opportunity to add further comments about what would help people to take steps to improve their health and the themes that emerged are set out in the table below. It isn't possible to break this down further

There was a range of answers which have been loosely grouped together for ease of analysis. Issues that were most likely to come up were cost and accessibility of services. Comments were also made about specific help for carers or for people with a range of long-term conditions.

#### Key points from the public survey

- Increased physical activity, losing weight and better wellbeing (less stressed etc.) were the key changes people wanted to make. These are interrelated and given that people want to make more than one change at once, it is sensible to promote the cross benefits of these changes and ensure they are integrated in any lifestyle service offer.
- Whilst stopping smoking was not the priority for most people, those who did want to stop smoking were more likely to report being disabled and having poorer health.
- Access to services is important to people; in the free text sections people asked for personalised services, available in the evening and staffed by knowledgeable professionals. People valued choice in what services they were offered but it isn't clear what this choice should look like. A single point of telephone access was less important, perhaps reflecting that people didn't value a single service as much as a range of services they could pick from and maybe unlikely to access the service by phone at all. Whilst a single point of access is less important to people who responded to this survey it may have other advantages for professionals wanting to refer in.
- There was also strong support for people to be able to access services and information which allowed them to think about more than one lifestyle change at a time. People in the free text section also mentioned multiple issues they would like help with.
- There was strong support for a digital offer. Over 80% of people wanted a website and being able to book online attracted support from 67% of people. A fully interactive website may allow for a broad reach of information and better advertising of what is available was a common comment.
- From the questions on services they would like to access, and in the comments sections, people asked for support from professionals and there was a preference for face to face support. However, given that most people in this survey reported their health as good or very good it is unlikely that many responders to this survey would need to access face to face support from a new service. The in-depth interviews should be able to give us more information about what type of service is favoured by those more likely to need this service.
- There was a range of long term conditions mentioned in the free text sections of the survey. People reported difficulty in managing to access specialised advice and support which took into account their specific needs. People also reported struggling with pain. Given the range of long-term conditions people are living with, working with specialist voluntary and statutory services to upskill them in working towards a healthier lifestyle may ensure that people have the specialist advice and help they need.
- 50% of people report that their health was good or very good and yet two thirds of people could identify lifestyle changes that they wanted to make. People also identified face to face support as an important component of a service to help them achieve these changes. Expectations need to be managed to ensure that people are aware that this level of service

is unlikely to be available and upskilling of people and communities to support each other can be considered as a cost-effective alternative to face to face support.

### Summary of in-depth interviews

In order to get the views of people who are less likely to respond to an online survey we commissioned Foster and Brown research, to recruit participants from areas of deprivation within South Gloucestershire and follow up with a 20 – 30 minute telephone interview. This ensured we heard from people who are frequently the target group for services and enabled the opportunity to explore some issues in more depth.

There were 60 participants in this exercise. Of them, all were from areas of deprivation. 44 were women and 16 were men. There was a range of ages and all participants had some kind of health issue.

This group of people expressed the desire to lose weight and exercise more. However, a much higher percentage of those interviewed wanted to stop smoking, compared to those who responded to the survey, reflecting that they were more likely to come from areas where smoking prevalence is higher.

### **Key points from Consultation survey**

People reported worse health than the public survey, reflecting the distribution of ill-health by socio-economic status.

People want the chance to address several issues and they want a choice of how they access that support.

Help to stop smoking is a priority for many people interviewed in the consultation

Being able to get help via digital means – a website or app was important but so was having face to face support when needed.

## SECTION 3 - IDENTIFICATION & ANALYSIS OF EQUALITIES ISSUES AND IMPACTS

Key points from the research, service data and consultation	What in the proposed service would address these concerns?	Equalities Impact
<p>The equalities data shows that some groups have higher rates of smoking than others. They are people who identify themselves as LGBTQ+, white people and those of mixed heritage and men.</p>	<p>The new service model will have different options for people to access services, including online and face to face.</p> <p>The service will also allow people to access more than one element, meaning that people can address multiple issues at the same time. Given that the data shows that some of these groups have multiple needs, services which address several issues simultaneously may be better placed to meet the needs of these service users.</p>	<p>Having a digital platform will allow for greater flexibility in how services are targeted and delivered with the opportunity for specific information to be available, potentially anonymously and sensitively to try and reach potential service users with different and specific needs.</p>
<p>Men are more likely to be overweight and obese than women, and whilst obesity is a concern for all ethnicities prevalence is high amongst people who are black who suffer worse outcomes at a lower BMI than white people. Prevalence of obesity increases with age</p>	<p>The new service will ensure that there is choice in what services an individual can access, that there is a tiered approach, from advice and information through to face to face support. The service will be accessible at different times with a website so that people can get weight management services in a way that suits them. There will also be a single number to call for support and 1:1 support from a health coach</p>	<p>Having a range of options means that men will be able to access a service how they wish. Weight management services are often perceived as for women only but this service will have options which will make it attractive for men to access.</p> <p>There will be a range of advice which will be culturally sensitive and relevant to different groups of people.</p>
<p>More women than men are inactive and people from non-white ethnic groups are also more likely to be inactive. There are lower levels of physical activity amongst people who are LGBTQ+.</p>	<p>The new service will have a website with information and offering people a choice of services. This could include workouts people can do at home.</p> <p>There should be a choice of physical activities available which should be designed with diversity in mind and be appealing to different groups of people. The website element will also allow for the development of specific</p>	<p>Recognising stigma and self-consciousness are barriers to people, especially those who may identify as LGBTQ+ or be from a non-white ethnic background is a first step in being able to engage with people.</p> <p>Having several options, including a home based option will allow people to build up confidence, with support of a trained professional.</p>

	support groups should there be a demand.	
People in mid-life have worse wellbeing than older people. People from a non-white background and those who identify as LGBTQ+ also have worse mental wellbeing than white people and heterosexual people.	The service will offer a range of support options which allow people to access them in combination. Evidence suggests that eating well and exercising is good for mental wellbeing as well as the options currently available through the wellbeing college. Integrating the wellbeing element of services with the physical health elements will allow for people to have access to mental wellbeing support whilst concurrently accessing support to lead a physically healthier lifestyle. The service will be linked to services which give specific support for people from non-white ethnic backgrounds and people from the LGBTQ+ community. An element of the new service will be that it will support other services to give specific health and wellbeing advice and help.	The holistic approach will help people who may be time-poor with many commitments to get help and support. The service recognises the specific needs of different people and by linking with existing services for them they can ensure that people who are at risk of poor mental wellbeing have access to advice and help.
Overall men drink more than women but younger women are the most likely to binge drink. White people are most likely to drink and alcohol use is higher amongst people who identify as LGBTQ+.	This service will offer alcohol support and help, with referral on to specialist treatment services if needed. This will link into other health behaviours such as smoking giving people the opportunity to address more than one issue at once.	The service will offer support to people in a non-judgmental way and staff will be trained in having difficult conversations. Because it is integrated, referral to other services, or elements of the service should be straightforward. This should make it easier for people, especially those who may not engage in alcohol services to think about and reduce their alcohol intake.
More women than men access the stop smoking service and the most common ethnicity is white. Data on sexual orientation is not collected, however, we know from ONS research that people who identify as gay, lesbian or bisexual are more likely to smoke than those who identify as heterosexual.	The new service will be flexible and the on-line and telephone support options, as well as the availability of signposting to other apps for support should help make the service more accessible to men than it currently is.	Service users will be able to access the service online, increasing their participation in the service.

<p>More women than men access the weight management service. People's ethnicity and sexual orientation is not routinely recorded</p>	<p>The service is changing to a holistic service with a significant online presence. There will be the opportunity for self-care and volunteering as part of the service.</p>	<p>Services can be seen by men as female centric and this model allows for a range of delivery options which should appeal to men and people from different ethnic backgrounds. The service will be culturally sensitive and flexible.</p> <p>There will be monitoring of equalities data, referenced to the needs identified through this assessment, and in the context of the diversity of South Gloucestershire to see if the service is reaching out to those with high levels of need.</p>
<p>The majority of SportsPound service users are female. People from a non-white background are well represented.</p>	<p>The service can be part of the weight management offer and work alongside the wellbeing college to widen the access to SportsPound.</p>	<p>Integrating services should make it easier for different groups to access each element. All new services will be required to collect data on sexual orientation</p>
<p>Wellbeing college service users are more likely to be women, despite but people from a BAME are represented in relation to the South Gloucestershire population. Sexual orientation statistics were not reported.</p>	<p>The wellbeing college will become more integrated into the service so people will be encourage to access different elements of it. All services will be required to monitor and report on all equalities data</p>	<p>Better data collection will allow the service to target appropriately and take action when people are not accessing services.</p>
<p>People want to be able to address more than one issue at a time</p>	<p>The new service proposes to allow people to address any health lifestyle issue concurrently with staff trained to be able to offer a holistic service.</p>	<p>This should allow for people with limited time to be able to access the service.</p> <p>This should allow for people to not be continually assessed and to have the chance to develop a trusting relationship with their health professional which should help people with protected characteristics in accessing the service.</p>
<p>People want a choice in provision</p>	<p>The service provider(s) are not yet established, however, there will be a choice of activities, times and locations that people can choose between.</p>	<p>This will allow people greater access and control which will make it easier for a wide range of people to access services.</p> <p>This will allow people of working age to access services outside of working hours. People of working age report worse well-being then other groups.</p>

Website and apps to support them	The service offer is to be underpinned by a digital platform which will have advice, information and support. This will allow more people to access the services as not everyone will need to be seen and assessed by a worker.	This should allow people to access services when they wish to and can overcome barriers in going to services in person by having online support. This could potentially build into a more intense and face to face service in time.
Face to face support from a health professional	There will be specialist support available for people to access. This will depend on assessment of need and motivation.	For people with complex needs this element of the service will allow them the opportunity to get the support they need. This may be especially important for people with disabilities, long-term conditions or multiple needs.

## SECTION 4 - EqIAA OUTCOME

This section will be completed post consultation.

State one of the following outcomes and why it has been selected:

Outcome	Response	Reason(s) and Justification
Outcome 1: No major change required.	<input type="checkbox"/>	
Outcome 2: Adjustments to remove barriers or to better promote equality have been identified.	<input type="checkbox"/>	
Outcome 3: Continue despite having identified potential for adverse impact or missed opportunities to promote equality.	<input type="checkbox"/>	
Outcome 4: Stop and rethink.	<input type="checkbox"/>	

## SECTION 5 - ACTIONS TO BE TAKEN AS A RESULT OF THIS EqIAA

### Consultation

The consultation documents and surveys will be specifically publicised to groups representing women, people from black, Asian and other minority ethnic groups, groups representing the LGBTQ+ community, groups representing older people and young families. We will ask people from these groups if our service proposals meet their needs and incorporate changes as the project progresses. This is not an exhaustive list of groups we will consult with.

### The new service specifications

The new service will have a service specification, regardless of whether it is provided in-house or is subject to competitive tendering. The specification will outline the expectations in relation to the gaps identified in this assessment. This will focus on actions to ensure that:

- Services are targeted to those with the most need
- Services are culturally appropriate in relation, not only to ethnicity, but to sexual orientation, gender and age. There should be plans in place to ensure that staff are trained to be culturally competent.
- There is a choice of activities and if viable, these could be protected for specific groups such as men-only weight loss groups, for example.
- Specific targets around equalities may be considered, especially in relation to the health inequalities faced by people from BAME backgrounds and people who are LGBTQ++.
- All staff will be required to undertake training in relation to equalities issues, for example, specific training in engaging with the LGBTQ++ community.
- Service providers will be expected to have an equalities statement
- Services will be encouraged to work towards the sexual orientation monitoring standards from NHS England and other standards in diversity, including questions on gender identity.

### **Monitoring**

The service will be required to monitor in relation to equalities data. There are currently gaps in our information which makes assessment of services response to equalities difficult.

The service will be required to take actions to address any deficits in people from groups identified in this assessment to their service.

Outcomes will be monitored against equalities data

## **SECTION 6 - EVIDENCE INFORMING THIS EqIAA**

Sport England, (2017) Active Lives Survey

Office of National Statistics, (2018) Integrated Household Survey

House of Commons Library (2018) Obesity Statistics

Public Health England Outcomes Framework

London Assembly (2017) Health and Wellbeing of LGBT Londoners

Public Health England (2016) LGBT PH Outcomes Framework Companion Document

LGBT Partnership Foundation (2016) LGBT People and Physical Activity, What You Need to Know

NHS Digital (2017) Statistics on Alcohol

Cancer Research UK (2016) Statistics on Alcohol

## INITIAL EQUALITY IMPACT ASSESSMENT (EqIAA) Healthy Lifestyle Service May 2018

### Appendix 1 – Research and Consultation Data Companion

Data in this section is based on national data, local data, service information and results of the consultations we have conducted to date.

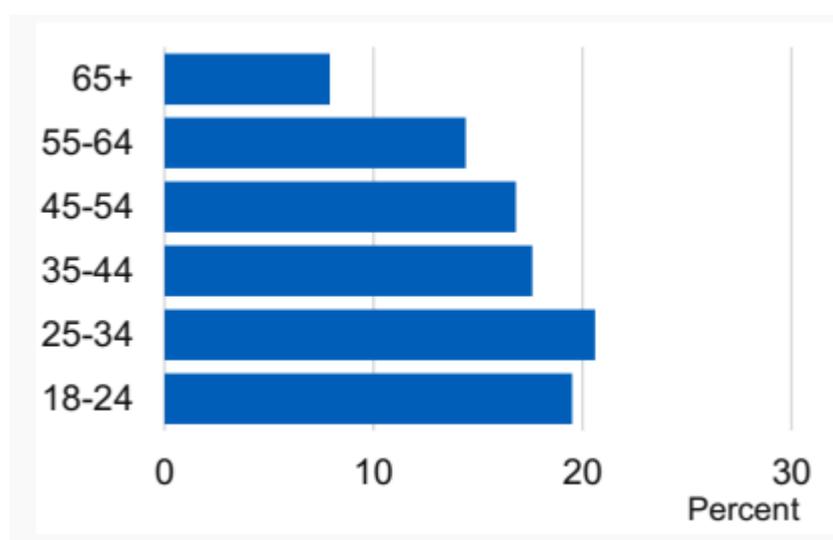
#### Research Information

**Prevalence of smoking, obesity, physical activity, poor mental wellbeing and alcohol use.**

#### Smoking

Equalities data on smoking prevalence is only available at national level.

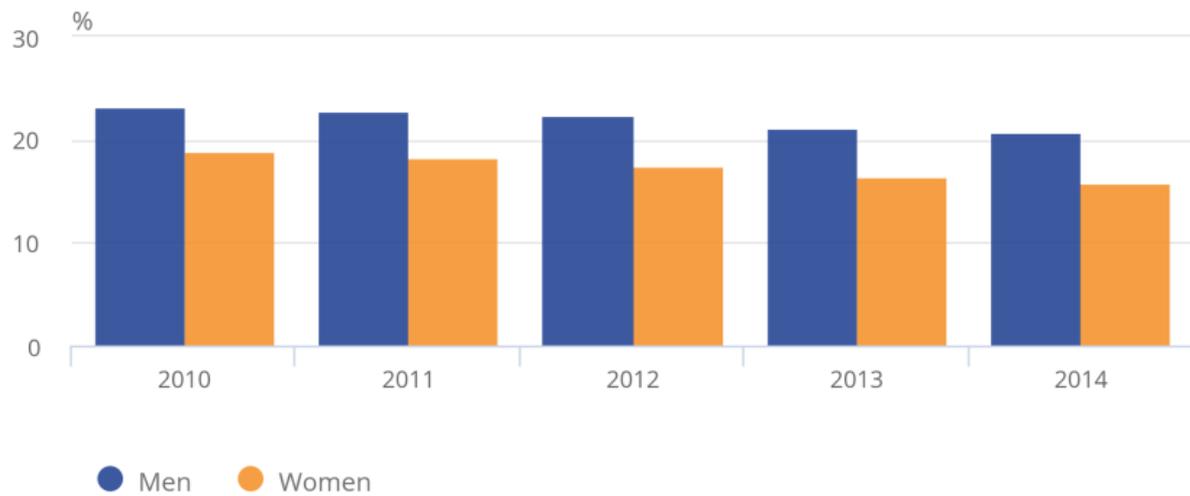
Figure 1: Smoking prevalence by age, England (2015)



Source: ONS Integrated Household Survey 2015

Smoking prevalence is highest for the age group 25 -34 and then begins to decline.

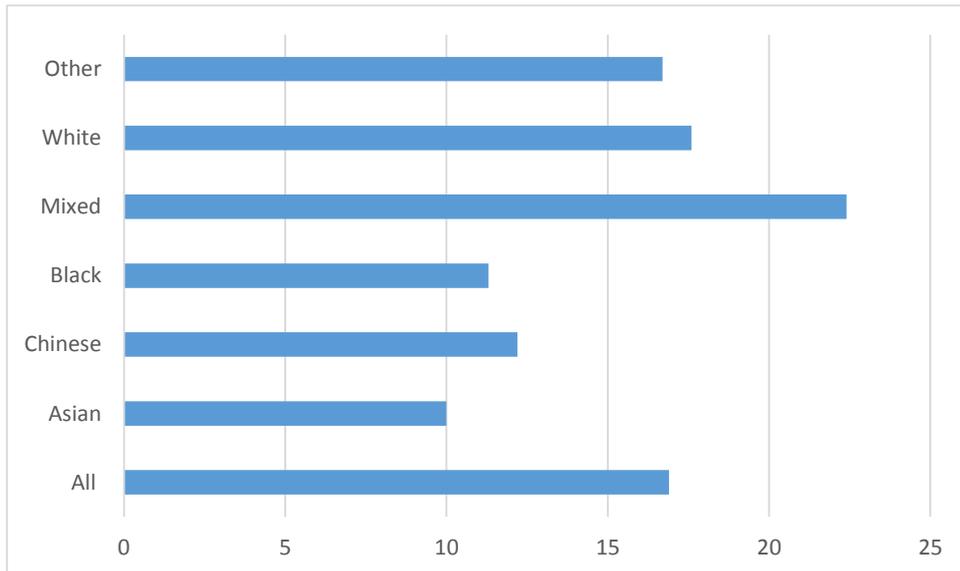
Figure 2: Smoking prevalence by year and gender, England, 2010 - 2014



Source: ONS Integrated household survey, 2015

Figure 2 shows that whilst smoking has declined annually since 2010, the rate remains higher in men than women.

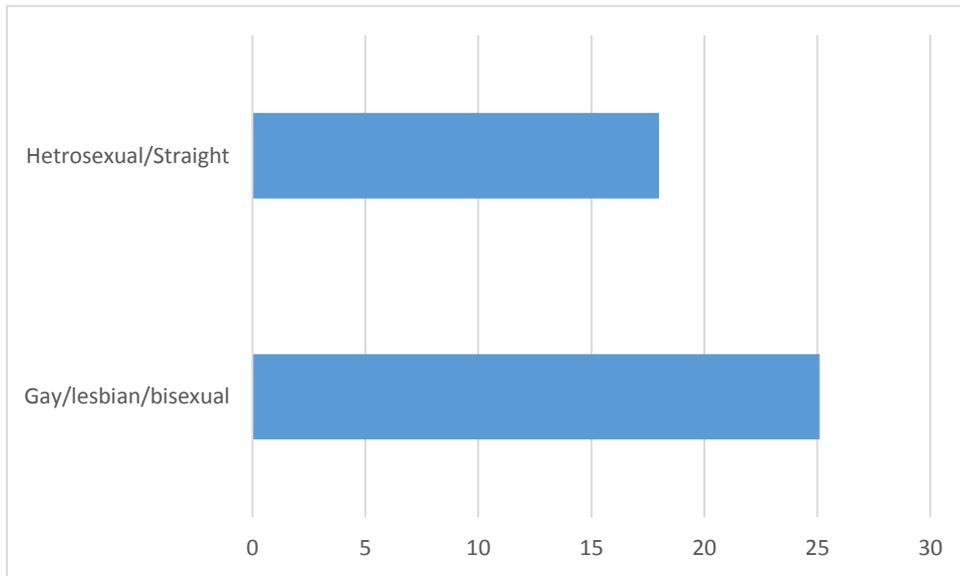
Figure 3: Smoking Prevalence by ethnicity, England, 2014



Source: ONS, Integrated Lifestyle Survey, 2015

Smoking rates are higher in people who are of “Mixed” heritage, followed by “White” and those of “Other” ethnicity. Rates are lower for “Black” and “Asian” people.

Figure 4: Smoking Prevalence by Sexual Orientation, England, 2015



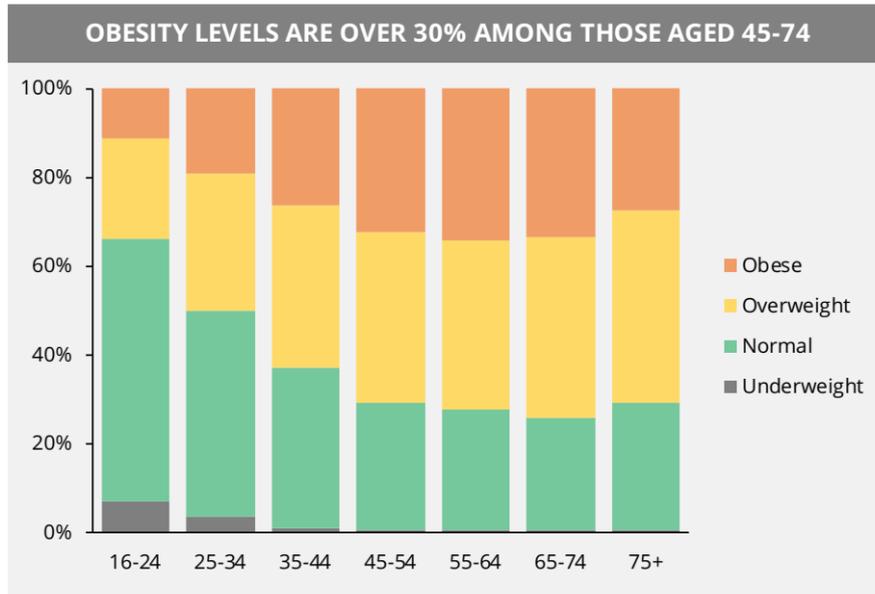
Source: ONS integrated healthy Lifestyle Survey, 2015

Figure 4 shows that people who identify as gay, lesbian or bisexual are more likely to smoke than those who identify as heterosexual.

## Obesity

Up to date statistics are not available for the prevalence of obesity by ethnicity or sexual orientation. However, a parliamentary briefing on obesity in adults showed that the age group most likely to be obese are those aged 55 – 64 but only by a small margin and obesity effects all age groups once adulthood has been established.

Figure 5: Overweight and obese by age (England) 2016



Source: Obesity Statistics, House of Commons Library, 2018.

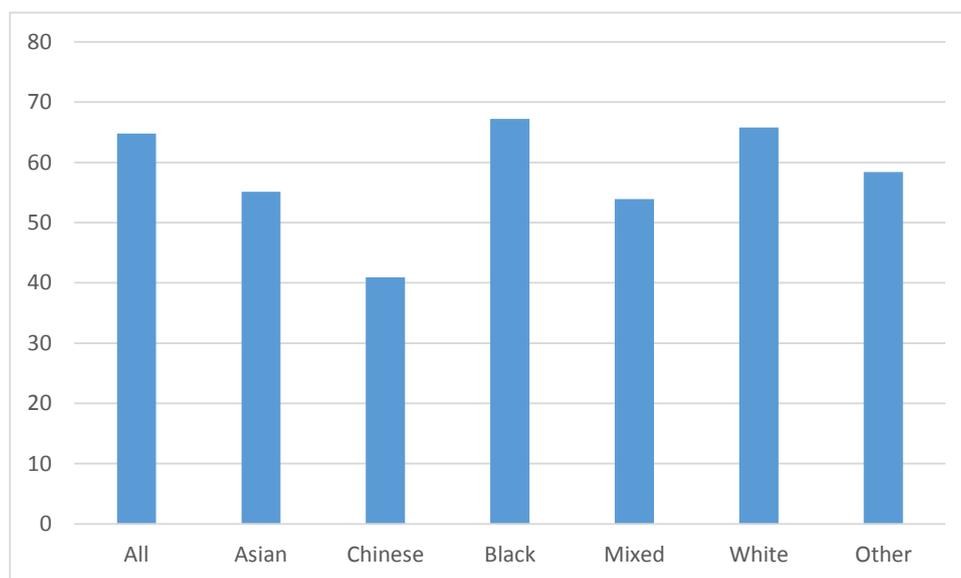
Figure 6: Overweight and obese by age and gender (England) 2016



Source: Obesity Statistics, House of Commons Library, 2018

Figure 6 shows the distribution of obesity in each age group by gender. Throughout adulthood men are more likely to be overweight and obese although, it is important to note the high proportion of women who are overweight and obese as well.

Figure 7: Prevalence of overweight and obese by ethnicity, England, 2014-16



Source: *Public Health Outcomes Framework, 2018*

There are high levels of obesity in England and this affects all ethnicities. However the rates are higher for people from “Black” and “White” groups. The rates are lowest for “Asian” people and “Chinese” people. A point to consider is that excess weight causes more health problems in non-white people at a lower Body Mass Index (BMI). Therefore, the impact of obesity is higher in people from non-white ethnic groups.

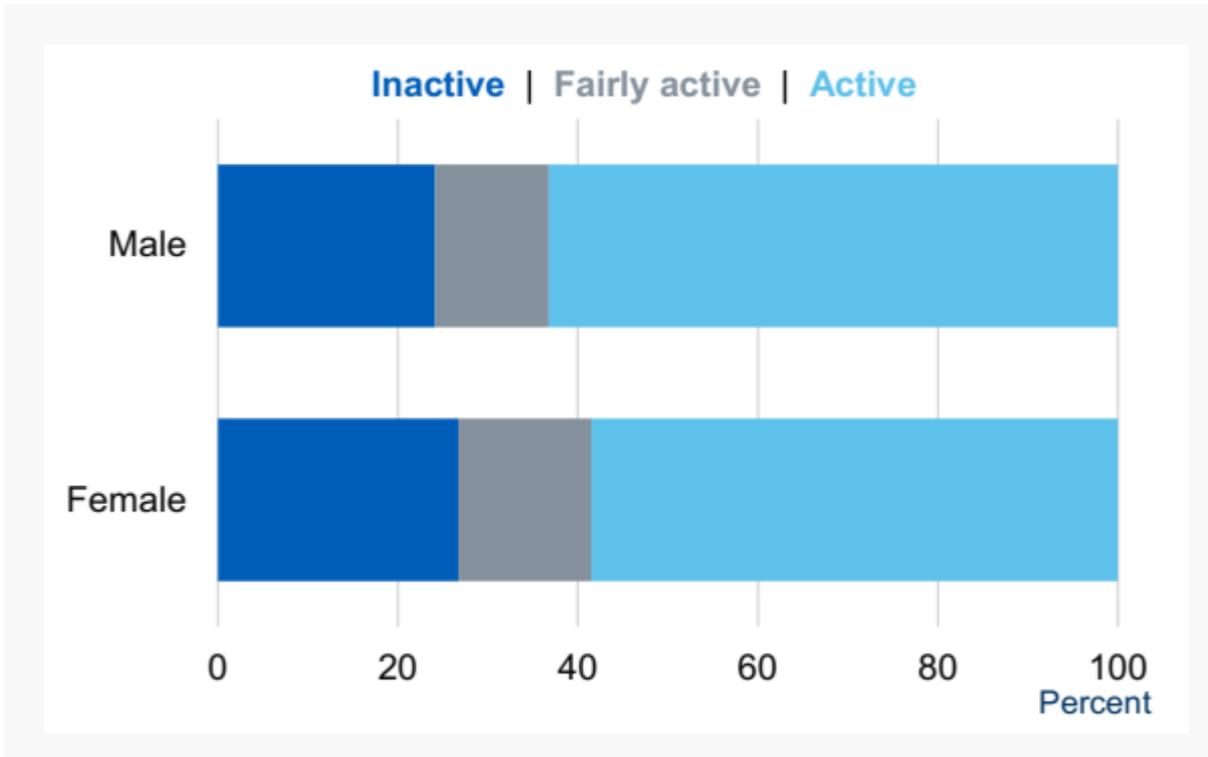
The Lesbian, Gay, Bisexual and Trans Public Health Outcomes Framework Companion Document suggests that gay and bisexual men are less likely to be overweight than heterosexual men, and that lesbian and bisexual women may be more likely to be overweight than heterosexual women.

- 44% of gay and bisexual men are overweight or obese compared to 70% of men in general.
- International research suggests lesbian and bisexual women are more likely to be overweight and obese than heterosexual women. However, UK research has found similar BMI levels for lesbian and bisexual women and heterosexual women.

## Physical Activity

National data taken from the Active People Survey shows that 21% of men and 25% of women are classed as inactive. People become less active as they get older. 72% of adults aged 25 – 34 are active but this drops to below 60% for people aged 55 and over and sharply drops to 30% for adults over 75.

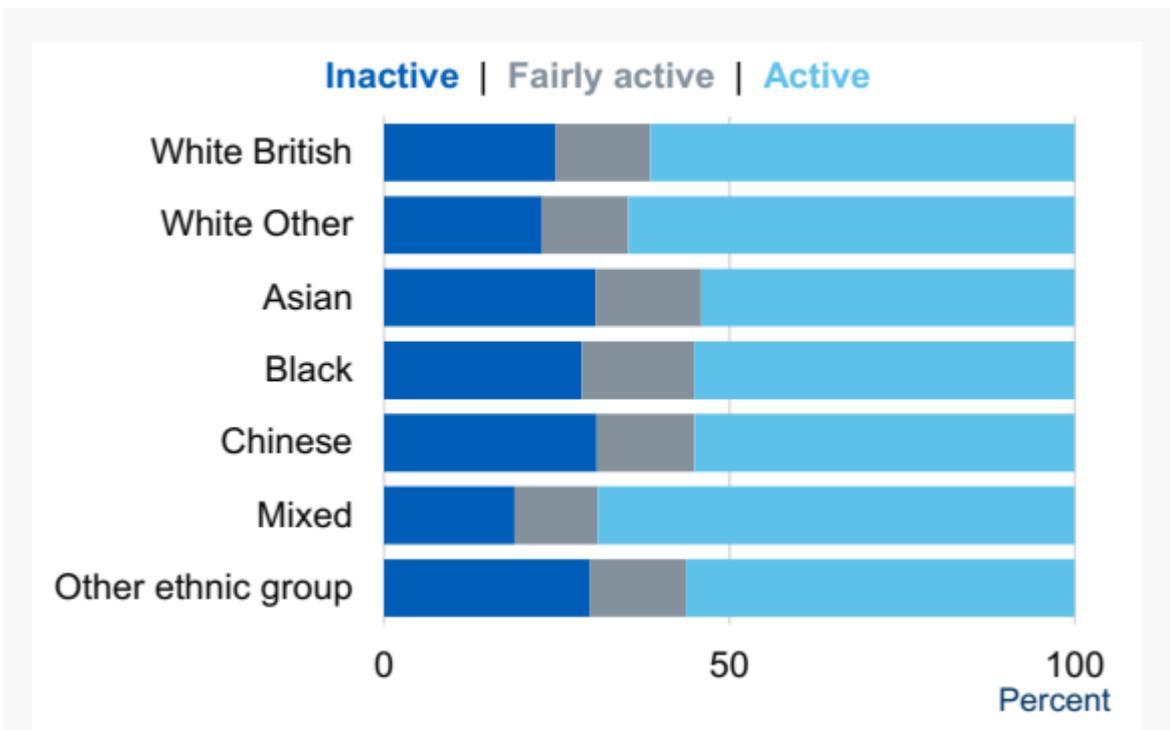
Figure 8: Activity levels by gender, England, 2016



Source: Active Lives Survey, 2015/16

Women have lower activity levels than men and are more likely to report that they are inactive.

Figure 9: Physical activity by ethnicity, England, 2015/16



Source: Active Lives survey, 2015/16

This chart shows that people from “Black”, “Asian” and “Other” ethnic backgrounds are likely to be inactive. The highest levels of active people are those from a “Mixed” background and “White Other” backgrounds.

A study by the National LGB&T Partnership, published in February 2016, raised concern about levels of physical activity amongst the LGBTQ+ community. With support from Public Health England, a survey of nearly 1,000 LGBT people living in England was undertaken, asking both about sport participation and other physical activity. Key findings of the survey include the following:

Within the LGBTQ+ community

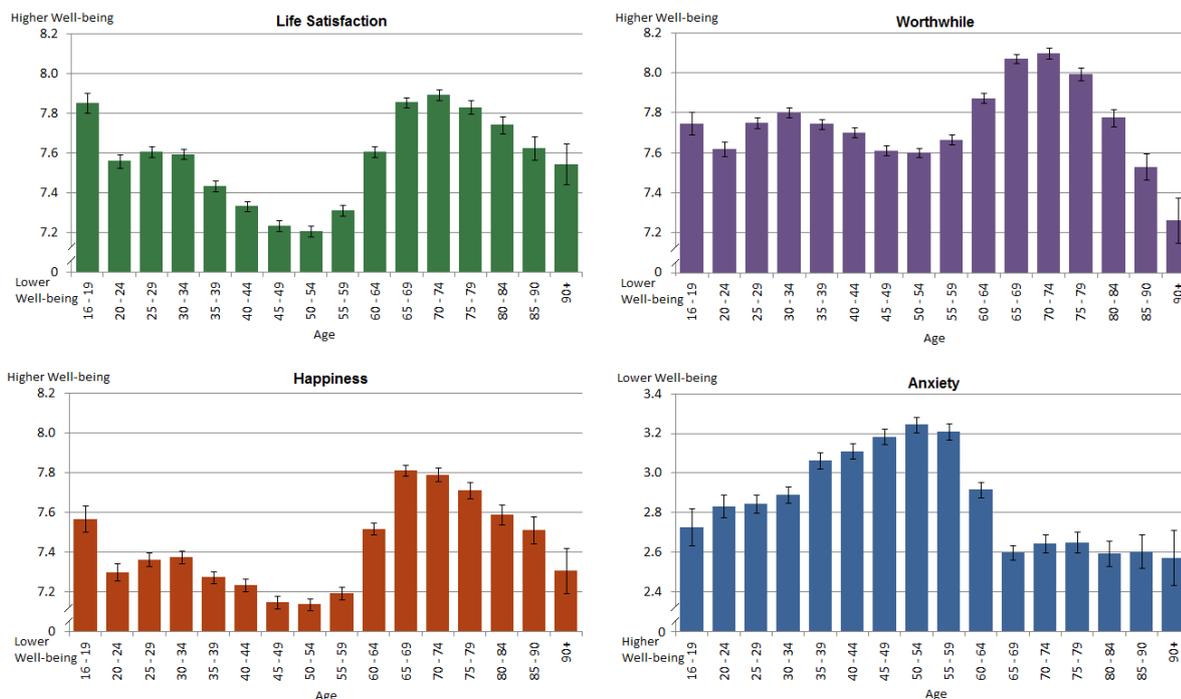
- 55% of men were not active enough to maintain good health, compared to 33% of men in the general population
- 56% of women were not active enough to maintain good health, compared to 45% of women in the general population
- 64% of LGBTQ+ people who identified as something other than male or female (e.g. genderfluid or genderqueer) were not active enough to maintain good health

### Mental Wellbeing

This section is concerned with mental wellbeing as **defined** as a state of **well-being** in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community rather than to describe mental illness.

We do not have equalities data on wellbeing at a local level. The office for National Statistics (ONS) has been collecting data on wellbeing since 2010. They ask a series of questions asking people to rate their life satisfaction, feeling worthwhile, happiness and anxiety.

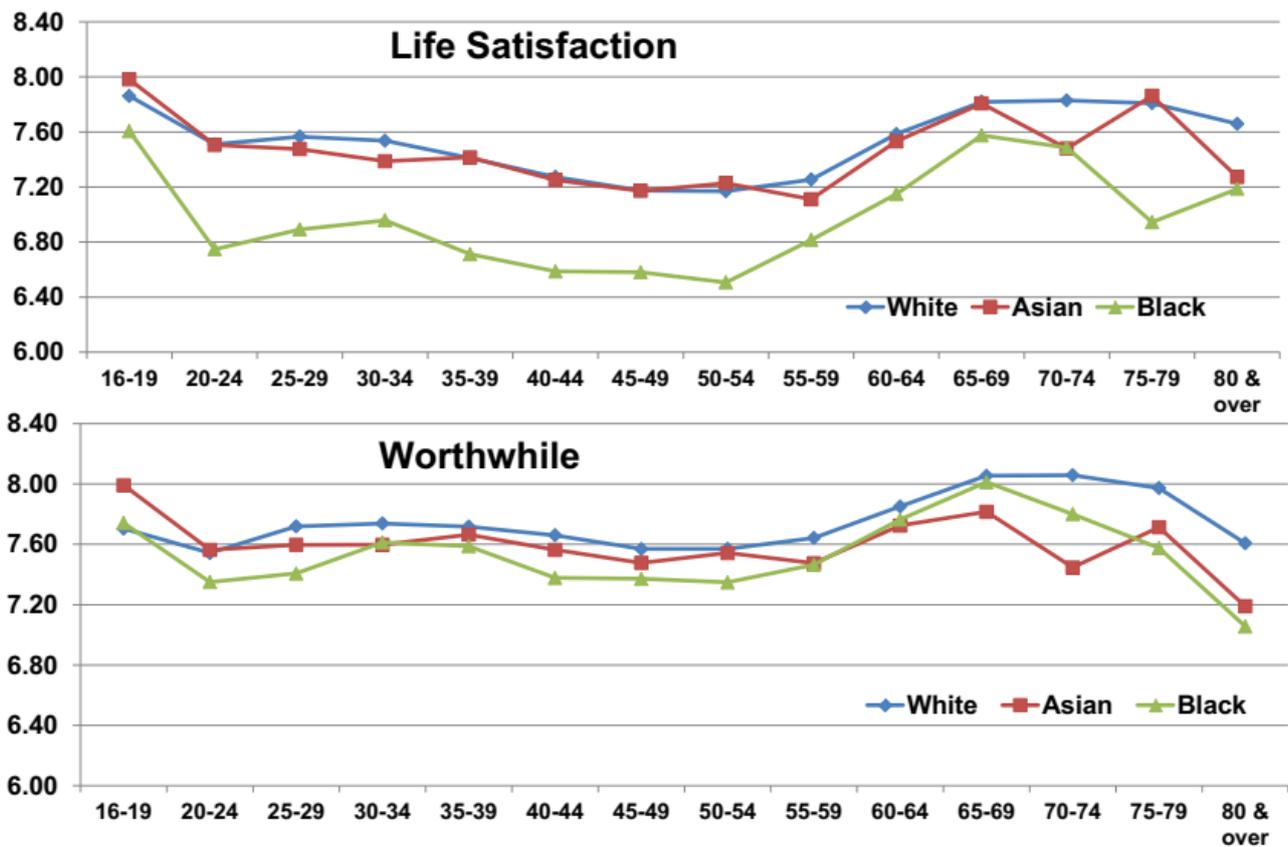
Figure 10: Wellbeing by age



Source: ONS Annual Population survey 2018

People report lower life satisfaction in mid-life whilst older people are more likely to report higher life satisfaction, feeling worthwhile and happiness. Anxiety seems to peak between ages 50 – 59.

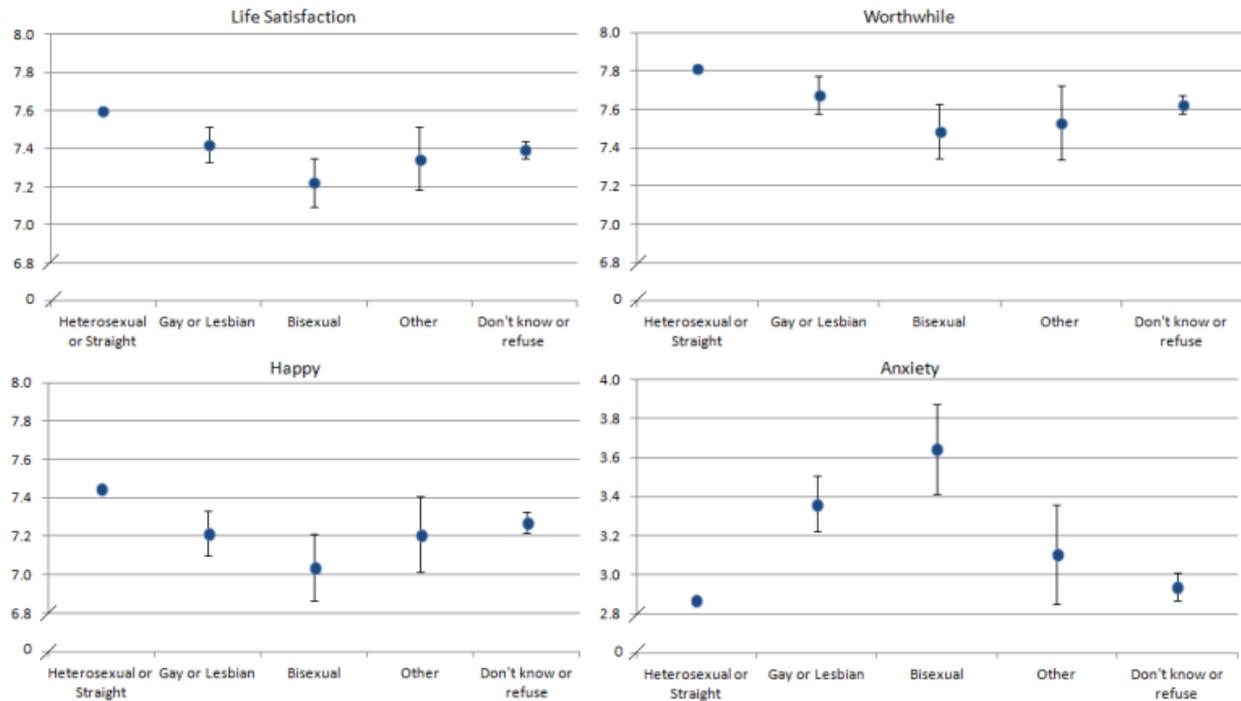
Figure 11: Life Satisfaction and feeling worthwhile by ethnicity and age, England, 2016



Source: ONS, *Measuring wellbeing*, 2017

Figure 11 shows that people from a “Black” ethnicity report lower life satisfaction and feeling worthwhile than other ethnicities. “Asian” people report lower scores than “White” people.

Figure 12: Personal well-being by self-reported sexual identity, 3 years ending December 2015



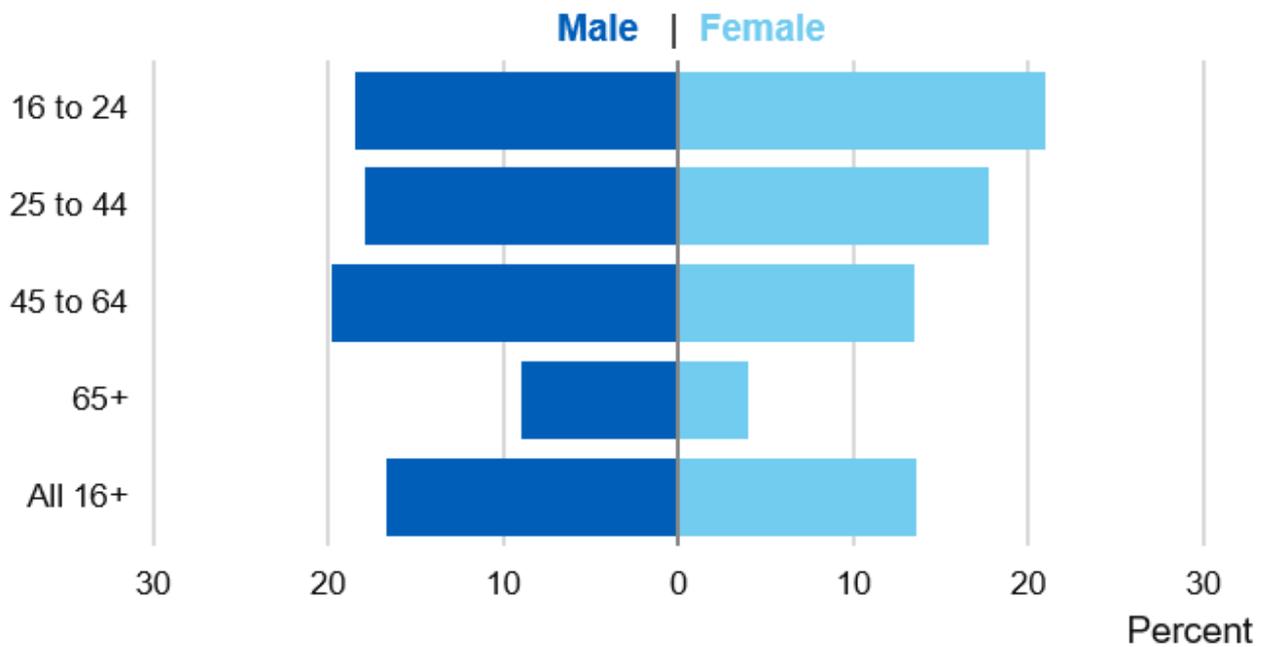
Source: ONS, *Measuring wellbeing, 2017*

On every measure of wellbeing, people who are gay, lesbian, bisexual or other report worse wellbeing than those who identify as heterosexual.

In addition, we know that groups at high risk of mental ill-health in South Gloucestershire include people living in Priority Neighbourhoods, the unemployed, people with disabilities, prisoners, Gypsies and Travelers, substance misusers (including alcohol misusers), smokers, people with long term conditions, people in the LGBTQ+ community and victims of domestic abuse.

## Alcohol

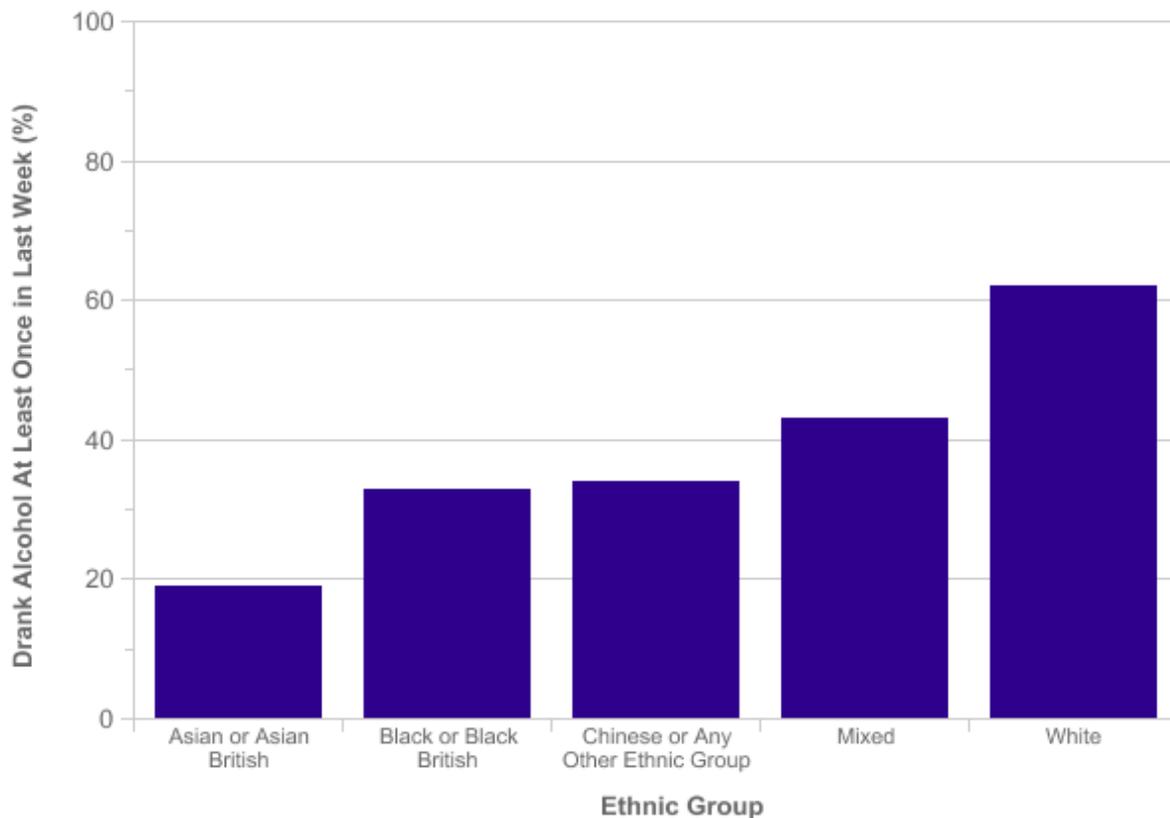
Figure 13: Men drinking more than 8 and women more than 6 units on their heaviest drinking day by age, England, 2017



Source: NHS Digital, *Statistic on alcohol 2017*

Women aged 16-24 were more likely to report binge drinking but by age 45, men were more likely to report drinking more than 8 units and this difference is more pronounced by age 65. Overall, men are more likely than women to drink more than the recommended amount on a particular day.

Figure 14: Alcohol Consumption by Ethnic Group, England, 2012



Source: *Cancer Research UK*

Figure 14 shows that “White” people are more likely to drink than any other ethnic group.

The Health and Wellbeing of Lesbian, Gay, Bisexual and Trans Londoners (2013), published by Mayor of London and the London Assembly suggests that:

- Binge drinking is high across all genders, ages and sexual orientations in the LGB group, with 34% of males and 29% of females reporting binge drinking at least once or twice a week.
- 62% of trans people may be dependent on alcohol.

## Services

There are a number of services under review which may be part of the proposed new service. For each, where data is available, service usage has been reported by protected characteristics.

### Community Connectors

Community connectors is a service which provides social prescribing services to people who are isolated

Table 1: Service users of community connectors by age, gender, ethnicity and sexual orientation 2017/18

	<b>% of Service Users</b>
<b>Age</b>	
Under 18	0
19 - 24	0.7
25 – 44	5.5
45 - 64	11.5
65 - 74	5.9
Over 75	17.5
Prefer not to say	17
Unknown	17.8
<b>Ethnic Origin</b>	
Asian/Asian British – Bangladeshi	0
Asian/Asian British – Indian	0
Asian/Asian British – Pakistani	0
Asian/Asian British – Chinese	0
Asian/Asian British – Other (please state)	0
Black/African/Caribbean/Black British – African	0
Black/African/Caribbean/Black British – Caribbean	0.3
Black/African/Caribbean/Black British – Other (please state)	0
Gypsy or Traveller of Irish Heritage	0
Mixed/Multiple Ethnic Groups – White & Asian	0
Mixed/Multiple Ethnic Groups – White & Black African	0
Mixed/Multiple Ethnic Groups – White & Black Caribbean	0
Mixed/Multiple Ethnic Groups – Other (please state)	0.3
White – English/Welsh/Scottish/Northern Irish/British	42
White – Irish	0.3
White – Other (please state)	1
Other ethnic group (please state)	0
Prefer not to say	14
Unknown	41.8
<b>Gender</b>	
Male	20.5
Female	38
Prefer not to say	0
Unknown	41
<b>Disability</b>	
Do you consider yourself to be disabled?	
Yes	25
No	31

	<b>% of Service Users</b>
Prefer not to say	1.6
Unknown	42.4
<b>Sexual Orientation</b>	
Bisexual	0
Gay man	0
Gay woman / lesbian	0
Heterosexual	37
Other	0.6
Prefer not to say	20.5
Unknown	51.9
<b>Religion / belief</b>	
Buddhist	0
Christian	13
Hindu	0
Jewish	0
Muslim	0
Sikh	0
Any other religion (please state)	0.6
No religion	8
Prefer not to say	37
Unknown	49.4
<b>Transgender</b>	
Do you identify as a transgender person?	
Yes	0
No	38
Prefer not to say	20.5
Unknown	41.5

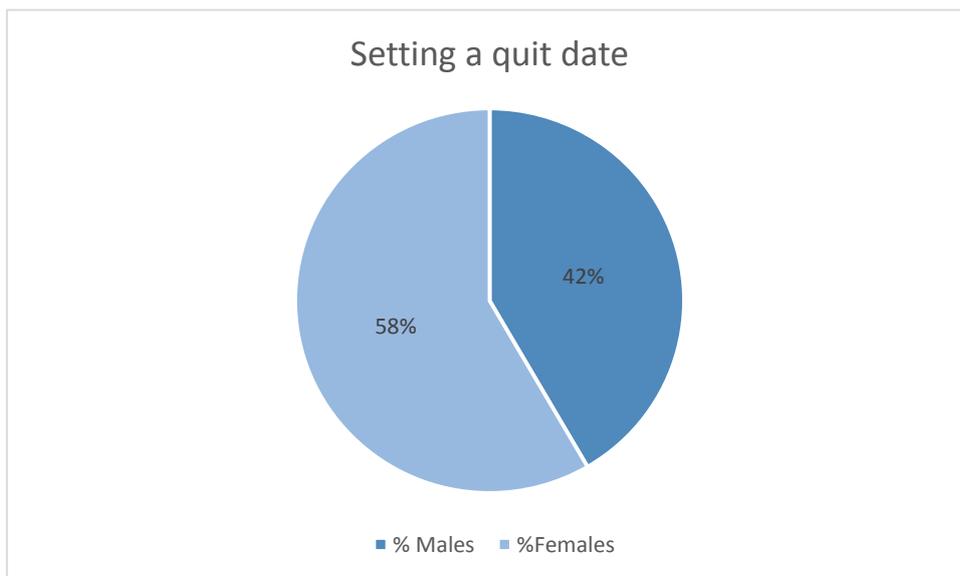
Two thirds of services users were female. No service users identified as transgender or non-heterosexual, although many people declined to answer this question. The majority of service users were white.

However, there is missing data in the table as where the responses have not been recorded, even as a “prefer not to say”, making accurate assessment of the diversity of service users difficult.

#### Specialist stop smoking service

The stop smoking service provides one to one and group support to people who wish to stop smoking and prescribes nicotine replacement therapy to help people quit.

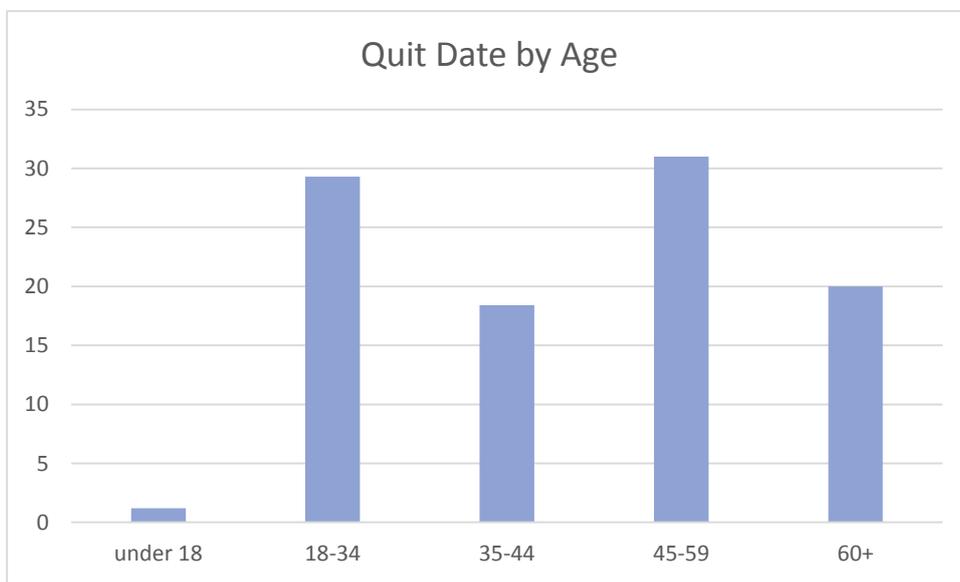
Figure 15: Setting a quit date by gender, 2016/17



More women than men accessed the service, despite more men being smokers than women.

86% of people setting a quit date were "White British", 6% were not stated and 4% were "White Other". The ethnicity of the remaining 4% of people were non-white backgrounds, the largest being Indian at 0.7%.

Figure 16: % of people setting a quit date by age, 2016/17



The age group most likely to use the service was 45 – 64. The group most likely to stop smoking was the over 65s, with the quit rate decreasing in each descending age band. For women, the age group most represented in services were the 18 – 34s, and the group most likely to stop smoking were the over 65s, but the quit rate was similar in the other age groups.

## Life shape

Life shape is a service for people who want to lose weight. It consists of vouchers for weight watchers and sports pound

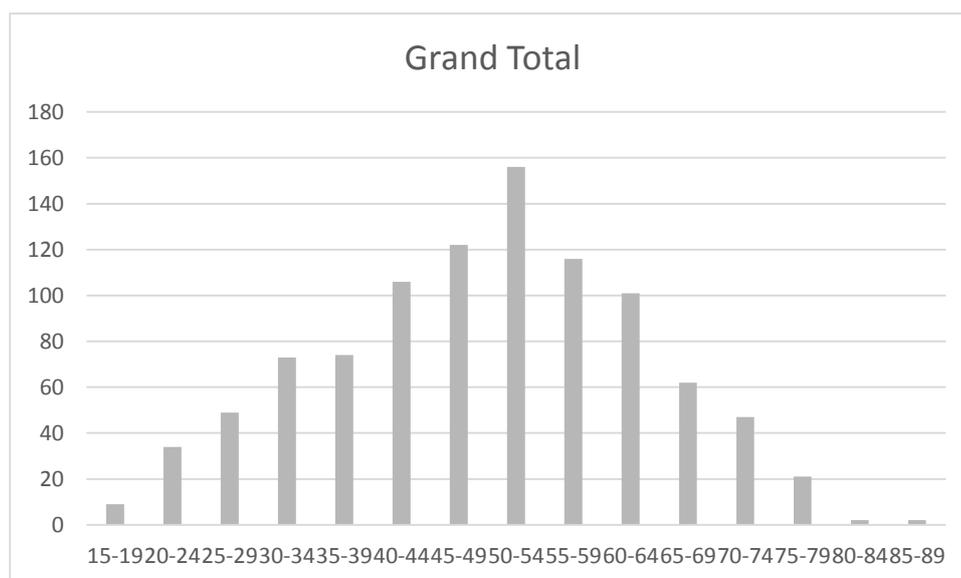
Table 2: Service users of Life shape by gender, 207/18

	Female	Male
Percentage	76%	24%

Table 3: Percentage of service users of Life Shape by ethnicity, 2017/18

	Asian Asian British	Black / African / Caribbean / Black British	Mixed Ethnic Groups	Not stated	Other ethnic group	Prefer not to say	Sikh	White British	White - Irish	White Other
%	1	1	0.4	60	0.1	1	0.1	34	0.2	2.2

Figure 17: Age distribution of service users of Life shape, 207/18

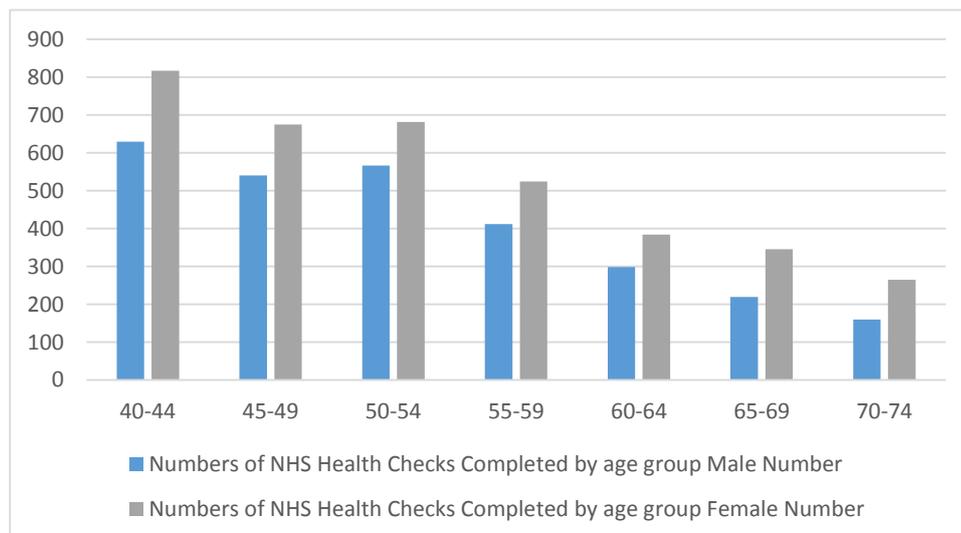


Three quarters of the service users were women. Their ethnicity was most likely to be white or not stated. Age 50 – 54 was the most common age.

## **NHS Health Checks**

NHS Health checks are a national programme to prevent cardiovascular disease by screening people aged 40 – 74 every 5 years for risk factors for CVD such as blood pressure, cholesterol, BMI and smoking status. 23 of 24 GPs surgeries take part in the programme.

Figure 18: Number of health checks by age and gender, 2016/17



Across all age groups more women had health checks than men. There is a declining number as people age. A likely explanation for this is that people become ineligible as they get older as they are more likely to be on a disease register for other conditions such as hypertension and, of course, there are fewer people age 74 than there are aged 40.

Table 4: Ethnicity of people having a health check

Health Checks by Ethnicity	% of total
<b>Ethnic status</b>	
African	0.2
British Asian	0.2
British or mixed British	44
Caribbean	0.1
Chinese	0.4
Indian or British Indian	0.7
Irish	0.3
Middle Eastern	0.1
Other White European	0.1
Other ethnic category	0.3
Other Asian	0.1
Other Black	0.6
Other mixed	0.2
Other white	0.2
Pakistani or British Pakistani	2.1
Polish	0.2
White and Asian	0.1
White and Black African	0.2
White and black Caribbean	0.3
White British	21.5
Not recorded	28.3

The majority of the NHS health checks are taken by people from a white background, as you would expect in South Gloucestershire. However, there is a large percentage where the ethnicity is not recorded.

## Sports Pound

Sports pound is a scheme which aims to help people become more physically active. People can receive vouchers to attend a course or activity free of charge or they can attend the gym for free for a month.

Table 5: SportsPound % service users by age, gender, disability and ethnicity, 2017/18

SportsPound 2017/18 Financial Year	
<b>Total Participants</b>	<b>1648</b>
<b>Total Sessions</b>	<b>12507</b>
Age	
14 - 25	13
26+	86
Not stated	1
Gender	
Male	21
Female	77
Not Stated	2
Disability	
Disability	19
No disability	81
Ethnicity	
White	82
Black/other	18
<b>Total</b>	

1648 people accessed this service in a year. 81% of them were white. 20% of service users had a disability. 75% of service users were female and 90% were adults over 26.

## Wellbeing College

The wellbeing college is a service offering wellbeing courses and taster sessions to people in South Gloucestershire.

The demographic data was collected for the service users who attended Wellbeing Sessions, not the taster sessions. Additionally, there were significant gaps in terms of the data collected by the three organisations, in that the data collection was not in line with the council's equalities core dataset for commissioned services.

In terms of **gender**, just under seven out of ten service users (69%, n=166) were females. This shows 1.4 times more females accessing the service than the proportion of females within South Gloucestershire (50.3%).

For **ethnicity**, 6% of the service users (n=15) belong to the Black and Minority Ethnic (BME) community, which is slightly higher than the South Gloucestershire's BME population of 5%.<sup>3</sup> In terms of **age**, over four out of five service users (45%, n=107) were between ages 25 and 44. A further 36% of service users (n=86) were aged 45 – 64. Comparing the age of the service users to the general South Gloucestershire population, the service users who were classified as working age population accessing the Wellbeing Sessions were over-represented by 1.4 times. Equally, people over the age of 75 were under-represented within the service.

## **Consultation information (to date)**

The council has undertaken a series of research and consultation exercises to inform the development of this proposal.

- In January 2018 there were a series of stakeholder events, organised by the care forum designed to test out some assumptions underlying this proposal
- There was a public survey, available on line and in print in libraries, from 28<sup>th</sup> February to 14<sup>th</sup> March 2018 which was promoted through social media with 467 responses, asking people what they needed from services to improve their health and wellbeing
- We commissioned a specialist organisation to do some in-depth telephone interviews with people less likely to respond to online surveys to get their views on how best to improve their health and wellbeing. Recruitment was completed the week beginning 26<sup>th</sup> March with the interviews taking place from 3<sup>rd</sup> April to the 13<sup>th</sup> April 2018.
- As the model developed we ran further stakeholder events on the 25<sup>th</sup> and 26<sup>th</sup> April 2018 to ensure that we were developing in line with the views expressed at the first events.
- We have conducted focus groups in May 2018 with specific groups to gather their views and will continue to do so throughout the consultation period.

We intend to do further public engagement work. As part of this consultation we will promote the consultation on social media. We are doing a series of three roadshows where we will invite people to share their views which will be backed up by a poll on twitter for those unable to attend or don't want to answer all the questions on the full consultation. We will also undertake further focus groups with services for people with a range of issues. There will be outreach events on the morning of 14<sup>th</sup> June at Kings Chase shopping centre, 20<sup>th</sup> June in Yate Shopping centre and 28<sup>th</sup> June, in Willow Brook shopping centre.

## *Summary of Stakeholder feedback*

The key messages from the stakeholder events were:

- People wanted a holistic service which allowed people to address more than one lifestyle issue at a time
- Joined up services so that people did not have to go to lots of places and repeat their story to get their needs met
- Mental health and wellbeing is a vitally important part of health
- The whole health community needs to be engaged in promoting healthier lifestyles and signposting to services who can offer further help
- Single access point will help other services refer in
- Tiered approach to target intensity of interventions according to need
- Digital technology supports the offer
- Strengthen the role of advocates, peer and community support

## Summary of public engagement survey

A public engagement survey was designed to gather the views of the community about healthy lifestyles and services. The full report is in the appendix.

The survey was available on line for 2 weeks in March 2018 and was promoted by Facebook and Twitter. There were 467 responses to the survey. The demographics of the survey responses are below.

Table 6: Characteristics of survey responders

		Total	Percentage %
<b>Gender</b>	Female	397	85%
	Male	63	13%
	Prefer not to say	3	1%
<b>Age</b>	Under 17	1	0%
	18-24	8	2%
	25-44	184	39%
	45-64	200	43%
	65-74	59	13%
	Over 75	11	2%
	Not stated / prefer not to say	2	0%
<b>Disability</b>	Disability	80	17%
	No disability	331	71%
	Not stated / prefer not to say	54	11%
<b>Sexuality</b>	Heterosexual	399	85%
	LGBTQ+	21	4%
	Not stated / prefer not to say	47	10%
<b>Ethnicity</b>	White British	415	89%
	White other	15	3%
	BAME	13	3%
	Not stated / prefer not to say	24	5%
<b>Employment status</b>	Employed full-time	149	32%
	Employed part-time	144	31%
	Self-employed/ freelance	31	7%
	Unemployed	11	2%
	Government funded training course/ apprenticeship	1	0%
	Studying full-time	5	1%
	Studying part-time	4	1%
	Away from work (ill, maternity leave, holiday or temporarily laid off)	11	2%
	Looking after home/family	33	7%
	Long term sick/disabled	27	6%
	Retired	81	17%
	Other	4	1%
	Prefer not to say	2	0%

Our survey respondents were typically female and heterosexual and white. 17% had a disability and most were either employed part time, full time or self-employed.

Where possible responses are shown by age, gender, ethnicity and sexual orientation. The next series of table shows the responses to the questions we asked.

Table 7: How do you rate your health by age, gender, disability, sexual orientation and ethnicity?

	Total	Your age:							Your gender:			Disability Aggregate		Sexual orientation Aggregate		Ethnicity Aggregate		
		17 or under	18 - 24	25 - 44	45 - 64	65 - 74	75 +	Prefer not to say	Female	Male	Prefer not to say	Disability	No disability	Heterosexual	LGBTQ +	BAME	White British	White Other
<b>Base</b>	467	1	8	182	200	59	11	2	396	63	3	80	331	397	21	13	413	15
<b>Overall health</b>																		
<b>Very</b>	10%	-	-	10%	11%	5%	18%	-	10%	11%	-	3%	13%	10%	-	-	10%	20%
<b>Good</b>	40%	100%	50%	44%	38%	36%	45%	-	40%	43%	-	24%	48%	40%	52%	54%	39%	47%
<b>OK</b>	33%	-	25%	35%	31%	37%	18%	100%	33%	27%	100%	30%	34%	33%	33%	46%	33%	27%
<b>Poor</b>	14%	-	25%	8%	17%	22%	9%	-	14%	13%	-	36%	5%	14%	10%	-	15%	7%
<b>Very Poor</b>	3%	-	-	3%	4%	-	9%	-	3%	6%	-	8%	1%	3%	5%	-	4%	-

This table shows self-rated health by age, gender, disability, sexual orientation and ethnicity. There are very small numbers of people aged under 24 who took part in the survey as well as people who are LGBTQ+ and from a BAME background so caution needs to be applied in over interpreting the results. However, people aged 45- 64 and 65 – 74 report worse health. Men are more likely to report very poor health (although very small numbers) and people with disabilities are more likely to say they have poor or very poor health than those without. Question 2 asked people how important improving their health was. 97% of the respondents said it was important or very important and consequently this was the same for all categories of people.

Table 8: What Lifestyle changes would you like to make by age, gender, disability, sexual orientation and ethnicity.

	Total	Your age:							Your gender:			Disability Aggregate		Sexual orientation Aggregate		Ethnicity Aggregate		
		A. Less than 17	B. 18 - 24	C. 25 - 44	D. 45 - 64	E. 65 - 74	F. 75 or over	G. Prefer not to say	A. Female	B. Male	C. Prefer not to say	A. Disability	B. No disability	A. Heterosexual	B. LGBTQ+	A. BAME	B. White British	C. White Other
Base	466	1	8	184	198	58	11	2	395	62	3	79	329	396	21	13	412	15
Be more active	67%	100%	50%	74%	62%	55%	82%	50%	68%	61%	33%	62%	69%	69%	48%	92%	67%	60%
Lose Weight	63%	100%	25%	65%	63%	60%	45%	50%	65%	47%	67%	66%	62%	64%	52%	77%	63%	47%
Feel less stressed, worried or anxious	61%	100%	75%	68%	60%	41%	55%	-	62%	60%	67%	70%	58%	62%	62%	46%	63%	53%
Quit Smoking	6%	-	-	6%	8%	2%	-	-	6%	5%	-	10%	4%	5%	10%	-	6%	7%
Eat more healthily	42%	-	88%	58%	34%	22%	9%	-	44%	29%	33%	41%	43%	44%	38%	69%	43%	13%
Drink less alcohol	11%	-	-	11%	11%	9%	-	50%	9%	19%	67%	8%	12%	10%	10%	-	10%	33%
None of the above	1%	-	-	1%	1%	5%	-	-	1%	2%	-	4%	1%	2%	-	-	1%	-
Other	5%	-	-	4%	7%	5%	-	-	5%	3%	-	8%	4%	5%	10%	23%	5%	7%

Again, there are small numbers in some of these categories and caution must be exercised in interpreting the results. In comparison to other ages people aged 25 – 44, 45 – 64 and over 75 wanted to be more active. People from a BAME group also were more likely to say this. People aged 25 – 74 were more likely to want to lose weight than other ages and women were also more likely to report this than men. Younger people and people with a disability wanted to feel less stressed or anxious. People with a disability and people from LGBTQ+ groups were more likely to want to stop smoking. The younger age groups also reported wanting to eat more healthily as did women. Men were more likely than women to want to drink less alcohol.

There was an opportunity to add further comments about what would help people to take steps to improve their health and the themes that emerged are set out in the table below. It isn't possible to break this down further

Table 9: What would help you make changes to live a healthier life? (Grouped by theme)

Theme	Number	% of survey responders
Cheaper Activities	32	7%
Specific activities	22	5%
Better advertising of what is available	14	3%
Other comments	13	3%
Better access to healthy food	11	2.5%
Breastfeeding Support	11	2.5%
Accessible Services	11	2.5%
Time	8	2%
Support Groups	7	1.5%
LTC specific	7	1.5%
Childcare/Child-friendly	6	1.5%
Range of services	5	1%
Cycle paths	5	1%
Park Run	4	1%
Mental Health Support	4	1%
Housing	4	1%
Carers support	4	1%
Personalised service	3	1%
Parking at leisure centre	2	>1%
Alcohol	1	>1%

There was a range of answers which have been loosely grouped together for ease of analysis. Issues that were most likely to come up were cost and accessibility of services. Comments were also made about specific help for carers or for people with a range of long-term conditions.

#### Key points from the public survey

- Increased physical activity, losing weight and better wellbeing (less stressed etc.) were the key changes people wanted to make. These are interrelated and given that people want to make more than one change at once, it is sensible to promote the

cross benefits of these changes and ensure they are integrated in any lifestyle service offer.

- Whilst stopping smoking was not the priority for most people, those who did want to stop smoking were more likely to report being disabled and having poorer health.
- Access to services is important to people; in the free text sections people asked for personalised services, available in the evening and staffed by knowledgeable professionals. People valued choice in what services they were offered but it isn't clear what this choice should look like. A single point of telephone access was less important, perhaps reflecting that people didn't value a single service as much as a range of services they could pick from and maybe unlikely to access the service by phone at all. Whilst a single point of access is less important to people who responded to this survey it may have other advantages for professionals wanting to refer in.
- There was also strong support for people to be able to access services and information which allowed them to think about more than one lifestyle change at a time. People in the free text section also mentioned multiple issues they would like help with.
- There was strong support for a digital offer. Over 80% of people wanted a website and being able to book online attracted support from 67% of people. A fully interactive website may allow for a broad reach of information and better advertising of what is available was a common comment.
- From the questions on services they would like to access, and in the comments sections, people asked for support from professionals and there was a preference for face to face support. However, given that most people in this survey reported their health as good or very good it is unlikely that many responders to this survey would need to access face to face support from a new service. The in-depth interviews should be able to give us more information about what type of service is favoured by those more likely to need this service.
- There was a range of long term conditions mentioned in the free text sections of the survey. People reported difficulty in managing to access specialised advice and support which took into account their specific needs. People also reported struggling with pain. Given the range of long-term conditions people are living with, working with specialist voluntary and statutory services to upskill them in working towards a healthier lifestyle may ensure that people have the specialist advice and help they need.
- 50% of people report that their health was good or very good and yet two thirds of people could identify lifestyle changes that they wanted to make. People also identified face to face support as an important component of a service to help them achieve these changes. Expectations need to be managed to ensure that people are aware that this level of service is unlikely to be available and upskilling of people and communities to support each other can be considered as a cost-effective alternative to face to face support.

### Summary of in-depth interviews

In order to get the views of people who are less likely to respond to an online survey we commissioned Foster and Brown research, to recruit participants from areas of deprivation within South Gloucestershire and follow up with a 20 – 30 minute telephone interview. This

ensured we heard from people who are frequently the target group for services and enabled the opportunity to explore some issues in more depth.

There were 60 participants in this exercise. Of them, all were from areas of deprivation. 44 were women and 16 were men. There was a range of ages and all participants had some kind of health issue.

Figure 19: Age of survey interview subjects

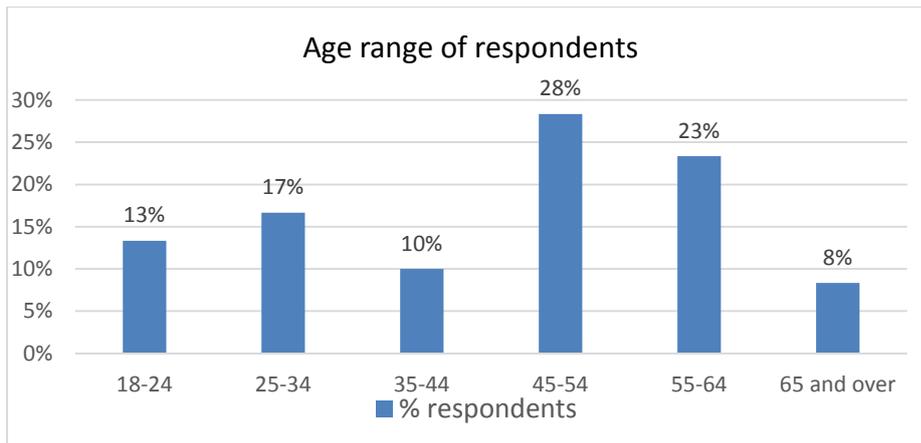
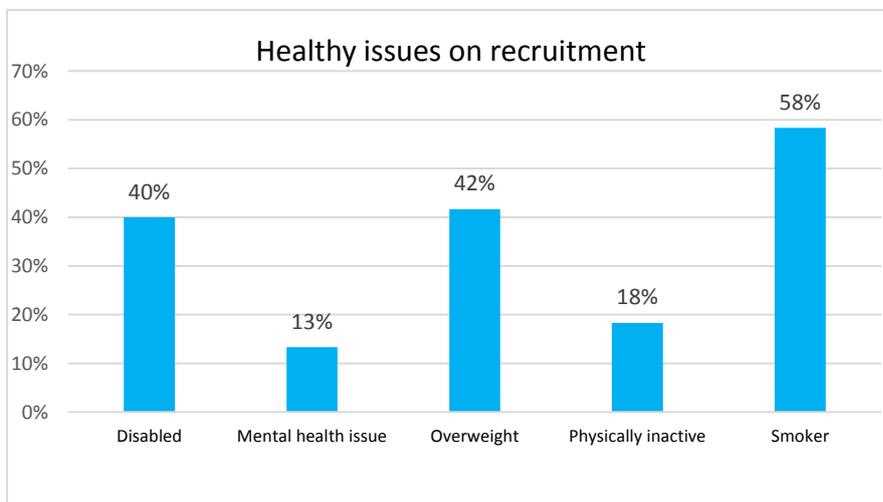
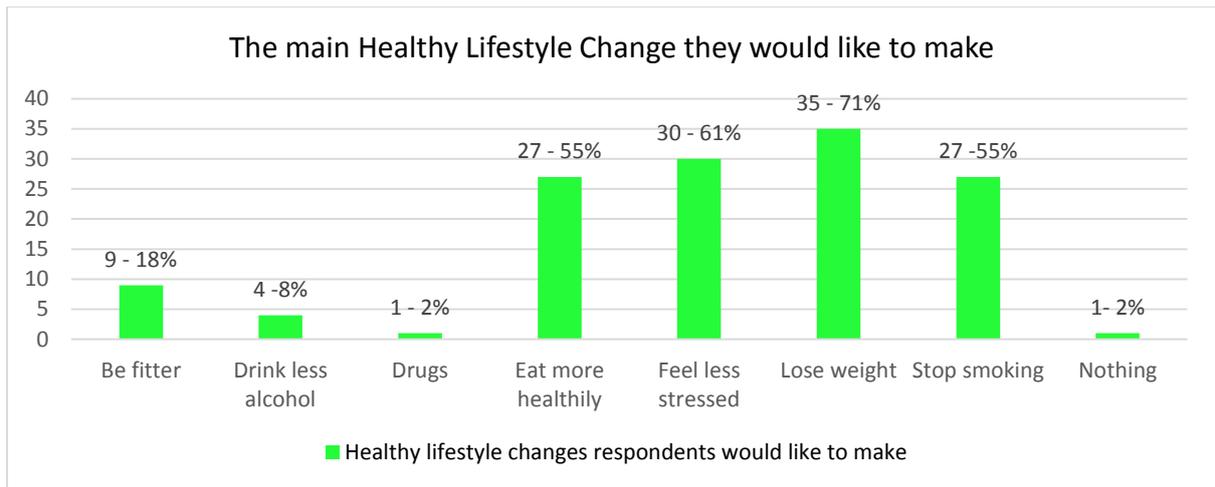


Figure 20: Health concerns of interview subjects





This group of people expressed the desire to lose weight and exercise more. However, a much higher percentage of those interviewed wanted to stop smoking, compared to those who responded to the survey, reflecting that they were more likely to come from areas where smoking prevalence is higher.

### **Key points from Consultation survey**

People reported worse health than the public survey, reflecting the distribution of ill-health by socio-economic status.

People want the chance to address several issues and they want a choice of how they access that support.

Help to stop smoking is a priority for many people interviewed in the consultation

Being able to get help via digital means – a website or app was important but so was having face to face support when needed.