Public Document Pack

Health and Wellbeing Board

Wednesday, 19th December, 2018
at 5.30 pm

Conference Room 3 - Civic Centre

This meeting is open to the public

Members

Councillor Fielker
Councillor Murphy
Councillor Paffey
Councillor Shields
Councillor Taggart

Rob Kurn – Healthwatch
Hilary Brooks – Service Director, Children and Families Services
Carole Binns – Designated Director Adult Services
Dr J Horsley – Director of Public Health
Dr M Kelsey – Clinical Commissioning Group
Dr E Mearns – NHS England Wessex Local Area Team

Contacts
Pat Wood
Democratic Support Officer
Tel: 023 8083 2302
Email: pat.wood@southampton.gov.uk

BACKGROUND AND RELEVANT INFORMATION

Purpose of the Board

The purpose of the Southampton Health and Wellbeing Board is:

- To bring together Southampton City Council and key NHS commissioners to improve the health and wellbeing of citizens, thereby helping them live their lives to the full, and to reduce health inequalities;
- To ensure that all activity across partner organisations supports positive health outcomes for local people and keeps them safe.
- To hold partner organisations to account for the oversight of related commissioning strategies and plans.
- To have oversight of the environmental factors that impact on health, and to influence the City Council, its partners and Regulators to support a healthy environment for people who live and work in Southampton

Responsibilities

The Board is responsible for developing mechanisms to undertake the duties of the Health and Wellbeing Board, in particular

- Promoting joint commissioning and integrated delivery of services;
- Acting as the lead commissioning vehicle for designated service areas;
- Ensuring an up to date JSNA and other appropriate assessments are in place
- Ensuring the development of a Health and Wellbeing Strategy for Southampton and monitoring its delivery.
- Oversight and assessment of the effectiveness of local public involvement in health, public health and care services
- Ensuring the system for partnership working is working effectively between health and care services and systems, and the work of other partnerships which contribute to health and wellbeing outcomes for local people.
- Testing the local framework for commissioning for:
    - Health care
    - Social care
    - Public health services
    - Ensuring safety in improving health and wellbeing outcomes

Smoking policy – The Council operates a no-smoking policy in all civic buildings.

Mobile Telephones:- Please switch your mobile telephones to silent whilst in the meeting

The Southampton City Council Strategy (2016-2020) is a key document and sets out the four key outcomes that make up our vision.

- Southampton has strong and sustainable economic growth
- Children and young people get a good start in life
- People in Southampton live safe, healthy, independent livesSouthampton is an attractive modern City, where people are proud to live and work

Fire Procedure – In the event of a fire or other emergency, a continuous alarm will sound and you will be advised, by officers of the Council, of what action to take

Access – Access is available for disabled people. Please contact the Democratic Support Officer who will help to make any necessary arrangements.

Use of Social Media:- The Council supports the video or audio recording of meetings open to the public, for either live or subsequent broadcast. However, if, in the Chair's opinion, a person filming or recording a meeting or taking photographs is interrupting proceedings or causing a disturbance, under the Council's Standing Orders the person can be ordered to stop their activity, or to leave the meeting. By entering the meeting room you are consenting to being recorded and to the use of those images and recordings for broadcasting and or/training purposes. The meeting may be recorded by the press or members of the public.

Any person or organisation filming, recording or broadcasting any meeting of the Council is responsible for any claims or other liability resulting from them doing so.

Details of the Council's Guidance on the recording of meetings is available on the Council's website.

Dates of Meetings: Municipal Year 2018/19

2018	
20 June	
19 December	

CONDUCT OF MEETING

BUSINESS TO BE DISCUSSED
Only those items listed on the attached agenda may be considered at this meeting.

PROCEDURE / PUBLIC REPRESENTATIONS
At the discretion of the Chair, members of the public may address the meeting on any report included on the agenda in which they have a relevant interest. Any member of the public wishing to address the meeting should advise the Democratic Support Officer (DSO) whose contact details are on the front sheet of the agenda.

RULES OF PROCEDURE
The meeting is governed by the Executive Procedure Rules as set out in Part 4 of the Council's Constitution.

QUORUM
The minimum number of appointed Members required to be in attendance to hold the meeting is 3 who will include at least one Elected Member, a member from Health and Healthwatch.

DISCLOSURE OF INTERESTS

Members are required to disclose, in accordance with the Members' Code of Conduct, ***both*** the existence ***and*** nature of any "Disclosable Pecuniary Interest" or "Other Interest" they may have in relation to matters for consideration on this Agenda.

DISCLOSABLE PECUNIARY INTERESTS

A Member must regard himself or herself as having a Disclosable Pecuniary Interest in any matter that they or their spouse, partner, a person they are living with as husband or wife, or a person with whom they are living as if they were a civil partner in relation to:

(i) Any employment, office, trade, profession or vocation carried on for profit or gain.
(ii) Sponsorship:
Any payment or provision of any other financial benefit (other than from Southampton City Council) made or provided within the relevant period in respect of any expense incurred by you in carrying out duties as a member, or towards your election expenses. This includes any payment or financial benefit from a trade union within the meaning of the Trade Union and Labour Relations (Consolidation) Act 1992.
(iii) Any contract which is made between you / your spouse etc (or a body in which the you / your spouse etc has a beneficial interest) and Southampton City Council under which goods or services are to be provided or works are to be executed, and which has not been fully discharged.
(iv) Any beneficial interest in land which is within the area of Southampton.
(v) Any license (held alone or jointly with others) to occupy land in the area of Southampton for a month or longer.
(vi) Any tenancy where (to your knowledge) the landlord is Southampton City Council and the tenant is a body in which you / your spouse etc has a beneficial interests.
(vii) Any beneficial interest in securities of a body where that body (to your knowledge) has a place of business or land in the area of Southampton, and either:

a) the total nominal value of the securities exceeds £25,000 or one hundredth of the total issued share capital of that body, or
b) if the share capital of that body is of more than one class, the total nominal value of the shares of any one class in which you / your spouse etc has a beneficial interest that exceeds one hundredth of the total issued share capital of that class

Other Interests

A Member must regard himself or herself as having an, 'Other Interest' in any membership of, or occupation of a position of general control or management in:

Any body to which they have been appointed or nominated by Southampton City Council

Any public authority or body exercising functions of a public nature

Any body directed to charitable purposes

Any body whose principal purpose includes the influence of public opinion or policy

Principles of Decision Making

All decisions of the Council will be made in accordance with the following principles:-

- proportionality (i.e. the action must be proportionate to the desired outcome);
- due consultation and the taking of professional advice from officers;
- respect for human rights;
- a presumption in favour of openness, accountability and transparency;
- setting out what options have been considered;
- setting out reasons for the decision; and
- clarity of aims and desired outcomes.

In exercising discretion, the decision maker must:

- understand the law that regulates the decision making power and gives effect to it. The decision-maker must direct itself properly in law;
- take into account all relevant matters (those matters which the law requires the authority as a matter of legal obligation to take into account);
- leave out of account irrelevant considerations;
- act for a proper purpose, exercising its powers for the public good;
- not reach a decision which no authority acting reasonably could reach, (also known as the "rationality" or "taking leave of your senses" principle);
- comply with the rule that local government finance is to be conducted on an annual basis. Save to the extent authorised by Parliament, 'live now, pay later' and forward funding are unlawful; and
- act with procedural propriety in accordance with the rules of fairness.

AGENDA

1 APOLOGIES AND CHANGES IN MEMBERSHIP (IF ANY)

To note any changes in membership of the Board made in accordance with Council Procedure Rule 4.3.

2 STATEMENT FROM THE CHAIR

3 DISCLOSURE OF PERSONAL AND PECUNIARY INTERESTS

In accordance with the Localism Act 2011, and the Council's Code of Conduct, Members to disclose any personal or pecuniary interests in any matter included on the agenda for this meeting.

4 MINUTES OF THE PREVIOUS MEETING (INCLUDING MATTERS ARISING)

To approve and sign as a correct record the minutes of the meeting held on 20 June 2018 and to deal with any matters arising.

5 HEALTH AND WELLBEING STRATEGY ANNUAL REVIEW

Report of the Director of Public Health outlining progress against the Health and Wellbeing Strategy 2017-25.

6 DIRECTOR OF PUBLIC HEALTH ANNUAL REPORT

Report of the Director of Public Health detailing the annual report for 2017.

Tuesday, 11 December 2018 Director, Legal and Governance

This page is intentionally left blank

HEALTH AND WELLBEING BOARD

MINUTES OF THE MEETING HELD ON 20 JUNE 2018

Present: Councillors Dr Paffey, Payne, Shields, Taggart and Murphy

Rob Kurn, Hilary Brooks, Jason Horsley and Dr Mark Kelsey

Apologies: Mr H Dymond

1. **ELECTION OF CHAIR**

RESOLVED that Councillor Shields be elected as Chair for the 2018/2019 Municipal Year.

2. **ELECTION OF VICE CHAIR**

RESOLVED that Dr Kelsey be elected as Vice-Chair for the 2018/2019 Municipal Year.

3. **DISCLOSURE OF PERSONAL AND PECUNIARY INTERESTS**

Councillor Shields declared a personal interest in that he was a Council appointed representative of the Clinical Commissioning Group and remained in the meeting and took part in the consideration and determinations of items on the agenda.

Councillor Payne declared a personal interest in that he was a Council appointed representative of Solent NHS Trust and remained in the meeting and took part in the consideration and determinations of items on the agenda.

Dr Kelsey declared a personal interest in that he was a member of the Clinical Commissioning Group Governing Body and remained in the meeting and took part in the consideration and determinations of items on the agenda.

Dr Horsley declared a personal interest in that he was a member of the Clinical Commissioning Group Governing Body and a joint appointment with Portsmouth City Council and remained in the meeting and took part in the consideration and determinations of items on the agenda.

4. **MINUTES OF THE PREVIOUS MEETING (INCLUDING MATTERS ARISING)**

RESOLVED that the minutes of the meeting held on 14th March 2018 be approved and signed as a correct record.

5. **BETTER CARE YEAR END REPORT**

The Board received and noted the report of the Director of Quality and Integration detailing the Better Care Year End Report and a presentation setting out:

- the vision for Better Care in Southampton;
- the approach taken in delivering the service;
- progress to date (person centred local co-ordinated care, responsive discharge, re-ablement and building capacity);
- the impact of the service and how it is making a difference to people; and

- the Priorities and key enablers for 2018/19.

RESOLVED to note the end of year 2017/18 report for Better Care.

6. **CLEAN AIR ZONE CONSULTATION**

The Board considered the report and presentation of the Service Manager, Scientific Service detailing the Clean Air Zone Consultation due to start on 21st June, 2018.

The Board discussed the importance of the Clean Air Zone Consultation and the favourable impacts this should have on the health of the City in the future.

RESOLVED to note the proposed consultation, to be launched June 2018 (subject to Cabinet decision on 19th June, 2018).

7. **JOINT STRATEGIC NEEDS ASSESSMENT UPDATE**

The Board considered the report and a presentation of the Director of Public Health detailing an update to the Joint Strategic Needs Assessment.

RESOLVED:

(i) The Board welcomed the update and noted the changes to the JSNA and the move towards a Single Needs Assessment;

(ii) The Board noted the updated Health and Wellbeing Strategy Scorecard and agreed to direct any further questions through the Service Lead – Policy, Partnerships and Strategic Planning.

DECISION-MAKER:		**Health and Wellbeing Board**		
SUBJECT:		**Health and Wellbeing Strategy Annual Review**		
DATE OF DECISION:		**19 December 2018**		
REPORT OF:		**The Director of Public Health**		
CONTACT DETAILS				
AUTHOR:	**Name:**	**Felicity Ridgway, Service Lead-Policy, Partnerships and Strategy Planning**	**Tel:**	**02382 833310**
	E-mail:	**Felicity.Ridgway@Southampton.gov.uk**		
Director	**Name:**	**Jason Horsley, Director of Public Health**	**Tel:**	**02380 832028**
	E-mail:	**Jason.Horsley@Southampton.gov.uk**		

STATEMENT OF CONFIDENTIALITY
Non applicable.

BRIEF SUMMARY
The Southampton Health and Wellbeing Strategy 2017-2025 was developed by the Health and Wellbeing Board, and adopted by Full Council in March 2017, in agreement with Southampton Clinical Commissioning Group (CCG) Governing Body.
Health and wellbeing is important to everyone in Southampton, whether they live, work or learn in the city. The joint Health and Wellbeing Strategy for Southampton aligns with: • the City Strategy 2015-2025 with its vision to make Southampton a 'city of opportunity where everyone thrives', and priority around 'healthier and safer communities'. • the Council Strategy 2016-2020 and its outcome 'people in Southampton live safe, healthy, independent lives' • NHS Southampton City Five Year Health and Care Strategy and the Local Delivery Plan.
The strategy sets out the strategic vision for improving the health of residents and workers, and reducing health inequalities in the city. It includes the outcomes the city wants to achieve over the next eight years, and is based on evidence from the Joint Strategic Needs Assessment (JSNA), stakeholder engagement and public consultation. This paper provides an update on the progress of the strategy in the last year.

RECOMMENDATIONS:		
	(i)	That the board notes the progress against the Health and Wellbeing Strategy to date.

REASONS FOR REPORT RECOMMENDATIONS	
1.	Local Authorities and Clinical Commissioning Groups (CCGs) have equal and joint statutory duties to deliver a Health and Wellbeing Strategy that sets out how they plan to work together with local partners to meet health and care needs identified in the JSNA.

2.	The purpose for providing this briefing to the Health Overview and Scrutiny Panel is to review the outcomes of the current Health and Wellbeing Strategy annually. A review of progress at the request of the Panel in October 2017.
ALTERNATIVE OPTIONS CONSIDERED AND REJECTED	
	None
DETAIL (Including consultation carried out)	
	Background
3.	The Health and Wellbeing Strategy sets out our vision that Southampton has a culture and environment that promotes and supports health and wellbeing for all and our ambition to significantly improve health and wellbeing outcomes and reduce citywide health inequalities in Southampton by 2025. The strategy identifies four key outcomes we want to achieve, and a number of high level activities which will contribute to achieving them.
4.	We know that improvements in health outcomes can take years to achieve at a population level, and that no single action will improve health across the city. The strategy therefore includes a number of measures from the Public Health Outcomes Framework, which will be monitored over the 8 years of the strategy. **Appendix 1** provides a scorecard outlining the current position, regional, national and statistical comparators, and recent trends for each measure. This report provides an update on our overarching outcomes and progress against each of the four priority outcomes in the strategy.
	Overarching outcomes
5.	The Public Health Outcomes Framework is a comprehensive list of desired outcomes and indicators that help measure how well health and wellbeing is being improved and protected in an area. One of the Health and Wellbeing Strategy's overarching outcomes is to maximise the life expectancy of residents in Southampton. In Southampton, the life expectancy of males was 78.5 Years for the 2014-16 period. Although this continues to improve, it is still significantly lower than the England average of 79.5 years. For females, the local life expectancy was 82.8 years for the same period. This has remained fairly constant over the last 3 years and is similar to the England average of 83.1 years. In terms of healthy life expectancy in Southampton, the rate is 61.9 years for males which has recently improved from 60.9, but still below England average (63.3), and 63.1 years for females; similar to England average of 63.9.
6.	We want to prevent avoidable deaths, ensure that people are supported to stay well for longer, are able to live active, safe and independent lives and manage their own health and wellbeing. In Southampton, 22% of total deaths were considered preventable, from 2015 to 2017. In 2016 there were 1,924 deaths registered in Southampton's resident population, and of these cancer was responsible for 27.8%, coronary heart disease 12.5%, stroke 5.6% and other circulatory diseases 8.4%
	People in Southampton live active, safe and independent lives and manage their own health and wellbeing
7.	The strategy sets out our aim to encourage and promote healthier lifestyle choices and behaviours. In Southampton, there are many opportunities to be active in the community. The city hosts an annual cycle ride, the third largest park run in the country, a half marathon, free family activities in local parks and there are a number of indoor and outdoor sports facilities. However, recent trends show that inactivity has increased (Public Health Outcomes Framework): • 24.2% of adults are inactive (do less than 30 minutes per week) which is similar to the England average (22.2%).

	• 65.2% adults in Southampton do at least 150 minutes of activity per week this is similar to the England average (66.0%). • Nationally it is estimated that of 5-15 year olds only 23% boys and 20% girls met the physical activity guidelines. • Inactivity increases with age, with a greater proportion of older age groups classed as inactive compared to younger groups. To address some of the challenges and opportunities in this area, a Healthy Weight Plan and Physical Activity strategy has been developed with the Health and Wellbeing Board to enable citywide approaches to behaviour change.
8.	Smoking is the leading cause of preventable death and disease in the UK. In Southampton, smoking prevalence is higher than the England average and 2nd highest amongst neighbouring authorities. Furthermore, Southampton has a higher rate of hospital admissions for alcohol in 2016/17 than England and is amongst the highest compared to similar areas. In order to address this, we have run a number of local campaigns in support of national initiatives, such as Stoptober, and are preparing for Dry January in the new year. Both aim to raise awareness of the harmful effects of smoking and alcohol.
9.	To encourage and promote healthier lifestyle choices, a new behaviour change service was commissioned by Southampton City Council and launched in April 2017 'Southampton Healthy Living'. It is a partnership between NHS and voluntary services, with Social Care in Action as the lead provider. This service was delivered to more than 5,000 adults in 2017/18. In the first year, 147 people received a mini cardiovascular health check, 329 people who were overweight lost at least 5% of their body weight and 432 staff in other organisations were trained in behaviour change and brief interventions. Further to this, the behaviour change service supported 562 people to stop smoking for at least 4 weeks, 817 people were recorded to have increased their physical activity and 2,176 people were screened for harmful levels of drinking.
10.	Part of enabling people to live healthy lifestyles includes ensuring that they have access to information and advice that is coordinated and accessible. To facilitate this, the community navigation pilots have been extended to reach all areas of the city, targeted at the most vulnerable populations, including older people and people living mental health conditions. These models are being developed to reflect the learning from pilots to date.
11.	Southampton has continued to actively promote and extend a telecare service across the city to support people to be more independent in their own home and have access to their local community. We have been using GPS devices which have enabled more people to remain independent in their own home while reducing the impact on carers and emergency services when people go missing. We have further been using technology that provides a reminder to secure their accommodation at night. This has improved people's confidence for some individuals to continue to live independent and safe lives.
12.	Mental and physical wellbeing are closely linked; people with poor physical health are at higher risk of experiencing mental health problems and people with poor mental health are more likely to have poor physical health. Work has been undertaken to ensure that mental health needs are considered in all physical health care pathways. This includes investment in more psychological therapy, by Southampton City Clinical Commissioning Group, for people who have co-morbid mental health and long term physical health conditions. It is hoped that those who receive the tailored psychological therapy alongside their physical health care will experience benefits to both their physical and mental health. Also, there has been an increase in access to mental health support in primary care, with more support being targeted to people in

	their GP practice, supporting recovery and avoiding the need for people to access secondary care mental health services.
13.	Further mental health promotion activities in 2018 have seen more investment to increase practitioners within Central and East Community Mental Health teams and Assertive Outreach services to ensure that support is available in the community when it is needed. A Crisis lounge is now open all day every day in Antelope House giving support to people who may be experiencing highly distressing symptoms; the service supports individuals in a recovery-focused way to manage their episode of crisis and helps reduce the need for hospital admission. There has been an increase in psychiatric posts at University Hospitals NHS Trust to provide improved access all day, seven days a week. The team provide psychiatric assessment and treatment to those patients who may be experiencing distress whilst in hospital and provide a valuable interface between mental and physical health services.
14.	The CAMHS (Children and Adolescent Mental Health Services) transformation plan is being implemented. This includes proposals on mental health support in schools, and a needs assessment of school age children and young peoples' mental health has been undertaken to inform the approach.
	Inequalities in health outcomes and access to health and care services are reduced.
15.	The conditions in which people are born, grow, live, work and age have profound influence on health and inequalities in health in childhood, working age and older age. The lower a person's social and economic status, the poorer their health is likely to be.
16.	Health inequalities arise from a complex interaction of many factors, such as housing, income, education, social isolation and disability, all of which are strongly affected by economic and social status. Action on health inequalities requires action across all the social determinants of health, including education, occupation, income, home and community. The greatest reductions in health inequalities can be achieved through providing support proportionate to level of need.
17.	Action to improve men's health to reduce the difference between male and female life expectancy is taking place and campaigns have been supported to address these health inequalities. Approaches such as: • Local Stoptober campaign included material aimed at men in routine and manual work • NHS Health Checks programme running, which identifies people at risk of Cardiovascular Diseases (CVD) in the subsequent 10 years. • Risky behaviour - commissioning for quality and innovation (smoking and alcohol) led by CCG as commissioners of community and acute Trusts. • Licensing and trading standards work for health-promoting places, particularly illegal tobacco and alcohol.
18.	We want to reduce inequalities in early childhood development by ensuring good provision of maternity services, childcare, parenting and early years support. Work with local breastfeeding support services has been undertaken to develop a Southampton breastfeeding improvement plan. The local Breastfeeding Operational Group delivered a positive Breastfeeding in Southampton programme for World Breastfeeding Week 1-7 August 2018, including a series of pictures celebrating breastfeeding in iconic Southampton public settings. Furthermore, there has been a series of engagement activities in the Hampshire and Isle of Wight Maternity Pioneer project, this includes work to introduce direct self-referral for newly pregnant women from the autumn.
19.	There has been significant progress in reducing teenage pregnancies over the past 10 years, but the rate in Southampton is still high compared with our neighbouring authorities. Between 2014-2016, the number of under 18 conceptions in

	Southampton was 30 per 1000 population which is higher than the national average of 20.8 per 1000 population. Under the Children and Social Work Act 2017, the government committed to making relationships and sex education (RSE) statutory in all schools, including LA maintained schools, academies, free schools and independent schools. All schools will soon be required to have RSE in place and an RSE policy. The personal, social, health and economic (PSHE) education network is meeting in December 2018 to support schools in meeting new requirement and provide ongoing support in schools for healthy relationships.
20.	Further to our commitments to ensure health inequalities are taken into account in policy development and commissioning service delivery, the following details have actions have been taken forward by the CCG: • Priority given to improve uptake of screening in Cancer Care Plan; • impact on Health inequalities is monitored by CCG Clinical Governance committee; • There is improved access to annual health checks for people with a learning disability (the target of 60% uptake for LD annual health checks in 2017-18 was achieved).
21.	**Southampton is a healthy place to live and work with strong, active communities**
22.	Evidence shows that our greatest health challenges, for example, the prevalence of non-communicable diseases, health inequities and inequalities and increasing health care costs, are highly complex and often linked through the social determinants of health. By addressing the wider issues around the health and wellbeing of our neighbourhoods and making the city a place that supports improved health and wellbeing, we can start to influence positive health outcomes for our residents. 
23.	The Health and Wellbeing Strategy 2017-25 sets out actions to address the wider determinants of health including healthy workplaces, housing quality and environmental policies. The strategy also focuses on building resilient communities that both improve the wellbeing of individuals, and reduce pressure on health services.

24.	Fuel poverty is being addressed through the refresh of the Fuel Poverty action plan and this year we have supported over 380 households. Funding has been secured from the National Grid to support Southampton Healthy Homes Programme and we have now launched our own ethical energy brand called CitizEn Energy which is a not-for-profit company so, unlike the private energy suppliers, any surplus made will be reinvested into local energy efficiency initiatives to deliver real savings for customers. It is hoped that this will improve housing standards and reduce illness and avoidable deaths related to fuel poverty.
25.	Southampton City Council is one of five authorities in England outside of London required to assess the need for a Clean Air Zone. The primary objective of a Clean Air Zone (CAZ) is to bring about compliance with the EU Ambient Air Quality Directive limits of nitrogen dioxide (NO2) within the shortest possible time. We have consulted on a preferred option of a B Class CAZ that would charge non-compliant Heavy Goods Vehicles, buses, coaches, taxis and private hire vehicles that do not meet a Euro 6 diesel/Euro 4 petrol minimum. Over 9,000 separate written responses were received and feedback is now being thoroughly analysed and evaluated. Following this exceptional volume of feedback, and changes to baseline data that has impacted on the air quality modelling, further exploration into social and economic impacts is being undertaken. Southampton City Council will submit their business case regarding a Clean Air Zone to Government by 31 January 2019 for approval.
	People in Southampton have improved heath experiences as a result of high quality, integrated services
26.	The Health and Wellbeing Board had responsibility for the Southampton Better Care vision which is to become a city "where everyone thrives; built on the strengths of our communities and our services are joined up around individuals". The overall aims for integrated care in Southampton are: • Putting people at the centre of their care, meeting needs in a holistic way • Providing the right care, in the right place at the right time, and enabling individuals and families to be independent and resilient wherever possible • Making optimum use of the health and care resources available in the community • Intervening earlier and building resilience in order to secure better outcomes by providing more coordinated, proactive services • Focusing on prevention and early intervention to support people to retain and regain their independence.
27.	A key element of Better Care is to prioritise investment in and embed a prevention and early intervention approach, especially through development of clusters and integrated teams. An integrated approach to case management is being progressed to support development of integrated locality teams in line with this strategic approach. In addition, digital work across Hampshire, Portsmouth, Southampton and Isle of Wight is progressing to support the development of shared records as part of the Sustainability and Transformation Plan.
28.	To ensure that we deliver the right care, at the right time and in the right place, the focus has been to support the balance of care out of hospital settings to community providers. Developments so far include: • Enhanced Health in care Home pilot focussing on 15 residential homes which has shown significant impact in reducing attendances and admissions to hospital; • Worked to deliver a community based approach to end of life care in line with national best practice, enabling more people to die in the manner and setting of their choosing with dignity and respect; • Significantly increased the number of people having their assessments for health or social long term care undertaken in the community.

29.	Joint Commissioning between the council and CCG has led to the development of integrated provision, including rehabilitation and reablement. This has had a significant impact on helping people remain independent and is contributing to a reduction in long term care needs. Furthermore, the new Southampton Living Well Service formally went live in April 2018, which will transform the current older person's day services into a new wellbeing and activity offer delivered through Community Wellbeing Centres based within communities and wider community activity.
30.	The establishment of the Southampton Joint Commissioning Board was agreed by Cabinet and Council in July 2017. The Joint Commissioning Board is now in place, and has the role of ensuring effective collaboration, assurance, oversight and good governance across the integrated commissioning arrangements for health and care between Southampton City Council and Southampton City CCG. In March 2018 the Health and Wellbeing Board formally agreed to delegate responsibility for Better Care from the Health and Wellbeing Board to the Joint Commissioning Board. This will support a continued drive to deliver joined-up services that result in improved outcomes for our residents.
RESOURCE IMPLICATIONS	
Capital/Revenue	
31.	**None**
Property/Other	
32.	**None**
LEGAL IMPLICATIONS	
Statutory power to undertake proposals in the report:	
33.	Section 2B of the national Health Service Act 2006 inserted by section 12 of the Health and Social Care Act 2012 confers on local authorities a duty to improve public health. The Strategy sets out the strategic vision for improving the health or residents and workers.
Other Legal Implications:	
34.	**None**
RISK MANAGEMENT IMPLICATIONS	
35.	**None**
POLICY FRAMEWORK IMPLICATIONS	
36.	**None**

KEY DECISION?	**No**
WARDS/COMMUNITIES AFFECTED:	**All**

SUPPORTING DOCUMENTATION		
Appendices		
1.	**Health and Wellbeing Board Scorecard**	

Documents In Members' Rooms

1.	**None**	
Equality Impact Assessment		
Do the implications/subject of the report require an Equality and Safety Impact Assessment (ESIA) to be carried out.		**No**
Privacy Impact Assessment		
Do the implications/subject of the report require a Privacy Impact Assessment (PIA) to be carried out.		**No**
Other Background Documents **Other Background documents available for inspection at:**		
Title of Background Paper(s)	**Relevant Paragraph of the Access to Information Procedure Rules / Schedule 12A allowing document to be Exempt/Confidential (if applicable)**	
1.	**None**	

Healthy Southampton

Health and Wellbeing Strategy 2017-2025

Health and Wellbeing Scorecard

November 2018

Comparison with England:	Significantly Worse	Worse (but not sig)	Similar	Better (but not sig)	Significantly Better
England Ranking Quintile:	20% Worst	2nd	3rd	4th	20% Best

Priority area	Measure	Unit	Latest Period	Southampton sparkline	Southampton value	England Value	Comparison with England	ONS Comparator Ranking (12 LAs) (1 = worst)	England LA Ranking (1 = worst)*	Updated November 2018	Updated May 2018	Updated February 2018	Direction of travel comparison with ghost rank of last time: Comparator ranking direction of travel	ONS Comparator Ranking (12 LAs) (1 = worst)	England ranking direction of travel	England LA Ranking (1 = worst)*
Overarching	Life expectancy at birth (Male)	Years	2014-16		78.5	79.5	Significantly lower	5	49			*	↔	5	↑	46
	Life expectancy at birth (Female)	Years	2014-16		82.8	83.1	Lower	9	68			*	↔	9	↓	71
	Life expectancy at 65 years (Male)	Years	2014-16		17.9	18.8	Significantly lower	4	37			*	↓	5	↓	39
	Life expectancy at 65 years (Female)	Years	2014-16		20.8	21.1	Lower	8	64			*	↓	9	↓	73
	Healthy Life Expectancy at birth (Male)	Years	2014-16		61.9	63.3	Lower	8	64			*	↑	6	↑	49
	Healthy Life Expectancy at birth (Female)	Years	2014-16		63.1	63.9	Lower	9	74			*	↑	7	↓	77
	Under 75 years mortality rate from cardiovascular disease (Male)	per 100,000	2015-17		120.9	101.3	Significantly higher	5	41 of 150	*			↑	3	↑	35 of 149
	Under 75 years mortality rate from cardiovascular disease (Female)	per 100,000	2015-17		43.8	45.2	Lower	9	89 of 150	*			↔	9	↑	81 of 149
	Under 75 years mortality rate from respiratory disease (Male)	per 100,000	2015-17		56.8	39.9	Significantly higher	2	23 of 150	*			↔	2	↑	12 of 149
	Under 75 years mortality rate from respiratory disease (Female)	per 100,000	2015-17		34.5	29.0	Higher	7	51 of 149	*			↑	5	↑	37 of 149
	Mortality rate from causes considered preventable (Male)	per 100,000	2015-17		296.7	228.6	Significantly higher	2	21 of 151	*			↓	3	↓	22
	Mortality rate from causes considered preventable (Female)	per 100,000	2015-17		160.7	137.7	Significantly higher	4	38	*			↓	6	↓	57

Priority area	Measure	Unit	Latest Period	Southampton sparkline	Southampton value	England Value	Comparison with England	ONS Comparator Ranking (12 LAs) (1 = worst)	England LA Ranking (1 = worst)*				Comparator ranking direction of travel	ONS Comparator Ranking (12 LAs) (1 = worst)	England ranking direction of travel	England LA Ranking (1 = worst)*
Children & Young People/Early Years	Smoking status at time of delivery	%	2016/17		13.8	10.7	Significantly higher	3	39 of 149				↑	2	↑	36 of 148
	Breastfeeding prevalence at 6-8 weeks after birth	%	2016/17	Not available	Not available	Not available	Not available	Not available	Not available			*				
	Child excess weight in 4-5 year olds	%	2017/18		23.3	22.4	Higher	6	59 of 148	*		*	↓	7	↓	65
	Child excess weight in 10-11 year olds	%	2017/18		37.4	34.3	Significantly higher	4	48 of 148	*		*	↓	6	↓	77
	Population vaccination coverage – MMR for one dose (2 years old)	%	2017/18		93.9	91.2	Significantly higher	10	110 of 151	*		*	↑	9	↑	109 of 149
	Looked after children rate	per 10,000	2017		108.0	62.0	Significantly higher	2	11			*	↑	1	↑	2
	School readiness: Good level of development at the end of reception	%	2016/17		70.2	70.7	Lower	7	87			*	↓	10	↑	71
	School readiness: Year 1 pupils achieving the expected level in the phonics screening check	%	2016/17		81.6	81.1	Higher	10	82			*	↓	11	↓	94
	Children in low income families (under 16s)	%	2015		19.7	16.8	Significantly higher	7	57		*		↑	6	↓	58
	Hospital admissions from unintentional & deliberate injuries (0-14 yrs)	per 10,000	2016/17		110.3	101.5	Higher	10	59 of 148			*	↑	8	↑	28
	Under 18 years conception rate	per 1,000	2016		31.7	18.8	Significantly higher	1	7 of 150		*		↓	3	↓	20

Priority area	Measure	Unit	Latest Period	Southampton sparkline	Southampton value	England Value	Comparison with England	ONS Comparator Ranking (12 LAs) (1 = worst)	England LA Ranking (1 = worst)*				Comparator ranking direction of travel	ONS Comparator Ranking (12 LAs) (1 = worst)	England ranking direction of travel	England LA Ranking (1 = worst)*
Adults	Smoking prevalence in adults	%	2017		17.4	14.9	Higher	2	34 of 150	*			↓	3	↓	42 of 150
	Suicide rate	per 100,000	2015-17		13.3	9.6	Significantly higher	3	13 of 149	*			↑	1	↑	6 of 149
	Depression recorded prevalence	%	2016/17		9.2	9.1	Similar	5	68 of 151		*		↔	5	↓	71 of 152
	Injuries due to falls in people aged 65+ (Persons)	per 100,000	2016/17		3134.9	2113.8	Significantly higher	2	5 of 148			*	↔	2	↓	11
	Injuries due to falls in people aged 65+ years (Male)	per 100,000	2016/17		2647.4	1714.9	Significantly higher	2	5 of 148			*	↔	2	↓	7
	Injuries due to falls in people aged 65+ years (Female)	per 100,000	2016/17		3453.8	2395.6	Significantly higher	1	4 of 148			*	↓	2	↓	13
	HIV late diagnosis	%	2015-17		49.2	41.1	Higher	4	44 of 144				↑	1	↑	16 of 145
	Under 75 years mortality rate for liver disease considered preventable	per 100,000	2015-17		21.2	16.3	Significantly higher	4	34 of 150	*			↓	7	↓	63 of 140
	TB incidence (3 year average)	per 100,000	2015-17		12.2	9.9	Higher	4	48 of 151	*			↓	5	↓	55

Priority area	Measure	Unit	Latest Period	Southampton sparkline	Southampton value	England Value	Comparison with England	ONS Comparator Ranking (12 LAs) (1 = worst)	England LA Ranking (1 = worst)*				Comparator ranking direction of travel	ONS Comparator Ranking (12 LAs) (1 = worst)	England ranking direction of travel	England LA Ranking (1 = worst)*
Healthy settings	Fraction of mortality attributable to particulate air pollution	%	2016		6.0	5.3	Higher	3	42		*		↔	3	↑	40
	Percentage of people aged 16-64 years in employment	%	2017/18		74.7	75.2	Lower	5	67 of 151	*			↔	5	↑	45
	Excess winter deaths index (Persons)	Ratio	Aug 2014-Jul 2017		20.4	21.1	Lower	7	79 of 150	*			↓	12	↓	112
	Excess winter deaths index (Male)	Ratio	Aug 2014-Jul 2017		19.4	18.1	Higher	4	63 of 150	*			↓	12	↓	116
	Excess winter deaths index (Female)	Ratio	Aug 2014-Jul 2017		21.3	23.9	Lower	10	104 of 150	*			↑	8	↑	88

** Ranking is out of 152 Upper Tier Local Authorities unless otherwise stated*

This page is intentionally left blank

DECISION-MAKER:		HEALTH AND WELLBEING BOARD		
SUBJECT:		THE DIRECTOR OF PUBLIC HEALTH ANNUAL REPORT		
DATE OF DECISION:		19 December 2018		
REPORT OF:		THE DIRECTOR OF PUBLIC HEALTH		
CONTACT DETAILS				
AUTHOR:	**Name:**	Jason Horsley Joint Director of Public Health	Tel:	023 8083 3318
	E-mail:	Jason.horsley@southampton.gov.uk		
Director	**Name:**	Jason Horsley Joint Director of Public Health: Southampton City Council and Portsmouth City Council	Tel:	023 8083 3818
	E-mail:	Jason.horsley@southampton.gov.uk		

STATEMENT OF CONFIDENTIALITY
NOT APPLICABLE
BRIEF SUMMARY
The Southampton Director of Public Health Annual Report 2017 focuses on Childhood Obesity. Obesity harms children's physical and emotional health in their childhood and is likely to go on to harm their adult health, cutting short lives and placing further strain on health services.
This report is an independent review written by the Joint Director of Public Health for Southampton and Portsmouth. This is the first joint report written jointly for both Southampton and Portsmouth, since the introduction of a joint Director in 2016. There are benefits in developing a joint report for the two cities, as they share a number of similar characteristics. They are both Port cities, close to London, and they both have significant pockets of deprivation which makes addressing the public health problems more challenging. The recommendations in the report are therefore applicable to both cities.

RECOMMENDATIONS:		
	(i)	To note the Director of Public Health Annual Report 2017
REASONS FOR REPORT RECOMMENDATIONS		
1.	The Director of Public Health has a duty to prepare an annual report on the health of the people of Southampton, and the council has a duty to publish this report under section 73B(5) & (6) of the National Health Service Act 2006, inserted by section 31 of the Health and Social Care Act 2012).	
ALTERNATIVE OPTIONS CONSIDERED AND REJECTED		
2.	None	
DETAIL (Including consultation carried out)		
3.	Childhood Obesity is a serious problem confronting both the current generation and also future generations, since the consequences of childhood obesity	

	impact both on the individuals affected, and also on wider society as we battle to make our stretched healthcare resources work effectively.
4.	Rates of obesity in children have continued to climb in the UK, over the last decade and rates in Southampton and Portsmouth are similar to those seen in our statistical neighbours (cities with similar profiles and similar levels of deprivation). Nationally, rates of childhood obesity are high, and are much higher than they were 20 years ago. • More than 1 in 5 five-year-olds in England are obese or overweight. • By year 6 (age 11) this is one in three. Overweight adolescents have a 70% chance of becoming overweight adults.
5.	At a simple level, rising rates of childhood obesity results from a reduced level of physical activity in children and diets that are too reliant on high calorie processed foods. However, there are a number of cultural shifts underlying these simple drivers that should be recognised.
6.	The attached Annual Report 2017 makes a case that existing activity and interventions, while helpful, are not enough to address the issue of Childhood Obesity in Southampton and Portsmouth. The report includes examples of work that already exists, but that either needs to be done more often or replicated across a wider area and well as international models that appear to have been effective.
RESOURCE IMPLICATIONS	
Capital/Revenue	
7.	None
Property/Other	
8.	None
LEGAL IMPLICATIONS	
Statutory power to undertake proposals in the report:	
9.	The Director of Public Health has a duty to prepare an annual report on the health of the people in the area of the local authority, and the local authority has a duty to publish the report under section 73B(5) & (6) of the National Health Service Act 2006 , inserted by section 31 of the Health and Social Care Act 2012. The content and structure of the report is something to be decided locally.
Other Legal Implications:	
10.	N/A
RISK MANAGEMENT IMPLICATIONS	
11.	None
POLICY FRAMEWORK IMPLICATIONS	
12.	None

KEY DECISION?	No
WARDS/COMMUNITIES AFFECTED:	All wards

SUPPORTING DOCUMENTATION
Appendices

1.	DPH Annual Report 2017 – Childhood Obesity

Documents In Members' Rooms

1.	None

Equality Impact Assessment	
Do the implications/subject of the report require an Equality and Safety Impact Assessment (ESIA) to be carried out.	**No**
Privacy Impact Assessment	
Do the implications/subject of the report require a Privacy Impact Assessment (PIA) to be carried out.	**No**

Other Background Documents
Other Background documents available for inspection at:

Title of Background Paper(s)		**Relevant Paragraph of the Access to Information Procedure Rules / Schedule 12A allowing document to be Exempt/Confidential (if applicable)**
1.	None	

This page is intentionally left blank

SOUTHAMPTON CITY COUNCIL

Portsmouth CITY COUNCIL

DPH Annual Report 2017
Childhood Obesity

Agenda Item 6

Appendix 1

02

CONTENTS

ISBN 978-0-9955048-1-3
Published September 2018

You can download this report from Portsmouth's joint strategic needs assessment website: www.jsna.portsmouth.gov.uk

We would be pleased to receive your comments about this report.

Email: jason.horsley@portsmouthcc.gov.uk

© The News, Portsmouth

Jason Horsley
Director of Public Health

EXECUTIVE SUMMARY

I have chosen to look at the problem of childhood obesity this year. This is a serious problem confronting both the current generation and also future generations, since the consequences of childhood obesity impact both on the individuals affected, and also on the wider society as we battle to make our stretched healthcare resources work effectively.

Obesity harms children's physical and emotional health in their childhood and is likely to go on to harm their adult health, cutting short lives and placing further strain on our health services.

It has been over a decade since the landmark Foresight report[1] highlighted that "Significant effective action to prevent obesity at a population level is required". This gives us a chance to see if we are having the impact we would hope.

Rates of obesity in children have continued to climb in the UK over the last decade. Rates in Southampton and Portsmouth are similar to those seen in our statistical neighbours (cities with similar profiles and similar levels of deprivation). However, being "average" for this problem is not something we can take comfort in – nationally rates of childhood obesity are too high, and are much higher than they were 20 years ago. We have to be ambitious if we are going to make a difference to a problem we cannot ignore.

At a simple level, rising rates of childhood obesity results from a reduced level of physical activity in our children and diets that are too reliant on high calorie processed foods. However, there are a number of cultural shifts underlying these simple drivers that we need to recognise.

There have been numerous interventions that attempt to reduce the rates of childhood obesity in our population. In this report I will make a case that what we have been doing, while helpful, is not enough. In this report we have included a lot of great examples of work that already exists, but that either needs to be done more often or replicated across a wider area. We have also looked for international models that appear to have been effective.

I don't think relying on our healthcare system or even the growing gym industry can be the answer. While the consequences of obesity impact on our healthcare system, the reasons why we have the problem in the first place cannot be addressed through healthcare provision. Too often we have placed the responsibility back on individuals, through healthcare providers and used individualised interventions. I would argue that childhood obesity is a population problem, and needs interventions that reach everyone.

There are things that everyone can do to improve the situation – this is a problem that will need the coordinated actions of central and local governments, schools, food producers and providers, employers, and not least parents and children.

Jason Horsley
Director of Public Health

04 DANGERS OF OBESITY

We often view obesity as a "healthcare" problem – but it's a problem created by society that has a massive impact on health[2]. GPs, hospital doctors and nurses don't have the capacity to deal with a problem that affects about 60% of the adult population.

Being inactive increases the risk of a range of conditions usually associated with old age including heart disease, type 2 diabetes and certain cancers.

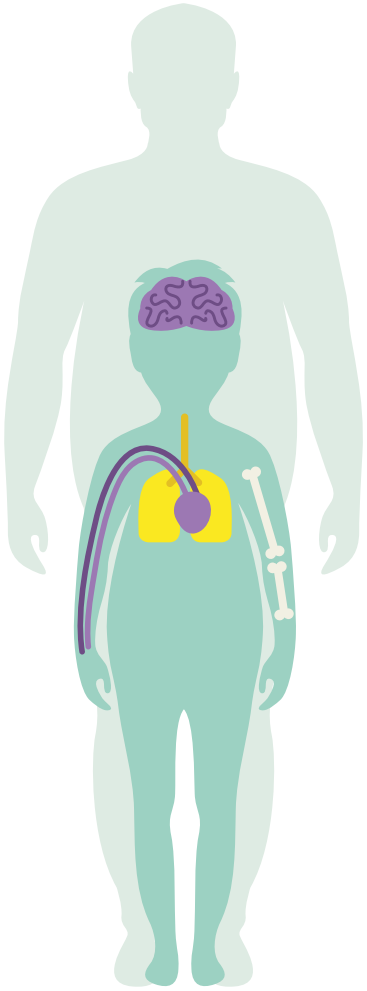
Obesity harms children and young people:

Emotional and behavioural
Stigmatism
Bullying
Low self esteem

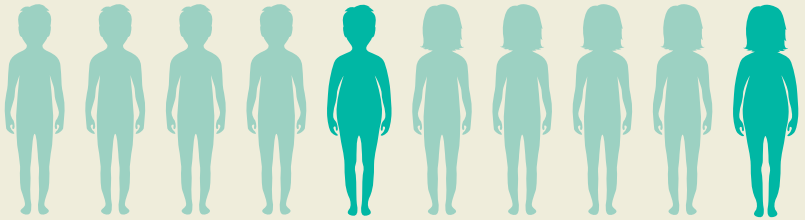
School absence

Physically
High cholesterol
High blood pressure
Pre-diabetes
Bone and joint problems
Breathing difficulties

Adult life
Increased risk of becoming overweight adults
Risk of ill health and premature mortality in adult life

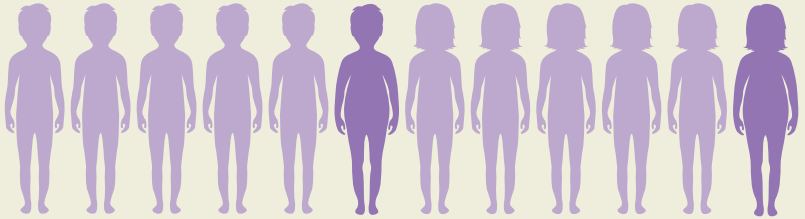


QUICK FACTS



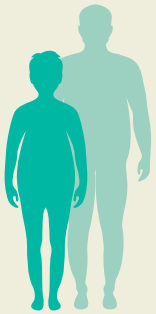
More than 1 in 5 five-year-olds in England are obese or overweight[2].

By year 6 (age 11) this is one in three[2].



In 1980 the rate in 2 – 19 year olds was only one in six[3].

Overweight adolescents have a 70% chance of becoming overweight adults[3].



TRENDS IN OVERWEIGHT AND OBESITY IN CHILDHOOD

The National Child Measurement Programme has helped us to monitor trends over time:

- Prevalence of obesity and overweight in 5 year olds (reception year) has apparently plateaued – although at a level that is way too high to manage.
- The prevalence of obesity and overweight in 11 year olds (year 6) is still slowly rising and is now 34.2% for England. In Southampton it is slightly higher (34.9%) and even higher in Portsmouth (35.9%)[4].

The rise in obesity between reception year (age ~ 5) and Year 6 (age ~ 11) suggests that interventions in these school years could be highly effective.

Unfortunately excess weight tracks through to adulthood – 61.3% of the adult population is either overweight or obese[4].

We need to ask ourselves, are we happy to reach England average levels for childhood obesity. Or do we want to do better than that?

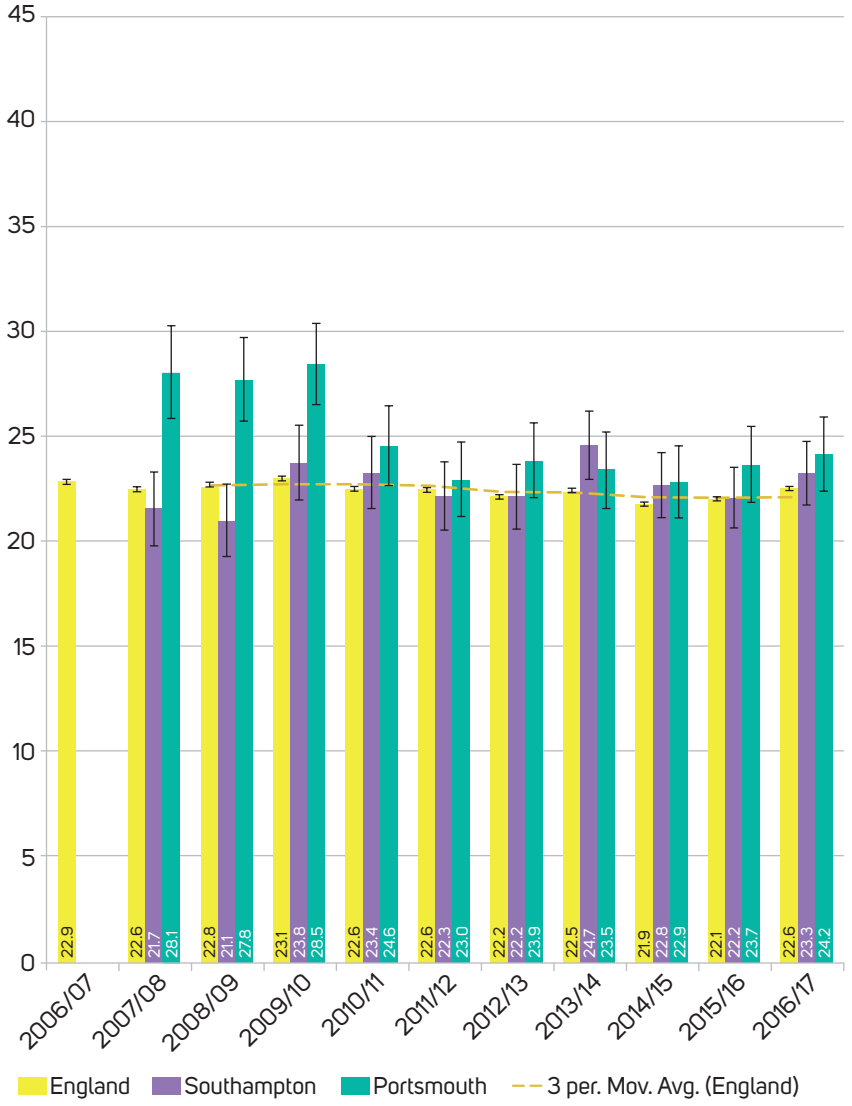
For inspiration we need to look at examples of cities that have made a difference for their residents:

- Seinäjoki in Finland has reduced obesity in five year olds from similar levels to the UK (1 in 5 five-year-olds) to almost half that.
- Freiburg in Germany has transformed the environment for its residents to a place where walking, cycling and public transport are prioritised.

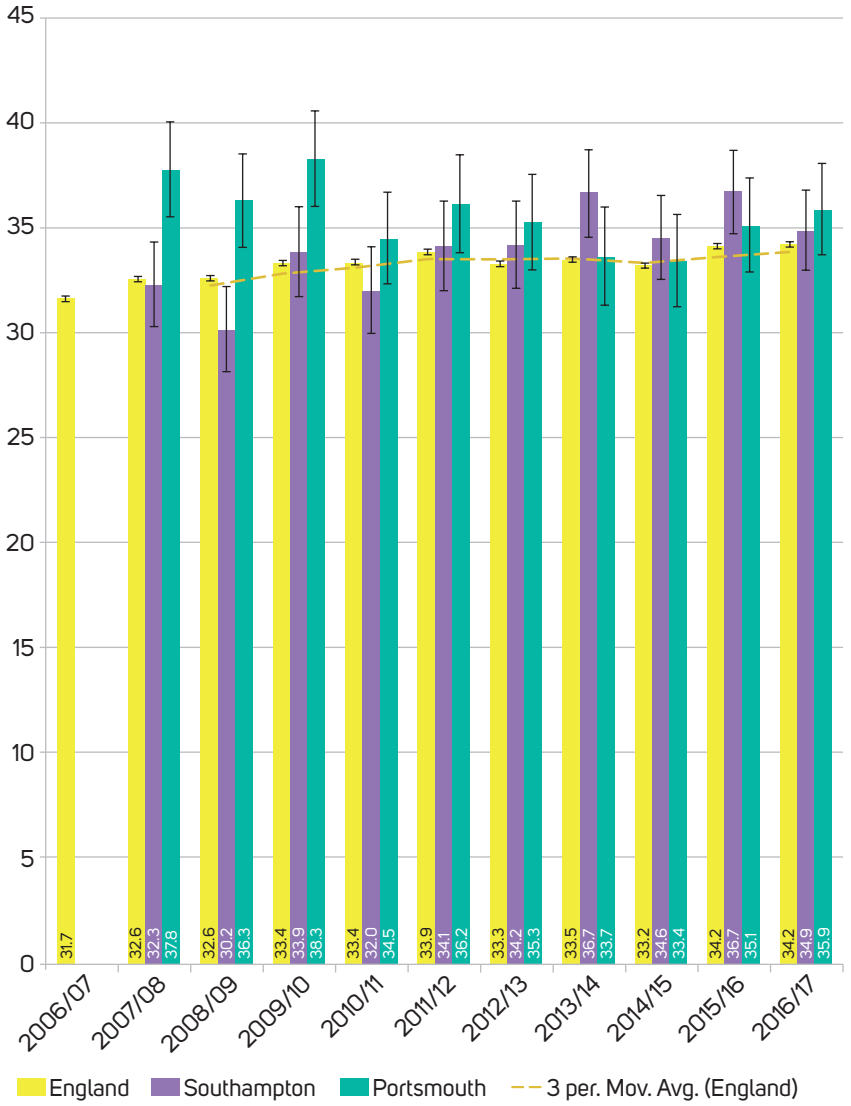
These interventions won't work overnight, but we have to use the most effective ones, and for long enough to see results.

06

TRENDS FOR PROPORTION OF CHILDREN WHO ARE OVERWEIGHT OR OBESE IN RECEPTION YEAR



TRENDS FOR PROPORTION OF CHILDREN WHO ARE OVERWEIGHT OR OBESE IN YEAR 6



DEPRIVATION PLAYS A MAJOR ROLE, AND IS DRIVING INEQUALITIES IN HEALTH OUTCOMES

07

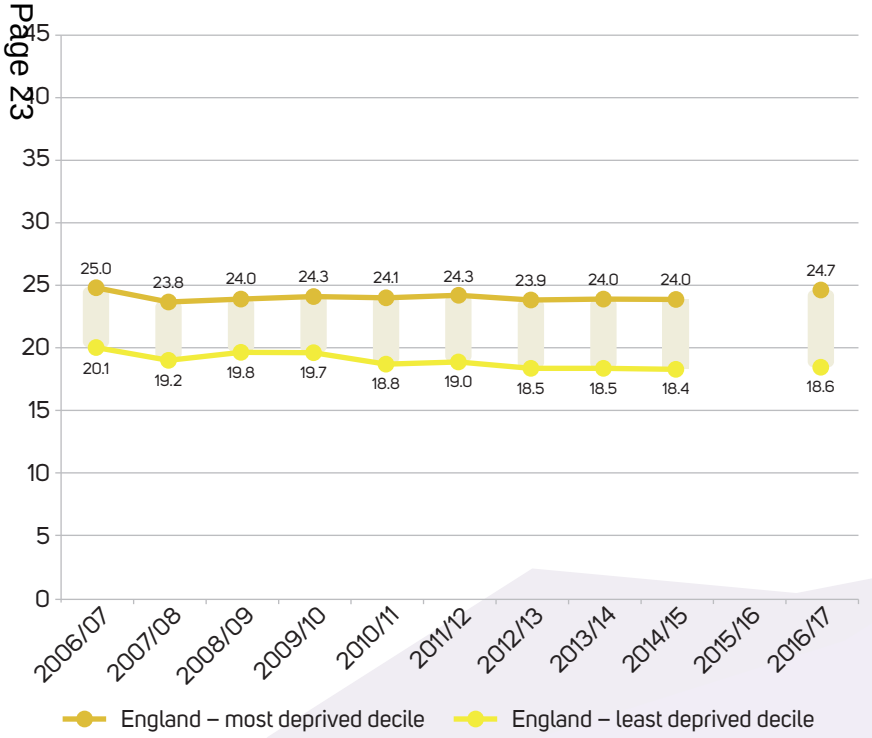
The graphs below show the gap between rates of obesity and overweight in the most and least deprived wards in the country.

They show three disturbing facts:

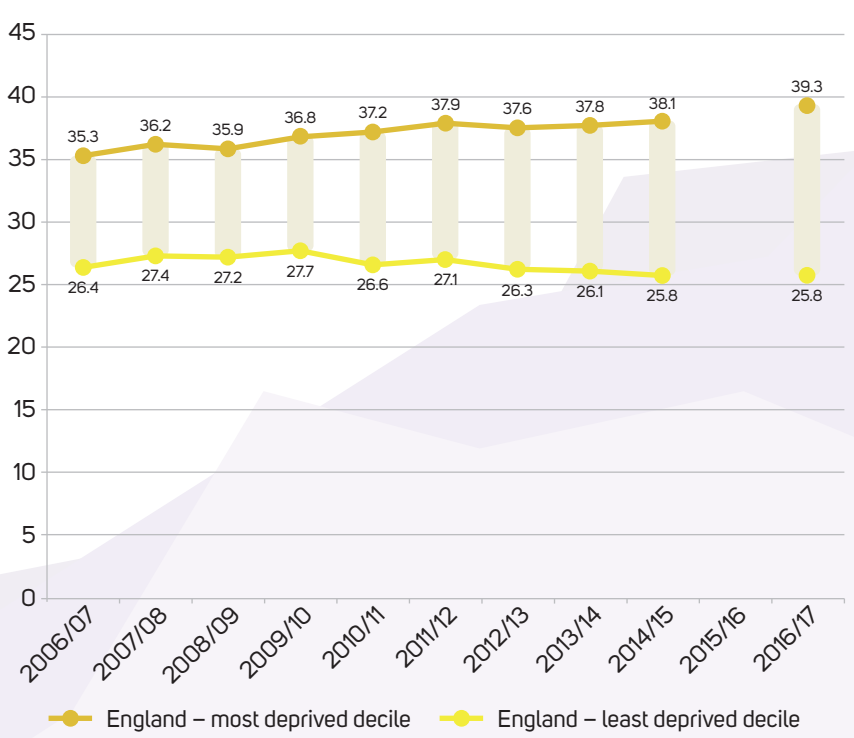
- First that there is a big difference between the rates of overweight and obesity between the richest and poorest areas in the country.
- Second that this gap appears to be growing.
- Third is that the gap is growing because rates are getting worse in the most deprived areas, and better in the least deprived areas – suggesting our current interventions are only working in the richer parts of the country.

For our two cities, where there are pockets of significant deprivation, these figures suggest we need to do more to target the most deprived wards in the city.

TRENDS FOR PROPORTION OF CHILDREN WHO ARE OVERWEIGHT OR OBESE IN RECEPTION YEAR BY DEPRIVATION DECILE



TRENDS FOR PROPORTION OF CHILDREN WHO ARE OVERWEIGHT OR OBESE IN YEAR 6 BY DEPRIVATION DECILE



08

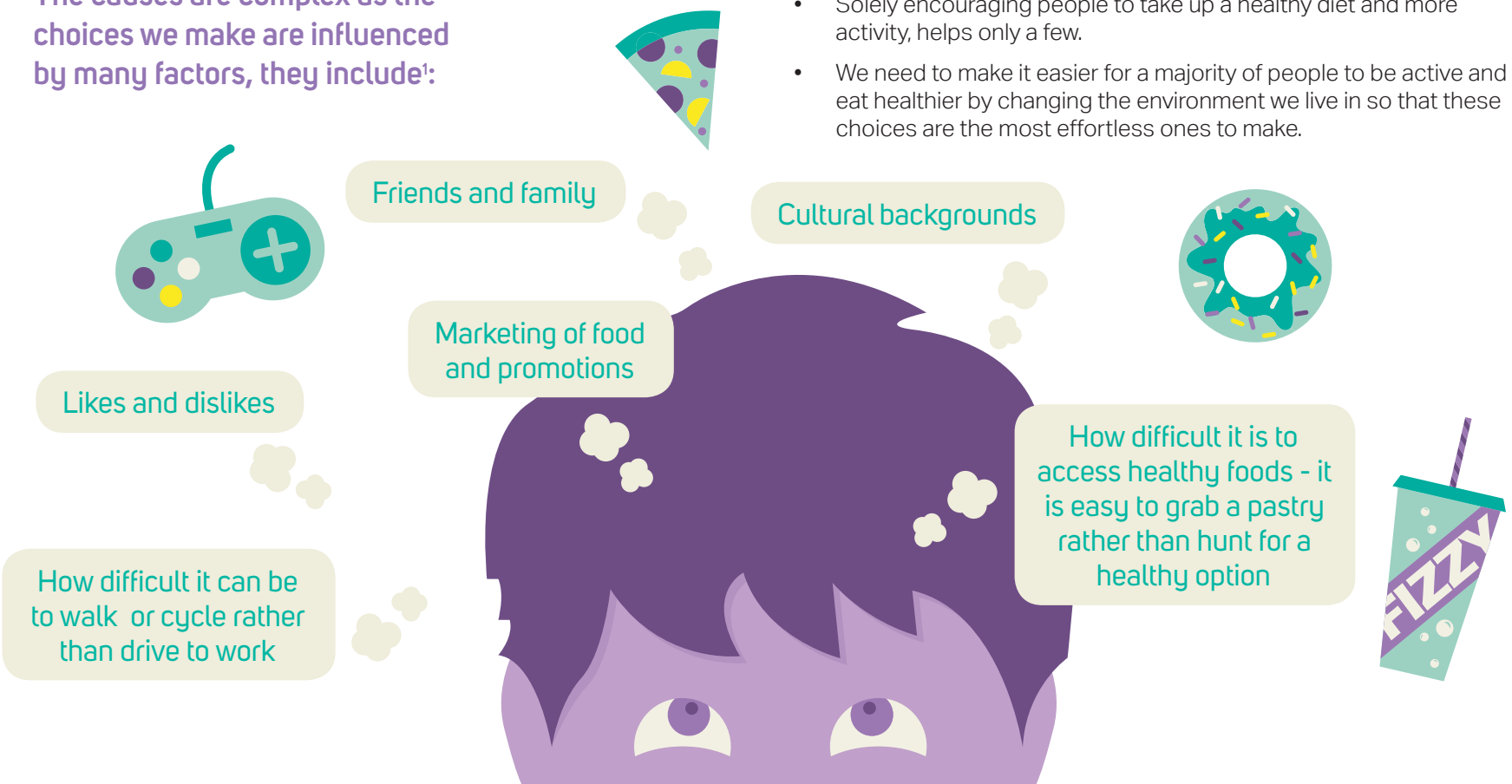
HOW HAVE WE GOT HERE?

It is a popular belief that if people ate less and did more activity, then obesity would be solved

BUT…

Years of evolution have designed us to preserve energy whenever possible, and to value high calorie foods. Our genetics mean we get pleasure from eating to excess, and by default we are inherently lazy. Unconsciously we have designed our lifestyles according to these basics.

The causes are complex as the choices we make are influenced by many factors, they include[1]:



We need to recognise we are not winning with our current approach.

- The trend for rising rates of obesity has not reversed for over a decade.
- Medical interventions and weight management support through intensive lifestyle advice cannot provide the answer alone. Support programs often have a high drop out rate and we don't have the resources to provide them to everyone who could benefit (over 60% of the adult population).
- Solely encouraging people to take up a healthy diet and more activity, helps only a few.
- We need to make it easier for a majority of people to be active and eat healthier by changing the environment we live in so that these choices are the most effortless ones to make.

RELATIONSHIP WITH HOW WE MOVE

MOST OF THE EXERCISE WE GET EVERYDAY IS THROUGH MOVING FROM ONE PLACE TO ANOTHER

A majority of the trips we make are for shopping, personal business and visiting friends.

Only **15%** of the trips we make are for commuting. (National Travel Survey 2016)[5]

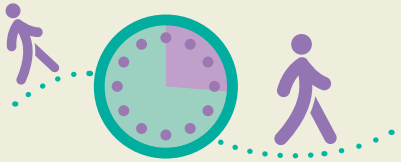
Nationally 62% of our trips are made by car and 25% by walking and the number of trips we have made by walking has been steadily decreasing since 2002. (National Travel survey 2016)

Over the long term the cost of purchasing cars has decreased and 77% households own at least one car. (National Travel Survey 2016)

Increasingly we have made it easy to travel without moving as we have designed cars into every aspect of our lives. We feel it's safer to drive at 30 – 50 mph than for people to travel at 5 – 15 mph on a cycle.

Recently we have made it even easier to move less as we can purchase most of the things we need through online shopping.

HOW CAN WE REVERSE THIS TREND AND MOVE MORE?



People are more likely to walk if they are taking a short trip, on average each walking trip lasts just 16 minutes (National Travel survey 2016)

If our cities were designed around walking, not cars, the walking trips we take should increase. This would have added benefits of:

- Reduced air pollution
- Reduced road injuries
- Stronger social interactions
- Sense of belonging
- Reduced crime rate
- Improved physical and mental health[6]

To see this change we must commit to making walking a priority, ensure walking features strongly in town plans, create a walking network and design streets as places for children to enjoy (Creating Walking Cities a Blueprint)[6].

10

RELATIONSHIP TO FOOD ENVIRONMENTS

Our food all has an impact on our diet and its nutritional content. It is influenced by how we:

Research shows

- Shops in poorer areas have fewer healthy food options[7]
- Fast food outlets are more common in deprived areas nationally[8 9]
- These factors have been associated with poorer diets and health problems that can result from poor diets[10 11]

The good news is that we have the ability to make changes to the local environments which will help people make better diet choices.

For example, ensuring that healthy options are easy and accessible to all (relatively cheap, available, convenient etc.) is a key factor if everyone is to have the opportunity to eat a healthy, balanced diet. This includes places like:

» Businesses selling prepared food for immediate consumption (canteens, cafés, restaurants, takeaways, high-street shops etc.)

» Supermarkets

» Corner shops

CASE STUDIES

CASE STUDY: THE DAILY MILE

Arundel Court have been doing the Daily Mile for over a year with Key Stage 2 pupils and it's proved very successful. The students walk, jog or run a mile during each school day.

Perceived barriers:

- **No time?** Once you get into the habit of scheduling 10 mins each day it becomes part of routine.
- **Limited space?** It doesn't matter, our kids do 7 laps of our go-kart track to make a mile!
- **Bad weather?** It hasn't been an issues, even on rainy days you can generally find 10 minutes where it isn't pouring.

Benefits:

- Real improvements in fitness and confidence
- Inclusive (all pupils can participate)
- Children feel "happier", "increased enjoyment in activity" and "have friends to play with"

Would you recommend other schools get involved in the daily mile?

"Absolutely. We've seen nothing but positives and haven't encountered any problems with setting it up. Just give it a go and it'll become routine before you know it".

"Pupils love it, we're looking at rolling it out to all pupils this year"

12

CASE STUDY: ROAD CLOSURE OUTSIDE ST JOHN'S PRIMARY SCHOOL FOR CLEAN AIR DAY IN SOUTHAMPTON

The event:

A road closure organised outside school enabled the street to be transformed so that children and families could participate in street play, cycle training and Bike Doctor sessions, dance workshops, renewable energy lessons and seed planting activities.

What happened?

- Majority of pupils travelled actively to school (walk, scoot, cycle or Park & Stride)
- 85 bikes fixed by the Bike Doctor.
- 120 pupils participated in bike agility courses
- 300 pupils participated in outdoor dance sessions
- 60 pupils participated in renewable energy workshops

Who was involved?

All pupils and staff. Southampton City Council School Travel Officer, Sustrans staff, The Environment Centre Team and Global Action Plan staff.

The legacy:

Success of one-day road closure has led to consultation with residents for a permanent timed road closure outside the school.

CASE STUDY: POMPEY MONSTERS – WALK TO SCHOOL CHALLENGE

The programme:

An incentivised programme to encourage long-term behaviour change to reduce car travel to school, thus reducing congestion and improving health.

Launched in 2017:

Initially piloted in 3 schools over a 7 week period, using a video of the monsters and a visit by 'Stomper'. Parents received flyers to encourage online sign-up.

Introduction:

Registered pupils received an information pack and the monster characters (who all carry a different road safety message) were introduced. Children also got a chart to record their walks to school, a Park and Stomp (stride) map and a pedometer voucher.

In action:

The road safety team visited schools, distributing the monster keyrings (incentive for walking, different ones to collect) once pupils proved they walked to school 3 or more times per week.

Results:

- 68% of pupils registered to participate
- 92% collected 4 or more keyrings
- Over 97% are very likely or likely to continue walking
- Over 81% said they enjoyed walking to school more frequently
- Nearly 84% of parents said they valued time walking with their child

Impact:

- 60% indicated they now walked 4/5 times per week
- 96% said scheme helped teach road safety

The legacy:

The scheme has been rolled out to 3 more schools, with encouraging results to date.

CASE STUDY: SO18 BIG LOCAL – HELPING TO INCREASE USE OF LOCAL GREEN SPACES

The programme:

Harefield, Midanbury and Townhill Park in Southampton were allocated Big Lottery funding to each come together to make their areas even better places to live. The project named SO18 Big Local has a number of aims which include getting local people out and about and enjoying the green areas on their doorsteps.

What happens?

- Work with local schools to teach children about the biodiversity in the area
- Engaging with local residents and making them aware of local 'wild' areas
- Promoting active participation in local hands-on activities in natural spaces

Who was involved?

SO18 Big Local is driven by a group of people that all live, work or volunteer in the area.

Impact

- Awareness has increased – many local residents were not even aware of the local green space available on their doorstep
- More people engaging in activities in Frogs Copse
- More people are involved in helping maintain their local green spaces

"I never even knew this space was here"

14

CITIES THAT HAVE MADE A DIFFERENCE FOR THEIR RESIDENTS

FINLAND [12 13]

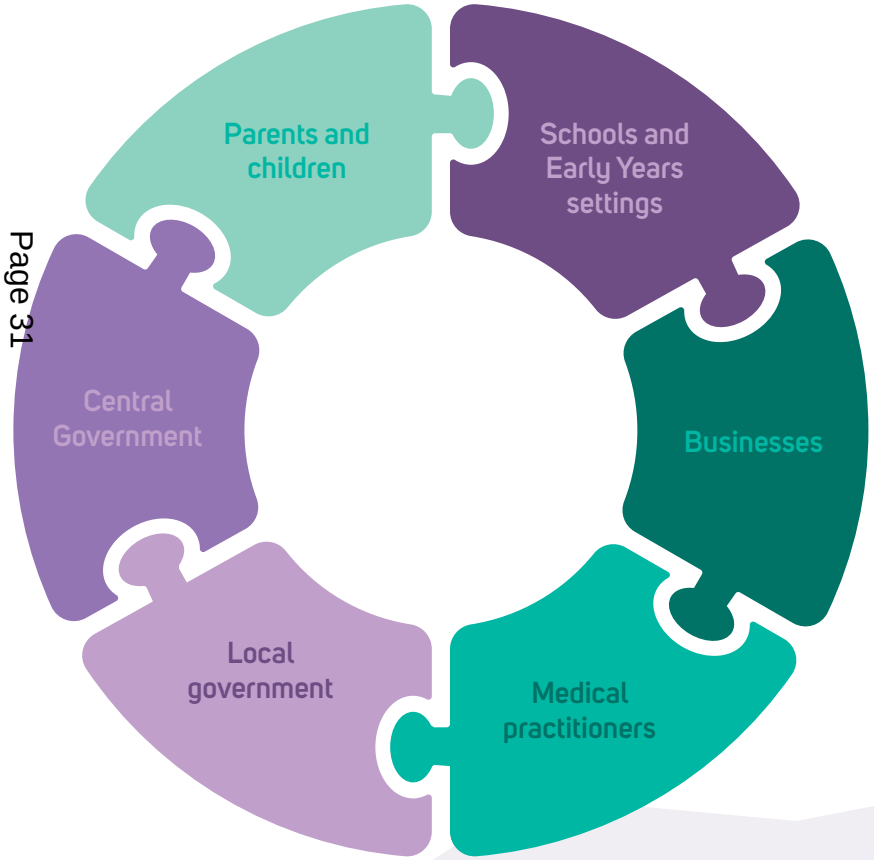
- Seinäjoki in Finland has a population of over 60,000 and is a fast growing urban area of Finland. The businesses in the area focus on food , agriculture and agro-technology
- Seinäjoki managed to half the proportion of overweight and obese five year olds in the city in just 6 years
- They did this by getting the right policies in place and understanding that preventing childhood obesity lies outside the health sector.
- The city worked on having a health in all policies approach and by working out how different departments could work together (e.g. planning, education, recreation and health) and having clear role for each department
- They worked to increase physical activity and improve food choice.

GERMANY [14 15]

- Freiburg is a city located in South Germany with a population of 220,000. After the devastation of the Second World War, sustainable development featured strongly in rebuilding the city. Freiburg developed a car-lite system focussing on walking, cycling and public transport. Use of cars is restricted and two-thirds of the land is devoted to green uses.
- The impacts have been notable, the living standards in this city are among the highest in Germany, and residents have a strong understanding of environmental issues which effects lifestyle choices. This approach to urban planning has improved community cohesion and improved the health as well as safety as children can play safely outside the home. There has also been a reduction in the differences (social inequalities) between the richest and poorest groups, indicating that the whole population are more likely to flourish.

WHAT ARE OUR OPTIONS?

If we are to reduce the high levels of childhood obesity, action is required at all levels to make healthy choices the easier choices – a "whole systems" approach.



THE PLACE FOR INDIVIDUAL ACTION

People who can have the biggest impact are still parents and children

What would we expect of parents:

- Be a role model – eat well and move more
- Teach children about healthy food choices from an early age
- Be active as a family-make play a part of every day life
- Reduce screen time
- Teach kids about advertising and how it is trying to influence them
- Encourage schools to offer opportunities for physical activity and provide healthy meals/ snacks

ROLES FOR EDUCATION INSTITUTIONS

Embrace physical activity

- Improves school performance!
- Sport should be fun first (competition has its place but the first aim is to ensure there is something for everyone)
- It doesn't have to come under the label of "sport" – examples of other initiatives include:
  - Daily Mile or Golden Mile **thedailymile.co.uk** or **golden-mile.org**
  - Walking buses
  - Active travel plans
- Encourage good diets in school. Make sure school foods meet the national school food standards
- Use PHSE to explore issues sensitively
  - Understanding healthy diets
  - Recognising value of physical activity

ROLES FOR LOCAL BUSINESS

For most businesses the best asset they can have is a healthy workforce. Similarly a loyal, healthy customer base will make them more likely to operate on a sustainable profit.

Many businesses, especially small and medium sized ones, do better when they have higher footfall, which in turn is dependent on measures that increase walking, cycling and public transport.

Businesses have a role to play by:

- Making it easier for staff and customers to travel by active transport, or provide incentives when they do.
- Food retailers can make healthy options more prominent on shelves.
- Food retailers can have healthier snacks at the checkout and price promotions on healthy meal or snack options.
- Investing in the local community to promote healthier choices.
- Larger businesses must consider how to support smaller suppliers, and especially when they are offering a healthier alternative.

ROLE FOR LOCAL GOVERNMENT[16]

My biggest ask of local governments is to use their powers to shape the built and natural environment, and to influence transport.

The Town and Country Planning Association has developed a great list of actions for planning departments to help plan healthy weight environments.

I would also ask elected members to recognise the importance of this problem, and to make addressing it a priority in all their actions. Officers will need their support.

Planning Healthy – Weight Environments – Six Elements

Movement and access 1

- Clearly signposted, with direct walking and cycling networks
- Safe and accessible networks, and a public realm for all
- Walking prioritised over motor vehicles, and vehicle speed managed
- Area-wide walking and cycling infrastructure provided
- Use of residential and business travel plans

Open spaces, play and recreation 2

- Planned network of multi-functional green and blue spaces
- Easy-to-get-to natural green open spaces of different sizes
- Safe and easy-to-get-to play and recreational spaces for all, with passive surveillance
- Sports and leisure facilities designed and maintained for everyone to use

Healthy food 3

- Maintain and enhance opportunities for community food growing
- Avoid over-concentration of unhealthy food such as hot-food takeaways in town centres and in proximity to schools or other facilities aimed at children and young people
- Shops/food markets that sell a diverse offer of food choices and are easy to get to by walking, cycling or public transport

Neighbourhood spaces and social infrastructure 4

- Community and healthcare facilities provided early as part of a new development
- Services and facilities co-located within buildings where feasible
- Public spaces that are attrative, easy to get to, and designed for a variety of uses

Buildings 5

- Adequate internal spaces for bike storage, dining and kitchen facilities
- Adequate private or semi-private outdoor space per dwelling
- Car parking spaces are minimised across the development
- Well-designed buildings with passive surveillance

Local economy 6

- Enhance the vitality of the local centre by providing a more diverse retail and food offer
- Centres and places of employment that are easy to get to by public transport, and on walking and cyling networks
- Facilities are provided for people who are walking and cycling to local centres and high streets, such as street benches, toilets and secure bike storage

Source: TCPA Dec 2014

18

ROLE FOR HEALTHCARE PROVIDERS

I think we have relied too heavily on healthcare providers. They have an important role in recognising when people have a problem and in signposting to help, but healthcare facilities can only help once a problem has started. To be effective we have to work to prevent obesity starting.

There is a significant role for health visitors and midwives to promote healthy eating from the very beginning, and to signpost young parents to information they need to get their children off to the right start.

- In adults there is good evidence that healthcare providers can make a difference by providing brief opportunistic interventions to motivate weight loss[17]
  - Primary care appointments are an ideal opportunity for this intervention which could take as little as 30 seconds.
  - It can achieve moderate weight reduction in patients and has been shown to be highly acceptable by patients.

ROLE FOR CENTRAL GOVERNMENT

Central government has done a lot over the years to promote physical activity and healthy food. There has been a huge amount of support for sport. New measures like the sugar tax on beverages are welcome.

All too often though, initiatives don't have the impact they could. Initiatives led by governments from all major parties have not been as effective as they could be because we:

- **Forget to make the healthy choice the easy (and fun) choice** - for example, much of the money spent on sport ends up supporting elite sports-people – there seems to be very little benefit to public health from this. Most people would like to participate in sport as a social activity, and many are put off by highly competitive environments.
- **Cannot see the possibilities within the framework of existing structures** – for example, much of the money we invest in transport continues to be spent on improving the road network for private vehicles. Active transport could be most people's default choice if the infrastructure was better, yet we don't invest anywhere near as much in it.
- **Fail to explain to vested interests (media, corporate structures, existing government departments) why change is needed** – in recent years concerns over first the financial crisis, and then the Brexit referendum have dominated political debate, and both civic society and our politicians seem to have lost focus on some of the big challenges of our time. We need strong political leadership.

What would I like central government to do (top three):

» **Distribution of transport monies needs to change** – Government must ensure that the proportion of transport money that is invested in active transport options continues to grow, and that this money is spent on infrastructure (cycle paths, covered walkways, public transport etc) in preference to publicity campaigns.

» **Grasp the opportunity to subsidise healthy food production over sugar production** – Historically the biggest beneficiaries of the EU farming subsidies have been producers of sugar beet. This has artificially lowered prices for producing sugar, at the expense of crops which have much greater nutritional value With Brexit, we have an opportunity to change this, and to prioritise subsidies for healthier food.

» **Actions to reduce exposure to advertising and to make parents less susceptible to "pester power"** – Advertising to children has shifted mediums and regulation has not kept up. Social media and internet companies need to reduce promotion of unhealthy foods to minors. Similarly supermarket price promotions could be regulated to ensure healthy food is promoted and prominently placed in stores.

20

REFERENCES

1. Foresight. Tackling Obesities: Future Choices – Project report. 2007. Government Office for Science
2. PHE. Childhood Obesity Applying All Our Health. 2015. https://www.gov.uk/government/publications/childhood-obesity-applying-all-our-health/childhood-obesity-applying-all-our-health
3. Ng M, Fleming T, Robinson M, Thomson B et al. Global, regional, and national prevalence of overweight and obesity in children and adults during 1980–2013: a systematic analysis for the Global Burden of Disease Study 2013. The Lancet. 2014;384(9945):766–81.
4. Public Health outcomes Framework 2016/17. https://fingertips.phe.org.uk/profile/public-health-outcomes-framework/data#gid/1000042
5. Trends in Active Travel. National Travel survey 2016 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/633077/national-travel-survey-2016.pdf
6. Creating Walking Cities a Blueprint. https://www.livingstreets.org.uk/media/2527/blueprint-for-change.pdf
7. Black C, Ntani G, Kenny R, Tinati T, Jarman M, Lawrence W, Barker M, Inskip H, Cooper C, Moon G, Baird J. Variety and quality of healthy foods differ according to neighbourhood deprivation. Health and Place. 2012; 18(6):1292-99.
8. Macdonald L, Cummins S, Macintyre S. Neighbourhood fast food environment and area deprivation—substitution or concentration? Appetite, Volume 49, Issue 1, 2007. Pages 251-254, ISSN 0195-6663, https://doi.org/10.1016/j.appet.2006.11.004. (http://www.sciencedirect.com/science/article/pii/S0195666306006519)
9. Maguire, E. R., Burgoine, T., & Monsivais, P. (2015). Area deprivation and the food environment over time: A repeated cross-sectional study on takeaway outlet density and supermarket presence in Norfolk, UK, 1990–2008. Health & Place, 33, 142–147. http://doi.org/10.1016/j.healthplace.2015.02.012
10. Vogel C, Ntani G, Inskip H, Barker M, Cummins S, Cooper C, Moon G, Baird J. Education and the Relationship Between Supermarket Environment and Diet. American Journal of Preventive Medicine. 2016 51(2):e27-34.
11. Vogel C, Parsons C, Godfrey K, Robinson S, Harvey NC, Inskip H, Cooper C, Baird J. Greater access to fast food outlets is associated with poorer bone health in young children. Osteoporosis International. 2016; 27(3):1011-1019.
12. City of Seinajoki https://www.seinajoki.fi/en/index/cityofseinajoki/aboutseinajoki.html
13. WHO. Finland curbs childhood obesity by integrating health in all policies. 2015 http://www.who.int/features/2015/finland-health-in-all-policies/en/
14. World Habitat Awards. 30 Years of Planning Continuity in Freiburg, Germany. Finalist 2013. https://www.world-habitat.org/world-habitat-awards/winners-and-finalists/30-years-of-planning-continuity-in-freiburg-germany/
15. Ralph Buehler & John Pucher (2012) Sustainable Transport in Freiburg: Lessons from Germany's Environmental Capital, International Journal of Sustainable Transportation, 5:1, 43-70, DOI: 10.1080/15568311003650531
16. Town and Country Planning Association. Planning Healthy Weight Environments- Six Elements. https://www.tcpa.org.uk/Handlers/Download.ashx?IDMF=0dd9f88d-260b-4954-a359-ac905aa416c4
17. Aveyard P, Lewis A, Tearne S, Hood K, Christian-Brown A, Adab P, Begh R, Jolly K, Daley A, Farley A, Lycett D, Nickless A, Yu LM, Retat L, Webber L, Pimpin L, Jebb SA. Screening and brief intervention for obesity in primary care: a parallel two-arm, randomised trial. Lancet. 2016 Oct 21. pii: S0140-6736(16)31893-1. doi:10.1016/S0140-6736(16)31893-1.

ABOUT THIS REPORT

This is my first attempt at writing a joint report for both the cities of Southampton and Portsmouth. There are benefits in comparing the two cities, as they share a number of similar characteristics – they are both Port cities, close to London, and they both have significant pockets of deprivation which makes addressing the public health problems more challenging.

This report is independent of the political administrations and other officers' views. It is my independent review of serious problems that are challenging the health of the people living in the cities.

I have chosen to focus on one topic in particular. This approach allows us to look at a single issue and ask ourselves if we have got the right approach, and if we are doing enough to address the problems it presents. For more of an overview of the various problems that are impacting on health in both cities, we also produce a Joint Strategic Needs Assessment to inform commissioning, and there are a wide variety of helpful statistics that Public Health England collates available at **https://fingertips.phe.org.uk/**

I have made recommendations from this report at a number of levels – not just for the local authorities involved, but also thinking about all the other drivers of a problem, and what could be done by private and public organisations and citizens with the power to improve the situation.

I am very grateful to the following people in particular for their help in producing this report:

- Ravita Taheem and Andrea Wright
- Cheryl Scott and John Showalter
- Jo Proctor and Barbara Hancock SO18 Big Local
- Ian Bailey Parks and Open Spaces, Southampton City Council
- Dr Christina Vogel MRC Lifecourse Epidemiology Unit, University of Southampton

22

You can get this information in large print, braille, audio or in another language by calling 023 9284 1560

Designed by: **marketing@portsmouthcc.gov.uk** • Published: **September 2018** • Ref: **114.95**