Portsmouth CITY COUNCIL

NOTICE OF MEETING

HEALTH AND WELLBEING BOARD

WEDNESDAY, 17 JUNE 2015 AT 9.00 AM

CONFERENCE ROOM A - CIVIC OFFICES (FLOOR 2)

Telephone enquiries to Lisa Gallacher, Customer & Communications, PCC Tel: 9283 4056
Email: lisa.gallacher@portsmouthcc.gov.uk

Health and Wellbeing Board Members
Councillors Luke Stubbs (Joint Chair), Donna Jones, Neill Young and Gerald Vernon-Jackson
Dr James Hogan (Joint Chair), Dr Janet Maxwell, Innes Richens, Ruth Williams, Di Smith, Rob Watt, Healthwatch Portsmouth, Dianne Sherlock, Sue Harriman, Ursula Ward and Jackie Powell

Plus one other PCCG Executive Member: Dr Linda Collie , Dr Elizabeth Fellows , Dr Dapo Alalade and Dr Tim Wilkinson

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

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

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.

A G E N D A

1 Welcome, introductions and apologies for absence (5 mins)

2 Declarations of Members' Interests

3 Minutes of Previous Meeting - 25 February 2015 and matters arising (5 mins) (Pages 1 - 6)

Matters arising will include:

- Changes to governance recommended by this board in February were fully endorsed by full Council in March and have now taken effect.

RECOMMENDED that the minutes of the HWB meeting of 25 February 2015 be agreed as a correct record.

4 Better Care - update/progress report (20 mins)

Jo York, Head of Better Care
Presentation updating the Board on progress with the Better Care Programme.

5 Portsmouth Dementia Action Plan (10 mins) (Pages 7 - 12)

Information report by Preeti Sheth, Director of Integrated Commissioning to update the HWB on the progress of the Portsmouth Dementia Action Plan and wider older peoples agenda for 2015/16.

6 Use of Public Health Grant (20 mins) (Pages 13 - 16)

Report by Janet Maxwell, Director of Public Health to update the Health and Wellbeing Board on the way forward for distributing the Public Health Grant.

RECOMMENDED that the HWB note the implications of redistribution of the Public Health ring fenced grant.

7 Pre-birth to 5 years old - update on the Health Visitor transfer and the Healthy Child Programme (20 mins) (Pages 17 - 22)

Information report by Janet Maxwell, Director of Public Health, Portsmouth City Council and Ruth Williams, NHS England (Wessex) on this key strand of work. This is to update the Health and Wellbeing Board on pre-birth to 5 public health services; the Health Visiting transfer and Healthy Child Programme.

8 Smoking, Alcohol and Substance Misuse (20 mins) (Pages 23 - 32)

Report by Janet Maxwell, Director of Public Health PCC, to inform the Health & Wellbeing Board of the proposed funding reductions for substance misuse prevention and treatment services in the coming 3 years, what is necessary to achieve these and the likely impact for Portsmouth residents.

RECOMMENDED the Health & Wellbeing Board notes this paper and agrees to discuss the impact of funding reductions to substance misuse provision in Portsmouth.

9 **Integrated Wellbeing Service (information report) (15 mins)** (Pages 33 - 42)

Mary Shek, Transition Manager, Public Health
Introducing the new Wellbeing Service that will see a range of health outcomes addressed holistically within communities. The report updates the Health and Wellbeing Board on progress towards the implementation of the integrated wellbeing service.

10 **Tacking Poverty Strategy draft priorities (information item)** (Pages 43 - 46)

Kate Kennard has provided the draft priorities of the Portsmouth Tackling Poverty Strategy for the information of the HWB Board.

11 **Work programme for the Health & Wellbeing Board (information item)** (Pages 47 - 48)

The HWB work programme/intended list of items for discussion is attached for noting.

12 **Date of next meeting (for information) and briefing on Liver Health Needs Assessment**

To note that the next HWB meeting will be held on Wednesday 16 September at 9am in the Civic Offices.

Please note that there will be a briefing on the Liver Health Needs Assessment from 11.00-11.30am in Conference Room A for board members and the public.

Members of the public are now permitted to use both audio visual recording devices and social media during this meeting, on the understanding that it neither disrupts the meeting or records those stating explicitly that they do not wish to be recorded. Guidance on the use of devices at meetings open to the public is available on the Council's website and posters on the wall of the meeting's venue.

HEALTH AND WELLBEING BOARD

MINUTES OF THE MEETING of the Health and Wellbeing Board held on Wednesday, 25 February 2015 at 10.00 am in Conference Room A, Civic Offices, Portsmouth.

Present

Councillor Frank Jonas (in the Chair)

Councillor Donna Jones
Councillor Gerald Vernon-Jackson

Dr James Hogan
Innes Richens
Julian Wooster
Dr Janet Maxwell
Tom Passarelli, Healthwatch Manager

Non-voting members

Julian Wooster

Officers Present

Matt Gummerson, Jo York, Mark Sage and Joanne Wildsmith

1. Welcome, Apologies for absence, introductions and any declarations of members' interests (AI 1)

Apologies for absence had been received from Councillors Neill Young, Luke Stubbs and John Ferrett, David Williams, Ruth Williams (NHS England) and Tony Horne (Healthwatch).

Councillor Frank Jonas as chair welcomed everyone to the meeting and asked if introductions could be made around the table.

There were no declarations of members' interests.

2. Minutes of previous meeting - 26 November 2014 with Matters Arising - including Pharmaceutical Needs Assessment report (AI 2)

The minutes of the Health & Wellbeing Board meeting held on 26 November 2014 were approved as a correct record by the Board.

There was the following matter arising regarding the **Pharmaceutical Needs Assessment (PNA)** - a paper had been circulated with the agenda which was

to report back after the consultation exercise. This was to be noted by the Board with no changes to the PNA.

3. Health and Wellbeing Board Governance (AI 3)

The report by Matt Gummerson had been circulated separately to members of the board and was available on the website. The changes to the HWB constitution would need ratification by the Full Council.

RESOLVED the members of the Health & Wellbeing Board endorsed the changes to the constitution for the Health & Wellbeing Board as set out in the report for approval by Full Council.

4. Public Health - Portsmouth's 'Plan on a Page' (AI 4)

Janet Maxwell presented this item linking the public health strategy for Portsmouth (Longer, Healthier, Fairer Lives) to the changing needs of the city. The 'Plan on a Page' would be published on the council's website.

The public health agenda was not now just to look at people's cause of death and how they live with long term conditions, but to also to help people lead healthy lives, including the value of mental wellbeing and the wider determinants of health. The Department of Health funding equates to £77 per head for Portsmouth residents from the national fund of £2.79 billion. There was a need to look at lifestyle behaviours as these were developed from young ages and the need to look at the issue holistically and not just individual issues.

Some of the figures quoted were:

- 36,000 smokers in Portsmouth
- 8,300 dependent on alcohol
- 84,000 adults physically active
- 98,000 adults overweight/obese
- 219 early deaths from cancer p.a.

Whilst some of Portsmouth's health comparisons nationally were not favourable Janet Maxwell was pleased to announce that the teenage pregnancy rate continues to fall and is now at the national level.

There would be £1.47 million of public health grant shifted on upstream to address the wider determinants of health. Her report set out the creation of city wide alliances which covered tobacco, alcohol, food and physical activity. There was integration of early years and health visitors to develop the healthy child project and as part of the City Deal there was encouragement of employment among vulnerable groups. Dr Maxwell was involved in developing ways for other directorates to help shape policies to create a healthy city. A Rapid Participatory health needs assessment is being set up to improve engagement with communities in helping agree priorities for action and work had been undertaken with the third sector.

Questions raised were regarding:

- The success of walking to school - the high figures in Portsmouth were to be built on and work continued in promoting safer routes for walking and cycling to school.
- If the effects are known of electronic cigarettes? Janet Maxwell responded that the effects of these were not yet known and whilst there could be benefits on less coming forward for help to prevent smoking there could be changes to behaviours for earlier users.

5. Tackling poverty needs assessment (decision item) (AI 5)

Mark Sage presented this report which was a refresh of the 2011 needs assessment and had looked across the whole community not just the statutory requirement of looking at children in poverty. The draft poverty needs assessment is a large document but it was hoped this would be a useful reference tool and would be included as part of the JSNA. Once approved the accompanying strategy would be written with the aim of improving longer term outcomes addressing issues such as low pay, financial debt and also mitigating the effects of poverty. He requested feedback on the draft before the chair signs off the document for final publication.

Comments on the document included Councillor Donna Jones requesting that there be reference to the spare room subsidy rather than the bedroom tax and Councillor Gerald Vernon-Jackson suggested there be a reference to the encouragement of benefits take-up campaigns. Councillor Gerald Vernon-Jackson also asked regarding the links to affordable housing as there would be less supply of this which would impact on vulnerable families who may be staying in sub-standard accommodation due to the lack of decent affordable housing. Dr Hogan commented that being in poverty makes it more difficult for people to develop healthy behaviours and lifestyles, so it is important to tackle poverty in order to give people the opportunity to make better health choices.

It was agreed that the period for feedback be two weeks before the document was signed off.

RESOLVED (1) that the Health and & Wellbeing Board considered any feedback that it wishes to put in to the needs assessment and discusses this at the meeting

(2) that the needs assessment is then circulated for a final period to the Board after the meeting (for two weeks) to enable Board members to submitted their final views.

(3) that the chair of the Health & Wellbeing Board be authorised to sign off the final needs assessment on behalf of the Board for publication.

6. Better Care Update (AI 6)

A presentation was made to the HWB on the Better Care Fund (BCF) by Jo York, Head of Better Care Programme. Whilst Better Care would formally start in the financial year 15/16 work was already well underway to pool

funding which in Portsmouth would equate to £16 million. From 1 April 2015 there would be joint bank account of PCC and the CCG for the Better Care Fund. There would be co-location of social care and community nursing teams with single locality leadership model. Benefits would include reduced isolation, reduced admissions and re-admissions and the aim was for a 'tell it once' approach. There was also partnership working with Age UK on preventative work and with Solent NHS.

The cluster approach would be three teams for the north, central and south parts of the city, to deliver the service at the same time across the city, working with NHS Solent, GPs and Adult Social Care with teams being in place by April with the co-location and shared leadership.

Outcomes were already being measured with a reduction of total non-elective admissions in hospital being on target for 3% for 2014/15 (the current value was 4,655 actual admissions for the third quarter against projection of 4813) and the plan for 2015/16 is for further 3% reduction of 548 less admissions this year. This information on the slides could be made available to members of the HWB and on the website which will also show the progress on the reduction of admissions to residential and nursing care homes.

Jo York was thanked for her presentation.

7. Creating sustainable healthy environments (AI 7)

A revised version of this report had been circulated in advance of the meeting and made available on the website. Janet Maxwell presented her report which outlined the outcomes of the five seminars that had been held so far working with different directorates:-

(i) Transport and Health - looking at the Portsmouth transport policy refreshing the LPT3 including safer routes to school
(ii) Sustainability and Health - need to work here on renewable energy, working with partners to raise activity and participation in sport and linking with Ben Ainsley Racing to promote involvement in watersports
(iii) Urban Planning and Health - refresh of the Portsmouth Plan with stronger links to planning a healthier environment
(iv) Skills, Employment and Health - developing better health support for people returning to or gaining employment
(v) Housing and Health with work taking place in housing options regarding homelessness and links to poor health

Work had now started around the arts and culture agenda and discussions were underway about funding for work with young people to encourage their building of skills, such as through the 'Strong Voices' programme.

In response to **questions** Janet Maxwell confirmed that:

- the £1.5m public health redistribution funding came from efficiencies from existing services by taking a holistic approach e.g. of work with primary care colleagues around improving community based services

for sexual health and work with Solent NHS Trust for the reshaping of the service.
- The Early Years Service would also include health visitors as part of integrated teams.

Julian Wooster suggested it would be useful to have a further formal report regarding the added value as a result of this series of seminars on building a healthier city and to provide transparency and accountability around the use of Public Health Grant.

8. Mental Health and Wellbeing (AI 8)

Dr Matt Smith presented his report on the establishment and progress of the Mental Health Alliance which had been in place since June 2014 and will lead the development of a mental health strategy (the timeline for this is set out in paragraph 4.5 of the report). He suggested that a draft strategy be brought back to the HWB during the consultation phase.

Arising from **questions** it was reported that:
- The steering group would be taking forward this work to ensure that the strategy is achievable by those expected to deliver it.
- The police are part of the alliance so had been consulted.
- There is a crisis care concordat that is used in the legal process with services sharing information on those apprehended with mental health difficulties.
- The work of the CAMHS team is valued but there is a rising demand and it was noted that there was a national increase in suicide from teenagers. Dr Hogan confirmed that locally Portsmouth mirrored the national picture for suicides and there was a lot of work taking place regarding improving parenting skills which is working well.

9. Work Programme for HWB (information item) (AI 9)

Matthew Gummerson reported that the work programme would be taken as a regular information item to ensure accountability and to give the public view of forthcoming items. It was noted that the Winterbourne View report had been rescheduled to go to the next meeting in June.

10. Date of next meeting (AI 10)

The date of the next meeting was confirmed as 17 June 2015 at 9.00 am at the Civic Offices.

The chair wished to thank Julian Wooster at his last meeting of the HWB because he would be leaving Portsmouth for his new post in Somerset and on behalf of the board wished to thank him for his hard work and also for his support to him as chair. Members of the HWB joined the chair in wishing Julian well in his new post. Julian Wooster responded by expressing his enjoyment of working at PCC and with his health colleagues and being impressed by the high level of integration in Portsmouth.

It was noted that at the next meeting Dr Hogan would be chairing under the new constitutional arrangements.

The meeting concluded at 11.30 am.

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Councillor Frank Jonas
Chair

Portsmouth CITY COUNCIL

THIS ITEM IS FOR INFORMATION ONLY

Title of meeting:	Health and Wellbeing Board
Subject:	Portsmouth Dementia Action Plan 2014 - 2015
Date of meeting:	17th June 2015
Report by:	Director of Integrated Commissioning Unit
Wards affected:	All

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1. **Requested by:** Cabinet Member for Health and Social Care.

2. **Purpose:** **To update the HWB on the progress of the Portsmouth Dementia Action Plan and wider Older peoples agenda for 2015/16.**

3. **Information Requested**

Background

3.1 The term dementia describes a set of symptoms which include a loss of concentration, memory problems, mood and behaviour changes and problems with communication and reasoning. Dementia is a progressive condition with symptoms becoming more severe over time, for which there is currently no cure. People with dementia and their families have to cope with a changing capacity in their ability to manage day to day activities alongside major life event decisions.[1] The projections for Portsmouth estimate an increase from 2015 of 2134 to 3119 by 2030 of the number of people 65 years ad over to have a dementia diagnosis[2].

3.2 Objective one of the Portsmouth Joint Health and Wellbeing Strategy 2014-17[3]is to improve the quality of Dementia services and care. The strategy proposes a number of areas for action and these have been translated into actions within the 14/15 and 15/16 Portsmouth Dementia Action Plan.

[1] Department of Health (2015). *Prime Minister's Challenge on Dementia 2020*.
[2] POPPI data. Projecting Older people population information system
[3] Portsmouth City Council and Portsmouth Clinical Commissioning Group, Joint health and wellbeing strategy 2014-2017 https://www.portsmouth.gov.uk/ext/documents-external/hlth-jhwellbeingstrategy2014-17.pdf

4. Policy context

4.1 Dementia is a growing, global challenge, as the population ages it has become one of the most important health and care issues facing the world. Given this background there are a number of policy documents to support and inform the way forward:

- Living Well With Dementia - A national dementia strategy, DoH, February 2009
- Quality outcomes for people with dementia: Building on the work of the national dementia strategy, DoH, September 2010
- The Prime Minister's Challenge on Dementia: Delivering major improvements in dementia care and research by 2015, DoH, March 2012
- The NHS mandate, a mandate from the Government to the NHS Commissioning Board; April 2013 to March 2015, November 2012
- Prime Ministers Challenge on Dementia 2020

4.2 Each of these documents build on the 2009 national dementia strategy, setting out priorities and areas for service improvement in order to help people with dementia live better lives.

4.3 The NHS and the Adult and Social Care outcomes frameworks have two measures in place to support Enhancing quality of life for people with Dementia. The first part measures diagnosis rates for people with dementia, the second part aims to measure the effectiveness of post diagnosis care in sustaining independence and improving quality of life respectively. Supporting this The National Institute for Health and Clinical Excellence (NICE) has published a number of standards, guidelines and guidance tools for dementia.

5. Dementia prevalence

5.1 Dementia prevalence calculators. (DPC)

There have been a number of updates and changes to the way the dementia diagnostic rates have been calculated, the DPC v. 3 was based on rates from the Delphi consensus, for 15/16 there is an improved modelling system, the Cognitive Function and Ageing Study (CFAS ll) calculator. The different calculators have used different methodologies for calculating the rates, with the latest CFAS ll version providing a more accurate and relevant rate which takes into account the different practice deprivation indices and rates in BME populations.

The latest figures available on the primary care website use DPC v. 3 and shows data up until March 2015. NHS England has also reported separately applying the CFAS ll calculator up until March 2015, with confirmation that NHS England will be using the CFAS ll calculator for planning and monitoring progress going forward for 15/16.

For this report both DPC will be reported, however it is anticipated that for 15/16 onwards only the CFAS ll rates will be reported.

5.2 Prevalence forecasts for Portsmouth in 14/15, taken from the DPC v. 3[4] show

- 2305 residents will have some form of dementia
- 55% (1258) will be mild, 33% (752) will be moderate, 13% (295) will be severe
- About a third (768) will be male and two thirds (1537) will be female
- 1743 will be living in the community and 562 will be living in residential care
- Portsmouth 2014/15 diagnosis rate is 66.29% (1528 people) ranking Portsmouth second within Wessex region, against a national ambition of 67%

5.3 Applying the CFAS ll calculator, using the over 65 year populations, provides an improved diagnosis rate of 72.1%, which achieves the CCG target of 70%.

5.4 The CCG have agreed a target of 72.4% for 15/16 (using the revised calculation method based on the CFAS II denominator). Portsmouth GP practices have significantly improved their diagnosis rates across the city, having been the top performing CCG for most of 14/15 in the Wessex region. This momentum will continue with commitment from the CCG to achieve the revised and uplifted target during 15/16.

5.5 Portsmouth GP practices have signed up to the 2014/15 Dementia Directed Enhanced Service, and the majority of practices opted to sign-up to the additional Dementia Identification Scheme offered by NHS England between October 2014 – March 2015, utilising the Dementia Quality Toolkit; however, the sign-up period for the 2015/16 Dementia Directed Enhanced Service is still ongoing and practices have until the 30th June to sign up.

6. Achievements November 2014 to June 2015

6.1 **The Dementia Steering Group formerly The Dementia Action Group -** This group met monthly during 14/15 to oversee and support delivery of the dementia action plan. It was agreed in January 2015 that the group having been in existence for 3 years, needed to evolve and provide support and governance at a strategic level rather than operational level. Terms of reference were agreed, a change in group name, a revised membership and a new chair alongside a change in meeting frequency, to enable work to be completed. The action plan has also been refreshed to reflect the end of year achievements and new actions will be discussed at the next quarterly meeting in July 15

Organisation	Position
Primary Care	Lead GP Dementia Champion (chair)
Integrated Commissioning Unit Portsmouth City Council /Portsmouth NHS CCG	Older People's Mental Health Programme Lead Senior Project Manager
Solent NHS Trust	Lead Clinician - Older Persons Mental health
Public Health Portsmouth City Council	Advance Health Improvement Practitioner
Lead Provider(s) of commissioned	Service Manager(s)

[4] Dementia prevalence calculator (By clinical commissioning group), adjusted for care homes in the area.

Community and Voluntary Sector Dementia Services	
Portsmouth NHS Hospitals Trust	Head of Nursing for Older People, Rehabilitation and Stroke
Adult Social Care Portsmouth City Council	Asst. Head of Adult Social Care

6.2 Linkages between the work of the Dementia steering group and the wider transformation work for Older People Mental Health services (provided by Solent NHS Trust), is crucial to ensure sustainable services for the future. The Older People Mental Health (OPMH) services transformation group programme is tasked to deliver an agreed redesigned service that will ensure high quality care, and which provides efficient long term sustainable services for the city. This needs to be aligned with the work of third sector organisations to support lower level support of those people diagnosed with dementia and their carers aims to ensure reductions in the need for crisis management when carers become no longer able to cope in their caring role, and aims to reduce pressures within the system by providing a more proactive responsive service for service users and their carers.

6.3 The OPMH transformation programme is due to provide an option paper providing a direction of travel for the service which includes inpatient care, outpatient clinics and community mental health team support. The current thinking suggests the need to rationalise the number of inpatient beds whilst increasing capacity within the community team to wrap support around the patient, enabling them to stay supported within the community maintaining independence for as long as is appropriate. The support provided to people diagnosed with dementia and their carers will be an essential element which feeds into this wider pathway, and will be connected across all the provider organisations.

6.4 It is important to note this work also links into the better care work and the community bed capacity programme of work which is tasked with determining the number and types of beds needed across the city to ensure appropriate levels of care can be provided for the future. This includes placements for those patients with complex mental and or health needs, including challenging behaviours which can make finding suitable care placement extremely difficult.

7 Review of achievements against the 14/15 dementia action plan

7.1 Pilot schemes during 14/15 - The current pilot schemes running across the city provided by Alzheimer's society were due to cease at the end of April, and those provided by Solent Mind and Housing 21 were due to cease at the end of June 2015. Commissioners have secured CCG funding extensions for the Alzheimer's society dementia advisors, memory café's, dementia network and carers support training (CRISP), and the dementia voice nurse service. The pilot scheme run by Solent Mind providing reablement advisors at Queen Alexander Hospital will cease from July 15, as it was considered to have achieved the training targets set, but also provided a level of duplication of roles with the other pilots that within a newly revised pathway could be better managed.

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7.2 The University of East London Dementia Pathway Review Report was completed and shared with commissioners at the end of January 2015. The recommendations from the report have been used to support mapping the needs of service users and their carers for a service going forward. Key recommendations include;

- More focus on prevention rather than interceding at crisis points
- Proactive following of people with dementia and their carers throughout their dementia journey
- A re branded dementia advisor / support worker service
- Reconfiguration of the dementia café's
- Build on successes of the dementia voice nurse
- Longer term contracts to ensure sustainability and engagement from primary care colleagues, commissioned via one lead organisation.
- Inclusion of dementia friendly communities' coordinator role to ensure achievement of dementia friendly city recognition.

7.3 The lead author from the university continues to work with commissioners to support further development of a draft service specification, and will continue to work with service users and their carers to ensure full involvement and participation at all stages of the new pathway development.

7.4 Commissioners are in the process of exploring longer term funding arrangements for this new dementia pathway, so that procurement from the third sector can commence with an anticipated service commencement date of January 2016. A very successful third sector workshop took place in April 15, where the recommendations from the Dementia pathway review report were presented, evidencing the need for future change, sharing best practice from the current pilots, and the opportunity to identify the barriers of joint working between organisations, and what support the providers felt they would need from us to overcome them. A second event is planned during this month.

7.5 Work continues with colleagues in Learning and development to roll out a programme of Dementia Friends training across Portsmouth City Council and Portsmouth Clinical Commissioning Group to raise awareness of dementia. There are a total of 2779 dementia friends now trained across the city, with 102 of these having gone onto also complete the dementia champion training.

7.6 The latest version of the Portsmouth Dementia Action plan can be found online at http://www.portsmouth.gov.uk/yourcouncil/29971.html

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:

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THIS REPORT IS FOR INFORMATION ONLY

Portsmouth CITY COUNCIL

Title of meeting:	Health and Wellbeing Board
Date of meeting:	17 June 2015
Subject:	Use of the Public Health Grant
Report by:	Director of Public Health
Wards affected:	All

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1. Requested by Health and Wellbeing Board

2. Purpose

2.1 To update the Health and Wellbeing Board on the way forward for distributing the Public Health Grant.

3. Recommendations

3.1 That the Health and Wellbeing Board:

a. note the implications of redistribution of the Public Health ring fenced grant.

4. Background

4.1 In October 2013 the Health and Wellbeing Board (HWB) received a report on the way forward for distributing the Public Health Grant in 2014-15 and 2015-16 (Reference A). In summary that report outlined the following:

- The Council's leadership role in tackling the causes of ill-health and reducing health inequalities
- The conditions by which the grant is spent and that it should be used to significantly improve the health and wellbeing of the local population
- Recognition of the continuing reduction on local government financial settlements and the need to redistribute the grant to council services which could potentially meet Public Health outcomes
- Informed by the JSNA, and therefore addressing citywide inequalities and poor health, providing a vision and 'roadmap' for change. This change programme was principally aimed at reshaping traditional public health services to 'achieve more with the resources available, add value to the council's overall offer and that of partner organisations and to ensure more

services are provided in a “joined-up” way’. This efficiency programme was also intended to release funding for redistribution to council services to facilitate better health outcomes for the city.

5. Update

5.1 In the past 18 months a review and redesign of alcohol, obesity and smoking provision has been undertaken, the outcome of which has resulted in the introduction of an in-house integrated wellbeing service that provides a more holistic service to residents. This service is due to be launched on 1 October 2015. A report on the implementation of the integrated wellbeing service is provided separately for the June HWB.

5.2 In parallel, reviews of the Healthy Child Programme, Sexual Health and Substance Misuse Services have, and continue to be, undertaken which address efficiencies and release of funding. A report on the impact of efficiency measures to Substance Misuse, Alcohol and Smoking services is provided separately for the June HWB.

5.3. In February 2015 the HWB received a report by the Director of Public Health on Creating Sustainable Healthy Environments. This report outlined the pan-council work on promoting prevention throughout services to deliver better public health outcomes. Included within the report was a briefing note on the principles of redistributing the grant and how savings are achieved.

6. Finance and redistribution

6.1 To date Portsmouth City Council has received the following annual allocations in the form of a Public Health grant against which a redistribution target has been applied:

Year	Budget	Target	Achieved
2013/14	£15.7M	£1M	604k
2014/15	£16.1M	£1.685M (inc £400k rolled fwd)	£1.685M
2015/16	£16.1M	£1.47M	£1.47M

6.2 To date the total sum redistributed to council services is £3.8M (23.4% of the grant). It is anticipated that pressure on the authority’s overall budget will continue and will correspondingly impact on the grant. If, as in previous years, the same level of percentage saving measures are applied to the grant for 2016/17 it is estimated that another £1.2M will have to be taken from commissioned services resulting in the total for redistributing to £5M (31% of the grant).

6.3 During this financial year city council will receive a £2M allocation in October for Health Visitor commissioning which will be included in the Public Health ring-fenced grant settlement. In addition, following the internal senior management restructure the transfer of Children’s Centres responsibility to the Director of Public Health will inflate the budget by approximately £1.2M. It is anticipated that these allocations will

be included in the Director of Public Health's overall budget bringing it to just over £20M, which could then inflate the overall savings target to £2m; concomitantly these services will have to bear an equitable level of savings alongside other public health commissioned services. If not, then the overall savings target will have to be borne by remainder of the Public Health services.

7. Going forward

7.1 Currently the distribution of the Public Health grant is reasonably balanced toward medium and long-term achievement of better health outcomes for people of Portsmouth. In short, commissioned services support individual behaviour change relating to poor and/or chaotic lifestyles whilst the Creating Sustainable Healthy Environments programme is aimed at the wider determinants of health and bringing about longer term change. Both approaches are however inter-related and necessary to provide a cohesive primary prevention agenda which underpins the reduction in the level of spending on health treatment and social care.

7.2 Going forward, of significant concern is the impact of continued reduction of funding in commissioned public health services and the shift in the balance of funding to other council services. The report on Substance Misuse, Alcohol and Smoking articulates the direct impact such reductions are estimated to have in cost transfer, cost avoidance and likely negative impact on outcome indicators. The import of this report can be equally applied to other Public Health commissioned services. From a contractual perspective there is increasing concern that continued reduction in funding for commissioned serves are likely to make them unsustainable. This reference is made, in particular, to sexual health services and provision of specialist clinical services around sexually transmitted infections and contraception. The principle does however equally apply to other commissioned services for which the grant is provided.

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Signed by: Director of Public Health

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
Public Health Grant use 2014 -2016	PCC HWB shared folder
Creating sustainable healthy environments	PCC website

THIS ITEM IS FOR INFORMATION ONLY

Portsmouth CITY COUNCIL

Agenda item:

Title of meeting:	Health and Wellbeing Board
Subject:	Update from the Pre-birth to 5 years old - Update on the Health Visiting Transfer and Healthy Child Programme
Date of meeting:	17 June 2015
Report by:	Director of Public Health, Portsmouth City Council, and Director of Nursing, NHS England (Wessex).
Wards affected:	All

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1. Requested by Health and Wellbeing Board

2. Purpose

To update the Health and Wellbeing Board on pre-birth to 5 public health services; the Health Visiting transfer and Healthy Child Programme.

3. National context

3.1 The evidence for giving children the best start in life, preventing problems before they arise and intervening early is well established. In recognition of this, the four-year 2011 Health Visiting Programme was established to increase the numbers of health visitors and transform health visiting services. The programme aimed to improve outcomes for children and young people.[i]

3.2 Health Visiting, a workforce of specialist community public health nurses who deliver the universal 0-5 Healthy Child programme. They provide expert advice, support and interventions to families with children in the first years of life, and help empower parents to make decisions that affect their family's future health and wellbeing. This service is led by health visitors and supported by a skill mix team. The service is central to delivering public health outcomes for children.

3.3 The Family Nurse Partnership is an intensive, evidence based, structured, home visiting programme, which is offered to first time parents under the age of 20. A specially trained family nurse visits the mother regularly from early pregnancy until the baby is 2 years old and builds a close, supportive relationship with the family.

3.4 The Healthy Child Programme is an evidence based programme for children and families, including developmental reviews, information and guidance needed to achieve their optimum health and well-being. The HCP aims to improve a range of outcomes such as: strong parental-child attachment; better child social and emotional

well-being; a reduction in childhood obesity; prevention of serious and communicable diseases; improved readiness for school and learning; better short and long-term outcomes for children at risk of social exclusion.[ii]

3.5 The Health Visitor Implementation Plan 2011-15 sets out four-levels of services families can expect from health visitors. The first two elements, are provided universally to all families, the 'Community' and 'Universal' services. Additional support is available for those who need it through the 'Universal Plus' and 'Universal Partnership Plus' elements.

3.6 Commissioning responsibility for public health services for 0-5 year olds (including Health Visiting and Family Nurse Partnership) transfers from NHS England to Local Authorities from on 1 October 2015.

4. Early years services in Portsmouth

4.1 The Pre-birth to 5 Board of the Portsmouth Children's Trust Board aims to "Ensure Portsmouth is a city where all young people get the best possible start in life, focussing on the crucial pre-birth to five years and achieve their full potential." One of its 3 objectives is to "Improve outcomes for the pre-birth to 5 age group through effective and integrated support. This requires a joined-up multi-agency strategy and an increasingly integrated service offer for families with young children."

4.2 Following Portsmouth City Council's Senior Management Review, responsibility for the delivery of Children's Centres moved from the Education to Public Health Directorate from 1st April 2015.

4.3 The Children's Trust Board has agreed an implementation programme to deliver services for 0-19 year olds through Multi-Agency Teams from April 2016.

5. Progress to date

5.1 The Portsmouth Transition Project Group, led by NHS England Wessex team is in place to oversee the transition of public health services 0-5 years from NHS England to Local Authorities. Meetings are held on a bi-monthly basis

5.2 Solent NHS Trust have delivered the Portsmouth City target set through the 2011 Health Visiting Trajectory programme, to increase the number of Qualified health visitors to 60.5 whole time equivalent . The FNP programme has a full complement of staff to deliver places to families in the City. Portsmouth City Council has and continues to fully two nurses as part of an agreement to invest locally in this programme. A number of FNP nurses are also qualified Health Visitors and are included in the overall Health visitor trajectory.

5.3 The funding transfer allocation announced is £3.946m annually, including £30k commissioning costs. The half-year funding for 2015/16 is just under £2m.

5.4 The current Health Visiting NHS contract will novate on 1st October 2015 and expire 31st March 2016. Options for the future contact from April 2016 are being considered,

and a decision will be taken through the Cabinet Member for Health and Social Care. Elements of health visitor service provision are mandated which will present a challenge with the flexibility of the workforce and the potential for efficiencies.

5.5 NHS England have invited the Director of Public Health's representative to shadow their Commissioning Contracts Performance Meeting with the provider, in preparation for transition.

5.6 An integrated Early Years Steering Group was established in January 2015 to explore how Health Visiting and Children's Centres can be integrated, consisting of Early Years, Solent and Public Health. This group has progressed work on joint outcomes and training needs. This has now been superseded by the Multi-Agency Team Board and workstreams.

5.7 The Director of Public Health and Director of Children's Services are meeting regularly to oversee the transition of delivery of Children's Centres from Education to Public Health in response to the PCC Senior Management review and to consider the implications associated with the development of Multi Agency Teams, commissioning, resources and statutory responsibilities

5.8 The Director of Public Health, Director Children's Services and Director of Children's Services at Solent NHS Trust are members of the Multi-Agency Teams Delivery Board.

5.9 The pre-birth to 5 Board has agreed to refresh its targets and Implementation Plan for 2016, so that it can continue monitor outcomes for children pre-birth to 5 and provide assurance to the Children's Trust Board during this period of transformation.

……
Signed by Director of Public Health

Appendix - Examples of the Health Visiting and Family Nurse Partnership work

The following describes how the Healthy Child programme is impacting in real terms for the families and children resident in Portsmouth City.

Health Visiting

Pre and Post natal depression
Maternal mental ill health is common, with around 1 in 10 mothers experiencing mild to moderate postnatal depression. The condition can have a significant impact not only on the mother and baby, but also on her partner and the rest of the family. It is recognised nationally that most pre and postnatal mental health go unrecognised, and are under detected and under reported. Evidence suggests that 10 – 15% of the Health Visitor caseload are identified with Post natal Depression (low maternal mood) by 12 weeks post-natally.

In order to address this improving early identification of mothers suffering with low maternal mood and onwards referral for appropriate care was implemented as part of Commissioning for Quality and Innovation (CQUIN) by NHS England, the current commissioners.

To achieve this Solent NHS Trust trained Health Visiting staff to assess low maternal mood from 6-8 weeks post-natally, assess parental attachment and offer interventions to families.

Further to this sixty health visitors were trained between October and December 2014 to provide 4-6 effective listening visits to support women showing very early signs of mental distress.

As a result of this 95% of women received a recognised maternal mood assessment of which 11% were identified as suffering with a degree of low mood, confirming national evidence. Of those women identified all were referred to an appropriate level of intervention, support and treatment
Initial feedback from both mothers and Health Visitors was positive with women and families receiving appropriate support preventing escalation of symptoms. This work is now embedded as core business within the service.

Family Nurse Partnership

The work of the Portsmouth FNP was commended in the Portsmouth City Council Ofsted report in September 2014 and has been recognised as one of the top performing sites in the country. In October 2014 the team were nominated and won The Portsmouth News Team of the Year award. Furthermore the Portsmouth site was picked as one of two teams from the national FNP programme to feature in The Observer national newspaper illustrating how the programme is improving the outcomes for children and families in their care.

Currently there are 185 clients who have enrolled on the programme. As shown in the table below the Portsmouth FNP service continues to outperform in key health improvement areas than the overall programme nationally.

Outcomes	FNP national programme %	FNP Portsmouth programme %

Breastfeeding initiation	55.8	59.1
Breast feeding at 6 weeks	14.3	19.6
Smoking at booking	36.9	34.6
Smoking at 36 weeks of pregnancy	32.9	29.3
A&E visits due to injury/swallowing 0-12 months	9.4	4.5
Immunisations completed and up to date	91.4	97.5

Portsmouth FNP Annual Report 2015

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

[i] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/407644/overview1-health-visit.pdf

[ii] https://www.gov.uk/government/publications/healthy-child-programme-pregnancy-and-the-first-5-years-of-life

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Agenda Item 8

THIS REPORT IS FOR INFORMATION ONLY

Portsmouth CITY COUNCIL

Agenda item:

Title of meeting:	Health and Wellbeing Board
Date of meeting:	17 June 2015
Subject:	Impact of funding reductions on substance misuse
Report by:	Director of Public Health
Wards affected:	All

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1. Purpose of the report:

To inform the Health & Wellbeing Board of the proposed funding reductions for substance misuse prevention and treatment services in the coming 3 years, what is necessary to achieve these and the likely impact for Portsmouth residents.

2. Recommendation:

The Health & Wellbeing Board notes this paper and agrees to discuss the impact of funding reductions to substance misuse provision in Portsmouth.

3. Background

Portsmouth City Council has a responsibility, as part of its Public Health function, to provide drug and alcohol prevention and treatment services. As an area with above average deprivation, Portsmouth has a higher than average incidence of drug and alcohol misuse, and associated problems.

Why invest in alcohol and drug treatment services?

3.1 Life Expectancy and health

- **At least 2 Portsmouth residents die each week from alcohol related causes**, a higher rate than the national average. Recent data from Public Health England[1] showed that Portsmouth had the 4th highest rate of alcohol-specific deaths[2] in England, behind only Blackpool, Liverpool and Manchester. Our residents are also more likely to die younger and of chronic liver disease than the England average.
- Nationally alcohol related deaths rose 30% between 2001 and 2010.
- Approximately 40,000 Portsmouth residents drink at levels that are harmful to their health.
- Of these around 7,000 will be alcohol dependent.
- Around 4,000 Portsmouth residents are admitted to hospital with an alcohol related condition annually. This used to be the highest rate in the South East and

[1] www.lape.org.uk

[2] These are preventable deaths that are wholly attributable to alcohol and could not have occurred without alcohol. Most of these deaths are due to long term heavy drinking.

significantly higher than the England average. For the past 2 years, following significant investment in prevention and treatment services the Portsmouth rate is now lower than the England average and 4th highest in the South East.

- 17% of road deaths involve alcohol
- Drug use is widespread, but addiction is concentrated, there are an estimated 1,500 heroin and crack cocaine users in Portsmouth.
- Death rates among heroin users are 10 times the rate of the general population
- The use of NPS ("legal highs") is increasing with a corresponding increase in associated health risks.

3.2 Crime and community Safety

- Alcohol is linked to 50% of violent crime, including domestic abuse
- Nationally 40% of prisoners report having used heroin
- A typical heroin user spends £1,400 per month on heroin
- On average any heroin or crack user not in treatment commits crime costing £26, 074 per year
- In 2014/15 the drug arrest referral service provided advice, information and support to 467 people detained in police custody; this led to 98 referrals for drug treatment;
- 831 people were assessed by the alcohol arrest referral paramedic, with 153 referred on for ongoing support;
- 114 people received a "conditional caution" for alcohol related offences, of whom 100 fulfilled the requirement of their condition;
- Between June 2014 and April 2015 the service delivered drug treatment support to 51 people subject to court Drug Rehabilitation Requirements, with 63% of these successfully completing their orders;
- For the 6 months from October 2014 to April 2015, 34 people engaged with support for substance misuse from the through-care worker on release from prison.

3.3 Families and communities

- Nationally 1,200,000 people are effected by drug use in their families, mostly in poorer communities
- Nationally 29% of serious case reviews involve parental drug misuse and 27% mention alcohol
- 13% of our 'troubled families' have substance misuse identified upon referral, although drug and alcohol issues were identified in more cases once families had engaged in the programme.
- The Recovery Hub works with approximately 300 parents, with a total of over 600 children; of these 11 are documented as being subject to Children in Need plans and 27 Child Protection plans - any reduction in drug and alcohol support for these families is likely to increase the immediate and longer-term risks to the children concerned.

4. Cost benefit analysis

Public Health England has undertaken analysis of the costs and benefits of drug treatment, looking at the costs listed above. They have found that:

- **For every £1 spent on young people's drug and alcohol treatment there is a lifetime benefit of £5- £8.**
- **For every £1 spent on adult treatment £2.50 is saved in crime and NHS costs.**

These costs are an average across the whole treatment population. The benefits are greater with more targeted services, for example those targeted at offenders.

In addition PHE found that:

- 1 alcohol nurse in hospital can prevent on average 97 A&E visits and 57 hospital admissions; however our local Alcohol Specialist Nurse Service at QA hospital found an additional weekend nurse prevented 114 admissions and saved 375 overnight stays by engaging patients into treatment and enabling earlier discharge.
- For every 100 alcohol dependent people receiving alcohol treatment 18 A&E visits and 22 hospital admissions are avoided
- The Portsmouth High Impact Patients project works with a small number of alcohol misusing patients who frequently attend A&E or are admitted to hospital. The project has achieved up to a 50% reduction in admissions amongst this group, saving significant sums of money.

In Portsmouth annually we provide:

- Drug treatment to around 900 people per year, 60% of our problematic drug using population.
- Alcohol treatment to around 1000 people per year, just short of 15% of our alcohol dependent population.

We have seen significant reductions in alcohol related violent crime and acquisitive crime in the past 5 years, following a period of gradually increasing resources for prevention and treatment.

5. How much are we planning to dis-invest in drug and alcohol services in the coming years?

Due to the budget setting process and the requirement on public health to redistribute current spend to other parts of the Council there is a requirement to reduce spending on treatment and prevention services.

Drug and alcohol treatment funding is primarily from the Public Health Grant, although there are smaller contributions from Adult Social Care and the Police and Crime Commissioner (currently £220K and £69k per annum respectively). Both of these sources are also anticipated to cease or reduce over the next three years. The table below shows total funding for substance misuse services. This demonstrates the

savings achieved since the transfer of responsibility from the old PCTs to Public Health, primarily through greater efficiencies introduced with the previous re-modelling, as well as the projected further cuts:

Year	total drug/alcohol budgeted spend	Saving achieved or required	
2012/13	£4,829,889	Baseline	*cumulative*
2013/14	£4,330,145	£498,744	*£498,744*
2104/15	£3,884,800	£445,345	*£944,089*
2015/16	£3,404,498	£480,302	*£1,424,391*
2016/17	£3,130,973	£273,525	*£1,697,916*
2017/18	£2,797,178	£333,795	*£2,031,711*

Projections include the proposed cuts to drug and alcohol budgets to facilitate re-distribution of the public health grant and removal of the Social Care funding. From October 2015 some of the Alcohol specific funding will be moved as the Alcohol Interventions Team move into the new Integrated Wellbeing Service. It is anticipated that approximately £105,000 will be reduced from that budget over the course of 2015/6 - 2016/7 which is additional to the totals stated above.

6. How will we manage this reduction in funding and what will the impact be?

The Recovery Hub, hosted in Adult Social Care, currently provides assessment and care coordination for people with drug and alcohol problems. A range of providers including the NHS and voluntary sector deliver medical, counselling and group-work to provide the range of interventions indicated in NICE guidance for drug and alcohol treatment.

The current model has been in place since July 2013, having been designed following consultation with service users to ensure more consistent access to treatment and recovery. Recent evaluation of the model recognised that improvements have been made since its introduction and the latest available performance reports from Public Health England demonstrate marked improvement in the numbers of drug users successfully completing treatment.

In order to further reduce expenditure on the scale set out above we will need to re-tender all these different aspects of provision into a single contract from July 2016, with a reduced amount of provision. A single contract should bring about some economies of scale and management efficiencies which may offset some of the impact of the reduced funding.

One of the most significant areas of expenditure, which has proved very difficult to reduce, is the cost of substitute opiate prescribing. Whilst we hope that the procurement process can provide a more cost effective means of delivering medical interventions, it should be noted that when we re-tendered in 2013, no more cost-effective options were offered. It is also likely that there may be considerable on-off set up costs associated with re-tendering, due to probable reduction in staff numbers and associated redundancy costs.

The reduced management costs alone will not achieve the level of savings required; hence, we do expect that the reduced funding will lead to reduced capacity. Currently there are approximately 51 whole time equivalent clinical and recovery support staff employed across the agencies, supporting approximately 1800 people (drug and alcohol) to address their substance misuse problems. The further reductions proposed would be likely to result in a reduction to 35 wte staff, lowering capacity proportionately would mean approximately 500 fewer people able to be supported per annum. If half of these people are heroin/crack cocaine users, then based on national modelling of drug related offending costing £26,074 per dependent user, this could mean an additional £6.5m in crime and justice costs per annum for the City.

In terms of service delivery reduced capacity will mean reducing the number of people engaging in treatment services and/or reduced accessibility and intensity - e.g. moving from 5 or 7 day per week provision to 3 days per week in some areas of service. The impact is likely to include:

6.1 Reduced Access and Increased Waiting times

Currently we work in a very open preventative way, proactively seeking drug and alcohol misusers (e.g. in hospital or in police cells) to encourage them to access treatment. In order to manage a reduction in capacity the new service may have to:

- Prioritise clients and introduce tighter eligibility criteria. Prioritisation may be on the basis of assessed risk of harm to self or others, or on an assessment of motivation, as focusing on people with higher motivation to change rather than trying to motivate change yields more positive outcomes. Either approach would result in more people continuing to misuse substances with all the negative impacts as noted above.
- People would have to wait longer before being able to access expensive residential detoxification and rehabilitation programmes. Past experience has shown that excessive delays in accessing detoxification, leads to more people "dropping out" of treatment, increased number of relapses and less long term recovery.
- Reduced expenditure on the Alcohol Specialist Nurse Service. The service is very effective at engaging patients into treatment and successfully detoxifying them. However the longer-term effectiveness of these interventions is dependent on sufficient capacity in the community services to support ongoing recovery. This would lead to a reduction in the number of patients receiving alcohol treatment with subsequent increased A&E attendances and increased hospital admissions.
- Reducing the amount of time people spend in treatment, particularly substitute prescribing is already one of the main aims of the services. At present this involves targeting more intensive interventions and attempting to engage longer-term service users with volunteers from the recovery community. However, reduced staff capacity would potentially threaten this work which could lead to increased costs due to more people remaining on long-term prescribing; or, alternatively the introduction of more rigid time-limited prescribing, which is counter to good practice guidance and also potentially ineffective if people discharged when not ready relapse, resulting in increased societal costs and re-presentation for treatment.

6.2 Reduced specialist Criminal Justice provision:

We may have to remove or significantly curtail our criminal justice specialist provision. Within the recovery hub we currently provide specific services for offenders, this includes:

- Arrest Referral - workers visiting police cells to engage drug and alcohol misusing offenders into treatment;
- Through-care engagement and support with offenders in custody to enable more of them to engage with drug and alcohol treatment upon release;
- Support for Community Orders - Drug Rehabilitation Requirements, Alcohol Treatment Requirements and Alcohol Specified Activity Orders;
- Specific criminal justice groups, peer support and accommodation as part of the Integrated Offender Management (IOM) programme.

This additional focused work with offenders enables them to access drug treatment and helps to prevent re-offending. However, it requires more intensive worker input to build motivation and maintain engagement.

Reducing the recovery workforce, would lead to a reduction in the number of offenders able to be maintained in drug and alcohol treatment. There is a well evidenced close link between substance misuse and offending. It is likely that crime, particularly acquisitive and violent crime, and repeat offending will increase if fewer offenders are supported to access and complete treatment.

6.3 Reduced capacity for "Think Family" and Community Focused Working:

Substance misuse services have been at the forefront of developments in more whole-family approaches to working with people who misuse drugs and alcohol. This contributes to the effectiveness of programmes such as the troubled family initiatives and parenting programmes which are crucial to the more preventative approach to health and wellbeing the City is pursuing. Whilst this approach will, in time lead to reduced demand for treatment services, the rapid removal of funding planned for treatment services will make it difficult to sustain staffing resources to contribute fully to inter-agency working as they do now. This would have a negative impact on their ability to support partnership work with initiatives such as positive family futures, mental health services to manage complex dual diagnosis patients, domestic violence interventions; all of which would result in poorer outcomes for the most vulnerable members of our community and increased costs to other areas of the health, social care and justice systems.

7. Summary Considerations:

Whilst expenditure on drug and alcohol services currently represents a relatively high proportion of Public Health spend for the council, this should be viewed in the context of the extent and far reaching impact of problematic alcohol and drug use for the City, in health, criminal justice and community harms. The proposed re-tendering to a single contract service will enable the required savings to be achieved; however, the board

should be aware that the extent, timing and pace of savings required will result in a reduction in scope and quality of service as highlighted in this paper and this is likely to have a negative impact for health, families and communities.

Portsmouth CITY COUNCIL

Appendix A Performance Summary

Substance Misuse Key Performance Indicator Trends:

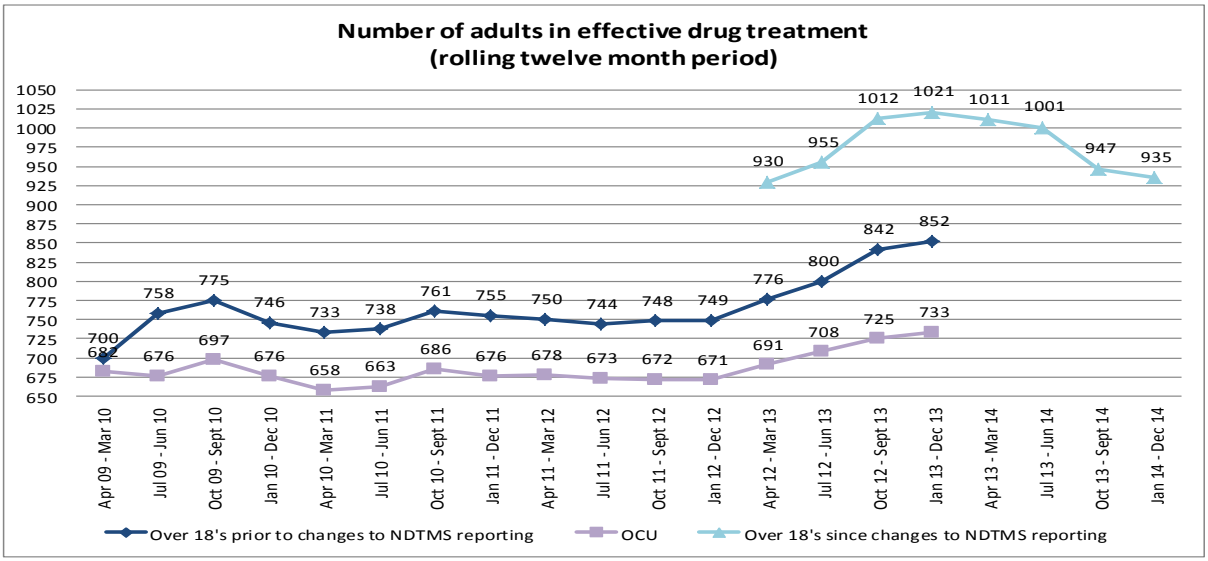
The overarching aim of drug treatment services following the 2010 Drug Strategy is to increase the number of people achieving and sustaining recovery from drug and alcohol problems. The principle performance measure to indicate achievement of this aim is the number of people completing treatment drug free (successful completions) as a proportion of the total number in treatment. Alongside this, supporting key indicators are a reduction in the number of people re-presenting for treatment within six months of completion and sustaining the overall number of people in treatment.

Completions & Re-presentations:

The latest data shows a significant improvement in the proportion of successful completions in Portsmouth. In 2014/15, 11.0% (n82) of those in treatment for opiate use completed successfully and 43.3% (n39) of non-opiate users completed successfully. This is an improvement compared to the previous year when 7.7% (n61) of opiate users and 24.0% (n29) of non-opiate users successfully completed treatment. This builds on gradual improvement over the past year, following a dip in performance prior to and immediately following the re-modelling. Whilst this is an area where Portsmouth was previously performing badly, Portsmouth now ranks 1st out of 8 in the SPP most similar group (MSG), where 8th is the worst, for both opiate and non-opiate successful completions.
Similarly, substantial improvements have been seen in the re-presentation rates for those who have successfully completed treatment. For this purpose, a re-presentation is defined by NDTMS as an individual who successfully completed treatment within a given period and then subsequently represented to treatment within six months. It does not include any clients who re-presented to treatment within 21 days of a successful completion and this is instead counted as one continuous period of treatment.

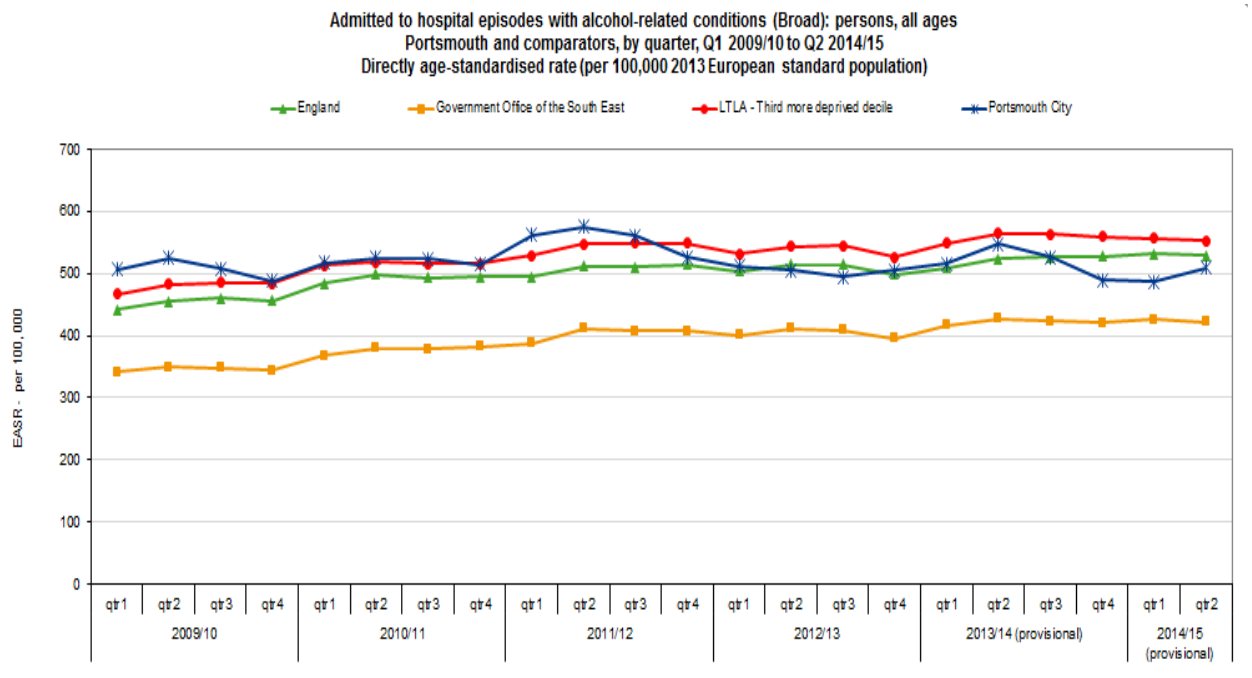
Number in Effective Treatment:

The table below shows the number recorded as being in effective treatment over a rolling 12 month period since 2010. Although the national data method changed in 2013, the period of duplicate reporting shows that Portsmouth initially improved its numbers and has subsequently sustained these since implementation of the new recovery model.



Alcohol Harm Reduction:
The key performance indicators used to gauge performance in reducing alcohol related harm are: the number of alcohol related hospital admissions; numbers of people in treatment for alcohol problems, and; proportion of alcohol users successfully completing treatment and not re-presenting within 6 months of discharge.

Alcohol related hospital admissions:
This has been the main performance indicator since it became a national indicator in 2007/8 and locally in the Portsmouth Alcohol Strategy in 2009. The aim was to reduce admissions if possible, but also to be no higher than the England average rate.
Alcohol related hospital admissions are a combination of conditions which are wholly attributable to alcohol or partly attributable to alcohol. A wholly attributable condition can only occur due to alcohol use, such as alcohol liver disease or alcohol poisoning. A partly attributable condition could be linked to alcohol, for example national evidence highlights that 30% of admissions to hospital due to assault are linked to alcohol, therefore 30% of cases locally count towards our data. Other conditions included as partly attributable include strokes, hypertension, some cancers (i.e. oesophagus) etc.
In Portsmouth our rate of admissions per 100,000 population, the national measure has stabilised, increasing from a rate of 2,025 in 2009/10 to 2,079 by 2013/14, a 2.7% increase. There is a lag on data for 2014/15, but the first 6 months shows a reduction in admissions compared to the previous year. During the same time period the England average rate per 100,000 increased from 1,813 to 2,087. The chart below highlights how the Portsmouth rate is now lover than the England rate and that for comparator areas.



Number in Alcohol Treatment:
In the Portsmouth Alcohol Strategy 2009 a target was set to increase the numbers receiving alcohol treatment to 15% of our dependent drinker population per year. We had an estimated problem drinker population of 7,000, so the target was to have 1,050

annually. At the time around 550-600 people were in treatment annually. Following significant new investment from Portsmouth City PCT in 2010, by 2012/13 this had increased to 1038, just short of the target. In 2013/14 there were 1032 in treatment. We currently only have treatment data for the first 6 months of 2014/15 due to problems with the NDTMS system, however this data is showing a small fall (5%) in the numbers in treatment, which is likely to be reflective of the savings taken to date. These numbers will fall further in 2015/16 with the additional savings and changes to the Alcohol Interventions Team. From October 2015 the Alcohol Interventions Team will no longer exist, merging in to the integrated Wellbeing service. They will no longer report to the NDTMS, removing around 290 clients from the system. Specialist alcohol treatment will be managed through the Recovery Hub.

Completions & representations:
For alcohol treatment (NDTMS data), Portsmouth has a higher number of unsuccessful completions and a higher number re-resenting within 6 months. Analysis of re-presentations highlights that this is almost exclusively due to the existence of our Alcohol Specialist Nurse Service at QA. The service is not a conventional community treatment service, which is more suited to NDTMS reporting, therefore there ia a data anomaly. In addition the service provides alcohol treatment to patients admitted to hospital who have not volunteered to enter treatment, this has happened due to their admission and subsequent withdrawal from alcohol. It would therefore be expected that a higher proportion with not complete treatment and will re-lapse. We are undertaking further analysis of cases to understand better the data anomalies.

THIS REPORT IS FOR INFORMATION ONLY

Portsmouth CITY COUNCIL

Agenda item:

Title of meeting:	Health and Wellbeing Board
Date of meeting:	17 June 2015
Subject:	Implementing the Integrated Wellbeing service
Report by:	Director of Public Health
Wards affected:	All

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1. Requested by Health and Wellbeing Board

2. Purpose

2.1 To update the Health and Wellbeing Board on progress towards the implementation of the integrated wellbeing service

3. Background Information

3.1 On 13 March 2014 the then Cabinet Member for Health & Social Care approved the commencement of planning for an integrated Wellbeing service (then named the Integrated Healthy Lifestyle Service), which would bring together current public health services commissioned independently of each other and therefore operating in silos.

3.2 The development and implementation of this Wellbeing service now forms part of the 2014 - 2017 Health and Wellbeing Strategy as well as the prevention work stream for the Better Care Programme (BCP).

4. Life expectancy & lifestyle factors

4.1 The health of people in Portsmouth is generally worse than the England average and there are significant health inequalities related to deprivation. Life expectancy for women is comparable to the England average, however male life expectancy is significantly shorter than the England average. Men living in deprived wards in the city live nearly 11 years fewer than those living in the least deprived wards.

4.2 The main, broad causes of death contributing to the gap in life expectancy between the most and least deprived in Portsmouth are circulatory diseases, cancers, liver disease and respiratory disease. These are linked to smoking, alcohol, poor diet and low levels of physical activity which for Portsmouth are higher than the England average.

4.2 The Kings Fund reported that "close to half of the burden of illness in developed 3 countries is associated with the four main unhealthy behaviours: smoking, excessive consumption of alcohol, poor diet and low levels of physical activity"[1].

4.3 The report found that around 70% of adults engage in 2 or more of these unhealthy behaviours, although the number of people engaging in 3 or 4 or these behaviours has reduced to 25% of the population, from 33% in 2003. However, almost all this behaviour change has been in the higher socio-economic and educational attainment groups. The poorest and those with no qualifications have seen little change. Those from unskilled manual backgrounds are more than three times more likely to have all four risk behaviours than professionals. Those with no qualifications are more than five times more likely to have all four risk factors than those with the highest level of qualification.

4.4 The report concluded that "a more integrated approach to behaviour change is required that links more closely to inequalities policy and is focused more directly on the government's stated goal to 'improve the health of the poorest, fastest'".

5. Portsmouth wellbeing service

5.1 This new service aims to help and support residents with the key factors that contribute to significant health risks like smoking, alcohol misuse, poor diet and lack of exercise as well as support around mental wellbeing.

5.2 The new service will be the culmination of a number of months work requiring the cancellation of a number of contracts with several providers in order to deliver a more cost effective and efficient service; the service will deliver a more integrated approach to behaviour change and at a larger scale than our current arrangements.

5.3 Importantly this service will work with other council services to provide help and support with debt, housing and unemployment, which tend to be contributory or underlying causes for poor lifestyle. This is why the service name has been changed to the Wellbeing Service, in recognition of the wide ranging needs of our population. By marrying these services together residents will be able to access a 'one-stop shop' to get the support they need to make changes to their lives and therefore reduce their long term dependence on services.

5.4 Currently, where services operate by having individual workers working with residents single issues, this format will be replaced by more generic 'wellbeing workers' able to work more integrated way across a broad range of issues. There will be support from specialist wellbeing workers within the service and links with partners where appropriate.

5.5 Wellbeing workers will be placed in locations across the city, in areas of deprivation where they are needed the most. It will be part of their role to work with the

[1] http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/clustering-of-unhealthy-behaviours-over-time-aug-2012.pdf

residents and the community to understand what matters to them and develop and enhance the service through participative methods.

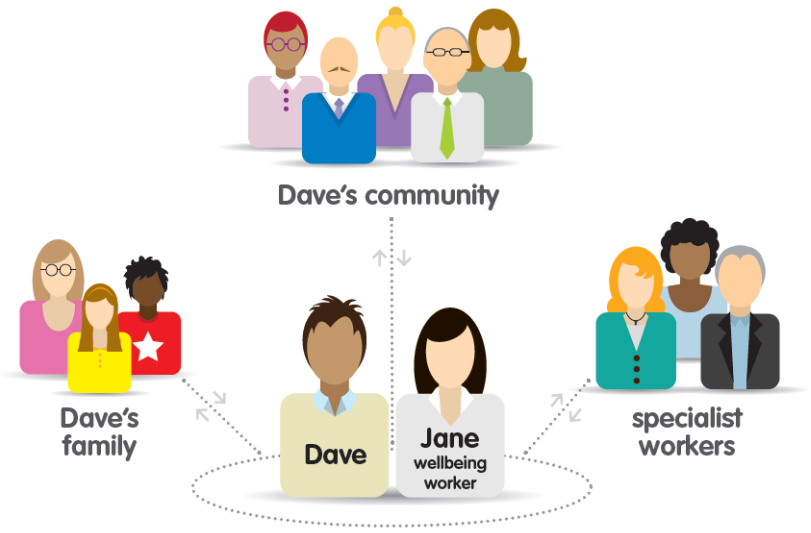
5.6 As part of core service provision front line staff, volunteers and members of the community will be trained to 'Make Every Contact Count' around key health and wellbeing factors and where to go for additional help.

5.7 Initially the focus for the service will be adult-based however children of adults entering the service will be involved as part of family interventions, where this is required. A 0-19 age group Wellbeing Service is also being developed in parallel and will mobilise at a later date.

5.8 The service will comprise in total 40 staff that will operate across the city in 3 localities and hospitals and probation settings. This level of staffing is estimated to support approximately 6000 adults and their families/per year with 3000 achieving positive outcomes through seamless pathways to other services including adult mental health, substance misuse, sexual health and 0 - 19yrs wellbeing service. The lack of historic output data for similar services is an issue when estimating the match of staffing levels to service throughput, as integrated wellbeing services are a new concept. Workforce modelling is currently being piloted in Somerstown, the data from which should inform and help shape the service workforce levels sufficient to support residents needs and make the impact on prevalence of population health risks.

5.9 The structure of the service will be a Service Manager and 4 Practice Leaders providing citywide expertise and training on smoking cessation, alcohol, healthy weight and mental health. Each Practice Lead will manage a team of Wellbeing workers (28). There will be 5 apprentices in health and wellbeing (4) and administration (1) roles.

The model shows how 'Dave', a Portsmouth resident, might interact with the wellbeing service when he meets 'Jane', a wellbeing worker:



5.10 Recognising the complexity and the flexibility required of this new type of service and expected changes which will evolve as the service beds in, it was agreed by the Health and Social Care Cabinet that the service would initially be established in-house. It is estimated that the service will cost approximately about £1.3M making efficiency savings of approximately £360K on existing services.

6. Consultation

6.1 We have undertaken consultation with the public and key stakeholders, including GPs and service providers. This consultation on the whole has supported the development of an integrated service, focusing on smoking, alcohol and weight management. A key requirement from residents is that they would like to visit one place and see one worker that can help them with a range of issues. In addition factors which address the wider determinants of health should be included, including debt, employment and housing advice. A report of the stakeholder consultation is attached for information (Appendix 1).

7. Implementation of the wellbeing service

7.1 The start date for the wellbeing service is 1 October 2015. Currently commissioned services including the quit smoking services, Pompey Quit and Solutions 4 Health, as well as Health Trainers have been given notice and service delivery will cease on 30 Sept 2015. Actions on the re-deployment of the alcohol intervention services within PCC to the wellbeing service have started. Exit strategies for existing services are aligned to mobilisation of the new service and the intention is for service continuity through transition.

7.2 Communication of the start of the new service and the exiting of existing services is key. A newsletter for stakeholders and the public will become available from July onwards. Wider stakeholder consultation events were held on 22 and 23 April.

7.3 Some elements of the service are being tried out and phased in, particularly in Somerstown as part of the CCG funded Health and Wellbeing Community Assets Programme that is due to provide a final report to the CCG Clinical Strategy Committee meeting on 1 July 2015.

7.4 We are looking to work with primary care over the next months to develop community profiles based on GP and public health data, identifying areas for focus. We plan to work with the community in those targeted areas to develop the service

7.5 Management and governance of this programme is overseen by a programme board chaired by the Director of Public Health comprised of stakeholders from the city council, CCG and voluntary sector. The programme is formed on eight workstreams, updates from which are provided for information at Appendix 2 which includes current risks and issues.

8. Aligning Local Commissioned Services (LCS) to the wellbeing service

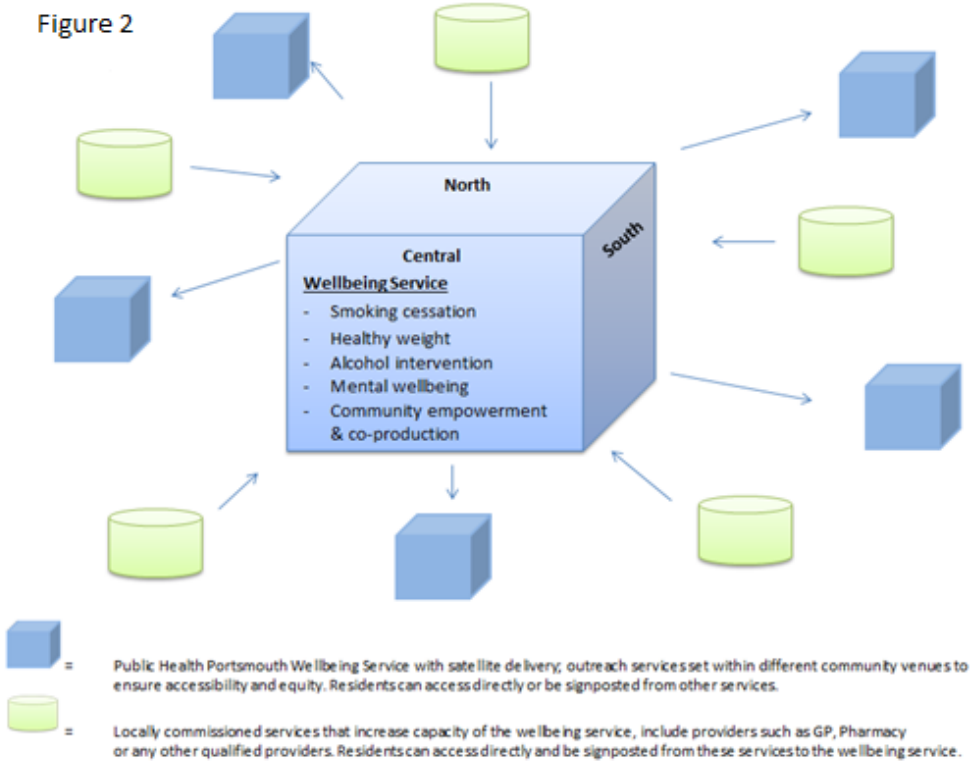
8.1 Using a similar service model Public Health Portsmouth wants to align the existing LCS (previously known as Local Enhanced Services)(LES)) currently delivered by

GP and community pharmacy to enhance the capacity of the wellbeing service as well as provide a more diverse and specialist service for residents.

8.2 The current LCS contract is due to expire on 31 March 2015 and a waiver has been agreed to extend these existing contracts for a further 12 months in order to allow engagement and redesign as well as time to complete the tendering of a new model. The expectation is that the market for the service will widen beyond GP and pharmacy to any qualified provider, potentially including children's centres, job centres, QA hospital etc, where appropriate.

Figure 2 shows the final overall model for the wellbeing service

Figure 2



9.0 Finances

9.1 The existing services listed above and other current spend linked to our wellbeing work totals £1.75 million. As part of the savings requirement within Portsmouth City Council and the remodelling, we anticipate the budget for the Wellbeing Service would be approximately £1.3 million per year recurring, with some additional pump priming over the first 2-3 years.

9.2 Whilst this level of saving would obviously reduce the level of service available across the city, we consider that by using a new integrated approach and by working closely with our more deprived communities, we can continue to support those that are in need of help. Whilst we have anticipated that the service will be able to support 6,000 individuals / families per year, with approximately half making a positive change, a combination of the service being successful and high prevalence of risky behaviours across our population is likely to present a significant

risk that this service will not be able to meet demand. Such a scenario would mean that additional funding could be needed in future years.

……
Signed by: Director of Public Health

Appendices:

1. **Report on consultation with stakeholders**
2. **Update reports from programme workstreams**

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

Portsmouth CITY COUNCIL

Appendix 1

Report on consultation with stakeholders

Workshop Notes

Summary of themes arising from workshop sessions on 22 and 23 April.

Buy-in / support for the service	Clarity of communication / Mis-information	Advice / areas for consideration / recommendations
• Single point of contact • Holistic approach • Relationships / trust with WW • Joined up approach • Environment (relaxed/informal/comfortable) • Locality working multi-agency team • Evidence of this model working well in other areas / for other services • Prolonged contact with clients • No falling through the gaps • Asset based approach • Prevention • Addressing social isolation • Adds capacity to GP role • Located in the community • Offers of premises • Promoting maximum utilisation of resources in the community • Reducing silos • Coaching (rather than advice) reduced dependency • Creates community resilience • Accessible	• Quality assurance (qualifications/training of WW) • Loss of specialisms • Duplication with existing services (e.g. pharmacy, social workers) • Dismantling of services before new one in place • What is the demand? • Referral pathway • Need for wider social support/drop ins for families/peer support • How do WW decide what to do first? • Who can refer?	• Named WW contact for each GP practice • Scope of service • Capacity of service (number of WW, hours of support for each client) • Evening and weekend provision • Sharing data / sending information back to the referrer • What are the 'touch points' at 'wobble points' - are we engaged? • Accessibility (physical location, language) • Continued dialogue with stakeholders • Information governance • Home visits • Safeguarding (need for operating procedures) • Link to Healthwatch • Ex-forces access

WW - wellbeing worker

Stakeholders mentioned by name:

Stakeholders	
• Schools • Learning disabilities • League of Friends • Sustrans • Community pharmacies • GPs • Solent Trust - Adult mental health • Pompey in the Community • Diabetes Research • Portsmouth CCG • Libraries (inc. mobile libraries)	• Portsmouth FC • Big Lottery Fund • Job centre • John Pounds Centre • Probation • Solent MIND • RELATE • Learning Links • Home Start • CAB • Learning disabilities colleagues (Mark Staples) • You Trust Advice Centre - North End

Portsmouth CITY COUNCIL

Appendix 2

Updates reports from Integrated Wellbeing Service programme workstream including risks and issues

Governance, Quality and Performance, Finance

1. The Programme Board with terms of reference has been set up with monthly meetings since February 2015.
2. The Programme Implementation Group with 8 work packages leads meet monthly.
3. The work on Quality assurance framework, evaluation, Equality Impact Assessment in progress.
4. Financial budget for the service has been costed and will be reviewed nearer to October 2015.

Communications

1. A communications strategy and action plan has been developed.
2. Presentations were made to our colleagues in Public Health, Alcohol Intervention teams, Health and Social Care Cabinet, Better Care Fund for All, Tobacco Alliance, Wessex Public Health workforce leads, Public Health England Wessex Health Promotion team and Pharmacists Learning Day.
3. A paper was presented to the CCG Clinical Governance Committee on 4 March 2015.
4. Two stakeholders workshops with 89 external delegates were held on 22 and 23 April 2015 with active discussion and feedback. Follow up actions and engagement with interested stakeholders is in progress.
5. Briefings were sent to GPs via the CCG system.
6. Presentations and further dialogues are planned for 3 June 2015 GP commissioning event and at June TARGET event.
7. Various communications mode are being piloted in Somerstown with evaluation.

Contracts

1. The current services: Health trainers, Pompey Quit and Solutions for Health contracts will end on 30 Sept 2015.
2. Active discussion is in progress about the transition plan: handover of clients information, information about services venues prior to October 2015.
3. The Internal Alcohol Intervention services will be deployed.

Human Resources

1. Internal consultation with staff from Alcohol Interventions Team and Somerstown pilot Wellbeing team concluded on 19 May 2015 with job matching by beginning of June 2015.
2. Recruitment for Service Managers, Practice Leads (Smoking and Mental Health), Wellbeing workers and administrator is planned from June 2015.
3. The work on developing the apprenticeship scheme is in progress internally. Health Education Wessex is interested in piloting a national trailblazer Health and Wellbeing apprenticeship scheme with this service.

Workforce development

1. A Skills competency framework for Wellbeing staff has been developed and a training programme drafted. This includes mandatory training on PCC policies and procedures, essential training such as Making Every Contact Count Level 3, National Committee On Smoking Cessation Training (NCSCT) Smoking Cessation Levels 1 & 2, Nutrition and Healthy Weight Level 3, Award in Understanding Alcohol Misuse, GP Exercise on Referral for Health Management, Mental Health First Aid.
2. Plan to include reflective practice, supervision and audit is included.

Information Technology

1. The service specification for a Client Record Management system has been developed.
2. Procurement for this system is planned for early June 2015 with the aim of testing in September 2015. We are also exploring the potential to use the same client record management system now being introduced by Portsmouth general practices and the community provider (System One) provided by the company TPP. The purpose of this is to align patient referrals across the health economy.

Somerstown neighbourhood pilot

1. An assets map has been produced.
2. The Wellbeing workers are developing relationships with residents, colleagues from Housing, children centre, Pharmacy and local agencies.
3. The team has been developing and testing the service delivery and community approaches.
4. Since January 2015, the Somerstown team has worked with 55 clients on a 121 basis. This number excludes group sessions.
5. Evaluation with case studies of clients, staff focus group, 121 interviews with staff and stakeholders is done.
6. A report will be presented to the CCG Clinical Strategy Committee on 1 July 2015.
7. Learning will be used to inform roll out of the city wide service.

Community Profiling and Co-production

1. A toolkit of community development approaches will be developed for city wide use
2. Rapid Participatory Appraisal will be piloted in Paulsgrove in summer and to be rolled out citywide.
3. Information will be used to inform JSNA, work of this service and other programmes.

Significant risks and issues

1. Unable to recruit quality staff impacting on the service

   Mitigation

   - To recruit widely and starting from June 2015.
   - To sell on CPD opportunities to potential applicants.

2. Tight timescale for IT system impacting on time to test out teething issues

   Mitigation

   - Procure earlier and have longer testing time

3. Lack of Smoking cessation expertise

   Mitigation

   - To recruit Practice Leader (Smoking) early June 2015
   - To commission North 51, recommended by the National Committee for Smoking Cessation Training to provide advice, consultancy and face to face training.

4. Lack of buy-in from key stakeholders

   Mitigation

   - To have active engagement with key stakeholders e.g. GPs, NHS Trusts, Pharmacists, Third Sector via events, visits, communication briefings
   - To request CCG and GP Alliance to be champions

5. Lack of clarify in the transition prior to October 2015 launch date

   Mitigation

   - To have exit and transition plans from current providers including mapping of current services, venues, live cases, data to ensure continuity and seamless transfer to the new service.
   - To provide clear communications and joint briefing with current providers for stakeholders about the transition, the scope of new service, referral routes and contacts etc.

Portsmouth CITY COUNCIL

Portsmouth's Tackling Poverty Strategy - Executive Summary and headline priorities

2015 - 2020

Developed through the Tackling Poverty Strategy Group, a multi agency partnership in Portsmouth. Reporting to Portsmouth's Health and Wellbeing Board. The full Tackling Poverty Strategy will be circulated electronically and is available on request from Kate Kennard on kate.kennard@portsmouthcc.gov.uk

Executive Summary

This strategy has been developed under the umbrella of Portsmouth's Joint Health and Wellbeing Strategy (JHWS), whose vision is to improve and protect the health and wellbeing of people who live and work in Portsmouth. Recognising the clear links between health inequalities and poverty, the tackling poverty strategy is one of the JHWS's workstreams.

Therefore the aim of the tackling poverty strategy is to support the JHWS's vision to improve the health and wellbeing of people who live and work in Portsmouth, by working to ensure that no-one is prevented from achieving this through the effects of poverty or financial hardship. This workstream seeks to not only alleviate the immediate effects of poverty, but to break the inter-generational cycle of deprivation longer term, through the six priorities below. (The full version of these priorities, which makes the link with work that is already happening in existing workstreams and strategies, and also describes how services can support the priorities through their own work, is located at the end of this strategy).

Priority One - improving our children's futures The tackling poverty strategy workstream will add value to existing work on this through
- Providing training for frontline staff on new ways of working to improve outcomes - Embedding the latest child poverty research into current work such as pre-birth to 5 services, the new Multi Agency Team model and work with Families with Multiple Problems - Testing and rolling out approaches to help build resilience in children - Sharing evidence of what works with schools and childcare providers in relation to 'narrowing the gap' for children from low income families
Priority Two - providing good quality, sustainable employment opportunities that enable a reasonable standard of living for residents The tackling poverty strategy workstream will add value to existing work on this through
- Promoting with businesses the benefits of providing a Living Wage and clearer progression paths - Working with services to improve employment outcomes for residents - Co-ordinating employability support, including a digital inclusion strategy to get people online - Exploring and addressing the needs of groups at a higher risk of poverty and unemployment - Working together with agencies to understand and share information about current and future labour markets, in order to equip residents with the skills and advice they need - Promoting the benefits of traineeships and apprenticeships to services and residents
Priority Three - helping residents to be financially resilient The tackling poverty strategy workstream will add value to existing work on this through
- Co-ordinating with DWP the local support pathway for claimants of Universal Credit - Refreshing the city's welfare reforms risk assessment and plans in light of further welfare cuts - Producing a digital inclusion strategy to assist employability and money management - Training frontline staff to work with people on income maximisation and financial resilience - Delivering public education messages on the dangers of high cost credit (and affordable options) - Providing training and materials for financial education for children in the city - Co-ordinating 'money advice' webpages on Council website

Priority Four - helping people move out of immediate crisis, but also helping them to solve their problems longer term The tackling poverty strategy workstream will add value to existing work on this through
- Skilling up services to work more holistically with people at point of crisis in order to address their deeper underlying causes - Continuing to co-ordinate directory of crisis resources. Seeking sustainable options for provision of affordable furniture and white goods. - Promoting work based on evidenced need, and a sound understanding of what matters to customers when using services in the city - Influencing assessment processes to ensure better assessment of people's financial and employment circumstances e.g. Adult Social Care assessments, Single Assessment Framework - Working with services to provide the right support and advice for people in financial crisis who might have mental health issues as an underlying need
Priority Five - improving residents' lives by recognising the links between poverty and health inequalities The tackling poverty strategy workstream will add value to existing work on this through
- Working with the Health and Wellbeing Service, integrating work in areas of deprivation and on some of the causes of reduced life expectancy and poor health such as smoking, debt, mental health issues and unemployment - Promoting joined up work across health, social care and education services to improve children's health and wellbeing, which is linked to their ability to achieve a good quality education - Co-ordinating resources to support frontline staff in reducing fuel poverty and excess winter deaths - Supporting and providing training to the city's foodbanks to co-ordinate approaches and maximise resources, including exploring how foodbanks can work more preventatively with people in crisis - Further co-ordinating approaches around healthy eating, budgeting and cooking skills - Exploring the integration of health and wellbeing work further into foodbanks through, for example, co-location of staff, or 'surgery' approaches where there is evidence of need
Priority Six - shaping wider policies and decisions so they reduce the risk of poverty The tackling poverty strategy workstream will add value to existing work on this through
- Highlighting the impacts for people in poverty to inform decisions around services in light of local authority cuts - Influencing commissioning processes around the need to address social value via integration of tackling poverty strategy priorities in contracts - Supporting work on creating positive environments in the city, e.g. exploring how planning and/or licensing laws can be used to contribute to reducing problem debt and gambling - Influencing economic regeneration and creation of jobs to benefit residents in financial hardship - Working with businesses to address low pay and career progression pathways - Promoting to decision makers the need for affordable homes, including work with private sector landlords to negotiate more affordable rents - Maximising resources, working together across statutory, voluntary and community sector services, including maximising the benefits of volunteering

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Intended programme of items for discussion at Portsmouth's Health and Wellbeing Board (HWB) in 2015 (updated June 2015)

The programme of agenda items for the HWB has been developed based on the agreed Joint Health and Wellbeing Strategy 2014-17. The timings of which issue comes to each meeting is potentially subject to change, and other items may be scheduled in addition.

17th June 2015

- **Smoking, Alcohol and Substance Misuse**: progress report from Matt Smith on this JHWS priority area (NB alcohol and substance misuse are led by the Safer Portsmouth Partnership). Includes information on the Liver Health Needs Assessment

- **Pre-birth to five years old**: Report updating on progress with the Health Visitor Transfer and the Healthy Child Programme

- **Better care**: Quarterly update from Innes Richens, Chief Operating Officer at Portsmouth Clinical Commissioning Group (CCG), on local efforts to integrate health and social care in the city.

- **Wellbeing Service**: Update from the Public Health team on this new service being developed to address the JHWS workstream to explore 'integrated lifestyle hubs'.

- **Public Health Grant**: Report on the impact on services of the public health grant savings target and service remodelling.

- **Dementia**: Progress report from Preeti Sheth, Head of the Integrated Commissioning Unit, on this key HWB priority.

16th September 2015

- **Portsmouth Together**: Brian Bracher, Chief Service Officer for Portsmouth Together, will report on the progress this new initiative using impact volunteering to address key city challenges has made at the end of its first year.

- **Health related barriers to employment**: Report from Paddy May, Corporate Strategy Manager, on how the City Deal is helping those long-term unemployed due to health-related issues back into sustainable work.

- **CCG Strategic Priorities**: Annual report from Dr Jim Hogan, Clinical Lead at PCCG, on how the HWB partners are supporting the CCG to deliver its strategic priorities.

- **Better Care**: Quarterly update from Innes Richens, Chief Operating Officer at Portsmouth Clinical Commissioning Group (CCG), on local efforts to integrate health and social care in the city.

- **Public Health Annual Report**: Dr Janet Maxwell, Director of Public Health, presenting her statutory annual report for approval by the HWB.

- **Tackling Poverty Strategy**: approval by the HWB of this key strategy

2nd December 2015

- **Portsmouth Safeguarding Adults Board Annual (PSAB) Report**: David Cooper, independent chair of PSAB, presenting key issues for the HWB in relation to safeguarding adults.

- **Portsmouth Safeguarding Children Board Annual Report**: Reg Hooke, independent chair of PSCB, presenting key issues for the HWB in relation to safeguarding adults.

- **Improving Educational Attainment**: Annual report from the Director of Children's Services, on this Children's Trust priority to improve the educational attainment of Portsmouth's children.

- **Better Care**: Quarterly update from Innes Richens, Chief Operating Officer at Portsmouth Clinical Commissioning Group (CCG), on local efforts to integrate health and social care in the city.

- **Wellbeing Service**: Update from Rachael Dalby on this new service being developed within the public health team to address the JHWS workstream to explore 'integrated lifestyle hubs'**.**

- **Dementia**: Progress report from Preeti Sheth, Head of the Integrated Commissioning Unit, on this key HWB priority.

- **Mental Health and Wellbeing:** Matt Smith, Public Health Consultant, presenting the Mental Health Strategy that will be developed by the Mental Health Alliance in 2015