Cambridgeshire County Council

Cambridgeshire Healthy Behaviours Needs Assessment

Evidence-base and Analytical Report 2025

Contents

1. Executive Summary

1.1 Aim and approach

The aim of the health needs assessment is to comprehensively understand the needs of the populations of Cambridgeshire with regards to healthy behaviour. It brings together a range of information and perspectives from epidemiology, published evidence and best practice through to qualitative insights from professionals and service users. This information has been used to identify gaps or areas of improvement for local healthy behaviour change prevention and treatment services. Findings and recommendations from the needs assessment will be used to improve future services and inform the recommissioning of local authority funded services.

1.2 Key Findings

Demographics

Cambridgeshire has a rapidly growing population. Cambridgeshire's population was recorded as 678,855 in the 2021 Census, showing a 9.3% increase since 2011. This growth has been uneven across age groups, with the 65+ population rising by 26.3%, while those under 15 increased by 6.3% and those aged 15-64 by 5.9%. The population is characterised by an ageing demographic, with districts such as Huntingdonshire experiencing significant growth in older age groups, contrasting with Cambridge City's younger population driven by its large student base. The county's mix of urban centres and extensive rural areas creates unique challenges for service accessibility and health outcomes and this picture of growth and aging population this is likely to see increased demand for all health services, including healthy behaviour services.

Deprivation levels vary widely across Cambridgeshire, with Fenland being the most deprived district, marked by higher levels of child poverty, while South Cambridgeshire ranks as the least deprived. Ethnic diversity is most evident in Cambridge City, although across the county, 10% of residents identify as 'Other White,' reflecting a significant Eastern European population. Indian, Chinese, and other Asian communities are also notable, with language diversity including Polish and Lithuanian. These demographic variations underscore the need for localised, culturally competent public health initiatives.

Life expectancy in Cambridgeshire is above the England average, though disparities exist between districts. Fenland has the lowest life expectancy, particularly for females, which has been declining since 2011. This contrasts with South Cambridgeshire, where life expectancy is among the highest in the region. The county's ageing population, coupled with its socio-economic disparities and diverse communities, presents a complex landscape for addressing health inequalities and planning targeted interventions.

Smoking and Vaping

Prevalence: Smoking rates in Cambridgeshire show substantial geographic and socio-economic disparities. While the county-wide prevalence is below the national average at 10.8% (compared to 11.6%), areas like Fenland report rates as high as 24%, disproportionately affecting vulnerable groups such as routine and manual workers, homeless individuals, and those with mental health conditions.

Youth Vaping: Vaping among young people in Cambridgeshire is a growing concern, with 21% of pupils having tried vaping, surpassing smoking rates. District-level variations, such as higher vaping rates in Fenland and East Cambridgeshire, highlight the need for targeted interventions. Half of the children trying vaping nationally have never smoked, raising concerns about long-term nicotine addiction.

Vulnerable Populations Face Unique Barriers: High smoking prevalence is observed among vulnerable populations, including routine and manual workers (34.7% in Fenland), Eastern European communities, and individuals with mental health conditions. These groups face unique challenges, such as cultural norms, entrenched habits, or limited access to cessation services, necessitating tailored, community-specific approaches.

Obesity and Healthy Weight

Adult and Childhood Obesity: Fenland has the highest adult obesity rate in Cambridgeshire at 40.1%, while Cambridge City reports the lowest at 18.8%. Childhood obesity rates also vary widely, with Year 6 obesity reaching 40% in Fenland compared to 25.4% in South Cambridgeshire.

Socioeconomic Disparities: Obesity prevalence is closely linked to deprivation, with less affluent areas facing disproportionately high rates. This underscores the need for place-based interventions to address social determinants.

Physical Activity

Inactivity Patterns: Physical inactivity is a persistent issue, particularly in rural and deprived areas of Cambridgeshire, where barriers such as cost, accessibility, and availability of tailored programmes remain significant.

Positive Impact of Action: Evidence demonstrates that even modest increases in physical activity can yield substantial health benefits, emphasising the value of community-led initiatives.

Alcohol Use

Harmful Drinking Patterns: In Cambridgeshire, approximately 20% of adults are estimated to drink at levels that increase their risk of harm, aligning with national trends. Harmful drinking is often linked to stress, social isolation, and cultural normalisation, particularly in rural areas.

Barriers to Early Intervention: Limited awareness of alcohol-related harm and a lack of understanding of what constitutes risky drinking are common barriers. Additionally, rural residents face challenges accessing early intervention services, exacerbating the issue.

Opportunities for Early Intervention: Evidence supports the use of Alcohol Identification and Brief Advice (IBA) in primary care and community settings. IBAs have been shown to reduce weekly alcohol consumption by an average of 12% when delivered effectively. Scaling up IBAs in Cambridgeshire could address harmful drinking in at-risk populations.

Service Gaps: While services like "Healthy You" offer alcohol awareness support, engagement levels could be improved through targeted information campaigns and streamlined referral pathways. A

focus on integrating alcohol interventions with other healthy behaviour initiatives could enhance outcomes.

Cardiovascular Health Checks

Performance Recovery Post-COVID-19: Cambridgeshire's NHS Health Check programme has demonstrated a strong recovery following the disruptions of COVID-19, achieving higher-than-average performance compared to national metrics.

Health inequalities remain a concern. Attendance rates are lower among men, younger adults (40–44 years), and ethnic minority groups, while individuals from socio-economically deprived areas and older adults (60–74 years) are more likely to attend. These disparities highlight the need for targeted outreach to underrepresented groups.

Geographic Variability and Delivery Models: Substantial geographic variability exists in the delivery and uptake of health checks, both regionally and locally. Practices with low performance contribute to inequitable access to preventative care, underscoring the need for more standardised monitoring and the exploration of alternative models, such as neighbourhood and district hubs.

Data Gaps and Incomplete Records: Incomplete recording of critical data points—such as alcohol consumption, physical activity, and CVD risk scores—hinders the programme's ability to evaluate its full impact. Addressing these gaps through improved practitioner training and digital systems will strengthen monitoring and ensure compliance with national best practices.

Falls Prevention

High Falls Risk: One in three people over 65, and half over 80, experience a fall annually. Falls are more frequent in nursing homes and hospitals, with those who fall once being two to three times more likely to fall again within a year.

Severe Health Impact: Falls are the leading cause of injury-related deaths in over-75s. Hip fractures have high mortality rates, with 10% dying within a month and one-third within a year. Up to 90% of hip fracture patients never regain their previous mobility or independence.

Rising Demand: Cambridgeshire's 65+ population increased by 26.3% (2011-2021) and is projected to grow by 46.6% by 2041. With falls-related hospital admissions already exceeding national averages, this growth will place increasing pressure on falls prevention services and healthcare resources.

Cross-Cutting Themes

Digital Access and Inclusion: While digital services improve accessibility for some, digital exclusion is a concern, especially for older adults and those in remote areas of Cambridgeshire.

Cultural and Linguistic Barriers: Communities such as Eastern Europeans face challenges in accessing culturally tailored services, highlighting the need for localised and inclusive approaches.

Environmental Challenges: The obesogenic environment, characterised by the availability of unhealthy food and limited opportunities for active living, remains a significant barrier to adopting healthier behaviours.

2. Introduction to Healthy Behaviours

Human behaviour significantly influences health and wellbeing, with effects that can be either beneficial or detrimental and vary across an individual's life. Healthy behaviours are shaped by a complex network of factors, including genetic predispositions, environmental and societal influences, cultural contexts, and personal relationships. Attributing behaviours solely to individual choice oversimplifies this complexity and fails to acknowledge the broader determinants that influence how people act.

It is useful to think of health and wellbeing as existing on a continuum that evolves over the life course. While the extent of influence and the need for intervention differ between individuals, the fundamental components of healthy behaviours are relevant to everyone. These behaviours can positively impact health and wellbeing at all stages of life. Consequently, the potential benefits of encouraging and supporting healthy behaviour changes should not be underestimated. National evidence shows that a substantial proportion of adults in England engage in multiple behavioural risk factors, reinforcing the importance of comprehensive public health strategies.[1]

Most individuals with multiple comorbidities are affected by conditions that could have been prevented or mitigated through lifestyle behaviour changes. Evidence suggests that poor diet, physical inactivity, smoking, and excessive alcohol consumption are key contributors to preventable chronic diseases such as diabetes, cardiovascular disease, and certain cancers. Unhealthy behaviours tend to cluster together creating multiple risk factors for poor health both in individuals and communities. Addressing these risk factors through targeted public health interventions could significantly reduce the burden of multimorbidity and improve overall population health.[2] [3]

3. Background and Scope

The aim of this healthy behaviours needs assessment is to comprehensively understand the needs of the populations of Cambridgeshire with regards to adopting healthy behaviours such as being physically activity, moving more, becoming or maintaining a healthy weight, sustaining being smoking free, having good mental health and alcohol use. This needs assessment also considered approaches and barriers to citizens ceasing harmful, addictive behaviours such as smoking and drinking alcohol.

The current local authority funded health improvement behaviour change prevention and treatment services for Cambridgeshire require recommissioning from October 2025. It is therefore essential that the current needs, demands and services are mapped, and any gaps identified ahead of the recommissioning. This will help to inform future commissioning of services as well as wider service improvements in Cambridgeshire. This needs assessment brings together a range of information which has been reviewed and considered in order to develop informed recommendations for improving the current and future healthy behaviour change services of Cambridgeshire.

[1] Oxford Academic
[2] Office for National Statistics
[3] UK Health Security Agency Blog

This needs assessment will predominantly focus on areas of healthy behaviour change which are commissioned by Cambridegshire local authority although it will also seek to consider areas for the improvement of the wider system.

A healthy lifestyle needs assessment was conducted in 2019 prior to the tendering of the current Integrated Healthy Lifestyle Service *Healthy You*.

This needs assessment is one of a suite of research pieces taking place in the Autumn/Winter 2024-25, and therefore report should be viewed and considered alongside the following:

- Cambridgeshire and Peterborough Qualitative Healthy Behaviours Needs Assessment
- Cambridgeshire Review of the Health You Integrated Behaviour Change Service
- Peterborough Review of the Integrated Lifestyle Service
- Sheffield Hallan University Behavioural Insight Reseach

4. Methodology

This healthy behaviour needs assessment brings together quantitative data alongside relevant national and local contextual information. The following work is included in the needs assessment:

1. Review of national guidance to understand national priorities and guidelines for addressing health inequalities across a range of healthy behaviours.
2. Review of current service provision and epidemiological evidence.
3. Consideration of both the qualitative and quantitative information to identify gaps and unmet needs.
4. Recommendations for local services to meet any identified unmet needs and improve the healthy behaviour outcomes for Cambridgeshire.

Contextual information

Relevant contextual information was collated through searches of national and local publications and from partners who engaged in the needs assessment process including through the expert engagement panels, interviews and focus groups. This includes information such as:

- Demographic and census data for the Cambridgeshire and Peterborough population and for the service user population.
- National trends with respect healthy behaviours
- Relevant national and local policies including recent policy changes, service commissioning and funding.

Information governance

The majority of quantitative data in this needs assessment is from publicly available sources. Where data is from service providers, this has been reproduced with their permission and all data sources are recorded within the needs assessment.

Gaps in data

While this needs assessment seeks to be as comprehensive as possible, it is important to acknowledge that there are some gaps in the data presented here. In particular, much of the routine data is aggregated at a high level making it difficult to draw conclusions around specific subgroups in the population.

5. Local population

This section sets out the population demographics for Cambridgeshire as well as demographic information on the users of healthy behaviour change services.

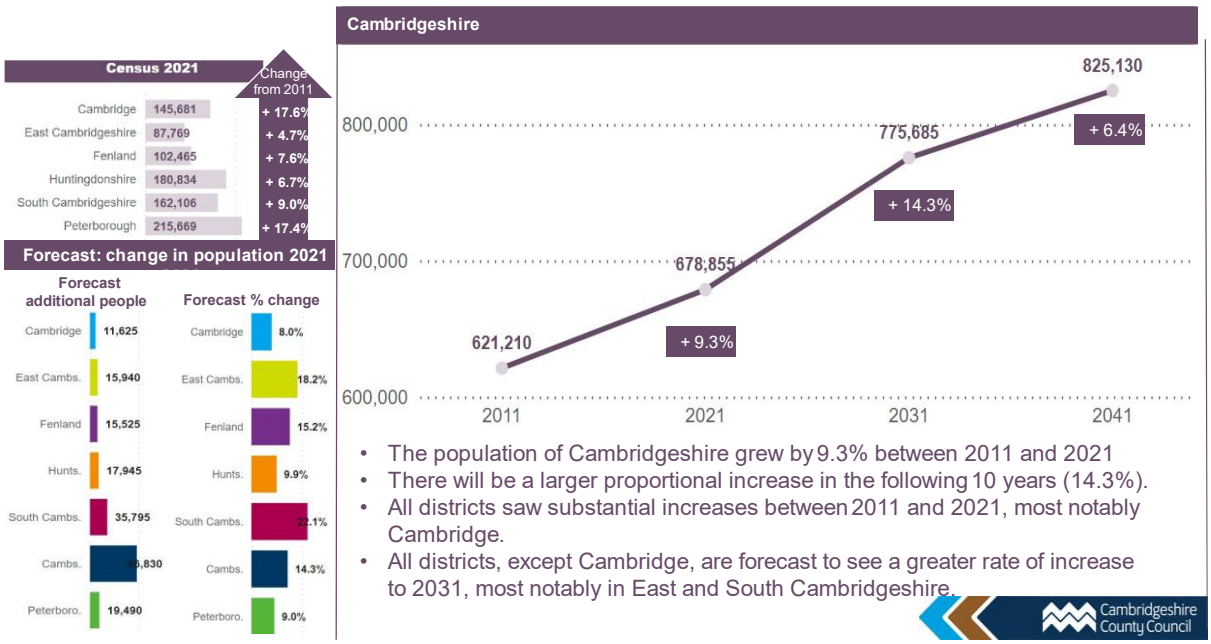
Cambridgeshire is a varied area with urban populations in Cambridge and Ely Cities, as well as key towns (Huntingdon and St Neots) and a large rural population. The accessibility of health services varies as a result, with the larger towns and cities being well connected and having easier access to secondary care and specialist services.

5.1 Population and age structure

Population

The population in the 2021 census was 678,855 in Cambridgeshire, our population is growing faster than the national average, with more to come. Since 2011, the population increased by 9.3% in Cambridgeshire among the highest increases in the UK. This increase was not evenly distributed across age groups with a 26.3% increase in people age 65+ compared to a 6.3% increase in those under 15 and 5.9% increase in those age 15-64. The county is made up of five districts with varying populations. The five districts in Cambridgeshire are Huntingdonshire, Fenland, East Cambridgeshire, South Cambridgeshire and Cambridge.

Figure 1. Projected Population Growth and Demographic Changes in Cambridgeshire (2011–2041)



The greatest increase in population between 2011 and 2021 was seen in Cambridge city and the lowest was in East Cambridgeshire. Cambridge also saw a greater increase in the under 15, and 15-64-year population groups. Huntingdonshire saw the greatest increase in the over 65 years age group (figure 2). It is projected that Cambridgeshire and Peterborough will continue to see rapid population

Table 1. Population age structure change of Cambridgeshire, between Census 2011 and Census 2021. ONS

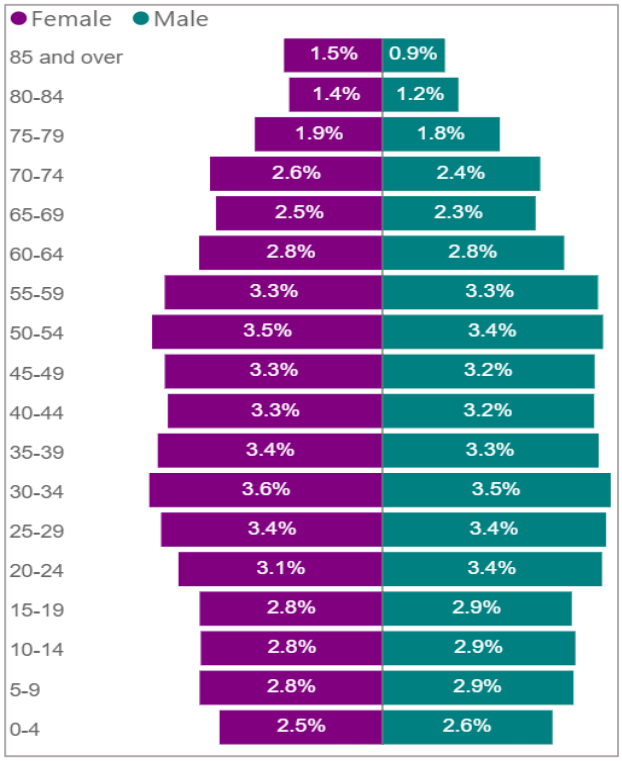
	Total population		Under 15		15 to 64		65+	
Area	*Count*	*%*	*Count*	*%*	*Count*	*%*	*Count*	*%*
Cambridge	21,814	17.6%	2,913	17.4%	16,884	18.3%	2,017	13.8%
East Cambridgeshire	3,951	4.7%	-18	-0.1%	53	0.1%	3,916	27.4%
Fenland	7,203	7.6%	950	6.1%	2,166	3.6%	4,087	21.2%
Huntingdonshire	11,326	6.7%	496	1.6%	1,592	1.4%	9,238	33.8%
South Cambridgeshire	13,351	9.0%	2,318	8.4%	3,935	4.1%	7,098	28.7%
Cambridgeshire	57,645	9.3%	6,659	6.3%	24,630	5.9%	26,356	26.3%
Peterborough	32,038	17.4%	8,719	23.8%	17,609	14.4%	5,710	23.0%
Cambridgeshire and Peterborough	89,683	11.1%	15,378	10.8%	42,239	7.9%	32,066	25.6%

growth, with South Cambridgeshire predicted to grow by 37% by 2041. This is likely to put increasing pressures on the health services in these areas.

Age structure

While Cambridgeshire (and Peterborough) overall has an ageing population there is significant variation across the area. The two city populations of Cambridge and Peterborough are younger than the four rural districts.

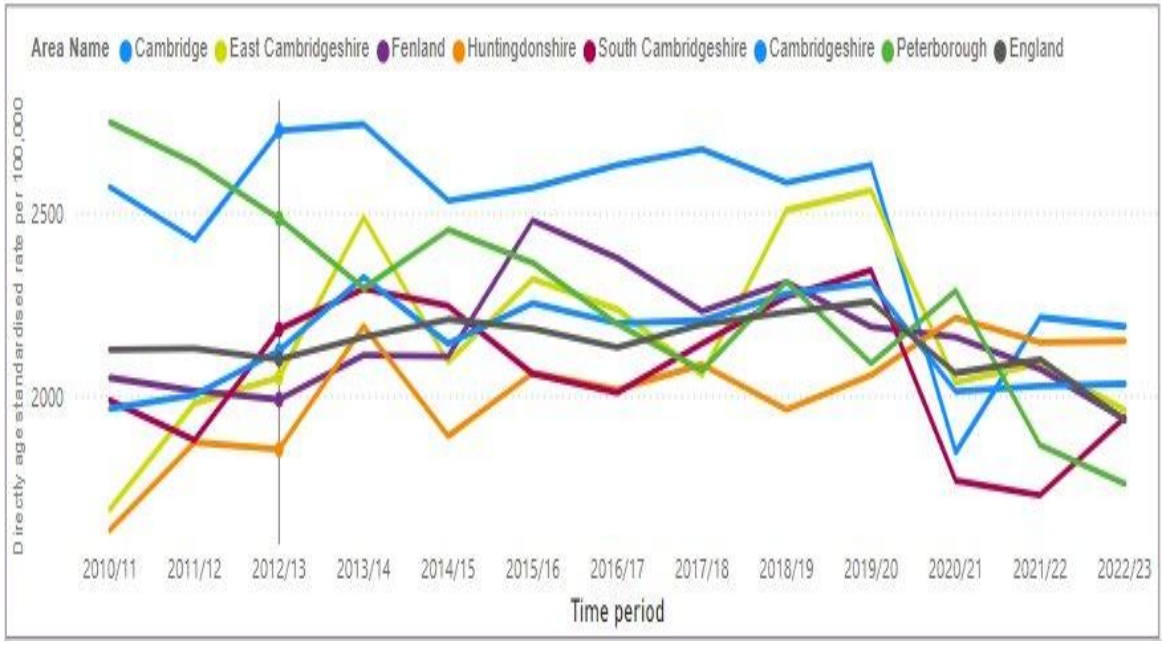
Figure 2. Population age structure of Cambridgeshire, Census 2021. Source: ONS



Overall Cambridgeshire has a lower proportion of children and a high proportion of older people. Cambridgeshire has a high proportion of people age 20-24 compared to national, partly due to the high student population in Cambridge (figure 3). 125,585 people aged 65+ live in Cambridgeshire (Census, 2021). There was a 26.3% increase in 65+ between 2011 and 2021, higher than the 9.3% for the overall population. There is forecast to be a 46.6% increase in 65+ in Cambridgeshire between 2021 and 2041.

Figure 3 depicts the directly age-standardised mortality rate per 100,000 population across different areas in Cambridgeshire (Cambridge, East Cambridgeshire, Fenland, Huntingdonshire, South Cambridgeshire, and Peterborough) compared to the England average over time (2010/11 to 2022/23). It highlights significant variation in age-standardised mortality rates across Cambridgeshire districts. Fenland consistently shows higher mortality rates compared to other areas and the national average, reflecting potential health inequalities, while South Cambridgeshire and Huntingdonshire maintain lower rates. Most areas, including the England average, demonstrate a general downward trend over time, suggesting improvements in healthcare and public health efforts. However, the 2019/20 to 2021/22 period saw sharp fluctuations, likely due to the impact of the COVID-19 pandemic. These disparities emphasise the need for targeted health interventions in areas like Fenland and Peterborough, where mortality rates remain persistently high.

Figure 3. Trends in Age-Standardised Mortality Rates Across Cambridgeshire Districts and England (2010/11–2022/23



5.2 Income and multiple deprivation measures

Cambridgeshire has both areas of affluence and pockets of deprivation. Fenland has higher levels of deprivation than other parts of Cambridgeshire, particularly for children. South Cambridgeshire has the lowest levels of deprivation in the area (table 3 and figure 4).

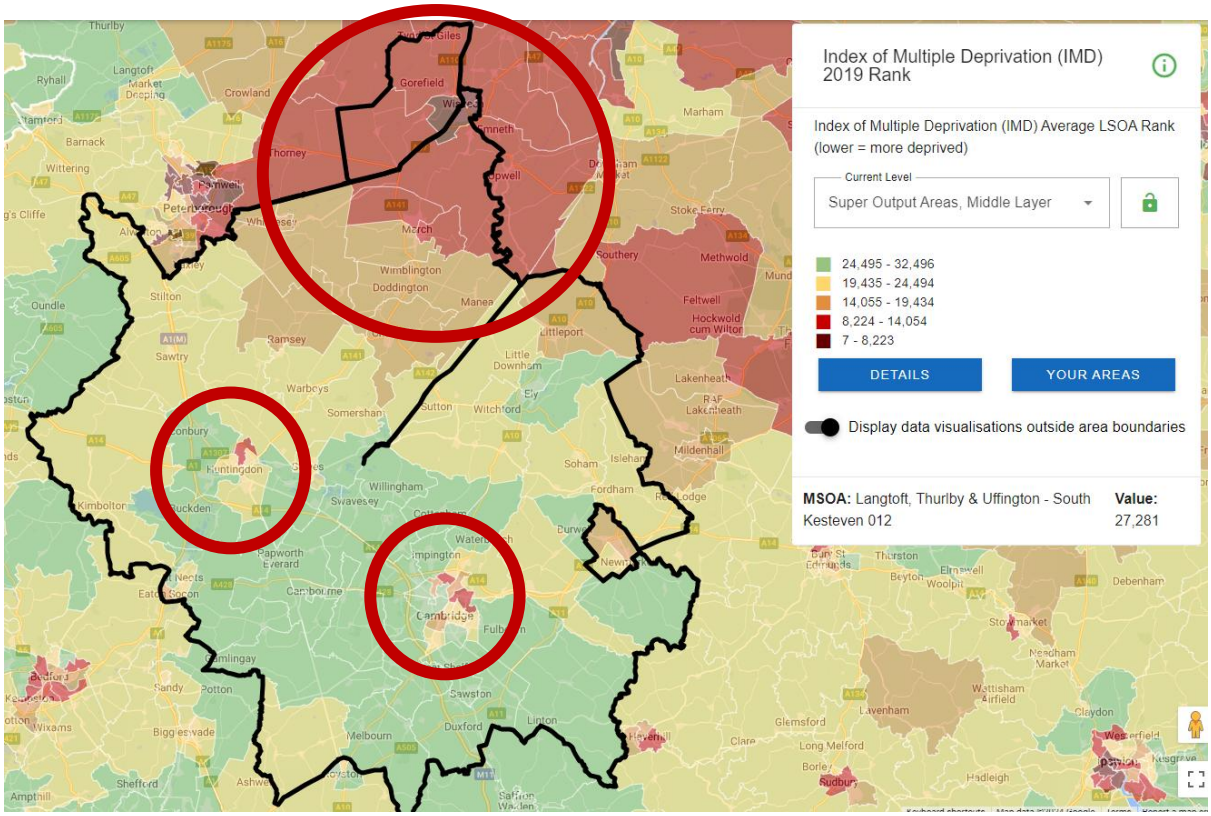
Employment sectors and occupations vary considerably across the areas. Agriculture is important in Fenland and East Cambridgeshire with some people working seasonally. Professional and technical employment are higher than the national average in South Cambridgeshire and Cambridge City. Earnings are lower in Peterborough and Fenland with higher unemployment also seen.

Table 3. Index of multiple deprivation (IMD), income deprivation affecting children (IDAC), and income affecting older people (IDAOPI), Cambridgeshire and Peterborough, 2019. Source: ONS

Index of Multiple Deprivation	IMD Rank	IDACI Score %	IDAOPI Score %
Peterborough	51	20.8%	16.9%
Cambridgeshire	132	11.1%	9.6%
Cambridge	210	12.2%	11.2%
East Cambridgeshire	272	8.3%	9.5%
Fenland	80	20.1%	14.2%
Huntingdonshire	248	10.7%	8.1%
South Cambridgeshire	301	7.5%	6.9%

Note: the lower the rank the higher the level of relative deprivation, ranked out of 317 LTLAs.

Figure 4. Indices of multiple deprivation 2019: National Decile for Overall Deprivation by Lower Super Output Area (LSOA)



5.3 Ethnicity and language

The majority of residents in Cambridgeshire identified as white ethnicity in the 2021 census with the majority of white residents identifying as English, Welsh, Scottish, Northern Irish or British (table 4).

However, there are substantial minority ethnic populations. In Cambridgeshire, Indian, Chinese and other Asian were the next most common ethnicities. Cambridgeshire and Peterborough also have a significant traveller community with 10 traveller sites in Cambridgeshire and 2 in Peterborough.

In Cambridgeshire, over 10% of the population identified as 'other white' ethnicity. A high proportion of residents who do not speak English as their main language speak Eastern European languages such as Polish and Lithuanian (table 5). Differences in the ethnicity of residents between Cambridgeshire and Peterborough are also seen in the languages spoken, for example, Urdu features in Peterborough's top 10 languages due to the high number of Pakistani residents but not in Cambridgeshire. Language as well as other factors including trust, prevalence of myths and knowledge about services may act as barriers to accessing sexual health services for different ethnic groups.

Table 4. Ethnic breakdown of residents (top 10), Census 2021, Cambridgeshire. Source: ONS

Ethnicity	%	Count
White English, Welsh, Scottish, Northern Irish or British	77.22%	524,194
Other White	10.03%	68,094
Indian	1.89%	12,824
Chinese	1.41%	9,594
Other Asian	1.40%	9,523
Any other ethnic group	1.04%	7,040
White and Asian	1.04%	7,039
African	0.98%	6,631
Other mixed or multiple ethnic groups	0.86%	5,843
Irish	0.84%	5,685

Table 5. Main language spoken by residents, if not English, (top 10), Cambridgeshire and Peterborough, Census 2021. Source: ONS

Cambridgeshire

Main languages	%	Count
Polish	14.6%	8,969
Lithuanian	8.4%	5,150
Romanian	6.3%	3,847
Spanish	6.2%	3,780
Portuguese	5.8%	3,562
Italian	5.3%	3,251
All other Chinese	4.8%	2,937
Russian	3.4%	2,058
French	3.0%	1,819
Hungarian	2.7%	1,717

Peterborough

Main languages	%	Count
Polish	18.1%	7,507
Lithuanian	16.2%	6,720
Portuguese	9.0%	3,707
Romanian	8.6%	3,575
Urdu	6.0%	2,470
Latvian	4.4%	1,805
Panjabi	4.1%	1,704
Russian	2.8%	1,172
Slovak	2.6%	1,082
Kurdish	2.2%	931

5.4 Life expectancy trends over time.

Cambridgeshire average life expectancy is above the England average (Figures 5 and 6). After a decade of increases in life expectancy between 2001-2011, there has been little change in life expectancy or healthy life expectancy over the last decade in the County.

Significant contrast between life expectancy in South Cambridgeshire and Fenland. Life expectancy has declined in Fenland since 2011 and there is now a gap of 0.8 years Female and 1.4 years Male with the England average. Fenland has one of the lowest female life expectancies in the East of England.

Figure 5. Trends in Female Life Expectancy at Birth Across Cambridgeshire Districts and England (2001–2022)

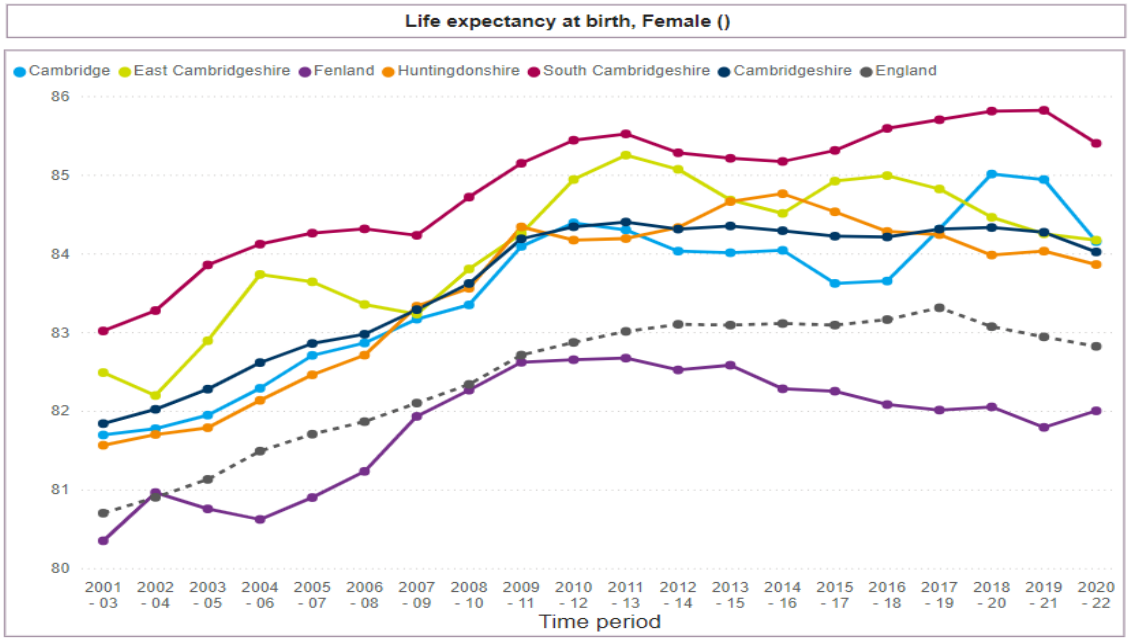
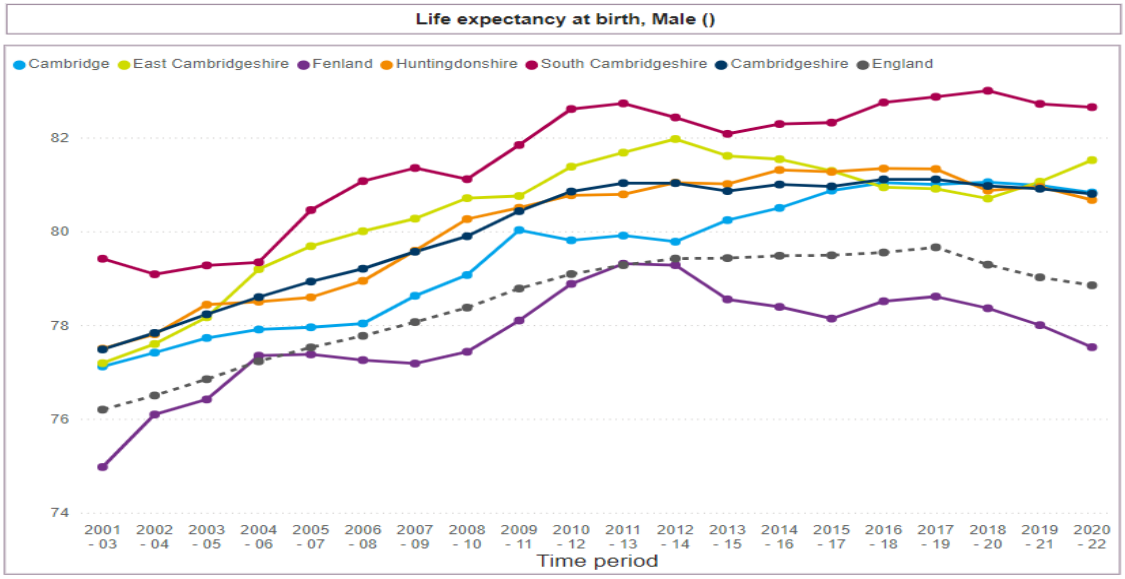


Figure 6. Trends in Male Life Expectancy at Birth Across Cambridgeshire Districts and England (2001–2022)



5.5 Influences on Health Outcomes

The graphic below (figure 7), based on research from the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute[4], illustrates the factors influencing health outcomes and their relative contributions. It highlights four main domains: health behaviours (30%), socio-economic factors (40%), clinical care (20%), and built environment (10%).

Figure 7. Determinants of Health: Contributions of Behavioural, Socioeconomic, Clinical, and Environmental Factors

SOURCE: Robert Wood Johnson Foundation and University of Wisconsin Population Health Institute in US to rank countries by health status

1. **Health Behaviours (30%)**: Includes individual choices like diet, exercise, smoking, alcohol use, and sexual health, which directly impact health outcomes.
2. **Socio-economic Factors (40%)**: The largest contributor, encompassing education, employment, income, family/social support, and community safety. These determine the opportunities and resources available for maintaining good health.
3. **Clinical Care (20%)**: Focuses on access to and quality of medical care, which is essential for addressing immediate health issues.
4. **Built Environment (10%)**: Includes environmental quality and infrastructure, such as housing and access to safe recreational spaces, which affect long-term health.

This breakdown underscores the importance of addressing not only individual health behaviours but also the broader socio-economic and environmental determinants of health. In Cambridgeshire, behaviour change services like **Healthy You** play a vital role in tackling health behaviours (30%), such as promoting physical activity, smoking cessation, and healthy eating. However, the data suggests that services must also work collaboratively with partners to address socio-economic inequalities, ensuring interventions are targeted toward groups with the greatest needs.

[4] Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute (US)

Programmes in Cambridgeshire must focus on integrating behaviour change efforts with community support, workplace engagement, and environmental improvements to create sustainable health outcomes.

6. Smoking and Vaping

6.1 Introduction and Scope

This chapter will look at smoking including prevelence rates, vaping, cessation methods and prevention. It will briefly cover past and future national policy, the picture in Cambridgeshire and then focus past literature and strategies used in vulnerable groups: pregnant individuals, homeless individuals, those with poor mental health, routine and manual workers (RMWs), Eastern European population and those with learning disabilities.

6.2 Impact of smoking

Smoking is known to have a detrimental effect on health throughout an individual's lifetime. It can lead to increased risk of still or preterm birth, childhood asthma, chronic respiratory disease, increased risk of cardiovascular disease, dementia and stroke.[5] Smoking is also responsible for 1 in 4 of all UK cancer deaths and for most lung cancer cases. Exposure to second-hand smoke also puts individuals at increased risk of these harms, especially young children.[6]

This puts pressure on the NHS, through GP appointments and inpatient admissions. The total cost of smoking to UK is estimated at 17 billion pounds, which includes 13 billion for lost productivity from early death, unemployment and lost earnings.[7] Many smokers know these risks and want to stop but struggle due to addiction, on average it takes 30 attempts to quit successfully.[8] Eighty percent of smokers start aged under 20 years old and are addicted for life and the majority wish they had never started.

Tobacco related harm is the single biggest preventable cause of ill health, death and disability therefore preventing usage and encouraging cessation will have a multitude of benefits. For those who currently smoke, if they can quit successfully before 30 years old they can increase their life expectancy by 10 years.[9]

Smoking is more common in men and in those aged 25-34 years old. We also know that those who are from more deprived backgrounds, are unemployed or on low incomes are twice as likely to smoke and experience mortality from smoking than those in the least deprived areas. Combating smoking will help address inequality.

6.3 Vaping

Vaping is defined as the use of battery-operated devices that people use to inhale an aerosol, which typically contains nicotine. They are significantly less harmful than smoking as they do not contain tobacco however the long-term health effects are unclear.[10]

Vaping has been identified as a highly effective method for helping adult smokers quit, surpassing standard nicotine replacement therapy (NRT) in success rates. A Cochrane review found that vaping

[5] Stopping the start: our new plan to create a smokefree generation.
[6] The Smokefree 2030 ambition for England
[7] ASH
[8] BMJ Open
[9] World Health Organization (WHO)
[10] Vaping Devices (Electronic Cigarettes) DrugFacts

was 70% more effective than NRT, and it is estimated to have supported 50,000–70,000 adults in quitting smoking.[11] Vaping is also central to the government's "Swap to Stop" initiative, which encourages smokers to transition to vaping as part of a structured cessation program.[12] However, concerns about vaping have grown due to its increasing prevalence among children. Nationally, the proportion of children trying vaping tripled in the past three years, with 20.5% reporting having tried it in 2023 compared to 15.8% in 2022.[13] Approximately half of these children had never smoked, raising concerns about nicotine addiction and exposure to potentially harmful chemicals. Vaping is strongly discouraged for non-smokers, particularly children

In Cambridgeshire, vaping among children and young people has surpassed smoking. Local data from 2022 shows that 10% of children and young people reported vaping, with rates as high as 19% in Fenland compared to 8% in Cambridge. The ASH Youth Survey further found that 8.6% of 11–18-year-olds vaped nationally, compared to 4.8% in 2020, and 11.5% of never-smokers in this age group had tried vaping. Among adults, surveys from 2021 indicate that 6.9%–7.1% vape, with only 0.6% of those who have never smoked engaging in this behavior.[14] While vaping remains an effective tool for smoking cessation, its use among non-smokers and children presents significant public health challenges.[15]

The Healthy You service has exceeded referral targets and successfully engages individuals to set quit dates with stop-smoking providers. However, it has not met its targets for self-reported quit rates at four weeks or for CO-validated quitting. Barriers include difficulties with CO monitor use among older or less IT-literate clients, as well as the predominance of virtual rather than face-to-face appointments, which impacts data collection.[16] Healthy You anticipates improved outcomes with the introduction of initiatives such as "Swap to Stop" and cytisine medication, which are expected to enhance accessibility and effectiveness of cessation support.[17]

6.4 National Policy

Over the last 30 years through legislative change and funding commitments the smoking prevalence has decreased to 12.9%, which is the lowest recorded. Health warnings on cigarette packets, banning smoking in public places, raising the legal age to purchase tobacco from 16 to 18 have contributed to decreasing smoking rates and discouraging smoking initiation in young people. Discouraging young people is vital for prevention as we know most smokers start when aged under 20 years old. In 2019 a national ambition was set for England to be smokefree by 2030 (defined as a prevalence of 5% or less) but it is not currently on track to meet this.[18]

[11] Cochrane Library
[12] NHS England
[13] ASH
[14] ONS
[15] Cochrane Library
[16] Healthy You Service
[17] NHS England
[18] The Smokefree 2030

The Khan review in 2022[19] made a series of recommendations to accelerate towards this goal which contributed to a 2023 government paper, *Stopping the Start: Our New Plan to Create a Smokefree Generation*. The primary policy change is that the government will raise the age of sale for tobacco year on year indefinitely to ensure that future generations never start smoking. They recommend vaping as a substitute for smoking as part of a new initiative "Swap to Stop" and will also provide additional financial investment for local authorities to invest in smoking prevention and cessation, particularly for pregnant smokers and those using mental health services.

Swap to stop involves the Government offering 1 million smokers a free vaping starter kit together with behavioural support to help then quit smoking. They also focus on reducing youth vaping and plan to restrict vape flavours, regulate packaging and sale displays and restrict the sale of disposable vapes.

6.5 Local policy and strategy

In Cambridgeshire (and Peterborough), we work through Healthy You who are a stop smoking service and can provide NRT / medication through a GP or pharmacists. Individuals are referred by a healthcare professional or refer themselves. In addition to this service Healthy You also offer other interventions.

Swap to Stop supports adult smokers to switch their cigarette for a free vape starter kit as part of a 12-week programme of support. They can also benefit from interventions such as NRT.

Smoke free app, clients of Healthy You can sign up to this free app to order NRT and access 24 hour from stop smoking advisors and peers also attempting to quit. The app also allows users to track how much money they are saving by not smoking.

In addition, Cambridgeshire also support the two annual media campaigns of "Stoptober" and "No Smoking Day."

The Healthy You Healthy Schools Smoking service for young people provides smoking and vaping support for young people in Cambridgeshire and Peterborough. It provides a referral pathway for any young person who is smoking or vaping through a series of non-judgemental, supportive workshops on the school site. These can be 1:1 or in small groups. They also provide informal drop-in sessions or lunchtime stands to try and engage young people.

Secondly, the Healthy School service also provides *Catch Your Breath* which is a free schools bases programme focused on prevention of smoking and vaping. This is delivered through a 90-minute interactive workshop for students focused on prevention and cessation methods. Since November 2021, the programme has been delivered in 28 Primary and 19 Secondary schools, reaching 12,216 pupils. Pre and post workshop questionnaires are carried out with Primary school students and so far, these have shown a 59% reduction in the number of children saying they might or will smoke in

[19] Making smoking obsolete: Independent review to make smoking obsolete

the future and a 32% reduction in the number of children saying they would vape in the future. This is positive although this is self-report rather than actual smoking figures.

Over the last year, as described above, the government has made the decision to invest more in smoking prevention and cessation with more funds for local authorities. Therefore, we need to ensure that our policies and interventions are effective particularly for vulnerable groups with a higher smoking prevalence.

6.6 Smoking Prevalence in Cambridgeshire

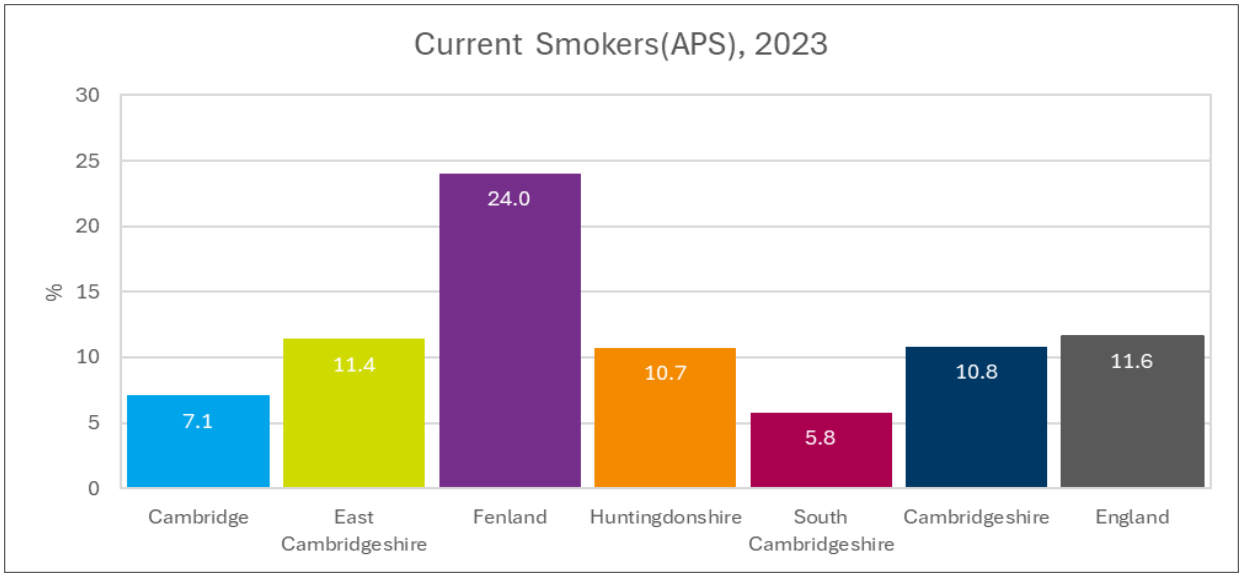
Adults

Smoking is the leading preventable cause of death in the UK, contributing to over 70,000 deaths annually.[20] Smoking prevalence in Cambridgeshire has historically been lower than the England average, with a consistent decline observed since 2011. In 2023, the national smoking prevalence stood at 11.6%, while in Cambridgeshire it was slightly lower, at 10.8%.

Whilst only one in ten adults smoke in Cambridgeshire but variation between districts is stark - one in 17 smoke in South Cambs and one in four adults smoke in Fenland. Fenland has correspondingly high rates of preventable death from cancer and respiratory diseases.

Within the five districts of Cambridgeshire we see higher rates in Fenland (24%) and East Cambridgeshire (11.4%). In South Cambridgeshire (5.8%) and Cambridge (7.1%) rates are much lower. We know that higher smoking rates are associated with deprivation, those who smoke are more likely to live in deprived areas and there are certain groups in the population with higher rates.

Figure 8. Percentage of Current Smokers by Region, 2023 (Annual Population Survey)



[20] Cancer Research UK

Young People

The Health-Related Behaviour Survey (HRBS) 2024 highlights that 21% of Cambridgeshire pupils have tried vaping, while 8% have smoked in the past or currently smoke.[21] Smoking prevalence is lowest in Cambridge, reflecting more favourable health behaviours in this district. However, vaping rates were notably higher in East Cambridgeshire, Fenland, and Huntingdonshire, again indicating countywide variations in health-risk behaviours among young people.

The survey reveals that risk-taking behaviours, such as smoking and vaping, increase with age and are more common among Year 10 pupils, particularly girls. This suggests that targeted interventions need to account for gender and age-specific factors influencing smoking and vaping uptake. Furthermore, vaping has emerged as a prevalent risk-taking behaviour that correlates strongly with other behaviours such as alcohol and drug use, warranting a comprehensive approach to health education and prevention.

Significant district-level disparities were identified in the survey. Fenland and East Cambridgeshire exhibit higher rates of smoking and vaping compared to the county average, consistent with broader trends linking higher smoking prevalence to areas with greater deprivation. These HRBS findings highlight the importance of prioritising resources and support in districts where young people are most at risk of engaging in these behaviours particularly Year 10 pupils, and include gender-specific strategies to address the growing uptake among girls.

6.7 Prevention

Over 90% of people start smoking before the age of 19.[22] It has been estimated that each year in Peterborough 472 young people start smoking, in Cambridgeshire the figure is 1,141. It is illegal to sell tobacco products or vapes to anyone under the age of 18. Nationally, half of the tobacco bought by 14 to 15-year-olds is illegal tobacco and 1 in 4 young smokers are regularly offered illegal tobacco, which is substantially cheaper and linked to crime, tobacco use inequality and difficulty quitting smoking. Therefore, prevention of smoking must be focused on young people and on preventing illegal sales of tobacco and vaping.

School based interventions are commonly used, including here in Cambridgeshire and Peterborough. There is evidence that these interventions are effective particularly the programmes that combine a social competence with a focus on resisting social influences. Evidence of incentive driven smoking prevention is limited; recent research suggests that these programmes do not prevent smoking in young people. Family based interventions for 11–14-year-olds have been found to be effective either alone or as an adjunct to a schools-based interventions.

As the age to purchase tobacco increases it will become more important to clamp down on tobacco sales to underage individuals and illegal tobacco sales. It is known illicit tobacco sales target children in disadvantaged areas and contribute to health inequality from tobacco. The government is

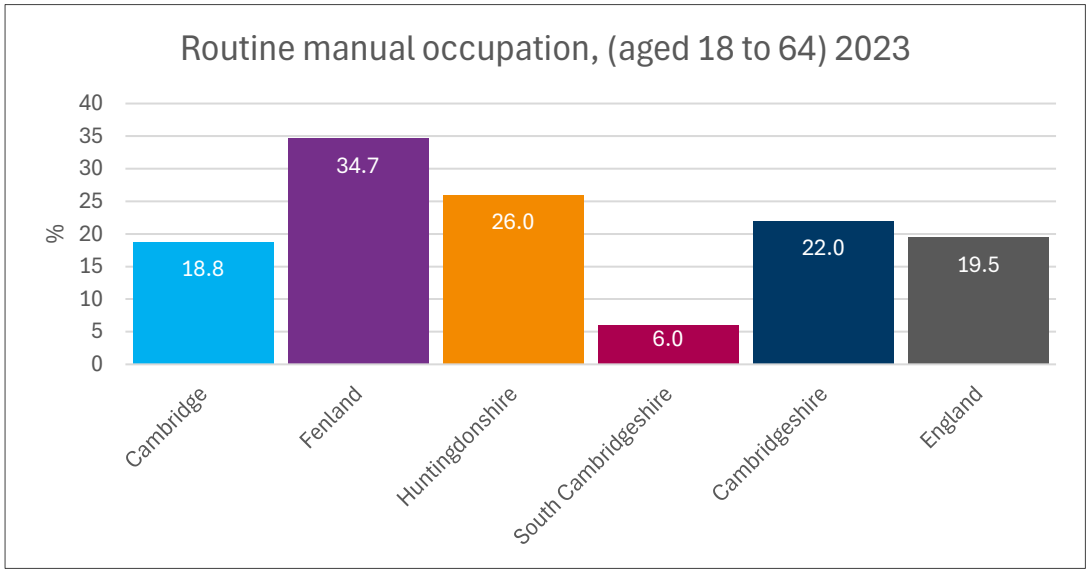
[21] CCC HRBS 2024
[22] State of Child Health

allocating 30 million pounds to enforcement agencies to target this and also granting local authorities the authority for spot fines for underage tobacco sales.

Routine and Manual Workers

The prevalence of smoking among routine and manual workers (RMWs) is significantly higher than in the general population. In 2022, smoking prevalence was recorded as 43.6% in Cambridge, 34.6% in Fenland, and 29.7% in South Cambridgeshire. By 2023, these rates had shifted to 18.8% in Cambridge, 34.7% in Fenland, and a notable 6% in South Cambridgeshire. However, it is important to note that the confidence intervals for this data are wide due to the small sample size, which can explain the considerable variation observed such as in South Cambridgeshire. Research indicates that self-reported smoking status can often be unreliable, leading to underestimation of true smoking prevalence. Despite these limitations, the consistently high prevalence in Fenland highlights the need for targeted smoking cessation efforts in this area. We know routine and manual workers are 2.5 times more likely than professionals & managers to smoke. It is interesting to note high prevalence in both our urban and rural areas in Cambridgshire.

Figure 9. Smoking Prevelence of Adults Aged 18 to 64 in Routine Manual Occupations, 2023



Research from the Department of Health in 2010 suggested that for RMW can be daunted by the prospect of smoking cessation, they can tend to establish routines in which smoking becomes entrenched.[23] Smoking can also be common amongst their family and local community so smoking cessation can contribute to social isolation. Smoking can also be seen as integral to their identity, it can be coping strategy, a reward, a method of relaxation and so to quit is not only hard and difficult but also something that would change their character. Research also suggests that this population may find it harder to quit as they are "more addicted", 37% have their first cigarette within 5 minutes of waking and they live and work in environments where smoking is more visible and socially acceptable therefore making cessation more of a challenge.[24]

[23] GOV.UK
[24] The NSMC

There is limited research on specific interventions for this group. One study conducted focus groups amongst RMWs in London. They found awareness of the negative health consequences of smoking but limited knowledge of cessation methods. Many wanted to give up and the possibility of a work-based smoking cessation intervention was favourable to this group.

A Cochrane review from 2014 found that workplace interventions using group behaviour therapy, individual counselling, medication or sometimes combined therapy did help people stop smoking and that this intervention was as effective in the workplace as in other settings.[25] Whilst workplace based interventions may be beneficial we know that RMWs may have unstable work environments (casual arrangements changing work places) and so these interventions may only target those with more stable work.

In 2010 NHS Kirkless (West Yorkshire) set up a targeted group intervention for this population which saw an increase in RMW accessing smoking cessation interventions and setting a quit date.[26] They conducted local focus groups to inform the intervention design and found that, groups that's "felt like a club," had a focus on family, were informal, non-clinical and run by an ex-smoker were suggested. RMWs also commented that not knowing what the sessions would entail beforehand was a barrier, so creating promotional material with this information was beneficial.

Eastern European Populations

It is known that smoking prevalence amongst eastern Europeans (both men and women) living in the UK is higher than white British individuals. Many eastern European individuals work in routine or manual work roles so there is overlap with the previous section.

Those who have migrated to the UK recently will have the obvious barriers of language and communication. They also may have different cultural norms around smoking and perhaps less understanding about smoking related harm. They are also likely to be young, healthy and have less motivation to engage with smoking cessation. They will also have experience with a different healthcare model and not know where to seek smoking cessation advice or only expect it from doctors. They may also return to a home country where tobacco is cheap and therefore have greater opportunity to bring it back to country.

Considering these differences targeted interventions for this population may be more effective. An example is when Kick (a stop smoking provider) provided smoking cessation services targeted at eastern European populations in London including a clinic run at a local Polish social and cultural centre and stop smoking events at a Polish church. Both models were successful but ended up drawing people from across different council areas. (disparate populations) so across council collaboration may be beneficial.[27]

In Berkshire, a targeted smoking cessation initiative successfully engaged over 5,300 individuals from Romanian, Polish, and Lithuanian communities. The programme recruited staff from these communities, participated in local events such as school sports days and Polish church gatherings,

[25] Cochrane Library
[26] The NSMC
[27] Welcome to Kick It

and collaborated with community organisations. They utilized targeted communication in specific languages, on social media, and community-specific websites. This culturally tailored approach effectively reached and supported a significant number of individuals in their quit attempts.[28]

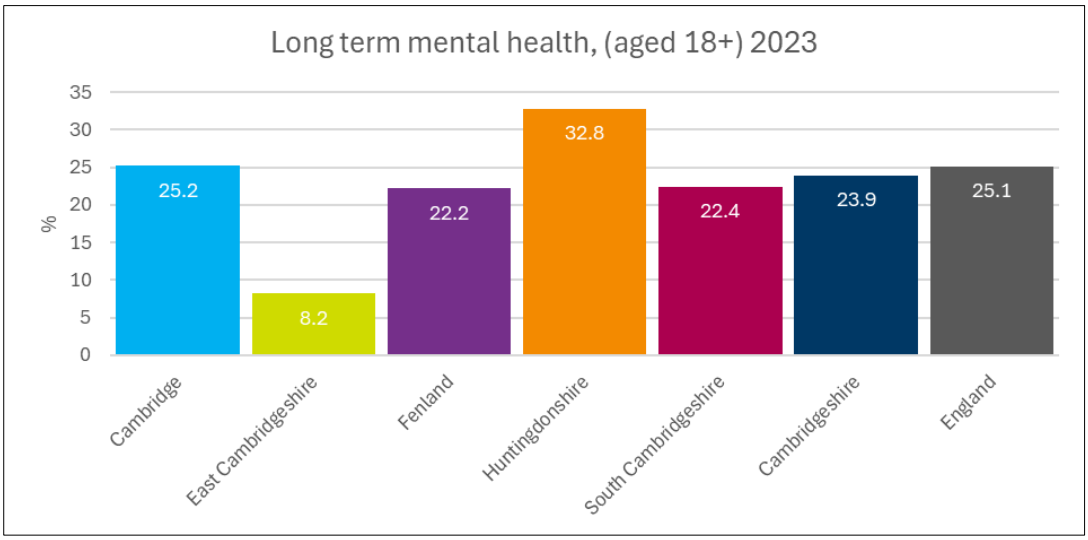
This suggests community focused interventions targeted at the local Eastern European population run by staff recruited from those populations may be beneficial.

Mental Health

Higher rates of smoking are seen in those with mental health conditions. Rates have been decreasing since 2013 in Cambridgeshire and Peterborough but remain high. People in Cambridgeshire with long-term mental health are twice as likely to smoke vs general population. In Cambridge, Huntingdonshire and South Cambridgeshire, smoking prevalence in long-term mental health conditions groups is more than three times that of the general population.

In 2022, in Cambridge the smoking prevalence in those with a long-term mental health condition was 17.3% and 23.1% in Fenland, in 2023 as seen in figure 10 below, these rate have changed but remain concerningly very high.

Figure 10. Smoking prevalence of Long-Term Mental Health Conditions Among Adults Aged 18+, 2023



Contrary to previous concerns, quitting smoking has been shown to improve mental health outcomes for individuals with mental health conditions. Research indicates that cessation leads to enhanced physical health, reduced anxiety, depression, and stress, as well as an improved quality of life. Additionally, some patients experience a reduction in the required dosage of psychiatric medications after quitting. A systematic review and meta-analysis published in *The BMJ* found that individuals who quit smoking experienced significant reductions in depression, anxiety, and stress, along with improvements in psychological quality of life, compared to those who continued smoking.[29]

[28] Smoke Free Life Berkshire

[29] BMJ

The NHS also reports that stopping smoking can lead to reduced anxiety, depression, and stress levels, as well as improvements in positive mood and quality of life.[30]

These findings underscore the mental health benefits of smoking cessation, highlighting its importance for individuals with mental health conditions.

Whilst it is true that those with mental heal conditions anticipate more difficulty in quitting smoking, if they are offered evidence-based interventions than they are generally still able to do so. Evidence suggests that bespoke interventions designed for smokers' mental health conditions are more efficient than interventions for the general population.

The Smoking Cessation Intervention for Severe Mental Ill Health Trial (SCIMITAR) is a pilot randomised controlled trial of a smoking cessation strategy designed specifically for people with severe mental ill health. It involved a mental health practitioner trained in smoking cessation who delivered pharmacological and behavioural support to individuals. At the end of the trial, smoking cessation was highest among individuals who received the bespoke intervention (36% vs. 23%). Research has shown that buprenorphine and varenicline are effective when used in this population.[31]

Training of mental health staff to empower them to engage smokers with these interventions is also important. Previously it was thought that staff would be reluctant to engage smokers due to concerns about damaging the relationship between them. However, this is changing. It is well documented that when the smoke-free policy for mental health facilities was introduced in 2013, it led to reduced exposure to second-hand smoke, increased motivation amongst patients to quit and more patients being offered smoking cessation advice. Specific training for stop smoking staff regarding those with mental health difficulties has been shown to be beneficial.

Pregnant Individuals

Smoking in pregnancy increases the risk of stillbirth, preterm birth and sudden infant death syndrome. Mothers from disadvantaged groups and those aged under 20 years old were more likely to smoke and children who grow up with a smoking parent are more likely to smoke themselves. Therefore, encouraging pregnant mothers to stop smoking will contribute to preventing young people of the future from smoking. The 2017 tobacco control plan aimed to reduce the prevalence of smoking in pregnant mothers to 6% by 2022.[32] Although the prevalence has decreased over time this aim was not met with a national figure of 9.1% in 2022 and 9.7% for Peterborough and Cambridgeshire.[33]

Research has explored various smoking cessation interventions for pregnant individuals. A 2020 Cochrane review found that nicotine replacement therapy (NRT), combined with behavioral support, may slightly improve smoking abstinence in pregnancy compared to behavioral support alone.

[30] nhs.uk
[31] University of York
[32] GOV.UK
[33] democracy.peterborough.gov.uk

However, the evidence is of low certainty, and when restricting the analysis to only randomized placebo-controlled trials, a clear benefit was not observed.[34]

Additionally, financial incentives have been shown to be effective and cost-effective in promoting smoking cessation among pregnant smokers. A 2015 Cochrane review concluded that providing incentives, such as vouchers or cash rewards, can significantly increase the likelihood of quitting smoking during pregnancy.[35]

Recent evidence strongly supports the use of financial incentives to promote smoking cessation during pregnancy. A 2025 Cochrane review found that incentives, such as vouchers or cash rewards, are particularly effective in increasing quit rates among pregnant smokers. The review highlights that this approach is not only impactful but also cost-effective, offering significant benefits for maternal and neonatal health.[36]

Interventions targeting the household of the pregnant individual, rather than focusing solely on the individual, have also been found to be effective. Involving partners and family members in cessation efforts can create a supportive environment that enhances the chances of quitting successfully.

These findings highlight the value of integrating financial incentives into smoking cessation programs for pregnant individuals, alongside NRT, behavioral support, and household-targeted interventions. Combining these approaches can effectively address the challenges of smoking cessation during pregnancy and improve health outcomes for both mothers and their children.

There is little research into vaping in pregnancy but as an alternative to smoking it is likely to be less harmful so women who do wish to use vaping to help them stay smoke free should be supported to do so.

Locally smoking cessation pathways for Pregnant Individuals have been implemented through Healthy You and a programme rolled out through both North Anglia hospitals and Cambridge University Hospital trust which provides specially trained smoking cessation practitioners to support Pregnant Individuals. It provides flexible counselling and appointments and NRT throughout the pregnancy and for up to 12 weeks after. Assessment of this pathway is ongoing.

Homeless Individuals

A recent Homeless Health Needs Assessment revealed that 77% of homeless individuals in Cambridgeshire and Peterborough smoked, consistent with national figures. Prevalence was higher in Cambridge City (80%) and Peterborough (87%) compared to East and South Cambridgeshire (39%), potentially reflecting migration to areas offering specialized homeless healthcare services, such as Cambridge Access Surgery and CGL.[37] This highlights an urgent need for targeted cessation interventions.

[34] Cochrane Library
[35] Cochrane Library
[36] Cochrane Library
[37] Cambridgeshire Insight

The assessment also found that 34% of homeless smokers expressed a desire to quit, with 64% having been offered cessation advice—higher than the 54% reported in the *Unhealthy State of Homelessness* report (Unhealthy State of Homelessness).[38] Of those offered advice, 69% engaged with cessation support, indicating progress but underscoring the need for sustained efforts.

A 2020 Cochrane review evaluated interventions such as e-cigarettes, medications, intensive counseling, and behavioral therapies for reducing tobacco use among homeless populations. While evidence was low-quality, intensive interventions showed modest benefits.[39] A 2021 feasibility trial testing free e-cigarettes for homeless smokers showed early signs of efficacy, and a full trial is in development.[40] Research on barriers to healthcare services in Cambridge suggests that flexible, tailored approaches designed for the homeless are most effective. Applying these principles to smoking cessation programs, such as providing vaping interventions, may further improve outcomes.[41]

Individuals with Learning Disabilities

In those with learning disabilities there is no national data on smoking and vaping prevalence, however one study in 2015 suggested there may be a higher prevalence of smoking in adults with mild learning difficulties than their peer groups.[42] One paper from the USA suggests there is higher use of vaping in young adults with learning disability but there is little research to corroborate with this.[43]

6.8 Recommendations

Strengthen Smoking Cessation Services

- Focus efforts on routine and manual workers (RMWs), pregnant individuals, and individuals with mental health conditions, where prevalence and challenges are most pronounced in areas like Fenland and Cambridge City.
- Integrate smoking cessation advice, NRT, and behavioural support into local services such as primary care, pharmacies, and community-based settings to increase accessibility.
- Pilot workplace-based cessation interventions targeting RMWs, incorporating group support, culturally appropriate materials, and informal, non-clinical sessions.
- Establish a centralised, user-friendly single point of access, streamlining self-referrals and professional referrals.
- Address digital barriers for older clients and non-IT users by increasing face-to-face options in community hubs.

[38] Homeless Link
[39] Cochrane
[40] Journal of Smoking Cessation
[41] Cambridgeshire Insight
[42] Oxford Academic
[43] College of Public Health

Tackle Youth Vaping

- Strictly enforce age restrictions and crack down on illegal vape sales, especially disposable vapes, through enhanced collaboration with Trading Standards.
- Partner with schools to scale up evidence-based programmes like "Catch Your Breath," focusing on the prevention and cessation of smoking and vaping among students.
- Expand the “Swap to Stop” initiative with robust outreach in high-prevalence areas to transition adult smokers to vaping as a cessation tool while monitoring youth uptake.

Address Smoking Inequalities

- Deploy place-based programmes in Fenland and Cambridge City, which have the highest smoking rates, utilising local partnerships to reduce disparities.
- Tailor culturally sensitive interventions for Eastern European communities, incorporating multilingual materials and outreach at local community hubs.
- Focus on groups such as homeless individuals, people with learning disabilities, and those in unstable employment, using flexible, person-centred approaches.

Integrate Services Across Systems

- Align efforts with NHS, public health, and local district councils to implement a county-wide integrated cessation framework targeting high-need areas and populations.
- Embed tobacco cessation services into broader health initiatives like diabetes prevention, mental health support, and maternal health programmes.
- Collaborate with voluntary organisations, faith groups, and local businesses to deliver Making Every Contact Count (MECC) training and expand outreach.

Enhance Monitoring and Innovation

- Set specific, measurable goals for reducing smoking and vaping prevalence in key demographics by 2025.
- Invest in digital cessation tools and e-referral systems to enhance service efficiency and uptake while addressing gaps in CO-validated reporting.
- Pilot cytisine-based cessation programmes and expand behavioural support tailored to mental health service users.

Engage the Public Effectively

- Leverage campaigns like Stoptober and No Smoking Day to emphasise the health and financial benefits of quitting smoking.
- Utilise social media platforms and community events to engage young people and underserved groups.
- Highlight success stories and peer support to tackle stigma and inspire positive change within communities.

7. Obesity and Healthy Weight

7.1 Introduction and Scope

This chapter will examine obesity prevention, management, and support for achieveing and maintaining a healthy weight. It will briefly review past and upcoming national policies, outline the obesity landscape in Cambridgeshire, and focus on past literature and strategies addressing obesity and weight management in vulnerable groups.

7.2 Definition

According to the World Health Organization (WHO) overweight and obesity are defined as abnormal or excessive fat accumulation that presents a risk to health.[44] Overweight, obesity and excess weight - a collective phrase covering both overweight and obesity - describe conditions where an individual has an amount of body fat that may negatively affect their health, measured primarily by Body Mass Index (BMI).

Body Mass Index (BMI) is used to assess weight status and identify excess weight in both adults and children. While not without limitations, BMI remains the most practical and reliable tool currently available for assessing weight status at a population level.

The table below shows the BMI classification for adults (left) and children (right):

Table 6: BMI and BMI Centile Classification for Weight Status

Classification	BMI (kg/m 2)
Underweight	Below 18.5
Healthy weight	18.5 – 24.9
Overweight	25 – 29.9
Obese	30 – 39.9
Morbidly Obese	40 or more

Classification	BMI Centile
Underweight	2 or below
Healthy weight	2.1 - 90.9
Overweight	91 - 97.9
Very Overweight	98 or above

Note, for individuals from a South Asian, Chinese, other Asian, Middle Eastern, Black African or African-Caribbean family background, the BMI thresholds are reduced by 2.

BMI is also utilised for children; however, the calculation differs from that for adults and involves greater complexity. In children, BMI is categorised using variable thresholds that account for both age and sex, reflecting developmental changes. These thresholds are based on a reference population known as a child growth reference.

Although lifestyle and environmental factors play a role, achieving and maintaining a healthy weight is challenging for many, especially for vulnerable groups.

[44] WHO

7.3 Causes of Excess Weight

Obesity and overweight is caused when extra calories, particularly those from foods high in fat and sugar, are stored in the body as fat. However, we know that obesity is far more than just a consequence of poor diet and/or physical inactivity. The causes of excess weight are multifaceted, involving a complexity of factors such as our biology, opportunities to be active, constant availability and easy access of less healthy foods/drinks and our personal feelings and beliefs around food. The root causes of obesity exist in the places where we live grow, work and play. The modern-day environment we live in, often termed the 'obesogenic environment', means that the food and built environment not only make it more difficult for people to eat healthily and do enough physical activity, but can arguably go entirely against adopting healthy behaviours.

Genetics can play a significant role in obesity, with some individuals inheriting specific gene variants, such as the FTO (fat mass and obesity-associated gene), which influence appetite regulation, satiety levels, and how the body processes and stores fat. According to the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK), these genetic factors can increase susceptibility to weight gain.[45] Additionally, certain medications can contribute to weight gain, including corticosteroids, drugs used to treat diabetes, high blood pressure, and mental health conditions such as antidepressants and antipsychotics. The NHS highlights that these medications can alter metabolism or appetite, leading to weight changes.[46]

7.4 Language and Stigmatisation

Weight stigma is defined by the World Obesity Federation (WOF) as "the discriminatory acts and ideologies targeted towards individuals because of their weight and size".[47] A recently published position statement by WOF describes weight stigma as both a social determinant of health and a human rights issue. Despite this, weight stigma is not included within the Equality Act, and as such has not been afforded the same protection from discrimination and bias as the other nine characteristics, despite it being widespread throughout our society.[48]

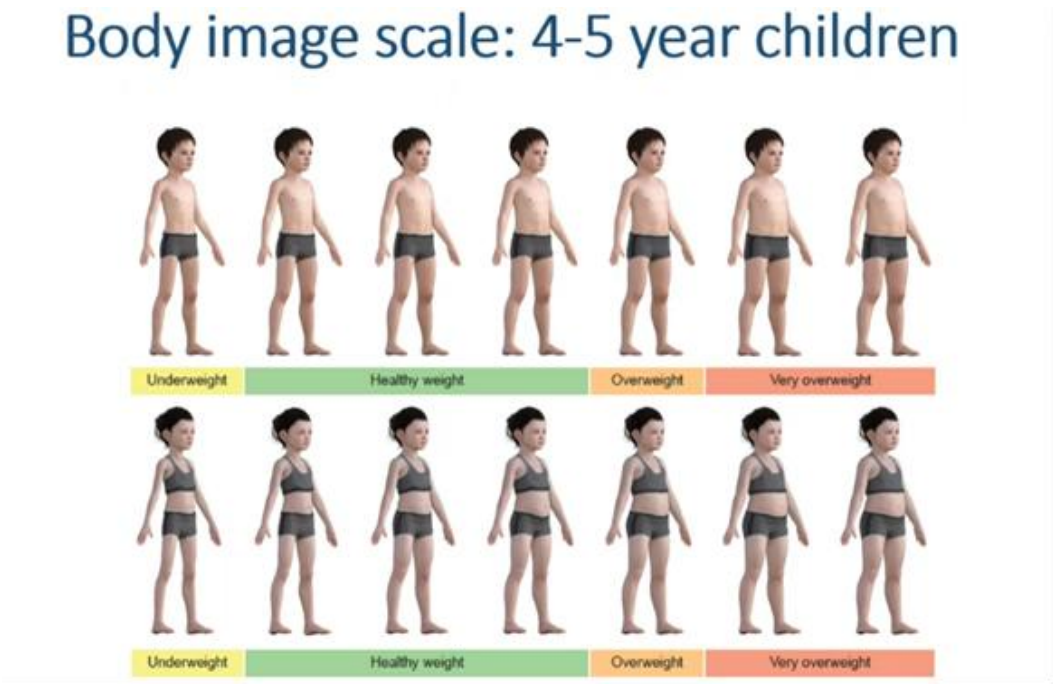
As a greater proportion of the population are living with excess weight, it can be harder for individuals to identify excess weight in themselves or others (e.g. their children). Further to this, media coverage and images of obesity tend to focus on the more extreme cases. An example of this is demonstrated below (image 1), where a screenshot is presented of some of the images included in recent news articled relating to childhood obesity.

When compared with the 'MapMe' body image scales[49] below (image 2), it is clear that there is a disparity between what a child living with severe excess weight would actually look like, versus the more extreme images often presented by the media.

[45] NIDDK
[46] NHS
[47] World Obesity Federation
[48] Stigma and inclusive language in dietetics (bda.uk.com)
[49] PubMed

Image 1. Media portrayal and coverage examples of overweight and obese children

Image 2. Body Image Scale for 4–5-Year-Old Children



Research has highlighted that people generally believe obesity is caused by factors within a person's control, focusing on diet and exercise without recognition of other important determinants;[50] only further cementing the stigma for those living with excess weight.

Image 3. Local examples of healthy weight campaign promotion

Some local authorities, such as Doncaster, have adopted a compassionate approach to health and wellbeing in order to reduce weight related stigma. Image 3 above-right shows Doncaster's overarching approach and a real-life example of some compassionate communications relating to weight.

7.5 Impacts of living with excess weight

Excess weight affects people across the life course and has wide ranging negative impacts across the whole system: upon individuals, families, communities, organisations and health/social care. Obesity prevalence stands at 28% in the UK, but rates are notably higher among certain groups.

Associated diseases and Long-Term Conditions

Carrying excess weight increases the risk of a wide range of health conditions, including:

- Type 2 Diabetes
- High Blood Pressure
- High Cholesterol and Atherosclerosis
- Coronary Heart Disease
- Stroke
- Asthma
- Metabolic syndrome (a combination of diabetes, high blood pressure and obesity)
- Several types of cancer, including bowel cancer, breast cancer and womb cancer
- Gallstones
- Reduced fertility
- Osteoarthritis
- Sleep apnoea
- Liver disease
- Kidney disease
- Pregnancy complications, such as gestational diabetes and pre-eclampsia

[50] National Library of Medicine (US)

Obesity is a significant health concern, reducing average life expectancy by 3 to 10 years. Additionally, it adversely affects healthy life expectancy, defined as the number of years an individual can expect to live in good health, free from chronic disease and disability. This dual impact underscores the importance of addressing obesity to improve both the quantity and quality of life.[51]

Social and economic impacts

A 2023 study by Frontier Economics estimated the overall cost of adult overweight and obesity in the UK, as outlined below, to be £98 billion:[52]

Table 7: Estimated Economic Costs of Obesity in the UK (£ Billion)

Cost Type	**£ Billion**
Individual costs: Quality-adjusted life years Informal social care	63.1
NHS costs: Obesity-related illnesses Mental health	19.2
Wider society costs: Productivity losses Formal social care	15.6
TOTAL COST	**97.9**

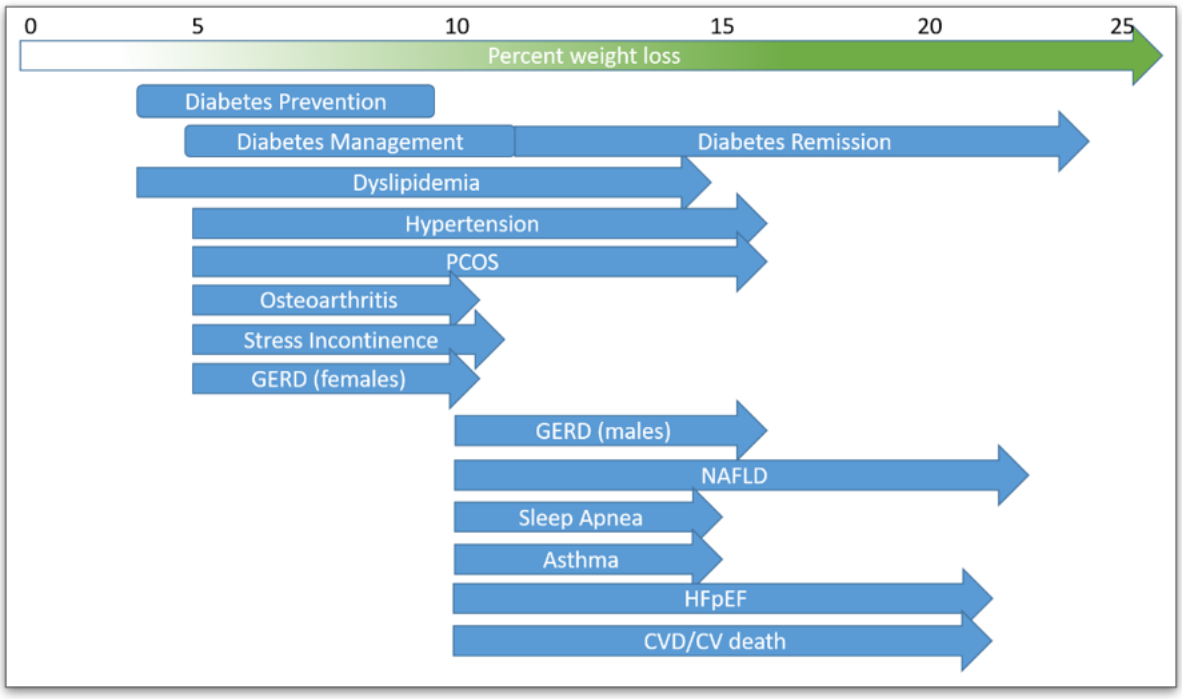
It is forecast that these costs will rise by around 10% by 2020, increasing the figure to £109.4 billion.[53] Furthermore, when taking in to account the rising childhood obesity rates (many of whom will not have reached an age where adverse health conditions require treatment until beyond 2040), this figure is likely to continue to rise exponentially for many decades to come. As an example of the impact on our local health system, in 2019/20 obesity was a factor in 7,845 hospital admissions in Cambridgeshire.[54]

7.6 Benefits of taking action

Losing even a small amount of weight, such as 3%-5% of original body weight, and maintaining this for life, can significantly reduce an individuals' risk of developing obesity-related complications. The graphic below demonstrates the impact of weight loss on certain health conditions, showing the greater the weight loss % the greater the impact on a wider range of obesity related comorbidities.[55] However, it also highlights that even a relatively modest weight loss of 3-5% does have a positive impact and should hence be supported.

[51] GOV.UK
[52] The Tony Blair Institute
[53] Unhealthy Numbers: The Rising Cost of Obesity in the UK
[54] NHS Digital
[55] Lancet

Figure 11. Health Benefits Associated with Percent Weight Loss



The Local Government Association conclude that there is good evidence that behavioural weight management services can help adults to lose weight and that, given the wide-ranging implications of living with obesity on health and beyond, investing in weight management services is beneficial to individuals and the wider community.[56]

7.7 National policies, strategies and guidance

The UK Government, through the Department of Health and Social Care, has committed to implementing a range of measures aimed at encouraging healthier choices, addressing obesity, alleviating pressure on the NHS, and stimulating economic growth.[57] [58] Below is an overview of recent actions taken, as well as future plans:

Recent Measures:

- Soft Drinks Industry Levy: Introduced to reduce sugar content in soft drinks, the levy has led to the removal of over 45,000 tonnes of sugar from these products.
- Calorie Labelling: The introduction of calorie labelling on food and drink items empowers individuals to make informed dietary decisions.
- Restrictions on Food Placement: New legislation now restricts the placement of foods high in fat, sugar, or salt in supermarkets, aiming to reduce impulse purchases.

[56] LGA
[57] DHSC
[58] GOV.UK

- Funding for Active Lifestyles: Over £600 million is allocated for the PE and Sport Premium over the next two academic years, alongside £22 million for the School Games Organisers network, to encourage physical activity among children and young people.
- Weight Loss Drugs: The government is committed to the safe introduction of new weight loss medications within the NHS and is exploring ways to increase accessibility for eligible individuals.

The World Health Organization (WHO) launched its "Acceleration Plan to Stop Obesity" in 2022,[59] promoting multi-sectoral action to combat obesity globally. The plan supports WHO's recommendations on obesity prevention and management and contributes to the achievement of key global health targets, including the 2025 Global Nutrition Targets for children under 5 and the 2030 Sustainable Development Goal of a 30% reduction in premature mortality from noncommunicable diseases.

Future Plans:

- Advertising Restrictions: From October 2025, advertisements for less healthy foods will be banned on television and on-demand platforms before the watershed (9pm to 5:30am) and will also be prohibited online 24/7. This aims to limit exposure, particularly among children, to unhealthy food adverts, which research shows can influence unhealthy eating behaviors.

- Ban on Multibuy Promotions: The government plans to ban promotions such as Buy One Get One Free (BOGOF) on unhealthy foods starting in 2025.

In addition, the NHS Long Term Plan, published in 2019, includes a series of commitments related to obesity, which will expand service provision for individuals living with excess weight and related health conditions.[60] Other government strategies, such as the National Food Strategy and the National Strategy for Disabled People, also intersect with efforts to combat obesity

Overall, these measures are part of the UK government's commitment to reduce obesity, relieve NHS pressure, and enhance public health.

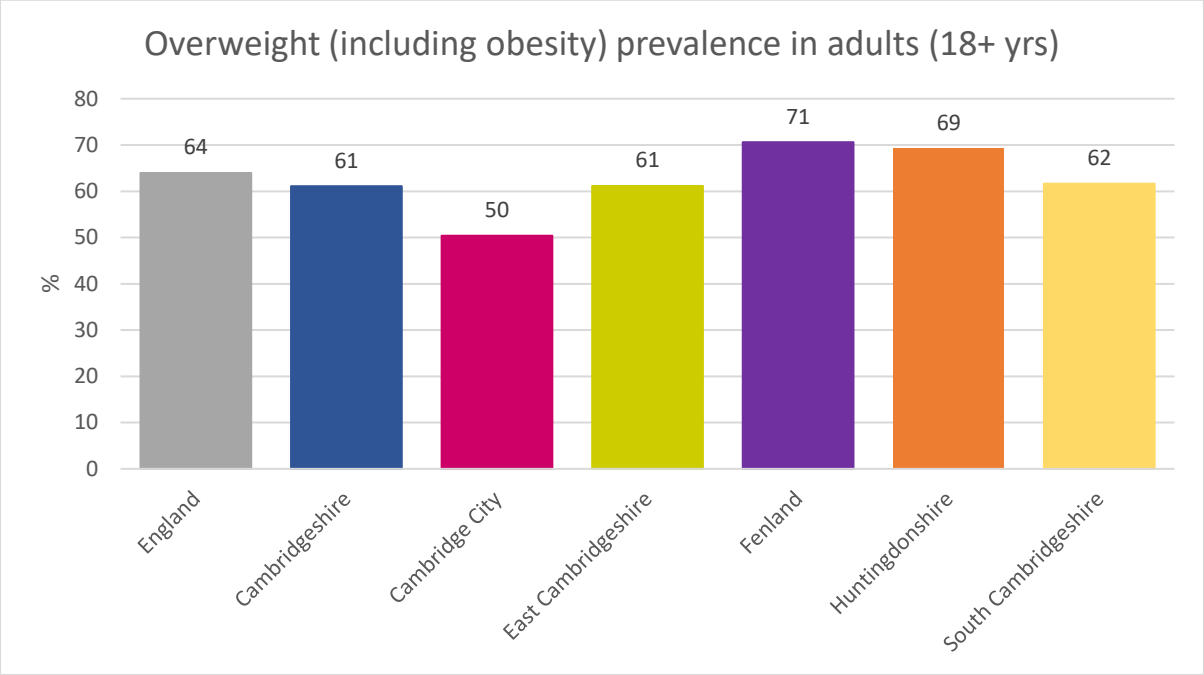
7.8 Prevalence in Cambridgeshire

This chart below illustrates the prevalence of overweight and obesity (combined) in adults aged 18 and over across England, Cambridgeshire, and its districts.

Nationally, 64% of adults are classified as overweight or obese, while Cambridgeshire's overall rate is slightly lower at 61%. There is notable variation across the districts, with Fenland having the highest prevalence at 71%, followed by Huntingdonshire at 69%, and East Cambridgeshire at 61%. South Cambridgeshire (62%) and Cambridge City (50%) exhibit the lowest rates within the county, with Cambridge City significantly below the national and county averages. This highlights significant geographical disparities in overweight and obesity prevalence, suggesting the need for tailored public health interventions to address these differences.

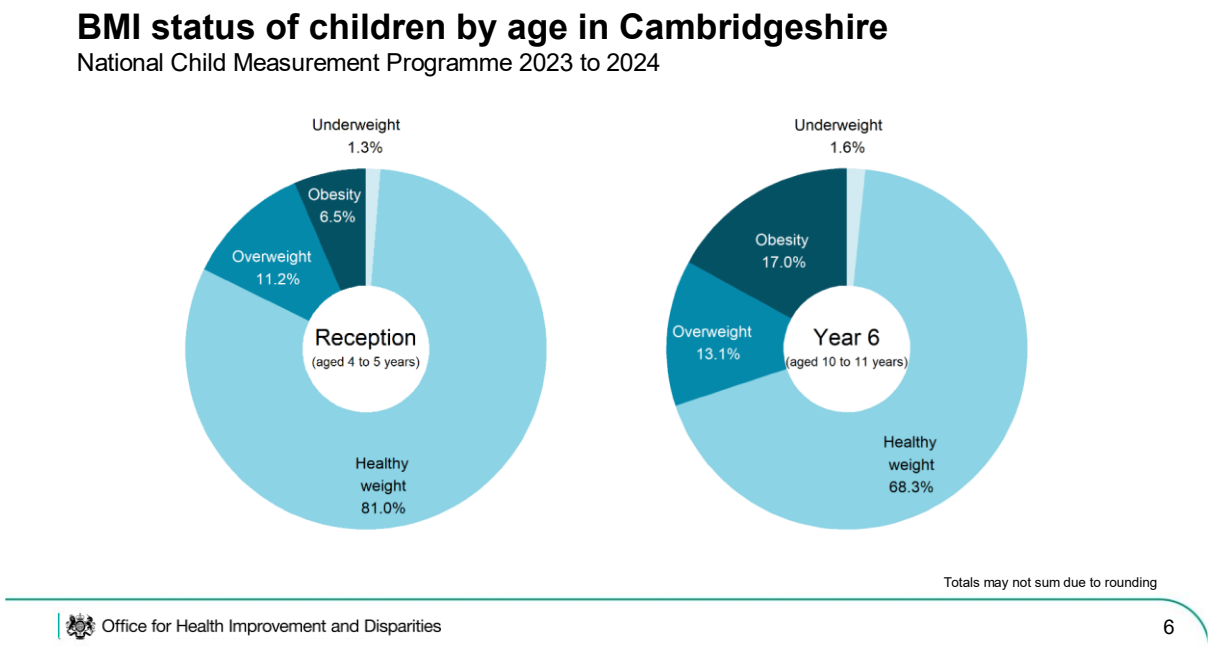
[59] WHO acceleration plan to stop obesity
[60] NHS Long Term Plan (2019)

Figure 12. Prevalence of Overweight and Obesity Among Adults (18+ Years), 2023



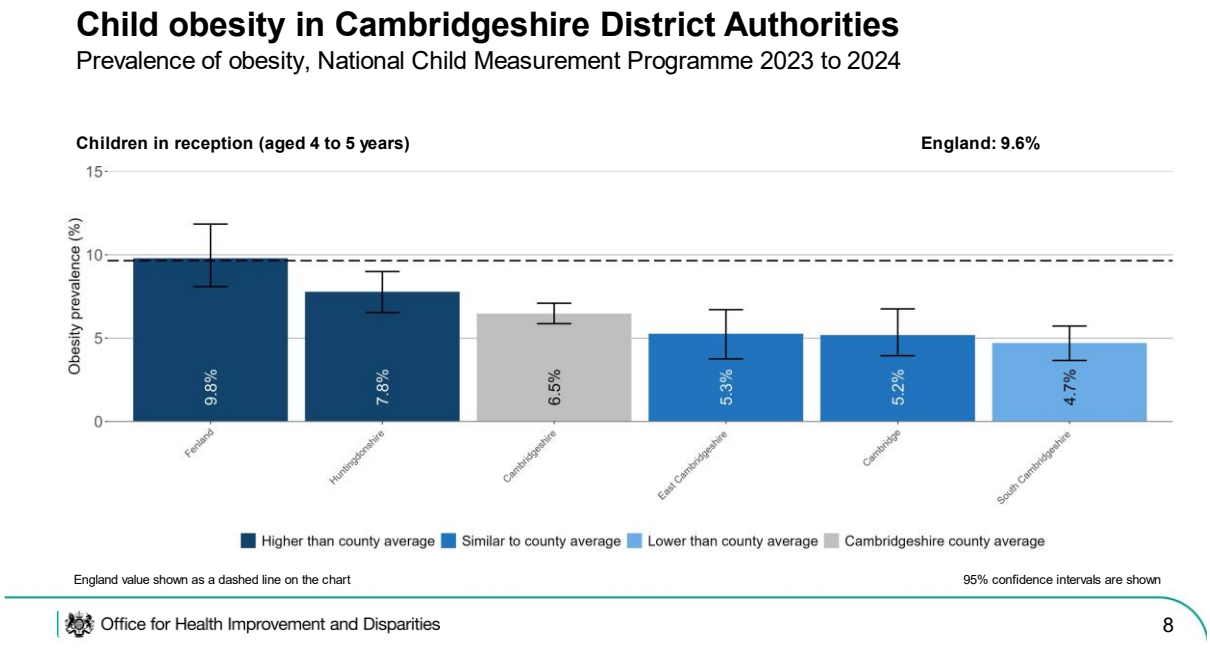
The pie charts below (figure 13) shows BMI status for children in Cambridgeshire from the 2023–2024 National Child Measurement Programme. Among Reception-aged children (4–5 years), 81.0% are classified as having a healthy weight, with 6.5% classified as obese and 11.2% as overweight. In Year 6 (10–11 years), the proportion of children with a healthy weight decreases to 68.3%, while obesity prevalence rises significantly to 17.0%, and 13.1% are overweight. These figures highlight a concerning trend of increasing overweight and obesity levels as children age, indicating the need for early and sustained interventions.

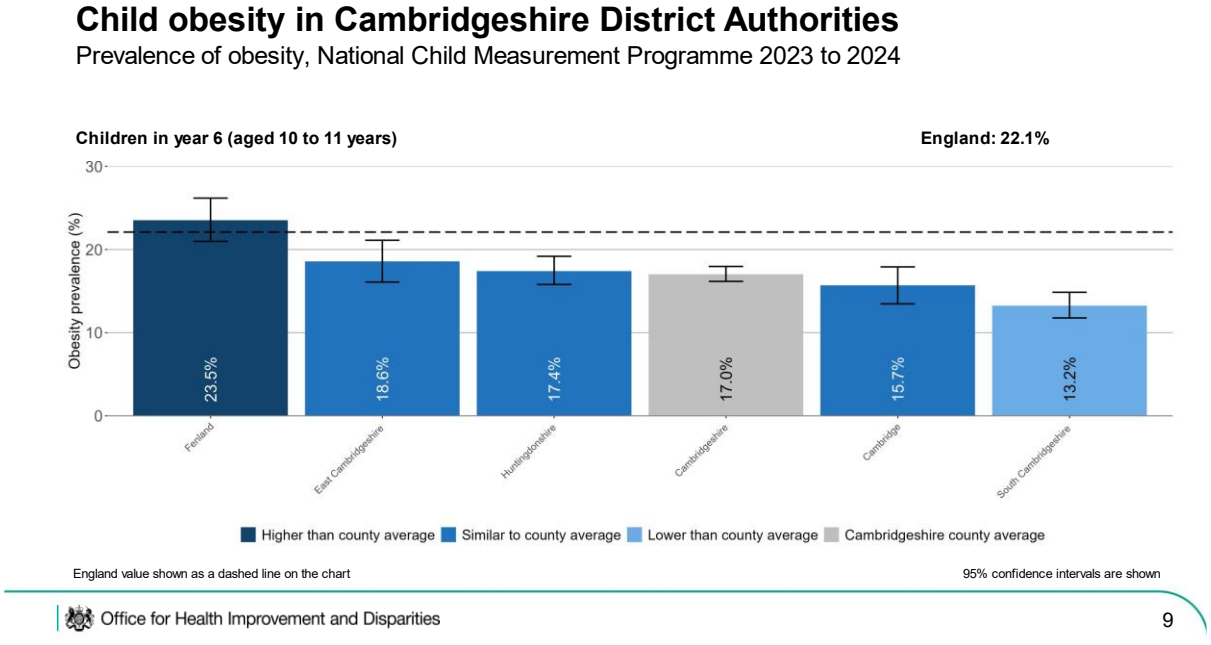
Figure 13. BMI Status of Children by Age Group in Cambridgeshire: NCMP 2023–2024



These two charts (Figure 14 and 15) highlight obesity prevalence in Reception-aged and Year 6 children across Cambridgeshire districts. Fenland consistently shows the highest rates (9.8% and 23.5% respectively), exceeding both county and national averages. In contrast, South Cambridgeshire has the lowest prevalence (4.7% and 13.2%), reflecting significant geographic disparities requiring targeted interventions.

Figure 14 and 15. Child Obesity Prevalence in Reception Age (4–5 Years & Yr 6) Across Cambridgeshire District Authorities: NCMP 2023–2024

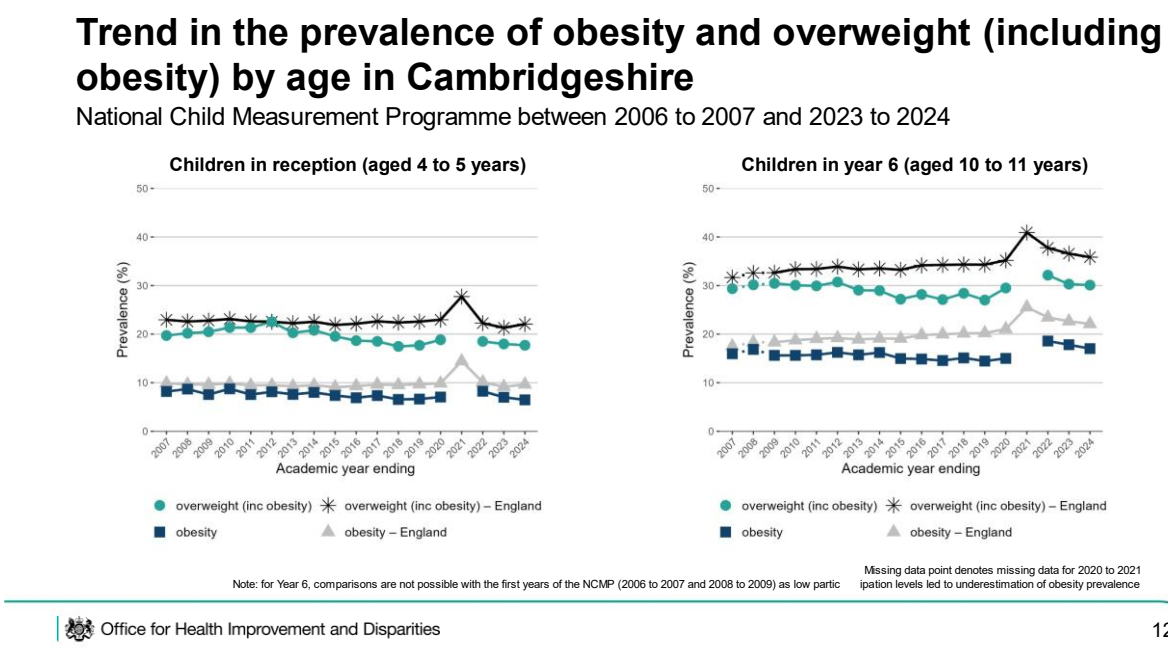




This graph below (figure 16) shows trends in the prevalence of overweight and obesity among Reception-aged (4–5 years) and Year 6 (10–11 years) children in Cambridgeshire from 2006–2007 to 2023–2024, compared to national averages.

For both age groups, the prevalence of overweight (including obesity) and obesity remained relatively stable until a spike in 2020–2021, likely reflecting the impact of the COVID-19 pandemic, such as reduced physical activity and changes in dietary habits during lockdowns. Following this peak, rates have slightly declined but remain above pre-pandemic levels.

Figure 16. Trends in Obesity and Overweight Prevalence Among Children in Cambridgeshire by Age Group: National Child Measurement Programme (2006–2024)



These figures underscore the disparities in obesity rates across different regions within Cambridgeshire, highlighting significant increases between Reception and Year 6 levels. The data aligns with broader national trends that indicates that there are inequalities in excess weight and where obesity is more prevalent in less affluent areas, highlighted by some of the key data statements below:

Both adults and children from more deprived areas are more likely to be overweight or obese. For example, across England obesity prevalence in children living in the most deprived areas is twice as high compared with those living in the least deprived areas (NCMP, 2022/23).

Individuals from certain ethnic backgrounds are more likely to be overweight or obese. For example, in Reception children, rates of 'overweight' and 'obese' pupils are statistically significantly high within Black ethnic groups and for Year 6 pupils, obesity' rates are highest among Asian, Black, Mixed and 'Any other ethnic group' categories.

Males are more likely than females to be overweight or obese even in childhood, and this appears to increase over time with more of a gender gap in adulthood.

7.9 Local policies and strategies to promote healthy weight

Cambridgeshire has developed several local strategies and policies to promote healthy weight and tackle obesity through integrated initiatives focusing on both prevention and intervention. Key measures include:

- **Joint Health and Wellbeing Strategy:** This overarching plan emphasizes reducing inequalities in health, tackling obesity, and promoting physical activity. It aims to create a supportive environment where residents can make healthy lifestyle choices. There is a priority focused around childhood and adult obesity: 'create an environment to give people the opportunity to be as healthy as they can be'. Obesity and its related co-morbidities are also embedded into the wider ICS strategy e.g., Diabetes and Cardiovascular Disease.

- **Healthy You Lifestyle Services**: This service offers personalized support for weight management and healthy living, targeting both adults and children. Programs are designed to encourage physical activity, healthy eating, and long-term behaviour change. For children and families, tailored services such as workshops and one-on-one support are available to promote healthier habits among young people

- **Children's Weight Management Services**: A new initiative provides family-centred sessions for children aged 4–12 and teen-specific programmes for those aged 12–17. These services address weight management and encourage sustainable lifestyle changes, aligning with goals from the Joint Health and Wellbeing Strategy and Integrated Care Partnership Strategy.

- **Promotion of Active Travel**: Both councils actively encourage walking and cycling through infrastructure improvements and community programmes. These efforts aim to reduce sedentary behaviour and increase daily physical activity levels, a critical component in maintaining a healthy weight

- **Early Childhood and School Programmes**: Schools play a pivotal role in delivering nutrition education, physical activity initiatives, and monitoring growth via the National Child Measurement Programme (NCMP). This helps identify areas needing targeted interventions to combat childhood obesity. The Learn-2-Live Well Fund is a Cambridgeshire County Council initiative designed to address childhood obesity by supporting primary schools in promoting healthy eating and physical activity. Managed in partnership with Living Sport, the fund provides grants (up to £10,000) for innovative projects that encourage a whole-school approach to healthy lifestyles.

These initiatives demonstrate a multi-faceted approach to promoting healthy weight across all age groups in Cambridgeshire, focusing on education, community engagement, and practical support for sustainable change. For detailed local plans, refer to resources provided by the councils or the Cambridgeshire Insight website

7.10 National campaigns and resources

The NHS *Better Health* campaign has a focus on weight management and includes resources such as the free NHS Weight Loss Plan app, NHS BMI calculator and information on weight management

programmes and physical activity opportunities. There is also a Better Health – Healthier Families arm which focuses on child weight management and includes the Healthy Steps programme as well as general healthy eating and physical activity advice/ideas, and weight information relating to the National Child Measurement Programme (NCMP).

Veg Power is a UK-based initiative aimed at encouraging people, particularly children, to eat more vegetables as part of a healthy diet. The campaign leverages creative marketing strategies, partnerships, and educational programs to make vegetables appealing and fun.

Eat Them to Defeat Them is a national campaign and schools programme that aims to increase children's vegetable intake. School places are funded by both local growers/producers and Public Health. In 2024 50 schools participated.

Growing To Love... Tomatoes is a growing programme available to schools that aims to increase awareness of where food comes from and encourage vegetable consumption. 26 schools took part in 2024.

BiteBack is a national youth activist campaign aimed at challenging the food system to offer healthier food options and avoid using marketing tactics that specifically target children with unhealthy food and drink products. Additionally, they fight for better school food provision and free school meals being available to all those who need them.

7.11 Local campaigns and resources

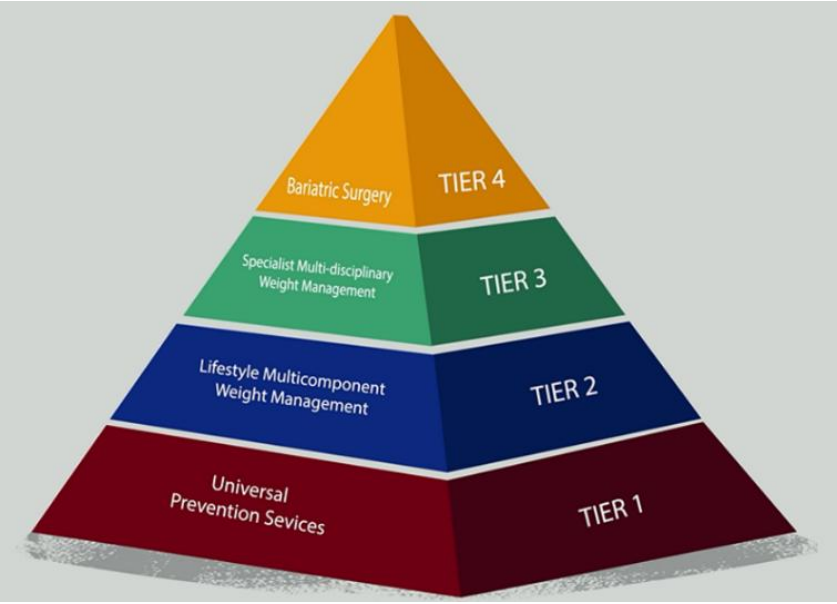
In summer 2023 there was a countywide *Get Activated* Campaign. The campaign promoted free or low-cost schemes and activities to unleash the power of play, sport and physical activity, from reading to enjoying a cycling route. There was also the opportunity to win supermarket vouchers through a photo competition.

The Healthy You virtual festival is organised through the Tier 1 Healthy Lifestyles service and runs annually throughout the month of January. The festival is free to participate in with the aim of providing a range of virtual opportunities to promote active and healthy lifestyles and facilitate positive behaviour for the year ahead. In January 2024 there were 25 live Zoom sessions with 249 attendees and 50 pre-recorded sessions on YouTube which were viewed 1971 times within the month.

7.12 Current local assets and service provision

Weight management services are categorised by 'tiers', with Tier 1 being population level preventative approaches, through to Tier 4 (weight loss surgery) which is a very targeted and clinic service for those with severe and complex obesity. Tiers 1 and 2 are commissioned by local authorities, Tier 3 is commissioned by local authorities and/or ICB's, and Tier 4 is commissioned by ICB's. The Local Government Association have produced the graphic below, showing the four different tiers of weight management:

Figure 17. Weight Management Tiers, The Local Government Association



Locally, the existing Integrated Lifestyles Service (under the brand *Healthy You*) includes Tiers 1-3 of adult weight management, as detailed below:

Tier 1

Delivered by a consortium of Living Sport and District/City Councils, Tier 1 provides community-based programmes promoting physical activity and healthy eating. It offers tailored guidance and support to individuals and families seeking to improve their lifestyle.

Tier 2

Delivered by Everyone Health, Tier 2 offers two structured weight management options:

- A 12-week programme (virtual or face-to-face) combining a 45-minute nutrition workshop and a 45-minute physical activity session.
- 12 weeks of vouchers for Slimming World or WW (formerly Weight Watchers).

Tier 3

A specialist service for individuals with severe and complex obesity, delivered through a multi-disciplinary team (MDT) approach. Three intervention options are available:

- **Everyone Health's 'Fresh Start' Programme** – A 12-session programme (fortnightly) with a combination of nutrition workshops, physical activity, and one-to-one support from a Health Psychologist.
- **Addenbrooke's Intensive Weight Management Programme (IWMP)** – A consultant-led service offering medical management, psychological interventions, and specialist support groups. Addenbrooke's is subcontracted by Everyone Health.

- **MoreLife Programme** – A separate Tier 3 contract providing a 12-week, 90-minute session programme focusing on psychological aspects of weight management, including mindful eating and self-care.

Tier 4

Commissioned by the Integrated Care Board (ICB), Tier 4 provides bariatric surgery. There are no Tier 4 providers in Cambridgeshire, requiring patients to travel to Luton and Dunstable, Homerton, University College London, or Portsmouth hospitals for treatment. All Tier 3 providers can refer directly into Tier 4 services.

There is evidence to suggest that the current tiered approach to weight management is too rigid, limiting its ability to adapt to individual patient needs. A potential solution at the local level is the development of a more integrated, streamlined, and flexible model with two tiers: one for prevention and one for treatment.

Implementing this approach would require close collaboration with the Integrated Care Board (ICB). However, it has the potential to better meet patient needs across Tiers 2–4 while remaining within the existing cost framework.

While the local Tier 1 service includes provision for children and families, integrated lifestyle weight management services primarily focus on adults. To address this gap, a new child weight management service covering Tiers 1–3 was commissioned in 2023 across Cambridgeshire. As illustrated in the graphic below, this model allows for greater flexibility in patient pathways, moving away from the rigid hierarchical structure of traditional weight management services.

Figure 18. Treatment and Prevention Model

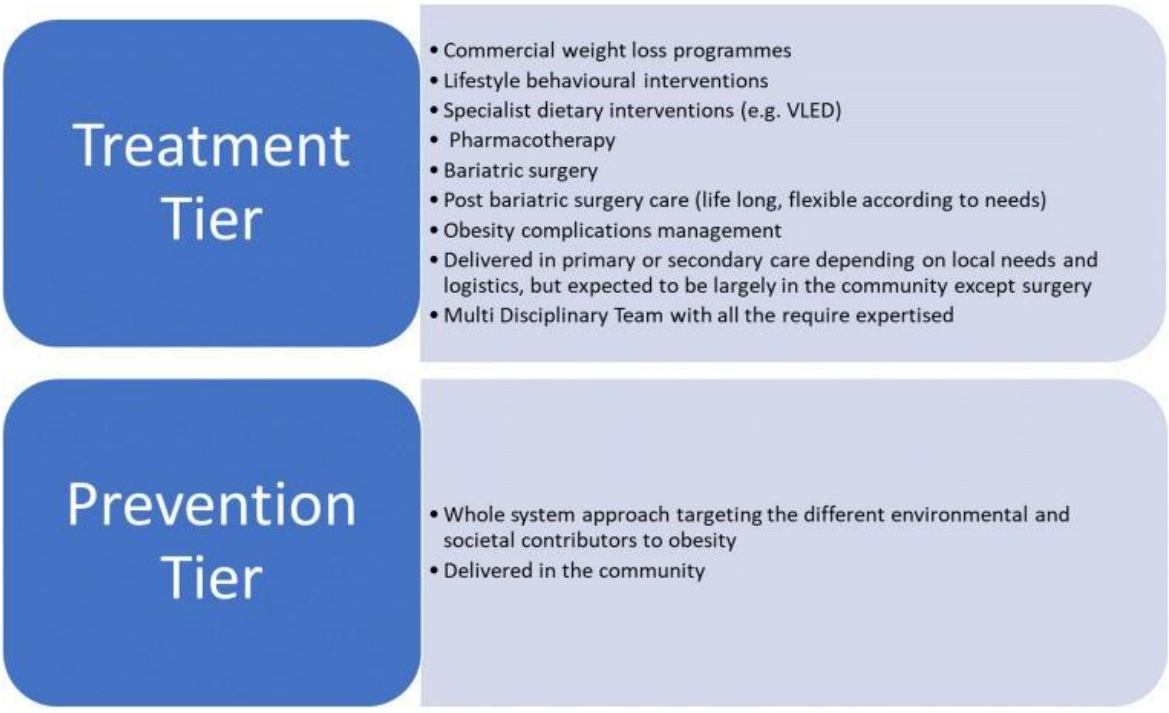
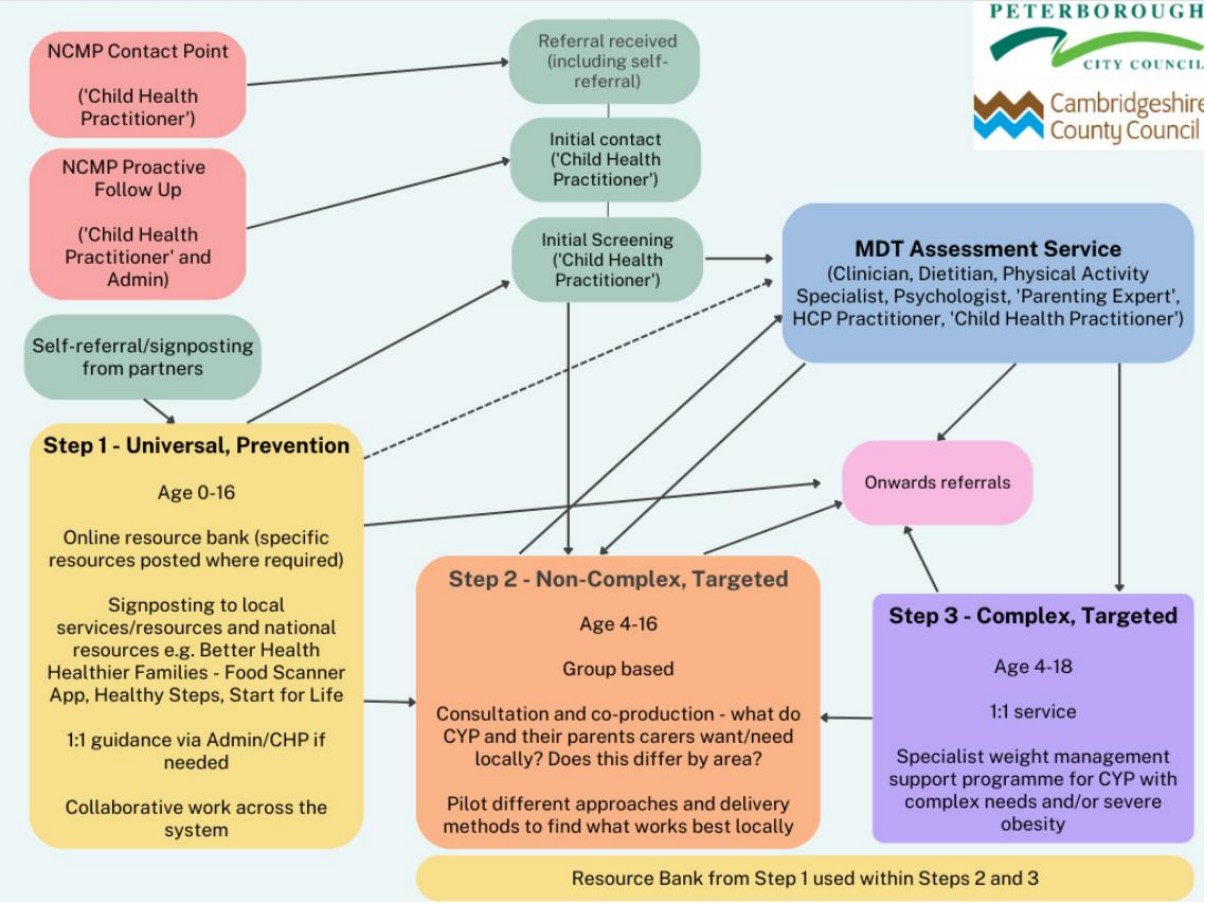


Figure 19. Stepped approach



7.13 Weight Loss Drugs

Cambridgeshire faces significant obesity challenges, with areas like Fenland having obesity rates among adults as high as 40.1%. National evidence suggests pharmacological interventions like semaglutide (Wegovy) and tirzepatide (Mounjaro) can be an effective adjunct to lifestyle and behavioural weight management programmes for individuals with obesity or overweight-related health complications.

Evidence Base for Wegovy

1. **Effectiveness**:

- Clinical trials indicate Wegovy facilitates substantial weight loss when combined with behavioural support, with weight reductions of approximately 15% over 68 weeks for some users.[61]
- Beyond weight reduction, it has demonstrated benefits in reducing obesity-related comorbidities, such as type 2 diabetes and cardiovascular risks.

[61] Drugs.com

2. **Cost-Effectiveness**:

- NICE guidance supports semaglutide for use in tier 3 weight management services, recognising its potential to reduce healthcare costs associated with obesity-related complications in high-risk populations.[62]

3. **Equity Considerations**:

- Weight loss drugs may address barriers for individuals unable to achieve significant weight reduction through lifestyle interventions alone. This includes populations with mobility limitations, psychological barriers, or biological predispositions.[63]

7.14 Recommendations

Enhanced Weight Management Services

- Strengthen the Healthy You Tier 1–3 services, ensuring cultural competence and tailored support for diverse populations, including ethnic minorities and socioeconomically disadvantaged groups.
- Integrate pharmacological options (e.g., Semaglutide and Tirzepatide) into Tier 3 services alongside behavioural and lifestyle interventions.

Addressing Weight Stigma

- Reduce stigma by embedding compassionate and inclusive communication strategies in public health campaigns, following best practices from other local authorities.

Monitoring and Evaluation

- Establish robust performance metrics (KPIs) to monitor service uptake, programme retention, and health outcomes. Expand long-term evaluation frameworks to assess obesity-related interventions.

Targeted Support for Vulnerable Groups (Place-Based)

- Develop and promote family-centred weight management programmes for children and teens, addressing disparities in childhood obesity across Cambridgeshire districts.
- Tailor interventions to meet the needs of high-risk groups, including individuals with disabilities, ethnic minorities, and residents in deprived areas.

Strategic Approaches

- Adopt a whole systems approach by collaborating across sectors such as healthcare, district councils, and education to create supportive environments for healthy lifestyles.
- Embed healthy weight priorities into local strategies, including the Joint Health and Wellbeing Strategy and Integrated Care Partnership plans.

[62] NICE
[63] BMJ

Community and Education-Based Interventions

- Partner with schools to deliver early interventions such as nutrition education and physical activity initiatives. Expand successful campaigns like *Eat Them to Defeat Them* and *Growing to Love... Tomatoes*.
- Promote active travel through infrastructure improvements and targeted campaigns like Get Activated, encouraging physical activity across all age groups.

8. Alcohol

8.1 Introduction and Scope

This chapter will examine alcohol use prevention and management, with a particular focus on individuals at mild to moderate and increasing risk levels. It will briefly review past and current national policies, outline the alcohol landscape in Cambridgeshire, with reference to Peterborough where relevant, and explore past literature and strategies addressing alcohol use and harm reduction in vulnerable groups.

8.2 Background

From harm to hope: A 10-year drugs plan to cut crime and save lives[64] is a policy paper published in December 2021, putting forward the Government's 10-year strategy to combat illegal drugs. While illegal drugs are the headline focus of the plan, alcohol dependence is also included in its priorities.

Alcohol misuse can be defined as drinking more than the lower risk levels advised by the UK Chief Medical Officers: i.e., adults regularly exceeding 14 units per week. [65]

Worldwide, 3 million deaths every year result from the harmful use of alcohol. This represents 5.3 % of all deaths. [66] Overall, 5.1 % of the global burden of disease and injury is attributable to alcohol, as measured in disability-adjusted life years (DALYs).

There is a causal relationship between harmful use of alcohol and a range of mental and behavioural disorders, other non-communicable conditions as well as injuries. Beyond health consequences, the harmful use of alcohol brings significant social and economic losses to individuals and society at large.

There are gender differences in alcohol-related mortality and morbidity, as well as levels and patterns of alcohol consumption. The percentage of alcohol-attributable deaths among men amounts to 7.7 % of all global deaths compared to 2.6 % of all deaths among women. Total alcohol per capita consumption in 2010 among male and female drinkers worldwide was, on average 19.4 litres for males and 7.0 litres of pure alcohol for females.

There are an estimated 602,391 dependent drinkers in England. Only 18% are receiving treatment.[67]

24% of adults in England and Scotland regularly drink over the Chief Medical Officer's low-risk guidelines, and 27% of drinkers in Great Britain binge drink on their heaviest drinking days (over 8 units for men and over 6 units for women).

[64] GOV.UK Harm to hope
[65] CMO's Low Risk Drinking Guidelines
[66] WHO Alcohol factsheet
[67] Alcohol Change UK: Alcohol statistics

8.3 Impact of Alcohol Use

Consuming alcohol at any level carries some degree of health risk and the risk increases as the level of alcohol consumed increases. There is a growing consensus in the UK, supported by scientific evidence, that no level of alcohol consumption is completely safe. This perspective is reflected in research findings and public health messaging over recent years, although the guidelines do not advocate total abstinence for all individuals.

Alcohol use is the third leading preventable cause of ill health and the top cause of poor health and disability in people aged between 15 to 49 years (Institute for Health Metrics and Evaluation, 2022).

Alcohol use remains a significant public health issue across the UK, including in Cambridgeshire and Peterborough, where alcohol-related harms contribute to inequalities in health outcomes. While alcohol is legally available and culturally embedded, its misuse impacts physical health, mental well-being, families, and communities.

Recent local data from Cambridgeshire and Peterborough shows varying trends in alcohol consumption, hospital admissions, and mortality, with higher levels of harm concentrated in specific populations and geographic areas.

Alcohol misuse in Cambridgeshire and Peterborough has been linked to:

1. Rising rates of alcohol-specific mortality, particularly in Fenland and Peterborough.
2. Disproportionate harm in urban centres like Cambridge City, where rates are 60% above the England average.
3. Significant healthcare utilisation, including emergency admissions, with alcohol-related hospital admission rates lower than national averages but varying widely across localities.

8.4 Alcohol Clinical Guidelines

Developed by the UK Chief Medical Officers, these guidelines provide evidence-based recommendations on alcohol consumption to minimise health risks.

The key guidance includes:

1. Weekly Alcohol Consumption Limits for Adults
   - Men and women are advised not to consume more than 14 units of alcohol per week.
   - If drinking up to this limit, it should be spread across three or more days to avoid binge drinking.

2. Alcohol-Free Days
   - Regular alcohol-free days are recommended to reduce overall risk and provide recovery time for the liver and other systems.

3. Single Drinking Occasions
   - Limiting the total amount consumed in a single session is crucial.
   - Advice includes eating food beforehand, pacing consumption with non-alcoholic drinks, and avoiding risky behaviours like driving.

4. Risks of Alcohol Consumption
   - There is no safe level of alcohol consumption, as even small amounts increase the risk of certain cancers, including breast and oesophageal cancers.
   - Risks rise significantly with increasing consumption beyond the 14-unit weekly guideline.

5. Pregnancy
   - Pregnant Individuals or those trying to conceive are advised to abstain completely, as alcohol can harm foetal development.

6. Health Risks from Long-Term Drinking
   - Consuming alcohol regularly above the guidelines can lead to liver disease, cardiovascular disease, and mental health problems.

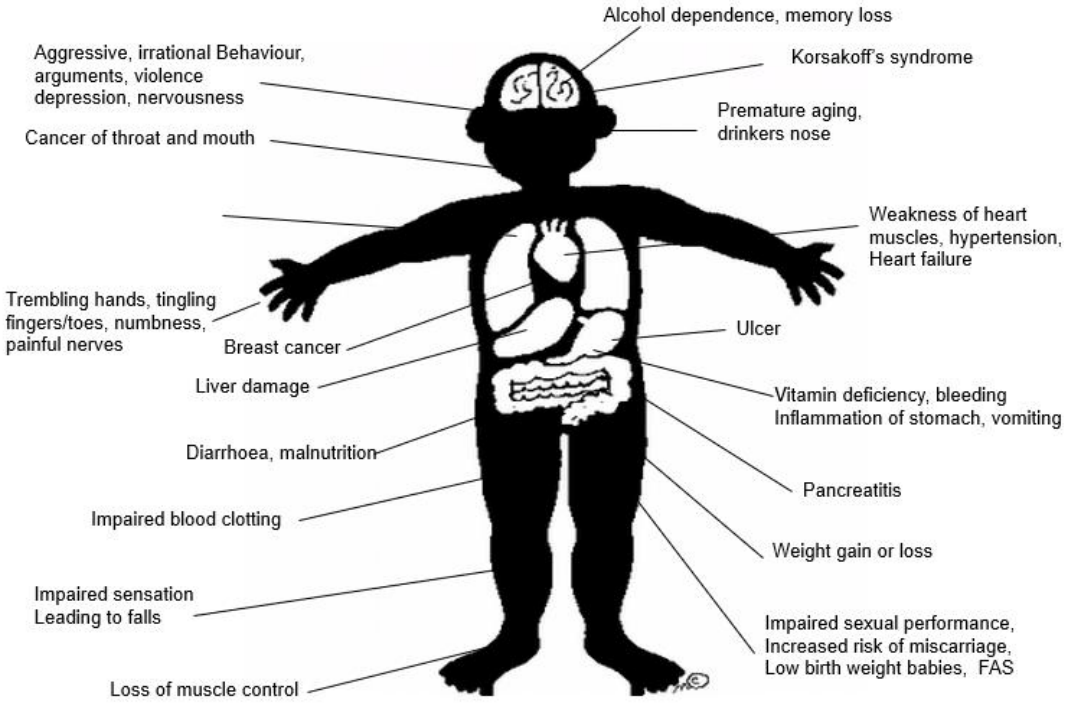
The guidelines emphasise that individuals who drink less or abstain entirely have the lowest risk of alcohol-related harm. They aim to support informed decision-making by highlighting the direct link between alcohol use and health outcomes.

8.5 Health Conditions associated with alcohol use

The Alcohol Clinical Guidelines 2023 identify alcohol consumption as a contributing factor to over 60 medical conditions, underscoring its significant public health impact. These conditions include chronic diseases such as liver disease, hypertension, strokes, heart disease, and atrial fibrillation. Furthermore, alcohol is associated with substantial damage to the central nervous system, manifesting as alcohol-related brain damage, Wernicke's encephalopathy, and peripheral neuropathy.

The pictorial below illustrates how alcohol affects different parts of the body:

Figure 20. Comprehensive Health Impacts of Alcohol Consumption on the Human Body



Usage in UK Adults Excessive alcohol use is also strongly linked to various cancers, including those of the lip, oral cavity, pharynx, oesophagus, larynx, colon, rectum, liver and intrahepatic bile ducts, and breast. These associations highlight the need for targeted prevention strategies to reduce alcohol consumption and mitigate its associated health risks.

8.6 Comsumption in UK Adults

The Health Survey for England (HSE) 2022[74] provides comprehensive insights into the drinking habits of adults in England. Key findings include:

- **Alcohol Consumption in the Last 12 Months**: 81% of adults reported consuming alcohol in the past year, with a higher prevalence among men (84%) compared to women (78%).
- **Weekly Drinking Frequency**: 55% of men and 42% of women drank alcohol at least once a week.
- **Exceeding Low-Risk Drinking Guidelines**: 32% of men and 15% of women consumed more than the recommended 14 units of alcohol per week, categorising them at increasing or higher risk of alcohol-related harm.
- **Age-Related Drinking Patterns**: Individuals aged 55 to 64 exhibited the highest proportion (30%) of consuming over 14 units per week. In contrast, younger adults aged 16 to 24 had a lower prevalence of exceeding these guidelines.
- **Problem Drinking Indicators**: Utilising the Alcohol Use Disorders Identification Test (AUDIT), the survey found that 88% of adults had low-risk drinking behaviours or abstained. However, 20% of individuals aged 16 to 24 exhibited increasing risk drinking behaviours or possible alcohol dependence, the highest among all age groups.

These findings from the HSE 2022 highlight that while a significant portion of the adult population consumes alcohol within low-risk guidelines, there remains a notable segment, particularly among younger adults, exhibiting patterns associated with higher risks of alcohol-related harm.

Changing attitudes

In 2017, Drinkaware in conjunction with YouGov researched UK adults' drinking behaviours and attitudes:[68]

- Over a quarter (26%) of UK adults typically exceed the limit recommended by the UK Chief Medical Officers of 14 units per week.
- Having a small number of drinks at home with a partner as a couple was the most common situation in which adults drink overall.
- The most common motivations overall for drinking were social reasons with 84% of those who drink saying they do so for social reasons at least some of the time.
- Coping reasons are an important, but less common, reason overall for drinking with 47% of UK drinkers saying they drink alcohol to cheer them up when they are in a bad mood.

[68] YouGov

- One in 10 UK alcohol drinkers say that they have found that they had not been able to stop drinking once they had started at least once a month.
- Almost a fifth say they are changing their drinking behaviours right now.
- At least two-fifths have utilised certain scheduling or planning methods to cut down.
- Younger people (18-34 year olds) are more likely to employ methods of avoiding alcohol altogether in certain situations, whereas older drinkers are more likely than others to limit themselves when they do drink.

Recent data from sources including Alcohol Change UK and Drinkaware indicates a shift in UK adults drinking behaviours and attitudes since the 2017 Drinkaware and YouGov research:

- **Exceeding Recommended Limits:** In 2024, over a third (35%) of men reported drinking above the low-risk guidelines of 14 units per week, compared to less than a quarter (22%) of women[69], a 23.6% combined men and women usage rate, down from 26% in 2017.
- **Drinking Motivations**: Anxiety after drinking, termed "hangxiety," has influenced drinking habits, particularly among younger adults. Approximately 36% of drinkers aged 18-34 reported reducing their alcohol consumption due to post-drinking anxiety.
- **Binge Drinking Trends**: Binge drinking has declined, especially among young adults. The percentage of adults aged 18 to 34 who never binge drink increased from 22% in 2018 to 31% in 2023. Overall, only 11% of adults reported binge drinking weekly.[70]
- **Alcohol-Free Initiatives**: Participation in alcohol-free challenges has grown. Almost one in three (32%) men planned to abstain from alcohol during January 2025, and just over one in five drinkers (21%) aimed to reduce their overall alcohol consumption in 2025.
- **Younger Adults' Drinking Habits**: A significant portion of younger adults are choosing sobriety. A quarter of individuals aged 18 to 24 are now completely teetotal, with rates of sobriety in this group twice as high as in their parents' generation.

A 2018 study that analysed 3,499 interviews conducted as part of the Alcohol Toolkit Study found that most adults in England agree that healthcare providers should routinely ask about patients' alcohol consumption. However, older adults and those in lower socio-economic groups are less supportive.

Despite robust evidence for their effectiveness, it has proven difficult to translate alcohol prevention activities, such as alcohol use screening and brief interventions, into routine healthcare practice.[71]

8.7 Attitudes among UK Young People

The Smoking, Drinking and Drug Use among Young People in England Survey (2021) found that:

- Pupils who lived with people who drank alcohol were more likely to drink alcohol themselves.
- 49% of pupils said their parents did not, or would not like them to drink alcohol.

[69] Alcohol Change UK
[70] Drinkaware Home
[71] BMC Public Health

- Pupils who lived with people who drank alcohol were less likely to say their parents do not or would not like them drinking.
- Pupils' attitudes to drinking alcohol by pupils of their own age were similar to 2018, though acceptance of both drinking and getting drunk have slowly increased since 2014.
- In 2021, the proportion of 15 year olds who reported usually drinking at least once a month was 36%. 14% usually drank at least weekly. 45% of 15 year olds believed that most (but not all) people their own age drink alcohol, with a further 25% saying about half.
- The most commonly held belief among young people was that pupils of their own age drank to look cool in front of their friends (74%). Other common beliefs were because their friends pressured them into it (66%), to be more sociable with friends (62%), and because it gave them a rush or a buzz (62%).
- Pupils were more likely to have drunk alcohol, either in the last week or ever, if they had a higher family affluence score.

8.8 National Policy

The 2012 National Alcohol Strategy offered a framework for addressing alcohol harm but has not been updated. NICE guidance (e.g., PH24) emphasises the importance of local policies like Identification and Brief Advice (IBA) and outlet density regulation. Licensing Act 2003. This legislation regulates the sale and supply of alcohol in England and Wales, establishing a framework for licensing authorities to manage alcohol availability and associated public health concerns.

8.9 Local Policy and Strategy

Local efforts include:

- Cumulative Impact Policies (CIPs): Implemented in Cambridge City and Peterborough to manage alcohol outlet density and mitigate harm.
- Change Grow Live (CGL): Provides integrated treatment services, including Tier 3 (community) and Tier 4 (inpatient detox and rehab) interventions.
- Healthy You: Delivers alcohol brief interventions for individuals identified as drinking at increasing risk levels (Audit C scores of 8-15).

Expanded funding under the National Drugs Strategy (2021) has increased capacity across alcohol treatment services, focusing on criminal justice, homelessness, and employment. However, this funding is set to end in 2025, posing a significant risk to service sustainability.

8.10 Usage in Cambridgeshire

Cambridgeshire has above average rates of unsafe alcohol consumption. It has been estimated that a greater proportion of adults in Cambridgeshire drink over 14 units of alcohol a week (28.7%) than

the national average (22.8%). A higher proportion than average of adult binge drink on their heaviest drinking day (17.7%), compared to the national average (15.4%).[72]

Hospital Admissions:

Admissions related to alcohol can be defined broadly (including primary or secondary diagnosis of alcohol-attributable mental and behavioural disorders) or narrowly (only counting primary diagnosis of alcohol-attributable mental and behavioural disorders)

Broad alcohol-attributable hospital admissions are falling but remain a concern, particularly in Fenland. Narrow measures (admissions where alcohol is the primary cause) remain stable, with Peterborough rates slightly below the regional average.
Alcohol-related hospital admissions for mental and behavioural disorders have been significantly higher in Cambridge than the national rate since 2016/17, for both narrow and broad definitions of alcohol-related admissions. The rate of hospital admissions in all other areas across Cambridgeshire and Peterborough have been significantly lower or statistically similar to the national rates. [73]

Mortality:

Alcohol-related harms often develop over time, with a lag between changes in consumption patterns and observable health impacts. Although many alcohol-related conditions progress chronically, making immediate changes hard to detect, monitoring these trends remains essential to understand and address the impact of alcohol use on public health.

Overall, mortality from alcohol by a number of measures in Cambridgeshire were similar or better than England in 2022/23, when the most recent data from OHID is available, as shown in figure 21.

Figure 21. 'Alcohol profile' indicators from OHID, Cambridgeshire compared with England.

Indicator	Period	Cambs			England			
		Recent Trend	Count	Value	Value	Worst	Range	Best
Alcohol-related mortality (Persons)	2022	→	242	36.0	39.7	73.7		25.3
Alcohol-related mortality (Male)	2022	→	162	51.1	60.3	106.5		38.5
Alcohol-related mortality (Female)	2022	→	80	22.8	22.0	43.7		14.1
Alcohol-specific mortality	2023	↑	86	12.8	15.0	31.4		6.7
Under 75 mortality rate from alcoholic liver disease (1 year range)	2023	↑	59	9.8	12.0	25.4		5.3
Under 75 mortality rate from alcoholic liver disease (3 year range)	2021 - 23	–	165	9.2	11.7	24.7		5.1
Mortality from chronic liver disease, all ages	2023	↑	81	12.0	15.0	33.5		5.6
Potential years of life lost (PYLL) due to alcohol-related conditions (Male)	2022	→	3,359	1,031	1,211	2,263		639
Potential years of life lost (PYLL) due to alcohol-related conditions (Female)	2022	→	1,842	540	536	1,196		199
Potential working years of life lost (PWYLL) due to alcohol-related conditions (Male)	2022	↑	1,152	429	484	1,033		193
Potential working years of life lost (PWYLL) due to alcohol-related conditions (Female)	2022	→	536	196	202	515		81

Alcohol-specific Mortality

Deaths which have been wholly caused by alcohol consumption are monitored by OHID and ONS, in order to provide an evidence base for activities to reduce the harmful use of alcohol. The rate of these deaths, referred to as alcohol specific mortality, has increased since 2019 in both Cambridgeshire and in England on the whole. The most recent annual mortality rate from 2023 for Cambridgeshire was 12.8 per 100 000, which is a significant recent increase and which brought

[72] Drugs and Alcohol Needs Assessment for Cambridgeshire and Peterborough: summary report
[73] GOV.UK

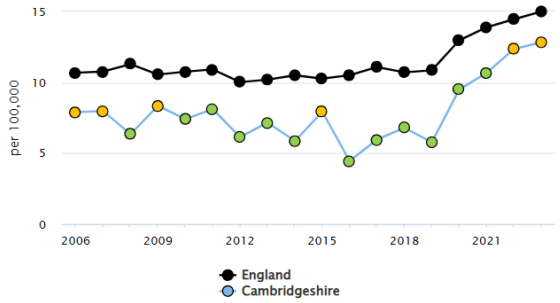
Cambridgeshire closer to the national rate (15 per 100 000), where it had previously been significantly lower. This is demonstrated in figure 22.

Figure 22. Alcohol-specific mortality in Cambridgeshire and England over time

Alcohol-specific mortality

Directly standardised rate - per 100,000

Show confidence intervals Show 99.8% CI values ▶ More options



Recent trend: Increasing & getting worse

Period		Cambridgeshire Count	Value	95% Lower CI	95% Upper CI	England
2006	●	42	7.9	5.7	10.7	10.7
2007	●	43	8.0	5.7	10.8	10.8
2008	●	36	6.3	4.4	8.8	11.3
2009	●	48	8.3	6.1	11.1	10.6
2010	●	43	7.4	5.3	10.0	10.8
2011	●	47	8.1	5.9	10.8	10.9
2012	●	36	6.1	4.3	8.5	10.0
2013	●	43	7.2	5.2	9.7	10.2
2014	●	36	5.9	4.1	8.1	10.5
2015	●	48	7.9	5.8	10.5	10.3
2016	●	28	4.4	2.9	6.4	10.5
2017	●	37	6.0	4.2	8.2	11.1
2018	●	43	6.8	4.9	9.2	10.7
2019	●	37	5.8	4.1	8.0	10.8
2020	●	62	9.5	7.3	12.2	13.0
2021	●	70	10.7	8.3	13.5	13.9
2022	●	82	12.3	9.8	15.3	14.5
2023	●	86	12.8	10.3	15.8	15.0

Source: OHID, based on Office for National Statistics data

Alcohol-related mortality rates in Cambridgeshire are similar to the average rate amongst statical neighbours (NHS England), but not all similar areas have seen a trend of recent worsening.

Treatment:

Estimates suggest that in 2023, there were 5,775 adults in Cambridgeshire and 2,284 adults in Peterborough in need of alcohol treatment.[74] However, a comparison of these estimates with the number of people accessing alcohol services highlights that the majority of adults in need are not receiving treatment.

In the year ending March 2024, the estimated proportion of adults with unmet need for alcohol treatment was:

- **Cambridgeshire**: 75.3% (95% CI: 68–81%)
- **Peterborough**: 70.3% (95% CI: 63–77%)
- **England**: 77.8% (95% CI: 73–82%)

Alcohol Use Prevalence Estimates

Understanding alcohol consumption patterns is essential for assessing public health risks and identifying areas for intervention. Alcohol use is typically categorised into levels of risk:

[74] Drugs and Alcohol Needs Assessment for Cambridgeshire and Peterborough: summary report

- **Low risk:** Consuming within the recommended limits (14 units per week for adults in the UK).
- **Increasing risk:** Regularly exceeding these limits, which heightens the likelihood of alcohol-related harm.
- **High risk:** Heavy drinking associated with serious health and social consequences.

Higher rates of risky drinking are noted among routine and manual workers, as well as specific ethnic groups, particularly Eastern Europeans in Fenland.

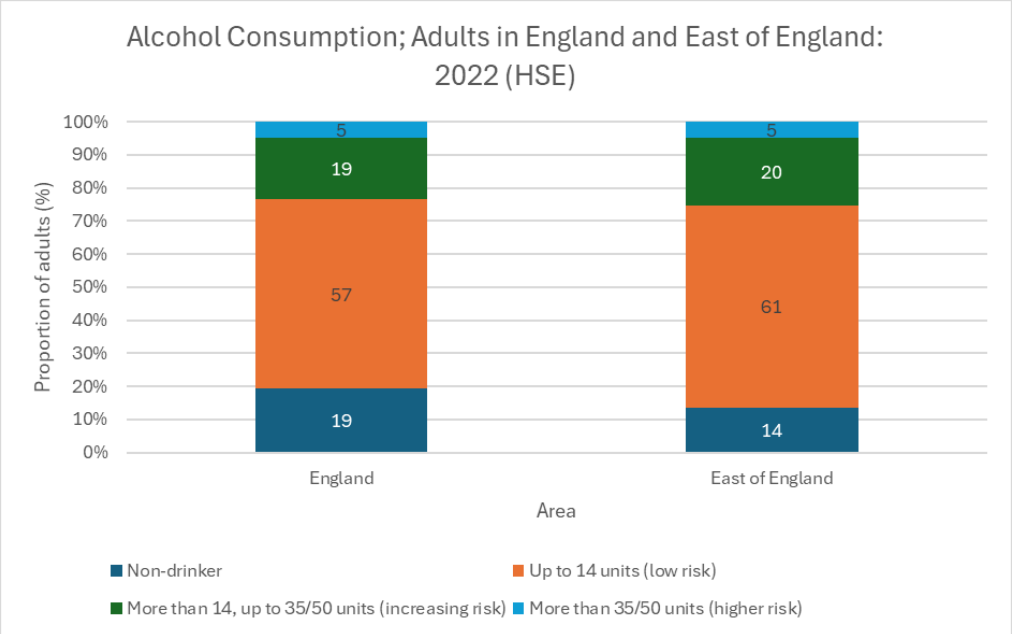
Adults

Previous prevalence estimates from 2019 Health Survey for England indicate that levels of drinking in Cambridgeshire are higher than national levels, with fewer people abstaining from alcohol, and more drinking above low risk levels,

- **Abstainers**: Lower locally (9.3%) compared to England overall (16.2%).
- **Drinking above low-risk levels**: Higher locally (28.7%) compared to England (22.8%).
- **Binge drinking**: Slightly higher locally (17.7%) compared to the national average (15.4%).

A more recent edition of the survey in 2022 only provides information by region. This showed that levels of drinking in East of England were slightly higher than national levels, with 5% more adults drinking at either a low-risk or increasing-risk level, as shown in the figure below. This was a similar comparison to findings in 2023.

Figure 23. Alcohol in England and East of England, HSE 2022



Children and Young People

The prevalence of alcohol use among local secondary school pupils highlights concerning trends that persist over time, with noticeable changes as students progress through school years. According to

the Health-Related Behaviour Survey (HRBS) 2024, 19% of Year 8 and 10 pupils (aged 12–15) reported drinking alcohol in the last week, a decrease from 22% in 2021 and 25% in 2018. This suggests a positive downward trend in overall alcohol consumption among pupils. However, the proportion remains significant, especially in Year 10, where a quarter of pupils reported drinking alcohol in the past week.

While gender differences remain minimal (HRBS 2024 does not provide separate figures for males and females for recent drinking), harmful patterns of alcohol use persist. Among those who drank alcohol, 12.5% reported drinking on one day in the past week, and 5.2% reported drinking on two or more days.

Intoxication rates continue to be a concern, in HRBS 2018, 23.5% of pupils who consumed alcohol reported getting drunk at least once, with higher rates in Year 10 (33.5%) compared to Year 8 (25.8%). These figures indicate early exposure to harmful drinking behaviours, despite an overall decline in prevalence.

The data in the HRBSs highlights the increasing prevalence of alcohol use with age and the need for targeted education and early interventions to reduce the risks associated with underage drinking. Trends over time demonstrate a gradual decline in alcohol consumption, but the persistence of risky behaviours underscores the importance of continuous public health efforts to address these challenges.

8.11 COVID19

A survey conducted by Drinkaware found that one in 10 drinkers – equivalent to 4.6 million people – drank more than normal throughout COVID-19 restrictions.[75] Alcohol consumption during anxious times is not uncommon and tends to go with other health behaviours such as eating less healthily and reducing physical activity. Provisional data for England and Wales shows that there was a 19.6% increase in alcohol specific deaths compared to 2019, and 2020 showed the highest annual total since 2001.[76]

8.12 Prevention

Identifying people early and giving them brief advice on how to reduce their alcohol drinking has been shown to provide a return on investment. Alcohol identification and brief advice (IBA) aims to find and support people who are at risk from harm due to their alcohol consumption. Effective IBA can reduce the amount a person drinks each week by 12% on average.[77]

Local prevention strategies include:

The **Healthy You** programme in Cambridgeshire provides tailored support through Alcohol Health Trainers to help individuals aged 18 and over reduce their alcohol intake. Available to residents and those registered with a GP in Cambridgeshire or Peterborough, the service offers personalised one-

[75] Drinkaware Home
[76] Office for National Statistics
[77] Alcohol Change UK

on-one sessions to explore relationships with alcohol, set reduction goals, and understand safe drinking levels. In addition to alcohol reduction, trainers take a holistic approach, supporting healthier lifestyles through advice on nutrition, physical activity, stress management, and weight loss.

The **Short Term Alcohol Reduction Service (STARS)** in Cambridgeshire is a programme designed to help individuals reduce their alcohol consumption. This service offers one-on-one support sessions, including an initial assessment to understand your needs and goals. The programme focuses on providing education, support, and behaviour change tools to help you gain control over your drinking and maintain these changes long-term. The STARS programme is available to adults aged 18 and over who are motivated to reduce their alcohol intake but are not dependent on alcohol. Referrals to the programme are typically made by health professionals

IBA Implementation: Widely used in primary care, NHS Health Checks, and through Healthy You services.

Public Campaigns: Cambridgeshire and Peterborough councils support national initiatives such as Dry January and Alcohol Awareness Week to increase public engagement.

Licensing: Local licensing teams actively enforce CIPs to reduce harm from alcohol outlet density.

Routine and Manual Workers

Routine and manual workers in areas like Fenland and Peterborough show higher levels of alcohol-related harm. Efforts to address this include workplace-based IBA, targeted campaigns, and partnerships with employers.

Eastern European Populations

Fenland's Eastern European population experiences significant alcohol-related harm. Barriers include stigma, language difficulties, and limited awareness of available services. Multilingual outreach and culturally sensitive services are being explored to bridge these gaps.

Mental Health

Cambridgeshire and Peterborough Integrated Care System (ICS) highlights alcohol misuse and mental health as co-occurring issues. Integrated care pathways are needed to improve outcomes for individuals with dual diagnoses.

Pregnant Individuals

Local midwifery services in Cambridgeshire and Peterborough are incorporating routine alcohol screening and referral pathways to Healthy You. Awareness campaigns focus on educating women about the risks of foetal alcohol spectrum disorders (FASD).

Homeless Individuals

Homelessness is a growing challenge in Peterborough, with alcohol misuse compounding vulnerabilities. Street outreach teams and housing-first programmes, supported by CGL, offer targeted interventions.

Individuals with Learning Disabilities

Local authorities are working to make alcohol services more accessible for people with learning disabilities by providing simplified materials and specialist support through CGL and other partners.

Other Target Populations

1. **Young Adults (18-24):** Cambridge City, home to a large student population, faces challenges with binge drinking. Universities are implementing targeted education and support.

2. **Older Adults (65+):** Primary care teams are increasing screening for older adults at risk due to medication interactions and isolation, particularly in rural areas like Fenland.

3. **Families and Children of Alcohol-Dependent Parents:** Social services in Cambridgeshire and Peterborough report a rising need for support programmes targeting children affected by parental alcohol misuse.

4. **LGBTQ+ Individuals:** Local Pride events and LGBTQ+ community organisations are exploring collaborations to raise awareness of alcohol harm and provide tailored support.

6. **Rural Populations:** Mobile health clinics are expanding alcohol services in remote areas, addressing access challenges in villages across Cambridgeshire.

8.13 Recommendations

Recommendations for Mild to Moderate and Increasing Risk Alcohol Use (e.g., AUDIT score ≤16) as preventative measures for behaviour change services.

Secure sustained funding for Alcohol Prevention Services

- Advocate for ongoing funding to maintain prevention services like Healthy You, which focus on individuals at increasing risk rather than dependency. Emphasise the cost-effectiveness of reducing long-term healthcare burdens through early intervention.
- Explore joint funding initiatives with employers and schools to expand brief intervention availability.

Improve Access to Culturally Appropriate Services

- Tailored Support for Eastern Europeans and Other Minorities: Focus on providing culturally sensitive IBA services in community hubs frequented by these groups (e.g., churches, cultural centres). Materials should be multilingual and highlight the benefits of moderation.
- Engage Trusted Leaders: Partner with local influencers or community leaders to deliver prevention messages through familiar and respected channels.

Embed Alcohol Prevention work in Schools and Workplaces

Schools:

- Introduce alcohol education aligned with PSHE programmes, emphasising moderation and the risks of mild to moderate alcohol use. Tailor interventions to address patterns of experimentation and binge drinking common among adolescents.

- Provide teacher training to recognise signs of increasing alcohol use in pupils and refer them for brief interventions where appropriate.
- Limit Advertising Exposure Limit Advertising Exposure: Collaborate with local district councils to reduce alcohol advertising near schools, youth centres, and workplaces.

Workplaces:

- Implement awareness campaigns targeting industries with prevalent social drinking cultures (e.g., hospitality, manual trades). Include short interventions during workplace health checks for employees scoring 8-15 on AUDIT.

Enhance Dual-Purpose Pathways for Early Mental Health and Alcohol Use Support

- Integrate low-intensity mental health services, such as counselling, with alcohol brief intervention programmes to address mild anxiety or stress that may drive increasing alcohol use.
- Digital Support Tools: Expand access to self-monitoring apps and online counselling platforms aimed at AUDIT ≤16 drinkers, providing real-time feedback on drinking habits and coping strategies.
- Evaluate the SiSU Health Kiosk use and impact to assess the value in expanding this provision in the next Behaviour Change service commission.

Develop a comprehensive Alcohol Prevention Strategy

- Focus on widespread implementation of Identification and Brief Advice (IBA) in primary care, pharmacies, and community settings, specifically targeting individuals scoring between 8 and 16 on the AUDIT. Ensure these interventions are short, structured, and accessible.
- Develop campaigns to encourage self-assessment and early help-seeking behaviours among individuals at increasing risk.

Additional Local Recommendations

- Focus on Rural Populations: Enhance mobile outreach services for rural Cambridgeshire areas, where residents may score in the moderate risk range but lack accessible services.
- Evaluate Campaigns: Include short-term impact evaluations of workplace and school-based interventions to refine approaches tailored to AUDIT 8-16 groups.
- Social Norms Campaigns: Launch locally tailored campaigns debunking myths about "safe" drinking levels while promoting benefits of alcohol-free days.

9. Physical Activity and Moving More

9.1 Instruction and Scope

This chapter will explore the role of physical activity in preventing and managing obesity, as well as its impact on other health conditions such as cardiovascular disease and mental health. It will briefly review past and upcoming national policies, outline the landscape of physical activity and health in Cambridgeshire, and examine strategies and literature addressing physical activity, obesity, and related health conditions in vulnerable groups.

9.2 Background

Regular physical activity is crucial for enhancing health and well-being, helping individuals lead happy, healthy, and fulfilling lives. As the UK Chief Medical Officers' Physical Activity Guidelines (2019) state, “If physical activity were a drug, we would refer to it as a miracle cure, due to the great many illnesses it can prevent and help treat.” Physical activity encompasses all forms of movement, including walking, cycling, wheeling, sports, active recreation, and play, and can be enjoyed at any skill level by everyone. Even everyday tasks such as household chores or physically demanding jobs contribute to maintaining an active lifestyle.

9.3 Definition

Physical activity includes any movement that increases energy expenditure, encompassing activities such as walking, cycling, sports, household chores, and recreational play. The UK Chief Medical Officers define moderate activity as movements where an individual can talk but not sing, while vigorous activity involves being unable to speak comfortably.

9.4 Guidelines for Physical Activity

The UK Chief Medical Officers have developed guidelines on the frequency, intensity and type of physical activity people should be doing to improve their health.

The guidelines recommend that adults (aged 19 to 64 years) should:

- Aim to be physically active every day, any activity is better than none, and more is better still.
- Do activities to develop or maintain strength at least two days a week.
- Do either, or a mixture of at least:
  - 150 minutes moderate intensity activity,
  - 75 minutes’ vigorous activity, or a mixture of both,
- Minimise extended periods of inactivity, breaking them up with at least light physical activity.

Activity ‘intensity’: Moderate activity may include walking, cycling or shopping, whilst vigorous activity may include sports such as football, dancing or swimming. The intensity can be differentiated by the ‘talk test’: being able to talk indicates moderate intensity activity, while having difficulty talking without pausing is a sign of vigorous activity.

Developing or maintaining strength: This includes muscle and bone strength which underpin physical function and support balance. It is important to work all major muscle groups during muscle strengthening activities. Bone strengthening involves moderate and high impact activities to

stimulate bone growth and repair. In addition, balance training involves a combination of movements that challenge balance and reduce the likelihood of falling.

Periods of inactivity: this may also be referred to as sedentary behaviour. Energy expenditure is very low during this time, which commonly involves sitting, lying and reclining with little movement during waking hours.

9.5 Causes of Physical Inactivity

Physical inactivity is driven by various factors, many of which are deeply embedded in modern life. Barriers to physical activity include:

- **Socioeconomic Challenges:** Limited access to affordable facilities or activities.
- **Cultural Norms:** Differences in gender roles or attitudes toward exercise.
- **Health Conditions:** Disabilities and long-term illnesses limiting activity.
- **Lack of Awareness**: Many people underestimate the importance of physical activity or believe it only involves intense exercise, like gym workouts or marathons.
- **Sedentary Habits**: The prevalence of sitting or lying down for extended periods—whether for work, watching TV, or using a computer—significantly contributes to inactivity.
- **Environmental Factors**: A lack of safe and accessible spaces for physical activity can discourage movement, particularly in urban areas.
- **Psychosocial Factors**: Stress, depression, and a lack of motivation can all reduce the likelihood of engaging in physical activity.
- **Urbanisation**: City environments often prioritise convenience, reducing opportunities for physical activity. Increased reliance on sedentary lifestyles due to modern conveniences.
- **Technology**: The increase in screen time due to computers, smartphones, and other devices has led to a decline in physical activity.
- **Work Demands**: Many jobs are sedentary, and long working hours further limit opportunities for physical movement.
- **Social Norms**: Cultural and social norms can either discourage physical activity or place greater value on other activities.
- **Health Conditions**: Chronic illnesses, pain, or disability can also act as barriers to staying active.

9.6 Language and Stigmatisation

Framing physical activity positively is crucial for engagement. Avoiding judgmental language that implies fault can encourage uptake in diverse populations. Campaigns focusing on incremental changes rather than "ideal" behaviours help reduce stigma.

9.7 Impacts of Physical Inactivity

Health Impact

Physical inactivity has severe health consequences. It is associated with one in six deaths in the UK and is a leading risk factor for global mortality, accounting for 6% of deaths worldwide. Conversely, regular physical activity has significant benefits for physical and mental health:

- **Preventing Noncommunicable Diseases (NCDs)**: Regular physical activity helps prevent and manage NCDs such as heart disease, hypertension, stroke, diabetes, and several types of cancer. Individuals who lead active lifestyles have a 20-35% lower risk of cardiovascular disease, coronary heart disease, and stroke compared to their sedentary counterparts.[78]
- **Healthy weight**: Physical activity is crucial for maintaining a healthy body weight, reducing the risk of obesity, a common risk factor for these NCDs. Obesity's rising prevalence significantly impacts public health, contributing to various chronic conditions and placing a heavy burden on healthcare systems.
- **Mental Health and Well-Being**: Physical activity reduces symptoms of depression and anxiety, enhances overall well-being, and improves quality of life. Among older adults, regular physical activity is linked to better health, improved cognitive function, and a reduced risk of falls which is especially important for those with mobility issues.[79]
- **Cognitive Benefits**: Engaging in physical activity has been shown to enhance cognitive functions, such as thinking, learning, and judgment skills.[80]

Social and Economic Impacts

Physical inactivity places a substantial economic burden on the UK. The annual cost is £7.4 billion, this includes £0.9 billion in direct costs to the NHS.[81] In contrast, physical activity generates nearly £4 in return for every £1 spent, contributing to health, well-being, community building, and economic growth.[82] Active lifestyles also prevent approximately 900,000 cases of diabetes and 93,000 cases of dementia each year, leading to significant savings of £7 billion for the UK economy. Thus, investing in physical activity is not just a public health priority but can also contribute to economic prosperity.

9.8 Benefits of Taking Action

Promoting physical activity yields health, economic, and social benefits. Interventions such as community-based programmes improve quality of life, reduce health inequalities, and foster a sense of belonging.

The benefits of physical activity extend beyond personal health. A wide range of evidence supports its positive impacts on educational attainment, social connections, and the economic and environmental sustainability of local communities. Despite these advantages, our social and physical environments often make it easier to remain sedentary, contributing to reduced life expectancy in the UK due to preventable diseases, that could be mitigated through regular physical activity.

Incorporating regular activity into daily life doesn't have to be complicated. Moderate physical activity can be achieved through everyday tasks like walking to the shops, commuting via public transport, or cycling with children to school, as well as through recreational activities like sports, dance, or play. This strategy recognises the diversity of activities that can help individuals stay active,

[78] World Health Organization (WHO)
[79] CDC
[80] Oxford Academic
[81] GOV.UK
[82] London Sport

acknowledging that preferences may vary across different life stages as commitments and social networks evolve. Transforming our community into an active population is crucial to enabling every citizen to lead a healthier, happier life. Achieving this goal will require collective effort from all of us.

Physical activity is vital for maintaining physical and mental health across all age groups. Evidence shows that engaging in regular physical activity can significantly reduce the risk of over 40 chronic conditions, including type 2 diabetes, cardiovascular disease, and some cancers. It also plays a role in managing mental health, reducing symptoms of anxiety and depression.[83]

9.9 National Policies, Strategies, and Guidance

Key frameworks guiding physical activity interventions include:

- Everybody Active, Every Day (PHE, 2014): A strategy for embedding activity into daily routines.
- All Our Health Framework (OHID, 2024): Resources for healthcare professionals to promote active lifestyles.
- NICE Guidelines: Recommendations tailored for specific population groups, including children and older adults.

9.10 Prevalence in Cambridgeshire

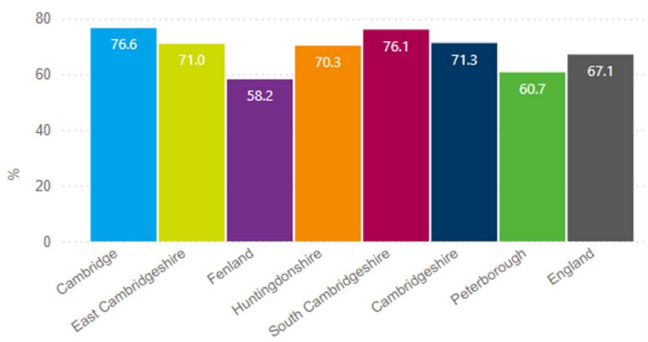
Local data indicates that 71.3% of adults in Cambridgeshire meet recommended activity levels, above the national average of 67.1%. Fenland has the highest inactivity rates, highlighting geographic disparities.

Figure 24. Physical Activity Levels in Adults (Percentage Meeting Guidelines), 2023

ii. Cambridgeshire Districts

Area Name	Number	Value
Cambridge		76.6
South Cambridgeshire		76.1
East Cambridgeshire		71.0
Huntingdonshire		70.3
Fenland		58.2

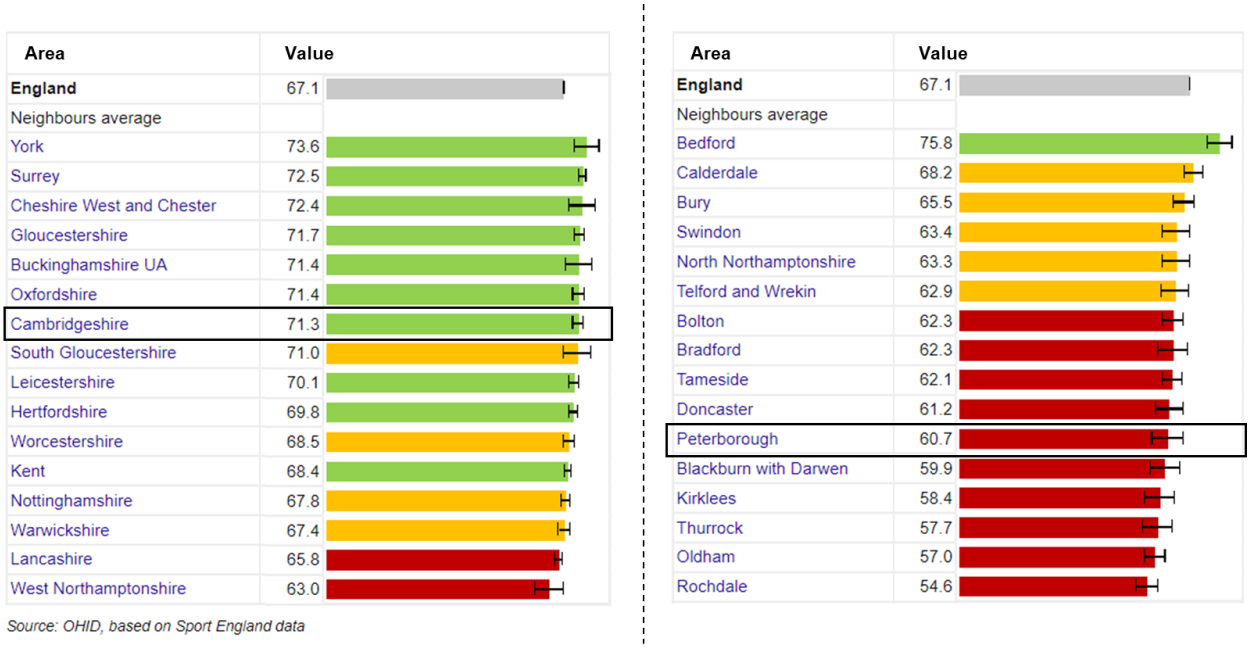
iii. Comparison across districts and unitary authority



[83] World Health Organization (WHO)

Compared to other regions, both Cambridgeshire and Peterborough are positioned among their statistical neighbours, ranking 7th and 11th out of 16 respectively. This suggests that there is potential for improvement, although they are not among the lowest performers, as shown in figures below.

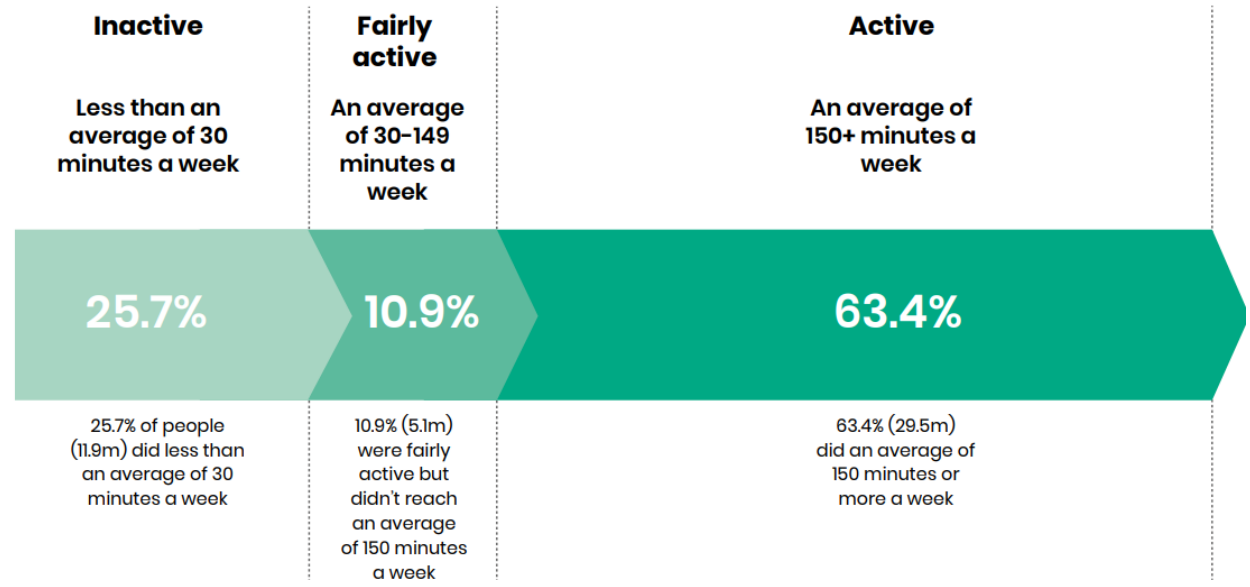
Figure 25. Comparison of Adult Physical Activity Levels by Region Against the England Average, 2023



Source: OHID, based on Sport England data

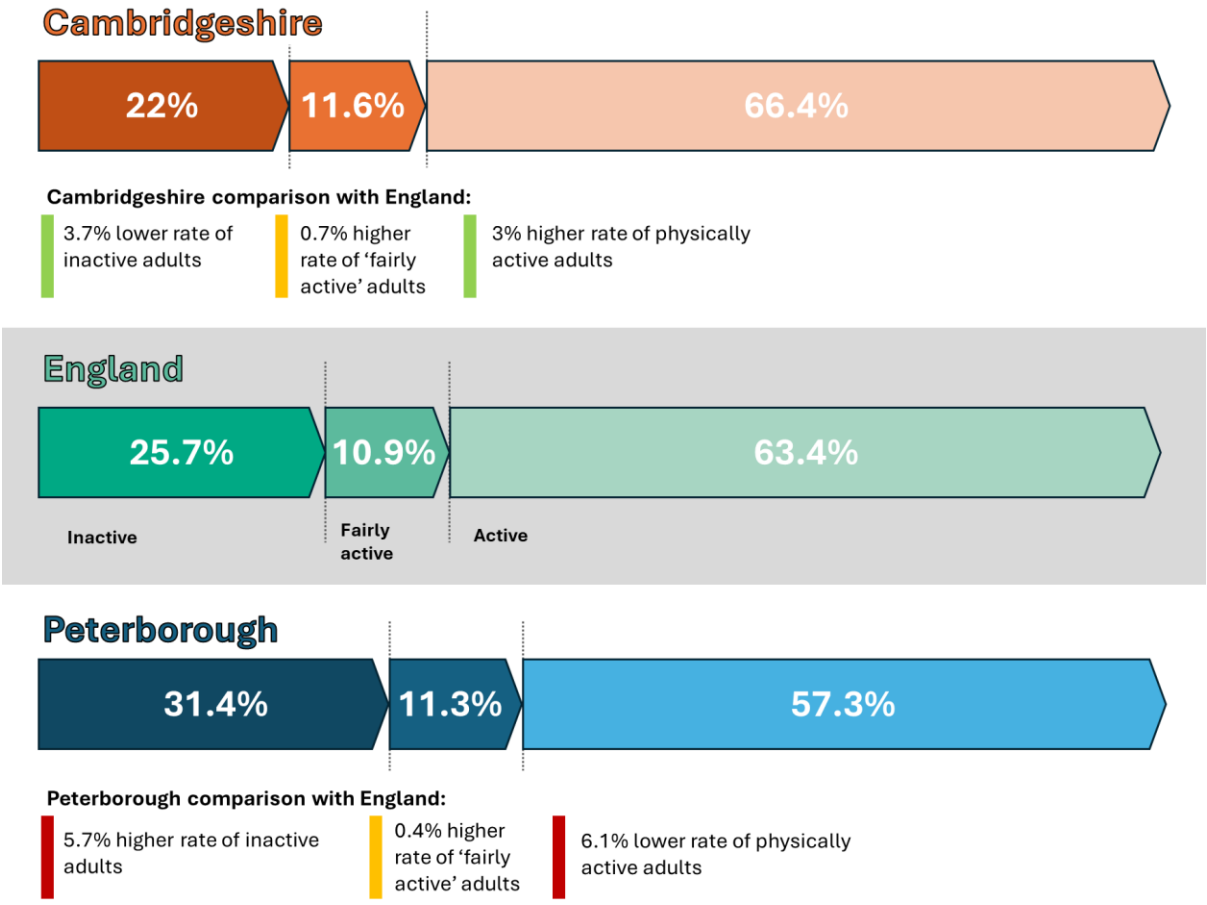
As described above, physical inactivity is a distinct health concern, and is not merely the absence of activity. The Active Lives survey categorises the population into three groups to illustrate this distinction. Individuals who do not meet the recommended activity levels may be classified as 'fairly active', if they engage in some physical activity but fall short of recommended levels. Individuals are categorised as 'inactive' if they engage in minimal or no physical activity. This is illustrated below.

Figure 26. Levels of Activity; Adults (aged 16 and over) in England 2022-23



As may be expected, trends in inactivity are generally in line with those observed in physical activity, but inversed, i.e. increasing levels of those who are physically active corresponds with decreasing levels of those who are inactive. This is demonstrated in Figure 27, which shows that there is a lower proportion of inactive adults in Cambridgeshire compared with England, and a higher proportion in Peterborough.

Figure 27. Comparison of Physical Activity Levels: Cambridgeshire, Peterborough, and England, 2022-23



9.11 Population Subgroups

Disparities in physical activity are well-documented and often reflect broader socio-economic, cultural, and structural inequalities, contributing to increased health risks and exacerbating existing health disparities. Data from the Active Lives Survey highlights patterns across key characteristics, including age, gender, socio-economic status, disability, ethnicity, and other factors.

Age

Activity levels decline with age, particularly in adults aged 55 and older. From 2015 to 2023, 69% of adults aged 16-54 in Peterborough and Cambridgeshire met recommended activity levels, compared to 53% of those aged 55 and over. Despite slight improvements in recent years, older adults remain more likely to be inactive, with 1 in 3 reporting less than 30 minutes of weekly activity compared to 1 in 5 among younger adults.

Gender

In 2022-23, men in Cambridgeshire were slightly more active than women, reflecting national trends. However, in Peterborough, women exhibited higher activity levels than men, reversing the typical pattern. Nationally, individuals identifying as transgender or "another gender" reported the lowest activity rates (56%) and highest inactivity rates (33.8%), suggesting significant barriers to participation.

Socio-Economic Status (SES)

Lower SES is strongly linked to reduced activity levels. In Cambridgeshire, activity rates among the least deprived groups were 70%, compared to 53.9% in the most deprived groups—a disparity of 16.1%.

Disability and Long-Term Health Conditions

Activity rates among individuals with disabilities or long-term conditions are lower both nationally and in Cambridgeshire. In Cambridgeshire, 64.3% of individuals with disabilities report being inactive, highlighting a significant disparity compared to those without disabilities, where activity levels are notably higher

Ethnicity

Nationally, physical activity levels among White British adults have increased by 2.1% since 2015-16, while no significant changes have been observed among other ethnic groups, widening inequalities. Local data for Cambridgeshire is limited, but national trends suggest that ethnic disparities are likely to persist.

Implications for Targeted Interventions

Evidence underscores the need for tailored approaches to increase physical activity in underrepresented groups, particularly older adults, individuals with disabilities, and those in lower socio-economic groups. Strategies should focus on reducing barriers, such as cost, access to facilities, and cultural stigma, while leveraging community-based programmes and inclusive messaging to foster greater participation across all population subgroups.[84] [85] [86]

9.12 Local policies and strategies to promote Physical Activity

Local initiatives include:

- *Healthy You Tier 1*: in Cambridgeshire, Healthy You is a free health and well-being service commissioned by the local public health teams to support residents in achieving healthier behaviours including phsyical activity sessions in the community.
- *Active Fenland:* Community programmes tailored to improve activity levels in Fenland.
- *Let's Get Moving Cambridgeshire:* A countywide strategy for supporting physical activity in diverse populations.

[84] International Journal of Behavioural Nutrition and Physical Activity
[85] ScienceDirect
[86] Public Health England

- *Uniting the Movement Strategy:* Launched in 2022 by Sport England, this 10-year vision aims to transform lives and communities through sport and physical activity. It focuses on five key issues: recovering from the COVID-19 pandemic, connecting communities, providing positive experiences for children and young people, integrating health and well-being, and creating active environments.

9.13 National Campaigns and Resources

Prominent campaigns include:

- Better Health – Get Active: Encouraging small changes to increase daily movement.
- This Girl Can: Focused on overcoming gender-related barriers to activity.

9.14 Local Campaigns and Resources

Efforts to promote activity include:

- Local walking and cycling initiatives in South Cambridgeshire.
- Programmes integrating physical activity into schools and community settings.

9.15 Current Local Assets and Service Provision

Key services include:

- Exercise referral schemes in Cambridgeshire.
- Community-based support for older adults to reduce fall risks.

9.16 Recommendations

Expand Community-Based Programmes

- Increase funding and accessibility for initiatives like *Active Fenland* and *Let's Get Moving Cambridgeshire* to target populations with higher inactivity rates, such as older adults, individuals with disabilities, and socio-economically disadvantaged groups

Enhance accessibility for vulnerable groups

- Provide subsidised or free physical activity sessions for low-income groups, tailored to address barriers such as cost, transport, and childcare.

Target Older Adults and reduce Sedentary Behaviour

- Develop and promote community-based strength and balance classes, particularly for adults aged 55 and older. Partner with local care homes and older adult clubs to increase participation.

School and Workplace Interventions

- Incorporate daily activity into school schedules (e.g., walking or cycling to school initiatives, active breaks).
- Partner with workplaces to implement "active commute" programmes, standing desks, and movement breaks during work hours.

Invest in Active Travel Infrastructure

- Improve and promote safe walking and cycling routes in urban and rural areas. Increase cycle hire and secure bike parking schemes across Cambridgeshire.

Address Disability-Related Barriers

- Expand adapted physical activity programmes, such as seated exercise classes, for individuals with disabilities or chronic illnesses.
- Train instructors in inclusive practices to increase accessibility.

Leverage Technology for Engagement

- Use apps, social media, and digital platforms to promote virtual physical activity challenges, local events, and progress tracking. Technology can reach sedentary individuals and motivate participation through gamification and community involvement. Consider reward incentive schemes such as BetterPoints.

Integrate Physical Activity into Healthcare Pathways

- Train healthcare professionals in "physical activity prescriptions" as part of primary care consultations. Refer patients to schemes like *Healthy You Tier 1* and exercise referral programmes. Embedding activity promotion into healthcare systems ensures regular touchpoints with at-risk individuals.

10. Cardiovascular Health Checks

10.1 Introduction

Cardiovascular disease (CVD) is the leading cause of death worldwide, accounting for 17.9 million deaths per year. The British Heart Foundation[87] report that there are approximately 7.6 million people living with heart and circulatory diseases in the UK, of which around 53% are men and 47% are women. Cardiovascular disease (CVD) causes more than 160,000 deaths each year in the UK, which contributes to over one quarter of deaths each year.

The NHS Health Check (NHSHC) is a national programme that aims to reduce the risk of CVD in adults aged 40-74, with no underlying CVD-related health conditions. It achieves this by assessing the top seven risk factors driving the burden of non-communicable disease in England, and by providing individuals with behavioural support and, where appropriate, pharmacological treatment.

The NHSHC is a rolling programme in which the eligible population can complete a health once check every 5 years.

10.2 National policy/ strategy

Under the Health and Social Care Act 2012, the NHS Health Check programme is one of the mandatory public health functions for the local authorities. Local authorities have a legal responsibility to:

- offer an NHS Health Check to 100% of their eligible population once every five years,
- ensure information related to each completed check is recorded and processed
- ensure subsequent information relating to the person undergoing the health check, including the risk to health, shall be communicated to that person as soon as reasonably practicable thereafter.
- The programme has the potential to:
- prevent 1,600 heart attacks and strokes
- prevent 4,000 people a year from developing diabetes
- detect 20,000 cases of diabetes or kidney disease each year
- avoid at least 650 premature deaths a year

NHS England published the Long-Term Plan (LTP) implementation framework in June 2019 set out to prevent 150,000 strokes, heart attacks and vascular dementia cases over the next 10 years.[88] In that same year, the Cardiovascular Disease Prevention System Leadership Forum published guidance[89] setting out to improve the detection and management of atrial fibrillation (AF), high blood pressure and raised cholesterol, and reduce the health inequalities associated with CVD, the initiative was termed CVDPREVENT.

Local authorities (LAs), Clinical Commissioning Croups (CCGs) - now Integrated Care Boards (ICBs) - general practice (GP), pharmacists and community settings have been called to action to deliver a

[87] British Heart Foundation (BHF)
[88] NHS Long Term Plan
[89] Health Matters

whole systems approach to achieving these ambitions. LAs have a responsibility to offer population lifestyle programmes; raise public awareness of blood pressure and its opportunistic detection; and promote an improve the uptake of the NHS Health Check.

In December 2021, the Office for Health Improvement and Disparities (OHID) released a review of the NHS Health Check programme and made recommendations for ways in which the programme could be developed further to support the NHS prevention agenda, and particularly to reduce inequalities in health outcomes.[90]

The main points of the review's findings were:

- the NHS Health Check programme has largely achieved its aims, reaching 2 in 5 eligible people, including those at higher risk of disease, and delivering better outcomes for attendees,
- multiple opportunities exist to improve the NHS Health Check across the entire pathway,
- people's risks set in early, so behaviour change is needed sooner,
- a wider view of health could address the current burden of disease,
- greater use of technology may help target, reach and personalise the NHS Health Check for individuals.

The 6 recommendations were to:

1. build sustained engagement,
2. launch a digital service,
3. start younger,
4. improve participation,
5. address more conditions,
6. create a learning system.

They estimated that full implementation of the recommendations for the new NHS Health Check could be achieved within five years, subject to investment, demonstrating their commitment to the development and improvement of the programme. There has been an increased prioritisation of the new digital service and improving participation which have been fast-tracked for advancement within the first three years.

10.3 Digital NHS Health Checks

Following discovery insight work completed in Greater Manchester and London Borough of Southwark in 2018 and pilots of a new Digital version of an NHS Health Check in Cornwall supported by OHID and independently in Southwark, OHID announced in June 2023 the rollout of a national digital check.

[90] GOV.UK

Tens of thousands of cases of hypertension are expected to be identified and hundreds of strokes and heart attacks prevented. Each digital check could save 20 minutes of NHS time – potentially freeing up hundreds of thousands of primary care appointments.

Around 1.3 million health checks are delivered each year, identifying 315,000 people living with obesity, 33,000 cases of hypertension and preventing over 400 heart attacks and strokes.

Anticipated benefits to the digital NHS Health Check that will be tested through piloting and evaluation include the following:

- By providing people with the choice to complete their NHS Health Check in their home, more people will engage in the life-saving programme, and local commissioners and providers could target their in-person service to those needing or wanting in-person support.
- A digital NHS Health Check may attract people who are otherwise reluctant or find it difficult to engage in healthcare settings.
- The digital NHS Health Check could offer efficiencies for commissioners.
- The digital NHS Health Check has the potential to bolster local capacity to deliver NHS Health Checks.
- The digital NHS Health Check could help to overcome some local variability in delivery.
- Long term, by identifying and managing more people at greater risk of CVD earlier they anticipate that the programme can ease pressure on the NHS.

Government is investing almost £17m to develop the digital NHS Health Check product.

The subsequent private Beta phase in 2024/25 will help to determine the most suitable commissioning and delivery approach for rollout at scale, with a recognition that there is considerable variability across different local commissioners. The Digital health check is expected to deliver an additional one million checks over four years, while easing pressure on GP surgeries.

10.4 NHS Health Checks, COVID-19 Outbreak and COVID recovery.

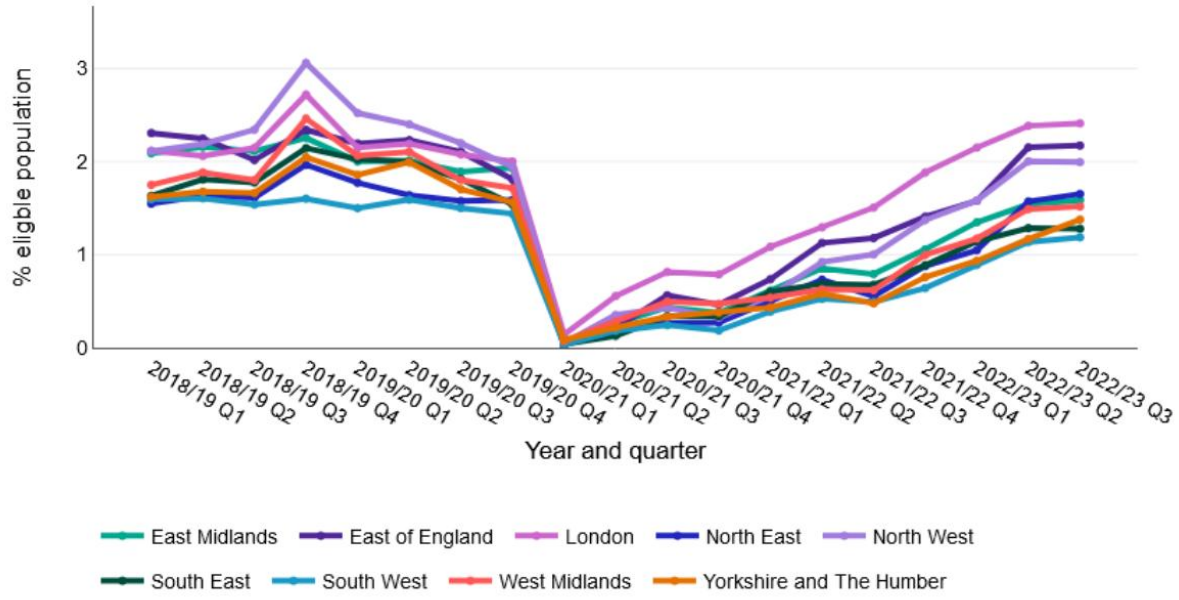
Since the start of the pandemic, the impact of COVID-19 on primary care has been significant. NHS Health Checks, among other primary care services, were temporarily de-prioritised nationally to alleviate the pressure on primary care services in response to the COVID-19 pandemic.

In January 2022, NHS England/Improvement published guidance advising that all providers should restore routine care where services were paused in line with guidance previously released by NHSE/I, including the NHS Health Check service.

Data gathered by OHID indicates that the number of checks delivered in 2022/23 reached 91.5% of pre-pandemic Q3 average activity, an improvement from Q2 2022/23 (85.0% of pre-pandemic Q2 activity).

Offers continue to increase and are currently advised to back to pre-COVID levels, with 146 out of 152 local authorities in England have restarted the service. Based on these current rates of recovery, OHID expected appointment delivery activity for the NHS Health Check to return to pre pandemic levels by end of 24 (Figure 28).

Figure 28. NHS Health Check 5-year performance by region.



10.5 National and Regional Programme Performance 2020/21 to 2024/25

The total eligible population (TEP) are entitled to an NHS Health Check every 5 years, which equates to 20% of the TEP receiving an NHS Health Check invite each year. Whilst OHID expects 20% of the eligible population to be invited each year it aspires to a 66% uptake nationally and 75% to meet original cost effectiveness metrics (proportion of which is based on economic modelling) and to optimise clinical effectiveness of the programme.

National context

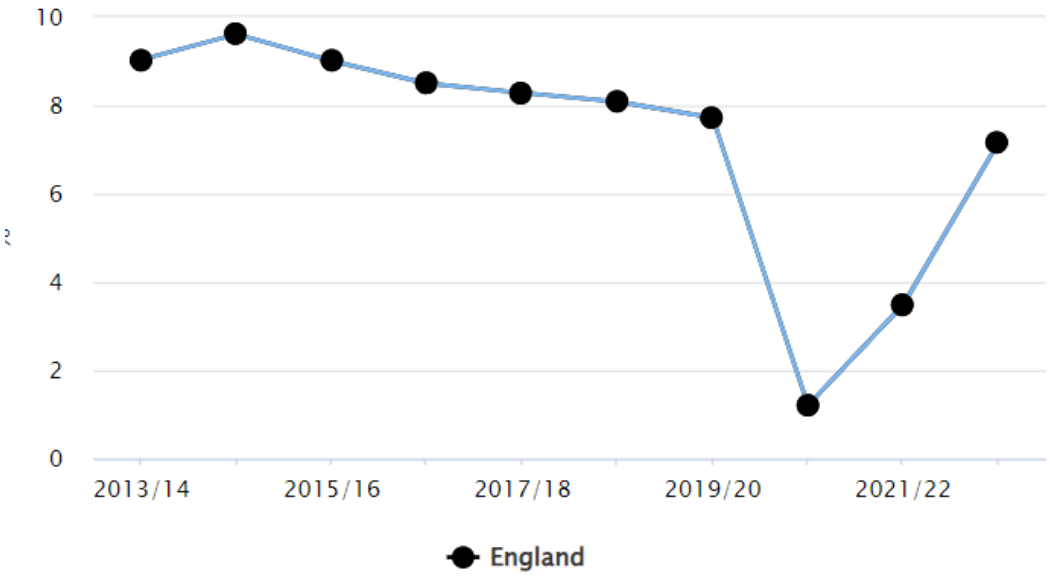
Between April 2019 and March 2024, approximately 4.5 million people (28.1% of the Total Eligible Population, TEP) received an NHS Health Check. However, this accounts for less than half of the eligible population, with only 44% of eligible adults attending—falling short of programme targets.

During this period, 69.1% of the TEP (11.1 million people) were invited for a health check, with a national average uptake of 40.6% following an invitation.

For comparison, in the previous two-year reporting period (2017/18 to 2021/22), 3.1 million people (28.8% of the TEP) attended an NHS Health Check. This suggests that, in terms of data reporting, the programme has substantially recovered from the impact of COVID-19.

In the 'clean' five-year period prior to COVID19 between 2015 and 2020, the programme was still in the process of significantly scaling up the standardised check and refining measurement methods (JBS2 to QRISKs for example), reaching an average of 41% (6,466,090) of eligible people in England.

Figure 29. NHS Health Check 5-year performance in England.



Whilst the programme was attempting to scale up nationally, however, the programme was demonstrating a decline in overall performance from a peak in 2014/15 (Figure 29), this decline is amplified when considering that the eligible population for the programme was increasing year-on-year - by 2.4% (370,000) between 2020 and 2024 nationally.

Similarly, local authorities spent £48 million on NHS Health Checks in 2019/20, down from a peak of £63 million in 2014/15.[91] Conversely, local authorities received a total of £2.794billion of public health grant funding for their public health duties in 2014/15 rising to £3.134 billion in 2019/20. This equates to 2.25% of the national public health grant spent on the programme in 2014/15 was subsequently reduced to 1.53% in 2019/20, prior to the outbreak of the pandemic, an overall reduction in investment in the programme of one-third.

Regional context

Between 2019/20 and 2023/24, approximately 593,000 people in the East of England received an NHS Health Check, representing 32.4% of the Total Eligible Population (TEP). During this period, 75.6% of the TEP (1.38 million people) were invited for a health check, with an uptake rate of 42.9%.

The East of England has consistently outperformed the national average across all key programme metrics.

[91] Ministry of Housing, Communities and Local Government

Figure 30. NHS Health Check 5-year performance in England.

Indicator	Period	East of England			England			
		Recent Trend	Count	Value	Value	Worst	Range	Best
Percentage of NHS Health Checks offered to the total eligible population in the quarter	2023/24 Q4	→	81,786	4.5%	5.5%	3.9%		8.6%
Percentage of NHS Health Checks received by the total eligible population in the quarter	2023/24 Q4	→	43,789	2.4%	2.4%	1.9%		3.2%
Percentage of NHS Health Checks offered which were taken up in the quarter	2023/24 Q4	↑	43,789	54%	44%	35%		54%
People invited for an NHS Health Check	2019/20 Q1 - 2023/24 Q4	–	1,382,017	75.6%	69.1%	49.0%		95.5%
People receiving an NHS Health Check	2019/20 Q1 - 2023/24 Q4	–	592,730	32.4%	28.1%	20.5%		37.9%
People taking up an NHS Health Check invite	2019/20 Q1 - 2023/24 Q4	–	592,730	42.9%	40.6%	34.3%		48.7%
People invited for an NHS Health Check per year	2023/24	↑	426,899	23.4%	22.1%	13.9%		33.6%
People receiving an NHS Health Check per year	2023/24	↑	184,185	10.1%	8.8%	6.4%		12.0%
People taking up an NHS Health Check invite per year	2023/24	→	184,185	43.1%	39.9%	31.1%		47.4%

Figure 31: variation in proportion of eligible people having a NHS Health Check by local authority across England, with a zoom in on East of England, 2015 to 2016 and 2019 to 2020

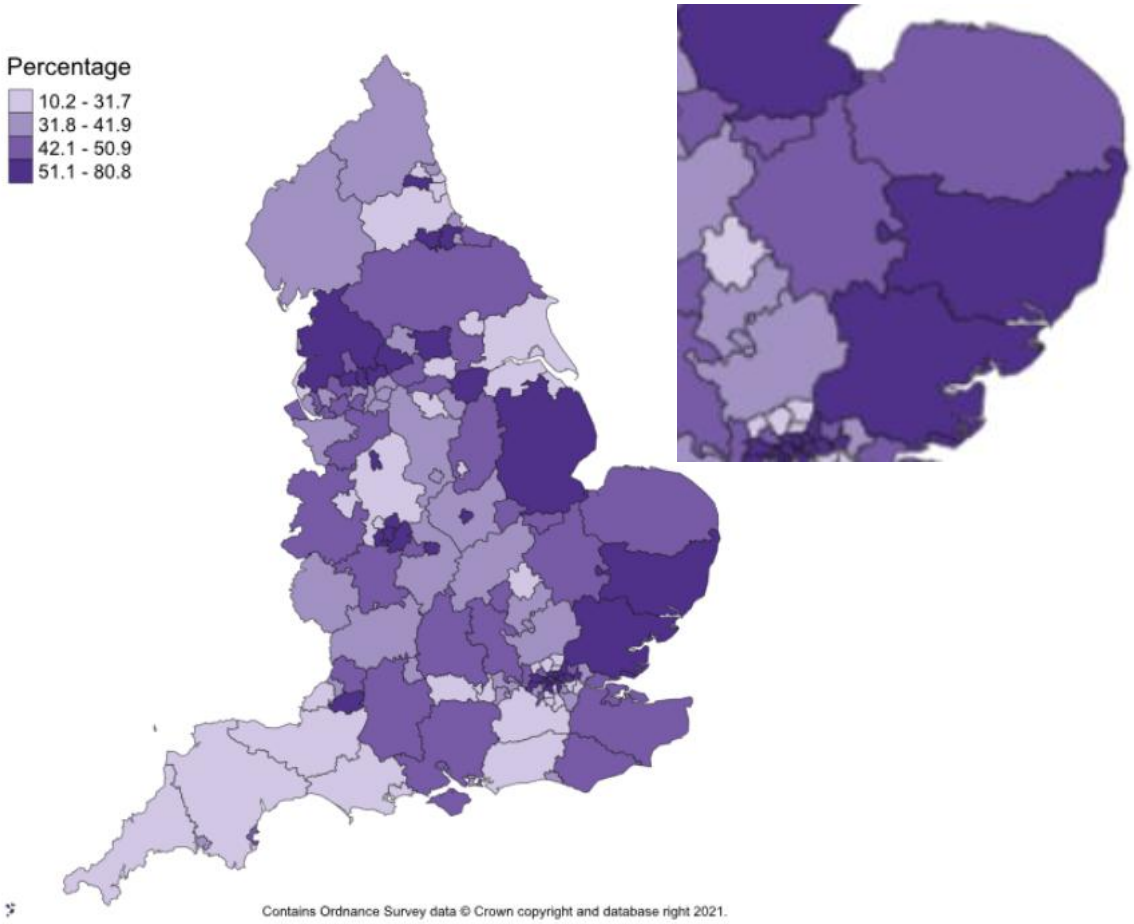


Figure 31 presents a map of England and a zoomed-in view of the East of England, divided by local authority areas to illustrate the proportion of eligible people who completed an NHS Health Check between 2015 and 2020.

Local authorities are categorised into four bands based on uptake rates, the darker the colouring the better the uptake of the programme. The map highlights significant variation in NHS Health Check uptake both nationally and within the East of England, with no clear regional patterns emerging. This stark disparity reflects differences in delivery models and the perceived value of the programme across local authority boundaries—a long-standing challenge since the programme's inception.

10.6 Programme outputs and outcomes

The NHS Health Check programme, introduced in 2009, aims to prevent cardiovascular disease (CVD) and other related conditions by identifying risk factors in adults aged 40-74. This initiative has had significant outcomes in terms of demographics and case finding of risk factors.

Demographic Reach and Participation

The NHS Health Check programme has been successful in reaching a broad demographic cross-section of the population. According to a review by the Office for Health Improvement & Disparities, the programme has assessed millions of eligible individuals, representing a diverse socio-economic and ethnic mix.[92] This inclusivity is crucial as it ensures that the benefits of early detection and prevention are accessible to all segments of society, including those at higher risk of disease.

Age and Gender Distribution

The programme targets adults aged 40-74, a critical age range for the early detection of CVD risk factors. Data indicates that older people are more likely to attend an NHS Health Check appointment than younger people, with the 60-74 age category being the most likely, and a particular low attendance rate for the 40-44 group. One study found the odds of uptake were 72% higher for those aged 65–74 years compared with those aged 40–44 years.[93] Lack of knowledge on the purpose of the NHS Health Check, time constraints or conflicting priorities were likely conclusions to this age divide. Some studies show that women patients are around 50% more likely to attend an NHS Health Check than men[94] others that women have shown only a slightly higher participation rate compared to men,[95] though there is consistently strong evidence that NHSHC uptake by males, is universally found to be lower. This gender difference in attendance could be attributed to various factors, including health-seeking behaviours and awareness levels. A reflection of the wider trend that women more often attend their GP practice compared to men; thus increasing the potential for an opportunistic NHSHC invitation.

Socio-Economic and Ethnic Representation

One of the notable achievements of the NHS Health Check programme is its reach across different socio-economic groups. Despite initial concerns that the programme might predominantly attract the 'worried well'—those who are already health-conscious and proactive about their health—the actual demographic data shows a representative mix. This includes individuals from deprived areas who are often at higher risk of CVD.[96]

[92] Office for Health Improvement & Disparities (OHID)
[93] Journal of Public Health
[94] Journal of Public Health.
[95] UK Government
[96] Department of Health and Social Care

Ethnic diversity is another critical aspect of the programme's demographic reach. The programme has successfully engaged individuals from various ethnic backgrounds, which is essential given the varying prevalence of CVD risk factors among different ethnic groups. For instance, South Asian populations have a higher risk of diabetes and heart disease, making their participation in the programme particularly beneficial. NHS Digital reports that White British are in general more likely to attend an NHSHC compared with Non-White, however examining broader ethnic groups in more detail the evidence is inconclusive with variations across different studies and settings.[97]

More people in the most deprived quintile compared with the least deprived quintile receive an NHSHC. These findings are encouraging to dispel reported concerns that the programme is not equitable or indeed cost-effective, though must be tempered with the potential bias that some programmes were proactively prioritising invitations to people in lower socioeconomic groups.[98]

Case Finding of Risk Factors

The primary goal of the NHS Health Check programme is to identify and manage risk factors for CVD and related conditions. The programme has been effective in detecting a range of modifiable risk factors among attendees.

Cardiovascular Risk Factors

The NHS Health Check includes assessments for several key risk factors, such as blood pressure, cholesterol levels, body mass index (BMI), and lifestyle factors like smoking and physical activity. The findings have been significant:

- Hypertension: A substantial number of attendees have been found to have elevated blood pressure, a major risk factor for CVD. Early detection allows for timely intervention through lifestyle changes and medication.
- Cholesterol: High cholesterol levels have been identified in many participants, leading to interventions such as dietary advice and statin prescriptions.
- Obesity: The programme has highlighted the prevalence of obesity, prompting referrals to weight management services.

Diabetes and Pre-Diabetes

The NHS Health Check also screens for diabetes and pre-diabetes. Given the rising prevalence of diabetes, early detection is crucial. The programme has identified numerous cases of undiagnosed diabetes and pre-diabetes, enabling early management and prevention of complications[2].

Lifestyle Factors

Lifestyle factors, including smoking, alcohol consumption, and physical inactivity, are also assessed during the health check. The programme has been effective in identifying individuals with unhealthy

[97] BMC Public Health volume
[98] BMJ Open

lifestyle habits and providing them with the necessary support and resources to make positive changes.

Impact on Health Outcomes

The identification of risk factors through the NHS Health Check programme has led to significant health outcomes. Early detection and intervention have the potential to reduce the incidence of CVD and other related conditions.

Reduction in Cardiovascular Events

One of the key outcomes of the programme is the reduction in cardiovascular events, such as heart attacks and strokes. By identifying and managing risk factors early, the programme helps prevent the progression of CVD. A national evaluation estimated that the programme has prevented thousands of cases of major cardiovascular incidents over its first five years.

Improved Health Behaviours

The programme has also contributed to improved health behaviours among participants. Many attendees have reported making positive lifestyle changes following their health check, such as increasing physical activity, adopting healthier diets, and quitting smoking. These behavioural changes are critical for long-term health and well-being.

10.7 Challenges

Despite its successes, the NHS Health Check programme faces several challenges. Addressing these challenges is essential for maximising the programme's impact.

Geographical Variation

Due to high heterogeneity of delivery of the NHS Health Check programme at a local authority level, uptake rates and attendance vary considerably. There is significant geographical variation in the uptake of the NHS Health Check across different regions of England. Some areas have higher participation rates than others, which can lead to disparities in health outcomes. Efforts are needed to standardise the delivery of the programme and ensure equitable access for all eligible individuals. This geographic variation is also evident at a local level with uptake by GP practices seeing significant variation. Attendance rates vary substantially between GPs in a single local authority setting.

Engagement with Non-Attendees

Engaging individuals who do not attend their health checks remains a challenge. Non-attendees may include those at higher risk who could benefit the most from early detection and intervention. Strategies to increase engagement, such as targeted outreach and personalised invitations, are crucial.

Digital Integration

The integration of digital technology into the NHS Health Check programme offers opportunities for improvement. Digital tools can enhance the efficiency of the programme, facilitate follow-up, and provide personalised health information to participants. The review by the Office for Health Improvement & Disparities recommends a move towards a more proactive, predictive, and personalised approach, leveraging digital advancements.

10.8 Cambridgeshire

Cambridgeshire NHS Health Checks 24/25 Targets

Until 2023, Public Health commissioners have applied a significantly reduced local target for practices in comparison to the total eligible population. An increased target will be brought in over the three years in March 2027 towards achieving 75% uptake.

Figure 32: national annual eligible population estimate by OHID

B - Area Name	D - Persons aged 40-74 (excluding prisoners)	E - Estimated number of persons 40-74 not-eligible	F - % not eligible	**G - Estimated Total Eligible Population for 2019-24: OHID proposal**	**Annual Estimated Total Eligible Population: OHID.**
Cambridgeshire	286,491	91,393	31.9%	**195,098**	**39,020**
Peterborough	82,833	24,796	29.9%	**58,037**	**11,607**
England	**23,729,489**	**7,625,222**	**32.1%**	**16,104,267**	**3,220,853**

Performance against national and local targets

Cambridgeshire has an ambition to move towards meeting the national target of 75% uptake as set out in the three year imporvement plan shown below.

Cambridgeshire (eligible c.39,000):

- 2023/24 = 20,000 (51%) - Baseline
- **2024/25 = 23,500 (60%)**
- 2025/26 = c.26, 500 (68%)
- 2026/27 = c.29,250 (75%)

Between Q1 2019/20 and Q4 2023/24 (the five-year health check cycle), Cambridgeshire did not meet the historical 66% NHS Health Check completion target set by Public Health England (now OHID). Instead, only 29.2% of the eligible population received a health check.
The impact of COVID-19 was a major factor in this shortfall, affecting performance at local (29.2%), regional (32.4%), and national (28.1%) levels.

Despite this, Cambridgeshire performed slightly above the national average (28.1%), ranking 63rd out of 153 local authorities. It is important to note that the GP-extracted data includes NHS Health Checks carried out by non-GP providers, such as GP Federations and Healthy You.

Figure 33: Cambridgeshire and National NHS Health Check perfromance, OHID

Indicator	Period	Cambs			England			
		Recent Trend	Count	Value	Value	Worst	Range	Best
Percentage of NHS Health Checks offered to the total eligible population in the quarter	2023/24 Q4	↑	7,575	3.9%	5.5%	0.0%		32.5%
Percentage of NHS Health Checks received by the total eligible population in the quarter	2023/24 Q4	↑	5,712	2.9%	2.4%	0.0%		8.2%
Percentage of NHS Health Checks offered which were taken up in the quarter	2023/24 Q4	→	5,712	75%	44%	0%		214%
People invited for an NHS Health Check	2019/20 Q1 - 2023/24 Q4	–	87,568	45.2%	69.1%	4.2%		100%
People receiving an NHS Health Check	2019/20 Q1 - 2023/24 Q4	–	56,648	29.2%	28.1%	3.2%		80.4%
People taking up an NHS Health Check invite	2019/20 Q1 - 2023/24 Q4	–	56,648	64.7%	40.6%	15.8%		100.0%
People invited for an NHS Health Check per year	2023/24	↑	29,644	15.3%	22.1%	0.1%		100%
People receiving an NHS Health Check per year	2023/24	↑	20,274	10.5%	8.8%	0.1%		22.2%
People taking up an NHS Health Check invite per year	2023/24	↑	20,274	68.4%	39.9%	12.0%		145.9%

Figure 33 and 34 shows that in 2023/24, Cambridgeshire successfully provided health checks to 10.5% of the total eligible population (equivalent to 52.5% of its 20% eligible 5-year population), higher than the national average of 8.8%, suggesting an improvement in programme outcomes and/or a quicker service recovery from COVID19 than other areas. Performance against other programmes in the region was significantly above average, 4th/11, yet placing below the much larger counties of Norfolk and Essex.

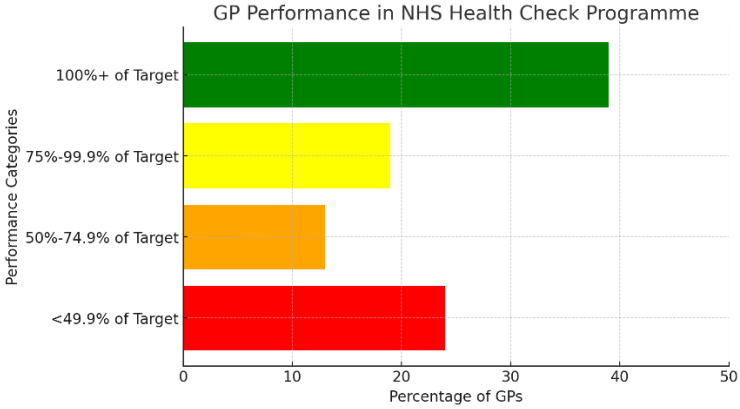
Figure 34: Regional NHS Health Check perfromance, OHID

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	↑	1,418,929	8.8	8.8	8.9
East of England region (statistical)	↑	184,185	10.1	10.0	10.1
Norfolk	↑	44,161	16.5	16.4	16.6
Thurrock	↑	4,576	11.2	10.9	11.5
Essex	↑	48,004	10.9	10.8	11.0
Cambridgeshire	↑	20,274	10.5	10.3	10.6
Luton	↑	5,779	10.0	9.8	10.2
Suffolk	↑	21,901	9.8	9.7	9.9
Peterborough	↑	4,858	8.4	8.2	8.6
Hertfordshire	↑	23,525	6.7	6.6	6.7
Southend-on-Sea	↑	3,444	6.5	6.3	6.7
Bedford	↑	3,115	5.9	5.7	6.1
Central Bedfordshire	→	4,548	5.2	5.1	5.4

Performance Targets:

The graph (Figure 35) illustrates GP performance in the NHS Health Check Programme, categorising GP practices based on their achievement against set targets. A total of 27 GP practices (39%) surpassed their target (100%+), indicated by the green bar, demonstrating strong engagement with the programme. The second-largest category, 75%-99.9% of target (yellow bar), represents 13 GPs (19%), showing moderate performance levels. Meanwhile, 9 GPs (13%) met only 50%-74.9% of their target (orange bar), suggesting areas for improvement. The lowest-performing group, GPs achieving less than 49.9% of their target, accounts for 17 practices (24%) (red bar), highlighting a significant proportion struggling to meet targets.

Figure 35: Local NHS Health Check perfromance 2023/24



This performance variation aligns with national geographical trends, as observed in previous analysis of NHS Health Check programme data. Nationally, uptake has varied across regions, often influenced by differences in delivery models and perceived value of the programme. The local disparities in GP performance mirror the broader challenges seen nationally, where some areas outperform others based on resource availability, prioritisation, and engagement strategies.

While Cambridgeshire has shown an overall better-than-average performance when compared to national figures, the presence of underperforming GP practices suggests a need for targeted interventions to bridge the gap. Encouraging lower-performing GPs to adopt best practices from higher-performing ones could be a strategic approach to improving overall uptake. Additionally, further investigation into whether these variations are due to resource constraints, patient engagement challenges, or data recording issues may help refine programme delivery for greater impact.

These disparities between the top performing and the starkly underperforming practices, are a cause for concern by creating and exasperating health inequalities between practices and populations.

10.9 Risk Management following NHS Health Checks

People can be referred onto their GP following their NHS Health Check appointment if their biometric measurements are of concern to the practitioner and/or they have a moderate or high CVD risk score (further details can be found in the NHS Health Check Best Practice Guidance). Those with a high or moderate CVD risk score may be eligible for a statin prescription. People having health checks would also benefit from tailored brief advice and access to local healthy lifestyle interventions. There is no data available that monitors the referrals from an NHS Health Check.

10.10 Summary and way forward

Cambridgeshire has performed satisfactorily in programme delivery over the past 5 years, largely mirroring the England average, if not just below, and recovering well from the global pandemic.

Compared to regional performance, similar-sized local authorities have achieved significantly better outcomes, effectively maximising patient engagement, leveraging 'teachable moments' within

appointments, and facilitating referrals to clinical assessments and behaviour change interventions. As the programme moves beyond COVID-19 recovery, maintaining the status quo may further widen this performance gap. To achieve excellence rather than mediocrity, a whole-system approach focused on incremental improvements across multiple areas is essential.

At a practice level there are significant levels of over-performance, with several practices potentially catching up on lost appointments created from the pandemic years, which is indeed significantly positive. This does not, however, offset the majority of practices that remain underperforming, in some cases unacceptably so, thus hindering the overall performance of both programmes. Targeting these poor performers is a short-term service priority.

The incomplete dataset presents a significant concern, making it difficult to assess missed opportunities and case findings due to errors and gaps. Resolving this issue should be a priority in discussions with system partners to ensure an accurate evaluation of the programme's impact and to establish clear priorities and actions for improvement.

In the first analysis of the England data extracted from the first 9 million patient medical records it was demonstrated that among the 5.1 million who attended their NHS HC, physical activity was measured in 64.5% and alcohol measured in 38.3% of patients. In Cambridgeshire 2023/24 patient completion records for NHS Health Checks, the highest proportion of missing data/data not recorded is observed in records for alcohol consumption and physical activity assessments (and CVD risk score). Whilst physical activity and alcohol scores does not contribute to the QRISK score, AUDIT and QRISK are listed in Regulation 4(8) of The Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2013 as a necessary risk factors for communication back to the patient. Factors that could influence this includes: the absence of a coding option in the patient records for refusal to participate in an assessment; time restrictions of asking the questions; lack of understanding in using the correct tool (particularly for alcohol consumption) and sensitivity/intrusiveness of the questions. Interviews and/or survey completions with/by practitioners may help to understand the reasons behind the absence of data for these assessments and others.

Cambridgeshire is well-positioned to accelerate progress in delivering NHS Health Checks, supported by a range of evidence-based healthy lifestyle interventions for diabetes, weight management, alcohol reduction, smoking cessation, and physical activity. With well-established Primary Care Networks (PCNs) and Integrated Neighbourhoods, this presents an opportunity to explore alternative delivery models. Underperforming or resource-limited GP practices could collaborate with neighbourhood hub providers, such as Everyone Health, or operate through PCN-led initiatives funded via ARRS, while still benefiting from QOF and PCN DES/LES incentives.

Additionally, partnerships with Integrated Care Boards (ICBs) through shared Section 76 contracts offer a valuable mechanism for enhancing programme delivery. This approach would enable the NHS Health Check programme to contribute more effectively to Integrated Care System (ICS) priorities, including CVD prevention (AF, BP, cholesterol) and Type 2 diabetes prevention, aligning with the NHS CVDPrevent framework.

10.11 Key Programme Priorities and Recommendations

Target Underperforming Practices

Provide tailored support to the lowest-performing GP practices through additional training, incentives, and shared delivery models with PCNs or Healthy You. Addressing the stark variability in performance between practices will reduce health inequalities and improve programme outcomes.

Expand accessibility for vulnerable populations

Deploy self-service health kiosks, mobile units, workplace-based checks, and community settings (e.g., leisure centers, libraries) to engage socio-economically deprived groups, ethnic minorities, and individuals with disabilities. Bringing health checks to underserved communities addresses structural barriers and ensures equitable access.

Promote Digital NHS Health Checks

Actively promote the digital health check option, emphasising its flexibility and ability to reduce pressure on GP surgeries, while offering hybrid models for those preferring in-person support. Digital options can reach reluctant or hard-to-engage groups, increasing participation and reducing service variability.

Tailor messaging to improve engagement

Develop culturally sensitive, gender-specific, and age-appropriate campaigns to target groups with lower participation rates, such as men, younger adults, and ethnic minorities. Tailored messaging increases awareness, reduces barriers, and drives engagement among underrepresented groups.

Enhance opportunistic Health Checks

Integrate health checks into routine healthcare interactions, such as flu clinics or smoking cessation appointments, and use behavioral nudges like text reminders and personalized follow-ups. Utilising existing patient touchpoints and nudges will increase participation while addressing logistical barriers.

Strengthen data collection and referral pathways

Improve the recording of data on alcohol, physical activity, and CVD risk scores through clearer guidance, coding options for patient refusals, and training. Ensure robust referral pathways for high-risk patients. Accurate data supports effective programme evaluation and follow-ups, ensuring health risks are addressed and outcomes are maximized.

Build partnerships and pilot new delivery models

Collaborate with community organisations, employers, and faith groups to promote checks. Pilot shared delivery models, allowing underperforming GP practices to delegate services to neighbourhood hubs. Partnerships expand reach and trust, while shared models address capacity challenges in underperforming practices.

11. Falls Prevention

11.1 Background

A fall is defined as an unintentional event, which results in a person coming to rest inadvertently on the ground or another lower level but is not the result of a major internal event such as a stroke.[99]

Falls are a significant public health issue due to their high incidence and impact on older adults' health and independence. Both the incidence and severity of falls and falls-related injuries increases after the age of 60 years old[100] with the highest rates of hospital admission in those aged 80 years and above.

Around one in three people over 65 years old, and half of those over 80, experience a fall at least once a year.[101] The incidence rates of falls in people living in nursing homes and patients admitted to hospitals are almost three times the rates of those living in the community. Those who fall once are two to three times more likely to fall again within the year.

The causes of falls are multifactorial, and over 400 separate risk factors have been identified. These risk factors can be classified as either intrinsic or extrinsic and may be modifiable or non-modifiable.

Major intrinsic risk factors include muscle weakness, poor balance, visual impairment, and a number of specific conditions. These include a wider range of long-term conditions such as arthritis, cognitive impairment, depression, diabetes, high alcohol consumption, incontinence, Parkinson's disease, stroke and syncope. Major extrinsic risk factors include polypharmacy (i.e., taking over four prescription medications), psychotropic medications, and environmental hazards such as inadequate lighting, poorly fitted carpets, and lack of equipment for bathing.

The risk of falling has been shown to increase as the number of risk factors increases - a fall generally results from an interaction between multiple diverse risk factors and situations.[102] For example, environmental hazards may create conditions likely to cause trips or slips for an older person who may already have multiple risk factors for fall and this risk may be aggravated by behavioural risk factors – such as the faller was hurried or moving beyond limits of stability - leading to a fall[102].

Previous history of falls is a significant predictor of future falls.

Major risk factors for fragility fractures are varied. They include low bone mineral density, previous fracture, age, female sex, previous falls, use of glucocorticoids, rheumatoid arthritis, smoking, high alcohol consumption, low BMI and visual impairment.

[99] Office for Health Improvement and Disparities. Falls: applying All our Health
[100] American Geriatrics Society
[101] World Health
[102] The Journals of Gerontology

Falls can affect a diverse range of older adults right through from the youngest-old to the oldest-old. Falls can be a sign of a new health condition (potentially temporary one) or the worsening of chronic underlying health issues such as frailty[Error! Bookmark not defined.].

11.2 Impacts of falls

Falls are a major cause of morbidity and the primary cause of injury related deaths in people aged 75+ in the UK. Approximately 10% of falls in the community result in serious injury and 5% of these are fractures. Injury rates are considerably higher in nursing homes and hospitals with 10-25% of institutional falls resulting in fracture, laceration, or the need for hospital care. Hip fractures are among the most severe fall-related injuries, with approximately 10% of individuals dying within a month of the fracture and around one-third within a year. Up to 90% of older patients who fracture their hip do not return to their previous level of mobility or independence.[103] Falls are a significant factor in people having to move from their own homes into high-cost long term residential care.

Falls have a large impact on quality of life as well as physical health. This can include distress, chronic pain, loss of confidence, activity avoidance, loss of independence, social isolation and increasing frailty.

The impact of falls on healthcare costs is significant. Approximately, 255,000 falls-related emergency hospital admissions occur in people aged 65 and older every year in England and these are estimated to cost the NHS £2.3 billion a year. Fragility fractures are estimated to cost the UK £4.4bn; £2bn of this can be attributed to hip fractures and £1.1bn to social care.[104]

11.3 The picture in Cambridgeshire

Demography

According to the latest Census 2021, the resident population aged 65+ in Cambridgeshire in 2021 was 126,585 (Table 8). Between 2011 and 2021, the number of people aged 65+ in Cambridgeshire increased by 26.3% (26,356 people).[105] This is notably higher than the 9.3% growth in the overall Cambridgeshire population (all-age) since 2011[106]. Of the five districts in Cambridgeshire, Huntingdonshire showed the greatest increase in the population of 65+ (33.8%), followed by South Cambridgeshire (28.7%), East Cambridgeshire (27.4%), Peterborough (23%), Fenland (21.2%), and Cambridge (13.8%).[107] Huntingdonshire is seen to have the highest population of adults aged 65+ in 2021.

Looking forward, the number of older people aged 65+ is forecast to increase significantly between 2021 and 2041, increasing by 46.6% in Cambridgeshire. The districts of East Cambridgeshire and South Cambridgeshire are expected to see the greatest increase (52.3% and 51.8% respectively).

[103] Cambridgeshire & Peterborough Insight – JSNA 2023
[104] Office for Health Improvement and Disparities. Falls: applying All our Health
[105] Cambridgeshire Insight - Cambridgeshire
[106] Cambridgeshire Insight - Peterborough
[107] Cambridgeshire & Peterborough Insight – JSNA 2023

Table 8. Cambridgeshire 65+ Population

	2011	2021	2031	2041	% change between 2021 and 2041
Cambridge	14,600	16,620	20,160	23,650	42.3
East Cambridgeshire	14,305	18,225	23,960	27,760	52.3
Fenland	19,320	23,405	29,180	33,605	43.6
Huntingdonshire	27,300	36,540	46,200	52,245	43.0
South Cambridgeshire	24,700	31,800	40,765	48,280	51.8
Cambridgeshire	100,230	126,585	160,270	185,540	46.6

Source: 2011 and 2021 data from the Census, 2031 and 2041 from Cambridgeshire County Council population forecasts[108]

In terms of 65+ population, Cambridgeshire has a higher proportion of female residents aged 65+ compared to males (Falls Prevention Equality Impact Assessment 2023). The number of both males and females peaks in the 70-74 age-band before steadily declining to the fewest number in the 90+ age-band.

96.1% of the 65+ population identifies as White, 2.4% as Asian, 0.5% as Black, 0.5% as 'other', and 0.4% as mixed or multiple ethnic groups. The main language most commonly spoken in the 65+ population in Cambridgeshire is English (Cambridgeshire: 98.08%), followed by Other European language (EU): Any other European Languages (Cambridgeshire: 0.55%). In Cambridgeshire the third most common main language spoken in 65+ is Polish (0.2%), followed by East Asian language: Mandarin, Cantonese, and other Chinese languages (0.19%), and finally, East Asian Language: Any other East Asian languages: 0.09%.

The Income Deprivation Affecting Older People Index (IDAOPI) indicates that Fenland has the highest level of relative deprivation in older adults followed by Cambridge, East Cambridgeshire, Huntingdonshire, and South Cambridgeshire (IDAOPI rank 115, 175, 226, 270 and 300 respectively out of 317 lower tier local authorities in England).[109]

The estimated prevalence of mild, moderate and severe frailty among people aged 65+ living in the UK is 35%, 12% and 3% respectively.[110] Applying the national prevalence to local population data, it is estimated that in Cambridgeshire in 2021, 44,305 older adults are experiencing mild frailty, 15,190 are experiencing moderate frailty and 3798 and experiencing severe frailty.

11.4 Incidence of falls and hip fractures

Estimated prevalence of older adults who experience a fall

The Projecting Older People Population Information (POPPI) system estimates that approximately 35,763 people aged 65+ in Cambridgeshire and 8,622 people aged 65+ in Peterborough reported at

[108] Cambridgeshire & Peterborough Insight – JSNA 2023
[109] Cambridgeshire & Peterborough Insight – JSNA 2023 – Demography – Inequality groups
[110] BMJ

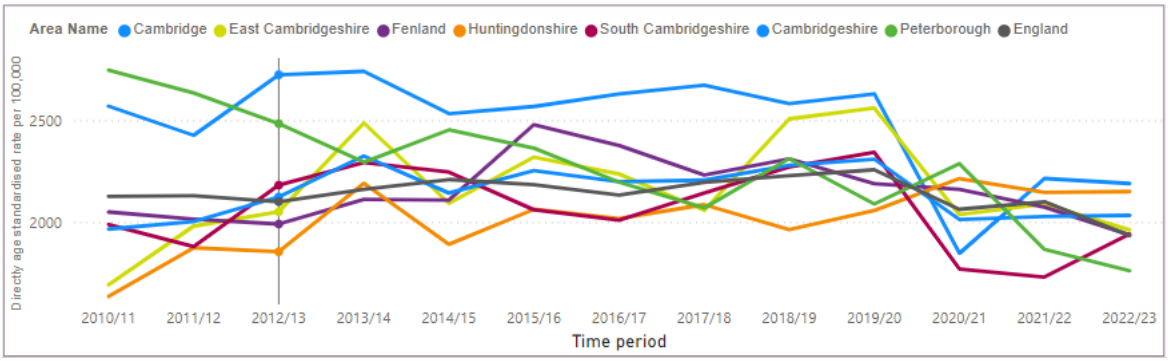
least one fall during the 12 months of 2023.[111] The POPPI forecasts that in 2040, 48,589 people aged 65+ in Cambridgeshire will report a fall in that year. The estimated falls prevalence takes account of all falls, including those that result in injury as well as those that do not result in injury.

Emergency hospital admissions due to falls

The Public Health Outcomes Framework reports on admissions for injury due to falls and hip fractures. In 2022/23, the directly age-standardised rate (DASR) of hospital admissions for injury *due to falls* in people aged 65+ years in Cambridgeshire was statistically worse than the national average (2,033 per 100,000 in Cambridgeshire compared to 1,933 per 100,000 in England.

Cambridge City and Huntingdonshire districts had statistically worse rates of admission due to falls than the national average (2,189 per 100,000 in Cambridge and 2,150 per 100,000 in Huntingdonshire compared to 1,933 per 100,000 in England). All other districts were statistically similar to the England average.

Figure 36. Emergency admissions due to falls in over 65s in Cambridgeshire and Peterborough



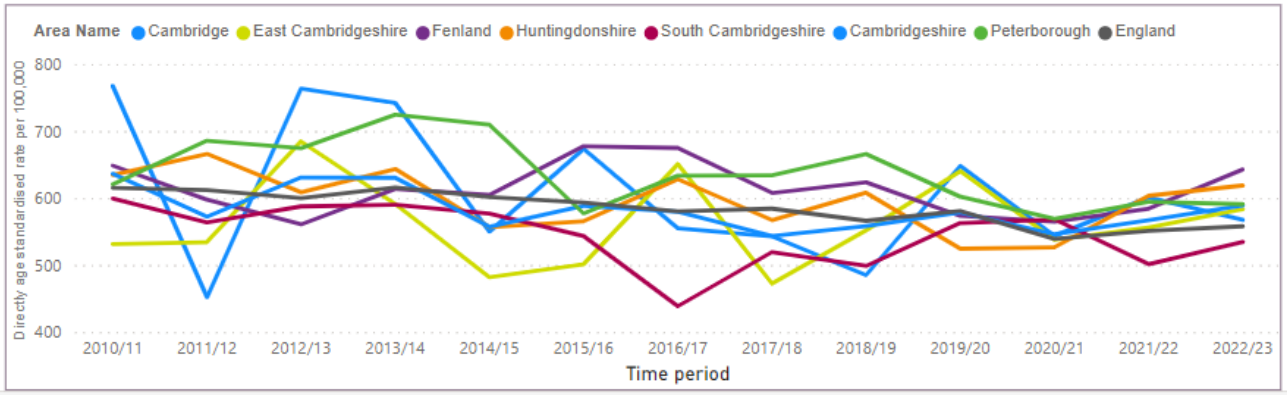
Source: Hospital Episode Statistics, NHSE - Fingertips, Office for Health Improvement and Disparities

Emergency admissions due to hip fractures

The age-standardised rate of admissions due to *hip fractures* in people aged 65+ in Cambridgeshire and Peterborough was statistically similar to the England average in 2022/23 (Cambridgeshire: 589.1 per 100,000; Peterborough: 590.9 per 100,000; England 558 per 100,000)(Figure 37). All the districts had rates statistically significantly similar to the England average.

[111] Projecting Older People Population Information System (poppi.org.uk)

Figure 37. Emergency admission due to hip fracture in 65+ in Cambridgeshire and Peterborough



Source: Hospital Episode Statistics, NHSE - Fingertips, Office for Health Improvement and Disparities

Falls and hip fractures by deprivation

The 2022/23 Public Health Outcome Framework data shows that there are health inequalities associated with admissions due to falls and hip fractures. The data shows that there is a general trend of higher rates of admissions due to falls and hip fractures in the most deprived deciles in England compared to the least deprived deciles. There are no data available to reflect this at the Cambridgeshire or Peterborough level but national level data can be used as a proxy.

11.5 Evidence base

11.5.1 Multi-factorial falls risk assessments

Effectiveness and cost-effectiveness

The latest Cochrane systematic review and meta-analysis (2018) concludes that:

- Multifactorial interventions[112] may reduce the rate of falls[113] by 23% (low-quality evidence). However, there may be little or no effect on other fall-related outcomes.
- Multiple interventions[114] probably reduce the rate of falls by 26% and risk of falls[115] by 18% (moderate-quality evidence).

The review indicates there is increasing uncertainty around the evidence of effectiveness of the multifactorial intervention. A National Falls Prevention Coordination Group (NFPCG) evidence briefing issued in 2019 advises no changes to clinical practice and strategic commissioning of services until the evidence base is fully reviewed by NICE. NICE had briefly reviewed the available evidence in 2019 as part of a review of the 'Falls in older people: assessing risk and prevention' clinical guidance

[112] Multifactorial intervention is an intervention with multiple components that aims to address the risk factors for falling that are identified in a person's multifactorial assessment. NICE guidance or multifactorial interventions where component interventions differ based on individual assessment of risk

[113] Rate of falls refers to the number of falls and is measured as the number of falls per person in time

[114] Multiple component interventions is an intervention with multiple components where the same interventions are provided to all people irrespective of risk

[115] Risk of falls is defined as the number of people with 1 or more falls

161.[116] NICE interpretation of the evolving evidence base is that 'multiple interventions' appear to be effective whereas 'multifactorial interventions' do not appear to be effective. The conclusion is that an update of the NICE guidance is warranted to indicate whether multiple interventions should be offered. The publication of the updated guideline, "Falls: assessment and prevention in older people and people aged 50 and over at higher risk", is expected on 26 March 2025, with a consultation on the draft guidance taking place between 27 September – 8 November 2024.[117]

Clinical guidelines – NICE and World Falls Prevention Guidelines

NICE clinical guidance 161 (2013) outlines the UK guidance for assessing and managing risk in older adults. The World clinical guidelines, developed by a World Falls Task Group and published in Age and Ageing in 2022, currently offers a more up-to-date and accurate understanding of current research evidence and implications for practice compared to NICE cg161.[118] These two documents form the basis for the review.

Age

NICE cg161 indicate that their recommendations apply to community dwelling older adults aged 65 years. The reason stated is that people over 65 have the highest risk of falling. For older people admitted to hospital, the recommendations apply to a broader scope of people from 50-64 years of age who are judged by a clinician to be at higher risk of falling because of an underlying condition.

In contrast, the World Guidelines state "there is no scientific rational for the application of a strict chronological definition of older age" when using their guidelines. The guidance recognises that "in some circumstances, age 60 years may be more appropriate depending on the context and health expectancies". In addition, it recognises that different intervention studies were undertaken in different age groups so inconsistency in the ages of older adults participating in the studies.

Falls Risk Stratification

NICE recommendations provides guidance as to what cohorts should be offered certain interventions in the community as follows:

1) Strength and balance interventions - older people reporting a fall or considered at risk of falling[119] should be observed for balance and gait deficits and considered for their ability to benefit from interventions to improve strength and balance.

2) Multifactorial Falls Risk Assessments (MFRA) - The guidance suggests that the following should be offered a MFRA:

    a. Older adults who present for medical attention because of a fall

    b. Older adults who report recurrent falls in the past year (2 or more falls)

[116] National Institute for Health and Care Excellence
[117] National Institute for Health and Care Excellence
[118] National Library of Medicine (US)
[119] NICE definition: Presents for medical attention with a fall, reports recurrent falls and or has abnormalities of gait or balance

c. Older adults who demonstrate abnormalities of gait and/or balance.

The World Guidelines sets out a Falls Risk Stratification approach for falls prevention and management for community older adults (Figure 38). It stratifies falls risk into three categories – Low Risk, Intermediate Risk and High Risk. The categories can be defined as follows:

- Low risk
  - Cohort: Older adults who:
    i) have no history of a fall in the past 12 months and/or a) feels unsteady when standing or walking, and b) worries about falling)[120] or
    ii) who have experienced a non-severe fall[121] but do not have a gait and balance deficit.
  - Goal: primary prevention.
  - Offer: Older adults should be offered falls prevention education and exercise for general health and falls prevention.

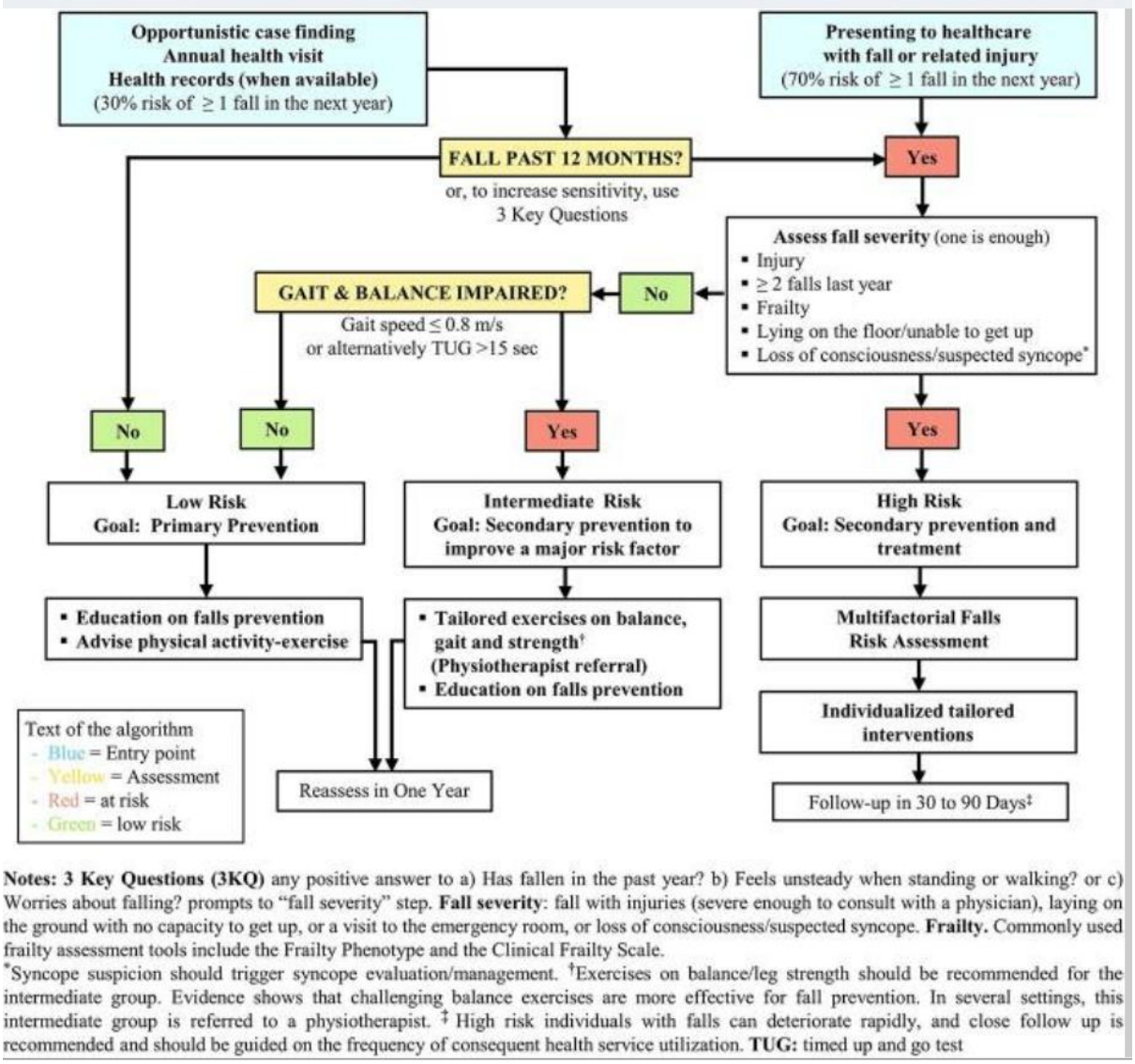
- Intermediate risk
  - Cohort: People who have had a non-severe fall in the last 12 months but they have a gait and balance impairment.
  - Goal is secondary prevention to improve a major risk factor.
  - Offer: Tailored exercises on balance, gait and strength or a physiotherapy referral in addition to falls prevention education.

- High risk
  - Cohort: People who have had a severe fall in the past 12 months.
  - Goal is secondary prevention and treatment.
  - Offer: A Multifactorial Falls Risk Assessment which will inform individualised tailored interventions.

[120] Use of the 3 Key Questions (3KQ) improves sensitivity

[121] A severe fall refers to an older adult with a falls and one or more of the following characteristics: i) A fall with injury severe enough to consult with a physician for medical treatment, ii) recurrent falls/2 or more falls in the last year, iii) Frailty, iv) Lying on the floor unable to get up independently for at least one hour, v) Transient loss of consciousness/suspected syncope.

Figure 38. World Guidelines Falls Risk Stratification approach for falls prevention



Notes: 3 Key Questions (3KQ) any positive answer to a) Has fallen in the past year? b) Feels unsteady when standing or walking? or c) Worries about falling? prompts to "fall severity" step. **Fall severity**: fall with injuries (severe enough to consult with a physician), laying on the ground with no capacity to get up, or a visit to the emergency room, or loss of consciousness/suspected syncope. **Frailty.** Commonly used frailty assessment tools include the Frailty Phenotype and the Clinical Frailty Scale.
*Syncope suspicion should trigger syncope evaluation/management. †Exercises on balance/leg strength should be recommended for the intermediate group. Evidence shows that challenging balance exercises are more effective for fall prevention. In several settings, this intermediate group is referred to a physiotherapist. ‡ High risk individuals with falls can deteriorate rapidly, and close follow up is recommended and should be guided on the frequency of consequent health service utilization. **TUG:** timed up and go test

Assessment

NICE guidance

The guidance suggests that the MFFRA may include the following:

- Identification of falls history
- Gait, balance and mobility, and muscle weakness
- Visual impairment
- Cognitive impairment and neurological impairment
- Urinary incontinence
- Cardiovascular review
- Medication review
- Home hazards
- Perceived functional ability and fear relating to falling
- Osteoporosis risk

World Guidelines

The World Guidelines provide a list of potential risk factors to cover in the MFFRA alongside recommended instruments and assessment tools to measure and assess the risk factor. This includes:

- Mobility (Balance, Gait, Muscle Strength, Walking aid, Footwear and foot problems, Fear of Falling)
- Sensory function (Dizziness/Vestibular, Vision, Hearing)
- Activities of Daily Living (Functional ability)
- Cognitive Function (Cognition, Delirium, Behaviour)
- Autonomic function (Orthostatic Hypotension, Urinary incontinence)
- Disease history (Cardiovascular disorders, Contributing diseases/atypical disease presentation, Parkinson Disease, Depressive disorders)
- Medication History (Medication)
- Nutrition history (Nutritional status, Vitamin D)
- Environmental risk (Environment).

Management and interventions

NICE

The following interventions/referrals are suggested:

- Strength and balance training – Recommended particularly for older people living in the community with a history of recurrent falls and/or balance and gait deficit
- Home hazard assessment and intervention - Older people who have received treatment in hospital following a fall should be offered a home hazard assessment and safety intervention/modifications by a suitably trained healthcare professional
- Vision assessment and referral
- Psychotropic medications - Older people on psychotropic medications should have their medication reviewed, with specialist input if appropriate, and discontinued, if possible, to reduce their risk of falling
- Cardiac pacing - Cardiac pacing should be considered for older people with cardioinhibitory carotid sinus hypersensitivity who have experienced unexplained falls
- Encouraging the participation of older adults in falls prevention programmes
    - To promote the participation of older people in falls prevention programmes the following should be considered:
        - Healthcare professionals involved in the assessment and prevention of falls should discuss what changes a person is willing to make to prevent falls
        - Information should be relevant and available in languages other than English
        - Falls prevention programmes should also address potential barriers such as low self-efficacy and fear of falling, and encourage activity change as negotiated with the participant.
- Education and information giving
    - Individuals at risk of falling, and their carers, should be offered information orally and in writing about:
        - what measures they can take to prevent further falls

- how to stay motivated if referred for falls prevention strategies that include exercise or strength and balancing components
- the preventable nature of some falls
- the physical and psychological benefits of modifying falls risk
- where they can seek further advice and assistance
- how to cope if they have a fall, including how to summon help and how to avoid a long lie.

<u>World Guidelines</u>

The following interventions/referrals are suggested:

- Mobility
  - Balance - Consider referral to physiotherapist
  - Footwear and foot problems - Consider referral to Podiatrist
  - Fear of Falling – Consider referral to specialist
- Sensory function
  - Dizziness/Vestibular - Consider referral to ENT/ORL specialist
  - Vision - Ophthalmologist or optometrist
  - Hearing - Audiologist or ENT/ORL specialist
- Activities of Daily Living (Functional ability)
  - No intervention stated
- Cognitive Function
  - Cognition – No intervention stated but further session and additional testing if required (full neuropsychological test battery)
  - Delirium - No intervention stated
  - Behaviour - No intervention stated
- Autonomic function
  - Orthostatic Hypotension - No intervention stated
  - Urinary incontinence – Referral to urologist/gynaecologist
- Disease history
  - Cardiovascular disorders – consider referral to cardiologist or syncope specialist
  - Perform a CGA
  - Contributing diseases/atypical disease presentation - Perform a CGA
  - Parkinson Disease - No intervention stated
  - Depressive disorders – Consider referral to specialist
- Medication History
  - Medication – Perform a structured medication review and consider deprescribing
- Nutrition history
  - Nutritional status – Screening
  - Vitamin D – Assess status
- Environmental risk
  - Environment - Assess the home.

11.5.2 Strength and balance exercise programmes

Effectiveness and cost-effectiveness

There is a plethora of evidence supporting the effectiveness of strength and balance exercise in reducing falls rate[122] and risk[123], as follows:

- A Cochrane systematic review and meta-analysis showed that:
  - Balance and functional exercises reduce the rate of falls by 24% and the number of people experiencing one or more falls (risk) by 13% (high-certainty evidence).[124]
  - 'Multiple types' of exercise reduce the rate of falls[125] by 34% and the number of people experiencing one or more falls by 22% (moderate-certainty evidence)[Error! Bookmark not defined.]. 'Multiple types of exercise' commonly refers to balance and functional exercises plus resistance exercises. The OTAGO exercise programme (OEP)[126,127,128] and the Falls Management Exercise (FaME) programme are classified as this type of intervention.
  - Tai Chi may reduce the rate of falls by 19% (low-certainty evidence) and reduces the number of people who experience falls by 20% (high-certainty evidence). The evidence indicates that Tai Chi (or Tai Ji Quan) is most effective in healthy, able-bodied older adults at low risk of falling. It is less effective in people at high risk of falls and older, frail people.

- OTAGO progamme (OEP) evidence:
  - In the original randomised control study in 1997, the OTAGO exercise programme (OEP) was shown to reduce the rate of falls by 32% in frailer, women aged 80+.129 There have been many RCT studies exploring the use of OEP in different cohorts and adapted for different lengths of time. Later Life Training summarises the efficacy as:
    - "OEP when delivered over one year of home exercise with 6 support and progression visits and calls reduced falls by 46% in older people with deficits of strength and balance, when delivered over 6 months with less support visits and lower risk older adults, did not reduce falls significantly".[130] The ProAct65+ study looked at lower risk older adults.
    - The evidence shows OEP is effective as a secondary prevention approach in frailer older people with poor strength and balance and at high risk of falls (defined as >3 falls in previous year). It is not effective as a primary prevention approach for people who have not fallen.[131]

[122] Rate of falls refers to the number of falls and is measured as the number of falls per person in time
[123] Risk of falls is defined as the number of people with 1 or more falls
[124] Cochrane Library.
[125] Rate of falls refers to the number of falls and is measured as the number of falls per person in time
[126] Laterlifetraining.co.uk
[127] National Council on Aging
[128] silverchair.com
[129] National Library of Medicine (US)
[130] laterlifetraining.co.uk
[131] Later Life Training

- FaME programme evidence:
    - The FaME programme has been shown in clinical studies to reduce the rate of falls by 31% in the original study (9 month intervention with high risk of falls/frequent fallers. Or a reduction in rate of 54% if taking into account the entire study including a 50-week follow-up)[132] and by 26% in FaME delivered over 6 months with lower risk older adults.[133]

    - Later Life Training summarises the efficacy of a multitude of clinical studies:

        - FaME is effective for use as a primary and secondary prevention approach to falls prevention (defined as people at low risk and high risk of falls). The FaME programme was designed as a route for progression from OTAGO increasing the level of challenge and increasing habitual physical activity. It is worth noting that not all older adults are suitable for FaME as they must be assessed and meet eligibility criteria which requires a prerequisite level of functional ability.

    - As well as reducing the rate of falls, FaME has been shown to significantly increase self-reported physical activity levels 12 months post-intervention compared to OEP and usual care (ProAct65+ multicentre randomised control study).[134, 135, 136]

    - In the real-world setting, an implementation study showed that the FaME programme reduced the falls incident ratio rate (IRR) by 24% at the end of the intervention and by 18% at 6-months follow-up. However, neither reduction achieved statistical significance, potentially due to the study being under-powered affecting the ability to detect significant differences.[137] There were statistical improvements in proxy functional measures including Balance Confidence, Fear of Falling, Functional reach, and Timed up and Go. The authors concluded that maintaining the fidelity of the programme (delivery of the evidence-based intervention in practice) is important particularly around adherence and exercise maintenance.

    - A mixed methods implementation study analysed the implementation fidelity of the FaME programme compared to clinical trials. It showed that 72-78% of programme content was delivered and 80-84% of the quality criteria were met.[138] The content most commonly missed out included the floor work, Tai Chi moves and home exercises. The quality criteria commonly missed out was explaining the purpose of exercises, asking about falls in the previous week and asking about absence of attendance.

[132] British Geriatrics Society
[133] Later Life Training
[134] Health Technology Assessment
[135] British Journal of General Practice
[136] PubMed (nih.gov)
[137] Age and Ageing | Oxford Academic
[138] ScienceDirect

- Group based or home based exercise evidence:
    - Falls Prevention exercise interventions have been found to be effective when delivered on an individual basis or in a group-based setting.
    - Home-based and group based strength and balance programmes reduce the rate of falls by 29% and 32% respectively with both demonstrating a £1:£1 financial Return on Investment (ROI) and a societal ROI of around £2.20:1.
    - Group based OEP has been shown to improve strength and balance more quickly than a home-based programme.

- Evidence-based strength and balance exercise programmes:
    - Strength and balance programmes should last at least 24 weeks in order to effectively reduce falls.[139] They should consist of one hour of structured exercise per week under the guidance of a qualified instructor and one hour of prescribed exercises to be performed at home. This reaches the "minimum dose" of 50 hours that has been demonstrated to be required for the prevention of falls. Exercises need to be highly challenging and progressive, include walking programmes as appropriate, and include follow-up visits to support progression with telephone support for motivation. In addition, motivation and support strategies need to be included for long term adherence.

- Dance for falls prevention evidence:
    - There is currently insufficient evidence on the effectiveness and cost-effectiveness of dance interventions for falls prevention (includes a lack of evidence around a dance format of PSI/OEP). Further research is required.140

    - Later Life training recommend that dance, and a dance format of PSI/OEP, can be used for:
        - the primary prevention of falls to help older people maintain an active lifestyle (actives and those in transition)

        - and as an exit route from OTAGO and FaME who have been prepared to dance safely.

        - But it should not be recommended as an alternative to a structured and evidence-based strength and balance programme (OTAGO and FaME).[141,142]

- Parkinson's Disease and strength and balance exercise
    - NICE NG71 Parkinson's disease in adults: diagnosis and management advises healthcare professionals to refer individuals diagnosed with early-stage Parkinson's disease to an experienced physiotherapist for assessment, education, and advice,

[139] NSW Public Health Bulletin
[140] Manchester.ac.uk
[141] Later Life Training Ltd
[142] Later Life Training Ltd - Statement

specifically regarding physical activity.[143] Individuals facing balance or motor function issues due to Parkinson's disease should be provided with specialised physiotherapy tailored to their condition.

- World guidelines for falls prevention and management for older adults: a global initiative advises that older adults in the early to mid-stage of Parkinson's disease (PD) and with mild or no cognitive impairment should receive personalized exercise plans, incorporating both balance and resistance training exercises[118]. Individuals in the advanced stages of Parkinson's disease (PD) may benefit from exercise training that targets balance and strength, especially when supervised by a physiotherapist or a qualified professional. Water-based exercise, home-based programs, dual-task training, Tai Chi, aerobic exercise, dance, and virtual rehabilitation training all show associations with improved balance among individuals with Parkinson's disease.

- A 2022 Cochrane review showed that exercise (across all types) probably reduces the rate of falls by 26% and the number of people experiencing one or more falls by 10% in people with mild to moderate Parkinson's disease (moderate certainty evidence).[144] This is supported by a more recent systematic review showing that balance and combined exercise programmes significantly reduce the risk of falls in frail individuals and those with neurodegenerative diseases such as Parkinson's disease, dementia and stroke survivors.[145] In another, physical exercise, including moderate to heavy activity, was shown to be effective in improving motion, reducing Parkinson's disease (PD) risk, slowing disease progression, improving cognitive symptoms, preventing falls, and alleviating non-motor symptoms, highlighting benefits over drugs. Treadmill-based training and Taijiquan show promise in reducing falls and improving movement.[146] Tai Chi was noted in another recent systematic review and meta-analysis to have benefits in terms of reduction in falls for people with Parkinson's disease.[147] A 2024 Cochrane review looking at Physical exercise for people with Parkinson's disease showed that various forms of physical activity were beneficial for improving movement and quality of life although it suggested the type of physical activity might be less important.[148]

- The efficacy of OTAGO and FaME to reduce falls rate and risk in Parkinson's Disease is uncertain given the scarcity of studies in this area.

- Exercise proven to strengthen muscles, balance and bone health. A Public Health England review showed that certain physical activities maintain and improve muscle strength, bone

[143] National Institute of Health and Care
[144] Cochrane Library
[145] Frontiers Media S.A
[146] Wiley Online Library
[147] ScienceDirect.com
[148] Cochrane

health and balance.[149] This includes: Tai chi, Yoga, Dance, Nordic Walking, Resistance training, Circuit training, Ball games and Racquet sports (including walking sports), running and cycling.

Clinical guidelines - NICE

NICE plan to review their recommendation on strength and balance training to prevent falls in the new clinical guidance expected in 2025. This is based on the evidence suggesting a range of exercise may be effective at preventing falls. It also recognises the importance of the need to be active and meet recommended levels of physical activity at all ages to reduce the risk of falls.

11.6 Population-based interventions for falls prevention

A recent Cochrane review showed there is a lack of available evidence of effectiveness of population-based intervention[150] for falls prevention in those 65+.[151] The authors conclude that further research is required due to the few studies and the very low quality of the evidence available. The population-based intervention studies tended to be implemented as part of multicomponent interventions. The components of multicomponent interventions were exercise, initiatives to reduce fall hazards in the community (improving pavements and street lighting) or people's homes (adding grab rails or non-slip mats), and education (staff and public) and community-wide policies for vitamin D supplementation for older people.

11.7 Insight from older adults and instructors

Recent qualitative studies have explored older adults' experiences with the FaME programme and Otago Exercise Programme (OEP), identifying key facilitators and barriers to participation and adherence. These insights inform the commissioning of future strength and balance programmes.

Communication of Benefits & Tailored Exercises

Clear communication of health benefits enhances uptake and retention. Participants reported improvements in mobility, strength, balance, flexibility, energy levels, and overall well-being. [152,153] FaME participants also noted increased social interaction, reduced isolation, improved self-confidence, and a sense of purpose.

A primary motivator for engagement is the desire to maintain independence. Personalised adaptations, including home exercises, are crucial; lack of tailoring can lead to disengagement, frustration, and attrition.

Enjoyment & Social Opportunities

Enjoyment sustains participation, particularly in group settings. Most FaME participants found the exercises enjoyable, whereas OEP participants were more variable (Lafond et al., 2019). Social

[149] Public Health England
[150] Cochrane
[151] Cochrane Library
[152] Oxford University Press
[153] Cambridge University Press

interactions, shared experiences, and a sense of belonging were key facilitators. Studies indicate post-class social opportunities further enhance uptake.

Home exercises face challenges such as lack of self-discipline and boredom. Regular self-monitoring, feedback, and appropriately tailored exercises help maintain motivation. FaME participants valued peer comparison and reassurance in group settings.

Programme Options to Suit Preferences

Older adults prefer either group-based (FaME) or home-based (OEP) programmes based on personal needs. Some value flexibility, while others find scheduled sessions and instructor-led motivation more effective. Carers may struggle to attend group sessions, highlighting a need for alternative formats, such as home-based programmes.

Follow-Up Classes

Participants expressed disappointment when FaME ended without follow-up classes, indicating the need for continued structured support.

Instructor Role, Class Structure & Safety

Instructors play a crucial role in fostering a positive and motivational environment, enhancing uptake and adherence. Effective instructors are friendly, approachable, enthusiastic, and knowledgeable in adapting exercises to individual abilities. Delivering mixed-ability classes poses challenges in adapting exercises and monitoring participants. Studies suggest a second instructor improves safety, participant confidence, and programme fidelity. [154;155;156]

Cost

Affordability is a key factor, though participants were generally willing to pay more for quality classes.

Venue Accessibility & Facilities

Location, transport availability, and parking influence attendance. Barriers include limited public transport, lack of car-sharing options, noise levels in shared spaces, and uncomfortable venue temperatures.

Health-Related Barriers

Tiredness, pain, and fear of aggravating conditions deter participation. Awareness of age-related fitness decline can reduce confidence, leading to withdrawal (Gumber et al.). [157] Tailored exercise progression is essential to prevent discomfort and improve adherence.

11.8 Issues and Gaps in Falls Prevention (Cambridgeshire & Peterborough)

The following issues and gaps have been identified by stakeholders and the falls prevention strategy:

[154] The Gerontologist
[155] Human Kinetics
[156] National Library of Medicine (US)
[157] Physiotherapy Theory and Practice

Access to Multi-Factorial Falls Risk Assessments (MFFRAs) for Under-65s

Individuals under 65 with falls history are generally ineligible for face-to-face MFFRAs due to age-based criteria aligned with NICE CG161. Exceptions are made on clinical judgement, but this creates inequity of access—potentially exacerbating health inequalities in areas of deprivation, where falls occur earlier due to poorer health.

Limited Access to Evidence-Based Strength & Balance Programmes

Step-down gap: Frailer older adults exiting CPFT rehabilitation who do not meet FaME eligibility must access fee-based community classes, which lack structured, evidence-based strength and balance training.

Step-up gap: Individuals self-referring or referred by other professionals who cannot meet FaME's functional requirements have limited alternative options.

Fidelity to the FaME Programme

Independent quality audits highlight areas for improvement in any future commissioning:

- Structured session planning: Weekly plans should ensure tailored exercises for participants, including risk assessments.
- Individualised home exercises: Tailored to participant goals and priorities.
- Timely documentation: Assessments should be recorded in IT systems within 24-48 hours to meet Information Governance standards.

11.9 Opportunities for Improvement & Recommendations

Improve Access and Reduce Inequity

Remove the age-based eligibility criteria (currently 65+) for MFFRAs and FaME, basing access on need instead. Consider adopting 60+ eligibility in line with World Falls Prevention Guidelines.

Introduce falls prevention education for lower-risk individuals instead of full MFFRAs, following NICE CG161 guidance on:

- Preventing further falls
- Staying motivated for strength & balance exercises
- Coping strategies for falls prevention

Strengthen Falls Prevention Exercise Provision

Develop a free, core offer of OTAGO strength & balance exercise (group or one-to-one) for frailer older adults who cannot access FaME, ensuring inclusivity.

Enhance FaME programme delivery by:

- Improving uptake & adherence:
    - Clearly communicate physical, mental, and health benefits in marketing and at initial contact.
    - Offer a behaviour change conversation for those declining FaME.
    - Ensure social opportunities post-class to encourage retention.

- Improving quality of delivery:
    - Consider a second practitioner during FaME sessions, particularly for floor-based exercises.
    - Allocate one hour of planning time after each session for tailored exercise adjustments.
    - Introduce quality assurance KPIs in contracts to ensure adherence to best practice guidelines.

Support Long-Term Transition to Community-Based Exercise

- Ensure structured transition planning post-FaME to prevent relapse into inactivity.
- Introduce follow-up calls post-discharge to assist with ongoing participation.
- Explore funding mechanisms to subsidise initial participation in fee-based classes (e.g. first six weeks free).
- Reduce transition barriers between services by improving IT systems, performance indicators, and referral pathways.

Develop a Clear Strength and Balance Framework

- Establish a structured, accessible framework outlining safe and suitable strength & balance options for older adults across different functional levels, including:
    - Face-to-face classes
    - Digital/online resources
    - Printed/home-based programmes
- Improve signposting guidance for community providers to ensure older adults receive consistent advice.

Address Transport Barriers in Rural Areas

- Assess the impact of bus service cancellations on attrition and adherence.
- Explore alternative transport solutions for older adults attending falls prevention programmes.

12. Authors & Contributors

Principle author:

Paul Stokes, Senior Public Health Strategic & Operational Commissioner Prevention and Health Improvement, Public Health

Public Health Consultant lead:

Val Thomas, Deputy Director of Public Health.

Public Health Intelligence leads:

Helen Whyman and Sarah Dougan

Co-authors and chapter leads:

Rose Earland, Imogen Gray, Kerri Marshall, Joseph Keegan, Susie Talbot, Dr Susannah Langtree, Dr Alice Middleton, Brigitte McCormack and Helen Tunster.