Portsmouth CITY COUNCIL

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NOTICE OF MEETING

HEALTH AND WELLBEING BOARD

WEDNESDAY, 20 JUNE 2018 AT 11.00 AM

CONFERENCE ROOM A - CIVIC OFFICES

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

If any member of the public wishing to attend the meeting has access requirements, please notify the contact named above.

Health and Wellbeing Board Members
Councillors Matthew Winnington (Joint Chair), Gerald Vernon-Jackson CBE, Luke Stubbs, Rob Wood and Leo Madden (non-voting)
Innes Richens, Dr Jason Horsley, Mark Cubbon, Dr Linda Collie (Joint Chair), Dr N Moore, Ruth Williams, Dianne Sherlock, Sue Harriman, Patrick Fowler, Alison Jeffery and Andy Silvester

Dr Linda Collie (Joint Chair)
Plus one other PCCG Executive Member: Dr Elizabeth Fellows, Dr J. Lake, Dr A Eggins and Dr N Moore

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

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

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

A G E N D A

1 Apologies for absence, Declarations of Interest and Introductions

2 Membership Update (for information)

At the City Council meeting of 15 May 2018 the Portsmouth City Council 4 representatives appointed were: Councillors Matthew Winnington (Joint Chair of HWB and Cabinet Member for Health, Wellbeing and Social Care),

Councillor Gerald Vernon-Jackson (Leader), Councillor Rob Wood (Cabinet Member for Children and Families) and Councillor Luke Stubbs (Deputy Leader of the Opposition).

3 Minutes of Previous Meeting - 21 February 2018 (Pages 5 - 10)

RECOMMENDED that the minutes of the Health & Wellbeing Board held on 21 February 2018 be agreed as a correct record.

4 Joint Health and Wellbeing Strategy Monitoring Framework (Pages 11 - 14)

Dr Jason Horsley, Director of Public Health to present the report which outlines indicators which present a monitoring framework for progress against the Joint Health and Wellbeing Strategy.

RECOMMENDED that the Health & Wellbeing Board note the current Portsmouth position on the indicators presented.

5 Delivering the Portsmouth Blueprint Commitments - Progress Report (Pages 15 - 30)

Report by Jo York to provide an update to the Health and Wellbeing Board regarding the progress to date of the Health and Care Portsmouth (HCP) programme, the City wide transformation programme to deliver the Portsmouth Blueprint.

RECOMMENDED that the Health and Wellbeing Board note the progress made through the adults' delivery element of the Health and Care Portsmouth programme to deliver the Portsmouth Blueprint.

6 Drug Related Harm (Pages 31 - 38)

a) Dr Jason Horsley/Claire Currie to present the report on drug related harm in Portsmouth.

RECOMMENDED that the contents of the report be noted.

b) Fentanyl Briefing - Verbal update by Dr Jason Horsley, Director of Public Health

7 Dates of next meetings (for information)

To note the dates previously agreed as: 3rd October and 28 November - 10am starts.

A date in February has to be agreed - suggested date of 13 February 2019 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, 21 February 2018 at 10.00 am in Conference Room A, Civic Offices, Portsmouth.

Present

Dr Linda Collie (in the Chair)
Councillor Luke Stubbs
Councillor Donna Jones
Councillor Gerald Vernon-Jackson CBE
Councillor Jennie Brent
Councillor Leo Madden

Innes Richens
Dr Jason Horsley
Patrick Fowler
Alison Jeffery
Andy Silvester
Sarah Austin
Dr N Moore
Lois Howell (for M Cubbon)

33. Welcome by Dr Collie, Apologies for Absence and Introductions (AI 1)

Dr Collie welcomed everyone to the meeting and introductions were made of those present.

Apologies for absence had been received from Councillor Ryan Brent, David Williams, Sue Harriman (represented by Sarah Austin), Mark Cubbon (represented by Lois Howell), Dianne Sherlock and Kelly Nash.

34. Declaration of Members Interests (AI 2)

There were no declarations of members' interests.

35. Minutes of the previous meeting - 29 November 2017 (AI 3)

RESOLVED that the minutes of the Health & Wellbeing Board held on 29 November 2017 be agreed as a correct record.

36. Pharmaceutical Needs Assessment (AI 4)

Claire Currie introduced the report of the Director of Public Health. The draft had been brought to the previous meeting of the Health & Wellbeing Board, prior to going out to consultation, and the findings were being reported back. Claire wished to thank all involved in the consultation process which had achieved a good response. The comments received showed satisfaction with the report with additional comments mainly about the quality of services and accessibility.

Questions were raised by HWB members.

It was asked whether a question had been included in the consultation enquiring about whether local residents would be happy if their local pharmacy closed. It was confirmed that this was not a specific question asked. It was reiterated that in considering the recent consolidation application NHS England consulted with patient participation groups at GP practices in the surrounding area. Dr Horsley also emphasised that this process was as a result of national legislation and gaps in provision have to be considered.

Regarding the weight management service it was reported that this had been an innovative service in place until a couple of years ago, and the review was not necessarily funding related.

Some of the feedback had suggested the need to promote the services of pharmacies, to show their positive contribution to the community as well as relieving demand on other health services.

After a vote it was resolved by majority (with one vote against and one abstention) that:

The Health and Wellbeing Board approved the final Portsmouth Pharmaceutical Needs Assessment (PNA) 2018 for publication on 1st April 2018.

37. Health and Wellbeing Strategy - Refresh 2018-2021 (AI 5)

Dr Jason Horsley, as Director of Public Health, presented his report. The strategy had been widely consulted on and the difficulty was in narrowing down to choose priorities. This was for the Health and Wellbeing Board, rather than the City Council, to approve and for all the members of the HWB to help with its delivery.

Members of the board were impressed by the strategy and questions were raised on the following areas:

- How homelessness was being dealt with; Dr Horsley reported that there is a working group and cross department work taking place to come up with a range of measures to tackle this national tragedy. There are also links to the lack of affordable housing. Councillor Jones reported that there is adequate provision in the city which is not being accessed, with some blockages linked to mental health issues.

- Air Quality issues: it was reported that to see health benefits there is encouragement of active travel and was a priority for the strategy. Councillor Stubbs wished to point out that private cars accounted for approximately 20% of the problem with HGVs, buses, shipping and central heating also being major causes. Councillor Jones reported on

the important data provided by monitoring equipment in the city and conversations with DEFRA on the improvements made to improve air quality.

- Isolation - Dr Horsley reported the difficulties in addressing this problem in society, partly caused by demographic changes. Whilst there were advances in technology that could be applied this did not always guarantee a quality of interaction. Public Health is contributing to work on this issue.

- Holding to account by HWB - it was asked how the Board carried out this function? If it was seen that a boy is doing something which counters the health of the city they could be invited to attend to explain their actions, without duplicating the role of other scrutiny bodies.

- Armed Forces - there was an expectation through the joint covenant of better consideration of ex-service personnel. Councillor Jones reported on discussions with the Naval Services Doctor to combat stress/trauma, and there was the potential for more work with the navy on mental health issues. There is funding for a needs assessment with the armed forces (and work was being undertaken by Lisa Wills at Portsmouth City Council). Dr Moore reported on work by GPs to code letters of veterans, feeding into the hospital systems.

Innes Richens reported that the strategy reflected the priorities of the CCG, and offered to make a presentation to a future HWB meeting on Adult Health Care, which was welcomed by members.

Patrick Fowler of Healthwatch welcomed the strategy document in giving an oversight of actions to be taken by the partner organisations. Sarah Austin confirmed the support of Solent Health, where this would be taken to their board for adoption and it would help in the setting of their priorities and would be happy to report back on their actions.

Alison Jeffery appreciated the insertion of the elements relating to children's issues.

RESOLVED - the Health and Wellbeing Board:

(1) Approved the Health and Wellbeing Strategy (attached at Appendix 1 of the report);

(2) Recommended that partner organisations adopt the strategy through their own governance arrangements (as set out on paragraph 6.1 of the report);

(3) Gave consideration to the approach to progressing the strategy as set out in section 6, and proposed areas for HWB consideration with members reporting back to future meetings.

38. Portsmouth Suicide Prevention Plan (AI 6)

Amy McCullough, Public Health Consultant, presented the report of the Director of Public Health. The draft plan had been considered at the previous HWB meeting. The aim was to reduce the number of suicides in Portsmouth by 10% over the next 3 years. The plan had been presented to other organisations, including both the Children and Adults Safeguarding boards, the Safer Portsmouth Partnership and consultation events at a CCG event and with the voluntary sector to ensure wide consultation, with Solent Mind facilitating a focus group.

The changes since the previous draft included:

i) Section 7 further information on research on attempted suicides and ensuring appropriate referrals

ii) There had been refined actions

iii) Additional stakeholders had been consulted as requested and the owners of the actions had been spoken with to ensure their commitment to the delivery of these

The approved plan would be shared with partners, and would be evaluated and reported back to the HWB on an annual basis. Training would also take place with teachers.

Dr Horsley congratulated Amy McCullough and Jane Leech on their work and stressed that this was a partnership plan that would need delivery without new resources. This is a very difficult area to set low targets for (with some areas setting zero targets for those having contact with services) but the aim is to reduce the local suicide rate, and monitor progress. The work recognised the strong link to self-harm, and work was also planned with bereavement services.

In response to members' questions, the work taking place with schools and the LGBT community, and veterans groups was also reported on. Discussion also took place on the 'designing out' of possible suicide locations through talks with the Planning Department at PCC (whilst still maintaining a healthy environment) and looking at Building Control regulations.

There are plans to access points of contact, such as voluntary groups, taxi drivers etc. to provide training on suicide prevention. Tracking of high-risk areas had been discussed with the Adults Safeguarding Board.

Dr Horsley was pleased that there was a lot more sharing of information between agencies such as between the police and health services. Councillor

Stubbs reported that the Public Health Transformation Fund included an allocation of £18k towards training.

Sarah Austin reported on contributory work of Solent Health and the benefits of 1 information system in city health so vulnerable individuals can be flagged up where at risk, and through accessing primary care there is early detection of emotional distress. There is also A&E crisis intervention for mental health issues.

RESOLVED - the Health and Wellbeing Board approved the Portsmouth Suicide Prevention Plan.

39. Date of next meeting (AI 7)

It was agreed that the next meeting take place on Wednesday 20th June at 11am.

And the following meetings were noted:

Weds 3rd October & 28th November at 10am

The meeting concluded at 11.15 am.

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Dr L Collie
Chair

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Portsmouth CITY COUNCIL

Title of meeting:	Health and Wellbeing Board
Subject:	Joint Health and Wellbeing Strategy monitoring
Date of meeting:	20th June 2018
Report by:	Director of Public Health
Wards affected:	All

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1. Requested by
Jason Horsley, Director of Public Health

2. Purpose
2.1 To present indicators which present a monitoring framework for progress against the Joint Health and Wellbeing Strategy

3. Recommendations
3.1 To note the current Portsmouth position on the indicators presented

4. Background
4.1 The Portsmouth Joint Health and Wellbeing Strategy was approved by Health and Wellbeing Board members in February 2018. The strategy indicated that progress against the areas set out in the strategy would be tracked through the annual reports presented by the Director of Public Health setting out progress against the Public Health Outcomes Framework. This contributes to the commitment to hold each other to account respectfully and supportively for delivering on the objectives in the Health and Wellbeing Strategy.

4.2 The overarching aim of the Portsmouth Joint Health and Wellbeing Strategy is to improve healthy life expectancy in the city and reduce inequality by improving the areas with the lowest expectancy fastest.

4.3 The monitoring framework is structured around each of the strands of the strategy, namely to:

- Support good physical health by
  - Reducing harms from tobacco and other substances
  - Reducing the harms from physical activity and poor diets
  - Focusing on good physical health in children and young people
- Support social, emotional, mental and economic health by
  - Promoting positive mental wellbeing across the lifecourse
  - Reducing the drivers of isolation and exclusion
- Make improvements for marginalised groups fastest for
  - People with complex needs
  - People in the armed forces community

  - Children and people with special educational needs and disabilities, and their families
  - Looked after children and care leavers
- Improve access to health and social care support in the community through implementation of the Portsmouth Blueprint for health and care [this programme comprises a transformational work which indicators would not reflect meaningfully]

5. Reasons for recommendations

5.1 Overall, these indicators make clear that progress is needed to improve the health and wellbeing of the Portsmouth population which will benefit focused attention through this strategy. Some of this can be explained by the deprivation experienced by the local population. However, without working to improve the current picture, the health and wellbeing of the Portsmouth population will continue to lag behind that of England, and in some cases, behind other 'similar' areas.

By virtue of the fact that the population needs identified in the strategy reflect wicked issues, or complex problems, many of these indicators require sustained and co-ordinated action to address. Being upfront about this is realistic and asks that all partners take ownership of the strategy. Improvements will not be achieved either through isolated actions in one part of the system or through a single piece of work.

Within the monitoring framework, there are some areas of encouragement which demonstrates the important work to date in the city and commitment of partners.

6. Information Requested

None

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Signed by Dr Jason Horsley, Director of Public Health

Appendices:

Appendix 1: Joint Health and Wellbeing Strategy monitoring framework

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's Health and Wellbeing Strategy 2018-2021

Monitoring Framework

June 2018

Significantly worse
No different
Significantly better
Significantly higher
Significantly lower

- Could not be calculated
↑ Increasing and getting worse
↑ Increasing and getting better
↓ Decreasing and getting worse
↓ Decreasing and getting better
↔ No significant change
↑ Increasing
↓ Decreasing

Theme	Priority	Indicator	Time Period	Sex	Age	Unit measure	Portsmouth Value	England Value	Portsmouth Compared to England	Comparator Ranking (1 = worst or 1= highest)	Portsmouth Sparkline	Portsmouth statistical trend (over 5 time periods)	Portsmouth direction of travel (compared to previous time period)	England direction of travel (compared to previous time period)	Last updated
Overarching	Overarching	Healthy life expectancy at birth (males)	2014 - 16	Male	All ages	Years	61.3	63.3		7 (out of 11 ONS/CIPFA LAs)		-	↓	↓	Feb 2018
		Healthy life expectancy at birth (females)	2014 - 16	Female	All ages	Years	61.0	63.9		6 (out of 11 ONS/CIPFA LAs)		-	↓	↓	Feb 2018
		Life expectancy at birth (males)	2014 - 16	Male	All ages	Years	77.9	79.5		4 (out of 11 ONS/CIPFA LAs)		-	↑	↑	Feb 2018
		Life expectancy at birth (females)	2014 - 16	Female	All ages	Years	82.3	83.1		4 (out of 11 ONS/CIPFA LAs)		-	↑	↑	Feb 2018
		Life expectancy at birth - gap between least and most deprived areas (males)	2014 - 16	Male	All ages	Years	8.8		Not compared	8 (out of 11 ONS/CIPFA LAs)		-	↓	-	Feb 2018
		Life expectancy at birth - gap between least and most deprived areas (females)	2014 - 16	Female	All ages	Years	7.2		Not compared	7 (out of 11 ONS/CIPFA LAs)		-	↑	-	Feb 2018
1) Support physical good health	Priority 1a: Reduce the harms from tobacco and other substances	Smoking status at time of delivery	2016/17	Female	All ages	%	12.7	10.7		6 (out of 11 ONS/CIPFA LAs)		↓	↓	↓	Nov 2017
		Smoking Prevalence in adults - current smokers	2016	Persons	18+ yrs	%	20.1	15.5		2 (out of 11 ONS/CIPFA LAs)		-	↑	↓	Mar 2018
		Smoking Prevalence in adults in routine and manual occupations - current smokers	2016	Persons	18-64 yrs	%	25.3	26.5		9 (out of 11 ONS/CIPFA LAs)		-	↓	↓	Mar 2018
		Deaths from drug misuse	2014 - 16	Persons	All ages	DSR per 100,000	9.3	4.2		1 (out of 11 ONS/CIPFA LAs)		-	↓	↑	Nov 2017
		Alcohol-related hospital admissions (narrow definition)	2016/17	Persons	All ages	DSR per 100,000	600.5	636.4		10 (out of 11 ONS/CIPFA LAs)		-	↑	↓	Feb 2018
	Priority 1b: Reduce the harms from physical inactivity and poor diets	Reception: Prevalence of overweight (including obese)	2016/17	Persons	4-5 yrs	%	24.2	22.6		3 (out of 11 CSSNBT LAs)		↓	↑	↑	Feb 2018
		Year 6: Prevalence of overweight (including obese)	2016/17	Persons	10-11 yrs	%	35.9	34.2		4 (out of 11 CSSNBT LAs)		↑	↑	↑	Feb 2018
		Percentage of physically active adults	2016/17	Persons	19+ yrs	%	66.6	66.0		7 (out of 11 ONS/CIPFA LAs)		-	↑	↓	Apr 2018
		Percentage of physically inactive adults	2016/17	Persons	19+ yrs	%	22.5	22.2		7 (out of 11 ONS/CIPFA LAs)		-	↓	↓	Apr 2018
	Priority 1c: Support the physical good health of children and young people in Portsmouth	Under 18s conception rate	2016	Female	<18 yrs	per 1,000	26.4	18.8		5 (out of 11 CSSNBT LAs)		↓	↑	↓	May 2018
		Population vaccination coverage - Flu (aged 2-4 years old)	2016/17	Persons	2-4 yrs	%	40.2	38.1		10 (out of 11 CSSNBT LAs)		-	↑	↑	Aug 2017
		Hospital admissions for asthma (under 19 years)	2016/17	Persons	0-18 yrs	per 100,000	158.3	202.8		7 (out of 11 CSSNBT LAs)		↓	↓	↑	Feb 2018
2) Support social, emotional, mental and economic health	Priority 2a: Promote positive mental wellbeing across Portsmouth	Self-reported wellbeing - people with a low satisfaction score	2016/17	Persons	16+ yrs	%	3.5	4.5		11 (out of 11 ONS/CIPFA LAs)		-	-	↓	Feb 2018
		Utilisation of outdoor space for exercise/health reasons	Mar 2015 - Feb 2016	Persons	16+ yrs	%	16.2	17.9	Not compared	5 (out of 11 ONS/CIPFA LAs)		-	↓	↑	May 2017
		Sickness absence - the percentage of working days lost due to sickness absence	2014 - 16	Persons	16+ yrs	%	1.3	1.2		5 (out of 11 ONS/CIPFA LAs)		-	↑	↓	Nov 2017
		Depression: Recorded prevalence (aged 18+)	2016/17	Persons	18+ yrs	%	8.5	9.1		10 (out of 12 CCGs)		↑	↑	↑	Mar 2018
		Dementia: Recorded prevalence (aged 65+)	Sep-17	Persons	65+ yrs	%	4.7	4.3		5 (out of 12 CCGs)		-	↓	-	Mar 2018
	Priority 2b: Reduce poverty and other drivers of isolation and exclusion	Suicide rate	2014 - 16	Persons	10+ yrs	DSR per 100,000	13.3	9.9		3 (out of 11 ONS/CIPFA LAs)		-	↓	↓	Nov 2017
		Hospital admissions as a result of self-harm (aged 10-24 yrs)	2016/17	Persons	10-24 yrs	DSR per 100,000	545.7	404.6		5 (out of 11 CSSNBT LAs)		-	↓	↓	Mar 2018
		Children in low income families (aged under 16 yrs)	2015	Persons	<16 yrs	%	20.3	16.8		5 (out of 11 CSSNBT LAs)		↓	↓	↓	May 2018
		Unemployment	2016	Persons	16+ yrs	%	5.7	4.8		6 (out of 11 ONS/CIPFA LAs)		-	↓	↓	Nov 2017
		Social Isolation: % of adult social care users who have as much social contact as they would like	2016/17	Persons	18+ yrs	%	45.6	45.4	Not compared	6 (out of 11 ONS/CIPFA LAs)		-	↑	-	Nov 2017
		Fuel poverty	2015	Persons	All ages	%	14.5	11.0	Not compared	3 (out of 11 ONS/CIPFA LAs)		↑	↑	↑	Nov 2017
3) Make improvements for marginalised groups fastest, including our most vulnerable children, young people and adults	Priority 3a: People with complex needs	Statutory homelessness - households in temporary accommodation	2016/17	Persons	Not applicable	per 1,000	0.7	3.3		8 (out of 11 ONS/CIPFA LAs)		↑	↑	↑	Nov 2017
		Homeless young people aged 16-24	2016/17	Persons	16-24 yrs	per 1,000	1.1	0.6		4 (out of 11 CSSNBT LAs)		↓	↓	↓	Dec 2017
		Hospital admissions for violence	2014/15 - 16/17	Persons	All ages	DSR per 100,000	23.6	42.9		10 (out of 11 ONS/CIPFA LAs)		-	↓	↓	Feb 2018
		Concurrent contact with mental health services and substance misuse services for drug misuse	2016/17	Persons	18+ yrs	%	27.8	24.3		10 (out of 11 ONS/CIPFA LAs)		-	↑	↑	Dec 2017
	Priority 3c: People with special educational need or disabilities, and their families	% of all primary school age pupils with special educational needs	2016	Persons	Primary school age	%	13.4	13.4		10 (out of 11 CSSNBT LAs)		-	-	-	Mar 2017
		% of primary school pupils with social, emotional and mental health needs	2017	Persons	Primary school age	%	2.4	2.1		3 (out of 11 CSSNBT LAs)		-	↑	↑	Feb 2018
	Priority 3d: Looked after children and care leavers	Children in care (aged under 18 yrs) per 10,000	2017	Persons	<18 yrs	per 10,000	81.0	62.0		3 (out of 11 CSSNBT LAs)		↑	↑	↑	Dec 2017
		Average difficulties score for all looked after children aged 5-16 who have been in care for at least 12 months on 31st March	2016/17	Persons	5-16 yrs	mean score	14.7	14.1	Not compared	6 (out of 11 CSSNBT LAs)		-	↑	↑	May 2018

Notes: DSR = Directly age-Standardised Rate
ONS & CIPFA comparator LAs = Unitary authorities in the 2011 OAC ONS Business, Education and Heritage Centres group and in the CIPFA 2018 nearest neighbours group.
CSSNBT LAs = Children's Services Statistical Neighbour Benchmarking Tool
CCG comparators = 2017 Clinical Commissioning Groups in the 2011 OAC ONS Larger Towns and Cities group and Brighton and Hove CCG and Nottingham City CCG from the University Towns and Cities group (all within the Business, Education and Heritage Centres supergroup)

Both ONS and CIFPA UAs
Portsmouth
Bournemouth
Brighton and Hove
Bristol
Coventry
Liverpool
Newcastle upon Tyne
Nottingham
Plymouth
Sheffield
Southampton

CSSNBT UAs
Portsmouth
Bournemouth
Bristol
Coventry
Derby
Peterborough
Plymouth
Sheffield
Southampton
Southend-on-Sea
Telford and Wrekin

ONS CCGs
NHS Portsmouth CCG
NHS Bath and North East Somerset CCG
NHS Brighton and Hove CCG
NHS Bristol CCG
NHS Canterbury and Coastal CCG
NHS Leeds West CCG
NHS Liverpool CCG
NHS Newcastle Gateshead CCG
NHS Norwich CCG
NHS Nottingham City CCG
NHS Sheffield CCG
NHS Southampton CCG

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Title of meeting:	Health and Wellbeing Board
Date of meeting:	20th June 2018
Subject:	Delivering the Portsmouth Blueprint Commitments - Progress Update
Report by:	Jo York, Director, New Models of Care, Portsmouth CCG
Wards affected:	n/a
Key decision:	No
Full Council decision:	No

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1. Purpose of report

1.1 The purpose of this paper is to provide an update to the Health and Wellbeing Board regarding the progress to date of the Health and Care Portsmouth (HCP) programme, the City wide transformation programme to deliver the Portsmouth Blueprint.

2. Recommendations

2.1 The Health and Wellbeing Board is recommended to:

a. Note the progress made through the adults' delivery element of the Health and Care Portsmouth programme to deliver the Portsmouth Blueprint.

3. Background

3.1 As the health and care landscape becomes more complex and challenging, and as demand for services and financial pressures increase, the need for change has been recognised both locally and nationally. The NHS 5 year Forward View, published in 2014, sets out the options for new models of care delivery including Multi-specialty Community Providers (MCPs) and primary and acute care systems (PACS) as new vehicles for achieving more integrated delivery and improved outcomes; as well as improving commissioning and contractual levers to enable the transformational change to be achieved.

3.2 Locally, The Portsmouth Blueprint was developed in 2015, in partnership with all health and care organisations in the City and outlines the high level vision and ambition for changes to the way services are offered across the whole spectrum of health and care. The actions to deliver The Blueprint feed into the Portsmouth and South East Hants Accountable Care system improvement plan and the Hampshire and Isle of Wight Sustainability and Transformation Plan (STP) to achieve the delivery of new models of care across the system.

3.3 As part of the HCP transformation programme, there is a great deal of work underway in all organisations and services, as business as usual, in order to achieve savings and efficiencies, and in order to achieve more transformational change as envisaged in the Blueprint.

3.4 Over the last 12-18 months, the CCG has expressed a commissioning intention to explore the development of a MCP model of care to deliver the vision set out in The Blueprint. Engagement has been undertaken with practices, existing providers, and other key stakeholders resulting in a partnership agreement and 'virtual MCP' governance arrangements being put in place between NHS Portsmouth CCG, Portsmouth City Council, Adult social Care, Solent NHS Trust and the Portsmouth Primary Care Alliance (PPCA) to support the development and delivery of transformational change required to achieve a new out of hospital model of care.

3.5 In the future, it is envisaged that the MCP will become the delivery vehicle to support the transformational change programmes, enabling the development of a new model of community based care for all client groups.

3.6 This paper explores the progress of this approach to date, in light of changes to the wider health and care system, and the challenges and next steps for partners to continue to achieve the Portsmouth Blueprint.

4. Strategic context

4.1 The context in which the local health and care system operates is detailed below:

4.2 ***Hampshire and Isle of Wight Sustainability and Transformation Plan***

Health and care systems across HIOW have come together in partnership to develop an STP, setting out the strategic aims and objectives for transformation across the county. The key aims and objectives of the Portsmouth Blueprint are reflected within this wider system plan. There is a shared desire to build a strong primary and community care service which is the foundation for the delivery of the Portsmouth Blueprint. It has been agreed that delivery of the STP needs to take place at local level, within local delivery systems. The City of Portsmouth forms part of PSEH (Portsmouth and South East Hampshire) delivery system. Health and care partners in PSEH have come together to form an ACS (Accountable Care System).

4.3 ***Accountable Care System***

The aims, objectives and key work programmes to deliver the Blueprint are reflected in the ACS plans. The PSEH ACS has been developed as an added value vehicle for delivering the New Models of Care set out in the NHS 5 year forward view and the programmes outlined in the STP at a local level. The ACS aims to address the behaviours and capacity issues that exist within the

Portsmouth and South East Hants system that are causing progress to be slowed or stalled. The ACS focuses on flattening and reducing demand by concentrating on rapid acceleration of programmes that are focused on improvement for patients. It is viewed this in turn will rapidly accelerate and refocus key projects to scale up and ensure sustainability by driving out non-value adding costs in the system and aligning quality, innovation, productivity and prevention (QIPP) and cost improvement programme (Quality) schemes to reduce costs.

4.4 ***Multi-layered Planning Approach***

This multi-layered planning approach (figure 1) enables system partners in the city to focus the delivery of the commitments through either local delivery or with wider system partners where it makes sense to do so and whereby, in coming together, maximum gains can be achieved. Across the wider system, we are working on the principles that transformation must be based on local needs and where possible delivered locally. However, effective partnership working across PSEH and STP allows us to work together in areas of commonality and where there are shared aims. This will ensure alignment and ability to operate on a wider footprint to achieve efficiencies from a truly 'do it once' approach, where it makes sense to do so.

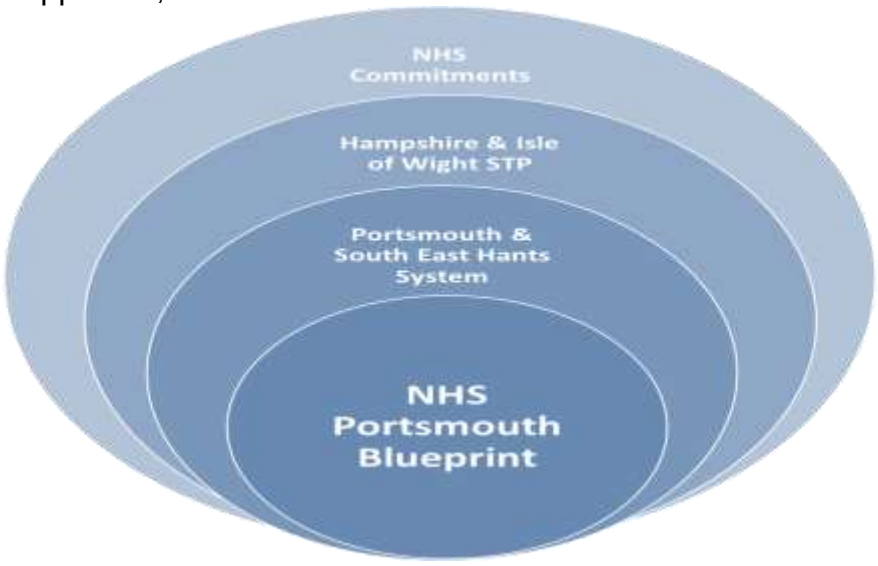


Figure 1 - How the plans fit together

5. The Portsmouth Blueprint

5.1 The Blueprint for Health and Care in Portsmouth is now well-established as the set of guiding principles that set out how the key health and care organisations in the city will work together, with an overarching goal *where everyone is supported to live healthy, safe and independent lives by health and social care services that are joined up around the needs of individuals and are provided in the right place at the right time.*

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

delivery of the Blueprint is integral to improving the long term health of the population.

5.3 The Blueprint set out 7 commitments for change that all partners signed up to.

- We will build our health and 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 will 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 will **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 will 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 will **establish a single or lead provider for the delivery of health and social care services for the City.** This would involve looking at organisational options for 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 sector or primary care
- We will **simplify the current configuration of urgent and emergency and out of hours services**, 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 will 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.

5.4 A key element of the Blueprint is the need to radically transform the way we commission care to support the integration of front line services and the delivery of more person centred care approaches. As an Integrated Personal Commissioning (IPC) demonstrator site we are committed to developing a completely different approach to planning and commissioning health, community, social care and other services, with the adoption of evidence-based approaches to delivering personalisation at scale. This will enable an outcome based approach to commissioning, supported by increased use of personal health and care budgets to enable people to have more choice and control in the delivery of their health and care needs.

5.5 IPC is characterised by five key shifts in current models of care (figure 2). Together these will drive improved outcomes for people, the system, and the tax payer. Delivery of this will be central to how we commission services to deliver the Blueprint and we will measure ourselves against them.

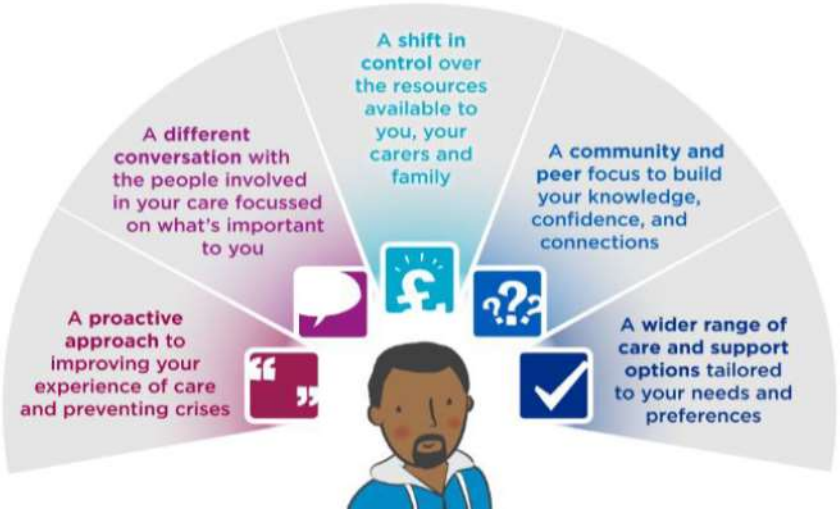


Figure 2: Integrated personalised commissioning - 5 key shifts

6. Delivering the Portsmouth Blueprint

6.1 **The new model of community based care -** The new model of health and care in the city is clearly articulated at a high level, in the Portsmouth Blueprint. As part of the MCP Programme, work is ongoing to further define the high level model and key outcomes. Work is ongoing with Healthwatch to develop and refine an outcomes framework and virtual MCP partners have agreed an out of hospital model of care, which will form the basis of the model of care to be to be delivered in the future.

6.2 This model is based on effectively supporting population health and preventing ill health to manage demand for services in future; ensuring the sustainability of primary care through the development of an integrated 24 hour primary care service to support urgent care demand, enabling improved and enhanced access to primary care during traditional out of hours periods. As well as the development of integrated primary and community case based teams to support people with complex needs.

6.3 The three fundamental principles are;

- Expedient discharge from hospital to a community setting for the assessment of long-term needs
- Community, social and primary care engaged through a single point of access and available 24/7
- People are triaged based on the urgency of the response required and the nature of their needs

6.4 This model will need to provide a more effective primary and community rapid response to prevent emergency admissions and facilitate early supported discharge, achieved through the provision of rapid assessment, triage, and care

‘wrapped around’ the individual so their health and care needs can be safely managed within their own home or a community environment.

6.5 Development of this model will enable a new integrated service and ensure the community in Portsmouth is more effective in preventing admissions to hospital as well as ensuring a robust 'home first' community based approach to effectively deliver discharge to assess pathways.

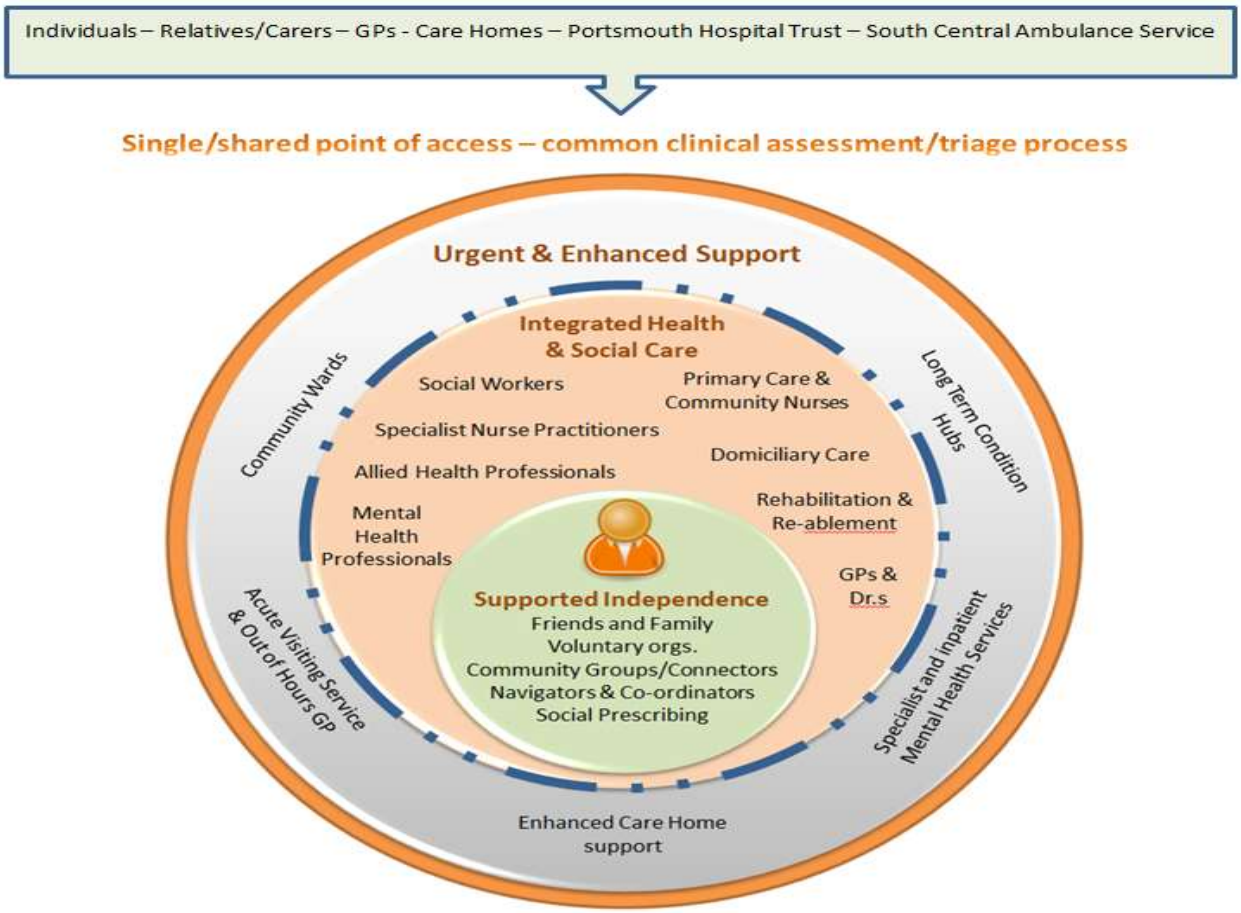


Figure 3: The Portsmouth Community Model

6.6 Early help and support is core to the model and this element aims to empower individuals to self- manage their long term conditions using social prescribing, the voluntary sector and assistive technology for support as required. The model provides early intervention where this is needed, incorporating health promotion and easy access to nursing and social services for frail and vulnerable people to support them to keep living ‘well’ in the community.

6.7 If, however, an individual should require additional support, the model enables a proactive rapid response from an integrated team, providing effective urgent care through a range of community support to prevent avoidable emergency admissions and repeated, unplanned primary care contact.

6.8 The integrated care team will be able to wrap services around the individual to return them to a well and independent position. This rapid response will form part of each 'locality' so that they can work with the short-term service as the needs of the individual de-escalate. This will mean the individual 'flows' through

the service without the need to have their case moved through different teams and buildings, and will also support better communication and case management.

6.9 Should an individual require a hospital admission, the same team will provide a crisis response and proactively in-reach into the hospital to 'pull' people out and enable more effective early discharge, both reducing the length of stay and the potential for decompensation. The team will be able to support the individual in the community, helping to prevent readmission to hospital and returning the person to supported independence where possible.

6.10 The final element of the model is proactive care management; should an individual require longer term care, the extended team will be in a position to better support individuals to remain in their own home reducing the need for a residential admission.

6.11 The work required to achieve this model will aim to move from the current position where health and care community services are co-located and work together side-by-side, to a position where true integration exists across the system. This will enable crossover in each person's care management and support referral free zones for professionals alongside a single assessment document so that each person truly only tells their story once.

6.12 Similar transformation work programmes are being developed specifically for mental health and children's services, all on similar principles of wellness and prevention through empowering people to self-care, with rapid access to support as required to enable recovery.

6.13 Through the PSEH ACS, both the new models of care and mental health workstreams are enabling the CCG to work with wider system partners to develop these new models of care in ways that are consistent across traditional local authority and NHS organisational boundaries. Recognising that whilst local delivery models may be different to meet local needs this should be within a consistent operating framework and a standard offer. In all areas, consideration is being given to how service models can be delivered once across Portsmouth and South East Hants, where this makes sense.

7. Progress against the 7 commitments to date and Next Steps

7.1 The table below outlines the achievements against the 7 commitments in the Portsmouth Blueprint and future developments.

Commitment one: We will build our health and 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."	
Achieved so far	**In progress**
There has been significant investment primary and community care services supporting improved access to primary care. **An Acute Visiting Service (AVS)** has been commissioned which provides a dedicated GP home visiting service on behalf of practices to registered patients requiring an urgent visit in their own home. This increase capacity enables patients to be seen quicker and helps to increase capacity within general practice and is delivering an additional 6,000 on the day home visits per annum. In addition, the **GP Enhanced Access service** is delivering urgent primary care appointments on Saturdays 08:00-18:00 and on weekday evenings from 18:30-20:00. The provision of routine appointments on Saturdays has also recently commenced, improving access to primary care services. To help enable GPs to focus their time on seeing patients who require their generalist expertise, a pilot has been established to deliver **Musculoskeletal (MSK) triage in general practice**. This service enables patients contacting their GP practice with an urgent MSK issue to access a physiotherapist the same day. Currently half the population of Portsmouth are benefiting from this service.	From June 2018 the CCG will commission an **Integrated Primary Care Service incorporating the provision of three interconnected services: Out of Hours (OOHs), the AVS, and GP Enhanced Access.** Integrated provision of the three interdependent services will ensure safe, effective delivery of primary medical care services 24 hours a day, 7 days a week, and improve access to primary care services by increasing capacity outside of core general practice operating times. In addition to this we will be exploring (through the development of robust business cases) further rollout of the MSK triage in general practice across the city. Ongoing work with practices to look at opportunities to increase capacity and capability within the practice to improve access, such as use of **care navigator roles, e-consult and on-line booking options**
Commitment 2 - We will 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."	
Achieved so far	**In progress**

A collaborative approach has been taken to include the VCS as an equal partner in the provision of health and care to Portsmouth residents. Through **the signposting service**, an easy access route for GPs has been available to access non-medical support from the VCS for their patients. The creation of **Project Bridge** where representatives from a range of VCS organisations and the PCC and CCG have met to discuss known problems and identify solutions which can be jointly developed. Through the Project Bridge umbrella, a proposal for a 'sitting service' is being developed. A jointly agreed a commissioning plan for the development of **social prescribing** within the City. Existing contracts have been reviewed, with joint commitment for the development of a replacement integrated social prescribing service. Due to start in June 2018. **Adult Social Care strategy development** has led to establishing its Principles for Transformation which will enable *'Nothing for us without us '*embedded in service design, monitoring and evaluation; and *Core Outcomes agreed across ASC* (at individual, operational and strategic levels) of *good health, independent lives, meaningful days and employment, social inclusion.* Through the **Integrated Personalised Commissioning Programme** (IPC) we have seen the completion of over 2000 personalised care and support plans and the establishment of 500 integrated budgets which meet the criteria of **personal health budgets,** with a small number converting into direct payments. The relationship with the VCS and those with 'lived experience' is also particularly strong within the integrated mental health services. The role of **peer support workers in community mental health** services is now well established.	It is envisaged that both **the sitting service and the integrated social prescribing service will be co-located and operated through a Single Point of Contact (SPOC)** for access to VCS within the City. This will enable a more personalised and tailor made service for carers and their families to be made available through a strengthened VCS resource, offering economies of scale and establishing a strong presence within the City. ASC will be developing outcome-based commissioning across ASC that includes options for extending use of personal budgets, ISFs, micro enterprise etc. This work will be aligned with, supported by and build upon IPC pilot work which will include personal health budgets too. The development of a **Long Term Condition (LTC) Hub** in the city which would pool existing primary, community, and secondary care professionals into a single team, ensuring patients receive consistent, high-quality care. The LTC Hub will predominantly focus on empowering individuals to maintain good health by equipping them with education, skills, and knowledge leading to lasting self-management techniques and behavioural change. The current **well-being service**, which offers support lifestyle support to help people manage their weight, alcohol consumption and quit smoking, has been through a systems thinking intervention, leading to a re-design of provision, which in the long term will improve the offer and enable greater integration with the long term conditions hub. Through the Mental Health Transformation programme, the concept of a **'Well-Being House'** is being developed to increase support offered for people with low level mental health needs; enabling them to access VCS and community support to help them in a more person centred

In relation to **children's services**, HIOW is one of only four areas in the country where the STP includes a **clear workstream for children's services.** There are credible plans, partly delivered, in relation to supporting primary care around urgent and emergency care avoidance and family health literacy. **Future in Mind Mental Health Transformation** programme includes work in schools and support for the roll-out of consistent restorative practice across the city - seen by NHS England as a strong basis for further integration.	way and offer community based alternatives to the traditional service offering in order to improve health outcomes. The local delivery system is continuing to develop more effective whole system approaches to **children's mental health.** Promotion of the **Portsmouth Children's Trust Physical Health Strategy**, to tackle obesity, smoking, drugs and alcohol as well as self-help in lower level health needs. A more radical, effective and sustainable approach to care, support and education provision for **children with autism.**
Commitment 3 - We will **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	
Achieved so far	**In progress**
Considerable progress has been made towards utilising a **single clinical record across providers** to: improve communication between healthcare professionals; enable improved quality of care; and deliver safe, consistent provision. **All GP practices** within the city (bar two) and **Solent NHS Trust use TPP SystmOne as their primary clinical system**. From the remaining two GP practices not on the system, one is scheduled to go-live from April 18, and the other is in discussion with the CCG about transferring to SystmOne. The Communications and engagement teams have embarked on a programme of joint working and support and have developed a **shared communications and engagement programme** to support HCP. Working with partners across primary, community, secondary care, and the local authority, the CCG has utilised monies received from the national Estate and Technology Transformation Fund (ETTF) to	**Adult social care due to be operating on SystmOne by October 2018**. Leading to creation of **truly joint health and care record**. A request by social prescribing to be able to utilise SystmOne for ease of feedback to health and care professionals has also been made – this will require further investigation in terms of IG issues, appropriateness and cost. In recognition of the inconsistencies with existing healthcare estate within the city (in terms of condition, statutory compliance, functional suitability, quality, and accessibility), and the fact there is NHS and Local Authority owned buildings in the city that are not fully utilised, creating void space which incurs avoidable cost to the system, a project team has been created to devise and implement **a strategic estates plan** for the city, including primary, community, and local authority partners. This team will implement the projects commenced

undertake feasibility studies and options appraisals to assess estate potential in the city and progress the development of physical Hubs within the North and Central localities. **Children's teams** have already been co-located as part of three geographically focused multi-agency teams, working to deliver the **integrated strategic programme "Stronger Futures",** bringing together public health, mental health and social care/early help services.	under the ETTF and continue to develop suitable and sustainable estate solutions for the city. **Strengthening of integration of support for children with SEND** to provide more inclusive, affordable care and education, including the potential creation of a Portsmouth specialist SEND hub.
Commitment 4 - We will 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**	
Achieved so far	**In progress**
Partnership working between the CCG and PCC has increased, leading to the appointment of a Joint LA Director of Adults Services role and CCG Chief Operating Officer role. This has led to the creation of the Health and Care Directorate including and team approach across commissioning, transformation adult social care, quality and safeguarding. The BCF pooled fund arrangements have been increased to £27 million and now include additional services such as carers, and community beds for both health and care and OT services. Developing model of joint working across the CCG and NHS Solent with combined senior commissioning and Operations Manager post. The **integrated Early Help and Prevention service** has operated under one Head of Service since March 2017. This has supported the	Continuing to develop as a single adults health and care directorate, as well as strengthening integrated commissioning function. Continued discussions across CCG and PCC as to how we can explore further joint and pooled funding arrangements.

development of a new targeted health visiting offer, and a modernised delivery of universal support.	
Commitment 5 - We will **establish a single or lead provider for the delivery of health and social care services for the City.** This would involve looking at organisational options for 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 sector or primary care	
Achieved so far	**In progress**
A partnership arrangement has been agreed between the CCG, Solent NHS Trust, the Local Authority, and the PPCA (a GP federation representing general practice), effectively creating a **'virtual Multi-speciality Community Provider (MCP)'** in the city. The MCP programme includes a suite of transformational change projects for health and care services in the city working to provide more effective, efficient, and integrated care; that will delivered the plans for the community model (outlined in section 5), that has been developed jointly by the MCP programme team. A prime example of the partnership working, without boundaries, to date, has been the implementation of the **Portsmouth Enhanced Care Home Team Pilot.** This has provided 5 of the 27 Portsmouth Care Homes with regular clinical input from a nurse led Care Home Team. A further 2 Care Homes have received a full weekly Multi-Disciplinary Team meeting comprising of a GP, Physical and Mental Health Nurses, Pharmacists and Care Home Team staff. This team has direct access to Physio and Occupational Therapy support. The outcomes for these homes over a 3 month period have seen a reduction in 999 calls made by 32% and reduction in conveyances to hospital by 27%. At the ACS level a **PSEH Mental health transformation programme** has been established. This has led to partnership working between the two mental health providers to better manage acute in-patient mental	The CCG is seeking to progress the 'virtual MCP' arrangements further by exploring risk/gain share arrangements and Integration Agreements between the community provider and GP practices for suitable projects within the MCP programme. This work will enable the CCG to better understand the requirements of commissioning a **further integrated MCP arrangement**, through a formal procurement process at some stage in the future. Discussions are required to explore the potential of **Portsmouth Hospital Trust (PHT) and the VCS becoming represented in the partnership arrangement.** For the VCS, this could be through the development of a VCS collaboration, in a similar way to which a GP federation represents general practice. This will enable a much broader range of community services to become integrated. Enhanced support to Care Homes is also a system wide priority and commissioners from Fareham and Gosport, South East Hampshire and Portsmouth CCG are working with clinicians to produce the case for a Care Home Team model that will reduce utilisation of urgent care at scale.

health beds leading to a reduction in out of area placements for South East Hampshire patients, savings and improved utilisation of City acute in-patient beds.	
Commitment 6 - We will **simplify the current configuration of urgent and emergency and out of hours services**, 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	
Achieved so far	**In progress**
The CCG has issued to the market its intentions to work with existing system partners over a three year period to implement the national requirements of **Integrated Urgent Care (IUC),** which seeks to simplify and integrate the current configuration of urgent and emergency services. Alongside this, the St Mary's Treatment centre has been designated as a wave one **'Urgent Treatment Centre (UTC),'** again as part of a national initiative to simplify the urgent care offering across the country. Partnership working across PSEH to strengthen the Urgent Care Centre and GP streaming within ED to better enable people to receive the most appropriate care. In addition, mental health crisis services have been reviewed and implementation plans in plan for improvement.	As part of the development of the Integrated Primary Care Service, from June 2018 and linking with plans to implement IUC, UTC requirements, the CCG intends to amalgamate the existing and complex urgent care landscape into a simplified point of access for patients, which delivers consistent and integrated urgent and emergency care. This includes **linking the Integrated Primary Care Service with the Urgent Treatment Centre, Urgent Care Centre (GP Streaming at ED), a Clinical Assessment Service, and overnight community provision, to provide a compelling alternative to ED** available within 2018- 2019. Plans are also underway to establish a PSEH **mental health assessment unit**, to provide better support within ED and general acute inpatient services to people with mental health conditions; which it is envisaged will lead to a reduction in emergency admission or reduced length of stay
Commitment 7 - We will 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	
Achieved so far	**In progress**
A Good Neighbours network has also been established within the City. This promotes community help and wellbeing, with volunteer led groups developing in three initial areas within the City to offer health	The **neighbourhood team model**, which is at the heart of the delivery of the new Portsmouth Community model incorporating primary, community, and social care within an integrated team, is due to be piloted shortly.

and social transport, befriending and social activities, informal care and help with tasks.	We are due to start testing in May 18 which will see individuals that require additional support provided by the team either after they have left hospital in order to return them to independence or to wrap care and support around them when they are at risk of being admitted to hospital. Once tested and rolled out to one locality, the model will be rolled out to the 2nd then the 3rd. We will then need to ensure private provider services are commissioned and develop in a way that best works with the new model of care. Social Care will soon be carrying out a systems intervention on Domiciliary Care which will inform this. Solent are partnering with a domiciliary care organisation to test a new way of working with care providers. We will take this learning and establish a care offer that is able to respond how people needs it to whilst is more robust and sustainable against market influences experienced nationally (work force issues generally). Residential and Nursing care services in private homes will be reviewed in the context of Therapy Led Units (TLU) and the benefits of working in a different way to reduce DToC, MFFD and to reduce long term care placements. Linked to the current developments with VCS partners, we are also actively promoting opportunities for the asset development within communities, enabling communities to increase control over their own health and wellbeing. Community centre approaches offer a stronger way to use local resources and to reshape them to meet local needs. Coproduction will be integral to ensure that local needs are understood. An approach to ensure robust engagement for service development plans will be put in place.

8. Health and Care Portsmouth Communications and Engagement

8.1 To support the transformation programme, a single, shared communications and engagement work stream has been established; with representation from all partners who meet together on a weekly basis to enable closer joint working. Key pieces of work undertaken to date include:

8.2 A new website for the project has launched, and will provide a central point from which to communicate the changes happening to health and social care services across Portsmouth. The site is intended to:

- Provide a central place to direct people to for engagement around health and care system changes.
- Provide a platform from which to tell the stories around health and care system changes.
- Provide an organisationally neutral space from which to share changes with staff across the system.

8.3 The first Health and Care Portsmouth newsletter was sent on Saturday 3 March 2018, featuring updates around health and social care including winter wellness updates, a feature on the Shared Lives service and the Patient Activation Measure survey.

8.4 The Patient Activation Survey (PAM), using the 'Different Conversations' brand extension, was launched on 3 March 2018. This survey uses the PAM tool to benchmark the population's proclivity to manage their own care. The survey will run at the same time each year in order to monitor population-level changes in the ability of people to manage their own care.

8.5 Staff engagement work on two projects is also under way. A piece of staff engagement with co-located community teams sits under the 'new models of care' brand extension and aims to establish how best to support staff through changes. A second piece of workforce engagement sitting under the 'different conversations' brand extension will focus on practitioners across Portsmouth City Council, Solent NHS Trust and Portsmouth CCG, and aims to benchmark staff confidence around using the 'five key shifts' model proposed by the Integrated Personal Commissioning project.

9. Governance Arrangements

9.1 Each of the key transformation work streams, mental health, MCP and Adult social care transformation have a programme board to drive delivery of the change programme, which feed into and support an ACS level work programme.

9.2 To enable co-ordination and to drive the overall integration agenda for adults' services, the Adults' Delivery Board has been established to oversee all of the adult delivery elements of The Blueprint. This feeds into the Portsmouth Health and Care Executive and ultimately the Health and Well Being Board to continue to develop and drive the strategic agenda for the City. Oversight of arrangements for children's

services continues to be provided through the well-established children's trust board arrangements.

10. Conclusions

10.1 The Blueprint for Health and Care in Portsmouth is now well-established as the set of guiding principles that set out how the key health and care organisations in the city will work together. As part of the HCP transformation programme, there is a great deal of work underway in all organisations and services, as business as usual, in order to achieve savings and efficiencies, and in order to achieve more transformational change as envisaged in the Blueprint.

11. Equality impact assessment

11.1 A preliminary EIA was completed for the Portsmouth Blueprint on its development and concluded that there will be no negative impact on any of the protected characteristics arising from the strategy. Any individual projects or measures arising from the strategic approach outlined will be subject to impact assessments in their own right.

12. Legal implications

12.1 Legal implications are set out in the body of the report.

13. Director of Finance's comments

13.1 Not sought. This work will be undertaken using existing resources and will not incur additional costs.

……
Signed by:

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:

Agenda Item 6

Title of meeting:	Health and Wellbeing Board
Date of meeting:	20th June 2018
Subject:	Drug Related Harm
Report by:	Director of Public Health
Wards affected:	All

1. Purpose

1.1 To update the Health and Wellbeing Board on drug related harm in Portsmouth

2. Recommendation

2.1 To note the contents of this report

3. Background Information

3.1 Drug use is widespread, with approximately 12,000 residents using illegal drugs annually[1], but addiction is concentrated, there are an estimated 1,427 heroin and crack cocaine users in Portsmouth. There is significant unmet need for support.

3.2 Portsmouth suffers disproportionate drug related harm, with high rates of drug related crime and deaths.

3.3 The cost of drug misuse is far reaching, including not only financial costs, but also the costs of drug related crime, health issues and impact on families and communities, therefore tackling drug misuse is a priority for the Safer Portsmouth Partnership.

3.4 In July 2017 the Government published a new national drugs strategy, which had 4 key priorities:

- Reducing demand
- Restricting supply
- Building Recovery
- Global Action

There are many positive approaches and commitments within the drugs strategy, although no additional resource to help achieve it. Indeed in the coming years the Public Health grant is being cut by central government, it is from this grant that drug treatment and prevention work is funded. This is in addition to significant funding reductions seen in the sector over the past 5 years.

[1] Ipsos MORI summary report of findings, Health and Lifestyle Survey 2015

4. Performance

4.1 Drug related deaths

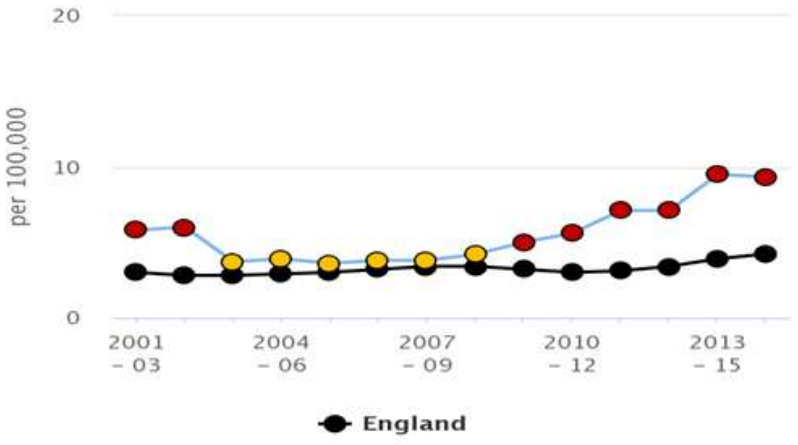
Portsmouth has the 4th highest rate of drug related deaths in England, and the highest rate (per 100,000) amongst our comparator areas for deprivation as shown in the table below[2]:

2.15iv - Deaths from drug misuse 2014 - 16

Area	Count	Value
England	6,803	4.2
Second most deprived decile (IMD2015)	1,250	5.2
Portsmouth	55	9.3
Norwich	36	9.2
Tendring	31	9.2
Pendle	20	7.8
Newcastle upon Tyne	65	7.6
Bristol	93	7.2
Sheffield	107	6.7
Wirral	61	6.7
Oldham	43	6.7
Sunderland	52	6.6
Redcar and Cleveland	24	6.6
Bolton	48	5.9
Westminster	41	5.7
Peterborough	34	5.7
Rotherham	41	5.7

The number of deaths has been rising steadily between 2010 and 2015, having fallen in the previous years. Deaths increased from 22 deaths between 2007-2009 rising to 55 deaths during 2014-2016, as highlighted Chart 1:

Chart 1 Drug related deaths in Portsmouth



Drug related deaths have been increasing nationally. Analysis by Public Health England suggests the increase in deaths since 2013/14 is partly due to an ageing cohort of heroin users from the 1980s and 1990s who are now developing associated health conditions which are contributing to their deaths (liver disease,

[2] This data should be treated with caution as reporting and recording may not be accurate. In addition there are wide confidence intervals which could mean Portsmouth's rate is somewhere between 7 per 100,000 or 12.2 per 100,000

COPD etc.). In addition there has been a reduction in the price and an increase in the purity of heroin. PHE did not draw a link to reductions in drug treatment funding over this period.

An audit of drug related deaths in Portsmouth during 2016 found the average (mean) age for men dying was 35 years old, women 37 years old. The age range was 19-55 years old. 38% of deaths were women, compared to 25% nationally. Poly drug use was common amongst those dying.

4.2 Drug Treatment

4.2.1 Public Health England has undertaken analysis of the costs and benefits of drug treatment. They have found that:

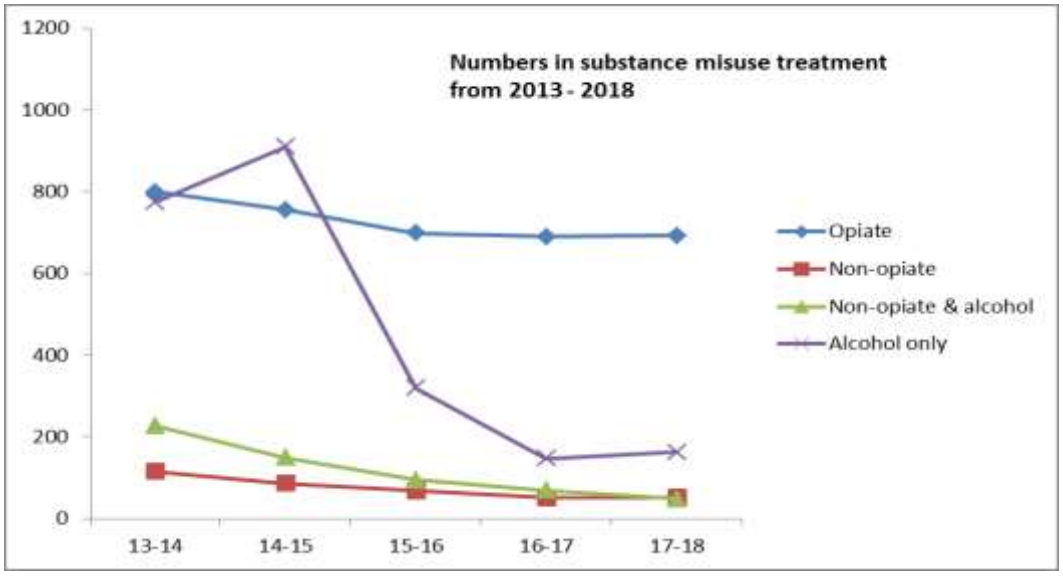
- *For every £1 spent on young people's drug and alcohol treatment there is a lifetime benefit of £5- £8.*

- *For every £1 spent on adult treatment £2.50 is saved in crime and NHS costs*

4.2.2 There have been significant reductions in the number of people receiving drug treatment, particularly non-opiate users (chart 2) and young people under the age of 25 (chart 3).2. In addition there has been a large drop in people accessing alcohol treatment (chart 2), although a significant proportion of this drop (approx. 50% is due to the Alcohol Specalist Nurse Service at QA Hospital no longer reporting to the national data system from summer 2015).

Of our 1,427 estimated opiate and crack cocaine users (OCUs) in the city, 49% are currently engaged in treatment services, this compares to a national rate of 50% of OCUs engaged in treatment.

Chart 2 Number of adults in substance misuse treatment, by substance type



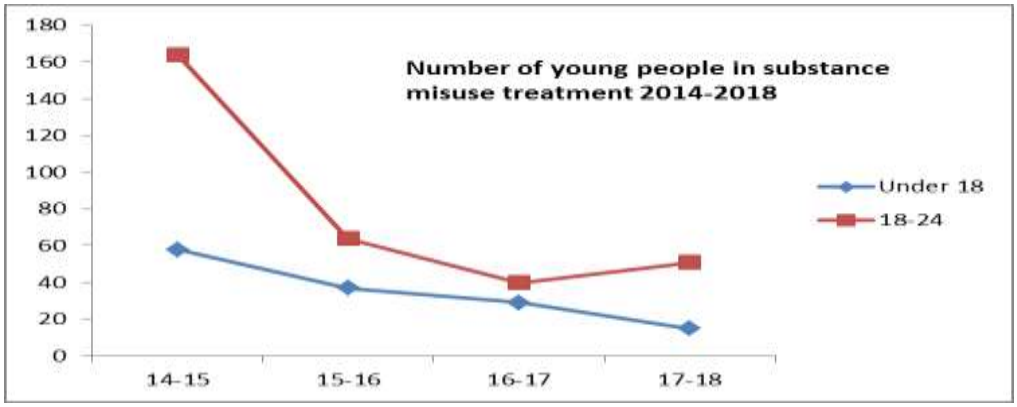
4.2.3 In part these reduction are linked to changes in funding for substance misuse (drug and alcohol) treatment, with the budgets over the past 6 years and current year detailed below.

2012/13	£4,829,889
2013/14	£4,330,145
2014/15	£3,884,800
2015/16	£3,404,498
2016/17	£3,130,973
2017/18	£2,797,178
2018/19	£2,809,400

This has led to a significant reduction in service provision, workforce, use of inpatient detoxification and residential rehabilitation during this period. In addition there has been systemic change and services have been integrated, which has potentially excluded some people from accessing them (i.e. alcohol or non-opiate clients who do not want to mix with opiate users).

4.2.4 In 2015-16 the number of young people in Portsmouth in treatment for substance misuse were in line with those elsewhere in England, but have since declined by 55% (from 37 to 15) for under 18s (chart 3). This decline is more severe than seen elsewhere in England (10.5%) or in comparator areas most similar to Portsmouth (25%). Among 18-24 year olds numbers in treatment declined by 76% from 2013/4 (n.164) to 2016/17 (n.40), compared to 19% nationally, although in 2017/18 there was a slight increase amongst 18-24 year olds accessing support (from 40 to 51).

Chart 3 Number of young people receiving substance misuse treatment.



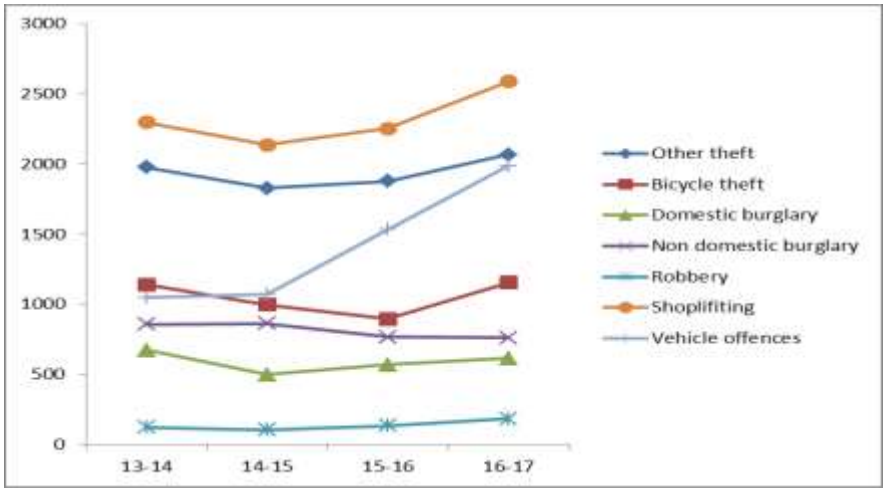
The most common age group for adults accessing drug treatment is 35-39 years old (the same as the mean ages for drug related deaths), suggesting many years of addiction before seeking help. This may also be a barrier to younger people receiving support when their drug use is less entrenched and they do not want to mix with older drug users.

4.2.5 There have been recent changes in both the adult and young people's services to address the decline in numbers. The adult 'Recovery Hub' has recently undertaken a Vanguard systems thinking review and is rolling out a new way of engaging and working with adult clients. In addition a separate alcohol pathway has been developed to better meet the needs of alcohol users. The Children's service has developed the Drug and Alcohol Support Service (DASS) to increase referrals of high risk young people into substance misuse support.

4.3 Drug related crime

Drug related crime is typically that which is acquisitive in nature, committed in order to then sell on or trade for drugs. In the past 3 years there has been a general upward trend in recorded acquisitive crime, as demonstrated in Chart 4 below, which may be reflective of the disinvestment and reduction in numbers within drug treatment.

Chart 4 Acquisitive crime in Portsmouth 2013-2017



There has been a general decline in the number of drug offences (possession and supply) in Portsmouth from a peak of 985 in 2012/3 to 585 in 2016/17. This is likely to be more a reflection of reduced police capacity and enforcement action, rather than a reduction in the availability of drugs.

5. Drug related harm

5.1 Children and young people

- The What About YOUth survey conducted with fifteen year olds in Portsmouth in 2014/15 found that 4.7% had used cannabis in the last month, and 1.1% had used other drugs with or without cannabis use.

- Nationally, around 20% of children in need are affected by drug misuse and drug misuse was involved in 38% of serious case reviews.

- In 2015-16, the number of young people in Portsmouth in treatment for substance misuse was in line with those elsewhere in England, but has since declined by 55% for under 18s. This decline is more severe than seen elsewhere in England (10.5%) or in comparator areas most similar to Portsmouth (25%). Among 18-24 year olds numbers in treatment have declined by 76%, compared to 19% nationally.

- Estimates of the extent of substance misuse in the city indicate that several hundred young people under 25 are using substances at a frequency likely to cause harm (450 using drugs twice a week and 260 daily). To deliver services at a similar level to that delivered by other areas of England in 2016-17, a substance

misuse service is estimated to require capacity to support about 57 young people under 18, and 111 people aged 18-24 each year.

- Nationally nearly twice as many under 18 young men as young women start treatment, and the most common vulnerabilities in young women are different to those in young men. Young women in treatment are less likely than men to engage in antisocial behaviour, but relatively more likely to be affected by others' substance misuse or domestic abuse; to have a mental health problem or have self-harmed; or to have suffered sexual exploitation. Injecting behaviour amongst under 18s is rare, and certainly in Portsmouth we have not provided needle exchange or opiate substitute to anyone under 18 for a number of years.

- There is significant unmet need regarding parental drug use. It is estimated there are 296 adults with a drug dependency who live with 523 children. Of these 49% (n.145) of the adults are engaged in drug treatment, covering 54% of the children (n.283). For alcohol the figure is much more challenging, with 608 alcohol dependent adults living with 1141 children, with only 8% in treatment (49 adults, living with 89 children).

5.2 **Drug supply**

- The availability of illegal drugs and particular class A drugs such as heroin and crack cocaine has been an issue in Portsmouth for many years. In more recent years drug dealing networks from major cities have moved in to the Portsmouth market and operate across boundaries, known as 'County lines'. Often networks from areas within London will send down dealers to link in with local runners to sell drugs, using known mobile phone contacts. In many cases the local people, who are exploited by the transient drug dealers, are vulnerable to exploitation, either through age (with the vulnerabilities listed above) or drug use. The out of area dealers are known to use more serious violence to enforce debts and increase market share.

- The drugs market in the UK is a significant size, any enforcement action against drug dealers on the ground in Portsmouth is likely to have a very limited and temporary effect on the availability of drugs in the city.

5.3 **Drug related crime**

- Around 45% of acquisitive crime (theft, burglaries etc.) are committed by heroin and crack users. Nationally 40% of prisoners report having used heroin

- A typical heroin user spends £1,400 per month on heroin and on average any heroin or crack user not in treatment commits crime costing £26, 074 per year

- However drug/alcohol treatment reduces crime, with a 44% reduction in the number of individuals re-offending in the 2 years after starting treatment for dependency, with a 33% decrease in the number of offences committed.

5.4 **Other harm**

- Only 10% of people new to drug treatment in 2017/18 were in employment (n.30), with 52% (n.162) classed as long term sick or disabled. Most commonly, the time since last paid employment was 2-3 years.

- 47% (n.145) of new clients to treatment had a mental health need identified, however 44% (64) were not receiving any mental health support. None were engaged with IAPT, 14.5% with specialist mental health services and 37% received support from their GP.

- 38% (n.117) of new drug treatment clients had an identified housing need, with 24% (n.75) having an urgent housing problem / no fixed abode. Housing is a common barrier to people engaging and sustaining drug treatment.

6. **Conclusion**

Drug related harm in Portsmouth is significant and apparently increasing in the past few years. Over recent years the resources available for drug and alcohol services and preventative and policing work have been reduced. This is in a context where the cost of illicit drugs had been falling and organised criminal gangs have become much better at distributing drugs.

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Signed by: Director of Public Health

Appendices:

None

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**

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