Boston Health & Wellbeing Action Plan

2014-2017

Boston Borough Council

Introduction

Due to the historical shaping of the borough and the wide diversity of its population, there are substantial and persistent inequalities in the health needs of those living in Boston compared to Lincolnshire and the rest of the country.

The Boston Health and Wellbeing Strategic Framework has identified the priority areas for action over the next 3 years in order to work toward addressing inequalities, health needs and outcomes and these have been signed off by the Boston Strategic Health Group and Boston Borough Council. The priorities align with the strategic themes contained within the Lincolnshire Joint Health and Wellbeing Strategy.

The priority areas are:

In order to deliver on these priorities, an action plan has been developed focusing on prevention and better collaboration between partners. The Action Plan clearly articulates what the Borough Council and its partners will do to tackle local health priorities over the next 3 year period and how its progress will be monitored and measured in both the short and long term, recognising that effecting real changes take time.

Background and rationale

Given that capacity and resources are limited, it is our view that it is better to focus on a few key actions. Having reviewed the evidence and consulted partners, we have decided to focus on six key actions which require sustained effort by several

partners working together. For each of those actions we have listed what the evidence tells us.

Action 1:	Improve public uptake of existing services amongst adults and families, focusing on healthier lifestyles

From the 2014 Public Health England profiles it is known that levels of excess weight in adults (69.9%), adults achieving recommended physical activity levels (49.6%), hospital stays for alcohol related harm (715 per 100,000 population), recorded diabetes (6.8%), obese adults (26.8%) and obese children (22%) are all worse than the England average. These elevated levels have a causal effect upon the prevalence of associated comorbidities and consequently has substantial practical and financial implications for primary care systems. For example, physical inactivity in Boston led to a total cost of £31,299,282 in 2010 (BHF, 2010). Healthier lifestyles have therefore been established as a local priority.

Boston has experienced an exponential growth in the migrant population. The Social Impact of Population Change Report (2012) and Ensuring Inclusive Healthcare (2013) found that generally the A8 registered patients are young, fit and healthy and therefore require little medical support or GP appointments. The migrant population however do sometimes struggle to access health services due to the language barrier and cultural differences.

Having mapped current work strands relating to healthier lifestyles it is apparent there are a broad spectrum of services that support the promotion and adoption of healthier lifestyles in Boston, however they are currently underutilised. Recognising financial constraints and limited capacity, better partnership working is essential to maximise outcomes within current resources. With this in mind, rather than develop another service supporting healthier lifestyles, the focus will be on improved collaboration by service providers and better engagement with individuals and vulnerable sections of the community. Innovative approaches to improving participation rates are needed.

Almost half the burden of illness in developed countries is associated with four main unhealthy behaviours: smoking, excessive consumption of alcohol, poor diet and low levels of physical activity. It is vital to consider the combination of these as well as each of these in isolation. Men, younger age groups and those in lower social classes are more likely to exhibit multiple lifestyle risks (Schuit et al., 2002). Similarly people with no qualifications are more than five times as likely as those with higher education to engage in all four poor behaviours (Buck & Frosini, 2012). Given that the 2011 Census shows that Boston ranks 11th in the UK for the most people claiming to have no qualifications (22.6%), this is of particular concern. Addressing health inequalities amongst lower socio-economic groups is more likely to succeed if a holistic approach to policy and practice is adopted that encompasses multiple unhealthy behaviours, as well as addressing underlying social and economic factors. Successfully persuading every individual to adopt an entirely healthy lifestyle could be deemed unrealistic. However people may manage to modify their behaviours in a

positive direction, with a general reduction in the prevalence of those engaging in three or four behaviours and a causal increase in single behaviours (Buck & Frosini, 2012).

This need for a holistic concept has been factored into the proposed actions. Expanding the Making Every Contact Count initiative and strengthening interlinking referral pathways between existing services will lead to increased multidisciplinary support for the service users relating to more than one lifestyle issue.

Action 2: Encourage Active Travel, supporting people to walk and cycle more in their everyday lives and reduce sedentary behaviour

On average an inactive person spends 38% more days in hospital than an active person and utilises 5.5% more GP visits, 13% more specialist services and 12% more nurse visits than an active individual (East Midlands Clinical Senate Report, 2014).

Regular physical activity is a key contributor to energy balance, helping to prevent obesity and excess weight (Butland et al, 2007), two issues known to have a high prevalence in the local area.

People often perceive barriers to participation in physical activity such as time, cost, access to facilities and childcare. Walking and cycling are low cost activities, that can be performed with the family, can be fitted into everyday lives in bouts of 10 minutes or more, and require little or no specialist equipment or facilities. Physical activity that can be incorporated into everyday life has been found to be as effective for weight loss as supervised programmes (Department of Health, 2011), thus offering people an effective alternative. As is already the case in many European countries, walking and cycling should be normalised into daily routines from childhood and maintained throughout the life course. One important action is to modify the environment so that it does not promote sedentary behaviour (Lake & Townshend, 2006). Therefore increasing active travel forms part of the action plan, focusing on extra investment in cycling infrastructure and the public realm, coupled with promotional schemes to encourage behavioural change.

Many people use their cars out of habit when in fact a lot of their local journeys could be made by foot, bike or public transport. They often overestimate the walking and cycling journey times and underestimate the duration of car journeys (Sustrans).

Research (Merkur et al., 2013) shows that when local infrastructures are made more comprehensive, cycling increases by 3%. Several cost–benefit analyses also suggest positive returns from investment in cycle trails (Sassi et al.,2009). Investment in active travel is significantly cheaper and better value than traditional motor traffic schemes, with cost benefit ratios seven to ten times better (Sustrans, 2007).

More walking and cycling has the potential to contribute to other related objectives. For example, it would help increase the number of people of all ages out in the streets, making public spaces seem more welcoming and inviting opportunities for social interaction. It is also likely to contribute to a reduction in car travel, air pollution, congestion, road danger and noise (Cavill & Rutler, 2013). Active travel is also inclusive for people with impairments that may find it difficult to engage in other forms of physical activity, so that they can experience and enjoy the outdoor environment (NICE, 2012).

As an array of studies evidence, regular physical activity yields a range of health benefits including reduced risk of cardiovascular disease, mental health conditions and strokes, thus reducing the need for medication. Walking in particular is associated with a reduced risk of dementia (Abbott et al., 2004) which is of particular interest given the projected growth in the ageing population.

Research shows an adverse relationship between time spent sitting and obesity, overweight, blood lipid profiles and unhealthy blood glucose; even amongst those that meet the physical activity recommendations (Healy et al., 2012). It is essential therefore to include actions aimed at reducing sitting time in the workplace. For example, adjustable workstations have been shown to reduce swelling in the feet, spinal shrinkage and musculoskeletal discomfort (Paul & Helander, 1995) whilst increasing energy expenditure by up 100 calories per hour (Levine & Miller, 2007)

Action 3: Address alcohol misuse, focusing on street drinking and education

The majority of people who drink do so in a responsible way, but too many people still drink to excess.

High levels of alcohol consumption pose a risk to both society and the individual. Alcohol, particularly sustained heavy drinking, impairs personal security, health, educational attainment and productive employment. By highlighting alcohol misuse as an action point, it is also hoped that anti-social behaviour will decrease. This is particularly important in the case of street drinking, which has been identified by the Boston public as a major cause of concern. 94% of respondents said that people should not be allowed to drink alcohol in public places (Drinking in Public Places Survey, April 2014)

At any given level of alcohol consumption, poorer people can be as much as four times more likely to die from an alcohol-related condition as richer people (Rehm et al., 2009). With Boston being an area of significant deprivation and low incomes, it is therefore important to address wider socio-economic factors in tandem with alcohol issues. Alcohol costs to the healthcare system in Lincolnshire are estimated to be £41.6 million in 2010/11, equating to £72 per adult (Lincolnshire Alcohol and Drug Strategy, 2014)

In 2013, 9.1% of police incidents from the Boston district were alcohol related compared with the Lincolnshire average of 6.6%. Hospital admissions for alcohol

related harm in Boston (715 per 100, 000 population) were also above the Lincolnshire average (651) and East Midlands average (646) for 2012/13.

We need to support a change in the public's attitude and behaviours towards alcohol harm. Education and information needs to be easily available, ensuring that those requiring treatment are supported to recover effectively.

Action 4: Support people with dementia and their carers

In line with the rest of the UK, the people of Boston are living longer, with an estimated 20.5% of the population now aged 65 or above (ONS 2012 mid-year population estimates). This is projected to grow by 21% by 2020. An ageing population presents a challenge in providing care and support, both now and in the future. Residents will require more support to maintain their health and independence for as long as possible, not only to improve the quality of life in their elder years but also to reduce the burden on health and social care services.

As a consequence of demographic change, the number of people with dementia is set to increase by 33% by 2021 and the current demands on service provision are already evident. 40% of people admitted to hospital and at least two thirds of care home residents in the UK have dementia. Evidence from the national Dementia Strategy, showing that early provision of support at home can decrease institutionalisation by 22% and case management can reduce admission to care homes by 6%, demonstrates the positive impact that greater support could have on the individual and the care system. The information below from The Alzheimer's Society further supports this claim:

> "Living in the community with dementia (excluding the initial memory services assessment) is estimated to cost £24,128 each year. This includes the cost of an integrated health and social care package, together with respite, therapies and medication. A year in residential care costs an average of £35,424. For each person who is able to live at home there is a saving of £11,296 per year or £941 per month."

Diagnosis rates in Lincolnshire averaging 46% are broadly in line with national performance (Lincolnshire Joint Strategy for Dementia, 2014)

Over 670,000 people in the UK act as primary carers for people with dementia (Alzheimer's Society, 2012). Carers provide critical support to our care systems; therefore it is essential that the health of carers is supported and maintained wherever possible. This will be reflected in the action plan.

Interestingly 59% of dementia patients present with two or more co-morbidities due to poor lifestyle behaviours, possibly because of unsupportive and sometimes restrictive environments, for this particular population group. This information

highlights the complementary and combined impact that delivery of Actions 1 and 2 could have on people living with dementia.

Action 5:	Seek to expand the Fit 4 Your Future project to cover private sector accommodation and introduce complementary support programmes
Action 6:	Enhance quality of private sector housing and improve availability of affordable homes

Evidence suggests that living in poor housing can lead to an increased risk of cardiovascular and respiratory disease as well as anxiety and depression. Problems such as damp, mould, excess cold and structural defects which increase the risk of an accident also present hazards to health. Despite low wages, rents in Boston are higher than the East Midlands average. The proportion of private sector properties lacking modern facilities is higher than both the county and England average. Areas of high multiple occupancy exist within certain parts of the town. With more people living in privately rented accommodation, more must be done to improve professionalism and drive up standards. Homelessness and rough sleeping is also showing an increase.

Latest results from the Dwelling Level Housing Stock Modelling Condition report (July 2014) indicate that 1,081 dwellings in the private rented sector have a category 1 (serious) Housing Health and Safety Rating System (HHSRS) hazard. This equates to 24% of properties in the private rented sector. 3,996 owner occupied dwellings (22%) have a HHSRS category 1 hazard. The main hazards identified for all stock are excess cold (14%), which on its own is bad enough but it can also lead to damp and mould growth, and can interrelate to fall hazards (10%).

The highest concentrations of fuel poverty and excess cold in the in the private sector are found in the wards of Five Village , Old Leake and Wrangle, Swineshead and Holland Fen.

The average Simple Standard Assessment Procedure (SAP) score for all private sector dwellings is 50 compared to 55 for England. For the owner occupied stock in Boston Borough the figure is 50 and for the private rented sector it is 49.

In the case of Energy Performance Certificate (EPC) ratings, 23% of all private sector dwellings (5,220) and 24% of private rented dwellings (1,088) in Boston Borough are estimated to have an EPC rating below band E. Under the Energy Act 2011, new rules mean that from 2018 landlords must ensure that their properties meet a minimum energy efficiency standard, likely to be set at EPC Band E.

To address local housing requirements the Strategic Housing Market Assessment shows that there needs to be an annual delivery range in the order of 226 to 262

dwellings within the Borough, of which at least 50% would need to be affordable (Boston Borough Housing Strategy, 2012-2017)

Alignment with county and district priorities

The following matrix demonstrates how the six key actions align with priorities outlined in the Lincolnshire Joint Health and Wellbeing Strategy, Boston Health and Wellbeing Strategic Framework and Lincolnshire East Clinical Commissioning Group priorities

	Actions					
	Improve public uptake of existing services, focusing on healthy lifestyles	Encourage Active Travel and reduce sedentary behaviour	Support people with dementia and their carers	Address alcohol misuse, focusing on street drinking and education	Expand Fit 4 Your Future and complementary programmes	Enhance quality of private sector housing and improve availability of affordable homes
JHWS Themes						
Promoting Healthier Lifestyles	✓	✓	✓	✓		
Improve the Health and Wellbeing of Older People	✓	✓	✓		✓	✓
Delivering High Quality Systematic Care for Major Causes of ill Health and Disability (Long term conditions)	✓	✓	✓	✓	✓	✓
Improve Health and Social Outcomes for Children and Reduce Inequalities	✓	✓			✓	✓
Tackling the Social Determinants of Health				✓	✓	✓
Boston Health & Wellbeing Strategic Framework						
Promoting healthier lifestyles in Boston	✓	✓	✓	✓		
Improve the health and wellbeing of older people in Boston	✓	✓	✓	✓		✓
Address the housing and financial capability issues that most affect the health and wellbeing of people living in Boston					✓	✓
Lincolnshire East CCG Priorities						
Chronic Obstructive Pulmonary Disease (Lung diseases)	✓	✓				✓
Heart Failure	✓	✓				✓
Impaired Glucose Tolerance (at risk of developing type 2 diabetes)	✓	✓				

Delivery and monitoring of actions

The table overleaf outlines the actions that will be undertaken, the projected time scale, partners involved and how the outcomes will be monitored.

Included within the table are both local outcome measures and national indicators to monitor trends. These are explained in further detail within the appendix.
It is important to appreciate that the proposed actions are unlikely to have a significant impact on longer term trend measures within a 3 year period. However, it is hoped that the changes made will have a direct and comparatively rapid effect on the local outcome measures.

Resourcing

A key driver of this Action Plan is to improve collaboration between partners. Many of the actions require sustained effort and enhanced ways of working rather than additional resources. We need to be creative with existing resources, including the Health Improvement Grant, to add value in improving the health and wellbeing of our population.

However, there are significant elements of the Action Plan where extra resources will be needed to secure progress on key actions. Year 1 actions are fully resourced from a range of sources including Lincolnshire Highways, European Regional Development Fund, iCount, DCLG Rogue Landlord Fund, Boston Borough Council capital programme, Housing Unlocking Fund and contributions from the Homes and Communities Agency and social housing providers.

For years 2 and 3 we will work with partners to actively explore opportunities for attracting additional support. Potential sources of funding include the Boston Big Local, Reaching Communities, Mental Health Prevention Fund, Greater Lincolnshire LEP and charitable foundations of banks and financial institutions.

Key Area	Key Activities	Timescale	Local outcome measure	National indicator (trend)	Lead organisation & key partners
Priority 1: Promoting healthier lifestyles in Boston amongst adults and families					
Action 1: Improve public uptake of existing services	-Provide better information resources for referrers and potential service users including information booklet and website improvements -Sustain and improve partnership working with healthy lifestyle programme providers, including development of a Healthier Lifestyles Working Group -Support implementation of MECC, Lincolnshire Wellbeing Service, community hubs and workplace health programmes -Organise joint community-based events to promote services -Support delivery of relevant pharmacy campaigns	April 2014 – March 2015 April 2014 – March 2015 4 meetings per annum April 2014 – March 2017 April 2015 – March 2017 April 2014 – March 2017	-Number of hits to BBC 'Leisure and healthy green issues' webpage (1.01) -HT number of CIAs, information/signpostings & PHPs (1.04, 1.05, 1.06) -Swim sessions at GMLC (1.07) -Health Walk throughput and new walkers (1.08, 1.09) -Active Pilgrims attendance rates (1.12) -Phoenix referral rates (1.11) -DART referral rates (1.13) -Addaction referral rates (1.14) -Exercise Referral Scheme participation rates (1.15) -Number of Cook4 Life sessions and attendees (1.16, 1.17) -Allotment vacancies (1.18) -Fit Kids Participation rates (1.19) -Number of MECC sessions and attendees (1.02, 1.03)	-Excess weight in children (1.2, 1.21) -Excess weight in adults (1.22) -Percentage of physically active adults (1.25) -Smoking prevalence (1.26) -Early mortality from CVD (1.27) -Recorded diabetes (1.28) -Self reported wellbeing (1.29) -Alcohol related admissions to hospital (1.3)	**LCC** BBC LECCG LCHS ULHT LCVS Boston Mayflower Phoenix BUITC DART Addaction Boston Body Hub Lincolnshire Sport

	-Improve leisure facilities and opportunities for local people	April 2015 – March 2017	-Enhance facilities and activities at PRSA, GMLC and Peter Paine Sports Centre -Improving play facilities	-Number of users of PRSA – Gym members/swim and other	1Life Boston College BBC BTAC Parish Councils
Action 2: Encourage active travel and reduce sedentary behaviour	-Promote local travel plans, including enhanced cycle storage provision -Improve leisure infrastructure e.g. Black Sluice Trail, Boston Woods, coastal path -Continue network improvements in the urban area, including Haven Bridge corridor -Further develop health walks -Ensure planning process prioritises walking and cycling on new developments -Work with Boston Wheelers, Boston Ramblers and other groups to introduce new people to cycling and walking	April 2014 – March 2015 April 2014 – March 2017 April 2014 – March 2017 April 2014 – March 2017 April 2014 – March 2017 April 2014 – March 2017	-Health Walkers car usage (1.1) -Cycle counts (1.23, 1.24) -Membership of local groups (1.31) -Number of workplaces participating in campaign (1.32)	-Percentage of physically active adults (1.25)	**LCC/BBC** BUITC Local groups e.g. Boston Wheelers, Boston Ramblers Sustrans Lincolnshire Sport LECCG ULHT LCHS Natural England

	-Explore opportunities to work with Sustrans, LCC and other organisations to improve promotion and marketing of active travel -Organise promotional events and explore incentives, e.g. Walk to Work week -Launch 'Sit Less-Be Active' campaign in the workplace. First phase to include equipment and promotional material. Second phase to include promoting initiative to other workforces in the local area -Enhance green spaces to encourage visits on foot and by cycle	April 2014-March 2015 May 2015 May 2016 Nov 2014 – March 2015 April 2015 – April 2016 April 2014 – April 2017			
Action 3: Address issues surrounding alcohol misuse focusing on street drinking and education	-Re-introduce Operation Dakota in Boston -Identify medium and long term strategies to address street drinking in Boston (e.g. work with Addaction to signpost individuals to support/treatment services)	April-Dec 2014 April 2015-March 2016	-% of alcohol related incidents (1.33)	-Alcohol related admissions to hospital (1.30)	**BBC / Lincolnshire Police** LCC DART (LPFT) Addaction LECCG LCHS ULHT

	-Replace the current DPPO with a Public Space Protection Order, prohibiting the consumption of alcohol in a designated area. -Support delivery of the 'Blue Light Project' -Increase knowledge and awareness by supporting projects such as Pharmacy Alcohol Brief Intervention project -Delivery of brief intervention training to partners	May 2014-March 2015 TBC Jan 2015 April 2015-March 2017			
Priority 2: Improve health & wellbeing of older people					
Action 4: Support people with dementia and their carers	-Determine current work strands and services in place -Carry out consultation with existing support groups about shortcomings in existing provision -Explore the possibility of working towards a Dementia	April 2014 – March 2015 April 2014 – March 2015 April 2014 – March 2016	-Number of dementia support groups engaged with (2.01) -Number of Dementia Friends sessions and attendees (2.02, 2.03) -Number of local organisations hosting Dementia Friends training (2.05) -Number of local organisations registered with SLDAA (2.04)	-Health related quality of life for older people (2.06) -Enhancing quality of life for people with dementia (2.09) -Social connectedness (2.07) -Enhancing quality of life for carers (2.08)	SLDAA LCC BBC Age UK Boston and South Holland LECCG LCHS ULHT

	Friendly Community -Support the CCG in developing the Dementia Pathway initiative -Support the relevant pharmacy campaign -Register BBC as member of the South Lincolnshire Dementia Action Alliance and encourage other partner organisations to do likewise	 April 2014 – March 2017 April 2015 – March 2017 April 2014 – March 2015		-Carers can balance their caring roles and maintain their desired quality or life (2.1)	
Priority 3: Address housing and financial capability issues that most affect health & wellbeing					
Action 5: Seek to expand the Fit 4 Your Future * project to cover private sector accommodation and complementary programmes	-Support Greater Lincolnshire LEP funding bid (EU SIF proposals for 2014-2020) -Identify potential funding streams -Complete gap analysis -Submit funding applications	April 2014 – March 2015 April 2014 – March 2015 April 2014 – March 2015 April 2015 – March 2016	-Number of referrals into Fit 4 Your Future scheme (3.01) -Improved financial confidence (3.02) -Percentage of Fit 4 Your Future clients supported into employment (3.03)	-Fuel poverty (3.09)	**Boston CAB** Boston Mayflower BBC LCC LPFT Taylor ITEX Centrepoint Outreach Lincolnshire Credit Union Boston Foodbank Framework Housing LECCG LCHS

*Financial Inclusion Training (FIT) 4 Your Future currently helps social housing tenants to manage their household finances and make the most of their money.					
Action 6: Enhance quality of private sector housing and improve availability of affordable homes	-Enhance enforcement of the private rented sector -Introduce telephone hotline to report 'Rogue Landlords' -Improve engagement with tenants and landlords to address poor housing conditions through advice and information -Continue to promote landlord accreditation scheme to drive up quality standards - Carry out improvements to private sector housing to address serious hazards to health and wellbeing -Reduce homelessness and rough sleeping, focussing on support for single people - Secure funding and	Feb 2014 – March 2017 April 2015-Oct 2016 April 2014 – March 2017 April 2014 – March 2017 April 2015 April 2014 – March 2017 April 2014 –	-Number of properties with improved standards (3.05) -Number of non-local authority owned empty homes returned to occupation (3.07) -Homelessness prevented (3.06) -Number of affordable homes (3.04)	-Fuel poverty (3.09) -Statutory homelessness (3.08)	**-BBC** Gangmasters Licensing Authority Lincolnshire Police Lincolnshire Fire and Rescue Landlords Local letting agents Centrepoint Outreach Framework Housing Churches Together Social housing providers Homes and Communities Agency GLLEP LCC

	delivery of increased stock of affordable homes	March 2017			

Glossary

ASCOF:	Adult Social Care Outcomes Framework
BBC:	Boston Borough Council
BUITC:	Boston United in the Community
CVD:	Cardiovascular disease
DART:	Drug and Alcohol Recovery Team
ERS:	Exercise Referral Scheme
HTs:	Health Trainers
LCC:	Lincolnshire County Council
LCHS:	Lincolnshire Community Health Services
LCVS:	Lincolnshire Community & Voluntary Service
LECCG:	Lincolnshire East Clinical Commissioning Group
LPFT:	Lincolnshire Partnership Foundation Trust
NHSOF:	National Health Service Outcomes Framework
PHOF:	Public Health Outcomes Framework
QOF:	Quality Outcomes Framework (Primary Care)
ULHT:	United Lincolnshire Hospitals Trust

References

Buck, D. & Frosini, F. (2012). *Clustering of unhealthy behaviours over time, implications for policy and practice*. The Kings Fund. London.

Butland, B., Jebb, S., Kopelman, P., McPherson, K., Thomas, S., Mardell, J., et al. (2007). *Tackling obesities: future choices – project report*. London.

Cavill, N. & Rutler, H. (2013). *Obesity and the environment: increasing physical activity and active travel*. Public Health England.

Department of Health. (2011). *Start active, stay active: a Report on Physical Activity from the Four Home Countries' Chief Medical Officers*. Department of Health. London

Healy GN, Lawler SP, Thorp A, Neuhaus M, Robson EL, Owen N & Dunstan DW 2012. *Reducing prolonged sitting in the workplace (An evidence review: full report)*, Victorian Health Promotion Foundation, Melbourne, Australia.

Lake, A. & Townshend, T. (2006). *Obesogenic environments: exploring the built and food environments*. J R Soc Promot Health. [Research Support, Non-U.S. Gov't Review]. Nov; 126(6): 262-7

Levine, J & Miller, J. (2007). The energy expenditure of using a “walk-and-work” desk for office workers with obesity. *Br J Sports Med*2007;41:558-561

Merkur, S., Sassi, F. & McDaid, D. (2013). *Promoting health, preventing disease: is there an economic case?* World Health Organisation. Copenhagen

National Institute for Health and Care Excellence. (2012). *Walking and cycling: local measures to promote walking and cycling as forms of travel or recreation*. London.

Paul, R. D., & Helander, M. G. 1995. *‘Effect of sit-stand schedule on spinal shrinkage in VDT operators.’* Designing for the Global Village: Proceedings of the Human Factors and Ergonomics Society 39th Annual Meeting. San Diego, California. The Human Factors and Ergonomic Society. 1:563-567.

Sassi, F., Cecchini, M., Lauer, J. & Chisholm, D. (2009). *Improving lifestyles, tackling obesity: the health and economic impact of prevention strategies*. OECD Health Working Papers. Paris.

Schuit, A., Loon, A., Thijhuis, M. & Ocke, M. (2002). *Clustering of lifestyle risk factors in a general adult population.* Preventative medicine, vol 35, no 3, pp19-24.

Appendix

Promoting healthier lifestyles in Boston amongst adults and families

ID	Indicator Name	Baseline	Geographical Level	Reliability/ Frequency	Estimated Data	Perverse incentive	Polarity	Source
1.01	Number of hits to BBC 'Leisure and healthy activity' webpage since updating information	✓	District	Quarterly			↑	Richard Steele (BBC)
1.02	Number of MECC sessions hosted	New	District	Annually			↑	Kathryn Sperring / David Clark (LCC)
1.03	Number of individuals who have completed MECC training	New	District	Annually			↑	Kathryn Sperring / David Clark (LCC)
1.04	Health Trainers-number of CIAs	✓	District	Quarterly		Although an increase in referrals is desirable, it is more important for clients to progress onto PHP		Jan Gould-Martin (LCVS)
1.05	Health Trainers-Number of clients receiving information or signposting	✓	District	Quarterly			↑	Jan Gould-Martin (LCVS)
1.06	Health Trainers- Number of clients with a PHP	✓	District	Quarterly			↑	Jan Gould-Martin (LCVS)

1.07	Total admissions to Geoff Moulder swimming facilities	✓	District	Quarterly			↑	David Horry / Phil Perry (BBC)
1.08	Healthy walking throughput (number of individual sessions completed by walkers)	✓	District	Quarterly			↑	Fran Taylor (BBC)
1.09	Number of new walkers	✓	District	Quarterly			↑	Fran Taylor (BBC)
1.10	Percentage of walkers self-reporting using their cars less	✓	District	Quarterly	✓		↑	Fran Taylor (BBC)
1.11	Phoenix referral / quit rates	?	District	Annually				?
1.12	Active Pilgrim attendances	✓	District	6 monthly			↑	Nicola Drummond (UITC)
1.13	DART referral figures	?	District	Annually				?
1.14	Addaction referral figures	?	District	Annually				?
1.15	Number of clients that attended an initial consultation for ERS	✓	District	Quarterly			↑	Liisa Chadburn (BBC)
1.16	Cook 4 Life- number of sessions (peripatetic and cooking courses combined)	New	District	Quarterly			↑	Deborah Broadley (Boston Mayflower) / Karen Stengel (BBC)
1.17	Cook 4 Life- number of attendances (peripatetic and cooking courses combined)	New	District	Quarterly			↑	Deborah Broadley (Boston Mayflower) / Karen Stengel (BBC)
1.18	Allotment vacancies based on 6 sites	New	District	Annually			↓	Jenny Moore / Hannah Gosling (BBC)

1.19	Number of children & families engaged in Fit Kids programme	✓	District	Quarterly			↑	David Horry / Phil Perry (BBC)
1.20	Percentage of children aged 4-5 years classified as overweight or obese	✓	District & County	Annually			↓	PHOF 2.06i
1.21	Percentage of children aged 10-11 years classified as overweight or obese	✓	District & County	Annually			↓	PHOF 2.06ii
1.22	Percentage of adults classified as overweight or obese	✓	District & County	Annually			↓	QOF OB 001, PHOF 2.12
1.23	Number of cycle journeys made on Sleaford Road, Boston (north side)	✓	District	Annually			↑	Fiona Baxter (LCC)
1.24	Number of cycle journeys made on Sleaford Road, Boston (south side)	✓	District	Annually			↑	Fiona Baxter (LCC)
1.25	Percentage of adults achieving at least 150 minutes of physical activity per week in accordance with UK Chief Medical Officer recommended guidelines on physical activity	✓	District & County	Annually	✓		↑	PHOF 2.13
1.26	Prevalence of smoking amongst persons aged 18 years and over	✓	District & County	Annually	✓	Sample size can be small	↓	QOF SMOK001, PHOF 2.14
1.27	Age standardised rate of mortality from all cardiovascular diseases in persons less than 75 years of	✓	District & County	Annually			↓	PHOF 4.04, NHSOF 1.1

	age per 100,000 population							
1.28	Percentage of QOF-recorded cases of diabetes registered with GP practices aged 17+	✓	District & County	Annually	✓	Awareness campaign could cause an increase in diagnosis prevalence		PHOF 2.17
1.29	Percentage of respondents scoring 0-4 to the question "How satisfied are you with your life nowadays?"	✓	County	Annually			↑	PHOF 2.23
1.30	The number of admissions involving an alcohol-related primary diagnosis or an alcohol-related external cause, directly age standardised rate per 100,000 population, 2012/13	✓	District & County	Annually			↓	PHOF 2.18
1.31	Total number of members registered with local cycle groups	New	District	Annually			↑	Secretaries
1.32	Number of workplaces participating in 'Sit Less-Be Active' campaign	New	District	Annually			↑	Ian Farmer (BBC) / Kathryn Sperring (LCC)
1.33	Percentage of alcohol related incidents	✓	District & County	Annually			↓	Adam Eden (BBC)

Improve health and wellbeing of older people

ID	Indicator Name	Baseline	Geographical Level	Reliability/ Frequency	Estimated Data	Perverse incentive	Polarity	Source
2.01	Number of dementia support groups engaged with	New	District	Annually			↑	Kathryn Sperring (LCC)
2.02	Number of Dementia Friends awareness sessions held	New	District	Annually			↑	Kathryn Sperring (LCC)
2.03	Number of attendees at Dementia Friends sessions	New	District	Annually			↑	Kathryn Sperring (LCC)
2.04	Number of local organisations registered as SLDAA members	New	District	Annually			↑	Alzheimer's Society/ Kathryn Sperring (LCC)
2.05	Number of organisations hosting dementia friends training for their staff and volunteers	New	District	Annually			↑	Kathryn Sperring (LCC)
2.06	Health related quality of life for older people	✓	County	Annually			↑	PHOF 4.13
2.07	Social isolation: Percentage of adult social care users who have as much social contact as they would like according to the Adult Social Care Users Survey	✓	County	Annually			↑	PHOF 1.18
2.08	Enhanced quality of life for carers	✓	County	Annually	✓		↑	NHSOF 2.4, ASCOF 1D

2.09	Enhancing quality of life for people with dementia	✓	County	Annually			↑	NHSOF 2.5
2.10	Carers can balance their caring roles and maintain their desired quality of life	✓	County	Annually			↑	ASCOF 1D

Housing and financial capability issues that most affect health & wellbeing

ID	Indicator Name	Baseline	Geographical Level	Reliability/ Frequency	Estimated Data	Perverse incentive	Polarity	Source
3.01	Number of referrals into Fit 4 Your Future scheme	✓	District	Annually			↑	Katy Roberts (Boston Mayflower)
3.02	Improved Financial Confidence after second assessment (comparison of first score and second score based on a scale +1 (best) to -1 (worst). Aggregate differences and average to provide an annual figure.	✓	District	Annually			↑	Katy Roberts (Boston Mayflower)
3.03	Percentage of Fit 4 Your Future clients supported into employment	✓	District	Annually			↑	Katy Roberts (Boston Mayflower)
3.04	Number of affordable homes delivered	✓	District	Quarterly			↑	Stuart Horton (BBC)
3.05	Number of properties where housing standards have been improved through local authority and partnership activity	✓	District	Quarterly			↑	Stuart Horton (BBC)
3.06	Number of homelessness cases prevented	✓	District	Quarterly			↑	Stuart Horton (BBC)

3.07	Number of non-local authority owned empty homes returned into occupation as a result of action by the local authority and partners	✓	District	Quarterly	✓		↑	Stuart Horton (BBC)
3.08	Statutory homelessness crude rate per 1,000 households	✓	District & County	Annually			↓	PHOF 1.15
3.09	The percentage of households that experience fuel poverty based on the "Low income, high cost" methodology	✓	District & County	Annually			↓	PHOF 1.17