Public Document Pack
SOUTHEND-ON-SEA BOROUGH COUNCIL

Health & Wellbeing Board

Date: Wednesday, 18th September, 2019 @ 17.00
Place: Committee Room 5 - Civic Suite
Contact: Robert Harris (Principal Democratic Services Officer)
Email: committeesection@southend.gov.uk

A G E N D A

1 **Apologies for Absence**

2 **Declarations of Interest**

3 **Minutes of the Meeting held on Wednesday 12th June 2019** (Pages 1 - 4)
Minutes attached.

******** **Items for discussion**

4 **LeDeR Mortality Review** (Pages 5 - 26)
Report of the Interim Director of Public Health, attached

5 **Primary Care Networks**

6 **BCF 2019/20**

7 **Community Dementia Plan**

8 **Teenage Pregnancy and Young Parents in Southend-on-Sea: Understanding the bigger picture of needs through case load analysis** (Pages 27 - 36)
Report of the Interim Director of Public Health, attached

******** **Items for information**

9 **Brexit in the context of the Health and Wellbeing Board**

10 **Southend Physical Activity Strategy 2016-2021- Progress Update** (Pages 37 - 106)
Report of the Interim Director of Public Health, attached

11 **A Better Start Southend Update** (Pages 107 - 120)
Report of the Chair, ABSS, attached

12 **Southend Tackling Harmful Behaviours Strategy** (Pages 121 - 146)
Report of the Director of Public Protection, attached

13 **Annual Public Health Report 2018-19** (Pages 147 - 182)
Report of the Interim Director of Public Health, attached

Members:

Cllr T Harp (Chair), Cllr M Davidson, Cllr A Jones, Cllr I Gilbert, Cllr C Mulroney, Cllr C Walker, J Garcia-Lobera (Vice-Chair), Mr T Huff, Ms J Gardner, Ms Y Blucher, Mr A Khaldi, Mr A Pike, Mr S Leftley, Mr K Ramkhelawon, Ms K Jackson, Ms S Morris, Dr K Chaturvedi, Mr M Freeston, Ms A Griffin, Ms S Dolling, Ms J Cripps, Ms C Panniker and Ms J Broadbent

SOUTHEND-ON-SEA BOROUGH COUNCIL

Meeting of Health & Wellbeing Board

Date: Wednesday, 12th June, 2019
Place: Darwin Room - Tickfield

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Present: Dr J Garcia-Lobera (Vice-Chair in the Chair)
Councillors M. Davidson, A. Jones, I Gilbert, C. Mulroney and *M Flewitt
S. Leftley, A. Khaldi, K. Ramkhelawon, S. Waterhouse, J. Broadbent, D. Townsend, S. William, J. Gardner,

*Substitute in accordance with Council Procedure Rule 31.

In Attendance: Councillor L. Salter (observer – People Scrutiny Committee Chair)
R Harris, N Faint and S Baker, S. D Ford, L. Watson,

Start/End Time: 5.00 - 6.25 pm

59 Apologies for Absence

Apologies for absence were received from Councillor Harp (no substitute), Councillor Walker (substitute: Cllr Flewitt), E. Chidgey; Y. Blucher, T. Huff, Dr, K Chaturvedi, S. Morris, A. Griffin and S. Dolling.

60 Declarations of Interest

Dr J. G. Lobera – Minute 65 (Primary Care Networks) – non-pecuniary interest – will be involved in some of the work around Primary Care Networks.

61 Questions from the Public

There were no questions from the public.

62 Minutes of the Meeting held on Wednesday 20th March 2019

Resolved:-

That the Minutes of the Meeting held on Wednesday 20th March 2019, be confirmed as a correct record and signed.

63 Southend-on-Sea, Essex and Thurrock Suicide Prevention Strategy- Progress Update

The Board considered a report of the Director of Public Health presenting an update on the Southend-on-Sea, Essex and Thurrock (SET) Suicide Prevention Strategy 2017.

The Board noted that the report would be submitted to the next meetings of the Essex and Thurrock Health and Wellbeing Board's.

The Board asked a number of questions which were responded to by officers. The Board also made the following comments:

- It was a comprehensive strategy;
- Auditing of delivery of Option 2 needs to take place (this will be driven through the Suicide Prevention Partnership Steering Group);
- Toolkits and delivery in schools essential – two toolkits developed around self-harm and suicide prevention across the safeguarding arena – will be released to schools in September supported through healthy schools – toolkits have been designed to be flexible for use in any educational setting;
- Need to consider how embed in foster care training – will be raised at the Children's and Emotional Wellbeing Board;
- Ensure links in with the Youth Council's Mental Health 1757 Voices Charter;
- Challenges for the HWB – alcohol is a key driver and will need to look at focused activity in this area (The Harm Reduction Strategy was referred to which will be presented to the next meeting of the Board);
- Need to address the wider determinants of suicide, e.g. access to opportunities to commit suicide;
- It was noted that the JSNA Steering Group update should have been a standing item on the agenda. This will now be included and the revised terms of reference will be circulated for the next meeting of the Board.
- Some work to do around primary care and with GPs on suicide prevention, i.e. spotting the signs;
- Recognise that social media has an impact;

Resolved:

1. That the SET Suicide Prevention Strategy 2019 update, be noted.

2. That the (draft) SET Suicide Prevention Steering Group Board Terms of Reference be endorsed and that the Steering Board be authorised to have decision making responsibility on behalf of the Health and Wellbeing Board, as appropriate.

3. That suicide prevention training and bereavement by suicide support be priority actions for development on a SET footprint.

4. That Option 2, as detailed in Section 5 of the report, be the preferred mechanism for implementing suicide preventing training.

64 Southend Physical Activity Strategy 2016-2021- Progress Update

The Board considered a report of the Deputy Chief Executive (People) providing a review and update on the progress to date with the implementation of the Southend-on-Sea Physical Activity Strategy 2016-2021 refreshed action plan.

The Board discussed the report and made the following comments:

- Encouraging progress to date – people continue to be engaged in the programmes and successful in removing some of the barriers to access physical activity;
- Need to continue to build on the progress and successes;
- Welcomed the approach to be more community-led;
- The role of Councillors, Board members, etc to champion in their respective communities;
- The opportunities available through various other strategies, etc, e.g. the Local Plan;

Resolved:

That the progress and update on the Southend Physical Activity Strategy 2016-2021, including its successes, challenges and future opportunities, be noted.

65 Primary Care Networks

The Board received a verbal update covering the progress with the development of Primary Care Networks. The following information was presented:

- PCNs should go live from July 2019;
- All GPs are part of the networks;
- PCNs are based around population of 30,000-50,000;
- Southend ahead of other areas in developing / implementing PCNs;
- PCNs will build resilience within primary care enabling work at a wide scale while retaining locality;
- Each network will provided extended hours;
- Networks will provide greater integrated working;
- Will be 10 new clinical directors – consideration being given to how they will be represented on the Board and in other areas of activity;
- Collaborative approach across the 3 Health and Wellbeing Boards (Southend, Essex and Thurrock) through the Population Health Management Programme.

The Board made the following comments:

- Positive approach – aligning with localities key to successful provision of health and care within primary care in communities;
- Need to be flexible – each network will have different needs and requirements;
- Need to consider how the networks will align with Southend 2050 and South Essex 2050 and what the opportunities are to build on these and other relationships;
- Wider than GP practices – need to build resilience across the whole primary care system;
- Key message that the networks will improve the provision of care and wellbeing, as defined in the Primary Care Strategy in their respective areas;
- Healthwatch nationally carried out piece of work around citizens understanding of primary care networks – results / outcomes from the surveys are currently being assessed and would be provided to the next meeting of the Board;

Resolved:

1. That the update and progress on the development of the Primary Care Networks, be noted.

2. That a further progress/update on the primary care networks be presented to the next meeting of the Board.

3. That the outcomes from the survey carried out by Healthwatch relating to citizens understanding of primary care networks, be presented to the next meeting of the Board.

66 A Better Start Southend Update

The Board considered a joint report of the Chair and Director of A Better Start Southend providing an update on key developments since the last meeting of the Health & Wellbeing Board.

The Board discussed the report and made the following comments:

- Commended the current position with the programme in good shape;
- Need to start to see the impact and outcomes – what is working and how it can be replicated across the borough;
- Connectivity with all parts of the NHS has significantly improved.

Resolved:

That the report be noted.

67 Date and time of future meetings

The meeting scheduled for Wednesday 4th September 2019 will be rearranged and will take place towards the end of September / beginning of October 2019.

Chairman: _____

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LeDeR Southend Essex and Thurrock
End of Year Report 18-19

Rebekah Bailie | LD Integrated Health Commissioner/LeDeR Local Area Coordinator |
April 2019

1. National Context

The LeDeR National Annual Report has been released and action into learning sets have reported. Where we have comparable data, SET compares to national findings as follows:

	SET LeDeR	National LeDeR	Comment
Gender Split	57% male 43% female	58% male 42% female	
Age at death	Median 61 years (55-64 years 23%; 65-74 years 28%)	Median 59 years Males 60 years Females 59 years	National population median 2015-17: Male 83 years Female 86 years
Ethnicity	3% BAME	10% BAME	National population 14% BAME
Cause of death (Pt 1 Certificate)	Chest/Respiratory/pneumonia 37% (aspiration pneumonia a further 7%) Sepsis 19% (multiple organ failure a further 11%) Cancer 15% (note total = 27 redacted reviews – small sample)	Pneumonia 25% Aspiration pneumonia 16% Sepsis 7% Dementia 6% Ischaemic heart disease 6% Epilepsy 5%	
% falling short of best practice with potential or actual adverse impact	7%	8%	
Place of death	Hospital 53% Usual residence 38% Other 9%	Hospital 62% Usual residence 30% Other 8%	National population Hospital 46%

The national findings indicate that people from Black and Minority Ethnic (BAME) groups (particularly children) and those with profound and multiple learning disability are more at risk of dying younger than other people with LD. As the percentages of SET notifications are small for both these groups (BAME 3% and Children 8%), not enough relevant reviews have been completed to make any statements or comparisons at this point.

The general information for SET does not highlight any specific area which stands out as more problematic than the national picture, but neither are we providing any better outcomes. For discussion of local learning and actions compared to national themes, see sections below.

NHSE have requested an audit, which has been carried out for SET by the LAC in order to clearly establish the baseline of outstanding reviews and this will enable NHS England to allocate £5million national funding to address the backlog up to December 2018. This

could be resourced through CSUs or through local management (dependent on submission of a successful trajectory and bid).

2. Performance/KPIs

1. Each CCG must be a member of a learning disabilities mortality review (LeDeR) steering group, and have a named person with lead responsibility.

Each CCG has a named person who is invited to each Steering Group meeting and receives all information, minutes and resources relevant to the group. Patricia D'Orsi is the Director of Nursing with lead responsibility.

2. There must be a robust CCG plan in place to ensure that a LeDeR review is undertaken within six months of the notification of a death in its area.

SET does not currently have reviewer capacity to comply with this KPI, but has a robust plan to achieve this (see "Trajectory" below). There are currently 98 incomplete reviews which were notified more than 6 months ago (63% of all incomplete reviews) There are 7 reviews with a reviewer for more than 12 months, which require support from Senior Managers to free up time to conclude these.

									Incomplete reviews:		Those with a reviewer	
NHS ENGLAND LONDON REGION Steering Group & CCG	All Notifications (in scope)	% unassigned	% complete	% in progress	With LAC for allocation	With reviewer for completion	With LAC for approval	Completed	> 6 months since notification	% active reviews >6m.	> 6 weeks since allocation	% allocated > 6 wks ago
Essex steering group	**188**	**61%**	**18%**	**22%**	**114**	**34**	**7**	**33**	**98**	**63%**	**30**	**88%**
NHS BASILDON AND BRENTWOOD CCG	12	42%	8%	50%	5	5	1	1	8	73%	5	100%
NHS CASTLE POINT AND ROCHFORD CCG	15	73%	13%	13%	11	1	1	2	9	69%	1	100%
NHS MID ESSEX CCG	38	68%	13%	18%	26	3	4	5	23	70%	2	67%
NHS NORTH EAST ESSEX CCG	58	64%	17%	19%	37	10	1	10	28	58%	10	100%
NHS SOUTHEND CCG	25	48%	28%	24%	12	6	0	7	10	56%	4	67%
NHS THURROCK CCG	16	56%	25%	19%	9	3	0	4	8	67%	3	100%
NHS WEST ESSEX CCG	24	58%	17%	25%	14	6	0	4	12	60%	5	83%

Progress towards an improved position has been broadly as predicted

	Notifications				Status			
	No.	% unassigned	% complete	% in progress	With LAC for allocation	With Reviewer for Completion	With LAC for Approval	Completed
Sep 2018	137	61%	11%	28%	84	34	4	15
Dec 2018	152	57%	13%	30%	86	45	1	20
Mar 2019	188	61%	18%	22%	114	34	7	33

Predicted Position	Actual
• 187 Notifications	188 Notifications
• 35 Reviews completed	33 Reviews completed

• 114 outstanding of which 85 will be outstanding for over 6 months	114 outstanding of which 98 are for over 6 months.

The main cause of discrepancy has been reviewers leaving their posts without completing expected reviews or not completing long outstanding reviews within expected timescales. The actions identified to address these are as follows:

a) Additional funding committed to provider additional fixed term reviewer capacity
b) Request through TCPB to prioritise long outstanding reviews in reviewer roles.

Trajectory

The trajectory has been updated to show how additional resource (on top of two full time permanent reviewer posts) will be used to address the backlog and enable two permanent reviewers to sustain the system within KPI targets. Additional funding has been agreed through the Collaborative Agreement across SET and will be used to recruit

a) Part time consultant reviewers starting in June 2019 until end March 2020 or when interim posts offer sufficient capacity at a lower cost

b) Interim reviewer posts up to 2 x full time

Additional funding from NHSE has not yet been confirmed and so has not been applied to this trajectory, but would further shorten the timescale to remove the backlog.

	April	May	June	July	August	Septembe	October	November	December	January	February	March
Outstanding Reviews	135	143	151	153	147	141	123	105	87	65	43	21
Reviews over 6 months	106	114	122	124	118	112	94	76	58	36	14	-8
Notifications	10	10	10	10	10	10	10	10	10	10	10	10
Reviews (LeDer Reviewers)	0	0	0	6	14	14	26	26	26	30	30	30
Reviews (Pool)	2	2	2	2	2	2	2	2	2	2	2	2
Total Reviews Complete	2	2	2	8	16	16	28	28	28	32	32	32
LeDeR Reviews Completed	39	41	43	51	67	84	112	140	168	200	232	264

3. CCGs must have systems in place to analyse and address the issues and recommendations arising from completed LeDeR reviews.

The Local Area Coordinator analyses the learning from reviews on behalf of the CCGs and presents this to the Steering Group, who collectively form the action plan to address the issues. These themes and actions are reported to:

Health and Wellbeing Boards, Safeguarding Boards, Transforming Care Partnership Board, Quality Committees within all organisations represented on the Steering Group, Expert by Experience Forum.

4. An annual report, detailing the findings of local LeDeR reviews and the actions taken, must be submitted to the appropriate board/committee for all statutory

partners, and shared amongst other local health and social care boards as appropriate.

This report forms the annual summary and will be updated quarterly to the relevant boards and partners.

3. Themes and Learning

The proportion of notification by CCG broadly reflects the proportion of social care provision across the County, but there is a need for thorough analysis of population, mortality and notification against a number of factors. Clarification of GP LD registers and comparison of notifications with ONS data are two pieces of work being carried out by LD Integrated Health Commissioners, but resource is required to carry out a more detailed project.

CCG	No. deaths	%
NHS NORTH EAST ESSEX CCG	58	31%
NHS MID ESSEX CCG	38	20%
NHS SOUTHEND CCG	25	13%
NHS WEST ESSEX CCG	24	13%
NHS THURROCK CCG	16	9%
NHS CASTLE POINT AND ROCHFORD CCG	15	8%
NHS BASILDON AND BRENTWOOD CCG	12	6%
SET steering group total	**188**	

Local Learning from Completed Reviews

This is an abbreviated form of a more detailed paper with redacted examples from 27 completed and redacted reviews (21 adult, 6 children), which have been presented to the Steering Group and form the basis of the action plan.

1. Early frailty and deterioration

Sepsis and pneumonia are commonly identified as the clinical causes of death (both nationally and locally), but they are often the end in a period of deterioration following common features of frailty. This pattern typically occurs earlier the life of a person with Learning Disability i.e.in their 50's for a number of reasons:

a) Falls and mobility
b) Long term conditions
c) Deterioration

2. Dysphagia

Pneumonia, respiratory failure or chest infection was shown as a cause or contributory factor in 12 cases but only 2 of these were identified as aspiration pneumonia. it is not clear whether swallowing issues were involved as an underlying cause in the others.

3. DNACPR/Decision not to treat

Do not Attempt Cardio-Pulmonary Resuscitation (DNACPRs) are almost always in place at the time of death and are marked as correctly completed. However the reasoning behind the decision is rarely clear from the review. Quality of life is referenced but available information on the person's quality of life before they became ill is not robust.

4. Mental Capacity Act/Health Insight

Assessments may be lacking or queried by later assessments. It is not clear what work has been done to support an adult understand the implications of health conditions or the consequences of choices (health insight).

5. End of Life

A number of recommendations referenced the need to plan early to support people with LD to identify where they would like to die and how they would like to be supported

6. Not known to services

Sometimes adults are not known to specialist health or social care services and only occasionally attend GP. They then are known only in crisis and shortly before death. At other times people were known to one service, but not referred to others which could have usefully intervened.

Cancer is a significant cause of death (relative to the small sample size of redacted reviews) and while no formal recommendations were yet made by reviewers, the members of the Steering group identified local issues which will be held on the action plan.

Actions

The LeDeR National Annual Report has been released and action into learning sets have reported. There are 12 national recommendations and 5 key areas for national action, which will be implemented across SET:

- Pneumonia – efforts will focus on increasing the uptake of the flu vaccine among people with a learning disability alongside other at risk groups through a targeted awareness campaign.
- Respiratory – The NHS will commission an independent review into the deaths of people with a learning disability due to respiratory conditions to address inequalities amongst this patient group.
- Constipation – the NHS will launch a national campaign to promote awareness around the risk of constipation including how it can be prevented, recognised and treated to better support families, carers and staff who work with people with a learning disability.

- Sepsis and deterioration – Earlier this year NHS England took action to help ensure hospital staff spot and treat the killer blood condition within an hour to save thousands more lives.
- Cancer – the uptake of screening to ensure early diagnosis of cancer is a priority for the NHS with a focus on people with a learning disability in the national screening review. The NHS is prioritising making reasonable adjustments for screening including the roll out of easy read information.

SET Action Plan

The SET action plan is based on the 27 completed reviews accepted and returned from Bristol, which have been presented to the Steering Group, but will also take account of National actions and guidance from the Action Learning Sets. Further reviews will be presented to the Steering Group at bi-monthly meetings and the action plan will continuously be updated. Actions will need to be taken at different levels:

a) Systems Level:
- Single record of information (adult held)
- Shared understanding and escalation of risks to health
- Reasonable adjustments
- Best practice pathways
- Integrated and multi-disciplinary working including case management

b) Individuals
- Availability of accessible information on health and resources
- Support for decision making
- Support to plan End of Life

c) Families and Carers
- Information on health and resources
- Involvement in decision making
- Training on health issues

It is clear that health and wellbeing are everybody's responsibility and that all parts of the health and social care system need to work together. There will be a need to prioritise key areas for implementation this year and commitment from all partners will be needed.

LeDeR Action Plan 1.0.xlsx

Rebekah Bailie
LeDeR Local Area Coordinator
LD Integrated Health Commissioner

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Southend Essex and Thurrock LeDeR Action Plan

Actions

Issue	Recommendations	Local	Lead	National	Timescale	Measure
1. Frailty and Deterioration	Earlier treatment when carers first identified the person was "off colour" plus referral for NGT in community may have helped give XX the strenth to withstand infection	1.1 provider forums to be mapped and communications planned to include national information 1.2 Health and Wellbeing Strategy for LD to be established covering social prescribing, care navigation, and accessible information 1.3 results of national working groups to be circulated when known	Public Health(Krishna Ramakhelawon)	sepsis and pneumonia working groups Flu vaccine programme		Carers can identify changes in health and know what to do to get the relevant help and prevent deterioration/crisis
	social care staff failed to identify the deteriorating patient					
	The process to access funds for someone who has a deputy under court of protection is clear and functions well in day to day life but when the individual has rapidly deteriorating health and unplanned interventions the system is slow and cumbersome There needs to be a process to bypass this or more advanced planning to ensure this is not the case	Item to be agreed at the next meeting				
	multiple attendance at A&E should trigger action	1.5 LD Dynamic Risk Register (currently held by Essex Learning Disability Partnership ELDP) to be expanded to raise health alerts. Criteria and mechanisms to be developed across organisations including LD Liaison nurse flagging and Primary Care.	HPFT (Wellington Makala)			There is a shared system for identifying and escalating risks to health across health and social care When risks are identified, health and social care intervene to prevent escalation/deterioration
	People at high risk of falls and reduce mobility should be escalated					
	Multiple (old) fractures should be escalated					
2. Long Term Conditions	improved care is needed for people with learning disabilities who have diabetes with a holistic person centred approach to their care and NICE guidance followed.	2.1West, Mid and South STP Diabetes leads to consult and agree a systematic approach	STP Diabetes Leads			People with Long Term Conditions will have access to best practise. Adults and Families will have access to accessible information on LTCs Reasonable adaptations will be made to specific pathways
	Review people with epilepsy on LD registers and if they are on AEDs, effect this is having and whether MCA/best interest is required	2.2 Awareness on AED effect on bone health and management to be circulated to families and social care providers	Inder Sawnhey			
	DNAs (E.g. for cardiac appt) should be escalated	see multi disciplinary working below				
	Seriousness of condition not understood by carers	2.3 Health awareness to be raised through care provider networks. People living independently at risk. 2.4 Accessible information to be collated on LTCs 2.5 role of advocacy and waits to be explored 2.6 Annual Health Check results including Health Action Plan to be widely shared and named coordinator identified.	? Lindsay Darby ?			
	Support for understanding/catheter management should be escalated to specialist services	2.4 Information on available services, resources and how to access to be collated	CCG commissioner of urology service			
3. Dysphagia	SALT recommendations for modified diet should be transferred home on discharge from acute hospital	3.1 LD Hospital liaison nurses to raise with forum and internal processes	Sarah Haines			
4. MDT Working	Communication across agencies- insulin dose had been reduced by Guys hospital - XX was taking the previous higher doses.	to be discussed at next meeting (Medicines Management Committees to be consulted)				
	An individual with learning disabilities needs a profession to coordinate their care to provide consistency and ensure that treatment is prompt. This needs to be a professional who is involved in their care	4.1 Mechanisms to be identified which will support communication and care coordination across organisations 4.2 Families and social care providers to be supported to recognise health needs, symptoms and how to support good health and wellbeing overall. 4.3 Purple book to be reviewed and consulted on SET-wide use. LAC to bring info to next meeting 4.4 Results of national working group to be circulated when known.	Comms Lead (Claire Routh) LAC to set meetings for review of Purple Book	NHS Digital Shared Care Record Named Social Worker Pilot LD Standards NHS Accessible Information		People with multiple conditions will have a care coordinator and a person-owned record and a single plan.
	Identify whether persons on LD registers have a care coordinator					
	No monitoring/care coordination in place despite disalysis stopped/poor control of disabetes and all other health needs/bowels					
5. End of Life	A person from the care home should have been involved in acute care planning and could have brought in family. He might not have died alone.	5.1 "My Care Choices" Register or alternative to be considered across 3 STPs with potential to extend to LD. 5.2 Processes for using this register to share information across a range of organisations to be considered. 5.3 "Thinking Ahead" and other End of LIfe resource to be reviewed and communication plan agreed.	DoNs (Patricia D'Orsi)			People will be supported to plan their end of life and their wishes will be implemented
	Early referrals should be made to palliative care team					
	Preferred place of death should be identified early					
	Where a ppd is identified, these wishes should be planned for and achieved					
	Communication around terminal status needs to be better handled between acute hospitals and families					
	EofL care needs to be discussed earlier with the patient and those who are supporting so that it is re planned rather than crisis support					
	support staff who are familiar with needs, should be available in hospital					

	anticipatory meds should be available over BHs so that people can pass away at home					
	Patients should go from hospital to outpatientwithout being discharged home when in poor physical condition					
6. Communication	SALT recommendations should be implemented to support patient's communciation	6.1 flagging system to raise awareness of specific reasonable adjustments to be explored (ref purple book or tech solutions) 6.2 findings on national LD Awareness training to be fedback when available 6.3 information on AAC support, SALT services, ICE, apps etc to be collated and circulated	Comms Lead and LAC			Reasonable adjustements in general and for each specific person will be well understood and implemented across health and social care services
	Hearing aids should be available in hospital (glasses and other aids also relevant)					
	reasonable adjustments should be made to support communication					
7. MCA	People with LD should be encouraged to make whatever decisions they have capacity to make and if unable should still be involved in/contribute to decision making	7.1 long waits for advocacy to be investigated 7.2 Gaps in skills or capacity to properly support people with LD to understand (including availability of accessible information) to be raised 7.3 Each organisation to audit/review recording of MCAs	Social Care Leads/MCA leads	MCA Forum		MCA will be understood and fully implemented so that people with LD can make informed decisions wherever they are able
	Completion of MCA would facilitate engagement of patient and appropriate decision making					
	MCA should be completed and in medical records					
8. Health Insight	There should be evidence of understanding of health needs and consequence of refusals	8.1 accessible health information to be available in libraries, GP surgeries, community venues 8.2 information on what to ask for at a Health Check to be collated 8.3 Good practise on AHC completion to be circulated	Comms Lead and LAC			People are able to easily access information about health and what resources/services are available to them locally
	Safeguarding alert should be raised for ongoing self neglect	see also points under 7.2 above				
9. Living arrangements	Delays in moving people to appropriate provision should be avoided	Item to be agreed at the next meeting				
	The diabetes team should have greater involvement with decision making on care and placement needs for their patients with LD					
	professionals need to make their recommendations for care of a patient with learning disabilities known to the funding authorities					
	More action should be taken when living arrangements are harmful (E.g. financial abuse by neighbour or lack of services due to place)					
	Health care professionals need to understand supported living					
	When a person moves home a full history should come with them including care plans					
	homes should actively communicate with theh hospitals rather than waiting for information					
	Remote placements for those with mobility problems not appropriate					
10 Coroner/cause of death	Liaise with coroner about use of cerebral palsy as a primary cause of death on certificate	10.1 Details to be shared directly with Coroner who will feedback to Steering Group. 10.2 Acute hospitals will share mortality review process with LAC for sharing and early learning	LAC/Coroner Sarah Haines			learning disability and conditions which do not lead to death will not be listed as cause of death
11. DNACPR		11.1 LD Hospital Liaison nurses to share process for review of DNACPR	Ld Hospital Liaison Nurses (Sarah Haines)			LD or a presumption about the person's quality of life because of LD will not be used to justify DNACPR
12. Children's	Suggest sharing of care across boundaries	Item to be agreed at the next meeting				
	Recommend universal assessment for clients with LD during transition age					
13. Cancer		13.1 screening nurses in primary care to be considered 13.2 Cancer scanning pathway for those requiring sedation/GA/alternatives to be raised at LD Hospital Liaison nurse forum and shared.	CCG DoNs (PD) Liaison Nurses (SH)			

Integrated LD Health Commissioning

LeDeR End of Year Report 2018-2019

Update for Southend Essex and Thurrock Experts by Experience Forum

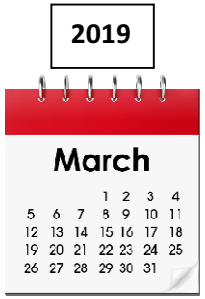
10th June 2019

Essex County Council

Progress - Performance

Southend Essex and Thurrock LeDeR		
When?	No. notifications	Completed
Sep-18	137	15
Dec-18	152	20
Mar-19	188	33

How many people died?

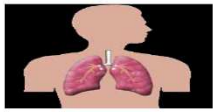


- **188 people with learning disability died in Southend, Essex and Thurrock**

Different from the rest of England?

Measure	 SET LeDeR	 National LeDeR	Comment
 	57% male 43% female	58% male 42% female	Same ⇔
Age at death 	61 years	59 years LeDeR 84 years – everyone else	LeDeR ⇑ National ⇓
Ethnicity 	3% BAME	10% BAME LeDeR 14% everyone else	LeDeR ⇩ National ⇩

Cause of Death

Measure	 SET LeDeR	 National LeDeR
Cause of death		
	Chest/Respiratory /pneumonia 37% (aspiration pneumonia a further 7%)	Pneumonia 25% Aspiration pneumonia 16%
	Sepsis 19% (multiple organ failure 11%)	Sepsis 7%
	Cancer 15%	
		Dementia 6%
		Ischaemic heart disease 6%
		Epilepsy 5%

are

Measure	 SET LeDeR	 National LeDeR	Comment
% falling short of best practice with potential or actual adverse impact 	7%	8%	Same ⇔
 Place of Death	Hospital 53% Usual residence 38% Other 9%	Hospital 62% Usual residence 30% Other 8%	National population Hospital 46%

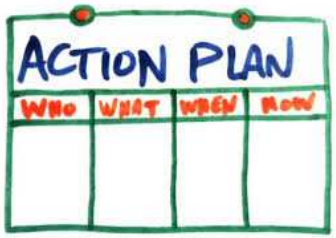
Things we must do

1. People from health must be at the Steering Group

2. Deaths must be investigated within 6 months

Things we must do - continued

3. A plan and a system for making changes



4. Annual Report

How will we make it better – we know the big local problems

Frailty and Deterioration

Swallowing

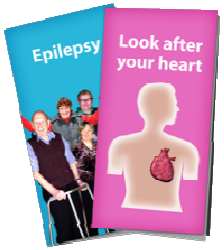
Do not Resuscitate Orders

Mental Capacity/Health Insight

End of Life

People who are not known

Other Things we can make better



Long Term Conditions

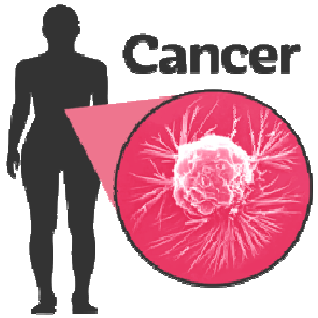
Working Better Together

Communication and Reasonable Adjustments

Living Arrangements

Cause of Death on certificate

Areas with no recommendations

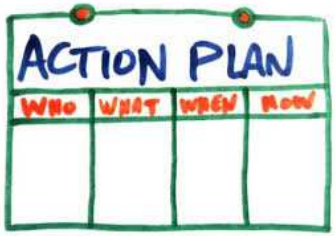


Cancer

Children’s

What will help

Steering Group



Action Plan

New Reviewers

Southend-on-Sea Health & Wellbeing Board

Agenda Item No.

8

Report of the Interim Director of Public Health

To

Health & Wellbeing Board

On

18th September 2019

Report prepared by: Erin Brennan-Douglas,
Senior Public Health Principal

For information only		For discussion	x	Approval required	x

Teenage Pregnancy and Young Parents in Southend-on-Sea: Understanding the bigger picture of needs through case load analysis

Part 1 (Public Agenda Item)

1. Purpose of Report

The purpose of this report is to update the Health & Wellbeing Board partners on the insights and development being explored as part of the wider deep dive review of under 18 conceptions, teenage pregnancy and young parents support in Southend-on-Sea. The local rates for reducing under-18 conceptions have plateaued in Southend-on-Sea and there is now an opportunity to review and reflect on the 2018 Public Health England document: *Good Progress but more to do: Teenage pregnancy & young parents*.

The inequalities facing young parents are well documented nationally. The purpose of the case review of 38 young parent records was to explore some of those key inequalities and vulnerabilities, to get a better picture of local needs and investigate what additional opportunities can be reviewed, explored and introduced into the system to complement existing areas of good practice. The long term outcome and view is to further reduce the rate of under-18 teenage conceptions and maximise outcomes for young parents.

2. Recommendations

2.1 The Board is asked to agree that the final report with key recommendations will be discussed at the Health and Wellbeing Board in December 2019, to help finalise the collective approach and initiate an implementation plan in early 2020 that includes alignment to the Southend 2050 ambitions.

3. Background & Context

3.1 Over the last 18 years the under-18 conception rate across England has fallen by almost 60% with all councils achieving reductions, but inequalities remain.

3.2 Young people in England still experience higher teenage birth rates than their peers in Western European countries, teenagers remain at highest risk of unplanned pregnancy.

3.3 The under-18 conception rate for Southend-on-Sea in 2017 was 24.3 (per 1,000), or 70 conceptions – *this data will be updated in early October*. Southend-on-Sea's reduction in rates has plateaued since 2013 and is not falling in comparison with rates for the East of England region (16 per 1,000) and England 17.8 per 1,000) – see table below. Southend-on-Sea is the only outlier in the East of England.

4. Definitions and exclusions

4.1 The conception data in England combines births, legal abortions and stillbirths. It excludes illegal abortion and miscarriage.

4.2 It is estimated 1:4 pregnancies end in miscarriage, although this is not counted. Younger women have lower miscarriage rates but women at 20 years still have miscarriage rates around 15% of pregnancies.

4.3 A woman's age at conception is calculated as the number of complete years between her date of birth and the date she conceived. In many cases her birthday will occur between conception and the birth or abortion; a woman may conceive, for example, at age 19 and give birth at age 20. The conception and birth may also occur in different calendar years does not match the number of maternities and abortions to women of the same given age in the same given year.

4.4 Southend-on-Sea picture of Under 18 conceptions

The under- 18 conception rate in Southend-on-Sea has seen a 56.9% reduction between 1998 and 2017.

The latest full year under 18 conceptions data for 2017

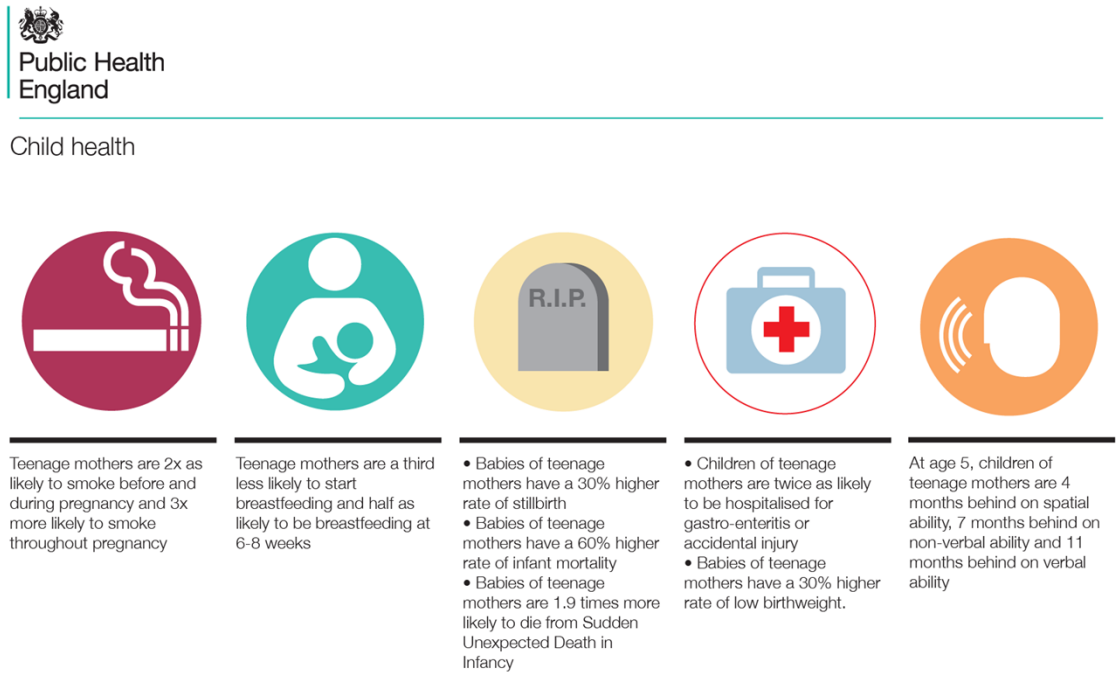
Recent trend: ⬇

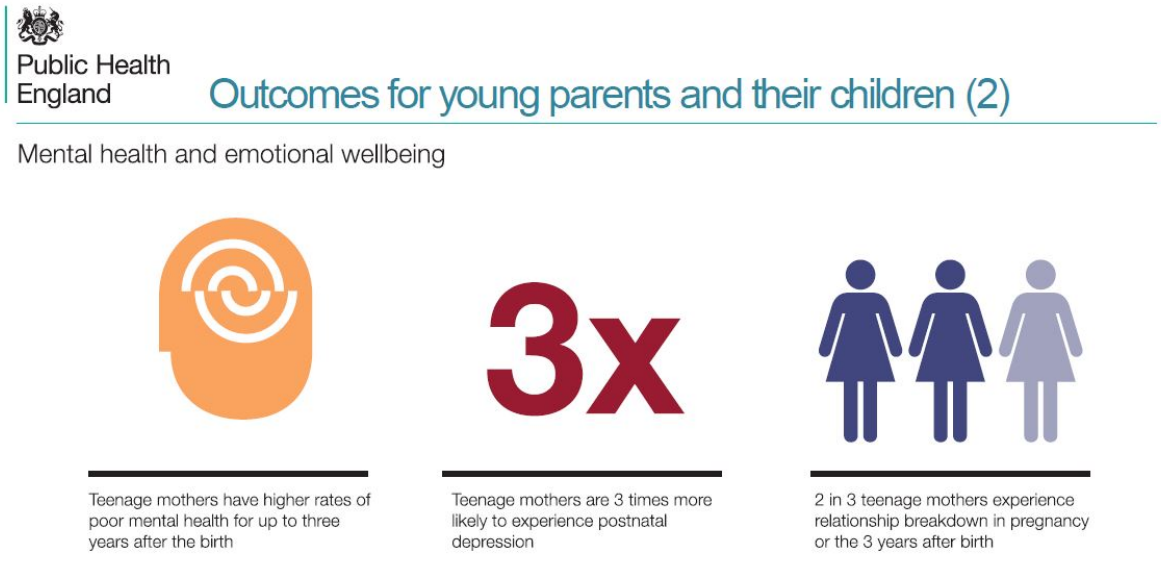
Period		Southend-on-Sea				East of England region	England
		Count	Value	Lower CI	Upper CI		
1998	🔴	155	56.4	47.9	66.0	37.9	46.6
1999	🟡	132	48.5	40.5	57.5	36.4	44.8
2000	🟡	126	46.8	39.0	55.7	35.1	43.6
2001	🟡	130	47.4	39.6	56.3	34.2	42.5
2002	🔴	146	50.9	43.0	59.8	34.6	42.8
2003	🟡	140	47.7	40.1	56.3	33.1	42.1
2004	🟡	135	46.8	39.3	55.4	32.4	41.6
2005	🟡	136	46.2	38.7	54.6	32.4	41.4
2006	🟡	143	47.5	40.0	55.9	33.1	40.6
2007	🟡	127	40.7	33.9	48.4	33.0	41.4
2008	🟡	131	41.8	35.0	49.6	31.1	39.7
2009	🟡	128	41.4	34.5	49.2	30.7	37.1
2010	🟡	109	36.1	29.7	43.6	29.1	34.2
2011	🟡	108	34.8	28.6	42.1	26.6	30.7
2012	🟡	94	30.3	24.5	37.1	23.2	27.7
2013	🟡	83	26.5	21.1	32.9	21.0	24.3
2014	🔴	89	28.7	23.1	35.4	20.2	22.8
2015	🟡	79	26.1	20.6	32.5	18.8	20.8
2016	🔴	81	27.1	21.5	33.7	17.1	18.8
2017	🔴	70	24.3	19.0	30.8	16.0	17.8

Source: Office for National Statistics (ONS)

5.0 Inequalities for a teenage parent and child

Summary of the inequalities teenage parents under 20 year old and young children face are summarised in the pictorials below:





6.0 A review of the current caseload

Part of the deep dive was to explore where Southend-on-Sea's young parents needs were in comparison to the risks and vulnerabilities identified for young parents. The analysis and interpretation is underway and will make up part of the wider deep dive recommendations, which will come to the Health and Wellbeing Board in December 2019:

- 38 Family Nurse Partnership cases that were open to Early Help were reviewed with a focus on vulnerabilities, mental health and housing concerns;
- 62 current cases (July 2019 snap shot) on the shared caseload were reviewed with partners for engagement including: Early Help, Children's Centres, Social Care, Universal Health Services- Health Visiting, Family Nurse Partnership, Young People's Drug & Alcohol Service, and Youth Offending to look at what agencies are involved with our current young parents leading to a review of existing pathways;
- 8 young mothers were interviewed to hear the users experience of being a young parent and the engagement of the services;
- Family Nurse Partnership Board case studies for the young parents from 2017-2019 and themes explored including the Outcome Star, housing, and general vulnerabilities.

7.0 **Emerging themes**

The following themes have been identified as requiring more in-depth analysis and interpretation:

- A need for a system pathway and offer for all young parents from entry and exit that is commissioned in a seamless way;
    - There were no formal pathways in place and the offer is not clear.
- Shared outcomes and data sets and learn from each other;
    - Each service has different data sets and recording systems and there is a fragmented picture. There is no vehicle to share learning or challenges.
- Monitoring longer term outcomes for children and impact of services;
    - Each of the service is focused on service level outputs and no clear process to monitor outcomes at system level, although the services have measures for individual progress.
- Educational attainment and young parents that are not in education, employment or training (NEET) ;
    - The education attainment at time of pregnancy and NEET are both standing out from the initial review. The proportion of the current

caseload is weighted towards the ages 17-19 with only 3 young mothers of school age. This requires more analysis and understanding of the journey before pregnancy.

- Adverse childhood experience and vulnerabilities in the cohort;
    - A significant proportion of the young mothers in the most deprived wards had multiple adverse childhood experiences (ACEs) as a child that included (not exclusive) domestic abuse, being themselves subject to safeguarding concerns/child in need, separation and loss, substance misuse in parents and mental health issues in parents.
- Strategic leadership, service and support co-ordination and oversight;
    - There is no current partnership group overseeing this work at a strategic or operational level. Each service is working in isolation and there is no joined up commissioning. There is no formal pathway commissioned.
- Role of prevention;
    - There is an opportunity to review relationship and sex education (RSE) in schools in line with new statutory mandate from September 2020. There is variability in the current offer and in access. It is unclear the current offer to children and young people on reduced timetables, moving between schools, in alternative education, home schooled and or missing large amounts of school. There was a significant proportion of young mothers on the FNP caseload that were not educated locally. There were some key schools where targeted work might be beneficial.

8.0 Next steps to develop the deep dive and recommendations

- Complete the Public Health England Teenage Pregnancy Self-assessment System Level Review with engagement from the national Teenage Pregnancy lead-Autumn 2019;
- Analyse the findings of the caseload analysis for themes and recommendations-Autumn 2019;
- Review the School Health Education Unit (SHEU) survey to understand children and young people perception of prevention in schools - Autumn 2019;
- Review the information and intelligence coming from the new sexual health service - Autumn 2019;
- Analyse the information and intelligence from the CCG and primary care services for contraception, births and termination of pregnancy - ongoing;
- Complete the collation of conception data (2017) and local data sets-Autumn 2019;
- Review the Family Nurse Partnership case studies for examples of user experience (parents come to board to tell their stories to be explored)-Autumn 2019;
- Understand the housing offer from Sanctuary Housing-Autumn 2019.

The final report with key recommendations will be discussed at the Health and Wellbeing Board in December 2019, to help finalise the collective approach and initiate an implementation plan in early 2020 that includes alignment to the Southend 2050 ambitions.

9. Corporate Implications-Contribution to the Southend-on-Sea 2050 Road Map

Teenage pregnancy and young parent agendas links directly to the following Southend-on-Sea 2050 ambition themes and outcomes:

- **Safe and Well**
  - People in all parts of the borough feel safe and secure at all times.
  - Southenders are remaining well enough to enjoy fulfilling lives, throughout their lives.
  - We are well on our way to ensuring everyone has a home that meets their need
  - We are all effective at protecting and improving the quality of life for the most vulnerable in our community.
- **Pride & Joy**
  - there is a tangible sense of pride in the place and local people are actively, and knowledgeably, talking up Southend-On-Sea
- **Opportunity & Prosperity**
  - Our children are school and life ready and our workforce is skilled and job ready
- **Active and Involved**
  - Even more Southenders agree that people from different backgrounds are valued and get on well together
  - The benefits of community connection are evident as more people come together to help, support and spend time with each other
  - Public services are routinely designed, and sometimes delivered, with their users to best me their needs
- **Connected and Smart**
  - it is easier for residents and people who work here to get in and around the borough
  - people have a wide choice of transport options

10. Financial Implications

There are no direct financial implications arising from this report. There is an element of the strategy that includes opportunities for integration and pathway development that may be identified as the deep dive develops.

11. Legal Implications

None

12. People Implications

Teenage pregnancy and support for parents starts with prevention in education but is linked to wider determinants of health including parenting, social economic background, familial domestic abuse, alcohol and drug misuse of parents, neglect and wider contextual safeguarding issues including County Lines. It is no one services problem to face, but requires a system level approach.

13. Property Implications

There is a Sanctuary Housing scheme to support young parents.

14. Consultation

A task and finish group with wide representation across the services has contributed to the teenage pregnancy self-assessment process and invited for a stakeholder mapping event and review to context of the findings in late September.

15. Equalities and Diversity Implications

Pregnancy and maternity are protected characteristic and fall formally under the Equality Act in addition to age. Young Parents face many adversities and there are well recognised inequalities for both young parents and children of young parents.

16. Risk Assessment

Risk assessments are bespoke to individual services working with young parents and those young people who find themselves pregnant.

17. Value for Money

Public Health England financial modelling for teenage pregnancy prevention suggests that addressing teenage pregnancy can bring the following savings:

- £4 saved in welfare costs for every £1 spent;
- Every young mother who returns to education, employment and training saves agencies £4,500 a year;
- For every child prevented from going into care, social services would save on average £65,000 a year;
- Return on investment for contraception alone shows for every £1 spent, £9 is saved over a 10 year period. This applies to women of all ages but is particularly relevant for teenagers who are at highest risk of unplanned pregnant

18. Community Safety Implications

There is no direct overall impact on community safety; however individual young people and young parents may be engaged in antisocial behaviour. The current caseload of young mother reviewed highlight that no young mothers sampled are were on the youth offending caseload.

19. Environmental Impact

Not Applicable

End Report

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Southend Health & Wellbeing Board

Agenda Item No.

10

Report of the Director of Public Health

To

Health & Wellbeing Board

on

18th September 2019

Report prepared by: Lee Watson, Health Improvement Practitioner Advanced

For information only		For discussion	X	Approval required	

Southend Physical Activity Strategy 2016-2021- Progress Update

Part 1 (Public Agenda Item)

1. Purpose of Report

1.1 To review and update the board on the progress to date with the implementation of the Southend-on-Sea Physical Activity Strategy 2016-2021.

2. Recommendations

2.1. The Health and Wellbeing Board is asked to note the update provided.

3. Background & Context

3.1. Physical inactivity is the fourth largest cause of disease and disability and is directly responsible for 1 in 6 deaths in the UK. The latest data from Public Health England highlights that 22.6% of adults in Southend are inactive, undertaking less than 30 minutes of physical activity a week. This puts them at a greater risk of developing a number of conditions including heart disease, cancer, obesity, diabetes, depression and dementia.

3.2. The Southend-on-Sea Physical Activity Strategy (which is the delivery mechanism for the refreshed Health and Wellbeing Strategy 2017-2021) provides a framework and action plan to support the long term vision for Southend to be a healthier, more active borough. This will be achieved through making the participation in an active healthy lifestyle a social norm for people who live or work in Southend.

There is an action plan to ensure delivery of the strategy's aims. A multi-agency prioritisation process identified 5 key priorities for 2019/20, aligned with Southend 2050 Active and Involved outcome: "More people have active lifestyles and there are significantly fewer people who do not engage in any physical activity." and other emerging strategic and operational opportunities.

4. Strategy Progress

4.1 Progress on the strategy is outlined below by theme from the five priority actions for 2019/20.

4.2 Active Southend Projects:

Southend Borough Council working with Active Southend Partners have worked together to deliver "Park Lives" and "Move Out" physical activity programmes in Parks and Open spaces across the borough. Park Lives is aimed at children, whilst Move Out has focused on adult activities. As a result of Move Out regular yoga on the beach session have continued to take place on a weekly basis, although overall, the other sessions were poorly attended. Next year's offer will have be reviewed accordingly.

For 2019/20 Active Southend has embedded it's funding from Active Essex into the pre-existing Culture and Wellbeing Grants Scheme. As a result £10,000 will be ring-fenced within this grant to support local community-led physical activity provision. A prerequisite of all bids will be a requirement for match funding (which can be in in-kind funding) which will enable the reach and impact of the financial resource to be greatly increased. Applications will be assessed against the desired outcomes of Active Southend and the Physical Activity Strategy. The grant opened week beginning 02/09/19.

4.3 Southend Wellbeing Service:

The new Wellbeing Service went live on the 1st June 2019. Delivered by Everyone Health (**EH**), the new service has three specific developmental areas.

Exercise Referral programme
Following consultation with GP services locally, who have advised us on the limitation of the scheme being gym-based and most patients being unwilling to partake. EH, in partnership with Fusion Lifestyle and other local providers the current scheme is being reviewed and re-designed to broaden the offer of physical activities available on the scheme. The new programme will run from January 2020 and will include swimming and water based activity as well as a broad range of outdoor activities including health walks and seasonal activities. As per clinical suggestions, a number of low impact activities will also be considered, including Tai Chi, pilate and yoga.

Falls Prevention programme
In a similar arrangement the Council, Everyone Health, Fusion and other physical activity providers are continuing the development of the Falls Prevention Strength and Balance programme. The current "Staying Steady" service has extended to a 36 week programme aligned to the evidence base for this activity. A more community-led, asset based approach to delivery is being taken to enable greater capacity within the programme and to create more community based opportunities for those finishing the intervention to remain active.

Social Prescribing
Everyone Health, SAVS, Primary Care and other local organisations are involved in the development of Social Prescribing in Southend, one key element

is the delivery of brief interventions training (including physical activity). This workforce strand aims to provide an appropriate level of training to a range of public facing workforce, with consistent messaging around key areas of health and wellbeing.

4.4 Planning and Physical Activity:

Active Southend are working with the Strategic Planning team to further embed consideration of physical activity opportunities into planning decisions. The implementation of the Playing Pitch Strategy and Built Facilities Strategy is central to this, as well as further influencing the Local Plan for the borough.

4.5 Public Health Responsibility Deal:

The Public Health Responsibility Deal encourages local organisations to take voluntary action to improve the health and wellbeing of their staff and/or their customers. In 2019/20, 16 organisations have signed up to the Public Health Responsibility Deal. Half of these organisations have made commitments related to increasing physical activity levels. The proportion of businesses focusing on physical activity remains high, with an increasing appetite by local businesses to support emotional health and wellbeing of staff/customers.

5 Reasons for Recommendations

5.1 Increasing levels of physical activity in the borough and reducing levels of inactivity will lead to improved health and wellbeing and help to reduce health inequalities. A healthy population will reduce demands on services and provide a healthier workforce to contribute to the economic prosperity of the borough.

6. Corporate Implications

6.1 Contribution to the Southend 2050 Road Map

The strategy contributes to the Southend 2050 ambition across all five themes, whilst the Active and Involved theme has a specific physical activity outcome there are significant co-benefits that can be delivered through the other four outcomes, for example Connected and Smart can relate to infrastructure for active travel and community led activities that may sit within Pride and Joy can contribute to increasing physical activity levels.

6.2 Financial Implications

The strategy and associated action plan will be delivered within existing resources and in collaboration with a range of partners.

6.3 Legal Implications

The strategy is informing the development of future planning policy. Changes to these policies will aim to facilitate the population to increase their physical activity levels through better access to facilities for physical activity and environments that support active travel and other “activities of everyday living”.

6.4 People Implications

There is an element of the action plan that includes workforce development; therefore there is a resource implication to enable staff to undertake continuing professional development in relation to physical activity promotion.

6.5 Property Implications

None

6.6 Consultation

The strategy, action plan and prioritisation of actions for 2019/20 has been developed with input from SBC teams and external partners including the Health and Wellbeing Board.

6.7 Equalities and Diversity Implications

Any changes to services or approaches in response to the strategy will require further Equality Analysis.

6.8 Risk Assessment

Any changes to services or approaches in response to the strategy will require appropriate Risk Assessment

6.9 Value for Money

Many of the actions that are within the action plan have an evidence base to suggest that a positive return in investment can be achieved through programmes designed to increase physical activity.

6.10 Community Safety Implications

Community led physical activity can have an impact on perception of safety of and area. Physical Activity can also be used as a diversionary activity for a range of “high risk” populations to prevent crime.

6.11 Environmental Impact

Actions within the strategy aiming to increase active travel can have a positive impact on air quality through reduced car usage.

7. Appendices

uk-chief-medical-offic
ers-physical-activity-

Department of Health & Social Care

Llywodraeth Cymru
Welsh Government

Department of Health
An Roinn Sláinte
Männystrie O Poustie
www.health-ni.gov.uk

Scottish Government
Riaghaltas na h-Alba
gov.scot

UK Chief Medical Officers' Physical Activity Guidelines

Published 7 September 2019

Contents

Foreword by the Chief Medical Officers

Professor Dame Sally C Davies
Chief Medical Officer, England

Dr Frank Atherton
Chief Medical Officer/Medical Director NHS Wales

Dr Michael McBride
Chief Medical Officer, Northern Ireland

Dr Catherine Calderwood
Chief Medical Officer, Scotland

In 2010, we were among the first Nations in the world to set out the evidence for how much and what kinds of physical activity we need to do to keep ourselves healthy.

Since then, the evidence has become more compelling and the message is clear:

> "If physical activity were a drug, we would refer to it as a miracle cure, due to the great many illnesses it can prevent and help treat."

Physical activity is not just a health issue. It brings people together to enjoy shared activities and contributes to building strong communities whilst supporting the economy to grow.

These physical activity guidelines update the 2011 guidelines across all age groups. We have also drawn on new evidence to develop additional guidance on being active during pregnancy and after giving birth, and for disabled adults.

We want as many people as possible to make use of these guidelines to work towards and achieve the recommended activity levels. With that in mind, we have developed updated infographics to help bring these guidelines to life and make them easy for everyone to use.

Being active every day provides a foundation for a healthier and happier life. The recommendations we made in 2011 on muscle strength have not achieved the recognition we believe they merit. We therefore want to underline the importance of regular strength and balance activities: being strong makes all movement easier and increases our ability to perform normal daily tasks.

We want this report to be a catalyst for change in our attitudes to physical activity. Our environment can make it difficult to be healthy and our health is being damaged by inactivity. But the good news is that even small changes can make a big difference over time, such as using the stairs for a couple of floors rather than taking the lift or getting off the bus a stop early and walking the rest of the way.

You always feel better for being active. We want as many people as possible to protect their future health and start their journey to a healthier life now.

September 2019

Acknowledgements

We would like to give special thanks for the support we have received from the Centre for Exercise, Nutrition and Health Sciences, School for Policy Studies at the University of Bristol and the leadership provided by Dr Charlie Foster.

We would like to thank the contributing authors and members of our UK Chief Medical Officer (CMO) Guidelines Writing Group and the members of the expert working groups (listed in Annex B). Their ongoing advice and support have been invaluable.

UK CMO Guidelines Writing Group

- Chair: Dr Charlie Foster, Centre for Exercise, Nutrition & Health Sciences, School for Policy Studies, University of Bristol, England
- Under 5s: Professor John Reilly, School for Psychological Sciences and Health, University of Strathclyde Glasgow, Scotland
- Children & Young People: Professor Russell Jago, Centre for Exercise, Nutrition & Health Sciences, School for Policy Studies, University of Bristol, England
- Adults: Professor Marie Murphy, Doctoral College and Sport & Exercise Sciences Research Institute, Ulster University, Northern Ireland
- Older Adults: Professor Dawn Skelton, Centre for Living, School of Health & Life Sciences, Glasgow Caledonian University, Scotland
- Sedentary Behaviour: Professor Ashley Cooper, Centre for Exercise, Nutrition & Health Sciences, School for Policy Studies, University of Bristol, England
- Sedentary Behaviour: Dr Richard Pulsford, Sport and Health Sciences, University of Exeter
- Disability: Professor Brett Smith, School of Sport and Exercise Sciences, Durham University, England
- Communications & Surveillance: Professor Nanette Mutrie, Physical Activity for Health Research Centre (PAHRC), Institute for Sport, Physical Education and Health Sciences (ISPEHS), The University of Edinburgh, Scotland

Thanks also to Kate Willis (Centre for Exercise, Nutrition and Health Sciences, School for Policy Studies, University of Bristol); Catherine Falconer (England Chief Medical Officer's office); and Scottish Physical Activity Research Connections (SPARC), who all contributed to the report and/or to the Scientific Consensus meetings; as well as to the UK policy leads

for physical activity of the four home countries for their contributions. Our thanks to our UK External Reviewers: Professors Melvyn Hillsdon, Gareth Stratton, Alan Batterham, and Dr Simon Williams.

Finally, a special thanks to the UK Government Department of Health of Social Care and Active Scotland Division of the Scottish Government, in particular Beelin Baxter and Caspian Richards who project managed this work on behalf of the four home countries, supported by Fiona Cunnah and Ian McClure. We would like to also acknowledge support provided by Sport England and Dr Mike Brannan at Public Health England.

Executive Summary

This report presents an update to the 2011 physical activity guidelines issued by the four Chief Medical Officers (CMOs) of England, Scotland, Wales and Northern Ireland. The UK CMOs draw upon global evidence to present guidelines for different age groups, covering the volume, duration, frequency and type of physical activity required across the life course to achieve health benefits.

Since 2011, the evidence to support the health benefits of regular physical activity for all groups has become more compelling. In children and young people, regular physical activity is associated with improved learning and attainment, better mental health and cardiovascular fitness, also contributing to healthy weight status. In adults, there is strong evidence to demonstrate the protective effect on physical activity on a range of many chronic conditions including coronary heart disease, obesity and type 2 diabetes, mental health problems and social isolation. Regular physical activity can deliver cost savings for the health and care system and has wider social benefits for individuals and communities. These include increased productivity in the workplace, and active travel can reduce congestion and reduce air pollution.

Our understanding of the relationship between physical activity and health has grown. In general, the more time spent being physically active, the greater the health benefits. However, we now know that even relatively small increases in physical activity can contribute to improved health and quality of life. As such, although we recommend that all individuals work towards achieving these guidelines, they are not absolute thresholds and we recognise the benefits that can be achieved at levels both above and below the thresholds.

This report emphasises the importance of regular activity for people of all ages, and for the first time presents additional guidance on being active during pregnancy, and after giving birth, and for disabled adults. These new guidelines are broadly consistent with previous ones, while also introducing some new elements and allowing for more flexibility in achieving the recommended levels of physical activity for each age group.

This report underlines the importance of all age groups participating in a range of different activities. Considering the importance of strength for physical function, particularly later in life, we did not feel the 2011 recommendations on strengthening activities were given the merit they deserve. In childhood, strengthening activities help to develop muscle strength and build healthy bones, while in adults and older adults they help to maintain strength and delay the natural decline in muscle mass and bone density which occurs from around 50 years of age. The new guidelines reinforce the importance of these types of activities for all age groups and highlight the additional benefit of balance and flexibility exercises for older adults.

The report also highlights the risks of inactivity and sedentary behaviour for health. There have been notable developments in the evidence base for the health effects of sedentary time in adults, with research suggesting sitting time is associated with all-cause and cardiovascular mortality, and cancer risk and survivorship. Similar effects are seen in children where sedentary behaviour is associated with cardiovascular fitness and obesity. In all groups, the relationships of sedentary behaviour and health occur independently of moderate-to-vigorous physical activity (MVPA) for some health outcomes. Prolonged sitting is harmful, even in people who achieve the recommended levels of MVPA. Despite this, the evidence does not currently support including a specific time limit or minimum threshold of sedentary time within these guidelines.

This report recognises an emerging evidence base for the health benefits of performing very vigorous intensity activity performed in short bouts interspersed with periods of rest or recovery (high intensity interval exercise, HIIT). The available evidence demonstrates that high intensity interval exercise has clinically meaningful effects on fitness, body weight and insulin resistance, and can be as or more effective than MVPA. This option has therefore been incorporated into the recommendation for adults.

These new guidelines allow greater flexibility for how and when children and young people can achieve the recommended levels of physical activity across the week. Contrary to 2011, the current evidence does not support a specific minimum daily threshold of 60 minutes of MVPA for health benefits, and instead recommends an average number of 60 daily minutes to be achieved across the week.

Evidence now demonstrates that there is no minimum amount of physical activity required to achieve some health benefits. The previous requirement for a 10-minute bout of activity is no longer valid and is no longer included. However, specific targets - such as aiming to do at least 10 minutes at a time - can be effective as a behavioural goal for people starting from low levels of activity

We present the new guidelines following a life course approach with a separate chapter for the age groups covered in the report: Under-5s, Children and Young people (5-18 years), Adults (19-64 years), and Older Adults (65+). Each chapter includes an introduction, sets out the guidelines for that age group, summarises the evidence to support the new guidelines, and outlines any changes made since 2011.

We hope these guidelines will be read by health professionals, policy makers and others working to promote physical activity, sport, exercise and active travel. The guidelines are designed to aid health professionals and others to provide individuals and communities with information on the type and amount of physical activity that they should undertake to improve their health.

Summary of Guidelines by age group

Under-5s

Infants (less than 1 year):

- Infants should be physically active several times every day in a variety of ways, including interactive floor-based activity, e.g. crawling.

- For infants not yet mobile, this includes at least 30 minutes of tummy time spread throughout the day while awake (and other movements such as reaching and grasping, pushing and pulling themselves independently, or rolling over); more is better.

NB: Tummy time may be unfamiliar to babies at first, but can be increased gradually, starting from a minute or two at a time, as the baby becomes used to it. Babies should not sleep on their tummies.

Toddlers (1-2 years):

- Toddlers should spend at least 180 minutes (3 hours) per day in a variety of physical activities at any intensity, including active and outdoor play, spread throughout the day; more is better.

Pre-schoolers (3-4 years):

- Pre-schoolers should spend at least 180 minutes (3 hours) per day in a variety of physical activities spread throughout the day, including active and outdoor play. More is better; the 180 minutes should include at least 60 minutes of moderate-to-vigorous intensity physical activity.

Children and Young People (5 to 18 years)

- Children and young people should engage in moderate-to-vigorous intensity physical activity for an average of at least 60 minutes per day across the week. This can include all forms of activity such as physical education, active travel, after-school activities, play and sports.

- Children and young people should engage in a variety of types and intensities of physical activity across the week to develop movement skills, muscular fitness, and bone strength.

- Children and young people should aim to minimise the amount of time spent being sedentary, and when physically possible should break up long periods of not moving with at least light physical activity.

Adults (19 to 64 years)

- For good physical and mental health, adults should aim to be physically active every day. Any activity is better than none, and more is better still.

- Adults should do activities to develop or maintain strength in the major muscle groups. These could include heavy gardening, carrying heavy shopping, or resistance exercise. Muscle strengthening activities should be done on at least two days a week, but any strengthening activity is better than none.

- Each week, adults should accumulate at least 150 minutes (2 1/2 hours) of moderate intensity activity (such as brisk walking or cycling); or 75 minutes of vigorous intensity activity (such as running); or even shorter durations of very vigorous intensity activity (such as sprinting or stair climbing); or a combination of moderate, vigorous and very vigorous intensity activity.

- Adults should aim to minimise the amount of time spent being sedentary, and when physically possible should break up long periods of inactivity with at least light physical activity.

Older Adults (65 years and over)

- Older adults should participate in daily physical activity to gain health benefits, including maintenance of good physical and mental health, wellbeing, and social functioning. Some physical activity is better than none: even light activity brings some health benefits compared to being sedentary, while more daily physical activity provides greater health and social benefits.

- Older adults should maintain or improve their physical function by undertaking activities aimed at improving or maintaining muscle strength, balance and flexibility on at least two days a week. These could be combined with sessions involving moderate aerobic activity or could be additional sessions aimed specifically at these components of fitness.

- Each week older adults should aim to accumulate 150 minutes (two and a half hours) of moderate intensity aerobic activity, building up gradually from current levels. Those who are already regularly active can achieve these benefits through 75 minutes of vigorous intensity activity, or a combination of moderate and vigorous activity, to achieve greater benefits. Weight-bearing activities which create an impact through the body help to maintain bone health.

- Older adults should break up prolonged periods of being sedentary with light activity when physically possible, or at least with standing, as this has distinct health benefits for older people.

Despite the widely reported benefits of physical activity, most adults and many children across the UK are insufficiently active to meet the full set of recommendations. We want this report to act as a catalyst for a change in our attitudes to physical activity.

These guidelines present a UK-wide consensus on the amount and type of physical activity that is needed to benefit health across the life course. The guidelines have been updated using the best available evidence and reflect what we know now about the relationship between physical activity and health. The guidelines apply across the population, irrespective of gender, age or socio-economic status. We know there are clear health inequalities in relation to physical inactivity and therefore interventions to promote physical activity must consider this.

We want as many people as possible to make use of these guidelines to work towards and achieve the recommended activity levels. With that in mind, we have developed the updated infographics included in this report to help bring the guidelines to life and make them easy for everyone to use. We hope these guidelines help all individuals to become more active. The good news is that even small changes can make a big difference over time. As we say in these guidelines: some is good, more is better.

Introduction

What is the aim of this report?

This report is a UK-wide document presenting the UK Chief Medical Officers' (CMO) new Physical Activity Guidelines for different age groups, covering the volume, duration, frequency and type of physical activity required across the life course to achieve general health benefits. The guidelines present thresholds for the achievement of optimal health benefits at the recommended levels of physical activity in terms of strength, moderate and vigorous physical activity, and balance activities.

Who is this report for?

The main intended audience for this report is professionals, practitioners and policymakers from a wide range of organisations concerned with formulating and implementing policies and programmes that promote physical activity, sport, exercise and active travel to achieve health gains. These groups will want to adapt the messages and recommendations in this report to suit the specific needs and interests of those they are working with and the context they are working in.

A UK Communications Working Group is being established to provide advice on approaches to communicating these messages and recommendations to the wider public, and on disseminating the guidelines to a wide range of stakeholders.

Principles

Physical activity for good health and wellbeing

Regular physical activity provides a range of physical and mental health benefits. These include reducing the risk of disease, managing existing conditions, and developing and maintaining physical and mental function.

The UK CMOs' guidelines provide recommendations on the frequency, intensity, duration and types of physical activity at different life stages, from early to later years. Benefits are accrued over time, but it is never too late to gain health benefits from taking up physical activity.

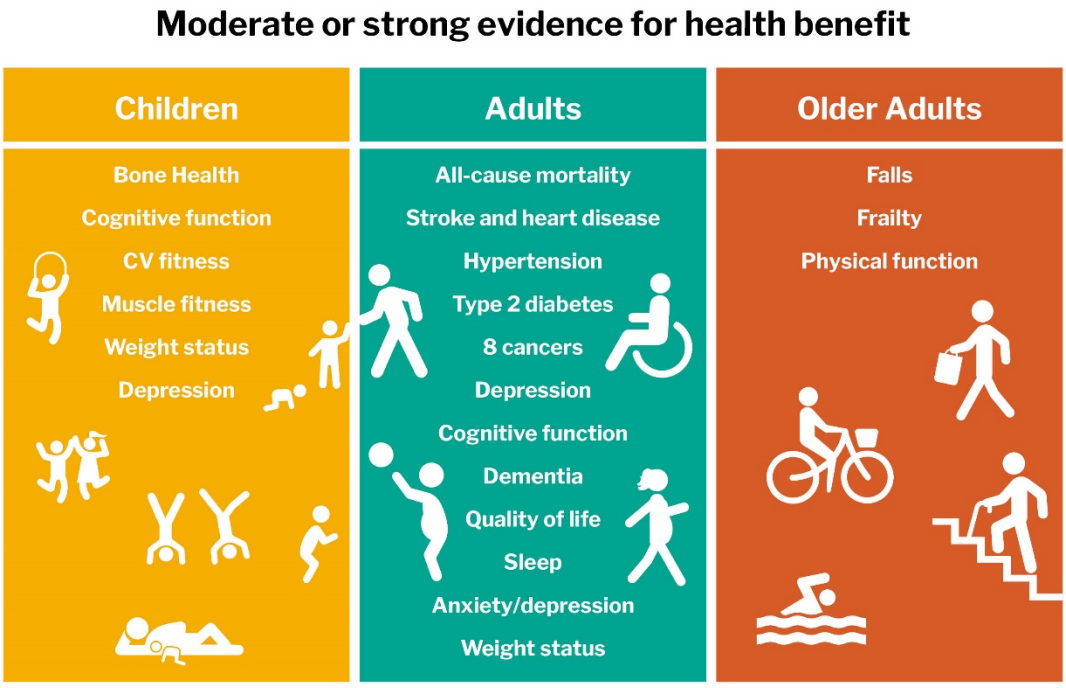


Figure 1: Cumulative health benefits of physical activity across ages. Adapted from (1)

Some is good, more is better

Although we recommend that all individuals work towards achieving these guidelines, there are no absolute thresholds: benefits are achieved at levels both below and above the guidelines.

In general, the more time spent being physically active, the greater the health benefits. However, the gains are especially significant for those currently doing the lowest levels of activity (fewer than 30 minutes per week), as the improvements in health per additional minute of physical activity will be proportionately greater.

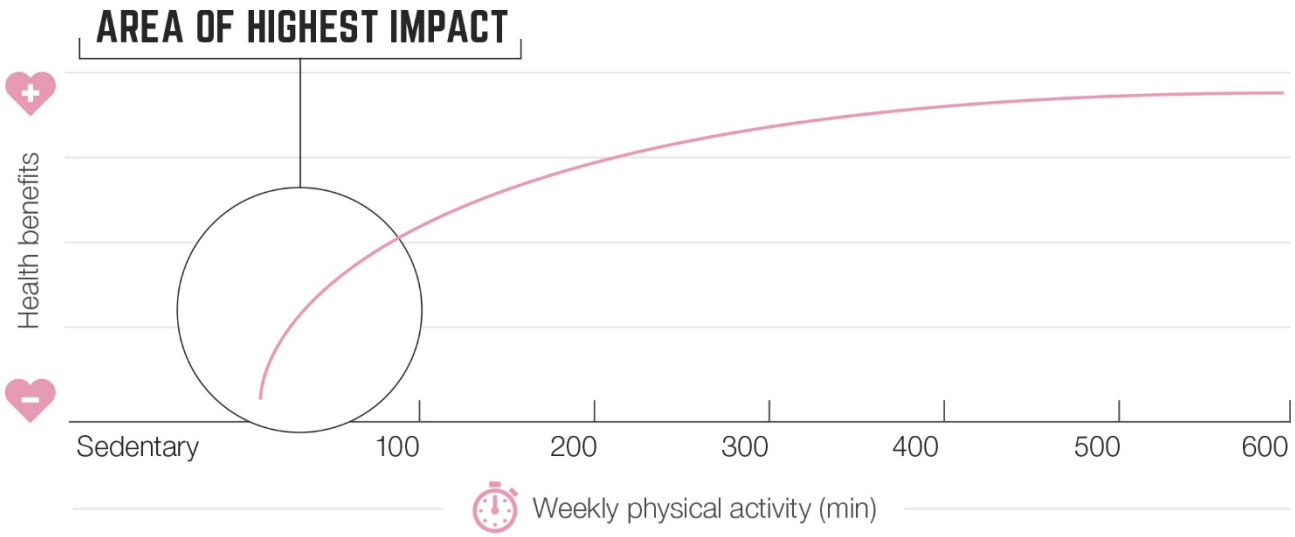


Figure 2: Dose-response curve of physical activity and health benefits. Adapted from (2)

There is no minimum amount of physical activity required to achieve some health benefits. Specific targets below the recommended levels – such as aiming to do at least 10 minutes at a time – can be effective as a behavioural goal for people starting from low levels of activity (3) (including disabled adults and those with long-term conditions), and as a step on the journey towards meeting the recommended levels set out in the UK CMOs' guidelines. Small bouts (i.e. of fewer than 10 minutes) accumulated over the day and week will also provide benefits (4).

It is recommended that people are active every day. Spreading activity across the day or week can help make the guidelines achievable within daily living; for example, walking, wheeling or cycling for daily travel is often the easiest way to get physically active.

Health benefits of different types of physical activity

Physical activity is defined as any bodily movement produced by skeletal muscles that requires energy expenditure. It takes many forms, occurs in many settings, and has many purposes (e.g. daily activity, active recreation, and sport).

Health-enhancing physical activity includes multiple types of activity: cardiovascular; muscle and bone strengthening; and balance training.

Cardiovascular activity

Cardiovascular activity, sometimes called aerobic activity, increases breathing rate and makes the heart and muscles work harder. It can be of low, moderate or vigorous intensity and is relative to an individual’s fitness. Therefore, what could be light intensity for a young

person (who is very fit and active) could be moderate or vigorous intensity for an older adult or a younger individual who is inactive and unfit.

Although activity of any intensity provides health benefits, greater intensity provides more benefit for the same amount of time. Activities need to be of at least moderate-to-vigorous intensity to achieve the full breadth of health benefits.

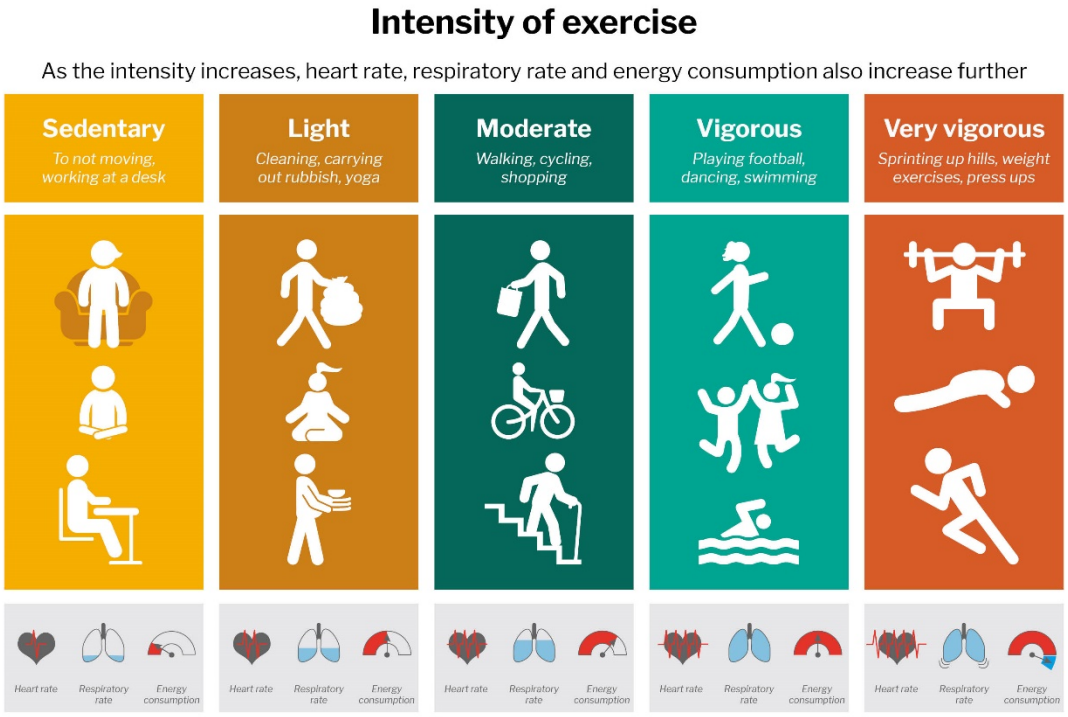


Figure 3: Types of physical activity and their intensities with examples of everyday activities and exercises - adapted from Netherlands Physical Activity Guidelines 2017 & Ainsworth et al 2017 (5)

Moderate and vigorous activity can be differentiated by the 'talk test': being able to talk but not sing indicates moderate intensity activity, while having difficulty talking without pausing is a sign of vigorous activity.

Very vigorous physical activities performed in short bursts interspersed with rest or lower intensity activity breaks, sometimes referred to as High Intensity Interval Training (HITT), have been shown to bring health benefits (6). Data on HIIT is still emerging, but evidence so far suggests benefits for a range of physiological health outcomes. Further work is needed to identify an optimal amount and form of HIIT to recommend, but overall there are clear benefits from these types of activity.

Muscle and bone strengthening and balance training activities

Muscle strength, bone health and the ability to balance underpin physical function, particularly later in life. Each attribute contributes independently to overall health and functional ability, and in combination they provide lifelong benefits.

Muscle and bone strength play a critical role in ensuring good muscular and skeletal health, and in maintaining physical function. When undertaking muscle strengthening activities, it is important to work all the major muscle groups. Bone strengthening involves moderate and high impact activities to stimulate bone growth and repair.

Strengthening activities are important throughout life for different reasons: to develop strength and build healthy bones during childhood and young adulthood; to maintain strength in adulthood; and to delay the natural decline in muscle mass and bone density which occurs from around 50 years of age, maintaining function in later life.

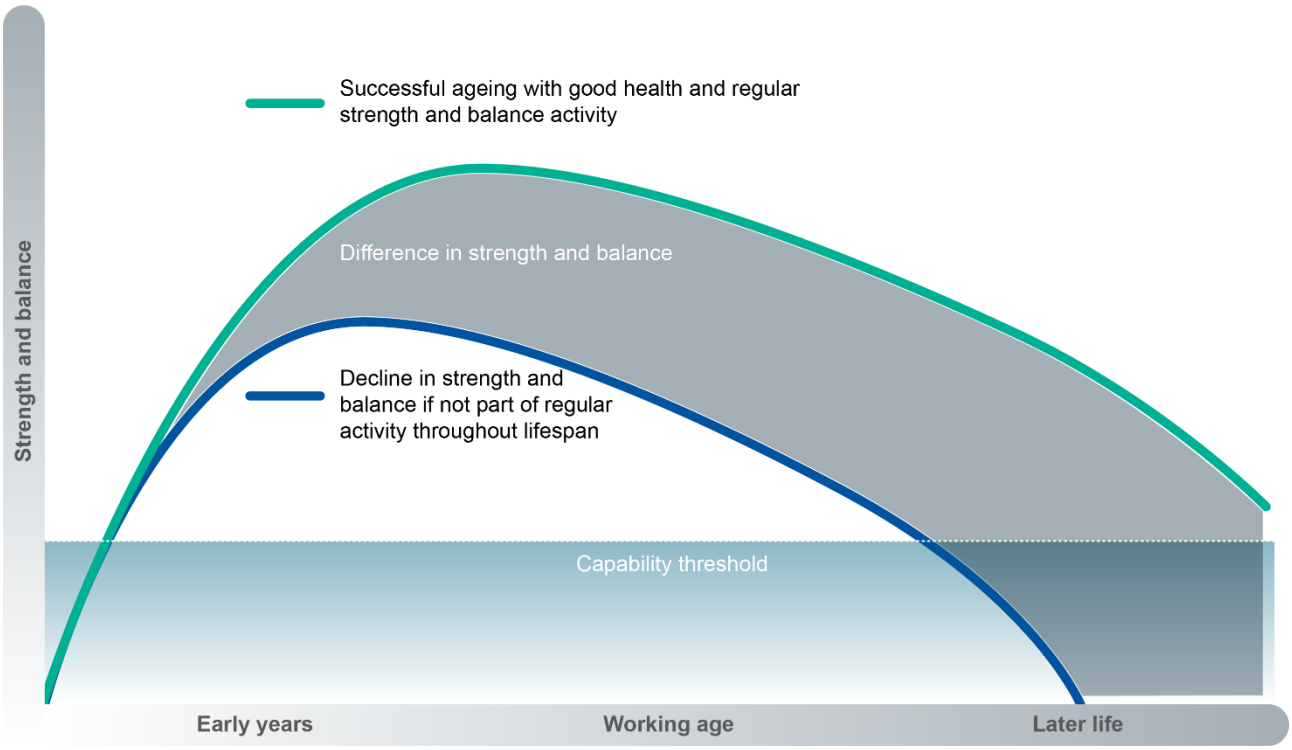


Figure 4: Physical activity for muscle and bone strength across the life course (7, 8)

Balance training involves a combination of movements that challenge balance and reduce the likelihood of falling (114).

Different activities have differential effects on muscle and bone strength and balance.

Type of sport, physical activity or exercise	Improvement in muscle function	Improvement in bone health	Improvement in balance
Running	★	★★	★
Resistance Training	★★★	★★★	★★
Aerobics, circuit training	★★★	★★★	★★
Ball Games	★★	★★★	★★★
Racquet Sports	★★	★★★	★★★
Yoga, Tai Chi	★	★	★
Dance	★	★★	★
Walking	★	★	☆
Nordic Walking	★★	?	★★
Cycling	★	★	★

★★★ Strong effect ★★ Medium effect ★ Low effect ☆ No effect ? Not known

Table 2: Types of activities that can help maintain or improve aerobic capacity, strength, balance and bone health and contribute to meeting the physical activity guidelines (8)

Inactivity and sedentary behaviour

Inactive and sedentary behaviours are those which involve being in a sitting, reclining or lying posture during waking hours, undertaking little movement or activity and using little energy above what is used at rest (9). Examples of sedentary behaviours include sitting in a chair while using a screen or reading, or a child sitting in a car seat or buggy. They do not include being active while in a sitting or reclining posture, e.g. wheeling, chair exercises, or seated gym work.

Periods of inactivity or sedentary behaviour are an independent risk factor for poor health outcomes and should be minimised when possible. Extended periods should be broken up by at least light physical activity. The term ‘when possible’ is emphasized as certain groups of people who depend daily on a wheelchair, unavoidably sit for long periods of time and sitting may therefore be the norm.

The relationship between sedentary behaviour and some health outcomes varies by the amount of MVPA also undertaken. Currently there is insufficient evidence to make specific recommendations on threshold levels of activity that would mitigate the negative impacts of sedentary time.

Physical activity and weight

As the most effective way of increasing our daily energy expenditure, physical activity plays a role in maintaining a healthy weight – including the prevention of weight gain and reduction in body fat – by balancing energy intake from our dietary intake. It also plays a role in the prevention of weight regain after substantial weight loss. However, irrespective of any change in weight, people who are overweight or obese will reduce their risk of cardiovascular disease and improve their health by being physically active.

In combination with dietary change, physical activity can support weight loss.

Risks of physical activity

The risk of adverse events from physical activity is relatively low, and the health benefits accrued from such activity outweigh the risks (1). This evidence also extends now to disabled adults, with the available evidence suggesting there are no major risks of engaging in physical activity when it is performed for an appropriate duration and at an appropriate level of intensity for the individual.

Musculoskeletal injury is more common during activities which involve impact and is inversely associated with total volume of physical activity, but the relative contribution of frequency, intensity and duration are unknown. Adverse cardiac events are rare and are inversely associated with volume of regularly performed vigorous activity. Some impairment groups who use a wheelchair and who participate in upper extremity activity or overhead-sports are at risk of rotator cuff tears. Therefore, although greater exercise intensity also brings greater levels of cardiorespiratory fitness, it also carries a greater risk of injury, especially in individuals who are unaccustomed to exercise.

Fear of injury or exacerbating a health issue can be a barrier to undertaking activity, especially for those who are not regularly active, are disabled, have a health condition, are pregnant, or are older or frail. However, there is little evidence to suggest that physical activity is unsafe for anyone when performed at an intensity and in a manner appropriate to an individual’s current activity level, health status and physical function (4, 10). Starting

at low durations and intensities and building up over time as the body adjusts is the safest way to progress from inactivity to meeting the guidelines.

As the frequency and intensity of physical activity increases, there are small increases in health risk (e.g. accidents and injuries). However, the health benefits of activity far outweigh the risks of being active.

Gender and ethnicity

Although most of the evidence underlying the association between physical activity and health has been derived from studies of men, more recent evidence has confirmed similar relationships in women. At this stage there is no reason to vary the guidelines according to sex. Data for non-white populations remain more limited, but do not suggest that the relationship between physical activity and health varies by ethnicity. Therefore, there is no reason to vary the guidelines according to ethnicity.

Disability

There is growing evidence on the volume, duration, frequency and type of physical activity required to achieve general health benefits for disabled adults. The evidence is, however, largely based on studies involving people with physical impairments (mostly spinal cord injury) or intellectual impairments. In comparison, the evidence base for people with sensory impairments is limited. Nevertheless, there is no reason to vary the guidelines according to impairment type.

Wider benefits of being active

Physical activity not only promotes good health and functioning and helps prevent and manage disease; it also contributes to a range of wider social benefits for individuals and communities.

The relevance and importance of the wider benefits of physical activity for individuals vary according to life stage and various other factors but include: improved learning and attainment; managing stress; self-efficacy; improved sleep; the development of social skills; and better social interaction.

In addition to the health benefits, increasing physical activity across a population also has social, environmental and economic benefits for communities and wider society. These come primarily from physical activities undertaken in a community setting, such as walking, cycling, active recreation, sport and play.

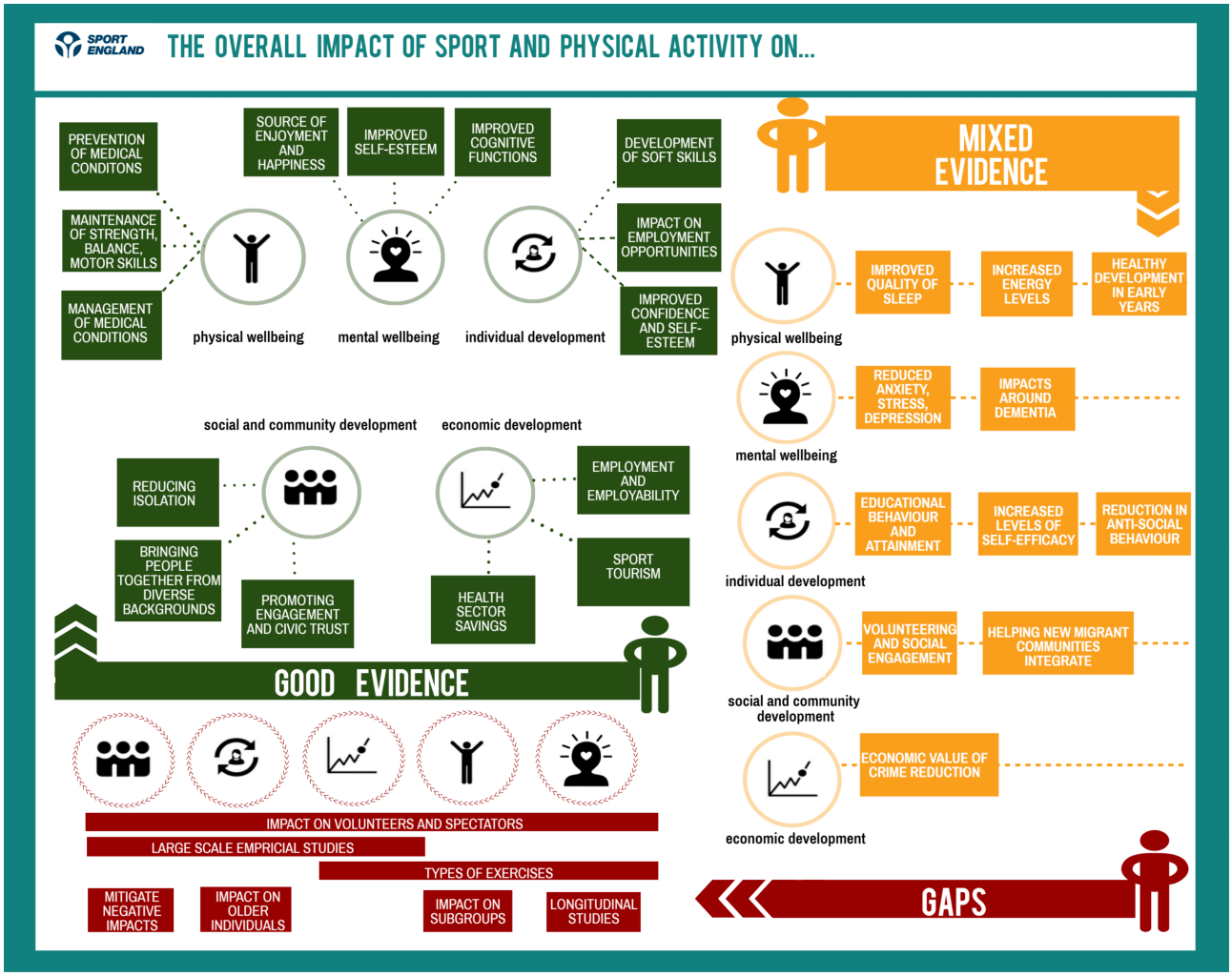


Figure 5: Individual and societal health and wellbeing benefits of physical activity (11)

Under 5s Physical Activity Guidelines

Introduction

The Under-5s age group encompasses a very wide range of developmental stages and physical capabilities. These new guidelines for the Under 5s follow the approach taken in the 2011 guidelines of considering three distinct developmental stages and age groups: infants (less than 1 year); toddlers (1-2 years); and pre-schoolers (3-4 years).

The evidence-base on physical activity in the Under-5s has expanded substantially since the development of the previous set of guidelines (12). There is now a large body of evidence that the amount of physical activity in the Under-5 period influences a wide range of both short-term and long-term health and developmental outcomes (13,14). For example, low levels of physical activity have been recognised as a contributor to increasing rates of child obesity in this age group (15, 16). It has become very clear that higher levels of physical activity are better for health, and lower levels worse, and that there are benefits to increasing levels of physical activity across the distribution of starting physical activity level (13, 14).

The evidence-base used to develop guidelines for the Under-5s has largely been restricted to studies of apparently healthy, typically developing, individuals. However, individuals with a medical condition or disability are also likely to benefit from higher levels of physical activity. The same may be said of disabled children, but the current evidence is limited to support any specific guidelines for this group.

Despite concern over levels of physical activity in the Under-5s, in both boys and girls the average level of physical activity reaches a lifetime peak around the age of school-entry (5 years old) and declines thereafter (17-19 years old). Achieving higher levels of physical activity in the early years should therefore help maintain higher levels later in childhood and adolescence (13, 14, 20, 21).

Physical activity guidelines for Under-5s

Infants (less than 1 year):

- Infants should be physically active several times every day in a variety of ways, including interactive floor-based activity, e.g. crawling.

- For infants not yet mobile, this includes at least 30 minutes of tummy time spread throughout the day while awake (and other movements such as reaching and grasping, pushing and pulling themselves independently, or rolling over); more is better.

NB: Tummy time may be unfamiliar to babies at first, but can be increased gradually, starting from a minute or two at a time, as the baby becomes used to it. Babies should not sleep on their tummies.

Toddlers (1-2 years):

- Toddlers should spend at least 180 minutes (3 hours) per day in a variety of physical activities at any intensity, including active and outdoor play, spread throughout the day; more is better.

Pre-schoolers (3-4 years):

- Pre-schoolers should spend at least 180 minutes (3 hours) per day in a variety of physical activities spread throughout the day, including active and outdoor play. More is better; the 180 minutes should include at least 60 minutes of MVPA.

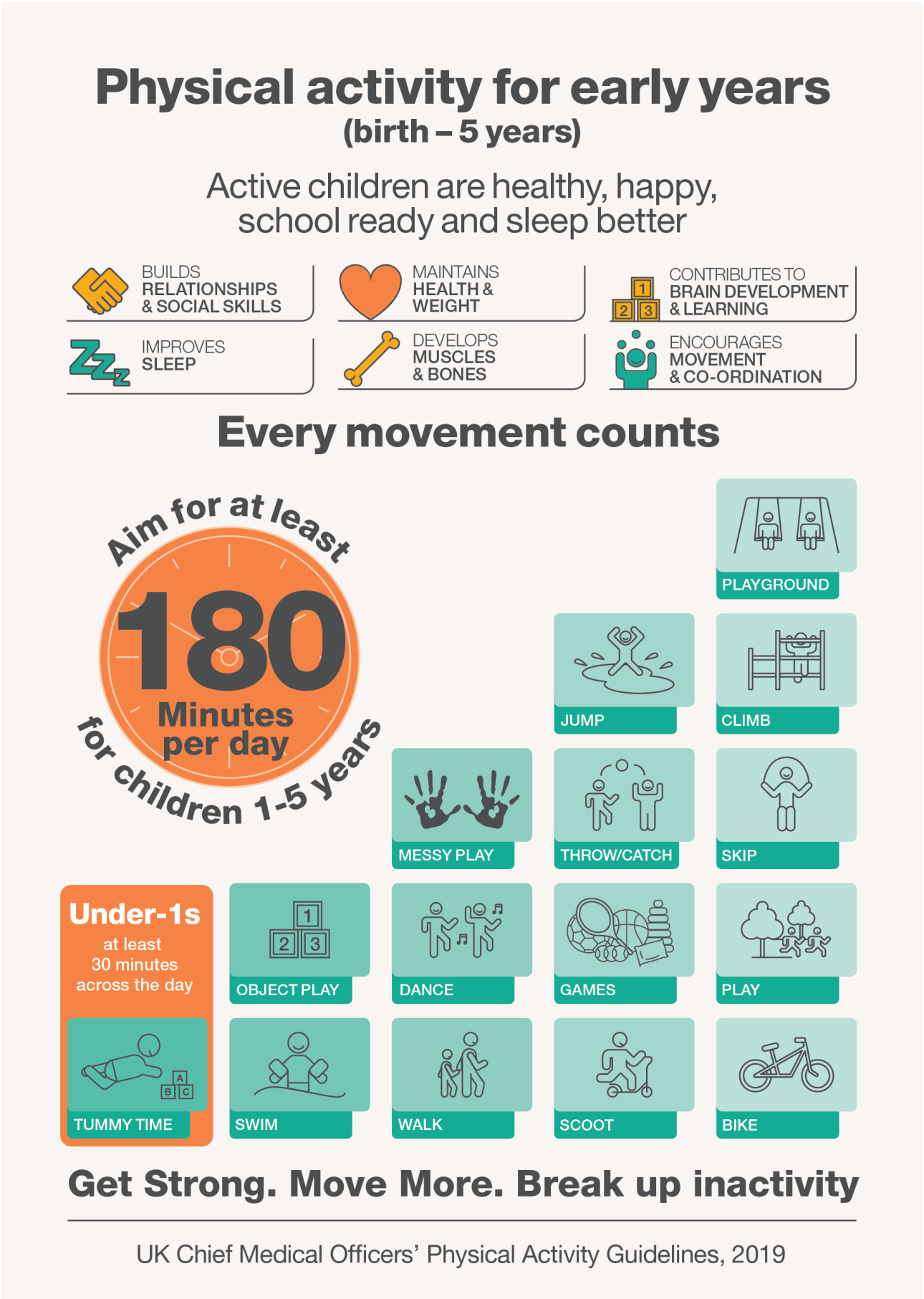
Summary of scientific support for the new guidelines

The last decade has seen an expansion in the evidence base on the health and developmental impact of variation in time spent in physical activity in the Under-5s. Whilst still lacking evidence regarding disabled children, new evidence shows the importance of time spent in physical activity of any intensity (for infants, toddlers, and pre-schoolers); time spent in MVPA (for pre-schoolers); and time spent in various specific types of physical activity (for infants, toddlers, pre-schoolers). As a result, these new guidelines for the Under-5s reflect these different exposures.

New recommendations for 2019 include time spent in physical activity ('tummy time') in infants, in MVPA in pre-schoolers, and new specific guidance on time spent in physical activity and outdoor play in pre-schoolers. These conclusions were based on evidence on the following health and developmental outcomes: adiposity; motor development; psychosocial health (e.g. wellbeing, quality of life); cognitive development; cardiovascular and musculoskeletal fitness; skeletal health; cardiometabolic health; and harms.

The evidence-base on the health and developmental impact of time spent in physical activity in the Under-5s was reviewed systematically and appraised critically using the Grading of Recommendations, Assessment, Development and Evaluation (GRADE) methodological approach in 2016-2018 (22). Full details for methods are available in Annex B.

As summarised in the following infographic, the evidence demonstrated that higher levels of time spent in physical activity were associated consistently with improved: adiposity (infants); motor development (infants, toddlers, pre-schoolers); cognitive development (infants, pre-schoolers); fitness (pre-schoolers); bone/skeletal health (pre-schoolers); and cardiometabolic health (pre-schoolers).


Physical activity for early years
(birth – 5 years)
Active children are healthy, happy, school ready and sleep better
BUILDS RELATIONSHIPS & SOCIAL SKILLS
MAINTAINS HEALTH & WEIGHT
CONTRIBUTES TO BRAIN DEVELOPMENT & LEARNING
IMPROVES SLEEP
DEVELOPS MUSCLES & BONES
ENCOURAGES MOVEMENT & CO-ORDINATION
Every movement counts
Aim for at least
180
Minutes per day
for children 1-5 years
PLAYGROUND
JUMP
CLIMB
MESSY PLAY
THROW/CATCH
SKIP
Under-1s
at least 30 minutes across the day
OBJECT PLAY
DANCE
GAMES
PLAY
TUMMY TIME
SWIM
WALK
SCOOT
BIKE
Get Strong. Move More. Break up inactivity
UK Chief Medical Officers' Physical Activity Guidelines, 2019

Children and Young People Physical Activity Guidelines

Introduction

The physical activity guidelines for children and young people are relevant to those aged from 5 to 18 years. Physical activity is associated with better physiological, psychological and psychosocial health among children and young people (23, 24). Global and UK-specific evidence has shown that boys are more active than girls at all ages and that physical activity levels decline through childhood into adolescence (17, 25, 26). There is also some evidence to suggest that physical activity levels track from childhood into adulthood (27). As such, ensuring that all children are as active as possible throughout childhood is important for current and future population health.

In recent years, there has been increasing awareness of the impact that inactivity and sedentary behaviour may have on health. As set out in the Introduction, sedentary behaviour is not simply the absence of moderate or vigorous physical activity. It includes behaviours such as watching television, reading, working with a computer, sitting while playing video games, or travelling in a motor vehicle. The most common measures of sedentary time used in the literature are self-reported time spent sitting, screen time, and the volume of device-based measures of sedentary time (accelerometer/inclinometer). For young people, evidence suggests that higher levels of sedentary behaviour are weakly associated with greater levels of obesity and lower physical fitness.

It is important to note that this chapter does not include specific recommendations for disabled children and disabled young people. Specific guidelines need to be developed for this group, but this speciality was beyond the remit and expertise of the group undertaking the review of the children and young people guidelines.

Physical activity guidelines for Children and Young People

- Children and young people should engage in MVPA for an average of at least 60 minutes per day across the week. This can include all forms of activity such as physical education, active travel, after-school activities, play and sports.

- Children and young people should engage in a variety of types and intensities of physical activity across the week to develop movement skills, muscular fitness, and bone strength.

- Children and young people should aim to minimise the amount of time spent being sedentary, and when physically possible should break up long periods of not moving with at least light physical activity.

Summary of scientific support for the new guidelines

The recommendations are based on the best available current evidence and are intended to provide guidance for children and young people, parents, and health professionals, but it is important to recognise that the benefits of physical activity operate on a continuum. Thus, for children and young people who are inactive, any increase in physical activity or any reduction in sedentary time is likely to provide health benefits and should be encouraged.

To develop these guidelines, the expert panel reviewed scientific evidence published from 2010 to 2018. The purpose of this review was to identify any new evidence justifying a change to the previous guidelines from 2011. Where insufficient additional evidence was available, the 2011 guideline was retained. The searches primarily focused on review-level evidence for longitudinal cohort studies examining the relationship between physical activity and health outcomes. Systematic reviews and meta-analyses were also examined, along with randomised controlled trials, to identify what types and volume of physical activity were used in effectiveness studies. Full details of methods are available in Annex B.

The three revised recommendations presented below are a refinement of the previous CMOs' guidelines from 2011 (12). The evidence leading to the updated recommendations is outlined below.

Children and young people should engage in MVPA for an average of at least 60 minutes per day across the week

The review of evidence indicated that it would be helpful to change this guideline to an average of at least 60 minutes of MVPA per day. This was because the current evidence base does not support a specific minimum daily threshold of 60 minutes of MVPA for health benefits. Current studies have broadly used an average of 60 minutes per day to assess the benefits of physical activity on health outcomes. The expert panel was unable to assess whether a 60-minute minimum daily threshold is required for health benefits. Recommending an average number of daily minutes more closely reflects the evidence and as such this is the new recommendation.

Children and young people should engage in a variety of types and intensities of physical activity across the week to develop movement skills, muscular fitness, and bone strength

The review of the evidence found broad support for health benefits of vigorous intensity physical activity and activities that would strengthen bone being undertaken by children and young people but found no strong evidence for specific numbers or durations of bouts of moderate-to-vigorous or vigorous intensity physical activity per day.

A recent analysis of nearly 30,000 children suggests that time spent in physical activity with increasing intensity was favourably associated with risk markers of future adult disease in youth, irrespective of bout duration (28). Furthermore, a recent paper has shown that children rarely accumulate physical activity in long bouts, and that the total time in MVPA, rather than time spent in specific bouts, was important for health outcomes (28, 29).

The evidence reviews identified moderate quality evidence that physical activity in children and young people is positively associated with increased proficiency in motor/movement skills (sometimes referred to as a component of physical literacy), and that this relationship is reciprocal (30). Moreover, exposure to different types of activities is implicated in higher perceptions of competence, which are also associated with higher physical activity levels (31). Physical education is likely to play a key role in the development of movement skills and supporting the promotion of high-quality physical education provision is therefore important for the development of children's skills and confidence to be physically active. Nevertheless, there is insufficient evidence to specify the intensity or amount of activity required to accrue such benefits, nor for specifying movements that contribute to fitness improvements.

The current evidence, does, however, suggest that developing a broader, more diverse range of movement skills, providing variety in the types of physical activity that children and young people engage in, is likely to be beneficial, although more high-quality evidence in this area is required (30, 32). The evidence therefore supports a guideline advocating a range of different types and intensities of physical activity across the week, in order to develop movement skills, muscular fitness, and bone strength.

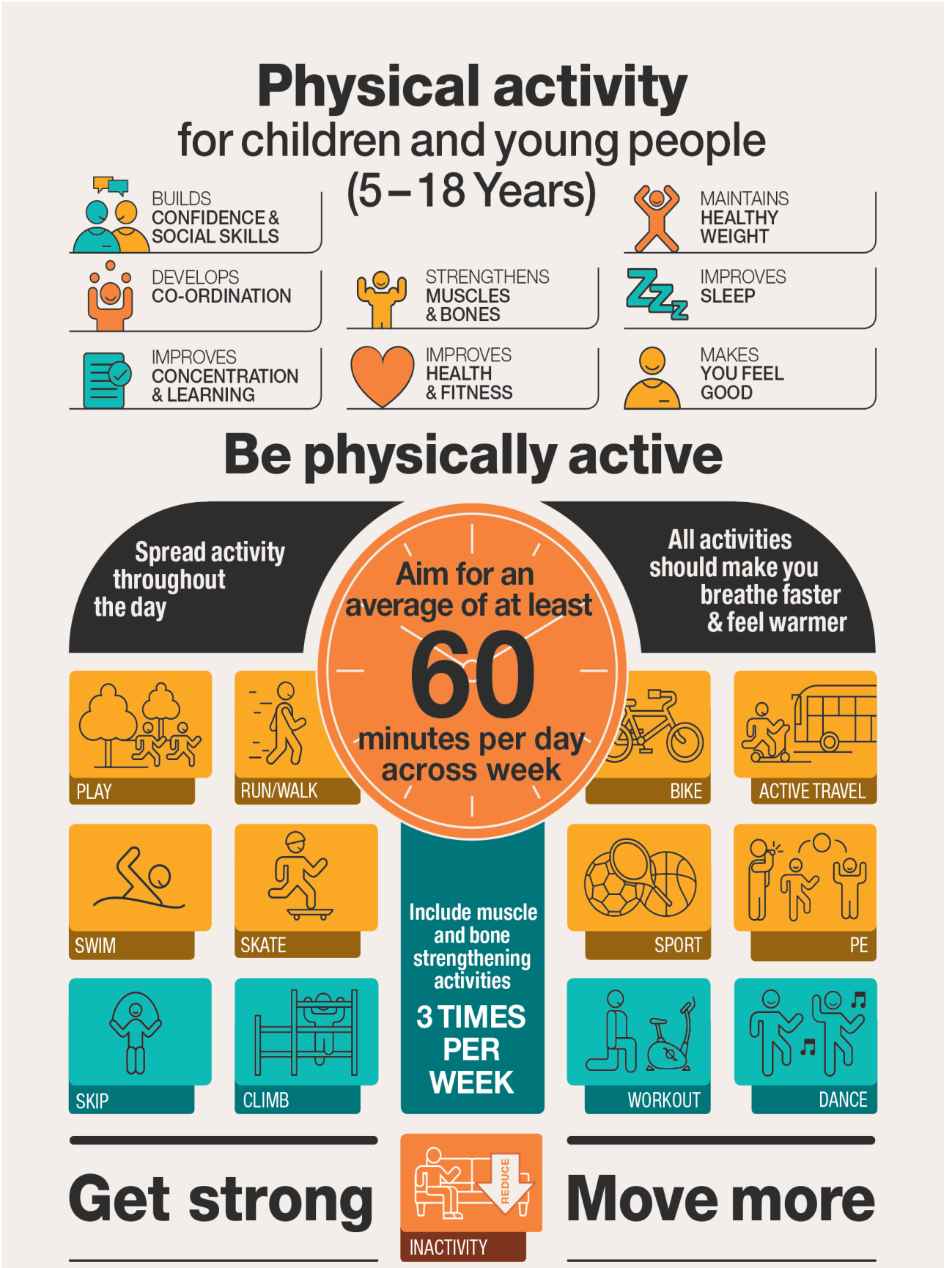
Children and young people should aim to minimise the amount of time spent being sedentary, and when physically possible should break up long periods of not moving with at least light physical activity

In relation to sedentary time, the review of the evidence base highlighted that there is little evidence to suggest modification of the previous guidelines, other than adding a statement recommending that young people reduce periods of inactivity, and replace these with a variety of activities, including light as well as MVPA. This clarification has therefore been made to the wording of the previous guidelines.

Types of physical activity for children and young people

As described above, a key finding from the evidence review is the benefits for children and young people of engaging in different forms of physical activity across the week. Children and young people should engage in a range of activities to improve their skills such as jumping, running and catching, as well as building the confidence to be active. There is therefore no single way in which children and young people should be active; the focus

should be on identifying activities that they find enjoyable, and on creating opportunities to be active. Equally, children and young people should aim to limit sedentary time and replace this with light intensity physical activity wherever possible. The following infographic suggests activities that could be key components of helping children and young people to be physically active.


Physical activity
for children and young people
(5–18 Years)
BUILDS CONFIDENCE & SOCIAL SKILLS
DEVELOPS CO-ORDINATION
IMPROVES CONCENTRATION & LEARNING
STRENGTHENS MUSCLES & BONES
IMPROVES HEALTH & FITNESS
MAINTAINS HEALTHY WEIGHT
IMPROVES SLEEP
MAKES YOU FEEL GOOD
Be physically active
Spread activity throughout the day
Aim for an average of at least 60 minutes per day across week
All activities should make you breathe faster & feel warmer
PLAY
RUN/WALK
BIKE
ACTIVE TRAVEL
SWIM
SKATE
SPORT
PE
SKIP
CLIMB
WORKOUT
DANCE
Include muscle and bone strengthening activities 3 TIMES PER WEEK
Get strong
REDUCE
INACTIVITY
Move more
Find ways to help all children and young people accumulate an average of at least 60 minutes physical activity per day across the week
UK Chief Medical Officers' Physical Activity Guidelines, 2019

Adults Physical Activity Guidelines

Introduction

This chapter presents revised physical activity guidelines for adults from 19 to 64 years of age. It also covers new guidelines and infographics developed for disabled adults (4, 33) and for pregnant (10) and post-partum women within this age group.

Regular physical activity is associated with decreased mortality and lower morbidity from several non-communicable diseases (34). Adults who are physically active report more positive mental and physical health (1). Since publication of the previous physical activity guidelines in 2011, the scientific evidence on the relationships between physical activity and health has continued to accumulate, including new evidence on the volume, duration, and frequency of physical activity for substantial health benefits for disabled adults.

The previous guidelines recommended that adults should undertake 150 minutes per week of moderate intensity physical activity (MPA) or 75 minutes of vigorous intensity physical activity (VPA) or a combination of the two, and resistance training two or more times per week, to gain a range of physical and mental health benefits, and to reduce the risk of many non-communicable diseases. They recommended that physical activity should be spread throughout the week by being active on most days and accumulated in bouts of 10 minutes or more.

However, more recent evidence suggests that these 150 minutes can in fact be accumulated in bouts of any length (35), and/or achieved in one or two sessions per week while still leading to health benefits. In addition, it suggests that health benefits may also be derived from lower volumes, intensities and frequencies of activity, particularly for individuals with low levels of physical fitness and for disabled adults. Further new evidence suggests that short duration, very vigorous exercise (at or close to all-out or maximal effort) at lower volumes than 75 minutes per week may bring equivalent health benefits to those derived from adherence to the previous guidelines, in a more time-efficient manner. Improving fitness also further reduces the risk of cardiovascular disease beyond the reduction associated with regular physical activity.

The evidence continues to suggest that at least twice a week, all adults should undertake activities which increase or maintain muscle strength (resistance training). The activities chosen should use major muscle groups in the upper and lower body. This can include activities such as using bodyweight, free weights, resistance machines or elastic bands, as well as activities of daily living such as stair climbing, wheeling your wheelchair, carrying shopping bags, lifting and carrying children, and gardening.

The evidence reviewed suggests that greater than 150 minutes of physical activity along with dietary restriction may be required for weight loss. Given the interdependency of

energy intake and expenditure, it is not possible to specify how much of an increase in physical activity is likely to result in weight loss. The evidence continues to support the role of physical activity in maintaining weight following weight loss, as well as the health benefits of physical activity in overweight and obese individuals even in the absence of weight loss.

Physical activity guidelines for Adults

- For good physical and mental health, adults should aim to be physically active every day. Any activity is better than none, and more is better still.

- Adults should do activities to develop or maintain strength in the major muscle groups. These could include heavy gardening, carrying heavy shopping, or resistance exercise. Muscle strengthening activities should be done at least two days a week, but any strengthening activity is better than none.

- Each week, adults should accumulate at least 150 minutes (2 1/2 hours) of moderate intensity activity (such as brisk walking or cycling); or 75 minutes of vigorous intensity activity (such as running); or even shorter durations of very vigorous intensity activity (such as sprinting or stair climbing); or a combination of moderate, vigorous and very vigorous intensity activity.

- Adults should aim to minimise the amount of time spent being sedentary, and when physically possible should break up long periods of inactivity with at least light physical activity.

Summary of scientific support for the new guidelines

To develop these guidelines, the expert panel reviewed scientific evidence published from 2010 to 2018. The purpose of this review was to identify any new evidence justifying a change to the previous guidelines from 2011. Where insufficient additional evidence was available, the 2011 guideline was retained. Evidence from recently published evidence reviews used to update international physical activity guidelines came from pooled analyses, meta-analyses and systematic reviews from prospective and randomised controlled trails (RCTs), and, in the case of disabled adults, also qualitative research. Full details of methods are available Annex B.

For good physical and mental health, adults should aim to be physically active every day. Any activity is better than none, and more is better still.

The scientific evidence continues to support 150 minutes of MVPA per week spread across the week, with a recent evidence review on disability adding weight to this. However, there is now evidence that lower volumes (less than 150 minutes per week),

lower intensities (i.e. light physical activity) and lower frequencies (one or two sessions per week) of physical activity may nevertheless confer health benefits.

This lower range for health benefits was also reported in the physical activity evidence review on disability. Setting a minimum dose of physical activity is a challenge given the broad spectrum of health outcomes. Different volumes and intensities of physical activity are likely to induce different physiological changes and health benefits among people with different conditions.

The curvilinear dose-response relationship between physical activity and health outcomes suggests that the proportionately greatest benefits come from progressing from being inactive to achieving moderate levels of activity which are still below the threshold of the guidelines. The evidence reviewed suggests that even light intensity physical activity is associated with a range of health benefits, including lower risk of obesity and all-cause mortality, and improved markers of lipid and glucose metabolism (36). Moreover, threshold recommendations (i.e. 150 minutes of MPA or 75 minutes of VPA) may appear as a barrier to many, particularly those starting from low levels of physical activity, and discourage them from seeking to become more active. This barrier was also identified in the recent evidence review of physical activity for disabled adults. As a result, the statement that 'some is good, more is better' included in the previous physical activity guidelines for Older Adults has now been incorporated into these revised guidelines for all adults by recognising that any activity is better than none, and more is better still.

Although recent evidence suggests that the way in which the recommended amount of physical activity is distributed across the week does not alter its health benefit, there is both previous (37-39) and new evidence (40-42) of short-term (acute) responses in the 24 to 48 hour period after physical activity, supporting the recommendation for being physically active every day.

Adults should also do activities to develop or maintain strength in the major muscle groups. Muscle strengthening activities should be done at least two days a week, but any strengthening activity is better than none.

The available evidence continues to support the recommendation that all adults should undertake activities which increase or maintain muscle strength at least twice a week. The activities chosen should ideally use major muscle groups in both the upper and lower body and be repeated to failure (i.e. until the muscles feel temporarily 'tired out' and unable to repeat the exercise until rested for a short period). Activities to meet this guideline could include using bodyweight, free weights, resistance machines or elastic bands. However, activities of daily living such as stair climbing, wheeling a wheelchair, carrying shopping bags, lifting and carrying children, and gardening will all contribute to developing and maintaining strength. Emerging evidence suggests that such activities performed just once a week at a higher volume of work can also provide similar health effects, but at this stage the evidence is insufficient to justify changing the frequency recommended.

Although not the intention, the recommendation in the previous guidelines regarding resistance training appears to have been interpreted as secondary to the primary message of achieving 150 minutes of MVPA, and there is some evidence that the strength guideline is both less well known and less often achieved. Given the importance of maintaining or increasing muscle strength, particularly for adults at the upper end of the 19-64 age range, this guideline should be given equal emphasis. The order in which the guidelines are presented has therefore been changed accordingly.

Each week, adults should accumulate at least 150 minutes (2 1/2 hours) of moderate intensity activity; or 75 minutes of vigorous intensity activity; or even shorter durations of very vigorous intensity activity; or a combination of moderate, vigorous and very vigorous intensity activity.

Although there is no consistent new evidence to suggest that the 150 minutes of moderate intensity activity per week threshold should be changed, it is nevertheless recognised that the specific figure of 150 minutes is somewhat arbitrary. This threshold has been widely adopted internationally, and therefore has good research evidence supporting the benefits of accruing that amount of activity. Furthermore, 150 minutes of moderate intensity activity per week is likely to be achievable for many people, when environments are accessible and inclusive. However, there is new evidence that these 150 minutes can be accumulated in bouts of any length, and/or achieved in one or two sessions per week, while still retaining the beneficial effects. Wording in the previous guidelines specifying that this physical activity should be in bouts of 10 minutes or more and distributed across most days of the week has therefore been removed in these new guidelines.

Dose-response relationship varies by disease risk. Often increases in the volume of physical activity bring additional reductions in risk. For example, for hypertension, the evidence suggests that 150 minutes (10 MET-h) of ‘leisure time PA’ reduces the risk of hypertension by 6%, with further reductions of a similar magnitude for every additional 150 minutes (43). For type 2 diabetes, dose-response analysis indicates that risk reduction can be achieved below 150 minutes of MVPA per week, but that substantially greater benefits can be achieved by being more active (44). For cardiovascular disease (CVD), recent evidence suggests that achieving the current guidelines is associated with reduced risk, but that moving from inactive to moderately active (6 MET-h per week, or less than half of the guideline amount) brings proportionately the greatest benefit.

Several meta-analyses and systematic reviews published since 2010 have demonstrated that very vigorous intensity activity performed in short bouts interspersed with rest or recovery (high intensity interval exercise) has clinically meaningful effects on fitness, adiposity, body weight and insulin resistance (6). There is limited evidence of the benefits of high intensity interval exercise for disabled people. The available evidence suggests that short duration, very vigorous intensity activity can be as or more effective than MVPA, and this option has therefore been incorporated into the recommendation.

Adults should aim to minimise the amount of time spent being sedentary, and when physically possible should break up long periods of inactivity with at least light physical activity.

There have been notable developments in the epidemiological evidence base for adults, particularly regarding associations between sedentary behaviour and cancer risk and survivorship (45-49). Recent meta-analytical data from 34 studies, including over one million unique individuals (50), concluded that for adults, above 6 to 8 hours per day of total sitting time and 3 to 4 hours per day of TV viewing time are associated with greater risk of all-cause and CVD mortality, independently of levels of MVPA. Despite these new studies, there currently remains insufficient evidence to determine a dose–response relationship or a threshold for clinically relevant risk. At present the evidence therefore does not support including a specific time limit or minimum threshold of sedentary time within this recommendation. New evidence on the health benefits of shifting from sitting to standing was insufficient to support including a recommendation to interrupt sedentary time by standing.

Weight loss and weight maintenance

Physical activity expends energy, and therefore makes a valuable contribution to weight management by reducing adiposity. The evidence reviewed suggests that greater than 150 minutes of physical activity, together with dietary restriction, may be required for weight loss. Given the interdependency of energy intake and expenditure for weight loss, it is not possible to specify how much more physical activity alone would be likely to result in weight loss. However, given the scale of the problem of overweight and obesity, the importance of physical activity and the need to simultaneously restrict energy intake should be emphasised. Moreover, the role of physical activity in maintaining weight following weight loss should be highlighted. It is also worth emphasising that the health benefits associated with physical activity are experienced by adults irrespective of weight status, and in the absence of weight loss.

Physical activity for disabled adults

A rapid evidence review was carried out of the evidence base on physical activity for general health benefits for disabled adults (4). It found that, with respect to safety, no evidence exists that suggests appropriate physical activity is a risk for disabled adults and analogous health benefits for disabled adults of engaging in physical activity as for the rest of the adult population. It concluded that any myths about physical activity being inherently harmful for disabled people should be dispelled.

Physical activity during pregnancy & during postpartum

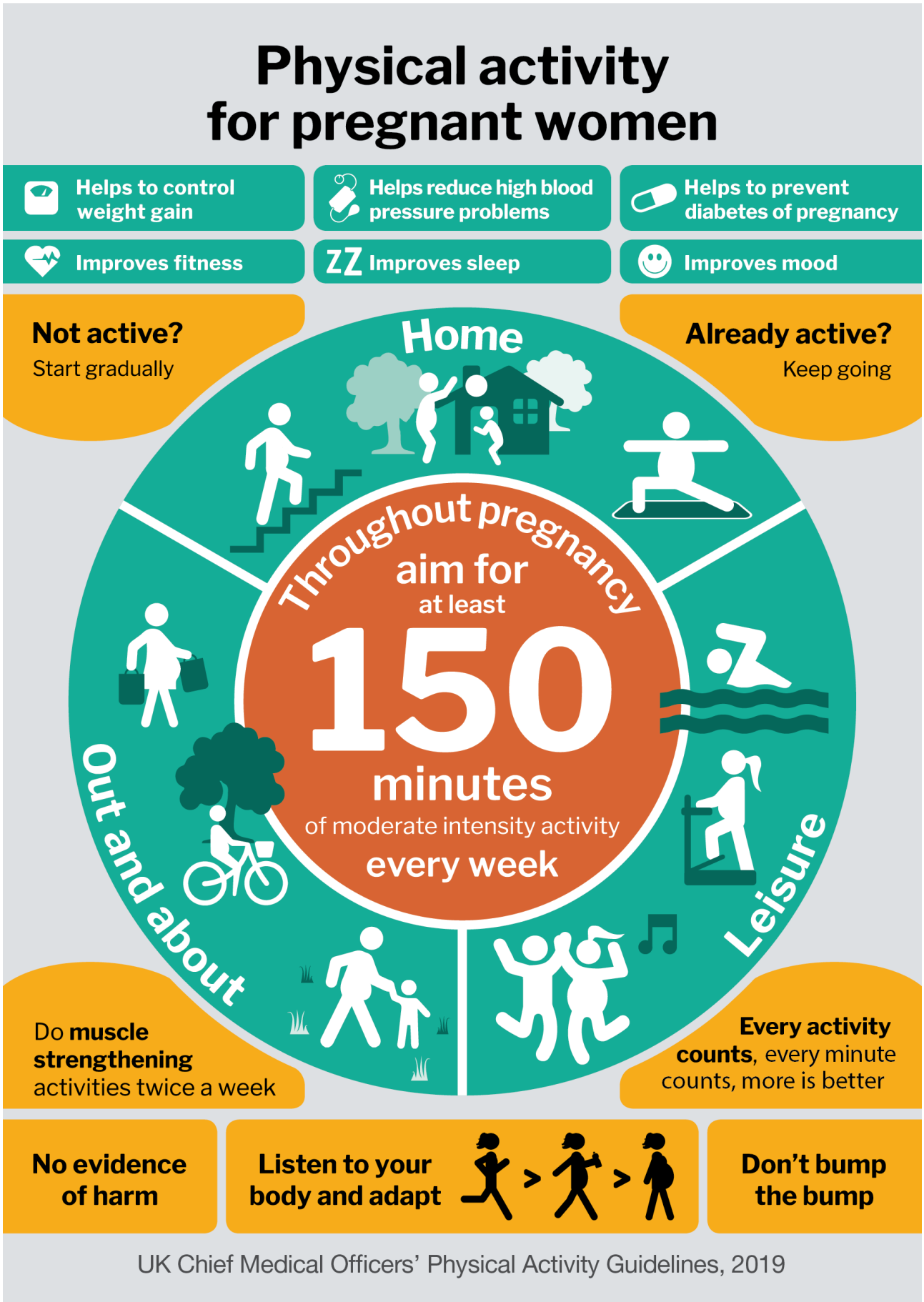
Evidence-based recommendations for physical activity and pregnancy and physical activity and postpartum have also been produced, following standard methods examining pooled analyses, meta-analyses and systematic reviews from prospective and randomised controlled trails (RCTs), and qualitative research on experiences of physical activity of health professionals and women (10). Based on these, the infographics included in this section have been co-produced and tested with health professionals and women.

The benefits of physical activity during pregnancy identified by the review were reduction in hypertensive disorders; improved cardiorespiratory fitness; lower gestational weight gain; and reduction in risk of gestational diabetes. The benefits of physical activity in the postpartum period (up to one year) were identified as a reduction in depression; improved emotional wellbeing; improved physical conditioning; and reduction in postpartum weight gain and a faster return to pre-pregnancy weight.

Physical activity can safely be recommended to women during and after pregnancy and had no negative impact on breastfeeding postpartum. Physical activity choices should reflect activity levels pre-pregnancy and should include strength training. Vigorous activity is not recommended for previously inactive women. After the 6 to 8 week postnatal check, and depending on how the woman feels, more intense activities can gradually resume, i.e. building up intensity from moderate to vigorous over a minimum period of at least 3 months.


Physical activity for adults and older adults
Benefits health
Improves sleep
Maintains healthy weight
Manages stress
Improves quality of life
Reduces your chance of
Type II Diabetes -40%
Cardiovascular disease -35%
Falls, depression etc. -30%
Joint and back pain -25%
Cancers (colon and breast) -20%
Some is good, more is better
Make a start today: it's never too late
Every minute counts
Be active
at least 150 minutes moderate intensity per week
increased breathing able to talk
OR
or a combination of both
at least 75 minutes vigorous intensity per week
breathing fast difficulty talking
Swim
Brisk walk
Cycle
to keep muscles, bones and joints strong
Build strength
on at least 2 days a week
Gym
Yoga
Carry heavy bags
Run
Stairs
Sport
Minimise sedentary time
Break up periods of inactivity
Bowls
Tai Chi
Dance
For older adults, to reduce the chance of frailty and falls
Improve balance
2 days a week
UK Chief Medical Officers' Physical Activity Guidelines 2019


Physical Activity
for
Disabled Adults
Make it a daily habit
Improves mental health and quality of life
Makes maintaining a healthy weight easier
Creates opportunities to meet new people and feel part of the community
Makes daily tasks easier and increases independence
Disabled adults
Physical activity makes you feel good
Give things a go and enjoy what you do
Being inactive is harmful to health
Don't be still for too long
Even a little movement is better than nothing
Helps to prevent chronic disease
Strengthens muscles and bones
Improves mobility and balance
Improves fitness
Do strength and balance activities on at least two days per week
For substantial health gains aim for at least 150 minutes each week of moderate intensity activity
Remember the talk test:
Can talk, but not sing = moderate intensity activity
Difficulty talking without pausing = vigorous intensity activity
UK Chief Medical Officers' Physical Activity Guidelines, 2019


Physical activity for pregnant women
Helps to control weight gain
Helps reduce high blood pressure problems
Helps to prevent diabetes of pregnancy
Improves fitness
Improves sleep
Improves mood
Not active?
Start gradually
Already active?
Keep going
Home
Throughout pregnancy
aim for
at least
150
minutes
of moderate intensity activity
every week
Out and about
Leisure
Do muscle strengthening activities twice a week
Every activity counts, every minute counts, more is better
No evidence of harm
Listen to your body and adapt
Don't bump the bump
UK Chief Medical Officers' Physical Activity Guidelines, 2019

Physical activity for women after childbirth (birth to 12 months)

- Time for yourself - reduces worries and depression
- Helps to control weight and return to pre-pregnancy weight
- Improves tummy muscle tone and strength
- Improves fitness
- Improves mood
- Improves sleep

- It's safe to be active. No evidence of harm for post partum women
- Depending on your delivery listen to your body and start gently
- You can be active while breastfeeding

UK Chief Medical Officers' Physical Activity Guidelines, 2019

Older Adults Physical Activity Guidelines

Introduction

Regular physical activity contributes to the key determinants of healthy ageing: good physical and mental function; opportunities for social interaction; a sense of control over, and responsibility for one's own health and well-being; and managing or coping with disease symptoms and functional limitations (51, 52). There is now also emerging evidence that increasing physical activity contributes to improving social functioning and reducing loneliness and social isolation.

Although age alone does not determine physical condition or capacity, older age (65 years and over) is associated with a greater risk and prevalence of many health conditions including coronary heart disease, stroke, type 2 diabetes, cancer and obesity, as well as depression and dementia. Older adults are also at greater risk of falling, often resulting in the avoidance of activity, and consequent fractures and impairments.

There is strong evidence that physical activity contributes to increased physical function, reduced impairment, independent living, and improved quality of life in both healthy and frail older adults. Physical activity in later life can help treat and offset the symptoms of a range of chronic conditions (e.g. depression, CVD, Parkinson's disease). Since the first UK physical activity guidelines specifically for older people were published in 2011, new evidence has strengthened and reinforced the main elements of those.

However, some changes have been made to the previous guidelines to take account of new evidence. Given the lower levels of physical activity amongst the population of older adults (53, 54), small increases in the volume of daily physical activity can produce important health and functional benefits. Growing evidence supports the importance of light intensity activity to health (55, 56), a message that is particularly important to communicate to those who are currently inactive and/or frailer. These revised guidelines for older adults therefore give greater emphasis to regular light activity. This can be a means of breaking up prolonged periods of sedentary time, and of building up gradually to the recommended weekly amount of MVPA. The previous recommendation that moderate intensity activity should be in bouts of 10 minutes or more is no longer considered necessary and has therefore been removed.

The value to older adults of activities which improve strength, balance and flexibility cannot be overstated, and therefore receive greater prominence in these revised guidelines. These components of fitness help maintain physical function, reduce the risk of falls, and help people feel more confident and able to meet the MVPA guidelines. It is now emphasised that activities to improve strength, balance and flexibility can be incorporated into sessions that also involve MVPA, rather than necessarily being in addition.

Physical activity guidelines for Older Adults (65 years and over)

- Older adults should participate in daily physical activity to gain health benefits, including maintenance of good physical and mental health, wellbeing, and social functioning. Some physical activity is better than none: even light activity brings some health benefits compared to being sedentary, while more daily physical activity provides greater health and social benefits.

- Older adults should maintain or improve their physical function by undertaking activities aimed at improving or maintaining muscle strength, balance and flexibility on at least two days a week. These could be combined with sessions involving moderate aerobic activity or could be additional sessions aimed specifically at these components of fitness.

- Each week older adults should aim to accumulate at least 150 minutes of moderate intensity aerobic activity, building up gradually from current levels. Those who are already regularly active can achieve these benefits through 75 minutes of vigorous intensity activity, or a combination of moderate and vigorous activity, to achieve greater benefits. Weight-bearing activities which create an impact through the body help to maintain bone health.

- Older adults should break up prolonged periods of being sedentary with light activity when physically possible, or at least with standing, as this has distinct health benefits for older people.

Summary of scientific support for the new guidelines

To develop these guidelines, the expert panel reviewed scientific evidence published from 2010 to 2018. The purpose of this review was to identify any new evidence justifying a change to the previous guidelines from 2011. Where insufficient additional evidence was available, the 2011 guideline was retained. Full details of methods are available in Annex B.

Physical activity plays a changing role in the lives of older adults, as for some it becomes more about the maintenance of independence and the management of symptoms of disease, rather than primary disease prevention. There is enough knowledge of the benefits associated with physical activity in older adults to categorically state that they outweigh the risks. In older adults with frailty, moderate-to-severe dementia, or a history of vertebral fractures or regular falls, it might be more appropriate for any new exercises to be initially supervised by a trained professional, to ensure efficacy and safe techniques to avoid injury.

Older adults should participate in daily physical activity to gain health benefits. Some physical activity is better than none: even light activity brings some health benefits compared to being sedentary.

The use of wearable devices to objectively measure the physical activity of older individuals during the activities of daily life, in addition to structured activity programmes, has provided a growing evidence base that supports the health benefits of light-intensity physical activity, independently of those provided by MVPA (57-60). Light activity is associated with a range of health benefits, including lower risk of obesity, CVD, cancer, and all-cause mortality (61); improved markers of lipid and glucose metabolism (56); and reductions in unplanned hospital admissions and future prescriptions for health conditions (62). Although still extremely limited in number, studies show a link between inactivity and loneliness and social isolation, and that increasing physical activity can reduce loneliness and social isolation, as well as improving social functioning (63, 64).

Older adults should break up prolonged periods of being sedentary with light activity when physically possible, or at least with standing, as this has distinct health benefits for older people.

Prolonged sedentary behaviour is associated with many poor health and functional outcomes in older adults (65). There is emerging evidence that for inactive older adults, replacing sedentary behaviour with light-intensity activity is likely to produce some health benefits. Specifically, for individuals who perform no or little MVPA, replacing sedentary or inactive behaviours with light-intensity activity (such as walking at 2 miles per hour, dusting or polishing furniture, or easy gardening) reduces the risk of all-cause mortality, cardiovascular disease incidence and mortality, and type 2 diabetes (57). In those transitioning to frailty and who find light activity difficult, there is emerging evidence that short periods of standing repeated hourly provides some benefits to physical function (66).

These revised guidelines therefore highlight the potential of light-intensity activity to benefit the health of older adults, and that increasing the volume of light-intensity movement in daily routines can bring important health benefits at a population level. This is particularly valuable for those older adults unable to perform moderate-intensity activity. Other evidence supports the benefits of being active throughout the day, such as better maintenance of bone health with higher volumes of light intensity activity spread throughout the day (67).

Older adults should maintain or improve their physical function by undertaking activities aimed at improving or maintaining muscle strength, balance and flexibility on at least two days a week.

A loss of muscle strength in advancing age is the primary limiting factor for functional independence (68). Physical function has a linear relationship with mortality, and those with poor physical function have a higher risk of all-cause mortality, even from mid-life (69). Multi-component strength and balance activities, including flexibility, are key to improving physical function (70). Poor balance also predicts a higher rate of cognitive decline, as well as higher all-cause mortality (71). Good balance and mobility are essential to the successful performance of most activities of daily living, as well as the ability or confidence to take part in recreational activity.

Evidence-based strength and balance exercise programmes reduce falls rate and risk (72), are cost-effective (73), increase confidence, and can increase habitual moderate physical activity towards meeting the guidelines (74). They can be group or home-based, and strength and balance activities can be embedded within everyday activities.

Each week older adults should aim to accumulate at least 150 minutes (2½ hours) of moderate intensity aerobic activity, building up gradually from current levels.

The evidence that at least 150 minutes of moderate intensity activity per week contributes significantly to the prevention of chronic disease has strengthened (1). In addition, the risk of progression of disabilities affecting the basic activities of daily living is almost halved in those who undertake regular moderate intensity physical activity, compared to those who do not (75). Bone mineral density is greater in those who meet the MVPA guidelines (67). There is strong support for the role of physical activity in reducing the risk of cognitive impairment and dementia (76), and bouts of 30 minutes of moderate activity per day almost halve the odds of experiencing depression (77).

Alternative ways of recording exercise, such as using pedometers or step counters, may be helpful to some older adults in tracking progress towards the MVPA guidelines. Evidence suggests that 30 minutes of daily MVPA accumulated in addition to habitual daily activities in healthy older adults is equivalent to taking approximately 7,000 to 10,000 steps per day (78-80). This evidence suggests 4500 to 5500 steps a day for improved health related quality of life, above 7000 steps a day for better immune function, and 8000 to 10000 steps a day for an effect on metabolic syndrome and maintenance of weight (81).

For those who are already regularly active, a combination of moderate and vigorous aerobic activity brings greater benefit (1). 75 minutes of vigorous aerobic activity spread across the week can produce comparable benefits to 150 minutes of moderate intensity activity (1). High intensity interval training is one approach to accumulating vigorous

intensity physical activity, but there is currently very limited evidence on its benefits and harms among older populations.

Emerging evidence from cross-sectional and prospective studies indicates that bouts of any length of MVPA contribute to the health benefits associated with accumulated volume of physical activity (1, 55, 59). The previous recommendation of a minimum bout length of 10 minutes is therefore no longer necessary for the optimal health message. This seems particularly relevant to older adults, given the sporadic nature of accumulated activity in this population.

Types of physical activities for this group

Older adults are more likely to have already been diagnosed with disease, and also experience different life events to middle-age adults, such as retirement, helping with grandchildren, and the increased likelihood of becoming a carer. These circumstances bring a new set of challenges in terms of physical activity participation and may temporarily halt people's ability to be active. Nevertheless, a few strategies can help to re-engage in physical activity and build activity levels up gradually. For those who are limited by disease or impairment, there is value in even small increases in activity, which can also help to slow or prevent further decline. This section provides examples of how a combination of different activities addressing the different components of the guidelines can be tailored to the range of circumstances encountered in older age, from those who are already active, to those who are losing function but otherwise healthy, to those who are frail (78-80).

Active Older Adults

Active older adults are those who are already active through daily walking, an active job, and/or who engage in regular recreational or sporting activity. For many, this may just involve aerobic activity such as brisk walking, whereas significant additional benefits can be achieved from incorporating activities to improve strength, balance and flexibility. Undertaking a programme of activity at least twice per week that includes resistance activities (lifting weights, using resistance bands or other equipment to provide resistance, etc.), some impact activities (running, jumping, skipping etc.), and balance activities (standing on one leg, backwards walking, activities that involve 3-dimensional movement etc.) would provide these benefits (8). A mix of sporting activities, Tai Chi, dance and aqua-aerobics, for example, would contribute to both the aerobic and the strength and balance guidelines.

In transition

Older people in transition describes people whose function is declining due to low levels of activity and too much sedentary time, who may have lost muscle strength and/or be overweight but otherwise remain reasonably healthy. 'Walk and rest for a minute' may be a useful strategy for adults in this age group to manage fatigue, particularly while building up

gradually towards the guideline level for moderate-intensity activity. The inclusion of strength and balance activities may be particularly useful to increase confidence and stability. Sit-to-stands, stair climbing, and home-based strength and balance exercises can all contribute to stability. They can also build the confidence to move safely on to activities that improve aerobic activity, such as brisk walking and exercise classes to improve strength and balance.

Frailer older adults

Frailer older adults are those who are identified as being frail or have very low physical or cognitive function, perhaps because of chronic disease such as arthritis, dementia or advanced old age itself. Any increase in the volume and frequency of light activities, and any reduction in sedentary behaviour, is a place to start and contributes towards health. For this group, more strenuous activities are less likely to be feasible. A programme of activities could focus instead on reducing sedentary behaviour and engaging in regular sit-to-stand exercise and short walks, stair climbing (82), embedding strength and balance activities into everyday life tasks (72), and increasing the duration of walking, rather than concentrating on intensity.

Conclusion

These revised UK Chief Medical Officers' Physical Activity Guidelines reflect the most up-to-date scientific evidence for the benefits of physical activity. They offer a recommended frequency, intensity, duration and volume of aerobic, muscle strengthening, and balance activities to achieve health benefits, based on reviews of evidence across the life course and through key life stages.

Maintaining a consistent set of physical activity guidelines across all the UK remains one of the key strengths of a joint report from the four Chief Medical Officers of England, Northern Ireland, Scotland and Wales. It provides the opportunity to communicate consistent messages, based on the same underpinning evidence, through the professional networks and public communications of each Chief Medical Officer in their respective countries.

Effective tools to support health professionals and the range of practitioners who carry out the vital work of supporting people to be physical active are essential if these guidelines are to make a difference in practice. The set of infographics included in this report have been developed with that purpose in mind. They are available on the Chief Medical Officers' Physical Activity Guidelines web pages as separate files in a range of formats and are intended for widespread dissemination and use.

Following on from publication of this report, two new Working Groups will be established to continue co-ordination on effective and consistent messages to support and encourage physical activity. Firstly, a Communications Working Group will consider approaches to develop and extend the materials and approaches used to communicate the physical activity guidelines more widely and provide advice on overall communications strategy for the guidelines. Secondly, a Monitoring and Surveillance Working Group will be convened to consider how physical activity levels are measured at population level, and to identify opportunities to improve the quality and consistency of data across the different countries within the UK.

Future work will also include ongoing reviews of these guidelines in the light of new evidence. It is anticipated that the next update will be considered via a scoping review of new evidence in 2024, with the next full revision completed before 2029.

Annex A: Glossary

Balance

Balance activities are those activities that involve the maintenance of the body balance while stationary or moving.

Bone Health

Bone health includes bone quality that refers to the capacity of bones to withstand a wide range of loading without breaking. Bone health also includes bone mineral content, structure, geometry and strength.

Disability

Disability refers to people who have long-term physical (e.g. spinal cord injury), sensory (e.g. visual impairment), cognitive (e.g. learning difficulties), and/or mental impairments (e.g. depression) which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others. Rather than focusing on just one impairment, the UK CMO Guidelines considered a range of impairments. See United Nations Convention on the Rights of Persons with Disabilities.

Epidemiological studies

The study and analysis of the distribution, patterns and determinants of health and disease conditions in defined populations.

Impact Activities

High Impact Activities are those activities or sports that put stress on weight bearing joints such as the knee, hip, or ankle.

HIIT

High Intensity Interval Training (HIIT) is very vigorous physical activities performed in short bursts interspersed with breaks.

Meta-analyses

A statistical analysis that combines the results of multiple epidemiological studies.

METs

Metabolic Equivalent of Task (MET) is the objective measure of the ratio of the rate at which a person expends energy, relative to the mass of that person, while performing some specific physical activity compared to the energy expended whilst sedentary.

MPA

Moderate physical activity is an activity that requires a moderate amount of effort and noticeably accelerates heart and breathing rate

MVPA

Moderate-to-vigorous physical activity (MVPA) are activities that can be done at different intensities like cycling. They can be differentiated by the ‘talk test’: being able to talk but not sing indicates moderate intensity activity, while having difficulty talking without pausing is a sign of vigorous activity.

Non-communicable diseases

A disease that is not transmissible directly from one person to another.

Postpartum

Postpartum refers to a period of time after the end of pregnancy. The postpartum period is commonly defined as up to six weeks following the end of pregnancy, with the late postpartum period from six weeks up to one year after the end of pregnancy. For the CMO Guidelines postpartum includes up to one year post delivery.

Sedentary behaviour

Inactive and sedentary behaviours are those involving being in a sitting, reclining or lying posture during waking hours, undertaking little movement/activity and using little energy above what is used at rest.

Systematic review

A technique that uses systematic methods to collect secondary data, critically appraise studies and synthesise findings.

VPA

Vigorous physical activity is an activity that requires a large amount of effort and causes rapid breathing and substantial increase in heart rate.

Annex B: Expert Working Groups and Methods

A number of Expert Working Groups (EWG) were established to review the evidence for updating the 2011 CMO physical activity guidelines. Each EWG drew upon three types of evidence: 1: recent published evidence reviews used to construct or update international physical activity guidelines; 2: the most recent pooled analyses, meta-analyses and systematic reviews from prospective and RCT research published since the most recent reviews used to update international guidelines; and 3: any additional relevant papers identified by each EWG. In addition, comments and suggestions regarding the 2011 CMO physical activity recommendations were identified for each EWG from the first National Consultation.

The sections below describe these review methods in further detail. The full technical reports produced by each EWG available on the UK CMO Physical Activity Guidelines Update website.

Methods for the Under-5s physical activity guidelines

Extensive guideline development work for 24-hour movement behaviours for the Under-5s has occurred internationally over the past 24 months (83-85). In order to develop draft recommendations for the UK, the Under 5s EWG used the GRADE-ADOLOPMENT (adoption and/or adaptation of an existing guideline, plus de novo development) approach (84, 86). This approach has been used to adopt/adapt the 2017 Canadian Society for Exercise Physiology 24-Hour Movement Guidelines for the Early Years (0-4 years) to produce guidelines for Australia in 2017 (84) and has been used to produce international (WHO) guidelines, and guidelines for South Africa (85).

The Under-5s EWG used the Canadian Society for Exercise Physiology 24-Hour Movement Guideline for the Early Years (0-4 years) (83) as the basis of the UK draft recommendations. The Canadian guidelines were chosen because (in contrast to other candidate guidelines): they met a number of essential/desirable criteria (84, 86): recently published; followed GRADE methodology; addressed clear questions; had an assessment of benefit/harms; had been assessed using the International Approach to Guidelines, Research, and Evaluation (AGREE) (87); could be updated; had risk of bias assessment; took a 24 –hour movement behaviour approach and provided access to evidence tables/summaries for consideration by the UK Under-5s EWG. The results of the literature searches (Summary of Findings and GRADE tables) were made available by the Canadian Society for Exercise Physiology and the Australian Guideline Development Group in 2017. It was desirable to update and extend these searches for the UK process which took place in 2018: the ‘WHO Guidelines Development Group for integrated 24-hour movement in young children: physical activity, sedentary behaviour and sleep time in

children under 5 years of age' kindly shared the results of their updated literature searches with the UK EWG in 2018. The EWG draft recommendations are based on the updated and extended evidence synthesis where possible.

The Under-5s EWG considered evidence for 3 distinct populations: infants (up to age 1 year); toddlers (age 1-2 years); pre-schoolers (age 3-4 years). A large number of exposures were considered, under the general headings of physical activity, sedentary behaviour, and sleep duration. We included the following outcomes: adiposity, motor development, emotional-behavioural regulation; psychosocial health (e.g. wellbeing, quality of life), cognitive development, cardiovascular and musculoskeletal fitness, harms (i.e. injuries), skeletal health, cardiometabolic health; growth, physical activity/TV viewing (outcomes with sleep as the exposure variable).

Methods for the Children and Young People, Adults, and Older Adults physical activity and sedentary behaviour guidelines

Each EWG adopted the same principle, namely, to identify whether there was any new evidence to suggest a change to the 2011 guidelines based on the GRADE-ADOLOPMENT process (88). Using the GRADE-ADOLOPMENT process, the most recent international physical activity guidelines for children and young people were identified: these were from the Netherlands. Together with the 2011 UK guidelines, this formed the starting point of the review.

The current UK physical activity guidelines were constructed as advice to the general population about the recommended frequency, intensity, time and types of physical activity required to prevent major chronic disease and to maintain health. In the UK, the diseases refer specifically to mortality, years of life lost, and disease burden (coronary heart disease, stroke, heart failure, diabetes mellitus type 2, chronic obstructive pulmonary disease (COPD), breast cancer, colorectal cancer, lung cancer, osteoarthritis, dementia and cognitive decline, and depression and depressive symptoms). The guidelines also focus on preventing premature (or all-cause) mortality and fractures, disabilities in the elderly, injuries and, in children, attention deficit hyperactivity disorder (ADHD) symptoms. Four risk factors were also included (systolic blood pressure, LDL cholesterol, body weight (BMI Z-score in children), and insulin sensitivity), which have a causal relationship with these chronic diseases. For the children and young people expert review, muscle strength, cardiorespiratory fitness, bone health, cognitive functioning and academic performance were included as key health indicators for this age group.

The specific steps that were followed to address items 1-3 highlighted above are described in detail below.

1. Identifying recent national evidence reviews used to construct or update physical activity guidelines

Google was used, and public health bodies (i.e. National Centre for Health and Clinical Excellence, Centre for Disease Control) were targeted to search for evidence reviews of physical activity that had been used to construct national physical activity guidelines and recommendations (published since 2010). International experts who had authored recent national guidelines to identify further examples of relevant reviews from Australia, Canada and the Netherlands (23, 89, 90) were also contacted. National evidence reviews for the construction of children's physical activity guidelines were found for 15 European countries and four other worldwide countries. Twelve of these evidence reviews were eligible for inclusion based on publication date (23, 89-99).

2. Identifying the most recent pooled analyses, meta-analyses and systematic reviews from prospective and RCT research to answer the specific questions posed

Purposive searches were undertaken to identify relevant literature on the relationship between physical activity and health outcomes. These primarily focused on review-level evidence for longitudinal cohort studies examining the relationship between physical activity and health outcomes. Systematic reviews and meta-analyses were also examined for randomised controlled trials to identify what types and volume of physical activity were used in effectiveness studies. PubMed was searched using a tailored set of broad MeSH terms (Medical Subject Headings) to capture the most current studies published, relevant to the needs of each EWG. For example, "resistance training", "muscle", "bone', "balance" AND "physical activity" AND "adults".

The terms of the searches and their dates reflected the most recent international evidence reviews searches. For example, the Netherlands searches were truncated at 1 October 2016, so searches include all publications from January 1st, 2016 (in case of delayed archiving) to 1st January 2018. EWGs synthesised the effectiveness of the evidence across their health outcomes using this process.

A total of 42 publications were identified via the PubMed search. Studies were excluded if they were outside of the date range, included 'at risk' populations or focussed solely on sedentary behaviour. The central review team research associate removed duplicates and assessed the eligibility of the studies against the key questions outlined below, and via this process a total of 14 publications were eligible for inclusion (30, 100-112).

3. Identification by each EWG of any additional relevant papers

Each EWG was also asked to identify any relevant outcomes and primary papers from their own sources and networks. EWGs identified the most relevant and up to date high

quality reviews from these sources and summarised the effectiveness of the evidence across their health outcomes.

Communication and Surveillance

The Communication and Surveillance EWG considered how the communication of the CMOs' guidelines could be made most effective and targeted to different audiences, and how monitoring of the uptake of the guidelines could be improved and made more consistent across the UK. A paper on the monitoring issues has been published (113), and further work on both communication and monitoring will be taken forward through two new working groups following publication of these guidelines.

Membership of Expert Working Groups

Expert Working Group	Members
Under 5s	Prof John Reilly - Chair Dr Kathryn Hesketh Dr Catherine Hill Dr Adrienne Hughes Dr Xanne Janssen Dr Ruth Kipping Prof Sonia Livingstone Dr Anne Martin
Children and Young People	Prof Russell Jago - Chair Prof Stuart Fairclough Dr Kelly Mackintosh Dr Paul McCrorie Dr Simon Sebire Dr Lauren Sherar Dr Esther van Sluijs Prof Craig Williams
Adults	Prof Marie Murphy - Chair Dr David Broom Prof Jason Gill Dr Cindy Gray Prof Andy Jones Dr James Steele Prof Dylan Thompson Dr Jet Veldhuijzen van Zanten
Adults with disabilities	Prof Brett Smith - Chair Nathalie Kirby Dr Rebekah Lucas Bethany Skinner Leanne Wightman

Expert Working Group	Members
Older Adults	Prof Dawn Skelton - Chair Dr Daniel Cleather Prof Rob Copeland Dr Carolyn Greig Dr Alexandra Mavroeidi Dr Afroditi Stathi Dr Garry Tew Prof Mark Tully
Sedentary Behaviour	Prof Ashley Cooper - Chair Prof Stuart Biddle Dr Sebastien Chastin Dr Stacy Clemes Dr Sally Fenton Dr Claire Fitzsimons Dr Richard Pulsford Dr Thomas Yates
Communication and Surveillance	Prof Nanette Mutrie - Chair Anna Chalkley Nick Colledge Dr Philippa Dall Dr Paul Kelly Bob Laventure Dr Karen Milton Dr Andy Pringle Sarah Ruane Laura Smith Prof Martyn Standage Dr Tessa Strain
Pregnancy	Professor Marion Knight - Chair Dr Lucy Mackillop Dr Anne Matthews Dr Manisha Nair Dr Hamish Reid Dr Ralph Smith
Postpartum	Dr Hayley Mills - Chair Katie Dalrymple Dr Marlize De Vivo Prof Marian Knight Dr Lucy Mackillop Dr Islay McEwan Prof Lucilla Poston Dr Shuby Puthussery Dr Ralph Smith
UK External Reviewers	Prof Alan Batterham Prof Melvyn Hillsdon

Expert Working Group	Members
	Prof Gareth Stratton Dr Simon Williams

International Advisory Group

Prof Ulf Ekelund Department of Sports Medicine, Norwegian School of Sports Sciences, Norway

Prof Abby King Health Research and Policy, Stanford University, USA

Prof Tony Okely Early Start Research Institute, University of Wollongong, Australia

Prof Russ Pate Arnold School of Public Health, University of South Carolina, USA

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Department of Health and Social Care, Llwodraeth Cymru Welsh Government, Department of Health Northern Ireland and the Scottish Government

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Agenda
Item No.
11

Southend Health & Wellbeing Board

Report by
Alex Khaldi, Chair, A Better Start Southend

to
Health & Wellbeing Board
on
18th September 2019

Report prepared by:
Jeff Banks, Director, A Better Start Southend

	For discussion	X	For information only		Approval required

A Better Start Southend - update

Part 1 (Public Agenda Item)

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1 Purpose of Report

The purpose of this report is to:

1.1 Provide an update from the Chair of A Better Start Southend (ABSS) on key developments since the last meeting.

2 Recommendations

HWB are asked to:

2.1 Note the contents of the report and raise issues and opportunities with the Chair of the ABSS Partnership Board, Alex Khaldi.

3 Background

GOVERNANCE

a) Partnership

The Director and Assistant Director have had positive meetings with the incoming administration at Southend-on-Sea Borough Council (SBC) including Councillor Ian Gilbert, Leader of the Council and Councillor Anne Jones, Cabinet Member for Children & Learning.

The Director met with Yvonne Blücher, Managing Director of Southend University Hospital (SHUFT), on 19th June 2019 and Mandeep Singh, Clinical Director for Women's and Children's services at SHUFT on 10th June 2019. A range of opportunities were explored and in particular, it is hoped there will be rapid progress on developing community liaison programmes with maternity services.

The Director also met with Jo Cripps, Programme Director (Interim) at Mid and South Essex Sustainability and Transformation Partnership (STP) on 13th June 2019 to explore opportunities for shared learning across the wider STP 'footprint', particularly in the areas of

supporting new care models, connectivity with the Mid and South Essex Local Maternity System and innovation in digital solutions. Further meetings have taken place with the STP's Group Director for Strategy & New Care Models and others are planned with leaders of the Local Maternity System.

b) The National Lottery Community Fund (NLCF)

The NLCF Annual Review took place on 5th June 2019 in Southend, with Brin Martin, Director of Learning, and Krishna Ramkhelawon, Interim Director of Public Health, representing Southend-on Sea Borough Council (SBC) and Michael Freeston, Director of Quality Improvement, representing the Early Years Alliance (EYA). The Annual Review was very positive, with good progress being made on all measures. The programme management team are putting in place action plans to ensure the small number of remaining 'amber' rag rated areas will quickly progress to 'green'.

Following the Annual Review, the regular Quarterly Review took place on 2nd July 2019 and in addition to looking at the standing review items (Programme Update, Budget, etc.) there was an opportunity to look in more depth at periodic report items (i.e. Marketing and Communications Plan and the Risk Register).

c) Governance

All meetings of Groups have been proceeding in accordance with the agreed Governance structure. The Insight and Analysis Group (IAG) has redesigned the process for reporting on 'Outputs' (i.e. the development of the comprehensive data collection system and Live Data Dashboard) and will now move onto the development of an integrated system for reporting on 'Outcomes'. At its meeting on 13th June, the IAG undertook a data 'deep dive' into the Speech and Language Data contained within the Live Data Dashboard.

Annual targets for each Group forming part of the Governance Structure have now been agreed with Group Chairs, and will be reviewed in the summer of 2020.

PROGRAMME MANAGEMENT UPDATE

a) Programme Management Office

The newly appointed Assistant Director, Stephanie Farr, is now in post and has been having a significant impact on operational effectiveness and capacity. The programme is particularly benefiting from Stephanie's long track record of work within the NHS and her strong knowledge of the programme. The Speech and Language Team, managed by Essex Partnership University NHS Foundation Trust (EPUT) are now re-established within the ABSS team, based from the Thamesgate House offices.

b) Programme Activity

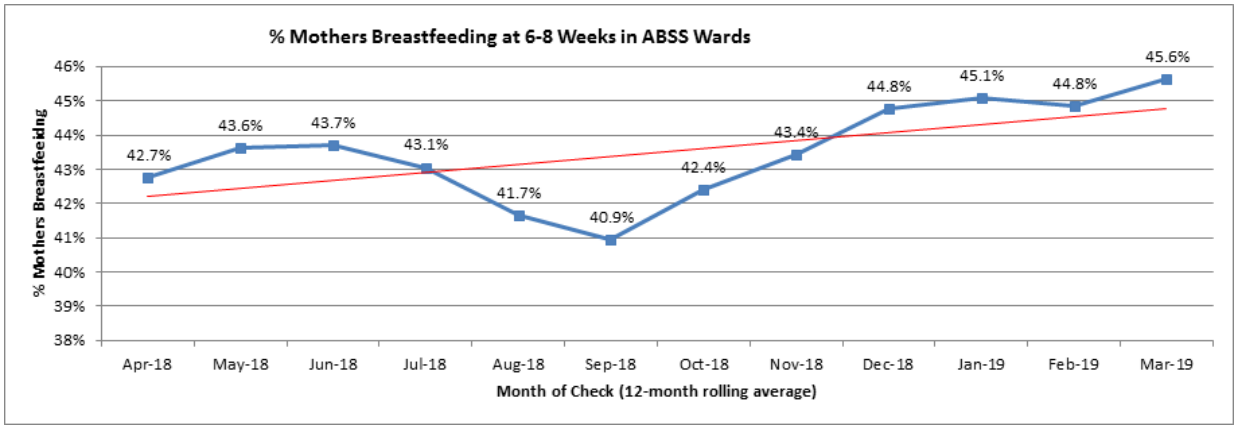
The Programme Manager reports in detail to the Programme Group at the monthly meetings but a number of highlights are included below:

Diet and Nutrition

The **HENRY** Programme continues to embed and is building momentum within the community, with increased uptake and good retention levels. **HENRY** are pro-active with engagement and recruitment and always trialling new ideas, with new taster sessions being held at primary schools, a presence at the Village Green festival and a range of summer activities planned.

There has been wide-ranging workforce training in **HENRY** techniques, and new activity is planned with Children's Social Care and specifically the Troubled Families team. Currently 83 beneficiaries have taken up the programme, which whilst below the initial targets set, is steadily increasing.

The **1-2-1 Breastfeeding** project is continuing with the provider, SHUFT, consistently performing close to their target for beneficiaries. As displayed in the corresponding graph, breastfeeding rates in ABSS wards indicates that **breastfeeding is sustained to 6-8 weeks at a rate of 45.6%**. The national breastfeeding prevalence rate at 6-8 weeks after birth according to Public Health England experimental statistics for Quarter 3, 2018/19, is 46.0% (with confidence intervals of 45.8-46.3%). This highlights an upward trend of breastfeeding rates within ABSS wards, which is now approaching the national average.



In June 2019, the ABSS Programme Group approved 2-year plans to continue and expand the **1-2-1 Breastfeeding** support and **Breastfeeding Group Support**, with expansion planned for Kursaal Ward in the next year of delivery and Victoria Ward by the end of year two. The **Breastfeeding Group Support** in particular will be able to expand, as the findings of the initial Test and Learn pilot phase were positive, and it is anticipated that, in combination, this will see continued improvement of breastfeeding in ABSS wards.

Since the Health Visiting **3 to 4 Month Contact** contract with EPUT expired at the end of March, when services were transferred over to SBC, the team have continued to honour the commitment to provide an additional Health Visiting **3 to 4 Month Contact.** In May 2019, the Programme Group approved the re-commissioning of this offer, and agreed an expansion to all ABSS wards. Specification development and contract negotiations are progressing well.

As part of the Family Action **Enhanced Children Centre Programme,** a number of initiatives have been progressing, including:

- Friars Children's Centre **'Food 4 Life'** food growing/allotment project as part of the Healthy Cooking for Families Programme. This project is in its infancy and it is too early to assess any impact of the initiative.
- The **Starting Solids Workshops,** which as yet have not achieved good attendance, with a number of sessions having to be cancelled. The expectation is that as the Health Visiting **3 to 4 Month Contact** is rolled out across the wards, this will inform parents of the sessions and motivate interest and attendance.
- The **Healthy Cooking for Families Programme** has been running since late last year and there has been refinement to the structure and content of the course. There has been a noticeable drop off in course attendance, which whilst the course is reaching targets, the original targets were set low. The programme is now being trialled at another Children's Centre and five families are booked on.

The project team are working with Family Action on all of these initiatives to improve uptake and participation across the various work-streams.

Communication and Language

Joint delivery between EPUT and the ABSS Specialist Early Years Teachers/Communication and Language Advisers of the **Let's Talk Programme** continues to demonstrate very positive outcomes on a range of programmes and initiatives. A review has been undertaken of the suite of offers to optimise engagement of beneficiaries and stretch targets have been agreed for beneficiary reach.

The ABSS Specialist Early Years Teachers/Communication and Language Advisers continue to offer a range of training opportunities, including WellComm screening of children in their Early Years setting prior to transition to reception class. The team are now working with 30 ABSS Early Years Settings (up from 15 at the time of the previous report) and training offers are being made to childminders on Saturdays with 26 attending a recent event.

Following engagement with Primary School leaders, as reported previously, specifically in relationship to **school readiness**, a new Communication and Language pilot project **Talking Transitions** was launched at Prince Avenue Children's Centre. This will see primary school EYFS staff and feeder early years' settings working together on an initiative to improve children's language and communication skills prior to entering school. It is anticipated the project will start in September 2019.

Parent Champions have worked positively supporting the Southend Libraries initiative **Bookstart** through a range of social media and practical activities. The team have analysed feedback from 40 respondents and utilising the test and learn approach, are looking to develop a monthly social media story reading feature, with a range of follow up activities linked to the story, all designed to stimulate and encourage more family participation in reading and talking activities.

The **First and Foremost** project, funded separately by the DfE, continues to progress well with roll-out to a range of non-ABSS areas. Early Years' settings screen the children at 2 years old and then receive support from the team following analysis of the results. A successful trial engaging parents in the **Whatsaap Weekend Talk Tips** has led to this being offered across the UK to the other hubs involved in the **First and Foremost** project. The ABSS team continue to deliver webinars from the EYA at the National Centre and have collaboratively produced language play cards for parents.

The **Fathers Reading Every Day (FRED)** project has now concluded, with extensive workforce development initiatives having taken place. A local mini conference was held on 27th June 2019 by the Fatherhood Institute. The final outcomes and learning are being collated and a range of materials will be available online, to support partners in continuing to deliver **FRED** activity locally. However, as part of the Family Action **Enhanced Children Centre Programme,** 8 **FRED** Programmes are being delivered per quarter across the ABSS Children Centre sites (Friars, Cambridge Road, Summercourt and Centre Place). Project level outcomes are: more fathers will read to their children at an earlier stage, thus contributing to their speech and language development; and fathers will spend quality time with their children, supporting their social and emotional development.

The **Family Support Workers for Social Communication Needs (SCN)** continues to receive exceptionally positive feedback from families that are being supported. Numbers are expected to continue to increase over the next 10 months and there is scope to increase capacity within the team to manage this. A case study for this service is attached as Appendix One.

Social and Emotional Development

The **Empowering Parents, Empowering Communities (EPEC)** programme being delivered by the South London and Maudsley NHS Foundation Trust (SLaM) is seeking to train local parent facilitators to develop safe, high quality, and effective peer-led parenting programmes.

The programme has some success in Southend previously, but is yet to achieve the outcomes anticipated. Meetings have taken place with SLaM and an options paper is being prepared around future delivery of the programme.

The **Perinatal Mental Health** project is progressing well, with specialist Health Visitors delivering training to a wide range of partners, with the expectation being that other professionals will be confident to recognise and refer mothers into the service appropriately. The specification is being reviewed in line with the test and learn methodology to ensure the initiative achieves maximum benefits for service users.

The **Family Nurse Partnership (FNP**) programme contract has been extended until March 2020 to enable a review of the needs of the local population to be evaluated. A number of staff are going to undertake a site visit to other localities where the programme is being delivered to a more targeted population. The team continue to pilot the New Mum Star as part of the **FNP ADAPT** initiative, enabling more targeted and themed intervention work which is being evaluated nationally.

The **Workskills** project continues to deliver positive results, supporting parents who wish to return to work or develop their own business ideas, with feedback from beneficiaries being exceptionally strong. An options paper is being prepared for the September 2019 Programme Group to review outcomes and explore potential to develop and extend the work activity delivered through the **Workskills** project.

Interviews with shortlisted providers for **Mixed-Approach Preparation for Parenthood** service took place on 10th July 2019. Mobilisation will commence in September.

Community Resilience

The **Engagement Contract** continues to work well, with Parent Champions actively being engaged in a wide range of activities and roles within ABSS. There is consistent engagement from Parent Champions at Programme Group meetings. The **ABSS Mascot 'PiP'** is going to be a regular attendee at events over the summer, promoting ABSS and the Parent Champions.

The **Engagement Fund**, which provides resources for parents to deliver regular small-scale community engagement activities, is current and active and the Programme Team are working to review and streamline the appraisal and approval process of the **Engagement Fund** ideas to ensure improved co-ordination and timely decision making. Proposals for the larger-scale **Resilience, Innovation & Ideas Fund** are progressing well, and the fund was launched on 23rd July 2019. The deadline for the first call for proposals is 30th September 2019 and it is anticipated the first programmes will go live in December 2019. The NLCF will be fully engaged in the design and selection process, to ensure it meets the governance and accountability requirements of the Lottery funding.

ABSS is working with SBC and Southend Association for Voluntary Service (SAVS) to employ a **Co-production Champion**, and recruitment is underway. Once appointed, part of the role will be to establish a **Citizens Panel**. The post will be hosted by SAVS but will have a broad ranging remit working across the ABSS partnership.

The ongoing use of the ABSS space at SAVS on Alexandra Street as a front-facing **Parent Champion Hub** is progressing. ABSS Project Managers are working with parents to explore this opportunity further and develop a family friendly, useable space which supports the work of ABSS and its partners.

Workforce Development

Whilst substantial workforce development activity takes places across the ABSS programme, work is being undertaken to 'refresh' the strategic approach to Workforce Development (WfD) and Systems Leadership (SL). This was referred to as 'Southend Way' and 'Approach' in the original ABSS Lottery bid. A steering group has been established to agree the vision for this along with the priorities and the scope. The reach to date is currently being reviewed, along with financials, strategic direction options and a new proposed implementation plan for consideration.

System Change

The ABSS / SBC **System Mapping Tool** will be deployed in the coming months on the development of the new integrated **Children Young People and Families 0-19 service**. ABSS staff are actively supporting the Children Young People and Families Steering Group and it is anticipated that this involvement will grow with the appointment of the Assistant Director, who will increasingly lead on this project.

The **Integrated Children's Centre Hub**, which was exploring how ABSS could help build upon the effective integrated working practices at both Centre Place and Friars Children's Centres as two initial pilot centres, is now taking a different direction, with the Children's Centre management organisation, Family Action, taking on leadership of this initiative.

The **Joint GP/Paediatrician Clinic** project continues to have positive impacts and information sharing arrangements are in development to ensure ABSS can effectively capture outputs/outcomes.

The **System Change and Community Resilience 'Think Tank'** continues to meet and is drawing in a wider range of experiences. Meetings have recently taken place with Ian Martin Chief Executive of Estuary Housing Association; Elaine McCorriston, Social Enterprise East of England; and Emma Cooney, Director of Regeneration and Business Development at Southend-on-Sea Borough Council, and the Social Enterprise lead at the South East Local Enterprise Partnership. The objective of these meetings has been to draw in wider thinking on the 'Case for Change' legacy plan for ABSS.

c) Knowledge Research and Evaluation (KRE)

The formal Specification and Contract for the hosting by the University of Essex (UoE) of the KRE function has been compiled and it is anticipated this will 'go live' in October 2019. In the early autumn, the joint ABSS and UoE team will develop proposals for the independent programme wide local evaluation.

In the meantime, the interim team have developed an evaluation 'offer', as per the agreed KRE strategy. This has been reviewed by the Insight and Analysis Group and can now start to be utilised to show progress against the agreed strategy, and to review and understand potential resource requirements in this area across the partnership. The current Formative Evaluation work has been put on hold, pending transfer to the University.

The Service Design Framework and Evaluation Framework are currently under review. Updates will see complimentary case studies (e.g. design thinking 'in action') being produced along with practical toolkits that can be accessed by the partnership 'on demand'. The cross-site learning on improvement science will also continue to be embedded into all frameworks and associated working practices.

In June, the Research Bulletin achieved an important milestone with its 25th edition being published. This is one of the ways that ABSS shows how we are committed to 'test and learn'

principles, and that practice and implementation is impacting on theory and research. The Knowledge Lab on the ABSS web platform is also progressing so that it can provide additional interactivity. The previously agreed Research Group and the establishment of Peer Researchers is also being developed and will similarly be picked up by the University of Essex.

Data Development and Analytics

Huge strides have been made in the development of the local dashboard. This has been made possible due to the tremendous efforts of our SBC Data partner. This first phase has enabled ABSS to provide (quantitative) insight to governance groups about the reach, and performance of projects and the overall programme in terms of delivery. The second phase of the work will be developing a robust set of tools for the measurement of outcomes for parents and children and the impact of the work. In addition, the interim ABSS KRE team are also supporting the partnership in terms of qualitative, and contextual information as well as literature reviews and synthesis e.g. interviews and case study development.

The decision has been taken collectively by NLCF and the five A Better Start (ABS) sites to adopt a different approach to the collection of cross-site data. Originally, a single contractor was commissioned to develop a national data dashboard, but this contract is now being brought to an end. There are elements of this work which will support future reporting but it was considered NLCF and the five ABS sites could develop this work more effectively themselves. The expert team at SBC who provide data analytics services for ABSS, and produce the highly regarded ABSS Data Dashboard, will work with other sites to establish alternative approaches.

National Cohort Study

The NLCF and the University of Warwick have agreed to revise the evaluation methodology and of the national evaluation, and take a different approach to meet the evaluation aims without undertaking a cohort study in ABS areas and the planned comparison areas. The University of Warwick will continue to deliver the Implementation evaluation work as initially planned whilst the revisions to the evaluation methodology are designed and agreed audience needs.

Data Dashboard

The Data Dashboard presented to the last Partnership Board covered the period to end of March 2019. This is refreshed quarterly and the draft dashboard for the quarter to June 2019 is included as Appendix Two. This will be presented to the next Programme Group and Partnership Board. The Dashboard is a live tool and Partners can request access as required.

d) Communication and Marketing

A range of Communications and Marketing activity work is ongoing. For the Big Little Moments (BLM) campaign, a Parent Advocate video is being produced to promote the campaign and is currently in the post-production stage. The mascot is making its first public appearances at local events such as Village Green. The mascot is also being copyrighted. Other recent activity has included the work on Southend Stories, in conjunction with the Communications and Language team, as well as a social media push on National Co-production Week (1st to 5th July 2019).

e) Other

Following the leadership changes within the Cabinet, the Director has met with the Leader of the Council, Cllr Gilbert and Children's Lead, Cllr Anne Jones to give them both an overview of the ABSS programme and progress across all the work streams, whilst also discussing our ambitions for the coming year. The Cabinet have set out their priorities and ABSS is looking forward to working closely with them in the future.

4 Reasons for Recommendations

4.1 ABSS Governance have reviewed and approved activities at the appropriate level. The Health and Wellbeing Board are asked to note the contents of the report.

5 Financial / Resource Implications

5.1 A moderate underspend is noted in the financial report with explanations given. There are no further financial/resource implications outside permitted programme projections. Quarter Four Summary Management Accounts are attached as Appendix Three.

6 Legal Implications

6.1 None at this stage

7 Equality & Diversity

7.1 None at this stage.

8 Appendices

Appendix One – Case Study – Family Support Worker for Social Communication Needs
Appendix Two – Quarter One 19-20 Data Dashboard summary
Appendix Three – Quarter Four 18-19 Summary Management Accounts

Jeff Banks, Director, ABSS
21 August 2019

Appendix One – Case Study

ABSS SOCIAL COMMUNICATION NEED FAMILY SUPPORT WORKER

Lucy* and her husband, Tommy, have started the journey of obtaining an autism diagnosis for their 4 year old son Jake. They also have an older child, Penny. Jake has complex sensory needs and behaviours which have left Lucy and Tommy feeling tired, stressed and needing support. Lucy and Tommy embraced having a Family Support Worker supporting the family. Lucy in particular found it beneficial having the FSW to speak concerning Jake's additional needs.

Lucy was offered a six week course of home visits from the Social Communication Needs Family Support Worker Service (SCN FSW). These visits were to concentrate on how the FSW could assist Lucy and Tommy's needs to support their child. The SCN FSW offers peer support and sign posting to services.

Straight away the FSW was able to suggest products and services that would be able to help the family. One in particular was Little Heroes Dad's Club. Dad's Club is for parents with a child who has a diagnosis of autism or is either awaiting one. The first visit to Dad's Club was a positive experience for the whole family but for Tommy in particular. Lucy felt Dad's Club gave Tommy a chance to speak to other Dads and share his experiences. Dad's Club provided a place suitable for all the family's needs and it was also free. Tommy now plans to visit Dad's Club every month.

Lucy and Tommy wanted to know if there were more, suitable and affordable, activities they could take both Jake and Penny to during the weekends. Lucy found it difficult to find time to research suitable activities. The FSW supported Lucy by researching into affordable activities which would suit the needs of both children within the local area. This helped Lucy and Tommy to feel less isolated and more empowered to go out as a family.

When the FSW first started visiting the family Lucy had been declined any level of support from the Disability Living Allowance for Jake. Lucy had spent a lot of time completing the form and felt very disheartened and depressed when Jake did not receive any level of support. The FSW spoke to Lucy about their personal experiences with the DLA and offered to support Lucy should she want to reapply. Lucy at first did not want to go through the experience of reapplying for the DLA. However, after speaking to the FSW throughout their sessions she felt empowered to re-apply and was awarded the level of supported higher than she expected.

Lucy felt Jake would greatly benefit from sessions with a Sensory Occupational Therapist. However, Lucy was unsure of where to start to look for a Sensory Occupational Therapist and how would she pay for the sessions. The FSW researched into a local Sensory Occupational Therapist and a private charity to apply for funding to cover the session costs.

The FSW sessions have now come to an end with the family. Lucy still keeps in touch with the FSW to let her know about all their positive progress they are making as a family.

*all names have been changed

Appendix Two – Quarter One Data Dashboard summary

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Operational Performance and Intelligence Reporting

A Better Start Southend: Programme Dashboard

Better Start Southend

BETA TEST VERSION

Reporting Period from 01 July 2018 to 30 June 2019

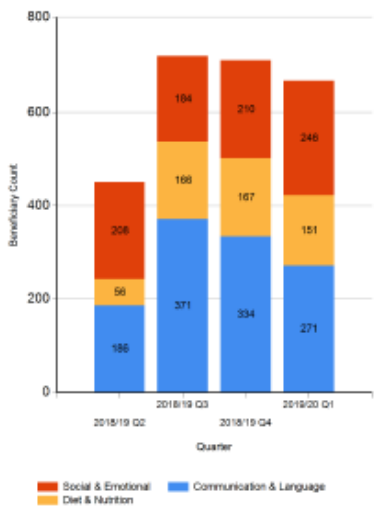
The total number of unique direct beneficiaries for this period is 1,407 which is 28.8% of all eligible ABSS beneficiaries.

1) Project Data Included in Dashboard

ID002: EPEC Baby & Us
ID003: EPEC Being a Parent
ID020: Let's Talk With Your Baby
ID020A: Talking Walk-In
ID020B: 23-Month Screening
ID020C: Chatting Children
ID020D: Super Sounds
ID020E: Little Listeners
ID020F: Attention ABS
ID020G: Talking Tiddlers
ID020H: Project Home and Early Years Setting
ID020I: Follow Up Sessions
ID020J: Talking Toddlers
ID020K: Babbling Babies
ID022: Fathers Reading Every Day
ID025: HENRY
ID028: Starting Solids
ID036: ABSS Work Skills
ID046: Engagement & Co-Production
ID049: Perinatal Mental Health
ID050: Family Nurse Partnership
ID052: GYMCA Group Breast Feeding Support
ID053: 3-4 Month Health Visitor Contact
ID054: SUHFT 1:1 Breast Feeding Support
ID059: SLCN Family Support Workers
ID060: Food 4 Life
ID082: Wellcom Screen
ID085: Healthy Cooking for Families

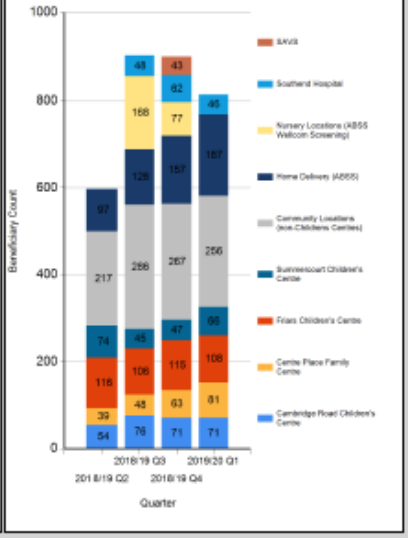
This table shows which current projects are included in the dashboard tables and charts. Data are provided at person-level for all families consenting to data sharing and are then aggregated for the purposes of this dashboard.

2) Direct Beneficiaries by Workstream/Quarter



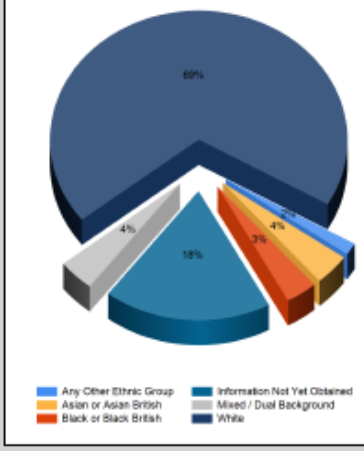
All events have been mapped to one of the programme workstreams and the number of direct beneficiaries involved in each workstream is shown above. See charts 10 and 11 for further details of the projects in each workstream over the most recent two quarters.

3) Direct Beneficiaries by Delivery Location



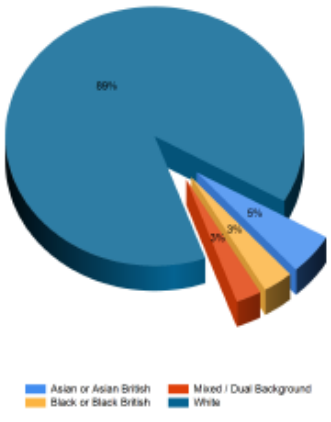
This chart shows an expanded list of locations where A Better Start projects are being delivered. At the start of the programme Children's Centre delivery accounted for almost all delivery but now represents approximately half of all events.

4) Direct Beneficiaries by Ethnicity



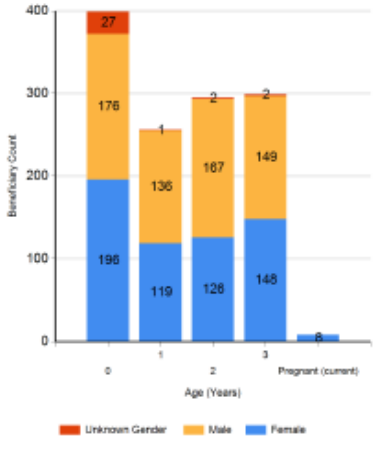
This chart shows the ethnic group breakdown of all ABSS direct beneficiaries in the above reporting period.

5) ABSS Wards Population by Ethnicity



For comparison purposes with chart 4, this chart shows the ethnic group breakdown of the whole population of the combined ABSS wards from the latest census data.

6) Direct Beneficiaries by Gender/Age



The age in years of the direct beneficiaries who are children is calculated as at the earliest date of the family's involvement in the project and currently pregnant mothers are shown separately. There were also 150 pregnant women participating througout the reporting period where the child has since been born and is included in the chart above.

Report produced by: **Operational Performance & Intelligence Team**

Report executed at 8/20/2019 11:16:07 AM by SBC\RichardWarren

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Data source: Children's Centre Capita eStart system

BETA TEST VERSION

A Better Start Southend: Programme Dashboard

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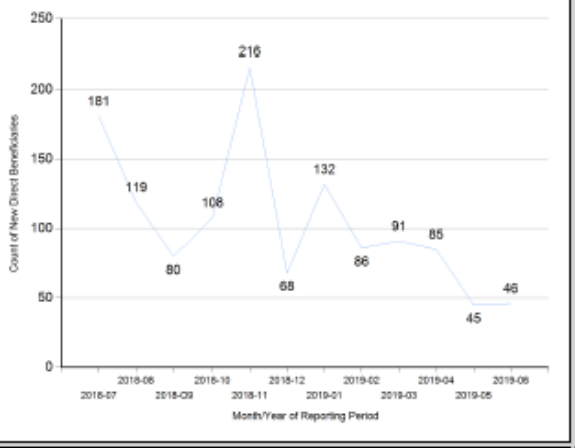
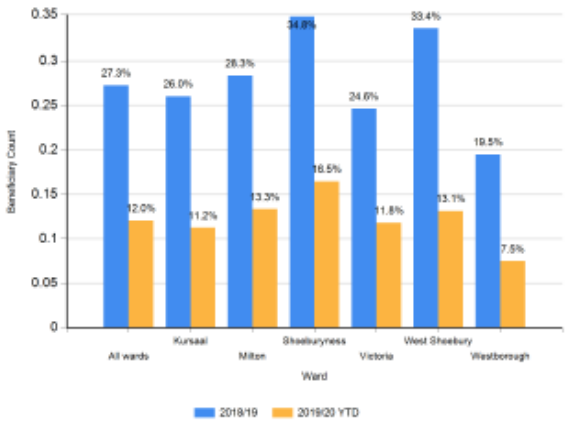
7) Monthly Uptake of New Beneficiaries



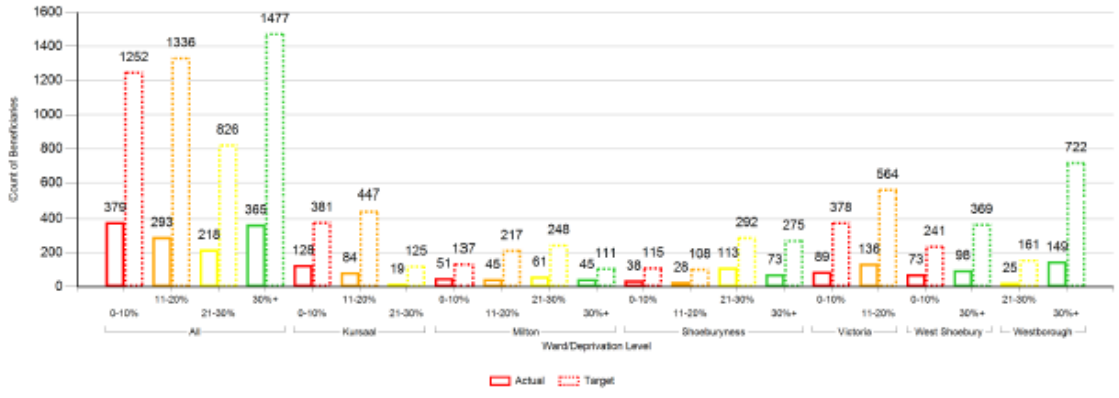
This chart is based on a rolling 12 month period and shows the number of new direct beneficiaries (i.e. children aged 0-3 or pregnant women) recruited into the programme each month who have never been involved in the programme previously.

8) % Reach by Ward



This chart shows the direct beneficiary engagement as a percentage of target children by ward for the current financial year compared to the previous year. The direct beneficiary targets include an estimate of pregnant women in addition to children aged under 4 years.

9) Engagement of Direct Beneficiaries by Target Areas



Using The English Indices of Deprivation 2015, published by the Department for Communities and Local Government (DCLG), the A Better Start wards have been further sub-divided into target action areas. The areas considered to require the highest level of intervention in order to meet the ABSS goals are red areas, followed by orange, yellow then green areas. In this regard, the following should be noted :"The neighbourhood-level indices provide a description of areas, but this description does not apply to every person living in those areas. Many non-deprived people live in deprived areas, and many deprived people live in non-deprived areas." (DCLG). The above chart shows the rolling 12month cumulative number of direct beneficiaries by ward engaged in the ABSS programme compared to the number of children aged 0-3 in each area according to mid-2017 population statistics.

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Data source: Children's Centre Capita eStart system

Report executed at 8/20/2019 11:16:07 AM by SBC\RichardWarren

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A Better Start Southend: Programme Dashboard

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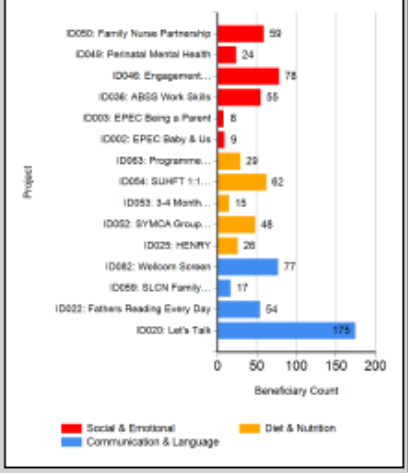
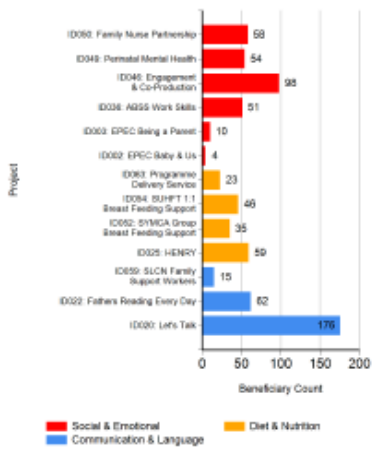
10) Direct Beneficiaries by Project: Quarter 4

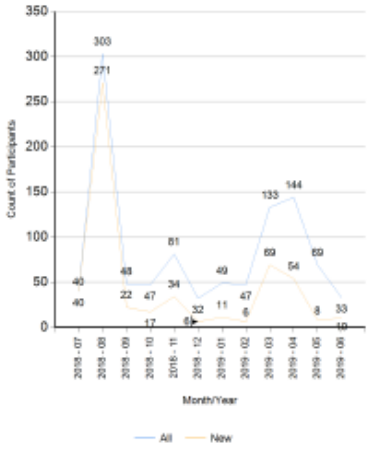


The above charts show the number of direct beneficiaries participating in each project in delivery over the past two quarters and within each workstream. This information is also summarised in chart 2 by workstream. Where families attended more than one project in the same workstream (e.g.FRED and Let's Talk) the combined figures for these projects will be different to the workstream total .

11) Direct Beneficiaries by Project: Quarter 1

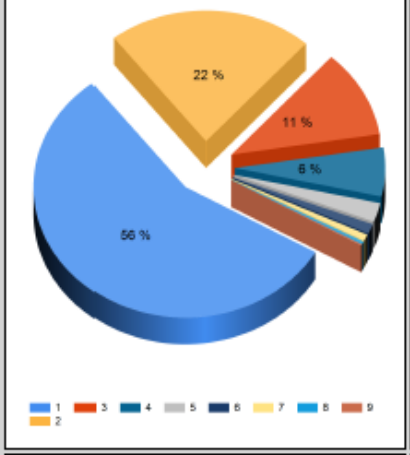


12) Participation in Engagement/Co-production



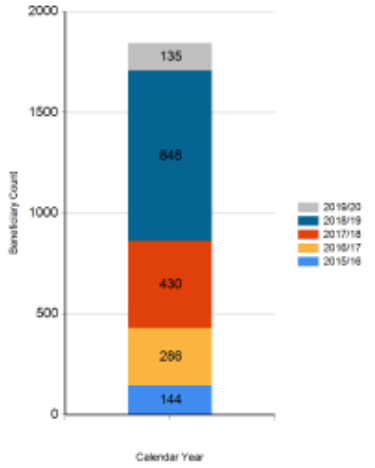
This chart shows the number of participants in SAVS events in the past 12 months. The number represented by the 'New' series did not have any previous involvement in this project. The total number of participants is 548 involved in 379 events in this period. The average number of attendees at each event is 7.

13) Number of Project Involvements since Start of Programme



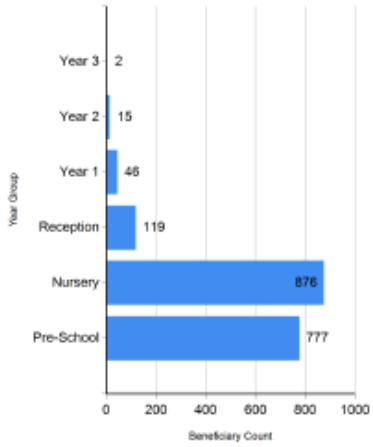
The above chart shows the proportion of direct beneficiaries that have been involved in single or multiple projects since the start of the programme. Table 1 shows the individual projects that are currently in delivery. The average number of projects that each beneficiary has participated in is 1.9.

14) Year of First Involvement of Direct Beneficiaries



The above chart shows the total number of direct beneficiaries by the financial year in which they were recruited to the ABSS programme, demonstrating the annual growth of the programme. The total beneficiary count is 1843 .

15) Current School Year of all Direct Beneficiaries since Start of Programme



The above chart shows the current school year of all direct beneficiaries from the start of the programme (not including pregnant women). This shows the proportion of children likely to be included in future end-of-year outcome measures (e.g. EYFSP outcomes and reception age obesity measures).

Report produced by: **Operational Performance & Intelligence Team**

Report executed at 8/20/2019 11:16:07 AM by SBC\RichardWarren

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Data source: Children's Centre Capita eStart system

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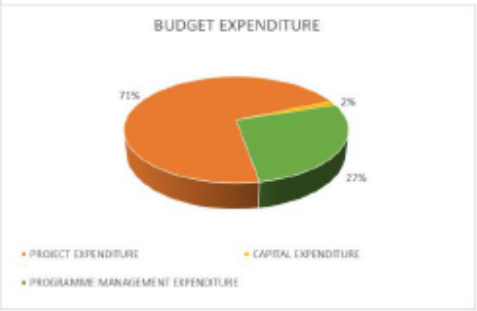
SUMMARY MANAGEMENT ACCOUNTS – CONFIDENTIAL

YEAR TO 31 MARCH 2019

The management accounts for the A Better Start Southend (ABSS) programme show income received and expenditure incurred during this financial year. Management accounts are presented to the ABSS Partnership Board quarterly, coinciding with the submission of returns to the National Lottery Community Fund. More detailed monthly accounts are reviewed by the ABSS Finance and Risk Group.

The accounts for the financial period from 1 April 2018 to 31 March 2019 show project expenditure of £1,949,000, capital expenditure of £nil and programme management (PMO) expenditure of £754,000. These are represented as a percentage of total spend in the first chart. Leveraged income for this period is £109,000 and £200,000 for the life of the programme to date.



Underspend against budget for all workstreams total £107,000.

Explanation:

- Lower crèche costs linked to lower than budgeted spend across projects and less reliance on expensive bank agency staff
- Less expenditure on monitoring and evaluation with more work being undertaken by the project team
- Note: there is re-allocation across budget lines between Community Resilience and other lines

Summary Management Accounts - Confidential
Period: QUARTER FOUR 2018-19

	Period: APRIL to MARCH 2019		
	Actual	Budget	Variance (adverse) or favourable
INCOME	£	£	£
REVENUE FUNDING RECEIVED FROM BIG LOTTERY FUND	2,798,000	3,112,000	(314,000)
CAPITAL FUNDING RECEIVED FROM BIG LOTTERY FUND	20,000	44,000	(24,000)
LEVERAGED INCOME	109,000	-	109,000
TOTAL INCOME	**2,927,000**	**3,156,000**	**(229,000)**
EXPENDITURE			
PROJECTS			
SOCIAL AND EMOTIONAL	541,000	565,000	24,000
COMMUNICATION AND LANGUAGE	635,000	629,000	(6,000)
DIET AND NUTRITION	364,000	435,000	71,000
SYSTEM CHANGE	118,000	258,000	140,000
COMMUNITY RESILIENCE	214,000	12,000	(202,000)
CRECHE SERVICES	58,000	110,000	52,000
MONITORING & EVALUATION	19,000	47,000	28,000
PROJECT EXPENDITURE	**1,949,000**	**2,056,000**	**107,000**
SALARIES AND SECONDMENTS	487,000	526,000	39,000
OTHER PMO COSTS	267,000	257,000	(10,000)
PROGRAMME MANAGEMENT EXPENDITURE	**754,000**	**783,000**	**29,000**
TOTAL REVENUE EXPENDITURE	**2,703,000**	**2,839,000**	**136,000**
CAPITAL EXPENDITURE	-	44,000	44,000
LEVERAGED COSTS	109,000	-	(109,000)
TOTAL EXPENDITURE	**2,812,000**	**2,883,000**	**71,000**
NET FUNDING IN ADVANCE/(OWED)	**115,000**	**273,000**	**(158,000)**

CUMULATIVE FIGURES FROM START UP TO DATE	£
INCOME	**9,490,000**
PROJECT EXPENDITURE	4,663,000
PROGRAMME MANAGEMENT EXPENDITURE	4,055,000
CAPITAL EXPENDITURE	542,000
LEVERAGED	200,000
TOTAL EXPENDITURE	**9,460,000**
NET FUNDING IN ADVANCE/(OWED)	**30,000**

CONVENTION: Brackets around a number signify either an amount owed by the Big Lottery or an adverse variance (ie income less than budget or expenditure greater than budget)

Southend Health & Wellbeing Board

Agenda Item No.

12

Report of the Director of Public Protection

To

Health & Wellbeing Board

on

18th September 2019

Report prepared by: Lee Watson, Health Improvement Practitioner Advanced

For information only	X	For discussion		Approval required	

Southend Tackling Harmful Behaviours Strategy

Part 1 (Public Agenda Item)

1. Purpose of Report

1.1 To introduce to the board the Southend Tackling Harmful Behaviours Strategy, this strategy sets out our ambitions to reduce the impact of smoking, alcohol, substance misuse and gambling in the Borough.

2. Recommendations

2.1. The Health and Wellbeing Board is asked to note the strategy (Appendix 1). An update paper will be presented at a future meeting to report of progress in delivery of the strategy, including future challenges and opportunities.

3. Background

3.1 The Tackling Harmful Behaviours strategy has been developed in response to an evaluation of the previous Tobacco Control Strategy and the previous Drug, Alcohol and Problem Gambling strategy. The evaluation found that whilst positive progress had been made on each topic in isolation there were some opportunities missed by not taking a more holistic and collaborative approach to addressing these harmful behaviours.

3.2 Taking a single strategic approach to tackling these harmful behaviours locally has synergy with recommendations from Royal Society of Public Health and Faculty of Public Health[1]. Taking a single approach will increase efficiency and improve collaboration between services, addresses the cross-cutting issues of addiction and substance misuse.

3.3 The strategy has been developed by a group of officers from Public Health, Regulatory Services, Community Safety, Drug and Alcohol Commissioning Team, Housing and Social Inclusion and Youth Offending Service. In the development of the strategy a wide range of relevant external partners were consulted including voluntary sector organisations.

4. The Strategic Approach

4.1 The strategy outlines an approach that works across five domains to tackle harmful behaviours, these are:

- Reducing demand
- Restricting supply
- Strengthening the treatment and recovery offer by driving collaboration and reducing fragmentation
- Ensuring an appropriately trained workforce to enable early identification
- Improving data quality and collection

Taking an evidence-based approach to working across these domains will ensure fewer people adopt harmful behaviours reduce harm in those who are already engaged with harmful behaviours through increased support and reduced stigma for everyone affected by harmful behaviours.

5. Reasons for Recommendations

5.1 The collaborative approach required to deliver this strategy will need engagement across the system. The strategy delivery will also support the work of the Southend Community Safety Partnership and Southend's Safeguarding Boards.

6. Corporate Implications

6.1 Contribution to the Southend 2050 Road Map

The strategy contributes to the Southend 2050 ambition across all five themes, further information is detailed in the strategy's forward.

6.2 Financial Implications

Whilst the strategy does not raise an immediate financial implication the inclusion of gambling and work to understand the impact of problem gambling within Southend may require additional resource or re-alignment of resource to address this challenge for the population. Development of a JSNA product around harmful behaviours is planned for development.

6.3 Legal Implications

The strategy will inform future development of various regulatory responsibilities of the Council. Changes to these policies enable appropriate and proportionate

restrictions to the availability of alcohol and gambling as well having the potential to improve our response as a local system to illicit tobacco and drugs.

6.4 People Implications

The strategy intends to influence a more collaborative approach to tackling harmful behaviours in the local population, this should result in closer working between Council officers from different teams and closer working with other key stakeholders such as the Police and Job Centre Plus staff.

6.5 Property Implications

None

6.6 Consultation

The strategy has been developed with input from SBC teams and external partners. At the initial development stage we also had engagement from the voluntary sector in collaboration with SAVS.

6.7 Equalities and Diversity Implications

An initial Equality Analysis for the Strategy has been completed. Any further changes to services or approaches in response to this strategy will require further Equality Analysis to inform approaches.

6.8 Risk Assessment

Any changes to services or approaches in response to this strategy will require appropriate Risk Assessment

6.9 Value for Money

The proposed approach ensures a more efficient way of working and the opportunity to generate savings to the wider local economy in the longer term.

6.10 Community Safety Implications

This strategy and associated action plan aims to reduce the impact of harmful behaviours many of which have significant implications for community safety, these include but are not limited to illicit tobacco, alcohol related violent crime and illicit drug misuse.

6.11 Environmental Impact

This strategy and associated action plan will help reduce litter associated with smoking and alcohol consumption.

7. Appendices

7.1 Tackling Harmful Behaviours Strategy

Tackling Harmful Behaviours Strategy

8. References

8.1 Royal Society of Public Health 2018 Taking a New Line on Drugs [online] available at https://www.rsph.org.uk/uploads/assets/uploaded/68d93cdc-292c-4a7b-babfc0a8ee252bc0.pdf

Tackling Harmful Behaviours Strategy

Southend Borough Councils strategy to reduce the harms caused by drugs, alcohol, gambling and tobacco

Foreword

Pride and Joy

By reducing harmful behaviours, Southend will highlight the strengths of the Borough that all residents can be proud of. Support with drug & alcohol issues for rough sleepers, and those at risk of rough sleeping, will contribute to cleaner & tidier streets whilst demonstrating the compassion of our residents and the borough. Safer & more attractive streets mean Southend's seafront will become a yet more appealing resource and visitors can further enjoy Southend's unique atmosphere. This will highlight Southend's cultural and historic heritage, resulting in new opportunities for our museums and galleries.

Safe and Well

Southend's residents will be assisted in reaching their potential, free from addiction to harmful behaviours. Those affected by gambling, drug, or alcohol issues can see their relationships, professional lives, and mental health issues deteriorate, impacting their ability to live successful and fulfilling lives. Tackling these problems helps reduce individual risks of homelessness or vulnerability to exploitation by gangs involved in the drug trade. In turn, this weakens the resources available to criminal gangs to act in Southend, making the town safer for all its residents.

Active and Involved

The role exercise can play in breaking harmful behaviours can result in improved holistic health and fitness for Southend's residents. Drug & alcohol issues can cause tensions between neighbours and stereotypes of certain groups, such as rough sleepers. Tackling harmful behaviours will break down barriers between individuals and neighbours, allowing for an understanding and inclusive borough in which all people have a say in the future Southend in which they will live. Community support for individuals recovering from harmful behaviours will bring people from different backgrounds together, further highlighting Southend's inclusive nature.

Opportunity and Prosperity

Residents who are no longer victims of harmful behaviours will have more fulfilling, productive, and meaningful careers, reducing dependence on council support and ultimately feeding back into Southend's economy. Measures taken to tackle harmful behaviours on a preventative level will guarantee that residents of all ages don't miss out on opportunities to reach their potential. Combined with regeneration projects, tackling harmful behaviours will give people a new start in a secure and prosperous town.

Connected and Smart

Tackling harmful behaviours in Southend will weaken the influence of the drug trade, in turn making it a less desirable target for those who profit from dealing drugs. Currently the public transport network is used to bring drugs, knives and illicit tobacco into the Borough. By reducing demand and ensuring appropriate restriction of supply we can reduce the capacity for these operations to engage in business in Southend. This will result in safer Southend-bound public transport as well as the wider borough, which will become increasingly important as we drive forward the Southend 2050 vision.

1. What are harmful behaviours and who is affected?

In the context of this document, references to harmful behaviours include;

- illicit drug use,
- tobacco use,
- a pattern of alcohol consumption causing health problems and that disrupts personal, family or recreational pursuits
- any type of repetitive gambling that disrupts personal, family or recreational pursuits[1]

All drug use increases the risk of some form of related harm, be it to the individual, those around them, wider society, or all three[2]. At both individual and population level, alcohol and tobacco cause far greater harm to health and wellbeing than many of their illegal counterparts. Tobacco kills the most people[3] and alcohol is not far behind, with death rates from alcohol misuse on the rise[4]. Alcohol and tobacco use alone costs society more than all Class A drugs combined[2].

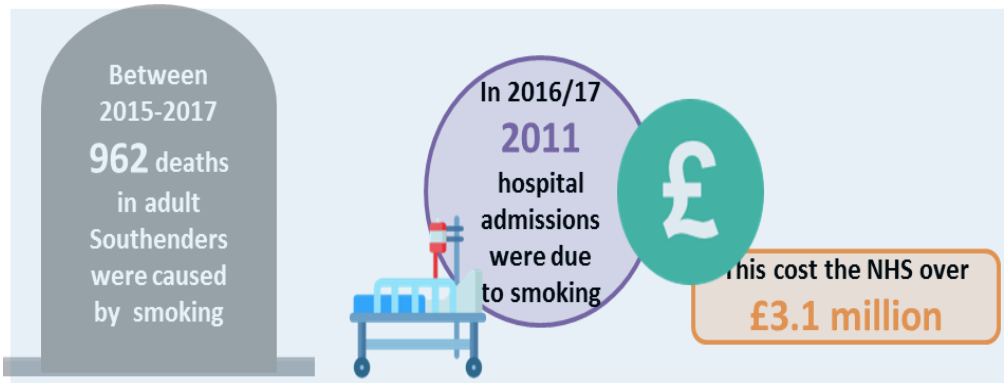
1.1 The National Context for Harmful Behaviours

In England there are currently national independent strategies for drugs[5], alcohol[6], gambling[7] and tobacco[3]. Responsibility for the development of the drug and alcohol strategies sits with the Home Office, whilst the tobacco control strategy is the responsibility of the Department of Health and Social Care. Responsibilities for ensuring the aims of the strategies are met rest with several government departments, indicating the breadth of harmful behaviours. Health elements are predominantly led by Public Health England (PHE), and crime elements by the Home Office.

The Gambling Commission is the unified regulator of gambling in Great Britain. It is an independent non-departmental public body sponsored by the Department for Digital, Culture, Media and Sport. Its work is underpinned by three key pieces of legislation: the Gambling Act 2005, the Gambling (Licensing and Advertising) Act 2014 and the National Lottery Act 1993[7]. For the first time, gambling harm was referenced in Westminster Governments priorities for Public Health England for 2018/19[8].

1.2 Tobacco

Of the four harmful behaviours addressed by this strategy smoking continues to be the leading cause of preventable illness and premature death in England[3].



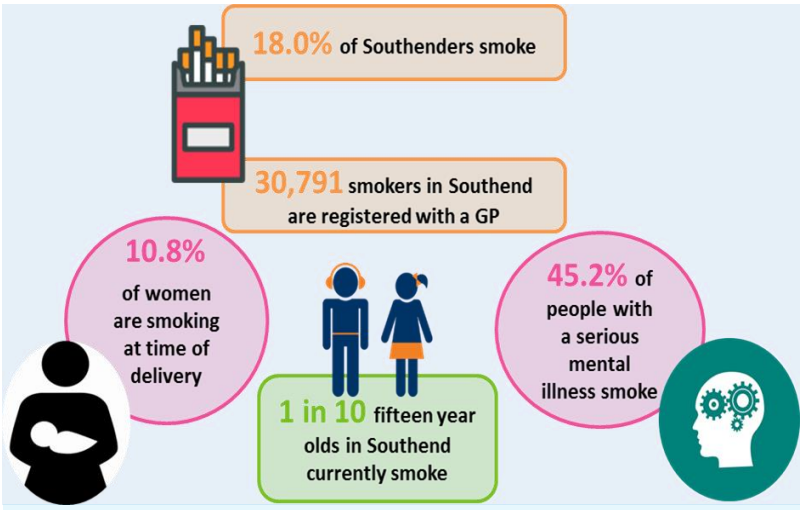
Data available from: https://fingertips.phe.org.uk/profile/tobacco-control/data#page/1/gid/1938132885/pat/6/par/E12000006/ati/102/are/E06000033

Smoking prevalence in adults is at its lowest since records began. The significant reduction in prevalence from 20.2% to 15.5% has been achieved through curbing advertising, establishing smokefree places, utilisation of more prominent graphic health warnings, a ban on proxy purchasing and smoking in cars with children, the introduction of standardised plain packaging and [3].

Nonetheless, smoking rates continue to be higher amongst those in our society who already suffer from poorer health and other disadvantages. Smoking accounts for approximately half the difference in life expectancy between the richest and poorest in society. This is demonstrated by the variation in smoking prevalence across England. The prevalence remains even higher in people with mental health conditions, where more than 40% of adults with mental illness smoke[3].

The 2017 Tobacco Control Plan for England sets out the government's vision to achieve a smoke free generation[3]. It aims to:

- maximise the availability of safer alternatives to smoking
- make all mental health inpatient services smoke free by 2018
- reduce the prevalence of 15 year olds who regularly smoke from 8% to 3% or less
- reduce smoking prevalence amongst adults in England from 15.5% to 12% or less,
- reduce the inequality gap in smoking prevalence
- reduce the prevalence of smoking in pregnancy from 10.7% to 6% or less



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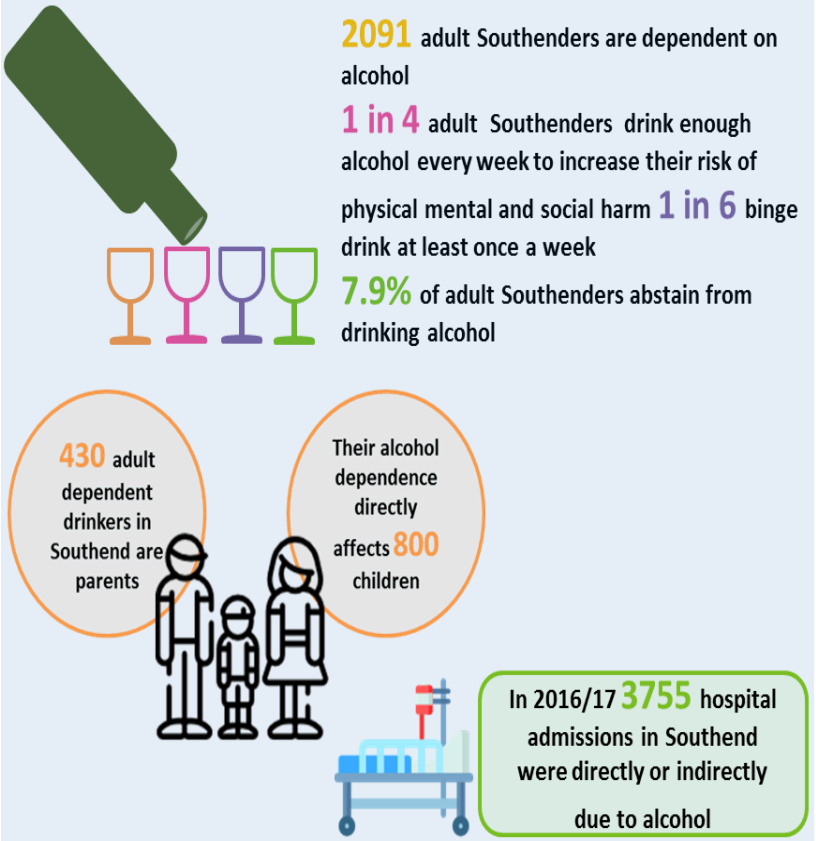
1.3 Alcohol

In England, among those aged 15 to 49, alcohol is now the leading risk factor for ill-health, early death and disability; across all age groups it is the fifth leading risk factor for ill-health. Every year there are over 1 million hospital admissions relating to alcohol, and alcohol related deaths have significantly increased, in particular, due to liver disease. A greater number of years of working life are lost as a result of alcohol-related deaths than a number of cancers combined[4].

This increase in the harmful impacts of alcohol can be explained by a 42% increase in alcohol sales since 1980. The growth in alcohol sales has been driven by increased consumption by women, a shift to higher strength products, increasing affordability an increase in the frequency people are socially drinking. Consumption has started to decline since it peaked in 2008; however it is unclear whether this is because drinkers are consuming less alcohol or because there has been an increase in the number of people who abstain from consuming alcohol completely[4].

The three key influencers of alcohol consumption include price (affordability), ease of purchase (availability) and the social norms around its consumption (acceptability). Policies to tackle the public health burden of alcohol target these key influences[4].

The government's new alcohol strategy publication is anticipated in 2019.

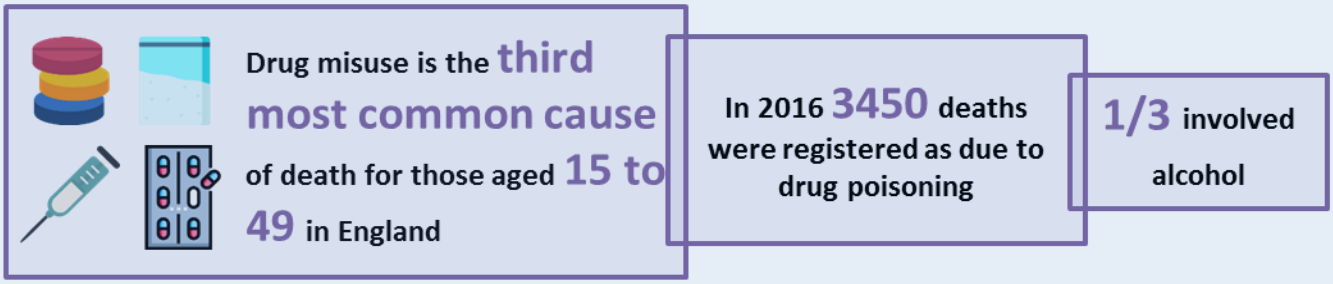


Data available from: https://fingertips.phe.org.uk/profile/local-alcohol-profiles/data#page/0/gid/1938132984/pat/6/par/E12000006/ati/102/are/E06000033

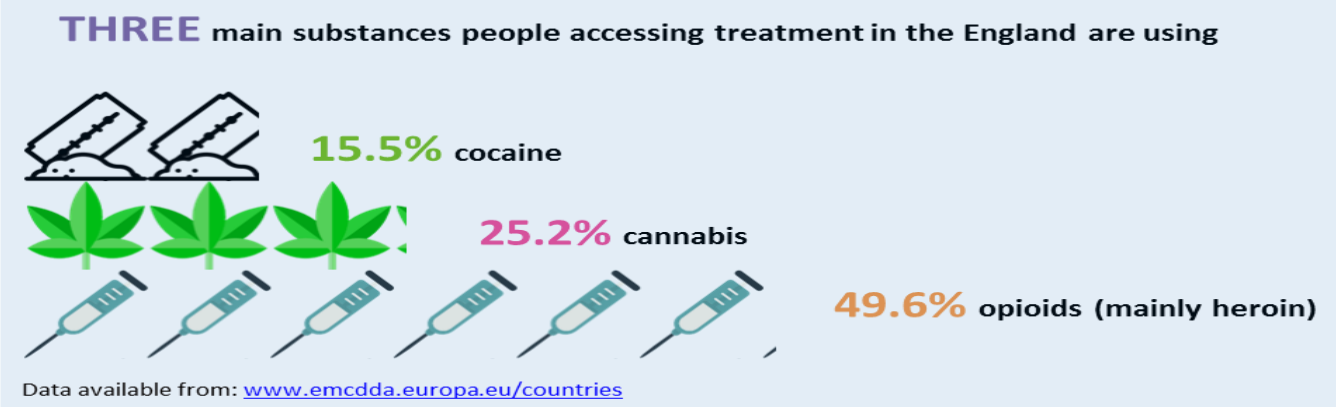
1.4 Drugs

Overall, illegal drug use in the UK has declined over the last 10 years; however, because of its relatively high prevalence, cannabis has remained a driver of this overall drug trend[5]. Cannabis remains the most commonly used illicit drug, while powder cocaine is the most prevalent stimulant in the UK and the second most prevalent drug overall[9].

There has been increasing recognition of the social harms recreational drug use is having in terms of increases in violent crime and vulnerable young people being exploited to facilitate the supply of drugs across the country[10].



Data available from: https://www.gov.uk/government/publications/health-matters-preventing-drug-misuse-deaths/health-matters-preventing-drug-misuse-deaths

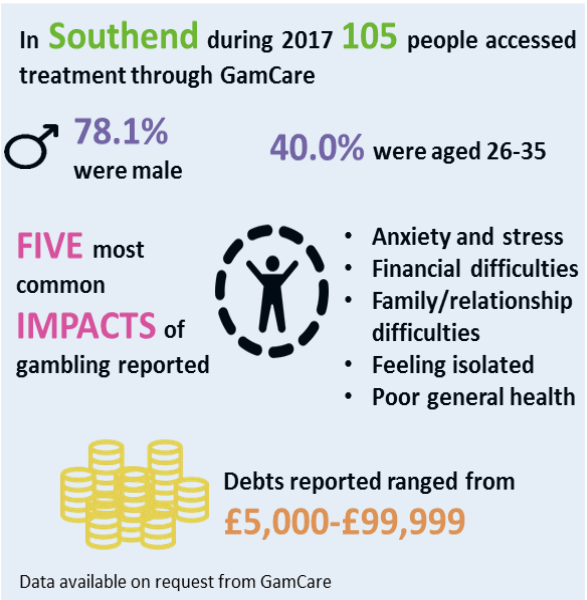


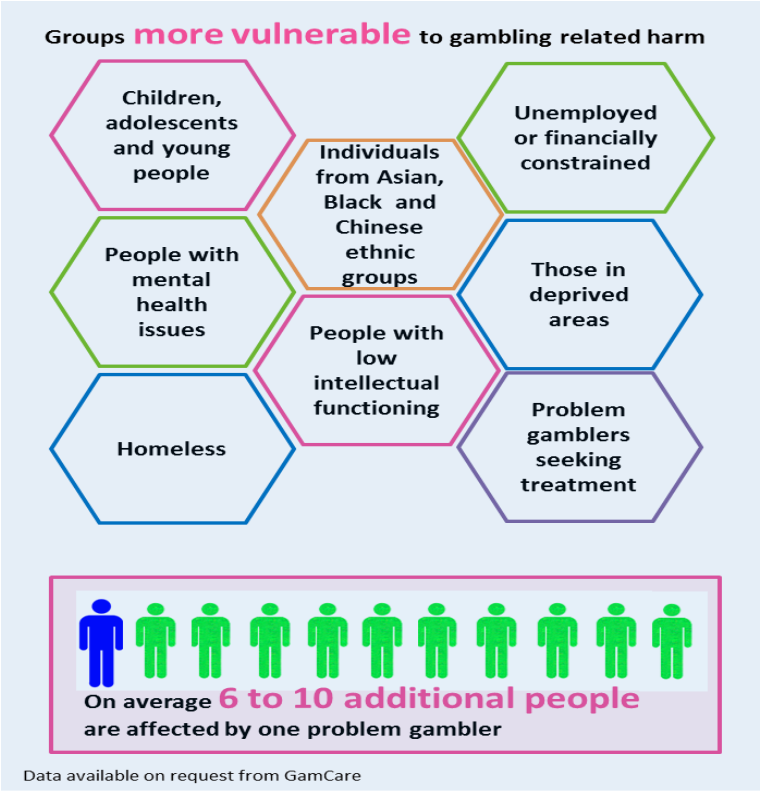
The governments Drugs Strategy 2017 builds on the existing approach of reducing demand, restricting supply and building recovery and taking a smarter, coordinated partnership approach[5].

1.5 Gambling

Awareness about harmful gambling and its impact on families and local communities, as well as individuals directly harmed by it, has been increasing for a number of years. The prevalence of high stakes betting machines on high streets; the significant increase in gambling advertising; and the rise in online gambling have all contributed to societal concern about gambling[1].

Conservative estimates, created from the National Health Survey for England, suggest that 0.7% of people in England identified as problem gamblers, and 3.6% of people are at low to moderate risk of experiencing negative effects due to their gambling behaviours but are not yet classified as problem gamblers[1].





The Gambling Commission Strategy presents a vision for the kind of gambling market they want to see: one that is fairer and safer for consumbers[7]. The strategies five priorities to deliver the vision are;

1. Protect the interests of consumers

2. Prevent harm to consumers and the public

3. Raise the standards in the gambling market

4. Optimise returns to good cause from lotteries

5. Improve the way we regulate

1.2.3 What are we currently doing about harmful behaviours in Southend?

Southend Borough Council provides a range of treatment and support services for residents who want to stop smoking or address their drug and/or alcohol use. The services work with health and social care professionals across the Borough to make sure they reach the people that need them. There is a specialist drug and alcohol treatment, advice, guidance and recovery support service available for children and young people under the age of 21.

These services are informed and designed by a range of expert partners across Drug and Alcohol Commissioning Team, Public Health, Community Safety, Regulatory Services, Police and Criminal Justice services. Local data and intelligence is applied to national evidence based guidance to ensure that we are providing the best services we can for Southenders.

Children's Social Care offers a single point of access for a range of services through their Early Help Front Door. By working with Adult Social Care where appropriate the aim of this range of services is to provide help as soon as needs present themselves to children and families to prevent those needs from escalating and requiring more intensive help and support later on.

In addition to the services we provide for Southenders who want help to address their harmful behaviours a range of education and training is undertaken in schools, with parents and professionals across the Borough to raise awareness and highlight the services which can offer support. Currently these do not include gambling as a harmful behaviour.

Southend Borough Council is also home of Regulatory Services (which includes Environmental Health and Licensing; Trading Standards amongst others) who have responsibilities to ensure that businesses comply with laws relating to food hygiene; consumer trading; licensing; and health and safety at work. In relation to harmful behaviours they are responsible for the issue and processing of permissions for Gambling and Alcohol within the parameters of the legislation and ensuring compliance with conditions attached with the protection of the public in mind.

Trading Standards carry out consumer protection activities which include those associated with tobacco and alcohol, both legal and illegal. They carry out test purchasing to ascertain if retailers are ensuring children cannot buy restricted products and if counterfeit or smuggled tobacco is being sold.

All of this work is overseen and monitored by Southend's four Strategic Boards: Health and Wellbeing, Community Safety Partnership, Safeguarding Adults and Safeguarding Children.

In February 2018 the Community Safety Partnership also started work to address the issues facing Southend Council and its partners to tackle the problem of Gangs, knife crime, 'county lines' and drug markets. It established an Action Plan that seeks to collaboratively disrupt and inhibit the operations of the drug gangs and create a resilient community response that is in line with Southend's vision for 2050.

The action plan illustrates a common view of the issue and signposts how Southends four Strategic Boards should focus on co-ordinated activity to engage and galvanise the local community to work with the local agencies to create a safer Southend.

2. The case for change

The individual and societal harm associated with misuse of over the counter and prescription drugs, alcohol, tobacco and gambling is just as great, if not greater, than the harm associated with many illegal drugs. Harmful behaviours often occur together, which significantly increases the harm they cause. While individually harmful behaviours require a tailored approach and dedicated resource, it is important to recognise them in combination as the harm they cause is comparable and often interlinked.

This should be reflected at a strategic level, with one strategy encompassing harmful behaviours guided by a set of common principles. This single strategic approach has already been used in the context of drugs alcohol and gambling in Southend over the last three years. It addresses system wide cross-cutting issues of addiction and substance misuse whilst enabling people to work more efficiently.

One strategy for harmful behaviours enables the right people to be consistently around the table to drive the strategy forward and ensure that the outcomes for each work-stream are achieved.

3. Our vision and strategic approach

By 2050 we want Southend-on-Sea to be prosperous and connected, but with a quality of live to match. We want Southend-on-Sea to have led the way in growing a sustainable, inclusive city that has made the most of the life enhancing benefits of new technologies.

To achieve this, in relation to harmful behaviours, over the next five years our mission is to;

Reduce the harm caused by harmful behaviours

Ensure fewer people adopt harmful behaviours

Support and respect everyone affected by harmful behaviours

We will do this by;

- Reducing demand
- Restricting supply
- Strengthening the treatment and recovery offer by driving collaboration and reducing fragmentation
- Ensuring an appropriately trained workforce to enable early identification
- Improving data quality and collection

The rationale for focusing on these key areas is detailed in Appendix 1.

Southends **Community Safety Partnership Board** will be responsible for ensuring that the outcomes of the strategy are being met. This multi-agency strategic board, with representation from health and social care, police and the criminal justice service is best placed to ensure health and societal harms of harmful behaviours are being tackled.

3.1 Reducing demand

Safe and Well

- **Southenders are remaining well enough to enjoy fulfilling lives, throughout their lives.**
- **We are all effective at protecting and improving the quality of life for the most vulnerable in our community.**

Opportunity and Prosperity

- Our children are school and life ready and our workforce is skilled and work ready

To achieve this, we will:

- Implement ASH's Smokefree School Gates across Southend Primary Schools
- Ensure midwives are confident in identifying and discussing harmful behaviours with expectant parents and that those parents who require additional support have access to specialist midwives
- Develop and roll out a set of quality standards for schools PHSE education. The quality standards will promote effective harmful behaviour education using a resilience-based model
- Deliver training and awareness campaigns to children and adults in Southend about harmful behaviours which enable them to make informed decisions.
- Support the roll out of education and training for children and parents about gangs, drugs and exploitation is already being undertaken by the Violence and Vulnerability Group. Further work will need to be undertaken to develop and deliver awareness about illicit tobacco and alcohol and gambling related harm

3.2 Restricting supply

Safe and Well

- **People in all parts of the borough feel safe and secure at all times**

Opportunity and Prosperity

- **The Local Plan is setting an exciting planning framework for the Borough.**
- **We have a fast-evolving, re-imagined and thriving town centre, with an inviting mix of shops, homes, culture and leisure opportunities.**

To achieve this, we will:

- Update the licensing policies to reflect the ambitions of the strategy where appropriate.
- Improve collection and analysis of local data to inform alcohol licensing applications and future policies to ensure that all decisions are evidence based and consider the adoption of a Cumulative Impact Policy if the data indicates there is a requirement for one
- Improve processes to gather and develop intelligence which can be used to restrict the supply of illicit alcohol and tobacco sales and inform test purchases at premises to ensure they comply with the law in respect of age restricted products
- Support the work of the Violence and Vulnerability Group in disrupting drug dealing and street gang activity through policing and non-policing methods
- Work with relevant partners in the development of the Local Plan to maximise opportunities
- Work closely with the Gambling Commission to support the delivery of their strategic priorities

3.3 Strengthening the treatment and recovery offer by driving collaboration and reducing fragmentation

Safe and Well

- People in all parts of the borough feel safe and secure at all times.
- Southenders are remaining well enough to enjoy fulfilling lives, throughout their lives.
- We are well on our way to ensuring that everyone has a home that meets their needs.
- We are all effective at protecting and improving the quality of life for the most vulnerable in our community.

Opportunity and Prosperity

- Our children are school and life ready and out workforce is skilled and job ready

Active and Involved

- Even more Southenders agree that people from different backgrounds are valued and get on well together.
- The benefits of community connection are evident as more people come together to help, support and spend time with each other.
- Public services are routinely designed – and sometimes delivered – with their users to best meet their needs
- A range of initiatives help communities to come together to enhance their neighbourhood and environment
- More people have active lifestyles and there are significantly fewer people who do not engage in any physical activity

To achieve this, we will:

- Facilitate a holistic approach to early intervention, treatment and recovery which incorporates individual's physical, mental and social health, with a particular focus on improving the opportunities for housing and meaningful employment for those where it is appropriate

- Work with Jobcentre Plus to ensure the employment, training and education needs of the drug and alcohol misusing population are met

- Improve access to stop smoking services amongst those in greatest need; pregnant women, individuals with mental health problems

- Support the needs of those affected by another's harmful behaviours by reviewing the current risk assessments and thresholds we have in place, making sure there are robust pathways to appropriate services for those individuals not yet meeting the safeguarding threshold

- Promote the available treatment services provided by GamCare for harmful gambling

- Reduce drug related deaths. We will reduce deaths relating to heroin overdose through continued promotion of the community naloxone programme. We will reduce deaths associated with County Lines and gang activity through the Violence and Vulnerability action plan

- Strengthen existing peer mentoring and volunteering schemes to support recovery

3.5 Ensuring an appropriately trained workforce to enable early identification

Safe and Well

- **Southenders are remaining well enough to enjoy fulfilling lives, throughout their lives**
- **We are all effective at protecting and improving the quality of life for the most vulnerable in our community**

To achieve this, we will:

- Work with key partners across primary and secondary care, the Department of Work and Pensions and Citizens Advice to implement NICE and Public Health England recommendations of delivering brief advice training in all adult and social care and criminal justice settings by ensuring all staff have access to brief intervention advice training about tobacco, alcohol and gambling and are able to sign post to relevant support

- Develop a harmful behaviours website which provides a one stop shop for information, advice, training and local referral pathways for professionals

3.6 Improving data quality and collection

Safe and Well

- **People in all parts of the Borough feel safe and secure at all times**
- **We are all effective at protecting and improving the quality of life for the most vulnerable in our community**

To achieve this, we will:

- Develop appropriate data sharing agreements between relevant partners across the system
- Work with partners in the Emergency Department at Southend University Hospital, East Anglia Ambulance Service and the Police to improve the quality of data collected through the Cardiff Model
- Collate data relating to drugs and drug related harm through the Violence and Vulnerability Data Dashboard
- Ensure partners take responsibility for appropriately recording identification of harmful behaviours, brief advice and signposting
- Develop processes to collect data about harmful gambling in partnership with agencies working with those at greatest risk of gambling related harm
- Ensure all relevant data about harmful behaviours is fed into the Joint Strategic Needs Assessment

4. Delivering the strategy

This five year strategy highlights the importance of tackling harmful behaviours in Southend and the key short-term measures that can be taken, in the context of Southend 2050, to start addressing the harms caused by these behaviours.

Due to the nature of harmful behaviours and the multiple complex needs of those affected by harmful behaviours all agencies working in partnership have a role to play in tackling them. Southend 2050 presents an exciting opportunity for us to transform together and enables closer collaboration between staff, members, partners and citizens.

This strategy articulates a collaborative approach to tackling harmful behaviours that will be led by the Harmful Behaviours Steering Group. This steering group will be made up of the relevant 2050 outcome leads who will work with appropriate teams across the council. The Harmful Behaviours Steering Group will report its progress towards the collaborative actions to the relevant strategic board (Community Safety Partnership, Health and Wellbeing Board, Safeguarding Board).

Southend's Community Safety Partnership will however have complete oversight of the implementation of the strategy, which will be reviewed on an annual basis.

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6. Appendix 1

Rationale for reducing demand

Population level approaches that reducing demand will subsequently reduce the aggregate level of harmful behaviours in a community and can therefore lower the whole communities' risk of harm[11,12]. There is limited evidence to suggest that simply providing information is sufficient to lead to substantial and lasting reductions in harmful behaviours. However, by increasing the populations understanding of harmful behaviours there is a chance that that public support for more effective policies will increase[4]. It is therefore important that we ensure all Southend residents have access to appropriate information to make informed decisions about their adoption of harmful behaviours as a starting point for changing social norms.

To protect individuals, families and communities from the effects of harmful behaviours we must start at the earliest opportunity to prevent people using drugs and tobacco in the first place, and prevent escalation of harmful use of alcohol and gambling[5,2]. Evidence shows that increasing resilience could contribute to healthy behaviours, higher qualifications and skills, better employment, better mental wellbeing, and a quicker more successful recovery from illness[13]. To ensure our children are life ready we advocate a resilience-based approach to harmful behaviours education in schools.

Rationale for restricting supply

Restricting the supply of products that lead to harmful behaviours through new legislation and taxation is outside the scope of this strategy. But there is still a lot we can do locally to restrict the supply of drugs, alcohol, tobacco and off-line gambling activities.

We want the Local Plan to set an exciting framework for Southend and for our town-centre to have an inviting mix of shops, homes, and culture and leisure activities. As a Licensing Authority we can use our Statement of Licensing Policies for alcohol and gambling to stipulate the

steps we will take and expect licensed premises to take to ensure the licensing objectives are upheld[14,15]. These will also help to ensure a safe and secure Southend.

As part of the Statement of Licensing Policy it is possible, where there is significant evidence of support available, to include a Cumulative Impact Policy which considers the potential impact on the licensing objectives that a significant number of licensed premises in one area might have. With regard to alcohol, policies that sufficiently reduce the hours which alcohol is available (such as early morning alcohol restriction orders (EMRO)), where there is evidence that they are appropriate for the promotion of the licensing objectives, have demonstrated a substantial reduction of alcohol related harm in the night-time economy[4]. When simultaneously enforced and targeted at the most densely populated areas these policies are cost-effective[4].

Since 2013 Directors of Public Health have been included as responsible authorities under the Licensing Act 2003. To ensure we, as a licensing authority, are making decisions that benefit and protect the health and wellbeing of Southend residents we must take advantage of Public Health's contribution particularly in the provision of information that is unavailable to other responsible authorities.

Changes to the planning system in 2015 mean that any new betting shops must now apply for full planning permission, as long as the new tenant is not moving into a unit that was formerly used as a betting shop[1]. This presents us with new opportunities to prevent additional betting shops appearing in the town centre.

Trading Standards play an important role in protecting individuals and restricting supply by monitoring the methods to supply and the supply of dangerous, illicit and counterfeit products in Southend. Trading Standards also carry out test purchases on products to ensure that age restricted products are not being sold or supplied to underage persons.

We want people in all parts of Southend to feel safe and secure at all times. Whilst Essex Police are the primarily responsible for enforcing the Misuse of Drugs Act the Community Safety Partnership is a statutory alliance of local partners who share the responsibility for tackling crime and disorder, anti-social behaviour and drug and alcohol offending. It has long been recognised that effective partnership working results in better crime reduction outcomes[16]. The Community Safety Partnership will have a responsibility to ensure that relevant outcomes of the Reducing Harmful Behaviours Strategy are being met.

As detailed previously a separate multi-agency group focusing on Violence and Vulnerability has been established in Southend. The violence and vulnerability group has key outcomes around tackling County Lines, gangs and related exploitation using policing and non-policing methods.

Rationale for Strengthening the treatment and recovery offer by driving collaboration and reducing fragmentation

Drug and alcohol treatment and recovery services should be easy to access, offer flexibility to cater for the needs of a broad range of people and problems and be designed with the users. They should aim to reduce the risk of harms associated with drugs and alcohol and raise the recovery ambitions of the individuals[11,12].

We want people to protect and improve the quality of life for the most vulnerable people in our community. Drug, alcohol and tobacco treatment services will be coming into contact with some of the most vulnerable in our community on a daily basis, whether it is the individual who is receiving treatment themselves or their family. It is essential that the treatment system we offer in Southend has established care pathways with a range of health, social care, criminal justice and community agencies which address not only their harmful behaviour but also wider determinants of health such as housing and employment. Working with vulnerable people also requires high quality safeguarding practices which are regularly reviewed and reported on to ensure they are meeting the needs of individuals, families and social groups so that they feel safe and secure.

We want to raise the recovery ambitions of individuals so that they can feel valued and come together with Southenders from different backgrounds, not just those who are also in recovery, to be supported by the community.

Rationale for ensuring an appropriately trained workforce to enable early identification

Targeted interventions aimed at individuals in at-risk groups can help make people aware of the harm and change their behaviour, preventing extensive damage to health and wellbeing[11]. Ensuring staff can identify the use of harmful behaviours and provide brief advice and appropriate signposting or referral will mean that Southenders will have the knowledge to make informed choices about their health and wellbeing.

NICE and Public Health England (PHE) recommends delivering identification and brief advice training in adult health and social care and criminal justice settings[17, 18]. We know that certain groups are more at risk of adopting harmful behaviours than others, therefore in Southend, it is paramount that staff working with groups at greatest risk of adopting harmful behaviours are adequately trained. In relation to harmful gambling identification and brief advice training has been found to be effective when delivered to people working in Citizens Advice, the Job Centre and the Criminal Justice System[19–20].

Rationale for improving data quality and collection

It is essential that we target our resources to where they are needed and tailor the services we provide to make sure they are accessible and effective to those that need them. Local data and intelligence are key to identifying problems and

understanding if our solutions are working. Comparing this data and information to what we know nationally or regionally can also help us to prioritise our actions.

Data from a range of agencies working across the Borough is currently be compiled into a central data warehouse which will form Southends Joint Strategic Needs Assessment. Data specifically relating to County Lines, gangs and related exploitation is being compiled into a Violence and Vulnerability data dashboard. Data about harmful behaviours will feed into both of these. It will help to inform the police and community safety response to drug and alcohol related crime to ensure people feel safe and secure at all time and contribute to our understanding of vulnerable groups in Southends.

In order to be effective, we need everyone to understand their role in collecting and recording data about harmful behaviours so that the data quality is high. However, there are still gaps in our understanding and there is a need to identify new processes for collecting additional data and information about harmful behaviours.

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Southend-on-Sea Health & Wellbeing Board

Agenda Item No.

13

Report of the Interim Director of Public Health

To

Health & Wellbeing Board

On

Wednesday 18th September 2019

Report prepared by: Director of Public Health

For information only		For discussion	x	Approval required	x

Annual Public Health Report 2018-19

Part 1 (Public Agenda Item)

1. Purpose of Report

1.1 To present the 2018-19 Annual Report of the Director of Public Health.

1. Recommendation

.1. That Cabinet considers and notes the content and recommendations of the 2018-19 Annual Report of the Director of Public Health.

3.0 Background

3.1 The Health and Social Care Act 2012 requires the Director of Public Health to prepare an annual report on the health of the local population. This is an independent report which the local authority is required to publish. The report is an opportunity to focus attention on particular issues that impact on the health and wellbeing of the local population, highlight any concerns and make recommendations for further action.

4.0 The 2018-19 Annual Report of the Director of Public Health

4.1 The Report this year provides an update on last year's report (2017 Annual Public Health Report) and covers the following themes:

- ✓ Description of the current health and wellbeing status in Southend-on-Sea;
- ✓ Healthy Lives – Focus on cardiovascular conditions and diabetes;

- ✓ Community Safety – Focus on disrupting drug-associated criminal behaviours and protecting our young residents, and re-focusing our efforts on reducing teenage conceptions;
- ✓ Infrastructure planning – Focus on developing a new Local Plan and maximising the health and wellbeing impact now and in supporting our Southend 2050 ambition.

4.2 In 2017-18, we highlighted that there are strong links between unemployment and poorer physical and mental health and mortality, with re-employment generally leading to improved health. It is recognised that poor quality, insecure, and low-paid work can be as harmful to health as unemployment, and both can lead to health inequalities. We have furthered our reach into the business community, through the Public Health Responsibility Deal, increased our engagement with the school community and agreed a renewed approach with the Department for Works and Pensions to signpost those claimants who can benefit from our programme.

4.3 The Southend 2050 Ambition and the NHS Long Term Plan collectively set out the key things we can expect to work as partners to turn the ambitions into improvements in services and build community resilience.

4.4 A number of key health and wellbeing measures for Southend compare favourably or are similar to the national average, namely obesity, some sexual health conditions, including new diagnosis and our educational achievements. However, many of the measures, including all our mental health and wellbeing indicators, are comparably worse and will require much more collective endeavours from local partnerships to yield better outcomes for Southenders.

4.5 Working with the NHS and other partners, we will refocus our collaboration to improve the local identification and management of cardiovascular conditions and diabetes as well as the uptake of the flu jab. These are also key priorities for the local STP and their Primary Care Networks. A new Wellbeing Service is being launched in June 2019, modelled with partners, to deliver a new approach and promote better resilience through the development of community-led initiatives.

4.6 Southend has a number of highly disadvantaged communities and 42% of children aged 5-15 years, rising to 1 in 2 for those aged 4 years and under, live in these communities. There is well-documented evidence of the poor health and wellbeing outcomes for young people in these communities. These are further compounded by the criminal psycho-social exploitation of children as a result of the County Line drug culture across the Southeast Essex-London corridor. We will build on the Greater Essex work already gaining momentum, to disrupt the drug market, provide new opportunities for our young residents and keep them safe. We will also undertake a deep-dive to further understand why we continue to experience higher teenage conception rates and plan our interventions working with the local communities and partners.

4.7 There is growing evidence of the links between good spatial planning, design principles and the health impacts. The development of a new Local Plan is a real opportunity for public health and planning to work together to shape the natural and built environment, reimagining our high streets and the town centre,

which can all contribute to positive health outcomes. Wide engagement with our neighbouring councils will have a positive gain for infrastructure development, digital advancement, improved transportation (including more on active travel), reduced air pollution and provide a wider spectrum of safe and affordable housing.

4.8 The nine key recommendations for the Health and Wellbeing Board to note are:

4.8.1 Reducing the impact of cardiovascular conditions and diabetes and improving related prevention work:

R1.1 Develop an agreed locality approach to improve earlier identification of Stroke and Diabetes, ensuring reduced variability in access to primary care services;

R1.2 Improve the management of patients at risk of stroke and those afflicted with diabetes, including the use of digital technology as appropriate, and delivery of the Diabetes Strategy;

R1.3 Increase referral to the new Wellbeing Service to reduce and/or better manage lifestyle risk factors and implement the Harm Reduction Strategy as a key enabler.

4.8.2 Improving community safety and building resilience, with a particular focus on our children and young people:

R2.1 Develop a programme of work that will provide for, and link into, a range diversionary activities and avenues for vocational development. This will include local apprenticeships to make young people safer, provide skill development and job opportunities and to have a healthier outlook on their lives;

R2.2 Build on the work already in progress across Greater Essex and regionally, to reinvigorate the local partnerships (Community Safety and Violence and Vulnerability groups) to disrupt the local drug market and to eliminate the criminal exploitation of young people and vulnerable adults in our communities;

R2.3 Undertake a deep-dive on local teenage conceptions to understand local determinants and triggers, including the link with child sexual exploitation, local opportunities for young people to promote a delaying approach to parenthood.

4.8.3 Ensuring that spatial planning incorporates health and wellbeing impacts, and delivers what residents will need to promote their health and wellbeing:

R3.1 Adopt new evidence on spatial planning, including the adoption of the PHE/Sports England's Active Design principles, making it a requirement on developers to undertake a Health Impact Assessment where most relevant and review the barriers inhibiting local access to our physical assets;

R3.2 Our housing renewal policy must take into consideration the need for more affordable housing which espouses a mix of social housing, adaptable homes which will ensure that the adverse health effects are mitigated, promote local ownership and more affordable rent, and support the drive to increase prosperity;

R3.3 Accelerate our local undertakings in improving local transportation to further reduce the risk of pollution and traffic congestion, and promote active travel.

5.0 Other Options

There are no other options presented as it is a statutory duty of the Director of Public Health to prepare an Annual Public Health Report.

6.0 Reason for Recommendations

6.1 The Health and Social Care Act 2012 requires Directors of Public Health to prepare an annual report on the health of the local population.

7.0 Corporate Implications

7.1 Contribution to Council's Southend 2050 Ambition and Priorities, including the STP shared priorities.

The Council has a statutory duty to protect the health of the local population. The 2018-19 Annual Public Health Report highlights the key issues for people in Southend, actions being taken to address them and key recommendations to be delivered by local partners.

7.2 Financial Implications

At this stage any financial implications arising from this report are unquantified and, as further work is undertaken, any resource implications will be identified and dealt with, primarily through the Public Health Grant, and other existing budgets as necessary.

7.3 Legal Implications

There are no legal implications arising directly from this report.

7.4 People Implications

There are Directorate performance indicators relating to the Public Health Responsibility Deal as well as national benchmarking information, showing how we compare against statistical neighbours, the region and nationally.

7.5 Property Implications

None.

7.6 Consultation

There will not be any formal consultation on the Annual Public Health Report, although it will go through the relevant governance route within the Council as well as to the Southend Health & Wellbeing Board.

7.7 Equalities and Diversity Implications

The Annual Public Health Report provides evidence that population health needs are assessed and considered.

7.8 Risk Assessment

A risk assessment will be undertaken of individual initiatives introduced to tackle the key issues highlighted in the report.

7.9 Value for Money

No implications.

7.10 Environmental Impact

None.

8.0 Background Documents

8.1 Background documents are referenced throughout the Annual Public Health Report, with direct web-links.

9.0 Appendices

9.1 The 2018-19 Annual Report of the Director of Public Health for Southend
9.2 The APHR's Implementation Plan

APHR 2019 v0.9 Final 30May19.pdf

APHR 2019-20 Implementation Plan

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Director of Public Health Annual Report 2018-19

CONNECTED & SMART

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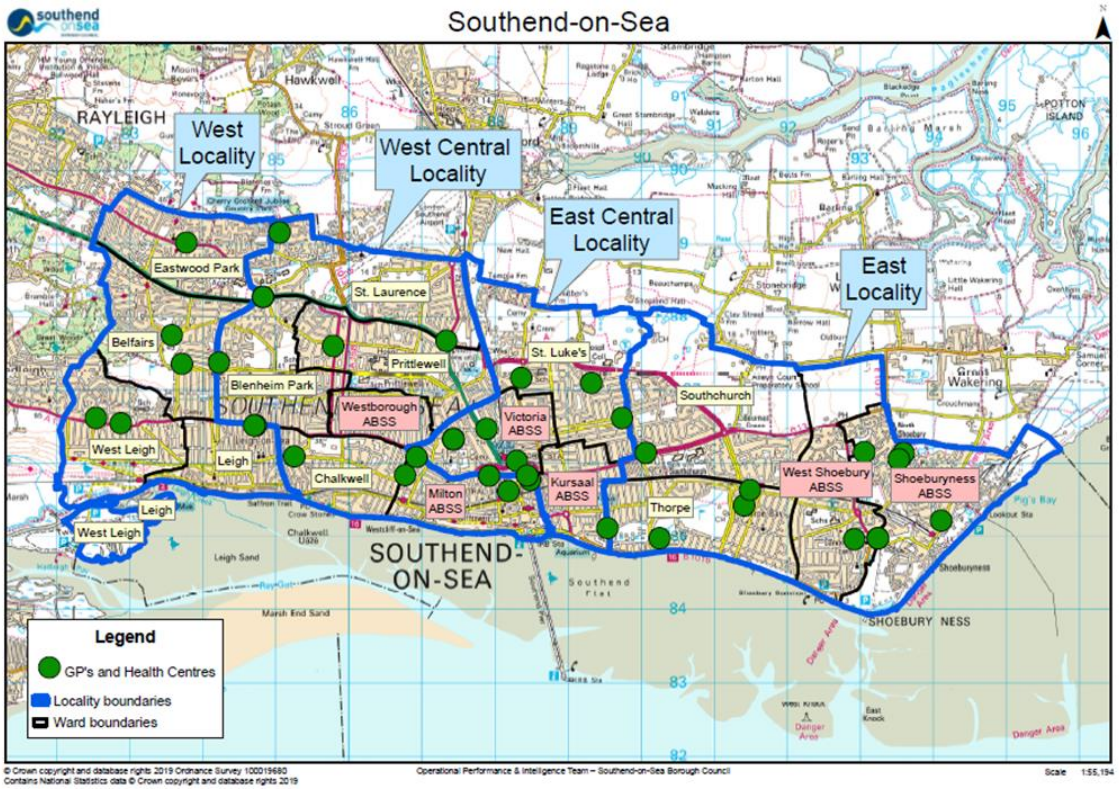
OPPORTUNITY & PROSPERITY



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Director of Public Health

Glossary

ABS	A Better Start. *"A Better Start aims to improve the life chances of babies and very young children by delivering a significant increase in the use of preventative approaches in pregnancy and first three years of life."*[1]
ABSS	A Better Start Southend. The ABS project running in Southend.
ASELA	Association of South Essex Local Authorities.
CE	Criminal Exploitation.
CSE	Child Sexual Exploitation.
CVD	Cardiovascular disease.
Early years	Educational performance figures for Early Years refer to pupils in the reception year of primary school, aged 4 to 5.
ESA	Employment Support Allowance
ForwardMotion	*"ForwardMotion is a new initiative to encourage people to think differently about the way they commute in and around south Essex"*[2]
IMD	Index of Multiple Deprivation. A summary measure describing the deprivation experienced in an area, relative to other areas in England.
JTAI	Joint Targeted Area Inspection. Inspections carried out by Ofsted, the Care Quality Commission (CQC), Her Majesty's Inspectorate of Constabulary and Fire and Rescue Service (HMICFRS) and Her Majesty's Inspectorate of Probation (HMI Probation)
Key stage 2	Educational performance figures for Key Stage 2 refer to primary school year 6, pupils aged 10 to 11.
Key Stage 4	Educational performance figures for Key Stage 2 refer to Secondary school year 11, pupils aged 15 to 16.
NCMP	National Child Measurement Programme, which measures the height and weight of children in Reception (age 4 to 5), and year 6 (aged 10 to 11).
NO2	Nitrogen Dioxide, an air pollutant produced when fuel is burned
PHE	Public Health England.
PHE Fingertips	The Fingertips website presents a wide range of statistics on health and related measures.
PIR	Police Intelligence Reports
PM2.5 **PM10**	Particulate Matter, PM2.5 and PM10 refer to different sizes of the particles.
RSE	Relationship and Sex Education.
SMI	Serious Mental Illness.
Southend 2050	*"The Southend 2050 programme is not about one single publication or statement. It is a mind-set – one that looks to translate the desires of local people and stakeholders into action, something that looks to the long term, but also at the action that is needed now and in the medium-term"*[3]
STP	Sustainability and Transformation Partnership - new partnership between NHS and Local Authorities to run services in a more coordinated way, to agree system-wide priorities, and to plan collectively how to improve residents' day-to-day health.
SystmOne	SystmOne is used by many GP's to manage patient records.

[1] https://www.abetterstart.org.uk/content/about-programme
[2] https://forwardmotionsouthessex.co.uk
[3] https://www.southend.gov.uk/info/100004/about_the_council/877/southend_2050

Foreword

This is my independent annual public health report on the health and wellbeing of the population of Southend-on-Sea highlighting key issues and some areas of focus for the coming year, in supporting our Southend 2050 ambition, our collective health and wellbeing priorities and infrastructure growth.

Working with partners, a number of joint strategic needs assessments (JSNA) have been compiled over the past 15 months, including a summary JSNA in January 2019[4], which provide a richer form of information synthesis behind this report. We have identified cardiovascular conditions and diabetes as two health areas to achieve further improvements – these are two of the four STP priorities agreed for 2019 onwards. We need to stay true to our community resilience building whilst also acknowledging the need to continue raising our children's aspirations, improve their wellbeing and tackle some of the vulnerabilities which create further inequalities locally. As we embark on developing a new Local Plan, it is timely to consider how our ambition, drawn together from the voices of Southenders, can be better realised, striving for a highly digitally-enhanced capacity to promote growth, improve connectedness and maximise the potential for health care benefits.

Much of local engagement in developing the Southend 2050 ambition, has been inspirational and should provide us all across Southend and the wider geography, with the impetus to forge more meaningful partnerships, accelerate our collaborative undertakings to improve lives and encapsulate how to measure the impact of our endeavours. More alignment to our STP work programme is afoot to ensure we can better harness our joint efforts in delivering the same outcomes.

We have collectively established a set of 23 outcomes that we can continue to aspire in achieving for Southend. They are broad enough to enable a myriad of interventions and community-led actions to emerge and I am enthused in contemplating how some of these will be supported as we move to focus across the three themes highlighted in this report. For example, by preventing ill-health and further improving the management of people with cardiovascular diseases, we can ensure that '*Southenders are remaining well enough to enjoy fulfilling lives, throughout their lives*' and that '*More people have active lifestyles and there are significantly fewer people who do not engage in any physical activity*.'

In working together with vulnerable young people, we can make sure that '*We are all effective at protecting and improving the quality of life for the most vulnerable in our community*.' In return a safe environment for young people to grow and prosper means '*There is a tangible sense of pride in the place and local people are actively, and knowledgeably, talking up Southend-on-Sea*.'

In sharing our knowledge and with real engagement with the local population in developing our Local Plan, our proposals can ensure '*We act as a green city with outstanding examples of energy efficient and carbon neutral buildings, green open spaces, streets, transport and recycling*' and '*We have a fast-evolving, re-imagined and thriving town centre, with an inviting mix of shops, homes, culture and leisure opportunities*.'

These are but a few examples of how we can all demonstrate our commitment to support these outcomes and that they will touch most of the borough-wide priorities regardless of boundaries. I hope this report will be a catalyst to help all agencies and residents to work together to improve the lives of our residents, support our businesses and ensure our town will continue to grow and prosper.

Mr Krishna Ramkhelawon – *Interim* Director of Public Health

[4] https://www.southend.gov.uk/downloads/download/356/joint_strategic_needs_assessments

Introduction

The challenges we face in the context of austerity and wide-ranging vulnerabilities in our populace, require a wide range of strategic partnerships to proactively jointly deliver a more positive impact on health outcomes. We will aim to enhance growth and development in the borough and across South East Essex through the roles of strategic partners.

Our communities will become more resilient to the challenges if, across all sectors, we engage them in developing our approach and local solutions. Working with the NHS's STP forum, we will support local priorities such as prevention and improved management of people with pre-existing conditions.

Our Southend 2050 shared ambition will enable us to set sail to achieve significant improvement in the health and wellbeing and the local infrastructure of our beautiful coastal town.

The focus of the report this year will cover:

- Reducing the impact of cardiovascular conditions and diabetes and improving related prevention work;
- Improving community safety and building resilience, with a particular focus on our children and young people;
- Ensuring that spatial planning incorporates health and wellbeing impacts, and delivers what residents will need.

Last Year's Annual Report

Our focus from last year's report was on workplace health and supporting people to retain employment. The commitment through our Public Health Responsibility Deal (PHRD), saw great strides being made with our businesses and schools:

New Organisations signed up to PHRD	2017/18	2018/19
Other Businesses	47	44
Micro businesses	16	17
Schools	15	9
Eateries for healthier eating award	4	6

Some of the most popular activities included different physical recreations (most onsite to support team building opportunities), health checks and mental health awareness trainings for staff including personal resilience and dementia awareness.
We also trailed the MoveOut programme devised to promote physical activity and raise awareness of the green spaces in the Borough, as adults working in retail and micro businesses would not have space in their workplaces to encourage participation.
For 2019, the activities will move to more outdoor spaces and we are working with the Department for Works and Pensions to signpost those claimants who can benefit from our programme.

Southend 2050 – Shared Ambition

Our ambition was developed following extensive conversations with those who live, work, visit, do business and study in Southend-on-Sea. The ambition is grounded in the values of Southenders. It is bold and challenging and will need all elements of our community to work together to make it a reality. They are grouped under five themes with key outcomes for all of us to work together to grow Southend-on-sea (see **Appendix A** for outcomes).

The Health of Southend's population

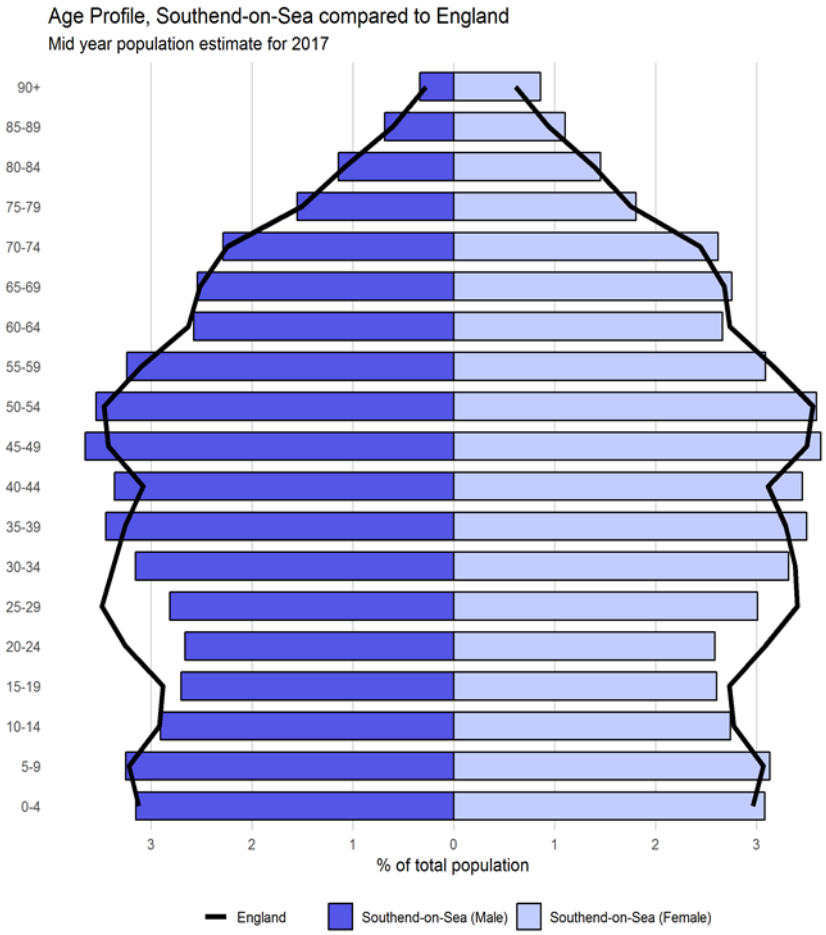
Population size

Since 2001, Southend-on-Sea's population has grown from 160,362 to 179,799. This is a growth rate of 12% which broadly matches the rate for England.

Estimates based on projections suggest that the population of Southend-on-Sea at mid-year 2018 was around 181,800.

By 2031, the projected population for Southend-on-Sea will be 202,935. This assumes a growth rate of 12.9% which is higher than the projected growth rate for England (10.1%).

The proportion of the population who are of working age is projected to decrease by 3% by 2031 while the over 65 population is projected to increase by 4%.



Ethnicity

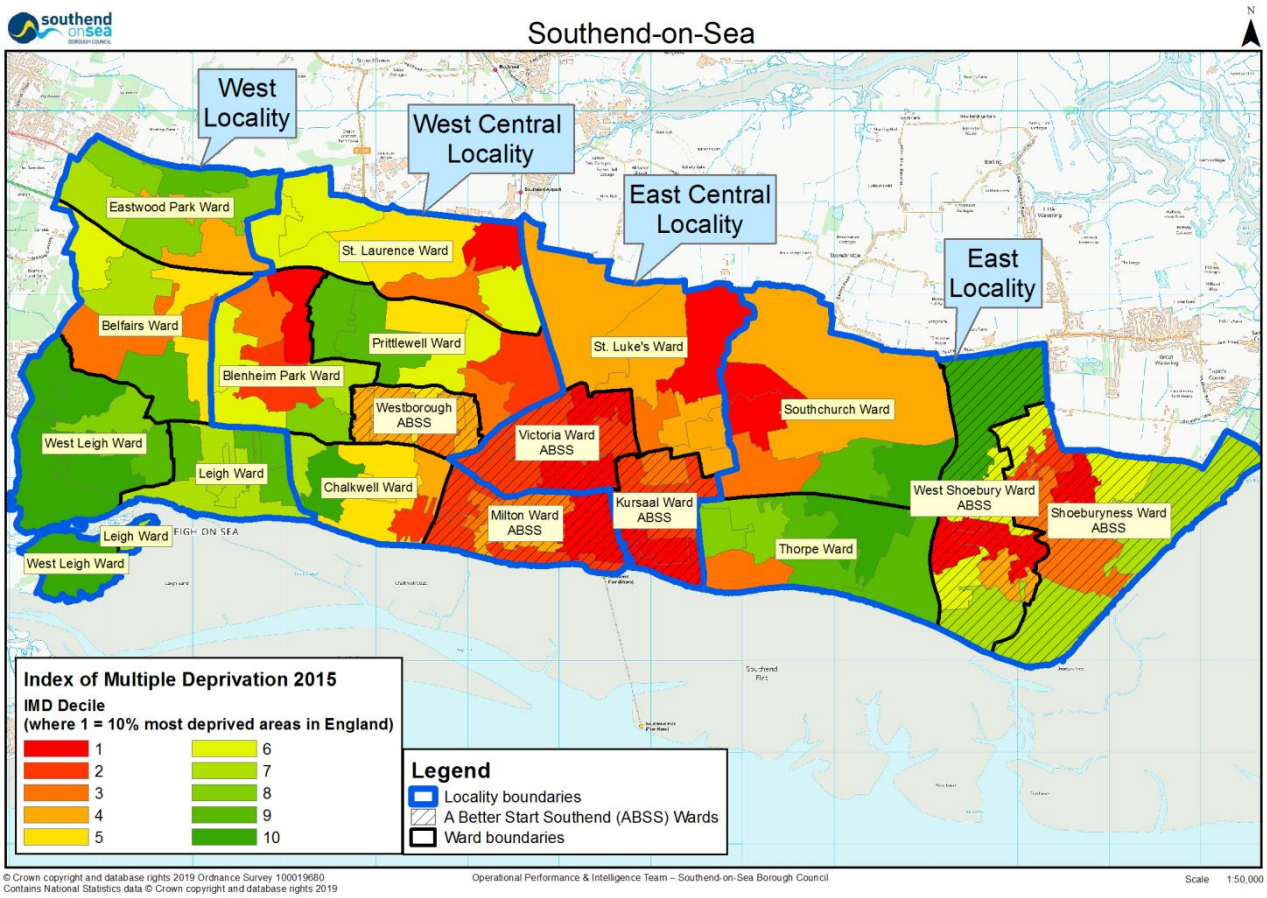
	Southend (%)	East of England Region(%)	England (%)
White	91.6%	90.8%	85.4%
Mixed/multiple ethnic groups	2.1%	1.9%	2.3%
Asian/Asian British	3.7%	4.8%	7.8%
Black/African/Caribbean/Black British	2.1%	2.0%	3.5%
Other ethnic group	0.5%	0.5%	1.0%

*See **Appendix B** for detailed ethnicity breakdown*

Source: 2011 Census, via Nomis[5]

[5] https://www.nomisweb.co.uk/census/2011

Deprivation



The Index of Multiple Deprivation (IMD) is a measure which is used to determine deprivation in every small area in England, relative to other areas in England. The map shows the deprivation deciles, areas marked in dark red are amongst the most 10% deprived small areas in England.

Many of our more disadvantaged communities are located within the **Southend 'town centre' wards, Blenheim Park, the Shoebury area and across Southchurch and St Luke's wards.**

42% of children aged 5-15 live in the 30% most deprived areas in the country.

The proportion rises to 46% of children aged 0-4.

Risk Factors

Harmful substances

Southend-on-Sea is currently developing a new strategy with partners to drive and support harm reduction from tobacco use, substance abuse, alcohol consumption, and gambling.

This summary provides context for the current situation in Southend in relation to harmful behaviours.

Smoking

Impact

Between 2015-17 ,**962 deaths** of adults in Southend were caused by smoking, a rate of 295 per 100,000, which is **worse** than the England average (263 per 100,000)

In 2016/17 there were **2011 hospital admissions** due to smoking. This cost the NHS over **£3.1 million**

Smoking prevalence

15 year olds (2014/15) 10%, **similar** to England

Adults (2017) 18%, **worse** than England (15%)

Pregnant women smoking at time of delivery (2017/18) 11%, **similar** to England

Adults with serious mental illness (SMI) (2014/15) 45% , **worse** than England (41%).

Alcohol

1,863 adults in Southend are dependent on alcohol

1 in 4 adults in Southend drink enough alcohol every week to increase their risk of physical, mental, and social harm

1 in 6 binge drink at least once a week

7.9% of Southend's adults abstain from drinking alcohol

Impact

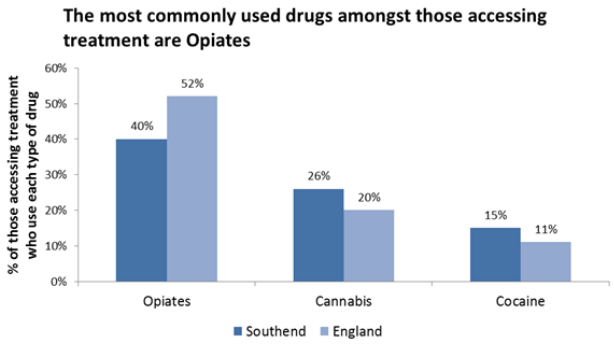
In 2017/18, **4,310** hospital admissions in Southend were directly or indirectly attributable to alcohol (or 2,426 per 100,000, which is **worse** than the England average of 2,224 per 100,000)

430 adult dependent drinkers are parents

Their alcohol dependence affects approximately 800 children

Drug misuse

Drug misuse remains the third most common cause of death for those aged 15 to 49. In 2017, 3,756 deaths were registered as due to drug poisoning. Around a third of these involved alcohol.

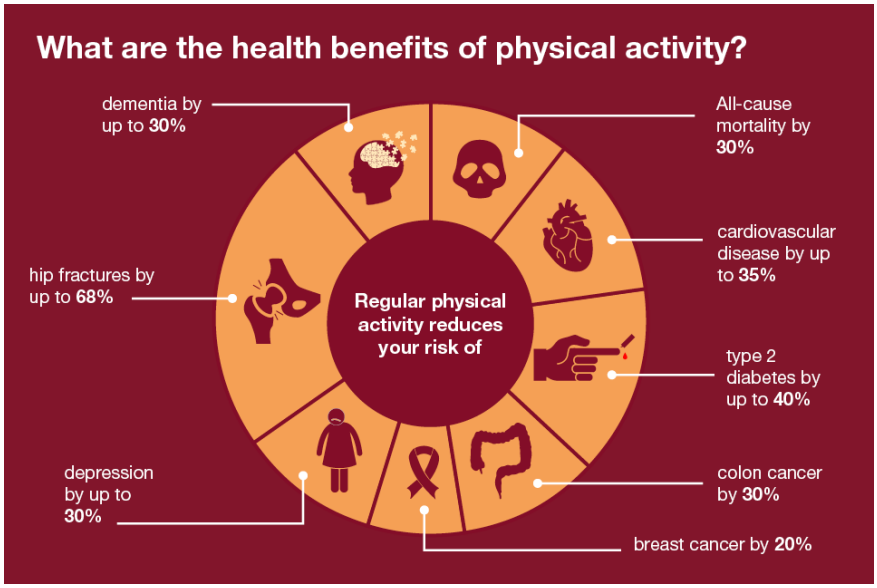


Problem gambling

On average, 6 to 10 additional people are affected by one problem gambler.

Excess weight and inactivity

Physical inactivity is putting more individuals at a greater risk of a number of diseases, including coronary heart disease, cancer, stroke, type 2 diabetes and obesity. In addition to the impact on health and wellbeing of individuals, it is estimated that every year the health related costs, associated with the low levels of physical activity in the borough, are in the region of £5 million.



Adults

Excess weight in adults (2016/17)
58.5%, similar to England (61.3%)

Children

Prevalence of Overweight (including obesity)
Reception (Age 4-5) (2017/18)
22.7%, similar to England (22.4%)

Year 6 (Age 10-11) (2017/18)
32.5%, similar to England (34.3%)

Prevalence of Obesity (including severe obesity)
Reception (Age 4-5) (2017/18)
8.6% similar to England (9.5%)

Year 6 (Age 10-11) (2017/18)
18.6%, similar to England (20.1%)

Inactivity
74% of Southend's 15 year olds had a mean daily sedentary time in the last week of over 7 hours per day, which was worse than the England average.
Source: What about YOUth survey 2014/15, via PHE Fingertips (App B: 4-2)

Sexual health

Southend-on-Sea Borough Council commissioned a comprehensive open access sexual health service including free testing and treatment of sexually transmitted infections, and free access to contraception for Southend-on-Sea residents including young people. During 2019, a new online sexual health service will be launched to further improve access to this service and reduce our infection rates.

Between Aril 2018 and February 2019, 19% of individuals attending the Southend-on-Sea Integrated Sexual Health Service were aged 19 and under, (**similar** to England 2017 percentage at 19.1%)

Syphilis diagnostic rate / 100,000 (2017)	**6.6** **Better** than England
Gonorrhoea diagnostic rate / 100,000 (2017)	**46.5** **Better** than England
Chlamydia detection rate / 100,000 aged 15-24 (PHOF indicator 3.02) (2017)	**2269.2** Rated **Amber** against benchmark
HIV diagnosed prevalence rate / 1,000 aged 15-59 (2017)	**2.9** Rated **Amber** against benchmark
HIV late diagnosis (%) (PHOF indicator 3.04) (2015 - 17)	**58.3%** Rated **Red** against benchmark *(See Note 1)*
New STI diagnoses (exc chlamydia aged <25) / 100,000 (2017)	**666.1** **Better** than England
HIV testing coverage, total (%) (2017)	**38.4%** **Worse** than England
New HIV diagnosis rate / 100,000 aged 15+ (2017)	**9.4** **Similar** to England

Note 1: There is a known issue with the calculation of this indicator for Southend

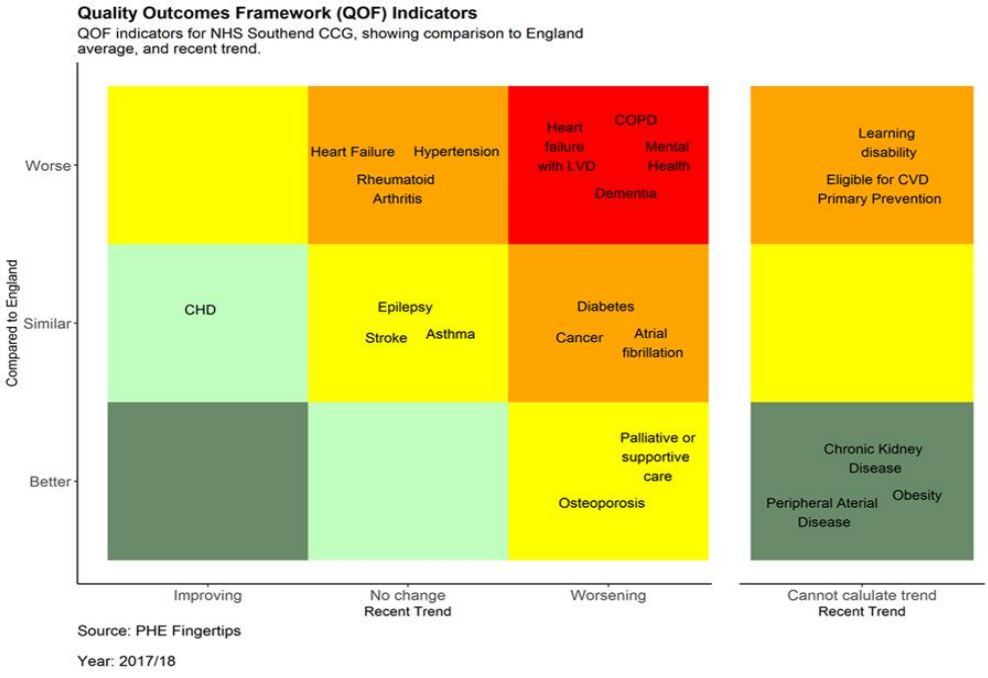
Prevalence of certain conditions

PHE Fingertips indicators relating to deprivation where Southend is a negative outlier

Health improvement	SoS	East	Eng
Smoking prevalence in adults %	18.0	14.2	14.9
Estimated diabetes diagnosis rate %	75.3	76.7	78
Successful completion of alcohol treatment %	32.0	38.2	38.9
Cancer screening coverage – breast	68.1	75.5	74.9
Cancer screening coverage - bowel	53.9	60	59
Children in low income families %	18.9	13.9	17
Rate of complaints about noise**	11.9	5.0	6.3
Preventable u75 mortality rate from liver disease*	22.5	12.7	16.3
Preventable u75 mortality rate from respiratory disease*	24.0	15.6	18.9
Proportion adults in contact with secondary mental health services %	7.3	4.8	5.4
Excess winter deaths (all ages) %	42.4	24.4	21.6

At the end of March 2019, 796 people had quit smoking (target was 771 for 2018-19) with almost 1,800 smokers supported to try and quit.

Key indicators from the Quality Outcomes Framework



This shows the challenge we still face in reducing the level of ill-health related to cardiovascular conditions and diabetes

Life Expectancy

Males		Females
78.7 years **Worse** than England (79.6) Ranked 94 / 150	**Life expectancy at birth**	**82.4** years **Worse** than England (83.1) Ranked 101 / 150
61.2 years **Worse** than England (63.4) Ranked 100 / 150	**Healthy life expectancy at birth** How many years can a person expect to live in good health?	**62.8** years **Similar** to England (63.8) Ranked 81 / 150
11.5 years **Worse** than England (9.4) Ranked 133 / 149	**Inequality in life expectancy at birth** What is the difference between the life expectancy of people living in the most deprived areas, compared to the least deprived?	**10.3** years **Worse** than England (7.4) Ranked 141 / 149

NOTE ON RANKS
This is Southend's rank within all English Local Authorities with a valid entry.
1 = Best

Recent studies have shown that the poorest groups in society are dying almost a decade earlier, and this is worse in other most vulnerable groups, such as those homeless, who can expect to life 30 years less. We still have a long way to go to further improve health outcomes in Southend-on-Sea.

Educational Achievements

Early Years
Percentage of pupils achieving a good level of development:

Southend-on-Sea	73.9%
England (all schools)	71.5%

Key Stage 2 (Primary School – Year 6)
Percentage of pupils meeting expected standard:

Southend-on-Sea	69%
England (State funded)	64%
England (all schools	64%
Reading	Average
Writing	Above average
Maths	Above average

Key Stage 4 (Secondary School – Year 11)
Grade 5 or above in English/Maths GCSE

Southend-on-Sea	55.1%
England (State funded)	43.0%
England (all schools)	39.9%

A Level Performance
Achieving AAB or higher in 2 subjects

Southend-on-Sea	22.8%
England (State funded)	14.3%
England (all schools)	17.0%

There is strong evidence that the first few years of life build the foundations for future health and wellbeing. Every child deserves the best possible start in life and support to fulfil their potential. Ofsted rated 99% of the local provision as Good or Outstanding. Nearly a 1,000 working families with 3-4 year olds are accessing extended 30 hour entitlement, this and Tax Free Childcare is a platform to help lift children out of poverty.

We should be proud of the level of educational attainment in Southend-on-sea and work to create more local training and job opportunities to retain local talent and prosper.

Health Protection

Vaccination is one of our key prevention interventions to keep the population safe and well from unpleasant and dangerous communicable diseases.

Childhood vaccinations and immunisations

Uptake of the first dose of MMR is lower than the national average but higher for the second dose. We are working across the region to better identify children with incomplete vaccination history to support GPs in providing catch up vaccination.

1 year old
93.6% received Diptheria, Tetanus, Polio, Pertussis, & Hib in 2017/18.
Similar to the target (95%) and **similar** to England (93.1%).

1-5 years old
94.9% received Dtap/IPV/Hib 1st visit in 2017/18.
Similar to the target (95%) and **similar** to England (95.1%).

89.4% received MMR in 2017/18.
Lower than the target (95%) and **lower** than England (91.2%)

5 years old
94.1% received Hib/Men C booster in 2017/18.
Similar to the target (95%) but **higher** than England (92.4%)

89.6% received both doses of MMR in 2017/18
Lower than the target (95%) but **higher** than England (87.2%)

Flu vaccination coverage

Flu vaccination coverage for Southend-on-Sea has seen a general slight declining trend since 2011. Uptake for all groups is lower than the regional and national average with the exception of primary school children. Improving flu vaccine uptake is a key priority in Southend's Prevention Strategy action plan for 2019/20. Plans are being developed to link in flu vaccine provision with other interventions for key risk groups such as the NHS Health Check programme to maximise opportunity for uptake.

Sep 2018 to Feb 2019	Target	Southend	East	England
65+	75%	64.3%	71.1%	72.0%
Under 65 at risk	55%	40.5%	46.2%	48.0%
Pregnant	55%	40.1%	44.1%	45.2%
Age 2 not at risk	50%	43.0%	51.1%	43.6%
Age 2 at risk	50%	46.0%	60.1%	54.5%
Primary school*	65%	63.5%	60.5%	60.5%

* Data for primary school children is from September 2018 to January 2019

Mental health

The estimated proportion of Southend-on-Sea's adult population with a common mental health disorder is 16.8%. This is **higher** than both the regional and national average. A number of factors contribute to poor mental health and wellbeing which has been further compounded by life pressures following years of austerity.

	Southend	East England	England
Estimated prevalence of mental ill health in children aged 5-16	**9.1%**	8.8%	9.2%
GP recorded incidence/prevalence of depression	**1.6%** **10.1%**	1.4% 9.4%	1.6% 9.9%
Prevalence of depression and anxiety	**15.1%**	12.5%	13.7%
Depression and anxiety among social care users	**52.2%**	53.7%	54.5%
% of respondents to GP patient survey Long term mental health problems	**6.4%**	5.2%	5.7%
New cases of psychosis (rate per 100,000 population)	**21.2**	19.9	24.2
Severe mental illness GP recorded prevalence	**1.24%**	0.85%	0.94%
ESA claimants for mental and behavioural disorders (rate per 100k)	**34.6**	22.5	27.5

Perinatal mental health

Based on the national prevalence of between 10%-20%, we anticipate that Southend may have in the region of 200 to 400 new mothers per year who may be impacted by perinatal mental health issues.

A parent's ability to bond with and care for their baby, their parenting style and the development of a positive relationship can predict a number of physical, social, emotional and cognitive outcomes through to adulthood.

Through A Better Start Southend (ABSS) programme, we have developed a number of innovative interventions, co-designed with community champions and professionals, to help prevent, minimise and alleviate the consequences arising from perinatal mental health issues.

Cardiovascular Conditions and Diabetes

Epidemiology and risk factors

Cardiovascular disease (CVD) is a term that describes a family of diseases including heart disease and stroke and also relates to other conditions such as vascular dementia, chronic kidney disease, Type 2 diabetes, sudden cardiac death and heart failure. As reported in the previous sections, there is more we can do to prevent CVD as well as improving the local management of these conditions to minimise the poor associated health outcomes and disabling consequences.

Epidemiology of CVD and Diabetes Mellitus

U75 mortality rate from all CVD (2015/17)
71.5 / 100,000, similar to England

U75 mortality rate from preventable CVD (2015/17)
40.9 / 100,000, similar to England

CHD QOF prevalence (2017/18)
3.2%, similar to England

Stroke QOF prevalence (2017/18)
1.8%, similar to England

Diabetes QOF prevalence – recorded (2017/18)
6.7%, similar to England

Diabetes – Estimated prevalence (diagnosed & undiagnosed) (2015)
8.8%

Diabetes- Estimated diagnosis rate
75.3%, %, similar to England

Clinical risk factors for CVD events

Atrial fibrillation (irregular heartbeat) significantly increases the risk of stroke. Hypertension similarly raises the risk of stroke along with CHD and diabetes.

Atrial Fibrillation QOF prevalence (2017/18)
1.9%, similar to England

Estimated we have diagnosed only 61% of AF cases (below national average)

Hypertension QOF prevalence (2017/18)
15.2%, higher than England

Behavioural risk factors

Current 18+ smokers (2017), from ONS Annual Population Survey
58.4%, worse than to England
In the period 2011-2017, this has been in the range 17.2% - 21.8%

Smoking prevalence QOF estimate (2017)
19.1%, worse than England

Smoking prevalence at 15 (2014/15)
9.9%, similar to England

Proportion of the population meeting recommended '5-a-day' (2016/17)
58.4%, similar to England

Overweight or obese adults (2016/17)
58.5%, similar to England

Child excess weight at 4-5 yr old (2017/18)
22.7%, similar to England

Child excess weight at 10-11 yr old (2017/18)
32.5%, similar to England

Percentage of physically inactive adults (2016/17)
24.1%, similar to England

Prevention planning

Local STP Priorities

The STP has agreed some shared priorities across South and Mid Essex:

- Stroke (Atrial Fibrillation)
- Diabetes
- Mental Health and Wellbeing
- Respiratory Illnesses

Working through the Localities development, we will accelerate our focus on key prevention work against these four priorities through the ongoing establishment of the STP's Primary Care Networks across Southend and neighbouring districts.

Prevention interventions in Southend

There are known key behavioural risk factors shared for CVD and diabetes: smoking, inactivity, poor diet, excess alcohol consumption.

These behavioural factors increase the risk of high blood pressure (hypertension) and overweight/obesity which in turn increase the risk of CVD and Type 2 diabetes.

The new Wellbeing Service brings a new approach to supporting the population in addressing these risk factors. This will include working with the local population and local groups and providers to develop more sustainable preventative interventions which helps identify individual barriers and promote self-help and self-care.

The NHS Health Checks programme for people aged 40-74 years, without long term conditions can identify behavioural and clinical risk factors and provides an opportunity to support people better in improving their lifestyle. The additional good practice being introduced through the development of a social prescribing scheme (see next sub-section), will support this approach as part of a revamp of the Wellbeing service.

New approaches being developed with lead GP practices across Southend to improve detection and treatment of atrial fibrillation and hypertension are also being explored.

Further interventions are planned across Southend to increase the uptake for the flu immunisation across all risk groups as people aged 65 years and over.

Social prescribing

Social prescribing has been defined as a way of: 'Enabling healthcare professionals to refer patients to a link worker (or similar), to co-design a non-clinical social prescription to improve their health and wellbeing' (National Social Prescribing Network, 2016).

Social prescribing supports the individual, families, local and national government, and the private, voluntary and community sectors to work in collaboration. When done well, it can offer many people an individualised and flexible offer of support to self-manage a personal situation at a pace that is appropriate to the person.

Social prescribing usually includes a range of voluntary activity, being and socialising with others, often an element of learning and physical activity and recognition of the local environment. It can influence a wide range of factors including employment, housing, debt, social networks and culture.

The new Southend-on-Sea Wellbeing Service will develop from June 2019, in conjunction with a wide range of partner organisations, the local approach and model to social prescribing to support individuals, families and the wider community to improve their health and wellbeing.

Community Safety and Resilience

Violence, Criminality and Young People

My focus in this section is on a number of key issues that are negatively impacting on the lives of the children and young people in Southend-on-sea.

What are county lines?

County lines are a very serious issue where criminal gangs develop drug dealing operations outside of their usual operating area. This commonly involves gangs based in large cities distributing and dealing heroin, cocaine, and other drugs to smaller towns. Gangs recruit children and young people to move drugs, money, and weapons for them. Gangs frequently target vulnerable children for these tasks. They also target vulnerable adults to take over their homes to use as a base for manufacturing and selling drugs. This is known as cuckooing.

County lines in Southend

As at March 2019, there were **26 active county lines gangs in Southend-on-Sea**.
These gangs are working out of London using the train routes out of Fenchurch Street and Liverpool Street to traffic drugs into the Borough.

Once the drugs arrive in Southend, the gangs use local runners to deal the drugs.

Between September 2018 and February 2019, there were **2,345 reliable Police Intelligence Reports (PIRs)** concerning gangs, county lines, and drugs in Southend. This equates to between **300 and 400 per month**.

Interventions across Southend

Prevention interventions can include a wide range of approaches which can complement each other from a universal approach to selective approach (vulnerable groups) and indicative approach (high risk groups), with specific intelligence-led multi-agency operations.

Tackling harmful behaviours strategy

Southend-on-Sea Borough Council published its Tackling Harmful Behaviours Strategy in 2019. This strategy encompasses direction for prevention interventions across areas such as smoking and tobacco control, gambling, and substance misuse. This collective approach, not only helps to improve health outcomes, but supports impacting positively on psycho-social drivers of criminal behaviour.

The key approaches noted for reducing demand for recreational drugs in the borough are:

- Developing and rolling out quality standards for schools' PHSE education (using a resilience-based model)
- Delivering training and awareness campaigns to children and adults in Southend about harmful behaviours which enable them to make informed decisions
- Supporting the roll out of education and training for children and parents about gangs, drugs and exploitation

Knife crime

The vast majority of young people in nationally are not involved knife-crime but those carrying knives in Southend need to be identified and supported through targeted interventions due to the risk and harm to themselves and others.

In a response to ongoing concern regarding knife crime, Essex Police launched a campaign in 2017 to highlight the consequences and impacts of carrying knives. Knives can be disposed of in designated knife boxes and in Southend this can be found outside of Southend Police Station, Victoria Avenue, Southend.

Child Sexual Exploitation

There are 78 children in Southend that have been supported for risk of exploitation.

Child sexual exploitation (CSE) is a form of child sexual abuse. It occurs where an individual or group takes advantage of an imbalance of power to coerce, manipulate or deceive a child or young person under the age of 18 into sexual activity. The average age of victims of CSE is 15 but there is a growing cohort of younger children identified (10 -14 years).

It is recognised that there is significant under reporting of the issue which is felt to be due to issues of shame, perceived or actual threats to the young person or their family, or to the young person's failure to recognise that they are being exploited.

It is difficult to find reliable data regarding the prevalence of CSE. The National Society of Prevention of Cruelty to Children (NSPCC) estimate the numbers to be 5-16% of children under 16yrs.

Criminal exploitation

What is fuelling county lines is a local drug taking culture in Southend. Using national statistics this equates to around 9,000 people in Southend using drugs.

In 2016, 24% of children reported having ever taken a drug nationally. Locally this equates to around 2,100 children in Southend.

County Lines as described, utilise child criminal exploitation (CCE) as gangs and use children and vulnerable people to move drugs and money. Criminal sexual exploitation is heavily linked to county line activity.

How is Southend doing?

In March 2018, Southend were involved in a targeted Joint Targeted Area Inspection (JTAI) focusing on child exploitation including sexual exploitation and gangs. Following this inspection Southend received a very positive outcome letter which stated that:-

> *"Partner agencies in Southend have a shared commitment to tackling risk to children and young people from sexual and criminal exploitation, gangs and going missing from home, care or school. Inspectors met with staff across the agencies, who are tenacious in their efforts to engage with, and make positive difference for, vulnerable children and young people".*
>
> *"Work in Southend to tackle child sexual and criminal exploitation, gangs and the risks arising from going missing from home, care or school is underpinned by strong working relationships and a shared commitment and drive for continuous improvement".*

A public health approach to violent crime involves utilising the perspectives, methods and skills of public health towards a partnership approach to tackle violent crime.

Prevention also occurs at different levels – these are called Primary (preventing crime in the first place), Secondary (preventing repeat offences and escalation from minor to serious crime) and Tertiary (reducing the harm to victims of violence) prevention. A public health approach to preventing violence would take account of these levels of prevention and focus particularly on tackling Adverse Childhood Experiences.

Local recommendations on how Southend can adopt a public health approach to violence prevention include:

- Strengthen the education in schools and wider prevention activities;
- Analyse data from community safety, health and police using health intelligence skills from a public health perspective;
- Adopt a "Health in All Policies" approach that includes violence & vulnerability prevention as a public health initiative;
- Increase the number of families accessing all Southend children's services, allowing for early identification of risk or exposure to Adverse Childhood Experiences with appropriate referrals to services to support the child and the family.

Teenage conceptions & Support

Under 18 conceptions and abortions

Local Conception rate for 15-17 year olds (2017 ONS Data)	**24.3 / 1000** (England 17.8)
Local Under 18 conceptions leading to abortion (2017 ONS Data)	**45.7%** (England 52%)
% of abortions provided to 15-17yr olds Southend CCG residents in a NHS Hospital only (April 2018-February 2019 local data)	**8%**
% of birth activity, babies born to 15 -17yr olds Southend CCG residents in an NHS Hospital only (April 2018-February 2019 local data)	**1.2%**

Emergency Contraception

Emergency contraception, to prevent pregnancy after unprotected sex, is available free of charge to young people at Southend-on-Sea's sexual health services.

School Nursing Service

The local School Nursing Service provides young people with non-judgemental advice about sexual health and health education aimed at reducing under 18 conception rates.

Relationships and Sex Education (RSE)

RSE is learning about the emotional, social and physical aspects of growing up, relationships, sex, human sexuality and sexual health. The established Enhanced Healthy School Project supports Schools with Relationships and Sex Education.

Local Schools were offered an age-appropriate comprehensive RSE package, since 2015 (2019 local data)	**100%**
Primary School uptake (2019 local data)	**80%**
Secondary School uptake (2019 local data)	**50%**

22 Southend-on-Sea Schools engaged in the Emotional Health and Wellbeing Enhanced Healthy School Project.

128 Teenage Mothers, age 17 and under supported on the Health Visiting Service caseload.
(April 2018-March 2019 SystmOne local data)

63 The Family Nurse Partnership service offers support to teenage parents and expectant parents and those young people who decline this offer, receive an individualised care plan from Health Visiting based on health needs.

43 Teenage Mothers accessing the Teenage Pregnancy Service for a range of support including education, employment or training information, benefit advice and support including Care To Learn, housing advice and support in accessing online applications, signposting or referral onto other relevant services.

We need to explore the key triggers for teenage conceptions in Southend given that our teenage pregnancy rate are comparative still much higher. As highlighted in the report some key new interventions have already been instigation with a new sexual health service, proposed new RSE support for schools and more after-school 'clubs' will also need to be explored with young people.

Infrastructure planning

Local planning, Housing and Health & Wellbeing

Local Plan Development (2021-2036)

Modern town planning principles emerged from decades of poor-housing quality, deprivation and associated health and wellbeing issues. Planners have an important role in tackling public health issues[6] – from making communities safer, more attractive, creating open and green spaces and locating housing close to existing local amenities and more readily accessible via active travel.

The development of a new Local Plan[7] is a real opportunity for public health and planning to work together in generating more health-enhancing environments where the healthier choice is the easier choice. The planning process is an important lever to shape the natural and built environment, reimagining our high streets and the town centre, which can all contribute to positive health outcomes[8]. We should continue to develop and embrace our coastal assets which are much loved by locals as well as millions of visitors.

The Council is working to adopt the Active Design[9] principles published in 2015 and aligning the approach with our neighbouring councils – Association of South Essex Local Authorities (ASELA) Partnership (*see map on page 22*). The provision of strong infrastructure connections and continued investment into the transport network is regarded as essential for supporting economic development and employment activities across South Essex.

Public realms improvements, like green-pedestrian zoning, outdoor seating with refreshment facilities and safe outdoor activities increase footfall for retailers, create economic and wellbeing vibrancy.

We will continue to explore opportunities to grow Southend as a digital city and work with the STP to innovate around digitally enhanced care and ensure that local residents can benefit from the accelerated introduction of the latest proven healthcare technologies, which can transform health outcomes through earlier diagnosis, more effective treatments, and care services which are provided in the home and in the community, rather than in hospitals.

The lack of safe, locally affordable housing in the borough means that at present low income households spending a disproportionate amount of their income on rent who may benefit from affordable housing do not qualify for inclusion on the council's housing register, as the borough's limited supply of social housing is reserved for those with even greater housing needs. Our new strategy[10] will help deliver our rehousing strategy for people who require the right environment to live safely, especially in discharging our prevention duty in reducing homelessness. It is also vital that system leaders should collaborate to improve the physical and mental health of people who become homeless or consider themselves to be rough sleepers.

[6]https://www.housinglin.org.uk/_assets/Resources/Housing/OtherOrganisation/TCPA_Public_Health_in_Planning_Good_Practice_Guide.pdf

[7]https://localplan.southend.gov.uk/sites/localplan.southend/files/2019-02/Southend%20New%20Local%20Plan.pdf

[8] https://www.gov.uk/government/publications/spatial-planning-for-health-evidence-review

[9] https://www.sportengland.org/facilities-planning/active-design/

[10]https://www.southend.gov.uk/downloads/file/6156/housing_homelessness_and_rough_sleeping_strategy

Opportunities

Challenges

MAP - Association of South Essex Local Authorities (ASELA) Partnership

Air quality

Air pollution increases the risk of respiratory illnesses, heart disease and lung cancer. There is growing evidence that outdoor pollutants are causing an increase in lung cancer and further exacerbating respiratory functions[11]. The biggest locally-controllable source of PM2.5 air pollution is **domestic wood burning**. This is exacerbated by use of low-standard wood burners and non-seasoned wood. **Car pollution and domestic wood burning** make up 35% of risk locally in regards to Nitrogen Dioxide pollution.

The Council's Low Carbon Energy and Sustainability Strategy focuses on delivering low carbon growth, improving energy efficiency and providing for a more sustainable future with the aim of establishing Southend as a Low Carbon Smart City.

Sources of background Southend air pollution

Nitrogen dioxide (NO2)
Toxic molecule produced when fuel is burned

- External 37%
- Traffic 25%
- Shipping 23%
- Domestic 10%
- Industry 5%
- Aircraft <1%

Particulate matter (PM2.5)
Catch-all term for particles small enough to enter the lungs – from a wider range of sources

- External & secondary 77%
- Domestic 15%
- Traffic 3%
- Shipping 2%
- Industry 2%

[11] https://journals.sagepub.com/doi/abs/10.1177/0141076819843654?journalCode=jrsb&

Local assets

Link to the Community Assets map[12]

Sports facilities open to the public, and those schools offering some public access[13]

14 Gyms, studios and fitness suites.
91% of our residents live within 1 mile of one of these facilities

8 swimming pools
66% of our residents live within 1 mile of one of these facilities

36 pitches
All of our residents live within 1 mile of one of these facilities

12 sites offering courts for non-racquet sports
(e.g. volleyball, netball)
80% of our residents live within 1 mile of one of these facilities

12 sites offering courts for racquet sports (e.g. tennis)
99% of our residents live within 1 mile of one of these facilities

3 Golf courses or driving ranges
40% of our residents live within 1 mile of one of these facilities

2 athletics tracks
28% of our residents live within 1 mile of one of these facilities

Source: Sport England Active Places facility data, 10th January 2019

Percentage of the residents of the stated area who are within 1 mile of each type of facility

Area type	Area name	Athletics tracks	Golf	Gyms	Courts: non-racquet sports	Pitches	Courts: racquet sports	Swimming pools
Locality	East	18%	59%	97%	97%	100%	97%	92%
Locality	East Central	47%	47%	100%	63%	100%	100%	70%
Locality	West	32%	65%	64%	90%	100%	100%	84%
Locality	West Central	23%	10%	98%	74%	100%	100%	36%

Less than 50%	
Between 50% and 75%	
Greater than 75%	

There is growing evidence of the links between good spatial planning, design principles and the health impacts on key health challenges such as obesity, mental health, physical inactivity, the needs of an ageing population and how to promote healthy, sustainable communities and improving local access to good amenities in enabling good health and wellbeing[14]. The five aspects of the built and natural environment that have been identified as the main characteristics that can be influenced by local planning policy are: (a) neighbourhood design (b) housing (c) healthier food (d) natural and sustainable environment and (e) transport[8] – these have been reflected in our Southend 2050 Outcome Development Plans.

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[12] http://southend.maps.arcgis.com/apps/webappviewer/index.html?id=052d7b43ff074d77b52ef976e37b0d6b

[13] Source: Sport England Active Places facility data, 10th January 2019

[14] https://publichealthmatters.blog.gov.uk/2017/07/06/improving-peoples-health-through-spatial-planning/

Active travel – changing mind sets

Benefits of Active Travel

- Increase opportunities for physical activity in daily routine
- Reduce vehicle congestion, air pollution, noise, accident risk
- Reduce costs and parking needs for individuals
- Tackle health inequalities – air quality poorest in our poorer neighbourhoods

Current infrastructure

The *ForwardMotion* initiative across SE Essex supports and encourages sustainable, active travel through:

- Personal travel planning
- Information and guidance on safe cycle routes and rail and bus connections
- Links to cycle training and cycle buddying
- Support for business on training, storage, and maintenance

Cycle paths and maps are available in specific parts of the Borough.

Simply Stride supports health positive walking for individuals and groups.

Future infrastructure

There are multiple aspirational outcomes from the Southend 2050 Vision which can be contributed to by supporting active travel. Key proposed actions include:

- Integrated travel hubs for multi-modal journeys
- Expanded air quality monitoring
- Live travel data available
- More options for bicycle and e-bicycle hire
- Support for school travel planning
- Improved public cycle facilities and support for cycling facilities in private buildings

The 2016/17 Sports England Active Lives survey found that 3% of adults in Southend cycle for travel on at least three days a week. This is **similar** to the England average.
Source: PHE Fingertips

The same Sports England survey found that 23.6% of adults in Southend walk for travel on at least three days a week, down from 28.7% in the previous year. This is **similar** to the England average.
Source: PHE Fingertips

Recommendations

In summary, this report should espouse to our collectivism and partnering approach. We can use the Southend 2050 Outcome Delivery Plans as a backdrop for delivery as these readily dovetail with the local STP priorities – [a] Stroke and Diabetes, [b] Self Care and Prevention, [c] Childhood Mental Health and Wellbeing, [d] Digitally enabled care alongside the Health and Wellbeing Board priorities – [e] Obesity and Physical Activity, [f] Teenage Conception and the wider development of the Localities integrated public sector service delivery as well as the Community Safety Partnership's priority in tackling violence and vulnerabilities, and reducing harmful behaviours related to substance and tobacco misuse and gambling.

Therefore my recommendations are that we focus on the following during 2019-20 and build consensus and momentum:

[1] Reducing the impact of cardiovascular conditions and diabetes and improving related prevention work:

R1.1 Develop an agreed locality approach to improve earlier identification of Stroke and Diabetes, ensuring reduced variability in access to primary care services;

R1.2 Improve the management of patients at risk of stroke and those afflicted with diabetes, including the use of digital technology as appropriate, and delivery of the Diabetes Strategy;

R1.3 Increase referral to the new Wellbeing Service to reduce and/or better manage lifestyle risk factors and implement the Harm Reduction Strategy as a key enabler.

[2] Improving community safety and building resilience, with a particular focus on our children and young people:

R2.1 Develop a programme of work that will provide for, and link into, a range diversionary activities and avenues for vocational development. This will include local apprenticeships to make young people safer, provide skill development and job opportunities and to have a healthier outlook on their lives;

R2.2 Build on the work already in progress across Greater Essex and regionally, to reinvigorate the local partnerships (Community Safety and Violence and Vulnerability groups) to disrupt the local drug market and to eliminate the criminal exploitation of young people and vulnerable adults in our communities;

R2.3 Undertake a deep-dive on local teenage conceptions to understand local determinants and triggers, including the link with child sexual exploitation, local opportunities for young people to promote a delaying approach to parenthood.

[3] Ensuring that spatial planning incorporates health and wellbeing impacts, and delivers what residents will need to promote their health and wellbeing:

R3.1 Adopt new evidence on spatial planning, including the adoption of the PHE/Sports England's Active Design principles, making it a requirement on developers to undertake a Health Impact Assessment where most relevant and review the barriers inhibiting local access to our physical assets;

R3.2 Our housing renewal policy must take into consideration the need for more affordable housing which espouses a mix of social housing, adaptable homes which will ensure that the adverse health effects are mitigated, promote local ownership and more affordable rent, and support the drive to increase prosperity;

R3.3 Accelerate our local undertakings in improving local transportation to further reduce the risk of pollution and traffic congestion, and promote active travel.

Appendices

A: Southend 2050

There is a tangible sense of pride in the place and local people are actively, and knowledgably talking up Southend.
The variety and quality of our outstanding cultural and leisure offer has increased and we have become the first choice English coastal destination for visitors.
We have invested in protecting and nurturing our coastline, which continues to be our much loved and best used asset.
Our streets and public spaces are clean and inviting.

People in all parts of the borough feel safe and secure at all times.
Southenders are remaining well enough to enjoy fulfilling lives, throughout their lives.
We are well on our way to ensuring that everyone has a home that meets their needs.
We are all effective at protecting and improving the quality of life for the most vulnerable in our community.
We act as a Green City with outstanding examples of energy efficient and carbon neutral buildings , streets, transport, and recycling.

Even more Southenders agree that people from different backgrounds are valued and get on well together.
The benefits of community connection are evident as more people come together to help, support and spend time with each other.
Public services are routinely designed, and sometimes delivered, with their users to best meet their needs.
A range of initiatives help communities come together to enhance their neighbourhood and environment.
More people have active lifestyles and there are significantly fewer people who do not engage in any physical activity.

The local plan is setting an exciting planning framework for the Borough.
We have a fast-evolving, re-imagined and thriving town centre, with an inviting mix of shops, homes, culture and leisure opportunities.
Our children are school and life ready and our workforce is skilled and job ready.
Key regeneration schemes, such as Queensway, seafront developments and the Airport Business Park are underway and bringing prosperity and job opportunities to the Borough.
Southend is a place that is renowned for its creative industries , where new businesses thrive and where established employers and others invest for the long term.

It is easier for residents, visitors and people who work here to get around the borough.
People have a wide choice of transport options.
We are leading the way in making public and private travel smart, clean and green.
Southend is a leading digital city with world class infrastructure.

B: Detailed Ethnicity

	Southend (%)	East of England Region(%)	England (%)
White	**91.6%**	**90.8%**	**85.4%**
English/Welsh/Scottish/Northern Irish/British	87.0%	85.3%	79.8%
Irish	0.9%	1.0%	1.0%
Gypsy or Irish Traveller	0.1%	0.1%	0.1%
Other White	3.6%	4.5%	4.6%
Mixed/multiple ethnic groups	**2.1%**	**1.9%**	**2.3%**
White and Black Caribbean	0.6%	0.6%	0.8%
White and Black African	0.4%	0.3%	0.3%
White and Asian	0.6%	0.6%	0.6%
Other Mixed	0.5%	0.5%	0.5%
Asian/Asian British	**3.7%**	**4.8%**	**7.8%**
Indian	1.0%	1.5%	2.6%
Pakistani	0.6%	1.1%	2.1%
Bangladeshi	0.5%	0.6%	0.8%
Chinese	0.6%	0.6%	0.7%
Other Asian	0.9%	1.0%	1.5%
Black/African/Caribbean/Black British	**2.1%**	**2.0%**	**3.5%**
African	1.6%	1.2%	1.8%
Caribbean	0.3%	0.6%	1.1%
Other Black	0.2%	0.2%	0.5%
Other ethnic group	**0.5%**	**0.5%**	**1.0%**
Arab	0.2%	0.2%	0.4%
Any other ethnic group	0.3%	0.3%	0.6%

Source: ONS, 2011 Census

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Annual PH Report 2018-19 - Key Recommendations' Implementation Plan

Recommendations	Progress
[1] Reducing the impact of cardiovascular conditions and diabetes and improving related prevention work:	
R1.1 Develop an agreed locality approach to improve earlier identification of Stroke and Diabetes, ensuring reduced variability in access to primary care services;	Engagement with Primary Care Networks (**PCNs**) during Sept to agree approach. Local delivery of National Diabetes Prevention Programme (Healthier You) awarded on 1st April.
R1.2 Improve the management of patients at risk of stroke and those afflicted with diabetes, including the use of digital technology as appropriate, and delivery of the Diabetes Strategy;	*Local steering group reviewing interventions.*
R1.3 Increase referral to the new Wellbeing Service to reduce and/or better manage lifestyle risk factors and implement the Harm Reduction Strategy (**HRS**) as a key enabler.	New Welbeing Service in place on 1st June; a wider offer for the Exercise Referral scheme is being developed following engagement with the PCNs to include swimming and lower impact activities; We are developing a shared approach with the Social Prescribing service which is key to its successful implementation. The HRS Implementation Plan is in place.
[2] Improving community safety and building resilience, with a particular focus on our children and young people:	
R2.1 Develop a programme of work that will provide for, and link into, a range diversionary activities and avenues for vocational development. This will include local apprenticeships to make young people safer, provide skill development and job opportunities and to have a healthier outlook on their lives;	*tba*
R2.2 Build on the work already in progress across Greater Essex and regionally, to reinvigorate the local partnerships (Community Safety and Violence and Vulnerability groups) to disrupt the local drug market and to eliminate the criminal exploitation of young people and vulnerable adults in our communities;	An extensive drug market data mapping is being undertaken across SET

R2.3 Undertake a deep-dive on local teenage conceptions to understand local determinants and triggers, including the link with child sexual exploitation, local opportunities for young people to promote a delaying approach to parenthood.	This review is under way with the first highlights being shared at the HWB Board in Sept 2019. The final report with recommendations will be brought to the Dec 2019 HWB Board.
[3] Ensuring that spatial planning incorporates health and wellbeing impacts, and delivers what residents will need to promote their health and wellbeing:	
R3.1 Adopt new evidence on spatial planning, including the adoption of the PHE/Sports England's Active Design principles, making it a requirement on developers to undertake a Health Impact Assessment where most relevant and review the barriers inhibiting local access to our physical assets;	*tbc*
R3.2 Our housing renewal policy must take into consideration the need for more affordable housing which espouses a mix of social housing, adaptable homes which will ensure that the adverse health effects are mitigated, promote local ownership and more affordable rent, and support the drive to increase prosperity;	*tbc*
R3.3 Accelerate our local undertakings in improving local transportation to further reduce the risk of pollution and traffic congestion, and promote active travel.	A number of proposals are being developed under the Southend 2050 banner, to align to existing schemes across the local partnership.