

Improving health & wellbeing in Southampton

Health Improvement and Behaviour Change Services Engagement Event 21st March 2016



Southampton City Council & Southampton CCG

Who are we and what do we do?

Our aims are to protect and improve the public's health and wellbeing across Southampton City

Through an integrated commissioning unit we commission major programmes & services for sexual health, tobacco control, weight management, physical activity, drug and alcohol, NHS Health Checks

Healthy Southampton♥

Aims of the day

- Learn more about the need for health improvement and behaviour change services and the potential opportunities for providers
- Understand more about Southampton, the commissioners and the challenges
- Chance to get to know each other.
- Opportunity to shape the model that will improve healthy behaviours in Southampton

Burden of disease

Many early deaths and ill health could be prevented or delayed if people made healthier lifestyle choices.



Health and behaviour

Forty per cent of the UK's overall disability-adjusted life years lost are caused by tobacco, high blood pressure, overweight and obesity and low physical activity (2010 figures). This is through their contribution to diseases such as heart disease, stroke and lung cancer.

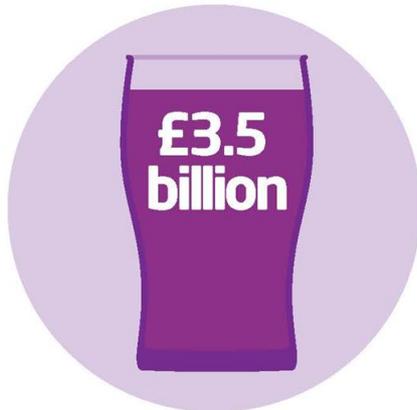
**40% of disability-adjusted
life years lost**

TheKingsFund

Local
Government
Association

Cost to the NHS

Unhealthy behaviours cost the NHS across the UK billions of pounds every year

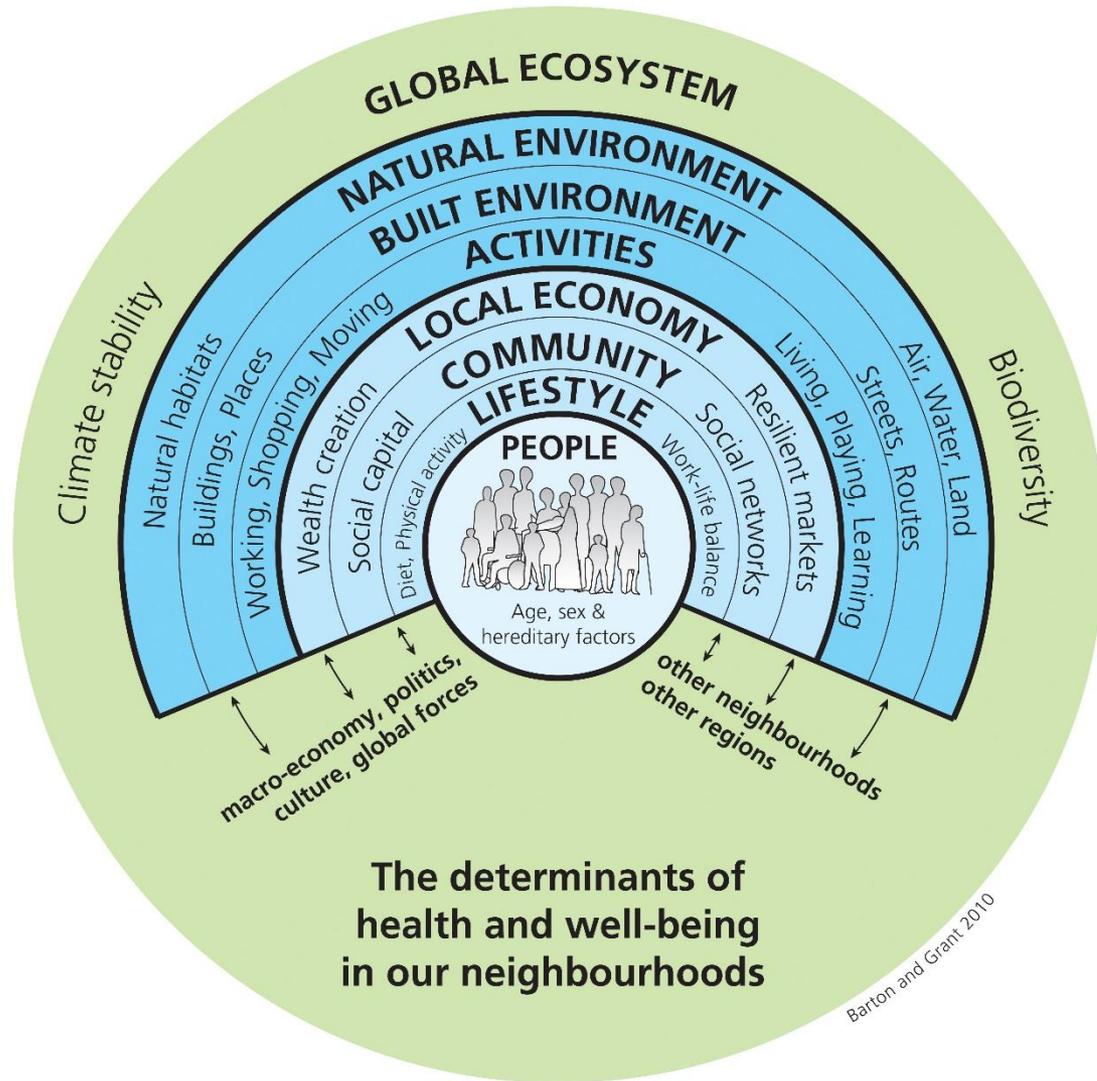


Health and behaviour

Unhealthy lifestyles cost the NHS across the UK billions of pounds every year. Smoking costs £5.2 billion, obesity £4.2 billion, alcohol £3.5 billion and physical inactivity £1.1 billion.

TheKingsFund





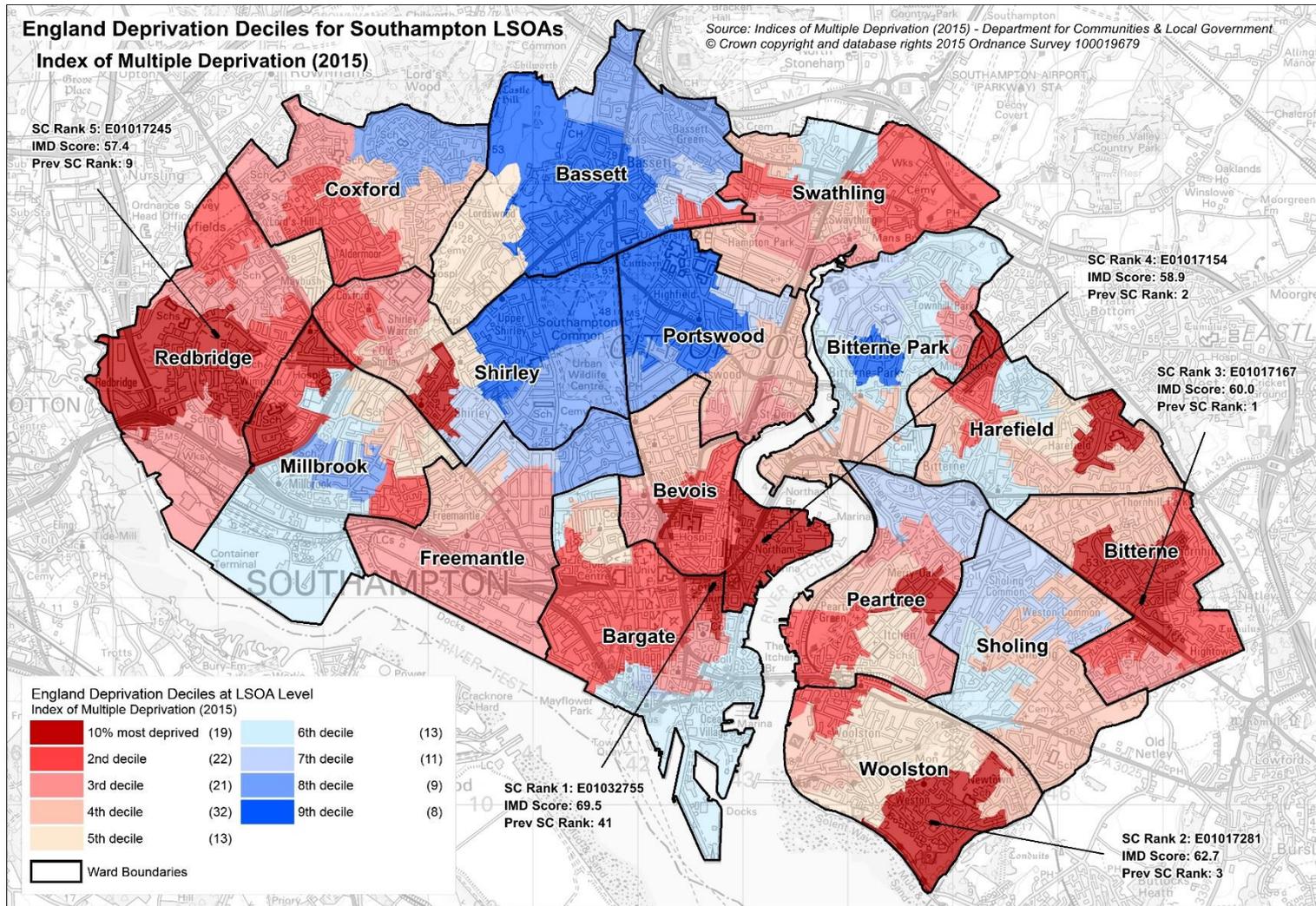
Welcome to Southampton City



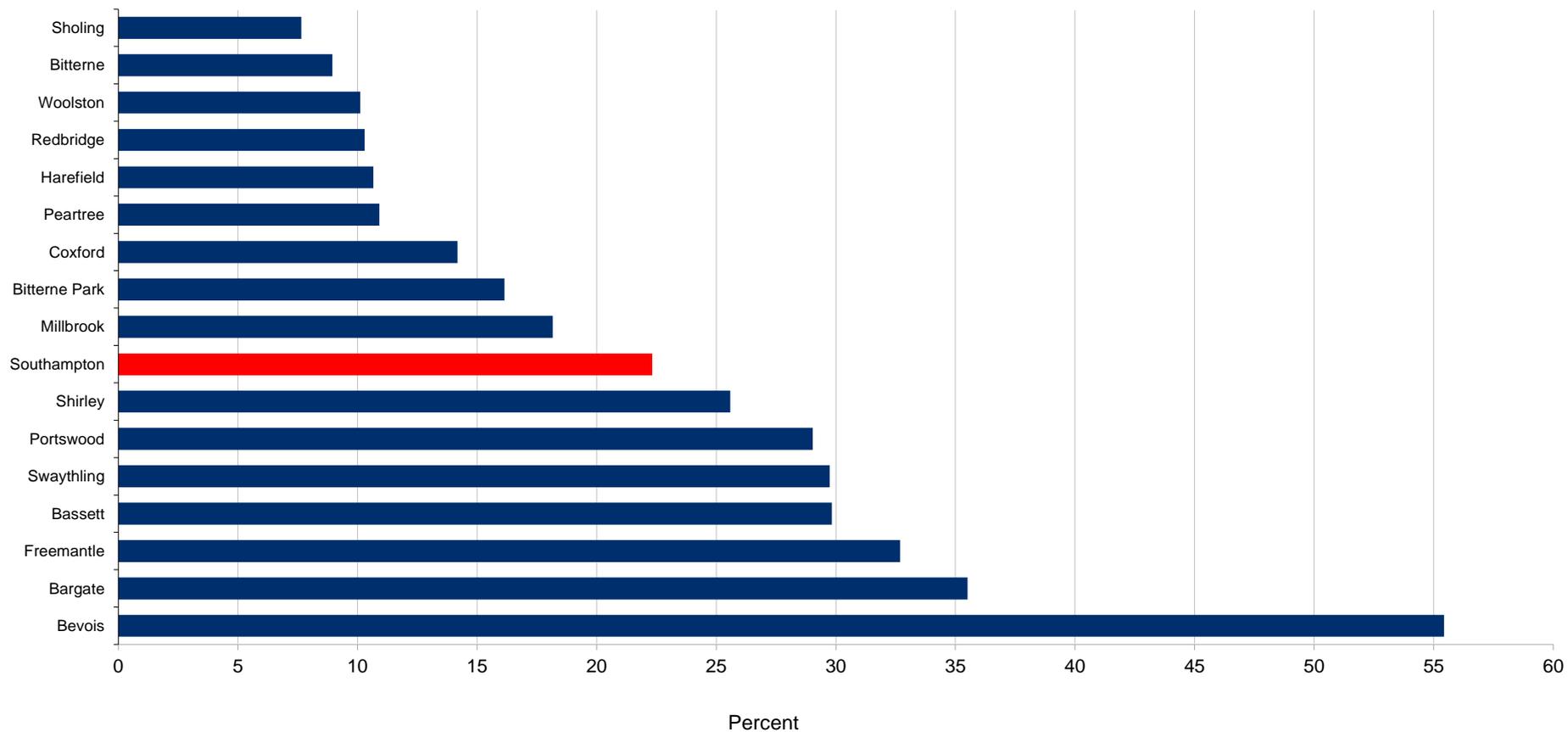
A City of two tales

A city of opportunity where everyone thrives

IMD (2015) – Map of ENGLAND Deprivation Deciles

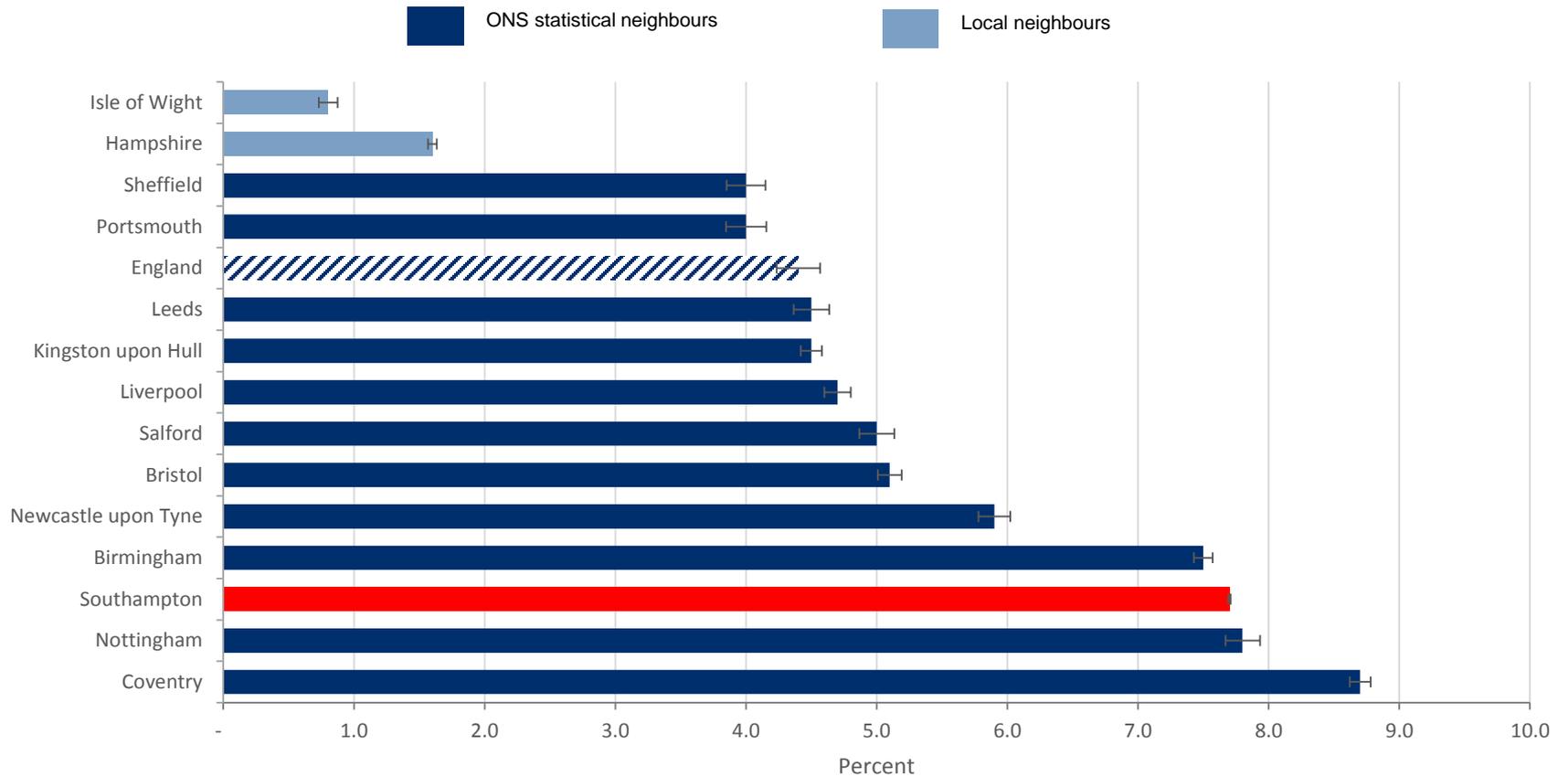


Percentage of population from an ethnic group other than White-British 2011: Southampton and wards



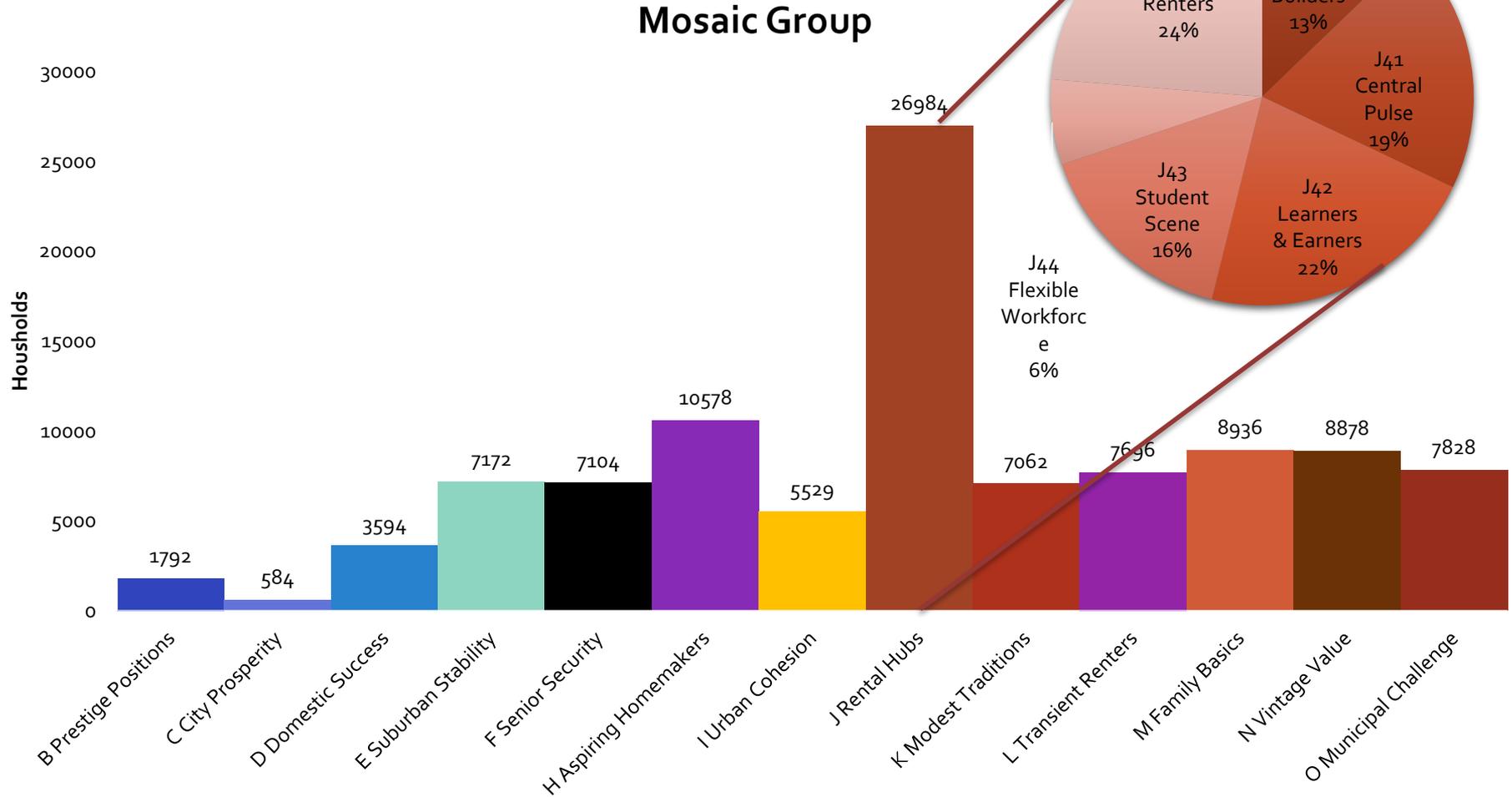
Sources: Office for National Statistics, 2011 Census, Crown Copyright

**% people in household with no English as a main language: Southampton and ONS comparators
2011 Census**



Sources: Office for National Statistics, 2011 Census, Crown Copyright

Southampton context



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Rental Hubs

Educated young people privately renting in urban neighbourhoods

Brighton and Hove

🏠 6.96% | 6.43% 👤



Who We Are



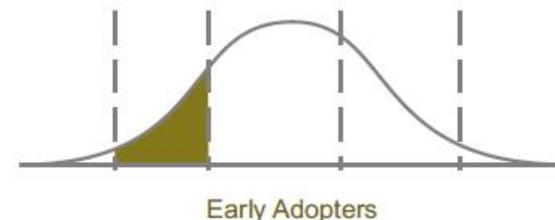
Channel Preference

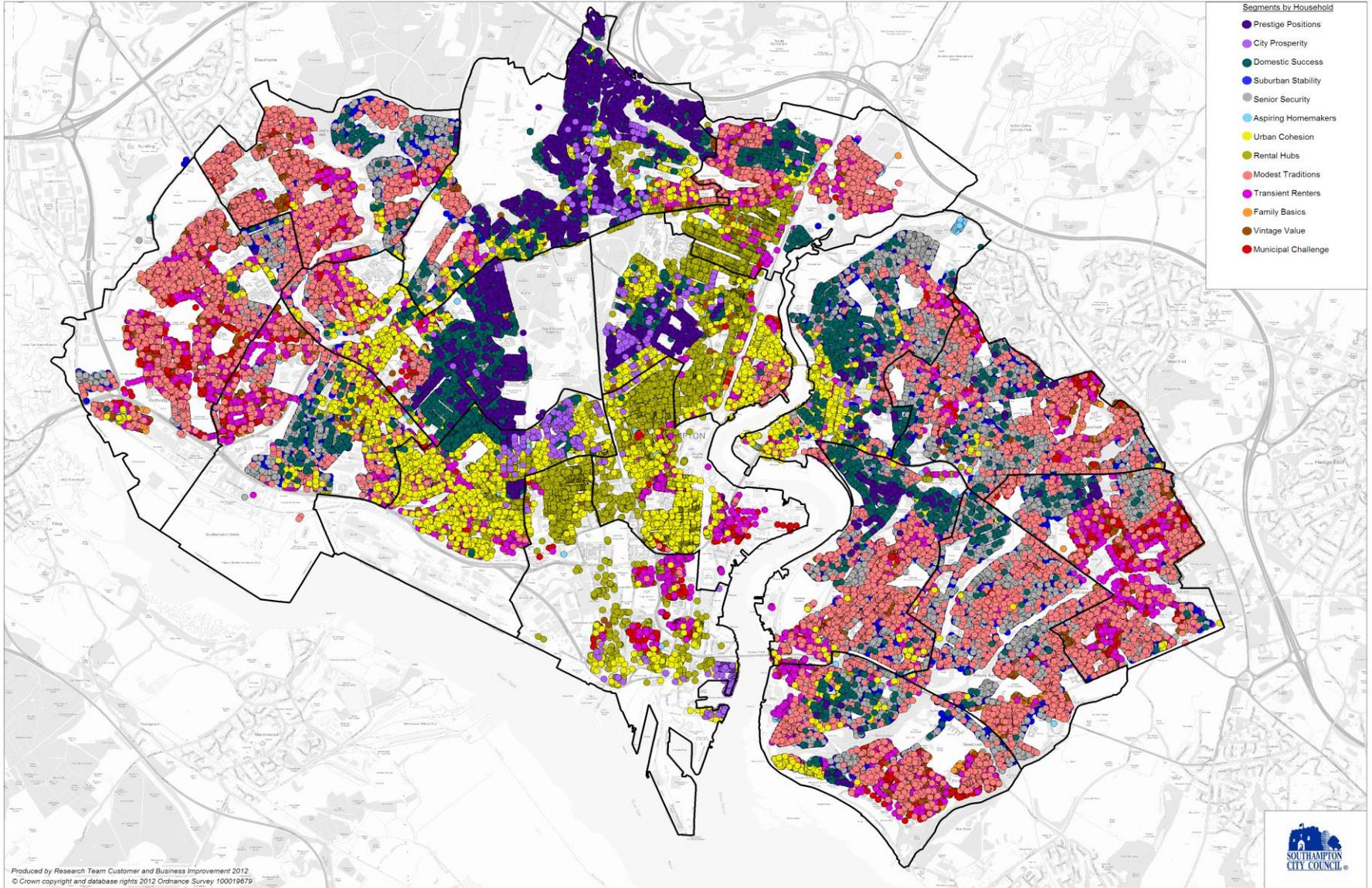


Key Features

- Aged 18-35
- Private renting
- Singles and sharers
- Urban locations
- Young neighbourhoods
- High use of smartphones

Technology Adoption





Smoking

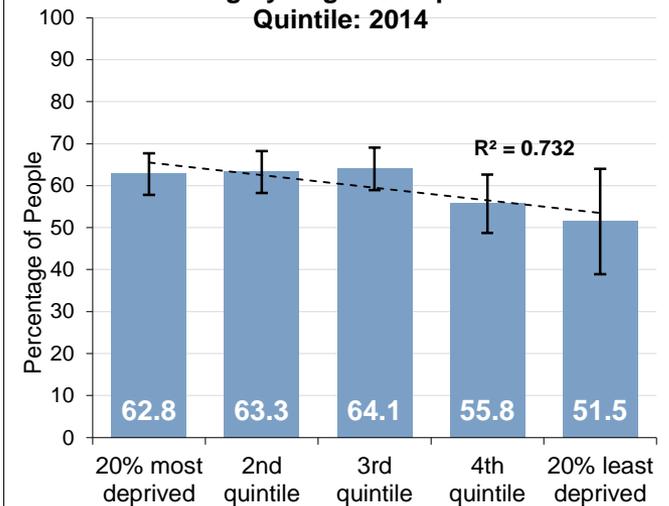
Smoking is the single largest preventable cause of death and disability in the developed world (WHO)

Smoking attributable hospital admissions have been reduced over the last 5 years

Smoking prevalence in Southampton is 21.5%, significantly higher than the England average of 18.4%

Southampton also has a significantly higher mortality rate attributable to smoking (329.2 per 100,000 pop vs 288.7)

Proportion of people reporting ever smoking by England Deprivation Quintile: 2014



Sources: Southampton City Council City Survey 2014

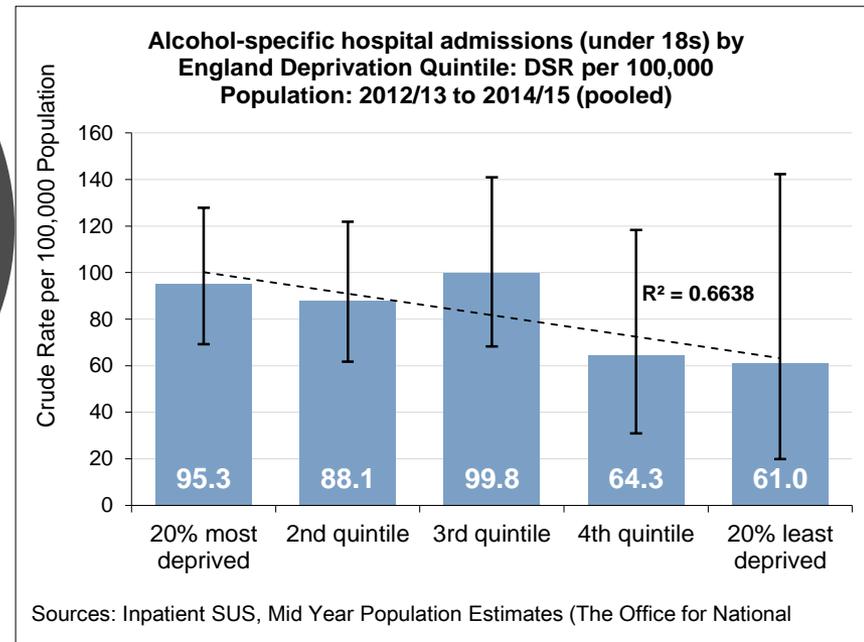
Alcohol

Alcohol-related hospital admissions have risen over the last 5 years

Alcohol misuse is estimated to cost the NHS about £3.5 billion per year and society as a whole £21 billion annually

Southampton has a significantly higher rate of benefit claimants due to alcoholism (201.3 per 100,000 working age population compared to 131 for England in 2014)

Alcohol consumption is a contributing factor to hospital admissions and deaths from a diverse range of conditions



Overweight and Obesity

Prevalence of obesity in Year R and Year 6 has remained at a similar level of the past 5 years.

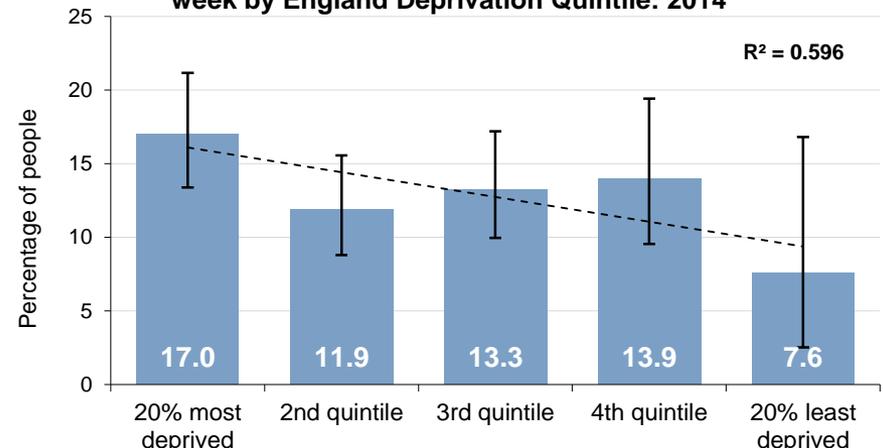
Obesity is linked to poor health in the longer term and increases the risk of conditions like diabetes, CVD and some cancers. It can also cause joint and back pain, mental health problems and social difficulties

Levels of overweight and obesity have increased over the last 20 years for adults – 62.2%

40% of obese children in Year 6 were a healthy weight in Year r

Being overweight can reduce life expectancy by up to 3 years and being obese can reduce it by up to 10 years

People doing no amount of physical activity during the week by England Deprivation Quintile: 2014



Sources: Southampton City Council City Survey

Multiple unhealthy behaviours and health inequalities

- **Multiple unhealthy behaviours have a cumulative effect on health.....**
 - Someone in mid-life who smokes, drinks too much, exercises too little and eats too poorly is four times as likely to die over the next ten years than someone who does none of these things
- **Nationally inequality in this area has increased: the rate of multiple unhealthy behaviours has decreased overall but not within the poorest parts of society**

Needs are high but the city and its communities have lots of assets too!



Current health improvement system

Unhealthy behaviours

Alcohol

Overweight/
obese

Inactive

Smokers

Mental Health

Sexual Health

Access points:

1^o care –
GP/Pharmacy/O
ptometrists

Health
Check

Self
referral

A&E

111

Walk in
centre

Hospital

Pathways:

Health Trainers

DAT

NHS Choices

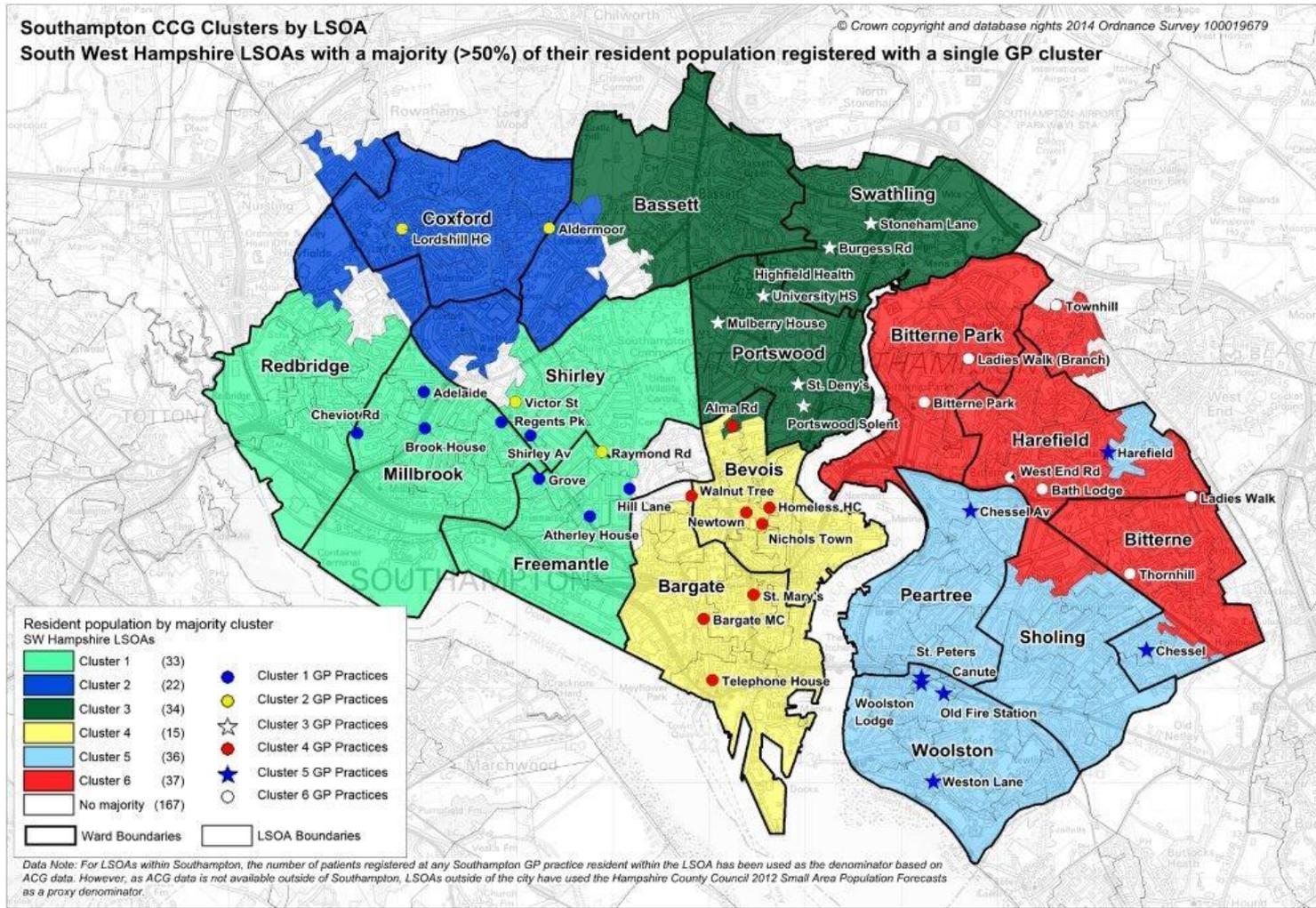
Quitters / GP /
Pharmacy

Sexual health
clinic

Weight
management

Non public
health pathways

GP Practice Clusters



Taking Responsibility for Health

The following reductions are needed in unhealthy behaviours to come in line with the England average.....



Vision for Southampton

Our vision is for Southampton residents to have access to a single, clear, consistent model of support which helps them have a healthy lifestyle and enables individuals, families and communities to develop more control over their lifestyle and health, facilitates positive behaviour change and creates environments where healthy behaviours are the norm.

Healthy Southampton[♥]

Our principles

- 1. Residents have access to a clear, consistent model of support**
- 2. Emphasis on prevention**
- 3. Behavioural insights are used to target interventions**
- 4. Frontline staff embed MECC in their daily work**
- 5. Lifestyle information & support widely available**
- 6. A passion for delivering behaviour change & community development**



Behaviour change: individual approaches

Public health guideline

Published: 2 January 2014

nice.org.uk/guidance/ph49

Behaviour change: individual approaches (PH49)

Contents

What is this guidance about?	6
1 Recommendations	7
Recommendation 1 Develop a local behaviour change policy and strategy	7
Recommendation 2 Ensure organisation policies, strategies, resources and training all support behaviour change.....	8
Recommendation 3 Commission interventions from services willing to share intervention details and data.....	9
Recommendation 4 Commission high quality, effective behaviour change interventions	9
Recommendation 5 Plan behaviour change interventions and programmes taking local needs into account.....	10
Recommendation 6 Develop acceptable, practical and sustainable behaviour change interventions and programmes	11
Recommendation 7 Use proven behaviour change techniques when designing interventions.....	13
Recommendation 8 Ensure interventions meet individual needs.....	14
Recommendation 9 Deliver very brief, brief, extended brief and high intensity behaviour change interventions and programmes	15
Recommendation 10 Ensure behaviour change is maintained for at least a year	16
Recommendation 11 Commission training for all staff involved in helping to change people's behaviour	17
Recommendation 12 Provide training for behaviour change practitioners.....	18
Recommendation 13 Provide training for health and social care practitioners	19
Recommendation 14 Assess behaviour change practitioners and provide feedback.....	20
Recommendation 15 Monitor behaviour change interventions	20
Recommendation 16 Evaluate behaviour change interventions	21
Recommendation 17 National support for behaviour change interventions and programmes	22
2 Who should take action?	24
Introduction.....	24
Who should do what at a glance.....	24
Who should take action in detail.....	25
3 Context	28



Community engagement: improving health and wellbeing and reducing health inequalities

NICE guideline

Published: 4 March 2016

[nice.org.uk/guidance/ng44](https://www.nice.org.uk/guidance/ng44)



Behaviour change: general approaches

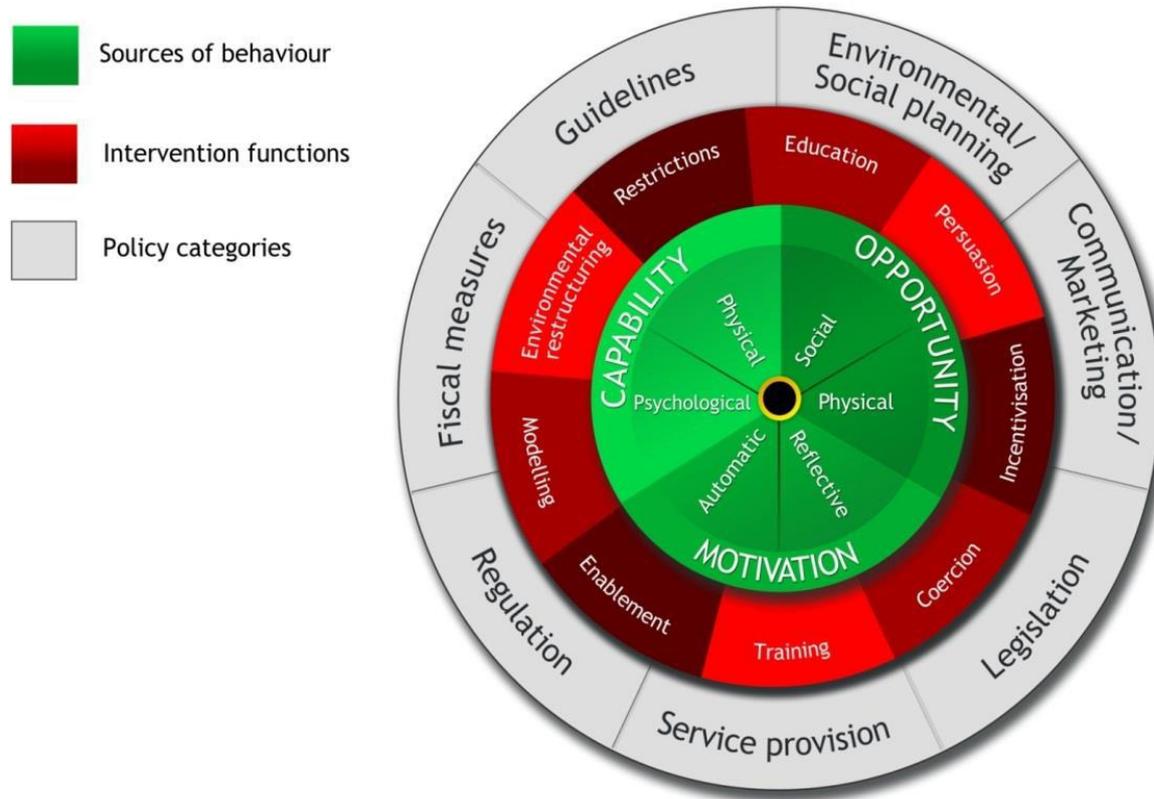
Public health guideline

Published: 24 October 2007

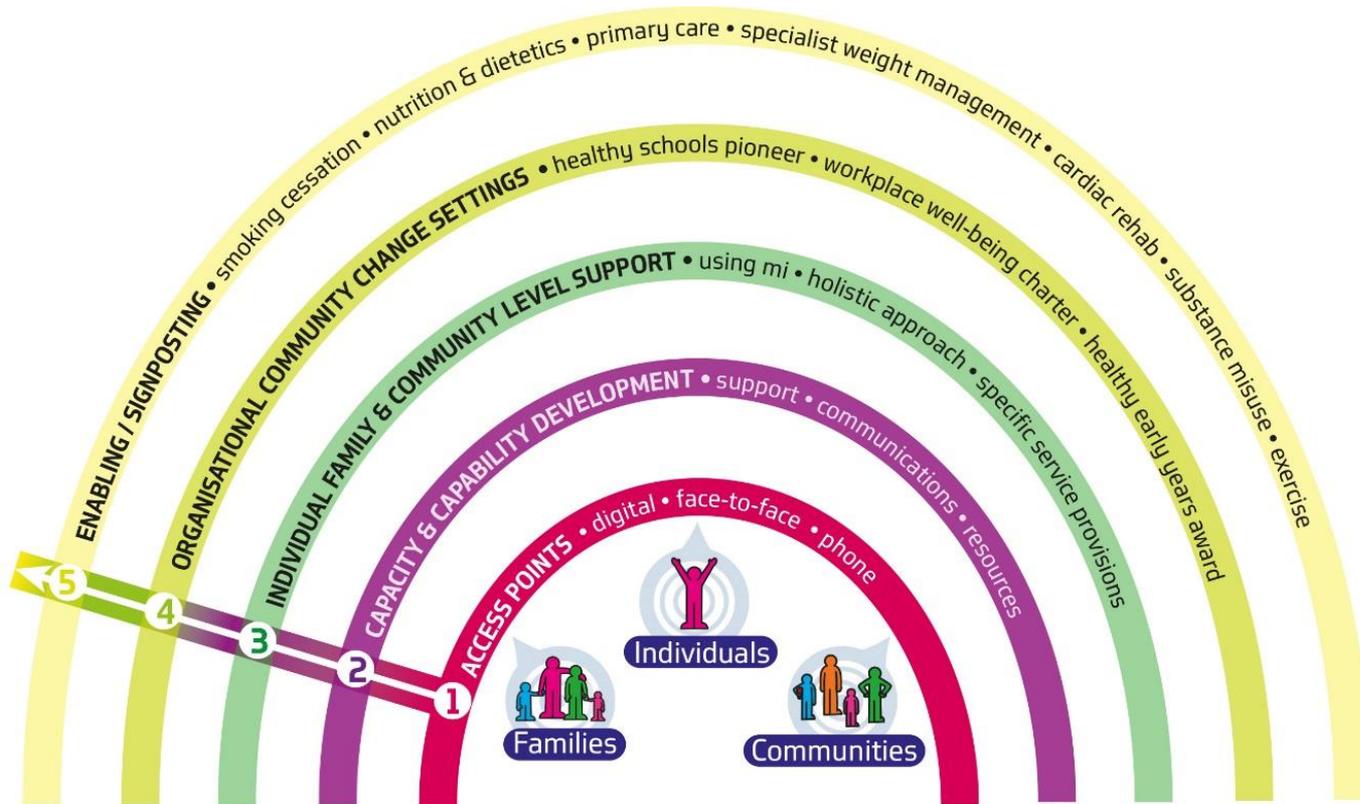
[nice.org.uk/guidance/ph6](https://www.nice.org.uk/guidance/ph6)

Behaviour Change Wheel

UCL Centre for Behaviour Change



Southampton model



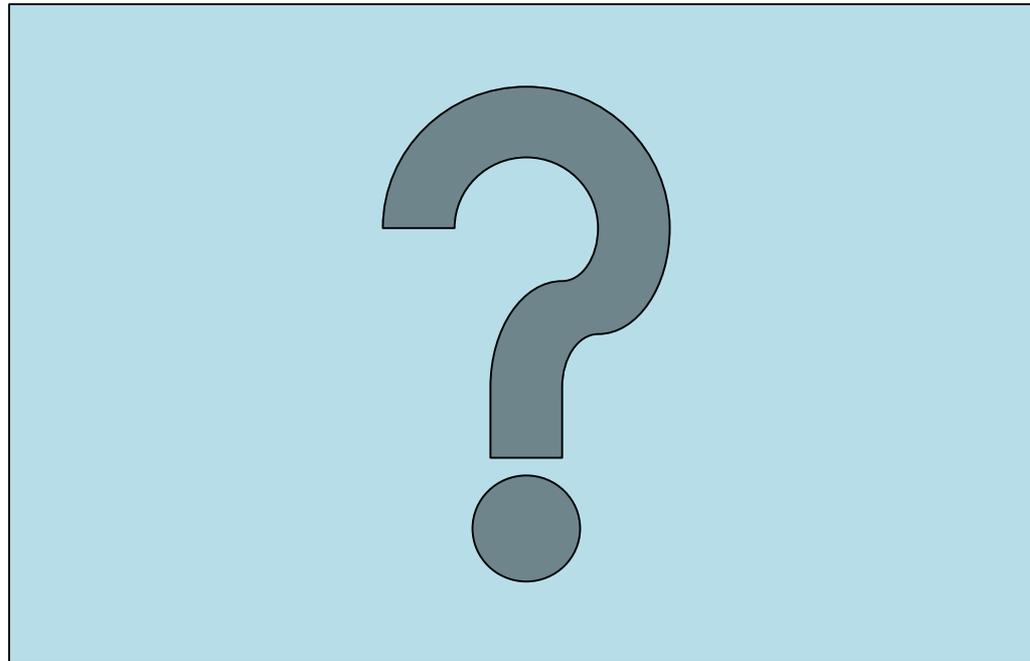
Scope of services

- Smoking
- Physical activity
- Healthy eating
- Alcohol – low level interventions

The new service model might include:

- Training and capacity development
- Volunteer development and support e.g. Youth Champions, Health Trainer Champions, Health Improvement Champions
- Resource development e.g. website / apps / directories
- Campaigns / communications
- Specific service provision - smoking, alcohol intake, physical activity, healthy eating, mental well being
- Targeted work and healthy settings – children and young people, schools, families, housing, adult social care , children's centres, offenders, workplaces
- Long Term Conditions - self-management, primary & secondary prevention

New Health Improvement and Behaviour change service(s)



Workshop 1

Understanding evidence and need.



What do we know about need for health improvement and behaviour change services in Southampton?

What are our local assets?

What works – local, national, research evidence?

Feedback from workshop

Need

- Behaviour change – does knowing/thinking
- Screening?
- A lot of small scale local projects – need for more awareness
- A service that works
- Need to build and redevelop partnerships – statutory/voluntary/ community
- Messages reaching children not getting to adults – needs to fill gap and translate knowledge in to action
- Workplace – gap/opportunity?
- Do we really engage and understand people behind statistics? Can we tap in to people's motivation more?
- Need to understand population and what's out there better
- Unhealthy health and care staff?
- Impact of service cuts and changes
- Make messages consistent
- Who doesn't engage? "Hard to reach"?

Assets

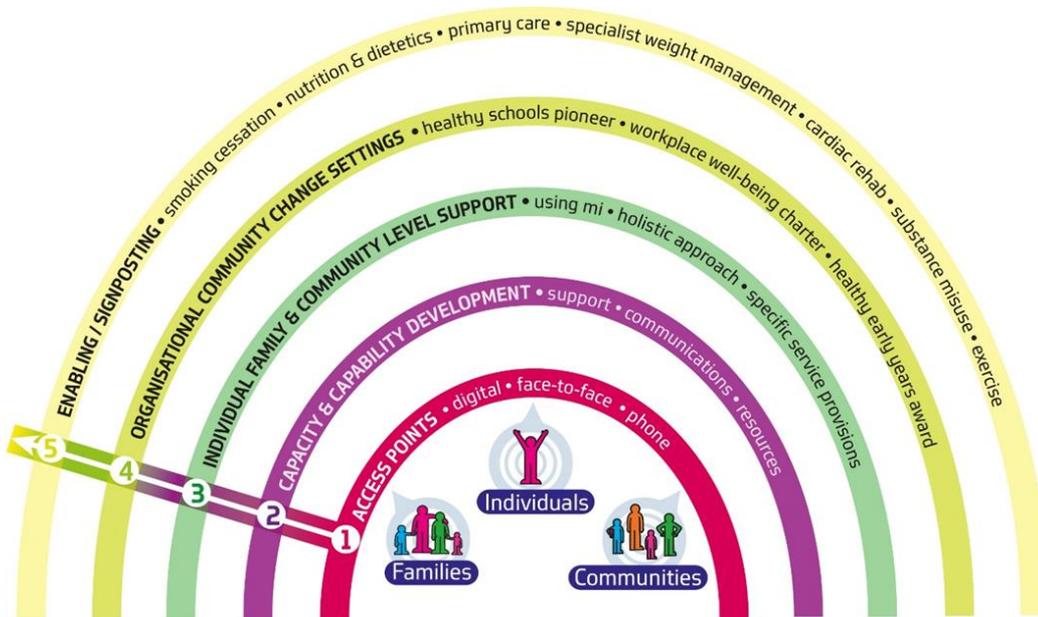
- Some times not noticed e.g. family resources, different cultures
- Vibrant multicultural community
- Existing knowledge, relationships and passion in service providers
- Existing digital assets and platforms eg Facebook and Twitter
- Barriers to some assets – how do we overcome these
- Southampton Football Club – big brand to reach target groups
- Student population – Universities
- Local radio – useful route to reaching target groups
- Corporate world
- Other services outside health – CJS, voluntary sector, homeless charities

What works

- Digital platforms
- Automaticity
- Making tools available to support change
- Outdoor gym equipment in parks
- Person-centred services
- Single point of access/directory of services
- Start with individual not need
- Variety of services and organisations working together
- 5 point physical activity test
- Challenging people about their behaviour and impact on them – raise awareness of need to make change
- Derbyshire kite mark – service provider – could we have accreditation scheme in city?
- Self-assessment and individualised support
- Build on existing services and touch-points – Community Pharmacy, Primary Care, Fire Service
- Targeting market segments
- Payment by outcome – incentives to achieve
- Advice Southampton currently being developed
- Balance between enforcement and individual support
- Southampton Information Directory
- Portsmouth – Health Employers accreditation
- Making healthy choices the norm – doesn't always have to be about engagement in service

Workshop 2

Developing the model.



What will a successful service look like?

- a) Access
- b) Digital platform
- c) Referrals
- d) Community development
- e) Capacity development and MECC
- f) Data collection
- g) Outcomes

Workshop 3

Working with partners and the community.

- **What will this look like for our communities and the organisations working with them?**
- **How do we build on existing assets?**
- **How can we work together to develop the model?**

Lifestyle:

- Smoking
- Healthy eating
- Physical activity
- Weight management
- Alcohol

Communities

- Age, gender
- Clusters/localities
- Faith, culture
- Language
- Ethnicity

Settings:

- Early Years
- Schools
- Workplaces

Feedback from workshop

- Access – range of platforms required – not just digital/phone
- Mobile partnerships, create levers. Community Pharmacies, schools, workplaces.
- Important to build partnerships and build on existing assets and workforces.
- Return on investment.
- Social media, app, self-referral as well as referral.
- Local community infiltration – finding different ways to engage.
- Working with and understanding community. Outreach.
- Deliver services where people are.
- Motivation. Challenging social norms. Engage at right points.
- Incentives? Financial?
- Community leaders to work with groups and services/employers to tell story through different groups.
- Healthy conversations – engage before referral to services.
- Southampton icons.
- Healthy Southampton campaign? Lose 1m kg in city – whole population challenge rather than individuals.
- Use schools and universities as focus groups.
- Public engagement – need to understand different perspectives.
- Healthy shops – can we use data? Rate healthiness?
- Confidence building and resources required as well as healthy messages.
- No “one size fits all” service.
- Commissioners to work with providers to enable them to come together and deliver what they do best.
- Important to have resources in the community to buddy – Health Trainers, Community Navigators
- Commission a model that makes it easy for Providers to work together.
- Move health messages away from health setting. Involve retailers – health sells.
- Use retail/business assets.
- Focus on motivation and using resources and assets we have already e.g. hairdressers as a workforce.
- Look at community assets differently – different functions for existing space during day. Breaking with tradition.
- Digital platform – more than a website and apps.
- Link to national campaigns, resources and support. Promote local events.
- Self-assessment, e-training, digital behaviour change and interventions. Use activity trackers and other new technology.
- Workforce development – opportunity to promote training and use websites to promote.
- Use online resources for referral.
- Access must be localised – comfortable and familiar for the community that needs to use it.
- Ensure there are access points locally and relevant to each community.
- GP Practices – can we ensure a minimum level of service? Universal service v. targeted local?
- Explore cost-effectiveness of digital platforms
- New Zealand model? Kings Fund Place Based System of Care. Providers working together.
- Build relationships and trust to ensure integrated care and support.
- How do we change culture and bring people together?