Portsmouth CITY COUNCIL

Public Document Pack

NOTICE OF MEETING

HEALTH AND WELLBEING BOARD

WEDNESDAY, 13 FEBRUARY 2019 AT 10.00 AM

CONFERENCE ROOM A - CIVIC OFFICES

Telephone enquiries to Joanne Wildsmith, Democratic Services Tel: 9283 4057
Email: democratic@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 Jennie Brent
Innes Richens, Dr Jason Horsley, Mark Cubbon, Dr Linda Collie (Joint Chair), Ruth Williams, Dianne Sherlock, Sue Harriman, Alison Jeffery, Jackie Powell/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 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 Minutes of previous meeting - 28 November 2018 and matters arising
(Pages 5 - 16)

RECOMMENDED that the minutes of the Health & Wellbeing Board held

on 28 November 2018 be agreed as a correct record.

A matter arising from this meeting was the letter regarding the STP/System Reform Statutory Board Pack, sent on behalf of the HWB by the joint Chairs, dated 4 December 2018, which is appended.

3 Adults Safeguarding Board annual report (Pages 17 - 30)

Robert Templeton, Chair of Portsmouth Adults Safeguarding Board (PASB) will attend to present the annual report.

4 Tobacco Harm Reduction (Pages 31 - 48)

The **information report** by the Director of Public Health was requested by Councillor Winnington and is to:

(1) describe harms of illicit tobacco and why it is relevant to partners across the city.
(2) provide an overview on how addressing illicit tobacco contributes to the overall strategy for tobacco control which requires a whole system approach.
(3) provide an overview of joint working between Trading Standards and Public Health to reduce harm from tobacco.

5 Health and Wellbeing Board - Revised Constitution (Pages 49 - 56)

Report by David Williams, PCC Chief Executive and Kelly Nash attached, which seeks approval for proposed changes to the constitution for the Health and Wellbeing Board (HWB). The changes are recommended to improve the effectiveness of the HWB as it fulfils its leadership role across the health and wellbeing system locally.

RECOMMENDED that the Health and Wellbeing Board support the changes to the constitution for the Health and Wellbeing Board set out below.

6 SEND Strategy and self-evaluation (update/information report)

Information report by Julia Katherine, Head of Inclusion, PCC seeks to update the Health and Wellbeing Board on the refreshed Special Educational Needs and Disability (SEND) Strategy and the SEND Local Area self-evaluation which identifies current areas of strength and areas where further development is required in readiness for the Local Area SEND Inspection. (**Report to follow)**

7 NHS Long Term Plan

Report by Innes Richens CCG Chief Operating Officer **to follow**.

8 Date of next meeting

A provisional date for the next meeting is suggested as Wednesday 19th June 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, 28 November 2018 at 10.00 am in Conference Room A, Civic Offices, Portsmouth.

Present

Councillor Matthew Winnington (in the Chair)
Dr Linda Collie

Councillor Gerald Vernon-Jackson CBE
Councillor Rob Wood

Innes Richens
Dr Jason Horsley
Mark Cubbon
Sue Harriman
Alison Jeffery
Siobhain McCurrach
Dr Nick Moore
Jackie Powell

Non-voting members

Councillor Jennie Brent

Officers Present

Kelly Nash
David Williams

58. Apologies for absence (AI 1)

These had been received from Dianne Sherlock and Councillor Luke Stubbs.

59. Declarations of Interest (AI 2)

There were no declarations of interest.

60. Previous Minutes - 3 October 2018 and Matters Arising (AI 3)

RESOLVED that the minutes of the Health and Wellbeing Board held on 3 October 2018 were approved as a correct record, with no matters arising.

61. Portsmouth Safeguarding Children's Board - Annual Report 2017/18 (AI 4)

Dr Richard John, the PSCB Independent Chair, presented the annual report (his first in this role). Dr John picked out the key points and went through how the priorities had been delivered (as set out on pages7-9):

- Children Experiencing Neglect
- Missing, exploited and trafficked children
- Children affected by Domestic Abuse

These had been discussed with the Ofsted inspectors (referenced page 12) and it was noted that there is some joint membership of the PSCB and the Health and Wellbeing Board.

A large scale programme of Restorative Practice training was being undertaken (with a reduction in numbers attending Safeguarding training, partly due to one trainer leaving who had since been replaced).

The data set out on page 13 included:

- 20,518 contacts to the Multi-agency Safeguarding Hub, for 10,905 children
- An increase of 12% on the number of assessments leading to the child being referred to the Children and Family Services
- An increase in the number of Looked After Children from 358 to 419

Dr John praised the professionalism of colleagues which resulted in a high standard of joint working. There had been 7 Serious Case Reviews from which there had been reflected learning. Looking ahead there would be broader issues with new safeguarding arrangements to be implemented, and work would continue to identify good practice from elsewhere.

Questions and points raised by HWB members included:

- The challenges and risks raised by a multi-media climate
- The continued rise in the number of Looked After Children had a knock on implications for resourcing
- The rise in the number of fixed term exclusions (by 25%) was of concern, although this was mirrored nationally and this could be linked to the growth of academies
- It was reported that Portsmouth was part of a Home Office pilot to better identify trafficked children, with the rise in the number of unaccompanied minors arriving in the UK as asylum seekers.
- An area that could receive further attention was reintegrating looked after children with their families (Alison Jeffery confirmed that this is being looked at)

- With regard to transparency it was noted that the recent Ofsted inspection of Children's Services had received a "good" rating

Councillor Gerald Vernon-Jackson, as Leader of PCC, thought that due to the significance of the issues contained in the annual report, it should be brought to the attention of all councillors. The report was being submitted to PCC Cabinet on 4th December, and he would like this to go on to full Council for their information.

Councillor Winnington, as Chair, had gone on the restorative practice training which he had found inspiring. As the Cabinet Member for Health Wellbeing and Social Care was pleased to see the joined up working with Adults Social Care and Public Health as evidenced, and he thanked Dr John for presenting the PSCB annual report.

RESOLVED that the content of the PSCB annual report 2017/18 be noted.

62. Portsmouth Health & Care Operating Model (AI 5)

Innes Richens, as Chief Operating Officer CCG, presented the report and outlined the main headline issues, with the review of ways of working between the NHS and the City Council, building on the integration already taking place and planned through the Portsmouth Blueprint and STP regional work (to be discussed in the next agenda item). The report set out the operating model structures, showing a collaborative approach for health and care providers for the city.

The report set out in section 7 the proposed Health & Care Operating Model, which were summarised as:

- Incorporate defined PCCG functions for children services within the existing Director for Children's' Services in PCC, mirroring the integrated role for adults already established within the Chief of Health & Care Portsmouth in PCCG
- Integrate defined Public Health and PCCG commissioning functions within a single role or roles (utilising existing roles)
- To strengthen support to the Chief of Health & Care Portsmouth in the discharge of their statutory Director of Adult Social Services (DASS) functions - create a dedicated Director of Adults Services role, from an existing post within Adult Social Care, reporting to the Chief of Health & Care Portsmouth. This will ensure sufficient leadership capacity for adult social care transformation in the City and for engagement in other tiers (in particular the local Integrated Care Partnership)
- Review existing PCC and PCCG capacity currently reporting to the Chief of Health & Care Portsmouth, Director of Children's' Services and Director of Public Health and align roles and portfolios to this integrated Health & Care Portsmouth executive

It was stressed that the intention was not to bring all the budgets together. It was also acknowledged that the review of the role of the Health & Wellbeing Board was underway and it was possible that a specific sub-group of HWB could focus on Health & Care.

Members of HWB welcomed the opportunity to see these proposals and to influence the shape of partnership working, which was successful in the city, rather than wait for the government to implement changes. The charts were useful, but did not show areas where there are overlaps in responsibility. The HWB would be a forum for broader discussions.

It was asked where the hospital fits in, as for the public this was the focus of healthcare with the NHS divisions not widely understood? Mark Cubbon responded that the proposals were positive in advocating even closer working between the organisations. He stressed that only one third of patients at Queen Alexandra Hospital were Portsmouth residents and two-thirds from South East Hants. Siobhain McCurrach reported that Healthwatch Portsmouth would offer support in engaging residents to aid their understanding of the changes.

The details on the scope of a HWB sub committee were not known at this stage.

Councillor Winnington as Chair, thanked Innes Richens for his report and advocated consensus working. The report had been endorsed by the CCG Board.

The Health and Wellbeing Board RESOLVED to give support to:

(i) Establishment of a single operating model for Health & Care Portsmouth between PCC and CCG

(ii) Establishment of a committee on behalf of PCC and PCCG for its commissioning of adult and children's health, social care and public health services

(iii)Integration of PCCG and PCC functions into joint roles: Chief of Health & Care Portsmouth, Director of Children's' Services and Director of Public Health

(iv) Review and reconfigure the structures and existing capacity under these roles to ensure capacity is available to deliver Health & Care Portsmouth whilst recognising the need to achieve running cost efficiencies

(v) A review of other enabling functions to assess the benefits of further integration to support delivery of the Health & Care Portsmouth operating model – specifically financial management, business intelligence, communications/ engagement, community sector partnership development

(vi) Direct the respective Accountable/Chief Executive Officers, working within their scheme of delegations and constitutional powers, to review the management and staffing structures currently in place in order to align this capacity with the new

Health & Care Portsmouth operating model and for this to include cost-share arrangements.

63. Hampshire & Isle of Wight (HIOW) Sustainability Transformation Partnership (STP) System reform paper (AI 6)

Innes Richens (for CCG & PCC) and Sue Harriman (Chief Executive Officer, Solent NHS Trust) presented this report which comprise the "System Reform Statutory Body Pack" presentation and the report's recommendations as set out in the covering summary document. The pack had been produced in August for consideration by all the region's NHS provider boards, CCG Governing Boards and local government cabinets. The aim was to get in principal agreement then there would need to be future approvals on the detailed developments in due course.

Sue Harriman reported that the report had been considered by boards around the county and by PCC's Health Overview & Scrutiny Panel the previous week. The NHS 10 year plan was awaited and this was expected in the first week of December.

Discussion took place on the role of clusters (detailed on slide 23) and this was further explained by Dr Collie regarding the need for input to decide what type of cluster is best for our area. Mark Cubbon welcomed the development of clusters as a positive step, and felt that there would be further clarity from the planning footprints of the Integrated Care System (ICS).

Alison Jeffery is involved in the children's strand, and would press for attention to early intervention and preventative work with families. She was also keen for children's mental health (a Portsmouth CCG priority) to be given protection.

Councillor Gerald Vernon-Jackson asked if there were any major areas of concern for the Health and Wellbeing Board? At the CCG Board discussions most concern had been regarding the geographical boundaries and not wishing Hampshire & Isle of Wight level responsibility for all functions and decisions. The need to maintain a strong sub regional emphasis was supported by HWB members, with the close relationship to the local hospital. David Williams, as PCC Chief Executive, advised a close watch on the progress of the STP to guard against subsidiarity and to ensure that decisions are only drawn up a level when necessary. Dr Horsley advised engaging in the development of the SPT to help steer its course. There was need for clarity (especially with the awaited NHS 10 year plan) of how budgets will be allocated and further distributed.

Regarding the accessibility of the proposals for public involvement and understanding, Healthwatch Portsmouth would be working on translating the messages and would work with the STP Communications team to encourage engagement in the process.

Councillor Winnington asked what was being learned from elsewhere in the country? Sue Harriman reported that there had been pilots of integrated

systems and the STP Executive Group worked with partners nationally and internationally. Sue Harriman had visited Berkshire West to see different models (which varied with demographics) and David Williams reported that links had been made with Dorset (where they have a different structure) and good practice had been seen in Salford.

Councillor Winnington reported that he and Dr Collie as joint chairs were liaising with the Southampton and Hampshire HWB Chairs to discuss the budgetary issues.

In considering the separate, summarised recommendations, it was agreed that a joint submission by the Portsmouth Health and Wellbeing Board rather than separately from Portsmouth City Council, to represent Portsmouth Health and Care which was supported by Dr Collie.

RESOLVED

(1) that the recommendations as set out in the covering report be supported

(2) that contact be made with Caroline Dineage MP

(3) that a joint response be sent for Health and Care in Portsmouth.

64. Date of next meeting (AI 7)

The date of the next meeting was noted as 13th February 2019 at 10am.

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At the conclusion of the meeting an informal meeting took place with Dr Horsley to create an action plan to tackle Childhood Obesity.

The meeting concluded at 11.27 am.

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Councillor Matthew Winnington and Dr Linda Collie
Chair

NHS
Portsmouth
Clinical Commissioning Group

Portsmouth
CITY COUNCIL

Councillor Matthew Winnington and
Dr Linda Collie
Joint Chairs of Portsmouth's Health and
Wellbeing Board

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Date: 4th December 2018

Dear Sir Neal

Hampshire and Isle of Wight Sustainability Programme System Reform

Portsmouth's Health and Wellbeing Board (HWB) considered the System Reform Statutory Board Pack at its public meeting on 28th November. The emerging proposals have previously been discussed by the HWB and its members in a number of different fora. This response can be taken as the combined response of the Portsmouth HWB, the Portsmouth CCG Governing Board (which formally considered the System Reform Statutory Board Pack at its meeting on 21 November) and Portsmouth City Council.

Members of the HWB were clear that they have participated in shaping the proposals so far, and acknowledged that the paper is trying to capture a very complex set of functions, relationships and dependencies. It was also recognised that the terminology and understanding of the tiers emerging from NHS England over the gestation period have also created uncertainty. Notwithstanding this, the broad vision for the system as set out in the paper was supported, and it was noted that it is aligned with the local 'blueprint' for health and care in Portsmouth. However, the very constructive discussion did highlight some of the clear tensions from this city's perspective.

Firstly, there is a challenge from the local perspective to the **geography** around which the proposal to form an Integrated Care System is based. Whilst there may be a role for some specific activities to be undertaken at a HIOW geography, the compelling case to support an ICS on HIOW boundary is not made. Many of the functions identified for an ICS - not just in these proposals but also in national thinking - are being delivered within systems working around acute catchment areas (such as Frimley, West Berkshire or Surrey Heartlands) or places based on local authority boundaries (and the two usually work in partnership).

Consequently, the roles and functions being set out for the HIOW tier in these proposals

are unfocused. We do believe that there are functions best delivered at the HIOW level (commissioning services that are required for a 2m+ population, assurance interface with NHSE) but the proposals risk missing the need for health and care for residents to reflect where they live and receive the majority of their care. Our view is that the functions described for an ICS are best delivered on a Portsmouth and South East Hampshire (PSEH) basis.

Community and primary healthcare are interdependent on a whole range of wider community resources, including social care, schools, housing, leisure provision and the local network of voluntary and community provision. In this city, there is a complex set of relationships and we broadly understand how these relate to each other. These are the relationships that will be characteristic of clusters - but in a compact, densely populated city, there will be many cases where the city operates as a cluster in its own right. What we cannot support is a system that requires multiple layers of governance, management and bureaucracy to enable this to happen, as appears to be the case in these proposals.

Our perspective is that in the attempt to distil complexity to an easily expressed formula, and to find a purpose for a +2m HIOW geography, a default single specification for levels has been developed, which does not map easily onto our circumstances. There needs to be local flexibility to develop the system that is right for the place.

This links to our second concern which is around **local accountability**. The resource for the HIOW STP should be applied to those issues that are best planned and delivered at HIOW level and should not be focused on developing and assuring the whole system or other elements of it such as cluster arrangements. Such an approach inevitably undermines subsidiarity and is liable to stifle creativity and tailored approaches to local needs. These are better developed by local place leaders working together in their local systems. This means recognising the strong part that local authorities play, as service commissioners and providers and advocates for their communities. The interface with social care services and early help and prevention is critical, and needs to be worked through locally.

This brings challenges around mandate. Decision-makers in local authorities have a direct democratic mandate from their electorate, and tensions within the system are best resolved in that system. Local health systems have already started to think through how this works in the development of health and wellbeing boards, and these boards have developed differently to reflect different local circumstances and dynamics. Our HWB has regard to the line of decision-making and resource allocation back to local governance bodies.

This dynamic means that there are real difficulties with the proposals around HIOW strategic commissioning and an 'alliance' of Health and Wellbeing Boards. Whilst there may be much to gain from the exchange of experience, the concept of an alliance is in itself questionable given the differing scope and authority of boards; and it is unclear how the two proposed entities will relate. Again, it makes sense to ensure that proposals are developed on a footprint that makes sense when viewed through the lens of local democracy and accountability.

Our third main concern links to the issue of local accountability and decision-making, and is about **ensuring 'equity' across a wider footprint**. In the city, we have gained an

understanding of the challenges faced by our population, and how these manifest themselves. We have developed responses to address this and allocated resources accordingly. This means that in some areas (for example, mental health services for young people) we are doing things differently to other parts of HIOW. We are always concerned when we hear suggestions that 'equity' is required, suggesting a homogenous response. What is needed is actually 'equity' in how communities are understood, advocated on behalf of, and responded to by decision-makers. This is achieved by allowing resources to be directed as flexibly as possible at the lowest possible level of geography, not by aggregating and levelling.

In Portsmouth, we are fully committed to innovative thinking about the delivery of all health and care services in our area, and have developed our local Blueprint to deliver this. We have many examples of how we are integrating and designing services around our residents to better serve the population, and are moving towards a new operating model for services that encompasses CCG and local authority functions. We understand how to make community and primary care work for our population, and understand what needs to be done to improve it. We strongly believe that as a local system, we should retain the discretion to do this as we see fit without being required to comply to a model that sees the world in uniform blocks. We also believe that there are services and needs that are appropriately organised on a wider footprint, and look forward to supporting the discussion about these as it develops.

As well as these thematic concerns, various discussions have highlighted specific issues with the text in the proposals, and we attach a summary of these points as Appendix One. We trust that you will take this feedback in the constructive spirit it is intended, and we look forward to continuing to work with you on shaping the proposals to ensure we serve the various HIOW communities as well as we possibly can.

Yours sincerely

Dr Linda Collie
Chief Clinical Officer
Portsmouth Clinical Commissioning Group

Councillor Matthew Winnington
Cabinet Member for Health, Wellbeing & Social Care
Portsmouth City Council

Joint Chairs of Portsmouth Health and Wellbeing Board, on behalf of:

Portsmouth City Council
Portsmouth Clinical Commissioning Group
Portsmouth Hospitals NHS Trust
Portsmouth Voluntary and Community Network
Solent NHS Trust
Portsmouth Healthwatch

Appendix One - detailed comments on Hampshire and Isle of Wight Sustainability Programme System Reform proposals.

The Vision (Slide 10+)
In line with the Board's vision and Portsmouth Blueprint

HIOW as a system for an ICS (Slide 12+)
Role and functions at the HIOW tier in these proposals are unfocused - for example, what is the relationship between strategic commissioning body and HWBB Alliance – is there a hierarchy?

Unclear about the sovereignty of the Health & Wellbeing Boards – sovereignty of HWB sits with respective LA not at HIOW

Muddles ICP (PSEH) and HIOW functions

Clusters (Slide 19+)
Proposals suggest there will be/needs to be cluster-based budgets, leadership and governance – we are opposed to this as it builds in additional layers of management and bureaucracy. The narrative suggests separate entities/areas below this level which does not make sense for us. In many instances the City will operate as a 'cluster' in its own right.

Common specification for clusters – not supportive of this approach, needs to be developed locally to reflect the local variation; can see sense in a coming together for good practice and possibly peer challenge (although this may be better from another region). Board expectation is that clusters will have a direct relationship to 'place' (ie. Portsmouth City) reporting to them, being resourced by them, being managed by them. Reporting lines are unclear in this proposal and seem to be based on a number of different expectations of the STP – is it an arm of the NHS regulator or not?

Balance of effort – strong view that in an environment of challenged resource, the priority should be to focus our collective resource on supporting front line operational delivery – thus would not support STP being resourced to drive and assure cluster development as this happens locally as well

Whilst place and clusters will be the priority for the City, PSEH system will be of similar priority – aligning the work in the city with work in footprint of PHT is required.

Place (Slide 26+)
Principles outlined here reflect the expectations of 'place' by the Board.

Integrated Care Partnerships (Slide 30+)
Strong view that the PSEH system should be the basis for an Integrated Care System. The notion of forming an ICS at a HIOW geography needs testing: does not stand up to many of the national criteria for ICS (such as acute catchment areas and LA boundary continuity), recent self assessment of HIOW to prepare for ICS suggests many of the functions expected of an ICS are currently being delivered at a City and PSEH level

The Board does not accept the underlying assumption in the proposals that ICPs have the

primary direct line relationship with clusters and thus drive their resourcing and development - this should remain with the 'place' (Portsmouth City). However, ICPs are the way that respective places come together to align their work around the acute - the Board is strongly committed to building the PSEH integrated system given the prominence and importance of the hospital to Portsmouth residents.

We do need to put more effort into defining and building this at a PSEH level – current collaboration is good but need to move on from a loose affiliation of the willing to having strongly defined delivery responsibilities, much clearer leadership based on roles within the City and also stronger governance. City Operating model can help to define this with a single voice for the City.

ICS self-assessment confirmed this view.

Also seems to align with the national thinking:

'Round two for STP plans: a fresh start or a dangerous distraction?'
Kings Fund, Nov 2018
'Our work with local systems has highlighted the value of local authority involvement and leadership, including a stronger connection with local communities, closer working across health and social care, and opportunities to act on the wider determinants of health. ICSs and STPs will only be able to realise the ambition of integrating care and improving population health if their primary focus is outwards towards local partners and residents, rather than upwards towards the asks of national NHS bodies.'

What should the NHS long-term plan say about STPs and ICSs?
October 2018
'national leaders should encourage further changes to the organisation of commissioning while avoiding the imposition of a national blueprint. There is particular need to work with the tension between reducing the number of clinical commissioning groups to align NHS commissioning with STPs and ICSs on the one hand, and a desire to secure greater engagement with local authorities on the other hand. The form of commissioning should reflect emerging understanding of the functions of commissioners in future at both the system level and in the places that make up the larger systems. Integrated commissioning between the NHS and local authorities is especially important in these places.'

'national leaders should also be cautious about unsettling the work of successful STPs and ICSs by prescribing their size and working arrangements. Progress is fastest where relationships and partnerships have been built, particularly where there has been continuity in the leadership community. This work would be undermined if systems were required to merge around larger footprints. Collaboration between smaller systems is already enabling issues to be dealt with at scale and is preferable to redrawing lines on the map.'

HIOW Strategic Planning (Slide 35+)

Previous comments apply re: weak case for HIOW as an ICS.

In principle support subject to the final scope, remit and terms of Reference of proposed joint committee returning to the Board prior to establishment.

If established, Board strongly supports the need for NHS provider, NHSE specialist commissioning and Local Authorities to have a presence on the committee, respecting that this will need to be cognisant of current legal and legislative requirements.

Portsmouth Safeguarding Adults Board

Annual Report

PSAB

2017 - 2018

Statement from the Independent Chair

I am pleased to be able to introduce the Portsmouth Safeguarding Adults Board's Annual Report for 2017/18. As a Board, our aim is to provide strategic leadership to ensure adults with care and support needs, who are at risk of abuse or neglect are effectively safeguarded. Prevention and early intervention is critical to this vision as is the need to identify and apply learning when people experience poor outcomes. We place equal focus on developing a safeguarding culture that focuses on the personalised outcomes desired by those people who may have been abused and who wish to access support.

We are being encouraged from a national perspective to work with the following key themes in relation to Adult Safeguarding:

- Prevention
- Making Safeguarding Personal
- Quality

These themes are reflected within our Business plan for the coming year. In particular I wanted to highlight that there are now resources available from the Association of Directors of Adult Social Services and the Local Government Association to describe what 'good' might look like in Making Safeguarding Personal and promotes ownership of this agenda within and across all organisations.

The recent publication of the Independent Inquiry into deaths at Gosport War Memorial Hospital[1] (and also other similar reports affecting the health and social care landscape across Hampshire such as the Mazars review of deaths at Southern Health NHS Foundation Trust)[2] means that going forward Portsmouth Safeguarding Adults Board will be placing a specific focus on gaining assurance from partner agencies of their processes to follow up unexpected deaths.

Given the context of increased pressures within all sectors, I am keen that the Board continues to identify opportunities for increased joint working and coordination across the wider strategic partnership.

Significant progress has been achieved in undertaking joint work with our neighbouring local safeguarding adults boards as well as the Portsmouth Safeguarding Children Board. This approach has led to the introduction of new pan-Hampshire ('4LSAB') work groups addressing areas of common interest. We continue to maximise opportunities for joint working with the Portsmouth Safeguarding Children Board leading to the development of a Whole Family Protocol.

[1] Gosport Independent Panel, *The Panel Report,* https://www.gosportpanel.independent.gov.uk/panel-report/

[2] Mazars LLP, *Independent review of deaths of people with a Learning Disability or Mental Health problem in contact with Southern Health NHS Foundation Trust April 2011 to March 2015*, https://www.england.nhs.uk/south/wp-content/uploads/sites/6/2015/12/mazars-rep.pdf

What is Safeguarding?

"Safeguarding means protecting an adult's right to live in safety, free from abuse and neglect. It is about people and organisations working together to prevent and stop both the risks and experience of abuse or neglect, while at the time making sure that the adult's wellbeing is promoted including, where appropriate, having regard to their views, wishes, feelings and beliefs in deciding on any action." (Care Act 2014)

Who are we?

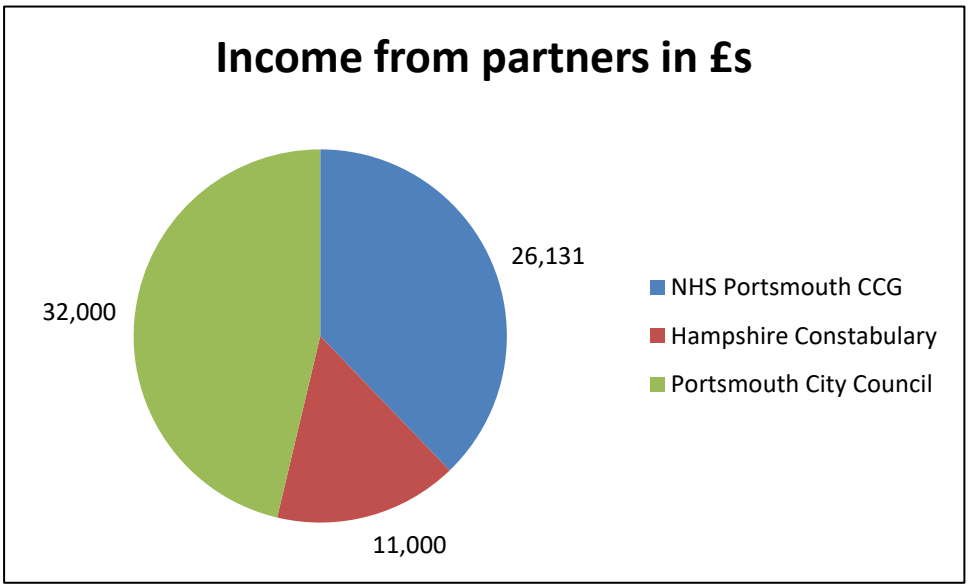
The Portsmouth Safeguarding Adults Board (PSAB) is a partnership of key organisations in Portsmouth who work together to keep adults safe from abuse and neglect. These include:

- Adult social care
- Health
- Emergency services
- Probation services
- Housing
- Community organisations

The board has an independent chair that can provide some independence from the local authority and other partners. This is especially important in terms of:

- offering constructive challenge
- holding member agencies to account
- acting as a spokesperson for the PSAB.

The Board is funded through contributions from its statutory partners (Portsmouth City Council, NHS Portsmouth Clinical Commissioning Group and Hampshire Constabulary). The agreed contributions are:



Our Vision

"Portsmouth is a city where adults at risk of harm are safe and empowered to make their own decisions and where safeguarding is everyone's business."

Safeguarding Duty

Under Section 42 of the Care Act, a local authority has a duty to make enquiries or cause others to make enquiries in cases where it has reasonable cause to suspect

- that an adult has needs for care and support (whether or not the local is meeting any of those needs) and
- is experiencing, or at risk of, abuse or neglect and
- as a result of those care and support needs, is unable to protect themselves from either the risk of, or experience of, abuse or neglect.

Portsmouth has an Adult Multi-Agency Safeguarding Hub (MASH). Hampshire Constabulary and Portsmouth City Council have created the MASH with a team of social workers and police officers working together who have direct links with colleagues in areas such as health, trading standards and children's safeguarding. The MASH manages a high volume of referrals.

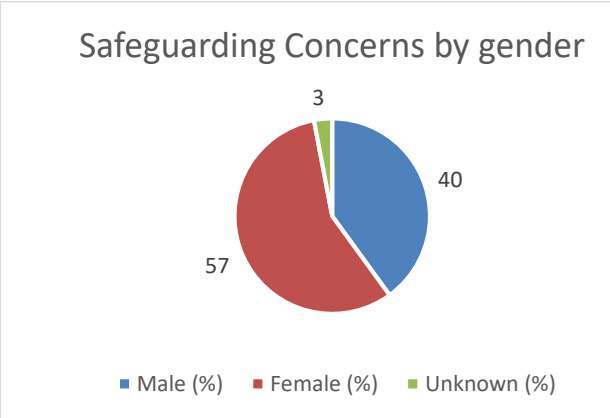
Safeguarding Activity

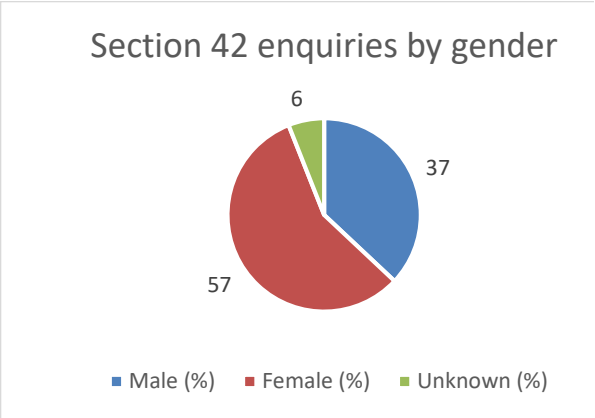
A *concern* is a 'worry' raised regarding a person's safety. There were 1779 concerns raised in 2017-18.

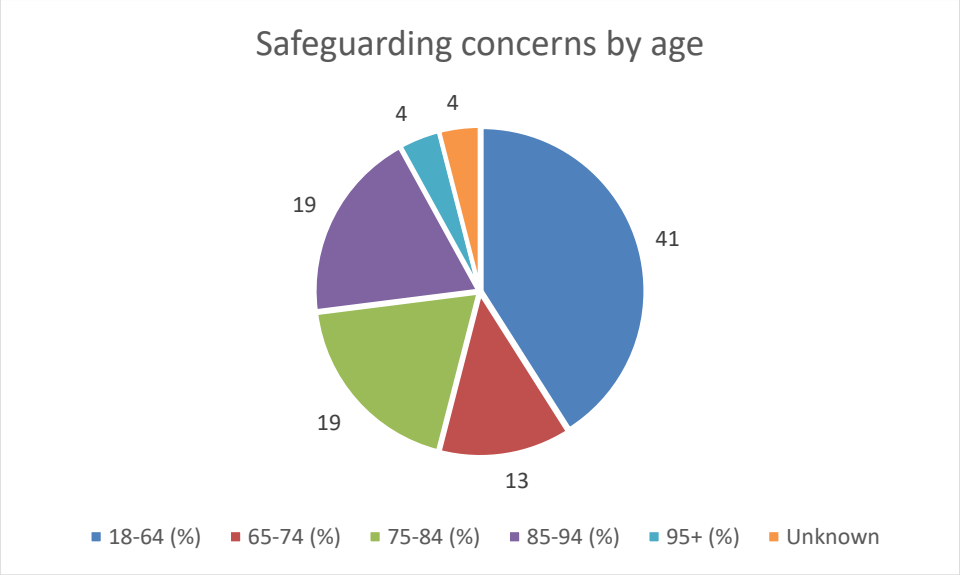
An *enquiry* is what needs to be looked at to confirm a person is safe. 195 were deemed to require further input and were taken forward as enquiries under Section 42 of the Care Act.

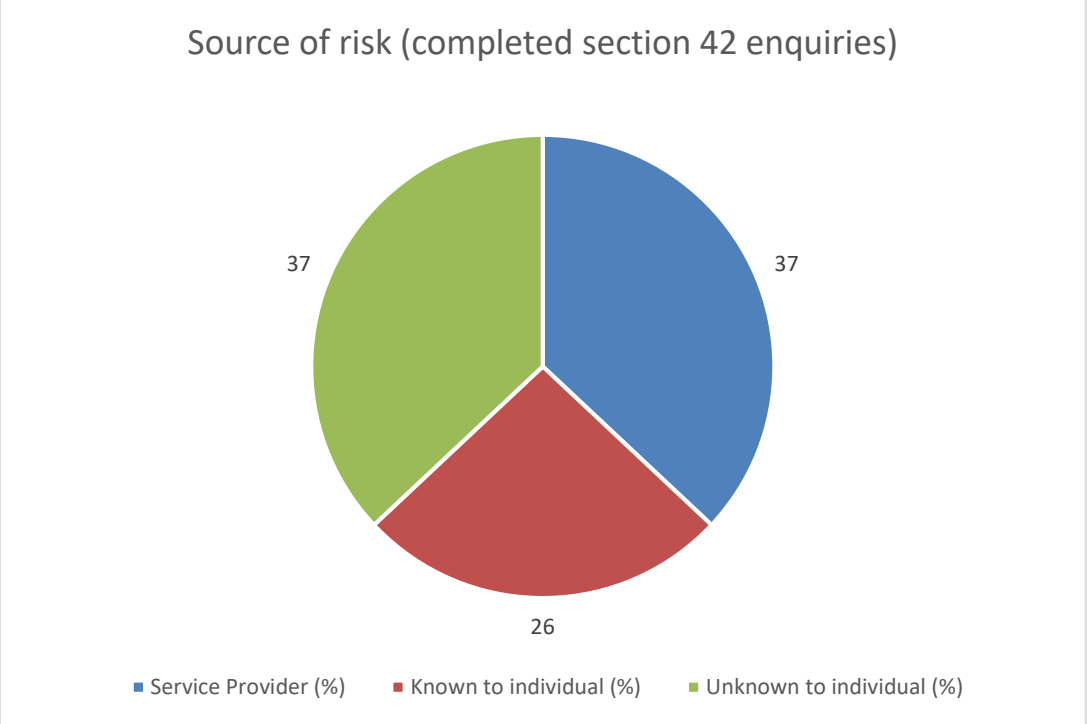
Data collected by the MASH gives further information about who has experienced abuse or neglect in Portsmouth, where abuse has taken place, and the types of risk they have experienced.

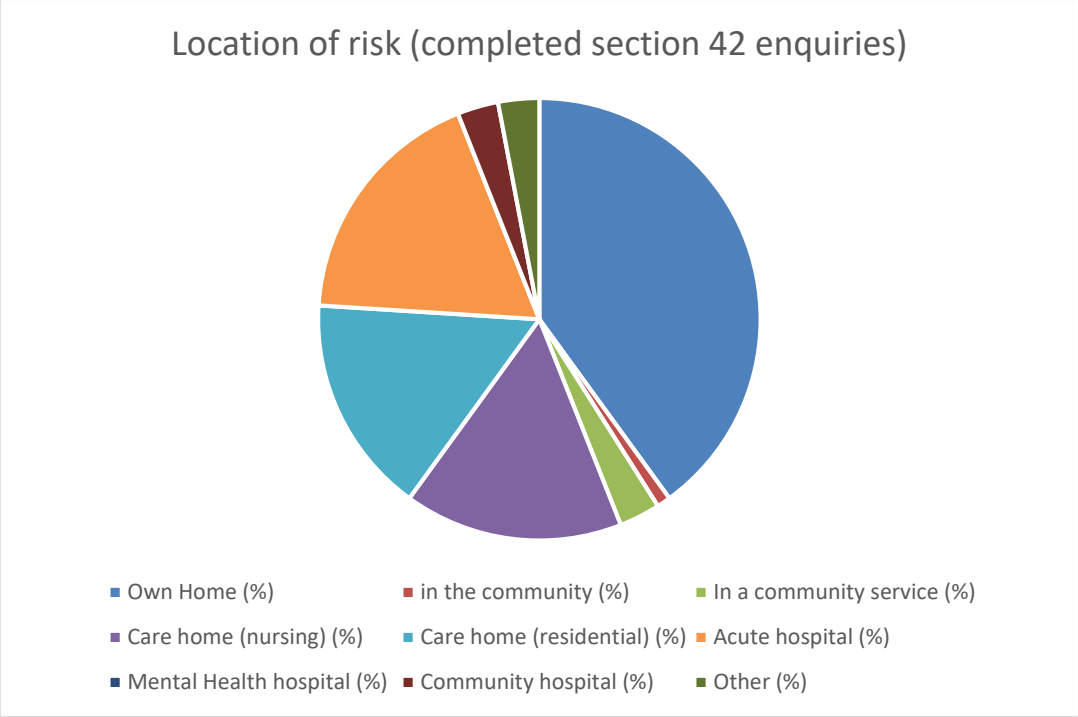
For the coming year, work will be undertaken with the other Local Safeguarding Adults Boards in Hampshire to establish a common dataset which will give the Board a greater understanding of safeguarding data drawn from all partners, and enable comparisons across the area.

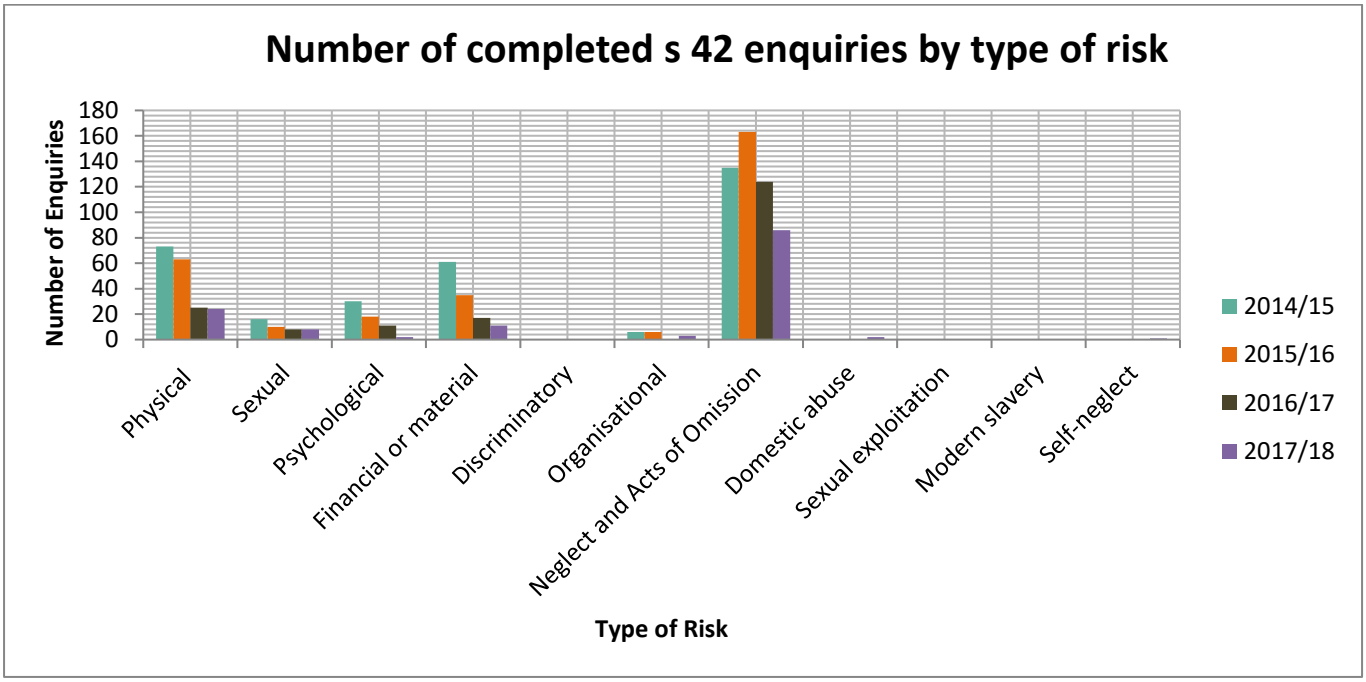





Safeguarding concerns by age
4
4
19
41
19
13
18-64 (%)
65-74 (%)
75-84 (%)
85-94 (%)
95+ (%)
Unknown

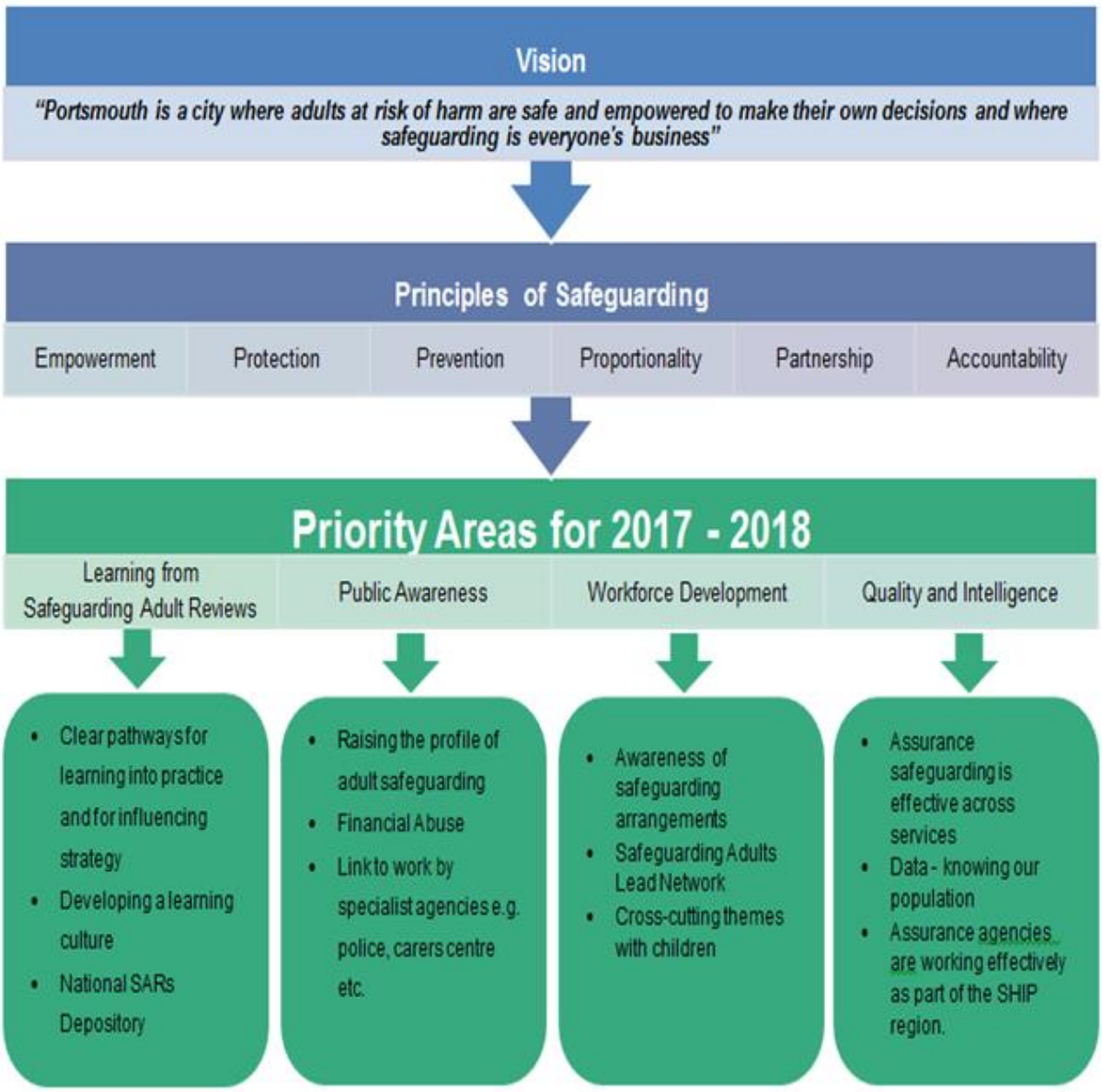

Source of risk (completed section 42 enquiries)
37
37
26
Service Provider (%)
Known to individual (%)
Unknown to individual (%)


Location of risk (completed section 42 enquiries)
Own Home (%)
in the community (%)
In a community service (%)
Care home (nursing) (%)
Care home (residential) (%)
Acute hospital (%)
Mental Health hospital (%)
Community hospital (%)
Other (%)


Number of completed s 42 enquiries by type of risk
Number of Enquiries
180
160
140
120
100
80
60
40
20
0
Physical
Sexual
Psychological
Financial or material
Discriminatory
Organisational
Neglect and Acts of Omission
Domestic abuse
Sexual exploitation
Modern slavery
Self-neglect
Type of Risk
2014/15
2015/16
2016/17
2017/18

Progress on 2017-18 strategic plan

Our priorities for 2017-18 are summarised below:



Learning from Safeguarding Adult Reviews

The Care Act 2014 states that a Safeguarding Adults Review (SAR) must take place when:

"There is reasonable cause for concern about how the Safeguarding Adult Board, members of it or others worked together to safeguard the adult, and death or serious harm arose from actual or suspected abuse".

The PSAB has a SAR sub-group which is chaired by the Deputy Director for Quality and Safeguarding from NHS Portsmouth Clinical Commissioning Group. The group is a multi-agency group with members who have a specialist role or experience in safeguarding adults. The group met monthly during 2017-18. In March 2017, the

SAR sub-group started a pilot joining up with the Portsmouth Safeguarding Children Board's (PSCB) Case Review Committee (CRC) to work together on cases which might involve both children and adult services. The pilot was reviewed during 2017-18 and it was concluded that there were many positive outcomes, including:

- Good relationships being built between adults and children's services
- That there are benefits on issues in common being looked at jointly by both groups
- There have been some good outcomes from some of the reflective practice events.

These joint meetings have now become a permanent way of working.

Summary of SAR activity during 2017-18

Four new SAR referrals were received in 2017-18. One of these referrals was found to meet the criteria for a SAR. The PSAB has therefore commissioned a SAR. A panel has been set up and an independent author has been engaged to write a report on the case. This work is due to be undertaken in 2018-19. For a second case, scoping has been initiated to identify whether or not the criteria for a SAR have been met.

In two further cases, after investigation, it was decided that they did not meet the criteria for a SAR. Through the NHS serious incident review process, learning was identified for prison health services and recommendations were communicated to the relevant service.

During 2017-18 the SAR sub-group took forward work on referrals from the previous year to ensure that relevant learning was identified and embedded within organisations. For example, a joint children and adult's multi-agency reflective practice workshop carried out as a result of a referral to PSCB CRC. The referral was made to the CRC in November 2016, regarding a child, but the case also involved an adult at risk. The criteria for a Serious Case Review was not met but the CRC and the SAR sub-group decided to proceed with a joint multi-agency reflective practice meeting. This would consider how agencies had worked together and what lessons could be learned to improve the outcomes in future situations.

Findings and Learning Points

- Tendency of services to focus on isolated incidents. Lack of seeing the bigger picture of the situation.
    - The sum impact of events needs to be considered
    - Individual agencies to be assured that they understand how to identify and respond to the cumulative effect of individual incidents and escalate / refer accordingly.

- Both individuals seen by multiple agencies on multiple occasions i.e. lots of input but not coordinated as no individual / agency seemed to be taking the lead.

    - To allow for more effective multi-agency working there needs to be an understanding of different agencies and individual roles, and in particular where responsibility of each starts and finishes

- The high intensity user group at the hospital agreed an approach to manage the mother's attendance at the Emergency Department, but didn't consider the impact this may have had on the child and other family members.
    - Agencies to consider risk assessing the impact of withdrawing services to the individual on the wider family.

A member of the Portsmouth SAR sub-group was on the panel for a SAR carried out by Hampshire SAB (Mr C) and it is planned that in 2018-19 the recommendations from that SAR will be reviewed by the sub-group so that any learning relevant to Portsmouth organisations can be acted upon.

On a national level, PSAB will engage with the new national library of SARs which is being established by the Social Care Institute for Excellence and the Learning Disabilities Mortality review programme to ensure that learning from other areas is considered within Portsmouth.

Public Awareness

During the year, work on re-branding PSAB has been completed, with a new logo launched. The website has been updated to reflect the new branding. A Twitter account has also been set up for the Board to enable communication of key messages about adult safeguarding through social media. This will assist with communication with the public, service users, stakeholders and professionals. The Board has also been working on developing some easy-read information about safeguarding. A pan-Hampshire approach has been taken to publicity materials for the Board, with posters and leaflets being shared with the other Local Safeguarding Adults Boards.

Workforce Development

Work has been undertaken to establish workforce development on a pan-Hampshire basis (see below). A 4LSAB workforce sub-group has been established, with the remit to review and map workforce development activity across the area and to develop a regional training offer.

On the national level, the Independent Chair has been involved with the development of a workforce framework focusing on the role of the Safeguarding Adults Board Chair.

Quality and Intelligence

A key part of work in this area has been the establishment of a Safeguarding Improvement Board to support Portsmouth Hospitals NHS Trust to address areas of concerns identified by the Care Quality Commission (CQC) (see below for further detail).

PSAB partners have also been engaged in work to address the number of providers rated as 'inadequate' or 'requires improvement' by CQC. Plans have been put in place by Portsmouth City Council and NHS Portsmouth Clinical Commissioning Group to establish a joint quality improvement team to work with residential and domiciliary care providers to improve care quality within Portsmouth.

On a pan-Hampshire basis, a Quality Assurance sub-group has been established and a workshop was held, hosted by Hampshire Constabulary, to plan the work programme for this group.

Nationally, work is underway to understand (via a SAB Chairs' audit) how Safeguarding Adults Boards are using NHS Digital data and how this data can drive more effective intelligence and decision-making.

Other activity

The Board has considered other key areas of concern which arose during the year. For example, they received presentations on Prevent and on Suicide Prevention. Following the tragic events at Grenfell Tower, the Board sought assurance from Housing and Hampshire Fire and Rescue on the response within Portsmouth.

Case Study: Safeguarding Improvement Board

During 2017-18 two inspection reports from the Care Quality Commission (CQC) were published regarding the quality of health provision in Portsmouth

- CQC Portsmouth Hospitals NHS Trust, Queen Alexandra Hospital Quality Report (publication date 24th August 2017).
- CQC Review of health services for Children Looked After and Safeguarding in Portsmouth (publication date 19th September 2017).

These reports both identified areas of good practice as well as some areas concern relating to safeguarding of both adults and children in Portsmouth's health services.

To ensure that both the PSAB and the Portsmouth Safeguarding Children Board had sufficient oversight of the improvement activity in partner agencies, whilst not overly burdening them with duplication of reporting, a Joint Safeguarding Improvement Board was convened. This Board was constituted as a sub-group of both PSAB and PSCB on a task-and-finish basis and had agreed terms of reference. As two-thirds of the patients attending Portsmouth Hospitals Trust live in Hampshire, the Safeguarding Improvement Board has also sought to work in partnership with the Hampshire Safeguarding Adults Board and the Hampshire Safeguarding Children Board.

This Board is jointly chaired by the Independent Chairs of the PSAB and PSCB and the membership is made up of:

- Chief of Health & Care Portsmouth, NHS Portsmouth CCG/Portsmouth City Council
- Deputy Director of Quality and Safeguarding, NHS Portsmouth CCG
- Head of Safeguarding, Portsmouth Hospitals NHS Trust

- Associate Director of Quality and Governance, Portsmouth Hospitals NHS Trust
- Public Health Consultant, Public Health
- Director of Children's Services, Portsmouth City Council
- Head of Health & Wellbeing Partnerships, Healthwatch Portsmouth
- Associate Director Quality & Nursing, South Eastern Hampshire/Fareham and Gosport Hampshire CCG Partnership
- District Manager for Hampshire Children's Services, Hampshire County Council
- Chief Superintendent, Head of Prevention and Neighbourhood Command Hampshire Constabulary
- Board Manager, Portsmouth Safeguarding Adults Board
- Safeguarding Partnerships Manager, Portsmouth Safeguarding Children Board
- Strategic Partnerships Manager, Hampshire Safeguarding Children Board
- Strategic Partnerships Manager, Hampshire Safeguarding Adults Board

The objectives of the Safeguarding Improvement Board are:

a. To ensure appropriate actions have been identified and undertaken to address the areas of concern
b. To provide a direct line of reporting and accountability for the actions / work streams being undertaken by providers
c. To provide an accessible escalation route to address any areas that may prevent or hinder the necessary actions being taken
d. To provide strategic support to providers as required.

The PSAB commissioned independent consultants CPEA to produce a report and recommendations to initiate the work.

Portsmouth Hospitals Trust, Solent NHS Trust, Portsmouth Clinical Commissioning Group, Public Health and the Society of St James all developed detailed action plans in response to the recommendations in these reports.

This work is ongoing and aims to be completed by September 2018, at which point any actions still outstanding will be reviewed by the PSAB and PSCB respectively.

Board structure and pan-Hampshire ('4LSAB') working

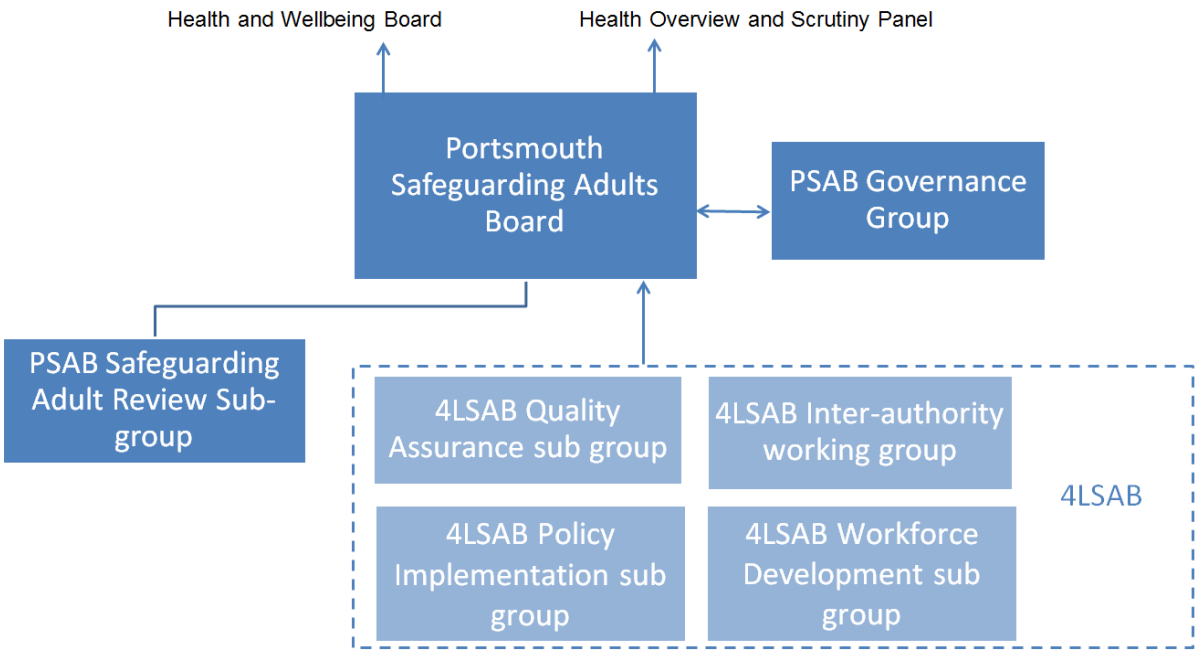
Over the past year, we have made significant progress to ensure we are working in a joined up and coordinated way with our Safeguarding Adult Board colleagues in the neighbouring local authority areas (Hampshire, Southampton and the Isle of Wight). This approach recognises the fact that the membership and priorities of our respective Safeguarding Adults Boards are often overlapping.

We have therefore, established joined working groups for Policy Implementation, Workforce Development and Quality Assurance and have agreed a shared vision and common objectives for these areas. We recognise however, the importance of flexibility to enable each individual Board to address specific priorities and objectives relevant to their Board and/or locality.

This joined approach has enabled us not only to reduce duplication but has also led to greater effectiveness and impact in a number of important areas including:

- Availability of consistent multi-agency policy and guidance.
- Sharing of expertise and best practice.
- Improved delivery of training and development.
- Wider application of learning from serious cases.
- Better use of time and resources for the Boards and partners.

Our new Board structure is set out in the diagram below:



Our Priorities for 2018-19 and beyond

During 2018 the Board has reviewed its approach to strategic planning, and has decided that a longer term approach would be beneficial. Strategic planning is now more firmly underpinned by a multi-agency assessment of key risks to keeping people safe across the City. The following priorities have been adopted for a three year planning cycle 2018-19 to 2020-21. Progress against the priorities will be reviewed on an annual basis.

1. Improve practice on MCA and DoLs
2. Reduce the number of care providers rated inadequate or requires improvement by CQC
3. Pan-Hampshire working a. Embed 4LSAB working b. Reduce Fire Deaths across 4LSAB area c. Ensure 4LSAB policies are translated into practice (Hoarding, Escalation, Family Approach, Thresholds) d. Develop vulnerability toolkit

e. Learning from deaths work
4. Improve the quality of transition
5. Ensure PSAB decision making is underpinned by robust data
6. Improve safeguarding adults practice within Portsmouth

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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:	Tobacco Harm Reduction
Date of meeting:	13th February 2018
Report by:	Director of Public Health
Wards affected:	All

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1. Requested by

Cllr Winnington, Cabinet Member for Health, Wellbeing and Social Care

2. Purpose

2.1 To describe harms of illicit tobacco and why it is relevant to partners across the city.

2.2 To provide an overview on how addressing illicit tobacco contributes to the overall strategy for tobacco control which requires a whole system approach.

2.3 To provide an overview of joint working between Trading Standards and Public Health to reduce harm from tobacco.

3. Background

3.1 In 2017, overall estimated smoking prevalence in adults in Portsmouth was 15.2%, similar to (although higher than) the England average. There is variation in prevalence between groups in the Portsmouth population (section 4).

3.2 Reducing harms from tobacco is a priority in the Portsmouth Joint Health and Wellbeing Strategy 2018-2021[i]. The Portsmouth Tobacco Control Strategy plan on a page (appendix A) updates the current strategy to 2022 to reflect the national direction.

3.3 Enforcement is an important strand of tobacco control to maximise the public health benefit delivered by Regulations. It also impacts legitimate local business. Local enforcement is the responsibility of local authorities[ii].

4. Illegal tobacco in Portsmouth

4.1 Illegal tobacco can take many forms. Illicit white cigarettes which have no legal market in the UK; counterfeit cigarettes which are illegally manufactured and sold; and genuine cigarettes which are smuggled into the UK without duty paid. The illicit tobacco trade is dominated by organised criminals.

4.2 The illegal trade undermines efforts to reduce smoking and reduces effectiveness of tobacco control measures - illicit tobacco products are cheaper partly because taxation is avoided[iii] and age restrictions are not adhered to. Unattended illicit tobacco products may continue to burn through non-compliance with regulatory standards[iv]. Ingredients of illicit tobacco products are not known or regulated and therefore may pose further harms to health.

4.3 Portsmouth findings of recent research across the South East identified:

a. 27% smokers buy illicit tobacco, South East average is 14% (Portsmouth is second highest in the South East)

b. Men, younger smokers (16-54), and individuals from lower socio-economic groups are more likely to buy illicit tobacco

c. Smokers in Portsmouth are more likely to be offered illicit tobacco then most other areas in the South East (see graph below).

5. Organised crime

5.1 Tobacco smuggling is associated with organised crime, including the smuggling of controlled drugs, weapons and human beings[v], with harms including exploitation of children.

5.2 Tackling the threat presented by the criminality behind illicit tobacco requires continuing collaboration across local government. Strategies include protecting local communities from potential harms and raising public awareness of the links between illicit tobacco and organised criminality to reduce local tolerance.

Example from Portsmouth

Trading Standards received a request from a 'Regional Serious Organised Crime' task force who were interested in individuals Trading Standards had prosecuted in the past in connection with the supply of illicit tobacco. One of the individuals concerned has recently been found guilty of organised immigration crime (human trafficking) and was sentenced to three years imprisonment. This example illustrates the nexus between the illicit tobacco trade and organised crime at a local level.

6. Tackling Illicit Tobacco in Portsmouth

6.1 Given a comparatively high percentage of smokers in Portsmouth use illicit tobacco (section 4.3), this demonstrates the need to tackle this activity.

6.2 A regulatory approach requires co-ordinated multi-agency working (illustrated in diagram below). This is one part of a comprehensive strategy of tobacco control.

6.3 Since 2014 Public Health have funded a post to work proactively within Trading Standards to tackle illicit alcohol and illicit tobacco including related products (such as products not conforming to e-cigarette regulations). This role works in partnership with other local authorities. Funding for this role has been agreed for 2019/20.

6.4 The main objectives of this role are to:

a. Address the trade of illicit tobacco and alcohol; gathering and using local intelligence
b. Reduce underage sales activity; alcohol, tobacco and nicotine inhaling products (NIPs)
c. Provide advice and guidance to local retailers of all alcohol, tobacco and NIPs products
d. To support Trading Standards with prosecutions/licence reviews relating to activity of the role.

6.5 Trading Standards officers enforce regulations concerning consumers, goods and services and have significant experience with regulating: Age Restricted Products, Product Safety and Intellectual Property (counterfeit goods).

False wall panel hide & illicit tobacco products hidden in bags of rice

7. Other nicotine and tobacco containing products

7.1 There has been rapid development of a range of nicotine and tobacco containing products. Over 3m adults in Great Britain are estimated to use e-cigarettes (nicotine containing products). Insight from Trading Standards on the evolution of products e.g.' heat not burn' tobacco products is crucial to enable timely public health advice.

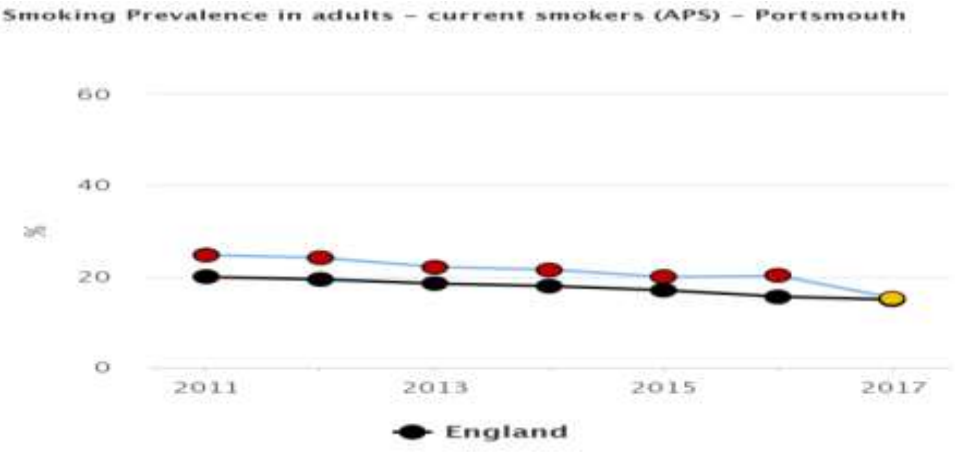
7.2 The Tobacco Products Directive 2014/14/EU (TPD) introduced new rules for nicotine-containing electronic cigarettes and refill containers (Article 20) from May 2016, and added further requirements in May 2017, for which local Trading Standards regulate.

7.3 The increase in demand for e-cigarettes and increase in local retailers suppling e-cigarettes and related products over recent years exemplifies the need to regulate these products and monitor adherence.

Counterfeit cigarettes in standardised packaging

8. Tobacco smoking in Portsmouth

8.1 Smoking prevalence in adults has declined (similarly to the national trend), from 24.7% in 2011, to 15.2% in 2017[vi]:



8.2 Tobacco is the risk factor which makes the greatest contribution to morbidity in the Portsmouth population in recently published local authority level *Global Burden of Disease* estimates.

8.3 Targeting population groups enables inequalities to be addressed, such as:

- Pregnant women (smoking at time of delivery in Portsmouth is significantly higher than England, 12.7% v 10.8%, 2017/18)

- Young people (estimated prevalence at age 15 of current smokers is significantly higher than England, 10.9% v 8.2%, 2014/15)
- Routine and manual workers (as a marker of socio-economic status) (estimated prevalence of current smokers in Portsmouth is similar to England, 27.0% v 25.7%, 2017)
- Individuals with a long term mental health condition (estimated prevalence of current smokers in Portsmouth is similar to England, 21.0% v 27.8%, 2017/18)

9. Tobacco Control in Portsmouth 2018-2022 - plan on a page

9.1 The refreshed plan on a page (appendix 1) is aligned with the themes set out in the Tobacco Control Strategy for England and recognises the role of changing social norms as well as supporting smokers to quit. It is informed by the World Health Organisation (WHO) Framework Convention on Tobacco Control, which takes a comprehensive approach to tacking supply and demand of tobacco products.

9.2 The vision for tobacco control in Portsmouth is to:

a. Reduce smoking prevalence in Portsmouth, both overall and in identified target groups
b. Support local communities to create a tobacco free culture for Portsmouth.

9.3 Themes for action in the local and national strategies are:

- Prevention first
- Supporting smokers to quit
- Eliminating variation in smoking rates
- Effective enforcement

9.4 The Tobacco Control Plan for England 2017-2022 sets the national ambition to reduce the prevalence of adults smoking to less than 12%, to reduce the inequality gap between those in routine and manual occupations and the general population and to reducing smoking amongst pregnant women to 6% by the end of 2022.

10. Current opportunities for Tobacco Control in Portsmouth

10.1 All partners have a role in continuing to progress this priority as part of the Portsmouth Joint Health and Wellbeing Strategy 2018-2021:

- The NHS Long Term Plan and Local Maternity System transformation provides opportunity for a focus on tackling smoking in pregnancy - building on the work underway through the Joint Smoking in Pregnancy steering group.
- Delivering the Commissioning for Quality and Innovation (CQUIN) 2017-2019 on reducing risky behaviours in healthcare providers is part of the HIOW Sustainability and Transformation Partnership plan to reducing smoking prevalence.
- Optimising implementation of Queen Alexandra Hospital achieving smokefree status on 14th January 2019, continuing this existing commitment at St James' Hospital Solent NHS Trust, as well as building on establishing the first smokefree children's play park in Portsmouth on 8th January 2019 contribute to reshaping social norms.

……
Signed by Dr Jason Horsley, Director of Public Health

Appendices:
Appendix A - Tobacco Control in Portsmouth 2018-2022 - plan on a page
Appendix B - Tobacco commissioning support pack for 2019/20

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

References:

[i] Portsmouth Health and Wellbeing Board (2018), *Portsmouth's Health and Wellbeing Strategy 2018-2021* [Online]. Available at https://democracy.portsmouth.gov.uk/documents/s18382/Portsmouth%20draft%20hwb%20strategy%2016032018%20Cabinet.pdf (accessed 23.01.19).
[ii] Department of Health and Social Care (2017), *Tobacco Control Plan Delivery Plan 2017 - 2022* [Online]. Available at https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/714365/tobacco-control-delivery-plan-2017-to-2022.pdf (accessed 23.01.19).
[iii] Illicit Tobacco Partnership (2017), *Illegal Tobacco PR guide* [Online]. Available at https://www.illicit-tobacco.co.uk/wp-content/uploads/2017/12/Illegal-Tobacco-PR-Guide-Dec-2017.pdf (accessed 23.10.19).
[iv] ASH (2018), *Smoking in the home: New solutions for a Smokefree Generation* [Online]. Available at http://ash.org.uk/wp-content/uploads/2018/11/FINAL-2018-Smokefree-Housing-report-web.pdf (accessed 28.01.19).
[v] HM Revenue and Customs (2011), *Tackling illicit tobacco: From leaf to light* [Online]. Available at https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/418732/Tackling_illicit_tobacco_-_From_leaf_to_light__2015_.pdf (accessed 23.10.19).
[vi] Public Health England (2018), *Local Tobacco Control Profiles* [Online]. Available at https://fingertips.phe.org.uk/profile/tobacco-control/data#page/4/gid/1938132886/pat/6/par/E12000008/ati/102/are/E06000044/iid/92443/age/168/sex/4 (accessed 28.01.19).

Tobacco Control in Portsmouth 2019–2022

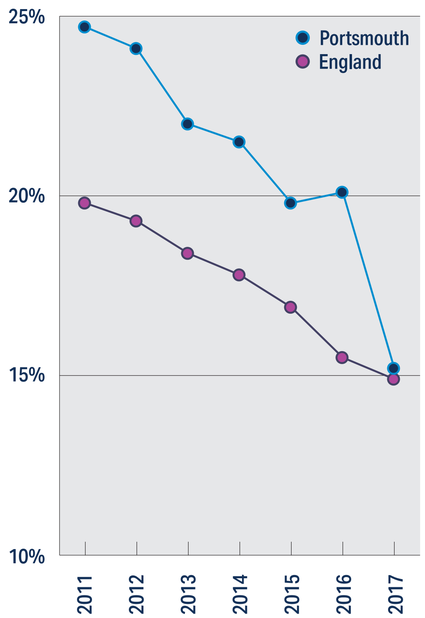
Plan on a page

Although smoking prevalence in Portsmouth continues to decline, the 2017 estimated smoking prevalence in adults in Portsmouth was 15.2%, higher than the average for England. For routine and manual workers estimated prevalence in 2017 was 27%. It is a national ambition to reduce the prevalence of adults smoking to less than 12%, and to reduce the inequality gap.

Reducing harms from tobacco is a priority in the Portsmouth Joint Health and Wellbeing Strategy 2018-2021, as well as the NHS Long Term Plan 2019. This plan on a page also reflects measures in the WHO Framework Convention on Tobacco Control.

Smoking costs the NHS an estimated £2bn a year, but the costs to society are significantly higher. The total additional spending on social care as a result of smoking for adults aged 50 and over during 2016/17 in Portsmouth was approximately £5,027,330 (Public Health England, 2019).

Smoking Prevalence in adults (%)– current smokers (APS)–Portsmouth



Portsmouth facts

945
deaths attributed to smoking
(2014-16)

1,514
hospital admissions attributed to smoking
(2016/17)

15.2%
of adults are current smokers
(2017)

12.7%
of mothers were smokers at the time of delivery
(2016/17)

Prevention First

To improve life chances for children, prevention means working towards a reduction of smoking prevalence during pregnancy, with emphasis on supporting pregnant women from deprived populations. Supporting people not to start smoking, while working to eliminate smoking among under 18s.

What?	Stamping out inequality: smokefree pregnancy. National target of <6% by end 2022.
How?	Work jointly with Portsmouth maternity centres, in line with NICE guidance to identify areas of development to achieve smoke free pregnancies.

What?	Work to eliminate smoking among under 18s and achieve the first smokefree generation. National Target of <3% by end 2022.
How?	Understand smoking and e-cigarette usage in young people using the Portsmouth 'You Say' survey and through promoting inclusion in Personal, Social and Health Education (PSHE).

Eliminating variation in smoking rates

To reduce the regional and socio-economic variations in smoking rates, we need to achieve system-wide change and target our actions at the right groups. Helping smokers to quit is the job of the whole health and care system. There is a higher prevalence of smoking in more deprived areas which contributes to inequalities, as smokers experience a greater incidence of poor health and disease. We must challenge the social norms that see smoking as acceptable or normal behaviour.

What?	A whole system approach; develop all opportunities within the health and care system to reach out to the large number of smokers engaged with healthcare services on a daily basis.
How?	Work with NHS Trusts to support identification, referral and treatment pathways for patients and through Making Every Contact Count.

What?	Local inequalities: eliminating health inequalities through targeting those populations where smoking rates remain high.
How?	Provide targeted stop smoking support for routine and manual workers, areas of greater deprivation and in mental health settings.

What?	Smokefree places: explore further opportunities to protect people from the harm of second-hand smoke and influence social norms.
How?	Implement smoke free environments, with support from local residents e.g. children's play parks.

Supporting smokers to quit

The majority of smokers in England want to quit and smokers who use stop smoking services are up to four times more likely to quit successfully compared to those who choose to quit without help. The most effective approach remains the provision of specialist behavioural support combined with pharmacotherapy as provided by evidence based local stop smoking services. Supported with local and national media messages e.g. Stoptober, OneYou and NHS Smoke Free.

What?	Continue to reduce the prevalence of adults smoking in Portsmouth. National target of <12% by end 2022.
How?	Provision of specialist stop smoking services providing behavioural support and pharmacotherapies including accessible support through pharmacies and workplaces.

What?	Parity of esteem: supporting people with mental health conditions.
How?	To assist in developing a comprehensive smoking cessation support system for patients accessing Mental Health Services in Portsmouth.

What	Backing evidence based innovation: develop a strong evidence base on the full spectrum of nicotine delivery products.
How?	Support e-cigarette policy development and providing training and updates.

What	A Smokefree NHS, leading by example: create and enable working environments which encourage smokers to quit.
How?	Support local NHS Trusts with implementing processes which focus on identifying and influencing patients who smoke to make a quit attempt and developing and monitoring referrals. Supporting local NHS Trusts to become smoke free for its staff and patients; forever.

Effective enforcement

Tobacco is the deadliest commercially available product in England. Comprehensive enforcement of tobacco regulation is an important strand of tobacco control to maximise the public health benefit delivered by tobacco regulations.

What?	Illicit tobacco: implement the illicit tobacco strategy and reduce the market share of these products
How?	Work with Trading Standards to reduce the supply and demand of illicit tobacco, including using opportunities to raise awareness of the harms of illicit tobacco.

What?	Regulation and enforcement: improve the use and effectiveness of sanctions and monitor the development of novel products.
How?	Working with retailers to ensure regulation of e-cigarettes and other nicotine containing products.

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Public Health England

Protecting and improving the nation's health

Tobacco commissioning support pack 2019-20: key data

Planning for comprehensive local tobacco control interventions

Portsmouth
(using latest available data)

PHE publications gateway number: 2018467

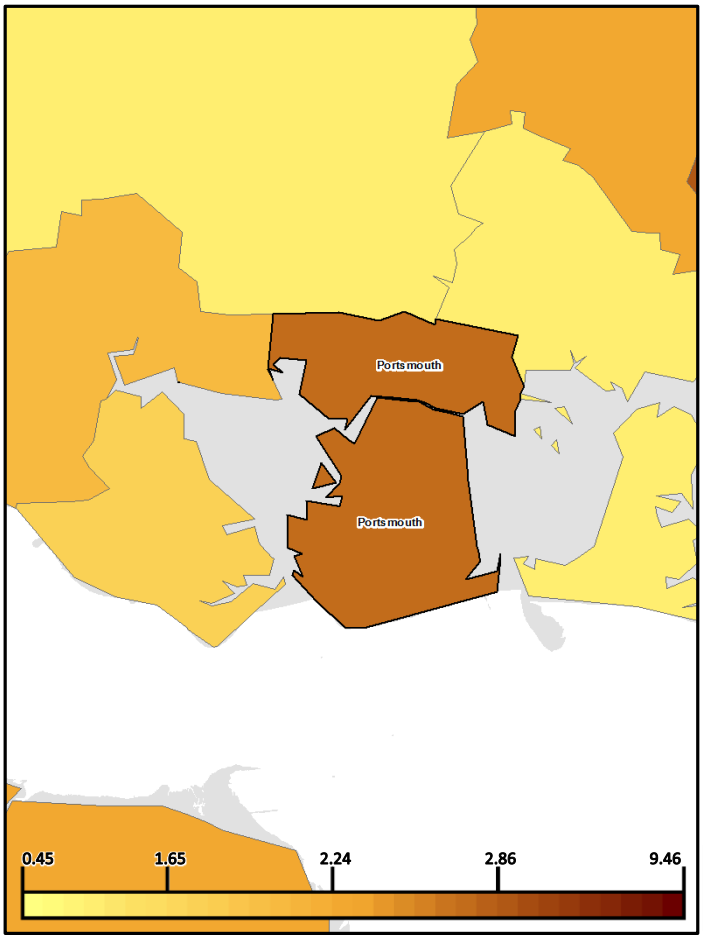
Introduction

Smoking continues to kill 78,000 people in England every year and is the number one cause of preventable death in the country, resulting in more deaths than the next six causes combined. Tobacco use is also a powerful driver of health inequalities and is perhaps the most significant public health challenge we face today. To fully understand how your local tobacco control network is responding to these problems, locally and nationally held data can be used. Data relating to local areas' targeted tobacco control interventions are not collected nationally, though should be available at a local level. The new Tobacco Control Plan for England (2017)[1] and the Tobacco Control Delivery Plan[2] challenges localities to identify and target their populations in most need of quit support.

This pack aims to signpost to available tools and datasets to support your work in making the case for local tobacco control interventions. Feedback and debate on the range of tools and datasets available nationally is encouraged, as well as an opportunity to champion the use of local data sources and analysis. The tools referenced within this pack are routinely updated with the latest datasets. Readers are reminded that this resource is comprised of extracts from the tools referenced at time of publication (October 2018) and are encouraged to access the tools directly for the most up-to-date data.

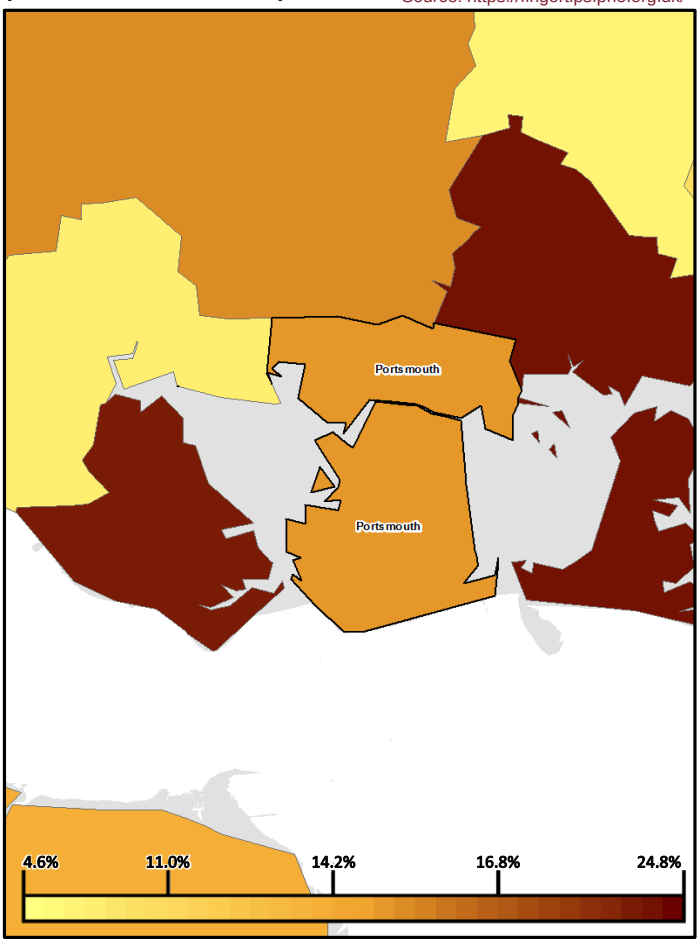
Reducing health inequalities

Socio-economic gap in prevalence (Odds ratio District level, APS 2017)

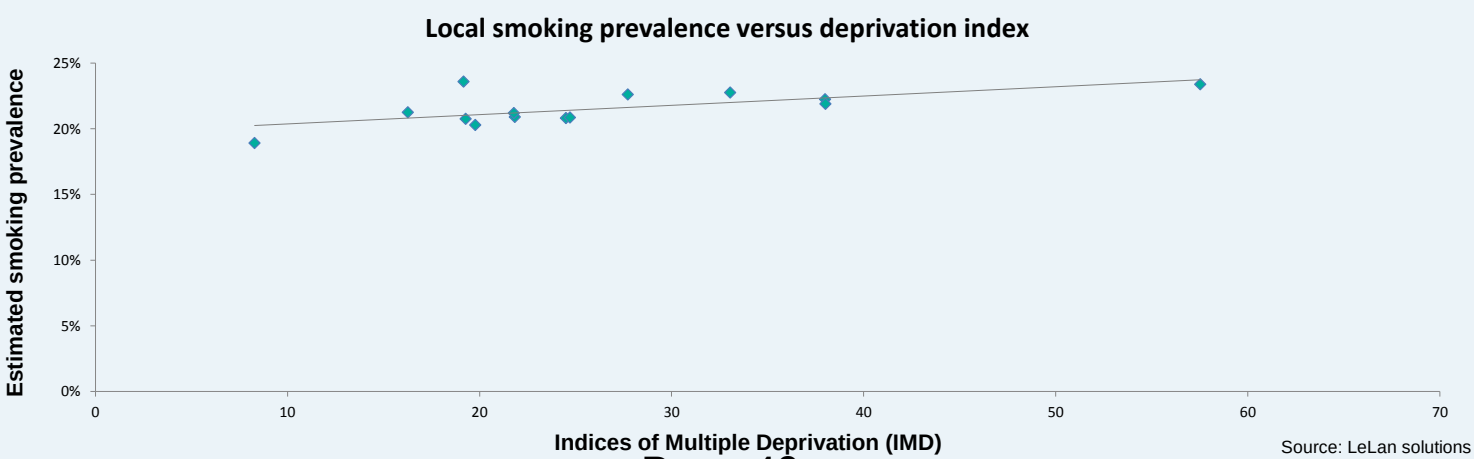


Smoking prevalence 18+ (District level, APS 2017)

Source: https://fingertips.phe.org.uk/



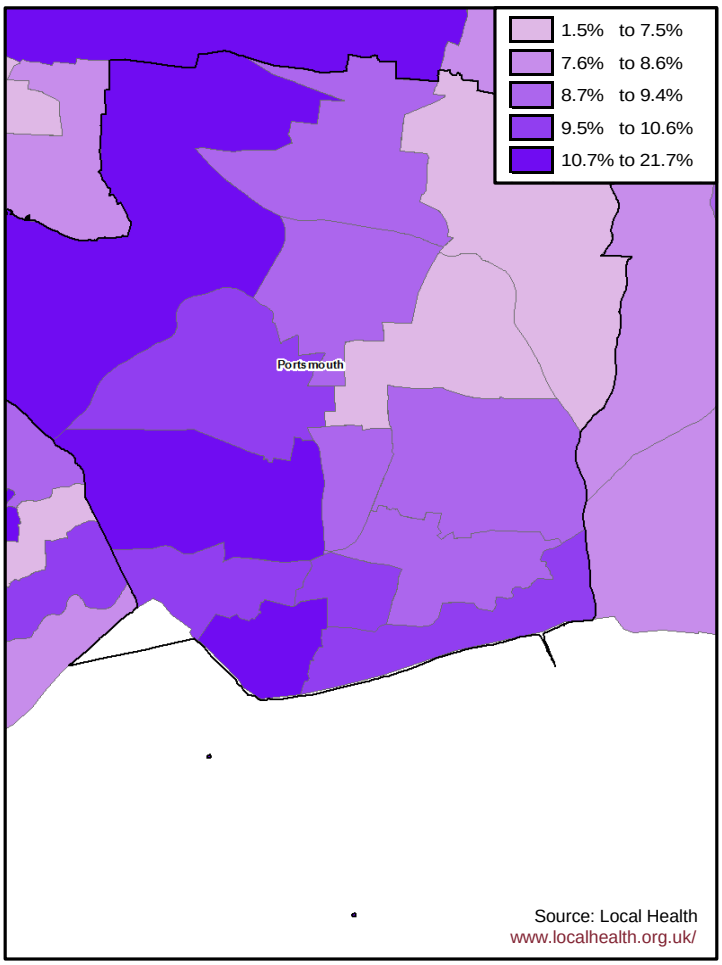
Smoking rates are much higher within certain groups and deprived communities. Smoking is around twice as common among people with mental disorders, and more so in those with more severe mental illnesses (estimates vary between 37% and 56%[3]). Lesbian, gay and bisexual communities are also significantly more likely to smoke, as are the long-term unemployed, and some minority ethnic groups, which also have gender disparities. Helping disadvantaged smokers quit is the best way to reduce health inequalities. Commissioners are encouraged to identify their communities most in need and target evidenced based interventions accordingly.



Source: LeLan solutions
See references 4.

Youth smoking prevalence

Regular smoker, modelled prevalence age 15 (Ward level)



There are several risk factors associated with increased likelihood of smoking initiation among young people. The following are associated with higher odds of youth smoking: exposure to parent, carer, sibling and peer smoking, lower socio-economic status, higher levels of truancy and substance misuse[5]. Smoking prevention is therefore not achieved by youth targeted interventions alone.

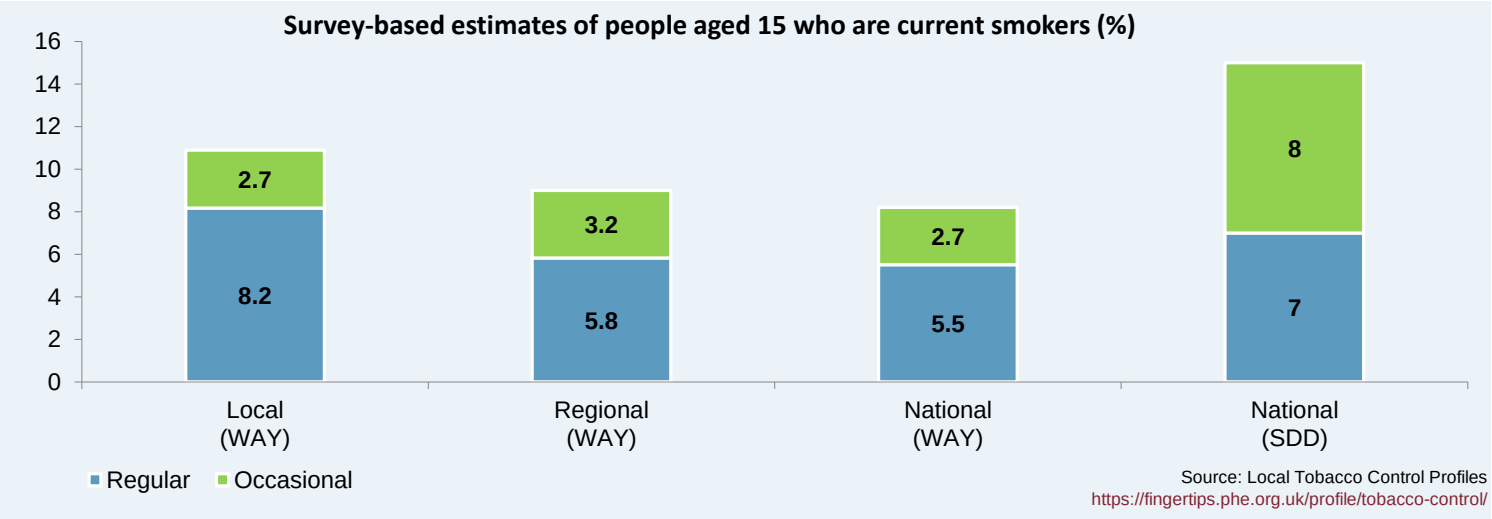
NICE guidance for smoking prevention suggests that school based interventions, mass media interventions and enforcement to restrict illegal access to tobacco among young people are effective[6,7]. The impact of these interventions are considered more effective when delivered as a package of multi-component interventions in family and community settings, particularly where there is an increased emphasis on reducing adult smoking through cessation[8].

'Securing a Tobacco Free Generation' resources

These resources have been created with content from Public Health England's national conference 'Working together to secure a tobacco-free generation'. The conference, delivered in association with the UK Centre for Tobacco and Alcohol Studies (UKCTAS) and Action on Smoking and Health (ASH) attracted delegates from across England working at national, regional and local levels to focus on effective strategies for tobacco control.

The resources include video presentations, instructions for facilitated discussion and tools for planning tobacco control interventions and can be used to i) facilitate delivery of local seminars, and ii) to inform planning of tobacco control interventions.

http://www.prezi.com/ovi0oixi92oy/working-together-to-secure-a-tobacco-free-generation



Current data sources for youth smoking prevalence are:

The Children and Young People's Health Benchmarking Tool:
https://fingertips.phe.org.uk/profile/child-health-profiles

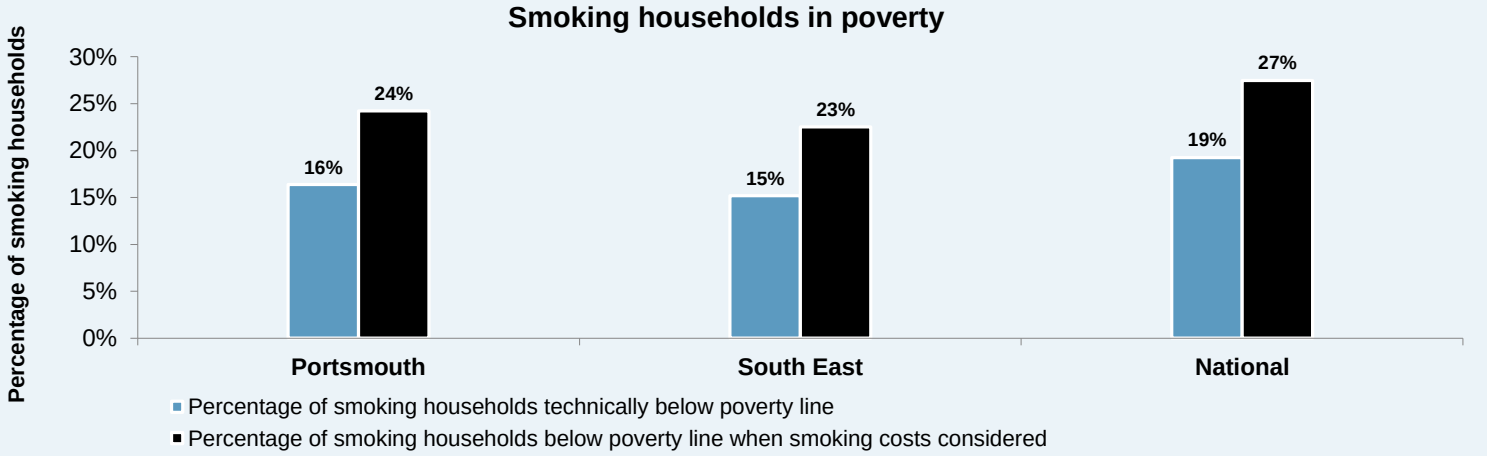
The Smoking, Drinking and Drug Use Amongst Young People in England survey 2016:
https://digital.nhs.uk/data-and-information/publications/statistical/smoking-drinking-and-drug-use-among-young-people-in-england/2016

The What About Youth survey:
https://digital.nhs.uk/data-and-information/areas-of-interest/public-health/what-about-youth-study

Family poverty

Approximately half of all smokers in England work in routine and manual occupations. Workers in manual and routine jobs are twice as likely to smoke as those in managerial and professional roles and unemployed people are twice as likely to smoke as those in employment. Ill-health caused by smoking is therefore much more common amongst the poorest and most disadvantaged in society.
When expenditure on tobacco is taken into account, around 500,000 extra households, comprising over 850,000 adults and almost 400,000 children, are classified as in poverty in the UK compared to the official Households Below Average Income figures. This shows that tobacco imposes a real and substantial cost on many low-income households.
It is important, however, to avoid concluding from these results that a suitable policy response would be to reduce tobacco taxation to make tobacco products more affordable. Previous research shows that increases in tobacco taxation are potentially a progressive measure in economic and health terms because poorer smokers are more likely to quit, and young people less likely to take up smoking, when tobacco prices increase because poorer households and young people are more sensitive to price increases[9]. Indeed, raising tax is the only tobacco control intervention which has been proven to have a greater effect on more disadvantaged smokers at population level and so contribute to reducing health inequalities[10].

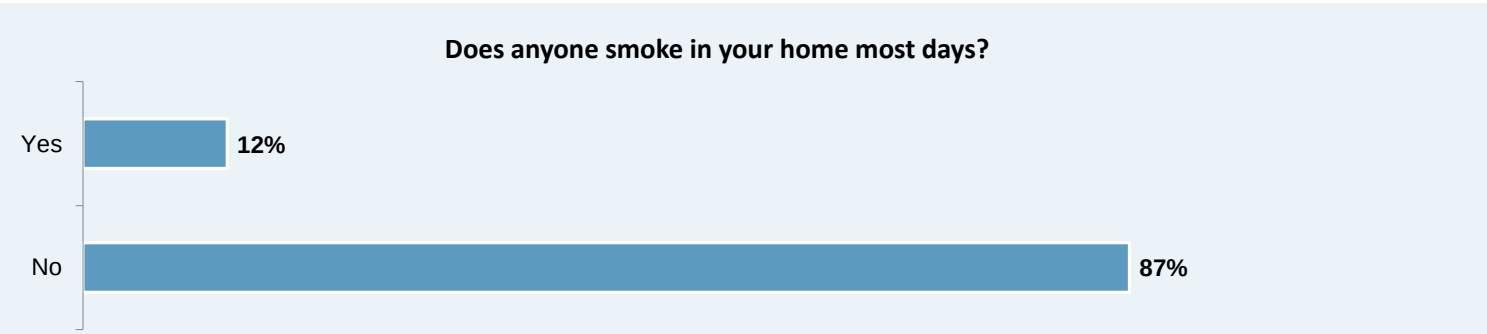
See also
Estimates of poverty in the UK adjusted for expenditure on tobacco:
http://ash.org.uk/category/information-and-resources/health-inequalities/health-inequalities-resources/



Source: Estimates of poverty in the UK adjusted for expenditure on tobacco
www.ash.org.uk/information-and-resources/health-inequalities/health-inequalities-resources/estimates-of-poverty-in-the-uk-adjusted-for-expenditure-on-tobacco

Smoking in the home

In this survey, over 8 in 10 adults in the South East region said that they do not allow smoking anywhere in their home or only in places that are not enclosed (such as in the garden or on a balcony). Only a minority (12%) stated that they would allow smoking anywhere in their house, or only in some rooms.



Source ASH Local Toolkit:
http://ash.org.uk/information-and-resources/local-resources/local-opinon/

Societal cost of tobacco control

Working together, ASH, the Faculty of Public Health, the Local Government Group, FRESH North East, Healthier Futures and Public Health Action have produced the Local Tobacco Control Toolkit. This provides local public health professionals with a set of materials to use with Councillors and other stakeholders to help ensure that tackling tobacco use is high on the local public health agenda. The online tool allows for analysis down to the local district and ward level.

Together these resources will allow you to:

- demonstrate the scale of the harm locally caused by tobacco use and the contribution this makes to health inequalities,
- demonstrate the cost to local communities, local economies and service providers,
- demonstrate the evidence of effectiveness of local action on tobacco and health.

The materials are designed for you to easily integrate local data from the Local Tobacco Control Profiles and the NICE Return on Investment tool.

Each year we estimate that smoking in Portsmouth costs society a total of approximately £53m.

Despite a contribution to the Exchequer, tobacco still costs the local economy in Portsmouth more than the duty raised. This results in a shortfall of about £17.3m each year.

Source: ASH Ready Reckoner 2018 Edition. Version 6.8 (25 May 2018)
http://ash.org.uk/category/information-and-resources/local-resources/

Cost of smoking to social care

The total additional spending on social care as a result of smoking for adults aged 50 and over during 2016/17 in Portsmouth was approximately:

£5,027,330

Total local authority spending on social care for adults aged 50 and over in 2016/17:

£2,748,760

Total spending by self-funded individuals aged 50 and over on social care in 2016/17:

£2,278,570

Research shows that smoking not only contributes to the social care bill but also has a significant impact on the wellbeing of smokers who need care on average nine years earlier than non-smokers.

The information in this extract synthesises data based on an analysis by Howard Reed of Landman Economics, for Action on Smoking and Health, entitled "The Cost of Smoking to the Social Care System in England" June 2014. The full report was updated in January 2017 and can be downloaded at: www.ash.org.uk/SocialCareCosts

Local stop smoking services

Stop smoking services are a key component of highly cost-effective tobacco control strategies at local and national level. Targeted, high-quality stop smoking services are essential to the reduction of health inequalities for local populations. All health and social care services can play a key role in identifying smokers and referring people to stop smoking services. For those people who are not ready, willing, or able to stop in one step, harm reduction interventions can support them in moving closer to becoming smokefree. Specialist interventions provided by trained practitioners are the most effective way of quitting smoking successfully. The quality of services has remained consistently high (51%), with services supporting 274,021 people during 2017/18, 138,426 of whom were successful at 4 weeks.

Stop Smoking Service Data

This data enables local authorities to benchmark their performance and identify which treatment settings and intervention types are consistently getting the best results.

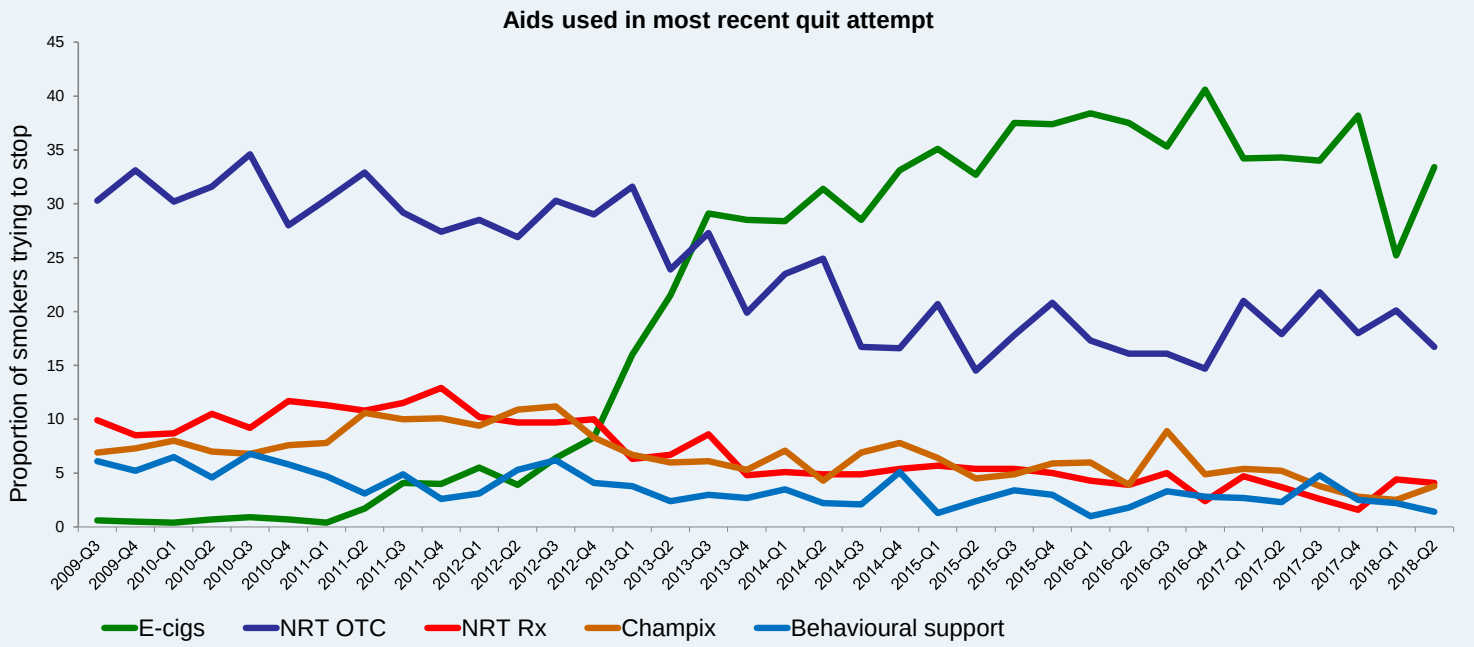
	Local					National	Comparison of 17/18 local and National data
	2016/2017		2017/2018			2017/2018	
18+ smoking population (Adult current smokers, APS 2017)		**20.1%**		**15.2%**	▼	**15%**	
Number setting a quit date per 100,000 smokers aged 16 and over	**3,394**		**3,017**		▼	**4,119**	
Number of successfully quit (self-report) per 100,000 of smoking population aged 16 and	**1,545**		**1,457**		▼	**2,081**	
Number setting a quit date	**1,195**		**795**		▼	**274,021**	
Number not known/lost to follow up	62	5%	25	3%	▼	23%	
Number of successful quitters (self-report)	544	46%	384	48%	▲	51%	
Number who had successful quit (self-report), confirmed by CO validation	317	27%	284	36%	▲	36%	
Number of pregnant women setting a quit date	**27**		**20**		▼	**13,712**	
Number not known/lost to follow up	:		:		◀▶	26%	
Number of successful quitters (self-report)	2	7%	4	20%	▲	45%	
Number who had successful quit (self-report), confirmed by CO validation	1	4%	3	15%	▲	27%	

'Source: Statistics on NHS Stop Smoking Services: https://digital.nhs.uk/data-and-information/publications/statistical/statistics-on-nhs-stop-smoking-services-in-england

* Data suppressed in source : Data unavailable in source

E-cigarettes and quit smoking support

E-cigarettes have become the most popular stop smoking aid in England. There is growing evidence that they can be effective in helping smokers to quit, particularly when combined with behavioural support from local stop smoking services. Currently, there are no medicinally licensed e-cigarettes available on the market and they cannot be prescribed for smoking cessation. However stop smoking services are encouraged to be open to smokers who want to use an e-cigarette in their quit attempt, and to provide the expert support that will give them the best chance of stopping smoking successfully.



Adults who smoke and tried to stop or who stopped in the past year.
Any use of quit aids during quit attempt, groups are not exclusive.

Source: The Smoking Toolkit Study, Electronic cigarettes in England - latest trends http://www.smokinginengland.info/latest-statistics/

Smokers within the healthcare system

Savings to the NHS can be accelerated by treating tobacco dependence as an essential part of care plans for patients. This can be achieved by a whole hospital approach as per NICE PH48 guidance by: 1) screening and recording smoking status during every patient episode; 2) providing immediate access to nicotine replacement therapy (NRT) and or pharmacotherapies; 3) enabling smokers to access specialist in-situ support to quit; 4) automatic e-referral for intensive behavioural support and other specialist treatment; 5) training of healthcare staff to deliver interventions; and 6) making secondary care settings smokefree.

The new Tobacco Control Plan for England focuses on the need for local health and care systems to support NHS users to become smokefree; underpinned by the NHS Mandate on Prevention and the National CQUIN for Acute and Mental Health providers[11]. A new report from the Royal College of Physcians argues that responsibility for treating smokers lies with the clinician who sees them, and that our NHS should be delivering default, opt-out, systematic interventions for all smokers at the point of service contact[12].

Smoking in Pregnancy

Addressing smoking in pregnancy should be a focus for all localities as this impacts on a range of issues related to health, inequalities and child development. NICE has produced guidance on how best to support women to stop smoking in pregnancy[13]. Smoking during pregnancy causes up to 2,200 premature births, 5,000 miscarriages and 300 perinatal deaths every year in the UK.

	Local		National		
Smoking at time of delivery (2016/17) *Denominator: Maternities*	314	12.7%	65,023	10.7%	Source: https://fingertips.phe.org.uk/
Low weight live births (2016) *Denominator: Live births*	56	2.4%	16,788	2.8%	Source: https://fingertips.phe.org.uk/
Stillbirths (2017) *Denominator: Live births*	6	0.2%	2,679	0.4%	Source: ONS - Birth Summary Tables - England and Wales
Neonatal deaths (South East, 2017) *Mortality rates, see source*	287	2.9	1,857	2.9	Source: ONS Death registrations summary tables England and Wales

* Value missing in source

Cessation in Acute Secondary Care Settings

Initiating treatment for tobacco dependence in hospital is critical but success will depend on continuing care after discharge. Patients who smoke should leave hospital with a clear treatment plan to address their tobacco dependence.

	Local		National		
Interventions in Secondary Care (2017/18) *Denominator: All interventions*	4	0.5%	7,898	2.9%	Source: https://digital.nhs.uk/data-and-information/publications/statistical/statistics-on-nhs-stop-smoking-services-in-england/april-2017-to-march-2018
Smoking attributable hospital admissions (2016/17 rate per 100,000)	1593		1685		Source: https://fingertips.phe.org.uk/
Cost per capita of smoking attributable hospital admissions (2016/17)	25.4		28.4		Source: https://fingertips.phe.org.uk/
Emergency hospital admissions for COPD (2016/17 rate per 100,000)	539		417		Source: https://fingertips.phe.org.uk/

Cessation in Mental Health Settings

People with mental health problems smoke significantly more and are more dependent on nicotine than the population as a whole, with levels about three times those observed in the general population. It is recognised that admission to a secure mental health unit can be an opportunity to intervene to reduce smoking and that interventions are welcomed and effective. Supporting individuals to stop smoking while receiving NHS care represents a significant opportunity to close the gap in morbidity and mortality, between those people experiencing mental health conditions, and the general population.

	Local		National		
Interventions in MH Acute (2017/18) *Denominator: All interventions*	0		252	0.09%	Source: https://digital.nhs.uk/data-and-information/publications/statistical/statistics-on-nhs-stop-smoking-services-in-england/april-2017-to-march-2018
Interventions in MH Community (2017/18) *Denominator: All interventions*	0		256	0.09%	
Smoking prevalence in adults with serious mental illness (2014/15)		42.6%		40.5%	Source: https://fingertips.phe.org.uk/

Tools & Resources

PHE has published NICE PH48 self-assessment tools for both Mental Health and Acute Trusts.
This and other useful resources can be found at:

https://www.gov.uk/government/publications/smoking-cessation-in-secondary-care-acute-and-maternity-settings

https://www.gov.uk/government/publications/smoking-cessation-in-secondary-care-mental-health-settings

Royal College of Physicians. Hiding in plain sight: treating tobacco dependency in the NHS. London: RCP, 2018.

National Centre for Smoking Cessation and Training; including the clinical case for proving stop smoking support to hospitalised patients

London Clinical Senate programme: Helping Smokers Quit: Adding value to every clinical contact by treating tobacco dependence

Local knowledge and intelligence service (LKIS)

The Local Knowledge and Intelligence Service (LKIS) is one of the six functional areas within the Knowledge and Intelligence Division, and part of the Chief Knowledge Officer Directorate in PHE. They support the development and use of nationwide health intelligence tools and resources. There is a single point of access to all PHE data and analysis tools:
www.gov.uk/guidance/phe-data-and-analysis-tools

This includes Public Health Profiles on over 20 topics such as the Public Health Outcomes Framework, Children and Young People, Mental Health, Cardiovascular Disease, and other tools such as Local Health and Spend and Outcomes Tool (SPOT).

If you have a specific request for support please contact your local team:
LKISSouthEast@phe.gov.uk

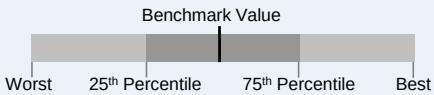
Local tobacco control profiles

The Local Tobacco Control Profiles for England provides a snapshot of the extent of tobacco use, tobacco related harm, and measures being taken to reduce this harm at a local level. These profiles have been designed to help local government and health services to assess the effect of tobacco use on their local populations. They will inform commissioning and planning decisions to tackle tobacco use and improve the health of local communities. The online tool allows you to compare your local authority against other local authorities in the region and against the England average. The tobacco control profiles are part of a series of products produced by Public Health England providing local data alongside national comparisons to support local health improvement.

Tobacco Control Profiles	Period	Local value	Eng. Value	Eng. Worst	England range	Eng. Best
Smoking prevalence in adults - current smokers (APS)	2017	15.2%	14.9%	23.1%		8.1%
Smoking prevalence in adults in routine and manual	2017	27.0%	25.7%	38.9%		13.9%
Successful quitters at 4 weeks	2016/17	1,545	2,248	36		5,529
Successful quitters (CO validated) at 4 weeks	2016/17	900	1,627	23		4,246
Completeness of NS-SEC recording by Stop Smoking Services	2016/17	99.1%	91.2%	12.2%		100%
Smoking status at time of delivery	2016/17	12.7%	10.7%	28.1%		2.3%
Low birth weight of term babies	2016	2.4%	2.8%	5.2%		1.3%
Lung cancer registrations	2014 - 16	88.3	78.6	155.4		37.3
Oral cancer registrations	2014 - 16	17.3	14.7	24.8		10.8
Deaths from lung cancer	2014 - 16	68.4	57.7	109.8		32.6
Deaths from chronic obstructive pulmonary disease	2014 - 16	69.8	52.2	102.3		29.4
Smoking attributable mortality	2014 - 16	336.6	272.0	499.3		162.5
Smoking attributable deaths from heart disease	2014 - 16	28.0	26.5	59.3		15.6
Smoking attributable deaths from stroke	2014 - 16	9.8	8.8	18.8		3.7
Smoking attributable hospital admissions	2016/17	1,593	1,685	3,116		969
Cost per capita of smoking attributable hospital admissions	2016/17	25.4	28.4	45.5		15.4
Cost per quitter	2016/17	£149	£493	£20,172		£67
Indicative tobacco sales figures (£ millions)	2013	£73	£15,446			

Compared with benchmark ● Better ● Similar ● Worse
Low ○ ○ ○ ○ ● High

* Value missing in source



Source: Local Tobacco Control Profiles (September 18)
https://fingertips.phe.org.uk/profile/tobacco-control/

Investment & value for money

The NICE tobacco return on investment tool has been developed to help decision making in tobacco control at local and sub-national levels. The tool evaluates a portfolio of tobacco control interventions and models the economic returns that can be expected across different payback timescales. Different interventions, including pharmacotherapies and support and advice, can be mixed and matched to see which intervention portfolio or package provides the best 'value for money', compared with 'no-services' or any other specified package. It also demonstrates the significant added value and return from GPs providing brief interventions and investing in sub-national activity.

The following is an example analysis for Portsmouth. It assumes that Portsmouth commissions NICE-approved services and that the provision matches the expected NICE-recognised levels of effectiveness. The following example models the potential returns of additional investment in sub-national programmes.

Example Scenario: investment in a sub-national control programme
Example investment cost for local stop smoking service (LSSS) interventions: £763,080
Number of quitters per 1,000 smokers expected as a result of LSSS interventions: 42
Additional investment required for sub-national programme at £0.41 per capita: £0.78
Number of additional quitters per 1,000 smokers expected as a result of sub-national programme: 28
Total number of additional quitters expected locally as a result of LSSS interventions + sub-national programme: 70
5 year returns expected as a result of LSSS interventions + sub-national programme for every £1 invested: £2.03

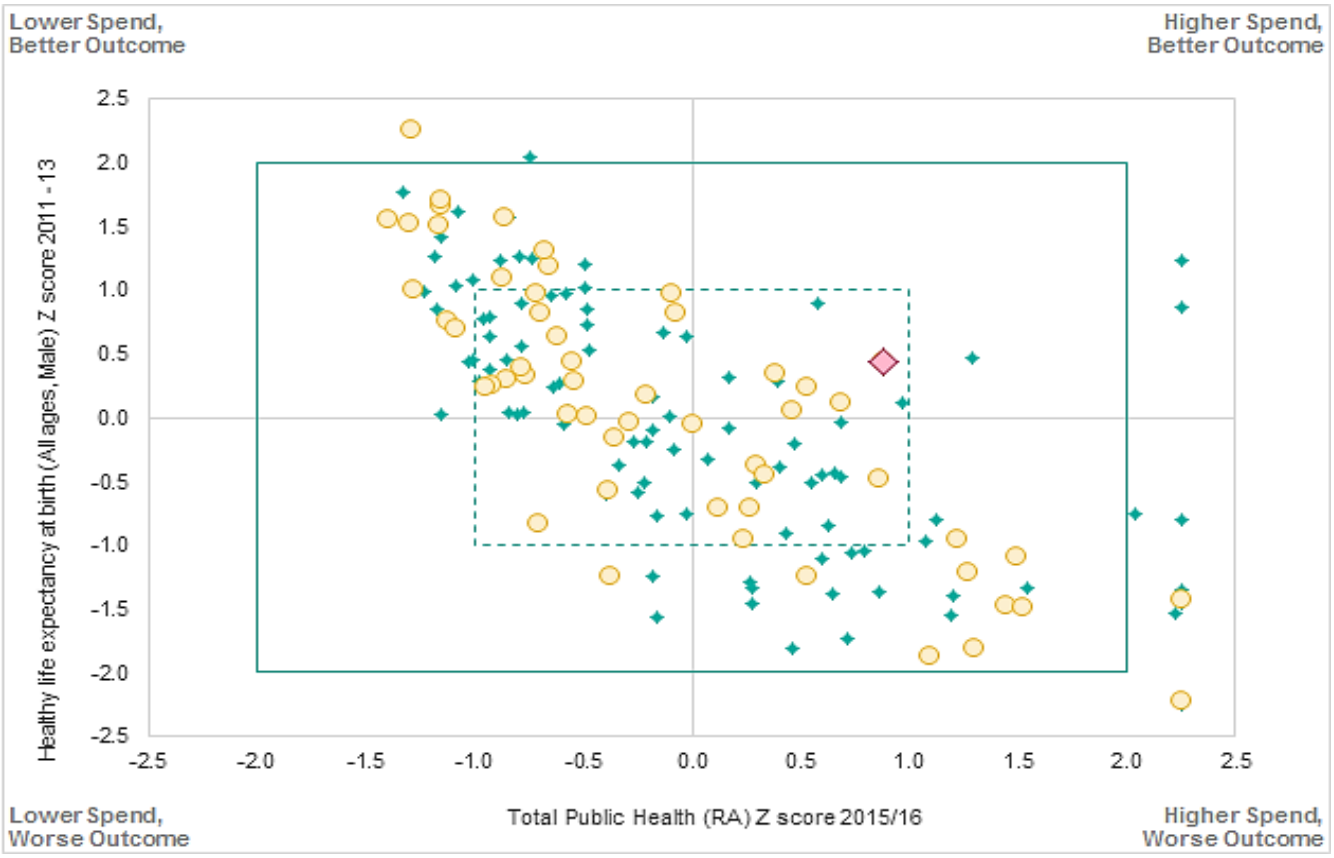
The tool also allows commissioners to define a specific sub-population and target interventions accordingly; whether that be a priority population such as smokers in the healthcare system, a particular geography or a specific demographic.

The above scenario is provided as an example only; localities are invited to use the tool to comprehensively replicate their currently commissioned package of interventions against the NICE baseline. The above example gives an indication of returns over a five year period; increased returns are demonstrated by running the analysis for ten years and lifetime scenarios. The tool can be downloaded via the NICE website or at: https://www.nice.org.uk/About/What-we-do/Into-practice/Return-on-investment-tools/Tobacco-Return-on-Investment-tool

Spend and outcome tool - SPOT

The Spend and Outcome Tool (SPOT) gives an overview of spend and outcomes across key areas of business. Local authority data for 2015 has been refreshed and clinical commissioning data for 2015 has been included. SPOT includes a large number of measures of spend and outcomes from several different frameworks. Similar organisations can be compared using a range of benchmarks and potential areas for further investigation identified. You can download a PDF factsheet for each local authority or clinical commissioning group. There is also an interactive spreadsheet that allows you to explore the data in detail.

The tool can be accessed at: www.yhpho.org.uk/



Legend:
- Portsmouth
- Other unitary authorities
- All other local authorities

References

1. Towards a Smokefree Generation - A Tobacco Control Plan for England (2017)
   https://www.gov.uk/government/publications/towards-a-smoke-free-generation-tobacco-control-plan-for-england

2. Tobacco control plan: delivery plan 2017 to 2022
   https://www.gov.uk/government/publications/tobacco-control-plan-delivery-plan-2017-to-2022

3. Royal College of Physicians, Royal College of Psychiatrists (2013) Smoking and mental health. London: RCP
   https://www.rcplondon.ac.uk/file/3583/download?token=bAgvRKDO

4. Lelan Solutions: http://www.lelan.co.uk/
   SAMOSP uses 18+ data from the Integrated Household Survey (2014), ONS Annual Small Area Population Estimates (mid-2014), SATOD estimates (2014/15), and NS-SEC data from the 2011 Census to model the disaggregation of smoking populations from local authority level to ward level according to the estimated local distribution of smokers in different socioeconomic groups.

   For further information please contact: tobacco.jsna@phe.gov.uk

5. Health & Social Care Information Centre Smoking, Drinking and Drug Use Among Young People in England – 2014.
   https://digital.nhs.uk/data-and-information/publications/statistical/smoking-drinking-and-drug-use-among-young-people-in-england/2014

6. The National Institute for Health and Care Excellence. Smoking prevention in schools [PH23].
   https://www.nice.org.uk/guidance/PH23

7. The National Institute for Health and Care Excellence. Smoking: preventing uptake in children and young people [PH14].
   https://www.nice.org.uk/guidance/PH14

8. Public Health Research Consortium. A Review of Young People and Smoking in England.
   http://phrc.lshtm.ac.uk/papers/PHRC_A7-08_Final_Report.pdf

9. The World Bank. Curbing the epidemic: governments and the economics of tobacco control. 1999

10. Amos A, Bauld L, Clifford D et al. Tobacco control, inequalities in health and action at a local level. York, Public Health Research Consortium, 2011.

11. Preventing ill health: Commissioning for Quality and Innovation (CQUIN)
    https://www.england.nhs.uk/publication/preventing-ill-health-cquin-supplementary-guidance/

12. Royal College of Physicians. Hiding in plain sight: treating tobacco dependency in the NHS. London: RCP, 2018.
    https://www.rcplondon.ac.uk/projects/outputs/hiding-plain-sight-treating-tobacco-dependency-nhs

13. NICE (2010). Quitting Smoking in Pregnancy and Following Child Birth. NICE public health guidance 26. London: National Institute for Health and Clinical Excellence
    https://www.nice.org.uk/guidance/pH26

Portsmouth CITY COUNCIL

Agenda item:

Title of meeting:	Health and Wellbeing Board, 13th February 2019 Governance and Audit and Standards Committee 8th March 2019 Council, 19th March 2019
Date of meeting:	
Subject:	Health and Wellbeing Board Constitution
Report From:	Chief Executive
Report by:	Kelly Nash, Corporate Performance Manager
Wards affected:	All
Key decision:	No
Full Council decision:	Yes

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1. Purpose of report

1.1. To seek approval for proposed changes to the constitution for the Health and Wellbeing Board (HWB). The changes are recommended to improve the effectiveness of the HWB as it fulfils its leadership role across the health and wellbeing system locally.

2. Recommendations

2.1. The Health and Wellbeing Board is recommended to support the changes to the constitution for the Health and Wellbeing Board set out below.

3. Background

3.1. Health and Wellbeing Boards (HWBs) were introduced as part of the Health and Social Care Act 2012. They are statutory in all upper tier local authorities in England. The Portsmouth HWB brings together Elected Members, key council officers, the Portsmouth Clinical Commissioning Group (PCCG), the NHS Commissioning Board and local Healthwatch to develop a Joint Strategic Needs Assessment and deliver it through a Joint Health and Wellbeing Strategy.

3.2. The HWB is a committee of the council and has been formally established as such since April 2013.

3.3. A recent review of partnerships has concluded that there would be benefits for efficiency of working, and effectiveness of decision-making, if the current three cross-organisation partnerships that look at issues around health and wellbeing in the city (the HWB, the Safer Portsmouth Partnership and the Children's Trust Partnership) came together as one grouping with a single Terms of Reference and membership, and that this should be under the auspices of the Health and Wellbeing Board as the statutory body.

4. Proposed changes recommended by the HWB

4.1 In order to ensure that the HWB is able to perform the wider function, it is proposed that the constitution as agreed in 2015 is amended to:

- broaden the core membership to include the superintendent of police, representation from Hampshire Fire and Rescue, from the National Probation Service, Community Rehabilitation Company and from the Portsmouth Education Partnership

- broaden the objectives to include specifically the strategic assessment of needs and issues in relation to Crime and Disorder and children's wellbeing; and the requirement to maintain a relationship with the office of the Police and Crime Commissioner and city safeguarding boards.

- note that from time to time, the Board may establish sub-boards to deal with matters that are delegated to it.

4.1 No changes to voting rights are proposed as these relate specifically to the role of a Health and Wellbeing Board in the commissioning of the local Health and Care system (for example, in relation to local pharmacy provision).

4.2 These changes have been incorporated into the revised Constitution for the Health and Wellbeing Board at appendix A.

5 Reasons for recommendations

5.1 The Board is recommended to support these proposals as they will support the Health and Wellbeing Board to operate effectively and continue to enable the council to fulfil its statutory requirements with regard to the Health and Wellbeing Board and in relation to the requirements of the Crime and Disorder Act 1998.

6 Equality impact assessment (EIA)

6.1 A preliminary EIA has been completed, indicating that there is no requirement for a full EIA at this stage.

7 City Solicitor comments

7.1 The basis and legality for the proposed amendments is set out in the body of the report. The appendix attached reflects the proposed changes to the Health and Wellbeing Constitution.

……
Signed by:

Appendices:

Appendix A - constitution for Portsmouth's Health and Wellbeing Board

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: Name and Title

Appendix A – revised constitution for Portsmouth's Health and Wellbeing Board (February 2019)

Constitution for Portsmouth's Health and Wellbeing Board

1. Aims

1.1 The Health and Wellbeing Board (HWB) will provide strategic leadership to improve the health and wellbeing of the population of Portsmouth through the development of improved and integrated health and social care services along with a range of other public service dependencies, including public health, the criminal justice system and children's services. It will:

a) Identify health and wellbeing needs and priorities across Portsmouth, and oversee the refresh and publication of the Joint Strategic Needs Assessment (JSNA) to support evidence-based prioritisation, commissioning and policy decisions, including a strategic assessment of crime and disorder in the local area as required by the Crime and Disorder Act 1998 (as amended) and a children's needs assessment.

b) Prepare and publish a Joint Health and Wellbeing Strategy (JHWS) for approval by the city council and Portsmouth Clinical Commissioning Group (CCG), which sets objectives and describes how stakeholders will be held to account for delivery, taking account of the JSNA, strategic analysis of crime and disorder, children's needs assessment, Director of Public Health Annual Report as well as national policy developments and legislation.

c) Monitor and review the delivery of the JHWS and take action where evidence is indicating a failure to achieve agreed outcomes.

d) To receive annual reports and regular updates from the Portsmouth Safeguarding Children Board and Safeguarding Adults Board; and to consult with safeguarding boards when considering how the welfare of children and vulnerable adults is to be safeguarded and protected.

e) Encourage integrated working between health and social care and oversee, where appropriate, partnership arrangements under the NHS Act such as pooled budgets.

f) Establish and maintain a relationship with the Police and Crime Commissioner to fulfil the mutual duty to co-operate and have regard to the priorities set out in their respective plans; and respond to requests to the Police and Crime Commissioner as set out in legislation.

g) Oversee, where appropriate, the use of resources across a wide spectrum of services and interventions, to achieve its strategy and priority outcomes and to drive a genuinely collaborative approach to commissioning, including the co-ordination of agreed joint strategies.

h) Support the inclusion of the voice of the public, patients and communities in the setting of strategic priorities, including (but not solely) through the involvement of local Healthwatch.

i) Communicate and engage with local people in how they can achieve the best possible quality of life and be supported to exercise choice and control over their own personal health and wellbeing.

2. Membership

2.1 Membership of the HWB shall reflect the fact that the HWB has a role in setting strategic direction for the whole health, care and wellbeing system. It will also contain provisions that allow it to be given greater executive powers on behalf of the city council and in partnership with the CCG, with provision for voting on certain matters to be reserved. Those items on which all members of the HWB can vote shall be termed 'part A items' while those on which voting is reserved shall be termed 'part B items'.

2.2 The members of the HWB, who shall have voting rights on all non-reserved items (part a items) shall comprise the following:

- Lead Member for Health and Social Care (Joint-Chair)
- Clinical Commissioning Group Chief Clinical Officer* (Joint-Chair)
- Lead Member for Children's Services
- Leader of the Council (or their nominated representative)
- Leader of the largest opposition group (or their nominated representative)
- Clinical Commissioning Group Chief Operating Officer*
- Two nominated CCG representatives chosen by the CCG Board
- Two nominated representatives from the Portsmouth Education Partnership
- Superintendant of police
- Hampshire Fire and Rescue representative (local commander level at least)
- Community rehabilitation company and National Probation Service
- Director of Public Health
- Director of Adults Services
- Director of Children's Services
- Healthwatch Portsmouth nominated representative*
- NHS Commissioning Board (Wessex) nominated representative*
- Portsmouth Hospitals NHS Trust nominated representative*
- Solent NHS Trust nominated representative*
- Portsmouth Voluntary and Community Network representative

2.3 The members of the HWB who have reserved powers to vote on 'part B items' are as follows:

- Lead Member for Health and Social Care (Joint-Chair)
- Clinical Commissioning Group Chief Clinical Officer* (Joint-Chair)
- Lead Member for Children's Services
- Leader of the Council (or their nominated representative)
- Leader of the largest opposition group (or their nominated representative)
- Clinical Commissioning Group Chief Operating Officer*
- Two nominated representatives from Portsmouth's Clinical Commissioning Group

*voting rights for co-opted members on what is a committee appointed under section 102 of the Local Government Act 1972 are provided for in Statutory Regulations published in

February 2013 "unless the local authority which established the board otherwise directs" and "before making a direction [to empower co-opted members], the local authority must consult the Health and Wellbeing Board"[1]. The provisions above are therefore subject to direction from the council in consultation with the board.

3. Chairing arrangements

3.1 The HWB will appoint the Lead Member for Health and Social Care at the City Council and the Chief Clinical Officer of the CCG as joint chairs of the HWB, with chairmanship alternating between the two on an annual basis. The other joint-chair shall act as vice chair during that year.

3.2 In the event that neither Chair nor Vice chair are present but the meeting is quorate, the voting members present at the meeting shall choose a chair for that meeting from amongst their number who has power to vote on 'part B items'.

4. Quorum

4.1 It is important that sufficient members are present at all meetings so that decisions can be made and business transacted. The quorum for the Board will comprise of four voting members and must include at least one voting Member from the City Council and one voting member of the CCG. If a meeting has fewer members than this figure it will be deemed inquorate - matters may be discussed but no decisions taken.

5. Substitutes

5.1 Nominating groups may appoint a named substitute member for each position. Substitute members will have full voting rights when taking the place of the ordinary member for whom they are designated substitute.

6. Appointments

6.1 In line with the Health and Social Care Act, before appointing another person to be a member of the Board (other than those that are statutorily obliged to be a member) the local authority must first consult the Health and Wellbeing Board. Nominations by the local authority must be in accordance with the Act.

7. Decisions and Voting

7.1 The HWB will be accountable for its actions to its individual member organisations and representatives will be accountable through their own organisation's decision making processes for the decisions they make.

7.2 It is expected that decisions will be reached by consensus, however, if a vote is required any matter will be decided by a simple majority of those members voting and present in the room at the time the motion is put. This will be by a show of hands, or if no dissent, by the affirmation of the meeting. If there are equal votes for and against, the Chair will have a second or casting vote. There will be no restriction on how the Chair chooses to exercise a casting vote.

[1] The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 No.218 regulation 6

7.3 Decisions within the terms of reference will be taken at meetings and will not normally be subject to ratification or a formal decision process by partner organisations. However, where decisions are not covered by the HWB's statutory functions and power or within the delegated authority of the Board members, these will be subject to ratification by constituent bodies.

7.4 Decisions within the current terms of reference will be deemed 'part A items'. In the event that the city council or the CCG delegate additional decisions to the HWB, it will be for the delegating authority to determine whether these are deemed 'part B items' with reserved voting rights as set out above.

7.5 From time to time, the Board may establish sub-boards to deal with particular areas of business delegated to the Board.

8. Status of Reports

8.1 Meetings of the Board shall be open to the press and public and the agenda, reports and minutes will be available for inspection at Portsmouth City Council's offices and on the City Council's website at least five working days in advance of each meeting. This excludes items of business containing confidential information or information that is exempt from publication in accordance with Part 5A and Schedule 12A to the Local Government Act 1972 as amended.

9. Members' Conduct

9.1 With the exception of those referred to at 9.2 below, the Councillors Code of Conduct of Portsmouth City Council will apply to all Board members, and such members should note in particular the obligations relating to Disclosable Pecuniary Interests (so described within the Councillors Code of Conduct), which they must declare upon appointment to the committee to the Monitoring Officer (unless they have made such a declaration).

9.2 The Code of Conduct for Employees of Portsmouth City Council will apply to all Board members who are officers of Portsmouth City Council.

9.3 The Monitoring Officer of Portsmouth City Council shall provide Board members with guidance in relation to these provisions

10. Review

10.1 This constitution and any conflicts of interest will be reviewed as and when required but at least annually.

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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:	SEND Strategy and Self-evaluation
Date of meeting:	13th February 2019
Report from:	Alison Jeffery - Director Children, Families and Education
Report by:	Julia Katherine, Head of Inclusion
Wards affected:	All

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1. Requested by

A regular update on the SEND Strategy has been requested by the Health and Wellbeing Board. The last update was provided in November 2017.

2. Purpose

The purpose of this report is to update the Health and Wellbeing Board on the refreshed Special Educational Needs and Disability (SEND) Strategy and the SEND Local Area self-evaluation which identifies current areas of strength and areas where further development is required in readiness for the Local Area SEND Inspection.

3. Information Requested

3.1 The SEND Strategy continues to be a priority within the Children's Trust Plan and has been agreed by the Children's Trust Board. The aim of the SEND strategy remains to promote inclusion and improve the outcomes for Portsmouth children and young people aged 0-25 years with SEND and their families. The full document is included as an appendix at the end of this report.

3.2 The SEND Strategy has been refreshed and updated following feedback from and discussion with all stakeholders. The strategy includes six key strands of work, as set out below.

3.2.1 **Inclusion**
This work strand seeks to ensure more children with SEND are successfully educated in mainstream school settings wherever possible by developing a shared ethos across the city, promoting and celebrating good inclusive practice, building capacity in mainstream schools, developing the workforce

and identifying and removing barriers to inclusion. The Inclusion group is chaired by a secondary head teacher and also oversees the Emotional Health and Wellbeing in Education Strategy and the Alternative Provision project. Recent developments include piloting an Inclusion Quality Mark school self-assessment to be launched in September 2019, Co-producing a Definition of Inclusion to be used to seek widespread endorsement (**see Appendix I**), and successfully bidding for government funding to develop innovative practice in relation to Alternative Provision. The funding is being used for the Turnaround project which seeks to use the PACE model of therapeutic intervention to increase the reintegration of pupils in Key Stage 3 back to mainstream schools following a period of time accessing Alternative Provision.

3.2.2 **Implementation of the SEND Reforms**

This strand of work ensures the effective implementation of the national SEND Reforms introduced in the Children and Families Act 2014. This includes the publication of the Local Offer, clear support for children at 'SEN Support', the introduction of co-ordinated, multi-agency Education Health and Care needs assessments and plans to replace 'statements', implementing personal budgets, offering short breaks and providing independent advice and support

3.2.3 **Joint Commissioning**

The Joint Commissioning Steering Group has overseen the Strategic SEND Review, which took a comprehensive look at SEND needs and provision within the city. The review made 49 recommendations for actions to be taken to ensure that we can continue to meet identified needs from the resources available. These have been incorporated into the 9 ambitions of the Joint Commissioning Plan:

- Delivering robust integrated multi-disciplinary support for children with SEND with a focus on clear accountability and monitoring for the most vulnerable children and young people (0-25) through the Lead Professional model**.**
- Ensuring capacity of places in local special early years settings and schools to meet need
- Improving the multi-agency commissioning of Out of City placements to reduce costs and meet needs
- Enabling inclusion within early years providers and mainstream schools to deliver high quality learning to children with SEND
- Improving parent and family support
- Deliver high quality support for children and young people with Social, Emotional and Mental Health
- Deliver the Portsmouth Neurodiversity Strategy
- Effective support and services for young people making the transition into Adulthood
- High quality health service for children and young people with SEND

3.2.4 **Participation and co-production**
Co-production with children, young people and parents and carers has long been established as key to designing services that best meet needs. We have established a vibrant forum for young people (Dynamite) and Portsmouth Parent Voice continues to engage large numbers of parents and carers in helping shape services through the 'Shaping Better Futures Together' and 'Empowering Children and Families' groups as well as via a range of participation and coproduction activities.

3.2.5 **Early identification and early support**
This work strand has included work to ensure that there is early identification and assessment of children with SEND and effective joint working across health and education services in order to ensure that the right support is put in place at the earliest opportunity to secure good outcomes for children.

3.2.6 **Preparation for Adulthood**
The SEND reforms place responsibilities on local areas to provide support for young people up to the age of 25. There is a range of work under this strand to improve engagement in post-16 learning, secure employment and make effective and smooth transitions into adulthood, including accessing adult health and care services, where appropriate.

3.3 Readiness for Local Area SEND Inspection

3.3.1 A Local Area SEND inspection will take place at some point over the next 2 years. The inspection will be undertaken by Ofsted and the Care Quality Commission. There will be 5 days' notice of the start of the inspection and inspectors will be on site in the city for 5 days.

3.3.2 The inspection will focus on how well local leaders know the effectiveness of local area SEND services across health and the local authority in identifying special educational needs and disabilities, meeting needs and improving outcomes. For this reason we have worked with all stakeholders, including professionals and service users, to develop a self-evaluation which sets out our areas of strength and areas where we know further work is required. The self-evaluation was reviewed and updated in September 2018.

3.3.3 The views of children and young people (aged 0 to 25) with SEND and their parents as to the effectiveness of services and support will be central to the inspection. The annual Portsmouth survey of parent and carer views about the support available in the city for children and young people with SEND has just been completed (analysis to follow). There is also an annual Dynamite 'Big Bang' survey of young people's views.

3.4 The **areas of strength** we have identified in our self-evaluation are:

- Strong partnership working
- Engagement, participation and co-production
- Quality and timeliness of EHCPs
- Quality of specialist provision

3.4.1 Strong partnership working

There is strong leadership, clear governance and shared accountability for improving outcomes for children and young people with SEND in Portsmouth. This strong partnership working is evident across organisations and at all levels. This is evidenced by:

- Clear reporting lines to the Children's Trust Board, Health and Wellbeing Board (and via the Portsmouth Blueprint for Health and Care) linking to the Transforming Care Partnership.
- Regular briefings for elected members.
- SEND Strategy, identified as a priority within the Children's Trust Plan since 2007, refreshed in 2016.
- An agreed SEND 0-25 Joint Commissioning Plan in place.
- Multi-agency planning and decision-making for SEND via the Inclusion Support Panel and High Support Needs Panel.

3.4.2 Engagement, participation and co-production

There is a commitment to co-production as the way that we work with families in Portsmouth. This is evidenced by:

- Co-production group of parents/carers, 'Shaping Better Futures Together' meets monthly to work strategically with the LA and partners on SEND e.g. co-design and on-going review and development of the Local Offer website, Future in Mind etc.
- Dynamite (young people's co-production group) annual 'Big Bang' survey and positively evaluated Young Inspectors programme, where trained young people inspect all services on the local offer and provide a feedback report.
- Trained parent/carer representatives are members of the Inclusion Support Panel (the decision-making panel for SEND), Inclusion Transport Appeals Panel etc.
- Parent/carer SEN Champions established in mainstream schools across the city.
- Evidence that this approach has been adopted more widely than SEND (e.g. Top tips for professionals, Co-production pledge, CAMHs developments, targeted short breaks etc).

3.4.3 Quality, timeliness and scrutiny of EHCPs

Portsmouth deliver a person centred EHC needs assessment process that results in high quality EHC Plans. This is evidenced by:

- All new EHC needs assessments and transfers of SEN statements to EHCPs include a person centred co-production meeting to co-produce the plan.
- 98.4% of new assessments are being completed within 20 week statutory timescales.
- 100% of transfers of SEN statements to EHC Plans were completed by March 2018.
- Low level of complaints and appeals to the first tier tribunal.
- Positive parent/carer and children and young people's feedback via annual survey.
- Continual improvement of EHCPs via ongoing multi-agency workforce development and termly multi-agency EHCP audit.

3.4.4 Quality of specialist SEN provision

The quality of provision for children and young people with EHCPs is good and this is ensuring that many outcomes for children and young people with EHCPs are in line with national or better. This is evidenced by published data and the SEND Strategy quarterly performance reports.

- All Special schools in the city are rated as 'Good' or 'Outstanding' by Ofsted.
- Two successful academy trusts are currently operating in the city, both with a track record of outstanding performance and improved outcomes for children with SEND, with formal links to all special schools.
- Recent developments have seen significant improvements in the vocational curriculum offer for children and young people with social emotional and mental health needs, including in October 2018 the move to the Vanguard Centre.
- Successful Special Free School bid, in partnership with Hampshire, to set up a new special free school for children with Autism and associated behaviour, learning or sensory processing needs.

3.5 The areas we have identified where further development work is required are:

- Increasing school attendance and reducing exclusions
- Improving educational outcomes for those on SEN Support
- Ensuring smooth and successful transitions between phases
- Improving services and support for children and young people with Autism
- Using data to capture, monitor and report on outcomes at an individual level
- Workforce development

3.5.1 Increasing school attendance and reducing exclusions

Children with SEND are more likely to receive a fixed period exclusion from school than those without SEND. The majority of children who are subject to fixed period exclusions, however, are those whose SEND fall into the social emotional and mental health difficulties (SEMH) category. Exclusions rates and trends are monitored by the Behaviour and Attendance Group (BAG). Exclusions in Portsmouth are above the national average and rising, numbers are particularly high in secondary and special phases and this is also reflected in the attendance data.

In order to improve this we are providing detailed data and targeted support and challenge to schools where overall school absence, persistent absenteeism and/or fixed period exclusions are high via the Portsmouth Education Partnership. In September 2018 a school attendance publicity campaign was launched to raise awareness of the importance of attendance for future life outcomes. Impact is monitored via the School Improvement Board.

3.5.2 Improving educational outcomes for those on SEN Support

Educational outcomes for those with SEND follow the pattern for all children in Portsmouth i.e. outcomes are below national for all Key Stages except at EYFS (however there has been a decline in the percentage of Portsmouth children achieving a Good Level of Development in 2018 so achievement is likely to fall below national this year). In a number of outcome measures, the gaps to national are largest for those pupils on SEN Support. There is evidence that good and outstanding schools in the city achieve above national average progress for pupils on SEN support, however this is not consistent across all schools. The School Improvement Board has identified the need to improve outcomes for those on SEN Support in mainstream schools as a priority.

In order to improve this there is a clear process for monitoring the performance and progress at a school level via the Portsmouth Education

Partnership and following up, where necessary, with support commissioned from the Teaching School Alliance. Educational outcomes for those children and young people at the SEN Support level remain a concern, however, and we are working with the Portsmouth Education Partnership on improving this, in particular sharing good practice via the SEN Support project. There are 22 schools engaged in this project which involves schools working with trained SEN leaders and SLEs. The schools involved are implementing action plans to embed a focus on SEND into everyday school improvement practice. CPD events, including a regional conference are scheduled to address the themes that are arising through the project. In order to maximise the impact of the project, other schools will be able to join all of the CPD events and the conference. The findings of the project will be shared through existing networks and forums including our termly SENCo network meetings.

3.5.3 Ensuring smooth and successful transitions

Transition arrangements to adult services for those with physical disabilities, complex learning difficulties and who attend a special school are good. The pathway is, however, less clear for those who do not meet the criteria for learning disability services, including some young people with autism spectrum difficulties, or those with SEND who are in mainstream schools. Young people tell us that they would like improved information on support to get into employment and to live independently. Whilst participation rates for young people with SEND are above national, there is a need to increase the numbers of young people with SEND in paid employment.

In order to improve this we are coproducing with young people clear and accessible transition information and guidance for young people, to be published as part of the local offer, including information to clarify the pathway from the Annual Review at age 14 onwards. A Transition Planning Group has also been established to ensure that there is appropriate information-sharing between agencies in order to improve the planning for transition and preparation for adulthood from the age of 14 onwards.

3.5.4 Improving services and support for children and young people with Autism

Feedback from parents/carers and young people tells us that we still have further work to do with regards to the offer of support for children and young people with Autism. There is an increase in home education in the city and some parents are turning to EHE because of a lack of confidence in provision for children with Autism in the city, in particular in mainstream schools. Transition into post-18 education and employment and training also needs to be improved for this group to ensure appropriate support is available.
The transition from children to adult social care for young people with higher functioning autism can be difficult.

In order to improve this we are developing a 0-25 Autism strategy, which will be aligned to the all-age Autism strategy and monitored via the SEND Board. We have started work on supporting schools and parents to ensure that there is good understanding of the way in which the Autism pathway operates. To

meet the growing need for specialist educational provision for children and young people with Autism we have created an Inclusion Centre for secondary aged pupils with Autism within one of our mainstream schools and we are ensuring that there a close links between the well-established primary Inclusion Centre and the newer secondary provision to ease transition from key stage 2 to 3. We have been successful in our bid for a new special free school for children with Autism which will meet the needs of pupils with autism and challenging behaviours which will result in more needs being met locally and a reduction in the need to source out of city provision. The Local Offer will be updated so that it is easier to find information about Autism all in one place. Training for all staff in education settings has been identified as a need and this will be delivered through a joint approach with educational experts in Portsmouth Special Educational Needs Support Partnership, CAMHS, and the Educational Psychology team.

3.5.5 Using data to monitor outcomes at an individual level, as well as to inform commissioning decisions

It has been identified that further work is required in order to be able to record (and therefore robustly report on) the health and social care provision specified within EHCPs and the outcomes achieved via Annual Reviews. Further work is required to track the impact of multi-agency interventions over time to ensure that overall progress (over all four domains of child development) is being made and maximise value for money. In addition, identifying costs of health provision within EHC plans is currently not possible due to CCG commissioning via block contracts. The SEND Strategic Review has confirmed the need for the development of a methodology to forecast future need and inform place planning and multi-agency commissioning and work on this is underway. A review of the use of coding is also being conducted in order to ensure that SEN data is accurate and can be used to identify trends and inform commissioning decisions. This is being taken forward as part of the Joint Commissioning Plan SEND place planning strategy.

3.5.6 Workforce development

There is a need to ensure that there is a coherent offer of SEND-focused professional support and development across the children's workforce and that this is effectively communicated so that all who need to access this are able to benefit. This professional development offer includes a graduated approach to enhancing the knowledge and skills of the workforce in relation to Autism and SEMH.

In addition to this and in response to recommendations made as a result of the SEND Strategic Review, we are reviewing our offer for families to ensure that professionals are working in a joined up way in the interests of children and their families. Work is underway to develop a SEND 'Hub', to deliver an integrated service to families. This work is in the early stages of development and is being overseen by the Joint Commissioning Group. The intention is that families will receive a child and family centred integrated 'offer', with a key worker identified and a team around the worker of other relevant

professionals. The SEND Hub is better described as an approach rather than a service. It will involve workforce development and co-ordination in order to ensure a more efficient use of resources and a better experience for families.

3.6 **Internal Peer Challenge** - On 3rd December 2018 we conducted an internal peer challenge to test out the areas of strengths and areas for development that we have identified in our self-evaluation, and follows on from an external peer review that took place in 2017. Focus groups were convened for each of the areas of development identified in the previous peer review. Feedback included the following:

- *Compared to previous challenge sessions, the overall impression was that groups were much better at telling the story of where we have been and come to, and setting out the areas of particularly strong practice. The discipline of nominating a chair for groups to set out the initial position and ensure areas are referenced is an important one. It continues to be the case though that some of the earlier developments are overlooked (for example, the story of the development of the SENCo network) and these are really important parts of the jigsaw. Revisiting past actions and achievements is critical to explaining why we are at our current point.*

- *There is a need to strengthen use of data to demonstrate outcomes and evaluating whether we have made the difference; and this means bringing into play parent and young person feedback, or school feedback, as well as quantitative data. There was not enough evidence that people knew what impact measures were having (or not) on the quality of life for children, young people and their families.*

- *The lack of strong representation from health commissioners and providers on the challenge day meant that this is an area that has not been fully explored and may not be properly reflected in the discussion.*

- *The sense from the discussion is that the city has achieved a great deal since the introduction of the reforms and developed some excellent processes and practice, but that the areas left to be tackled now are more challenging and are areas where there are competing policy frameworks and drivers to navigate (for example, a tougher curriculum in mainstream schools and more challenging examinations placing a strain on the inclusivity of schools for those with SEND; the challenge of trying to be needs-led rather than diagnosis or setting-led, when frameworks including the benefits framework demand diagnosis; the ongoing challenge of reducing resources, particularly in schools against increased and more complex demand). For the city, continuing to make a positive impact for children and young people will be challenging in the circumstances.*

3.7 The full feedback report from the internal peer challenge is included as an appendix at the end of this report (**see Appendix II**).

Signed by: Alison Jeffery, Director of Children, Families and Education

Appendices:

I. Definition of Inclusion
II. Feedback from Internal Peer Challenge

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

We've worked closely with young people, parents, carers and professionals in Portsmouth to agree what inclusion means to people in our city.

Inclusion means that every child or young person will:

Achieve their potential from education or training

Build and maintain positive social and family relationships

Make a successful move to employment, higher education and independent living

We want all children and young people in Portsmouth to…

- Feel included and part of their community
- Go to nursery, school or college locally
- Be valued and not discriminated against
- Have equal opportunities
- Have positive social and family relationships
- Make successful transitions to employment, higher education and independent living
- Develop emotional resilience and positive self esteem
- Aspire to live independently and participate in school and society
- Achieve their potential
- Be physically, emotionally and mentally healthy
- Be safe in a positive environment
- Be heard, for their views to be taken seriously and influence change

Our aim is for every child to excel in a local school.

We want all families in Portsmouth to…

- Feel their child or young person is included and feels a part of the local community
- Know their child's needs are understood and acted upon by those who support them to ensure consistency
- Feel welcome and included wherever they go
- Have a positive relationship with their child's school
- Have their voices heard
- Know where to go for advice and support when needed
- Be actively involved in the planning and delivery of their support plan or network
- Be at the centre of everything we do in the spirit of co-production

In order to achieve this we will…

- Aim for children and young people to attend a local mainstream nursery, school or college wherever possible
- Create an environment that is welcoming to all
- Support children and young people to develop skills and resilience to overcome barriers
- Work together across services
- Respect and value children and young people as individuals
- Develop the skills, knowledge and competence of the workforce
- Work together across whole organisations to challenge bullying and discrimination and have a plan that helps resolve bullying for the benefit of everyone involved

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Designed by: **marketing@portsmouthcc.gov.uk** • Published: **January 2019** • Ref: **1.214**

SEND internal challenge day - 3rd December 2018

An internal challenge day on Special Educational Need and Disability was held on 3rd December 2018, to test some of the areas highlighted as strengths and areas for development in the self-evaluation document. This is the second internal challenge that has been held, and came a year after a Peer Review visit from colleagues in Reading.

The full set of interviewees is attached in appendix 1.

Summary messages from the focus groups are as follows:

SEN Support:

The clear message from this focus group is that there are lots of initiatives taking place, and a huge amount of energy on this agenda, but that it is disappointing this is not yet reflected in the data.

There was a lot of discussion about the importance of the SENCo network, and the extent to which tis is now a vibrant and empowered group. It would be helpful to illustrate the progress with this group in particular over the last 4 years, as this is clearly an area where there has been a great deal of positive change.

One of the impacts of the work with schools and the SENCo network has been to address over-identification of SEN, and this impact can be demonstrated through the data over time.

One of the areas where it was felt that this otherwise very strong session could have been stronger is in the join up with post-16 work and the transition to FE. Although there is a different group leading on Preparing for Adulthood, and this work is largely captured in that group, it would be helpful if this area could be illustrated as this would demonstrate the clear approach being taken across the full set of services.

SEMH:

Again, a clear sense of breadth and depth of working came out of this group, although there was no health representation in this group. Data is used well to illustrate how areas for development are identified and how progress is tracked. There was a good balance struck in discussion between celebrating some successes, but also recognising the current issues that exist. The meeting covered a range of issues from attendance and exclusions, part-time timetables, alternative provision, and elective home education (which was consistent with issues raised at a political level).

One of the issues with this particular group was a slight disconnect between the professionals represented and the parent carers on the group. It became apparent that for some of the issues that professionals felt had been addressed, parents either hadn't recognised an impact or felt that work was not complete. This illustrates the

need to ensure that there is strong follow-up and evaluation of action to ensure that it is having the intended impact. A concern for parents is clearly inconsistency in schools and their approaches.

Two areas emerged as specific issues. Firstly, it was highlighted that not all GPS are clear on what is available to support children and their families and are not using the Local Offer website to signpost appropriately. The second is a clear gap around support for autism (this has been identified as a citywide issue and is reflected in the Autism workstream).

Co-production:

This was a focus group with no professionals represented, to get a clear view from parent carers and young people on how successful this feels as an approach in the city.

There was a clear view expressed that, as service providers, Education and Health colleagues approach co-production better than social care (this was specifically around children's services). Even then, it was felt that co-production is stronger at a strategic level, than at the individual level. The group felt that often, activity is still participation and consultation rather than true co-production.

There are opportunities for parent voice, and areas where this was done regularly and well included the SENCo Network and the Portsmouth Education Partnership. However, overall there is a concern that there is some dependence on excellent individual professionals rather than systemic embedding of co-production, and that there is some slippage back towards old practices. This was noted to be in the context of capacity for both professionals and parents - noted that Portsmouth Parent Voice have 13 reps but can't meet the demands that are made of them.

Young People's pizza evenings and young inspector programmes were really interesting and exciting areas and it would be helpful for these to be explained in more depth and detail, as they are really strong areas for the city.

Autism:

This was a new theme being explored as a separate area, and there was a good explanation of how this had come about, and why it was needed. Colleagues from school were very strong in explaining some of the impacts on service and how changes could be made to improve this situation.

The discussion could have been stronger in terms of the articulation of CAMHS commissioning around the area. There was little awareness demonstrated of the impact of wait times on children, parents and schools in particular, with the comment being "it's not as bad as regional", which may be true, but didn't demonstrate either empathy or a desire to improve the position further. There was no clear response to how commissioning would move away from being "setting-led" to "needs-led".

There was no clear explanation as to the rationale for the removal of the autism co-ordinator post (which parents had made clear was very valued) or plans for replacing the provision, other than a statement that "a consultant with 25 years experience didn't think it was necessary" which is an interesting challenge to an ethos of hearing parent voice and co-producing solutions. It was also not clear that any framework of joint commissioning had applied in this case.

There was some reference to elective home education, but it was clear that this is an area where the relationships could be more fully developed.

A particular area of interesting practice highlighted was the ethnic minorities' parent group, which reflected some of the cultural sensitivities around SEND and was about trying to ensure that children and families are still appropriately supported.

Preparing for Adulthood:

This group was a bit slow to get into its narrative but once it did get going, there were some interesting issues highlighted. There was no representation from Health colleagues.

There is now one overall protocol for transition between services in place, although it was recognised that this has not been co-produced.

There were very positive areas highlighted in relation to employment and independent living, and very positive discussion about work with FE providers, for example, in developing supported internships, and redesigning EHCPs around the PfA outcomes. There was discussion of development of social enterprise to support this agenda, and this is a very positive discussion.

It was noted that there is now a Transition Planning meeting and process that has been established, and a tracker has been established to ensure that adult services are aware of all young people who they may need to be working with, rather than just those in Mary Rose Special school.

It was noted that young people at the SEN support level may not be as well planned for in preparing for adulthood, and that ensuring that this group are able to maintain positive progress made is a priority.

Joint Commissioning:

This discussion was very positive, but suffered from a lack of health or social care input.

What was clear is that there is a strong strategic framework for joint commissioning and some strong relationships at the strategic level. This was the area where voice was given to the idea of a SEND Hub as a new way of working.

However, it also became apparent in the discussion that there are examples where joint commissioning is not as strong as it could be. The examples of multiple CAMHS contracts and the extent to which this is not supporting a strong needs led culture was highlighted, and it was clear that there has been no joint commissioning approach taken in relation to the Autism co-ordinator role. There was not clarity around the commissioning of the DCO role 19-25.

Consideration was given to the Performance Framework that underpins the work of the SEND Board and it was noted that at present this is not a fully joint framework.

Conclusions

Compared to previous challenge sessions, the overall impression was that groups were much better at telling the story of where we have been and come to, and setting out the areas of particularly strong practice. The discipline of nominating a chair for groups to set out the initial position and ensure areas are referenced is an important one. It continues to be the case though that some of the earlier developments are overlooked (for example, the story of the development of the SENCo network) and these are really important parts of the jigsaw. Revisiting past actions and achievements is critical to explaining why we are at our current point.

There is a need to strengthen use of data to demonstrate outcomes and evaluating whether we have made the difference; and this means bringing into play parent and young person feedback, or school feedback, as well as quantitative data. There was not enough evidence that people knew what impact measures were having (or not) on the quality of life for children, young people and their families.

The lack of strong representation from health commissioners and providers on the challenge day meant that this is an area that has not been fully explored and may not be properly reflected in the discussion.

The sense from the discussion is that the city has achieved a great deal since the introduction of the reforms and developed some excellent processes and practice, but that the areas left to be tackled now are more challenging and are areas where there are competing policy frameworks and drivers to navigate (for example, a tougher curriculum in mainstream schools and more challenging examinations placing a strain on the inclusivity of schools for those with SEND; the challenge of trying to be needs-led rather than diagnosis or setting-led, when frameworks including the benefits framework demand diagnosis; the ongoing challenge of reducing resources, particularly in schools against increased and more complex demand). For the city, continuing to make a positive impact for children and young people will be challenging in the circumstances.

Actions

- Share findings of the day with all represented, and with all the SEND sub-groups to ensure this can influence their thinking.

- Update the self-evaluation document to reflect the findings of the day.
- Book slots with management teams for children's social care, adult social care and the CCG to discuss the findings of the challenge day.
- Ensure that the quarterly performance report is more "joint" and enables triangulation with parental feedback
- Rerun the internal challenge session in 2019.

Appendix One - Attendees for challenge day

Pippa Cook, SEND Strategic review manager
Tracy Maytas, SEND South East regional co-ordinator
Paddy May, Corporate Strategy Manager
Kelly Nash, Corporate Performance Manager

Cllr Suzy Horton, Cabinet Member for Education
Sarah Christopher, Portsmouth Education Partnership strategy manager
Mike Stoneman, Deputy Director, Children, Families and Education
Jo Peach, Director, Portsmouth Teaching School Alliance
Penny Farrelly, Children's Services strategic information manager
Neil Stevenson, Admissions, attendance, exclusion and reintegration manager
Ian Hunkin, Headteacher, Harbour School
Stuart McDowell, Commissioning Project Manager
Liz Robinson, Service Manager, Education Support and Principal Educational Psychologist
Cathy Seal, Inclusion Unit Lead, Trafalgar School
Ashley Oliver-Catt, Headteacher, Cliffdale School
Barbara McDougall, Co-ordinator, Portsmouth Parent Voice
Joe McLeish, Co-ordinator, Dynamite
Carly Blake, Dynamite intern
Julia Katherine, Head of Inclusion
Hayden Ginns, Commissioning and partnerships manager
Mark Stables, Service Manager, Integrated Learning Disability Service
Michael Henning-Pugh, Service Manager, Children with Disabilities
Amanda Percy, Post-16 commissioning manager
Liz Le Ray, Team Manager, North Locality Team