Portsmouth CITY COUNCIL

Public Document Pack

NOTICE OF MEETING

HEALTH AND WELLBEING BOARD

WEDNESDAY, 2 DECEMBER 2015 AT 9.00 AM

CONFERENCE ROOM A - CIVIC OFFICES

Telephone enquiries to Joanne Wildsmith Democratic Services Tel: 9283 4057
Email: joanne.wildsmith@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

Portsmouth Councillor Standing Deputies:
Councillor Colin Galloway and Jennie Brent

(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

This will set out the progress made in developing the Blueprint for Health and Care in Portsmouth which was received and supported by the Health and Wellbeing Board (HWB) in September 2015. It outlines potential next steps including the key role a strengthened HWB could play in the governance of this agenda.

4 Portsmouth Safeguarding Adults Board Annual (PSAB) Report (Pages 23 - 54)

This report is information only, to update the Board on the current position and achievements of the PSAB in relation to the Care Act.

5 Portsmouth Safeguarding Children's Board (PSCB) Annual Report (Pages 55 - 82)

To introduce the Annual Report 2014-15 of the Portsmouth Safeguarding Children Board (PSCB)

RECOMMENDED:
Members of the Health and Wellbeing Board are invited to receive the Portsmouth Safeguarding Children Board Annual Report and to note areas of progress and challenges identified in the context of services being planned and commissioned.

6 JSNA - annual summary and progress with outcomes in JHWS (Pages 83 - 132)

The information report by the Director of Public Health seeks to:

- inform the Board of the city's key health and wellbeing trends and issues
- monitor progress in achieving the priorities of the Joint Health and Wellbeing Strategy

7 Mental Health and Wellbeing Strategy (Pages 133 - 162)

The purpose of this report is to inform members of the key strategic priorities to improve mental health and wellbeing in the City over the next five years.

RECOMMENDED that the Board adopts the proposed mental health and wellbeing strategy 2016-2021.

8 Progress of the Wellbeing Service (Pages 163 - 166)

The purpose of this information report by the Director of Public Health is to update the Health and Wellbeing Board on:

a. progress of the new integrated wellbeing service

b. the role and strategic priorities of the Wellbeing service within the wider health and social care system

9 Dementia - HWB Priority Update (information report) (Pages 167 - 172)

The information report by the Director of Integrated Commissioning Service is to update the HWB on the progress of the Portsmouth Dementia Action Plan and the wider older people's agenda for 2015/16.

10 Public Health Annual Report (Pages 173 - 190)

The Portsmouth's Director of Public Health's Annual Report 2014/15 is attached for the information of the HWB.

11 Future work programme of HWB for 2016

Matthew Gummerson will update members and circulate a copy of the future work programme at the meeting.

12 Date of next meeting

To note the dates of the next meetings which are:

17 February at 10am

22 June at 10am

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.

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HEALTH AND WELLBEING BOARD

MINUTES OF THE MEETING of the Health and Wellbeing Board held on Wednesday, 16 September 2015 at 9.00 am in Conference Room A, Civic Offices, Portsmouth.

Present

Councillor Luke Stubbs (in the Chair)

Councillor Donna Jones
Councillor Neill Young

Innes Richens
Ruth Williams
Di Smith
Rob Watt
Healthwatch Portsmouth
Dianne Sherlock
Ursula Ward
Jackie Powell
Sarah Austin (for Sue Harriman)
Dr Collie
Matthew Smith (for Janet Maxwell)
Tony Horne
Dr Alalade

Officers Present

Dr Dapo Alalade
Patrick Fowler
Matt Gummerson
David Williams
Brian Bracher
Angela Dryer
Matthew Smith
Emma Fawell
Julia Katherine
Mark Sage

23. Welcome, apologies for absence and declaration of members' interests (AI 1)

Apologies for absence were received on behalf of Dr Hogan and Councillor Stubbs therefore chaired this meeting. Apologies for absence had also been received on behalf of Dr Janet Maxwell, Sue Harriman and Councillor Gerald Vernon-Jackson. Councillor Luke Stubbs as chair welcomed everyone to the meeting and invited everyone at the table to introduce themselves which they did.

There were no declarations of members' interests.

24. Minutes of the Meeting held on 17 June 2015 (AI 2)

RESOLVED that the minutes of the meeting held on 17 June 2015 be confirmed and signed by the chair as a correct record.

It was suggested that an actions summary sheet be attached to the minutes in future and this was agreed.

25. Special Educational Needs and Disability (SEND) (AI 3)

(TAKE IN INFORMATION REPORT)

Dr Julia Katherine introduced the report and explained the background. The Disabled Children's Charter for Health and Wellbeing Boards was adopted by Portsmouth in September 2014 and this Charter requires evidence to be provided by September 2015 that seven key commitments have been achieved. The key commitments and achievements to date are shown on page 8 of the report.

The new statutory responsibilities of the Health and Well-being Board were highlighted. The effective deployment of these responsibilities will be inspected as part of the new SEND local area inspections which will start in 2016.

It was agreed that an update report would be brought to the HWB in 6 months' time.

The Chair of the Board thanked Dr Katherine for her presentation.

26. The Care Act - Presentation on Progress (AI 4)

(TAKE IN PRESENTATION)

Angela Dryer and Sara Langston provided a joint presentation on the Care Act. In response to queries the following matters were clarified:

- It was accepted that there is a need to work across sector fields and find opportunities to work together and to guard against conflicts within the city council.
- It was confirmed that difficulty in recruiting staff was not just a local issue but was a problem nationally. Basically the local authorities do not have sufficient money to fund the necessary posts.

The Chair said that the Living Wage was expensive to implement and it seemed that implementation could only be met by reductions in staffing. He thanked Angela Dryer and Sara Langston for their presentation.

27. Portsmouth Together (AI 5)

(TAKE IN INFORMATION REPORT)

Brian Bracher introduced the report which updates the Board on progress of Portsmouth Together (Cities of Service). He said that the Portsmouth Together service plan published in September 2014 had four impact volunteer initiatives

- Activate
- Portsmouth Counts
- Love Your Street and
- Love your Loft

During discussion the following issues were raised:

- It was suggested that Brian Bracher should meet with Dianne Sherlock outside the meeting to consider ways in which the ideas behind the 'Love your Loft' initiative could be revived.
- All members of the Health and Wellbeing Board were asked to give serious consideration to whether they could support Portsmouth schools by volunteering to become school governors.
- A comment was made that those who were currently unemployed may wish to volunteer but had concerns that this may affect their benefit. Brian Bracher said information about this aspect of volunteering is available on the Portsmouth Together website. In most cases volunteering had no effect on benefit as long at the Job Centre is informed and remain available for interviews.

The Chair of the Board, Councillor Luke Stubbs said there was a need to save money by building local community resilience.

28. Healthwatch Portsmouth Annual Report (AI 6)

(TAKE IN INFORMATION ONLY REPORT)

Patrick Fowler, Healthwatch Portsmouth Consultant introduced the report which presented Healthwatch Portsmouth's annual report to the Health and Wellbeing Board for consideration. He explained that Appendix A provided a summary of the Healthwatch Portsmouth annual report 2014/15 and that the full annual report for 2014/15 was presented to Health Overview & Scrutiny Panel in July 2015. Mr Fowler provided a short slide presentation which gave an overview of the work done by Healthwatch. This included

- Establishing governance structures
- Developing partnerships
- Establishing an online directory which consists of over 700 health and social care services and which is continually growing
- Advocacy - 33 individuals had been helped with their complaints.

During discussion the following points were raised

- It was agreed that all Health and Wellbeing Board members with commissioning responsibilities give consideration to the toolkit developed as part of the Wessex Community Voice project
- Innes Richens acknowledged the work done by Healthwatch and thanked them.
- Councillor Luke Stubbs said that he personally knew of one medical case that had been referred to Healthwatch and had been happy with the outcome. He thanked Patrick Fowler and Tony Horne.

The report was noted and a request was made that all HWB members with commissioning responsibilities give consideration to the toolkit developed as part of the Wessex Community Voice project.

29. Budgets: Presentation giving an overview of the council and CCG's budget positions for the years ahead (AI 8)

(TAKE IN SLIDE PRESENTATION)

The Chair agreed to hear agenda item 8, the budget presentation, before agenda item 7. The Chief Executive introduced the slides relating to the city council and provided an overview of the challenges facing the authority. He said that no adjustments had been made in the allocations to local authorities regarding their varying tax bases. So far there had been a 38% loss in funding from central government and this would rise to a 53% loss by 2018/19. He said that efficiency savings had been made but the city council had now reached the stage where further efficiency savings were difficult to identify and so other ways of making savings had to be explored. Consequently politicians were facing major issues and difficult decisions. As a result of budget pressures, Adult and Children's Social Care faced pressures to make cuts in year. The Chief Executive advised that a budget consultation was now taking place to identify how savings could be made and this would inevitably lead to cuts.

The Leader of the Council, Councillor Donna Jones said that feedback was important to assist with the budget process and advised measures being taken to encourage residents to engage with the process.

Innes Richens introduced the slides concerning the Clinical Commissioning Group. He outlined the challenges and said that there was a need for a citywide approach to work up joint savings plans.

Following the presentation a comment was made that care must be taken not to shift issues from one place to another - for example although cutting preventative services would have no immediate effect, problems would be stored up for the future.

Councillor Stubbs thanked David Williams and Innes Richens for their presentation and said that PCC and CCG faced huge financial pressure.

The Health and Wellbeing Board noted the presentations.

30. A Proposal for Portsmouth: A Blueprint for Health and Care in Portsmouth (AI 7)

(TAKE IN REPORT AND APPENDIX)

Innes Richens introduced the report which sets out a proposed direction and model for health and care in Portsmouth. He explained that the paper is being brought to the Health and Wellbeing Board for open discussion and debate and endorsement.

He advised that the Portsmouth blueprint was set out in Appendix 1 and the key commitments were set out on page 3 of that appendix. He said that basically the aim is to create a single health and care system for the city to include delivery of services but also planning, commissioning and managing of those services.

He urged members of the Board to read the blueprint and asked the Health and Wellbeing Board to support its aims in principle.

During discussion the following matters were raised:

- Sarah Austin that that Solent supports the blueprint and had taken it to their Board for approval. Ursula Ward said that Portsmouth Hospitals Trust support the approach in the Blueprint and that she would take this forward to the PHT board.
- Councillor Luke Stubbs said that PCC also supported the blueprint.
- Rob Watt endorsed the blueprint but cautioned that it must embrace the Care Act within it. He also commented that the level of integration in Portsmouth was already very good.
- It was agreed that Innes Richens would meet with Healthwatch Portsmouth to discuss the communication and engagement with local communities around the system's plans for the future as set out in the Blueprint document.
- The Leader of the Council, Councillor Donna Jones said that she was concerned about the speed of delivery as there would be impacts such as requiring much work on procurement for example with IT provision.
- It was agreed that PCC co-ordinate a letter countersigned by the CCG, PHT and Solent to the Secretary of State setting out local partners' plans for the health and care system in Portsmouth.
- Ursula Ward said that she would raise issues in the blueprint at the National Health Leaders event that she was due to attend on 17 September.
- David Williams said that it was important that staff and clients see close partnership working among the various groups. He said that care was needed to manage the geographical and demographic differences.
- It was agreed that PHCE meet again to develop more detailed plans for consideration by the Health and Wellbeing Board in December 2015.

RESOLVED that the Health and Wellbeing Board

(1) support in principle the statements in the Portsmouth Blueprint for Health and Care;

(2) require a more detailed report on the development of these proposals be brought to the Board meeting on 2 December 2015.

..... **31. Public Health Annual Report (AI 9)**

It was agreed that this item would be deferred to the next meeting.

32. Tackling Poverty Strategy (AI 10)

(TAKE IN REPORT)

Mark Sage, Lead Officer for Tackling Poverty, advised that the purpose of the report was to seek approval from the Health and Wellbeing Board for Portsmouth's new Tackling Poverty Strategy 2015/20 and accompanying action plan. He advised that Portsmouth's Tackling Poverty Needs Assessment was approved by the Health and Wellbeing Board in April 2015 and that a tackling poverty strategy had subsequently been developed based on the findings from this needs assessment and also from wider consultation. The new strategy had been circulated to the Health and Wellbeing Board with a request for feedback by 11 August 2015 and this feedback had now been incorporated into the revised version of the strategy. The action plan that had been developed is attached as Appendix A to the report.

In response to a query regarding the involvement of Citizens Advice Bureau in the strategy, Mark Sage confirmed that Portsmouth Citizens Advice Bureau is one of a number of important advice agencies in the city that are involved in the strategy, and that the forthcoming Portsmouth Advice Services Partnership event would look at how advice services can work together in the future.

RESOLVED (1) that the Health and Wellbeing Board considered the strategy and action plan for any final feedback at the Health and Wellbeing Board meeting;

(2) that the chair of the Health and Wellbeing Board be authorised to sign off the final strategy and action plan on behalf of the Board for publication;

(3) that authority to amend the action plan as set out in paragraph 5.2 of the report is approved.

33. Date of next meeting (AI 11)

The next meeting is scheduled for 2 December 2015.

The meeting concluded at 10.55 am.

Councillor Luke Stubbs, Chair

Portsmouth Clinical Commissioning Group

Portsmouth CITY COUNCIL

THIS ITEM IS FOR INFORMATION ONLY

Agenda item:

Title of meeting:	Health and Wellbeing Board
Date of meeting:	Wednesday 2nd December 2015
Subject:	**The Blueprint for Health and Care in Portsmouth**
Report by:	Innes Richens, Chief Operating Officer, NHS Portsmouth Clinical Commissioning Group David Williams, Chief Executive, Portsmouth City Council

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1. Requested by

1.1 Cllr Luke Stubbs and Dr Jim Hogan, Joint Chairs of the Health and Wellbeing Board (HWB).

2. Purpose

2.1 To progress the Blueprint for Health and Social Care in Portsmouth which was received and supported by the Health and Wellbeing Board at its meeting in September, and has subsequently been endorsed by boards of the Portsmouth CCG, PHT, Solent NHS Trust and the Cabinet of Portsmouth City Council. This paper updates on progress in developing the principles and collaboration behind the blueprint, explains how it aligns with national policy and the HIOW Devolution prospectus, and recommends a series of 'next steps' for the Board's consideration.

The Health & Wellbeing Board is asked to:

- Note the progress that has been made in developing the programme for the Blueprint
- Discuss the proposals for developing the HWB to allow it to manage a single health and care budget for the city and agree the next steps
- Support the Portsmouth Health and Care Executive (PHCE) in overseeing the ongoing development of the Blueprint and require a detailed presentation of the 'plan for a plan' at the next HWB meeting in February 2016.

3. Information Requested: The Blueprint for Health and Care in Portsmouth, December 2015

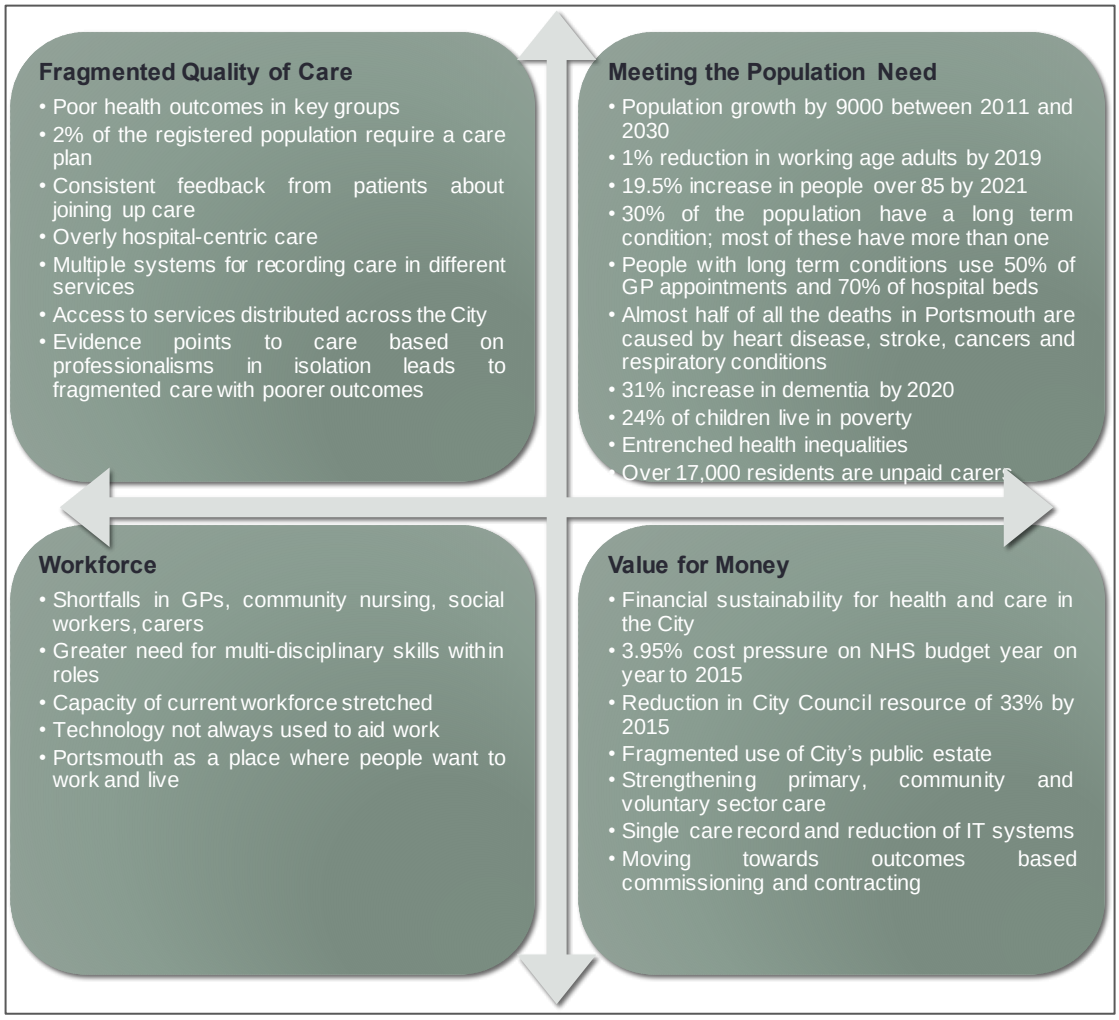
Introduction

Health and care services for people in Portsmouth are, overall, extremely good and have evolved over many years because of national and local policy and decisions. This has delivered good care for the majority of people but its design presents a number of problems that will significantly restrict the City's ability to meet our challenges and deliver our Vision. Most notable are the fragmented nature of how both the person and the professional navigate through the various services, and the growing costs to the public purse of delivering the services.

In September, the Board supported a paper that set out why we must continue to bring services together in a way that makes sense for the person but also allows front-line professionals to deliver care in a way that is not restricted by professional, organisational or financial boundaries.

Figure 1 summarises the main challenges facing health and care in Portsmouth, setting out the key reasons why the way this is delivered needs to change over the coming years.

Figure 1: Strategic Case for Change



The strategy is based on joining up (integrating) services around the care of the person. Our aim is to create a single health and care system for the City – this includes delivery of services but also planning, commissioning and managing these services.

The Portsmouth Blueprint is underpinned by a Vision for the transformation of health and social care in the city, a series of key commitments to Portsmouth, and a set of desired outcomes for the city and its population. For ease of reference, these are reproduced at Annex 1.

Our approach is squarely in line with the NHS Five Year Forward View[1]. It reflects the conclusions of the Barker Commission[2], the vision for social care set out by ADASS[3] and the recommendations of the latest King's Fund report on health and social care integration[4]. It fits with the statements in the Comprehensive Spending Review about all local areas needing a plan for integration of health and social care[5]. It is also in line with the outline proposals for health and care integration included in the Hampshire and Isle of Wight prospectus for Devolution, submitted to HM Treasury in September 2015.

The functions we aim to change for Portsmouth are set out in Figure 2.

Fig 2:

Implementing the Blueprint - getting on with it!

At a national level, since the publication of the Barker Report in 2014 there has been *"a substantial groundswell of support for the central proposition of a new settlement based on a single ring-fenced budget and a single local commissioner"*[6] but the biggest concern has been how this can be achieved without major organisational change which remains politically toxic. The NHS Five Year Forward View (2014) states that the national leadership of the NHS will need to *"act coherently together and provide meaningful **local flexibility** in the way payment rules, regulatory requirements and other mechanisms are applied."* It goes on to say that, *"We will **back diverse solutions and local leadership**, in place of the distraction of further national structural reorganisation."*[7]

Whilst many details of the Blueprint are still being developed, there is a strong desire by the partners to make progress where we can to achieve better services for the public and greater efficiency for the public purse. Momentum and the demonstration of our commitment to improve

[1] Five Year Forward View, NHS England et al, 2014
[2] Commission on the Future of health and Social Care in England, 2014
[3] Association of Directors of Adult Social Services, 'Distinctive, Valued, Personal: Why social care matters', 2015
[4] Kings Fund, 2015 Options for integrated commissioning; Beyond Barker
[5] HM Treasury, Spending Review and Autumn Statement 2015
[6] Options for Integrated Commissioning - Beyond Barker - The King's Fund, June 2015
[7] Five Year Forward View, NHS England et al, 2014 p.4

local delivery are powerful drivers and need to come from the top to empower the local health and wellbeing system. Bearing in mind that we are already a year in to the 'Five Year Forward View', the Board is recommended to adopt a pro-active approach in the spirit of 'diverse solutions and local leadership'. Considerable progress can be made within the existing legal provisions and the collaborative approach adopted by the partners, without the need to seek 'permission' or new legal powers.

Financial and governance arrangements - how far can we go?

The existing legal powers vested by statute in the partner organisations and the Health and Wellbeing Board provide considerable scope for meaningful progress to be made in some key areas. Two key areas are governance and finance - and the relationship between them.

Whilst it will be for the individual organisations and this Board to decide how far and how fast they wish to proceed, the following sets out the scope that exists within the current statutory frameworks.

Steps towards integrated system	**Can this be done within existing local powers?**	
Delegating council decisions from Full Council / Cabinet / Portfolio holder e.g. commissioning decisions to the HWB	☑	Within existing powers under Health and Social Care Act 2012. HWB Constitution makes provision for such decisions to be 'reserved' for PCC and CCG Members of the HWB
Delegating from the CCG Board e.g. commissioning decisions to the HWB	?	There is scope to do this through a variety of mechanisms but would need proper consideration once scope of 'single system' is clearer
Delegating from HWB to officers e.g. to PHCE or similar acting as an 'officer exec' for the HWB	☑	Within existing powers under Health and Social Care Act 2012 normal officer delegations can apply to powers delegated from the Executive.
Single leadership - joint appointments by PCC and PCCG to senior officer roles	☑	Current governance of s75 for integrated commissioning provides a model and there have been a number of joint appointments
Pooling health and care commissioning budgets between PCC and PCCG at scale - 'single health and care budget for the city'	☑	Existing s75 and s113 powers allow this, with a number of such agreements already in place. Genuine pooling of decision-making has been harder to achieve, and would need structural change to HWB
Aligned 3 or 5 year place-based health and care budgets	?	Some scope to do this within existing local powers but additional support would be needed e.g. around*:* - Full and early delegation of specialised commissioning budgets from NHS England - Transfer of some Public Health funding and responsibilities from PHE

Joint approach to intelligence and strategic planning	☑	Statutory duty on HWB to oversee JSNA and strategy that addresses it. Recent draft national planning letter to CCGs reiterates importance of system-wide strategic planning

In the light of this legal and financial framework we can begin to put some shape around the organisational machinery necessary to deliver our objectives. A catalyst to this will be to re-engineer some of our existing management structures and processes across the partners.

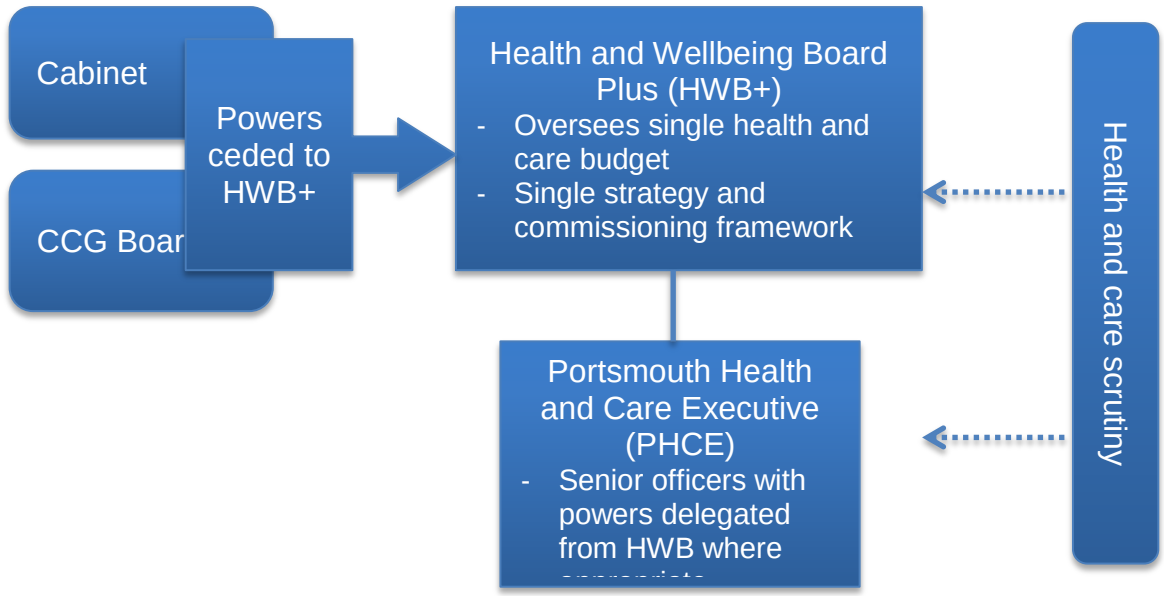
The existing financial and legal powers are sufficient to accommodate the following potential organisational models which could help accelerate our progress:

A 'Health and Wellbeing Board Plus':

- responsible for a single health and care budget for the City, which could be pooled using existing s75 powers or managed within existing organisational structures but presented and treated as a 'single budget';
- a single strategy, planning and commissioning framework, and revised Joint Health and Wellbeing Strategy;
- decision-making governance established around HWB with clear scheme of delegation so decisions at HWB do not then need to be referred back to constituent organisations for approval.
- Revised joint scrutiny arrangements appropriate to new model

Figure 3 sets out diagrammatically how this could look.

Fig 3: HWB+



In order to deliver this, the following steps are suggested:

Actions needed:	**Timescales:**
- report to PCC Cabinet and PCCG Board recommending delegation of powers for relevant health and social care commissioning to the HWB	Early in 2016
- review of HWB governance to ensure fit with proposed enhanced decision-making role e.g. political balance for Elected Members on HWB vs executive decision-making powers	Early in 2016
- report to PCC Governance and Audit and Standards Committee seeking support for recommendations of relevant changes to HWB governance to Full Council	Early in 2016
- review the Joint Health and Wellbeing Strategy and associated business of the HWB to ensure the Blueprint is central and the board's time is focussed on those areas where it can provide the system leadership	Spring 2016
- review with related partnerships (e.g. Children's Trust Board) how current arrangements could deliver this agenda more effectively and ensure the HWB+ is focussed on those areas where it can add most value	Spring 2016
- options appraisal for delivery and governance arrangements for a single commissioning function	Spring 2016
- developing shared frameworks for outcomes, risks and benefits realisation	Summer 16
- s75 agreement that significantly expands on the scope of existing s75 agreements (ICU, Better Care, AMH, CHC etc)?	Summer 16

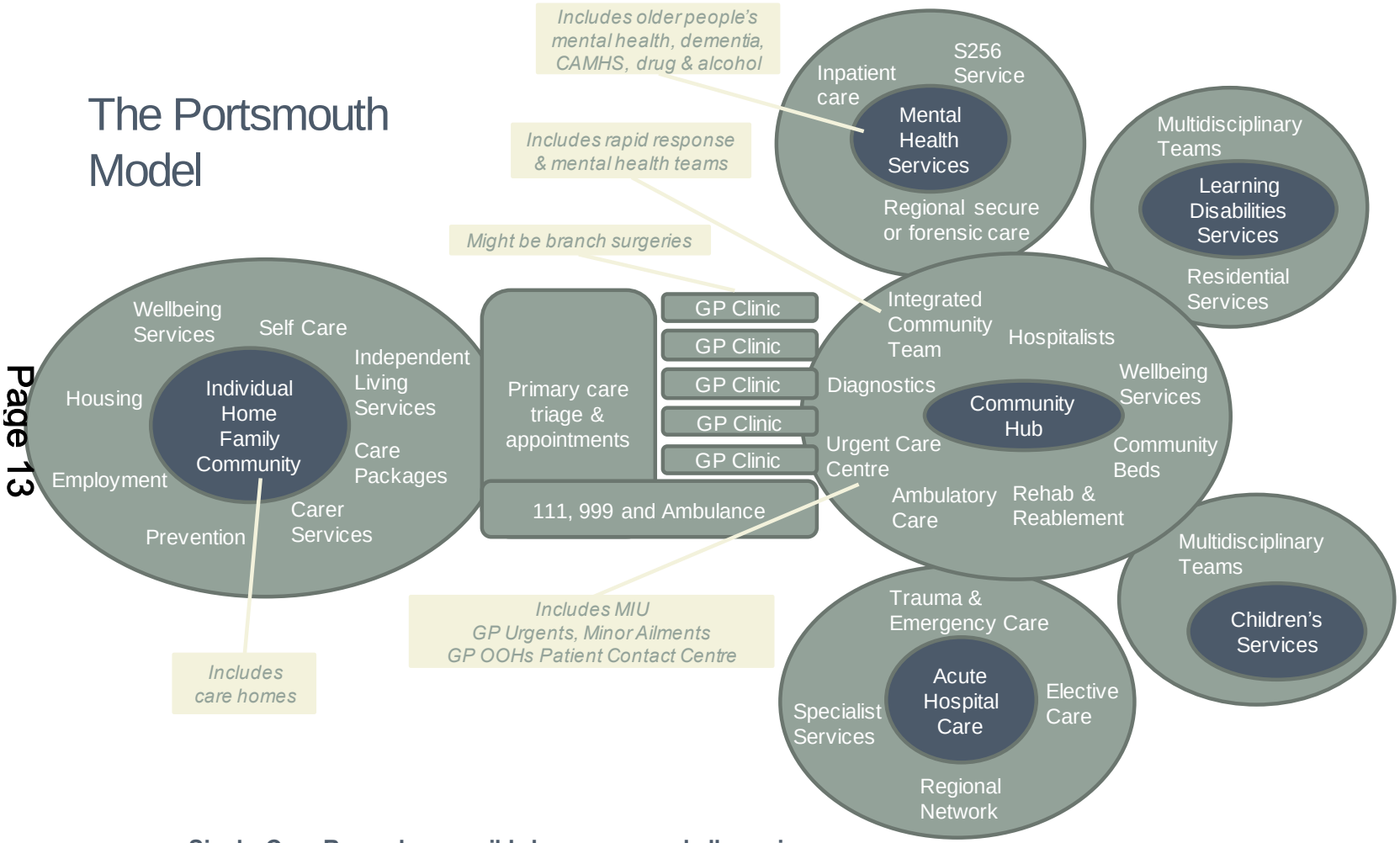
B Joint senior management arrangements between PCC and PCCG accountable to the HWB. This could include, for example, a new role of 'Director of Health and Adult Services' appointed jointly by PCC and PCCG. This post could manage operational leads for commissioning (supported by a shared intelligence and commissioning function), service delivery (exploration of single provider model envisaged for future), and transformation (including Better Care and programme management of Blueprint).

How We Will Organise Health & Care Provision

Over the next five years, we propose to change the way we offer services across the whole spectrum of health and care. Fig. 4 gives an overview of how the main health & care services could be organised in Portsmouth by 2020. To achieve this will mean bringing together some existing services, providing other services at scale, embracing technology, ensuring that people only go to hospital to receive care that can only be done in a hospital setting and that social care needs are met in the community wherever possible.

The sections that follow Figure 4 begin to set out the key features of each element of this overall model of care, giving further detail about the types of services that could be delivered and how we intend to change the health and social care offer for Portsmouth.

Fig 4: The Portsmouth Model of Health and Care



Prevention and Wellbeing

We will build support and capacity in all our neighbourhoods to support wellbeing and independence and agree priorities for action and develop better capacity and resources in each neighbourhood and community to support wellbeing.

We will create wellbeing services in or close to people's communities so that people can access support for a range of lifestyle issues which allows them to manage these better themselves, working with the whole community.

Single Point of Access and Triage

A single point of access will be created for health and social care services in Portsmouth so individuals, and their families and carers, find it easier to get the information and advice they need to make choices about the services they use and to manage their own care. By considering health and social care together, individuals would only need to tell their story once and only need one assessment.

Keeping Independence

We will improve the range of services people can access to maintain their independence.

We will make more use of personal budgets – people, their families and their carers will have more control, choice and flexibility over the support they receive

Establishing Community Hubs

We will create single health & care teams based in community hubs within key City localities. These teams will be seen as part of primary care services in the City and include a range of skills and services including primary and hospital care, social care, wellbeing & self-care, mental health (including elderly mental health) and community therapies (such as physiotherapy, occupational therapy).

Care will become more local. We will place more specialist services in the same localities as the community teams so that professionals have direct access to the right type of support to better manage the care of people – including ambulatory care, access to reablement and rehabilitation services and also a range of diagnostic services.

Creating a Different Primary Care Service

We will create a different primary care service for the City, one that retains the GP as the basis for the service but with a wider workforce which sees individual GP practices working together or merging to provide services collectively for the City. Primary care will be delivered as part of the single community teams but will also offer specific GP services in localities (similar to practices currently).

For people who need to access primary care, we will join up in-hours and out-of-hours health care so that access to urgent primary care appointments are seen as part of the overall urgent care service.

We will create a different type of workforce for delivering care for the City, one which will draw upon existing professions such as nursing, social work, emergency care and pharmacy to deliver primary care alongside GPs to ensure we have a workforce that can deal with the needs of the City.

Changing the Nature of Hospital Care

Better prevention and early intervention will enable hospital care to be more focused on planned treatment and, where urgent care is needed, choices will be simplified. By its nature, a single

health and care service for the City will be less hospital-centric; in order to do this we will require hospital clinicians to be working together with GPs and other out of hospital professionals to determine and manage the changes.

Delivering Social Care for the Future

Our model for care and support is built on four key elements.

- Good information and advice to enable us to look after ourselves and each other, and get the right help at the right time as our needs change.
- The recognition that we are all interdependent and we need to build supportive relationships and resilient communities.
- Services that help us get back on track after illness or support disabled people to be independent.
- When we do need care and support, we need services that are personalised, of good quality, that address our mental, physical, and other forms of wellbeing and are much better joined-up around our individual needs and those of our carers. Personal budgets are central to this approach.

We will look beyond people's immediate health and care needs to develop a model of social care that creates better opportunities for our children and young people, and reduces the numbers of children in care, in the offender system and young people not in education, employment or training.

We will create better opportunities for our most vulnerable members of the community including those with mental health problems, addiction problems or with learning disabilities. We will work with employers and work support agencies to support those people with health problems to remain in employment where possible.

We will continue to develop resources and capacity to support older people, especially for those with health problems including dementia and their carers.

Multi-disciplinary Teams for Children and Families

Co-located and integrated children's specialists will be part of the model. The current work to establish Multi-Agency Teams will continue but over time will become part of the broader Community Hubs.

We will ensure that in the design of the offer for children and families that our safeguarding children processes and practice remain robust and that there is a clear support pathway for children not just from primary care but also from nurseries, schools, colleges and the police.

We will ensure that the offer for children and families is family-focussed and fully integrates services for vulnerable parenting adults, notably around substance misuse, mental health, learning disability and domestic abuse.

In designing the offer for children and establishing the single provider, we will ensure that there are clear lines of accountability for risk around safeguarding and for the quality of services inspected by Ofsted.

How We Will Establish a City Approach to Strategic Planning, Prioritisation and Commissioning

Establishing a single health & care service for Portsmouth will require a joined up approach to planning, prioritisation and commissioning across the current public sector organisations. We will establish a single approach to strategic planning and commissioning for Portsmouth, bringing together functions and expertise from NHS Portsmouth CCG and Portsmouth City Council into a single service. We will develop the role of the Portsmouth Health and Wellbeing Board to act as the

single statutory Board for setting strategy, decision making, allocating resource and prioritisation for health and care in Portsmouth.

We will bring together how we use the information and expertise we have available to us currently – such as planning, commissioning and contracting services within the public sector but also the City's Joint Strategic Needs Assessment (JSNA), our Public Health capability and our developing approach to outcomes-based and population-based contracting.

How We Will Make Better Use of Public Sector Expertise and Support Services

Using Technology

We will establish an IT system for the City that can work across all health and care providers so that each person has a single care record which can be accessed by those who are providing their care. We will give people access to their own care record as well as giving them direct control over who else can access their record.

We will actively use current and future technology to support people to care for themselves or access services including the use of mobile apps, telehealth/care but also using technology to allow people to self-triage and book appointments for care.

Making Better Use of the Public Estate

In establishing a single health & care service for the City, we will review and manage the totality of the health & care estate in Portsmouth, including establishing ways of supporting current GP practices with their primary care estate. The City's total public sector estate will be used to enable our delivery of a health and care service but also will be our first point of call for the location of any specialist, support or management services.

In particular, we will maximise the use of key strategic sites for health and care in the City including (but not limited to) St Mary's campus, Civic Offices and Queen Alexandra Hospital. We will also maximise the use of community space to build capacity for community based organisations and activities.

Growing Our Workforce

We will not assume that tomorrow's health & care service will be provided simply by bringing together today's workforce, professions and services and requiring these to work differently or for longer hours; we cannot build a sustainable service for the future on this basis.

We will thus develop a workforce that matches the differing types of delivery this future model requires. Working with local and regional education providers as well as the national professional bodies we will aim to 'grow our own' workforce – ensuring that we not only design new roles but also establish the means by which they are trained and developed.

It is likely that our future workforce will include the following features:

- The right knowledge, skills and expertise to deliver their role
- Not constrained by current organisational forms and boundaries but working within the Portsmouth model of care
- Primary care specialists or consultants, able to work across the acute, community and social care sectors to manage the complete care of the individual
- Flexibility for professionals to portfolio work, mixing more general care delivery with specialist expertise

Our aim will be that the local health and care workforce expresses pride in the work they do, feels valued and sees Portsmouth as a place to work, pursue their career and live.

How We Will Deliver the Changes

Delivery Arrangements and Change Team

The scale of change we are aspiring to achieve will require us to agree and collectively establish a city transformation programme. Before the transformation programme can be set up, there are a number of decisions and actions, which must be undertaken by March 2016.

- Decision required between PCC and PCCG about how they are going to join up their commissioning functions to enable a single commissioning approach, including which budgets will be pooled and the mechanisms (formal and cultural) by which this will be achieved. This will both require and support strengthening of HWB's role.
- Decision about scope and authority of HWB and the delegated authority it requires from PCC and CCG, with implementation plan in place by 31 March 2016.
- Partnership agreement required to be in place between PCC, Solent, PHT and the Primary Care Alliance that allows them to work together to deliver the operational transformational changes as well as work to develop and review options for new single organisational form for service delivery.
- Clarity from each organisation about the impact of the changes above on their statutory functions and regulatory environment.
- Clear decision about which back office / support functions will be brought together and for whom, with a clear development and phasing plan to be in place.
- Agreement about how we are going to identify and manage those savings/CIP/QIPP proposals that either have implications for partners or run the risk of taking us in a direction away from the aims of the Blueprint. Appropriate governance arrangements need to be in place to support this.
- Clarity on our joint planning arrangements between now and April, with a clear articulation of which plans are truly joint and some agreement around how risks and benefits will be shared between partners.

Programmes do not deliver change in isolation. We will establish a single change team to run this programme by using existing roles, people and resource available across our organisations in the first instance.

These changes will be delivered whilst also maintaining the delivery of 'business-as-usual' in our services. This will require engagement and use of our best operational managers within this change programme. We will achieve this by having a defined Business Change Team within the programme – using experienced operational and commissioning managers to ensure the changes being developed by the programme can be introduced to our services. This also ensures the change programme benefits from having the experience of people who manage and deliver our services involved in delivering change.

Engagement and Consultation

Whilst a great deal of engagement, discussion and consultation has already occurred with people and staff in Portsmouth – this has tended to be about specific service changes. There has been some engagement with broader strategic direction – such as the CCG's 20/20 strategic vision document, children's services and the Better Care Programme. However we have yet to engage people in shaping and delivering this broader programme that seeks to transform how health and care is delivering in the City, including working with the established voluntary and community sector organisations that will be a key delivery partner for much of this work.

As part of the Better Care programme, a communications and engagement workstream is in place, led by the Better Care communications and engagement officer and involving communications leads from the partner organisations. Having already built relationships, established processes, mapped stakeholders and developed tools to work across the organisations and support communications and engagement, the workstream is well placed to evolve to take on Blueprint.

We also believe that Healthwatch Portsmouth must be a key partner in this change programme and have begun discussions to gain their early input and steer about how we go about this broader engagement work.

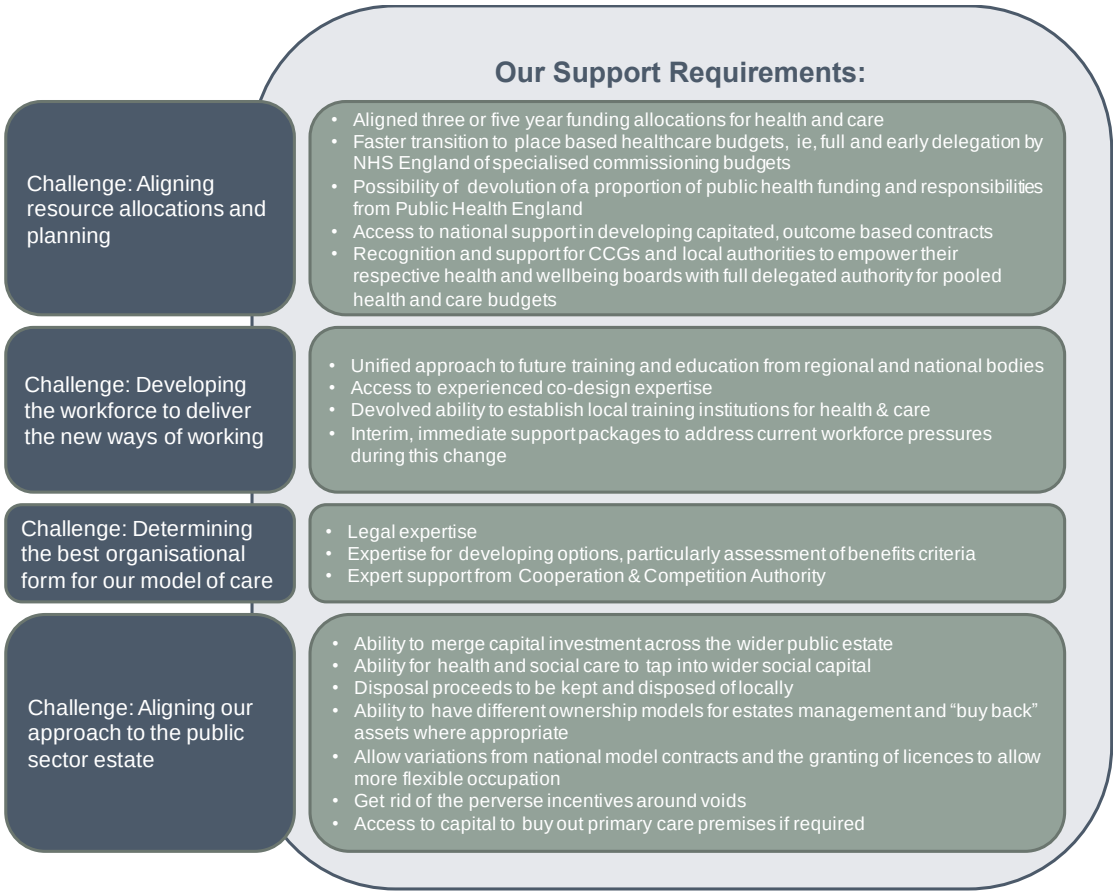
Our Challenges and Support Requirements

Changing services at this scale will require taking challenging local decisions. Whilst there is much within our current powers that will enable to us to do this, we do and will have requirements for support from other organisations outside Portsmouth, including central government.

These support requirements are currently being considered for inclusion within a wider proposal for devolved powers and authority to a wider Hampshire and Isle of Wight governance model.

Figure 6 below lists some immediate challenges to enacting this Blueprint and proposes the potential support required for our local plan

Figure 6: Our Challenges and Support Requirements



The Journey Towards Change

Whilst the change programme will define in detail the main actions and timescales (or milestones) required to deliver this ambitious transformation in health and care for Portsmouth, we will identify and agree a set of top level milestones by which we will judge collectively whether we are on track.

This will be particularly important for the first 12-18 months as the programme begins to tackle fundamental issues such as pooled finances, risk shares, organisational form and individual roles.

The Portsmouth Health & Care Executive are currently reviewing and agreeing proposed top level milestones for this first 18 month period and these can be reported to a future Health & Wellbeing Board.

David Williams, Chief Executive, Portsmouth City Council; and

Innes Richens, Chief Operating Officer, NHS Portsmouth Clinical Commissioning Group

On behalf of the Portsmouth Health & Care Executive

December 2015

Annex 1

Our Key Commitments to Portsmouth

To ensure our solution is of a scale of ambition sufficient to meet the challenges facing the City, we propose to the Portsmouth Health & Wellbeing Board that:

- We will build our health and social care service on the foundation of primary and community care, recognising that **people have consistently told us they value primary care as generalists and preferred point of care co-ordination**; we will improve access to primary care services when people require it on an urgent basis.
- We underpin this with a programme of work that aims to **empower the individual to maintain good health and prevent ill health**, strengthening assets in the community, building resilience and social capital.
- We bring together important functions that allow our organisations to deliver **more effective community based front-line services and preventative strategies**; this includes functions such as HR, Estates, IT and other technical support services.
- We establish a new constitutional way of working to **enable statutory functions of public bodies in the City to act as one**. This would include establishing a single commissioning function at the level of the current Health & Wellbeing Board with delegated authority for the totality of health (NHS) and social care budgets.
- We establish a lead provider for the delivery of health and social care services for the City. This would involve looking at organisational options such as **bringing together health and social care services into a single organisation, under single leadership with staff co-located**. The scope of this would include mental health, well-being and community teams, children's teams, substance misuse services and learning disabilities. In time, it could also include other services currently residing in the acute health sector or in primary care.
- We simplify the current configuration of urgent and emergency care and out of hours services, ensuring access to appropriate services 7 days per week and making what is offered out of hours and weekends consistent with the service offered in-hours on weekdays so that **people have clear choices regardless of the day or time**.
- We focus on building capacity and resources within defined localities within the City to enable them to commission and **deliver services at a locality level within a framework set by the city-wide Health & Wellbeing Board**.

Our Vision

Our vision is for everyone in Portsmouth to be enabled to live healthy, safe and independent lives, with care and support that is integrated around the needs of the individual at the right time and in the right setting. We will do things because they matter to local people, we know that they work and we know that they will make a measurable difference to their lives.

Primary and community care is at the core of our strategy. We recognise and value the contribution made by GPs and all primary care professionals to health & care in Portsmouth and understand they are highly valued by people. GPs and pharmacists are the main point of contact for the majority of people and their skills are essential for all aspects of health care, including health education and health promotion.

We will commission a sustainable health and social care system that achieves a shift in focus from acute care to community and primary care, early intervention, prevention and maximizes the contribution of the voluntary, community and independent sector. In order to deliver our strategy, improve the quality of services, meet rising demands and costs and ensure safe services at all times we will need to achieve at least £40m of efficiencies across health and social care by 2019; this figure is likely to rise as national and local spending reviews and settlements are confirmed.

Outcomes

Portsmouth's Health & Wellbeing Board sets the strategic outcomes for Portsmouth's health and care; these incorporate not just the findings from our ongoing Joint Strategic Needs Assessment (JSNA) but also considers feedback from people in the City, users of our services and their representatives as well as national and local evidence, modelling and planning from its constituent health and care partners.

For the People of Portsmouth

Within 5 years Portsmouth people will:

- be able to access effective services to meet their goals to manage their own health and stay well and independent;
- be able to plan ahead and keep control during times of crisis in their health and care;
- spend less time in hospital and institutional care;
- access responsive services which help them to maintain their independence;
- have access to the right information and support about services available;
- have access to simple, effective services when they have an urgent health, care or welfare need;
- have a strong voice about how services are designed and delivered;
- feel confident that their care is coordinated and that they only have to tell their story once;
- benefit from the use of technology to help them stay well and independent.

For the City

The outcomes for Portsmouth we are specifically aiming to improve are:

- A radically improved offer of early intervention and preventative health and social care services that allow individuals to have more choice and control over their own lives
- A healthy and sustainable environment, which supports wellbeing and in which people can live healthier lives - improved housing, warmth, transport and green space, better access to employment, healthier food and drink and clean air
- Support for wellbeing - both physical and mental wellbeing - that is holistic, integrated and promotes positive behaviour change, drawing on strengthened community assets and giving greater control to individuals over day to day life (including over care and support provided and the way it is provided).
- All children have the best start in life and parents are supported to keep their children healthy; families are supported to build positive relationships and provide safe and nurturing parenting
- A reduction in the number of children requiring a statutory safeguarding response
- Strong multi-agency safeguarding partnerships that provide timely and effective prevention of, and response to, abuse and neglect
- A reduction in children's absence from school
- Communities are able to support the needs of our most vulnerable those with learning disabilities, with enduring mental health or physical health problems including hearing or visual loss or problematic addictions
- Older people are well engaged and supported in the community to prevent isolation
- Improvement in the support to carers, including better access to information and advice
- An increased proportion of older people remaining at home 91 days after a discharge from hospital

- Further reductions in delays to transfers of care from the acute setting to the community, with improved quality of the discharge process
- People with complex needs who need to go into hospital are known to community locality teams and are safely and actively managed back into their home
- A further reduction in acute bed days for older people who need to go into hospital
- More people able to die in their preferred place of death

……
Signed by:
David Williams, Chief Executive, Portsmouth City Council

Appendices:

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

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

Title of document	**Location**

THIS ITEM IS FOR INFORMATION ONLY

Portsmouth CITY COUNCIL

Agenda item:

Title of meeting:	Health and Wellbeing Board
Subject:	Portsmouth Safeguarding Adults Board (PSAB) Annual Report
Date of meeting:	2/12/2015
Report by:	Rachael Roberts, on behalf of the Director of Adult Services
Wards affected:	All

---

1. **Requested by the lead Member for Health and Social Care**

2. **Purpose - For information only, to update the Board on the current position and achievements of the PSAB in relation to the Care Act.**

3. **Information Requested**

PSAB Annual Report

The report sets out the PSAB's achievements over the last year. The December meeting of the PSAB board will be used to agree the strategic priorities and work programme for 2016/17. A new independent chair has been appointed - Robert Templeton and he will take on the Chair's role at the December meeting of the PSAB

In 2014/15 the Board has focused on preparing for and implementing the Care Act.

One Safeguarding Adult Review (SAR) has been completed and a further one commissioned. Learning from these is being disseminated across all agencies and action plans are monitored and reviewed through the SAR sub group.

…….
Signed by Robert Watt, Director of Adult Services

Appendices: Appendix 1 - PSAB Annual Report 2014/15

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
PSAB Annual Report 2014/2015	PSAB Jan 2016

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ANNUAL REPORT - 2014 / 2015

Safeguarding is everyone's responsibility"

REPORT FROM INDEPENDENT CHAIR - David Cooper

It has been an extremely busy year for Portsmouth Safeguarding Adults Board, and its partner agencies, as they prepared for the implementation of the Care Act 2014, during a period when safeguarding has dominated the news as never before. It is a compliment to all these agencies and their frontline staff that this report is able to demonstrate significant progress.

This years report is being presented in a rather different format than before, which we hope you will find both more informative and more accessible. Any comments you have on the new format would be most appreciated.

This will be my last report as Chair, as I will be stepping down from this role at the end of August. When I was appointed in 2013 I was asked to ensure the board was prepared to meet the requirements of the Care Act, which was coming into effect in April 2015, and I believe we have achieved this.

However, before looking at some of the key developments over the past year, I want to look at the national and local context in which safeguarding operates.

In June 2014 the safeguarding service in Portsmouth City Council and the multi agency joint working arrangements (including the Safeguarding Adults Board) were the subject of an external Peer Review, which found examples of good practice, a strong commitment to safeguarding, and good informal working arrangements amongst partner agencies.

As indicated above safeguarding work is becoming ever more complex, and the environment in which it is being delivered more challenging, and yet the board received some examples of some excellent work by front line staff, including colleagues in the Police who have worked hard to engage partner agencies in improved joint working to prevent the radicalisation of vulnerable adults, while NHS colleagues have given a heightened focus around the issue of female genital mutilation and the board received some examples of excellent person centred practice from social workers in Portsmouth City Council.

Following the Peer Review and the emergence of guidance around the Care Act, the board held a very successful Development Day, and agreed a new set of working arrangements and membership, reflecting its new statutory status. These have been implemented in a phased manner over the past year, and the 'new board' is now in place, and meeting.

Fragility of the care market - while there are some excellent providers, as national data published by Care Quality Commission (CQC) in April 2015 found, there remain large variations in the quality of care services with 1% rated as outstanding, 59% as good, but 31.9% as requiring improvement and 8.7% as inadequate. This picture is consistent with the Institute of Public Care's report for CQC into the state of the care market published last year. As we know that many of these care providers are facing real financial difficulties, and the planned introduction of the national minimum wage, though welcomed, will only add to these financial pressures.

Impact of financial austerity on adult social care - a budget survey by the Association of Directors of Adult Social Services in June 2015 highlighted the continued financial pressure on Adult Social Care, with central government cuts in budgets of £4.6 billion since 2010, and further cuts of £1.1 billion planned for 2015/16, which has resulted in fewer people receiving social care services; despite the efforts of local politicians to protect social care budgets. In Portsmouth this has resulted in an on-going financial squeeze on social care budgets, with further cuts planned.

Impact of continued organisational change - one response to managing the financial pressures faced by partner agencies, is through improved productivity ie 'doing more for less'. Which in turn has resulted in considerable organisational change in Portsmouth City Council, Hampshire Police, Probation and NHS, and this places real pressure on frontline staff working in public and voluntary services, as evidenced in a national survey undertaken by the Guardian newspaper, published on the 10 June, with 93% of respondents stating they were stressed at work all or part of the time. Yet these are many of the same staff working with the most vulnerable members of society.

Complexity of safeguarding - I have worked in the area of safeguarding for over 30 years, and it is difficult to recall a period when safeguarding was more in the news. The scenarios in which it operates is also becoming more complex, including human trafficking, heightened awareness of domestic abuse, cases of historic sexual abuse emerging post the Jimmy Saville revelations, and radicalisation which saw 6 young men from Portsmouth lured to fight in Syria. While the CQC, following a freedom of information request from the Observer newspaper (published on the 9 August 2015) revealed that regulators were notified of 30,000 allegations of abuse involving people using social care services in the first six months of this year; while the rate of allegations made in 2015 is double that of 2011. In Portsmouth while the number of allegations may not have increased, the number that were taken forward as investigations went up by a third. All of these factors create a very challenging context for safeguarding.

Achievements of the Board over the past year - the main focus of the boards work over the past year has been in preparing, and implementing the Care Act , which came into effect in April 2015 and placed the Safeguarding Board onto a statutory footing for the first time. This has involved working with the 3 other local safeguarding boards (Southampton, Hampshire and Isle of Wight) in reviewing all our local procedures; providing training in the new working arrangements; generally raising awareness amongst staff and the public etc.

As indicated above safeguarding work is becoming ever more complex, and the environment in which it is being delivered more challenging, and yet the board received some examples of some excellent work by front line staff, including colleagues in the Police who have worked hard to engage partner agencies in improved joint working to prevent the radicalisation of vulnerable adults, while NHS colleagues have given a heightened focus around the issue of female genital mutilation and the board received some examples of excellent person centred practice from social workers in Portsmouth City Council.

Following the Peer Review and the emergence of guidance around the Care Act, the board held a very successful Development Day, and agreed a new set of working arrangements and membership, reflecting its new statutory status, and these have been implemented in a phased manner over the past year, and the 'new board' is now in place, and meeting.

Challenges facing the Board - But of course the Peer Review, the Safeguarding Adult Review inquiries, and the work of the board over the past year has also evidenced that there is much more which needs to be done to strengthen the joint working arrangements;

- Partner agencies need to work together to ensure that the board has access to more robust quality and performance information, to support improved safeguarding monitoring arrangements.
- Further work needs to be done to communicate and widen the governance of safeguarding across PCC, and there needs to be increased Council Member engagement in safeguarding at board level and across the wider system.
- More consideration needs to be given to 'making safeguarding personal' as a way of ensuring better outcomes and involvement of people experiencing safeguarding concerns.
- The new board will need to take a more strategic approach, taking into account the impact of the Care Act, the wider remit of safeguarding, and this in-turn requires enhanced financial and other support for the board (which has been much lacking) to manage both the pending changes in personnel over the next few months, and to respond in the long term to the demands facing safeguarding in future years.
- Finally I would like to take this opportunity to thank the board support staff, all board members, other colleagues, and members of the public for their support in my role as chairperson over the past 18 months or so. The board has agreed to appoint a new independent chair, and I would also like to offer them my best wishes for the future.

David Cooper
Independent Chair

THE CARE ACT 2014

The Act came into force in April 2015.

Clauses 42-48 of the Care Act provides the statutory framework for protecting adults from abuse and neglect from April 2015. Provisions include:

- Make or cause to be made, enquiries if it believes an adult is experiencing or at risk of experiencing abuse or neglect
- Arrange for independent advocacy to be available for those who may have difficulty in participating in any enquiries.
- Establish a Safeguarding Adults Board (SAB) to coordinate efforts across all partner agencies to safeguard adults with care and support needs.

  Ensure the SAB produces an annual report detailing it's achievements for the year alongside a strategic plan outlining it's main objectives and how they will be met.
- Conduct Safeguarding Adult Reviews in accordance with S44 of the Act, where someone who is experiencing abuse or neglect dies or there is concern about how authorities acted, to ensure lessons are learned.
- New ability for Safeguarding Adults Boards to require information sharing from other partners to support reviews or other functions.
- Abolition of the existing power (under section 47 of the National Assistance Act 1948) for local authorities to remove people from their homes.
- Provide information about services available in the area that can prevent abuse and support people to safeguard themselves.

Care Act 2014

ACHIEVEMENTS OF THE PSAB IN RELATION TO THE CARE ACT

- Portsmouth Safeguarding Adult Boards are implementing changes required under the Care Act.
- Paartnrs agencies have been requested to audit how they are implementing the Care Act locally
- A Safeguarding Adults Board has formed including review and revision of previous Board arrangements and the appointment of an Independent Chair.
- We have worked in partnership with neighbouring local authorities (4LSAB)to update the Pan Hampshire Multi Agency Safeguarding Policy and Procedures in light of the Care Act .
- A Designated Adult Safeguarding Manager (DASM) responsible for the management and oversight of individual complex cases has been ap-

Chapter 1– Local Demographics

Local Demographics

Portsmouth is a port city located in Hampshire on the south coast of England. It is the most densely populated area in the UK outside of London with an estimated population of 205,100, of which approximately 79.3% are over 18 years of age. Portsmouth has a predominantly White British ethnic population; 84% . Of the 16% Black and Minority Ethnic population the ethnicities with the highest representation are Bangladeshi, Indian, Chinese, Black African, Mixed White and Asian and Other White.

Portsmouth is ranked 76th most deprived out of 326 local authorities in England (Indices of Multiple Deprivation 2010), with 15% of the city's population experiencing income deprivation.

Vulnerable Groups

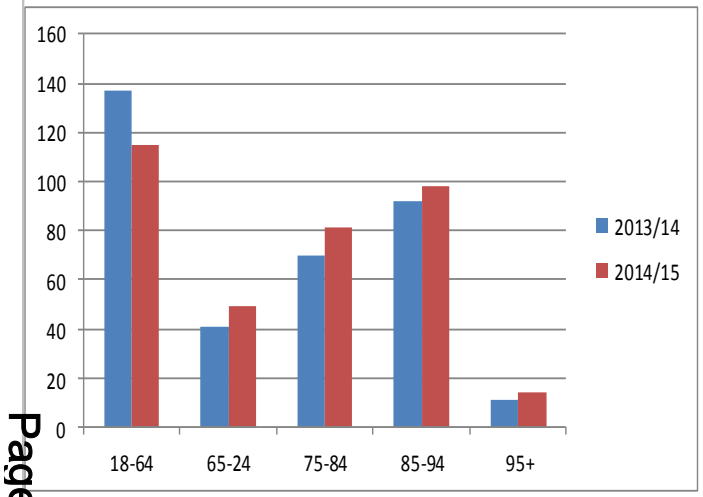
It is impossible to offer a complete picture of adults at risk in Portsmouth because, despite the best efforts of local services to identify, engage with, and support adults who are being harmed or are at risk of being harmed, some abuse or neglect may be hidden. What we do know is that we need the support of all services and the local community to raise awareness of what constitutes a safeguarding concern.

Abuse of vulnerable adults can take many forms, including financial, physical, emotional or linked to households where there is domestic abuse, substance misuse and mental health issues.

This annual report starts by looking at the categories of adults at risk in Portsmouth who have been identified by the local authority and other agencies as in need of protection as a result of their vulnerability.

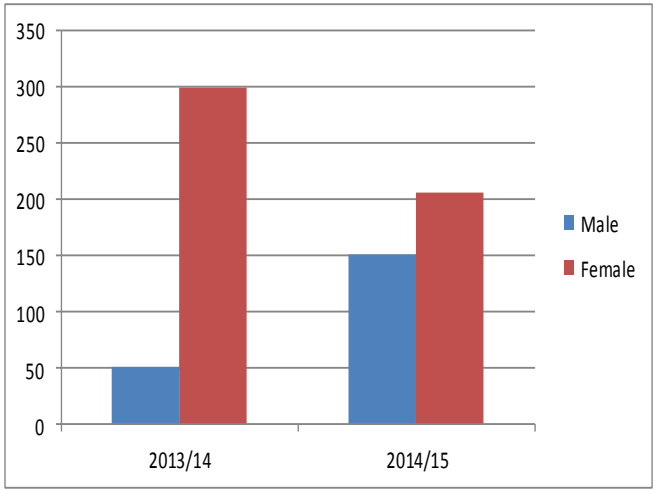
Statistical Analysis– Referral Breakdown

Referrals by Age 2013/14 and 2014/15



The graph above shows the number of referrals received in 2013/14 and 2014/15, that were considered under the Pan Hants Multi-Agency Safeguarding Procedures. The number of alerts raised over the last two years has remained steady at 1300 per annum. However the number of concerns requiring a safeguarding response under the Pan Hants Multi-Agency Procedures has from 239 in 2013/14 to 357 in 2014/15 indicating that there is increased awareness of what constitutes a safeguarding concern within the city.

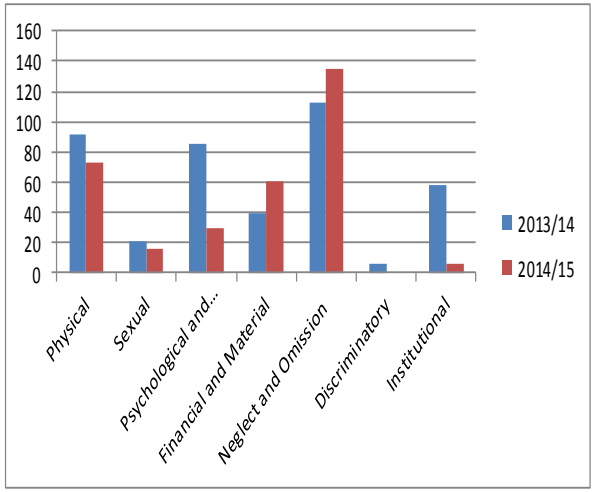
Referrals by Gender



The graph above shows the contrast of referrals by gender received in 2013/14 and 2014/15.

More concerns are raised about women than men in Portsmouth, this is in line with the national picture.

Referrals by Risk Type 2013/14 and 2014/15



The graph above is a comparison of the risk types that are referred. Although there is an upward trend in the year 2014/15 for Neglect and Acts of Omission, this could be due to a raised awareness in this area of Safeguarding work .

The statistics suggest a reduction in Institutional abuse but this is likely to be a result of changes to recording practice. Some safeguarding concerns occurring in care home settings are being recorded as Neglect or Omission, where previously they may have been recorded as institutional abuse.

National developments and local response

The Francis Report investigated the failings at the Mid Staffordshire Foundation Trust was published in February 2013. Since then, issues of patient safety, quality of care and a culture of collective leadership have been in the public eye more than ever. This was shortly followed by the Government publishing its response to address poor quality care in NHS services.

In February 2013, the Home Office introduced a new definition of 'domestic abuse' which has been extended to include incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality.

In April 2013, Health and Wellbeing Boards were established and became a statutory requirement. The PSAB has established links with the Portsmouth Health and Wellbeing Board and has developed a joint working protocol.

In April 2015 the Care Act became law. This Act places safeguarding adults on a statutory footing, providing a much welcomed legislative framework to support the work of the local authority and partner agencies. The Act re-affirmed the importance of embedding the six principles of safeguarding into the practice of all partner members of the safeguarding adults boards

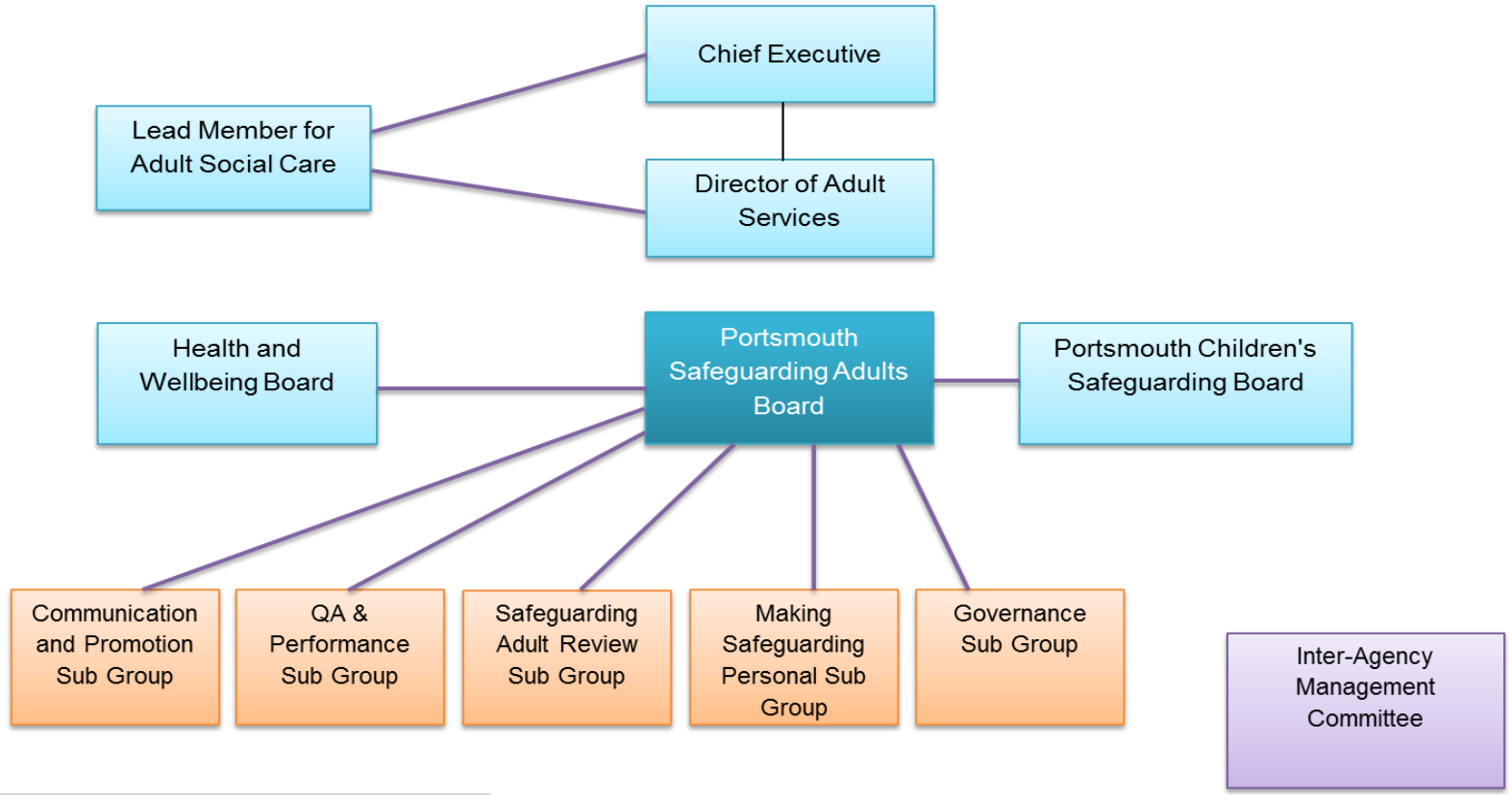
Six principles of Safeguarding

- **Empowerment**
  People being supported and encouraged to make their own decisions and informed consent.
- **Prevention**
  It is better to take action before harm occurs.
- **Proportionality**
  The least intrusive response appropriate to the risk presented.
- **Protection**
  Support and representation for those in greatest need.
- **Partnership**
  Local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse.
- **Accountability**
  Accountability and transparency in safeguarding practice.

CHAPTER 2

What is the Portsmouth Safeguarding Adults Board?

The Portsmouth Safeguarding Adults Board (PSAB) aims to promote awareness and understanding of abuse and neglect. Its work to generate community interest and engagement in safeguarding issues to ensure "Safeguarding is Everyone's Business". The well-being and safety of local people is our main concern and we adopt a zero tolerance stance on the abuse, neglect or discrimination of any person, including people at risk or in vulnerable situations in any setting. Our aim is to ensure there is effective partnership working at the local level, whenever concerns are raised, so that agencies work in a co-ordinated way. We work proactively with care providers to address any concerns raised about their service to ensure that local people have access to good quality and safe care when they need it.



The role and duties of Safeguarding Adults Boards (SABs) Director of Adult Services

The Director of Adult Services has specific responsibilities under statutory guidance issued by the Department of Health. These include:

- Maintain a clear organisational and operational focus on safeguarding adults.
- Make sure relevant statutory requirements and other national standards are met.
- Make sure Disclosure and Barring Service (DBS) standards are met.

The Director is also responsible, through the appointment of an effective Independent Chair, for ensuring :-

- That the SAB continues to develop an independent, objective and authoritative identity.
- The SAB will have clear independent leadership and strategic vision.
- That partners work effectively together to safeguard adults at risk in their area.
- To ensure adult safeguarding maintains a high profile across all agencies, organisations and communities in the city.
- The SAB will evaluate its effectiveness in scrutinising safeguarding work across all partner agencies.
- The SAB will work collaboratively with the other SAB's locally to reduce repetition and share the same working documents / strategies etc., particularly where organisations work across more than one Board.

The Purpose of a Safeguarding Adults Board

The overarching purpose of a SAB is to:

- Assure itself that local safeguarding arrangements are in place as defined by the Care Act
- Prevent abuse and neglect where possible
- Provide a timely and proportionate responses when abuse or neglect has occurred.

The SAB must take the lead for adult safeguarding across its locality and oversee and co-ordinate the effectiveness of the safeguarding work of its member and partner agencies. It must also concern itself with a range of matters which can contribute to the prevention of abuse and neglect such as the:

- Safety of patients in local health services
- Quality of local care and support services
- Effectiveness of prisons in safeguarding offenders

Core duties: -

SABs have three core duties. They must:

- Develop and publish an Annual Strategic Plan setting out how they will meet their strategic objectives and how their member and partner agencies will contribute.
- Publish an annual report detailing how effective their work has been.
- Arrange Safeguarding Adult Reviews for any cases which meet the criteria for such enquiries.

Portsmouth Safeguarding Adults Board and its Sub-groups

SAB (Safeguarding Adults Board): The strategic multi-agency steering group with statutory responsibility for the oversight and co-ordination of safeguarding activity across Portsmouth.

QA (The Quality and Performance Subgroup): Responsible for the production of effective management information and governance to the PSAB.

SAR (The Safeguarding Adult Review Subgroup): Responsible for the commissioning of and learning from Safeguarding Adult Reviews.

MSP (Making Safeguarding Personal): This sub group will help develop a culture within safeguarding services that ensures that the way we respond in safeguarding situations enhances the involvement, choice and control of adults at risk, alongside improving their quality of life , wellbeing and safety.

Fire Safety Development Group: Responsible for co-ordinating the learning and review of fire deaths and serious injury from a fire. (note this a 4 LSAB group).

Communication and Promotion of Safeguarding: Responsible for ensuring effective communication from the SAB as well as between partners and members of the board.

Governance: The Governance Subgroup is responsible for the review and development of multi-agency safeguarding policy and process that impacts upon all members of the SAB in terms of workforce and service users.

Training (The Training and Development Subgroup): Responsible for co-ordinating the development of multi-agency learning across the 4 LSAB and in Portsmouth we will be developing a training sub group to address the specific training needs of staff working across the city .

SABs primarily achieve their goals indirectly, through their agency members and through their partnerships with other boards and agencies. However, SABs may wish to commission some work themselves and secure funding to enable them to do so. This may, for example, be to test out an approach or to promote some research.

Quality Assurance and Performance Sub-Group

Aims:

- Consistent and robust outcomes for vulnerable adults.
- The monitoring of performance against the PSAB work plan.
- The sharing and application of learning and experience from practice in Portsmouth and across the UK, including from safeguarding adult reviews and audits.
- Audit the effectiveness of safeguarding arrangements across local partner agencies.
  Monitoring of the consistency of threshold decisions.
- The group will monitor performance of safeguarding, and provide a quarterly report to the PSAB, and annual summary report as part of the PSAB annual report.

Achievements during 2014/15 have been:

- Building on Data sets developed by 4 LSAB.
- Regular meetings with multi agency partners.

Safeguarding Adult Review Sub-Group

Aims:

- To act as a subgroup of the Portsmouth Safeguarding Adults Board (PSAB) to ensure the responsibilities of the Board are carried out in respect of safeguarding adult reviews and other forms of learning reviews activities.
- To ensure there is a clear process for commissioning and carrying out of safeguarding adult reviews and other forms of learning review activities within Portsmouth

Achievements during 2014/15 have been

- Bi– Monthly meetings with good representation across partner agencies .
- PSAB commissioned a serious case review (before the Care Act 2014 legislation) in May 2014 and the full report was published on the website in September 2015. Learning from this review was disseminated to agencies via the Board and actions are being monitored by the subgroup.
- A further SAR has been commissioned into another case and its findings are likely to be published in the 2016.

Making Safeguarding Personal

Aims:

- To promote Making Safeguarding Personal through all its work streams.
- Oversee the rewrite of relevant documentation to ensure that documents in relation to safeguarding.
- To compile an audit tool, carry out audits and report findings to the QA and performance sub group and then to the PSAB
- To facilitate effective ensure that Making Safeguarding Personal is embedded in practice.

Achievements during 2014/15 have been:

- Developing an outcome focused feedback form.
- Involvement in developing person led literature.
- Developed an audit tool to measure practice against the key principles embedded in making safeguarding personal

Communication and Promotion of Safeguarding

Aims:

- To raise awareness of safeguarding and communicate that safeguarding matters to everyone.
- To launch/communicate to the public the PSCB and PSAB websites and Adults' single assessment framework during Safeguarding Week 22-28 June

Achievements during 2014/15 have been:

- Activity has included editorial promotion and interviews with key stakeholders. Safeguarding messages disseminated during Safeguarding Week at a multi-agency event in Guildhall Square.
  Internal communications, videos and social media also used to spread the word.
- Editorial coverage for Safeguarding week equivalent to £1800 advertising spend
- 212 page hits / 139 unique views / hits to PSCB site
- 227 page hits / 111 unique views / hits to PSAB site
- Increased referrals and leads during the week and one alert as a direct result of the event.

CHAPTER 3

Local Safeguarding Representatives

NHS
Portsmouth
Clinical Commissioning Group

Key Developments/Achievements:

- Appointment of a CCG Quality Assurance Nurse for care homes and domiciliary care across the City.
- CCG safeguarding week in August 2014, including training to the executive board.
- Increased integration and information sharing across the CCG safeguarding and quality teams.
- Strong attendance, facilitation and participation at the PSAB and associated sub-groups.
- Safeguarding element of the quality schedule for health providers revised and strengthened in preparation for 2015-2016 contracts.
- Funding made available for MCA and DoLS across health and social care which included conferences across both statutory and independent providers and funding further Best Interests Assessors.

Roles and Responsibilities

CCG's are the major commissioners of local health services and need to assure themselves that the organisations from which they commission have effective safeguarding arrangements in place.

Safeguarding is embedded in the clinical decision making of the organisation, with the authority to work within local health economies to influence thinking and practice.

The Designated Nurse acts as a clinical expert and strategic leader to offer advice and support for other health professionals in provider organisations or to the Board.

Actions in Relation to the Care Act 2014

Basic awareness training presentation revised to include the Care Act, making safeguarding personal, domestic abuse, modern slavery and self-neglect.

CCG staff, GP's and primary care have received a Care Act briefing.

Care Act has been part of the safeguarding adult report to the CCG Quality and Safety Executive Group, which reports to the clinical executive committee.

Care Act is part of the quality schedule for major health providers.

Designated Nurse for Safeguarding Adults has been appointed as the Designated Adult Safeguarding Manager (DASM)

Designated Nurse is part of the Serious Incident Requiring Investigation (SIRI) panel and critically analyses quality issues relating to safeguarding and MCA within healthcare. This is replicated for complaints.

Queen Alexandra Hospital (QAH)

Within the hospital the year covered by this report has been a busy one, the main concerns have been raised in relation to visitors of patients and not necessarily from concerns raised within the hospital and of hospital staff. There has been a 30 % increase in alerts, however, a large proportion of these alerts were not substantiated. There has been improvement and an increase in staff within the hospital, Anne Taylor is the lead nurse and the DASM. There are also Service Area Lead Nurses for each clinical service areas who have an enhanced level of safeguarding training . Monthly reports are gathered and reported to Governance and Assurance groups .

Themes of alerts

* Poor care (6 substantiated)
* Allegation of neglect or actors of omission .

Achievements

* QAH had a full CQC inspection—evidence of strength within safeguarding.
* Fully involved in PSAB and some sub groups.
* Involvement in Safeguarding Awareness Week.
* QAH specific safeguarding week in October 2014 – variety of training delivered particularly in relation to DOLs/ MCA/ Domestic Violence.

Domestic Violence

Specific DV and Violence policy introduced and there was a pledge in relation to a Public Health responsibility. A media release supported this in 2014. Some challenges in the hospital around the impact of increases in DOLs referrals - QAH are undertaking a consultation, with partner agencies, in relation to DOLs .

Year ahead

Increasing support in team (admin), preparation for the Care Act , audits to re focus, safeguarding activity.

Integrated Commissioning Unit (ICU)

The unit jointly commissions services on behalf of the CCG, social care and public health .

They are also responsible for contract monitoring of services and as such can play a crucial role for the board and safeguarding The ICU can ensure that within contracts there are some specific contractual obligations in regard to safeguarding for providers . This can include requirements linked to the training of staff to recognise and act on safeguarding concerns.

Within ASC for Portsmouth there is direct liaison with the Safeguarding Team ensuring a seamless approach to preventative work for Adults at Risk .

How the ICU have actively supported the PSAB in the year 2014 :-

* Membership of the PSAB
* Contributing towards the Quality Assurance and Performance sub group
* Contributing to Safeguarding Adult Reviews and SAR action plans

All ICU staff will receive training in basic awareness of Safeguarding.

NHS England

In relation to safeguarding adults, NHS England is able to provide an overview on its achievements over the past 12 months:

- A training audit conducted in Primary Care GP practices across Hampshire, Southampton, Portsmouth and IOW had 73 responses of which 9 were from Portsmouth. Results were shared with the 4LSAB Safeguarding Workforce Development Sub-Group early in November 2014 and has informed a targeted approach in training GP practice safeguarding leads in Hampshire including Portsmouth.
- Two NHS Wessex Safeguarding events which included updates on FGM, Human Trafficking, Prevent, MCA/DoLS were held for designated nurses and named GPs across Wessex.
- The Wessex Safeguarding Forum was set up in 2013 to enable:-
  - Underpinning system accountability through peer review-based assurance and other sources of intelligence to identify local improvement priorities.
  - Identification and sharing of best practice across the local health system.
  - Leading and driving of improvement in safeguarding practice across the local NHS system, working closely with the LSCB/SAB as appropriate.
  - Membership includes designated nurses, named GPs and LAC nurses.
- SCIE Training - Local Safeguarding Boards are required to maintain a local learning and improvement framework that supports the regular conduct of reviews and audits beyond those meeting the statutory Serious Case Review (SCR) criteria. To this end SCIE training was funded by NHS England and offered to Board members across Wessex including Portsmouth. In 2013/14 a total to 106 members were trained.Joint work with Wessex Local Medical Committee (LMC) was undertake in preparing a number of learning videos focused on safeguarding adults / MCA and DOLs
- Joint work with Wessex Local Medical Committee (LMC) was undertake in preparing a number of learning videos focused on safeguarding adults / MCA and DOLs
- A Wessex-wide Primary Care Safeguarding Newsletter has been developed, raising awareness of training courses and sharing lessons - positive feedback received from primary care clinicians
- An internal process has been agreed with health partners for managing level 3 safeguarding alerts: The procedures have been designed to explain simply and clearly how NHS England (Wessex) should manage Level 3 multi-agency safeguarding investigations and work together with internal and external partners to protect people at risk and establish whether there are lessons to be learned from the incident. Furthermore, this protocol provided guidance on how lessons are identified, how they will be acted upon and what is expected to change within a given timescale; and as a result to improve practice. This is being updated in line with the Care Act 2014 and guidance related to Sec 42 enquiries.

This year NHS England has responded to a total of five alerts and contributed to two adult reviews in Portsmouth.

Healthwatch Portsmouth is an independent service provided for all people of all ages and circumstances in Portsmouth. We gather views and experiences of local people on the way health and social care services are provided so they are given a chance to speak up about services across the city. We collect local information through community engagement events and one-to-one advocacy to ensure people who plan, run and check services listen to people who use these services.

At the heart of Healthwatch are 8 statutory functions which include supporting the involvement of people in commissioning and scrutiny of local services, making reports and recommendations about how services could or ought to be improved, providing advice and information about access to these services, making recommendations to Healthwatch England to advise the Care Quality Commission to conduct special reviews, along with making recommendations to Healthwatch England to publish reports about particular issues.

With reference to safeguarding responsibilities, any concerns that are highlighted through the team's contact with people, whether at community events or through one-to-one advocacy and support around complaints, will be raised with the local safeguarding team to consider and follow up as necessary.

Healthwatch Portsmouth would welcome the development of the strategic which should consider as priorities some of the following :

Care Act and MSP – hearing the persons voice at all times

* Information and promoting awareness – annual event etc.
* Agreeing assurance data – what and how we plan to use
* Learning from SAR's

Until the Care Act 2014 came into force on 1 April 2015, there was no English law that dealt specifically with safeguarding adults who might be at risk of abuse or neglect.

Age UK Portsmouth is a local Voluntary Sector organisation which supports Portsmouth City Council and its Emergency Services by working in partnership to ensure safeguarding support for the most vulnerable older people in our Portsmouth and South East Hampshire community.

Various Local Safeguarding Adult Board Sub-Group meetings in the City are attended by the Charity's Chief Executive Officer to ensure continuity and consistency of purpose across all services offered by Age UK Portsmouth.

'Safeguarding is everybody's business' refers to the importance of everyone being alert to possible signs of abuse or neglect and acting on their concerns.

We consciously promote best communication between all of our own service teams, which is essential to recognising the links between domestic abuse, Adult abuse and abuse of vulnerable adults. Age UK Portsmouth engages holistically with, and signposts victims to, appropriate support networks in order to reduce risk to both vulnerable adults, and their carer's.

As with many services in Portsmouth, the Charity has had to evolve dramatically and rapidly to enable it to meet the challenges of its own donation and legacy income reduction whilst supporting more older person need than it has ever faced in its entire 75 year history.

Incorporating a clear understanding of what a safeguarding issue might look like, we ensure awareness is built into everything we do, with a goal to not only appropriately support recognition of safeguarding concerns but better yet, to develop interventions that encourage prevention.

'Safeguarding is personal', is intended to emphasise the importance of adults at risk being as involved as possible in any safeguarding process.

Throughout 2015, Age UK Portsmouth has consciously developed staff understanding of what a safeguarding issue might look or even sound like which gives them a heightened awareness of options that our Information and Advice (I&A Team can offer, support or report whilst working with the person directly throughout the safeguarding process.

Our I&A Team has doubled its number of dedicated staff and volunteers during the last year, and within the first quarter of 2015 the Team has outstripped and met the projected dramatic increase in demand on its actions from 2014. The Team is led by our Safeguarding Officer who understands that safeguarding issues can arise from housing deprivation, financial distress; within family disputes and neighbourhood differences. The I&A Team often face these emotional and distressful situations on a daily basis in order to assist and support a way out of, or through, each older person's safeguarding dilemma.

Safeguarding training is also supported for our I&A Team by our national brand partner organisation Age UK, and that provision with respect to vulnerable adults now includes the Care Act, which has been incorporated into I&A training sessions.

In some cases older people choose not to report their abuse, perhaps because they are afraid that it will damage a relationship that is very important to them. It can be so hard to know what to do. Sometimes it will still be right to override their wishes if, for instance, the perpetrator may be placing other persons at risk too. In this situation they may want to seek advice without initially disclosing the identity of the person they are worried about. They can do this by contacting the I&A Team at Age UK Portsmouth.

Hampshire Constabulary is a key stakeholder in the partnership response to safeguarding the most vulnerable in our community throughout Hampshire. Over the last 12 months, despite financial restraints, the Constabulary has continued to prioritise safeguarding.

The Constabulary structure has had to change to enable it to meet the challenges of a reducing budget and still deliver a quality service. One of the changes to safeguarding is the Safeguarding and Offender Management Teams (OMT) being incorporated into the Neighbourhoods and Prevention strand. The senior officers leading Safeguarding, Offender management and Neighbourhood policing all report back to a single Chief Superintendent, to ensure a coordinated approach. Also, the various Local Safeguarding Adult Board sub group meetings now have selected police attendees, to ensure continuity and consistency across the Hampshire 4LSAB structure. Incorporating Safeguarding and the OMT into the Neighbourhood and Prevent strand has combined the experience of these teams with the Neighbourhood Policing Teams (NPT - aka Beat Officers and PCSOs) to ensure a truly community focused service. This has encouraged better communication between the teams, which is crucial, having regard to the recognised links between domestic abuse, Adult abuse and abuse of vulnerable adults. NPT has taken ownership for medium risk domestic abuse victims by engaging and signposting victims to support networks, thus reducing the risk to both adults and their Adults.

In the second half of 2014/15, and coinciding with the Force structure change, Hampshire Constabulary has instigated a wide-reaching Safeguarding training programme for staff throughout the Force. This input is provided for staff managing first contact, through to the outcome stage and gives them a better understanding of risk indicators as well as options that put victims at the heart of the police response. This is an on-going training programme.

Specific training in respect to vulnerable adults includes the Care Act, which has been incorporated into Investigator and NPT training sessions. The Investigator training schedule is almost complete and the NPT schedule has commenced, with completion predicted around October 2015. NPT officers now have rotational 3 month attachments to the Safeguarding Teams to hone their skills in 'live' cases and attend Adult Safeguarding Conferences.

The national implementation of Clare's Law (DVDS - Domestic Violence Disclosure Scheme) and Sara's Law (CSOD - Adult Sexual Offences Disclosure) has contributed to the safeguarding of both adults and Adults by the disclosure of the risks an identified person poses to potential victims. It is estimated that there will be over 400 disclosure considerations in the year 2015/16, which will allow a person to make informed decisions around the risk to themselves and their Adults in respect to their intimate (ex)partners.

What did we do? How well did we do it?

Management of Fire Risk in a Social Care Provision - Training

Throughout 2014-2015, Hampshire Fire and Rescue Service have continued to support the Local Authorities and partner agencies of PSAB in providing training in the management of fire risks within a social or domiciliary care provision. This training package is delivered by HFRS Community Safety Officers and is available free of charge to the partner agencies (including their commissioned service providers) of the PSAB

Multi Agency Fire Risk Conference

Hampshire Fire and Rescue Service remains fully committed to delivering a multi agency approach towards the continuous monitoring and management of fire risks for adults identified as being at high risk of serious injury or death due to fire.

Home Safety Referral Pathway and High Risk Home Safety Visit

During 2014-2015, as an outcome of the Hampshire Fire and Rescue Service Home Safety Project, the Service developed a comprehensive risk assessment tool. This self assessment tool provides a mechanism for partner agencies to ensure a person presenting safeguarding concerns can be identified at the earliest opportunity and through submitting this information to HFRS, will ensure an appropriate level of intervention can be provided. A high risk Home Safety visit will be conducted by a local HFRS Community Safety Officer within 72 hours .Operational Response risk information will be gathered to ensure HFRS respond effectively to any reported incidents involving the 'adult at risk', with pre planned arrangements (enhanced attendance, flagging of address with Fire Control etc. Where necessary, Multi Agency action planning (Fire Risk Conferences) and support in devising Care Plan actions for the continuous monitoring and review of the risks being presented.

Appointment of HFRS Lead Safeguarding Officer

In December 2014 Hampshire Fire and Rescue Service appointed a full time Lead Safeguarding Officer. The Lead Safeguarding Officer undertakes the Designated Safeguarding Adults Manager (DSAM) responsibilities on behalf of the Service, as per the duties detailed within the Care Act 2014. The Lead Safeguarding Officer is primarily responsible for embedding fire vulnerability within the Safeguarding environment and ensuring HFRS are discharging their safeguarding responsibilities appropriately with Local Authorities and partner agencies. Other responsibilities include the following:

- Internal and external auditing of all HFRS Safeguarding activities.
- Managing the Safeguarding policies procedures (ensuring they are reflective of the Hampshire Safeguarding Multi Agency Policy and Procedures).
- Managing the Safeguarding training packages of HFRS.
- Referring fire deaths and serious injuries for Multi Agency reviews as per the HSAB Learning and Review Framework.

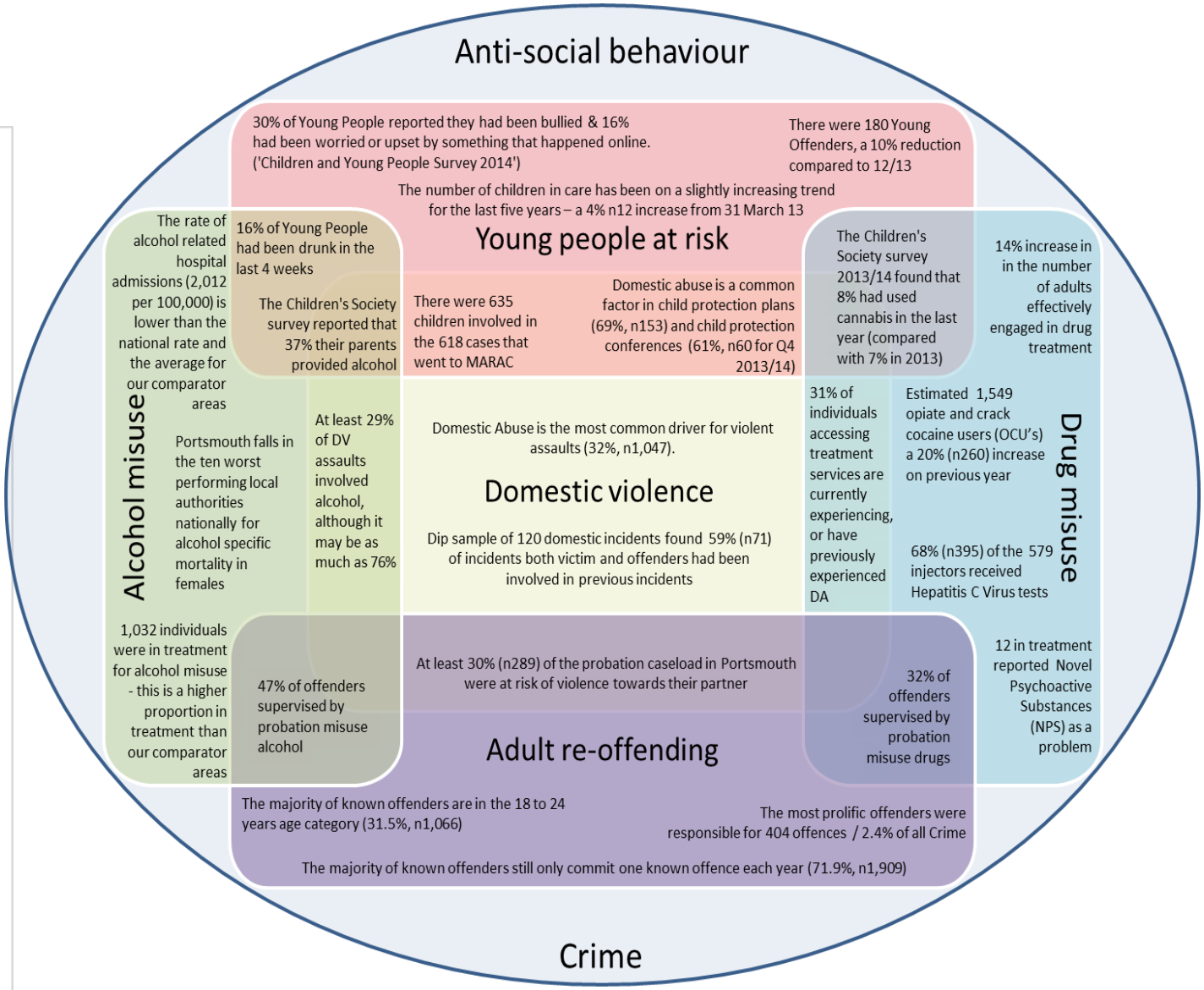
safer portsmouth partnership

reducing crime and substance misuse

Portsmouth Partnership (SPP) is responsible for reducing crime and substance misuse in Portsmouth, making the city a safe place to live, visit and work.

Our Priorities are to reduce:

- **Anti-social behaviour**
- **Alcohol Misuse**
- **Drug Misuse**
- **Violence and Abuse**
- **Young People at risk**
- **Offending**



http://saferportsmouth.org.uk/.

Solent Healthcare

Comparison of the Number of Alerts - and Number of contacts to the Safeguarding team for advice during: 2013/14 and 2014/5.

Solent Safeguarding Team records a range of all safeguarding information to support It in delivering the service. Over the last year the team has continued to make improvements to the type of information the team would like to collect.

In the later part of 2014/15 the team has started to be supported by Solent's Business Change Manager and Solent HQ. The team look forward to working on this new development.

There is a significant reduction in the numbers of Alerts sent to the Local Authority between 2013/14 and 2014/15. This is linked to the Solent Safeguarding Team's training, over the last two years, on when and what to alert.

In the past, alerts were sent linked to concerns that could and should be simply managed by the Alerter themselves and at times via the virtual wards or in a multi agency meeting. The multi-agency safeguarding process should be carried out in direct response to individuals experiencing abuse or neglect and where other approaches have not been able to resolve the preventing risks.

In this context, multi-agency safeguarding arrangements are the exception rather than the norm and are used to respond to the critical few cases that cannot be resolved by other means, or where the risks are very high.

In contrast to this there is a marked increase in contacts to the Solent Safeguarding Team for advice regarding staff concerns.

Priorities and Challenges for 2015/2016

The impact of the Care Act 2014, on adult safeguarding practice cannot be over estimated and the lack of capacity in the Team will compromise effective joint working with our partners and within Solent. Training, Advice to Staff and Supervision however remains a high priority for the team.

2015/16 will proof to be a challenging year

- **Key work stream that will take priority in 2015/16 is work to ensure compliance with the 'Care Act 2014'.**
- **Developing Solent's Designated Adult Safeguarding (DASM) role and Framework_.**
- **The development of Solent's Safeguarding Policy and procedures in line with Multi-Agency Policy Guidance and Toolkit.**
- **Roll out a programme of roadshows on 'safeguarding and the New Act'' to each service area.**

CHAPTER 4

ACHIEVEMENTS 2013/2014

Update on Annual Report from 2013/2014

Priority Areas and Action update on priorities 2014/2015

The PSAB has an agreed vision, objectives and terms of reference, with 4 subgroups and 3 regional and inter-Board work streams taking forward its agreed priorities. It has formally agreed to work to Pan Hampshire's multi agency policies and procedures to safeguard adults from harm. The table below summarises the priority areas and gives an update on these areas for this year to date.

	SUMMARY OF PRIORITY AREAS	PROGRESS TO DATE	RAG
1	Develop effective governance arrangements for the PSAB	• Constitution - awaiting sign off • Comprehensive procedures on PSAB Website	
2	Communication and Promotion of Safeguarding	• Activity has included editorial promotion and interviews with key stakeholders. • Safeguarding messages disseminated during Safeguarding Week at a multi-agency event in Guildhall Square. • Internal communications, videos and social media also used to inform. • 227 page hits / 111 unique views / hits to PSAB website. • Increased referrals and leads during the week and one alert as a direct result of the event. • Comprehensive Communication strategy developed. • Links with PSCB to ensure that messages delivered are holistic.	

CHAPTER 4

ACHIEVEMENTS 2013/2014

	SUMMARY OF PRIORITY AREAS	PROGRESS TO DATE	RAG
3	Personalisation (Making Safe-guarding Personal)	• Developed Audit tools for MSP • Set up MSP sub group • Developed TOR • Service users representative on subgroup • Feedback form developed.	
4	Quality Assurance	• Developed a Sub group and TOR • Ensure a wide multi agency involvement • Developing data sets that are consistent with other LSABs	
6	Training Development and Learn-ing	• Worked with other LSABs in developing Learning and Development Strategy • Ensured that there are learning opportunities on the PSAB website • PSAB held 2 Self Neglect workshops. • Agreed to develop Portsmouth training group for this year	
8	Develop and deliver Safeguarding Adult Reviews, ensure clear pro-cess for managing reviews and disseminating learning (learn from other cases that do not meet the threshold of SAR to ensure con-tinued learning)	• Learning and Review Framework embedded • SAR completed • Ensured learning from SAR cascaded	

Glossary

This glossary is not an exhaustive list, but explains some of the key words or terms that have been used in this report.

4LSAB Four Local Safeguarding Adults Boards covering Hampshire, Portsmouth, Southampton and the Isle of Wight.

Abuse includes physical, sexual, emotional, psychological, financial, material, neglect, acts of omission, discriminatory and institutional abuse.

ACPO (Association of Chief Police Officers), an organisation that leads the development of police policy in England, Wales and Northern Ireland.

ADASS (Association of Directors of Adult Social Services) is the national leadership association for directors of local authority adult social care services.

Adult Services arrange social care and support for adults who need extra support. This includes older people, people with learning disabilities, physically disabled people, people with mental health problems, drug and alcohol misusers and carers. Adult social care services include the provision by local authorities and others of care homes, day centres, equipment and adaptations, meals and home care Adult social care also includes services that are provided to carers.

Advocacy is taking action to help people say what they want, secure their rights, represent their interests and obtain services they need.

Alert is a concern that a person at risk is or may be a victim of abuse, neglect or exploitation. An alert may be a result of a disclosure, an incident, or other signs or indicators.

Central Referral Unit is where all adult safeguarding referrals to the police are received, risk assessed, graded and allocated for action by the most appropriate police team and/or partner agency.

CCGs (Clinical Commissioning Groups) were formally established on 1 April 2013 to replace Primary Care Trusts and are responsible for the planning and commissioning of local health services for the local population.

Clinical Governance is the framework through which the National Health Service (NHS) improves the quality of its services and ensures high standards of care.

Community Safety Partnerships bring agencies and communities together to tackle crime within their communities. Community Safety Partnerships (CSPs) are made up of representatives from the responsible authorities, these are Police, police authorities, local authorities, Fire and Rescue authorities, Clinical Commissioning Groups and Probation

CPS (Crown Prosecution Service) is the government department responsible for prosecuting criminal cases investigated by the police in England and Wales.

CQC (Care Quality Commission) is responsible for the registration and regulation of health and social care in England.

DASH (Domestic Abuse, Stalking and Harassment and 'Honour'- Based Violence) risk identification checklist (RIC) is a tool used to help front-line practitioners identify high risk cases of domestic abuse, stalking and 'honour'-based violence.

Disclosure and Barring Service (DBS) was established in 2012 through the Protection of Freedoms Act and merges two former organisations, the Criminal Records Bureau and the Independent Safeguarding Authority. The DBS is designed to help employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable adults. The DBS search police records and barring lists of prospective employees and issue DBS certificates. They also manage central barred lists of people who are known to have caused harm to vulnerable adults.

DOLS (Deprivation of Liberty Safeguards) are measures to protect people who lack the mental capacity to make certain decisions for themselves. They came into effect in April 2009 using the principles of the *Mental Capacity Act 2005*, and apply to people in care homes or hospitals where they may be deprived of their liberty.

Domestic Homicide Reviews are commissioned by local Safer Communities Partnerships in response to deaths caused through domestic violence. They are subject to the guidance issued by the Home Office in 2006 under the *Domestic Violence Crime and Victims Act 2004*. The basis for the domestic homicide review (DHR) process is to ensure agencies are responding appropriately to victims of domestic abuse offering and/or putting in place suitable support mechanisms, procedures, resources and interventions with an aim to avoid future incidents of domestic homicide and violence.

Family Group Conferences (FGC) are used to try and empower people to work out solutions to their own problems. A trained FGC coordinator can support the person at risk and their family or wider support network to reach an agreement about why the harm occurred, what needs to be done to repair the harm and what needs to be put into place to prevent it from happening again.

HealthWatch is the new independent consumer champion created to gather and represent the views of the public. It exists in two distinct forms - local Healthwatch and Healthwatch England at a national level. The aim of local Healthwatch is to give citizens and communities a stronger voice to influence and challenge how health and social care services are provided within their locality. Local Healthwatch has taken on the work of the Local Involvement Networks (LINks).

Health and Well-being Board a statutory, multi-organisation committee of NHS and local authority commissioners, co-ordinated

by the local authority which gives strategic leadership across Hampshire regarding the commissioning of health and social care services.

MAPPA (Multi-agency Public Protection Arrangements) are statutory arrangements for managing sexual and violent offenders.

MARAC (Multi-agency Risk Assessment Conference) is the multi-agency forum of organisations that manage high risk cases of domestic abuse, stalking and 'honour'-based violence.

MASH (Multi Agency Safeguarding Hub) is a joint service made up of Police, Adult Services and the NHS. Information from different agencies is collated and used to decide what action to take. This means the agencies will be able to act quickly in a co-ordinated and consistent way, ensuring that the person at risk is kept safe.

Mate Crime occurs when a person is harmed or taken advantage of by someone they thought was their friend. There is limited information on the prevalence of Mate Crime nationally, however there has been an increase in the number of safeguarding alerts that involve Mate Crime across Hampshire in recent years.

Mental Capacity refers to whether someone has the mental capacity to make a decision or not. The Mental Capacity Act 2005 and the code of practice outlines how agencies should support someone who lacks the capacity to make a decision.

NHS (National Health Service) is the publicly funded health care system in the UK.

OPG (Office of the Public Guardian), established in October 2007, supports the Public Guardian in registering enduring powers of attorney, lasting powers of attorney and supervising Court of Protection appointed deputies.

PALS (Patient Advice and Liaison Service) is an NHS service created to provide advice and support to NHS patients and their relatives and carers.

Safer Neighbourhood Teams are local police working with local people and partner agencies to identify and tackle issues of concern in their area to make neighbourhoods safer.

SAR (Safeguarding Adult Review) undertaken by a Safeguarding Adults Board when a serious case of adult abuse takes place. The aim is for agencies and individuals to learn lessons to improve the way in which they work.

SIRI (Serious Incident Requiring Investigation) is a term used for serious incidents in the NHS requiring investigation. It is defined as an incident that occurred in relation to NHS-funded services resulting in serious harm or unexpected or avoidable death of one or more patients, staff, visitors or members of the public.

Wilful Neglect or Ill Treatment is an intentional or deliberate omission or failure to carry out an act of care by someone who has care of a person who lacks capacity to care for themselves. *Section 44* of the *Mental Capacity Act 2005* makes it a specific criminal offence to wilfully ill-treat or neglect a person who lacks capacity .

APPENDIX

Membership of PSAB

David Cooper	Independent Chair
Robert Watt	Director of Adult Services , PCC
Angela Dryer	Assistant Head, Adult Services , PCC
Tracy Keats	Designated Safeguarding Nurse, Clinical Commissioning Group
Preeti Sheth	Director , Integrated Commissioning Unit
Rachel Loveridge	Operations Manager, Probation
Nicky Priest	Assistant Director Nursing, NHS England
Janet Maxwell	Director , Public Health , PCC
Rachael Roberts	Senior Manager, Adult Social Care, PCC
Lorraine Burton	Safeguarding Board Manager, PCC
Steve Foye	Area Manager , Community Safety, Hants Fire Service
Steve Apter	Assistant Chief Officer, Community Safety and Service Transformation, Hants Fire Service
Fran Williams	Head of Safeguarding , Solent NHS Trust
Carol Elliott	Healthwatch Board Advisor
Bruce Marr	Hidden Violence and young People's Service Manager , PCC
Maria Middleton	Senior Partnership Manager, DWP
Mandy Rayani	Chief Nurse, Solent NHS Trust
Liz Donegan	Action Hants
Debbie Corti-Young	Hampshire Care Association
David Powell	Chief Superintendent , Hants Constabulary
Cathy Stone	Director of Nursing PHT
Adrian Dunsterville	Inspection Manager, CQC
Owen Buckwell	Director of Housing and Property, PCC
Dapo Alalade	GP Executive Lead, Clinical Commissioning Group
Natalie Beckett	Safeguarding Board Administrator

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THIS ITEM IS FOR INFORMATION ONLY

Portsmouth CITY COUNCIL

Agenda item:

Title of meeting: Health and Wellbeing Board

Subject: PSCB Annual Report 2014/15

Date of meeting: Wednesday 2nd December

Report by: Lucy Rylatt

Wards affected: All

1. Purpose of report

1.1 To introduce the Annual Report 2014-15 of the Portsmouth Safeguarding Children Board (PSCB)

2. Recommendations

2.1 Members of the Health and Wellbeing Board are invited to receive the Portsmouth Safeguarding Children Board Annual Report and to note areas of progress and challenges identified in the context of services being planned and commissioned.

3. Background

3.1 The 'Protocol setting out the relationship between the Portsmouth Health and Wellbeing Board and the Portsmouth Safeguarding Children Board and Portsmouth Safeguarding Adults Board' was agreed in 2014.

3.2 The protocol sets out the expectation that between September and November each year the PSCB Annual Report will be presented to the Health and Wellbeing Board to provide the HWB the opportunity to:

- scrutinise and challenge the performance of the PSCB
- draw across any data to be included in the JSNA
- reflect on key issues that need to be incorporated in the refresh of the JHWS

3.3 The primary objectives of the PSCB are directed at both coordinating and evaluating the role of partner agencies in safeguarding and promoting the wellbeing of children in Portsmouth, particularly in relation to the priority areas outlined in the Business Plan. The planning and commissioning tasks of the Health & Wellbeing Board are vital in supporting these objectives.

3.4 The Annual Report concludes with key messages for individuals, groups and bodies to highlight and challenge them in their role in improving the well-being and safety of children in Portsmouth.

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Signed by: Di Smith, Interim Director of Children's Services

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Portsmouth CITY COUNCIL

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:

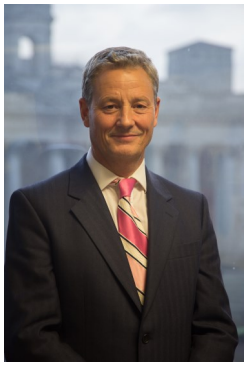
Title of document	Location

PSCB Annual Report 2014/15

PSCB
Portsmouth Safeguarding Children Board
Protecting Portsmouth's Children

Safeguarding the children of Portsmouth

A FOREWARD FROM THE INDEPENDENT CHAIR
Reg Hooke



It's my pleasure to present to you the annual report of the Portsmouth Safeguarding Children Board (PSCB) 2014/15. The PSCB is a partnership that works to safeguard and promote the welfare of children in Portsmouth by working with, and scrutinising, the work of those with key responsibilities for keeping children safe in the city. These include staff working in health, social care, police, probation and education settings as well as charity and voluntary sector organisations working with children in Portsmouth.

We concentrate our attention on the safety of the most vulnerable and at risk of harm and ensure that positive outcomes for children remain a priority.

In July 2014 the PSCB was inspected by Ofsted and judged 'Good'. This is a commendable achievement and reflects the commitment of all members and its committees to the city's children. It is particularly notable as less than a third of LSCBs nationally have been judged this high.

We are not complacent and much remains to be done as we meet new challenges in protecting children effectively at a time that budgets of many partner agencies continue to reduce.

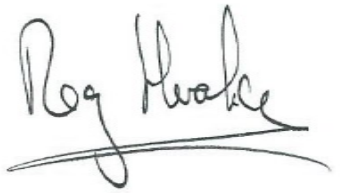
This Annual Report can be read in conjunction with the Business Plan for 2014-17 with details of how we are doing. In the last year we have made good progress in our priorities of tackling neglect, improving our communication to all communities in the city and working closer with children and young people's groups. Action to tackle neglect was kicked off with a very successful multi-agency conference in November and has led to the development of some excellent guidance for professionals. Our three very active lay members have helped develop a new more interactive PSCB website and they have led work to improve the way we link directly with

We have also been working with our partners and other LSCBs across the county in tackling child sexual exploitation and improving our arrangements for meeting our statutory responsibility to monitor any deaths of children in the city.

We will be seeing a lot of change in Portsmouth agencies in the coming year as they respond to their own learning as well as reduced budgets. The PSCB will continue to hold them to account through these times to ensure children remain protected.

Through some challenging times professionals working in the city consistently put doing the best for children in Portsmouth first and I am confident we will see agencies work in ever closer partnership to protect children and to find new and better ways to provide efficient, effective and accessible services.

PSCB's ambition is to ensure that arrangements to safeguard children in Portsmouth are outstanding. By working together and engaging our whole community I am confident we can do this.



Priorities for 2014/15 and how we delivered against them

PSCB will ensure that all consultation, audits, analysis, and recommendations have at the heart of them the views of children

- We consulted children on the annual report and produced a child friendly version of the paper
- We changed our training programme so that 'the voice of the child' runs throughout.
- We amended our training evaluation forms to include feedback about whether the courses help them 'focus on the child' and understand 'the child's world'
- We consulted local children on the main themes of the PSCB business plan
- We ensured all audits and reviews focused on the child's experience

PSCB will prioritise improving the effectiveness of agencies and the community in tackling situations where children are neglected or are at risk of neglect

- We facilitated a multi-agency neglect conference in September 2014 to raise professional awareness of neglect and its long term consequences on children.
- We have developed a tool for early help professionals and social workers to promote early identification of neglect within families

PSCB will improve communication across Portsmouth using technology, meetings and consultation so that appropriate knowledge of safeguarding is available to all and so that PSCB are hearing the views of professionals and from children, families and communities from all parts of the city

- We produced and distributed regular safeguarding newsletters
- We commissioned and developed the new user friendly LSCB website

The PSCB needs to constantly challenge itself to ensure it is being effective in improving situations for children and families so we will improve the way we manage our business and how we measure the impact PSCB has

- We improved our data and analysis so that the PSCB now receives 6 monthly reports on performance and specific recommendations for improvement and actin. These recommendations remain under review until completed
- We track all recommendations and actions so we can say whether we have had a impact on children's lives or not
- All board members have agreed to participate in one Section 11 audit a year to show leadership and commitment to constructive challenge

The Ofsted review of the PSCB

In June and July 2014 the Government inspectorate, Ofsted, reviewed the effectiveness of the Portsmouth Safeguarding Children Board as a part of the national inspection programme. The safeguarding Board was judged to be **good**. Nationally less than a third of LSCBs have been judged good. The following is the detailed comments Ofsted made:

The Local Safeguarding Children Board was judged as **good** because**:**

- Robust governance arrangements ensure that the Board meets its statutory responsibilities with membership at the appropriate seniority
- The four priorities identified by the Board are appropriate, and the Board's Business Plan demonstrates how those priorities will be met
- The Section 11 audit, Compact, is well established and the quality assurance of the process is good
- The Board uses a comprehensive multi-agency data set to routinely scrutinise and evaluate frontline performance
- The process for commissioning serious case reviews is set out appropriately in a detailed procedure, and all actions arising from recommendations of the most recent serious case review are complete
- The Board receives regular information about young people at risk and the CSE sub-committee, chaired by the police, leads strategic developments
- Routine and bespoke, internally commissioned multi-agency audits, along with analysis of data, inform and influence the focus of improvement activity
- The PSCB and Children's Trust threshold document is clear and widely disseminated. Child protection policies and procedures are good and regularly reviewed
- Appropriate multi-agency training is provided to all agencies. Take up is good with low rates of non-attendance

Priorities for 2015/16 - governance was a one-year project during 2014-15, and Ofsted concluded that PSCB's governance arrangement were robust. For 2015-17 priority area 4 will focus on tackling exploitation and abuse across young people aged 11+ in Portsmouth

Child neglect - Improve the effectiveness with which agencies and the community deal with it

Communication - Improve the awareness of safeguarding, including the work of PSCB among practitioners and the community, with a particular focus on the most vulnerable communities

Voice of the child - Ensuring that we hear the views of children and it helps improve what we do

Tackling sexual exploitation and abuse of young people across Portsmouth

The City of Portsmouth

Portsmouth is a port city situated on the southern coast of Hampshire. The city area spans just 15.5 square miles and with a population of approximately 208,900, it is recognised as being the most densely populated area in the United Kingdom outside of London.

- Approximately 48,500 children and young people under the age of 18 years live in Portsmouth. This is 20.6% of the total population in the area
- Approximately 24.4% of the local authority's children are living in poverty (the England average is 20.1%)
- The proportion of children entitled to free school meals in primary and nursery schools is 21.3% (the national average is 18%), and in secondary schools is 20.1% (the national average is 15.7%)
- Children and young people from minority ethnic groups account for 20.1% of all children living in the area, compared with 21.6% in the country as a whole

  The largest minority ethnic groups of children and young people in the area are Mixed Ethnic Group: White and Asian (3.5%), Asian/Asian British: Bangladeshi (3.5%) and White: Other White (2.9%).
- The proportion of children and young people with English as an additional language in primary schools is 15.1% (the national average is 18.7%) and in secondary schools is 12% (the national average is 14.3%). After English, Bengali and Polish are the most common languages spoken in Portsmouth schools
- Portsmouth has a relatively high proportion of Armed Forces personnel resident in the city, with 2.3% of the adult population compared to the England average of 0.3%
- The city's child poverty rate (24.4%), (compared to the national average of 20.1 %) masks significant differences at ward level, with rates ranging from 6.3% to 48.1%

Vulnerable Groups

Children can become vulnerable and subsequently be at increased risk of harm for a variety of reasons. National case reviews demonstrate that children living in households where there is domestic abuse, substance misuse or their parents are mentally ill are known to be at a greater risk.

We also understand the long-term damaging effects of neglectful parenting on children. We know that children who go missing from school or missing from home are also placed in greater danger of harm. Despite this it is not always possible to know the complete picture of the children whose safety is at risk because some abuse or neglect may be masked. To counter this partners in the PSCB have identified some groups of children that are understood to be at particular risk. This helps ensure that their needs are understood and that they form part of our local picture.

The PSCB annual report details our understanding of the categories of children and young people identified as being vulnerable and in need of protection.

Policy Context

Following consultation the government published amendments to statutory guidance Working Together to Safeguard Children (2015). Revisions include changes to:

- the referral and management of allegations against adults working with children
- notifiable incidents involving the care of a child
- definition of serious harm for the purpose of serious case review criteria.

Further information can be found at

www.gov.uk/**Working Together** to Safeguard Children.pdf

Table of Contents

PSCB contacts details

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CHAPTER 1

About the Portsmouth Safeguarding Children Board

The Portsmouth Safeguarding Children Board (PSCB) is the statutory partnership body responsible for coordinating and ensuring the effectiveness of services in Portsmouth for protecting and promoting the welfare of children.

The Board is made up of senior representatives from all the main agencies and organisations in Portsmouth with responsibility for safeguarding and promoting the welfare of children and young people in Portsmouth. The PSCB fulfils its statutory role in coordinating local work by:

- Developing robust policies & procedures
- Participating in the planning and commissioning of services for children in Portsmouth
- Communicating the need to safeguard and promote the welfare of children and explaining how this can be done

We ensure the effectiveness of local work by:

- Monitoring what is done by partner agencies to safeguard and promote the welfare of children
- Undertaking serious case reviews and other multi-agency case reviews, audits and deep-dives and sharing learning opportunities
- Collecting and analysing information about child deaths
- Publishing an Annual Report on the effectiveness of local arrangements to safeguard and promote the welfare of children in Portsmouth

Main Board

This is made up of representatives of the member's agencies. Board members must be sufficiently senior so as to ensure they are able to speak confidently and sign up to agreements on behalf of their agency, and make sure that their agency abides by the policies, procedures and recommendations of the PSCB.

Executive

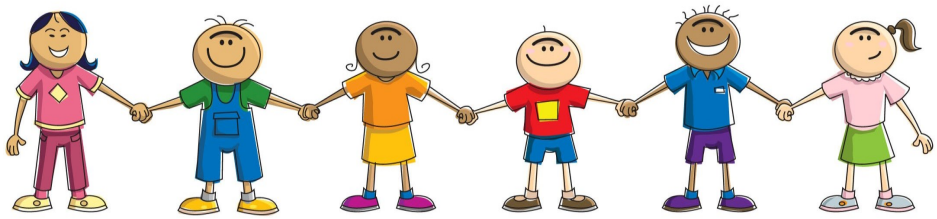
The Executive Committee manages the business and operations of the PSCB, ensuring there are clear governance arrangements in place and drives forward the strategic priorities as outlined in the Business Plan.

Committees

Membership of the committees are made up of staff from bodies or agencies represented at the PSCB, who are co-opted to ensure each group has the relevant expertise and knowledge to deliver the PSCB Business Plan. Membership of committees can include Board Members themselves.

4LSCB Arrangements

Portsmouth, Hampshire, Isle of Wight and Southampton each has its own LSCB, but come together under the 4LSCB umbrella in order to share procedures and policies, skills, knowledge, resources and learning.



CHAPTER 1

About the Portsmouth Safeguarding Children Board

Key PSCB Roles

Independent Chair

Reg Hooke was appointed to the role of Independent Chair to the PSCB in 2013.

The Chair is subject to an annual appraisal to ensure the role is undertaken competently and that the post holder retains the confidence of the PSCB members. The Chief Executive of Portsmouth City Council, David Williams, appoints the Chair and managerial support is provided by the Director of Children and Adults' Services.

Portsmouth City Council

Whilst the Chair and the Board itself is independent, Portsmouth City Council is responsible for establishing and maintaining the Safeguarding Children Board (PSCB) on behalf of all agencies.

The Director of Children and Adults' Services and the Director of Children's Social Care are required to sit on the Main Board of the PSCB as this is a pivotal role in the provision of adult's and children's social care within the local authority.

Leader of Portsmouth City Council

The ultimate responsibility for the effectiveness of the PSCB rests with the Leader of Portsmouth City Council, Councillor Donna Jones.

Lead Member for Children's Services

This role is held by Neill Young, a locally elected Councillor with responsibility for making sure that the local authority fulfils its legal responsibilities to safeguard children and young people. The Lead Member contributes to the PSCB as a participating observer and is not part of the decision-making process.

Partner Agencies

All partner agencies in Portsmouth are committed to ensuring the effective operation of the PSCB. This is supported by the PSCB Constitution which sets out the governance and accountability arrangements.

Designated Professionals

Health commissioners should have a designated doctor and nurse to take a strategic, professional lead on all aspects of the health service contribution to safeguarding children across the local area. Designated professionals are a vital source of professional advice on safeguarding children matters to partner agencies and the PSCB. There are Designated Doctors and Nurse roles in post.

Lay Members

The PSCB has three local residents acting as Lay Members who support stronger public engagement in local child protection and safeguarding issues and contribute to an improved understanding of the PSCB's work in the community.

During the last year PSCB Lay Members have been actively involved in the development of the Communication Strategy for the Board which has now begun to be implemented and is exploring the involvement of faith groups. They have also participated in learning reviews, Female Genital Mutilation (FGM) working groups and capturing the voice of the child. The PSCB is also hosting the South of England Lay Members event for 2015.

CHAPTER 1 About the Portsmouth Safeguarding Children Board

Key Relationships

Children's Trust

The Portsmouth Children's Trust is a partnership of agencies in the city committed to working together to improve all outcomes for children and governed by a Board with formal responsibility for strategic planning, commissioning services, and promoting effective integrated working.

The Children's Trust is responsible for producing the Children's Trust Plan which outlines how improvements in service delivery and design will be made.

The PSCB reports annually to this body and we hold them to account to ensure they commission the services that are needed based on the agreed safeguarding priorities.

Health and Wellbeing Board

This Board was established in Portsmouth in 2012/13. It brings together leaders from the County Council, NHS and partner agencies to develop a shared understanding of local needs, priorities and service developments.

The PSCB reports annually to the Health and Well-being Board and will hold it to account to ensure that it tackles the key safeguarding issues for children in Portsmouth.

Joint Protocol

The PSCB, Children's Trust and Health and Well-being Board have established a joint protocol outlining working arrangements between the three Boards.

Police and Crime Commissioner

The Police and Crime Commissioner (PCC) is elected by residents of Hampshire & the Isle of Wight and charged with securing efficient and effective policing across the two counties. On behalf of the public they set policing priorities for Hampshire Constabulary and holds the Chief Constable to account for the quality of policing service offered to the community. The PCC is committed to enabling good community cohesion and effective multi-agency relationships wherever policing and crime prevention have a role to play.

Members Agencies' Management Boards

PSCB Board members are senior officers within their own agencies providing a direct link between the PSCB and various agencies' boards.

During 2012/13 NHS agencies underwent significant reform and lines of communication changed and throughout 2013/14 the working links were built and strengthened between the Management Boards under the new structure and the PSCB.

Clinical Commissioning Groups

The Clinical Commissioning Group, NHS England and Health Services across Portsmouth have been important contributors to the PSCB during 2014/15.

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Protecting Portsmouth's Children

CHAPTER 1

About the Portsmouth Safeguarding Children Board

Financial arrangements

Board partners continue to contribute to the PSCB budget in addition to providing a variety of resources in kind.

Contributions from partners for 2014/15 were £149,907.

An underspend of £22,949 was carried forward from the previous year.

PSCB budget 2014/15

Income	Funding £
Portsmouth City Council	108,500
Portsmouth NHS Clinical Commissioning Group (CCG)	27,000
Police	11,617
Probation	2,000
Naval Personnel & Family Service	240
CAFCASS	550
Total Funding	**149,907**
Carry forward 2013/14	22,949
Total 2014-15 Budget	**172,856**

Budget item	Allocated budget £	Actual spend £
Staffing costs	96,400	91,200
MESC	5,000	5,000
Chronolator licence	554	554
Chair	25,000	24,000
Case review Overview Author	12,352	5,500
Review Independent Chair	n/a	6,050
Apprentice	2,500	2,500
HCC on line procedures maintenance	1,250	1,250
Tri-ex website maintenance	600	600
Child Death overview	12,500	12,500
Website	5,000	0
Neglect conference	1,000	1,000
e-Safety	5,000	4,900
MET	2,000	1,000
Neglect work stream	0	500
Publicity & promotions	2,000	1,976
PSCB dev. days 2015	1,000	1,600

CHAPTER 2

Children exposed to domestic violence and abuse

During 2014 32% of all violent crime in Portsmouth was domestic related, reflecting an increase of 6% on the previous year. There was a decrease in the number of child protection plans involving Domestic Violence and Abuse from 61% in 2013/14 to 58% in 2014/15.

Since the Domestic Violence and Abuse review in 2012, domestic abuse referrals to specialist agencies have increased year on year (890 in 2012/13 to 1,592 in 2014/15). We recognise there is still work to be done to improve the appropriate identification and referral of domestic abuse by all agencies.

Neglect

As at March 31st 2015, 66% of children subject to a child protection were placed under the category of neglect. Throughout the year, neglect was consistently the most used category of all child protection cases (averaging 70%) therefore tackling child neglect remains a priority for PSCB in 2015/16.

Child sexual exploitation, missing and trafficked children

The PSCB developed a comprehensive joint strategy allowing multi agency professionals to effectively identify children at risk of abuse or exploitation, assess their need and implement plans to manage risk and improve outcomes for vulnerable children. Practitioners from key agencies, including children's social care, education, health and police meet on a monthly basis to consider all children in Portsmouth at risk of going missing, being exploited or trafficked and to share information, including who is known to who and any connections to other children, 'hotspot' locations and potential perpetrators.

Barnardo's are commissioned to work with these vulnerable children, offering a specialist service to the children considered trafficked or being exploited and completing a return interview with those children who go missing from home so as to understand the factors leading them to do this and ensuring there are services in place to address these issues.

Child Sexual Exploitation (CSE)

PSCB launched a risk assessment and planning tool to assist practitioners across the workforce in exploring vulnerability factors and making an analysis of the level of risk of sexual exploitation. The tool allows practitioners to determine children considered at high, medium and low risk so that an appropriate response can be facilitated to meet their needs.

Robust data tracking from September 2014 onwards identified that as at March 2015 there were 109 children in Portsmouth considered at risk of CSE - 19 identified as being high risk, 48 medium risk and 11 low risk. Between September 2014 and March 2015 1 high risk case reduced to medium and 9 children moved from medium to low level risk.

Between 2013 and 2014 34% of Portsmouth children identified as being at risk of sexual exploitation were children in care.

Barnardo's provide training to primary and secondary school staff so that they are able to identify those children who may be vulnerable to sexual exploitation and the PSCB has online training available to all staff in Children's Social Care & Safeguarding.

Hampshire Constabulary, Portsmouth City Council Children's Social Care and Barnardo's have developed a project where CSE 'Guardian Angels' will patrol identified locations on Friday evenings to offer additional protection for vulnerable children and disrupt problematic, anti-social, exploitative and criminal behaviours.

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CHAPTER 2

Safeguarding children in Portsmouth

Missing Children

- Between April 2012 and March 2013 there were 1,398 children and young people under 18 years old who were recorded as missing in Portsmouth. This figure reduced significantly the following year (2013-14) to 801 and then saw a small increase to 956 in 2014-15
- 35 children and young people in care were reported missing in 2014/15, accounting for 315 missing reports. The majority were for less than 24 hours (267 episodes).

The overall reduction of missing reports is promising and we attribute this to earlier intervention by way of:

- Improved inter agency assessment and planning
- More effective coordination surrounding the Common Assessment Framework and Team Around The Child processes reducing the potential for escalation
- Accurate recording of missing / absent cases resulting in the identification of risk of harm to the children and young persons
- Formation of MET (Missing / Exploited / Trafficked) groups both at operational and strategic levels for Portsmouth and Hampshire respectively

The scrutiny of these cases identified gaps in the coordination and referral of cases between UKBA, National Crime Agency and local agencies and resulted in the following actions being implemented:

- Process map produced for all staff to follow to share information and make timely notifications
- Awareness raising of process to UKBA, Police and CSC staff
- All juvenile referrals to be routed via the JAT for full multi agency oversight
- Hampshire Constabulary to facilitate training & awareness for staff via Anti- Slavery Partnership Protect sub group
- Improved information sharing across agencies
- Aggregation of intelligence by Hampshire Police to inform local profiling

The PSCB is also represented on the Hampshire and IOW Anti-Slavery Partnership (ASP), which was been formed to tackle human trafficking and modern day slavery.

Child Trafficking

There are close links between trafficking and child sexual exploitation with national trends showing an upsurge in children entering the National Referral Mechanism from being trafficked within the UK for sexual exploitation. Portsmouth is a portal entry to the UK from mainland Europe;

During 2014/15 the United Kingdom Border Agency (UKBA) stopped 9 juvenile clandestine entries or unaccompanied minors and referred them to Children Social Care; of those 9 had trafficking indicators.

CHAPTER 2

Private Fostering

A privately fostered child is defined as 'a child who is under the age of 16 (18 if disabled) and who is cared for, and provided with accommodation, by someone other than:

the parent

a person who is not the parent but who has parental responsibility, or

a close relative defined in this context as a brother, sister, aunt, uncle, grandparent or step-parent.

A child who is looked after in their own home by an adult is not considered to be privately fostered. Children who are privately fostered are amongst the most vulnerable and the Local Authority must be notified of these arrangements.

Information collected locally mirrors the national situation in relation to low notifications and reports rarely coming from parents. There were 20 young people subject to private fostering arrangements between 1st April 2014 and 31st March 2015. Eleven of these were new notifications with 8 being male and 3 female. Of the current Private Fostering Arrangements only one person with parental responsibility makes a financial contribution to the placement. The placements were secure overall with only one placement breakdown. In all cases the child was visited within 7 working days of receipt of notification of the arrangement and additionally throughout the year on a six monthly basis, and an annual review.

The Ofsted inspection of Children's Services in 2014/15 identified the local authorities' response to children who are living in Private Fostering Arrangements as an area for improvement. A comprehensive marketing plan was subsequently established to address this.

Safeguarding children in Portsmouth

Children who offend or are at risk of offending

Portsmouth Youth Offending Team (YOT) is awaiting verified figures from the Youth Justice Board relating to throughput and interventions for 2014/15, a delay has been caused by a recent move to a new case management system.

The most recent available data indicates that the average age of young people subject to intervention during the period 2014/15 was 15 years and 3 months. Of those, 80% were male, 3.2% are currently from a Black or Minority Ethnic background and none were Unaccompanied Asylum Seekers.

45.95% were identified as having a Special Educational Need, 11% were currently children in care. 23.9% of the caseload are currently part of the Priority Young Person Cohort and most at risk of offending.

Since July 1st 2014 the YOT has been using a Live Re-Offending Tracker to measure live-time re-offending rates. Of those young people receiving an intervention since this time, 17.9% of young people re-offended, which is significantly below the projected National Frequency of 30.4%. In addition to this, use of custody continues to decline rapidly. In 2014/15 only 6 custodial sentences were imposed, whilst only 5 young people were remanded into secure Youth Detention Accommodation, compared to 24 in 2012/13. First Time Entrants to the Youth Justice System has risen during 2014/15 and the police and YOT have recently introduced a new Triage process to tackle this.

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CHAPTER 2

Safeguarding children in Portsmouth

Female genital mutilation (FGM)

Female genital mutilation (sometimes referred to as female circumcision or cutting) refers to procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons. **Illegal in the UK,** FGM is child abuse and a form of violence against women and girls, and therefore dealt with as part of existing child and adult safeguarding/ protection structures, policies and procedures. One of PSCB's functions is to raise awareness of this amongst partners.

During 2014/15 work was undertaken to:

- map prevalence and trends across the City
- agree actions necessary to prevent FGM
- deliver training and awareness raising for agencies
- develop a programme for community engagement
- develop a risk identification checklist

Child and young person's mental health and wellbeing

The Child Health Profile for Portsmouth (March 2014) identified the admission rate to hospital for children as a result of self-harm was higher than the England average and work was required to develop appropriate care pathways for children who self-harm.

The numbers of children presenting with Neurodevelopmental Disorders has also increased and work undertaken to develop clinical care pathways to enable timely and effective access to services.

In 2014 the Solent Child and Adolescent Mental Health Service (CAMHS) underwent a service redesign. A Single Point of Access Team (CAMHS SPA) was developed to co-ordinate all services available in Portsmouth City for children, young people and families who present with a range of emotional, behavioural and mental health needs. This team aims to speed up the response times for children, young people and families who do meet the criteria for a targeted and specialist child and adolescent mental health service.

Longer term specialist evidence based treatments for children, young people and their families are offered through the Extended Team, CAMHS Learning Disability Team, Early Intervention Team, CAMHS Children In Care Team, Multi-Systemic Therapy Team, Paediatric Liaison and Outreach Team. Providing individualised treatment interventions designed to address the needs of children and young people and their families / support networks who have serious to severe mental health disorders.

In addition the CAMHS Children in Care Team extended their offer for those groups of children and young people who present at a higher risk of developing mental health difficulties by offering training and consultation to adoptive parents, Special Guardianship carers and family and friends carers. Care Leavers aged 18 to 25 years will also be offered access to an emotional and mental health review together with information and advice regarding access to adult services.

CHAPTER 3

The child's journey

Early Help (including Common Assessment Framework (CAF) and Single-Assessment Framework (SAF))

In 2014/15 in excess of 700 CAFs were completed in Portsmouth.

In July 2014 Ofsted judged that the early help offer in Portsmouth required improvement; particularly in relation to services for adolescents.

Portsmouth Children's Trust responded to improve early help services for vulnerable children and families with the aim to restructure services into three locality-based Multi-Agency Teams (MATs) to improve the integration of key multi agency services for children and families.

The SAF will be launched in June 2015 and create a shared inter-agency assessment and planning tool. It will enable those working with a child or family to gain a holistic view of their needs and bring together the right services to meet those needs.

Joint Action Team

The Joint Action Team provides the gateway to secure safeguarding services for children in Portsmouth. This multi-agency triage service supports the children's workforce in delivering effective early help and safeguarding intervention for vulnerable children and families.

The Joint Action Team is made up of professionals from across children's and adults workforce and each member of the team is able to use their shared knowledge, skills and networks to ensure that children and families have access to the right services at the right time.

In 2014/15 the Joint Action Team assumed lead responsibility to coordinate the city's response to children considered at risk of sexual exploitation and children going missing from home.

It is envisaged that the Joint Action Team will be transformed in to a Portsmouth Multi-Agency Safeguarding Hub during 2015/16.

Children In Need

In 2014/15 11,966 contacts were made to the Joint Action Team which were converted into 1,627 referrals being made to Children's Social Care and Safeguarding; 1,600 assessments were completed to determine whether children and families should be provided with support under the statutory Children In Need framework (s17 Children Act).

In March 2015 there were 490 Children In Need in Portsmouth being supported by Children's Social Care and Safeguarding, the majority being supported through the Family Support Service.

The Family Support Service provides focused family intervention to improve outcomes for children in need over a 6 month period and works closely with colleagues from Health, Education and the Police as well as specialist provision from Substance Misuse and Domestic Abuse services.

Less than 20% of children receiving a service from Children's Social Care are re-referred and the service continues to achieve a reduction in these numbers indicating consistent service improvements.

Children subject to Child Protection Planning

Portsmouth saw a 22% increase in child protection plans over the last year compared to the previous year, this remains 1% below the statistical neighbour average. The number of children subject to a plan within a 2 year time period reduced over the year to 4% at the end of March 2015 and this relates to 11 children over the year. Duration on a plan over a 2 year period has reduced over the year but is above the statistical neighbour average.

Over the last year, the service has been restructured to increase the capacity of child protection conference chairs and plans are in place to explore the viability of a strengthening families model to child protection work over the coming year. PSCB challenged all agencies regarding the quality and timely submission of child protection conference reports in accordance with 4LSCB Child Protection procedures and this has been an area showing significant improvement.

CHAPTER 3

The child's journey

Children in Care

The majority of children in care are looked after because they have been neglected and/or physically, sexually or emotionally harmed by their parents; or are unaccompanied asylum seeking children. Children In Care can be living with foster carers (sometimes the foster carers are friends or relatives of the child), at home with parents under the supervision of Children's Social Care, in residential care or in other settings such as secure units, schools or hospitals.

The largest age group of Children In Care locally is our 6-13 years age group (42%). The other 58% evenly is represented across the 0-5 and the 14+ age groups. The implication of this being that the 6-13 year age group may have the potential to stay in care longer because returning home or being adopted is less likely for the older age group.

Nationally the number of Children In Care has been increasing since 2010 and indications are that there has been a further significant increase in year 2014/15. The number of children who left the care system through adoption has significantly increased (58% increase since 2010) following Government reforms. However this is slowing down and has led to further indications from Government regarding legislative change around Regionalisation of Adoption Agencies.

Portsmouth has a rate of 75 children in care per 10,000 of the population compared to the average national rate of 60 per 10,000, but remain the 3rd lowest in our statistical neighbour group. At the end of March 2015 we had 320 children in care compared with 318 last year.

Children In Care often have poorer outcomes than the non-looked after children. A high proportion, (67%) have special educational needs (SEN) and they are over-represented in the prison population and as adults in mental health institutions. These challenges make it all the more important that all partners in the City work together to help looked after children succeed and fulfil their ambitions, for example this year we have seen an increase in the number of our young people who leave care going to University.

CHAPTER 3

The child's journey

Placement stability is a key indicator and there is a co-dependency between placement stability, school attendance and positive progress and attainment for Children In Care. At the end of March 2015, 73% of our Children In Care children who had been Looked after for two and a half years had been in the same placement for over two years.

12% of our Children In Care are placed more than 20 miles away from Portsmouth City Council, 1% less than in 2014. The majority of these are living in Hampshire with our own Portsmouth City Council foster carers.

98% of our statutory visits are undertaken within the appropriate timescale (usually every 6 weeks, unless a child is in a permanent foster placement where it is 3 monthly).

7% of Children In Care aged 10-17 who have been looked after for more than 12 months had a conviction, final warning or committed an offence in the previous 12 months. This represented a 3% improvement on the previous year.

The majority of our children are placed in care services and are attending schools graded by Ofsted as 'Good' or 'Outstanding'.

There were only 7 young people in external residential care at the end of March 2015. This is a significant reduction from the previous year when 12 were looked after in external provision. Supporting young people out of area poses a much greater challenge for Social Workers and for young people placed away from their families and communities, therefore this is a very positive picture.

Service Improvements for Children in Care

Local residential services for Children in Care children have been re-provisioned, taking into account an analysis of local need and occupancy levels. The national average for Children in Care placed in residential care is 9%, locally 4.4% of our Children in Care children are in residential care (2.1% in external provision).

In line with the needs of our young people a remodelling of residential provision is planned during 2015/2016 with a move from a larger accommodation to a 3 bedded unit, focusing on a domestic model of care.

CAMHS now offers an "in-reach" service to Social Workers and residential provision following an extensive review of the overall service. This will be reviewed to ensure that it is impacting positively on our most vulnerable young people.

The reunification project has been set up in conjunction with the Department for Education and Loughborough University. The aim is to re-engage with families where there is ongoing positive contact between the child and their family and where there is a possibility of reunification, to ensure a thorough risk assessment process is implemented and there is safeguarding against risk of further abuse/harm.

CHAPTER 3

The child's journey

The Voice of the Child

PSCB partially funded the appointment of a local care leaver as an apprentice in a youth participation and engagement role for one year. This apprentice fulfilled a core role in championing and capturing the voice of the child as follows;

The Children in Care Council (CiCC) was consulted as to how to best approach delivering the key messages of the PSCB to young people, as a result -

- Children and young people commented and contributed to the content of the PSCB website
- A young person's version of the PSCB annual report was developed to capture the key outcomes from 2013-14 and the PSCB plans for 2015-16.
- The PSCB Annual Report and Business Plan (Children and Young Persons version) was shared with children and young people through a programme of workshops delivered in primary and secondary schools.

Through the workshops secondary school children identified the following as being their concerns around keeping safe in and around Portsmouth -

- Internet Safety - Online pop ups, not being confident knowing who people are online, fake internet accounts, being tracked on line (geo tagging), and on-line gaming, online bullying
- Keeping safe on the streets - concerns about unsafe areas, groups of young people, being followed or approached by strangers or drunk people, being mugged
- Peer pressure regarding drug use, meeting unsafe people, jumping off the sea walls (being reckless), feeling that saying 'No' brings unwanted attention, and can lead to bullying
- Unsafe relationships with older adults "being touched up"/sexual harassment

Learning from Workshops with Secondary School Pupils

- Young people's perception of safety is personal and not always the same as adults
- The e-Safety 'Beware of Lurking Trolls' campaign has had an impact but due to constant changes in social media and applications these messages need to be continually updated and delivered across schools
- A lot of children are using applications and on line games that are not age appropriate and not enough parents appear to know how to safeguard their children's use of the internet
- Young people locally are genuinely worried about risks of attack particularly from other young people and they need some basic lessons in staying safe
- A number of young people were concerned about experiencing harassment in public places, especially of a sexual nature. Predominately these were females and some were very young to have had those concerns. If children are visiting public places alone, or in small groups, they need to know how to deal with unwanted attention or inappropriate contact

CHAPTER 4

Children's workforce

PSCB Safeguarding Training

PSCB partners funded the provision of multi-agency safeguarding over 2014/2015 which resulted in 2,058 delegates being trained in safeguarding overall (1,115 multi-agency course delegates and 943 single agency/bespoke course delegates).

During 2014-15, the PSCB Multi-Agency Training Committee was established to oversee the local multi-agency safeguarding offer and quality assures the training programme.

A post safeguarding training evaluation and impact exercise was piloted in 2014 with delegates asked to evaluate the impact of learning from the course on their practice (6 months after the course). Response rates were very been good and feedback positive overall. The training committee has reflected on the first 6 months of the post evaluation exercise some changes to evaluation questions have been made to gather more specific responses with regards to impact of training on practice.

In 2014, we added a new course specifically for Designated Safeguarding Leads in Schools to the core offer, this proved popular with all courses places filled and there has been positive feedback from delegates. A new e-learning course on Child Sexual Exploitation was also offered to key groups of professionals.

PSCB
Portsmouth
Safeguarding
Children Board
Protecting Portsmouth's Children

CHAPTER 4

Children's workforce

Learning from PSCB audits

The PSCB oversees a range of audit activity to understand the effectiveness of early help and safeguarding in the city. These include multi-agency audits, single agency audits and Deeps Dives into specific topics.

This year, the PSCB undertook a Deep Dive audit into the safeguarding of children with disabilities with a focus on hearing the voice of children. There was some good practice identified; however there was some key learning that has led to an improvement plan, namely:

- How children presented was rarely being recorded in their files unless at crisis point
- The child's voice was not effectively captured in too many cases and was often implicit rather than explicit
- The identity of the Lead Professional was often unclear
- Awareness of the PSCB Working with Resistant Families guidance was not widespread or routinely being applied
- Too often, professionals did not know how to access specialist advice and information on how to communicate with children with disabilities
- It was noted that different electronic recording systems meant that it was not always possible to keep soft evidence of the children and young person voice e.g. pictures, 3 D modelling etc.

Other PSCB audit activity has highlighted the following:

- There has been improvement regarding the timeliness of agency reports to child protection conferences
- Children's participation in child protection conferences has improved
- Identification of domestic abuse and the potential impact on babies and young children needs to improve
- The early identification of child neglect and effective planning and intervention where it is a factor continues to challenge practice
- Thresholds for social care intervention appear appropriate and that decision-making made at the point of referral are good

CHAPTER 4

Children's workforce

Allegations against adults working with children and the Local Authority Designated Officer (LADO)

The number of notifications to the LADO during 2014/2015 remained consistent with the previous year with just one extra notification (133 in 2014/2015 against 132 in the previous year).

Notifications have come from all partner agencies and the voluntary sector. Whilst the overall numbers may not have increased, there is a decrease in notifications which do not meet the LADO criteria, this indicates that a greater percentage of notifications are being made appropriately and therefore indicates an increase in investigations required overall.

Notifications regarding staff in Education and Children's Social Care increased this year, and notifications relating to foster carers has remained at the same level as seen in the previous year. There has been a slight increase in notifications being made to the LADO within 24 hours of the referrer being made aware of the concern or allegation and there has been a 23% increase in strategy meetings being held within 2 working days of the LADO receiving the referral in accordance with procedures.

The timeliness of investigations is improved and currently investigations completed in 3 months is 89.3% and within 1 month is 75.23%. This is just below the recommendations of the guidance which is 90% and 80% respectively and will continue to be a focus of improvement over the next year.

Cross border working with neighbouring LADOs is well established and is supported by the network meetings available to the LADOs.

This year has highlighted a number of cases where individuals have been required to update safeguarding training in order to return to the agency's workforce. This has identified a need for bespoke training to help the individual recognise how their own behaviours may impact upon the safeguarding of children and young people. This is a development area for 2015/2016.

CHAPTER 5

What happens when a child dies or is seriously harmed in Portsmouth?

Child Deaths Reviews in Portsmouth

Serious Case Reviews

Local Safeguarding Children Boards are required to consider holding a Serious Case Review (SCR) when abuse or neglect is known or suspected to be a factor in a child's death or when a child has been seriously harmed and there are concerns about how professionals may have worked together.

The purpose of a SCR is to establish whether there are lessons to be learnt from the case about the way in which local professionals and organisations work together to safeguard and promote the welfare of children.

Following a recommendation from the Case Review Committee (CRC), the PSCB Independent Chair commissioned a Serious Case Review in 2014/15. The report from this review is incomplete at the time of this Annual Report but the findings will be available for reflection later in 2015. Any recommendations arising from this review will be carefully considered and implemented and it is the role of the CRC to oversee and monitor the implementation of any recommendations in a timely manner.

In addition the PSCB is committed to undertaking smaller scale reviews where the case does not meet the criteria for a Serious Case Review but it is considered that there are lessons for multi-agency working to be learnt.

Six cases have been bought to the attention of the CRC for discussion since publication of the last annual report. Notes of the discussions are circulated to all participating agencies for dissemination to support learning. The learning from case reviews was also presented to agencies at the PSCB away day. The Committee's aim is to highlight any learning from case reviews to agencies involved to help inform and improve future practice.

CHAPTER 5

What happens when a child dies or is seriously harmed in Portsmouth?

Child Death Overview Panel

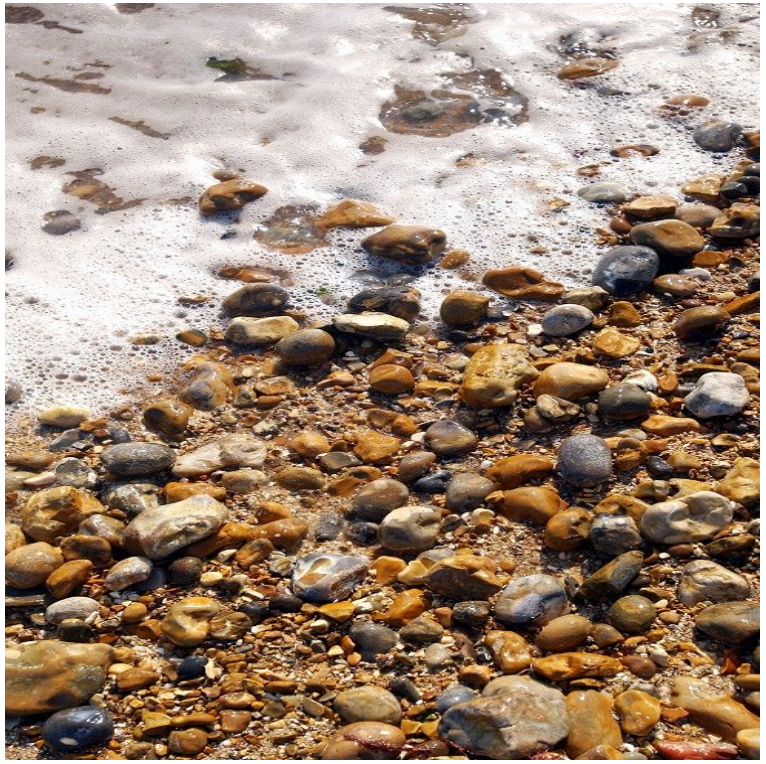
Since April 1st 2008, Local Safeguarding Children Boards (LSCBs) in England have had a statutory responsibility for the child death review process.

The 4LSCB Child Death Overview Panel (CDOP) receives notifications of the deaths of all children from birth to 18 years in Hampshire, Isle of Wight, Portsmouth or Southampton. Notifications are received from a number of sources including the Clinical Commissioning Groups (CCGs) and the Registrar of Births, Deaths and Marriages; the coroner(s); emergency departments; paediatricians; and the police force(s).

The CDOP review specified child deaths, drawing on comprehensive information from all agencies on the circumstances of each child's death. Particular consideration is given to the review of sudden unexpected deaths in infancy and childhood; accidental deaths; deaths related to maltreatment; suicides; and any deaths from natural causes where there are potential lessons to be learnt about prevention.

Through this review the Panel identify:

- any lessons to be learnt or overall patterns and trends, including any system or process issues within any agency or voluntary sector and any public health issues
- any case giving rise to the need for a referral to the Case Review Committee
- any matters of concern affecting the safety and welfare of children in the area
- any wider public health or safety concerns arising from a particular death or from a pattern of deaths in the area.



Portsmouth received 11 child death notifications to CDOP within 2014/2015 this year of which 7 were unexpected deaths, at the time of writing this report there are two cases pending review by the CDOP.

It is planned that the 4LSCB CDOP group will disband in late 2015 and local CDOP arrangements will be established.

CONCLUSIONS

Message for everyone

Be tenacious in your efforts to safeguard children. If you are concerned that a child or group of children are not getting the care or support they deserve persist in your efforts to engage them, their families and networks of support around them.

Messages for Elected Members

Demand the best for our children. Use your role as Corporate Parents to ensure that Looked After Children in Portsmouth get the high level of care and support they deserve.

Expect agencies to provide robust evidence from children and young people that the support they receive is improving their lives.

Scrutinise plans and reports and challenge safeguarding service delivery if it is not good enough.

Get to know Portsmouth from a child's point of view. Understand the risks children in Portsmouth face and the support they receive to address them.

Take advantage of training and development opportunities on safeguarding and promoting the welfare of children and young people.

Message for Children and Young People

Children and young people are at the heart of the child protection system. Your voices are the most important of all. The PSCB is developing better ways of hearing children and young people's views.

Messages for The Police and Crime Commissioner

Ensure Police commit fully to the delivery of the PSCB CSE strategy, which includes children who are missing and trafficked.

Ensure that there is an effective multi-agency response to incidents of child neglect, reducing the likelihood of the children suffering significant and long term damage.

Messages for Clinical Commissioning Groups

CCGs in the health service have a key role in scrutinising the governance and planning across a range of organisations.

You are required to discharge your safeguarding duties effectively and ensure that services are commissioned for the most vulnerable children.

Message for the Community

Remember that children in our community are all our responsibility. If you have concerns about a child contact the Joint Action Team on 0845 6710271.

Messages for the City Council

Continue your work to improve outcomes for children leaving care and increase their engagement in education, employment and training.

Messages for the Children's Trust

Make sure the plans for early help assessment promote the identification of and effective support for families experiencing neglect.

In your decision-making around structuring early help services ensure new arrangements promote links with the local community, particularly with those groups who find engaging with services challenging.

Messages for the Children's Workforce

Keep yourself up to date with national and local processes, practices and issues around Early Help and Safeguarding.

If you are concerned about the professional decision making around a child, challenge it, and escalate if it hasn't been resolved.

PSCB
Portsmouth Safeguarding Children Board
Protecting Portsmouth's Children

PSCB contacts details

Tel: 02392 841540

Email: pscb@portsmouthcc.gov.uk

Website: www.portsmouthscb.org.uk

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Portsmouth CITY COUNCIL

THIS ITEM IS FOR INFORMATION ONLY

Title of meeting:	Health and Wellbeing Board
Subject:	Joint Strategic Needs Assessment, Annual Summary, 2015
Date of meeting:	2 December 2015
Report by:	Director of Public Health
Wards affected:	All

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1. Requested by

Health and Wellbeing Board

2. Purpose

To inform the Board of the city's key health and wellbeing trends and issues
To monitor progress in achieving the priorities of the Joint Health and Wellbeing Strategy

3. Information Requested

Joint Strategic Needs Assessment Annual Summary

……
Signed by Dr Janet Maxwell, Director of Public Health

Appendices:
Appendix 1 - Joint Strategic Needs Assessment, Annual Summary 2015
Appendix 2 - Comparative health profile
Appendix 3 - JHWS Summary Outcomes

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
JSNA	www.jsna.portsmouth.gov.uk

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NHS
Portsmouth
Clinical Commissioning Group

Portsmouth
CITY COUNCIL

Joint Strategic Needs Assessment

Annual Summary, 2015

Contents

1 Introduction

The Joint Strategic Needs Assessment (JSNA) describes the current and future wellbeing, health and care needs of local communities. The Health and Wellbeing Board has a statutory duty to ensure that Portsmouth City Council and NHS Portsmouth Clinical Commissioning Group (CCG) jointly produce a JSNA. Portsmouth's JSNA has several elements:

- Providing health and social care commissioners and the Health and Wellbeing Board with intelligence about health and social care needs
- Maintaining a website with up-to-date research and statistics about health and wellbeing (http://data.hampshirehub.net/def/concept/folders/themes/jsna/portsmouth-jsna)
- Producing Annual JSNA summaries
- Working with the Children's Trust and the Safer Portsmouth Partnership in a knowledge and research programme to support and inform partnership decisions.

Previously, in this report, we have given the Health and Wellbeing Board an overview of key demographic, health and wellbeing trends and issues. The JSNA directly informs the priorities of the Joint Health and Wellbeing Strategy[1]:

1. Giving children and young people the best start in life
2. Promoting prevention
3. Supporting independence
4. Intervening earlier
5. Reducing inequality.

This year's Annual Summary focuses on the new Strategy and comprises:

- Key health and wellbeing trends and issues
- Monitoring progress in achieving the Joint Health and Wellbeing Strategy priorities

Previous JSNA Annual Summaries can be found here:

http://data.hampshirehub.net/def/concept/folders/themes/jsna/portsmouth-jsna/jsna-and-ward-summaries-and-outcome-frameworks/jsna-summaries

2 Recent research and investigations

Partner agencies and Scrutiny Panels continue to carry out a wide range of research into health and wellbeing in Portsmouth, including:

- "Knowledge Summits" held in January, February, November 2014. Identified 'Parenting' as key cross-cutting issue for Health and Wellbeing, Children's Trust and Safer Portsmouth Partnership

[1] Portsmouth City Council. NHS Portsmouth Clinical Commissioning Group. Joint Health and Wellbeing Strategy 2014-2017. https://www.portsmouth.gov.uk/ext/documents-external/hlth-jhwellbeingstrategy2014-17.pdf Accessed 27 October 2015

- Updated Electoral Ward profiles http://data.hampshirehub.net/def/concept/folders/themes/jsna/portsmouth-jsna/jsna-and-ward-summaries-and-outcome-frameworks/electoral-ward-summaries
- Index of Multiple Deprivation 2015 - resources updated on JSNA website

Socio-environmental factors:

- Series of 'Building a healthier city' seminars
- Annual Public Health Report 2014: Building a healthier city (in press)
- Food mapping
- Annual crime and anti-social behaviour strategic assessment
- Reported road casualties, 2010-2014. Hampshire Constabulary http://data.hampshirehub.net/data/reported-road-casualties-portsmouth-2010-2014
- Road safety around schools - investigation by the Traffic, Environment and Community Safety Scrutiny Panel http://data.hampshirehub.net/data/road-safety-around-schools-traffic-environment--community-safety-scrutiny-panel-review-2015
- Profiles of neighbourhoods especially Somerstown, Paulsgrove and Wymering, Portsea, Fratton to inform development of the Wellbeing Service
- Economic development, Culture and Leisure Scrutiny Panel - Revitalising Portsmouth's local high streets and secondary shopping areas http://data.hampshirehub.net/def/concept/folders/themes/jsna/portsmouth-jsna/social-and-environmental-context/the-economy-and-employment
- Intelligence to support development of Healthy Weight Strategy
- Research into cumulative impact zones to inform Licensing Policy
- Solent Local Economic Partnership strategies and plans

Tackling inequalities affecting vulnerable groups:

- Tackling poverty needs assessment http://data.hampshirehub.net/data/jsna/portsmouth-jsna/social-and-environmental-context/poverty-and-deprivation/tackling-poverty-needs-assessment to inform Tackling poverty strategy http://data.hampshirehub.net/data/tackling-poverty-strategy-2015-2020
- Health needs of homeless people http://data.hampshirehub.net/data/health-needs-assessment-of-homeless-people
- Better Care population needs and demand profiling
- Intelligence to support development of the Carers' Strategy http://data.hampshirehub.net/data/jsna/portsmouth-jsna/burden-of-ill-health-and-disability/carers/carers-strategy

Surveys carried out this year

- Annual 'You say' survey of secondary school age pupils

Community engagement/consultations carried out this year

- Physical activity
- Mental health strategy

Specific health and wellbeing issues:

- Liver health needs assessment http://data.hampshirehub.net/data/liver-health---needs-assessment-june-2015

- Pharmaceutical needs assessment (statutory) http://data.hampshirehub.net/def/concept/folders/themes/jsna/portsmouth-jsna/services/pharmacies
- Sexual health needs assessment http://data.hampshirehub.net/data/1-sexual-health-needs-assessment-2014 (to inform Sexual health strategy 2014-19 http://data.hampshirehub.net/data/1-sexual-health-strategy-2014-2019)
- Mental health needs assessment to inform Mental Health strategy
- Intelligence to support development of Infant Feeding strategy

Services

Review of health services for homeless people

Current needs assessments or research

- Health and lifestyle survey of adults aged 16+ years
- Survey of Veterans' health
- Impact assessment of retrofit of Wilmcote House, Somerstown
- Rapid participatory appraisals of health and wellbeing in Paulsgrove and Fratton
- Children's and young people's needs assessment
- Continence services
- Review of home to school transport and access to primary school places (Education, Children and Young People Scrutiny Panel)
- Support services for people aged 16-25 years living in isolation (Housing and Social Care Scrutiny Panel)
- How to develop wider opportunities for students to the mutual benefit of students and the city council (Economic Development, Culture and Leisure Scrutiny Panel)
- Consideration of options for, and improvements and variations to, Portsmouth's public transport system (Traffic, Environment and Community Safety Scrutiny Panel)
- What do we need to do differently in relation to parenting to improve outcomes in the city?
- Safer Portsmouth Partnership research identified in the annual strategic assessment

3 Demographic trends and deprivation

Population

- About 209,000 people live in Portsmouth - about 1,600 more than in 2013
- Each year, there are about 1,000 more births than deaths to city residents
- There were 2,685 live births - 23.6% born to non-UK born mothers
- ONS estimate that 0.8% of Portsmouth's population increase is due to net international migration. Net internal migration contributes -0.5% of growth (ie more people move out of the city to other parts of the UK than move in from other UK areas)

Diversity

- 16.0% of the city's population are not of White British ethnicity
- Children and young people have a different ethnic profile with 29% of school-age children being of non White British ethnicity (45% of school children living in St Thomas ward and 38% in St Jude ward are of non White British ethnicity)

Population change

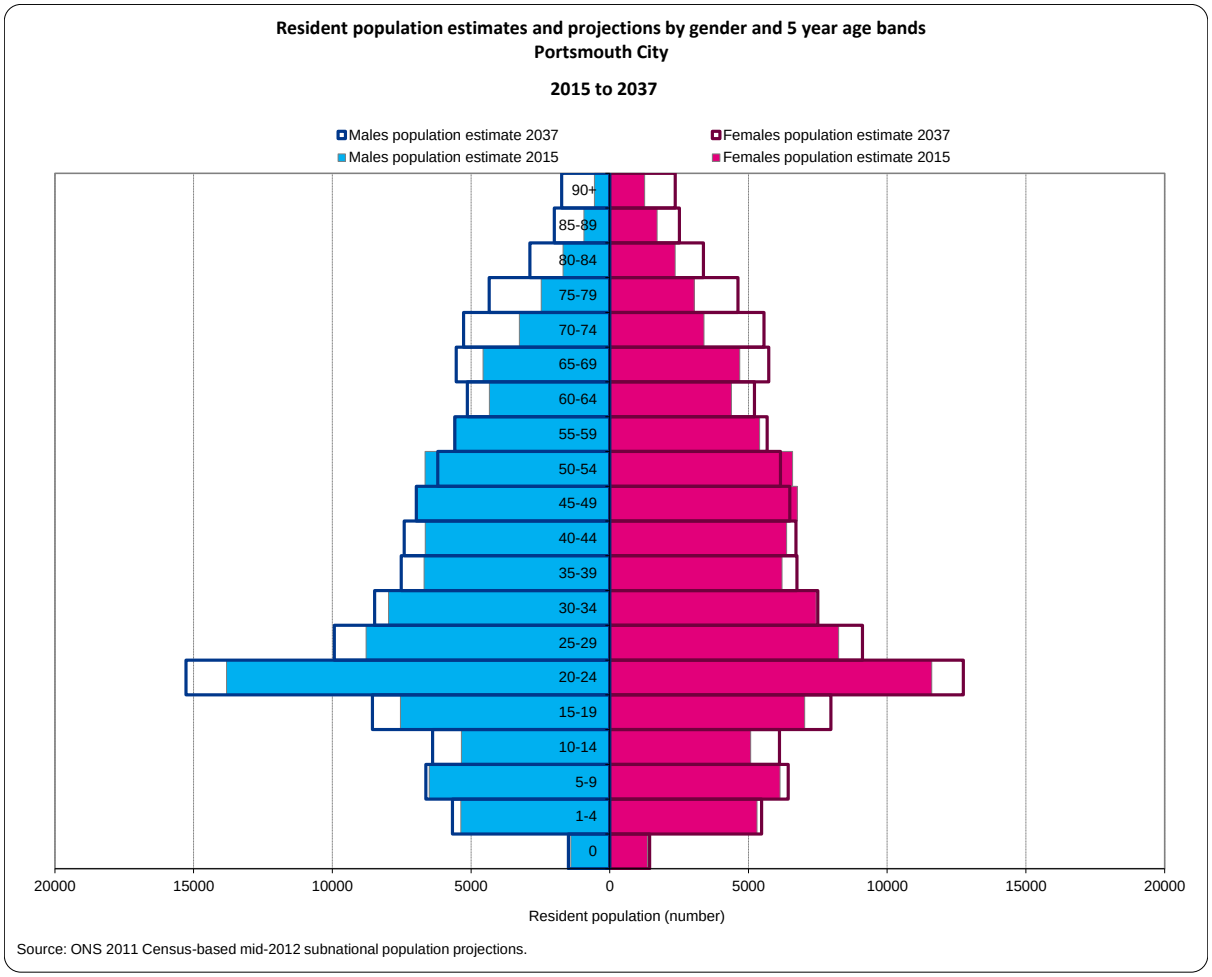
Over the next 22 years, the population is projected to increase to about 241,000 persons (13% increase). The greatest proportionate increase will be in the population aged 65+ years which will increase from 14% to 19%. The proportion of the population aged 0-19 years will slightly decline from 24% to 23%. (Figure 1)

Deprivation

The new Index of Multiple Deprivation, 2015 provides a relative ranking of areas across England according to their level of deprivation. Deprivation is experienced across a range of issues and refers to unmet need caused by a lack of resources - not just financial resources. For overall deprivation, Portsmouth is ranked 63rd of 326 local authorities (previously ranked 76th of 326 local authorities in 2010, and 93rd of 354 authorities in 2007) where 1 is the most deprived in terms of the average score.

Figure 2 shows relative deprivation across the city. Figure 3 shows in more detail, those areas of the city that lie within the most deprived 1%, 2%, 3-5% etc areas of England.

Figure 1



Source: ONS 2011 Census-based mid-2012 subnational population projections.

Figure 2

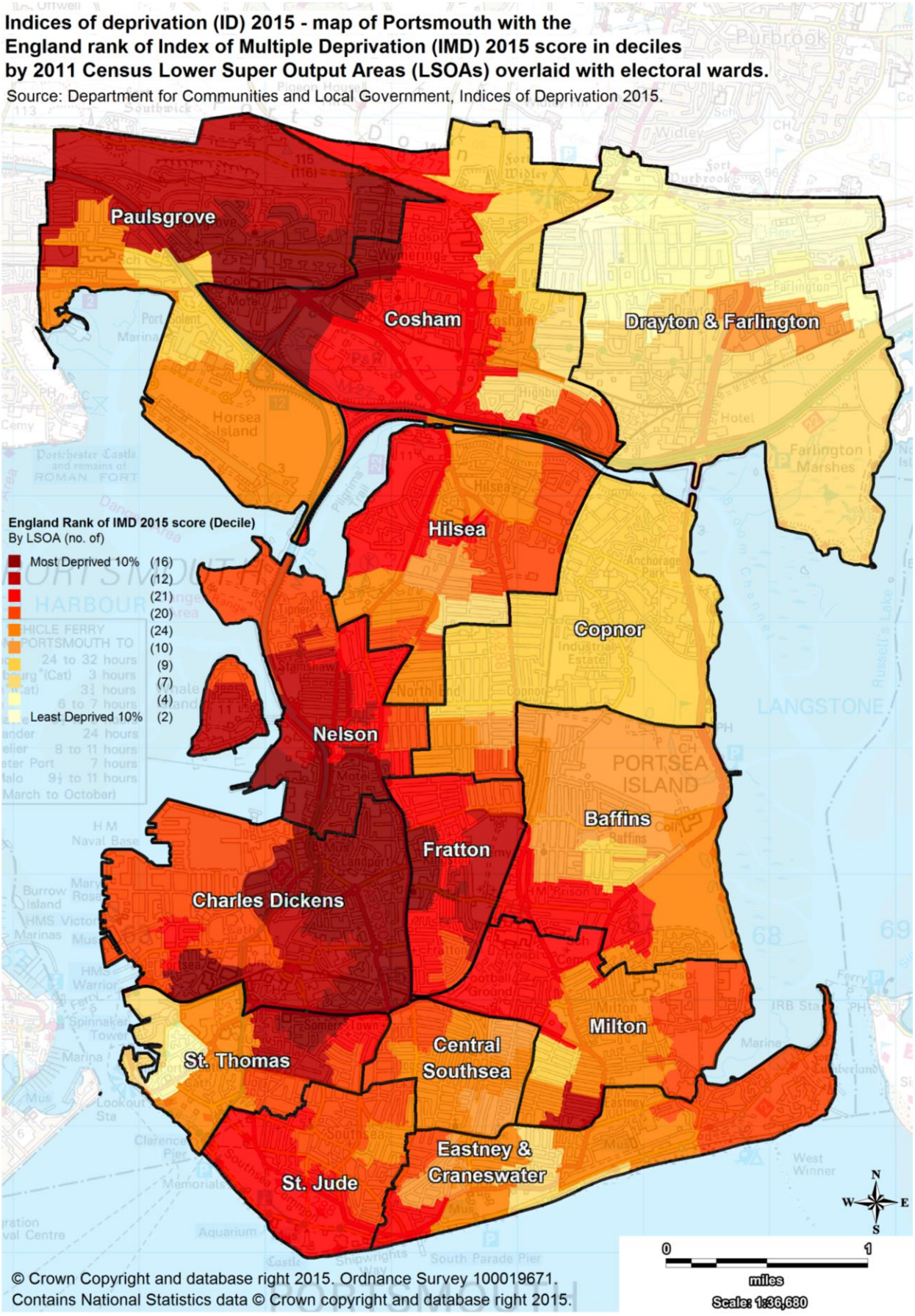
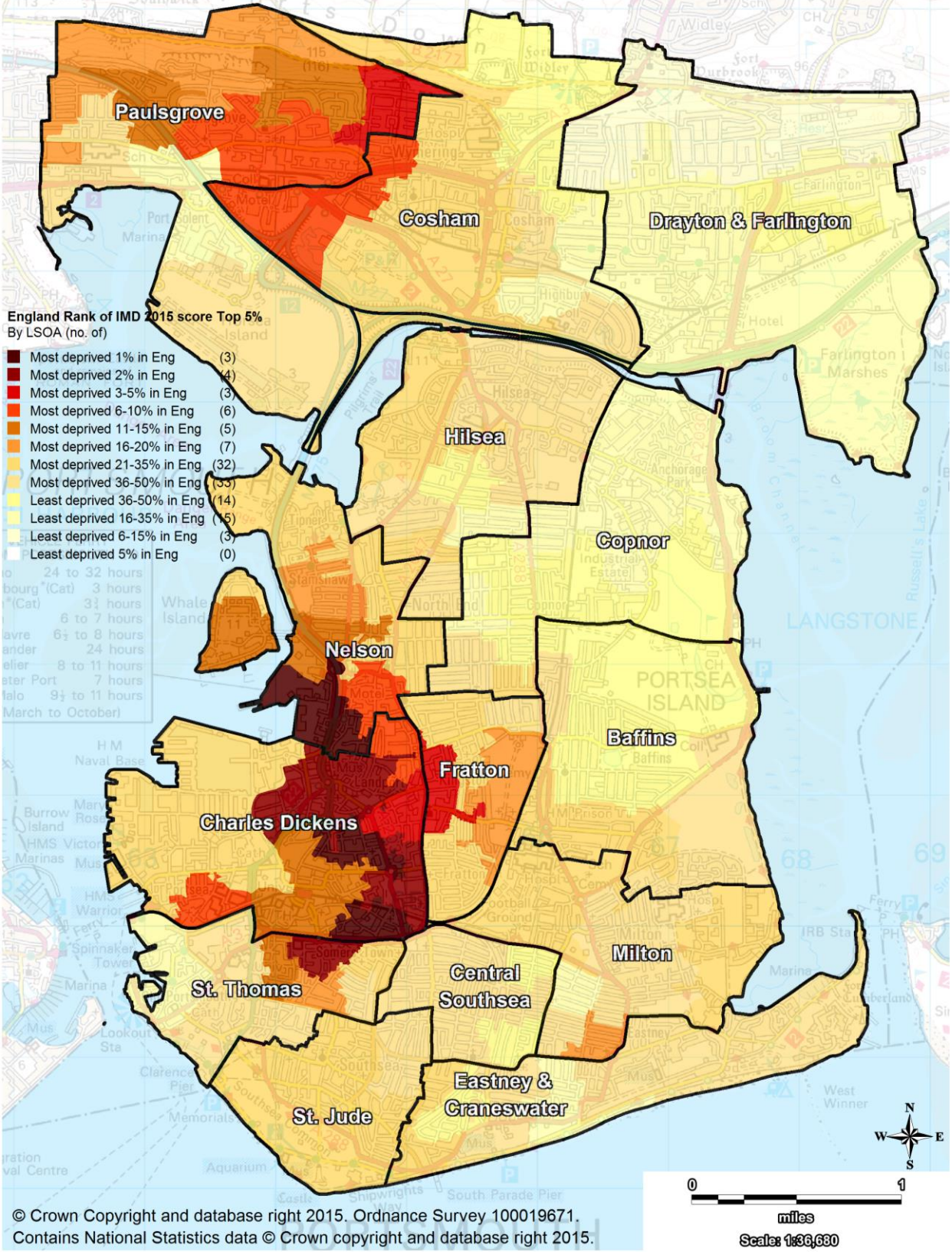

Indices of deprivation (ID) 2015 - map of Portsmouth with the England rank of Index of Multiple Deprivation (IMD) 2015 score in deciles by 2011 Census Lower Super Output Areas (LSOAs) overlaid with electoral wards.
Source: Department for Communities and Local Government, Indices of Deprivation 2015.
Paulsgrove
Cosham
Drayton & Farlington
Hilsea
Copnor
Nelson
Baffins
Fratton
Charles Dickens
Milton
Central Southsea
St. Thomas
Eastney & Craneswater
St. Jude
England Rank of IMD 2015 score (Decile)
By LSOA (no. of)
Most Deprived 10% (16)
(12)
(21)
(20)
(24)
(10)
(9)
(7)
(4)
Least Deprived 10% (2)
N
W
E
S
0
1
miles
Scale: 1:36,680
© Crown Copyright and database right 2015. Ordnance Survey 100019671.
Contains National Statistics data © Crown copyright and database right 2015.

Figure 3

Indices of deprivation (ID) 2015 - map of Portsmouth with the England rank of Index of Multiple Deprivation (IMD) 2015 score in top 1%, 5% and the rest by 2011 Census Lower Super Output Areas (LSOAs) overlaid with electoral wards.

Source: Department for Communities and Local Government, Indices of Deprivation 2015.



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Contains National Statistics data © Crown copyright and database right 2015.

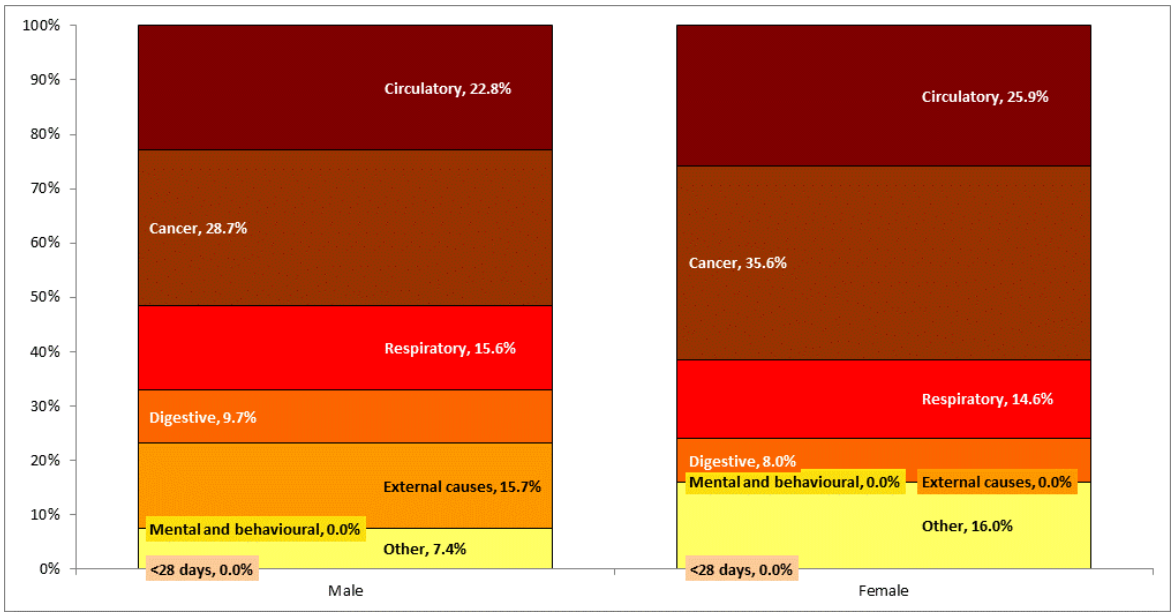
4 Key health and wellbeing trends

4.1 Overview

Reducing inequalities runs through all the outcomes presented in this report as the overall aim of the Joint Health and Wellbeing Strategy is "to improve the health of the poorest fastest".

Showing the impact of poorer physical and mental health outcomes, males in Portsmouth's most deprived areas die 9.5 years earlier than males in Portsmouth's least deprived areas. For females living in the most compared to least deprived areas, the gap in life expectancy is 6.0 years. Figure 4 shows the causes of this gap in life expectancy eg circulatory diseases contribute 23% of the gap for males and 26% for females.

Figure 4. Causes of the life expectancy gap between the most deprived quintile and the least deprived quintile in Portsmouth, 2010-12



Source: Segment tool. London Knowledge and Intelligence Team, PHE[2]

The data is stark. Between 2010 and 2012, comparing deaths in Portsmouth's most deprived areas compared to the least deprived areas there were:

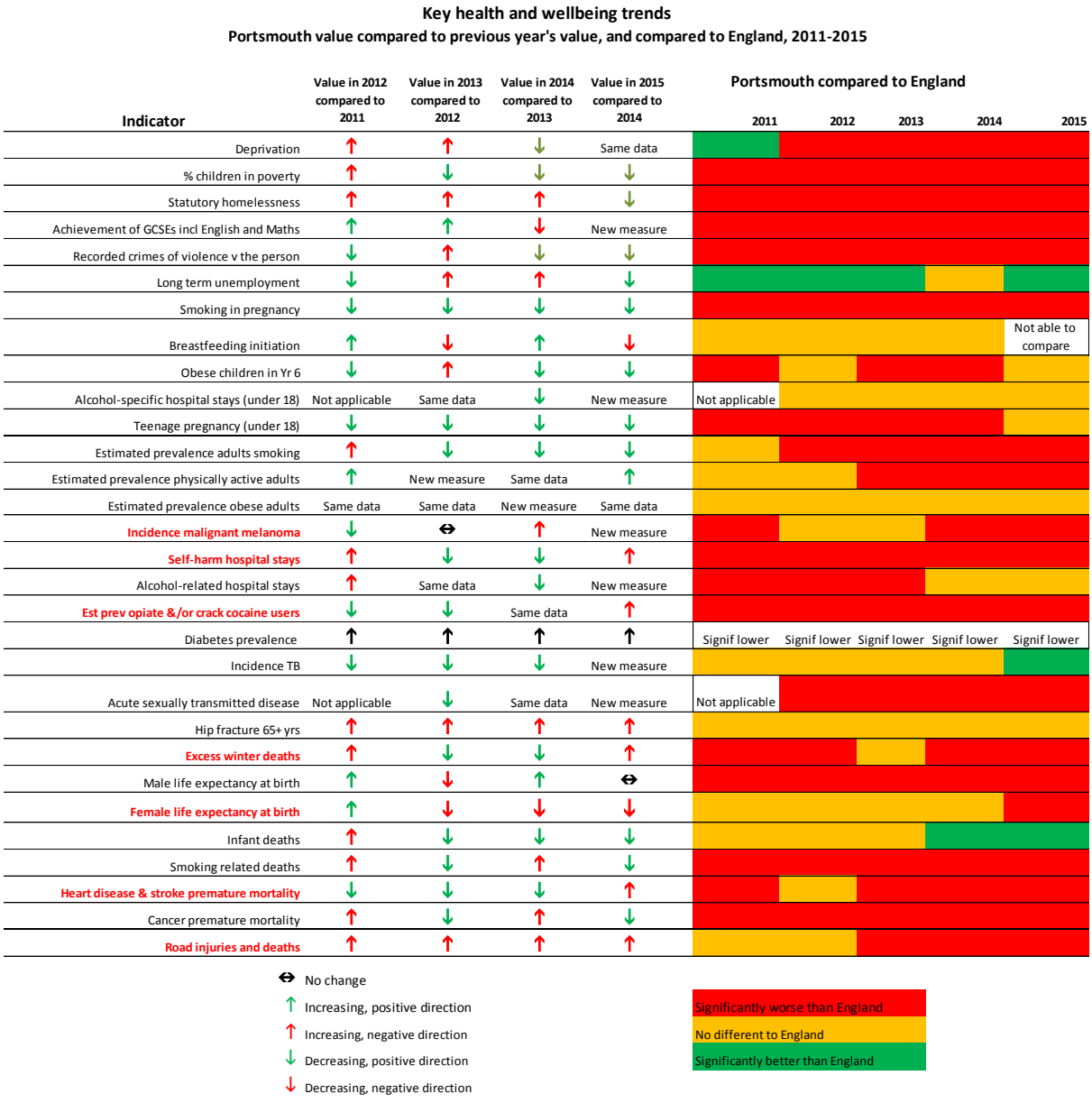
- 58 more male deaths and 57 more female deaths from circulatory disease (including coronary heart disease and stroke)
- 36 more male deaths and 35 more female deaths from lung cancer
- 44 more male deaths and 18 more female deaths from chronic obstructive pulmonary disease
- 19 more male deaths and nine more female deaths from chronic liver disease (including chirrhosis)
- Male suicide caused two additional deaths. [3]

[2] Segment tool. London Knowledge and Intelligence Team, Public Health England. http://www.lho.org.uk/LHO_Topics/Analytic_Tools/Segment/TheSegmentTool.aspx? Accessed 3 September 2015

[3] London Health Observatory. Segment tool: segmenting life expectancy gaps by cause of death. http://www.lho.org.uk/LHO_Topics/Analytic_Tools/Segment/Documents/LA_E06000044.pdf Accessed 3 September 2015

Public Health England's Health Profiles give an overview of key physical and mental health and wellbeing issues.[4] (summarised in Figure 5)

Figure 5. Key health and wellbeing trends, from national Health Profiles issued 2011-2015



Source: Health Profiles, Public Health England, 2011 to 2015

4.2 Issues

The main areas of concern are the seven areas highlighted in red text in Figure 3. The trend for each is worsening **and** Portsmouth is significantly worse than England:

- Female life expectancy

[4] Public Health England. Health Profiles, issued 2011 to 2015
http://www.apho.org.uk/default.aspx?QN=P_HEALTH_PROFILES Accessed 3 September 2015

- Premature mortality from heart disease and stroke
- Hospital stays for self-harm
- Estimated prevalence of opiate and/or crack cocaine users
- Incidence of malignant melanoma
- Road injuries and deaths
- Excess winter deaths

4.2.1 Female life expectancy

Life expectancy at birth is a summary measure of the all cause mortality rates in an area in a given period. It is the average number of years a new-born baby would survive, were he or she to experience a particular area's recent age-specific mortality rates for the whole of their life.

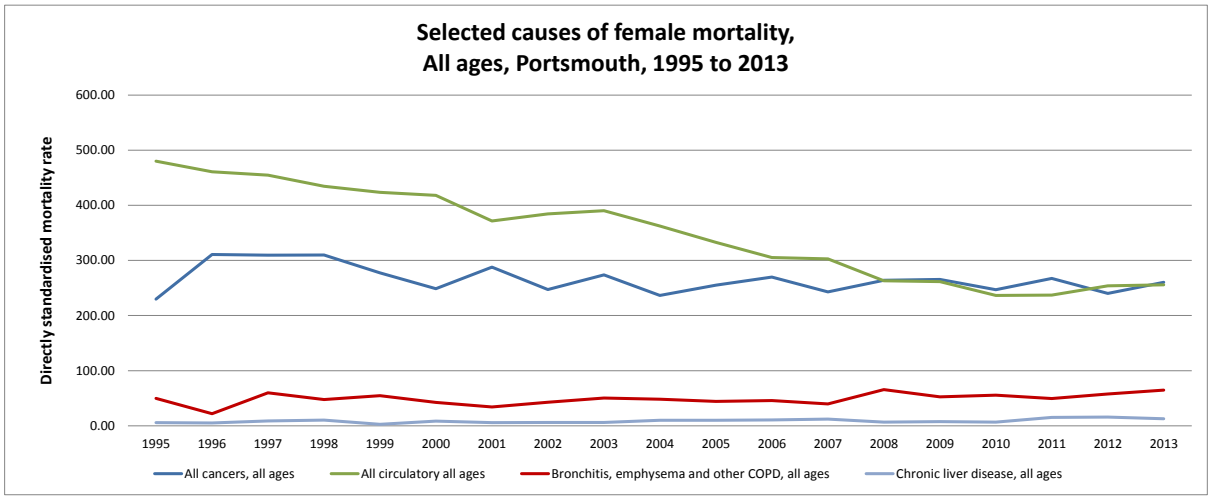
Male life expectancy in Portsmouth has been significantly shorter than the England average for some years now. The reasons for this were examined in the Director of Public Health's Annual Report 2012.[5]

However, Portsmouth's female life expectancy is now (in 2011-13 and 2012-14) also significantly shorter than the England female average.

Within the city, the chart above (Figure 4) shows that it is cancer (36% contribution), circulatory diseases (26%) and respiratory diseases (15%) that make the greatest contributions to the gap in life expectancy between females living in the most compared to the least deprived city areas.

Looking at the main contributors to local female mortality from 1995 onwards, mortality rates from circulatory disease have shown greatest improvement (this is also the case nationally for females, and is also the case nationally and locally for males). But there has been little improvement in female mortality rates for cancer and for certain respiratory conditions. (Figure 6)

Figure 6 Selected causes of female mortality, all ages, Portsmouth 1995 to 2013



[5] Director of Public Health, Portsmouth City Council, 2012. Public Health Annual Report: The health of men in Portsmouth. http://data.hampshirehub.net/data/jsna/portsmouth-jsna/the-people-of-portsmouth/public-health-annual-reports/the-health-of-men-in-portsmouth-public-health-annual-report-2012 Accessed 23 October 2015

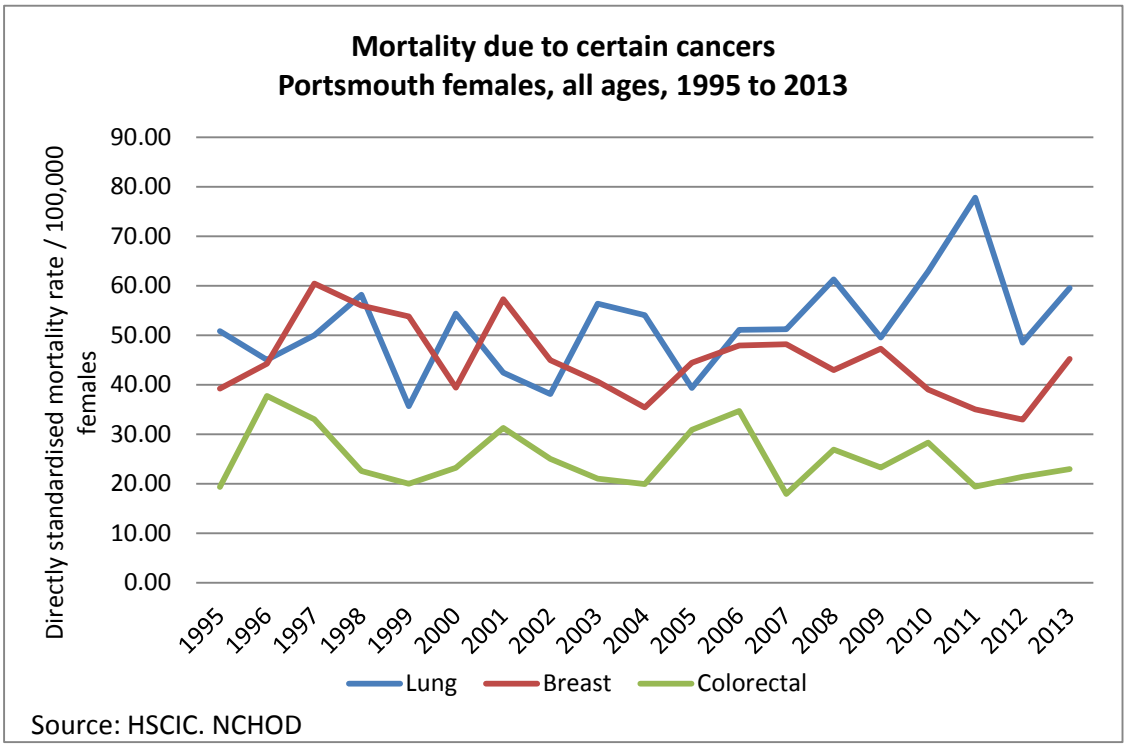
Between 1995 and 2013, the female mortality rate for chronic liver disease increased from 5.7 deaths per 100,000 females of all ages to 12.7 such deaths. One contributor to chronic liver disease is alcohol. Between 2006/08 to 2011/13, Portsmouth's female alcohol-specific mortality rate increased from 9.1 deaths per 100,000 females of all ages to 15.7 such deaths. The local rate has been significantly higher than the England rate for the last three rolling three year periods.

For 2011-13, Portsmouth's female premature mortality rate (ie females dying before they reach 75 years of age), is significantly higher than England for circulatory diseases, liver disease and cancers. The local female premature mortality rate for each of these diseases worsened between 2010-12 and 2011-13.

Local female premature mortality rates for circulatory disease and for liver disease with contributing factors which could have prevented early mortality (eg adopting healthy lifestyles, engaging with preventive and other health services) are also significantly worse than England .[6]

Within cancers, the most common female cancers are breast, lung and colorectal cancers. Of these, locally lung cancer has the highest mortality rate. Comparing 1995 and 2013, there has been little change in the breast and colorectal cancer mortality rates. The encouraging decreases in the female lung cancer mortality rate seen in late 1990s/early 2000s were not sustained and the local lung cancer mortality rate is now at 60 deaths per 100,000 females of all ages. (Figure 7)

Figure 7 Mortality due to certain cancers, females of all ages, Portsmouth 1995 to 2013



Source: HSCIC. NCHOD

As at March 2014, compared to England, significantly lower percentages of eligible Portsmouth females attended for breast (70.5%) or for cervical (70.7%) screening.

[6] Public Health England. Public Health Outcomes Framework. http://www.phoutcomes.info/public-health-outcomes-framework#page/4/gid/1000044/pat/104/par/E45000019/ati/102/are/E06000044/iid/40702/age/163/sex/2 Accessed 25 September 2015

4.2.2 Premature mortality from circulatory disease and stroke, under 75s

Portsmouth premature mortality rates from circulatory disease and stroke for males and for females (the latter outlined above) are both significantly higher than the England average. Compared to England, Portsmouth males and females also have significantly higher rates of premature mortality due to circulatory disease resulting from causes considered to be preventable.

One aim of NHS Health Checks is to identify people aged 40-74 years old who are at risk of circulatory disease (it also aims to identify people at risk of diabetes and kidney disease). For 2013/14 to 2014/15, Portsmouth had the third highest proportion of 19 South Eastern local authorities of the eligible population being offered a Health Check (47%). However, of these 19, Portsmouth had the lowest percentage of people actually taking up the invitation (26.5%).[7]

However, national HealthCheck's data reports on activity in the two financial years April 2013 to March 2015. Locally, uptake of NHS Health Checks by those invited was 15% in 2013/14 but has greatly improved to 40% in 2014/15. This positive upward trend has continued in the first quarters of 2015/16.

We need more information about the best ways to encourage people to have healthy lifestyles, and to take advantage of the wide range of health and other services which can identify problems and work alongside people to improve their wellbeing.

4.2.3 Hospital stays for self-harm, persons of all ages

Improving mental health and wellbeing and understanding more about emotional wellbeing of children and young people are workstreams within the Joint Health and Wellbeing Strategy. Mental health issues are covered by the Children's Trust and the Mental Health Alliance.

In 2013/14, Portsmouth had a significantly higher rate of people admited to hospital as emergencies for self-harm (332 such admissions per 100,000 persons of all ages).

At population level, levels of self-harm reflect wider community as well as personal issues. The use of alcohol or drugs is strongly associated with suicide in the general population and in sub-groups such as young men and people who self-harm.[8] Self-harm hospital admission rates also reflect variability in the type, ease of access to and availability of appropriate mental and physical health services.

Compared to England, the suicide mental health profile illustrates that Portsmouth has lower rates of long term health problems and of long term unemployment, but has higher rates of people who are separated or divorced, people living alone, households which are statutorily homeless, looked after children, children in the youth justice system and estimated prevalence of opiates or crack cocaine. Portsmouth

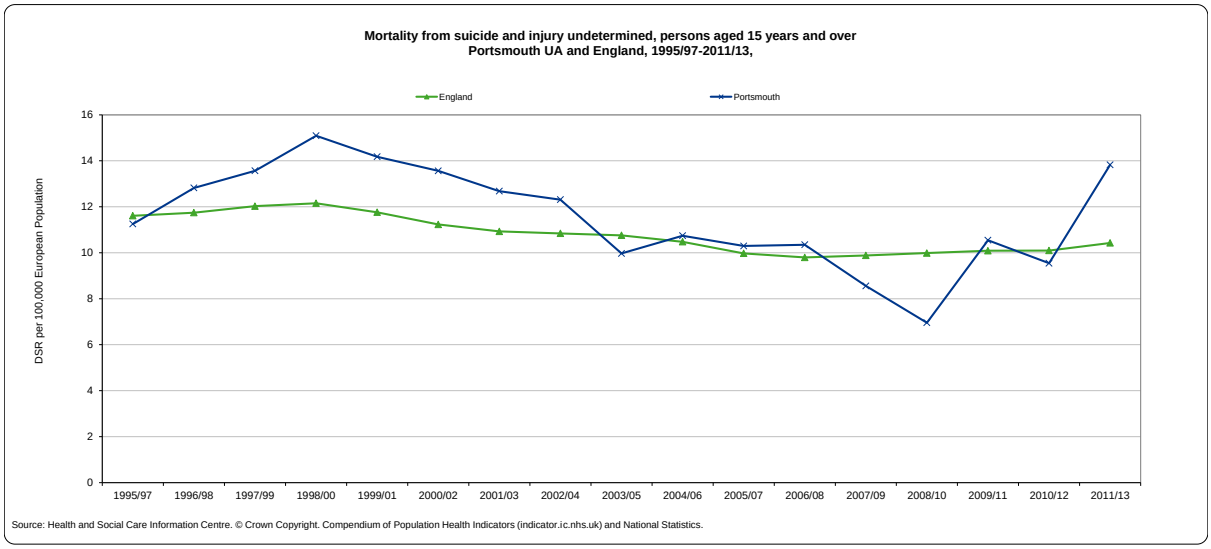
[7] Public Health England. Public Health Outcome Framework. http://www.phoutcomes.info/ Accessed 27 October 2015

[8] HM Government 2012. Preventing suicide in England: A cross government outcomes strategy to save lives. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/430720/Preventing-Suicide-.pdf Accessed 29 September 2015

also has a higher than national rates of mental health clients receiving services from adult social care, and of clients receiving specialist alcohol and drug services. [9]

For 2011/13, Portsmouth's suicide rate for persons aged 15+ years is now significantly higher than the England rate (13.8 per 100,000 persons aged 15+ years). This is the highest local rate since 1999/2001. (Figure 8)

Figure 8 Mortality from suicide and underdetermined injury, persons aged 15+ years, Portsmouth and England 1995/97 to 2011/13



In 2013/14,for children and young people aged 0-17 years, the rate of admission to hospital with a mental health problem was lower than the England rate (77 admissions per 100,000 persons aged 0-17 years). The reasons for these admissions include anxiety, stress, depression as well as severe mental health conditions and admissions due to use of substances and alcohol. However, this particular indicator does NOT include admissions where the main reason for admission was coded as intentional self-harm.

In 2013/14, hospital admissions for intentional self-harm by young people aged 10-24 years were significantly higher than England (533 admissions per 100,000 persons aged 10-24 years).[10] Nationally, between 2004/05 and 2013/14, hospital admissions for self-harm for young people aged 10-14 years increased by 67%, and for young people aged 15-19 years by 60% and it has been suggested that these large increases may be attributed to improved data collection.[11] However, it is concerning that the local admission rate for self-harm is reportedly significantly higher than the national rate. Further local investigations are underway to examine the issues around self-harm in young people.

[9] Public Health England. Suicide prevention profile. http://fingertips.phe.org.uk/profile-group/mental-health/profile/suicide/data#page/1/gid/1938132831/pat/6/par/E12000008/ati/102/are/E06000044 Accessed 28 September 2015

[10] Public Health England. CHIMAT. Child health profile http://www.chimat.org.uk/resource/view.aspx?QN=PROFILES_STATIC_RES&SEARCH=P* Accessed 28 September 2015

[11] HM Government 2015. Preventing suicide in England: Two years on. Second annual report on the cross-government outcomes strategy to save lives. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/405407/Annual_Report_acc.pdf Accessed 29 September 2015

Looking at other specific reasons for young persons' hospital admission, for 2011/12 to 2013/14, hospital admissions for young people aged 15-24 years for substance misuse (100 admissions per 100,000 young people aged 15-24 years) were significantly higher than England whilst hospital admissions for alcohol for 0-17 year olds (38 per 100,000 young people aged 0-17 years)were lower than England.

We need more information about the reasons behind the apparent high rate of hospital admissions for self-harm, for young people for self-harm, and for substance misuse. A CAMHS transformation plan is underway, which will include a health needs assessment for this age group.

A suicide audit is planned for autumn 2015.

4.2.4 Estimated prevalence of opiate and/or crack cocaine users, 15-64 years[12]

Substance misuse (including alcohol misuse) is the responsibility of Safer Portsmouth Partnership.

The latest (2011/12) estimate is that 1,549 Portsmouth residents, aged 15-64 years old, are opiate and/or crack cocaine users (10.9 per 1,000 residents aged 15 to 64 years). NB The prevalence is an estimate based on service users. Portsmouth's estimated prevalence is lower than other areas with a similar socio-economic profile but prevalence in Porsmouth has increased at a greater rate than elsewhere.

Drug use in the city continues to be higher than national averages, particularly for powder cocaine but also for ecstasy. While this may reflect the urban and age demographic of the city, tackling drugs continues to be a priority for the Safer Portsmouth Partnership. The Partnership also intends to monitor and respond to the changing profile of drug use in the city - particularly inceases in the use of new psychoactive substances. For young people this is now the third most reported substance use after alcohol and cannabis. Existing treatment services are more geared to opiate and crack cocaine.

The Partnership has found very clear links between alcohol and drug use and crime and anti-social behaviour and health outcomes for the city. Analysis of persistent and prolific offenders, young offenders and complex antisocial behaviour cases shows the impact of substances on perpetrators, their families and the local community.

For more information about substance misuse, please see Safer Portsmouth Partnership's strategic assessment, 2014/15.

4.2.5 Incidence of malignant melanoma, under 75s

For 2010-12, compared to England, Portsmouth had a significantly higher rate of people aged under 75 years being newly diagnosed (incidence) with malignant melanoma.

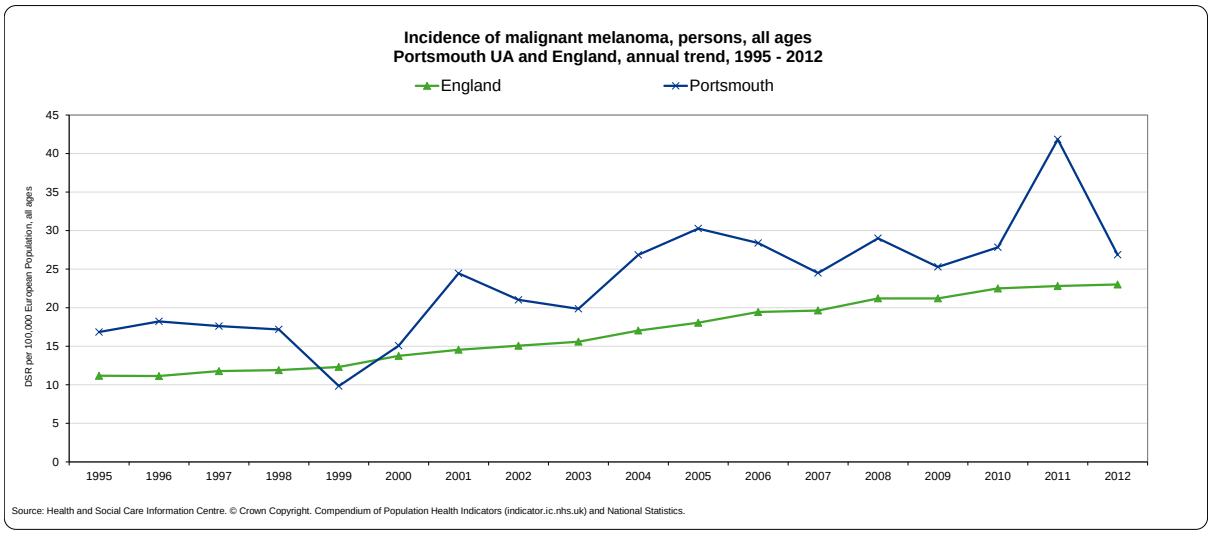
Excluding non-malignant skin cancer, malignant melanoma is the fifth most common cancer in the UK. The number of people getting melanoma now is five times higher than in the mid 1970s. In people aged

[12] Safer Portsmouth Partnership, 2015. Strategic Assessment 2014/15. https://hampshirehub-files.s3.amazonaws.com/98e5a2a1-108e-4374-bc38-228189adc2d8/API_STR_JSNA_SEC_CRIME_SPPStratAx2014-15.pdf

over 15 years, the incidence steadily rises with age with the highest incidence in people aged over 85 years. It is now the second most common cancer in people under the age of 50 years.[13]

For people of all ages, the incidence rate in Portsmouth peaked in 2011. (Figure 9)

Figure 9 Incidence of malignant melanoma, persons of all ages, Portsmouth and England, 1986 to 2012



Overexposure to ultraviolet light from the sun or sunbeds is the environmental factor that increases the risk of developing melanoma. Current incidence levels reflect previous exposure to these risk factors.

Public health advice about safe enjoyment of being outside in the sun includes using sunscreen and not staying out in the sun - particularly in the middle of the day.[14] The council registers and inspects all businesses engaged in cosmetic treatments including sunbeds.

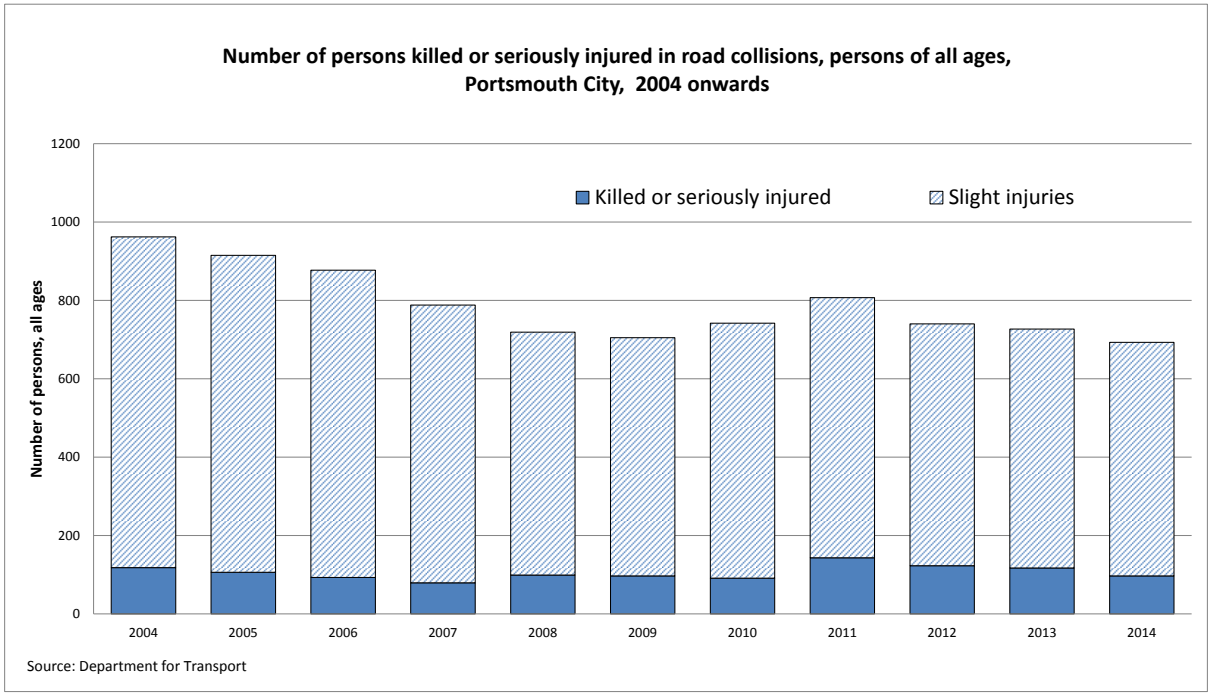
4.2.6 Road injuries and deaths, all ages

The most recent national comparative outcome measure covers 2011 to 2013 when an average of 127 Portsmouth residents of all ages were killed or seriously injured (KSI) each year (61.6 persons per 100,000 population -a significantly higher rate compared to England).

Figure 10 shows that there was a spike in the number of people who were "killed or seriously injured" in 2011. In 2011, the increase was in those with serious injuries as there were no local road traffic fatal injuries in that year.

[13] Cancer Research UK. Melanoma http://www.cancerresearchuk.org/about-cancer/type/melanoma/about/melanoma-risks-and-causes Accessed 29 September 2015
[14] NHS Choices. Sun safety. http://www.nhs.uk/Livewell/travelhealth/Pages/SunsafetyQA.aspx Accessed 9 October 2015

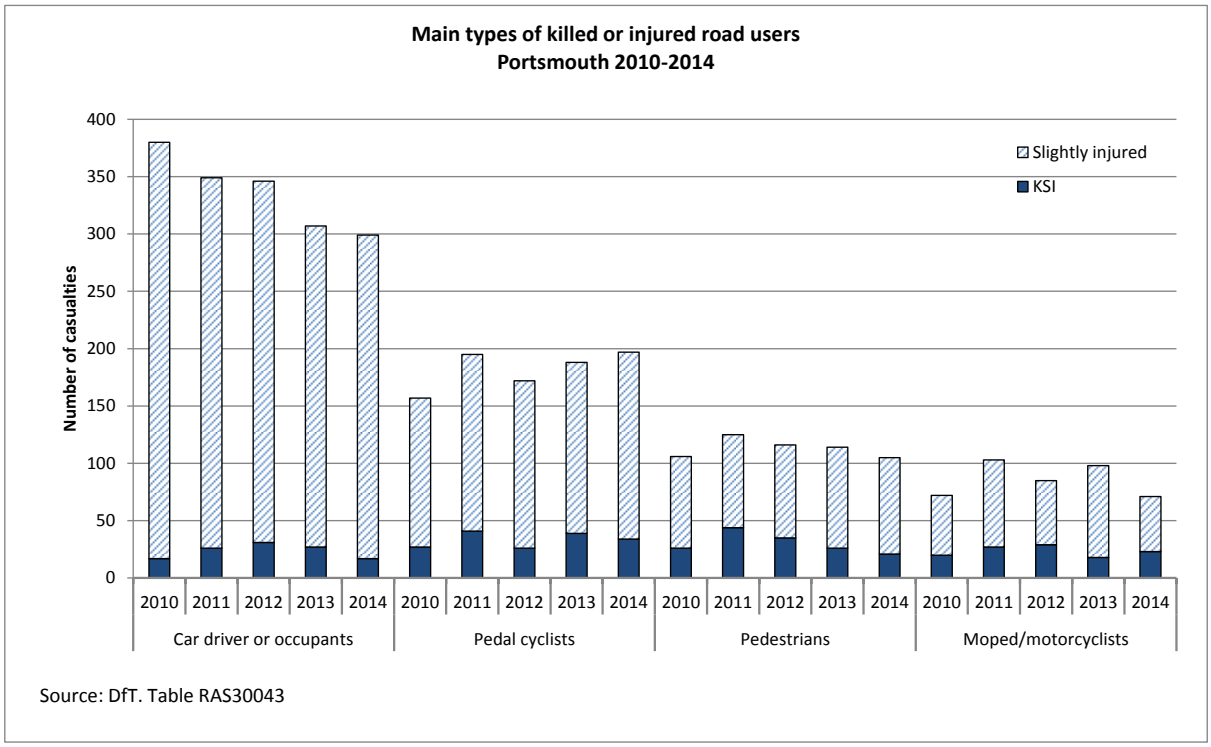
Figure 10 Number of persons killed or seriously injured in road collisions, persons of all ages, Portsmouth, 2004 to 2014



Between 2010 and 2014, car drivers and passengers made up the greatest proprotion of all people who were killed, or seriously or slightly injured in Portsmouth (45% of all casualties). However, for KSI casualties, higher proportions were more vulnerable road users (29% of all KSI casualties were pedal cyclists and 27% were pedestrians). (Figure 9)

Road casualties have reduced between 2012 and 2014. The reduction is most apparent for car occupant casualties - especially for 15-29 year old car occupants. For most other road user groups there has also been an encouraging decrease in casualties. However, pedal cyclists are the only road users with a year-on-year increase in the number of road casualties, and in their percentage contribution to all casualties, between 2012 and 2014. (Figure 11)

Figure 11 Main types of killed or injured road uses, Portsmouth, 2010 to 2014



Source: DfT. Table RAS30043

Between 2010-2014 and in-line with Portsmouth's population profile, 15-29 year old casualties account for the greatest proportion of all Portsmouth's road casualties. This is a wide demographic and includes those in compulsory education, at college/university and those in employment. Younger road users and male road users as car drivers, cyclists etc are more likely to take risks and are more likely to be injured. Encouragingly, for this age group there has been a year on year decrease in casualties. Conversely, there has been an increase in the number of injured road users aged 40-59 years - particularly those using mopeds/motorbikes (which is also a national trend).

Typical of cities, Portsmouth's personal injury collisions peak on weekdays between 1500-1759 - when there is more traffic on the roads. Research by Hampshire Constabulary found no seasonal trends.

Between 2010-2014, the greatest proportion of collisions (70%) occurred on single carriageway 30mph (23% of city roads have this speed limit) or 20mph roads (68% of city roads have this speed limit). Forty-two per cent of collisons occurred at staggered junctions, T-junctions or roundabouts on 30mph roads. These are typical locations for collisions as there is increased opportunity for conflict or human error.

Hampshire Constabulary's cluster analysis indicated that strategic A and B roads in the city have the greatest concentration of collisions, and in particular more serious collisions. These busy roads run through some of the city's most deprived areas which puts their local communities at increased risk.

Contributory factors grouped under the heading Driver/Rider Error were recorded for half of the vehicles involved in collisions. Specifically, 'Failed to look properly' and 'Failed to judge other persons path or speed' are most frequently recorded.[15]

[15] Hampshire Constabulary, September 2015. Reported road casualties, Portsmouth 2010-2014 http://data.hampshirehub.net/data/reported-road-casualties-portsmouth-2010-2014 Accessed 12 October 2015

The Traffic, Environment and Community Safety Scrutiny Panel investigated road safety around schools because Portsmouth has higher child pedestrian and child cyclist casualties than the national average. The Panel recommended:

1 Encourage schools to participate in council-run education programmes for KS1 and KS2 pupils and for bikeability training
2 Encourage schools to take some responsibility for road safety outside their schools at the start and end of the school day
3 Assess and make any improvements to signage and road markings associated with school safety
4 Consider engaging with local businesses to sponsor bicycle safety equipment including cycle helmets, high visibility jackets and reflective bands
5 All cyclists in council literature to wear helmets, high visibility jackets and have bicycles with lights
6 Publicise and enforce parking regulations outside schools
7 Promote joint working around pupils' road safety.

4.2.7 Excess winter deaths

Nationally, there are 21% more excess winter deaths in the quarter of homes that have the coldest indoor temperature compared to the quarter of homes that have the warmest indoor temperature.

The comparative measure in the Health Profile covers August 2010 to July 2013 when there were 26% excess winter deaths in Portsmouth (compared to 18% excess winter deaths across the South East). Portsmouth's excess winter death rate for these years and for the previous rolling three year period were both significantly higher than the national average.

Using local data for the period 2011/2 to 2013/14, South locality had the highest rate of excess winter deaths (27%) but at electoral ward level the highest excess rate was Nelson ward in Central locality (44%). Locally, the main causes of excess deaths in the winter are respiratory diseases - especially influenza and chronic obstructive pulmonary disease.

4.3 Other trends

For a further two areas (alcohol-related hospital stays, hip fractures in over 65s) Portsmouth's trend is worsening but the city's value is no different to England.

GCSE attainment remains significantly below the England average.

Partnership working is producing positive trends for:

- Childhood obesity
- Teenage pregnancy
- New cases of TB
- Infant mortality

5 Joint Health and Wellbeing Strategy outcome measures

The rationale for each outcome measure was set out in JSNA Annual Summary 2014.

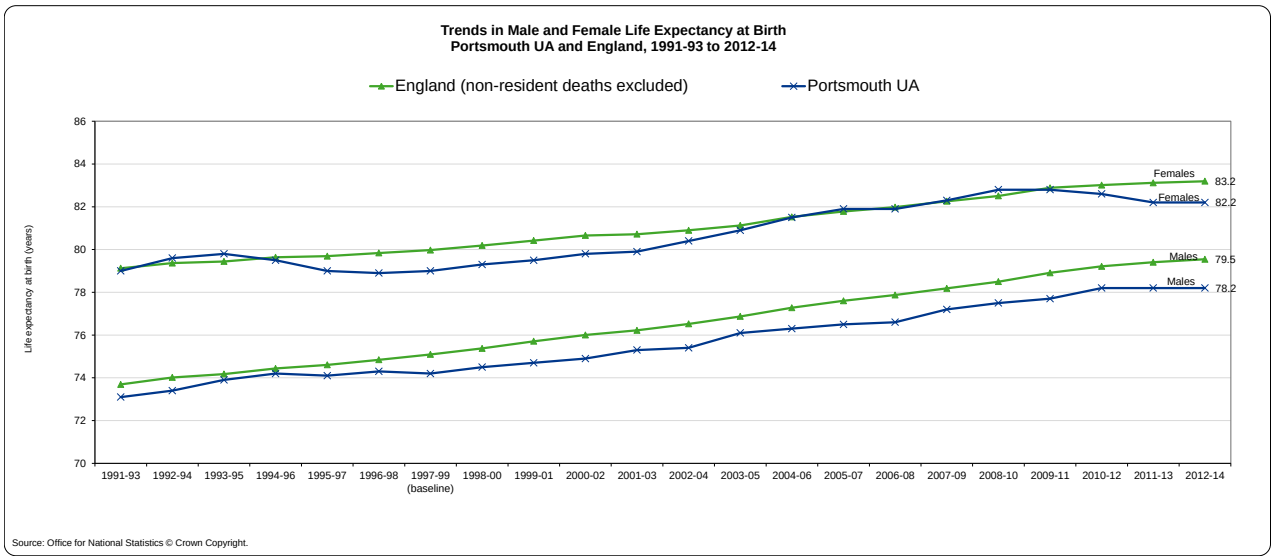
Monitoring data for each outcome, including for localities where available, is at Appendix 1.

5.1 Overall measure

The overall health outcome measure is to increase life expectancy rates in Portsmouth. Reducing differences in life expectancy is a key part of reducing health inequalities.

Life expectancy for males in Portsmouth is 78.2 years, and for females 82.2 years - both significantly shorter than their respective English average. (Figure 12)

Figure 12 Trends in male and female life expectancy at birth, Portsmouth and England, 1991/93 to 2012/14



Males in Portsmouth can expect to live 64.1 years in a state of 'Good' health. Females in Portsmouth can expect to live 63.4 years in a state of 'Good' health.

5.2 Priority 1: Giving children and young people the best start in life

Associated research

Children and young people's needs assessment

Intelligence to support development of the Infant Feeding Strategy

Annual 'You Say' survey of secondary school pupils

Review of support services for victims of domestic abuse

1a Improve outcomes for the pre-birth to 5 years age group

The vision for Portsmouth's under-5s is for all children to be safe, healthy, developing and ready for school. The Children's Trust is the partnership board with lead responsibility for improving outcomes for this age group and the Safer Portsmouth Partnership leads the city's response to domestic abuse.

Table 1 Outcome measures for improving outcomes for the pre-birth to 5 years age group

Measure	Strategy baseline (year)	Latest England	Latest Portsmouth	Latest Portsmouth compared to England	City trend	City action to match England average
Smoking in pregnancy (% of women giving birth who have smoked throughout pregnancy)	15.4 (2013/14)	11.4%	14.7%	Significantly higher	Improving	90 fewer women smoking during pregnancy
Breastfeeding within 48 hrs of baby's birth	66.1% (2013/14)	74.3%	74.6%	Higher	Improving	Need to maintain high level
Breastfeeding at 6-8 weeks (% of women breastfeeding at the time of the baby's 6-8 week check)	38.9% (2013/14)	43.8%	38.9%	Cannot compare - different methodologies	No change	Need to improve 6-8 wk rate. Baseline to be set
Early Years Foundation Stage: Meeting at least Expected Level in Communication and language - overall	75% (2013)	77%	79%	Higher	Improving	Achievement continues to be higher than England average - need to maintain level
Boys	67% (2013)	71%	73%	Higher	Improving	

Measure	Strategy baseline (year)	Latest England	Latest Portsmouth	Latest Portsmouth compared to England	City trend	City action to match England average
Girls	82% (2013)	83%	85%	Higher	Improving	
Early Years Foundation Stage: Meeting at least Expected Level in Personal, social, emotional development - overall	80% (2013)	81%	83%	Higher	Improving	Achievement continues to be higher than England average - need to maintain level
Boys	73% (2013)	75%	78%	Higher	Improving	
Girls	87% (2013)	87%	89%	Higher	Imnproving	

The overall positive picture hides city inequalities affecting certain groups eg ethnic minority communities, people in routine and manual socio-economic groups, looked-after children; and differences between genders.

1b Support the delivery of the 'Effective learning for every pupil strategy'

After high attainment at Foundation Stage, educational attainment in Portsmouth declines relative to other areas - the progress children make between key stage 1 and key stage 2 is not as good as nationally, and by GCSE level (key stage 4), Portsmouth pupils have some of the worst results in England. In addition to the Early Years Foundation Profile, a further three outcome measures have been selected to monitor how well we achieve the aims of the 'Effective Learning for every Pupil Strategy'.

Table 2 Outcome measures for the 'Effective learning for every pupil' strategy

Measure	Strategy baseline (year)	Latest England	Latest Portsmouth	Latest Portsmouth compared to England	City trend	City action to match England average
Pupil absence (average days lost per enrolment)	8 days (2012/13)	8 days lost per enrolment	9 days lost per enrolment	Higher	Worsening	1 day gained per enrolment

Measure	Strategy baseline (year)	Latest England	Latest Portsmouth	Latest Portsmouth compared to England	City trend	City action to match England average
Reading - % pupils making at least expected levels of progress between Key Stage 1 and Key Stage 2	82% (2013)	91%	88%	Lower	Improving	47 more pupils making at least expected progress
Writing - % pupils making at least expected levels of progress between Key Stage 1 and Key Stage 2	88% (2013)	93%	92%	Lower	Improving	26 more pupils making at least expected progress
Maths - % pupils making at least expected levels of progress between Key Stage 1 and Key Stage 2	84% (2013)	90%	87%	Lower	Improved 2009-2014 (although no change 2012-2013)	57 more pupils making at least expected progress
KS 2 results (Level 4+ in Reading/Writing/ Maths) - overall	69.8% (2013)	79%	75%	Lower	Improving	65 more pupils achieving Level 4+ R/W/M
Boys	66% (2013)	76%	71%	Lower	Improving	42 more boys achieving Level 4+ R/W/M
Girls	74% (2013)	82%	79%	Lower	Improving	23 more girls achieving Level 4+ R/W/M
English - % pupils making at least expected levels of progress between Key Stage 2 and Key Stage 4	Change to indicator in 2014	72%	65%	Lower	Change to indicator in 2014	110 more pupils making at least expected progress
Maths - % pupils making at least expected levels of progress		66%	60%	Lower		104 more pupils making at least

Measure	Strategy baseline (year)	Latest England	Latest Portsmouth	Latest Portsmouth compared to England	City trend	City action to match England average
between Key Stage 2 and Key Stage 4						expected progress
5 GCSE A* to C grades incl English and Maths - all pupils		53.4%	50.8%	Lower		46 more pupils achieving 5+ A*-C incl English and Maths
Boys	Change to indicator in 2014	48.2%	47.5%	Lower	Change to indicator in 2014	7 more boys achieving 5+ A*-C incl English and Maths
Girls		58.9%	54.3%	Lower		41 more girls achieving 5+ A*-C incl English and Maths

English and mathematics are assessed at **Key Stage 2** (ages 8-11 years). Although the trend is improving, both boys and girls in Portsmouth are currently achieving below the national average at Key Stage 2 (for achievement of Level 4+ in Reading/Writing/Maths: 76% nationally compared to 71% locally for boys, and 82% compared to 79% for girls). Again, nationally and locally girls out-perform boys. South locality again had the highest Key Stage 2 results (78.3% achieving level 4+ in these subjects) and Central the lowest (70.8%).

The national standard is that all pupils should achieve at least five **GCSEs graded A* to C**, including English and mathematics. Portsmouth pupils have never achieved the national average and in the baseline year (2013) Portsmouth was ranked third lowest of 151 local authorities. The measure has changed so the trend cannot be determined. In 2014, local achievement for both boys (39.7%) and girls (55.6%) was significantly lower than the national average. North locality again had the highest gold standard GCSE results (54.0%) and Central the lowest (46.8%).

1c Understand more about the emotional wellbeing of children and young people

The recent survey of Portsmouth children and young people aged between seven and 18 years, found that most are relatively happy with the lives with 10% to 13% having low overall wellbeing. Portsmouth children are happier than average with their money/belongings and their prospects for the future. They were less happy than average with their health and appearance.

As part of the child and adolescent mental health needs assessment, outcomes linked to emotional wellbeing in children and young people will be developed as we understand more about local children's sense of wellbeing and anxieties, and how most effectively to meet their needs.

5.3 Priority 2: Promoting prevention

Associated research

Series of 'Builing a healthier city' seminars

Annual Public Health Report 2014: Building a healthier city

Rapid participatory appraisals of health and wellbeing in Paulsgrove and Fratton (in development)

Road traffic incidents and casualties - Hampshire Constabulary

Road safety around schools - Scrutiny Panel investigation

Food mapping

Healthy weight strategy development

Annual secondary school pupil 'You say' survey (incl substance misuse)

Liver health needs assessment

Research into cumulative impact zones to inform licensing policy

2a Create sustainable healthy environments

This workstream explores how the urban and coastal environment (eg housing, open spaces such as the shoreline, seafront, parks and other civic spaces, and transport) can support people to lead healthy lives. The outcomes measure active travel and childhood obesity.

Initially, the workstream is focusing on how the physical environment can be improved to encourage "active travel" ie lessening our dependence on motorised transport, particularly the car. The city has a "Travel Active Portsmouth" strategy[16] and one key measure is that **walking and cycling become the travel 'norm' for short trips.** Data to set and monitor the Strategy outcome measure is not yet available but will be collected in conjunction with the University of Portsmouth.

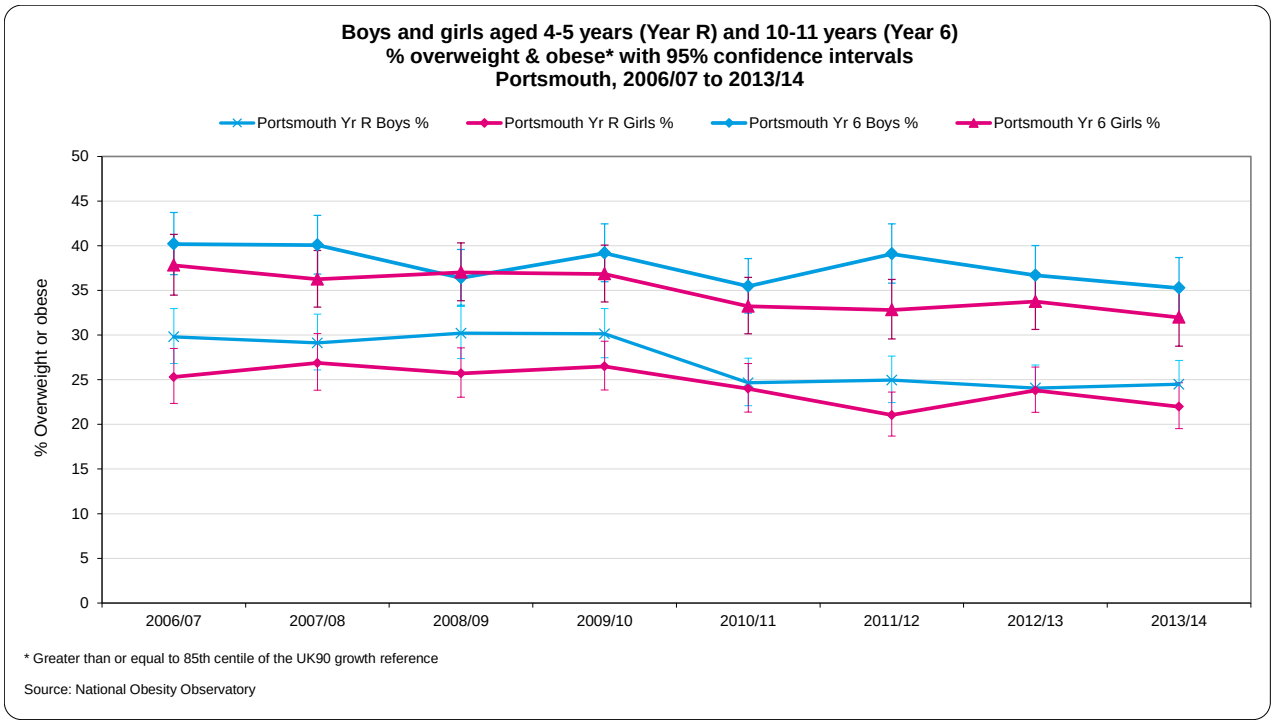
Healthy weight in childhood

The Travel Active Portsmouth strategy explicitly associates active travel with other measures to promote healthy weight. Childhood obesity measures (taken in Reception Year and in Year 6 of primary school) are

[16] Portsmouth City Council. Travel Active Portsmouth: A walking and cycling strategy for 2013 to 2023 http://www.hants.gov.uk/pccjsna/ActiveTravelStrategy.pdf Accessed 15 July 2014

key indicators of physical activity and of nutrition. Children of these ages are reliant on the adults around them for their nutritional needs. Overweight or obese children are of particular concern because habits learned in childhood of eating unhealthy food and being inactive can lead to a lifetime of obesity.

In 2013/14, 23.5% of Year R pupils resident in Portsmouth were overweight including obese - the local trend has not changed significantly since 2010/11. The chart shows that, for both genders, the prevalence of excess weight increases during primary school. By Year 6, the prevalence of overweight including obese pupils has increased to 33.6%.



2b Improve mental health and wellbeing

The Mental Health Alliance is currently producing the mental health strategy and action plan. We know that Portsmouth has significantly higher rates of factors which are risks for mental ill health (eg relative deprivation, alcohol misuse and violent crime) but lower recorded rates than the national average of, for example, depression. The Alliance has pledged to improve mental health and will also identify and monitor outcome measures.

2c Tackle issues relating to smoking, alcohol and substance misuse

The key outcome measures relate to reducing the prevalence of smoking and drinking alcohol amongst young people, reducing the prevalence of smoking in adults, and reducing alcohol-related hospital admissions. Achieving these outcome measures is linked to the development of the Wellbeing Service.

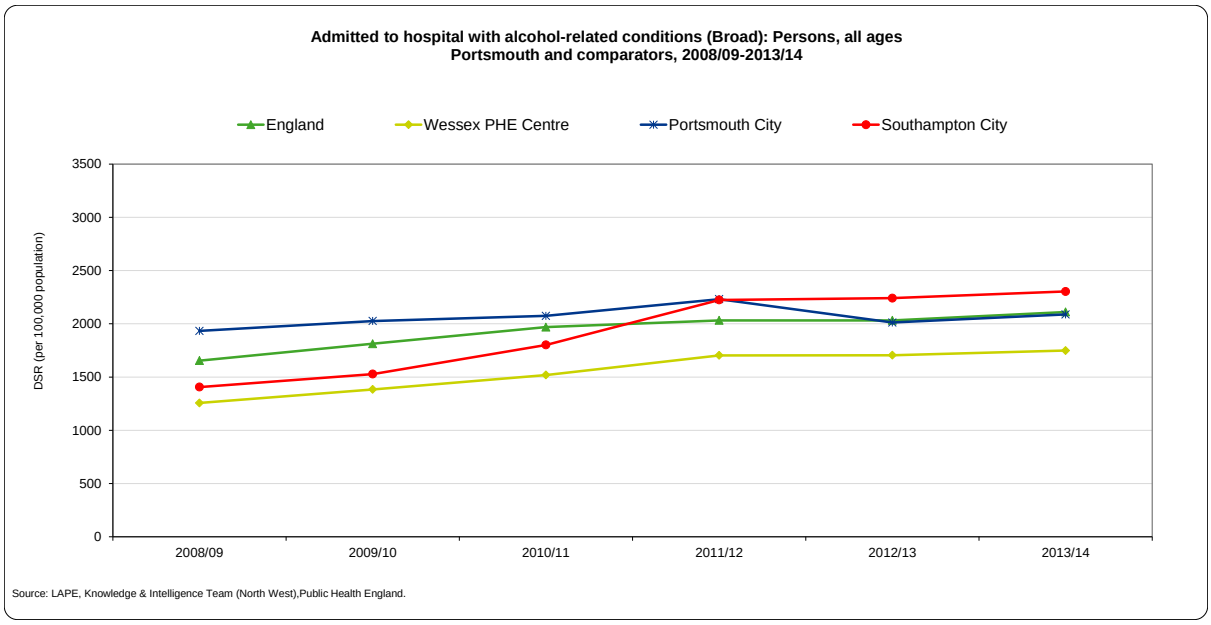
Measure	Strategy baseline (year)	Latest England	Latest Portsmouth	Latest Portsmouth compared to England	City trend	City action to match England average
Secondary school pupils report **never** tried tobacco	82% (2014)	N/A	78%	N/A	Worsening	N/A
Secondary school pupils report having drunk a whole alcoholic drink	53% (2014)	N/A	51%	N/A	Improving	N/A
Adult smoking prevalence	22.5% (2012)	18.4%	22.3%	Significantly higher	Improving	6,397 fewer adults smoking
Adult binge drinking	22.2% (2006-08)	20.0%	22.2%	Higher	N/A	3,636 fewer adults binge drinking
Alcohol hospital admissions misuse - broad measure	2,012 admissions per 100,000 population (2012/13)	2,111 admissions per 100,000 population	2,088 admissions per 100,000 population	No different	Worsening.	N/A
Alcohol hospital admissions misuse - narrow measure	609 admissions per 100,000 population (2012/13)	645 admissions per 100,000 population	650 admissions per 100,000 population	No different	Worsening	N/A

Smoking remains the main reason for the gap in life expectancy between rich and poor. Portsmouth has a significantly higher rate of deaths attributable to smoking compared to England. This year's local secondary school survey disappointingly found an decrease in pupils who had **never** tried tobacco.

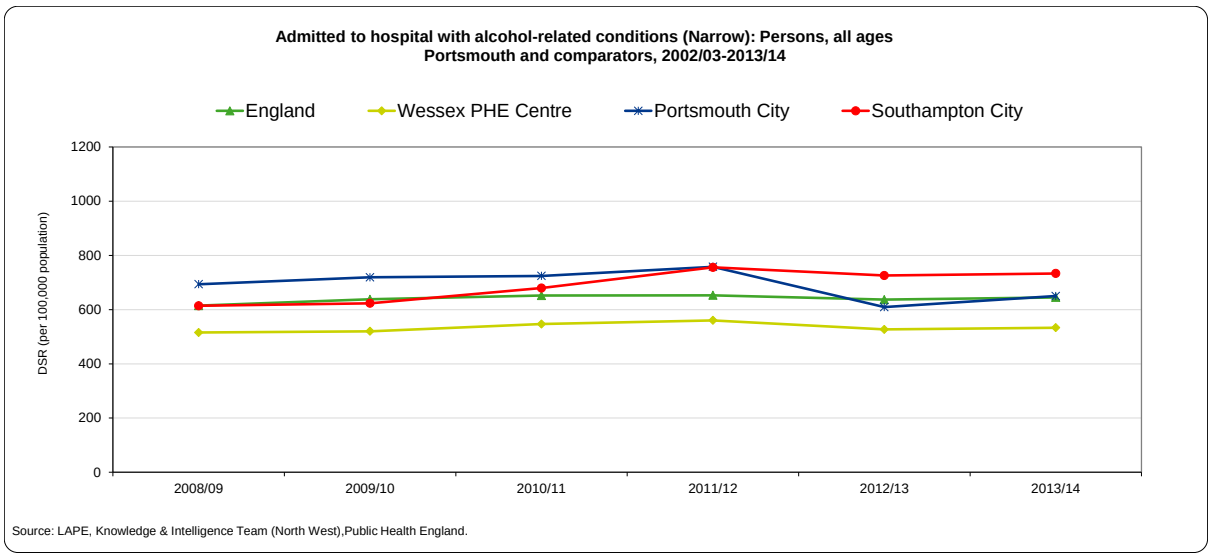
Drinking excessive alcohol adversely affects the wider community (eg compared to England, Portsmouth has significantly higher rates of working-age people claiming benefits due to alcoholism [and has the highest rate of 19 authorities in the South East]) as well as the individual.

There are two measures of alcohol-related hospital admissions - termed 'broad' and 'narrow'. The 'broad' measure provides a more realistic measure of the total burden that alcohol has on community and health services. It looks at admissions where the main diagnosis or any secondary diagnosis was attributable to

alcohol.[17] Using the broad measure, the local rate of alcohol-related hospital admissions has increased slightly but is now no different to the national rate.



The 'narrow' measure of admissions is a better measure than the 'broad' measure when looking at the effectiveness of local actions directly on alcohol. The narrow measure looks at admissions to hospital where the main diagnosis is attributable to alcohol **or** where a secondary diagnosis is an alcohol-related 'external' cause (eg accidents, assault or intentional self-harm). Using the narrow measure, the local rate of alcohol-related hospital admission has also increased slightly but is no different to the England rate.



Portsmouth's hospital admission rates on both broad and narrow measures are higher for males compared to females.

[17] There is a complicated methodology to calculate diagnoses that are 'attributable to alcohol'. This can include for example alcoholic liver disease but also proportions of other conditions such as stroke and takes account of age and gender, For more information see: https://publichealthmatters.blog.gov.uk/2014/01/15/understanding-alcohol-related-hospital-admissions/

The Safer Portsmouth Partnership has lead responsibility for tackling alcohol misuse. Back in 2008 it identified alcohol misuse as a significant driver for violent crime and this continues to be a top priority for the Partnership. The SPP leads a programme to address the priorities identified by detailed analysis in the SPP Strategic Assessment and Plan.[18]

We are currently surveying adults aged 16+ years about their health and lifestyles and will be able to obtain baseline data on the prevalence of adult smoking and drinking excess alcohol once this is completed.

[18] See Safer Portsmouth Partnership website for more information including Strategic Assessment and Plan http://www.saferportsmouth.org.uk/

5.4 Priority 3: Supporting independence

Associated research

Better Care Fund population needs and demand profiling - ongoing

Profiling neighbourhoods to inform the development of the Wellbeing Service

Rapid Participatory Needs Appraisals to inform the development of the Wellbeing Service, and community development

Intelligence to support development of the Carers' Strategy

Adult health and wellbeing survey

3a Develop and implement the Better Care Fund

A single health and social care system will use the Better Care Fund to provide integrated care. Focussing initially on older people, this includes the following schemes: establishing fully integrated locality-based health and social care community teams, reviewing current bed-based provision, and increasing re-ablement services. The key outcome measures for older people are:

Measure	Strategy baseline (year)	Latest England	Latest Portsmouth	Latest Portsmouth compared to England	City trend	City action to match England average
Reduction in total general and acute non-elective hospital admissions	19,635 admissions (2013/14)	N/A	19,635 admissions	N/A	N/A	N/A
Increase in proportion of older people still at home 91 days after discharge from hospital into rehab services	81.8% (2013/14)	82.1%	76.2%	Lower	Worsening	9 more older people still at home after discharge into rehab services

3b Explore and develop Wellbeing Service

Public Health Portsmouth's new Wellbeing Service - where local people can find information, advice and support to help lead healthier lifestyles - is in operation from October 2015. At a population level, the outcome measures will relate to increasing the prevalence of people having a healthy lifestyle - healthy nutrition, healthy weight, not smoking and reducing alcohol misuse - as well as improvements in wider issues affecting wellbeing eg school attendance, skills and getting out of debt.

A key role of the hubs will be to work with communities to identify needs and aspirations. Relevant outcome measures are described under other workstreams but tackling inequalities will necessarily mean improving the health and wellbeing of males of all ages, of Black and Minority Ethnic groups etc. Over time, different hubs are likely to have different outcomes reflecting the needs of their local communities, local assets etc. The main gaps in quantitative lifestyles intelligence will be filled by data from the current health and lifestyle survey of adults. The anonymised results will provide baseline information about current health and lifestyle issues, trend information when compared to the previous surveys in 1999 and 2005, and help us identify areas for direct action by the new Wellbeing Service.

3c Implement the City of Service model of high impact volunteering - Portsmouth Together

High impact volunteering will enable local people and communities to tackle some of the city's key challenges. The workstream itself has its own metrics for performance.

Measure	Strategy baseline (year)	Latest England	Latest Portsmouth	Latest Portsmouth compared to England	City trend	City action to match England average
GCSE attainment - average points scored (See Workstream 1b for GCSE Gold Standard attainment)			337 average point score for mentored students (279 for other Pupil Premium students. 333 for non-Pupil Premium students)			

Measure	Strategy baseline (year)	Latest England	Latest Portsmouth	Latest Portsmouth compared to England	City trend	City action to match England average
Adult numeracy skills (% of working age adults with numeracy skills at Entry Level 3 or below)	47.7%	49.2%	47.7%	Better	N/A	Already better than England
Love Your Street Residents engage in more voluntary activities in their neighbourhood	Data currently being collected by Love Your Street					
Satisfaction with neighbourhood as a place to live	Data currently being collected in local Health and Lifestyle Survey					

5.5 Priority 4: Intervening earlier

Associated research

Better Care Fund population needs and demand profiling - ongoing

Intelligence to support development of the Carers' Strategy

4a Safeguard the welfare of children, young people and adults

Portsmouth's boards for safeguarding children and adults are responsible for scrutinising and challenging safeguarding arrangements. Some outcomes are not quantifiable and some may not be solely influenced by the workstream's actions (eg increases in the number of incidents of harm may be due to increased public awareness and reporting). Outcome measures are reported to the Health and Wellbeing Board by the Safeguarding Boards.

4b Deliver NHS Portsmouth CCG strategic priorities

NHS Portsmouth CCG has four strategic priorities which are reported to the CCG Board. Two outcome measures have been chosen to reflect the priority theme of "Intervening earlier" and will be evidenced in fewer emergency readmissions to hospital and more people being supported to live at home. Although these outcomes focus on older people, CCG priority outcomes which affect other age groups are covered under other workstreams. Both of the selected CCG outcome measures for older people are also some of the Better Care Fund outcomes.

Measure	Strategy baseline (year)	Latest England	Latest Portsmouth	Latest Portsmouth compared to England	City trend	City action to match England average
Reduction in emergency re-admissions to hospital within 30 days	12.2% (2013/14)	11.8%	12.2%	Higher	Improving	N/A
Older adults with long term support needs met by admission to residential and nursing care homes	736.3 per 100,000 population (2014/15)	668.8 per 100,000 population	736.3 per 100,000 population (2014/15)	Higher	Change to indicator in 2014/15	20 fewer admissions

4c Improve the quality of dementia services and care

Dementia continues to be a national and local priority. Key aims of the workstream are to increase the proportion of people identified with dementia and provide the right support at the right time. The key outcome measure is, by March 2015, to increase the diagnosis rate to 80% of the population predicted to have dementia.

Measure	Strategy baseline (year)	Latest England	Latest Portsmouth	Latest Portsmouth compared to England	City trend	City action to match England average
Increasing diagnosis rate for people with dementia (% recorded dementia per registered patients of all ages)	0.68% (2012/13)	0.6%	0.66%	Significantly higher	Decreasing	Already higher than England

5.6 Priority 5: Reduce inequality

Associated local research:

- Rapid Participatory Needs Appraisals to inform the development of the Wellbeing Service, and community development
- Tackling poverty needs assessment and strategy
- Solent Local Economic Partnership strategies and plans
- Health needs of homeless people

a Implement 'Tackling Poverty Strategy'

For overall deprivation, Portsmouth is now ranked 63rd worst of 326 local authorities (where one is the most deprived, previously ranked 76th worst of 326 local authorities).

The Tackling Poverty Needs Assessment was refreshed in January 2015 in the light of the recession and changes in the welfare system. The needs assessment identifies the multiple factors which adversely and positively affect poverty including educational outcomes, employment and low-pay employment, financial exclusion and debt and the way services are organised to respond to people in crisis. [19] The Tackling Poverty Strategy sets out its own direct and indirect outcome measures.[20]

The Joint Health and Wellbeing Strategy baseline outcome measures look at poverty experienced by children, working-age adults and older people.

Measure	Strategy baseline (year)	Latest England	Latest Portsmouth	Latest Portsmouth compared to England	City trend	City action to match England average
Indices of Multiple Deprivation	76th worst of 326 local authorities (2010)	N/A	63rd worst of 326 local authorities		Comparatively worse in ranking	
Children aged 0-19 yrs in low income households	22.3% 9,335 children (2012)	18.0%	21.4% 9,035 children	Higher	Improving	1,416 fewer children

[19] Portsmouth City Council, 2015. Tackling poverty needs assessment. http://data.hampshirehub.net/data/jsna/portsmouth-jsna/social-and-environmental-context/poverty-and-deprivation/tackling-poverty-needs-assessment Accessed 26 October 2015

[20] Portsmouth City Council, 2015. Tackling poverty strategy. http://data.hampshirehub.net/data/tackling-poverty-strategy-2015-2020 Accessed 26 October 2015

Measure	Strategy baseline (year)	Latest England	Latest Portsmouth	Latest Portsmouth compared to England	City trend	City action to match England average
Index of Multiple Deprivation - Older People	18.1% IMD 2010	15.8%	19.0%	Worse	Now 63rd highest of 152 LAs	

5b Tackle health-related barriers to accessing and sustaining employment

'Creating fair employment and good work for all' is one of the six policy objectives in the Marmot Review into reducing health inequalities.

Measure	Strategy baseline (year)	Latest England	Latest Portsmouth	Latest Portsmouth compared to England	City trend	City action to match England average
Gap in employment between those in contact with secondary mental health services and the overall employment rate (% point difference)	68.1% (2012/13)	64.7%	69.1%	Higher	Worsening	N/A
Employment rate of people with a learning disability known to Adult Social Care	9.6%	6.0%	8.0%	Higher	Worsening	Already better than England
Young people aged 16-18 yrs not in education, training or employment	460 young people 7.7% of 16-18 yr olds known to PCC (2014)	4.67% of 16-18 yr olds known to all LAs	313 young people ie 6.8% of 16-18 yr olds known to PCC	Higher	Improving	91 fewer NEET young people Aim is for no young person to be NEET

Portsmouth's unemployment rate is typically lower than that of England but within the city there are inequalities with higher rates in the most deprived areas. Improving levels of educational attainment, tackling youth unemployment, increasing employment opportunities, tackling low pay and reducing inequalities in employment xperienced by adults with mental health problems and by people with a learning disability are part of the Tackling Poverty Strategy. The aim is to make Portsmouth a city where no young person is NEET.

5c Address issues raised in the Public Health Annual Report

This workstream picks up issues raised by the Director of Public Health's statutory Annual Report. The 2012 Report focused on men's health[21] and recommended that improving men's health should be a specific strategic aim for the Health and Wellbeing Board as well as for all city-wide strategic decisions.

In terms of contribution to reducing the gap in male life expectancy in the most and least deprived areas of Portsmouth tackling 'other cancers', 'other external causes' (such as accidents or falls), lung cancer, chronic obstructive airways disease, coronary heart disease and chronic cirrhosis of the liver will have greatest impact. The common lifestyle factors behind these causes of mortality are high rates of smoking and drinking alcohol to excess. Baseline outcome measures will be obtained from the Health and Lifestyle Survey.

[21] Portsmouth City Council, NHS Portsmouth CCG. Public Health Annual Report 2012: The health of men in Portsmouth. http://www.hants.gov.uk/pccjsna/API_STR_JSNA_POP_PublicHealthAnnualReport2012.pdf

5.7 Impact of selected Strategy outcomes

Even to achieve the current England average, each year the Portsmouth needs:

90 more pregnant women to stop smoking	Continue to provide a good Early Foundation Year education to pre-schoolers	**22** fewer Year R children to be overweight or obese
24 fewer Year 6 children to be overweight or obese	**1 additional day** attended at school per enrolment	**65** more pupils achieving Key Stage 2 Level 4+in reading, writing, maths
46 more pupils achieving 5 GCSE A* to C grades including English and maths	**91** more young people in education, training or employment	**1,416** fewer children living in poverty
3,640 fewer adults binge drinking	**4,870** fewer adults smoking	**20** fewer older people to be permanently admitted to nursing or residential care homes

6 Research required to develop and implement the Joint Health and Wellbeing Strategy

Workstream 2a Create sustainable healthy environments

At first, this workstream is focusing on active travel but we need to understand more about how Portsmouth's built environment (housing, planning, open spaces) can promote health and wellbeing. Understanding and then embedding health impact assessments into key decisions will be a key part of this intelligence.

The evidence for how to promote and sustain good mental and physical health and wellbeing will underpin the new Portsmouth Plan.

Workstream 2b Improve mental health and wellbeing

The Mental Health Alliance is identifying topics for further research from current known local population needs and comparing current client experiences and practice to the 'Closing the gap' priorities. The Alliance's remit will necessarily cover some of the needs relating to children and young people (working with the relevant Children's Trust sub-group on Workstream 1c 'Understand more about emotional wellbeing of children/young people'), transition from young people's to adults services, needs of adult clients and needs of carers. Environmental settings for good mental health cover workplaces and homes as well as the city's built environment.

A major research focus is likely to be child and adolescent mental health including the most effective ways to support parents and foster parents/carers.

Workstream 3a Develop the Wellbeing Service to meet local needs

The concept of lifestyle hubs is evolving and the involvement of communities in identifying and addressing local need is exciting. Research is likely to focus on (not exclusive list):

- Most effective means of promoting and increasing self-help at a population level
- Effective models of community engagement
- Best way to evaluate lifestyle hubs.

The Health and Lifestyle Survey of adults will inform actions for a range of workstreams.

Additionally, partners will need to be able to collate, analyse, interpret and share qualitative and quantitative intelligence for and about local communities.

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Local Health Profiles, 2015

Portsmouth rank compared to the most similar* eleven English unitary authorities or metropolitan districts to Portsmouth in the 2011 ONS Business and Education Centre group

*Note: most similar = by Squared Euclidean Distance (SED) value (via ONS), which includes Plymouth.

Indicator - Rank	Year	Liverpool	Hull	Salford	Newcastle	Sheffield	Coventry	Leeds	Plymouth	Bristol	Southampton	**Portsmouth**	Brighton and Hove	Compared to England: Portsmouth statistical significance compared to England (based on indicator value)
Deprivation	2013	1	2	3	4	5	6	7	8	9	10	**11**	12	
% children in poverty (under 16s)	2012	1	2	4	3	6	5	10	11	7	9	**8**	12	
Statutory homelessness	2013/14	12	5	8	10	4	2	11	7	6	9	**1**	3	
GCSE achieved (5A*-C inc. Eng & Maths) (ǂ)	2013/14	3	1	2	12	10	7	5	8	11	6	**4**	9	
Violent crime (violence offences)	2013/14	7	1	11	9	12	6	10	2	5	3	**4**	8	
Long term unemployment	2014	2	1	7	5	3	6	4	10	8	11	**9**	12	
Smoking status at time of delivery	2013/14	2	1	6	3	7	9	8	11	10	4	**5**	12	
Breastfeeding initiation	2013/14	2	4	3	6	No data	10	9	7	11	8	**5**	12	
Obese children (Year 6)	2013/14	1	7	4	2	8	5	9	11	10	3	**6**	12	
Alcohol-specific hospital stays (under 18) (ǂ)	2011/12 - 13/14	6	5	1	8	12	7	11	4	10	2	**9**	3	
Under 18 conceptions	2013	4	3	6	9	8	1	5	7	10	2	**12**	11	
Smoking Prevalence	2013	6	1	5	4	12	10	8	3	11	9	**7**	2	
Percentage of physically active adults	2014	1	7	2	8	9	5	12	3	11	4	**10**	6	
Obese adults	2012	4	1	2	10	7	3	11	8	9	5	**6**	12	
Excess Weight adults	2012	1	6	3	5	8	11	4	7	9	2	**10**	12	
Incidence of malignant melanoma (ǂ)	2010-12	6	12	9	10	7	11	8	2	5	3	**1**	4	
Hospital stays for self-harm	2013/14	11	5	1	8	12	7	9	10	6	3	**4**	2	
Hospital stays for alcohol related harm (ǂ)	2013/14	5	2	1	3	8	4	12	9	6	7	**10**	11	
Prevalence of opiate and/or crack use	2011/12	3	1	11	6	5	12	8	4	2	10	**7**	9	
Recorded diabetes	2013/14	5	1	4	7	3	2	8	6	11	10	**9**	12	
Incidence of TB (ǂ)	2011-13	9	11	7	5	4	1	6	12	2	3	**8**	10	
New STI (excl Chlamydia aged under 25)	2014	8	7	11	5	12	3	6	2	4	9	**10**	1	
Hip fractures in people aged 65 and over	2013/14	6	7	1	8	10	4	11	9	2	3	**5**	12	
Excess winter deaths (three year)	Aug 2010 - Jul 2013	6	9	12	8	11	7	4	5	10	2	**1**	3	
Life expectancy at birth (Male)	2011 - 13	1	2	2	4	11	4	10	4	4	4	**4**	11	
Life expectancy at birth (Female)	2011 - 13	2	3	1	4	7	7	5	7	11	10	**6**	12	
Infant Mortality	2011-13	4	8	7	6	5	1	9	2	10	11	**12**	3	
Smoking related deaths	2011-13	2	1	3	4	10	12	5	7	11	8	**6**	9	
Suicide rate	2011-13	10	3	11	6	12	8	9	5	7	2	**4**	1	
Under 75 mortality rate: cardiovascular	2011-13	2	4	1	5	8	9	7	11	10	6	**3**	12	
Under 75 mortality rate: cancer	2011-13	1	2	3	4	9	10	6	5	11	8	**7**	12	
Killed and seriously injured on roads	2011-13	5	4	11	10	9	7	6	12	8	3	**1**	2	

Local authorities in ONS Business and Centres Group ranked in descending order of deprivation

Four worst rank

Five to 8th rank

Four best rank

Key

Significantly worse

No different

Significantly better

(ǂ) Indicator has had methodological changes so is not directly comparable with previously released values.

Local Health Profiles, 2015

Portsmouth value compared to the most similar* eleven English unitary authorities or metropolitan districts to Portsmouth in the 2011 ONS Business Centre group

*Note: most similar = by Squared Euclidean Distance (SED) value (via ONS), which includes Plymouth.

Indicator - Value	Value type	Year	Liverpool	Hull	Salford	Newcastle	Sheffield	Coventry	Leeds	Plymouth	Bristol	Southampton	**Portsmouth**	Brighton and Hove	Compared to England: Portsmouth statistical significance compared to England (based on indicator value)
Deprivation	%	2013	64.4	51.8	47.2	37.6	34.9	32.8	28.7	26.3	26.0	24.9	**23.8**	22.0	
% children in poverty (under 16s)	%	2012	32.0	31.5	26.8	27.4	23.7	23.9	21.6	20.9	23.6	23.5	**23.5**	17.7	
Statutory homelessness	rate/1,000	2013/14	0.7	3.1	2.2	1.4	3.4	4.2	1.0	2.5	2.6	1.7	**5.3**	4.1	
GCSE achieved (5A*-C inc. Eng & Maths) (ǂ)	%	2013/14	49.9	45.1	47.3	57.3	53.9	52.6	51.0	53.1	55.2	51.0	**50.8**	53.6	
Violent crime (violence offences)	rate/1,000	2013/14	12.5	19.4	9.9	10.9	7.6	12.6	10.3	19.0	16.0	18.9	**18.4**	11.8	
Long term unemployment	rate/1,000	2014	14.6	23.5	8.9	10.1	11.4	9.0	11.2	5.7	6.9	4.5	**6.7**	4.4	
Smoking status at time of delivery	%	2013/14	17.0	21.6	15.1	16.6	13.8	13.0	13.2	11.3	12.7	16.4	**15.4**	6.3	
Breastfeeding initiation	%	2013/14	53.2	62.1	61.9	67.7	0.0	75.9	74.8	71.5	82.2	74.5	**66.1**	87.8	
Obese children (Year 6)	%	2013/14	23.7	20.3	21.4	23.0	19.5	21.2	19.3	18.1	19.3	21.8	**20.3**	13.3	
Alcohol-specific hospital stays (under 18) (ǂ)	rate/100,000	2011/12 - 13/14	48.6	51.0	87.3	41.5	17.0	45.5	34.7	57.5	35.5	87.1	**37.6**	63.1	
Under 18 conceptions	rate/1,000	2013	34.1	35.9	30.4	26.8	27.9	39.5	31.6	28.9	25.7	36.2	**24.8**	25.0	
Smoking Prevalence	%	2013	22.9	29.4	22.9	23.7	17.6	18.5	21.6	24.5	18.2	21.5	**22.3**	25.2	
Percentage of physically active adults	%	2014	47.6	57.4	50.5	59.0	59.7	55.4	63.8	50.9	61.3	54.8	**61.1**	56.2	
Obese adults	%	2012	25.9	28.4	27.0	21.6	24.9	26.2	19.5	24.7	23.8	25.1	**25.1**	12.8	
Excess Weight adults	%	2012	67.2	60.2	63.3	60.3	59.9	56.5	62.2	60.0	59.1	64.8	**57.9**	49.2	
Incidence of malignant melanoma (ǂ)	DSR/ 100,000	2010-12	19.6	13.2	15.9	15.7	18.7	14.8	16.2	26.5	19.6	22.9	**26.5**	22.5	
Hospital stays for self-harm	DSR/ 100,000	2013/14	190.3	308.4	390.8	229.7	177.9	284.5	223.5	199.8	286.0	355.0	**332.3**	355.2	
Hospital stays for alcohol related harm (ǂ)	DSR/ 100,000	2013/14	809.3	876.7	954.3	846.6	718.2	809.9	638.8	664.9	774.5	733.3	**650.0**	645.0	
Prevalence of opiate and/or crack use	rate/ 100,000	2011/12	16.5	18.5	9.8	11.4	11.5	9.2	10.7	12.1	18.0	9.9	**10.9**	10.4	
Recorded diabetes	%	2013/14	5.9	6.2	6.0	5.6	6.1	6.2	5.5	5.6	4.8	5.4	**5.4**	4.1	
Incidence of TB (ǂ)	rate/ 100,000	2011-13	9.3	8.4	11.1	14.4	16.7	36.3	13.8	6.3	20.6	18.1	**9.5**	8.5	
New STI (excl Chlamydia aged under 25)	rate/ 100,000	2014	959.9	971.5	865.2	978.3	645.0	995.7	978.1	1062.4	988.6	899.2	**875.4**	1534.3	
Hip fractures in people aged 65 and over	DSR/ 100,000	2013/14	647.3	646.1	770.5	639.3	588.7	648.0	561.0	589.3	656.3	654.5	**647.4**	560.4	
Excess winter deaths (three year)	%	Aug 2010 - Jul 2013	17.8	15.2	7.4	15.9	13.6	17.8	18.6	18.5	14.6	19.1	**26.0**	18.9	
Life expectancy at birth (Male)	Years	2011 - 13	76.2	76.6	76.6	78.2	78.8	78.2	78.3	78.2	78.2	78.2	**78.2**	78.8	
Life expectancy at birth (Female)	Years	2011 - 13	80.5	80.7	80.4	81.8	82.4	82.4	82.1	82.4	82.8	82.7	**82.2**	83.1	
Infant Mortality	rate/1,000	2011-13	4.2	3.6	3.9	4.1	4.2	4.7	3.4	4.7	3.3	2.6	**2.0**	4.5	
Smoking related deaths	DSR/ 100,000	2011-13	448.3	462.4	415.0	371.0	320.0	293.2	368.4	334.0	304.9	329.2	**341.0**	323.7	
Suicide rate	DSR/100,000	2011-13	9.5	11.7	9.2	10.2	8.5	10.0	9.8	11.3	10.0	12.1	**11.6**	12.9	
Under 75 mortality rate: cardiovascular	DSR/100,000	2011-13	108.8	102.8	115.9	96.9	89.6	88.9	91.1	85.1	88.8	93.8	**105.0**	71.0	
Under 75 mortality rate: cancer	DSR/100,000	2011-13	195.2	192.2	190.3	173.6	159.9	159.9	163.5	164.4	156.9	159.9	**161.8**	155.2	
Killed and seriously injured on roads	rate/100,000	2011-13	45.6	47.7	29.2	29.3	30.6	36.9	39.3	25.7	31.7	53.9	**61.6**	57.7	

Local authorities in ONS Business Centre Group ranked in descending order of deprivation

Four worst rank

Five to 8th rank

Four best rank

Key

Significantly worse

No different

Significantly better

(ǂ) Indicator has had methodological changes so is not directly comparable with previously released values.

Workstreams	Measure	Portsmouth Strategy baseline (Yr)	Latest England	Latest Portsmouth	Latest Portsmouth compared to England	City trend	Yearly city action to match England average	Locality values			Actions or issues			Specific issues	Source
								North	Central	South	North	Central	South		
ority	Increasing life expectancy for males	78.2 yrs (2010/12)	79.5 yrs	78.2 yrs	Significantly shorter than England	Static		79.8 yrs	76.5 yrs	78.3 yrs				Males in most deprived 10% of LSOAs live 9.5 yrs fewer than males in least deprived	ONS. 2012/14
	Increasing life expectancy for females	82.6 yrs (2010/12)	83.2 yrs	82.2 yrs	Significantly shorter than England	Static		83.3 yrs	80.6 yrs	82.5 yrs				Females in most deprived 10% of LSOAs live 6.0 yrs fewer than females in least deprived.	
ildren and young people the best start(*)															
	Smoking in pregnancy (% of women giving birth who have smoked throughout pregnancy)	15.4 (2013/14)	11.4%	14.7%	Significantly higher	Improving	90 fewer women smoking during pregnancy				Not yet available at locality level			Teenage mothers have higher rates of smoking during pregnancy	HSCIC. 2014/15
	Breastfeeding within 48 hrs of baby's birth	66.1% (2013/14)	74.3%	74.6%	Higher	Improving	Need to maintain high level				Not available at locality level			Lower rates for mothers from lower socio-economic status groups	HSCIC. For CCG localities. 2014/15
	Breastfeeding at 6-8 weeks (% of women breastfeeding at the time of the baby's 6-8 week check)	38.9% (2013/14)	43.8%	38.9%	Cannot compare - different methodologies	No change	Need to improve 6-8 wk rate. Baseline to be set				Not available at locality level			Lower rates for mothers from lower socio-economic status groups	HSCIC. For CCG localities. 2014/15
1a Improve outcomes for the pre-birth to 5 years age group	Early Years Foundation Stage: Meeting at least Expected Level in Communication and language - overall	75% (2013)	77%	79%	Higher	Improving	Achievement continues to be higher than England average - need to maintain level	79.6%	78.3%	81.4%	Achievement above England average - need to maintain level				
	Boys	67% (2013)	71%	73%	Higher	Improving	Achievement continues to be higher than England average - need to maintain level	72.3%	73.4%	76.1%	Achievement above England average - need to maintain level				
	Girls	82% (2013)	83%	85%	Higher	Improving	Achievement continues to be higher than England average - need to maintain level	87.6%	84.1%	86.2%	Achievement above England average - need to maintain level				
	Early Years Foundation Stage: Meeting at least Expected Level in Personal, social, emotional development - overall	80% (2013)	81%	83%	Higher	Improving	Achievement continues to be higher than England average - need to maintain level	83.2%	81.9%	86.5%	Achievement above England average - need to maintain level			Gender differences - boys have lower outcomes than girls	DfE Statistical First Release. 2014
	Boys	73% (2013)	75%	78%	Higher	Improving	Achievement continues to be higher than England average - need to maintain level	76.9%	76.8%	82.1%	Achievement above England average - need to maintain level				
	Girls	87% (2013)	87%	89%	Higher	Imnproving	Achievement continues to be higher than England average - need to maintain level	90.1%	88.1%	90.5%	Achievement above England average - need to maintain level				
1b Support delivery of 'Effective Learning for every Pupil Strategy'	Pupil absence (average days lost per enrolment)	8 days (2012/13)	8 days lost per enrolment	9 days lost per enrolment	Higher	Worsening	1 day gained per enrolment				Not yet available at locality level			Enrolment relates to a pupil as a pupil can be enroled more than once if moves between schools or are dually registered. 1,215 persistent absentees	DfE Statistical First Release, academic year 2013/14
	Reading - % pupils making at least expected levels of progress between Key Stage 1 and Key Stage 2	82% (2013)	91%	88%	Lower	Improving	47 more pupils making at least expected progress	87.6%	85.1%	94.2%	24 more pupils to match England average	36 more pupils to match England average	Achievement above England average - need to maintain level		
	Writing - % pupils making at least expected levels of progress between Key Stage 1 and Key Stage 2	88% (2013)	93%	92%	Lower	Improving	26 more pupils making at least expected progress	91.7%	90.5%	92.4%	9 more pupils to match England average	16 more pupils to match England average	2 more pupils to match England average		DfE Statistical First Release and Education Information Services GIS Analysis
	Maths - % pupils making at least expected levels of progress between Key Stage 1 and Key Stage 2	84% (2013)	90%	87%	Lower	Improved 2009-2014 (although remained same 2012-2013)	57 more pupils making at least expected progress	86.8%	85.4%	88.4%	23 more pupils to match England average	28 more pupils to match England average	6 more pupils to match England average		
	KS 2 results (Level 4+ in Reading/Writing/Maths) - overall	69.8% (2013)	79%	75%	Lower	Improving	65 more pupils achieving Level 4+ Reading/Writing/Maths	77.2%	70.8%	78.3%	13 more pupils to match England average	52 more pupils to match England average	3 more pupils to match England average		
	Boys	66% (2013)	76%	71%	Lower	Improving	42 more boys achieving Level 4+ Reading/Writing/Maths	73.2%	67.1%	73.7%	10 more boys to match England average	29 more boys to match England average	5 more boys to match England average	Gender differences - boys have lower outcomes than girls	DfE Statistical First Release and Education Information Services GIS Analysis
	Girls	74% (2013)	82%	79%	Lower	Improving	23 more girls achieving Level 4+ Reading/Writing/Maths	81.6%	74.7%	82.9%	2 more girls to match England average	23 more girls to match England average	Achievement similar to England average - need to maintain level		
	English - % pupils making at least expected levels of progress between Key Stage 2 and Key Stage 4	Change to indicator in 2014	72%	65%	Lower	Change to indicator in 2014	110 more pupils making at least expected progress	64.4%	61.5%	73.8%	51 more pupils to match England average	62 more pupils to match England average	Achievement above England average - need to maintain level		
	Maths - % pupils making at least expected levels of progress between Key Stage 2 and Key Stage 4	Change to indicator in 2014	66%	60%	Lower	Change to indicator in 2014	104 more pupils making at least expected progress	67.1%	53.7%	55.5%	Achievement above England average - need to maintain level	73 more pupils to match England average	38 more pupils to match England average		DfE Statistical First Release
	5 GCSE A* to C grades incl English and Maths - all pupils	Change to indicator in 2014	53.4%	50.8%	Lower	Change to indicator in 2014	46 more pupils achieving 5+ A*-C including English and Maths	54.0%	46.8%	52.3%	Achievement above England average - need to maintain level	42 more pupils to match England average	4 more pupils to match England average		
	Boys	Change to indicator in 2014	48.2%	47.5%	Lower	Change to indicator in 2014	7 more boys achieving 5+ A*-C including English and Maths	49.2%	44.6%	50.8%	Achievement above England average - need to maintain level	11 more boys to match England average	Achievement above England average - need to maintain level	Gender differences - boys have lower outcomes than girls (however Portsmouth boys are closer to boys nationally than Portsmouth girls are to girls nationally)	DfE Statistical First Release and Education Information Services GIS Analysis
	Girls	Change to indicator in 2014	58.9%	54.3%	Lower	Change to indicator in 2014	41 more girls achieving 5+ A*-C including English and Maths	59.5%	48.8%	53.7%	Achievement above England average - need to maintain level	33 more girls to match England average	11 more girls to match England average		
1c Understand more about emotional	Outcome measures to be determined within Mental Health Strategy (Workstream 2b)										Measures to be determined by Mental Health Alliance				
ing prevention															
	Walking and cycling becoming the travel 'norm' for short trips										Data not yet available. University of Portsmouth study planned				

Workstreams	Measure	Portsmouth Strategy baseline (Yr)	Latest England	Latest Portsmouth	Latest Portsmouth compared to England	City trend	Yearly city action to match England average	North	Central	South	North	Central	South	Specific issues	Source
2a Create sustainable healthy communities	Childhood obesity - Year R (% resident children who are overweight including obese)	23.9% (2010/11-2012/13)	22.4%	23.5%	Higher	Improving	22 fewer children of excess weight	Excess weight proportion 22.9% (23.1%)	Excess weight proportion 26.0% (26.0%)	Excess weight proportion 20.5% (21.7%)	About 4 fewer children of excess weight per year	About 29 fewer children of excess weight	Already below England average - maintain current level		National Child Measurement Programme, Health and Social Care Information Centre. 2011/12 -2013/14. Via National Obesity Observatory ward-level data
	Boys (% resident boys equal to or above 85th centile of UK90 growth reference)	24.1% (2012/13)	23.4%	24.5%		Worsening		26.4%	26.1%	20.1%					National Child Measurement Programme, Health and Social Care Information Centre. 2013/14 NB Data for boys and girls relates to one year
	Girls (% resident girls equal to or above 85th centile of UK90 growth reference)	23.8% (2012/13)	21.6%	22.0%		Improving		22.2%	23.2%	19.2%					
	Childhood obesity - Year 6 (% resident children who are overweight including obese)	35.3% (2010/11-2012/13)	33.6%	35.1%		Improving	24 fewer children of excess weight	Excess weight proportion 33.6% (34.3%)	Excess weight proportion 38% (37.0%)	Excess weight proportion 33.2% (34.6%)	Already at England level	About 25 fewer of excess weight each year	About 1 fewer of excess weight each year		National Child Measurement Programme, Health and Social Care Information Centre. 2011/12 -2013/14. Via National Obesity Observatory ward-level data
	Boys (% resident boys equal to or above 85th centile of UK90 growth reference)	36.7% (2012/13)	35.2%	35.3%		Improving		35%	37.10%	33.00%					National Child Measurement Programme, Health and Social Care Information Centre. 2013/14 NB Data for boys and girls relates to one year
	Girls (% resident girls equal to or above 85th centile of UK90 growth reference)	33.7% (2012/13)	31.7%	32.0%		Improving		32.5	36.70%	25.30%					
2b Improve mental health and wellbeing	Mental Health Alliance outcomes										Measures to be determined by Alliance				
	Prevalence of people diagnosed and recorded since 2006 as having depression in GP Practices (% of registered patients aged 18+ yrs)	5.5% (2012/13)	6.5%	5.7%	Lower	Increasing	Additional 1,514 patients diagnosed with depression	4.7% (4.4%)	5.8% (5.5%)	6.2% (6.3%)	Additional 871 patients diagnosed to match England average prevalence Additional 467 patients diagnosed to match Portsmouth average	Additional 409 patients diagnosed to match England average prevalence 69 fewer patients diagnosed to match the Portsmouth average	Additional 233 patients with recorded depression to match England average 397 fewer patients with recorded depression to match Portsmouth average	Portsmouth prevalence likely to reflect under-diagnosis or under-recording in GP Practices	Health and Social Care Information Centre. QOF. For CCG Localities 2013/14
	People with mental health conditions in settled accommodation (% of adults in contact with secondary mental health services to live in stable and appropriate accommodation)	57.4% (2013/14)	59.7%	57.4%	Lower	Improving	N/A	Not yet available at locality level							ASCOF 1H. PHOF 1.06ii Health and Social Care Information Centre. 2014/15
2c Tackle issues relating to smoking, alcohol and substance misuse	Secondary school pupils report never having tried tobacco	82% (2014)	N/A	78%	N/A	Worsening	N/A	Not yet available at locality level							Portsmouth City Council. Secondary school pupil substance misuse survey, 2015
	Secondary school pupils report having drunk a whole alcoholic drink	53% (2014)	N/A	51%	N/A	Improving	N/A	Not yet available at locality level							
	Adult smoking prevalence	22.5% (2012)	18.4%	22.3%	Significantly higher	Improving	6,397 fewer adults smoking	**Not yet available at locality level**						**Use national survey pending results of local health and lifestyle survey for adults**	**Integrated Household Survey via Tobacco Control Profiles. 2013**
	Adult binge drinking	22.2% (2006-08)	20.0%	22.2%	Higher	N/A	3,636 fewer adults binge drinking	19.0%	22.4%	25.4%	Already below England and city averages	1,035 fewer adults binge drinking to match England average 59 fewer adults binge-drinking adults to match Portsmouth average	3,306 fewer adults binge drinking to match England average 1,941 fewer adults binge-drinking adults to match Portsmouth average	Modelled estimates used pending results of local health and lifestyle survey of adults	Health Survey for England, 2006-08
	Alcohol misuse - broad measure (**) (Hospital admission episodes for alcohol-related conditions per 100,000 population)	2,012 admissions per 100,000 population (2012/13)	2,111 admissions per 100,000 population	2,088 admissions per 100,000 population	No different	Worsening	N/A	Not available at locality level							Local Alcohol Profiles 2015 (data period 2013/14) PHOF 9.01 and 10.01
	Alcohol misuse - narrow measure (**) (Hospital admission episodes for alcohol-related conditions per 100,000 population)	609 admissions per 100,000 population (2012/13)	645 admissions per 100,000 population	650 admissions per 100,000 population	No different	Worsening	N/A	Not available at locality level							
ting independence															
3a Better Care Fund	Reduction in total general and acute non-elective hospital admissions	19,635 admissions (2013/14)	N/A	19,635 admissions	N/A	N/A	N/A	Not yet available at locality level							BCF. Data for 2013/14
	Increase in proportion of older people still at home 91 days after discharge from hospital into rehab services	81.8% (2013/14)	82.1%	76.2%	Lower	Worsening	9 more older people still at home after discharge into rehab services	Not yet available at locality level							ASCOF 2B(i). BCF measure. 2014/15
3b Explore and develop lifestyle hubs	Smoking, drinking measures (see above)														
	GCSE attainment - average points scored (See Workstream 1b for GCSE Gold Standard attainment)	335.9 average point score all pupils (2015)	369.5 average point score all pupils (2015)	337 average point score for Portsmouth Together mentored students (279 for other Pupil Premium students. 333 for non-Pupil Premium students)	Lower									Two schools are currently running the programme and a bid has been submitted to the Education Endowment Fund to significantly increase the project over 3 years.	Portsmouth Together Provisional 2015 KS4 results (Education Team, PCC)
3c Implement the															

Workstreams	Measure	Portsmouth Strategy baseline (Yr)	Latest England	Latest Portsmouth	Latest Portsmouth compared to England	City trend	Yearly city action to match England average	North	Central	South	North	Central	South	Specific issues	Source
new City of Service model of high impact volunteering	Adult numeracy skills (% of working age adults with numeracy skills at Entry Level 3 or below)	47.7%	49.2%	47.7%	Better	N/A	Already better than England	49.5%	53.4%	42.3%	131 more adults obtaining Level 1 and above to meet England average 839 more adults obtaining Level 1 and above to meet Portsmouth average	1,510 more adults obtaining Level 1 and above to meet England average 2,049 more adults obtaining level 1 and above to meet Portsmouth average	Numeracy skills better than England average	Data source not yet updated nationally	Adult Skills Survey 2010 numeracy skills at Entry Level 3 or below - pending measure of outcomes set by participants in the Challenge
	Love Your Street Residents engage in more voluntary activities in their neighbourhood	Data currently being collected in local Health and Lifestyle Survey												Total of £6,500 in grants given to 13 projects. 70 volunteers in 4 projects have contributed 650 volunteer hours with 720 beneficiaries	Portsmouth Together
	Satisfaction with neighbourhood as a place to live		Data currently being collected in												
ning earlier															
4a Safeguard the welfare of children, young people and adults (**)	To be determined by Safeguarding Boards														
4b Deliver CCG strategic priorities (***)	Reduction in emergency re-admissions to hospital within 30 days	12.2% (2013/14)	11.8%	12.2%	Higher	Improving	N/A	Not yet available at locality level							NCHOD. NHSOF 3b. CCGOF 3.2. PHOF 4.11
	Older adults with long term support needs met by admission to residential and nursing care homes	736.3 per 100,000 population (2014/15)	668.8 per 100,000 population	736.3 per 100,000 population (2014/15)	Higher	Change to indicator in 2014/15	20 fewer admissions	Not yet available at locality level						Measure changed 2013/14. New baseline set 2014/15	ASCOF 2A(2). BCF measure. 2014/15
4c Improve the quality of dementia services and care	Increasing diagnosis rate for people with dementia (% recorded dementia per registered patients of all ages)	0.68% (2012/13)	0.6%	0.66%	Significantly higher	Decreasing	Already higher than England	1.0% (0.7%)	1.1% (0.6%)	0.4% (0.7%)	Already higher than England and city rates	Already higher than England and city rates	273 more patients diagnosed to meet England rate. 335 more patients diagnosed to meet city rate	Use this measure until data available to measure diagnosis of expected prevalence	Prevalence of recorded dementia by GP Practices, QOF 2013/14. Health and Social Care Information System
ng inequality															
5a Implement refreshed Tackling Poverty Strategy	Indices of Multiple Deprivation	76th worst of 326 local authorities (2010)	N/A	63rd worst of 326 local authorities		Comparatively worse in ranking		Data to be refined at locality level							Indices of Multiple Deprivation 2015 (data from 2012/13)
	Children aged 0-19 yrs in low income households	22.3% 9,335 children (2012)	18.0%	21.4% 9,035 children	Higher	Improving	1,416 fewer children	17.0% 2,750 children	27.1% 4,090 children	29.8% 2,185 children	Already below England and city levels. Highest rate in Paulsgrove 28.1%, 1,090 children	1,376 fewer children to meet England level. 867 fewer children to meet city level. Highest rate in Charles Dickens 42.7%, 1,765 children	201 fewer children to meet England level. Already better than city level Highest rate in St Thomas 31.9%, 760 children		Children in low income households local measure, 2013. HMRC, 30 September 2015 https://www.gov.uk/government/statistics/personal-tax-credits-children-in-low-income-families-local-measure-2013-snapshot-as-at-31-august-2013
	Index of Multiple Deprivation - Older People	18.1% IMD 2010	15.8%	19.0%	Worse	Now 63rd highest of 152 LAs		14.3%	26.7%	17.8%					Indices of Multiple Deprivation (IDAOPI) 2015 for LSOAs aggregated to ward level
5b Tackle health-related barriers to accesssing and sustaining employment	Reduce long-term unemployment (people claiming for more than 12 months per 1,000 working age population)	6.51 per 1,000 working age population (July 2014)	4.5 per 1,000 working age population	3.7 per 1,000 working age population	Lower	Improving	Already better than England	2.9 per 1,000	5.3 per 1,000	3.4 per 1,000	Already below England and city averages	35 fewer claimants to meet England rate 69 fewer claimants to meet Portsmouth rate	Already below England and city averages		NOMIS JSA Claimants as at July 2015. Hampshire County Council Small Area population forecasts. England mid-yr estimates
	Gap in employment between those in contact with secondary mental health services and the overall employment rate (% point difference)	68.1 (2012/13)	64.7	69.1	Higher	Worsening	N/A	Not available at locality level							PHOF 1.08 iii 2013/14
	Employment rate of people with a learning disability known to Adult Social Care	9.6%	6.0%	8.0%	Higher	Worsening	Already better than England	Not available at locality level							ASCOF 1E. 2014/15
	Young people aged 16-18 yrs not in education, training or employment	460 young people 7.7% of 16-18 yr olds known to PCC (2014)	4.67% of 16-18 yr olds known to all LAs	313 young people ie 6.8% of 16-18 yr olds known to PCC	Higher	Improving	91 fewer NEET young people Aim is for no young person to be NEET	87 young people	140 young people	86 young people	Not available at locality level (unknown population of 16-18 yr olds in each Locality)			Data collected monthly.	NEET per LA, 2014. Dept for Education
5c Address issues identified in "Men's health - Annual Public Health Report, 2012"	Narrowing of gap in life expectancy for males in least/most deprived areas							See overall priority above							

his table are as calculated. Rounded values shown in JSNA Summary text
l to Children's Trust
l to Safer Portsmouth Partnership
d to NHS Portsmouth Clinical Commissioning Group. Althought the measures for the CCG specific Workstream concern adult age groups, CCG priorities concerning children and young people are reflected in other Workstreams

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Portsmouth CITY COUNCIL

Title of meeting:	Health and Wellbeing Board
Date of meeting:	2/12/15
Subject:	Improving Mental Health and Wellbeing in Portsmouth
Report by:	Matt Smith
Wards affected:	All
Key decision:	No
Full Council decision:	No

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1. Purpose of report

The purpose of this report is to inform members of the key strategic priorities to improve mental health and wellbeing in the City over the next five years.

2. Recommendations

That the Board adopts the proposed mental health and wellbeing strategy 2016-2021

3. Summary

This five-year strategy covers all aspects of mental health and wellbeing. It is on purpose aspirational. The 11 Pledges are priorities from across the life course and range from promoting good mental health to ensuring the provision of high quality integrated services for citizens with complex problems.

The strategy was developed by the Mental Health Alliance at the request of the Health and Wellbeing Board. The Mental Health Alliance will oversee the development of the underpinning action plan and its subsequent implementation, reporting regularly to the Health and Wellbeing Board on progress. The action plan, where possible, will build on existing work, which varies by pledge by pledge.

There is no extra funding being provided to implement this strategy. It has been acknowledged throughout the process that this is about transforming the way we do things and these pledges outline the direction of travel we need to take.

The 11 pledges are:

1. We will find ways to share more power around the planning and delivery of services with service users, carers and other interested Portsmouth residents. We call this process co-production.

2. We will commit to ending the stigma and discrimination faced by people around their mental health, by improving awareness and challenging attitudes and behaviour.

3. We will build emotionally resilient communities to reduce the number of people going on to experience mental health problems and we will support early identification for individuals experiencing a mental health problem

4. We will work to create an environment that empowers individuals to make choices that enable recovery as defined by the individual and to live the most independent and fulfilling lives possible.

5. We will create a culture where people using services will be supported and encouraged to improve both their mental and physical health.

6. We will create a culture where all services work together to improve a range of outcomes for children, young people and their families with emotional and mental health needs.

7. We will work together to prevent crises because of a mental health condition happening whenever possible, through intervening at an early stage and we will also improve the system of care and support so that people in crisis are kept safe.

8. We will aim to ensure everyone is able to find information and advice regarding memory problems and dementia, and to receive a diagnosis of dementia, as early as possible.

9. We will ensure that people who experience problematic mental health alongside other conditions including drug and alcohol misuse, learning difficulties and long-term physical health conditions receive help, support, treatment and care that is accessible and effective

10. We will strive to reduce the number of people using self-harming behaviours as a coping strategy by supporting people to improve their resilience. We will also aim to improve the experience and outcome for those who self-harm.

11. We will work to reduce the number of suicides in the city and provide support for those bereaved by suicide.

4. Reasons for recommendations

4.1 The importance of mental health has been recognised by Health and Wellbeing Board members and is a work stream in the Board's Strategy; this is being taken forward by the Mental Health Alliance. Given the breadth of issues that affect good mental health the Alliance identified the need to develop an overarching mental health strategy for the City. This strategy has been aligned to national policy and strategy including the Parity of Esteem agenda, the Chief Medical Officers Annual Report focusing on mental health, the WHO Mental Health Action Plan, the national strategy No Health, Without Mental Health and Closing the Gap.

5. Equality impact assessment (EIA)

5.1 A preliminary EIA has been completed and a full EIA is not required at this stage.

6. Legal implications

6.1 The Health & Wellbeing Board must discharge its Public Sector Equality Duty (PSED) under s.149 of the Equality Act (EA) 2010 when making a decision whether to adopt the proposed mental health and wellbeing strategy 2016-2021. The PSED requires it to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations between people with a 'protected characteristic' (as defined by the EA 2010) and those without it. The protected characteristics are age, gender, disability, gender reassignment, pregnancy & maternity, race, religion or belief and sexual orientation.

6.2 Therefore, before the Health and Wellbeing Board make a decision whether to adopt the proposed strategy, it must consciously consider whether the pledges within the strategy could have a discriminatory effect on the persons it is aimed at. It is important that the Board is provided with sufficient information and analysis of any potential disadvantage to persons with any of the 'protected characteristics'. The Equality and Human Rights Commission in its guidance on discharging PSED, recommends that a written audit trail is kept of how PSED has been considered.

6.3 To this effect, a preliminary Equality Impact Assessment (EIA) has been completed and together with the Strategy provide the following information relevant for the consideration of the PSED by the decision-maker:

- A consultation exercise has been undertaken which sought views and comments from commissioners, providers and users of the services. In addition, a public consultation event was held, stakeholders attended at strategy development and specific pledge meetings and provided their views directly through the pledge leads. Their contributions have been taken into account when developing the strategy.
- The strategy's objectives are aspirational and wide in scope, with a focus on a co-production. This means that professionals and citizens will have an input in the design, resource allocation, service provision and evaluation of public

mental health services. This will assist in identification of any discriminatory impact and any mitigation measures.

- The strategy has been clearly identified as having a positive effect on people with a disability, and more specifically persons with mental health problems.
- The pledges proposed in the strategy are aimed at improving mental health and wellbeing services and are not therefore envisaged to have any indirect discriminatory effect on persons protected under the EA 2010.
- Pledge 2 specifically focuses on tackling discrimination associated with mental health problems and promoting equality and tolerance towards persons with mental health problems and their carers.

6.4 Whilst the preliminary EIA and the strategy itself provide sufficient information to enable the Health and Wellbeing Board to discharge its PSED when adopting the strategy, it must be noted that the PSED is a continuing duty. Therefore, those responsible for implementation of the individual pledges will need to have PSED in mind throughout the process of implementation. This may require completion of individual EIAs to ensure written record is kept.

7. Director of Finance's comments

7.1 As detailed in the main body of the report there are no financial impacts to this decision.

……
Signed by:

Appendices:
Appendix 1 - Mental Health Strategy 2016-2021

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

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

Title of document	Location

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

……
Signed by:

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Portsmouth CITY COUNCIL

Improving Mental Health and Wellbeing in Portsmouth

2016 to 2021

"Good mental health and resilience are fundamental to our physical health, our relationships, our education, our training, our work and to achieving our potential."[1]

Foreword

by Janet Maxwell, Director of Public Health

Dr Janet Maxwell
Director of Public Health

"This strategy has invited views, comment and feedback throughout the process and has adopted a co-production approach to its development. On behalf of the Mental Health Strategy Group I would like to thank everyone who has given their time and energy to support the direction and production of this strategy, whether that has been through the consultation event, attendance at the meetings or directly to the Pledge leads. We have welcomed this contribution and have incorporated this into the final document. Where you have commented, we have listened. Without the valuable insight of those who experience mental health problems and those who care for these we would not be in the position we are today to offer this truly joined-up and pragmatic approach to improving the mental health and wellbeing of the citizens of Portsmouth.

Mental health is something that affects us all - how we think and feel about ourselves and others, how we cope with difficult situations and how we manage our lives. In Public Health we understand how widespread mental health problems are – from someone experiencing a period of depression due to a personal hardship, to an individual living with long-term psychosis. This is why improving mental health outcomes for local people remains one of our top priorities.

Stigma and discrimination often means that mental health problems are not openly talked about. However, illnesses linked to mental health account for a third of GP consultations, and research shows mental health issues are closely associated with poorer outcomes for employment, personal relationships and physical health.

We know that improving life experiences of people with mental health issues is not something that can be managed in isolation. Instead, we must work with other health and social care agencies, the voluntary sector, patients, carers and the public, to look at services needed to enable people to live stable and happier lives, where they feel supported and in control of their own mental health and recovery.

This means ensuring that mental health becomes a part of everyday conversation and is something that everybody is aware of and cares about. Whether it is a midwife supporting a mother through the birth of a child, a school nurse helping children to develop emotional literacy, or a member of our new integrated community health and social care teams. It also means making sure we remain focused on quality, safety and patient choice, sharing decisions between service users and clinicians so that people receive the responsive care they need, in the right place, at the right time."

1. Department of Health. 2011. No health without mental health. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213761/dh_124058.pdf p5

Scope and governance

This five-year strategy covers all aspects of mental health and wellbeing. It is on purpose aspirational. The 11 Pledges are priorities from across the life course and range from promoting good mental health to ensuring the provision of high quality integrated services for citizens with complex problems.

The strategy was developed by the Mental Health Alliance at the request of the Health and Wellbeing Board (Appendix A contains further details of the development process). The Mental Health Alliance will oversee the development of the underpinning action plan and its subsequent implementation, reporting regularly to the Health and Wellbeing Board on progress. The action plan, where possible, will build on existing work, which varies pledge by pledge.

These are hard times. People are making difficult decisions. There is no extra funding being provided to implement this strategy. It has been acknowledged throughout the process that this is about transforming the way we do things and these Pledges outline the direction of travel we need to take.

There is a real commitment to share power between all citizens and professionals in the delivery of this strategy. We realise there is still a long way to go to achieve this and co-production, which underpins all the other Pledges, is also a Pledge in its own right.

Local context

Portsmouth is a large vibrant city on the south coast. In 2015 the total population is estimated to be about 211,500 with 219,000 registered with GP practices. We are highly urbanised with 52 people per hectare, making us the most densely-populated local authority outside London.

The age profile of the city's population is typical of university cities - 16% of Portsmouth's population is aged 18 to 24 years compared to just 9% nationally. Portsmouth is a diverse city. In 2011, 16% of residents were of an ethnic group other than White British compared to 20% nationally. Younger residents have a different ethnic profile with 29% of school-age children being of non-White British ethnicity.

Overall, Portsmouth is ranked 63rd of 326 English local authorities (where 1 is the most deprived). About 26,000 Portsmouth residents live within the 10% most deprived English small areas (or Lower Super Output Areas). The city has comparatively high levels of risk factors for mental ill health such as children living in poverty, teenage conceptions, children who are carers, low educational attainment and low income[2]. Detailed information on mental health issues in the city can be found in the Joint Strategic Needs Assessment.

http://data.hampshirehub.net/def/concept/folders/themes/jsna/portsmouth-jsna/burden-of-ill-health-and-disability/mental-health.

People and organisations planning and delivering health and care services in Portsmouth are developing a blueprint for health and care in Portsmouth. The model aims to join up prevention and wellbeing services, services for people with long-term conditions, and mental health and learning disabilities services amongst others. The Portsmouth Blueprint aims to bring together existing local work and will be shaped by the implementation of this strategy.

Co-production has been the theme when developing the Pledges for this strategy. Each Pledge has had its own specific development group involving the key stakeholders.

On the 24 September 2015 a public engagement event was held to ascertain the views of Portsmouth citizens. Each Pledge was laid out and each Pledge lead was present to answer any questions and receive verbal feedback. In addition, everyone was given the opportunity to express their view anonymously by giving written feedback. Views was also sought and invited from a variety of individuals and organisations. This has been incorporated into the final Pledges.

2. Public Health England. Children's and young people's mental health and wellbeing profiles. http://fingertips.phe.org.uk/profile-group/mental-health/profile/cypmh/data#gid/1938132752/pat/6/ati/102/page/0/par/E12000008/are/E06000044 and Common mental health disorders profiles http://fingertips.phe.org.uk/profile-group/mental-health/profile/common-mental-disorders/data#gid/8000041/pat/43/ati/102/page/0/par/X25004AD/are/E06000028 Accessed 15 May 2015

our 11 pledges

1. We will find ways to share more power around the planning and delivery of services with service users, carers and other interested Portsmouth residents. We call this process co-production.
2. We will commit to ending the stigma and discrimination faced by people around their mental health, by improving awareness and challenging attitudes and behaviour.
3. We will build emotionally-resilient communities to reduce the number of people going on to experience mental health problems and we will support early identification for individuals experiencing a mental health problem.
4. We will work to create an environment that empowers individuals to make choices that enable recovery as defined by the individual and to live the most independent and fulfilling lives possible.
5. We will create a culture where people using services will be supported and encouraged to improve both their mental and physical health.
6. We will create a culture where all services work together to improve a range of outcomes for children, young people and their families with emotional and mental health needs.
7. We will work together to prevent crises because of a mental health condition happening whenever possible, through intervening at an early stage and we will also improve the system of care and support so that people in crisis are kept safe.
8. We will aim to ensure everyone is able to find information and advice regarding memory problems and dementia, and to receive a diagnosis of dementia, as early as possible.
9. We will ensure that people who experience problematic mental health alongside other conditions including drug and alcohol misuse, learning difficulties and long-term physical health conditions receive help, support, treatment and care that is accessible and effective.
10. We will strive to reduce the number of people using self-harming behaviours as a coping strategy by supporting people to improve their resilience. We will also aim to improve the experience and outcome for those who self-harm.
11. We will work to reduce the number of suicides in the city and provide support for those bereaved by suicide.

pledge 1

We will find ways to share more power around the planning and delivery of services with service users, carers and other interested Portsmouth residents. We call this process co-production.

Context

The term co-production has been around since the 1970s and has more recently become a new way of describing the power-sharing that occurs as the result of working in partnership with people using services, carers, families and citizens.

In co-production, professionals and citizens share power in the planning and delivery of public services. This involves making use of each other's assets, resources and contributions to achieve better outcomes and/or improved efficiency. This power- sharing occurs at each and every stage of commissioning and service delivery:

- Co-design, including planning of services
- Co-decision making in the allocation of resources
- Co-delivery of services, including the role of volunteers in providing the service
- Co-evaluation of the service

Done well, co-production can lead to:

- Better services, meeting the needs of local residents
- The breakdown of barriers between people who use services and professionals
- The recognition and development of people's existing capabilities and skills

Actions

- We will develop and promote a shared understanding of meaningful and effective co-production
- We will work to embed co-production at every stage of commissioning and delivery of services that impact on the mental health and wellbeing of Portsmouth residents
- We will co-produce a framework for evaluating projects in terms of how closely they match the principles and values of co-production

Outcomes

- Improved services around mental health in Portsmouth, meeting the needs of Portsmouth residents more closely
- The degree of co-production involved in the development of new projects around the provision of mental health services in Portsmouth will be clear
- Portsmouth residents who get involved in co-production will report a positive experience
- There will be a positive impact on the wider community of Portsmouth

pledge 2

We will commit to ending the stigma and discrimination faced by people around their mental health, by improving awareness and challenging attitudes and behaviour.

Context

There is a huge social stigma attached to mental health, and people with mental health challenges can experience discrimination in all aspects of their lives.

National research shows nearly nine out of ten people with mental health challenges said that stigma and discrimination have a negative effect on their lives.

Time to Change is England's biggest programme to challenge mental health stigma and discrimination. Since Time to Change (www.time-to-change.org.uk) began in 2007, public attitudes towards mental health have improved. However, there is still more work to be done to end life-limiting stigma and discrimination. For example:

- A third of people would be unwilling to share a house with someone with a mental health problem
- Only 28% of people agree that women who were once patients on a mental health ward can be trusted as babysitters
- Nearly half of people said they would feel uncomfortable talking to an employer about their mental health
- A recent (2015) service user-led investigation showed that 68% of people had experienced stigma and discrimination from staff members whilst on inpatient wards across the country

Actions

- Portsmouth City Council will sign up to the Time to Change Pledge and commit to an action plan for reducing stigma and discrimination
- We will work with employers and education providers to raise awareness and challenge stigma and discrimination
- We will work with public and voluntary organisations across Portsmouth to ensure that people can access services without fear of discrimination

Outcomes

- People report less stigma and discrimination around mental health in Portsmouth
- People feel empowered to share their lived experiences around mental health and to challenge attitudes throughout their local community
- Other local organisations sign up to Time to Change

pledge 3

We will build emotionally resilient communities to reduce the number of people going on to experience mental health problems and we will support early identification for individuals experiencing a mental health problem.

Context

Mental health problems are common. In the population of Portsmouth that equates to around 52,879 people experiencing a mental health problem each year with half of all adult mental health problems present by the time the person is 14 years old.

By promoting wellbeing and building emotionally resilient communities we can reduce the number of people going on to experience a mental health problem. In addition, supporting early identification and intervention we can reduce the impact for individuals experiencing a mental health problem.

Actions

- Lobby to put and keep emotional health and wellbeing at the top of people's agendas
- Promote positive mental health through schools, further education, workplaces and communities
- Provide support, information and training to promote strategies to create individual and community emotional resilience and wellbeing
- Support businesses to be healthy workplaces
- Work to address the known factors which lead to poor mental health in the population
- Ensure mental health is at the forefront of service design, redesign and delivery
- Share what works and support others to take action

Outcomes

Fewer people will develop mental health problems. We will see this through:

- Increased school attendance and academic progress
- Businesses reporting fewer work days lost to sickness
- Increased self-reporting of positive mental wellbeing within the population of Portsmouth

pledge 4

We will work to create an environment that empowers individuals to make choices that enable recovery as defined by the individual and to live the most independent and fulfilling lives possible.

Context

National directives included in 'the NHS 5-year forward view' No Health without Mental Health, together with local ambitions to transform mental health services, have the aim of progressing from a medically-dominated model to one based on recovery principles incorporating individualised care packages, peer support, self-care and promoting wellbeing. Peer-led models of recovery support are a demonstrably effective way of enabling people to manage their wellbeing and achieve more fulfilling lives.

In Portsmouth we are developing an independent model of peer recovery support and have increased the role of the voluntary sector within the mental health recovery system. Over the next 3-5 years we aim to further develop personalised options for mental health treatment and support.

Actions

- To instil a more recovery-focused approach within in-patient and residential placements and beyond
- To continue to develop Peer Support across Portsmouth
- Work with voluntary and statutory providers, people who access services, and carers to develop options for personalised care and support packages including direct payments where appropriate

Outcomes

- More people sustaining recovery and supported to live as independently as possible
- Increased choice of care and support
- People who want peer support will be able to access group or individual support at all points in their recovery journey
- People with mental health problems will live better for longer

pledge 5

We will create a culture where people using services will be supported and encouraged to improve both their mental and physical health.

Context

"When unwell my family, carers and I will have access to services which enable us to maintain our mental and physical health. Staff will work with us to identify all our needs and everybody involved in ensuring our wellbeing listens and supports us, and actively collaborates to ensure our care feels like one package."

- Services tend to view physical and mental health treatment in separate silos
- People with poor physical health are at higher risk of experiencing mental health problems. For example, 27% of diabetics, 29% of people with hypertension, 31% of people with stroke, 33% of people with cancer and 44% of people with HIV or AIDS have depression. It is estimated that treating people with long term conditions that have co-existing mental health problems costs the NHS in the region of £8-13 billion
- People with poor mental health are more likely to have poor physical health. For example, life expectancy is reduced by 7 to 10 years in people with depression, 10 to 15 years in people with schizophrenia and 15 years for people with substance misuse and alcohol problems

Actions

- We will provide holistic assessments that identify the outcomes important for the individual
- Residents and carers will only have to tell their story once
- Providers will work with community groups, organisations and individuals to develop ways of keeping people well and providing help, which go beyond statutory health and social care provision
- Patients, carers and professionals will have the information needed to access the right care at the right time
- Seamless, person-centred care will be provided by integrated teams

To achieve these ambitions we will work with users and services to develop a shared, system-wide action plan.

Outcomes

- The number of patients and carers satisfied with the care they receive increases
- Life expectancy will increase in people with mental health disorders
- Rates of smoking and incidences of being overweight will decrease in people with mental health disorders
- The number of people with a mental health disorder having a physical health check increases
- The incidence of people with diagnosable mental illness is increased in people with long-term conditions
- Reduction in primary care prescribing of mood-stabilising and anti-psychotic medication
- Increases in the number of people using personal health and social care budgets

pledge 6

We will create a culture where all services work together to improve a range of outcomes for children, young people and their families with emotional and mental health needs.

Context

What does this mean for children, young people, parents and carers?

- An emphasis on helping the client, their child or young person to stay well and to have access to support when they need it, that joins up around them and delivers in places they find acceptable
- Choices made with the client about support or treatment based on the best evidence available
- Services and plans that listen to and take account of what the client says

Future in Mind is a five-year strategy to transform children's mental health and wellbeing provision, so that by 2020 England could lead the world in improving outcomes for children and young people with mental health problems.

The case for change:

- 9.6% or nearly 850,000 children and young people aged between 5-16 years have a mental disorder
- UK annual costs of mental illness during childhood and adolescence vary between £11,030 and £59,130 per child
- Mental illness during childhood has longer term economic impacts across the life course

Actions

- We will act early to prevent harm, by investing in the early years, supporting families/carers, and building resilience through to adulthood
- We will change how care is delivered and build it around the needs of children and young people and families to ensure easy access to the right support from the right service at the right time
- We will dismantle barriers and reach out to children and young people in need, regardless of their social and emotional needs or disability
- We will drive improvements in delivery of care and standards of performance to get best outcomes for children, young people and families/carers and value from investment
- We will develop a workforce that is ambitious, excellent in their practice, able to deliver the best evidenced care, committed to partnership and integrated working

Outcomes

- Improved crisis care - right place, right time, close to home
- A better offer of care for the most vulnerable children and young people
- Improved public awareness, less fear, stigma and discrimination
- Timely access to clinically-effective support
- More evidence-based outcomes-focused treatments
- More visible and accessible support
- Professionals who work with children and young people trained in child development and mental health
- Model built around the needs of children and young people
- Improved access for parents to evidence-based programmes of intervention and support

pledge 7

We will work together to prevent crises because of a mental health condition happening whenever possible, through intervening at an early stage and we will also improve the system of care and support so that people in crisis are kept safe

We will make sure we meet the needs of vulnerable people in urgent situations, getting the right care at the right time from the right people to make sure of the best outcomes.

We will do our very best to make sure that all relevant public services, contractors and independent sector partners support people with a mental health problem to help them achieve and maintain sustained recovery.

Context

The NHS Mandate for 2014/15 sets out a number of objectives for the NHS to improve mental health crisis care, which are as follows:

- NHS England to make rapid progress, working with clinical commissioning groups and other commissioners, to ensure delivery of crisis services that are at all times as accessible, responsive and high quality as other health emergency services
- NHS England to ensure there are adequate liaison psychiatry services in emergency departments
- Every community to have plans to ensure that no-one in crisis will be turned away, based on the principles set out in the Concordat.

Actions

- Develop our local plans to ensure that no-one in a mental health crisis is turned away and that the information on the services and support available is easily available
- Explore how standardised crisis plans could be used across all relevant services including peer support and mutual-aid groups
- Ensure partners in housing, carers groups and substance misuse have the skills, knowledge and confidence to promote mental health wellbeing and resilience and use crisis, wellbeing and advance-care planning as appropriate
- Develop an enhanced Psychiatric Liaison that meets the needs of those that need it at Queen Alexandra Hospital

Outcomes

- Improved information and access to support for people experiencing mental health crisis in Portsmouth
- More people in Portsmouth have crisis plans which are shared with support partners in order to be better prepared for the future
- Improved service-user experience and care outcomes
- Reduced emergency department waiting times for people with mental illness, and enhanced knowledge and skills of staff in Queen Alexandria Hospital

pledge 8

We will aim to ensure everyone is able to find information and advice regarding memory problems and dementia, and to receive a diagnosis of dementia, as early as possible.

Portsmouth aspires to be a dementia-friendly city where people with dementia will be treated with respect and feel included in their local communities. The aim is to ensure everyone is able to find information and advice regarding memory problems and dementia easily and quickly, and to receive a diagnosis of dementia as early as possible. This will enable people greater choice and control over their care, enabling individuals to remain independent in their own home for longer and minimising the crises that have previously resulted in lengthy acute hospital stays or admission to long-term care.

Context

Dementia care is a key national and local priority, forming part of the Prime Minister's call to action with associated national targets for diagnosis rates. It is cited as a priority in the CCG 20/20 vision and forms part of the priorities for the health and well-being board.

Portsmouth Clinical Commissioning Group initiated a number of Dementia pilots across the city between 2013 and 2014, namely Dementia Advisors service, Memory Cafes, a Dementia Voice Nurse and Reablement Workers. The Clinical Commissioning Group also commissioned an independent review by the University of East London, to provide an evidence base to ensure a better understanding of how dementia services were experienced across the city. The review took place during 2014/15 and outlined a number of recommendations, including reducing duplication, clarity of roles and a seamless post-diagnostic support service embedded into a single dementia support pathway. The chosen model has encompassed all the recommendations from the review alongside some of the learning from the pilots as they have continued to evolve.

The service objectives are:

- Proactively accompany (where wanted) people living with dementia over the course of their illness, enabling them and their carers to access support provision appropriate to need
- Maximise access to good quality, accurate information about diagnosis and local services
- Empower people to access and use services that support them to live well and effectively within the community, this including end-of-life support
- Develop networks of support that provide the opportunity for people to meet together with others in a similar situation and experience meaningful cognitive stimulation
- Provide the opportunity for service users and carers to meet with other community partners and contribute to service development
- Contribute to sustaining and improving Portsmouth Dementia diagnosis rates
- Enable Portsmouth to become a Dementia-Friendly Community

Actions

Recurrent funding has been agreed by the Clinical Commissioning Group, and an outcomes-based service specification has been developed in partnership with all interested Voluntary Community Sector providers via two workshop sessions. The aim is for one Voluntary Community Sector provider to act as the lead provider, with the responsibility to co-ordinate the dementia services, which include a dementia voice nurse (providing end-of-life support), dementia workers (these workers will be named workers offering support and advice as required by the service user and their carer), activity/ cafe sessions, and a dementia-friendly co-ordinator who will lead on creating a dementia-friendly city, and pull together the Portsmouth Dementia Action Alliance. This approach has been chosen to maximise the collective views and expertise of service users, their carers and the pilot organisations.

The service is currently out to tender with an expected start date of 1 January 2016. Focus groups will be used to enable service users and their carers to participate in the evaluation of the bids received, alongside full involvement with naming the service, the titles for the support workers and the wording and design of the supporting literature for the service.

Outcomes

- People with Dementia will be supported during their Dementia journey
- Carers of People with Dementia will be supported
- Portsmouth will become a Dementia-Friendly Community

pledge 9

We will ensure that people who experience problematic mental health alongside other conditions including drug and alcohol misuse, learning difficulties and long-term physical health conditions receive help, support, treatment and care that is accessible and effective.

Context

Nationally and locally people who experience mental health problems alongside drug or alcohol problems, homelessness or other long-term needs have experienced difficulty accessing services that are able to meet their needs. In Portsmouth specialist mental health and substance misuse services have pledged to work together to support each other in order to ensure that anyone accessing their services receives appropriate support for their drug, alcohol and mental health needs whichever service they start with.

Actions

- Ensure staff are trained and supported to recognise complex needs and have good contact between services to support each other in meeting these needs
- Develop a joint-agency complex needs delivery group to coordinate support for people whose needs are too complex for individual services to manage
- Support provision of a mental health specialist in the drug and alcohol service, and substance misuse specialist support within mental health teams
- Extend support and training to other relevant services such as Police and accommodation services to enable them to effectively support people with complex needs to access help and support

Outcomes

- Improved access to appropriate supported accommodation for people with dual diagnosis
- People with complex needs (dual diagnosis) will be supported to maintain recovery in Portsmouth
- Reduced rates of premature death, suicide and self-harm amongst people with complex needs in Portsmouth

pledge 10

We will strive to reduce the number of people using self-harming behaviours as a coping strategy by supporting people to improve their resilience. We will aim to improve the experience and outcome for those who self-harm.

Context

Self-harm is when somebody damages or injures their body. It is a way of coping with or expressing overwhelming emotional distress.

Self-harm is more common than many people realise, especially among younger people. It's estimated around 10% of young people self-harm at some point, but people of all ages do. This figure is also likely to be an underestimate, as not everyone seeks help or recognises their behaviour as self-harm.

Emergency hospital admissions for self-harm in Portsmouth is significantly higher than that of the England average. In 2013, 287.7 per 100,000 population hospital stays were reported in Portsmouth compared with the England average of 188 per 100,000 population.

The majority of people who self-harm do not require hospital admission. People self-harm in many different ways and although people who self-harm are at greater risk of suicide than those who don't, self-harm is about coping and staying alive.

Actions

- Promote mental wellbeing and positive coping strategies
- Provide support, information and training to help individuals and organisations recognise self-harming behaviours and support those affected
- Ensure those who require treatment receive the correct understanding, care and treatment

Outcomes

- Fewer people will self-harm as a coping strategy
- Fewer people will be admitted to hospital as a consequence of self-harm
- People's experience when presenting with self-harm is one of respect and understanding

pledge 11

We will work to reduce the number of suicides in the city and provide support for those bereaved by suicide.

Context

Suicide is used in this document to mean a deliberate act that intentionally ends one's life.

Suicide is often the end point of a complex history of risk factors and distressing events.

Suicide is a major issue for society and a leading cause of years of life lost. Suicides are not inevitable. There are many ways in which services, communities, individuals and society as a whole can help to prevent suicides

About 23 people, about 83% males, take their own lives by suicide each year in Portsmouth. This is slightly higher as a rate than the England average

Actions

Taking a lead from Preventing Suicide in England, A Cross-government Outcomes Strategy to Save Lives 2012, we will aim to:

- Reduce the risk of suicide in key high-risk groups
- Tailor approaches to improve mental health in specific groups
- Reduce access to the means of suicide
- Provide better information and support to those bereaved or affected by suicide
- Support the media in delivering sensitive approaches to suicide and suicidal behaviour
- Support research, data collection and monitoring

Outcomes

- Fewer deaths by suicides will happen in Portsmouth

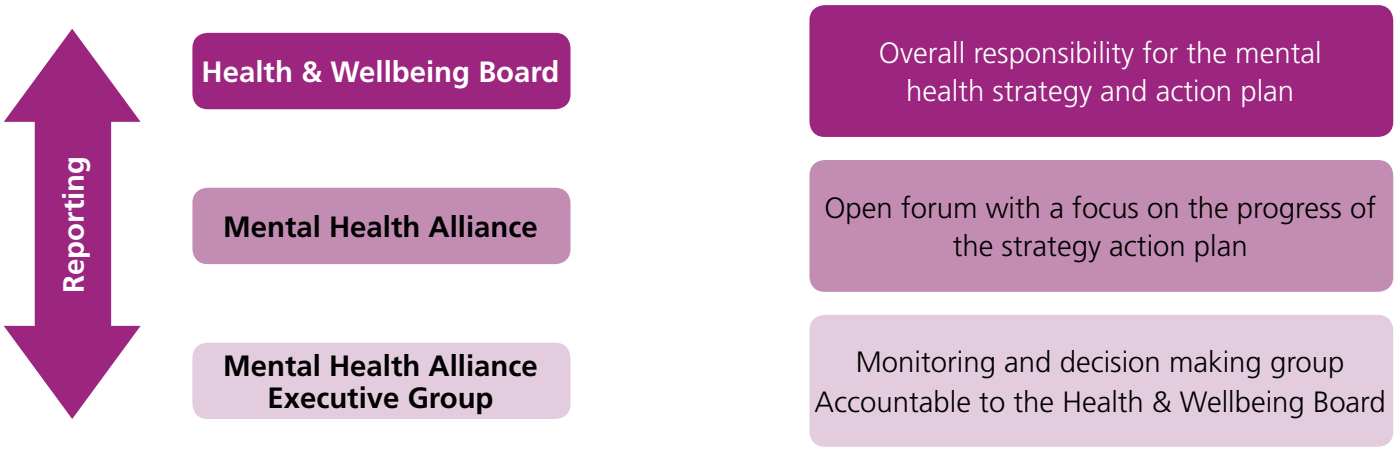
Appendix

Portsmouth Mental Health Alliance

The Mental Health Alliance for Portsmouth was established in the summer of 2014. The Alliance was formed to bring together all the stakeholders within Portsmouth to create a uniformed approach to improving the mental health of the citizens and people working in the City.

Through the work of the Mental Health Alliance this strategy was produced. The subsequent action plan will form an integral element of this strategy.

This work will ultimately be overseen by the Health & Wellbeing Board who will receive regular progress reports directly from the Mental Health Alliance executive group. This group is responsible for the monitoring of the action plan and reviewing the strategy. It will report to both the Health & Wellbeing Board and the Mental Health Alliance. The Mental Health Alliance is an open forum for the continuing co-production and development of the strategy and action plan.



Strategy development timeline, key dates

	2014		2015						2016		
Mental health Alliance	Launch event 5 June	10 Oct			3 July		20 Oct				Apr
Strategy Development Group			12 Mar	28 May	27 Jul	14 Sep	14 Oct	16 Dec	21 Jan	16 Mar	1 Apr Strategy action plan
Health & Wellbeing Board								2 Dec			
Public engagement event						24 Sep					
Individual pledge group meetings				May to September							

The membership of the Mental Health Alliance will comprise of, but not restricted to:

- Director of Public Health (Chair)
- Elected member
- Public involvement
- Voluntary and Community Sector representatives
- Chair of the Recovery Alliance
- Portsmouth Hospitals NHS Trust
- Solent NHS Trust
- Portsmouth Clinical Commissioning Group (CCG)
- Portsmouth University
- Healthwatch Portsmouth
- Portsmouth business representatives
- School representatives
- Strategy pledge leads
- Police service
- Ambulance service
- Carers Centre

The MHA executive board membership consists of:

- Director of Public Health
- Elected Member - TBC
- Voluntary and Community Sector Rep
- Chair of the Recovery Alliance
- Portsmouth Hospitals NHS Trust
- Solent NHS Trust
- Portsmouth Clinical Commissioning Group.
- Strategy pledge leads (in attendance)

The Mental Health Alliance Strategy Group:

- Stuart McDowell (Portsmouth City Council, Integrated Commissioning Unit)
- Barry Dickinson (Portsmouth City Council, Integrated Commissioning Unit)
- Matthew Smith (Consultant, Public Health Portsmouth)
- Lee Loveless (Public Health Portsmouth)
- Anne Fleming (Solent NHS Trust)
- Donald Robertson (Portsmouth City Council, Integrated Commissioning Unit)
- Kerry Pearson (Portsmouth City Council, Integrated Commissioning Unit)
- Joanna Kerr (Public Health Portsmouth)
- Thyagarajan Iravindranath. (Solent NHS Trust)
- Matthew Gummerson (Portsmouth City Council, Strategy Unit)
- James Gagliardini (Portsmouth City Council, Integrated Commissioning Unit)
- Dapo Alalade (Portsmouth Clinical Commissioning Unit)
- Emma Fernandes (Solent mind)
- Rachael Roberts (Portsmouth City Council, Social Care)
- Stephanie Murray (Portsmouth Clinical Commissioning Unit)
- Matthew Hall (Solent NHS Trust)
- Rebecca Stanley (Portsmouth City Council
- Victoria Rennie (Portsmouth City Council, Integrated Commissioning Unit)
- Danny Sullivan (Portsmouth City Council, Integrated Commissioning Unit)
- SHIFT members (Self Help Inspiring Forward Thinking)
- Nikodimova Slavena (Solent mind)
- Fiona McNeight (Portsmouth Hospital Trust)
- Kate Freeman (Portsmouth City Council)

Pledge Leads

Pledge		Lead
1	We will find ways to share more power around the planning and delivery of services with service users, carers and other interested Portsmouth residents. We call this process co-production	Don Robertson - Co-production Donald.Robertson@portsmouthcc.gov.uk
2	We will commit to ending the stigma and discrimination faced by people around their mental health, by improving awareness and challenging attitudes and behaviour	Don Robertson - Ending stigma and discrimination Donald.Robertson@portsmouthcc.gov.uk
3	We will build emotionally resilient communities to reduce the number of people going on to experience mental health problems and we will support early identification for individuals experiencing a mental health problem	Lee Loveless - Promoting wellbeing/prevention lee.loveless@portsmouthcc.gov.uk
4	We will work to create an environment that empowers individuals to make choices that enable recovery as defined by the individual and to live the most independent and fulfilling lives possible	Barry Dickenson - Recovery and individualised care Barry.Dickinson@portsmouthcc.gov.uk
5	We will create a culture where people using services will be supported and encouraged to improve both their mental and physical health	Matt Smith - Parity of esteem Matthew.Smith@portsmouthcc.gov.uk
6	We will create a culture where all services work together to improve a range of outcomes for children, young people and their families with emotional and mental health needs	Anne Fleming - Children, young people and families anne.fleming@solent.nhs.uk
7	We will work together to prevent crises because of a mental health condition happening whenever possible, through intervening at an early stage and we will also improve the system of care and support so that people in crisis are kept safe	Stuart McDowell - Crisis Care Stuart.McDowell@portsmouthcc.gov.uk
8	We will work to ensure everyone is able to find information and advice regarding memory problems and dementia easily and quickly, and to receive a diagnosis of dementia as early as possible	Kerry Pearson - Dementia Kerry.Pearson@portsmouthcc.gov.uk

Pledge		Lead
9	We will ensure that people who experience problematic mental health alongside other conditions including drug and alcohol misuse, learning difficulties and long-term physical health conditions receive help, support, treatment and care that is accessible and effective	Julie Lyne - Complex needs (dual diagnosis) julie.lyne@solent.nhs.uk
10	We will strive to reduce the number of people using self-harming behaviours as a coping strategy by supporting people to improve their resilience. We will also aim to improve the experience and outcome for those who self-harm	Lee Loveless - Self-harming lee.loveless@portsmouthcc.gov.uk
11	We will work to reduce the number of suicides in the city and provide support for those bereaved by suicide	Lee Loveless - Reducing suicide lee.loveless@portsmouthcc.gov.uk

For more information on the overall strategy please contact:

Matthew Smith, Public Health Consultant
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For specific information on any of the Pledges, please contact the Pledge lead directly.

You can get this information in large print, Braille, audio or in another language by calling 023 9284 1193

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Portsmouth CITY COUNCIL

Agenda item:

Title of meeting:	Health and Wellbeing Board
Date of meeting:	2nd December 2015
Subject:	Progress of the Wellbeing service
Report by:	Director of Public Health
Wards affected:	All

---

1. Requested by Health and Wellbeing Board

2. Purpose

2.1 To update the Health and Wellbeing Board on:
a. progress of the new integrated wellbeing service
b. the role and strategic priorities of the Wellbeing service within the wider health and social care system

3. Background Information

3.1 The implementation of this Wellbeing service, as part of the 2014 - 2017 Health and Wellbeing Strategy as well as the prevention work stream for the Better Care programme (BCF) has been successfully launched on **1st October 2015.**

3.2 The new service helps and supports residents with the key lifestyle issues that contribute to significant health risks like smoking, alcohol misuse, poor diet and lack of exercise as well as support around mental and emotional wellbeing on a holistic and client centred approach.

3.3 The service also works with local communities to increase their self-help and self-reliance using an empowering approach.

4. Progress of the new wellbeing service

4.1 The transition of work and handover of clients from previous providers, Pompey Quit, Solutions4health, the Health trainers and the redeployment of the alcohol service has been relatively smooth with no negative feedback from stakeholders

4.2 We had a soft launch on 1st October to manage capacity and to better understand the needs for the service in order to shape the service.

4.3 In Spring 2016, the service will be officially launched using the local version of the Public Health England national branding.

4.4 Majority of staff are now in post with a Service Manager, 4 Practice Leads and 28 (26fte) wellbeing staff in North, Central, South localities focusing on deprived neighbourhoods and a mobile team covering hospitals, Jobcentre Plus and probation. We have 18 new starters. One administrative apprentice has been in post for 2 months and 3 Health and wellbeing apprentices are starting end of November 2015.

4.5 Surgeries are being held in GP practices, community centres and libraries.

4.6 A total of 419 referrals have been made to the service from 1st October 2015 to 13th November 2015. 223 are from GPs (53%), 81 from self (19%) and the rest from other referrals. As on 17th November, out of 180 active cases, 90 are for smoking cessation, 59 for Healthy Weight and 31 for alcohol support.

4.7 Through triage process, clients are offered appropriate type of support including receiving support elsewhere. There are 180 clients are supported in the Wellbeing service during the above period.

4.8 The service has a budget of £657,461 till 31st March 2016, of which £223,138 was transferred from the internal Alcohol Interventions Service. We had spent- £33,246 on capital costs and £141,648 staff salaries so far. The balance is £482,567.

4.91 Stage 1 of the training development programme consists of in house and external training (provided by North 51 and YMCA). Each worker has a core training package that meets their individual needs so that they can be signed off as competent in each of the three areas (Smoking. Alcohol, Healthy Weight).

4.9.2 Stage 2 is a staff skill audit, assessed through the supervision and Personal Development Review (PDR) process and training packages will be created that support the service and their individual development.

4.9.3 We are collecting baseline data and developing an evaluation plan in the next few months. We will review the service in 6 months time.

5 Role and strategic priorities for the Wellbeing Service

Portsmouth Integrated Services:

Community Development

Promoting healthy communities, safe neighbourhoods and healthy lifestyles

The Wellbeing Service sits in the Living Well hub and has close links with Better Start and Ageing Well hubs and is underpinned by Community Development work.

5.1 The key priorities for the next phase of the Wellbeing service are:

a. Clear articulation of the role of the service in the Prevention agenda for Better care programme including Pre-diabetes and other long term conditions, Health Checks etc within the health and social care system;
b. Aligning with other integrated teams and workstreams: Multidisciplinary Area Teams (MAT), Better Care Programme, including Independence and Wellbeing Team (IWT), Community Development, and Integrated Personal Commissioning (IPC);
c. Embedding the community assets and social action approach in the service;
d. Robust quality assurance for the service;
e. Working out a strategy for the Service as part of the Portsmouth Blue Print

6. Key risks and issues

6.1 The service was established on 1st October and time is needed to embed the service. It is necessary to phase the development of medium and long term aspirations due to current capacity.

6.2 We are using the corporate policies and procedures and there is a need to develop bespoke procedures and further training for the service.

6.3 Our preferred IT system, System One is in the process of being established. Using an interim IT system, PharmOutcomes and a separate case management system means impact on capacity due to training and data migration.

Summary
The Wellbeing Service launched successfully from 1st October 2015 with a straightforward transition from existing services. We are working to ensure a quality, safe and effective service is provided to improve the health and wellbeing of Portsmouth residents and reduce the health inequalities.

Recommendations:

- The Board is asked to note the progress of the Wellbeing Service to date.
- The Board is to note the role and strategic placement of the Wellbeing Service within the Health and Social Care system

……
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

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:	2nd December 2015
Report by:	Director of Integrated Commissioning Service
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.

3.2 It is estimated that 679,000 people in England are living with dementia aged 65 or over. Portsmouth's dementia population is estimated to be 2181 with an estimated rise to 3119 by 2030[1].

3.3 Work stream 4c of the Portsmouth Joint Health and Wellbeing Strategy 2014-17[2] 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 15/16 Portsmouth Dementia Action Plan.

[1] POPPI data. Projecting Older people population information system
[2] 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

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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 Minister's 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 within domain two, 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)

Cognitive Function and Ageing Study (CFAS II) calculator provides a more accurate and relevant rate and takes into account the different practice deprivation indices and rates in BME populations.
NHS England is using the CFAS II for planning and monitoring progress going forward for 15/16 and 16/17. They are sending out, via email, the latest data to CCG's until the tool is available online.

5.2 Up to October 2015, the CFAS II provided a diagnosis rate of 70.3% (1410 people) of the local predicted prevalence had a diagnosis, against a local target of 72.4% (1458 people). This ranked Portsmouth 2rd within the Wessex region. See table A below:

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Table A shows dementia diagnosis rates within Wessex area (Provided by Public Health England)

CCG Name	Diagnosis Rate E.A.S.1 CFAS II (aged 65+) October 2015	Diagnosis Rate E.A.S.1 CFAS II (aged 65+) September 2015	Dementia Diagnoses (aged 65+) October 2015	Dementia Diagnoses (aged 65+) September 2015	Dementia Diagnoses (all ages) October 2015
NHS DORSET CCG	61.6%	61.1%	7922	7856	8101
NHS FAREHAM AND GOSPORT CCG	61.1%	61.6%	1678	1692	1722
NHS ISLE OF WIGHT CCG	68.6%	69.7%	1684	1710	1736
NHS NORTH EAST HAMPSHIRE AND FARNHAM CCG	66.3%	65.8%	1522	1509	1553
NHS NORTH HAMPSHIRE CCG	68.1%	68.0%	1595	1593	1630
NHS PORTSMOUTH CCG	**70.3%**	**68.5%**	**1410**	**1374**	**1458**
NHS SOUTH EASTERN HAMPSHIRE CCG	65.8%	66.0%	2078	2087	2136
NHS SOUTHAMPTON CCG	71.1%	71.4%	1603	1610	1649
NHS WEST HAMPSHIRE CCG	59.7%	59.5%	5026	5011	5150

5.3 NHS England has a national ambition that 67% [3]of the estimated number of people with dementia will have a diagnosis and access to post diagnostic support by March 2015.

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). It is expected that this target will be achieved in the next couple of months.

5.7 All bar four GP practices within Portsmouth have signed up to the 2015/16 Dementia Directed Enhanced Service.

6. Achievements June 2015 to November 2015

6.1 The Dementia Steering Group (DSG), which replaced the Dementia Action Group, has been in place since July 2015. Terms of reference were agreed and the membership updated to ensure links with key providers of services are maintained and developed further. These include Solent NHS Trust as provider of the Older Peoples Mental Health Services (OPMH), Portsmouth Hospital Trust, Portsmouth

[3] https://www.england.nhs.uk/wp-content/uploads/2013/12/5yr-strat-plann-guid-wa.pdf

Public Health and linkages with the wider mental health strategy and third sector organisations, along with Adult Social Care and primary care representation.
Updates and linkages between the work of this group and the wider transformation work for OPMH will ensure joint development and understanding of the wider strategic programmes of work being undertaken across the city. The main purpose of the DSG is to monitor and update the Dementia Action Plan in accordance with national and local developments.

6.3 The transformation programme of the OPMH services provided by Solent NHS Trust is a key programme of work requiring clear communication to ensure the direction of travel and joint thinking to steer sustainable services for the future for this vulnerable cohort. The group unanimously agreed the need to rationalise the number of inpatient beds whilst increasing capacity within the community team to wrap support around the patient. This will enable working towards an 'all age' service based on patient need providing the right support to enable them to stay within the community maintaining independence for as long as is appropriate. This programme of work is due to be completed by the end of this financial year, with the revised model in place February / March.

6.4 The British Legion have approached the Integrated Commissioning Service to announce they have secured charitable funding for 5 years to support a full time Admiral nurse post for the city. This post will support either veterans with Dementia or veterans who are carers of someone with Dementia. This programme of work will commence once the team which will also work across Hampshire has been fully recruited to. It is hoped this is likely in the spring of 2016. This work will be closely linked in with the new third sector Dementia pathway which is due to roll out in January 2016.

7 Review of achievements against the 15/16 dementia action plan

7.1 Pilot schemes during 15/16 - The current pilot schemes running across the city provided by Alzheimer's society, Solent Mind and Housing 21 are due to complete on 31st December.
A handover will take place between Alzheimer's Society and the successful bidders of the Community Pathway tender between Octobers to December mobilisation period.

7.2 The Community Dementia Pathway tender has been completed and the successful group of bidders were Solent Mind, The Rowans Hospice and Social Care in Action Group. We have now entered the mobilisation period and the new service will commence on 1st January 2016. Work is underway to ensure continuity of service for people with dementia and their carers during the transition period.

7.3 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. A virtual training tool is being trialled by L&D for use in care homes.

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7.4 As of September 2015 the number of trained Dementia Friends Champions was 117. The number of Dementia Friends who watched the video on the DF website and registered their details was 2727. The number of Dementia Friends who attended an Information Session run by a Champion whose address is registered in Portsmouth was - 6676.

7.5 A link to the latest version of the Portsmouth Dementia Action plan is available here: Dementia Action Plan 13 August 2015 v8

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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Portsmouth CITY COUNCIL

THIS ITEM IS FOR INFORMATION ONLY

Title of meeting:	Health and Wellbeing Board
Subject:	Public Health Annual Report 2014/15
Date of meeting:	(Deferred from) 16th September 2015
Report by:	Dr Janet Maxwell
Wards affected:	All

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1. Requested by

1.1 Dr Janet Maxwell, Director of Public Health

2. Purpose

2.1 To present Portsmouth's Director of Public Health's Annual Report 2014/15.

3. Information Requested

3.1 The Director of Public Health has a statutory duty to produce an annual report and present this to the council. The 2014/15 Annual Report is attached as appendix A to this report and will be formally received at the Cabinet Member for Health and Social Care's decision meeting on 24th September.

3.2 The Annual Report is also a workstream in the Joint Health and Wellbeing Strategy (JHWS). This year's report brings together the findings and discussions following the series of seminars held during the Autumn of 2014 and which have previously been presented to the HWB under the workstream 'creating sustainable, healthy environments'. It provides a summary of the important links between health and wellbeing and the wide-ranging responsibilities of the council.

3.3 The recommendations in the Annual Report highlight where further work is needed to secure maximum health gain for the population through creating healthy environments for all ages. It is now our challenge to take forward this work and actions recognising the financial pressure on the public purse but in the knowledge that, if we do not, the consequences of poor health will put greater burdens on already stretched services.

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3.4 The Annual Report includes a chapter on 'Skills, Employment and Health'. This report therefore also incorporates the JHWS workstream on 'tackling health related barriers to employment'. The initial focus of that workstream was the City Deal Labour Market Programmes. A summary of the progress to date with those programmes is attached as appendix B to this report.

……
Signed by (Director)

Appendices:

A - Public Health Annual Report 2014/15
B - Update on City Deal Labour Market Programmes

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

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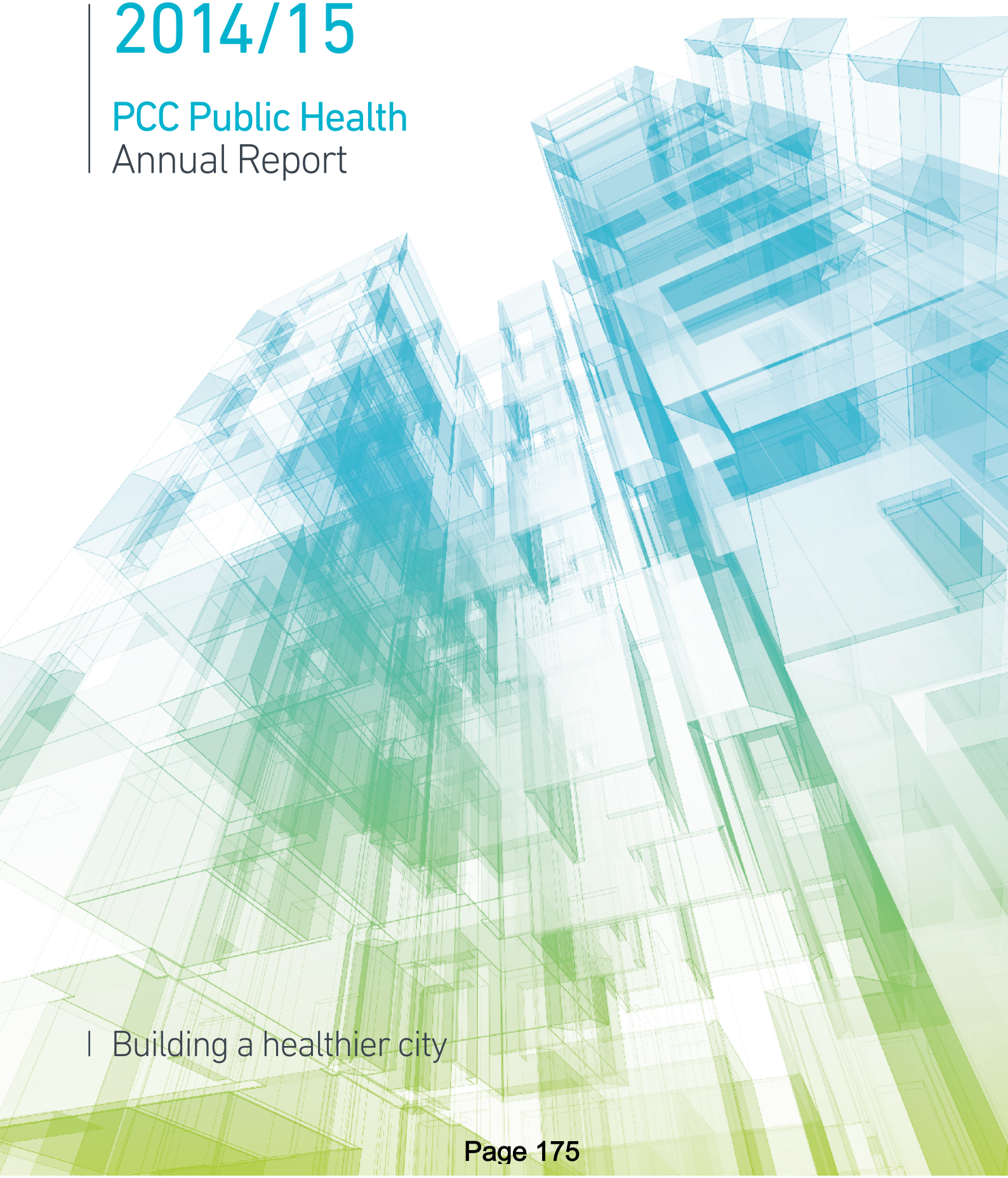
Title of document	Location

Portsmouth CITY COUNCIL

2014/15

PCC Public Health Annual Report



Building a healthier city

Acknowledgements

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Tim Raw
Nigel Selley
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Claire Upton-Brown
Kathy Wadsworth

External speakers at the Seminars

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Sustrans

Adrian Davis
University of the West of England

Emma Fernandes

Mark Gaterell
University of Portsmouth

Nick Grayson
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Public Health England

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Contents

Portsmouth CITY COUNCIL

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You can download this report from Portsmouth's joint strategic needs assessment website: **www.jsna.portsmouth.gov.uk.**

You can find the Seminar presentations via SlideShare: **http://www.slideshare.net/JoannaKerr/presentations**

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We would be pleased to receive your comments about this report. Email: **janet.maxwell@portsmouthcc.gov.uk**

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Dr Janet Maxwell
Director of Public Health

Introduction

The public health annual report for 2014 draws on the work carried out over the last year with colleagues across the council to highlight the importance of the wider determinants of health in supporting, strengthening and improving the health and wellbeing of the population of Portsmouth.

As the city moves beyond regeneration and austerity into strengthening its economic base, it is important that all its residents have an opportunity to gain the skills and training to be part of the current and future workforce. Being in secure employment contributes to good health and good health enables people to stay in work.

As well as good employment, people's health is supported by the environment in which they live – the built environment and infrastructure such as housing, schools, roads and leisure facilities and the natural environment in terms of access to clean air, green open spaces and water.

As the human population grows from a global figure of around one billion in the early 1800s to 7.3 billion this year and a projected figure of over 9 billion by 2020, more and more people are living in cities. In 1950, less than 30% of people lived in urban settings, by 1990 it was 50% and by 2025 it could be at least 60%. Good design, planning and architecture is imperative to make the best use of space for people to live well within neighbourhoods and communities. Portsmouth, with 205,000 residents living within just 15.5 square miles, is one of the most congested urban environments outside London. The design and layout of the city is influenced by its geography, its history, its politics and its people. We have to weave the heritage from the past with the challenges of the future to become a resilient and sustainable city in terms of effects of climate change, energy sources, food supplies, water and waste. Developing a circular economy from a traditional linear economy will help us address the need to protect our scarce natural resources and live better in harmony with our natural environment.

Portsmouth benefits from being situated in a rich and varied setting in the Solent - surrounded by sea, natural harbours, and bordered by the South Downs and Isle of Wight. These, together with its transport links to London and to mainland Europe, means it has a wealth of assets which can be used to great advantage for the wellbeing of our population, both now and in the future.

I commend this report to help make the most of the recommendations highlighted, in order to build on the strengths of the city and continue to build a healthy city for the future.

I hope you find this report interesting and useful and would be very pleased to receive any comments.

Dr Janet Maxwell
Director of Public Health

Chapter 1

Building a Healthier City

Portsmouth is a bustling island city on the south coast of England, with an estimated population of 205,000 people residing within 15.5 square miles. This makes Portsmouth the most densely populated city in the UK outside of London.

Creating resilient communities and supportive environments provides particular focus for improving wellbeing, recognising the strong link to underlying health inequalities. There is a real challenge in bringing about the significant change that is needed, requiring a whole-system approach.

This aspiration is also at the heart of the UK Healthy Cities movement, of which Portsmouth is a member. The UK Healthy Cities Network is a global movement for urban health that engages local authorities and their partners in health development through a process of political commitment, institutional change, capacity-building, partnership-based planning and innovative projects.

There is a real momentum in the city for reinventing places, infrastructure and the surroundings to support health and wellbeing, which in turn will support the development of a vibrant city. This is reflected also within Portsmouth's Joint Health and Wellbeing Strategy: 2014-17, which clearly recognises the importance of a sustainable and healthy environment for improving health and wellbeing in which the wider determinants of health are considered and addressed.

Building A Healthier City

Reducing the burden of ill-health, increasing healthy life expectancy and reducing health inequalities are key aims for public health in Portsmouth. Behaviours such as smoking, poor diet, lack of physical activity and high alcohol consumption are major causes of poor health and conditions such as diabetes, heart and kidney disease, stroke and cancer, often leading to premature death.

These behaviours are often a direct result of stress caused by difficult circumstances, such as unemployment, poor housing and poverty. It is important therefore that interventions that focus on promoting or improving 'health behaviours' address these wider determinants of health.

A series of five inter-directorate seminars for Portsmouth City Council have taken place and have provided an opportunity to examine the links between health and wellbeing and urban planning; transport; sustainability; housing and skills and employment.

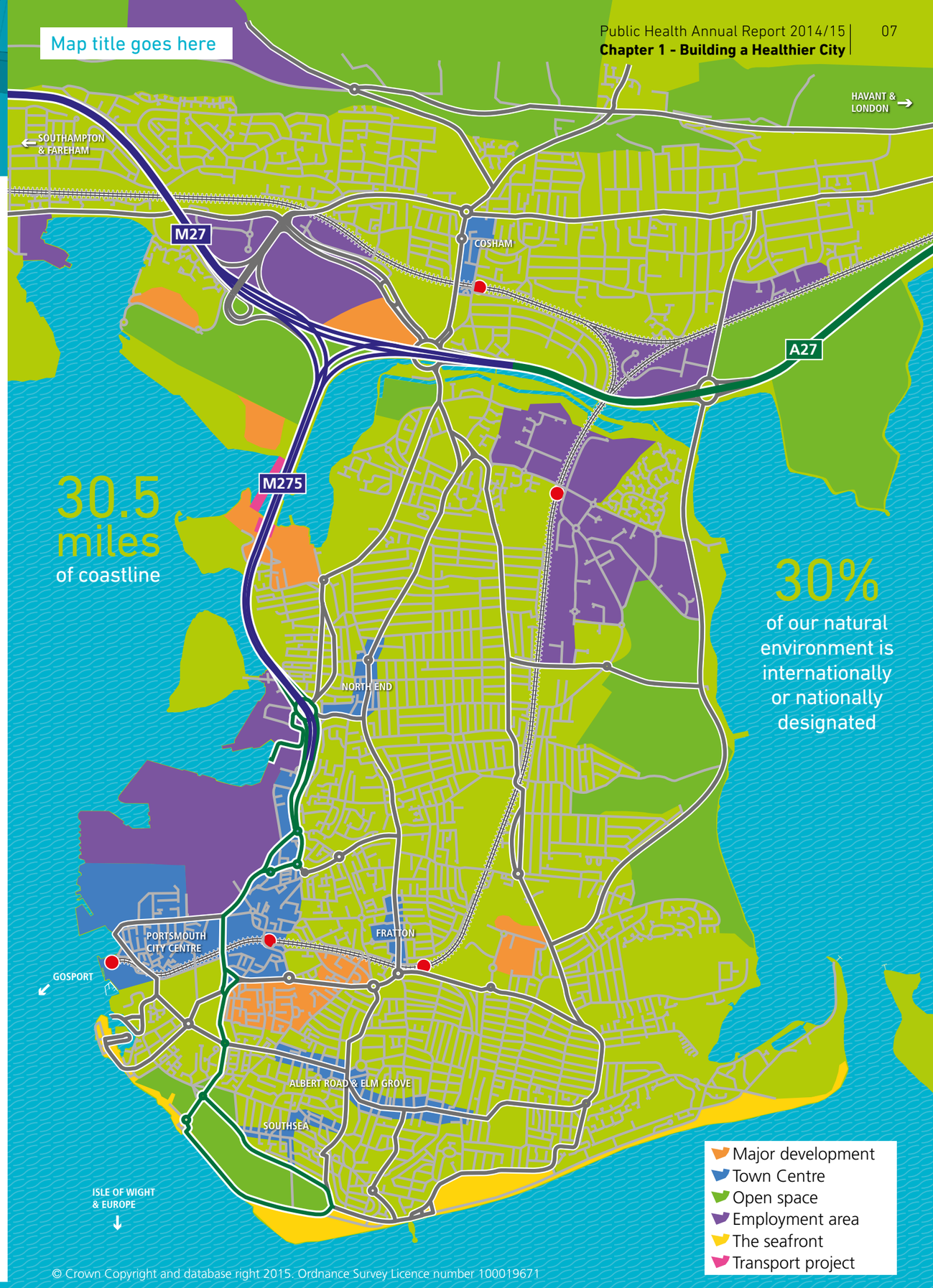
The specific aims of the five seminars were to:

- Demonstrate where efforts to improve the health and wellbeing of the local population can also deliver the aims and objectives of other services
- Strengthen the links between shared agendas
- Share learning and expertise across directorates
- Agree priority action areas to be taken forward
- Develop health champions across the organisation
- Improve outcomes relating to health and wellbeing for people in the city

Each seminar gave an overview of the key issues for Portsmouth, the connection with improved health and wellbeing, an example of good practice as well as table-top discussions focusing on opportunities, challenges and top priority action areas to be taken forward.

The seminars demonstrated how Public Health outcomes could be improved through more effective joint working across the authority and gave us the opportunity to discuss the best ways of addressing these.

The key issues, priorities and recommendations emerging from each of the seminars are described in subsequent chapters and many of the emerging themes and actions provide an important foundation to capitalise on the momentum across the council and its partners to build our work to improve the lives of residents.



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Chapter 2

Urban planning and health

Urban planning and planning decisions have profound impacts on the health and wellbeing of communities. There is a clear potential for urban planning to have significant influence on health including the wider determinants contributing towards a built environment which helps to support healthy living and mental wellbeing. This is recognised in the update National Planning Policy Framework (NPFF, 2012).

The NPFF requires planners to consider health in a range of different ways and highlights the importance of achieving social, economic and environmental objectives linked to health and with a strong focus on promoting healthy communities.

The NPFF also requires local authorities to work with public health and health organisations to develop a robust evidence base that takes into account future changes and barriers to improve health and wellbeing.

With this strengthened planning guidance and with the move of public health responsibilities into local authorities, the potential for delivering positive long-term health and wellbeing outcomes must be recognised with specific approaches and policies adopted to achieve this.

There is a clear potential for urban planning to have significant influence on health including the wider determinants contributing towards a built environment which helps to support healthy living and mental wellbeing.

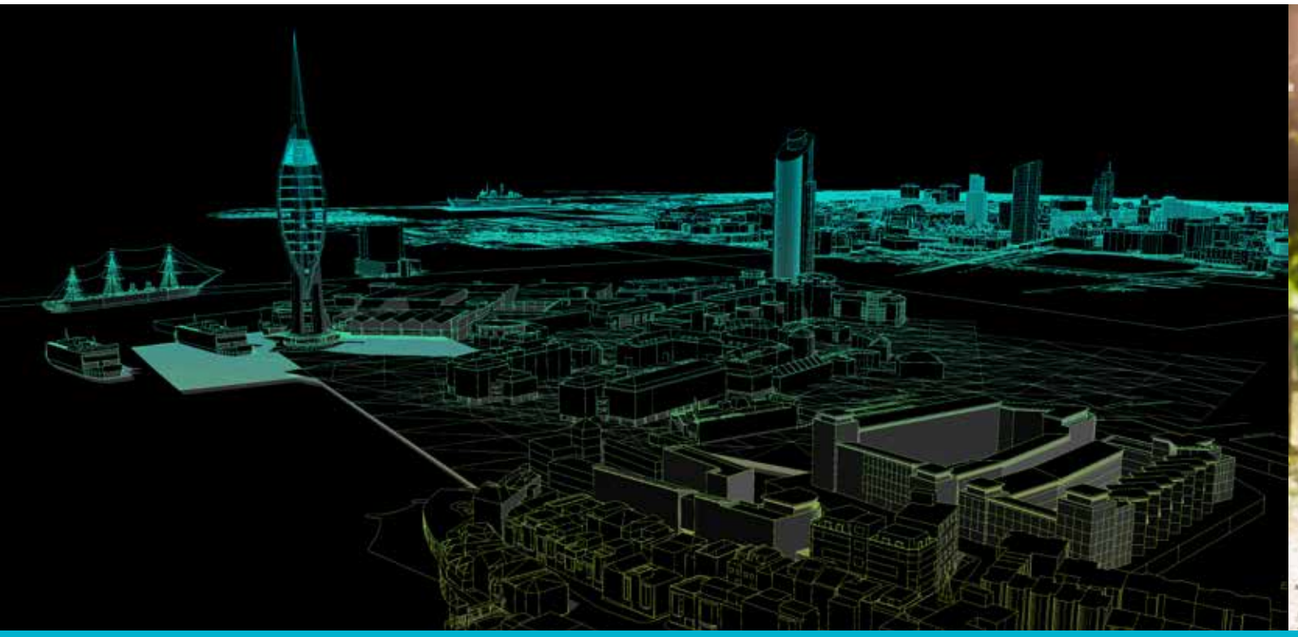
Recommendations

Given this context there is a key opportunity for the new Portsmouth Plan to provide a single strategic plan for the city, looking ahead to 2031 and beyond to bring together all the city's long-term strategic plans into one place.

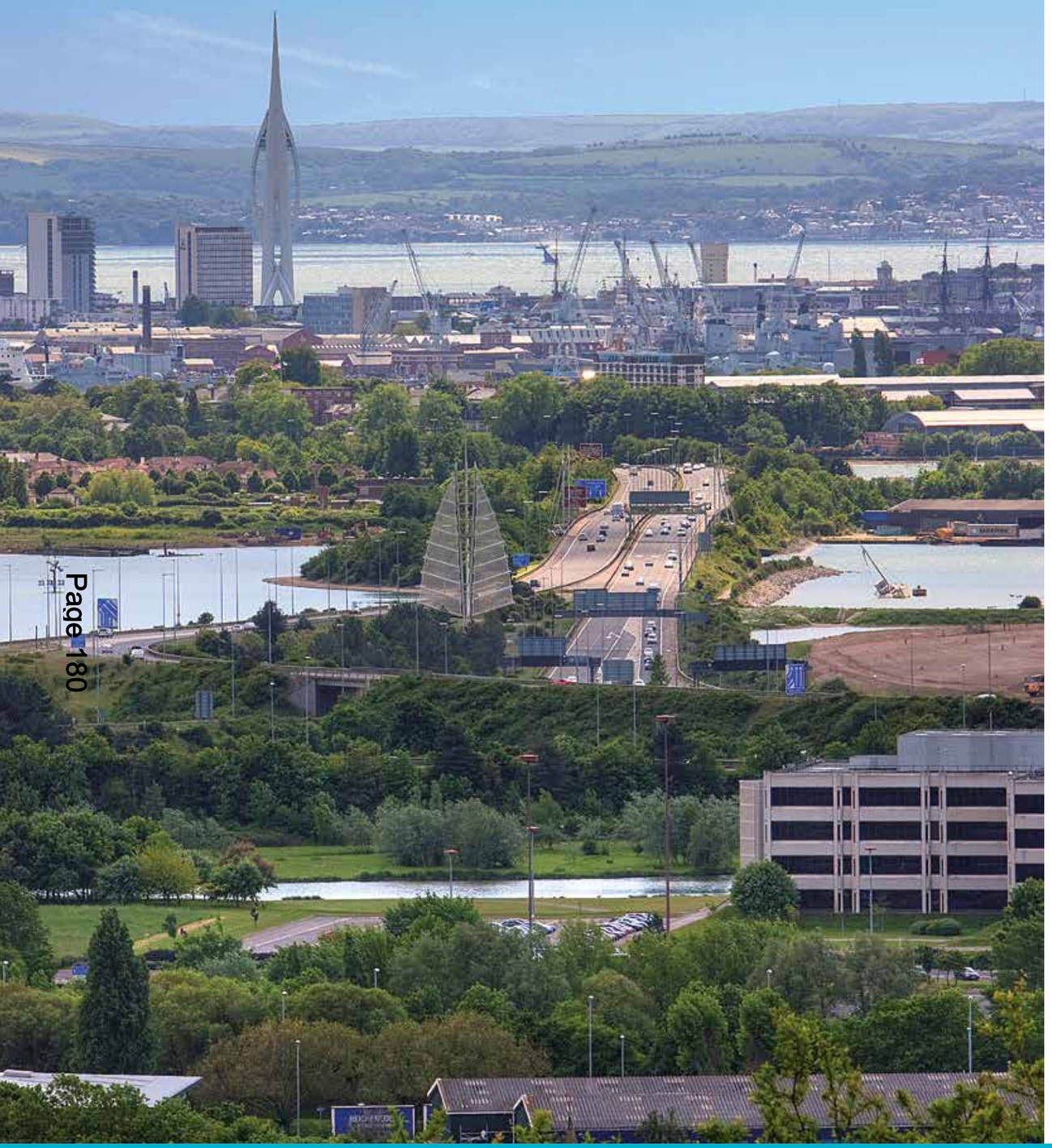
The new Portsmouth Plan will be more about place shaping and creating a city where people want to be. Therefore the plan, as well as delivering economic growth and managing development, needs to focus on improving job provision and prospects, boosting culture and tourism and our heritage, creating a healthy and sustainable environment, creating an efficient and sustainable transport network, ensuring access to high-quality education and ensuring that we provide enough of the right type of good quality housing to meet the different needs of our population.

It could help link the strategic policy elements for key Strategies and Plans for the city such as:

- Transport Plan
- Economic Strategy
- Waste Strategy
- Health and Wellbeing strategies
- Children and Young Peoples Plan
- Sustainable Communities Strategy
- Safer Portsmouth Partnership
- Housing Strategy
- Culture Plan



The new Portsmouth Plan will be more about place shaping and creating a city where people want to be.



The Plan will also provide guidance and detailed planning policies to:

- Ensure a high-quality environment with available land / buildings for business development and new housing. This in turn will attract employers to the city thus improving job opportunities for residents.
- Provide for enough new housing (of different sizes, types and affordability) to meet the needs of the city. This should help to ensure that everyone has access to an affordable, good quality home.
- Determine the location of new development so that they are connected to or have good access (via public transport, cycling or walking) to services and facilities. New housing development should have good access to shops, employment and community services. This will have a positive health impact as it will ensure access to job opportunities and reduce the possibility of social exclusion. New retail development should be located so that it is, or can be made, accessible by public transport, cycling and walking to ensure that these forms of travel are encouraged and so that those without a car have access to facilities.
- Ensure our town centres remain viable and vital areas through focussing certain uses in these areas (shops, restaurants, community facilities, and leisure facilities) and encouraging events such as markets. Town centres are generally accessible by public transport, cycling and walking – therefore such uses will be accessible to those without a car and will help to reduce the need to travel and encourage active travel.
- Preserve and enhance the natural environment through protecting important habitats and species, enhancing biodiversity, protecting open space and encouraging green walls and roofs. This inevitably has positive health and sustainability impacts.
- Ensure new developments meet sustainability standards in terms of energy use, natural light and ventilation.
- Safeguard land for transport routes and also ensure that new developments create new links to existing routes. This can help to achieve a high-quality public transport network with good cycling and walking routes.
- Identify infrastructure that is needed to support the growth of the city and ensure its timely delivery. This covers areas such as transport, flood defences and education.
- Help to secure funding for projects. Projects are more likely to receive funding if it can be demonstrated that there is certainty of delivery and that the project will contribute towards the growth for the city. If a project is in the Portsmouth Plan this gives a level of certainty and also demonstrates a link to growth.

Chapter 3

Transport and health

Transport has a large influence on health as it provides access to services and facilities and can encourage healthier lifestyles. Transport can change environments and behaviours to increase active travel, promote public transport and improve road safety.

Transport is closely linked to the health issues that have the most adverse impacts on life expectancy – these include circulatory diseases, cancers and respiratory diseases. People living in Portsmouth's most deprived wards have significantly shorter life expectancy. But increasing the opportunities for active travel can increase physical activity, and will help to improve the person's physical and mental health and wellbeing, reduce the number of vehicles, improve air quality in areas of deprivation along with other low carbon travel options, thus reducing the risk of respiratory diseases.

Physical Activity and Active Travel

The vision and ambition for the city until 2023 in terms of a modal shift to walking and cycling as part of their daily lives is set out in the city's Active Travel strategy, working with key partners on projects and initiatives to deliver the strategy such as: cycle training, cycle maintenance and road safety education.

Research has shown that active travel can be increased by improving cycling and walking routes, providing maps of routes, creating a better environment and public realm, improving retail areas and investing in routes to train stations.

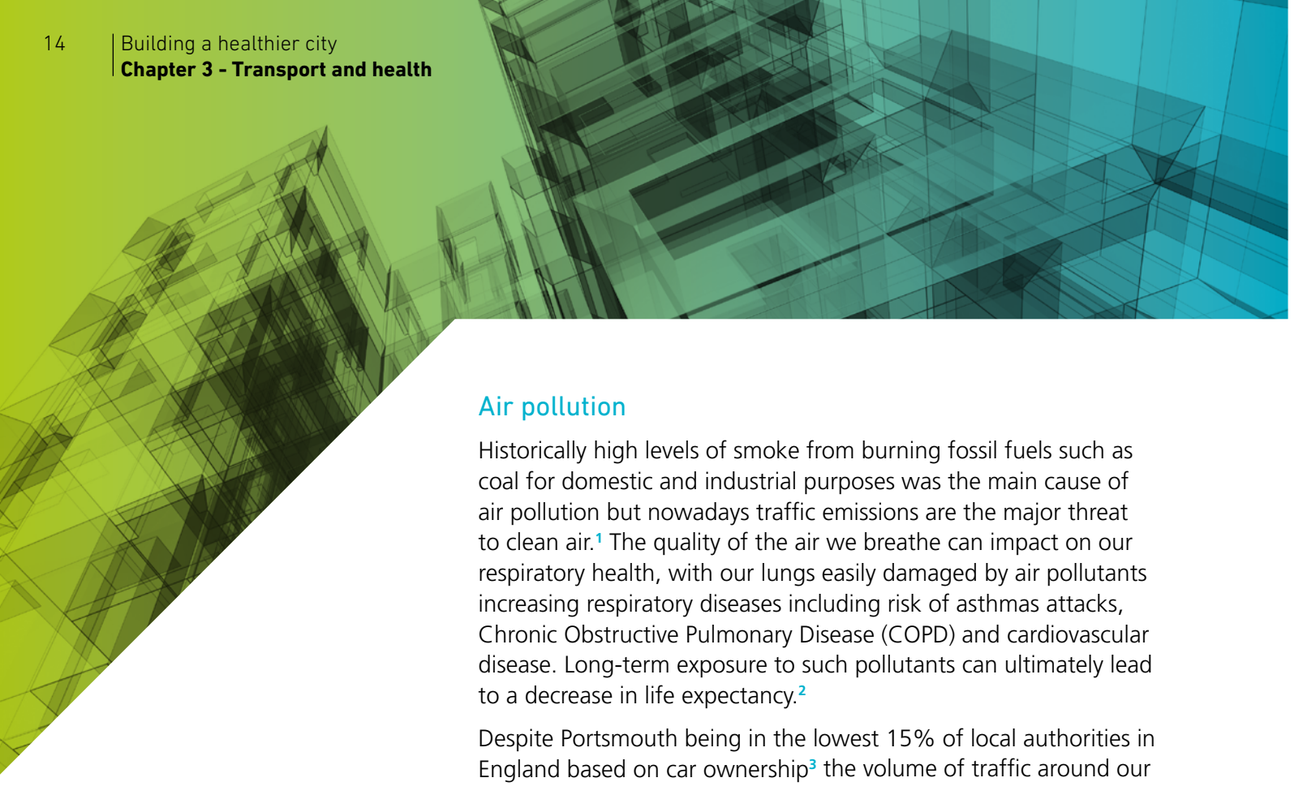
In Portsmouth there is already a strong emphasis on promoting active travel focusing on education, encouragement, enforcement and engineering. In addition key supporting policy frameworks – the Portsmouth Plan, and the Local Transport Plan will be redeveloped, offering an opportunity to further embed the principles of walking and cycling within the strategic framework of the city.

Community Severance – ring roads and car friendly – partly reduces walkability

Increasing the number of people walking and cycling in the city cannot be accomplished by hard engineering alone, but requires a combination of appropriate policies, good road design, education on the benefits of active travel, support to encourage and make it easier and safer, so that ultimately people change their behaviour and choose to use this cars less and less.

Accidents

Low-income families occupying poor-quality older terraces have the highest risk of road accidents in Portsmouth, particularly among children and young people both as cyclists and pedestrians. Although there is low car ownership within this group, given the nature of the road infrastructure, the main motorised vehicle routes in the city run through the key areas of deprivation plus many people in these locations tend to have young children. Given the level of casualties across Portsmouth, particularly those in deprived areas, it is clear that road safety and active travel have an important role to play within transport and health.



Air pollution

Historically high levels of smoke from burning fossil fuels such as coal for domestic and industrial purposes was the main cause of air pollution but nowadays traffic emissions are the major threat to clean air.[1] The quality of the air we breathe can impact on our respiratory health, with our lungs easily damaged by air pollutants increasing respiratory diseases including risk of asthmas attacks, Chronic Obstructive Pulmonary Disease (COPD) and cardiovascular disease. Long-term exposure to such pollutants can ultimately lead to a decrease in life expectancy.[2]

Despite Portsmouth being in the lowest 15% of local authorities in England based on car ownership[3] the volume of traffic around our city is high with air pollution and congestion the two biggest issues relating to vehicle use. Ironically it's our most vulnerable residents in the city who don't own cars that have the biggest exposure to air pollution due to the location of the main travel corridors through the city as figure 1 illustrates, therefore ensuring the maximisation of active travel (non-motorised travel) is vital to our city in terms of efficient travel (avoiding congestion and lengthy commutes) and our health (physical and mental health gains from being outside and being active).

Recommendations

- deliver business/action plans developed to support and deliver the priorities of the Local Transport Plan 3 and other transport strategies
- identify funding streams, particularly those which can meet the revenue shortfall to provide promotion and behaviour change activity
- continue to ensure that new developments consider all transport modes and users in the development of new and improved transport networks both in and around the site and the supporting infrastructure required such as secure and undercover cycle parking
- ensure Health Impact Assessments are shared for health input into new developments
- continue to work in partnership with public health and other PCC colleagues, transport operators, user groups, schools and other key stakeholders to promote active and sustainable travel modes and lifestyles and behaviour change
- continue to develop the Safer Routes to School initiatives

1. DEFRA, 2011 http://uk-air.defra.gov.uk/air-pollution/causes
2. PCC, 2015 https://www.portsmouth.gov.uk/ext/community-and-environment/environment/air-quality-and-pollution-in-portsmouth.aspx
3. RAC, 2012 http://www.racfoundation.org/assets/rac_foundation/content/downloadables/car%20ownership%20rates%20by%20local%20authority%20-%20december%202012.pdf)

Chapter 4

Sustainability and health

The behaviours and actions of individuals, families, communities and the business sector (public, private and voluntary) at a local, national and global level have an impact on both our natural and built environments. These behaviours can be both positive and negative in their contribution to sustainability and health agendas, through increasing or decreasing the risk of climate change and carbon emissions in particular, which have a direct impact on our natural environment. Those living in the greatest affected areas can be the most vulnerable as the active travel section demonstrates with those living in the most deprived wards with lowest car ownership suffering the effects of car emissions the most, similarly those with least mobility are at most risk during flooding etc.

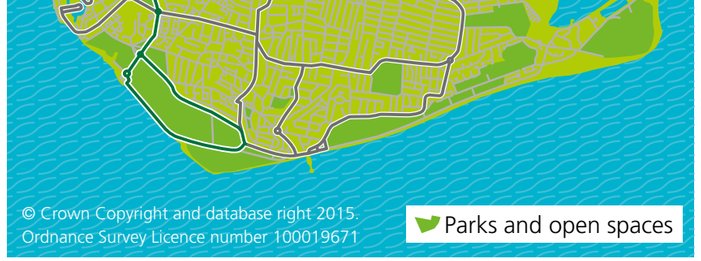
Climate change is a key priority both locally and nationally as the choices, decisions and behaviours displayed on an individual, industry and global perspective has changed through time and this has resulted in a change in how we connect with the environment we live in and around.

Changing our behaviours and making informed choices around transport, food and energy-use at an individual, local and national level can result in a more positive impact on our environment and ultimately improved health.

Our green and blue spaces within the city are vital to residents, they include areas such as: parks, playing fields, cemeteries, allotments/growing spaces, foreshores, lakes, ponds and the seafront. These outdoors green and blue spaces help to positively contribute to both our physical and mental wellbeing but are equally as important for our bio-diversity and eco-systems.

As a densely populated area, our outdoor spaces are precious, so making the most of them is important and the good news is they are well utilised by residents and visitors alike. The map below illustrates how every household is within 15 minutes of a park or green space and we know local residents, especially those living in flats and tower blocks without access to gardens, value these facilities.

Our blue space i.e. the lakes, ponds and the sea, is vital for recreation (sailing, water sports, fishing, paddling/swimming) but our coast also helps to contribute to jobs and our local economy – through commercial fishing for sourcing fish and shellfish, plus as a commercial port and home to the Royal Naval base – making the sea vital to many aspects of Portsmouth's survival.



Recommendations

» Implementation of the Portsmouth energy strategy. Ensuring carbon reduction and climate change are considerations within all major plans for city and new development proposals. Engage with residents and businesses around energy efficiency, behaviour change and increased shift to renewable energy sources.

» Flood defence – working to ensure best use of the funding for structural improvements and also via smart communications with residents to reduce flooding risk and impact following flooding.

» Strengthen local food economy and links with local food growers across the region to improve markets for access to local seasonal produce.

» Support people to grow their own food where possible through allotments and private and community growing space and promote reduction in waste including food waste, unnecessary packaging by buying loose produce, using reusable bags, buying fruit/veg in season and where possible buying locally-grown produce.

» Big recycle – keeping the quality of recyclable materials high and helping people and businesses recycle all the items they can. Consider recycling of food waste through anaerobic digestion.

» Move towards a circular economy where value and reuse of all natural biological and non-biological materials become the norm.

» Strengthening and linking the green infrastructure across the city – enabling more people to connect with the natural environment and utilising the green and blue spaces within the city for recreation and leisure.

» Enhancing the biodiversity both within the city and around the waterfront.

» Marine Conservation Zones and areas of national conservation promoted and celebrated.

Chapter 5

Housing and health

A good quality home that meets our needs is important for health and wellbeing. It is the place where many of us spend most of our time. At its most basic level a home should provide us with a safe, secure and warm environment. However, a good home should also meet our personal needs which change as we grow up, work, have families and enter the later stages of our lives. These needs may also be different for other reasons such as physical disabilities, mental health problems or learning disabilities. Finally, homes also create communities where we can fully realise our potential and support others to reach theirs. The home and the effects it can have on our lives can probably be most clearly seen when we do not have a place to call home.

There are a number of other important factors that affect housing in Portsmouth. Almost half (compared with two fifths nationally) of Portsmouth's housing is terraced and around 100 years old. The houses also tend to be small with only 55% of properties having three or more bedrooms, which is far lower than surrounding areas. The larger Victorian properties are often converted to multiple occupancy homes with poor facilities. Portsmouth also has a large number of post-war tower blocks and flats which have poor ventilation, insulation and energy efficiency. This is mainly council-owned or through housing associations. Although properties have lower prices than surrounding areas, more than 62% are in Council Tax Band A or B, houses are still relatively expensive as poverty is a significant issue for residents, who have lower skills and qualifications and are in lower-paid jobs. Affordable housing is therefore an important aspect of the housing market. Many of these issues have also led to higher than average levels of overcrowding in the City.

Portsmouth City Council has a comprehensive housing strategy, which aims to increase the number of affordable homes and the quality of housing across all sectors. The council also provides a range of high-quality housing services including Tenancy Management, the Housing Options Service, Tenancy Rights Service, Sheltered Housing Service, Telecare, Homecheck and support for disabled adaptions. However, for this report, I would like to highlight the regeneration work occurring in Somerstown.

The Somerstown regeneration project represents an ambitious vision to transform a deprived urban area to meet local residents' long-term hopes and aspirations shared through extensive and detailed consultation. This is a community-driven project which has brought vital and long overdue, modern health, community and youth services to a landmark building at the heart of the community as well as innovative play facilities and first-class, eco-friendly homes to provide local people with real, local housing options and the opportunity to raise their families in an area they are proud of.

Recommendations

- Better linkages with Housing teams as health and social care services integrate into localities and in recognition of the vital support that the housing teams provides for all residents. We need to make sure that housing teams play a key role in their development so that residents have a seamless service.
- Ensuring there are a range of living options and accommodation available as the elderly population is increasing both for those choosing independent living and supported housing; these need to be discussed in a more proactive way and not just when someone is in crisis, which will not only lead to improved outcomes but help to reduce under-occupancy in the city.
- Improving aspirations and reducing poverty is crucial for residents and we need to continue to support the regeneration work in Somerstown and other areas across the city.
- Continue to support the development of high-quality housing in both the owner-occupier and private-rented sector. Given the nature of the housing stock this is important.
- Undertaking a health needs assessment to inform the provision of health care to homeless people which may be affected by the planned redesign of health care services.





Chapter 6

Skills, employment and health

People's health is affected by their education, skills and employment. The Marmot review[4] highlighted the importance of action on employment with "Create fair employment and good work for all" as one of its six priorities.

The cost of ill-health to the UK tax-payer was estimated to be over £60 million in 2006[5], and the annual economic costs of sickness absence and worklessness estimated at over £100 billion, greater than the annual budget for the NHS at that time. An estimated 175 million working days are lost a year due to ill-health. There are also wider human costs of ill-health in the working-aged population which are often hidden and not quantifiable.

The importance of employment and health is highlighted in the NHS five-year forward view, with a priority to "develop and support new workplace incentives to promote employee health and cut sickness-related unemployment."[6]

The working environment itself influences health. Work can be good for health, reversing the harmful effects of long-term unemployment and prolonged sickness absence.

> "For most people, their work is a key determinant of self-worth, family esteem, identity and standing within the community, besides, of course, material progress and a means of social participation and fulfilment."

Investing in health and well-being programmes produces economic benefits. Put simply, a healthy workforce is good for business. Public Health England's workplace wellbeing charter supports businesses to develop this.[7]

Portsmouth has higher levels of children and young people not in employment, education or training (NEET), compared to the national average, the South East average, as well as some of our statistical neighbours such as Southend and Southampton. These young people are at greater risk of a range of negative outcomes such as depression, early parenthood and poor health.

Portsmouth residents entering the workforce have low skill levels.

There are more Portsmouth residents with entry level numeracy levels, and less with Level 1 numeracy and above and a clear correlation between lower levels of numeracy and deprivation in the city. Charles Dickens, Cosham, Nelson and Paulsgrove wards all have higher than average numbers of residents with numeracy at entry level 3 or below.

4. http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review
5. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/209782/hwwb-working-for-a-healthier-tomorrow.pdf
6. http://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf
7. http://wellbeingcharter.org.uk/Why-do-it.php

Levels of sickness absence in Portsmouth are higher than the national average, although this is comparable to areas similar to Portsmouth. Reducing sick levels may help to improve economic productivity.

Portsmouth and Southampton's joint City Deal programme aims to bring thousands of new jobs to the area.[8] It includes a focus on support for 1,000 people who are long-term unemployed, as well as a focus on reducing youth unemployment, with interventions for young people who are not in employment, education or training.

Portsmouth City Council's Workplace Health Team offers support to employers to achieve Workplace Health Charter accreditation and to train managers, staff and champions on implementing good practice into their workplace. In addition regular Workplace Health Forums and briefings support employers to develop and share good practice.

Recommendations

- Continuing to work with schools to develop a clear, holistic offer to children and young people, families, schools and communities, through the Healthy Child Programme.
- Ensuring there is a consistent high quality PSHE offer in place across all schools in the city.
- Working in partnership across the city to bring together the purposeful activities available to children and young people; to increase access to cultural and sports opportunities for all, particularly those who are most at risk of becoming not in employment, education or training.
- Portsmouth City Council to lead by example, supporting staff training and development, and signing up to the Workplace Health Charter.
- Support workplaces to achieve standards and work towards Workplace Health Charter accreditation.
- Provide training for Workplace Health Champions for managers, employees and champions.

8. https://www.portsmouth.gov.uk/ext/development-and-planning/regeneration/city-deal.aspx

Chapter 7

Conclusions and recommendations

This brief overview brings together the findings and discussions following the series of seminars held during the autumn of 2014 and helps provide a summary of the important links between health and wellbeing and the wide-ranging responsibilities of the council.

The recommendations highlight where further work is needed to gain maximum health gain for the population through creating healthy environments for all ages.

It is now our challenge to take forward this work and actions recognising the financial pressure on the public purse but in the knowledge that if we do not, the consequences of poor health will put greater burdens on already stretched services.

By working together and with wider partners across the city in education, business, health and the third sectors we can seek creative and transformative change. By engaging and empowering citizens and communities we can ensure a healthier, resilient and sustainable city for future generations.

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Update to Health & Wellbeing Board on the City Deal Labour Market Programmes

1) Purpose

1.1 To update the health and wellbeing board on the progress with the City Deal Labour Market programmes which were included within the Joint Health & Wellbeing Strategy (JHWS) as part of our response to workstream 5b - "Tackle health related barriers to accessing and sustaining employment".

2) Background

2.1 As part of the Portsmouth & Southampton City Deal, a labour market programme was agreed with central government. This programme had two strands; one of which was about dealing with access to the labour market by young people, and one about helping people with health conditions back into the labour market. It was agreed that both of these elements would be picked up within the JHWS as part of workstream 5b which is concerned with tackling health related barriers to accessing and sustaining employment.

2.2 The specific actions agreed as part of the workstream were:

- A £6m “Fit to Compete” programme will be implemented across South Hampshire that will look to integrate support services for long term unemployed people
- City Deal Labour Market Programme for Young People
- A proposal from RECRO is being explored as a potential way of addressing barriers to employment due to personal circumstance: learning difficulties, mental health, physical disability, drug and alcohol misuse, disturbed family background or limited educational attainment each reduce work opportunities

2.3 The Government are regarding the "Fit to Compete" programme as a pilot to see whether the extra interventions achieved significantly better outcomes. These extra interventions including intensive integrated support looking at health and employment issues and the opportunity to undertake a paid transitional employment programme placement. City Deal only provided 50% of the funding for the Fit to Compete programme and match funding was due to come from European Social Fund. There has been a significant delay in being able to access this funding and so it has not yet been possible to start the full programme. It was therefore decided to use some of the City Deal funding to do a small pilot of around 100 people across the two cities and this commenced at the start of 2015.

3) Update on performance

3.1 Southampton City Council has employed a City Deal programme manager on behalf of the two cities. She has set up the small pilot and has worked with PCMI who are delivering the programme in Portsmouth. The full evaluation of the pilot is yet to be completed although early indications are positive and suggest that a higher proportion of

referrals will get paid employment than if they had been through the Work Programme. Bearing in mind that the people referred to the programme have complex needs and have often already gone through the work programme this is considered a positive result. By the end of June there had been 78 referrals in Portsmouth and 50 of these (the maximum) had started the programme. 41 of the people who had started the programme had engaged with the activity and 17 of them had started work placements. Across the whole programme 31% had started the transitional employment programme and 7% were into sustained jobs. This was very early in the process and the figure is expected to rise to over 20%.

3.2 A recent evaluation workshop was held which looked at some of the issues that have become apparent through this small pilot. This workshop looked at issues around eligibility, referral routes and programme design and this will all feed into the design of the main programme (which will be a national pilot). The matched funding is available through a DWP European Social Fund "Call for Proposals". It is possible that the successful application will not be from Southampton and Portsmouth and so this would mean a fundamental rethink of the programme. The call closes on 9th October and if the application is successful it is likely that any procurement for the new activity would happen early in 2016. There is less funding available than was originally envisaged and it has to cover the Solent LEP area and so this will also lead to a reshaping of the programme.

3.3 In terms of the Youth Programme the two cities have agreed a 2 year programme which aims to address gaps in current provision for 16-24 year olds. The programme will:

i. Improve the central co-ordination and systematic referral processes
ii. Respond to the reduction in support for post 18 year olds
iii. Improve information sharing and case management
iv. Help with employer focussed interventions
v. Provide employment and learning engagement and support targeted to the needs of the young person

3.4 The Portsmouth part of the programme has been fully operational since the beginning of May with two full time staff and two part time staff recruited. The team are working closely with two staff who are working in a number of schools with young people at risk of not making a good transition to post 16 education or training. In addition the data tracking team, responsible for the statutory function of tracking young people and completing returns on participation to the DfE, have been integrated into the procedures established as part of the programme. Already there has been a positive impact on the NEET monthly data, particularly for year 13, where we have a high level of NEETs.

3.5 The final part of the workstream concerned a proposal from RECRO (an employment and recruitment consultancy). It was decided not to commission this service.