Portsmouth CITY COUNCIL

Public Document Pack

NOTICE OF MEETING

HEALTH AND WELLBEING BOARD

WEDNESDAY, 3 OCTOBER 2018 AT 10.00 AM

THE EXECUTIVE MEETING ROOM - THIRD FLOOR, THE GUILDHALL

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
Innes Richens, Dr Jason Horsley, Mark Cubbon, Dr Linda Collie (Joint Chair), Ruth Williams, Dianne Sherlock, Sue Harriman, Alison Jeffery, Andy Silvester and Siobhain McCurrach

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

2 Declarations of Interests

3 Previous Minutes - 20 June 2018 (Pages 5 - 10)

RECOMMENDED that the minutes of the Health and Wellbeing Board meeting held on 20 June 2018 be agreed as a correct record.

4 Membership Update

Healthwatch Portsmouth - to note the change in representative from Patrick Fowler to Siobhain McCurrach who is welcomed to the Health & Wellbeing Board.

5 Trafalgar Medial Group Practice and The Eastney Practice Merger (for info)

The previously notified practice merger, between Trafalgar Medical Group Practice (J82028) and The Eastney Practice (J82212) has now been completed. This merger was approved by the CCG Primary Care Commissioning Committee, and notified to the Health and Wellbeing Board on 12th March 2018. All patients transferred on 29th June 2018.

6 Blueprint for Health and Care in Portsmouth (information report) (Pages 11 - 12)

Innes Richens, Chief Officer for Health and Care Portsmouth, has provided an update as requested by the Health and Wellbeing Board.

7 Partnership Working (Pages 13 - 18)

The report by David Williams, Chief Executive of Portsmouth City Council, proposes a new approach to partnership working in Portsmouth.

RECOMMENDATION

The Health and Wellbeing Board is recommended to agree the proposals for a revision of partnership structures in Portsmouth, including revision to the remit of the Health and Wellbeing Board.

8 Director of Public Health's Annual Report 2017 (information report) (Pages 19 - 44)

The information report is to note that the Director of Public Health is publishing his statutory annual report for 2017. The topic of this year's report is childhood obesity.

The report includes examples of work that already exists and highlights some international models of action. It also sets out the need for a co-ordinated approach at local and national levels to enable improvements on this

important issue.

9 Adult Social Care Challenge (presentation item)

Innes Richens, as Director of Adult Services will do a presentation for the Health and Wellbeing Board on "The Adult Social Care challenge" and will provide members of the board with an overview of the national and local challenges around the provision of adult social care, and update members on Portsmouth's strategic approach to addressing these.

10 Complex Needs (Pages 45 - 50)

The report by Dr Jason Horsley, Director of Public Health, proposes the next steps in relation to the Health and Wellbeing Board's priority around making improvements for marginalised groups fastest, including our most vulnerable children, young people and adults, with particular reference to adults with complex needs.

RECOMMENDATIONS
The Health and Wellbeing Board is recommended to:

(1) endorse the development of the "Team around the Establishment" model linked to homeless and supported housing services, and agree to receive further progress reports;
(2) endorse the need to move forward with a data-matching and case study exercise, to enable conversations with information governance officers of relevant organisations to move forward.

11 Dates of future meetings

Members are asked to note the previously agreed dates of:

28th November and 13th February, 10am starts.

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, 20 June 2018 at 11.00 am in Conference Room A, Civic Offices, Portsmouth.

Present

Councillor Matthew Winnington and Dr Linda Collie (in the Chair)

Councillor Gerald Vernon-Jackson CBE
Councillor Luke Stubbs
Councillor Rob Wood
Councillor Leo Madden (non-voting member)
Sarah Austin
Innes Richens
Dr Jason Horsley
Dr N Moore
Patrick Fowler
Alison Jeffery
Andy Silvester

Officers Present

Kelly Nash, Jo York and Alan Knobel

40. Apologies for absence, Declarations of Interest and Introductions (AI 1)

Apologies for absence had been received from Mark Cubbon, David Williams and Dianne Sherlock.

Declarations of Interest - Councillor Wood made a declaration when the Mutiny event was mentioned as his daughter works for Motiv8, but this is non prejudicial or pecuniary.

41. Membership Update (for information) (AI 2)

The 4 City Council appointments were noted of Councillors Matthew Winnington, Gerald Vernon-Jackson, Rob Wood and Luke Stubbs. (Councillor Leo Madden remains a non-voting member as Chair of Health Overview and Scrutiny Panel.)

42. Minutes of Previous Meeting - 21 February 2018 (AI 3)

Councillor Madden pointed out minutes 37, page 3, "Holding to Account by HWB" should refer to "if it was seen that a **body**" which was agreed as a correction.

Subject to this amendment the minutes were agreed as a correct record.

43. Joint Health and Wellbeing Strategy Monitoring Framework (AI 4)

Dr Jason Horsley presented his report which looked at comparators for England and with similar CCG areas. Whist the life expectancy figures were going in the right direction there was more work to be focussed on smoking. He pointed out that alcohol related hospital admissions were now amber as there was a good service at the hospital, but that this did not necessarily imply that Portsmouth did not have a significant problem with alcohol-related harm.

Arising from questions the following arose:

- Depression and dementia were not rated as good or bad as Portsmouth is generally good at detecting these and it is important to capture rates of identification as much as prevalence of conditions.

- It is difficult to provide concrete indicators for mental health as the datasets are not as mature as for physical health, so those suggested are more generally proxy indicators.

- Under 18 pregnancies - the rate had started to rise at a time when there had been changes to the sexual health services and could be affected by availability of contraceptives (and specialist implant services) as well as educational aspirations. Alison Jeffery responded that school standards were improving (shown by Ofsted inspection results) but school attendance figures need to be addressed (1 in 5 secondary pupils having less than 90% attendance in recent figures) and this is also a worrying indicator about perceptions around education and value. It was agreed that consideration should be given to including school attendance indicators within the Framework.

- It was noted that some of the sample groups, such as for the U18 pregnancies and looked after children, are very small and that can drive fluctuations, so they need to be considered in the context of a trend over time. Public Health England had over 100 indicators so this report was looking at areas where focus was being made on making a difference.

- There was concern at the high level of 10-24 year olds being admitted to hospital due to self-harm. Dr Horsley would check whether poisoning was included as well as alcohol.

RESOLVED that the current Portsmouth position on the indicators presented be noted.

44. Delivering the Portsmouth Blueprint Commitments - Progress Report (AI 5)

Jo York presented the paper on the delivery of the Portsmouth Blueprint Commitments 3 years in of a 5-10 year Sustainable Transformation Programme (STP). She highlighted areas of particular note in providing local delivery of the 7 commitments, which included:

- Establishing acute home visiting service and the imminent change to the GPs out of hours service (giving access to patient notes)
- Engagement with the voluntary sector in supporting people to stay well
- Bringing together of back office functions
- Use of SystmOne by GP practices, a shared system that Adults Services could also use
- A joint estates strategy for the city and more co-location of teams
- New model of care - multi speciality community provider
- Improvements to emergency care via access to 24 hour primary care out of hours service
- More integration of health and social care teams and close links to Education as well as to the voluntary sector

In response to questions the following points were raised

How evaluation of projects can be made public - Jo York responded that the purpose of the Blueprint was to bring together the strategic programmes into a context for both the public and staff. Evaluation was taking place with colleagues in the SE Hants area on outcomes and also with Healthwatch.

It was acknowledged that the public do not always understand the different parts of the health service, and debate took place regarding the SE Hants model approach and decision making systems. The integrated model of care is circled around QA Hospital so it needs to be incorporated in the model but a home/community/family first approach is also being taken. Sarah Austin reported on examples of successful bridging services such as in mental health.

The high level of access to triage services was noted - this is used in most GP surgeries to give the appropriate referrals e.g. to physio.

Members asked about the current situation on hospital discharge figures. Sarah Austin reported that the situation and figures were being analysed by the A&E Board and for the next winter to be dealt with satisfactorily the rates would need to be 92% occupancy and 8% empty beds, and to get there complex discharges needed to be further reduced from current levels of 250 (May 2018), currently fluctuating 140-170 between Hants and Portsmouth. The Portsmouth target is 49 which is achieved by close work with social care

which had kept the acute trust on 'Green' status most days since Easter, which was an extraordinary position in recent years. The ambition was to reduce the target further own to 30 Portsmouth patients waiting for discharge, which would give the QA Hospital enough flexibility in the system for the winter. The intention was not to cancel operations and for elective surgery to take place. This included a model of resilience and putting together neighbourhood teams to help stop people going into hospital in the first place. It was reported that the SystmOne used by GPs was not compatible for Childrens Services and this was a provider issue (a new Mosaic system would be used by Childrens Services).

It was noted that a mental health assessment unit had been approved and capital works would take place at QA Hospital in the autumn.

Whilst the Equalities Impact Assessment (EIA) had been a preliminary EIA undertaken 3 years ago, and new ones were done for new services coming on line, but the existing overall EIA could be revisited by Jo York.

RESOLVED that the Health and Wellbeing Board noted the progress made through the adults' delivery element of the Health and Care Portsmouth Programme to deliver the Portsmouth Blueprint.

45. Drug Related Harm (AI 6)

a) <u>Report on Drug Related Harm</u>
Alan Knobel presented his report. There are 1427 heroin and cocaine users in Portsmouth and there is a disproportionate level of drug related harm and crime in the city. The most recent statistics showed 55 drugs related deaths over 2 years (see paragraph 4.1). The average age of those dying was 35 years for men and 37 for women, which is a young age to die. The average age of drug related deaths has been increasing though with older drug users now dying of other health complications linked to long-term drug use.

Public Health England had undertaken cost and benefits analysis of drug treatment:
"for every £1 spent on young people's drug and alcohol treatment there is a lifetime benefit of £5-£8
And
For every £1 spend on adult treatment £2.50 is saved in crime and NHS costs"

The report set out the reductions in numbers accessing treatment since 2014/15 and the reduced level of investment in these services. A separate alcohol pathway had been set up away from the drug users settings, and there is a young persons drugs service.

Paragraph 4.3 set out drug related acquisitive crime figures in the City 2013-17.

Results from the a survey carried out in schools in 2014/15 found 4.7% of 15 year olds had used cannabis within the last month (see section 5.1). The national picture is that drug misuse is seen in 38% of serious case reviews and currently there is a significant unmet need regarding parental drug and alcohol dependency.

The spending levels on drugs were set out - on average a heroin user spends £1,400 month, and the crime committed by heroin/crack users (not in treatment) can cost £26,074 per year. The link to reducing crime levels through the provision of treatment was explored in the report, and Alan also referred to the links with long term unemployment, mental health and housing needs. The trend for drug related harm was increasing in Portsmouth at a time when preventative services and funding have been reduced.

b) Fentanyl Briefing

Dr Jason Horsley as Director of Public Health gave a verbal update on the potential harm that could be caused with Fentanyl (a strong opioid medication) being 400x the strength of heroin and gave an overview of the rise in drug related deaths experienced in USA and Canada (first detected 2012). There is a danger of contamination in recreational drugs and from a clinical point of view it needs more antidote to treat users. This had so far only been implicated in a few deaths in UK - mitigating factors here include lower level of opioids in the health care system and free access to rehab treatment. However there are economic drivers so there is a concern it will get into the UK system and enforcement cannot stop the supply and testing regimes will be needed at a time when spending on drugs services has been reduced.

Areas to explore included:

- Drugs consumption rooms
- Better testing user supplies
- Giving heroin assisted therapy

Increasing the supply of Naloxone also has challenges for emergency workers. There is a nasal spray that is being developed but it is likely to be more expensive and the approval processes for its use are not completed yet.

RESOLVED that the contents of the report and verbal update be noted.

46. Dates of next meetings (for information) (AI 7)

The previously agreed dates of 3rd October and 28 November were noted. A further date of 13 February 2019 was also agreed (this would be circulated to members). Meetings to be 10am until 12 noon.

The meeting concluded at 1.05 pm.

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Dr Linda Collie
Joint Chair

THIS ITEM IS FOR INFORMATION ONLY
(Please note that "Information Only" reports do not require Equality Impact Assessments, Legal or Finance Comments as no decision is being taken)

Portsmouth CITY COUNCIL

Title of meeting:	**Health and Wellbeing Board**
Subject:	**Blueprint for Health and Care in Portsmouth**
Date of meeting:	**3rd October 2018**
Report by:	**Innes Richens, Chief Officer for Health and Care Portsmouth**
Wards affected:	**N/A**

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1. Requested by
Health and Wellbeing Board

2. Purpose

2.1 At the last meeting, PHCE received a paper that set out the achievements that have been made in progressing the Blueprint for Health and Care in Portsmouth, and highlighted a number of areas that would be the next steps. It was also noted that the developments in Portsmouth are taking place against a backdrop of extensive system change in the NHS, and consideration of local government forms in the light of ongoing debate around devolution.

2.2 It was considered that the broad commitments in the Blueprint remain the right ones for the city, and the activities were considered in terms of their fit with these. It was noted that in many cases an activity will have impact across a number of these.

3. Information Requested

3.1 Emerging from the paper, the following are the highest priority areas of action for 2018/19:

- Integrated Primary Care Service, incorporating provision of Out of Hours, Acute Visiting Service and GP Enhanced Access - further developments will be aligned to H&IoW integrated urgent care service and delivery of a local clinical assessment service.
- Increasing capacity and capability to improve access, such as use of care navigator roles, linked to the strategy for ASC in the city
- Develop the single point of contact for access to the VCS in the city
- Develop a Long Term Condition Hubs in the city

- Further develop the concept of a Wellbeing House to increase support offered to people with low level mental health needs
- Ensure Adult Social Care operating on SystmOne to support creation of a joint health and care record
- Progress the development of a strategic estates plan for the city, including consideration of a SEND hub
- Further develop the model for integrated commissioning building on existing learning from BCF arrangements
- Further progress the MCP arrangements
- Establish a PSEH mental health assessment unit
- Develop the neighbourhood team model, incorporating primary, community and social care.

3.2 Most of these programmes already have governance arrangements, either through the Adults' Delivery Board or the Children's Trust Board. The role for the Health and Wellbeing Board is therefore not to duplicate this but to ensure that in the context of wider change, the priorities for the city are still being delivered, barriers to this are being identified and removed, and solutions to support city priorities are identified and progressed.

……
Signed by (Director)

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

Portsmouth CITY COUNCIL

Title of meeting:	Health and Wellbeing Board
Date of meeting:	3rd October 2018
Subject:	Partnership review
Report by:	David Williams, Chief Executive, Portsmouth City Council
Wards affected:	N/A
Key decision:	No
Full Council decision:	No

1. Purpose of report

1.1 To propose a new approach to partnership working in Portsmouth.

2. Recommendations

2.1 The Health and Wellbeing Board is recommended to agree the proposals for a revision of partnership structures in Portsmouth, including revision to the remit of the Health and well Being Board.

3. Background

3.1 Portsmouth has a long and successful history of partnership working. The Safer Portsmouth Partnership (SPP) and Children's Trust Board (CTB) have been leading their respective multi-agency agendas on behalf of the city for over a decade. The Health and Wellbeing Board (HWB) was created as a statutory partnership and committee of the council from 2013/14. Its emergence coincided with the reorganisation of the health service, including the transfer of public health responsibilities to the city council. A number of previous requirements such as the Local Strategic Partnership (LSP) and Local Area Agreement had been abandoned nationally, and our arrangements evolved to reflect that, including the retention of a regular (but infrequent) meeting of city leaders as the Public Service Board.

3.2 In Portsmouth, the three partnerships (HWB, SPP and CTB) work alongside one another to address key local needs. The big picture of our "local" population is presented in the Joint Strategic Needs Assessment (JSNA). This includes the detailed SPP Strategic Assessment and the Children's Needs Assessment. The council and Clinical Commissioning Group (CCG) - via the HWB - have a statutory duty to oversee the production of the JSNA and to agree a Joint Health and Wellbeing Strategy (JHWS) to address the needs identified therein.

3.3 The Council (via our community safety partnership) is required to produce a strategic assessment of crime and disorder, anti-social behaviour, reducing re-offending and drug and alcohol misuse, and to develop local strategies that deal with the issues raised by it. Councils and their partners also have a duty to promote co-operation to improve children and young people's health and wellbeing. Partner agencies, and the city council, have invested considerable energy, commitment and financial resource over the years to develop and deliver the work set out in the respective partnership strategies. In addition, the Portsmouth CCG has a duty to have regard to the need to
(a) reduce inequalities between patients with respect to their ability to access health services, and
(b) reduce inequalities between patients with respect to the outcomes achieved for them by the provision of health services.

3.4 It is worth noting that the Council is also a member of a number of sub-regional partnerships (or equivalent) including the Partnership for Urban South Hampshire (PUSH), Solent Transport and the Solent Local Enterprise Partnership (Solent LEP). The Council is also a member of a number of national partnerships / networks including the Key Cities and the Unitary Council Network.

4. Reasons for recommendations - rationale for change

4.1 Increasingly, there is a recognition that the issues being looked at by the different Portsmouth partnerships overlap considerably and that there is common membership across the partnerships. It was also noted that the current arrangements have evolved from previous national regimes and that there may be better ways to organise partnership working to meet the needs of our locality. It was therefore agreed that a review of the partnerships would take place, to see if arrangements can be streamlined and impact increased. This also links to other changes taking place (such as the review of the Portsmouth Safeguarding Children Board, following the Wood review).

4.2 Early discussion took place with the partnerships, and key stakeholders . This highlighted the following additional issues:

- The "place" agenda is not picked up through existing partnership arrangements although there are local and sub-regional bodies such as the Shaping Portsmouth, as well as Solent LEP, Solent Transport and PUSH that are looking at these issues on a wider geography (although see paragraph 4.3 below)
- There is no single body that looks at the whole person - this means that artificial constraints are put in place and consideration of the whole life experience doesn't take place (examples would include substance misuse or adverse childhood experiences which are issues across all age groups and influenced by people across all ages)

- The same leaders are in the different partnership boards discussing similar issues
- It is important to capture the perspectives and contributions of those outside the big public sector organisations, including the voices of those in the voluntary and community sectors.
- The dialogue around 'the place' and those around 'the person' are not consistently brought together in an holistic manner

4.3 Similarly, there is a growing recognition that the sub-regional partnership landscape needs to be refreshed too in order to help provide some clarity about responsibilities and ensure that sub-regional work is properly aligned towards the common growth agenda.

5. Moving to new partnership arrangements in Portsmouth

5.1 There are many important aspects that are currently done well in Portsmouth that any new arrangements will need to retain. Portsmouth has positive relationships at a senior level - in many cases supported by co-terminous organisational boundaries. Any new arrangements must not be a barrier to this. Equally, the extent to which partnership arrangements allow for focused consideration of issues - where this is necessary and appropriate - is also an important function to retain. Any future arrangements need to move away from constraining "ownership of agendas" and ensure that issues are addressed openly and not territorially. A possible approach has been developed which it is felt is in line with these principles and which will simplify the arrangements.

5.2 The proposal is to expand the membership of the formal Health & Wellbeing Board and for this partnership to subsume the activity of the SPP and the CTB. This fits with the revised Health and Wellbeing Strategy incorporating the key themes from the Children's Trust Plan and Safer Portsmouth Plan, in recognition that many of the issues discussed are consistent with the wider determinants of health. This partnership would meet around three times a year and would own the strategic discussion on the 'people' agenda across the city. It is recognised that the 'place' agenda to an extent is already owned by 'Shaping the Future of Portsmouth' and we are discussing with them the extent to which they may play into the new arrangements. There is no change proposed to the existing operational sub-groups and partnerships - that would be for them to decide - but their reporting arrangements would be into the broadened Health & Wellbeing Board (if needed) rather than separate thematic partnerships. Where they may require or seek leadership buy-in or permission it is proposed that they could use the new Health & Wellbeing Board to achieve this.

5.3 It is recommended that twice a year there would be a city-wide partnership conference. One of these would be about 'the People in our City' and the new Health & Wellbeing Board would be responsible for putting this together. Subject to agreement with 'Shaping' they would be responsible for putting together the other conference - 'the City for our People'. These conferences would replace the existing Public Services Board and it is envisaged that a rapport could be developed between the two conferences to address the interdependent issues.

5.4 The aim of these new arrangements is to use valuable leadership time to reach a common understanding of an issue and a perspective on how it could be addressed, not to spend time on mechanistic matters of governance. Importantly, more broad-ranging discussion would surface issues of more strategic significance around how we see the city and what needs to happen to achieve the vision. The idea is that events should be energising and more exploratory, whilst still providing a mechanism to allow formal agenda items to be resolved.

5.5 If there is broad acceptance of these proposals, then detailed arrangements will be worked up, including revised Health and Wellbeing Terms of Reference. This will be brought back to the Health and Wellbeing Board in November. All of the Health and Wellbeing Board statutory functions and oversight would continue to be discharged. It is therefore suggested that a specific executive committee (or range of sub-committees) is convened to deal with these matters and that the ability to do so is formally delegated.

6. Equality impact assessment

6.1 Any equality matters arising through the partnership review will be considered as part of this process and will progress to November Health and Wellbeing Board alongside revised Terms of Reference.

7. Legal implications

7.1 The report has incorporated legal implications and accordingly there are no other immediate legal implications arising from this report.

8. Director of Finance's comments

8.1 There are no financial implications to bring to HWB members' attention at this stage. Revised arrangements will be accommodated within the current financial envelope for partnership support.

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

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

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

……
Signed by:

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(Please note that "Information Only" reports do not require Equality Impact Assessments, Legal or Finance Comments as no decision is being taken)

Portsmouth CITY COUNCIL

Title of meeting:	Health and Wellbeing Board
Subject:	Public Health Annual Report 2017
Date of meeting:	3rd October 2018
Report by:	Director of Public Health
Wards affected:	All

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1. Purpose

To note that the Director of Public Health is publishing his statutory annual report for 2017. The topic of this year's report is childhood obesity.

The report includes examples of work that already exists and highlights some international models of action. It also sets out the need for a co-ordinated approach at local and national levels to enable improvements on this important issue.

2. Information Requested

None

……
Signed by Dr Jason Horsley, 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
Nil	

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SOUTHAMPTON CITY COUNCIL

Portsmouth CITY COUNCIL

DPH Annual Report 2017

Childhood Obesity

02

CONTENTS

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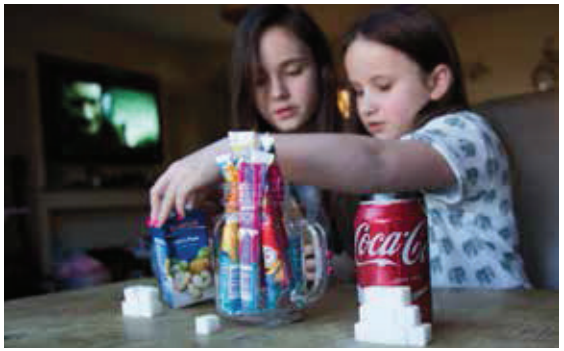
Published September 2017

You can download this report from Portsmouth's joint strategic needs assessment website: www.jsna.portsmouth.gov.uk

We would be pleased to receive your comments about this report.

Email: jason.horsley@portsmouthcc.gov.uk



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Jason Horsley
Director of Public Health

EXECUTIVE SUMMARY

I have chosen to look at the problem of childhood obesity this year. This is a serious problem confronting both the current generation and also future generations, since the consequences of childhood obesity impact both on the individuals affected, and also on the wider society as we battle to make our stretched healthcare resources work effectively.

Obesity harms children's physical and emotional health in their childhood and is likely to go on to harm their adult health, cutting short lives and placing further strain on our health services.

It has been over a decade since the landmark Foresight report[1] highlighted that "Significant effective action to prevent obesity at a population level is required". This gives us a chance to see if we are having the impact we would hope.

Rates of obesity in children have continued to climb in the UK over the last decade. Rates in Southampton and Portsmouth are similar to those seen in our statistical neighbours (cities with similar profiles and similar levels of deprivation). However, being "average" for this problem is not something we can take comfort in – nationally rates of childhood obesity are too high, and are much higher than they were 20 years ago. We have to be ambitious if we are going to make a difference to a problem we cannot ignore.

At a simple level, rising rates of childhood obesity results from a reduced level of physical activity in our children, and diets that are too reliant on high calorie processed foods. However, there are a number of cultural shifts underlying these simple drivers that we need to recognise.

There have been numerous interventions that attempt to reduce the rates of childhood obesity in our population. In this report I will make a case that what we have been doing, while helpful, is not enough. In this report we have included a lot of great examples of work that already exists, but that either needs to be done more often or replicated across a wider area. We have also looked for international models that appear to have been effective.

I don't think relying on our healthcare system or even the growing gym industry can be the answer. While the consequences of obesity impact on our healthcare system, the reasons why we have the problem in the first place cannot be addressed through healthcare provision. Too often we have placed the responsibility back on individuals, through healthcare providers and used individualised interventions. I would argue that childhood obesity is a population problem, and needs interventions that reach everyone.

There are things that everyone can do to improve the situation – this is a problem that will need the coordinated actions of central and local governments, schools, food producers and providers, employers, and not least parents and children.

Jason Horsley
Director of Public Health

04 DANGERS OF OBESITY

We often view obesity as a "healthcare" problem – but it s a problem created by society that has a massive impact on health[2]. GPs, hospital doctors and nurses don't have the capacity to deal with a problem that affects about 60% of the adult population.

Being inactive increases the risk of a range of conditions usually associated with old age including heart disease, type 2 diabetes and certain cancers.

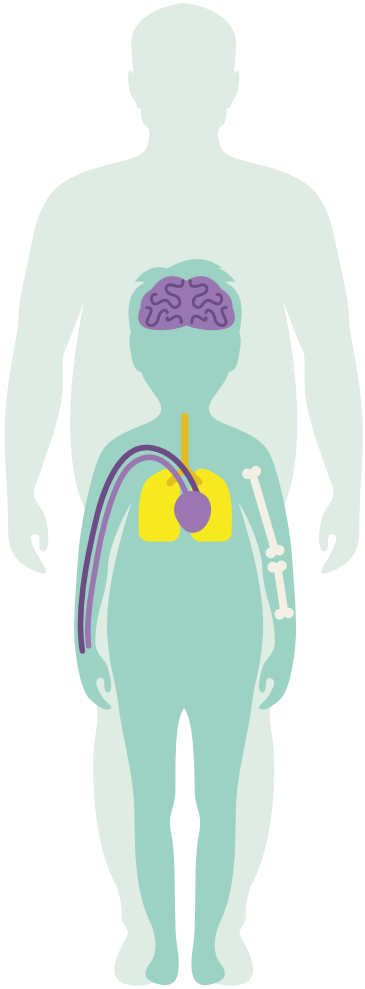
Obesity harms children and young people:

Emotional and behavioural
Stigmatism
Bullying
Low self esteem

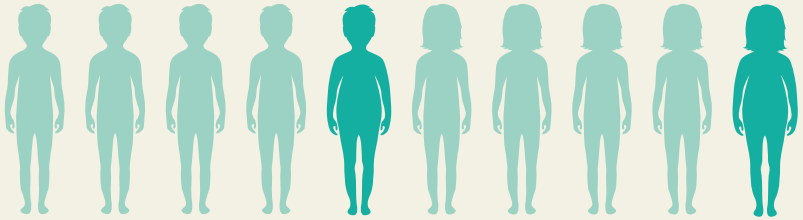
School absence

Physically
High cholesterol
High blood pressure
Pre-diabetes
Bone and joint problems
Breathing difficulties

Adult life
Increased risk of becoming overweight adults
Risk of ill health and premature mortality in adult life

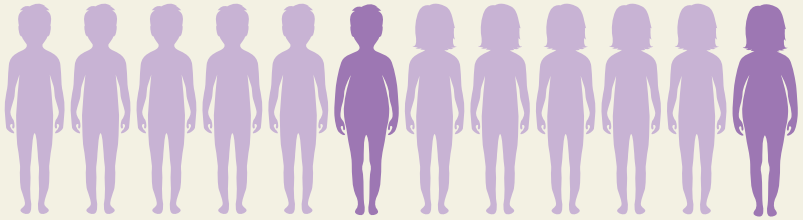


QUICK FACTS



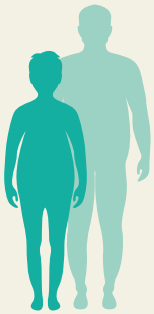
More than one in five five-year-olds in England are obese or overweight[2].

By year 6 (age 11) this is one in three[2].



In 1980 the rate in 2 – 19 year olds was only one in six[3].

Overweight adolescents have a 70% chance of becoming overweight adults[3].



TRENDS IN OVERWEIGHT AND OBESITY IN CHILDHOOD

05

The National Child Measurement Programme has helped us to monitor trends over time:

» Prevalence of obesity and overweight in 5 year olds (reception year) has apparently plateaued – although at a level that is way too high to manage.

» The prevalence of obesity and overweight in 11 year olds (year 6) is still slowly rising and is now 34.2% for England. In Southampton it is slightly higher (34.9%) and even higher in Portsmouth (35.9%)[4].

The rise in obesity between reception year (age ~ 5) and Year 6 (age ~ 11) suggests that interventions in these school years could be highly effective.

Unfortunately excess weight tracks through to adulthood – 61.3% of the adult population is either overweight or obese[4].

We need to ask ourselves, are we happy to reach England average levels for childhood obesity. Or do we want to do better than that?

For inspiration we need to look at examples of cities that have made a difference for their residents:

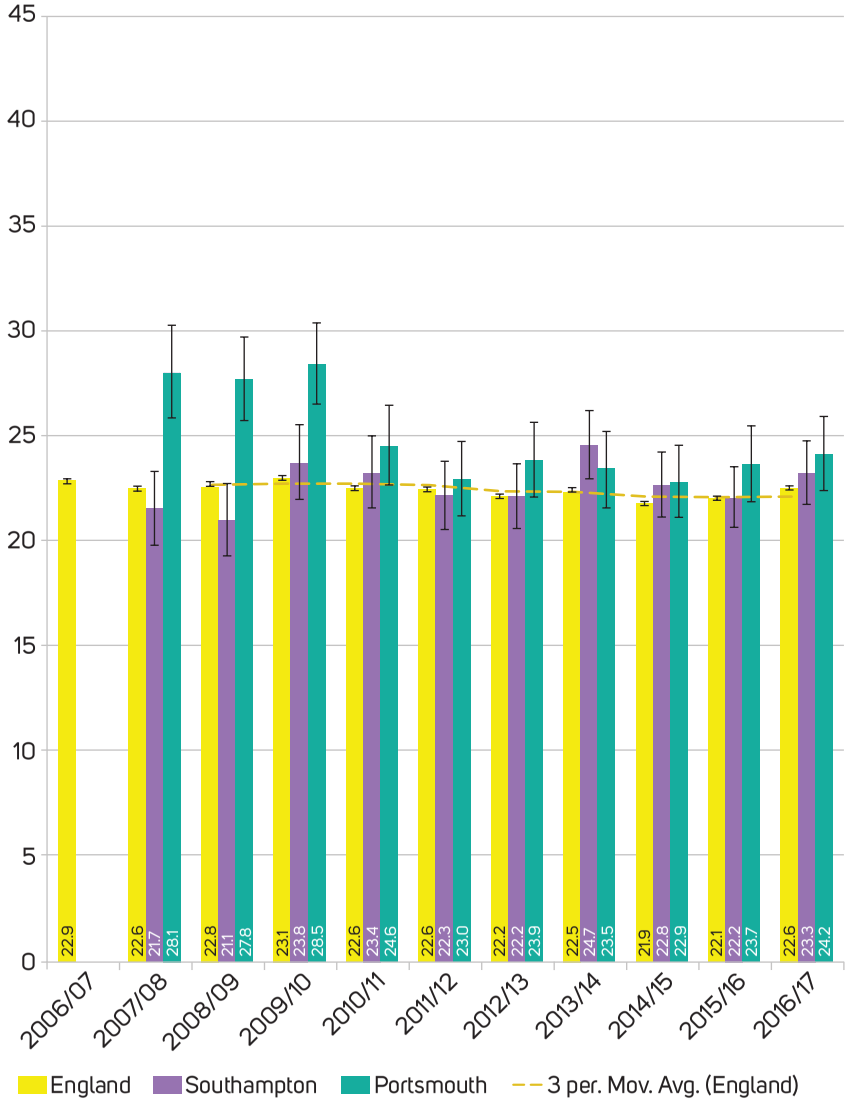
» Seinäjoki in Finland have reduced obesity in five year olds from similar levels to the UK (1 in 5 Five-year-olds) to almost half that.

» Freiburg in Germany has transformed the environment for its residents to a place where walking, cycling and public transport are prioritised.

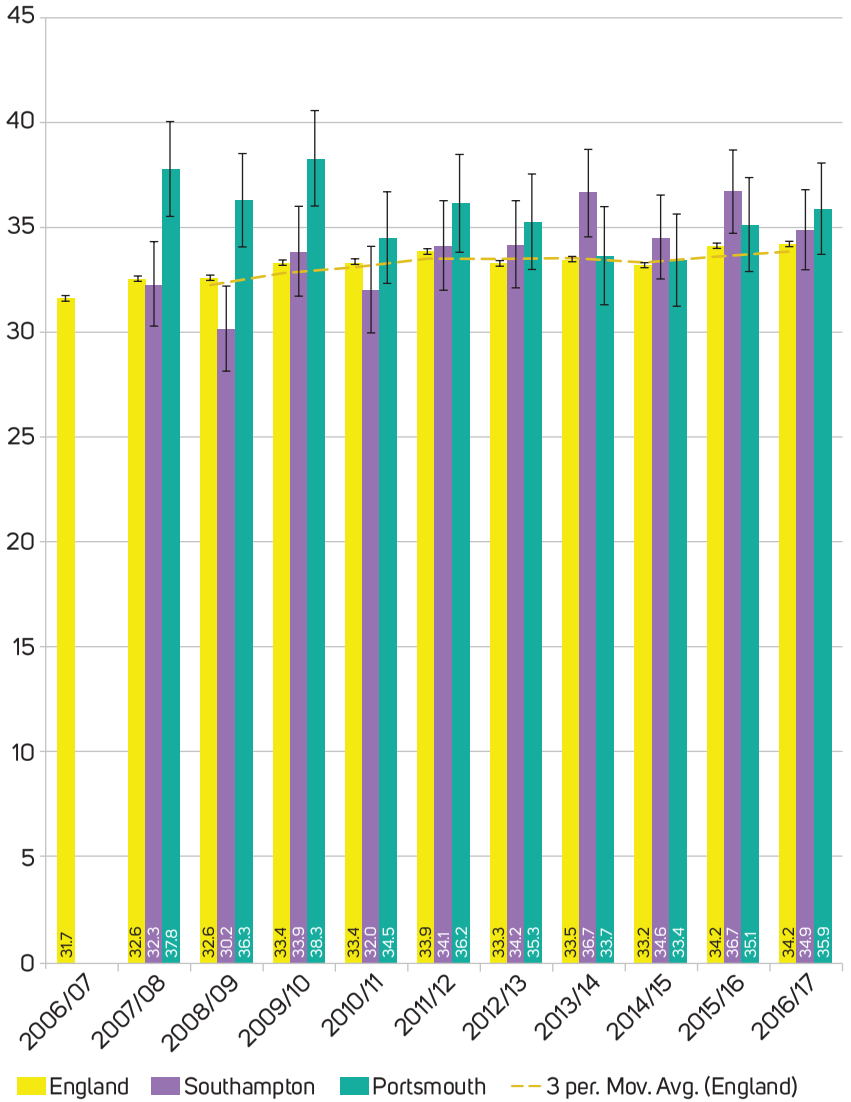
These interventions won't work overnight, but we have to use the most effective ones, and for long enough to see results.

06

TRENDS FOR PROPORTION OF CHILDREN WHO ARE OVERWEIGHT OR OBESE IN RECEPTION YEAR



TRENDS FOR PROPORTION OF CHILDREN WHO ARE OVERWEIGHT OR OBESE IN YEAR 6



DEPRIVATION PLAYS A MAJOR ROLE, AND IS DRIVING INEQUALITIES IN HEALTH OUTCOMES

The graphs below show the gap between rates of obesity and overweight in the most and least deprived wards in the country.

They show three disturbing facts:

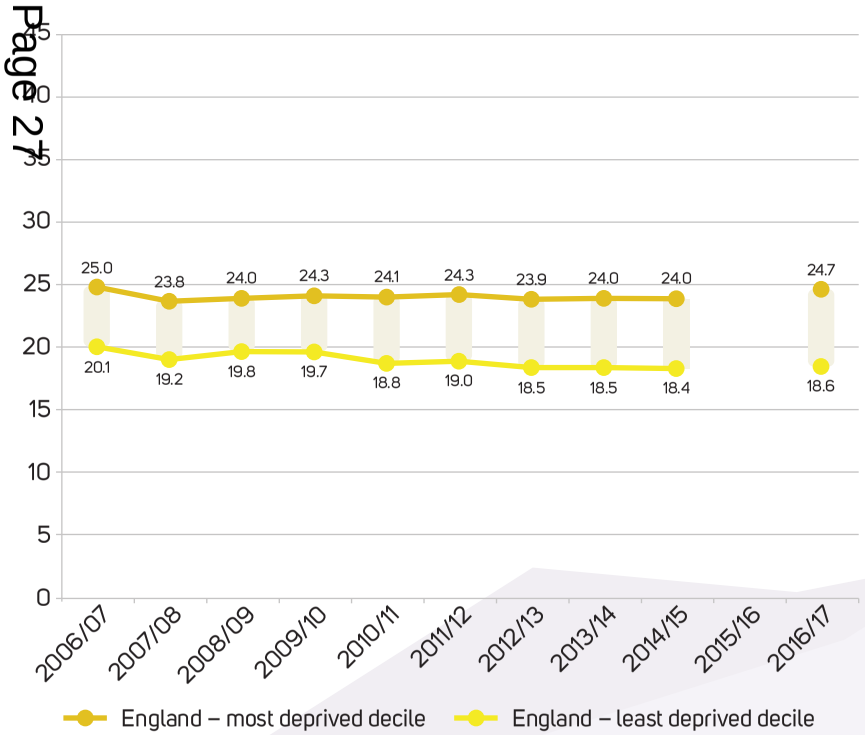
» First that there is a big difference between the rates of overweight and obesity between the richest and poorest areas in the country.

» Second that this gap appears to be growing.

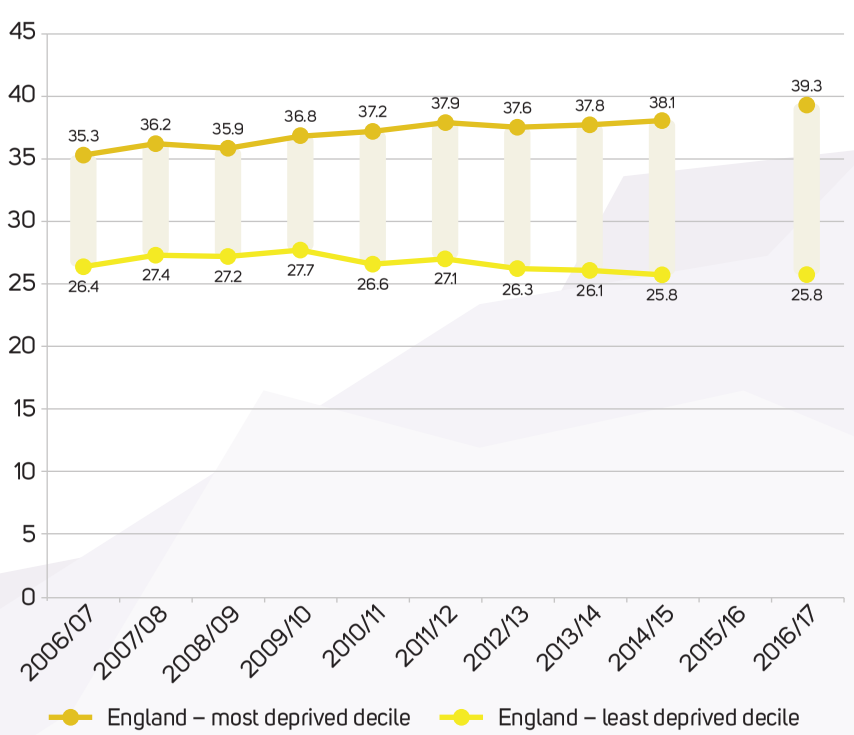
» Third is that the gap is growing because rates are getting worse in the most deprived areas, and better in the least deprived areas – suggesting our current interventions are only working in the richer parts of the country.

For our two cities, where there are pockets of significant deprivation, these figures suggest we need to do more to target the most deprived wards in the city.

TRENDS FOR PROPORTION OF CHILDREN WHO ARE OVERWEIGHT OR OBESE IN RECEPTION YEAR BY DEPRIVATION DECILE



TRENDS FOR PROPORTION OF CHILDREN WHO ARE OVERWEIGHT OR OBESE IN YEAR 6 BY DEPRIVATION DECILE



08

HOW HAVE WE GOT HERE?

It is a popular belief that if people ate less and did more activity, then obesity would be solved

BUT…

Years of evolution have designed us to preserve energy whenever possible, and to value high calorie foods. Our genetics mean we get pleasure from eating to excess, and by default we are inherently lazy. Unconsciously we have designed our lifestyles according to these basics.

The causes are complex as the choices we make are influenced by many factors, they include[1]:

Friends and family

Cultural backgrounds

Marketing of food and promotions

Likes and dislikes

How difficult it is to access healthy foods - it is easy to grab a pastry rather than hunt for a healthy option

How difficult it can be to walk or cycle rather than drive to work

We need to recognise we are not winning with our current approach.

- The trend for rising rates of obesity has not reversed for over a decade.
- Medical interventions and weight management support through intensive lifestyle advice cannot provide the answer alone. Support programs often have a high drop out rate and we don't have the resources to provide them to everyone who could benefit (over 60% of the adult population).
- Solely encouraging people to take up a healthy diet and more activity, helps only a few.
- We need to make it easier for a majority of people to be active and eat healthier by changing the environment we live in so that these choices are the most effortless ones to make.

RELATIONSHIP WITH HOW WE MOVE

MOST OF THE EXERCISE WE GET EVERYDAY IS THROUGH MOVING FROM ONE PLACE TO ANOTHER

A majority of the trips we make are for shopping, personal business and visiting friends.

Only **15%** of the trips we make are for commuting. (National Travel Survey 2016)[5]

Nationally 62% of our trips are made by car and 25% by walking and the number of trips we have made by walking has been steadily decreasing since 2002. (National Travel survey 2016)

Over the long term the cost of purchasing cars has decreased and 77% households own at least one car. (National Travel Survey 2016)

Increasingly we have made it easy to travel without moving as we have designed cars into every aspect of our lives. We feel is safer to drive at 30 – 50 mph than for people to travel at 5 – 15 mph on a cycle.

Recently we have made it even easier to move less as we can purchase most of the things we need through online shopping.

HOW CAN WE REVERSE THIS TREND AND MOVE MORE?

People are more likely to walk if they are taking a short trip, on average each walking trip lasts just 16 minutes (National Travel survey 2016)

If our cities were designed around walking, not cars, the walking trips we take should increase. This would have added benefits of:

- Reduced air pollution
- Reduced road injuries
- Stronger social interactions
- Sense of belonging
- Reduced crime rate
- Improved physical and mental health[6]

To see this change we must commit to making walking a priority, ensure walking features strongly in town plans, create a walking network and design streets as places for children to enjoy (Creating Walking Cities a Blueprint)[6].

10

RELATIONSHIP TO FOOD ENVIRONMENTS

Our food all has an impact on our diet and its nutritional content. It is influenced by how we:

Research shows

- Shops in poorer areas have fewer healthy food options[7]
- Fast food outlets are more common in deprived areas nationally[8 9]
- These factors have been associated with poorer diets and health problems that can result from poor diets[10 11]

The good news is that we have the ability to make changes to the local environments which will help people make better diet choices.

For example, ensuring that healthy options are easy and accessible to all (relatively cheap, available, convenient etc.) is a key factor if everyone is to have the opportunity to eat a healthy, balanced diet. This includes places like:

» Businesses selling prepared food for immediate consumption (canteens, cafés, restaurants, takeaways, high-street shops etc.)

» Supermarkets

» Corner shops

CASE STUDIES

CASE STUDY: THE DAILY MILE

Arundel court have been doing the daily mile for over a year with Key Stage 2 pupils and it's proved very successful. The students walk, jog or run a mile during each school day.

Perceived barriers:

- **No time?** Once you get into the habit of scheduling 10 mins each day it becomes part of routine.
- **Limited space?** It doesn't matter, our kids do 7 laps of our go-kart track to make a mile!
- **Bad weather?** It hasn't been an issues, even on rainy days you can generally find 10 minutes where it isn't pouring.

Benefits:

- Real improvements in fitness and confidence
- Inclusive (all pupils can participate)
- Children feel "happier", "increased enjoyment in activity" and "have friends to play with"

Would you recommend other schools get involved in the daily mile?

"Absolutely. We've seen nothing but positives and haven't encountered any problems with setting it up. Just give it a go and it'll become routine before you know it".

"Pupils love it, we're looking at rolling it out to all pupils this year"

12

CASE STUDY: ROAD CLOSURE OUTSIDE ST JOHN'S PRIMARY SCHOOL FOR CLEAN AIR DAY IN SOUTHAMPTON

The event:

A Road closure organised outside school enabled the street to be transformed so that children and families could participate in street play, cycle training and Dr Bike sessions. Dance workshops, renewable energy lessons and seed planting activities.

What happened?

- Majority of pupils travelled actively to school (walk, scoot, cycle or Park & Stride)
- 85 bikes fixed by Bike Dr.
- 120 pupils participated in bike agility courses
- 300 pupils participated in outdoor dance sessions
- 60 pupils participated in renewable energy workshops

Who was involved?

All pupils and staff. SCC School Travel Officer, Sustrans staff, The Environment Centre Team and Global Action Plan staff.

The legacy:

Success of one-day road closure has led to consultation with residents for a permanent timed road closure outside the school.

CASE STUDY: POMPEY MONSTERS – WALK TO SCHOOL CHALLENGE

The programme:

An incentivised programme to encourage long-term behaviour change to reduce car travel to school, thus reducing congestion and improving health.

Launched in 2017:

Initially piloted in 3 schools over a 7 week period, using a video of the monsters and a visit by 'Stomper'. Parents received flyers to encourage online sign-up.

Introduction:

Registered pupils received an information pack and the monster characters (who all carry a different road safety message) were introduced. Children also got a chart to record their walks to school, a Park and Stomp (stride) map and a pedometer voucher.

In action:

The road safety team visited schools, distributing the monster keyring's (incentive for walking, different ones to collect) once pupils proved they walked to school 3 or more times per week.

Results:

- 68% of pupils registered to participate
- 92% collected 4 or more keyring's
- Over 97% are very likely or likely to continue walking
- Over 81% said they enjoyed walking to school more frequently
- Nearly 84% of parents said they valued time walking with their child

Impact:

- 60% indicated they now walked 4/5 times per week
- 96% said scheme helped teach road safety

The legacy:

The scheme has been rolled out to 3 more schools, with encouraging results to date.

CASE STUDY: SO18 BIG LOCAL – HELPING TO INCREASE USE OF LOCAL GREEN SPACES

The programme:

Harefield, Midanbury and Townhill Park in Southampton were allocated Big Lottery funding to each come together to make their areas even better places to live. The project named SO18 Big Local has a number of aims which include getting local people out and about and enjoying the green areas on their doorsteps.

What happens?

- Work with local schools to teach children about the biodiversity in the area
- Engaging with local residents and making them aware of local 'wild' areas
- Promoting active participation in local hands-on activities in natural spaces

Who was involved?

SO18 Big Local is driven by a group of people that all live, work or volunteer in the area.

Impact

- Awareness has increased – many local residents were not even aware of the local green space available on their doorstep
- More people engaging in activities in Frogs Copse
- More people are involved in helping maintain their local green spaces

"I never even knew this space was here"

14

CITIES THAT HAVE MADE A DIFFERENCE FOR THEIR RESIDENTS

FINLAND [12] [13]

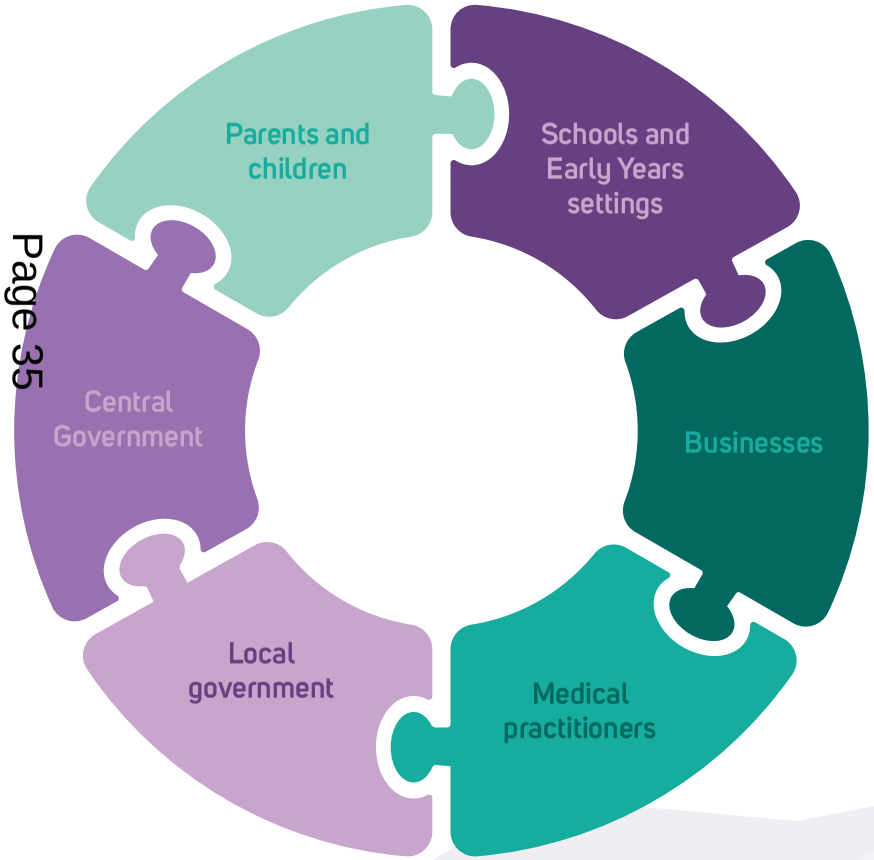
- Seinäjoki in Finland has a population of over 60,000 and is a fast growing urban area of Finland. The businesses in the area focus on food , agriculture and agro-technology
- Seinäjoki managed to half the proportion of overweight and obese five year olds in the city in just 6 years
- They did this by getting the right policies in place and understanding that preventing childhood obesity lies outside the health sector.
- The city worked on having a health in all policies approach and by working out how different departments could work together (e.g. planning, education, recreation and health) and having clear role for each department
- They worked to increase physical activity and improve food choice.

GERMANY [14] [15]

- Freiburg is a city located in South Germany with a population of 220,000. After the devastation of the Second World War, sustainable development featured strongly in rebuilding the city. Freiburg developed a car-lite system focussing on walking, cycling and public transport. Use of cars is restricted and two-thirds of the land is devoted to green uses.
- The impacts have been notable, the living standards in this city are among the highest in Germany, and residents have a strong understanding of environmental issues which effects lifestyle choices. This approach to urban planning have improved community cohesion, improved the health as well as safety as children can play safely outside the home. There has also been a reduction in the differences (social inequalities) between the richest and poorest groups, indicating that the whole population are more likely to flourish.

WHAT ARE OUR OPTIONS?

If we are to reduce the high levels of childhood obesity, action is required at all levels to make healthy choices the easier choices – a "whole systems" approach.



THE PLACE FOR INDIVIDUAL ACTION

People who can have the biggest impact are still parents and children

What would we expect of parents:

- Be a role model – your kids copy you!
- Teach children about healthy food choices from an early age
- Be active as a family-make play a part of every day life
- Reduce screen time
- Teach kids about advertising and how it is trying to influence them
- Encourage schools to offer opportunities for physical activity and provide healthy meals/ snacks

ROLES FOR EDUCATION INSTITUTIONS

Embrace physical activity

- Improves school performance!
- Sport should be fun first (competition has its place but first aim is to ensure there is something for everyone)
- It doesn't have to come under the label of "sport" – examples of other initiatives include:
  - Daily Mile or Golden Mile **thedailymile.co.uk** or **golden-mile.org**
  - Walking buses
  - Active travel plans
- Encourage good diets in school make sure school foods meet the national school food standards
- Use PHSE to explore issues sensitively
  - Understanding healthy diets
  - Recognising value of physical activity

ROLES FOR LOCAL BUSINESS

For most businesses the best asset they can have is a healthy workforce. Similarly a loyal, healthy customer base will make them more likely to operate on a sustainable profit.

Many businesses, especially small and medium sized ones, do better when they have higher footfall, which in turn is dependent on measures that increase walking, cycling and public transport.

Businesses have a role to play by:

- Making it easier for staff and customers to travel by active transport, or provide incentives when they do.
- Food retailers can make healthy options more prominent on shelves
- Food retailers can have healthier snacks at the checkout and price promotions on healthy meal or snack options.
- Investing in the local community to promote healthier choices.
- Larger businesses must consider how to support smaller suppliers, and especially when they are offering a healthier alternative

ROLE FOR LOCAL GOVERNMENT[16]

My biggest ask of local governments is to use their powers to shape the built and natural environment, and to influence transport.

The Town and Country Planning Association has developed a great list of actions for planning departments to help plan healthy weight environments.

I would also ask elected members to recognise the importance of this problem, and to make addressing it a priority in all their actions. Officers will need their support.

Planning Healthy – Weight Environments – Six Elements

Movement and access 1

- Clearly signposted, with direct walking and cycling networks
- Safe and accessible networks, and a public realm for all
- Walking prioritised over motor vehicles, and vehicle speed managed
- Area-wide walking and cycling infrastructure provided
- Use of residential and business travel plans

Open spaces, play and recreation 2

- Planned network of multi-functional green and blue spaces
- Easy-to-get-to natural green open spaces of different sizes
- Safe and easy-to-get-to play and recreational spaces for all, with passive surveillance
- Sports and leisure facilities designed and maintained for everyone to use

Healthy food 3

- Maintain and enhance opportunities for community food growing
- Avoid over-concentration of unhealthy food such as hot-food takeaways in town centres and in proximity to schools or other facilities aimed at children and young people
- Shops/food markets that sell a diverse offer of food choices and are easy to get to by walking, cycling or public transport

Neighbourhood spaces and social infrastructure 4

- Community and healthcare facilities provided early as part of a new development
- Services and facilities co-located within buildings where feasible
- Public spaces that are attrative, easy to get to, and designed for a variety of uses

Buildings 5

- Adequate internal spaces for bike storage, dining and kitchen facilities
- Adequate private or semi-private outdoor space per dwelling
- Car parking spaces spaces are minimised across the development
- Well-designed buildings with passive surveillance

Local economy 6

- Enhance the vitality of the local centre by providing a more diverse retail and food offer
- Centres and places of employment that are easy to get to by public transport, and on walking and cyling networks
- Facilities are provided for people who are walking and cycling to local centres and high streets, such as street benches, toilets and secure bike storage

18

ROLE FOR HEALTHCARE PROVIDERS

I think we have relied too heavily on healthcare providers. They have an important role in recognising when people have a problem and in signposting to help, but healthcare facilities can only help once a problem has started. To be effective we have to work to prevent obesity starting.

There is a significant role for health visitors and midwives to promote healthy eating from the very beginning, and to signpost young parents to information they need to get their children off to the right start.

- In adults there is good evidence that healthcare providers can make a difference by providing brief opportunistic interventions to motivate weight loss[17]
  - Primary care appointments are an ideal opportunity for this intervention which could take as little as 30 seconds.
  - It can achieve moderate weight reduction in patients and has been shown to be highly acceptable by patients.

ROLE FOR CENTRAL GOVERNMENT

Central government has done a lot over the years to promote physical activity and healthy food. There has been a huge amount of support for sport. New measures like the sugar tax on beverages are welcome.

All too often though, initiatives don't have the impact they could. Initiatives led by governments from all major parties have not been as effective as they could be because we:

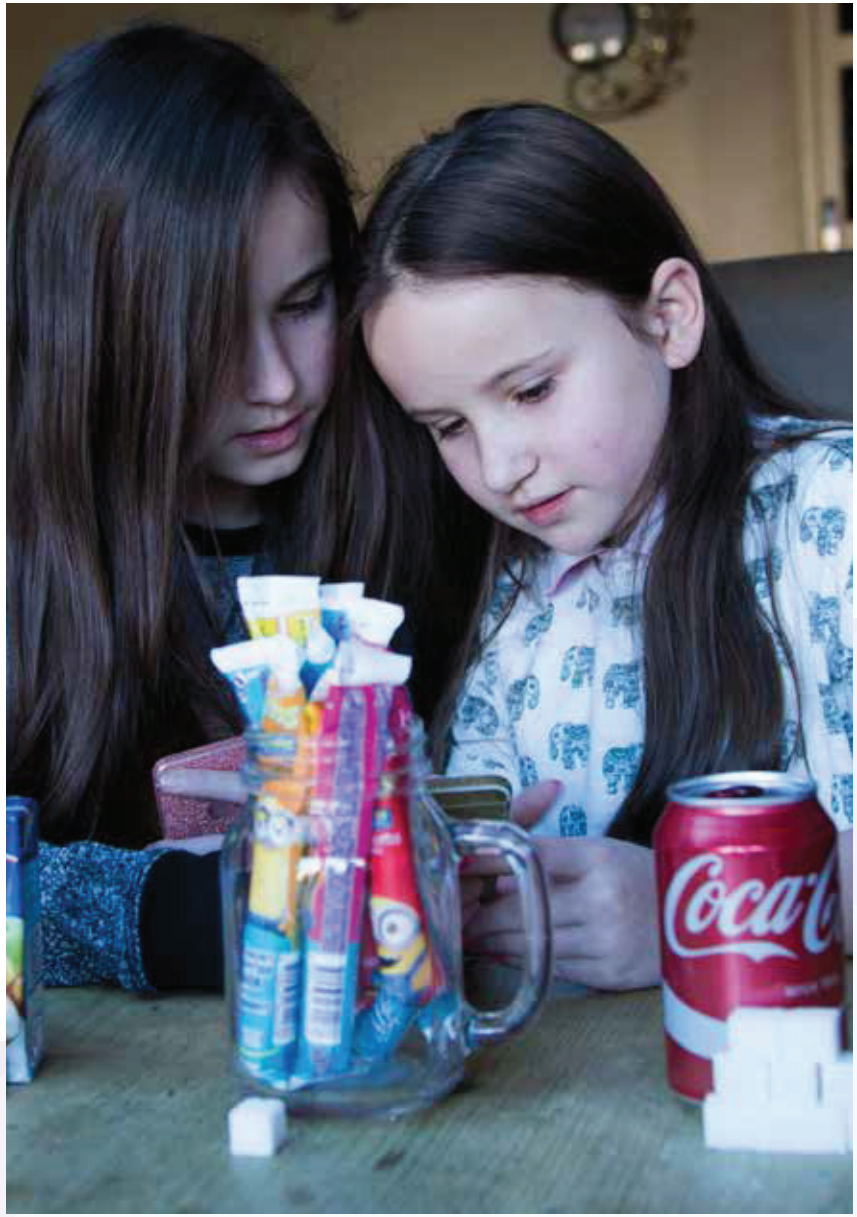
- **Forget to make the healthy choice the easy (and fun) choice** - for example, much of the money spent on sport ends up supporting elite sports-people – there seems to be very little benefit to public health from this. Most people would like to participate in sport as a social activity, and many are put off by highly competitive environments.
- **Cannot see the possibilities within the framework of existing structures** – for example, much of the money we invest in transport continues to be spent on improving the road network for private vehicles. Active transport could be most peoples default choice if the infrastructure was better, yet we don't invest anywhere near as much in it.
- **Fail to explain to vested interests (media, corporate structures, existing government departments) why change is needed** – in recent years concerns over first the financial crisis, and then the Brexit referendum have dominated political debate, and both civic society and our politicians seem to have lost focus on some of the big challenges of our time. We need strong political leadership.

What would I like central government to do (top three):

» **Distribution of transport monies needs to change** – Government must ensure that the proportion of transport money that is invested in active transport options continues to grow, and that this money is spent on infrastructure (cycle paths, covered walkways, public transport etc) in preference to publicity campaigns.

» **Grasp the opportunity to subsidise healthy food production over sugar production** – Historically the biggest beneficiaries of the EU farming subsidies have been producers of sugar beet. This has artificially lowered prices for producing sugar, at the expense of crops which have much greater nutritional value With Brexit, we have an opportunity to change this, and to prioritise subsidies for healthier food.

With Brexit, we have an opportunity to change this, and to prioritise subsidies for healthier food. Actions to reduce exposure to advertising and to make parents less susceptible to "pester power" – Advertising to children has shifted mediums and regulation has not kept up. Social media and internet companies need to reduce promotion of unhealthy foods to minors. Similarly supermarket price promotions could be regulated to ensure healthy food is promoted and prominently placed in stores.



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ABOUT THIS REPORT

This is my first attempt at writing a joint report for both the cities of Southampton and Portsmouth. There are benefits in comparing the two cities, as they share a number of similar characteristics – they are both Port cities, close to London, and they both have significant pockets of deprivation which makes addressing the public health problems more challenging.

This report is independent of the political administrations and other officers views. It is my independent review of serious problems that are challenging the health of the people living in the cities.

I have chosen to focus on one topic in particular. This approach allows us to look at a single issue and ask ourselves if we have got the right approach, and if we are doing enough to address the problems it presents. For more of an overview of the various problems that are impacting on health in both cities, we also produce a Joint Strategic Needs Assessment to inform commissioning, and there are a wide variety of helpful statistics that Public Health England collates available at **https://fingertips.phe.org.uk/**

I have made recommendations from this report at a number of levels – not just for the local authorities involved, but also thinking about all the other drivers of a problem, and what could be done by private and public organisations and citizens with the power to improve the situation.

I am very grateful to the following people in particular for their help in producing this report:

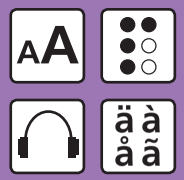
» Ravita Taheem and Andrea Wright

» Cheryl Scott and John Showalter

» Jo Proctor and Barbara Hancock SO18 Big Local

» Ian Bailey Parks and Open Spaces, Southampton City Council

» Dr Christina Vogel MRC Lifecourse Epidemiology Unit, University of Southampton



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Portsmouth CITY COUNCIL

Title of meeting:	Health and Wellbeing Board
Date of meeting:	3rd October
Subject:	People with complex needs
Report by:	Dr Jason Horsley
Wards affected:	n/a
Key decision:	No
Full Council decision:	No

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1. Purpose of report

1.1 To propose next steps in relation to the Health and Wellbeing Board's priority around making improvements for marginalised groups fastest, including our most vulnerable children, young people and adults, with particular reference to adults with complex needs.

2. Recommendations

2.1 The Health and Wellbeing Board is recommended to:

1. endorse the development of the "Team around the Establishment" model linked to homeless and supported housing services, and agree to receive further progress reports
2. endorse the need to move forward with a data-matching and case study exercise, to enable conversations with information governance officers of relevant organisations to move forward.

3. Background

3.1 As part of the refresh of the Health and Wellbeing Strategy, a priority was identified around the need to think differently about how we support adults with complex needs. The strategy highlighted that there is growing national and local evidence that a small cohort of adults in our communities are likely to experience 'severe and multiple deprivation' (SMD cohort), including substance misuse, homelessness, offending and mental health problems. They are likely to have ineffective contact with services that are often designed to deal with one problem at a time, and so regularly and persistently 'fall between the cracks' that open up between services.

3.2 The inter-relationship of these individual issues is complex and efforts to

improve outcomes for this cohort of people have been ongoing for many years across different agencies and agendas and across the UK a range of responses are being developed. This is not a new issue and Portsmouth is not unique in its experience. This group of people can have a disproportionate impact on those around them; their partners and the neighbourhoods in which they live - including businesses and visitors to the city - and most importantly, any children they may have.

3.3 Services have a range of processes, pathways, panels and interventions in place to support adults with a variety of complex needs. Services have in the main been commissioned or directly provided to meet a defined individual need - often successfully - but generally not designed to address composite and compounding needs e.g. homeless/mental health/substance misuse/criminal justice. Similarly, individual assessments of need by statutory services tend to focus on the presenting issue and there are different eligibility thresholds for accessing services that do not necessarily take into account complexity of needs and associate behaviour, the nature of 'recovery'.

3.4 As a result, customers with complex needs who are frequent (or inappropriate) service users may have contact with a range of services, have several “key workers”, have a number of personal plans in place and be involved in a number of panels/pathways/case management processes simultaneously or sequentially.

3.5 Previous work had used national research and local case studies to identify some specific themes for Portsmouth. It is clear from the case studies that valuable work is already being undertaken and there are some successes in supporting people to achieve positive outcomes, through effective collaborative working. However, customers, advocates and professionals have questioned the consistency of the effectiveness, efficiency and value of current approaches, particularly for those service users present with the most complex needs.

3.6 We also know that people with complex needs have often suffered adverse childhood experiences, including interaction with the care or youth justice systems, experience of domestic abuse or experience of a parent with substance misuse or mental health issues. Experiencing homelessness as a child can also impact on achieving settled accommodation as am adult. This means that the complex needs agenda directly links with other priority areas for the Health and Wellbeing Board such as support for looked after children and care leavers, or support for mental health.

4. Reasons for recommendations

4.1 Organisations in the city are already working together to take a strategic approach to the issues of street culture, including begging, and street sleeping to support people in these circumstances and tackle associated community safety issues. This includes ensuring that any enforcement activity is complemented by appropriate support. Individuals who are street sleeping are

by no means always individuals with complex needs; and people with complex needs do not necessarily become homeless or street sleepers. However, we do understand that there is an overlap between these groups, and a basis for developing partnerships and services from the street sleeping work that can have wider applicability.

4.2 The city has recently developed its first street homelessness and rough sleeping partnership strategy, to cover the period 2018-2020, which is intended to provide clear direction and a co-ordinated approach to maximise the contributions of partners to ensure that the right support is in place to meet demand. It is expected that the strategy will provide a framework for a continuous dialogue with statutory and voluntary partners about the nature of support. It is accepted that a "one size fits all" approach to service provision rarely works in resolving issues such as homelessness, and that instead a tailored approach is needed to minimise barriers to accessing services and support.

4.3 The strategy proposes an "Accommodation First not Accommodation only" programme, focusing on supporting individuals into affordable housing and also to provide consistent support to sustain any tenancy. The model builds on the provision of a Night Bed service which has been operational in the city since December 2017, and a Homeless Day Service. Both services are commissioned by Portsmouth City Council. The Accommodation First not Accommodation Only model will be consulted on on between October 2018 and December 2018.

4.4 In the new model, the expectation is that each individual will be worked with to develop a personalised housing plan, which will also include an assessment of needs in relation to employment, mental and physical health and finance. In securing and sustaining settled accommodation, the intention will be provide support around these dimensions of need to ensure that the individual does not become homeless once again. The development of this strategy is intended to be funded by the Rough Sleepers initiative funding package made available to local authorities by the Ministry of Housing, Communities and Local Government, and measures will be consistent with the "Prevention, Intervention, Recovery" approach in the Government's National Rough Sleepers Strategy.

4.5 The underpinning principles of the work, to change services away from traditional public sector models to more personalised plans and the development of navigator roles, can be used as concepts for developing a wider framework for supporting complex needs in the short term. The language of the Health and Wellbeing Strategy is that Portsmouth should be a "needs-led" city, where access to the services and support that people need to live their lives safely and independently is not dependent on a diagnosis or threshold.

4.6 We are therefore thinking about how we could enable a wider group of individuals to access some of the support available through the street homelessness strategy, accepting that for some people with complex needs, the establishments and networks around homelessness and supported housing services will be familiar. The proposal is therefore to develop a "team around

the establishment" model, where people in homelessness services or supported housing would be able to access a range of services at a single point of delivery, where relationships have been built. This support could include primary healthcare as well as support with mental health or substance issues. This would be a potential opportunity to make some immediate improvements to levels of support, building on existing service commissions.

4.7 The ask for the Health and Wellbeing Board is to endorse this as an approach and support further work to develop this model, to come back to a future meeting of the Board with a developed model.

4.8 However, whilst this would work provide an immediate and organic opportunity to develop some improvements, there remains a need to understand in more detail what the profile of need in Portsmouth is, and the ways in which services are working well for people, or could be improved. It is therefore recommended that work to data-match caseloads for key services (including substance misuse, mental health and criminal justice services) is reinvigorated, and some work is undertaken on case studies to identify where opportunities to provide support could have been taken.

4.9 The ask for the Health and Wellbeing Board is to endorse this recommendation, to enable conversations with information governance officers of relevant organisations to move forward. Progress will be reported to the Health and Wellbeing Board on a regular basis, as the foundation of developing more intelligently designed services and responses to some of our most vulnerable adults.

5. Equality impact assessment

5.1 This is a broad strategic approach and as such a preliminary EIA has concluded that there will be no negative impact on any of the protected characteristics arising from the development of a refreshed Health and Wellbeing Strategy. Any individual projects or measures arising from the strategic approach outlined will be subject to impact assessments in their own right.

6. Legal implications

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

7. Director of Finance's comments

7.1 The work outlined in the strategy will be undertaken using existing staffing resources and will not incur additional costs.

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Signed by: Dr Jason Horsley, Director Of Public Health

Appendices:

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

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

Title of document	Location

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

……
Signed by:

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