Title:	Public Health Outcomes Focused Leisure Contract Report
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Introduction

The Public Health Outcomes Framework, *Healthy lives, healthy people: Improving outcomes and supporting transparency*[i], sets out a vision for public health, desired outcomes and the indicators that will help us understand how well public health is being improved and protected.

The responsibility to improve and protect health lies with us all – government, local communities and with individuals. There are many factors that influence public health over the course of a lifetime. They all need to be understood and acted upon. The integration of public health into local government creates an environment where that can happen – services can be planned and delivered in the context of the broader social determinants of health, like poverty, education, housing, employment, crime and access to leisure and greenspace.

This report will look at how the provision of leisure services, extending to parks and open spaces, in Barnet can help meet the public health needs of the local community. To do this we have used the existing Public Health Outcomes Framework (PHOF) indicators. This model is transferrable to other areas of work, such as the ongoing work to develop the parks and open spaces strategy.

Methodology

The team who developed this report comprised a Leisure Contracts Manager, a Consultant in Public Health, and a Public Health Specialist. All members of the team have extensive combined experience in leisure and health improvement.

In carrying out the review for this report, the team met with and spoke with other London boroughs who have gone through a similar process. However, what became apparent was that London Borough of Barnet is developing the Public Health Outcomes Focused Leisure Contract to a level not before seen. Other London boroughs, such as Waltham Forest, had managed to incorporate things such as healthy vending, but the entirety of the contract was not related to public health, as this one is planned to be. There was considerable interest in the approach and a positive response to the ideas.

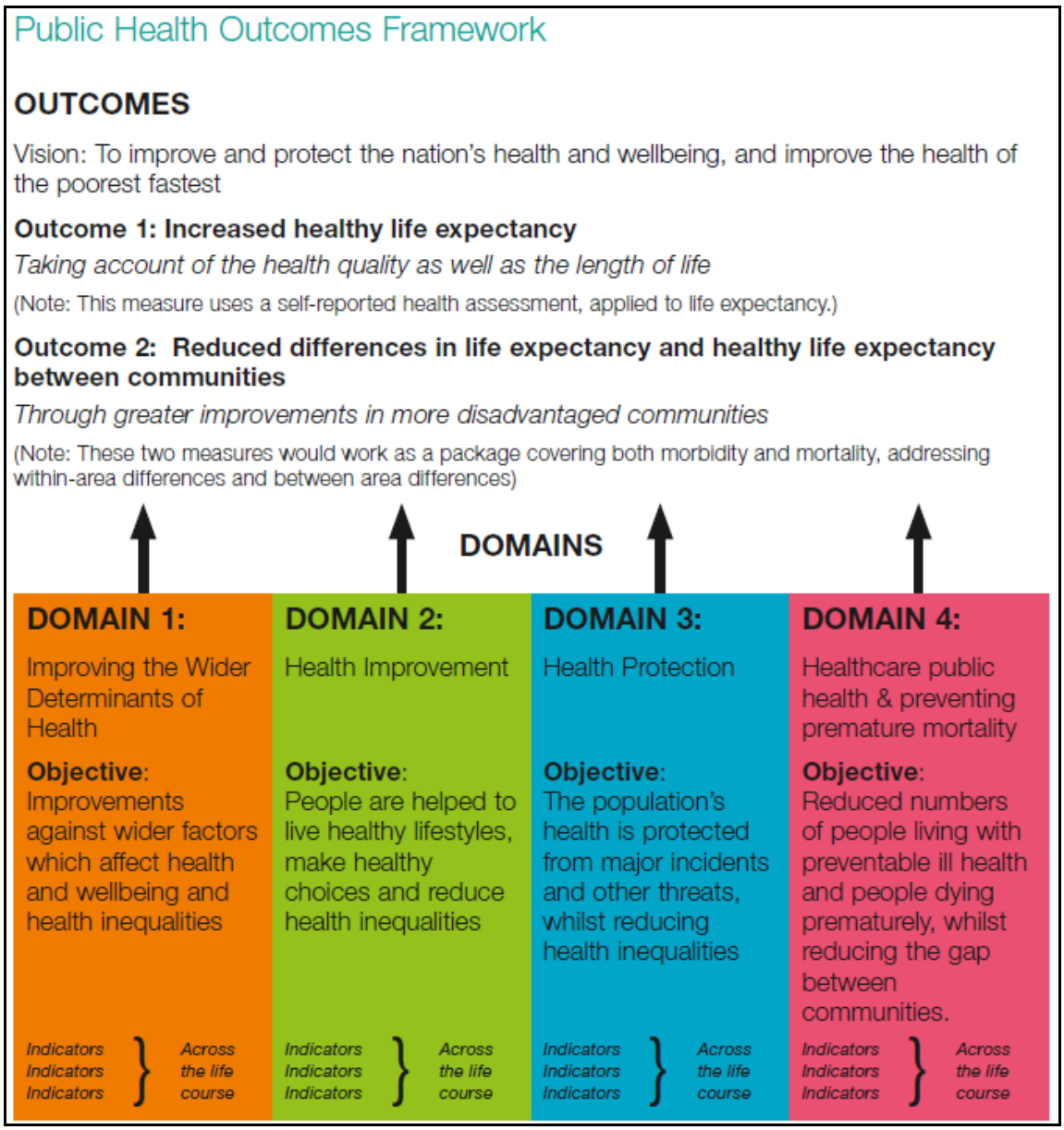
The report team met on several occasions to discuss progress and decide upon a method for making the leisure contract truly reflect health of the public in all its domains. The clearest method for achieving this was to relate the contract to the Public Health Outcomes Framework (PHOF), a set of four domains with far reaching indicators within them. It was

felt that even with the length of the contract the domains are unlikely to change even if the priorities with them do so.

The next step was to decide on how to prioritise the indicators. This was achieved by assigning each of the PHOF indicators as Core, Primary or Secondary, depending on how relevant that indicator was to the leisure contract and how much of an impact leisure could make against it. These are all colour coded in the tables in the appendices (attached separately) Particular attention should be given to Core indicators and it's recommended that these are prioritised and incorporated with additional weighting within the procurement process.

Public Health Outcomes Framework

The Public Health Outcomes Framework (PHOF) consists of two overarching outcomes that set the vision for the whole public health system of what we all want to achieve for the public's health.



The outcomes are:

- increased healthy life expectancy, which takes account of the health quality as well as the length of life;
- reduced differences in life expectancy and healthy life expectancy between communities (through greater improvements in more disadvantaged communities).

[Healthy life expectancy is used as the key headline measure to reflect our focus on morbidity as well as mortality. Life expectancy is also included in the second outcome to enable us to measure within-area inequalities as well as between-area inequalities in health (it is not feasible to collect data on within-area differences in healthy life expectancy).]

This framework is not just about extending life: it also covers the factors that contribute to healthy life expectancy, including, importantly, what happens at the start of life and how well we live across the life course. Because of this approach, achieving success against the PHOF indicators requires a holistic approach which includes a range of services working together towards a common goal. For this reason it makes sense to base the leisure contract on these over-arching principles. The leisure contract is perhaps better placed to accommodate this method given that at the core of leisure services is the requirement to offer lifestyle enhancing activities.

Many of the indicators are more pertinent to leisure than others, and as such, a leisure contract will have greater ability to tackle some indicators to a greater extent than others.

In relating the PHOF indicators, we have looked at a relevant outcome, an area for service development, and a suggested measure. In order to measure accurately we have noted what baseline data should be used, or noted that year one would need to be used for the collection of baseline data.

The attached appendices give full details on each of the indicators and the related outcomes and recommended service development areas.

Each domain has been mapped to an overall outcome to which leisure contributes, a service development and a service output which describe what the provider will undertake to contribute to that outcome. The measure will form the KPI and the baseline against will be formed in the first year of the contract, enabling a commitment to be made at the commencement to the systems and data requirements needed to achieve the baseline and on going recording. These can be seen in the appendix.

Domain 1. Wider Determinants of Health

This domain is about increasing access to the population for whom physical activity presents some challenges, either because of income, geography, disability or other barriers.

The indicators in Domain 1, Wider Determinants of Health, are in line with those recommended by Sir Michael Marmot in his report Fair Society, Healthy Lives in 2010[ii], and focus on the "causes of the causes" of health inequalities. To achieve a reduction in inequalities, Marmot created six policy objectives covering an individual's life course:

1. Give every child the best start in life
2. Enable all children, young people and adults to maximise their capabilities and have control over their lives
3. Create fair employment and good work for all

4. Ensure healthy standard of living for all
5. Create and develop healthy and sustainable places and communities
6. Strengthen the role and impact of ill-health prevention.

By looking at the leisure contract as an opportunity to support each of these objectives, it is possible to relate the PHOF indicators in a measurable way to outcomes we would want to see from a leisure service.

For example, giving every child the best start in life can be positively influenced by leisure providers creating opportunities for pregnant mothers to exercise and spaces where nursing mothers can do so in a clean and comfortable environment, as opposed to in a changing cubicle after a baby swimming lesson as can sometimes happen.

Policy objective 3 can be directly influenced by how the leisure provider looks after and values its staff, providing safe and nurturing working conditions. And policy objectives 2, 4, 5 and 6 are all clearly linked to leisure through the opportunity leisure facilities can create for life enhancing and health promoting activities. While these are important for all people within our borough, particular emphasis should be given to ensuring vulnerable groups are encouraged and supported to use leisure services. This would include, but not limited to, people with disabilities, people with mental health conditions, those living in poverty, and adults living with dementia.

For example, all-cause mortality rates among people with moderate to severe learning disabilities are three times higher than in the general population, with mortality being particularly high for young adults, women and people with Down's syndrome[iii]. Leisure facilities should provide access, both through facility design and programming, for people with learning difficulties to help reduce this inequality through their support of healthier lifestyles for all.

Both social isolation (Domain 1, indicator 1.18) and loneliness are associated with increased mortality. The provision of facilities that welcome the whole community and aim to bring people together have health and social benefits beyond those usually related to exercise. Outreach might be a key tool for a provider to engage with hard to reach communities and encourage use of leisure and other resources to promote active, avoid sedentary behaviour and increase engagement with peers and other groups. This would be an essential role of a provider to undertake.

Other considerations within the Wider Determinants domain, although not linked to the PHOF, could relate to the sustainability of facilities and services, and the environmental impact of those facilities, staff and service users. Leisure providers have a role to play in supporting green travel (also referenced with Domain 3, Health Protection, under

Environmental Sustainability), reducing waste and reducing the overall energy usage of facilities. For example, green and active travel for staff and users can be encouraged through reward programmes and through simple measures, such as the provision of secure cycle storage and well lit pathways.

We would seek to require a provider to outreach to communities for whom physical activity and sport can be a challenge to engage with, and for whom there are barriers. We would expect this to extend beyond the facility to the natural and other resources that Barnet has and for the anticipated lifetime of the contract.

Domain 2. Health Improvement

This domain is a focus on lifestyle and builds on the traditional contribution that public health has expected from a leisure provider. It is important that there is a balance between targeted support (likely to incur a cost to a provider) and universal support – which may be regarded as the direction in which leisure provision is growing at present. In relation to leisure services, this domain should also link with pathways to sport, which would include the journey from participation through to high performance sport.

The indicators in Domain 2 focus on actions to help people make healthy choices and lead healthy lifestyles. This is the domain which perhaps makes the clearest case for a link with the PHOF and the leisure contract. Core indicators include Excess weight in adults (indicator 2.12), Excess weight in 4-5 and 10-11 year olds (indicator 2.06), Falls and injuries in people aged 65 and over (indicator 2.24), and Recorded diabetes (indicator 2.17). Many leisure providers will provide specific services to target individuals suffering with ill health, and while these are generally good programmes, to really target these issues on a population level the leisure provider must have an ethos of health improvement running beyond facilities.

In linking the Health Improvement domain with the leisure contract we have tried to steer away from directing a provider towards specific programmes. Instead we have attempted to create general themes, for example, reducing the cost of certain activities to make it more attractive to parents to bring children to a facility, therein helping to tackle the obesity epidemic.

Obesity is a complex issue that is affected by a range of behavioural, psychological, social, cultural and environmental factors. Being obese increases the likelihood of the development of a range of health conditions, and the most important of these in terms of the burden on health services are type II diabetes, cardiovascular diseases and several types of cancer. However, obesity is also linked to increased risk or complication of the following conditions:

benign prostate hypertrophy, sleep apnoea, asthma, infertility and musculoskeletal problems[iv].

In simple terms, obesity is caused by an imbalance of the energy in, energy out equation; with more calories being consumed through food and drink, than expended through exercise. Therefore, as well as promoting a healthy diet, which leisure facilities can do through the provision of healthy foods, they have a pivotal role to play in supporting people to maintain energy balance through exercise.

The key findings of 'Tackling Obesities: Future Choices' [the] report released by Foresight[v]include:

- Most adults in the UK are already overweight. Modern living ensures every generation is heavier than the last – `Passive Obesity'.
- By 2050 60% of men and 50% of women could be clinically obese. Without action, obesity-related diseases will cost an extra £45.5 billion per year.
- The obesity epidemic cannot be prevented by individual action alone and demands a societal approach.
- Tackling obesity requires far greater change than anything tried so far, and at multiple levels: personal, family, community and national.

Preventing obesity is a societal challenge, similar to climate change. It requires partnership between government, science, business and civil society. The volume of people who come through leisure facilities provides a large captive audience, an audience who may often be in a mood state which is receptive to health promoting messages. That makes leisure facilities an ideal venue to promote other health messages and services, such as Stop Smoking, Alcohol Services, and Emotional Wellbeing services.

We would seek to ensure that heath and wellbeing becomes core business of the provider, our market engagement has demonstrated that this is acceptable to the market, and that the relationships between the local authority, the NHS and other providers is complementary in delivering priorities with the flexibility to respond to local needs.

Domain 3. Health Protection

Domain 3 includes a critical range of indicators focusing on those essential actions to be taken to protect the public's health. A lot of the indicators within this domain will be 'business as usual' for providers, such as water temperature and quality, standards of cleanliness within facilities, risk assessment, and COSHH. Full details of these indicators can be found in appendix 1. However, there are additions, such as on-site catering and vending,

and where the provider may have control over the environmental impact of the facilities and those who use it, including staff.

There are cross-overs between some of these domains, so environmental impacts will be discussed in this section from the perspective of air quality. Air quality is monitored by measuring particulate matter. PHE estimate the $PM^{2.5}$ causes **3,389 premature deaths** in London each year. $PM^{2.5}$ is one of three measures Particulate Matter from combustion, friction of engine components and brakes, tyres on road surfaces, and other sources like construction and agriculture. It comprises soot, part burnt diesel and petrol compounds that form benzene-based carcinogens, heavy metals, silica, bitumen, rubber and organic and other waste matter ground up on road surfaces.

Clearly, therefore, air quality is a health protection issue and one that everyone has a part to play in reducing. Effective methods of improving air quality include the promotion of cleaner transport methods and renewable energy sources. The former can be considered in terms of vehicles used by the leisure provider and, as previously mentioned, rewarding green travel for staff and users. The latter should be considered by both London Borough of Barnet and the future provider in terms of any future site developments.

Domain 4. Healthcare and Premature Mortality

Domain 4 indicators are generally led by local authorities and through health improvement actions, as defined in domain 2, the success measure is a reduction in early mortality. The majority of indicators relate to premature mortality (under 75 years) and has specific measures around diabetes, cardiovascular disease and cancers.

Although this may be seen as somewhat medical, the preventative measures that will help support a reduction in premature mortality are most likely to be community-based. These will include more specialised programmes, such as Phase IV Cardiac Rehab in the community, Stroke Rehab, Physical Activity for Cancer Survivors, and a range of other programmes dependant on the local population need. These would traditionally be added to an existing contract instead of, in our example, being integrated into the main business of the provider. This gives greater stability for programmes and a shared commitment to them.

But other indicators include Tooth Decay in Children aged 5, which can be tackled, in some part, by reducing the availability of highly sugared drinks; and, Suicide rate, which can also be tackled to some degree through the creation of community venues where people come together, therein leading to reduction in social isolation and loneliness.

Performance and Improvement

In addition to the four PHOF domains, the team have included an additional tab entitled Performance and Improvement. This covers indicators such as pricing for sports clubs, customer care, performance monitoring and performance default. These are all important for holding the provider to account on issues which relate to how they support grass-roots sport right through the high performance sport; the ability of their staff to be polite and considerate to customers; and, that sports clubs that are accredited by a National Governing Body receive reduced hire rates on facilities. it also gives the opportunity for review of the PH outcomes when this becomes appropriate.

Financial Implications

The London Borough of Barnet has proposed a new leisure contract will operate a zero subsidy with effect from 1st January 2018. It is intended that a future contract award must balance commercial risk against achieving the specified public health related outcomes.

A total of 16 core indicators have been identified which may affect a provider reaching zero subsidy from an effective contract date. In anticipation, the market may conclude a duration of up to x-years until zero subsidy can be achieved, which is something that would need lengthy discussion as part of the procurement process. However, critical to this are the council's plans for investment into the leisure portfolio.

As part of the procurement process there will need to be in-depth financial modelling to ascertain the potential economic impact of developing the contract in this manner. Public health programmes can often cost a lot when commissioned as independent services; for example, the average cost per child of a tier 2 weight management programme has been calculated at £488.

However, if such services are embedded within the contract, there would be efficiency saving, not to mention the longer term potential for income generation. While it may cost £488 while a child is part of a programme, the longer-term benefit of that child and family converting to an active lifestyle may lead in them becoming habitual users of leisure services.

Because of this uncertainty, the team behind this report have understood that there is will be a financial implication to developing the contract using this framework, but are not in a position to attribute an actual financial figure to this.

Market Engagement

The market engagement process enabled the testing out of the concept of organising the leisure contract along the line of the public health focused outcomes. It was possible to check how acceptable this might be with providers, what issues might arise and what the potential solutions.

There was an opportunity to discuss the plan to use the structure of the public health domains and explain the vision for a leisure contribution to wider outcomes.

This was received well by providers. There was a sense that health and wellbeing was increasingly part of the core business of leisure providers.

One of the key issues has been that until now many public health interventions have been planned as add on to existing contracts, therefore being an income stream, though often the programming is free to the target audience. The difference in this approach is that a wholes systems approach would be needed to be incorporated from the beginning, this would mean targeted interventions under one or more of the domains, and designed by the provider, may not continue to be free to the end user, though they may still have a subsidy, unless there was a later or subsequent agreement to fund additional contributions from the provider by another funder.

Despite this, the providers were still positive about the potential to design the contract in this way. They felt that there would be opportunities for business development, increased membership, other wellbeing services etc., and these might be offset by other activities where the benefits were not realised immediately-outreach for example.

In more general areas-vending and catering for example, the feedback from providers was mixed. Some felt that vending and catering has to be profitable and was not likely to be so with restricted choices, others felt that it was inappropriate to provide anything other than healthy choices and that the social benefits of a café or food outlet were worth the cost. This is an area where cost could be significant and vary between providers and that there would need to be compromise in determining the extent to which vending and catering is provided and on what basis. This has been reflected by the KPI pertaining to vending and catering.

The market engagement exercise highlighted the expertise and knowledge in this sector was extensive and that there were clearly providers who understood the purpose and point of the direction in which we are intending to travel, so although challenging, it was suggesting that the public health outcomes focused contract was entirely feasible.

Conclusion

The Public Health Outcomes Framework is intended to set out a vision for holistically improving population health. This concept is in harmony with the vision of council's providing leisure services; from the provision of Bath's in Roman Britain, to modern day leisure centres, the emphasis has been on mental and physical health and wellbeing, and on providing a service to be enjoyed by all people in society.

As this will be such a long-term contract, it is crucial that public health forms part of the ongoing monitoring and review process. Furthermore, it's likely that the PHOF will evolve over time. It was only in 2012 that PM2.5 was recognised as a cause of premature death and no-longer simply a probably cause. So air quality is very likely to become an indicator in the

future and the contract must be flexible enough to allow for such changes to be embedded in the practice of the leisure services provider.

This report is not intended to provide an outline of the types of programme which have typically been seen as "public health" within leisure services. Rather it is intended to outline a framework upon which the contract can be developed in order that it may reflect the holistic public health needs of this and future generations of Barnet residents.

Appendices

See separately attached spreadsheet.

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[i] The Public Health Outcomes Framework for England, 2013 2016 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216159/dh_132362.pdf

[ii] Marmot Review: http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review

[iii] Tyrer, F. and C. McGrother, Cause-specific mortality and death certificate reporting in adults with moderate to profound intellectual disabilities. Journal of Intellectual Disability Research, 2009. 53: p. 898-904.

[iv] Wang YC, McPherson K, Marsh T, Gortmaker SL, Brown M. *Health and economic burden of the projected obesity trends in the USA and the UK*, Lancet 2011; 378: 815–25

[v] Foresight, (2007) *Tackling Obesities – Future Choices*. Available from: http://www.foresight.gov.uk/