Portsmouth CITY COUNCIL

NHS Portsmouth

Public Health Portsmouth

Report for Health Overview Scrutiny Panel, March 2012

This Report is presented to the Health Overview Scrutiny Panel (HOSP) in response to HOSP's questions about inequalities in male life expectancy.

Question 1: What difference would be made to male life expectancy if Portsmouth's alcohol-related hospital admission rate were 'normal'?

We do not know what difference would be made to male life expectancy if the male alcohol-related **hospital admission** rate reduced. However, male life expectancy in Portsmouth would increase by 10.4 months if all alcohol-attributable **deaths** among males aged under 75 years were prevented (compared with 7.6 months increase for SE Region). [1]

Question 2: What has happened to male life expectancy since the Public Health Annual Report "Understanding the gap in life expectancy", 2008 came to HOSP?

1 Introduction

1.1 Between 2007-2009 and 2008-2010, life expectancy of males in Portsmouth (and England) increased by 0.3 years. However, local male life expectancy is still significantly shorter than the England average.

1.2 Local inequalities in male life expectancy (ie the difference in life expectancy for males in the least and most deprived areas within the City) are not significantly different to the England average but they have increased over this time period. There is now nearly 11 years' difference between the least and most deprived deciles in Portsmouth.[2]

1.3 Looking at smaller areas of the City (Middle Super Output Area (MSOA) level), there is a strongly positive correlation between male 'All age, all cause' mortality (0.86) and deprivation. There are 25 MSOAs in the City – shown in the map at the end of this Report against deprivation scores. The highest male all age all cause standardised mortality rates are in Buckland, Somerstown and Paulsgrove MSOAs. (Female all age all cause mortality is also strongly positively correlated with deprivation but less strongly than that for males at 0.72)

1.4 The 2008 Report identified the relative contribution made by different diseases to the gap in life expectancy between the City and England, and between males and females. The trends in the main diseases are set out below.

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[1] Local Alcohol Profiles for England. www.lape.org.uk Accessed 16 December 2011

[2] Mamot Indicators for Local Authorities in England, 2012. London Health Observatory. http://www.lho.org.uk/LHO_Topics/national_lead_areas/marmot/marmotindicators.aspx? Accessed 27 February 2012

2 Circulatory diseases

2.1 All circulatory diseases cause 30.4% of the gap in male life expectancy between the most and least deprived quintiles in Portsmouth. [3] Major components of circulatory disease are coronary heart disease and stroke.

2.2 Overall (for persons) the trends in premature mortality due to coronary heart disease (CHD) mortality are declining but the City rate remains higher than England (not significantly) and regional (significantly) rates. Portsmouth's rate is lower (not significantly) than the mortality rate for our comparable authorities

2.3 Geographical inequalities exist. There is a strongly positive relationship (0.89) between deprivation and premature mortality due to CHD at MSOA level. The highest rates of premature mortality due to CHD are in Buckland, Paulsgrove, City Centre, Wymering and Somerstown MSOAs.

2.4 Overall (for persons) the trends in premature mortality due to stroke are also declining but the City rate remains higher (not significantly) than both England and regional rates. Portsmouth's rate is lower (not significantly) than the mortality rate for our comparable authorities.

2.5 Neither hospital admissions for stroke nor mortality due to stroke are correlated with deprivation in the City.

3 Cancers

3.1 All cancers cause 15.5% of the gap in male life expectancy between the most and least deprived quintiles in Portsmouth.

3.2 Overall, the City's rate of premature mortality due to cancer (persons) is declining but the local rate remains significantly higher than England and regional rates. Portsmouth's rate is also higher (not significantly) than the mortality rate for our comparable authorities.

3.3 There is a strongly positive relationship (0.81) between deprivation and premature mortality due to cancer. The highest rates of premature cancer mortality are in Buckland, Somerstown, Paulsgrove, Wymering and City Centre MSOAs.

4 Respiratory diseases

4.1 Respiratory diseases cause 14.8% of the gap in male life expectancy between the most and least deprived quintiles in Portsmouth. These diseases include bronchitis, emphysema and other chronic obstructive pulmonary diseases.

4.2 There is a declining premature mortality due to these respiratory conditions (for persons) but the City rate remains significantly higher than England and regional rates. Portsmouth's rate is higher but not significantly than the mortality rate for our comparable authorities.

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[3] All disease-specific gap analysis taken from Source: Health Inequalities Tool, London Health Observatory. http://www.lho.org.uk/NHII/LEGap.aspx?la=00MR&comp=3 Accessed 28 February 2012

4.3 There is a strongly positive relationship (0.71) between deprivation and premature mortality due to these respiratory conditions. The highest rates of premature mortality for these conditions are in Paulsgrove, Somerstown, Stamshaw, Wymering and Buckland MSOAs

5 Digestive diseases

5.1 Digestive diseases cause 12.4% of the gap in male life expectancy between the most and least deprived quintiles in Portsmouth. This includes stomach ulcers and chronic cirrhosis of the liver.

6 Infant mortality

6.1 The 2008 Report noted that "Deaths under 28 days" contributed 7% of the difference in male life expectancy. Local infant mortality rates (for infants aged under one year) have increased slightly since 2005/07. However, the local rate is not significantly different to national, regional and comparable authority rates

7 External causes – suicide and undetermined injury

7.1 "External causes" of mortality contribute 9.0% of the gap in male life expectancy between the most and least deprived quintiles in Portsmouth. This category includes suicides and undetermined injury and accidents.

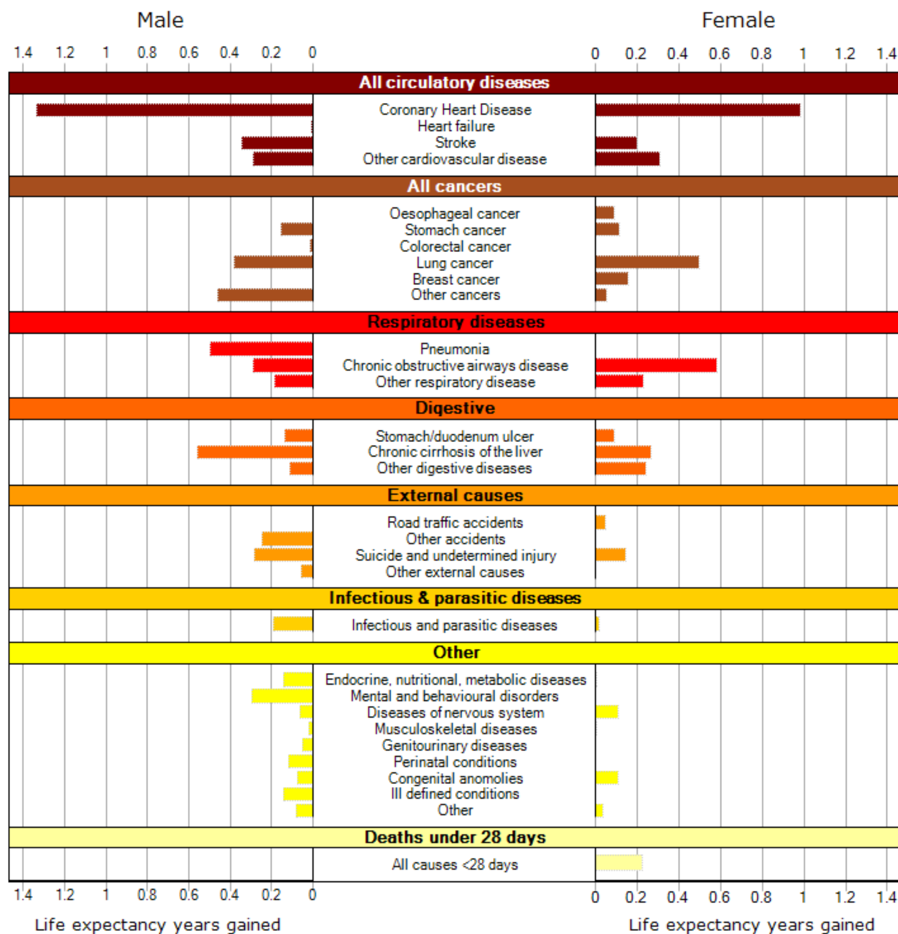
7.2 There is a declining trend in mortality rate for suicide and undetermined injury. Portsmouth's rate is significantly lower than the rate for England and for comparable authorities. The local male rate is significantly lower than the rate for comparable authorities and lower, but not significantly, than the England and regional rates

8 Years of life gained

8.1 Figure 1 illustrates the extra years of life associated with specific diseases which would be gained if Portsmouth's most deprived quintile experienced the same mortality as our least deprived quintile.

8.2 Figure 1 shows that the greatest gains in increasing male life expectancy can be made by tackling (in descending order) coronary heart disease, chronic cirrhosis of the liver, pneumonia, 'other cancers' and lung cancer.

Figure 1



Source: Health Inequalities Tool, London Health Observatory

Question 3: What were the recommendations were in the 2008 Report and what progress was made. The focus should only be on the five key points where the HOSP can make a difference.

1 Introduction

1.1 The 2008 Report made recommendations for healthy behaviours, individual diseases or conditions and developing effective local services. Several recommendations were repeated because achievement will have a positive impact on a wide range of health issues (eg stopping smoking).

1.2 To help local insight and inform actions, over the past three years, we invited to Portsmouth the National Support Teams for Health Inequalities, for Infant Mortality, for Cancers and for Smoking.

1.3 An example of a specific activity which targeted males is ‘Ahead of the Game’ - local projects engaging males aged 55+ years using football (Portsmouth Football Club) to promote cancer awareness and health screening. Nearly four hundred males had a Health Check. If problems were identified, the men were given information, advised to contact another health professional or a referral was made. The final report noted that health professionals need to be flexible, approachable and realistic in delivery of health

care ("Just because patients don't access our clinics, it doesn't mean that they are not concerned with their health and want to make changes.") and, that partnership working is crucial to achieve sustained change.

1.4 An example of a generic programme which aimed to reduce health inequalities and improve life expectancy with a focus on cardiovascular health is the 'Small Sparks' project funded by the Vascular Prevention programme. Small Sparks gave 47 grants to 29 voluntary groups to deliver projects which met the above aims. It sought to be innovative in finding new ways to engage 'seldom-heard' groups through the community and voluntary sector.

1.5 The following sections focus on issues which may be of interest to HOSP:

- Smoking
- Prevention and detection of disease in disadvantaged communities
- Suicide
- Tackling infant mortality – breastfeeding and teenage conceptions.

1.6 The recommendations in the 2008 Report are indicated in **<u>bold and underlined</u>** in the sections below.

2 Smoking

2.1 Smoking is the single greatest preventable cause of death. The Report's recommendations to tackle smoking addressed coronary heart disease, stroke, cancer and infant mortality. Specific recommendations to tackle smoking covered tobacco control, discouraging people from starting to smoke and access to, and use of, smoking cessation services.

2.2 **<u>Tobacco control</u> – BEING ACHIEVED**

2.2.1 Tobacco control activities include legislative restrictions on where people can smoke, warning pictures on cigarette packs, joint working with Environmental Health Officers and Trading Standards on illicit tobacco and enforcement (particularly under-age sales).

2.2.2 In 2010, Portsmouth and Liverpool piloted a joint Department of Health, HMRC and UK Border Agency campaign to raise awareness and report illicit tobacco in port cities. The HMRC and UK Border Agency Report about the pilot, notes that the campaign prompted the public in Portsmouth to report more instances of illicit trading to the Customs hotline.[4] Trading Standards also seized more than 24,000 cigarettes hidden in a shop and successfully prosecuted the shopkeeper.

2.2.3 Activities around tobacco control are dependent on funding. Three current main areas are:

- ProxyWatch – funded this year by Hampshire Constabulary. Aims to reduce the supply of tobacco (and alcohol) to young people [5]
- Intelligence-driven test purchasing
- Illicit tobacco – targeting "cheap whites", non-duty paid and counterfeit cigarettes [6]

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[4] HMRC and UK Border Agency. "Tackling Tobacco Smuggling – building on our success. A renewed strategy for HM Revenue and Customs and the UK Border Agency". April 2011

[5] More information about ProxyWatch at: http://www.portsmouth.gov.uk/business/18872.html

2.3 **Using social marketing techniques to help us understand what motivates smoking behaviour – PARTLY ACHIEVED**

2.3.1 We have researched motivation to give up smoking by people in some groups with higher prevalence. A social marketing insight report of female routine and manual workers found:

- The nature of routine manual work increases the likelihood of smoking due to perceived 'stress', the structure of the working day and a need for positive socialisation
- Their biggest barriers to quitting smoking include previous failed quit attempts, intimidation, gaining weight and dealing with 'stress'
- The barriers to maintaining quit attempts are pain, discomfort, not feeling ready, not having the heart in it and not feeling the benefits are worthwhile.

2.3.2 The social marketing report proposed seven 'concepts'. One 'concept' was piloted - 'Ann Smokers' parties which target women in the routine and manual group who have been described as 'ambivalents', 'poised' and 'excusers' (social marketing terms). This intervention uses a party-plan approach to give smokers and quitters a taster of the different services available to them. The host recruits the invitees to a party with free food and drink and recruitment is incentivised with a prize. Three parties have been held and an evaluation report is due in March 2012. Resources and tools for three other 'concepts' were produced and the Commissioning Manager and the Maternity service are currently considering whether these are suitable for use with women when they are most receptive to stopping smoking.

2.3.3 We have not specifically researched attitudes of male smokers in the 'Routine and manual' group. However, NHS smoking cessation services are starting to use the new Healthy Foundations profiles and insights for enabling and maintaining positive behaviours for males and females. (Healthy Foundations profiles model motivations behind health behaviours across all life stages.)

2.3.4 We still do not know enough about the motivations for smoking, and for stopping smoking, by other groups such as teenagers or pregnant women. Last year's substance misuse survey of Portsmouth secondary school pupils found 27% had smoked tobacco on at least one occasion but the main focus of the survey was other substances. We have just completed an evidence review of motivating interventions for pregnant women – this will inform activities which are being planned at the moment.

2.3.5 Collaborative work with partner agencies using Healthy Foundations insights will enable them to work more effectively with residents to tackle smoking, alcohol and weight management eg if appropriate, taking the opportunity to address someone's smoking whilst they are seeking help for weight management. The Healthy Foundations insights give information to agencies about the most effective way to communicate and engage with people to meet individual needs and motivations.

2.4 **Improve access to smoking cessation services[7] from groups with higher prevalence – PARTLY ACHIEVED**

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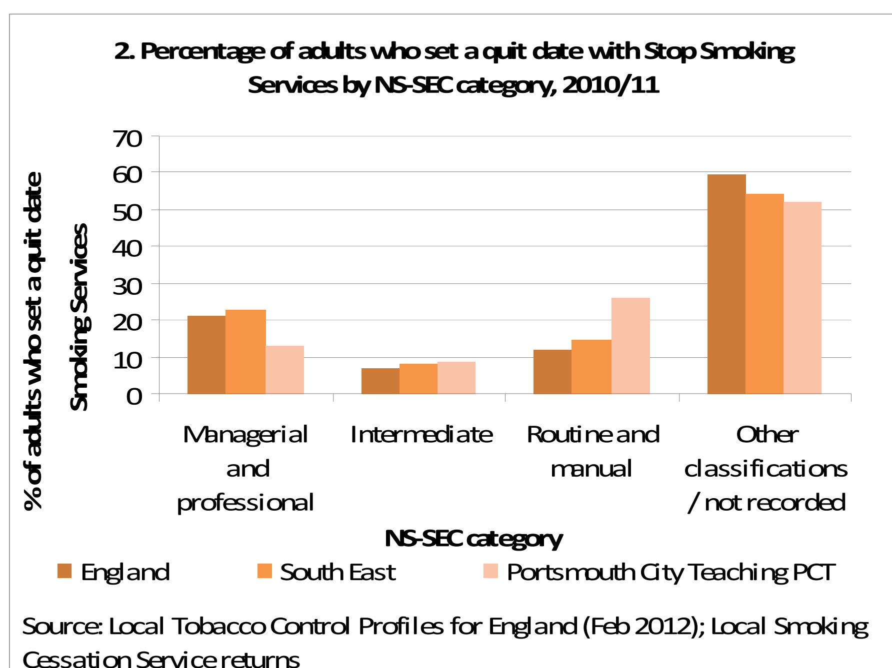
[6] Cheap whites' are brands produced by smaller, overseas manufacturers that make no legitimate supplies of any tobacco products to the UK.

[7] The local Stop Smoking Pathway includes Tier 1, 2 and 3 services:

- Tier 1: Referrals from professionals or others working in many agencies using NICE 3As approach (Ask, Advise and Act)

2.4.1 Groups with higher prevalence or prevalence of concern includes those in the 'Routine and manual' social classification group and pregnant women.

2.4.2 In 2010/11, Portsmouth achieved a higher percentage of smokers from the 'Routine and manual' social classification group setting a quit date compared to England or the South East Region.



2.4.3 Smoking during pregnancy can cause serious problems including complications during labour, increased risk of miscarriage, premature birth and even stillbirth. Portsmouth's rate of women continuing to smoke during pregnancy is higher than regional or national rates. The 'smoking at delivery' rate for women giving birth at Portsmouth Hospitals NHS Trust (PHT) has not changed for the past five years. The 2008 Report recommended that the post of specialist smoking cessation adviser in Maternity Services at PHT should be evaluated, and that Midwives and Health Visitors should receive training in smoking cessation brief interventions (a Tier 1 intervention).

2.4.4 The posts involved in smoking cessation for pregnant women have changed slightly over the past three years. However, there is still a clear pathway for referrals from Maternity to PompeyQuit (the specialist smoking cessation service for this group). The pathway has recently been re-launched with the Midwives. Maternity is one of three PHT inpatient areas (the other areas being Cardiology and Respiratory) and several outpatient areas, taking part in a Department of Health pilot for smoking cessation in secondary (hospital) care settings. Part of the pilot gives professionals access to on-line training in smoking cessation brief interventions. The Delivery Suite in Maternity is also

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- Tier 2: Services for individuals in a variety of settings: Solent HealthCare ("Pompey Quit"), young people's services, pharmacies and GP Practices, Solutions 4 Health and workplaces
- Tier 3: specialist services provided by Pompey Quit for pregnant and breastfeeding women, patients with mental health problems, people with chronic ill health, smokers wanting to join groups, smokers who have had three or more previous attempts to give up, smokers using Champix

piloting carbon-monoxide monitoring for women who are not actually in delivery but who present with problems and may therefore be more receptive to smoking cessation advice. The continuation of the secondary care project at PHT is currently being discussed by the Commissioning Manager and PHT.

2.4.5 The recently introduced Family Nurse Partnerships (FNP) target pregnant young smokers (aged under 19 years) and their partners. FNP is an evidence-based programme which works intensively with women from 16-28 weeks of pregnancy until the child is aged 2 years. The programme covers breastfeeding, smoking, attachment/relationships and self-efficacy (belief in ability to make changes).

2.5 **Increasing capacity of smoking cessation services - ACHIEVED**

2.5.1 Between 2006/07 and 2009/10, the overall number of smokers using NHS Smoking Cessation services who set a quit date increased from 2,966 to 5,838 (97% increase).

2.5.2 The percentage of those who set a quit date who are male has increased from 41% to 50% since 2008/09. By 2010/11, 52% of successful quitters were males.

3 Prevention and detection of disease in disadvantaged communities

3.1 Recommendations in the 2008 Report covered Health Trainers, cancer detection in deprived communities, immunisation and vaccination programmes and respiratory disease and air quality. In addition, this Report also includes information about NHS Health Checks.

3.2 **Health Trainers**[8]

3.2.1 Health Trainers identify and work with disadvantaged groups to support health-related lifestyle change for smoking, physical activity, weight management, alcohol, and emotional wellbeing. Recommendations were:

Performance review in improving health and reaching hard-to-reach groups and communities
Improved awareness of health trainers' existence - ACHIEVING

3.2.2 Uptake of Health Trainer appointments has increased each year, with most of the Health Trainer workforce now working with full client case loads and increased demands for their service in many more community and primary care venues.

3.2.3 In 2010/11 Health Trainers saw 677 clients. Just under half these clients were male. Eighty percent of clients were from a white British background, with significant numbers also coming from Bangladeshi and Chinese populations. Sixty-six percent of clients were between 18 and 45 years old.

3.2.4 In 2010/11, 497 clients accessed Health Trainers for one-to-one behaviour change support compared with just 296 clients in the previous year. (The remaining 180 clients in 2010/11 received information and advice or signposting to other services.)

3.2.5 The Health Trainer service has expanded its service by becoming the main community provider for weight management. Health trainers have also significantly increased awareness of their service and embedded into wider networks, specifically smoking, physical activity, weight management and alcohol referral pathways, and their

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[8] Portsmouth Health Trainers - http://portsmouthhealthtrainers.org/

links into services such as GP surgeries, acute hospitals, probation services, Job Centres and psychological therapies.

3.3 **Improve cancer detection in deprived communities**

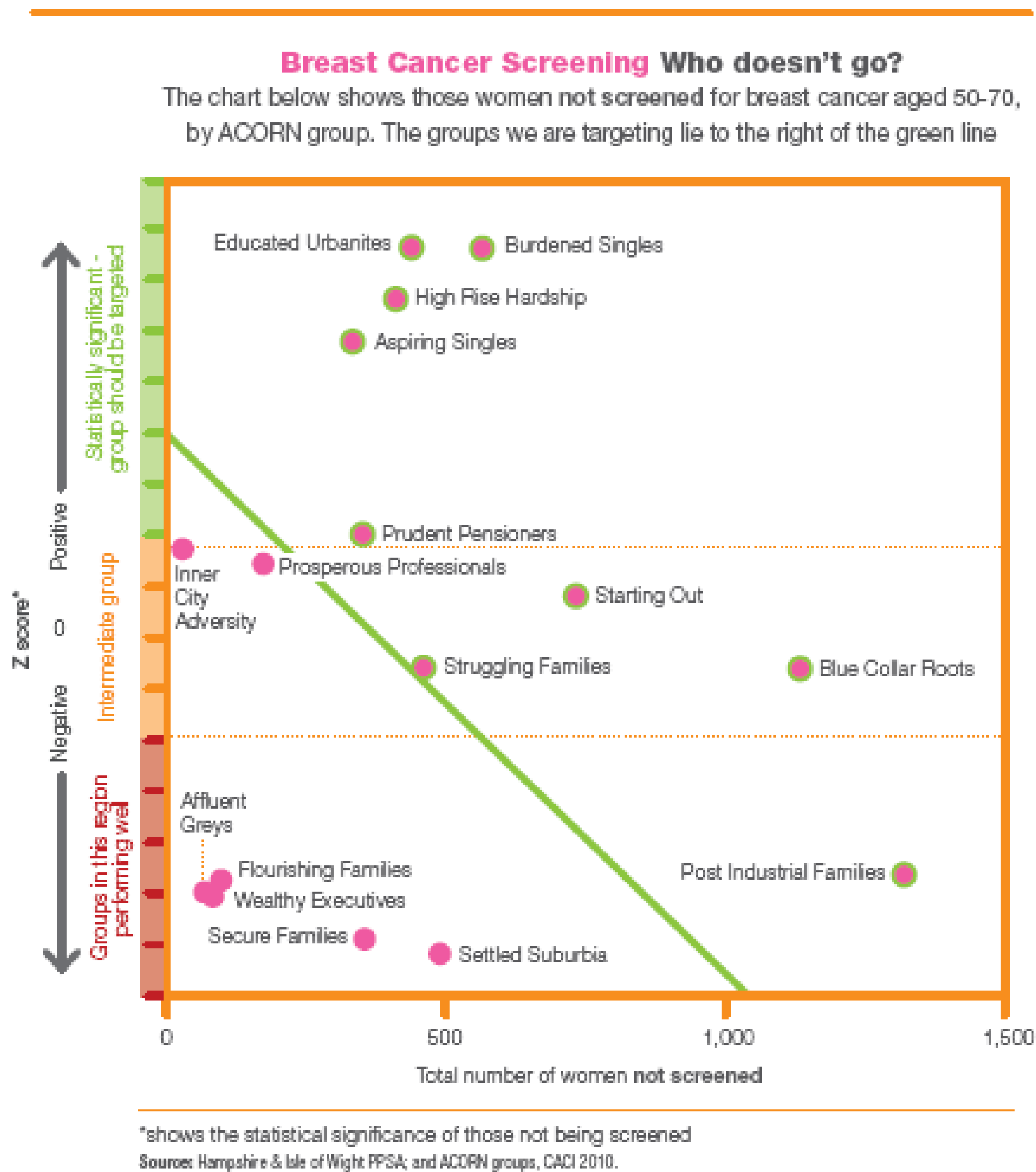
3.3.1 Recommendations were:

Use Health Equity Audits to identify priority areas
Promote cancer screening – especially where uptake is lower
Identify barriers that prevent or discourage some groups for attending screening
Work with groups identified with low uptake rates to break down barriers
ALL PARTLY ACHIEVED

3.3.2 The 2008 Report summarised the findings of Health Equity Audits for breast and cervical cancer which demonstrated that some screening uptake rates are lower in areas of higher deprivation and that screening uptake rates are lower for GP Practices serving the most deprived communities. This leads to unequal outcomes. The Health Equity Audits have not been repeated but further work has been undertaken to determine why some groups do not attend for screening and to take remediating action.

3.3.3 We have used social marketing analysis to segment the population and determine the most effective ways of increasing breast and cervical screening uptake. For example, Figure 2 shows the social marketing segmentation of women not attending breast screening.

Figure 2



3.3.4 Segmentation insights demonstrated where we might find women in these groups, the most effective ways for them to receive health information and what messages are likely to be most effective in engaging them. Members of the public and services were consulted to jointly design interventions to increase breast and cervical screen uptake.

3.3.5 Examples of associated actions include recruiting peer educators (as women were more receptive to health messages from their peers than from health professionals); commissioning a specialist female call centre to contact eligible women who had not responded to an invitation for cervical screening in the previous three years; changing the content of invitation letters after hearing the views of women in the target groups; and, trialing text messaging to reduce 'Failure to Attend' rates.

3.3.6 Additionally, we are now starting to segment populations using 'Healthy Foundations' profiles.

3.3.7 Public Health has also been working in partnership with the Cancer Network, following a successful bid to the National Cancer Action Team, to improve awareness and early diagnosis of bowel cancer. Primary qualitative and quantitative research was undertaken with people from areas of higher deprivation to understand the barriers and motivators to awareness and early diagnosis of bowel cancer. A group of community volunteers was used to supplement the public engagement strand of this project. Work is also being undertaken with primary care to support GP practices to audit their cancer data and generate insights on improving access and diagnosis. We plan further work in 2012 on improving awareness and early diagnosis of lung cancer.

3.4 Immunisation and vaccination programmes

3.4.1 **Research into reasons for poor uptake of childhood vaccinations esp MMR in some areas - NOT YET ACHIEVED**
A health equity review is planned for later in 2012.

3.4.2 **Encourage uptake of flu vaccine by over 65s, at risk under 65s and health/social care workers - ACHIEVED**
Overall seasonal influenza uptake in Portsmouth has been higher than national, regional and the rate in Southampton since 2008/09. An equity audit for uptake of seasonal 'flu vaccine is planned for 2012.

3.4.3 **Monitor Human Papilloma Virus (HPV) programme for low uptake in different areas, and counter this – NOT YET ACHIEVED**
This programme is for review later in 2012.

3.5 Respiratory disease and air quality

3.5.1 The 2008 Report included recommendations to tackle smoking and seasonal 'flu vaccinations (see above) to reduce respiratory disease. It also recommended examining air quality.

3.5.2 **Establish extent of respiratory illness related to poor air quality – NOT ACHIEVED**
The Joint Strategic Needs Assessment webpages include links to the Portsmouth Air Quality webpages and associated reports on air quality.[9] Last year's Air Quality Progress Report notes increases in nitrogen dioxide (NO2) in specific locations across the city. We have not looked specifically at any relationships between respiratory disease and poor air quality.

3.6 NHS Health Check programme

3.6.1 The NHS Health Check programme has been rolled out since the 2008 Report. The Health Check programme aims to prevent heart disease, stroke, diabetes and kidney disease. The target audience is everyone between the ages of 40 and 74 years, who has not already been diagnosed with one of these conditions. Each person is invited once every five years for a check to assess their risk of developing these diseases and is given support and advice to help reduce or manage that risk. People can choose to be assessed at their GP Practices (all except one are signed up) or at one of 13 Pharmacies. The NHS Operating Framework sets targets for Public Health for coverage (ie the eligible population receiving an invitation) and uptake of Health Checks.

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[9] http://www.portsmouth.gov.uk/living/22790.html

3.6.2 Over the next financial year we intend to use social marketing segmentation to profile populations who do and who do not accept the offer of a Health Check, identify how to best support uptake of the Health Check programme and enable and maintain positive lifestyle behaviours for the different population segments.

3.6.3 Further work will also look at health outcomes eg detection of hypertension and subsequent prescribing of anti-hypertensives. One of the 2008 Report's recommendations was to increase coverage of anti-hypertensives and access to statin therapy in relation to CHD. We will use the Health Checks data to review these links.

4 Suicide

4.1 **Incorporate annual audit of suicides as part of wider public health surveillance system - ACHIEVED**
The most recent audit of suicides which occurred between 2007 and 2010 has just been completed. The small number of suicides and open verdicts over this period makes it difficult to identify any significant trends. Key findings were that the number of suicides in Portsmouth remains low, with higher levels among men, those who are single and during the month of January.

4.2 **Develop suicide prevention strategy that promotes awareness of approaches to prevention and develops relevant prevention strategies for at-risk groups – PARTLY ACHIEVED**
A small working group has been convened to consider the best way to review patterns of suicide and attempted suicide to inform remediating actions as carrying out an annual audit (as recommended in the 2008 Report) may not be the most effective way.

4.3 **Review educational/training needs of GPs for recognising and assessing at-risk behaviour and delivering effective treatments to promote effective clinical and professional practices – PARTLY ACHIEVED**
The recent suicide audit found that almost half of people who had committed suicide (16 out of 34 people) had visited primary care in the twelve months before completing suicide. The Health Improvement and Development Service regularly run a mental health first aid course for anyone working with adults and young people to enable them to identify early stages of mental health distress in others, and to be able to signpost appropriately. Further work is planned on reviewing primary care needs in relation to providing interventions to address mental health as part of a project looking at reducing frequent users of the Emergency Department, as a recent audit has shown that many of these frequent users have mental health issues.

Both these recommendations are being followed up by the working group.

5 Tackling infant mortality – breastfeeding and teenage conceptions

5.1 Recommendations included smoking (see above), increasing the breastfeeding rate and reducing the teenage conception rate.

5.2 **Increasing breastfeeding rate – PARTLY ACHIEVED**
5.2.1 Breastfeeding initiation has increased between 2008/09 to 2010/11. The local breastfeeding initiation rate is now higher than the national rate. Prevalence of breastfeeding at the time of the baby's 6-8 week check has also increased but remains lower than the national rate. Health professionals are concerned at the decline in rates between initiation and continuing to breastfeed.

5.2.2 Actions to increase the rate are overseen by the Breastfeeding Strategy Group and a "Portsmouth Supports Breastfeeding Action Group". In 2009 the Strategy Group led a social marketing project to inform their strategy and priorities. There are four workstreams:

- Ante-natal - Ensuring individuals have clear messages about the benefits of breastfeeding
- Ante-natal - Ensuring community-wide clear communications about the benefits of breastfeeding
- Post-natal – Evaluating data and evidence to support interventions
- Post-natal – Access to seldom-heard groups – teenagers, people from black and minority ethnic communities, fathers and grandparents

5.2.3 The Group is also recruiting more breastfeeding peer supporters (volunteers) in hospital and community settings.

5.2.4 **<u>Achievement of full World Health Organisation/UNICEF Baby Friendly Initiative status in hospital and community settings</u> – PARTLY ACHIEVED**
Portsmouth Hospitals NHS Trust has achieved Stage 3. Community settings have achieved Stage 1 and are working towards Stage 2 by October 2012.

5.3 **<u>Teenage conceptions</u> – BEGINNING TO DECLINE**
5.3.1 In 2008/10, Portsmouth's conception rate in women aged under 16 years was 10.2 conceptions per 1,000 women aged 13-15 years – higher than the England and Regional rates and the rate in Southampton rates but this is the lowest the local rate has been since 2003/05.

5.3.2 In 2008/10, Portsmouth's conception rate for women aged under 18 was 46.3 conceptions per 1,000 females aged 15-17 years. This is the lowest it has been since 2001/03. The local rate remains higher than the national and regional rates but is lower than the Southampton rate.

5.3.3 Actions to reduce the teenage conception rate are regularly reported to the 14-19 years Partnership Board of the Children's Trust. The most recent update notes that improvements made to more streamlined and targeted service delivery over the last two to three years are starting to deliver positive outcomes for Portsmouth's teenage conceptions rates. Examples of initiatives and approaches are:

- Sex and Relationship Education (SRE) delivery schools – significantly improved joint working with secondary schools across the city (key in reducing under 16 year conception rates)
- Outreach Contraception Nurse role
- Targeted work by specialist teenage pregnancy team with girls at risk of becoming pregnant in schools
- Targeted campaigns (utilising social media and resources more effectively)
- Training the wider Children's workforce to support prevention work to reduce risk taking behaviours
- The Teenage Parent Peer Educator has been short listed for the JLS Young Person of the Year, National Sexual Health Brook Awards (Awards ceremony to take place in London in mid-March 2012)
- More effective partnership working across agencies.

Additional priorities for the coming year include:

- Strengthening the delivery of SRE and work with 'at risk' girls in College settings
- Personal, social, health and economic education (PSHE) – developing the offer for Portsmouth
- Further targeting of current 'hotspot schools' for under 16 conceptions
- Consolidating funding for specialist workforce and ensuring linkages with new targeted youth workforce are embedded
- Developing effective training programme for Parents on SRE
- Work with boys – on risk taking and responsible behaviours.

5.4 **Understanding local data and linking to Child Death Overview Panel – why babies die in Portsmouth – ACHIEVED**

Reviews carried out by the Child Death Overview Panel are fed back to the relevant sub-boards of the Children's Trust.

6 Future steps from a Public Health perspective

6.1 We know that significant variation in health and well-being across Portsmouth is due to a toxic mix of poverty, poor educational attainment and high levels of smoking as well as significant levels of harm caused by substance misuse and alcohol which all contribute to a high number of early preventable deaths from strokes, heart attacks and cancer. So-called 'troubled families' are likely to be less resilient against these factors, and to experience their impact to a greater degree than other Portsmouth families.

6.2 Public Health Portsmouth is undergoing major organisational change with the proposed transfer of public health responsibilities from the NHS to local government. We are developing a Strategy using the "Life Course Approach" recommended by the Government in "Healthy Lives, Healthy People" to focus on five key Public Health Strategic Objectives:

a Getting the best possible start in life

b Reducing long term ill health or incapacity

c Creating a healthy environment (Housing, Planning, Climate)

d Encouraging healthy lifestyles (Behaviour Change)

e Maintaining maximum independence and dignity in old age.