Appendix A - Draft Health and Wellbeing Strategy for early stakeholder consultation

Introduction

Developing the draft Health and Wellbeing Strategy

There is a statutory duty on local Health and Wellbeing Boards to produce a strategy for the Health and Wellbeing of their populations. The strategy should inform work that is done to improve health and wellbeing in local areas.

Portsmouth's previous strategy (2014-2017) is wide-ranging and provided a comprehensive overview of health and wellbeing matters in the city. In refreshing this for 2018-2021, we are focusing on the relationships to other work in the city, and on the areas of work that will have the highest impact in the context of the wider system.

We have sought to identify priorities based on the strong evidence we have about the city and the huge range of stakeholder information and feedback that members of the Board have access to. We remain committed to the reduction of health inequalities, by improving outcomes for those in the worst position fastest. We recognise that inequalities can be identified according to where people live, and that this is particularly true in some areas where there are high levels of deprivation and need; but there are also inequalities between genders, ethnicities, ages and abilities that we need to tackle.

In developing the draft, we have taken account of:

- the most up to date evidence of what is happening around health and wellbeing outcomes in Portsmouth, as summarised in our Joint Strategic Needs Assessment
- an assessment of our progress against the previous strategy
- latest relevant national guidance, strategies and plans
- local strategies and plans
- insight from local residents and communities

The strategy will be a critical piece of documentation for:

- Underpinning commissioning decisions: setting a framework for commissioning plans across the NHS, local authority and other agencies in the city
- Influencing decisions: providing a source of evidence and direction for policy and decision making in a wide range of areas across the city, such as development, community safety and education.
- Holding leaders of organisations across the city to account for improving outcomes: the strategy will be reviewed each year and provide a basis for conversations about where we are improving outcomes, and where more needs to be done.

We are consulting on our draft strategy, and the responses to this will be used to shape the final document. We will consult in detail with lead agencies and partnerships to ensure that the work

programmes proposed in the strategy are complementary to programmes already underway, and consider where the Health and Wellbeing Board can add additional value to those programmes.

For example, Portsmouth's Children's Trust Board will take the lead on issues relating to education and supporting families at the earliest point. Similarly, the Safer Portsmouth Partnership will lead on issues relating to violent crime. However, there are some issues with a very specific health and care emphasis, such as dealing with alcohol and substance misuse, or supporting people with special educational need and disability and we are proposing to reflect those in the Health and Wellbeing Strategy.

However, identifying where the biggest impact can be made by the Health and Wellbeing Board is the key element of this first stage consultation.

Critically, we want to know:

1. *Have we identified the right priorities and issues*
2. *How do you think the Health and Wellbeing Board can add value and bring about positive change?*
3. *What do you think will tell us if we are making an impact.*

Portsmouth - in a nutshell and the case for change

Portsmouth is a great waterfront city, home to over 200,000 people, with all the diversity, opportunities and challenges that come with that.

The city has great assets and potential. We have an extraordinary natural environment, world-leading status in industries including marine technology, aerospace and defence, and a vibrant cultural sector. Our university is thriving and respected and we have plans for regeneration of the city, including the development of thousands of homes on the Tipner site to the west of the city.

Despite this, the most recent summary of the Joint Strategic Needs assessment for the city showed that life expectancy in the city is lower than the national averages for both men and women. Main areas of concern for Portsmouth, when considering health and wellbeing data, are educational achievement at 16, high levels of recorded violence against the person, premature mortality from cancer, high levels of death from drug misuse and deaths from suicide.

We believe that if the city is to unlock its potential, we need to tackle these issues - and other areas where Portsmouth may be making improvements but is still in a poor position relative to other areas of the country, such as smoking prevalence and smoking-related deaths, and premature mortality from heart disease and stroke. We know that outcomes in health are more than about managing health problems and that the wider determinants of health are critical:

Source: Dahlgren and Whitehead, 1991
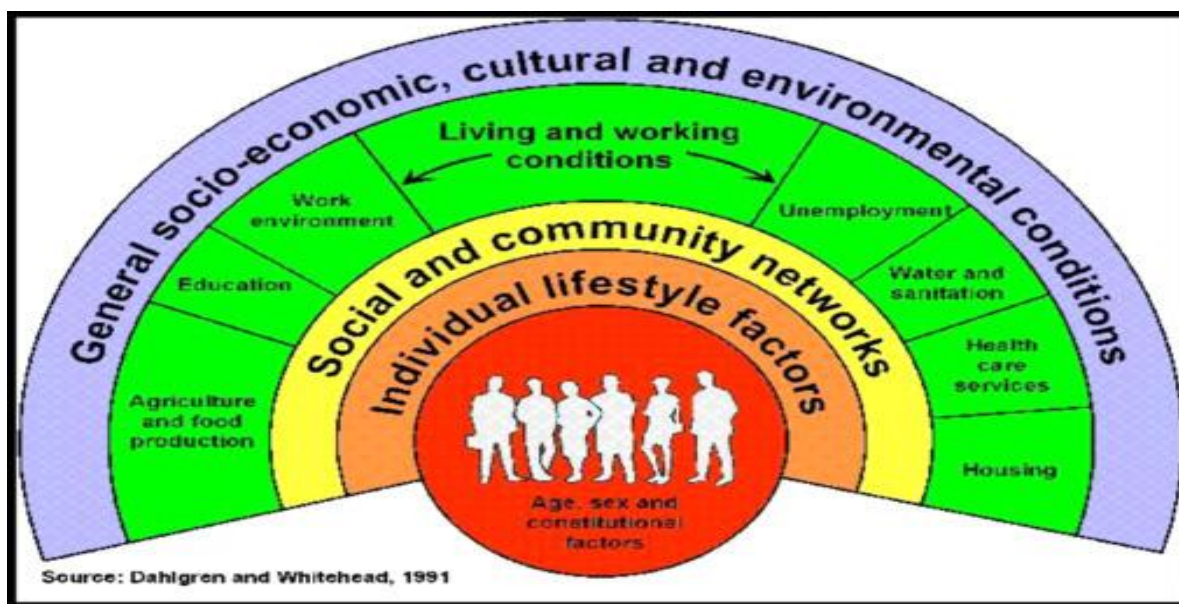
Put simply, people who have good quality and secure jobs and housing in the areas communities where they have families and social networks stay healthier, feel happier and live longer. In order for them to secure work, homes and relationships, they need a good start in life, support when they have problems, and care when they need it. When these conditions exist, areas are attractive to investors and visitors, creating more opportunities for residents, and more resources that can be directed to support the most vulnerable.

The case for improving health and wellbeing in Portsmouth is clear - unlocking the potential of the city and securing the prosperity it can generate depends on it.

Our vision and approach

We want to improve healthy life expectancy in the city; and reduce inequality by improving the areas with the lowest expectancy fastest.

We will do this by working to principles around:

- Promoting prevention
- Supporting independence
- Intervening earlier

We know that we want to give people the best possible start in life, empower them to live healthy lives and enjoy a healthy older age. In order to do this we will:

- Empower people to take care of their physical health
- Empower people to take care of their social, emotional and mental health
- Work with marginalised groups to make improvements for them fastest

Our strategy on a page

Themes	Priority	Example action areas where the health and wellbeing board can add value
Improve healthy life expectancy in the city; and reduce inequality by improving the areas with the lowest expectancy fastest		
Support physical good health	Reduce the harms from tobacco	- Promoting smoke-free environments - Helping people to quit - Promoting e-cigarettes as a harm reduction product
	Reduce the harms from physical inactivity	- Promoting healthy environments and good quality public realm - Supporting active travel in the city - Working with school and community groups to increase options for physical activity - Creating options for people who are currently inactive
Support social, emotional and mental health	Reduce the harms from alcohol and other substance misuse	- Support the recovery community in the city - Reduce the availability of low-cost, high strength alcohol - Use licensing powers to promote the responsible and moderate use of alcohol
	Reduce the drivers of isolation and exclusion, including poverty	- Promote the creation of quality employment in the city, including promoting healthy workplaces - Promote access to good quality homes - Use a combination of planning and licensing powers to reduce the harms of problem gambling
Make improvements for marginalised groups fastest	People with complex needs	- Promote access to housing for vulnerable people, recognising that having stability is the first step in addressing substance misuse and helping people deal with poor mental health
	People in the armed forces community	- Support a full needs assessment for the Armed Forces community and inform actions in response to this
	People with SEND	- Maintain oversight of the strategy for Special Educational Needs and disabilities in the city
Improve access to health and social care support in the community	Implementation of the Portsmouth Blueprint for health and care	

Theme 1: Support good physical health

Lifestyles, particularly physical inactivity, unhealthy diets, drinking alcohol to excess, and smoking are challenges in Portsmouth, with a significant proportion of adults exhibiting more than one unhealthy behaviour, which adversely contributes to the health inequalities of those living in Portsmouth's more deprived areas, and affects the predicted poor long-term health of those currently of middle age (35 to 64 years) living anywhere in the city. There is also a real challenge that many of these behavioural issues in adults impact negatively on children from pregnancy onwards (eg smoking in pregnancy, offering unhealthy food, snacks and drinks, not taking children to dental and other health appointments).

Priority 1a: Reduce the harms from tobacco

Why is this a priority?

Smoking remains the main reason for the gap in life expectancy between rich and poor. The Local Tobacco Control Profiles show that compared to England, Portsmouth has significantly higher rates of:

Measure	Portsmouth	England
Prevalence of current smokers in 15 year olds, 2014/15	10.9%	8.2%
Prevalence of regular smokers in 15 year olds, 2014/15	8.2%	5.5%
Smoking prevalence in adults 2015	19.8%	16.9%
Pregnant women smoking at the time of delivery	14.7%	11.4%
Smoking attributable mortality 2012/14	333 deaths per 100,000 persons aged 35+ years	275 deaths per 100,000 persons aged 35+ years

The national Tobacco Control Plan for England states "…nicotine addiction for most people starts in adolescence. In England, almost two-thirds of current and ex-smokers say that they started smoking regularly before they were 18 years old…. Very few people start smoking for the first time after the age of 25" The local Health and Lifestyle Survey found that 49% of all current tobacco smokers started to smoke when they were younger than 16 years, 24% between 16 and 17 years of age and 20% between 18 and 24 years of age.

The most recent local 'You say' survey of secondary school pupils encouragingly found an increase in pupils who had never tried tobacco from 78% in 2015 to 85.7% in 2016.

The local Health and Lifestyle Survey of adults found the highest levels of adults smoking daily or occasionally in Central locality (21% compared to 16% in North and 11% in South localities). Those with the lowest levels of mental wellbeing were more likely to smoke tobacco than those with the highest levels of mental wellbeing (16% compared to 9%). Seventy-seven per cent of local smokers say they would like to stop smoking. Of those who had given up smoking, 71% said they gave up without any help or support.

The Tobacco Control Alliance has recently agreed 'Smoke-free Portsmouth: Tobacco Control Strategy 2016-2020'. This four-year strategy covers all aspects of smoking and tobacco control to improve the health and wellbeing of the people of Portsmouth by reducing inequalities and by nurturing a tobacco free generation. Creating a smokefree generation is a key priority for us and we will ensure that we focus on preventing young people from starting to smoke to help achieve this.

This will be achieved through a reduction in the prevalence of smoking consistent with national targets and by addressing the wider tobacco control agenda.

We aim to:
i. Reduce smoking prevalence in Portsmouth, both overall and in identified target groups
ii. Support local communities to create a tobacco-free culture for Portsmouth

The strategy focus on the three important areas of protection, prevention, and cessation; with our key priorities for achieving a Smoke-Free Portsmouth being to:
1. Promote smokefree environments across the city
2. Motivate and assist every smoker to stop
3. Deliver effective communications and campaigns around the tobacco agenda
4. Provide leadership to create a smokefree city
5. Develop a workforce confident and competent to help reduce the harms of smoking
6. Improve health outcomes and reduce smoking related inequalities targeting young people, pregnant women, adults in routine and manual occupations and adults with mental health disorders.

Smoking is a significant issue reflected in the Public Health Outcomes Framework, and therefore there is a great deal of data about prevalence and harms linked to smoking, including low-birth weight babies, respiratory diseases and attributable mortality.

Priority 1b: Reduce the harms from physical inactivity

Why is this a priority?

The list of benefits of regular and adequate levels of physical activity is huge; some of the main ones were highlighted by the World Health Organisation:
- improve muscular and cardiorespiratory fitness;
- improve bone and functional health;
- reduce the risk of hypertension, coronary heart disease, stroke, diabetes, breast and colon cancer and depression;
- reduce the risk of falls as well as hip or vertebral fractures; and
- fundamental to energy balance and weight control.

Being physically active improves the health of everyone, regardless of age, sex, ethnicity, disability, wealth or waist size. Physical activity is commonly linked with obesity and healthy weight and whilst activity is an essential component in maintaining a healthy weight it should be regarded as a health priority in itself. The health benefits of physical activity extend beyond weight loss and are just as important for those overweight, underweight or at the correct weight.

As measured by the Active Lives Survey 65.4% of the Portsmouth population are classed as active. This is in line with the national averages but below that of the region and Hampshire. 22.7% of Portsmouth residents achieve less than 30 minutes per week of moderate intensity activity.

Levels of physical activity in the city decline with age. The largest increases in inactivity take place from 55 years of age. People with a disability are far more likely to be inactive than those without, and people of Asian, Black and Chinese ethnicity are more likely to be inactive. Household income and social status also demonstrate a distinct difference in levels of physical activity. The residents of Drayton & Farlington, St Judes and Eastney & Craneswater (the most prosperous wards in the city) have the highest levels of activity. The wards of Charles Dickens, Nelson and Paulsgrove, and parts of Cosham, Fratton and St Thomas, have the highest levels of inactivity. These are the areas where we see highest levels of deprivation in the city.

A number of surveys exploring attitudes and trends in regards to the health, including physical activity, of the Portsmouth population have been conducted recently the key findings for physical activity are details below.

The overall aim is to ensure that everyone meets the recommendations for physical activity. However, targeting those who are the most inactive to become more active will produce the greatest reduction in chronic disease. This applies even when this new activity falls short of the CMO's guidelines.

Therefore, we will aim to:

1. **Create Active Environments**
   Engineering activity back into daily life through infrastructure, transport, housing, workplaces and open space. Influence how people live their lives and choose being active

2. **Enable Active starts**

   Creating positive attitudes and behaviour amongst all children and young people. Ensuring that positive habits are resilient into adulthood and through periods of change.

3. **Support Active Lives**

   Engage and empower individuals, families and communities to be active every day. Build a culture of activity throughout every corner of daily life.

4. **Practice Active Medicine**

   Valuing and utilising physical activity to prevent and treat health conditions. Activity is viewed as a key component for physical and mental health and wellbeing.

This is an area where there is strong data available about levels of activity undertaken in the city (often commissioned by outside agencies) and around areas that we know are linked to activity, including healthy weight data. Therefore, we will propose to track progress against the following indicators:

1. Increase physical activity levels amongst children and young people
2. Reduce the number of physically inactive adults
3. Retain levels of activity through the life course
4. Reduce inequalities of activity levels amongst females, people with a disability, some ethnic groups and people living in Portsmouth's most deprived communities

---

TELL US:

In relation to Theme 1:

Are these the right priorities? Have we identified the right challenges?

What are the opportunities for the Health and Wellbeing Board to add value in this area and bring about change?

How will we know if we are making change for the better? What would be the measures or indicators of success?

Theme 2: Support social, emotional and mental health

We know that Portsmouth has significantly higher rates of factors which are risks for mental ill health (eg relative deprivation, alcohol misuse and violent crime) but lower recorded rates than the national average of, for example, depression.

Priority 2a: Reduce the harms from alcohol and other substance misuse

Why is this a priority?

Digestive conditions, including chronic liver disease and cirrhosis, contribute to the comparatively shorter life expectancy of males and females in the most deprived compared to the least deprived areas of the city. Liver disease is affected by physical activity, diet, tobacco smoking and alcohol as well as by Hepatitis B and C viruses: it is a largely preventable disease.

The Liver Disease Profiles and the Local Alcohol Profiles for England show that Portsmouth has significantly higher rates than England across for:
• Claimants of benefits due to alcoholism, 2015
• People admitted to hospital for alcohol-specific conditions, 2014/15
• Admission episodes for males aged 40-64 years, 2014/15
• Admission episodes for mental and behavioural disorders due to use of alcohol condition (broad definition) for males and for females, 2014/15
• Admission episodes for mental and behavioural disorders due to use of alcohol condition (narrow definition) for males 2014/15
• Admission episodes for intentional self-poisoning by and, exposure to, alcohol condition for males and for females, 2014/15
• Alcohol-specific mortality for males and for females, 2012/14
• Alcohol-related mortality for males, 2014
• Mortality from chronic liver disease for males and for females, 2014
• Premature mortality rate from liver disease for males and for females, 2012-14
• Premature mortality rate from alcoholic liver disease for males, 2012-14

The local Health and Lifestyle Survey found that 33% of adults are drinking alcohol at levels that put them at 'increasing risk' of developing an alcohol use disorder, with a further 12% drinking at 'high risk' levels. People from lower socio-economic groups do not necessarily drink more alcohol than people from other groups, but they do suffer disproportionately from alcohol-related illness due to the adverse impact of other lifestyle and socio-economic factors (the 'alcohol harm paradox').

The survey also found the highest rates of negative impacts of drinking alcohol to excess were reported in Central locality. A significantly higher proportion of people aged 16-34 years are at 'increasing risk' of developing an alcohol use disorder (44%) compared to 35-64 year olds (30%) or 65+ years (20%). A significantly higher proportion of 35-64 year olds are at 'high risk' of developing an alcohol use disorder (18%) compared to 16-34 year olds (9%) and 65+ year olds (3%).

The use of alcohol or drugs is strongly associated with suicide in the general population and in sub-groups such as young men and people who self-harm.

Data around the use of alcohol and associated harms is a feature of the Public Health Outcomes Framework.

Priority 2b: Reduce the drivers of isolation and exclusion, including poverty

Why is this a priority?

Compared to England, the risk factors section of Public Health England's suicide profile illustrates that Portsmouth has lower rates of people with long-term health problems and of long-term unemployment, but has higher rates of people who are separated or divorced, people living alone, children who are looked after, children leaving care, children in the youth justice system and estimated prevalence of opiates or crack cocaine. Portsmouth also has a higher than national rates of mental health clients receiving services from adult social care, of adult carers who have as much social contact as they would like, and of clients receiving specialist alcohol and drug services. Isolation is also a recognised driver of mental ill health. Mapping from Age UK shows that the most deprived communities in the city also have the highest risk of loneliness in those aged 65 and over.

The Mental Health Alliance has agreed 11 pledges to improve mental health and will also identify and monitor outcome measures. One of the 11 pledges in the mental health strategy is to: "work to reduce the number of suicides in the city and provide support for those bereaved by suicide"

For overall deprivation, Portsmouth is now ranked 63rd worst of 326 local authorities (where one is the most deprived, previously ranked 76th worst of 326 local authorities). The Tackling Poverty Needs Assessment was refreshed in January 2015 in the light of the recession and changes in the welfare system. The needs assessment identifies the multiple factors which adversely and positively affect poverty including educational outcomes, employment and low-pay employment, financial exclusion and debt and the way services are organised to respond to people in crisis. Current priorities for the Action Plan include re-commissioning a social welfare advice service for Portsmouth (Advice Portsmouth's contract expires in March 2017); responding to welfare reform (including the introduction of Universal Credit and the reduced Household Benefit Cap); and supporting access to resources for people in financial hardship, following the closure of the Local Welfare Assistance Scheme.

The confidential audits of deaths by suicide 2013-2015(part) identified potentially adverse life events affecting individuals before their death – bearing in mind that individual cases are complex and it is impossible to reduce suicide events to a single cause. Many people experienced more than one potentially adverse life event. The audits found that 39% of males and 25% of females were unemployed or were worried about employment, and 24% of males and 26% of females had finance worries. The audit cited a Royal College of Psychiatrists' report on the relationship between debt and mental health: people in debt are more likely to have mental health problems, and people with mental health problems are more likely to be in debt. One in two adults with debts has a mental health problem; and one in four people with a mental health problem is in debt. However, the relationship between mental health and debt is complex and one does not inevitably lead to the other.

Some groups are more vulnerable to low pay and poverty, and further research is required to understand how Portsmouth residents are affected, and how they can be assisted. This includes self-employed people, people with health and care plans or disabilities and black, minority ethnic and refugee communities.

TELL US:

In relation to Theme 2:

Are these the right priorities? Have we identified the right challenges?

What are the opportunities for the Health and Wellbeing Board to add value in this area and bring about change?

How will we know if we are making change for the better? What would be the measures or indicators of success?

Theme 3: Make improvements for marginalised groups fastest, including our most vulnerable children, young people and adults.

Priority 3a: People with complex needs

Why is this a priority?

There is growing national and local evidence that a small cohort of adults in our communities are likely to experience 'severe and multiple deprivation' (SMD cohort), including substance misuse, homelessness, offending and mental health problems. They are likely to have ineffective contact with services that are often designed to deal with one problem at a time, and so regularly and persistently 'fall between the cracks' that open up between services.

The inter-relationship of these individual issues is complex and efforts to improve outcomes for this cohort of people have been ongoing for many years across different agencies and agendas and across the UK a range of responses are being developed. This is not a new issue and Portsmouth is not unique in its experience. This group of people can have a disproportionate impact on those around them; their partners and the neighbourhoods in which they live - including businesses and visitors to the city - and most importantly, any children they may have.

Services have a range of processes, pathways, panels and interventions in place to support adults with a variety of complex needs. Services have in the main been commissioned or directly provided to meet a defined individual need - often successfully - but generally not designed to address composite and compounding needs e.g. homeless/mental health/substance misuse/criminal justice.

Similarly, individual assessments of need by statutory services tend to focus on the presenting issue and there are different eligibility thresholds for accessing services that do not necessarily take into account complexity of needs and associate behaviour, the nature of 'recovery'.

As a result, customers with complex needs who are frequent (or inappropriate) service users may have contact with a range of services, have several "key workers", have a number of personal plans in place and be involved in a number of panels/pathways/case management processes simultaneously or sequentially.

It is clear from the case studies that valuable work is already being undertaken. There are some successes in supporting people to achieve positive outcomes, and there are examples of good practice in effective collaborative working. However, customers, advocates and professionals have questioned the consistency of the effectiveness, efficiency and value of current approaches, particularly for those service users present with the most complex needs.

Recent research has also shown that adverse childhood experiences (ACEs), including witnessing domestic abuse for example, increase the likelihood of 'health harming behaviours'[1] in adulthood, so it's also important to act early when these risk factors are present to 'turn off the tap', reducing the numbers of people in this cohort in future years. This work is therefore complimentary to (and could inform) the current re-design and re-structuring of children's services in the city.

Priority 3b: People in the armed forces community, including veterans

Why is this a priority?

The armed forces community is made up of anyone who is or has served for at least 1 day in the armed forces (regular or reserve, including national service) as well as Merchant Navy Seafarers and fisherman who have served in a vessel that was operated to facilitate military operations by the armed forces. The armed forces community also includes spouses, civil partners and dependent children of those who currently are or have served for at least 1 day, even if the serving person is now deceased.

National estimates suggest 4.9% of adult population of England are Veterans. Pension data demonstrates more veterans live in the south east of England than anywhere else, however not all veterans get a pension, and the community is far larger than veterans. On 1st April 2016 140,450 Regular service personnel were stationed in the United Kingdom, the majority located in the South East and South West of England. Portsmouth's military significance makes it likely that a higher concentration of service personnel are based in the area. There is no way of fully knowing how many dependants, spouses and civil partners currently reside in Portsmouth.

National research suggests that the vast majority of this community have needs in line with the general population. However age, service undertaken and position within the Armed Forces community brings with it specific issues. For example Older Veterans are known to experience more hearing, skin and musculoskeletal issues than the general population, and a small yet significant number of people who leave service early experience mental health and substance misuse issues. Little is known about the health and wellbeing needs of reservists and their families, however the limited research that has been undertaken suggests family stress and mental health are emerging issues.

A needs assessment for the sub-Solent area is currently underway, and therefore a better picture of need and gaps in support will be available in Spring 2018.

Priority 3c: People with special educational need or disabilities

Why is this a priority?

Portsmouth Children's Trust publishes a strategic children's needs assessment as part of the city's Joint Strategic Needs Assessment (JSNA) process. In 2016, a detailed SEND Needs Analysis was undertaken as part of this process. The key findings are:

1. There is a wide range of potential disabilities or conditions which could start to affect someone from conception or during pregnancy, during labour, as a baby or as a child or young person. Understanding the cause of some disabilities is necessary to support multi-agency health promotion and early identification and intervention.

2. Overall prevalence of a child or young person having any special educational need has decreased by 38% since 2009 - mostly due to a fall in pupils identified as needing SEN Support (from 23.9% to 13.4%). Portsmouth has seen a steeper decrease than nationally with the overall percentage of SEN in Portsmouth now only 1 percentage point above national, having previously been much higher. This substantial decrease is considered to be due to the more accurate identification of those with SEN following implementation of the SEND reforms.

3. Between 2010 and 2015, there was a 13% increase in the number of children with statements of SEN or an Education, Health and Care Plan (EHCP) issued and maintained by Portsmouth LA. However, the proportion of the total population of young people identified as having a statement of SEN or EHCP has stayed fairly static throughout this time both nationally (2.8%) and within Portsmouth (3.1%).

4. There are gender differences in the prevalence of SEN, with twice the proportion of Portsmouth boys (17.4%) being SEN Support compared to girls (9.5%). Five per cent of boys have either a Statement of SEN or EHCP compared to 1.9% of girls. This reflects the national picture.

   Compared to national outcomes for SEN pupils, Portsmouth has poorer education outcomes for children with SEN in the following areas:

   • Attaining a Good Level of Development in the Early Years Foundation Stage Profile

   • Making progress between Key Stage 1 and Key Stage 2 in Reading, Writing and Maths

   • Key Stage 2 attainment of Reading, Writing and Maths (combined)

   • Making progress between Key Stage 2 and Key Stage 4 in English and Maths

   • 5+ GCSEs graded A*-C, including English and Maths

   • Achievement of a Level 2 or Level 3 qualification by age 19

5. The local survey of children and young people aged 7 to 18 years found that children who say they are disabled, or who have difficulties with learning, had significantly lower than average wellbeing compared to other children. SEN is over-represented in groups including looked after children, and the care leaving population. 65% of the average Youth Offending Team (YOT) caseload have SEN. National prevalence rates predict that 60-90% of them will have a communication disorder.

6. Overall, children with SEN are about four times as likely to be persistently absent from school than those without SEN. Nine per cent of all pupils with SEN Support were persistently absent; 11% of those with a statement of SEN or EHC plan were persistently absent.

7. Pupils with SEN were more than eight times as likely to receive fixed period exclusions than those without SEN. Compared to non-SEN pupils, higher percentages of children with SEN were excluded from school with no alternative provision for education being made.

8. The proportion of 16 and 17 year olds with SEN participating in education and training is slightly higher in Portsmouth than nationally and is lower for those with SEN than those without SEN, reflecting the national picture. However, the proportion of learners with SEN who progressed to education or employment/training is considerably lower in Portsmouth than nationally at the end of both Key Stage 4 and Key Stage 5.

9. Higher rates of disability prevalence are found in the most disadvantaged socio-economic groups nationally. Pupils with SEN in Portsmouth are twice as likely to be eligible for free school meals than those without SEN (26% compared to 13%). Children aged 0-15 years with a long-term health problem or disability, are almost twice as likely to be living in socially rented homes in Portsmouth than children with no limiting long-term health problem or disability.

10. The Dynamite Survey of young people with SEND found that Health and Employment were the areas that are most important to them, and that Employment was the area on which they found it most difficult to find out about choices and support.

The aim of the special educational needs and disability (SEND) strategy is to promote inclusion and improve the outcomes for Portsmouth children and young people aged 0-25 years with SEND and their families.

In order to improve outcomes, we aim to ensure that there are in place a range of high quality support services that contribute to removing the barriers to achievement for all Portsmouth children and young people, in particular those with special educational needs and disabilities. This includes enabling children and young people to lead healthy lives and achieve wellbeing; to benefit from education or training, with support, if necessary, to ensure that they can make progress in their learning; to build and maintain positive social and family relationships; to develop emotional resilience and make successful transitions to employment, higher education and independent living.

TELL US:

In relation to Theme 3:

Are these the right priorities? Have we identified the right challenges?

What are the opportunities for the Health and Wellbeing Board to add value in this area and bring about change?

How will we know if we are making change for the better? What would be the measures or indicators of success?

Theme 4: Improve access to health and social care support in the community.

### Priority 4a: Implement the Portsmouth Blueprint for Health and Care in Portsmouth

Why is this a priority?

208,900 people live in the City and 217,562 people are registered with a Portsmouth GP. We know there are significant health and care challenges in Portsmouth. Too many people have poorer health and wellbeing than in other similar cities. Demand for our health and care services is increasing and more people tell us that what matters to them is ease of access and joined up services. The Blueprint for Health and Care in Portsmouth is now well-established as the set of guiding principles that set out how the key health and care organisations in the city will work together, with an overarching goal *where everyone is supported to live healthy, safe and independent lives by health and social care services that are joined up around the needs of individuals and are provided in the right place at the right time.*

The Blueprint sets out a vision for the delivery of health and care services in the City that will be less fragmented and better able to support people to stay well and remain independent, through the delivery of 7 key commitments. The delivery of the Blueprint is integral to improving the long term health of the population.

There is a great deal of work underway in all organisations and services, as business as usual, inorder to achieve savings and efficiencies, and in order to achieve more transformational change as envisaged in the Blueprint. This landscape is increasingly complex as work also develops across a wider Portsmouth and South East Hampshire geography around an accountable care system, as well as responding to the county-wide STP footprint. Portsmouth is also increasing links with Southampton via the public health agenda.

Health and care systems across Hampshire and Isle of Wight (HIOW) have come together in partnership to develop a strategic transformation plan (STP), setting out the strategic aims and objectives for transformation across the county. The key aims and objectives of the Portsmouth Blueprint are reflected within this wider system plan. It has been agreed that delivery of the STP needs to take place at local level, within local delivery systems.   The City of Portsmouth forms part of the Portsmouth and South East Hampshire (PSEH) delivery system. Health and care partners in PSEH have come together to form an accountable care system (ACS) as a vehicle for delivering the New Models of Care set out in the NHS 5 Year Forward View publication. Once again the aims and objectives and key work programmes to deliver the Blueprint are reflected in the ACS plans.
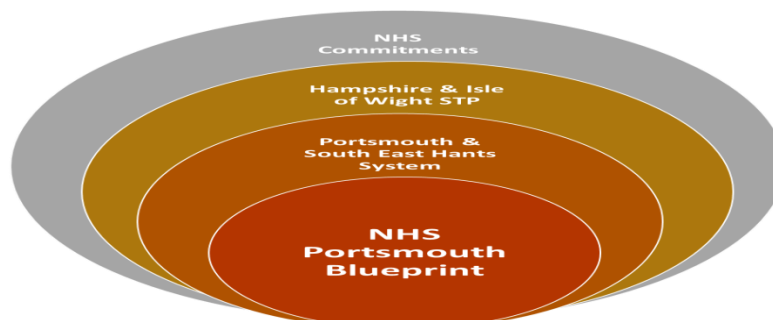
This multi-layered planning approach enables system partners in the City to focus the delivery of the commitments through either local delivery or with wider system partners where it makes sense to do so and whereby incoming together maximum gains can be achieved. We are working on the principles across the wider system that transformation must be based on local needs and where possible delivered locally. However, effective partnership working across PSEH and HIOW allows us to work together un areas of commonality and shared aims to ensure alignment and ability to operate on a wider footprint to achieve efficiencies from a truly 'do it once' approach where it makes sense to do so.

Projects include:

- development of the Stronger Futures programme for integrating care services for children, and supporting earlier intervention through a restorative approach
- developing integrated locality teams for adults services
- transforming adult mental health services
- developing a multi-speciality community provider model for services in the city
- developing a programme of assistive technology.

TELL US:

In relation to Theme 4:

Are these the right priorities? Have we identified the right challenges?

What are the opportunities for the Health and Wellbeing Board to add value in this area and bring about change?

How will we know if we are making change for the better? What would be the measures or indicators of success?

How we will deliver the strategy

Our approach will consider the complete environment in which people live, and the whole range of influences on their lives:

In our work with individuals, we will:

- ensure that people are empowered to take responsibility for their own well-being, transferring responsibility to them wherever possible to self-care and self-manage, to opt for personal budgets and to have a full say in designing and shaping the policies, services and plans that will affect them.
- Ensure we see the whole person and their whole set of issues, consider how these link together and support them to tackle problems holisitically.

In our work with communities, we will:

- Take an asset-based approach, recognising the many strengths that already exist in our cities and communities
- Consider community-based ideas and solutions to tackle problems, building on schemes such as community connectors.

In our work with each other, we will:

- Continue to work together on commissioning and delivering services, so that organisational structures and boundaries don't stand in the way of delivering the best solutions, and residents don't experience difficulty in access and navigating services
- Hold each other to account respectfully and supportively for delivering on the objectives in the Health and Wellbeing Strategy.

TELL US:

Is this the right delivery approach? What else should we be doing?