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Portsmouth CITY COUNCIL

NOTICE OF MEETING

HEALTH AND WELLBEING BOARD

WEDNESDAY, 26 FEBRUARY 2014 AT 9.00 AM

THE EXECUTIVE MEETING ROOM - THIRD FLOOR, THE GUILDHALL

Health and Wellbeing Board Members
Councillors Leo Madden (Chair), Rob Wood, Mike Hancock CBE MP, Sandra Stockdale, Rob New, Jim Patey
Dr James Hogan (Vice Chair), Dr Tim Wilkinson, Dr Janet Maxwell, Julian Wooster, Innes Richens, Mark Orchard, Finance Director, NHS England (Wessex) Tony Horne

Standing Deputies for Lib Dem councillor members:- Councillor David Fuller, Councillor Jason Fazackarley, Councillor Gerald Vernon-Jackson, Vacant

Standing Deputy for Labour councillor member:- Vacant

Standing Deputy for Conservative councillor member:- Vacant

Standing Deputies for non councillor members:- Dr Dapo Alalade, Dr Elizabeth Fellows, Dr Linda Collie

Non voting members: David Williams

Telephone enquiries to Vicki Plytas, Customer, Community & Democratic Services on 023 9283 4058
Email: vicki.plytas@portsmouthcc.gov.uk

(NB This agenda should be retained for future reference with the minutes of this meeting.)

Deputations by members of the public may be made on any item where a decision is going to be taken. The request should be made in writing to the contact officer (above) by 12 noon of the working day before the meeting, and must include the purpose of the deputation (for example, for or against the recommendations). Email requests are accepted.

Please note that the agenda, minutes and non-exempt reports are available to view online on the Portsmouth City Council website: www.portsmouth.gov.uk

A G E N D A

1 Welcome and introductions - (Chair) Councillor Leo Madden

2 Apologies for Absence

3 Declarations of Members' Interests

4 Minutes of the meeting held on 4 December 2013

RECOMMENDED that the Minutes of the meeting of the Health and Wellbeing Board held on 4 December 2013 be confirmed and signed by the Chair as a correct record.

5 Better Care Fund (Pages 1 - 10)

Report and presentation from Innes Richens and Rob Watt. (INFORMATION ONLY)

To inform and update the Health and Wellbeing Board (HWB) on the development of The Better Care Fund (BCF) plan for Portsmouth.

6 Special Educational Needs and Disabilities (SEND) reforms (Pages 11 - 20)

Report from Julian Wooster (INFORMATION ONLY).

To update the Board on the implications of the Children and Families Bill Part 3 for Health and Wellbeing Boards and Clinical Commissioning Groups.

7 City of Service (Pages 21 - 24)

Report from Matt Gummerson / Janet Maxwell - (INFORMATION ONLY)

To inform the Health and Wellbeing Board of Portsmouth's successful application to be one of the UK Cities of Service.

8 Sustainable, Resilient, Healthy People and Places (INFORMATION ONLY)

Janet Maxwell to introduce the Sustainable Development Strategy for the NHS, Public Health and Social Care System from NHS England and Public Health England.

(please note that there is no report for this item but a hard copy of the strategy will be placed in the group rooms and can be viewed on the website.)

9 Joint Health and Wellbeing Strategy 2014 - 2017: emerging themes and priorities (Pages 25 - 42)

Report and presentation from Janet Maxwell / Matt Gummerson. The purpose of the report is to set out the emerging themes and potential priorities which the HWB is asked to consider as it develops a refreshed Joint Health and

Wellbeing Strategy for 2014-2017.

RECOMMENDED that the Health and Wellbeing Board

- **Endorse the process and timescales for the refresh of the JHWS as set out in this report.**

- **Discuss the suggested themes at 6.5, which will be expanded on in presentation to the HWB, and agree that these should form the basis of a JHWS for the period 2014-17.**

- **Consider the potential priorities set out in section 6.6 to 6.10 and in the presentation to the board, and identify any gaps or areas for further consideration.**

10 Date of the Next Scheduled Meeting

To be arranged.

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Portsmouth Clinical Commissioning Group

Portsmouth CITY COUNCIL

THIS ITEM IS FOR INFORMATION ONLY

Agenda item:

Title of meeting:	Health and Wellbeing Board
Subject:	Better Care Fund
Date of meeting:	26th February 2014
Report by:	Innes Richens, Chief Operating Officer, Portsmouth Clinical Commissioning Group (PCCG), and Julian Wooster, Strategic Director for Children's and Adults Services, PCC

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1. Requested by

1.1 Cllr Leo Madden and Dr Jim Hogan, Chair and Vice Chair of the Health and Wellbeing Board (HWB).

2. Purpose

2.1 To inform and update the Health and Wellbeing Board (HWB) on the development of The Better Care Fund (BCF) plan for Portsmouth.

3. Information Requested

3.1 The Better Care Fund, previously referred to as the Integration Transformation Fund, was announced in June as part of the 2013 Spending Round. A useful summary with links to all the key documents is available from the Local Government Association.

3.2 The BCF supports the Joint Health and Wellbeing vision and strategic objectives, through:

- The creation of a single health and social care system
- Putting individuals at the centre
- A single commissioning vehicle and integrated service delivery.

3.3 People will experience integrated care that:

- Is personalised and promotes independence
- Does not duplicate assessments for individuals and efficiently manages resources
- Is in the right place at the right time by the right staff.

3.4 The joint presentation to the HWB from PCC and PCCG finance teams in October 2013 set out what was likely to be included in the BCF and it was agreed that the Integrated Commissioning Board and the BCF Working group would review the scope of the BCF and associated funding by end of December and identify opportunities for:

- Eliminating duplication
- Potential disinvestment
- Reshaping of existing services.

3.5 Detailed guidance was issued to local areas on 20th December. To summarise:

- Funding must be used to support adult social care services which also have a health benefit
- The local authority must agree with its health partners how the funding is best used within social care - "Health and wellbeing boards will be the natural place for discussions between NHS England, clinical commissioning groups and councils on how the funding should be spent, as part of their wider discussions on the use of their total health and care resources"
- Plans must have regard to the JSNA and existing commissioning plans for health and social care
- Plans must show how the funding transfer will make a positive difference to social care services "compared to service plans in the absence of the funding transfer".

4. Plan summary

4.1 The BCF is a five year transformational plan. Our local plan for 14/15 and 15/16 builds on existing priorities and delivers three interconnected schemes;

Scheme 1: Establishing fully integrated locality based health and social care community teams

Scheme 2: Review of current bed based provision

Scheme 3: Increased delivery of Reablement services

4.2 The schemes will be underpinned by an early intervention and prevention approach and have a number of supporting work streams (e.g. communication and engagement).

4.3 The total pooled budget to support the BCF is £15.195m in 14/15 and £16.409m in 15/16. The funding consists of existing CCG and PCC allocations and is currently being utilised to provide existing services such as Portsmouth Reablement and Rehabilitation Team, Community Nursing and Carers Grants. The realisation of the Better Care Fund schemes and the resources required will be dependent upon efficiencies gained in the acute sector.

THIS ITEM IS FOR INFORMATION ONLY

5 Progress to date

5.1 At the HWB on 4th December, Rob Watt and Jo York presented feedback from the Health and Social Care Partnership (HaSP) stakeholder meeting looking at developing the BCF plan. They reminded HWB members of the aims of the BCF and explained that a steering group had been set up to develop plans, reporting in to the Integrated Commissioning Board.

5.2 A draft plan was presented to the HWB on the 15th of January 2014 for consultation and the BCF working group was charged with making any necessary amendments. Due to the short timescale it was agreed that the Chair and Vice Chair would be given the authority to sign-off both the first-cut plan (by 14th February 2014) and following consultation and agreement with the Integrated Commissioning Board, the final plan (by 4 April 2014).

5.3 On 14th February 2014 the first-cut plan was signed-off by Cllr Leo Madden and Dr Jim Hogan and submitted to NHS England.

6 Next steps

6.1 The first-cut plan will be reviewed by NHS England and any required changes will be made between 15th February and 4th April. The plan will be presented to both the Integrated Commissioning Board and HaSP and the BCF working group will begin to map out the programme of work.

6.2 The final version of the plan will be signed off by the HWB Chair and Vice-Chair and submitted back to NHS England on 4th April 2014.

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Signed by:
Innes Richens, Chief Operating Officer, PCCG

Appendices:

Appendix A - presentation

Background list of documents: Section 100D of the Local Government Act 1972

THIS ITEM IS FOR INFORMATION ONLY

The following documents disclose facts or matters, which have been relied upon to a material extent by the author in preparing this report:

Title of document	Location

Portsmouth's Better Care Fund Plan

Health and Wellbeing Board

26th February 2014

Better Care Fund

- A pooled budget which can be deployed locally on social care and health
- A jointly agreed and developed plan
- National conditions are mandated
  - *'To be used to support ASC services in each LA which has a health benefit'.*
  - *'Flexibility to determine how this investment in social care services is best used'*
  - *'LA to agree with Health how funding is best used within social care'*

Aim of the Better Care Fund Plan

Supports the Joint Health and Wellbeing vision and strategic objectives, through:

- The creation of a single health and social care system
- Putting individuals at the centre
- A single commissioning vehicle and integrated service delivery
- People will experience integrated care that:
  - Is personalised and promotes independence
  - Does not duplicate assessments for individuals and efficiently manages resources
  - Is in the right place at the right time by the right staff

Better Care Fund – Five years on

- People will have a care plan they own and will know what to do when things go wrong
- More people dying in preferred place of death
- The proportion of older people who were still at home 91 days after discharge from hospital will be increased
- Further reduction of delayed transfers of care and improved quality of discharge planning
- Delivery of integrated locality teams across VCS, social care, primary care, community and acute care
- Promotion of choice and control and services tailored to individual need

Recommendations from Stakeholder Engagement

- More services supporting earlier intervention
- Co-location, MDT and single management
- Information sharing and IT connectivity
- Trusted assessors
- Focus on empowering and enabling individuals
- Greater role for community and VCS

Delivery of three inter-connected schemes for 14/15 and 15/16

Scheme 1: Establishing fully Integrated locality based health and social care community teams

Scheme 2: Review of current bed based provision

Scheme 3: Increased delivery of Reablement services

Enabling Work-streams

- Analysis of need and demand profiling
- Commissioning planning processes
- Data collection and analysis
- Risk stratification
- Single point of access
- Joint IT infrastructure and Information Governance arrangements
- Staffing - to include 7 day working, key worker role blueprint, workforce development and education
- Communication and engagement

Metrics

Metric		Historic Data		Current Baseline (as at .....)		Performance underpinning April 2015 payment	Performance underpinning October 2015 payment	Calculation
1.Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	Metric Value	852.69		842.70		N/A	836.80	Numerator / Denominator x 100,000
	Numerator	235		240			247	
	Denominator	27,560		28,480			29,517	
		(April 2011 - March 2012)		(April 2012 - March 2013)			(April 2014 - March 2015)	
2. Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Metric Value	70.83		71.43		N/A	76.33	Numerator / Denominator -
	Numerator	85		150			229	
	Denominator	120		210			300	
		(April 2011 - March 2012)		(April 2012 - March 2013)			(April 2014 - March 2015)	
3. Delayed transfers of care from hospital per 100,000 population (average per month)	Metric Value	81.76		85.04		83.54	83.32	Numerator / Denominator x 100,000 number of months
	Numerator	1613		850		1262	845	
	Denominator	164400		166583		167856	169026	
		(April 2012 - March 2013)		(April 2013 -Sept 2013)		(April 2014 - Dec 2014)	(Jan 2015 - June 2015)	
4. Avoidable emergency admissions (composite measure)	Metric Value	864.45	646.89	712.64	572.07	562.56	689.62	Numerator / Denominator x 100,000
	Numerator	1788	1338	1474	1195	1183.05	1459.26	
	Denominator	206836	206836	206836	208889	210298	211605	
		(October 11 - March 12)	(April 2012 - Sept 2012)	(Oct 12 - March 13)	(April 2013 -Sept 2013)	(April 2014 - Sept 2014)	(Oct 2014 - March 2015)	
5. Patient / service user experience (awaiting national measure)	Metric Value							
	Numerator							
	Denominator							
6. Proportion of adult social care users that have as much social contact as they would like	Metric Value	46		50		55	60	Numerator / Denominator x 100
	Numerator	204		86		95	103	
	Denominator	439		172		172	172	
		April 2011 - March 2012		April 2012 - March 2013		April 2013 - March 2014	April 2014 - March 2015	

Sources of BCF Plan funding 2014/15 - 2015 /16

Summary

Source of funding	2014/15 - £000's	2015/16 - £000's
Minimum fund required	6,627	14,193
Existing funding - already committed and required to be part of the pooled fund		
Health transfer monies to social care	3,900	4,100
Reablement funding	1,200	1,200
Carers grant	400	400
DFG	639	645
Social care capital	488	496
TOTAL	**6,627**	**6,841**
Existing funding for community services to be incldued as part of the local element of the pooled fund		
CCG investment in community nursing services	4,100	4,100
CCG investment in intermediate care services (PRRT)	900	900
PCC funding for ASC fieldwork services	198	198
PCC funding for intermediate care (PRRT)	970	770
TOTAL	**6,168**	**5,968**
New investment funding required for delivery: sourced from CCG		
Scheme 1	1,300	3,500
Scheme 2	1,000	
Scheme 3	100	100
TOTAL	2,400	3,600
TOTAL PROPOSED BCF PROPOSED POOLED FUND	**15,195**	**16,409**

Key Risks

Risk	Risk Rating	Mitigating Actions
Risk 1: Stakeholder resistance	High	• Comprehensive communication and engagement plan • Specialist resource allocated from PCC Comms. Team with links to CCG Comms. • Consultation processes to be followed
Risk 2: Financial risk of KPIs not being achieved	High	• Contingency plan in place (see above) • Robust programme management and strong governance in place
Risk 3: Increased need/ demand for services	Medium	• Needs analysis/demand profile to be carried out and a dedicated underpinning work stream to be created
Risk 4: Capacity planning and the acute sector	Medium	• Linking with system wide sustainability plan to ensure estates and finance implications of the transformational change programme do not de-stabilise the local health system

Better Care Fund Timetable

- Technical Guidance issued in late December 2013
- 14 February 2014: first cut of BCF Plan to NHS England
- 4 April 2014: final cut submitted
- Implementation by 1 April 2015
  - However, CCG and Portsmouth City Council want to bring forward some delivery into 2014/15

Thank you.

Agenda Item 6

THIS ITEM IS FOR INFORMATION ONLY

Portsmouth CITY COUNCIL

Agenda item:

Title of meeting:	Health and Wellbeing Board
Subject:	Special Educational Needs (SEN) and Disabilities Reforms
Date of meeting:	26th February 2014
Report by:	Julia Katherine Child Support Services Commissioning Manager

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1. Requested by

2. Purpose

2.1 To update the Board on the implications of the Children and Families Bill Part 3 for Health and Wellbeing Boards and Clinical Commissioning Groups.

3. Information Requested

3.1 The Children and Families Bill is currently progressing through Parliament. Part 3 of the Bill has major implications for the way in which we commission and deliver services for children and young people with SEN and disabilities.

3.2 The Bill outlines 7 new statutory duties for Local Authorities and Clinical Commissioning Groups:

i. A duty to jointly commission services across Education, Health and Social Care to meet the needs of children and young people with special educational needs and disabilities.
ii. A duty to publish a 'Local Offer' of the services available for children and young people with special educational needs and disabilities.
iii. A duty to implement an integrated assessment process to assess the needs of children and young people with special educational needs and disabilities.
iv. A duty to issue Education, Health and Care Plans for those with the most complex needs (instead of statements of special educational needs) following assessments.
v. A duty to deliver personal budgets and, where appropriate, direct payments to families with Education, Health and Care plans, where appropriate.
vi. A duty to extend the statutory protections currently available to pupils with statements of special educational needs from 0 to 25 years, where appropriate.
vii. The same duties apply to all educational providers e.g. Maintained schools, Academies, Free Schools, Further Education and Sixth Form colleges.

3.3 In Portsmouth, preparation for the implementation of the SEN reforms is integral to Children's Trust Plan Priority G: Improving services and outcomes for children, young people and their families with disabilities.

3.4 The Department of Health will soon be issuing guidance for Health and Wellbeing Boards (HWBs) on SEN and complex needs in children. This guidance will signpost HWBs to the best information on need and prevalence to support them in completing JSNAs and will include some practical suggestions for their scrutiny role.

3.5 Portsmouth are making good progress in implementing the reforms. In the recent Department for Education readiness survey, we were asked to report specifically on the engagement of the Health and Wellbeing Board in implementation.

3.6 For further information about the SEN Reforms and their implementation in Portsmouth please contact Julia Katherine, Child Support Services Commissioning Manager.

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Signed by

Julian Wooster, Director of Children's and Adults Services

Appendices:

Appendix A - presentation

Background list of documents: Section 100D of the Local Government Act 1972

The following documents disclose facts or matters, which have been relied upon to a material extent by the author in preparing this report:

Title of document	Location

SEND Reforms: Implementation in Portsmouth

Health & Wellbeing Board

February 2014

Dr Julia Katherine

Child Support Services Commissioning Manager

SEND Reforms: The vision

- Early identification & support
- Holistic assessments
- 0-25s process
- Person-centred
- Outcomes-focused
- Skilled staff
- Informed parents
- High aspirations
- More choice & control

New Legislation: key changes

1. Joint commissioning
2. Local offer
3. Integrated assessment process
4. Education, Health and Care Plan
5. Personal budgets
6. Extended statutory protections 0-25
7. Same duties apply to all

Winter 2014 update

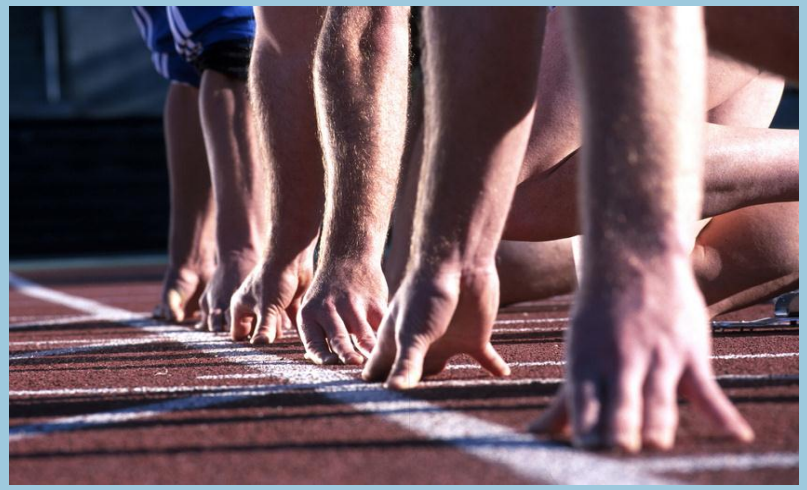
1. Children & Families Bill
2. Draft Code of Practice
3. Focus on implementation

Governance


Children's Trust Board
Priority G Board
Implementation Group

Readiness for implementation in Portsmouth: What are we doing?

1. Local Offer
2. Pilot of Assessment & EHC Plan
3. Pathway for 0-5s
4. Pathway for 16-25s
5. Parent &Young People's engagement
6. Personal Budgets
7. Communication
8. Workforce Development



Engagement of Parents and Young People

Stakeholder Event 24th Feb

THIS ITEM IS FOR INFORMATION ONLY

Portsmouth CITY COUNCIL

Agenda item:

Title of meeting:	Health and Wellbeing Board
Date of meeting:	26th February 2014
Subject:	Team Portsmouth - City of Service
Report by:	Janet Maxwell, Director of Public Health

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1. Information requested by

1.1 Cllr Leo Madden, Chair of Health and Wellbeing Board (HWB)

2. Purpose of report

2.1 To inform the Health and Wellbeing Board of Portsmouth's successful application to be one of the UK Cities of Service.

3. Information requested

3.1 Portsmouth's successful application to be a 'City of Service' will provide an opportunity explore how mobilising volunteers can deliver against some of the city's key challenges. The HWB are asked to note this valuable opportunity to demonstrate the impact volunteers can have in meeting some of the city's most pressing challenges and the potential links with the board's priorities.

4. Background

4.1 In September 2013 Portsmouth was one of 26 cities invited to get involved in a Nesta-run pilot inspired by the US Cities of Service movement. Nesta is an independent charity that provides grants, investments, research and networking opportunities to develop new ideas in service delivery. They are working with the Cabinet Office to manage a £14m innovation fund as part of the Social Action Fund launched in April 2013.

4.2 The City of Service concept was developed by Mayor Bloomberg as Mayor of New York City. It now involves 170 mayors from cities across America who work together to engage citizens to address city needs through 'high impact volunteerism'. The focus is on ensuring that people are only asked to volunteer through this programme for things that will have a clear and measurable impact to their local area. A series of 'blueprints' are now available of things that have been proven to work in the US and which Nesta are keen to test in England. One aspect of the work that was found to have played a crucial part was having dedicated leadership provided by a 'chief service officer' and supported by senior politicians and other partners.

4.3 The Bloomberg Foundation is now working with the Cabinet Office and Nesta to develop a similar model in England. Following a competitive bidding process, four 'partner cities' (Portsmouth, Plymouth, Bristol and Kirklees) have been chosen. Each will receive up to £150k over 2 years to support a chief officer post, and up to £30k of seed funding, as well as peer support, technical support and mentoring from a serving chief officer from one of the US cities.

4.4 Portsmouth submitted a bid in November 2013, with approval from Cllr Mason who agreed to be the 'ambassador' for the bid, and David Williams. In order to meet the bid's criteria, two local challenges were identified which could be addressed (in part) through mobilising volunteers. A total of four service initiatives were included, adapting the 'blueprints' from the US Cities of Service programme to reflect existing priorities in the city. These are shown in the table below.

Challenge A - **Creating positive learning experiences: how communities can expand their expectations of themselves and those around them through impactful volunteering.**	Challenge B - **Building resilient communities: how volunteering can keep your neighbours and neighbourhood safe, healthy and independent.**
Service Initiative 1 **'Coaching and Mentoring':** We will identify those pupils in years 10 and 11 who are most at risk of not achieving the results at GCSE that they need in order to achieve their goals and provide them with mentoring support from local volunteers. Our aim is to trial this in one secondary school in the city that serves some of our most challenged communities	Service Initiative 3 **'Love Your Street':** Team Portsmouth will mobilise volunteers to address a whole range of social issues that impact on local people's wellbeing. E.g. mobilising local neighbourhoods to improve the physical environment around them, or helping people in older terraced housing to address the thermal comfort and energy efficiency of their home, supporting neighbours with loft clearance etc.
Service Initiative 2 **'Numeracy Challenge':** To raise levels of numeracy in the city, residents will be encouraged to assess their current level of numeracy using an online evaluation tool. At the end of the assessment, the individual will receive information on their level of numeracy and advice and guidance on how to improve it. We will recruit and train volunteer mentors to support people with online assessment and learning.	Service Initiative 4 **'Volunteer Neighbour Navigators':** Through the mobilisation of local volunteers we would create a band of Neighbourhood Navigators who would help vulnerable residents to safely access and explore their community. We would like initially to run a small project in a neighbourhood / geographic area where we know that a number of vulnerable adult residents would benefit from using assistive technology but are unable to be supported by relatives in response to call outs.

4.5 The challenges are at various stages of completeness, but were explicitly developed with the aim of providing additional momentum and support behind programmes which already had local support. The schemes will begin in neighbourhoods in different parts of the city but will aim to be rolled out more widely if successful. We are also keen to explore ways in which the City of Service funding can similarly be used to add momentum to other service initiatives, while recognising that the funding must be used within the conditions on which it is granted.

4.6 A multi-agency steering group led by the Director of Public Health has been established. Sub-groups have been set up to further develop the plans for each service initiative. This will include identifying additional resources to support delivery by refocusing existing planned spend and leveraging in new resource from partners. Plans are in place to engage a wider range of stakeholders over the coming months. The City of Service Plan (and the national programme) will be launched in June 2014.

4.7 A Chief Service Officer (CSO) will be recruited, using the money specifically granted to the council by Nesta for this purpose. The CSO will lead the development and implementation of the City of Service Plan and will leverage in additional resources e.g. corporate sponsorship to enable piloting the initiatives to demonstrate their impact.

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Signed by:

Janet Maxwell, Director of Public Health

Appendices:

Background list of documents: Section 100D of the Local Government Act 1972

The following documents disclose facts or matters, which have been relied upon to a material extent by the author in preparing this report:

Title of document	Location
Team Portsmouth City of Service Application	W:_SHARED\City of Service

The recommendation(s) set out above were approved/ approved as amended/ deferred/ rejected by …… on ……

……
Signed by:

Portsmouth CITY COUNCIL

Agenda item:

Title of meeting:	Health and Well Being Board
Date of meeting:	26th February 2014
Subject:	Joint Health and Wellbeing Strategy 2014 - 2017: emerging themes and priorities
Report by:	Dr Janet Maxwell, Director of Public Health
Wards affected:	All
Key decision:	No
Full Council decision:	No

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1. Purpose

1.1 The purpose of this report is to set out the emerging themes and potential priorities which the HWB is asked to consider as it develops a refreshed Joint Health and Wellbeing Strategy for 2014-2017.

2. Recommendations:

2.1 The Health and Wellbeing Board are asked to

- Endorse the process and timescales for the refresh of the JHWS as set out in this report.
- Discuss the suggested themes at 6.5, which will be expanded on in presentation to the HWB, and agree that these should form the basis of a JHWS for the period 2014-17.
- Consider the potential priorities set out in section 6.6 to 6.10 and in the presentation to the board, and identify any gaps or areas for further consideration.

3. Summary

3.1 Portsmouth's Health and Wellbeing Board (HWB) have agreed to develop a refreshed Joint Health and Wellbeing Strategy (JHWS) covering the period 2014-2017. This is part of an aligned approach across our strategic partnerships. The HWB have also agreed that the strategy will address health and wellbeing in the widest sense, maximising the opportunities provided by the local authority's new

role in public health and the CCG's clinical leadership of health commissioning locally.

3.2 This report will:

- Provide a recap of 2012/13-13/14 JHWS
- Suggest how the refresh can build on the strong foundations in place to develop a strategy that provides a compelling narrative describing the board's ambitions for the local community. This will include some indicative priority themes and objectives for illustrative purposes
- Set out the process and timescales planned for the refresh of the JHWS
- Set out suggested priority themes and seek agreement from the board that these will form the basis of the refresh

4 A recap of the 2012/13 - 2013/14 strategy

4.1 In its 'shadow' phase, the HWB developed a Joint Health and Wellbeing Strategy which covered the period 2012/13 to 2013/14. The Health and Social Care Act 2012, while not enacted at that point, had made it clear that amongst the HWB's key responsibilities would be to oversee the production of Joint Strategic Needs Analysis (JSNA) and to develop a JHWS to address the issues identified within it. For detailed background see previous reports to Cabinet or HWB.

4.2 The HWB wanted a strategy in place by summer 2012 and agreed to focus on priorities where they could most readily demonstrate their impact as lead commissioners of health and social care.

4.3 Key topics were picked out from the JSNA for a 'deep-dive', and local needs were cross referenced with organisational priorities for key HWB partners. Priorities and planned activity to address them were identified in relation to:

- Dementia
- Supporting people to remain independent at home
- Pre-birth to 5 years old
- Quality and safeguarding

4.4 The JHWS has delivered on its aim to capture some of the key priorities for health and social care commissioners, with reports back on progress on key activity underpinning these at various points since. The HWB has been able to respond flexibly to local priorities as they have emerged, focussing for example on developing and articulating a vision for the local health and care system.

4.5 It is important that, in refreshing the strategy, Portsmouth's HWB does not lose sight of the strengths of its existing work. The Vision set out in the strategy was the basis

of development work around the Integration Transformation Fund led by the Health and Social Care Partnership and underpinned the Integration Pioneer bid.

4.6 However, it is also important to recognise that there is much more to do. In particular, while there is clarity about the priorities, their narrow focus has arguably prevented the JHWS from becoming widely understood as the strategic plan for health and wellbeing in the city.

5 Refreshing the strategy

5.1 The HWB agreed in December 2013 that "the scope of the Joint Health and Wellbeing Strategy should be broadened during the refresh in 2014 to cover wider issues impacting on health and wellbeing" as identified in the JSNA.

5.2 Workshops with a wide range of stakeholders including board members and members of the public highlighted some of the ways in which a broader conception of the HWB's leadership role could influence health and wellbeing in the city by working with different partners, sectors and communities.

5.3 The membership of the HWB brings together the system leaders - commissioners of health and care services, leaders across the breadth of local government's remit, and representatives of the voice of patients, service users and communities. The refresh of the JHWS, coordinated by Public Health but fully involving all partners, is an opportunity to fulfil the HWB's leadership role and address some of the key health and wellbeing challenges facing Portsmouth. The timescale for the rest of the process is set at appendix A.

5.4 The strategy will:

- set out a vision for health and wellbeing in Portsmouth around key themes
- identify the most important issues that will need to be tackled
- be clear who leads on each issue, including where another strategic partnership has already developed a plan
- Within the most important issues identified in the strategy as a whole, priorities those where the HWB will target its efforts in the short and medium term

5.5 Officers from the city's key strategic partnerships have been working together to aligning strategies and the governance that underpins them. As part of that, it is suggested that there should be a common expectation of what being a 'strategic priority' should be entail:

- A broad vision of what we are trying to improve
- An outline analysis of the issues and evidence of what works

- Clear set of manageable workstreams
- A set of measurable and 'monitorable' outcome indicators
- A set of measurable and 'monitorable' output indicators
- An action plan - who does what by when
- Linked delivery level plans or strategies where needed.
- A robust performance management process.

6. From needs analysis to themes and potential HWB priorities

6.1 The Joint Strategic Needs Assessment Annual Summary 2013 presents the big picture of health and wellbeing need in the city. All the information providing '**the** big picture' (data, charts, maps, reports, evidence of effectiveness etc.) is at: **http://www.portsmouth.gov.uk/living/19059.html** The 'Strategic Summary' provides a narrative of what this all means for Portsmouth and is set out in full at appendix B to this report.

6.2 Analysis in the JSNA identifies areas which would have most impact to improve the health and wellbeing of local people: tackling poverty; continuing to improve GCSE attainment; improving the health and wellbeing of males; and promoting healthy lifestyles for young people and adults (smoking, alcohol, healthy weight and mental wellbeing). Preventing the need for costly services to 'cure' problems by intervening earlier has long been established in principle across a range of health and care services. A period of declining budgets makes this need all the more pressing, yet more difficult to achieve as well. Working with local communities to achieve change will be essential, not just because, as a public sector, we can't afford the alternative but also because it works.

6.3 The NHS, local government, Public Health England and others recently set out a shared Sustainable Development Strategy which highlighted a further area strand underpinning many of the issues identified in the JSNA. As the strategy states, "a sustainable health and care system works within the available environmental and social resources protecting and improving health now and for future generations. This means working to reduce carbon emissions, minimising waste and pollution, making the best use of scarce resources, building resilience to a changing climate and nurturing community strengths and assets."

6.4 Our Vision, developed for the 2012 JHWS and revised and refreshed for the Better Care Fund Plan, is as follows:

Our vision is for everyone in Portsmouth to live healthy, fulfilling lives. When support is required, it will be tailored to the needs of the individual and delivered at the right time and in the right setting.

We will commission cost effective services that work together as one, intervening earlier, promoting independence and reducing inequality.

Pathways will be un-complicated; services will be accessible and convenient; people will be well-informed, in control and able to choose the support that is right for them.

6.5 Building on all the points above, the Joint Health and Wellbeing Strategy 2014-2017 will set out how local efforts to achieve this are underpinned by five key themes:

a) reducing inequality

b) giving children and young people the best possible start in life

c) creating healthy environments and resilient communities

d) promoting prevention

e) intervening earlier

6.6 Within each theme, there will be key issues or priorities that need to be tackled in order to achieve the board's vision. An initial set are set out in the table below. These will be refined over the coming months, subject to any changes the HWB makes to the themes in 6.5 (above).

6.7 Some of these issues/priorities for the city are already led by other partnerships or organisations with a clear plan agreed or in development (fulfilling the requirements suggested in section 5.5 above). Therefore while they are all important as part of the overall vision / strategy, only those in **bold** are suggested as forming the HWB's priorities.

6.8 Where another partnership is leading on this issue, this has been added *in italics*. The expectation is that the lead partnership will ensure the criteria set out in section 5.5 are in place. For some of the issues identified as potential HWB priorities, there are strategies or plans in place. Others will require more leadership from the board. The intention is to discuss and agree the thematic areas now, with the priorities agreed by the next meeting of the HWB in June 2014.

6.9 **The HWB are asked to agree the five key themes in section 6.5 and consider the potential priorities within those in the table below.**

6.10 Suggested priorities under each theme:

Thematic area	*Reducing inequality*	*Best possible start in life*	*Healthy environments and resilient communities*	*Promoting prevention*	*Intervening earlier*
Suggested Potential Priority	**Tackling Poverty**	Identification, assessment and support for families from 0-5 years old *CTB priority A*	**Explore and enhance community development models**	**Explore the role housing plays in determining wider health and wellbeing outcomes**	**Dementia**
	Reducing health inequalities among vulnerable groups	Reducing the attainment gap *CTB priority C*	**Support formal and informal carers**	**Promote healthy lifestyles**	Improving outcomes for families with multiple problems *CTB priority B*
	Overcoming health-related barriers to employment	**Improving emotional wellbeing of children and young people**	**Create sustainable environments that promote health and wellbeing**	Alcohol *SPP priority*	**Managing long-term conditions**
				Safeguarding	**End of Life Care**

7 Reasons for recommendations

7.1 This is an opportune time for the Health and Wellbeing Board to review its priorities to inform the development of the new Health and Wellbeing Strategy from 2014, taking into account the wider socio economic context for addressing the determinants of poor health and the priorities and challenges for Portsmouth which have been highlighted in the JSNA.

8. Equality Impact Assessment (EIA)

8.1 A full EIA will be carried out on the JHWS before it is approved.

9. Head of Legal's comments

9.1 There are no other immediate legal implications arising from this report

10. Head of Finance's comments

10.1 There are no direct financial implications contained within the recommendations of this report. However, whilst it is difficult to quantify, any improvement in the health and wellbeing of our residents has the potential to yield financial benefits to the City Council and other public sector partners through reduced demand for services and efficiency gains where NHS, City Council and other services are delivered in a more co-ordinated way.

……

Signed by: Dr Janet Maxwell, Director of Public Health

Appendices:
A - Timescales for refresh
B - summary of the JSNA

Background list of documents: Section 100D of the Local Government Act 1972

The following documents disclose facts or matters, which have been relied upon to a material extent by the author in preparing this report:

Title of document	Location

The recommendation(s) set out above were approved/ approved as amended/ deferred/ rejected by …… on ……

……
Signed by:

Appendix A - timescales for refresh of JHWS

September 2013	HWB agreed move to aligned 3 year cycle of priority setting with refreshed JHWS 2014 - 2017
December 2013	HWB received annual summary of the JSNA identifying key issues for the city, and agreed in principle to a broader strategy tackling wider determinants of health
February 2014	Public Health to lead discussion on headline strategic themes for refreshed JHWS and potential priorities
May/June 2014	Agreement of strategic themes and priorities, and headline outcome measures
June - September 2014	Engagement with partners, communities etc to reflect on the priorities and refine the plans for addressing them. This will include detailed measures for progress and named leads for each area of activity.
September 2014	HWB approve final refreshed JHWS 2014-2017

The big picture of health and wellbeing
Strategic Summary, 2013

Understanding Health and Wellbeing[1] in Portsmouth

Introduction

The Joint Strategic Needs Assessment (JSNA) is a continuous process that identifies the current and future health and wellbeing issues for the people of Portsmouth. To do this, we draw together research and information on a wide range of health and wellbeing topics and then try to find out the root causes and the most effective ways to tackle them including identifying the most complex '*wicked issues*[2]'.

We use this information in planning, commissioning and delivering services to reduce health inequalities and improve and protect the health and wellbeing of Portsmouth's residents. In particular, the JSNA findings inform and challenge the objectives set out in the Joint Health and Wellbeing Strategy: http://www.portsmouth.gov.uk/media/JHWellbeingStrategy201213and201314.pdf

The information in the JSNA helps us to check and ask:

- Have we considered demographic changes when planning future services?

- What are the future pressures on services and how can we respond to this?
- Are there any significant areas of unmet need?
- Are services in the city appropriately targeted and tailored to reflect need?
- Are there areas where we can link up to improve service outcomes?

In 2012, Portsmouth became a UK Healthy City and its core themes of this are reflected throughout this document. This is a brief summary of the findings of the JSNA. A more detailed report and the body of information that provides 'the big picture' (the data, charts, maps,

[1] Wellbeing refers to how people are able to experience their lives and flourish and therefore incorporates economic, social, health and environmental wellbeing.
[2] Wicked problems are complex often intractable challenges with interconnected and multiple causes. As such they require a shared reflection, debate and actions.

reports and evidence of effectiveness) is available at: http://protohub.net/jsna/portsmouth-jsna/ (The sources for the data in this summary are also available on the website.)

Overview

Portsmouth is a growing city with expanding population and developing economy. Many indicators show improvements in health and wellbeing but there are some indicators where more needs to be done and this document sets these out. Perhaps the main story is the differences within Portsmouth. Sometimes the overall picture can hide the different experiences for different areas and population groups. Where you live in the city is one of the biggest factors affecting your health.

Portsmouth's population has grown by nearly 10% since 2001 and is predicted to grow by a further 4.5% by 2021. The 208,900 city residents live in the most densely populated area outside of London. Population change is not spread evenly with some electoral wards seeing more growth than others. The largest increases are in St Thomas (31%) and Charles Dickens (22%). This may reflect housing development in the area and student accommodation increases. Only two wards, Nelson (-2.1%) and Paulsgrove (-1.2%) had a population decrease.

Portsmouth has a relatively young population, with 69% aged between 15 and 64 years (compared to 66% in England and 65% across the South East). The peak (and growing) age group is 20 to 24 years with 11% of our population in this age band (compared to 7% nationally). This is followed by age bands 25 to 29 years and 15 to 19 years. The number of young adults partly reflects the growing student population with nearly 18,400 full time and 4,000 part time students at the University of Portsmouth. This provides a large and growing working age population (16 to 64 years) and this will grow further between 2013 and 2021. This is potentially a good source of skilled workers to fill jobs as we develop the local economy.

The growth in the young adult age group may predict other changes. Portsmouth has a higher than average number of 0 to 4 year olds, which may be linked to the higher than average young adult population. The under 5s population is projected to grow by just 1% over the next 10 years but the population aged 5 to 15 years , is projected to grow by 9%. This will mean growing demand on services for pre-school and school age children over the next ten years.

There has been a small increase in the 65 to 74 year old population (1%) and a more significant growth in the 85 and over age group (12%). The over 65 age group will also continue to grow over the next ten years - especially the over 85s from 4,000 to 5,200 (19.5% increase). This will impact on people caring for family and loved ones, and on our services.

Sixteen per cent of city residents are from Black and Minority Ethnic (BME) communities[3]. The six largest BME communities are: Other White (3.8%), Bangladeshi (1.8%), African (1.4%), Indian (1.4%), Other Asian (1.3%) and Chinese (1.3%). Polish is the largest single ethnicity within the Other White group (0.8% of the total population). All BME communities have a larger proportion of their community of working age than White British. Some health and wellbeing issues adversely impact our BME communities.

In terms of deprivation, Portsmouth is ranked 84th out of 324 local authorities (where one is the most deprived) using indicators such as income, employment, health, education and barriers to housing and services. However, these indicators are not evenly spread, with

[3] This compares to 20% across England. BME communities include White Irish and White non-British communities.

Charles Dickens, Paulsgrove, Cosham and St Thomas wards experiencing higher deprivation levels. Charles Dickens has the most deprived smaller areas for income, employment, health, crime and education skills and training.

Growing up in poverty has a significantly negative impact on health and wellbeing outcomes for children. By the age of three years, children in poverty are estimated to be, on average, six months behind their peers in estimated school readiness. The impact of poverty is cumulative throughout schooling with the gap widening - and the consequences are wide ranging and long lasting. Children from lower income families are less likely to do well in school and are more likely to suffer ill health and face other pressures in their lives. Childhood poverty has the potential to expose children to more risk factors related to substance misuse, anti-social behaviour and criminality. However, bolstering "protective factors"[4] can mitigate this. Some areas of the city experience more childhood poverty than others.

Poverty also costs society, with government spending needed to boost protective factors and counter the effects - as well as the economic costs of children failing to reach their potential. It is estimated that child poverty costs Portsmouth £121 million every year.

The current recession continues to have an adverse effect on city residents. Last year (2011/12) twice as many people used one of the the city's food banks[5] than the previous year. Between 1 January and 30 September 2013 just under 2,000 food vouchers were given out (50% more than the same time last year). Money, debt and benefits advice services are reporting record numbers of people asking for assistance, rent arrears are increasing and about 131 families have been hit by the benefits cap each losing on average £73 per week. In addition, nearly 11% of households are in fuel poverty. This increases to 48% for households in the lowest income brackets[6]. National homelessness figures show that there has been a growth in homelessness since the recession began (9% increase between 2011 and 2012)[7]. The recession will continue to impact negatively on overall health and wellbeing indicators for those on the lowest income and living below the poverty line.

Portsmouth, like England and Wales as a whole, has seen a sharp decline in crime rates. There were approximately 90 crimes per 1,000 residents in 2012/2013 compared to 146 crimes per 1,000 in 2006/07. We have also seen a significant reduction in the number of young people entering the criminal justice system for the first time, with the successful implementation of a triage system[8]. However, there are continued priority issues that need to be addressed; reducing violent crime specifically domestic abuse, reducing reoffending by our most challenging offenders and young offenders, addressing crime and offending related to alcohol and drug misuse and maintaining the reductions in first time offending that are supported by bolstering protective factors around children and young people. This may be more challenging with the predicted growth in the youth population.

Creating a better environment

[4] Protective factors are those that may prevent risk from occurring, or block the adverse effects or interrupt the chain by which risk factors influence behaviour. Some of these factors are individual characteristics that cannot be easily changed such as genetic vulnerability. However, other factors such as individual resilience, strong social bonds especially with parents, interaction within the community or bonds with teachers amongst others, can mitigate some risk.
[5] The main reason for using the food bank was delays or changes to benefits.
[6] 78% of households in Portsmouth are in the private sector. The 2008 Private Sector Housing Stock Condition survey found that just over 1/3rd of private housing failed to meet the Decent Homes Standard (set for social housing) with the main reason being insufficient thermal comfort (or lack of central heating). Fuel poverty is more prevalent in the private sector (15% of households).
[7] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/8107/22109391.pdf
[8] Triage, now known as Youth Restorative Disposals, are where young people who are seen as low risk of reoffending are diverted from the criminal justice system through a more informal process.

Portsmouth is a developing and well-connected city with motorway, A road and mainline rail connections to and from the city and domestic and international ferry routes. However, there are limitations to road capacity with only three road routes on and off Portsea Island. This can impact on connectivity and lead to congestion. Residents have also highlighted the affordability of public transport specifically high bus fares as a concern.

There are 85,473 households in the city, 6,754 (c8%) more than in 2001. Owner-occupiers still make up the majority, representing 56% of households (although this is less than the 64% of owner occupiers across the UK). The biggest change in the last ten years has been an increase in the number of households renting from a private landlord or letting agency making up 22% of all households. Although below the overall UK rate, this represents a significant increase of 87% (n19,044). This change in tenure suggests both a boost in buy to let property and potentially poor quality housing. More research is needed to understand how this may impact on health and wellbeing as much depends on the quality of housing in this changing sector and issues relating to over-crowding, damp, draughts and cold.

Within its group of 19 similar authorities, Portsmouth has the highest rate of statutory homelessness. It is also significantly higher than the England and South East average for statutory homelessness. More needs to be done to understand what this is telling us but it may reflect housing poverty issues.
The city faces constraints on its land space bounded on three sides by the sea and Portsdown Hill to the north and much of the city's land is in the tidal flood plain. There are current flood risks, land contamination from past industry and further potential for climate change to increase vulnerability through increased risk of flooding. Current flood defences are not sufficient and a consultation process is currently underway to review options.

The city council has a target to reduce its carbon footprint by 30% by 2016/17. Current (2012) rates of CO2 emissions from Industry and Commerce and Road Transport Sources are similar to the national averages[9]. However, 32% of CO2 emissions in the city are from domestic sources compared to about 15% nationally. Air quality impacts on health and long term reductions in CO2 emissions may impact significantly on wellbeing.

However, whilst the city has restricted land space, it also has a rich natural environment with a wealth of parks, green corridors, sea front, historic and architecturally important buildings and visitor attractions. Our children are well provided for in terms of play spaces with most homes being within 800 metres of a play area. However, city residents responded to a survey in 2010 by saying there were not sufficient activities for children and young people in the city.

As a relatively flat and compact city, Portsmouth also offers opportunities for walking and cycling than could be better exploited to help improve the health and wellbeing of city residents. However, currently adult participation in sport and recreation in the city is below national and regional levels and has declined from 39% in 2009/10 to just 31% in 2012/13. In stark terms, if adult participation in sport increased to 50% of 40 to 79 year olds, 47 deaths would be prevented, and if increased to 75% then 89 deaths could be prevented. With the potential for easy access to sport and recreation, this could have a major impact on some health and wellbeing indicators.

The economy

[9] Industry and Commerce: Portsmouth 43% National 44%; Road Transport, Portsmouth 25%, national just under 25%

Portsmouth is an employment and visitor hub for the sub-region especially Fareham, Gosport, and Havant. This role has developed over the last ten years and brings with it potential growth and city income and investment. However, there are more commuters coming into the city than going out. In-commuters tend to occupy the better paid / higher level jobs. Both prosperity (gross value added per head) and productivity (gross value added by job filled) in Portsmouth are below expectation and not as high as similar areas. This may be because residents of working age continue to have comparatively low skills and economic developments may not have benefited city residents to the same degree as people coming into the city to work. Additionally, there are challenges faced by firms wishing to expand with limited land space and, most critically, the city is reliant upon a few large businesses with 23% of the workforce employed within 0.2% of business creating a potential risk factor. These include the Royal Navy and its associated heritage industry, business in the defence, maritime and aerospace sectors and a high dependence on the public sector including public administration and defence, education, health and social work. The current proposal to end shipbuilding contracts will impact negatively on the city economy, health and wellbeing.

Meaningful employment is important to health and wellbeing. Unemployment rates remain around 11% (compared to 5.6% nationally). However, only 3% of the working age population claims out of work benefits, with higher claimant rates in more deprived areas: Charles Dickens (5.7%), Nelson (4.1%) and Fratton (3.8%).

The current city strategy for regeneration, promoting Portsmouth as a great waterfront city and physically redeveloping sites (such as Tipner) is aimed at improving social outcomes for city residents by improving access to education, skills and employment and bringing more employment and more visitors to the city.

Children and young people

One of our greatest challenges will be to address the needs of a growing population of children and young people. Portsmouth has more young people aged under 16 years than ten years ago and this will continue to grow. Education, health and other services must continue to meet the challenge of population growth.

We face some very specific challenges. Currently, Portsmouth's young people have lower than the national average GCSE attainment and fewer 16 to 18 year olds in education, employment or training. We also have some poor health indicators including more hospital admissions as a result of self-harm, more children killed or seriously injured in road traffic accidents, a higher rate of teenage pregnancy (under 18 years) and more acute sexually transmitted infections in young people aged 15 to 24 years. Twenty-three per cent of children are obese when they start primary school and 36% are obese when they leave. Investing in the health and wellbeing of our children and young people will have long term benefits for all, not least because the foundations for a healthy and fulfilling adult life are established in childhood. .

About a quarter of city children grow up in poverty, which is above the England average. In some areas the number of children growing up in poverty is far higher: 67% in Landport, 66% in City North and sub-areas of Charles Dickens ward. The 2011 Census found that over 15% of households in Wymering, Buckland Stamshaw, Fratton and Paulsgrove had a triple combination of adults not in employment; long-term health issues and dependent children aged 0 to 4 years. Compared to England, Portsmouth also had more children facing family homelessness and more children in care. All of these are critical determinants of future life chances

The early years matter because they lay the cognitive and social foundations for children's future lives. Research across city services identifies a number of risk indicators that will impact in some way on the lives of children and young people. These include health, family, individual, peer group / community, education and social factors. It is the combination of these without counter-balancing protective factors that will impact most severely on children's lives. Bolstering protective factors within the home or through service interventions can have a positive impact. Much more detail is provided in the main JSNA and in related national research. However, in summary, the table below sets out some of the key indicators that if addressed will impact positively on long-term outcomes.

Health	Parental depression or mental illness Parental alcohol or drug misuse Smoking during pregnancy Parental illness of disability
Family	Domestic abuse Teenage mother Household overcrowding Financial stress and debt / Parental lack of basic skills / worklessness Parents attitude to offending / parents committing crime / prison[10] Poor parental supervision / discipline / neglect Family disruption
Peer group/ Community	Disadvantaged neighbourhood: high levels of unemployment and poverty Access to drug and alcohol / evidence of substance misuse ASB and criminality Access to facilities Poor levels of community cohesion / community disorganization or neglect often shown by high turnover of population Population density
Education	Low achievement (beginning in primary school) Organisation and ethos of school Absence from school Exclusion from school Aggressive behaviour including bullying
Individual Factors	Hyper-activity, impulsivity and cognitive impairment Unemployment[11] Early involvement in crime or drug or alcohol misuse

We know that experiences in early years can have life-long outcomes in terms of health, economic status, education achievement and general wellbeing. The systems review of families found that the issues involved with families with multiple problems included: domestic violence and abuse; mental health issues, drug and alcohol misuse, multiple home moves, anti-social behaviour, multiple fathers / step fathers, offending behaviour, debt, historic sex abuse, parents in prison, parents who left school early, complex school issues including truancy, exclusion and teenage pregnancy and workless-ness. Working alongside families and early intervention can stop problems escalating.

There are some generic indicators where Portsmouth is doing well. Sixty-four per cent of city children achieve a good level of development when assessed in reception year (the national average). At the end of key stage 1, Portsmouth children are performing above the national average in reading, writing and maths. In 2012, 87% of students progressed by two levels in Maths between key stage 1 and key stage 2. This is a significant improvement. We are still

[10] E.g: Farringdon (1996) found that 60% of boys whose father had a criminal conviction were at some point convicted themselves.
[11] Although studies suggest this leads to exaggerating existing anti-social or behavioural issues rather than creating them.

below the national average but have halved the gap since 2005. Sadly, this does not continue on to key stage two and the level of improvement is not reflected across all locations in the city with a correlation between lower levels of numeracy and areas of deprivation in the city. Charles Dickens, Cosham, Nelson and Paulsgrove all have higher than average numbers of residents qualified to entry level 3 (equivalent to expected levels of 9 to 11 year old standards). We also need to get more young people aged 16 to 18 years into education training or employment and we remain below the national and regional figures for this.

A recent lifestyle survey of secondary school children, aged between 11 and 15 years, shows promising results with fewer young people having tried alcohol or been drunk within the previous four weeks comparing 2013 with 2012 results. There is a decrease in the proportion of young people who smoke daily and who have ever used cannabis. We also have young people admitted to hospital for alcohol or drug misuse than the England average. However, for some young people substance misuse continues to have an impact and this most often links to those at risk such as young offenders. Addressing substance misuse by young people remains a challenge for the future. (See alcohol section).

Since 2005/06 we have also seen a steady reduction in young people committing crime (particularly for the first time) and the number of crimes committed. However, those young people who do commit crime have a 47% reoffending rate, significantly higher than the national or regional averages (36% and 33.9% respectively). The city has a small but significant cohort of young people committing multiple crimes.

In general, findings suggest that health and wellbeing indicators are poorer for children in need and in care and a focus on working with those most at risk and preventing others from becoming those at risk will have the most significant impact.

Vulnerable adults and those who care for them

People with poor **mental health** have fewer qualifications, find it harder to find and stay in work, have lower incomes, are more likely to face homelessness or be insecurely housed and are more likely to live in areas of high social deprivation. Portsmouth shows a strong correlation between adults receiving Adult Social Care for mental health problems and local areas of deprivation as well as other risk factors relating to family life such as domestic abuse. The links are complex as mental health issues reduce opportunities for good quality housing and employment and increase vulnerability, but lack of employment, housing, access to education and training and personal crimes such as domestic abuse can lead to poor mental health.

About 3,000 city residents over eighteen are estimated to have a **learning disability** of which around 700 were identified by general practitioners (these tend to be those adults with a moderate, severe or profound disability). Adult social care provided a service to 451 clients. Hilsea has the most adults with a learning disability in need of social care, which reflects the location of previous residential services. In general, people with a learning disability have higher rates of gastro-intestinal cancers, coronary heart disease, respiratory disease, mental ill health and challenging behaviour, dementia, epilepsy, sensory impairment, poor oral health and dysphagia and physical impairment. They are also at greater risk of inequalities such as poverty, poor housing, social isolation, discrimination, literacy, personal health risks and access to health care. . The comparatively poor outcomes for people with mental health problems or with a learning disability reinforces the need to draw greater links with relevant strategies such as the tackling poverty strategy and housing strategy amongst others to ensure that their needs are taken into account.

Portsmouth has fewer people aged over 65 years (13%) than the UK as a whole (16%) and fewer older people from BME communities (3% compared to 4% nationally). Thirty-eight per cent of people aged over 65 years live alone (with some wards having higher percentages). One in five of our older population lives in poverty, more in our areas of highest deprivation. Most recent national data shows that Portsmouth has the highest excess Winter death rate of 19 comparator authorities. The highest excess winter deaths were in Francis Avenue, Portsdown, Waverley Road, Prince Albert Road and Stamshaw. There is a strong link between excess Winter deaths and cold and damp homes - often private rented and owner occupied houses built before 1850. This reflects Portsmouth's housing stock. The main local cause of excess Winter deaths, are respiratory diseases such as influenza and chronic obstructive pulmonary disease. It may be possible to target specific groups who are vulnerable because of where they live.

Current estimates are that 2,142 city residents have some form of dementia with 55% having mild dementia, 32% moderate and 13% severe. Only 50 are predicted to be aged under 65 years. Most people with dementia live in the community with only 22% (n478) in residential care.

In connection with this, we also have more people caring for family members and loved ones[12] as we see an ageing population and more people living longer with limiting long term illness. This has a significant impact on the so called 'sandwich population' - those looking after children and their older, ill or disabled loved ones. As our older population continues to grow in size, how best to support people and their carers will continue to be a challenge.

Key health and well-being issues

Life expectancy is a key indicator of the overall health of a population and this can be measured for the city as a whole and in identifying differing trends between our communities. Life expectancy for women in Portsmouth is comparable to the England average. However, male life expectancy in Portsmouth is significantly shorter than the England average. Men living in the most deprived areas live nearly eleven years fewer than those living in the least deprived areas.

Portsmouth men can expect to live 77.7 years with 62.2 years spent in good health (80% of life expectancy in good health). Women can expect to live for 82.8 years with 62 years spent in good health (75% of life expectancy in good health). Healthy life expectancy for men and women is significantly lower than in the South East but not statistically different to England as a whole.

The causes are varied but this year's Annual Public Health Report identifies that to increase male life expectancy, we need to tackle coronary heart disease, chronic cirrhosis of the liver, pneumonia, other cancers and lung cancer. However, shorter male life expectancy is not simply addressed by accessing the necessary health care services but is as much affected by social and cultural issues. This echoes the findings of the Marmot Review in highlighting the importance of addressing early years, education and employment opportunities as well as addressing broader issues relating to smoking and alcohol use to enable healthier life opportunities. Actions are most effective if focused on early support to reduce the likelihood of young people not being in education, employment or training or misusing substances or offending.

[12] There has been a 14% increase since 2001. Nearly 9% (n17,136) of the city's population are now carers.

Smoking is the main reason for the gap in life expectancy between rich and poor. Compared to England, Portsmouth has significantly higher levels of lung cancer registrations, smoking attributable deaths from heart disease, smoking attributable deaths overall, deaths from lung cancer and from chronic obstructive pulmonary disease and mothers continuing to smoke during pregnancy. However, smokers using Portsmouth NHS Smoking Cessation Service are significantly more likely to quit smoking than those using other services across England.

Alcohol is a major contributor to poor health, anti-social and criminal activity and impacts negatively on access to education and employment, which in turn affects financial stability and the family. Just over 20% of the population drink at levels that may harm their health, which is a slightly more than the national and south east averages and when compared to our most similar areas. However, we have a more significant problem with people who binge drink to a level that may harm their health and could lead to longer-term problems with alcohol use. We also have a higher rate of alcohol related hospital admissions than the England average. However, over recent years the gap has been narrowing and we have seen substantial improvements. This is not reflected in hospital admissions relating to young people suggesting we may be turning the curve. Analysis of the most complex anti-social behaviour cases across the city found that 42% of perpetrators misused alcohol and were known to alcohol services including those with regular call outs for police and ambulance services. Compared to England and the South East and compared to similar local authority areas, Portsmouth also has higher than average recorded rates of alcohol related violent crime (even though violent crime has been reducing overall).

Healthy weight: Just less than 24% of adults are estimated to be obese. However, 36% of children aged 10/11 years are obese. This, coupled with lower adult engagement in sport and recreation, could be a cause for future health concerns.

For people of all ages **circulatory diseases** including coronary heart disease (CHD) are the most frequent causes of death locally and nationally. Premature mortality[13] caused by circulatory disease in Portsmouth is falling but is still higher than the national rate (although lower than the average rate of comparator local authorities). Premature mortality from cardio-vascular disease is higher than across the rest of England which suggests the adverse impact of lifestyle behaviours that could prevent premature death. The highest rates of premature mortality due to CHD are Buckland, Paulsgrove, Wymering, Somerstown and Fawcett areas. These mortality rates are also much higher for men than women.

Premature mortality rates due to **cancer** are improving everywhere but the rate of improvement in Portsmouth is lower. Four lifestyle factors account for 34% of cancers smoking, diet, being overweight or obese and drinking alcohol to excess. Locally, there is a very strong relationship between smoking and premature death.

Chronic lower **respiratory disease** (including chronic obstructive pulmonary disease, COPD) is the fourth more frequent cause of death in Portsmouth. Although rates are similar to rates for England as a whole, Portsmouth has far higher rates of hospital admission due to COPD with significantly higher rates from the city centre, Buckland, Paulsgrove, Somerstown and Wymering areas.

What is this telling us about the challenges for the future?

[13] Premature = deaths in people aged under 75 years.

The growing population at a time of recession will continue to place pressures on our services. It is increasingly important to target our resources to best effect and this should be supported by appropriate research and analysis

We already know that where you live in the city impacts on health and wellbeing outcomes with the most deprived areas having more people living in financial stress, living in fuel poverty and facing homelessness and/or worklessness, higher crime rates and poor health. This also means focusing resources to reduce the gap in outcomes across the city. Even where performance is improving across the city, there are pockets of lower levels of achievement, most often affecting in the most deprived areas of the city.

People from BME communities, those with mental health or learning disabilities and older people living in substandard property are also more likely to experience poor health and wellbeing outcomes.

There are also some key drivers for change that need to be addressed which will impact on a range of health and wellbeing outcomes. These are:

- Tackling poverty, debt, worklessness, alcohol misuse, smoking, domestic abuse and reducing re-offending will contribute positively to a range of health indicators
- Bolstering early intervention and building on the protective factors in the lives of young people that will reduce their risk of worklessness, involvement in crime, substance misuse etc
- Working with families with multiple problems across key areas including supporting the review of family based interventions using the Children's Trust Priority B programme. This will inform the response to the JSNA findings
- Developing a similar co-ordinated programme for adults with multiple problems such as those linked into the Adult Intervention Programme and who also take considerable resource. (This might include the Alcohol Frequent Flyers, Complex Anti-social behaviour and Prolific and Priority Offenders, etc)
- Securing safeguarding arrangements for children and for adults in a context of austerity measures and changing organisational structures.

The city's three partnership boards (Health and Wellbeing Board, Children's Trust and Safer Portsmouth Partnership) are committed to working together to research the underpinning issues that cut across and affect all boards.

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