Appendix 1

Background Paper on Need and Health Inequalities

1. Southampton has a diverse population and high need. An estimated 50,000 adults are obese, 34,000 adults smoke and 36,000 adults drink at higher risk levels. *Table 1* quantifies need and provides examples of why each risk is important for reducing health inequalities.

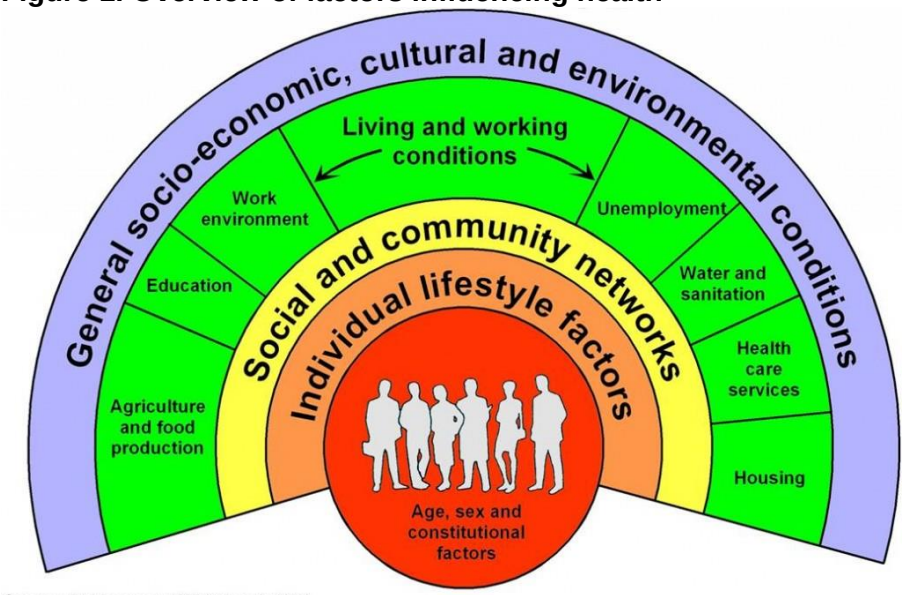
Table 1. City-level need

Adults who are:	Southampton - estimates		England - estimate	Period Most recent data available	Additional information about harm or inequalities, based on national data unless specified
	Approx no.	Prevalence	Prevalence		
Smoke	*34,000	16.8%	13.9%	2019	1 in 2 smokers die from smoking attributable conditions. Half of the difference in premature death rates (<75) between the least and most deprived is attributable to smoking. People living in the most deprived quintile (the most deprived 20% of neighbourhoods) in Southampton are 1.93 times more likely to smoke than people in the least deprived quintile.
Pregnant women smoking at time of delivery	384	12.3%	10.6%	2018/19	Women who smoke during pregnancy are twice as likely to experience stillbirth and up to 32% more likely to miscarry. Babies born to smokers are 3 times more likely to die from Sudden Infant Death Syndrome.
Overweight or obese	*132,000	63.7%	62.3%	2018/19	Obesity nearly twice as prevalent among women in the most deprived quintile

					compared to the least deprived
Inactive (active for less than 30 minutes a week)	*50,000	21.8%	21.4%	2018/19	In Southampton, inactivity is 2.63 times higher among those living in the most deprived areas of the city compared to the least deprived (2018 City Survey).
Drink more than 14 units per week	*36,000	17.8%	25.7%	2011-14	Alcohol is the biggest risk factor for death, ill-health and disability among 15-49 year olds

2. The city's health needs are complex and multifactorial. Environmental measures are important for addressing the "causes of the causes" of ill health and health inequalities longer term, such as transport, housing, planning, education and employment. These place-based and population-wide approaches are important for achieving change at scale. Community development and targeted place-based work has a role too. Figure 1 is a simple diagram summarising the influences on health.

Figure 1. Overview of factors influencing health



Source: Dahlgren and Whitehead, 1991

3. Behavioural services have their place and can be of benefit to individuals. But services for 1,000-2,000 people a year are not going to be singly effective at reducing the city's health inequalities. There is an opportunity cost to behaviour change services. The resources spent on services are thereby not available for environmental or population-level work. The converse also applies.

4. Enabling pregnant women and young families to live well is particularly impactful and cost-effective in the long term. A life-course perspective can be taken to tailor work to meet the needs of people at different life stages. Adverse Childhood Experiences

increase the risk of health and social problems in adulthood, including smoking, weight and alcohol issues.

5. Proportionate universalism is an approach which ensures that there is some provision for everyone in need and a graduated, more intensive support for those in greatest need. Universal services can inadvertently exacerbate health inequalities if purposeful efforts are not made to prevent this.

6. As a principle, supporting and embedding provision where people already are has advantages. It is less likely to exacerbate health inequalities, has been shown to be effective and is more sustainable in the long term. This applies to places and settings, were we live, work, study, shop, relax, worship and receive health and social care.

7. The NHS Long Term Plan commits to embedding key behaviour change interventions in to the NHS, specifically to:
    a. Provide smoking cessation support for hospital inpatients, pregnant women and "long-term users" of specialist mental health and learning disability services from 2023/24.
    b. Provide weight management services in primary care for people with a diagnosis of type 2 diabetes or hypertension who are obese. A timescale is not given.
    c. Double the national diabetes prevention programme over the next 5 years, which has behaviour change elements. The programme is commissioned by NHS England.
    d. Publish in 2019 a "menu" of evidence-based interventions for CCGs to reduce health inequalities

8. Future resources for behaviour change are limited and uncertain. The ring-fenced public health grant for local authorities ends nationally in March 2021. Funding mechanisms and levels for public health work in local authorities from April 2021 onwards has not been described. In previous years, funding at the local authority level has been confirmed in late December for the following March.

9. We do not know if the public health mandate will change with any new funding arrangement. Currently there is no legal requirement for local authorities to commission any behaviour change services, although it would be very difficult to not commission smoking cessation services given the strength of evidence of effectiveness.

10. Southampton experienced significant health inequalities before Covid-19. The expectation of the impact of Covid-19 is that health inequalities will be exacerbated. However, the evidence is emerging and future decision-making to reduce health inequalities should be informed by clinical, public health and wellbeing intelligence.

11. There are a range of evidence-based interventions for reducing health inequalities, which take a lifecourse and place-based approach. A focus on the wider determinants of health will have the maximum population impact. These approaches require a 'whole-system' approach.