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Despite the recent move of public health commissioning functions into local authorities, this does not mean that other organisations can take a back seat on health promotion. Hospitals are increasingly seen as having a public health function and have an important part to play in health improvement, by making every health contact count. Hospital staff have many millions of patient contacts each year. Whilst in hospital, patients are likely to be thinking about their own health, meaning these contacts are a prime opportunity to talk about health promotion. Trust services and policy are particularly important to support these activities.

The 2011 National Health Promotion in Hospitals audit shows hospitals do a great deal of work to assess and provide support for patients who have lifestyle behaviours that could lead to future illness. Many hospitals have relevant policies and high-level executive support as well. However, there is still a great opportunity for hospitals to do more. We recommend that all hospitals assess risk and provide support to patients with lifestyles issues, (both in-patients and outpatients). We also suggest that hospitals work with their partner organisations such as community services and local authorities to ensure that where required, patients can be referred to specialist services as seamlessly as possible, in a way that suits the individual’s needs. We believe all Trusts should have a written health promotion strategy and a group responsible for implementing it. In addition, all trusts should evaluate their health improvement to ensure they are performing well.

We endorse this audit and hope that it inspires further developments in this area, both for the participants and hospitals across the country.

Mike Farrar
Chief Executive
NHS Confederation
Executive Summary

Introduction
Current UK health policy emphasises the responsibility of all healthcare organisations in the delivery of effective public health measures to enable the population to lead healthier lifestyles and prevent disease. Smoking, alcohol misuse and obesity are significant lifestyle risk factors causally associated with a range of serious medical problems (e.g. cardiovascular disease and various cancers), which cost the NHS billions of pounds to treat every year. The NHS Future Forum’s Summary Report – Second Phase says to “make every contact count” NHS staff should:

The audit
The National Health Promotion in Hospitals Audit aims to provide key information on the provision of health promotion and behavioural interventions within hospitals. The current audit follows on from the first national audit in 2009, which itself followed from the previous Greater Manchester Health Promotion in Hospitals audit in 2007.

Fifty-six hospitals representing 52 Trusts across England took part in this audit. Trusts ranged in size from those that provide services to populations of 150,000, to specialist hospitals that cover the whole country.

The audit consisted of:
- an organisational survey providing information on health promotion policy, pathways and resources within Trusts and
- a case note audit of 100 patients per hospital (total sample: 5407).

The case note audit looked at assessment of, evidence of and health promotion for four lifestyle factors:
- smoking;
- alcohol misuse;
- obesity; and
- physical inactivity.

The results were compared to recommended standards.

Key organisational results
- Most of the 51 Trusts have a health promotion champion on their board and a Trust co-ordinator for health promotion (n=36 and n=34 respectively). Half have a group responsible for health promotion across the Trust (n=27).
- While still in the minority, the proportions of Trusts with a written strategy for health promotion (n=22), and a specific health promotion budget (n=12) appear to have increased from the 2009 results.
- For each lifestyle factor, more than half of Trusts have health promotion and education included in all care pathways.
- Fifteen Trusts provide external behaviour change training for their staff and 21 provide access to in-house training. Included in the above figures, ten provide both external and internal training.
Key patient results

Comparisons should be considered cautiously, as the sample of Trusts differed between 2009 and 2011.

Smoking

- 84% of all patients in the 2011 audit were assessed for smoking. Compared with the 2009 audit, this is a statistically significant increase of 3%. However, both figures fall short of the 100% standard.
- One in four assessed patients (25%) was identified as a smoker, exactly the same proportion found in 2009.
- Twenty-three per cent of current smokers were given health promotion for smoking, most commonly verbal advice, compared with 20% in 2009. However, both the 2011 and 2009 results were well below the 35% standard.
- Smoking rates fell as age increased, starting from a high of 45% of patients aged 17 to 24 years down to just 4% of those aged 90 years and over.
- Only one smoker in four was recorded as having been asked if they wanted to quit (25%).
- Smokers who were asked if they wanted to quit were much more likely to receive health promotion than those who were not (65% and 10% respectively).
- Two in five smokers in a hospital setting who were asked about quitting reported that they wanted to quit (40%).

Alcohol misuse

- Overall, 71% of all patients in the 2011 audit were assessed for misuse of alcohol, most commonly using the AUDIT-C tool. Compared with the 2009 audit, this is just a statistically significant increase of 3% overall. Only one trust met the 95% assessment standard however.
- Two in five patients with evidence of misuse of alcohol were given health promotion (41%), which is less than the 50% standard.
- Assessed male patients were twice as likely as assessed female patients to be categorised as hazardous (8% versus 3%) or harmful (8% versus 3%) alcohol users.

Weight

- 52% of all patients in the 2011 audit were assessed for obesity. This is a significant increase from the 2009 audit where only 40% were assessed. The 2011 figure exceeds the 45% standard.
- Only one in seven patients with evidence of obesity was given health promotion (14%). This is significantly less than 2009 (22%). Both are less than the 45% standard.

![Figure 1. Proportion of hospitals that did or did not meet standards (by actual percentage or within confidence interval) for assessment of each risk factor (Base: 56 hospitals)](image-url)
Patients aged 50 to 59 years are the most likely age group to be classed as obese or morbidly obese (32%).

**Physical Activity**

- Thirty-one per cent of all patients in the 2011 audit had their physical activity history recorded. This is a significant fall from the 2009 audit (39%) and is now less than the 35% standard.

- Assessment rates for physical inactivity have the highest variation amongst hospitals for any factor, with rates given between 0% and 97% of all patients. Twenty hospitals met or bettered the 35% standard.

- Half of the patients with evidence of physical inactivity were given health promotion (51%). This is a significant increase on the 46% found in 2009. Both figures were above the 45% standard.
Discussion and conclusions

The audit gives a range of positive and negative findings. Compared to 2009, health promotion in hospitals is moving in the right direction, with hospitals reporting significant increases in assessments for smoking, alcohol and obesity. However, there was a fall in physical activity assessments. Standards are still not met for most risk factors.

Some organisational survey results are positive, such as increases in the proportion of Trusts that have a definitive budget for health promotion.

Having a health promotion group or a written strategy for health promotion was linked to increased assessments of smoking and alcohol use. Establishing policies for health promotion shows a firm commitment to “making every contact count.” All Trusts should have a written health promotion strategy and a group responsible for implementing it into practice, with representation from all directorates and staff workgroups.

Including health promotion in integrated care pathways has improved significantly from the previous audit. In 2009, no more than six out of 23 Trusts had health promotion and education included in all care pathways (26%). In 2011, thirty out of fifty-one Trusts did (58%). This follows the recommendations set after the 2009 audit. This could link with increases in assessment rates.

The increase in the proportion of smokers asked if they want to quit (17% in 2009 to 25% in 2011) is important, since being asked about quitting is so strongly linked to the provision of health promotion. (Most smokers asked about quitting receive health promotion, most not asked do not). Therefore, encouraging staff to ask about quitting could be a way to increase the amount of health promotion offered for smoking.

Two in five smokers in a hospital setting reported that they wanted to quit (40%). This figure contrasts with the 63% of smokers answering they wanted to quit from the Health Survey for England 2009. While the methodologies of the audit and survey are very different, the size of the discrepancy is still of interest. Investigating this could be an important research topic in future.

The smoking rate in patients aged 17 to 24 years in this audit is 45%, close to double the rate found for 16 to 24 year olds on the Health Survey for England 2010 (25%). Younger patients in hospital are much more likely to be smokers than the population at large. These younger patients may benefit from the ‘targeting’ of extra resources, which fits with the principle of ‘proportionate universalism’ outlined in the report Fair Society, Healthy Lives – The Marmot Review.

Finally, the increasing focus on “making every contact count” (MECC) means that health promotion is now seen as a vital part of healthcare provision. For many Trusts, health promotion is a contracted requirement. Some Trusts also receive financial rewards for high rates of assessments through the Commissioning for Quality and Innovation (CQUIN) payment framework. This can be a positive influence for health promotion; however resources need to be orientated towards in-patient activity as well as out-patients.
Introduction

Background

Current UK health policy emphasises the responsibility of all healthcare organisations in the delivery of effective public health measures to help the population lead healthier lifestyles and prevent disease.\(^1\) Smoking, alcohol misuse and obesity are significant lifestyle risk factors causally associated with a range of serious medical problems (e.g. cardio-vascular disease and various cancers) which cost the NHS billions of pounds every year to treat.\(^2\) The most recent statistics suggest that one fifth of UK adults smoke\(^3\), more than 25% of men and 18% of women consume more than the recommended weekly amount of alcohol\(^3\), and more than 25% of adults are classified as obese.\(^4\)

The burden of these risk factors falls most heavily upon those within the lowest socioeconomic status groups.\(^5\) Hospitals may be the first point of contact with healthcare professionals for individuals from lower socioeconomic backgrounds. This means that frontline healthcare workers are in an optimum position to promote the benefits of leading healthy lifestyles. Previous research has indicated inadequate delivery of health promotion services to hospital patients.\(^6\)

The National Health Promotion in Hospitals Audit was developed by the Stockport NHS FT clinical effectiveness unit following a pilot audit across Greater Manchester. The audit aims to provide hospitals with information on the proportion of patients assessed for smoking, alcohol misuse, obesity and physical activity. A public website providing information about the project and a secure login area for NHPHA participants to enter audit data and access their summary reports was created in 2008 (www.nhphaudit.org). The first national audit began in spring 2009 and was reported in 2010.\(^7\) A repeat audit took place in 2011, which is the basis of this report.

Standards

The agreed audit standards for 2011 were the same as those for 2009. Agreed by the audit steering group, realistic (rather than ideal) standards were set for:

- the proportion of all patients assessed for each lifestyle factor (e.g. proportion of all patients asked about smoking status) and
the proportion of patients with a risk factor given health promotion (e.g. the proportion of obese patients who were given health promotion for achieving a healthy weight). These are subject to the exclusion criteria outlined in the methodology section. Health promotion included:

- verbal advice;
- written advice; and
- referral to a specialist or service.

Standards are not given for the prevalence of risk factors, since these are affected by variables outside of the hospital’s control, such as location, patient condition and other demographics.

### Sample

All acute Trusts in England were eligible to take part in the audit. There were 5407 patients audited across 56 hospitals in England. This compares with 5300 patients audited in 2009 within 53 hospitals.

One acute Trust audited three separate hospitals and another two separately audited two hospitals, meaning 52 acute Trusts took part. A full list of participating Trusts is included in the appendix. Figure 4 below gives their locations, with red markings for the 30 Trusts who participated in both 2009 and 2011, and blue markings for the 22 Trusts participating for the first time in 2011.

### Table: Risk factor Assessments Health Promotion

<table>
<thead>
<tr>
<th>Risk factor</th>
<th>Assessments</th>
<th>Health Promotion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Smoking</td>
<td>100% of patients</td>
<td>35% of smokers</td>
</tr>
<tr>
<td>Alcohol</td>
<td>95% of patients</td>
<td>50% of hazardous and harmful drinkers</td>
</tr>
<tr>
<td>Obesity</td>
<td>45% of patients</td>
<td>45% of obese patients</td>
</tr>
<tr>
<td>Physical Activity</td>
<td>35% of patients</td>
<td>45% of physically inactive</td>
</tr>
</tbody>
</table>

Figure 3. Standards for assessment and health promotion for each risk factor

Figure 4. Locations of Trusts participating in the 2011 audit. (Map © 2011 Google)
Methodology

Case Note Audit

The case note audit for the National Health Promotion in Hospitals Audit required a random sample of 100 patients discharged between March 1st and March 31st 2011 inclusive. Where there were insufficient qualifying patients in March, the start time could be extended backward.

The patients must have been:

- admitted for at least one day;
- discharged alive from either a medical or surgical ward; and
- aged 17 years or older.

Outpatients, patients from non-surgical or medical wards (e.g. maternity or rehabilitation patients) and day cases were excluded. Patients with a terminal illness were also excluded.

Trusts were asked to randomly select 120 patients meeting the criteria, to ensure 100 case notes could be located.

Data were entered by local Trust staff onto the secure database at the NHPHA website. This data entry was required by 30 September 2011. However, due to the inclusion of the NHPH audit on the Department of Health’s list of audits for Quality Accounts in July 2011, a number of Trusts requested (and were granted) a later data entry date.

Organisational survey

In addition to the case note audit, hospitals were also required to complete an organisational survey investigating their health promotion policies, resources and training.

This marked a slight change from the previous audit where completion was not compulsory, and this variation should be noted when comparing the results.
Organisational Survey

Background
The organisational survey had three aims:

- to provide a measure of health promotion within or available to Trusts;
- to inform the interpretation of data from the case note audit; and
- to inform the development of health promotion services within Trusts.

The survey covered health promotion policy, lifestyle assessments, commissioning and training.

Response
Fifty-one Trusts responded to the organisational survey. This compares to 23 Trusts who responded in 2009. Twelve Trusts completed the organisational survey in both 2009 and 2011.

The small numbers involved means that differences between the two years should be seen as indicative rather than statistical.

In 2011, Trusts reported responsibility for up to 90 wards (Trusts may cover multiple hospital sites). Trusts were also asked what size populations they served. Two specialist hospitals answered that they served all 52 million people in England; while another answered that they served 12 million people across their region. Excluding blanks, the median population size was 420,000 people.

Results

Policy
Half of the Trusts had a mission that included health promotion (n=26). About two in three had a health promotion champion on their board (n=36) or had a Trust co-ordinator of health promotion (n=34). Half of the Trusts had a group responsible for co-ordinating health promotion (n=27). The six policy questions that were also asked in 2009 are compared in Figure 5 below.

The twelve Trusts that completed the organisational survey in both audits can be directly compared between 2009 and 2011. Of these, an extra three Trusts now have a health promotion co-ordinator, (n=7 in 2009 to n=10 in 2011), and a lifestyles strategy (n=3 in 2009 to n=6 in 2011). Two more now have health promotion included in the Trust aims and strategy (n=7 in 2009 to n=9 in 2011). Two more also now have a budget for health promotion services and materials (n=0 in 2009 to n=2 in 2011).

The findings around budget are particularly encouraging in what is a time of economic difficulty for many Trusts. Looking at all responding trusts, only one reported having a specific budget for health promotion in 2009. Twelve Trusts reported having a specific budget in 2011. This suggests that health promotion is being more deeply embedded into organisations.

Figure 5. Areas of work that include health promotion by all Trusts (Bases: 2009, 23; 2011, 51)
Care pathways

We asked Trusts whether health promotion activities are included in care pathways for patients in all, some, or no cases. Health promotion and assessments need to be normal business for staff and integrating them with existing care pathways will save time.

For each lifestyle factor, more than half of the 51 Trusts had health promotion and education included in all care pathways. Health promotion was more likely to be included in all pathways than assessments. This is concerning, as some patients may be being missed by not being assessed. However, all Trusts reported having assessments for smoking, alcohol and obesity in at least some pathways.

Out of the four risk factors, physical activity was most likely to be included in pathways (n=33 of 51 Trusts). This is surprising since physical activity is the least assessed factor in the audit. 7

Support and facilities

Approximately two in three Trusts reported having trained smoking cessation nurses (n=33 of 51 Trusts). One in five had policies in place for the prescription of nicotine replacement therapy for all nursing staff (n=11). For alcohol, 33 Trusts used a validated screening tool, most commonly AUDIT-C (n=15). 8

Almost all Trusts had weighing scales on each ward (n=45). Ten Trusts had scales that automatically calculate body mass index (BMI), and five of these Trusts had these scales on all adult wards (n=5).

Eighteen Trusts had a gym within the hospital that patients could use. Nine had health trainers within the hospital setting. For staff, fifteen Trusts provided external behaviour change training and 21 provide access to in-house training. Of these, ten provide both external and internal training.
Demographics

Sex
The patient makeup was 52.6% female and 47.4% male. This was similar to the 2009 sample (52.5% female and 47.5% male).

Age and length of stay
Figure 8 and Figure 7 give the numbers of patients by age group and length of stay respectively. The numbers and proportions between years in each age group and length of stay are similar. The mean average ages of the two audits are 62.1 years in 2009 and 61.2 years in 2011. The mean average length of stay fell significantly, from 7.9 days in 2009 to 6.6 days in 2011. As can be seen from Figure 7, the change is particularly noticeable for patients only staying one day (29% in 2011 compared to 24% in 2009). Patients are also more likely to stay for two days than in 2009, and less likely to stay for 15 to 31 days.

Figure 7. Number of patients by length of stay
Figure 8. Number of patients by age group
Results

Chart interpretation
Chart figures are shown with 95% confidence intervals for all figures except for those hospitals with a base of fewer than twenty patients, where error bars are not shown due to high uncertainty on the result.

Charts with data for all hospitals are presented sorted from highest to lowest proportion and lines mark the upper and lower quartiles. For assessment and health promotion figures, the relevant standard is included for comparison. The overall result is highlighted.

Please note also that some charts are given with the results as a proportion of all patients in the audit, (e.g. Figure 11), whilst others give results as a proportion of the relevant population, such as the rate given for health promotion for smoking as a proportion of all current smokers (e.g. Figure 13). This is to allow the reader to have an idea of the size and proportions of behavioural issues and interventions.

Limitations
As with all case note audits, the results presented here rely on accurate recording in the notes and the consistency of data abstraction between hospitals. It may be that interventions were conducted but not recorded, but only documented interventions or assessments were included. In all captions and discussions, it should be born in mind that the proportions given are the proportions where the interventions were conducted and recorded.

Fifty-two acute Trusts took part in this audit, which is only a minority of the 167 acute Trusts in England. However, it is the largest audit of health promotion in the country and the world at this time (to the knowledge of the authors).

Comparisons are given between the 2009 and 2011 audits. However, as not all Trusts completed in both years, it could be that differences between audits are due to population differences.

Data quality
All participating hospitals were required to enter ten case notes using two staff members to compare inter-rater reliability. These were entered on the NHPH website and the results were compared by kappa analysis. All hospitals achieved a satisfactory level of agreement and therefore received a summary report of their own hospital's results.

Exclusions
Only patients with a terminal illness were excluded from the analysis, though the form did include space to record if the patient was not assessed due to delirium or dementia.
Smoking

2011 results compared to 2009 results

Assessments

84% of all patients in the 2011 audit were assessed for smoking. This is a statistically significant increase of 3% from the 2009 audit results (81%).

In 2011, 18 patients were recorded as not being assessed due to delirium and 62 patients were recorded as not assessed due to dementia.

Evidence

One in four assessed patients was identified as a smoker (25%), exactly the same proportion as in 2009.

There was an increase in the proportion asked if they wanted to quit smoking, from one in six smokers (17% in 2009) to one in four (25% in 2011).

Health Promotion

Twenty-three per cent of current smokers were given health promotion for smoking compared with 20% on the 2009 audit. Because of the slightly higher rate of assessment and health promotion combined, there is a small but statistically significant increase in the overall proportion of patients given health promotion, up from 4% in 2009 to 5% in 2011.

However, both the 2011 and 2009 results are well below the standard of 35%.

2011 results by hospital

Assessments

Assessment rates for smoking varied between 52% and 100%, with only one hospital meeting the 100% standard. Seventeen of the 56 hospitals assessed smoking for 90% or more of patients (Figure 11).

Evidence

In 2011, smoking rates at hospitals ranged from two in five (39%) to just one in ten patients assessed (10%). There was no clear pattern by location (Figure 12).

Health Promotion

Ten hospitals met the 35% standard. Of these hospitals, six were from the North West and eight had a group responsible for health promotion in the Trust (Figure 13).

There was wide variation in the provision of health promotion, from a high of 63% at one Trust to zero per cent at another.

Other results

Demographics

16% of all patients were not assessed for smoking. This increased with age. 21% of those aged 80 to 89 years and 16% of those 90 years and over were not assessed.
Assessed men are more likely to be current smokers than assessed women (28% versus 21%). In addition, female patients are much more likely to answer that they have never smoked (57% versus 39% of male patients).

Smoking rates tend to fall by age, from 45% of patients aged 17 to 24 years down to 4% of those aged 90 years and over.

**Asked to quit**

While 23% of audited patients had evidence of smoking, only one smoker in four (25%) was recorded as asked if they wanted to quit. It may be the case that some patients are asked if they want to quit but it is not recorded. However, 65% of those recorded being asked about quitting were offered health promotion, whereas only 10% of those not asked received some health promotion.

**Desire to quit**

When asked if they wanted to quit, two in five smokers answered that they wanted to quit (40%).

**Types of health promotion**

One in four smokers was given some form of health promotion. The most common was verbal advice (77%), which was three times as frequent as written advice (22%). One in four received nicotine replacement therapy (26%). Half received more than one form of support, (129 of 264 patients).
Assessment rates for smoking varied between 52% and 100%, with only one hospital meeting the 100% standard. Seventeen of the 56 hospitals assessed smoking for 90% or more of patients.
In 2011, smoking rates at Trusts ranged from two in five (39%) to just one in ten patients assessed (10%). There was no clear pattern by location.
Ten hospitals met 35% standard. Of these hospitals, six were from the North West and eight had a group responsible for health promotion in the Trust.

There was wide variation in the provision of health promotion, from a high of 63% at one Trust to zero per cent at another.

Figure 13. Proportion of patients who are current or recent smokers that received health promotion by hospital
Alcohol

2011 results compared to 2009 results

Assessments

Overall, 72% of all patients in the 2011 audit were assessed for misuse of alcohol, most commonly using the AUDIT-C tool. This is a statistically significant increase of 3% from the 2009 audit (69%).

Evidence

In both 2011 and 2009, eleven per cent of assessed patients were found to have evidence of alcohol misuse.

Health Promotion

Two in five patients found to have evidence of misuse of alcohol were given health promotion (41%). This compares to 45% in the 2009, though the difference was not statistically significant.

Neither figure met the standard of 50%.

2011 results by hospital

Assessments

Assessments for alcohol use varied between 30% and 95%, and only one hospital met the 95% standard (this hospital also met the smoking assessment standard).

Evidence

Potential alcohol misuse rates varied amongst hospitals from 0% to 23%.

Health Promotion

Eighteen hospitals met the standard of 50%. Variation in receipt of health promotion was wide, varying between all and none of the relevant patients. However nearly all hospitals had small bases of less than twenty patients.

Other results

Demographics

Patients aged 40 to 49 years were most likely to be hazardous or harmful alcohol users (21%). See Figure 14 below for more details.

Health promotion

The most common type of health promotion given for alcohol is verbal advice (88% of all health promotion). Referrals to an alcohol liaison worker (40%) and an alcohol service were the next most popular (35%).

![Figure 14. Patients assessed as hazardous or harmful alcohol users by age group. (Base: all patients assessed for alcohol use, 3487)](chart.png)
Assessments for alcohol use varied between 30% and 95%, and only one hospital met the 95% standard (this hospital also met the smoking assessment standard).

Figure 15. Proportion of patients assessed for alcohol misuse by hospital
Figure 16. Proportion of patients assessed for alcohol misuse with evidence of alcohol misuse by hospital.

Potential alcohol misuse rates varied amongst Trusts from 0% to 23%.
Eighteen hospitals met the standard of 50%. Variation in receipt of health promotion was wide, however nearly all Trusts had small bases of less than twenty patients.
Weight

2011 results compared to 2009 results

Assessments

52% of all patients in the 2011 audit were assessed for obesity. This is a significant increase from the 40% assessed in the 2009 audit. The 2011 figure is now above the 45% standard.

Evidence

In 2009 and 2011, 21% of patients assessed for obesity were found to be obese (a body mass index of 30 or higher). This does not necessarily mean that 21% of patients overall are obese, as not all patients were assessed and assessment may be specifically targeted to obese or underweight patients.

Of the 21% of patients with evidence of obesity, 19% were classed as obese, and 2.5% classed as morbidly obese.

Health Promotion

One in seven patients with evidence of obesity were given health promotion (14%). This is significantly less than the corresponding 22% in the 2009 audit. Both figures fell short of the 45% standard.

2011 results by hospital

Assessments

Assessments for obesity varied between 10% and 99%. Thirty-two hospitals assessed 45% or more of their patients for obesity, the assessment standard.

Evidence

Recorded obesity rates varied from 6% to 44%, depending on the Trust.

Health Promotion

Only three hospitals met the standard of 45%. Most hospitals had small bases of less than thirty patients.

Other results

Demographics

Patients aged 50 to 59 years are most likely to be classed as obese or morbidly obese (32%). Patients aged 90 years and above or 24 years and less are the most likely to be classed as healthy weight (68% and 62% respectively).

Female patients are slightly more likely to be obese or morbidly obese (23% versus 19% of male patients).

Figure 18. Proportion of patients assessed in each weight categorisation by age group. (Base: all patients assessed for obesity, 2795)
Assessments for obesity varied between 10% and 99%. Thirty-two hospitals assessed 45% or more of their patients for obesity, the assessment standard.
Recorded obesity rates varied from 6% to 44%, depending on the hospital.
Only three hospitals met the standard of 45%. Most hospitals had small bases of less than thirty patients.
Physical Activity

2011 results compared to 2009 results

Assessments
Thirty-one per cent of all patients in the 2011 audit had their physical activity history recorded. This is a significant fall from the 39% in the 2009 audit. These figures compare with an audit standard of 35%.

Evidence
As found for other lifestyle factors, there is no change in evidence of physical inactivity. 17% of assessed patients were classed as inactive in both 2009 and 2011. This was defined as the assessment identifying the patient as requiring health promotion.

Health Promotion
Half of the patients with evidence of physical inactivity were given health promotion (51%). This is a significant increase on the 46% found in the 2009 audit. Both figures are above the 45% standard.

2011 results by hospital

Assessments
Assessments for physical activity have the highest variation, with rates given between 0% and 97%. Twenty hospitals met or bettered the 35% assessment standard.

Evidence
One Trust recorded an evidence rate of 100%; however, this was based on a sample of one patient. Otherwise, Trust rates varied between 0% and 53%.

Health Promotion
Twenty-one hospitals met the standard of 45%, however these results need to be treated with caution due to small numbers.

Twenty-six hospitals did not record health promotion for any patient.
Assessments for physical activity have the highest variation, with rates given between 0% and 97%. Twenty hospitals met or bettered the 35% assessment standard.
One Trust recorded an evidence rate of 100%, however this was based on a sample of one patient. Otherwise, Trust rates varied between 0% and 53%.

Figure 23. Proportion of patients assessed for physical inactivity with evidence of physical inactivity by hospital.
Twenty-one hospitals met the standard of 45%, however these results need to be treated with caution due to small numbers. Twenty-six hospitals did not record health promotion for any patient.

Figure 24. Proportion of patients with evidence of physical inactivity that are given health promotion by hospital
Results overall

The following charts give the 2009 and 2011 overall results (split by smoking, alcohol misuse, obesity, and physical activity) against the agreed standards.

The results are given in two forms:

- on page 35, as an absolute proportion of all patients in the audit, to give an idea of the scale of health promotion, and

- on page 36, as a relative proportion of the relevant sample, to give an idea of how many more patients could potentially benefit.

For example, the proportion given health promotion for smoking is:

- 5% in the first chart on page 35, since 5% of all patients in the audit received health promotion for smoking; and

- 23% in the first chart on page 36, which represents the proportion given health promotion of all those found to be smokers.

The 5% and 23% both refer to the 55 people in the audit who received health promotion for smoking.
Figure 25. Key results for smoking in the 2009 and 2011 audits, given as a proportion of all patients in audit (Base: 2009, 5300; 2011, 5407)

Figure 26. Key results for alcohol in the 2009 and 2011 audits, given as a proportion of all patients in audit (Base: 2009, 5300; 2011, 5407)

Figure 27. Key results for obesity in the 2009 and 2011 audits, given as a proportion of all patients in audit (Base: 2009, 5300; 2011, 5407)

Figure 28. Key results for physical inactivity in the 2009 and 2011 audits, given as a proportion of all patients in audit (Base: 2009, 5300; 2011, 5407)
Figure 29. Key results for smoking in the 2009 and 2011 audits, relative to sub-sample who were assessed and/or need health promotion.

Figure 30. Key results for alcohol in the 2009 and 2011 audits, relative to the sub-sample who were assessed and/or need health promotion.

Figure 31. Key results for obesity in the 2009 and 2011 audits, relative to the sub-sample who were assessed and/or need health promotion.

Figure 32. Key results for physical inactivity in the 2009 and 2011 audits, relative to the sub-sample who were assessed and/or need health promotion.
Discussion

The results of the 2011 National Health Promotion in Hospitals audit provide a mixture of improvements and areas still in need of improvement. In particular, the results by Trust show a wide variation in the lifestyle services offered and delivered.

Smoking

Overall

Overall, smoking assessments have increased by 3%, which is a positive and statistically significant result. However, with a standard of 100% of patients assessed, only one hospital achieved the standard. The proportion of smokers offered health promotion (23%) is not significantly different to the 2009 figure, though this is still well below the target standard of 35%.

Smoking rates

Assessed men are more likely to be current smokers than women (28% versus 21%). Also, female patients are much more likely to answer that they have never smoked (57% versus 39% of male patients).

The overall figure of 23% who are current smokers is similar to the Office of National Statistics figures for smoking in the English national adult population (20%). This is despite differences in the hospitals’ patient population and the wider population.

While the overall results are similar to the Health Survey for England 2010, younger hospitalised patients are much more likely to smoke than respondents to the national survey of the same or similar age. For example, the smoking rate in patients aged 17 to 24 years in this audit is 45%. The smoking rate of 16 to 24 year olds on the HSE 2010 is close to half that figure (25%). Forty-one per cent of patients aged 25 to 39 years were reported as smokers in the audit, compared with 28% of people aged 25 to 34 years on the national survey.

Without accurate smoking by age figures for the hospital catchment populations, this should be viewed with a degree of caution. However, this audit may be the largest assessment of hospital smoking rates available anywhere. Participating Trusts come from a wide range of locations and levels of deprivation. The results show that younger hospital patients are much more likely to be smokers than the population at large. Indeed, their smoking status may be a direct reason why they are patients or alternatively indirectly linked via deprivation levels.

The overall crude smoking rate for patients in the audit is similar to the national average and is likely to be influenced by the higher average age of hospitalised patients and the lower average rates of smoking among older people. Smoking rates in the audit tend to fall as age increases, from 45% of patients aged 17 to 24 years to just 4% of those aged 90 years and over.

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*a Some caution is needed when comparing the audit and national figures, due to the different settings and questionnaires, (e.g. in-hospital vs in-home for the Health Survey for England)
Quitting

One of the most positive results in the audit is the large increase in the proportion of smokers being asked if they want to quit (17% in 2009 to 25% in 2011).

Another key finding is a link between patients being asked if they want to quit and receiving health promotion. Approximately two in three current smokers who were asked about quitting received health promotion, regardless of their actual desire to quit. As increasing the proportion of smokers offered health promotion should be a key priority, asking more smokers about quitting may be a way to help increase this figure. This could be because talking about quitting might facilitate the provision of health promotion.

Two in five smokers in a hospital setting answered that they wanted to quit (40%). This figure contrasts with the 63% of smokers answering they wanted to quit from the Health Survey for England 2009. While the methodologies of the audit and survey are very different, the size of the discrepancy is still of interest. Investigating this could be an important research topic in future.

Healthy weight

Overall

Assessments for obesity increased significantly (40% in 2009 to 52% in 2011) and surpassed the 45% standard, suggesting that this standard should possibly be raised for future audits.

As only one in seven patients with evidence of obesity was given health promotion, hospitals need to improve health promotion for obesity as a priority. Patients aged 50 to 59 years were the most likely to be classed as obese or morbidly obese (32%) and therefore would benefit from additional support.

Physical activity

Overall

Assessments for physical activity fell from 39% in 2009 to 31% in 2011. It has the largest range of percentages by hospitals, with assessment levels varying between 0% and 97%. Twenty hospitals met or bettered the 35% assessment standard. Health promotion for physical activity showed a similar wide variation in 2009 however, the reasons for this variation are unclear. It does not appear that mobility assessments were mistaken for physical assessments in some hospitals, as the case note pro-forma asked for mobility details separately. Therefore, it does appear that there is some wide variation in assessment. The launch of the Department of Health’s UK Guidance for Physical Activity in 2011 may encourage more trusts to assess it. In addition, it may also aid with consistency of assessment.
Some results from the organisational survey have improved significantly from 2009. One that particularly stands out is health promotion in integrated care pathways. In the 2009 audit, no more than six in 23 Trusts had health promotion and education included in all care pathways (26%). In the current audit, this increases to thirty out of fifty-one (58%). Trusts should see an increase in the rates of health promotion as a result. This follows on recommendations made after the 2009 audit.

Referral to health promotion services is also much more frequently seen in all pathways on the 2011 audit. In 2009, between zero and five (21%) hospitals included referrals in all care pathways, depending on the lifestyle factor. In 2011, at least twenty-seven of fifty-one hospitals (53%) did.

Organisational policy
Organisational policies appear to make a difference to the proportion of assessments. About half of Trusts have a group responsible for health promotion or public health in the Trust (n=27) or have a written strategy for health promotion (n=22). Patients attending these Trusts are significantly more likely to be assessed for both smoking and alcohol misuse than patients in Trusts that do not, (see Figure 33).

Training
In 2011, most Trusts reported providing health promotion training to staff (36 of 51 Trusts); however, it is not always clear to what level or to what proportion of staff. The NHS Yorkshire and the Humber behaviour change framework suggests four levels of health promotion skills: the first two of these include supporting patients to access information through to undertaking brief interventions. These two levels may be appropriate for all frontline staff, with levels three and four left to specialist advisors.

Comparison with recommendations from 2009 audit report
The previous audit report, released in 2010, provided a number of recommendations to improve lifestyles health promotion in hospitals. Those that can be fully or partially answered from the 2011 audit results are given in the table on the following page, along with the relevant findings from the organisational survey.
<table>
<thead>
<tr>
<th>2010 report recommendations</th>
<th>Findings from 2011 audit</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Trusts incorporate a validated alcohol assessment tool such as AUDIT or CAGE into their ICPs for in-patient care.</td>
<td>Many Trusts use a validated alcohol tool as part of their integrated care pathway (33 of 51).</td>
</tr>
<tr>
<td>All Trusts ensure that some basic training is available to ensure healthcare professionals feel confident in using alcohol assessment tools.</td>
<td>Thirty-three out of 51 Trusts provide some form of alcohol training for staff.</td>
</tr>
<tr>
<td>All Trusts have at least one nurse per ward trained in smoking cessation techniques.</td>
<td>As some Trusts provided whole time equivalent figures (WTE) and others provided staff numbers, this could not be calculated accurately. However, only two-thirds of participating Trusts answered that they had any smoking cessation nurses (33 of 51).</td>
</tr>
<tr>
<td>All Trusts undertake the necessary measures to ensure that smoking cessation nurses can prescribe nicotine replacement therapy (NRT).</td>
<td>Twenty-seven of 51 Trusts reported having policies in place for smoking cessation nurses to prescribe NRT (53%). This compares with eight of 23 Trusts in 2009 (35%).</td>
</tr>
<tr>
<td>All Trusts ensure that their staff are aware of community weight loss and physical activity programmes</td>
<td>Thirty-three out of 51 Trusts reported providing some form of alcohol training for staff.</td>
</tr>
<tr>
<td>All Trusts establish referral processes to community weight loss and physical activity programmes for suitable patients.</td>
<td>Twenty-eight of 51 Trusts reported having a system in place for referring patients to weight loss programmes within the community. Of these, one Trust only refers patients from lower socio-economic groups, while seventeen Trusts only refer patients over a certain body mass index (BMI). Thirty-one Trusts reported having community-based physical activity programmes, compared with 17 of 23 Trusts in 2009, a slightly lower proportion. Four Trusts had physical activity programmes held jointly in the hospital and community in 2011, compared with no Trusts in 2009.</td>
</tr>
<tr>
<td>Trusts ensure that healthcare professionals are aware of the importance of ensuring verbal advice is supported by written health promotion materials given to patients (either leaflets or healthcare). All Trusts should ensure that appropriate health promotion leaflets are always available in patient areas.</td>
<td>Most Trusts reported providing leaflets giving advice on smoking, alcohol and physical activity, while about half provide leaflets on healthy weight. It is not clear from survey responses whether these leaflets were always available and how staff were advised to use them.</td>
</tr>
<tr>
<td>All Trusts ensure that a commitment to delivering health promotion to patients, staff and visitors, is explicitly incorporated into their stated aims and mission.</td>
<td>Half of the 51 Trusts reported having stated aims and mission that include health promotion. This is the same proportion as on the 2009 audit.</td>
</tr>
<tr>
<td>The strategic and operational development of health promotion should be informed by a specific group that has representatives from both the Acute and Primary Care Trusts, and other partner organisations as appropriate.</td>
<td>More than half of the 51 Trusts reported that their health promotion work was directed by a specific group (n=27). Trusts were not asked to describe the membership.</td>
</tr>
</tbody>
</table>
Conclusions and recommendations

Overall

The findings of the National Health Promotion in Hospitals audit can link in with the recent NHS Future Forum’s Summary Report – Second Phase.Released in January 2012, the report says NHS staff should:

“...maintain or improve [patients’] mental and physical health and wellbeing where possible, whatever their specialty or the purpose of the contact.”

This focus on “making every contact count” (MECC) means that health promotion is increasingly seen as a vital part of healthcare provision. For many Trusts, health promotion is a requirement of their commissioners and part of the Commissioning for Quality and Innovation (CQUIN) payment framework. Consequently, high rates of assessment of lifestyle factors may mean a financial reward for the Trust. For example, Greater Manchester’s CQUINs for 2012/3 include indicators for smoking and alcohol (assessments and referrals). However, these indicators may not be oriented towards (or even include) in-patient activity and may be restricted to specific out-patient areas.

Trusts have reported on significant improvements through the organisational survey, such as adding health promotion and referrals to all integrated care pathways. However, with the exception of a slight increase for physical activity, this has not yet translated into improved rates of health promotion. Indeed, the proportion of health promotion delivered for obesity has fallen from 22% to 14%. However, the increase in health promotion pathways may be linked to the improved proportions of smokers being asked if they want to quit.

The opportunity within CQUIN to link health promotion performance with financial incentives may give rise to further improvements.

Training

While most Trusts reported having access to health promotion training, it is not always clear to what level and to what proportion of staff. We recommend that all Trusts provide health promotion training available to all patient-facing staff up to level two in the NHS Yorkshire and the Humber skills framework. However, training alone is not enough, and Trusts need a strong local commitment to assess and measure health promotion effectively. This is to ensure that staff are correctly assessing, advising and referring patients.

Policy

A written strategy for health promotion and a health promotion strategy group were the policy aims that most linked to improved assessment, possibly because only about half of the 51 Trusts reported having them. These respectively show a firm commitment to health promotion in the Trust and so might be linked to positive future performance. All Trusts should develop a written health promotion strategy and establish a group responsible for health promotion, with representation from all directorates and staff workgroups.

Wider policy issues that may be influenced by the audit findings include targeting referrals to those most likely to benefit. For example, smoking rates are very low amongst the oldest patients. Given the age profile of hospital patients, this means, for example, that most staff time is spent on patients who are the least likely to smoke,
with smokers who are least likely to want to quit. Whilst all patients should still be assessed and supported, it might be relevant to spend more time supporting patients who are most likely to smoke and quit. This is aligned with the principle of ‘proportionate universalism’ described in the report *Fair Society, Healthy Lives – The Marmot Review*.5

### Research

The findings of this audit also suggest a number of research questions that could help the delivery of health promotion services. In particular, a further study of the quality of assessments could identify why so few smoking patients in hospital want to quit compared with what is seen for the wider public in other surveys. For example, the 40% of smokers who wanted to quit in the 2011 National Health Promotion in Hospitals audit is significantly lower than the 63% of smokers who wanted to quit found by the *Office of National Statistics’ General Lifestyles Survey 2009*.3

In addition, it is important to understand what is preventing patients who do want to quit from being referred to support services. For example, a potential research study could identify what influences how the referral is offered or described such as the hospital location, the staff training, or patient expectations.
Acknowledgements

Contributors
We would like to acknowledge the following colleagues for contributing to this audit:

Katherine Lewis for data analysis and coding;

Helen Brown for administration, participant contact and communication and analysis support; and

Dr Charlotte Haynes for designing, managing and reporting the 2009 audit, and setting up the 2011 re-audit.

The NHS Confederation has been a strong supporter of the audit, collaborating with us on the national conference in March 2012 and this is greatly appreciated.

Participating Hospitals
We would also like to thank all participants for contributing to the audit.

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Appendix

Participating acute hospitals

Please note that some organisations participated as Trusts (sampling in one or multiple sites) and others participated as individual hospitals.

<table>
<thead>
<tr>
<th>Hospital Name</th>
<th>Hospital Name</th>
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<tbody>
<tr>
<td>Airedale General Hospital</td>
<td>Royal Brompton and Harefield NHS FT</td>
</tr>
<tr>
<td>Barts &amp; The London NHS Trust</td>
<td>Royal Cornwall Hospitals NHS Trust</td>
</tr>
<tr>
<td>Basingstoke &amp; North Hampshire NHS FT</td>
<td>Royal Derby Hospital</td>
</tr>
<tr>
<td>Blackpool Victoria Hospital</td>
<td>Royal Hampshire County Hospital</td>
</tr>
<tr>
<td>City Hospital</td>
<td>Royal Lancaster Infirmary</td>
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<tr>
<td>Countess of Chester Hospital NHS FT</td>
<td>Royal Liverpool University Hospital</td>
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<tr>
<td>Darlington Memorial Hospital</td>
<td>Royal Preston Hospital</td>
</tr>
<tr>
<td>Dorset County Hospital</td>
<td>Salford Royal NHS FT</td>
</tr>
<tr>
<td>Ealing Hospital</td>
<td>Salisbury District Hospital</td>
</tr>
<tr>
<td>Frimley Park Hospital</td>
<td>South Tyneside NHS FT</td>
</tr>
<tr>
<td>Furness General Hospital</td>
<td>Southport &amp; Formby District General Hospital</td>
</tr>
<tr>
<td>Gloucestershire Royal Hospital</td>
<td>St George’s Healthcare NHS Trust</td>
</tr>
<tr>
<td>High Wycombe Hospital</td>
<td>St Helier Hospital</td>
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<tr>
<td>Ipswich Hospital</td>
<td>St James’s Hospital</td>
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<tr>
<td>King’s College Hospital</td>
<td>St Mary’s Hospital</td>
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<tr>
<td>King’s Mill Hospital</td>
<td>Stepping Hill Hospital</td>
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<tr>
<td>Kingston Hospital NHS Trust</td>
<td>Tameside General Hospital</td>
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<tr>
<td>Leighton Hospital</td>
<td>The Queen Elizabeth Hospital</td>
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<td>Liverpool Heart and Chest Hospital</td>
<td>The Rotherham NHS FT</td>
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<td>Medway Maritime Hospital</td>
<td>The Royal Free Hampstead NHS Trust</td>
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<td>University College London Hospital</td>
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<td>University Hospital of Hartlepool</td>
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<td>Westmorland General Hospital</td>
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<td>West Suffolk Hospital</td>
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<td>Royal Blackburn Hospital</td>
<td>Wirral University Teaching Hospital</td>
</tr>
<tr>
<td>Royal Bolton Hospital</td>
<td>York Teaching Hospital NHS FT</td>
</tr>
</tbody>
</table>
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