

Joint Strategic Needs Assessment

Annual Summary

2016

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Introduction

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

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

1.2 The JSNA directly informs the priorities of the Joint Health and Wellbeing Strategy 2014-2017¹:

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

1.3 This year's Annual Summary focuses on delivery of the strategy and comprises:

- Key health and wellbeing trends
- Progress in achieving the Joint Health and Wellbeing Strategy priorities

1.4 Previous JSNA Annual Summaries can be found here: <http://data.hampshirehub.net/def/concept/folders/themes/jsna/portsmouth-jsna/jsna-and-ward-summaries-and-outcome-frameworks/jsna-summaries>

1.5 During the year, we restructured the JSNA website so that intelligence about children and young people is accessible from this webpage: <http://data.hampshirehub.net/def/concept/folders/themes/jsna/portsmouth-jsna/children-and-young-people>

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

Research and investigations



2.1 Research programme

Partner agencies and Scrutiny Panels continue to carry out a wide range of research into health and wellbeing in Portsmouth. Recent, current and planned research in support of the five priorities of the Joint Health and Wellbeing Strategy is listed in the following chapters. Research carried out over previous years is set out in Appendix 1. Planned research is set out in Appendix 2.

2.2 Information sharing and access to data

The Portsmouth Information Sharing Framework was revised and agreed by the Children's Trust, Safer Portsmouth Partnership and the Health and Wellbeing Board in 2016². The Framework sets out the principles for using and sharing personal data between agencies, our intention to share such data, and promotes good practice around sharing data. The Framework includes templates for Privacy Impact Assessments and Operational Agreements to enable agencies to share information and data. Local agencies who have signed up to the Framework are the Portsmouth City Council, NHS Portsmouth Clinical Commissioning Group, Portsmouth Hospitals NHS Trust, Solent NHS Trust, Hampshire Constabulary and Hampshire Fire and Rescue. The University of Portsmouth is also an active member of the Information Sharing Framework Group.

A continuing problem adversely affecting our (system-wide) ability to investigate the 'causes of the causes' of issues is lack of access to health data for research purposes. Personal confidential data can be shared locally, with consent, if it is for direct patient care, or (in Public Health) it relates to communicable diseases or other risks to public health. But there are legal constraints on analysing personal data for secondary purposes (such as research) without the consent of the data subjects.

The legal position is helpfully summarised by NHS Digital³.

To support implementation of the Portsmouth Health and Care Plan, it is recommended that the Health and Wellbeing Board prioritises resolution of how anonymised or pseudonymised data can legally be shared between local health providers, the CCG, the Commissioning Support Unit and various departments in the local authority.

- 2 Portsmouth City Council and partners, revised February 2016. Information sharing framework. <http://data.hampshirehub.net/def/concept/folders/themes/jsna/portsmouth-jsna/jsna-background-information-sharing-framework-and-technical-information/information-sharing-framework> Accessed 27 July 2016
- 3 NHS Digital webpage. FAQs on legal access to personal confidential data. <http://digital.nhs.uk/article/3638/Personal-data-access-FAQs#PublicHealthquestions> Accessed 27 September 2016

Demographic trends and deprivation

4 Portsmouth City Council and NHS Portsmouth CCG. JSNA webpage. Population mid-year estimates and projections (ONS and HCC) and Census 2011 <http://data.hampshirehub.net/data/jsna/portsmouth-jsna/the-people-of-portsmouth/demography-general/population-mid-year-estimates-and-projections-ons-and-hcc-and-census-2011> Accessed 27 September 2016

5 Office for National Statistics webpage. Population estimates for UK, England and Wales, Scotland and Northern Ireland www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/datasets/populationestimatesforuk-englandandwales-scotlandandnorthernireland Accessed 29 July 201

6 ONS, 23 June 2016. Ibid

7 Portsmouth City Council and NHS Portsmouth CCG. JSNA webpage. Ethnic groups by electoral ward (2011 and 2001 Census) <http://data.hampshirehub.net/data/jsna/portsmouth-jsna/the-people-of-portsmouth/ethnicity/ethnic-groups-by-electoral-ward-2011-and-2001-census> Accessed 27 September 2016

8 Portsmouth City Council and NHS Portsmouth CCG. JSNA webpage. Ethnic origin of pupils <http://data.hampshirehub.net/data/ethnic-origin-of-pupils> Accessed 27 September 2016

9 Portsmouth City Council and NHS Portsmouth CCG. JSNA webpage. Population mid-year estimates and projections (ONS and HCC) and Census 2011 <http://data.hampshirehub.net/data/jsna/portsmouth-jsna/the-people-of-portsmouth/demography-general/population-mid-year-estimates-and-projections-ons-and-hcc-and-census-2011> Accessed 27 September 2016

10 Portsmouth City Council and NHS Portsmouth CCG. JSNA webpage. Portsmouth: Social and environmental context: Poverty and deprivation <http://data.hampshirehub.net/def/concept/folders/themes/jsna/portsmouth-jsna/social-and-environmental-context/poverty-and-deprivation> Accessed 27 September 2016

3.1 Population

- ONS estimates that, in 2016, about 213,000 people live in Portsmouth – nearly 4,000 more than in 2014⁴
- Each year, there are nearly 1,000 more births than deaths to city residents⁵
- In 2014, there were 2,685 live births – 23.6% born to non-UK born mothers
- Between mid-2014 and mid-2015, ONS estimates Portsmouth's population increased by about 2,700 people. Sixty-eight per cent of this increase was due to net international migration and 36% due to births. Net internal migration contributed minus 4% of growth (i.e. more people moved out of the city to other parts of the UK than moved in from other UK areas)⁶

3.2 Diversity

- 16.0% of the city's population are not of White British ethnicity⁷
- Children and young people have a different ethnic profile with 20% of school-age children being of non-White British ethnicity (45% of school children living in St Thomas ward and 38% in St Jude ward are of non-White British ethnicity)⁸
- Over 100 languages are spoken by pupils attending Portsmouth schools

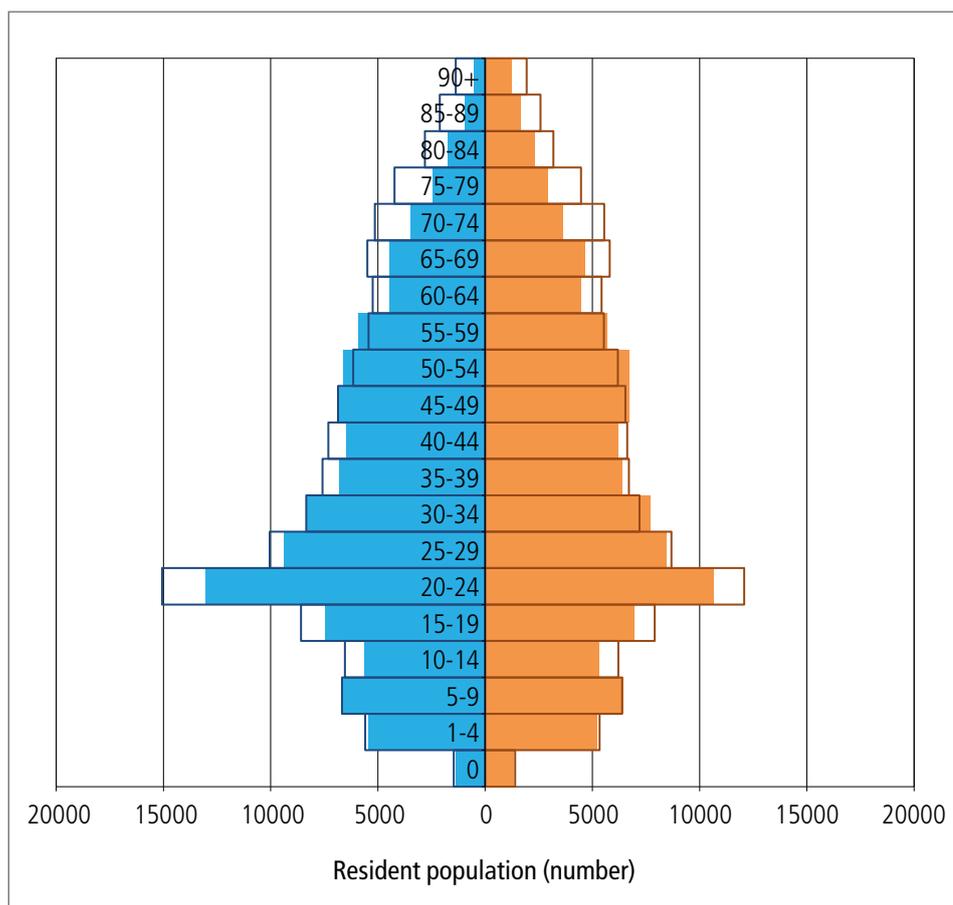
3.3 Population change

Over the next 20 years, the population is projected to increase to about 238,000 persons (11% increase). The greatest proportionate increase (49% increase) will be in the population aged 65+ years which will increase from 14% to comprise 19% of the total population. The proportion of the total population aged 0-19 years will slightly decline from 24.3% to 23.6%⁹. (Figure 1)

3.4 Deprivation

The Index of Deprivation, 2015 provides a relative ranking of areas across England according to their level of deprivation. Deprivation is experienced across a range of issues and refers to unmet need caused by a lack of resources – not just financial resources. For overall deprivation, Portsmouth is ranked 63rd of 326 local authorities (previously ranked 76th of 326 local authorities in 2010, and 93rd of 354 authorities in 2007) where 1 is the most deprived in terms of the average score¹⁰.

Figure 1 Resident population estimates and projections by gender and 5 year age bands, Portsmouth City 2016–2036



- Males population estimate 2036
- Males population estimate 2016
- Females population estimate 2036
- Females population estimate 2016

Source: SNPP Z1: 2014-based Subnational Population Projections. Local Authorities in England, mid-2014 to mid-2039, ONS © Crown Copyright 2016

Twenty-two per cent of all dependent children under the age of 20 years are living in poverty, which is above the England average with levels at twice the national average in some areas of the city (Charles Dickens ward). The percentage of pupils known to be eligible and claiming free school meals is higher than the national average, reflecting low incomes in the city.

Figure 2 shows relative deprivation across the city.

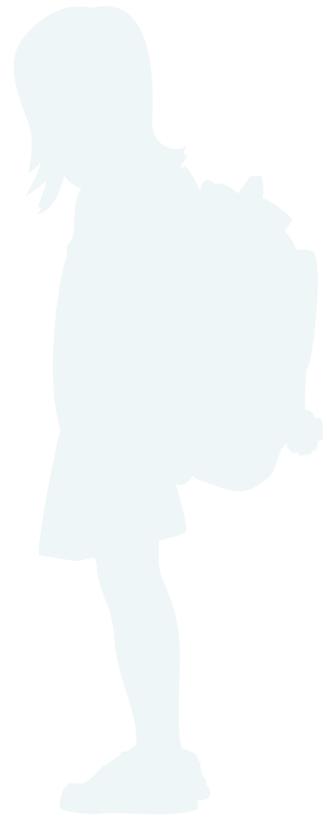
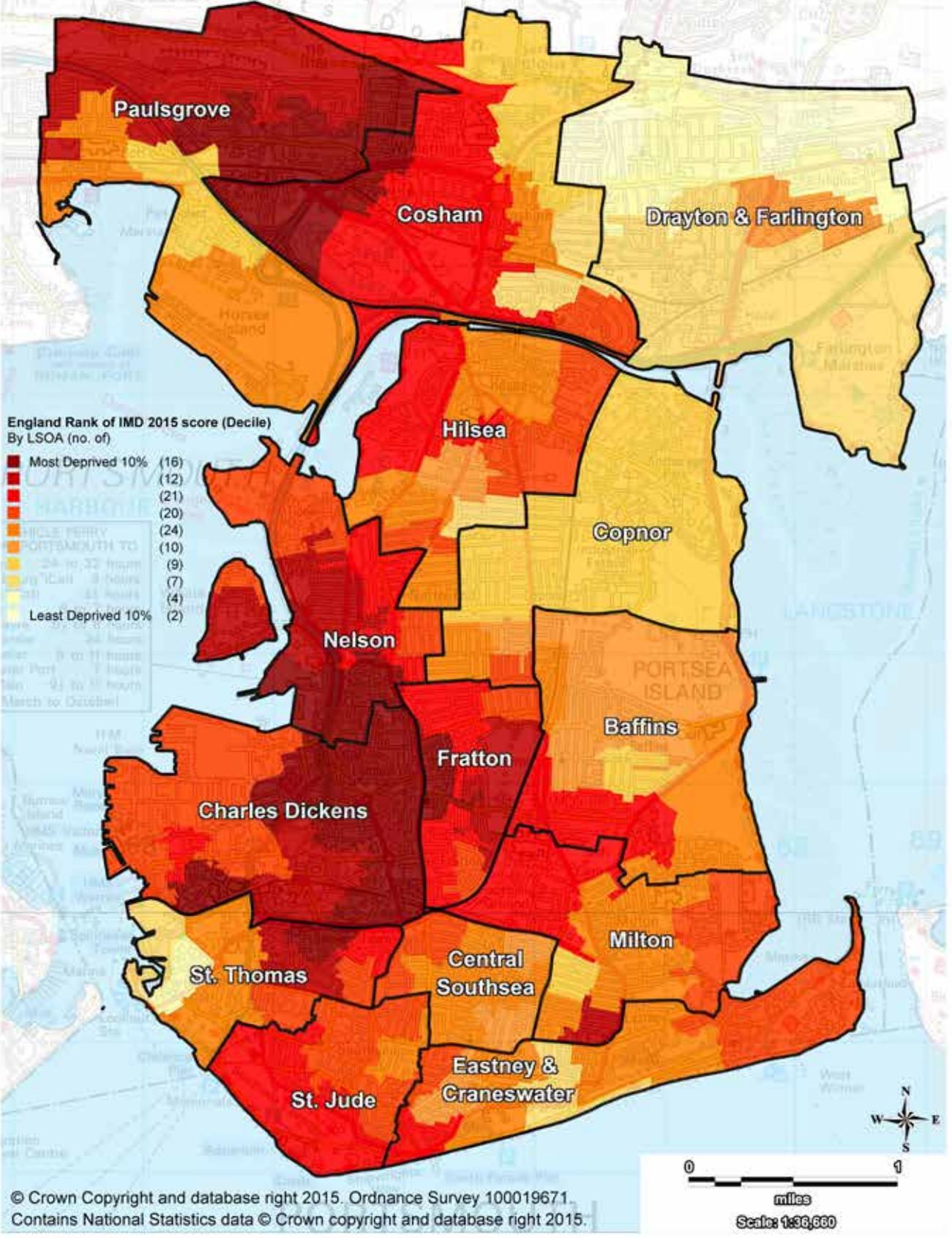


Figure 2 Indices of deprivation (ID) 2015 – map of Portsmouth with the England rank of Index of Multiple Deprivation (IMD) 2015 score in deciles by 2011 Census Lower Super Output Areas (LSOAs) overlaid with electoral wards.

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

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



Key health and wellbeing trends



4.1 Overview

Public Health England's wide ranging set of Public Health Profiles¹¹ cover different age groups, genders, healthy lifestyles, access and use of services and mortality.

Public Health England's Health Profiles give an overview of key physical and mental health and wellbeing issues¹² summarised in Figure 3. Appendix 3 shows Portsmouth compared to its CIPFA nearest neighbours, ranked in descending measure of multiple deprivation.

Figure 3 Key health and wellbeing trends, from national Health Profiles issued 2011-2016

Indicator	Value in 2012 compared to 2011	Value in 2013 compared to 2012	Value in 2014 compared to 2013	Value in 2015 compared to 2014	Value in 2016 compared to 2015	Portsmouth compared to England					
						2011	2012	2013	2014	2015	2016
Deprivation	↑	↑	↓	Same data	New measure						
% children in poverty	↑	↓	↓	↓	↓						
Eligible homeless not in priority need	N/A	New measure	↔	↔	↑	N/A	N/A				
Achievement of GCSEs incl English and Maths	↑	↑	↓	New definition	New definition						
Recorded crimes of violence v the person	↓	↑	↓	↓	↑						
Long term unemployment (>12 months)	↓	↑	↑	↓	↓						
Smoking in pregnancy	↓	↓	↓	↓	↓						
Breastfeeding initiation	↑	↓	↑	↓	↑					Not able to compare	
Obese children in Yr 6	↓	↑	↓	↓	↓						
Alcohol-specific hospital stays (under 18)	N/A	Same data	N/A	↓	↓	N/A					
Teenage pregnancy (under 18)	↓	↓	↑	↓	↓						
Estimated prevalence adults smoking	↑	New measure	↓	↓	↓						
Estimated prevalence physically active adults	↑	New measure	↑	↑	↓						

↑	Increasing, positive direction	↔	No change
↑	Increasing, negative direction	■	Significantly worse than England
↓	Decreasing, positive direction	■	No different to England
↓	Decreasing, negative direction	■	Significantly better than England

Continued on next page

¹¹ Public Health England. Public Health Profiles <http://fingertips.phe.org.uk/> Accessed 23 August 2016

¹² Public Health England. Health Profiles, issued 2011 to 2015 www.apho.org.uk/default.aspx?QN=P_HEALTH_PROFILES Accessed 3 September 2015

Indicator	Value in 2012 compared to 2011	Value in 2013 compared to 2012	Value in 2014 compared to 2013	Value in 2015 compared to 2014	Value in 2016 compared to 2015	Portsmouth compared to England					
						2011	2012	2013	2014	2015	2016
Estimated prevalence obese adults	Same data	Same data	New measure	Same data	New measure						
Cancer diagnosed at early stage	N/A	N/A	New measure	↑	↑	N/A	N/A	N/A			
Self-harm hospital stays	↑	↓	↓	↑	↓						
Alcohol-related hospital stays	↑	↑	↓	↑	↓						
Diabetes prevalence	↑	↑	↑	↑	↑	Signif lower	Signif lower	Signif lower	Signif lower	Signif lower	Signif lower
Incidence TB	↔	↓	↓	↓	↓						
New sexually transmitted infections excl Chlamydia	N/A	N/A	↓	↓	↓	N/A	N/A				
Hip fracture 65+ yrs	N/A	↔	↑	↑	↓						
Excess winter deaths	↑	↓	↓	↑	↓						
Male life expectancy at birth	↑	↑	↑	↔	↔						
Female life expectancy at birth	↑	↔	↓	↓	↔						
Infant deaths	↑	↓	↓	↓	↑						
Smoking related deaths	↑	↓	↓	↓	↓						
Heart disease & stroke premature mortality	↓	↓	↓	↑	↓						
Cancer premature mortality	↑	↓	↓	↓	↑						
Deaths from drug misuse	N/A	↑	↑	↑	↔	N/A					
Suicide rate	↓	↑	↓	↑	↔						
Road injuries and deaths	↑	↑	↑	↑	↓						

4.2 Areas of concern

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

- Male life expectancy
- Female life expectancy
- Achievement of GCSEs including English and Maths
- Recorded crimes of violence against the person
- Premature mortality from cancer

-
- Deaths from drug misuse
 - Deaths by suicide
 - More information about these issues, as well as relevant key findings from this year's research, is included in Chapters 5 to 10.

4.3 Other trends

Partnership working is producing positive trends for:

Improving but worse than England

- Children living in poverty
- Women still smoking at time baby was delivered
- Adult smoking prevalence
- Smoking related deaths
- Hospital stays for self-harm
- Newly diagnosed sexually transmitted diseases
- Killed and seriously injured on the roads
- Premature mortality from heart disease and stroke

Improving and in line with England

- Childhood obesity (Year 6)
- Teenage pregnancy
- Hip fractures in people aged 65+ years
- Excess winter deaths

Improving and better than England

- Cancer diagnosed at early stage
- Hospital stays for alcohol-related harm
- New cases of TB

Improving

- Recorded diabetes

Conversely, one measure is: Worsening but in line with England

- Infant mortality



5

Joint Health and Wellbeing Strategy outcome measures

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

Monitoring data for each outcome, including for localities where available and for trends, is at Appendix 4.

5.1 Overall measure

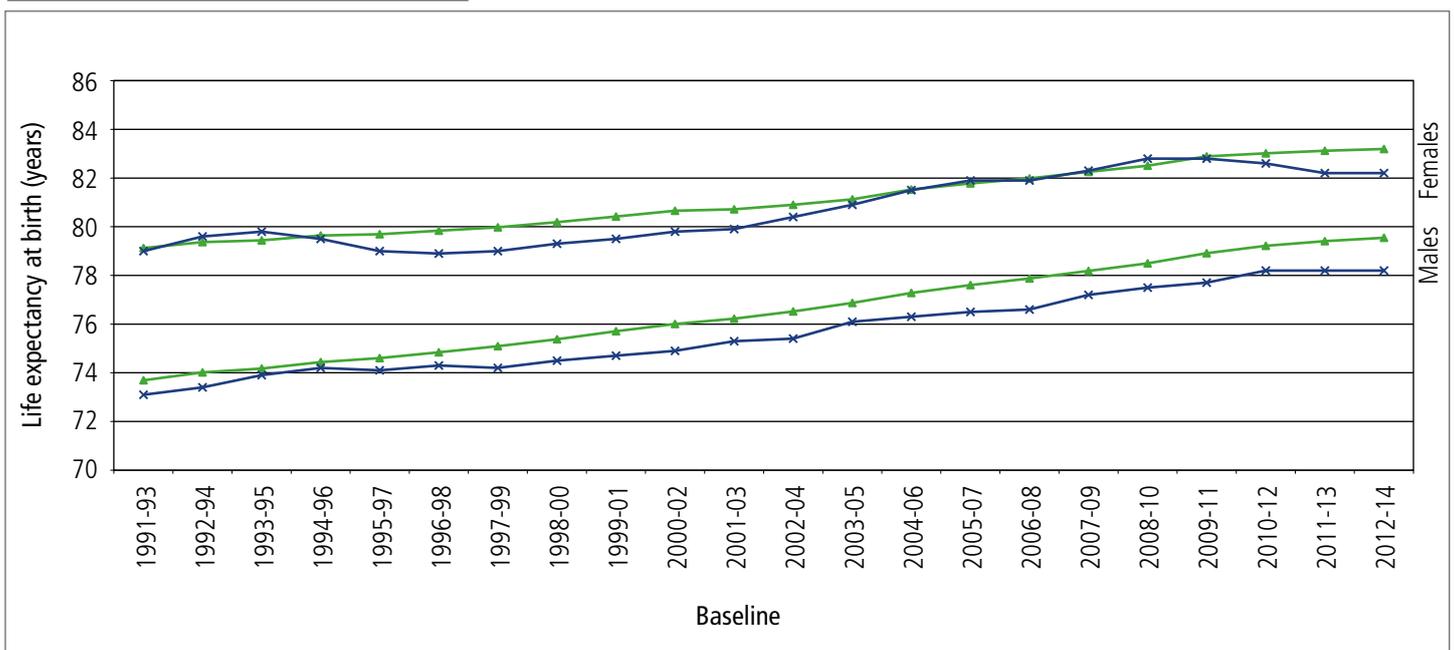
Reducing inequalities runs through all the outcomes presented in this report as the overall aim of the Joint Health and Wellbeing Strategy is “to improve the health of the poorest fastest”. Reducing differences in life expectancy is a key element in reducing health inequalities.

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

Life expectancy for both Portsmouth males and females is now significantly shorter than the England average. In 2012-14, comparative male life expectancy is 79.5 years in England and 78.2 years in Portsmouth; comparative female life expectancy is 83.2 years in England and 82.2 years in Portsmouth. Between 2011-13 and 2012-14 life expectancy stayed static for both genders in Portsmouth whereas the England values for both genders continued to increase. (Figure 4)

Source: Office for National Statistics
© Crown Copyright.

Figure 4 Trends in male and female life expectancy at birth Portsmouth and England, 1991–93 to 2012–15



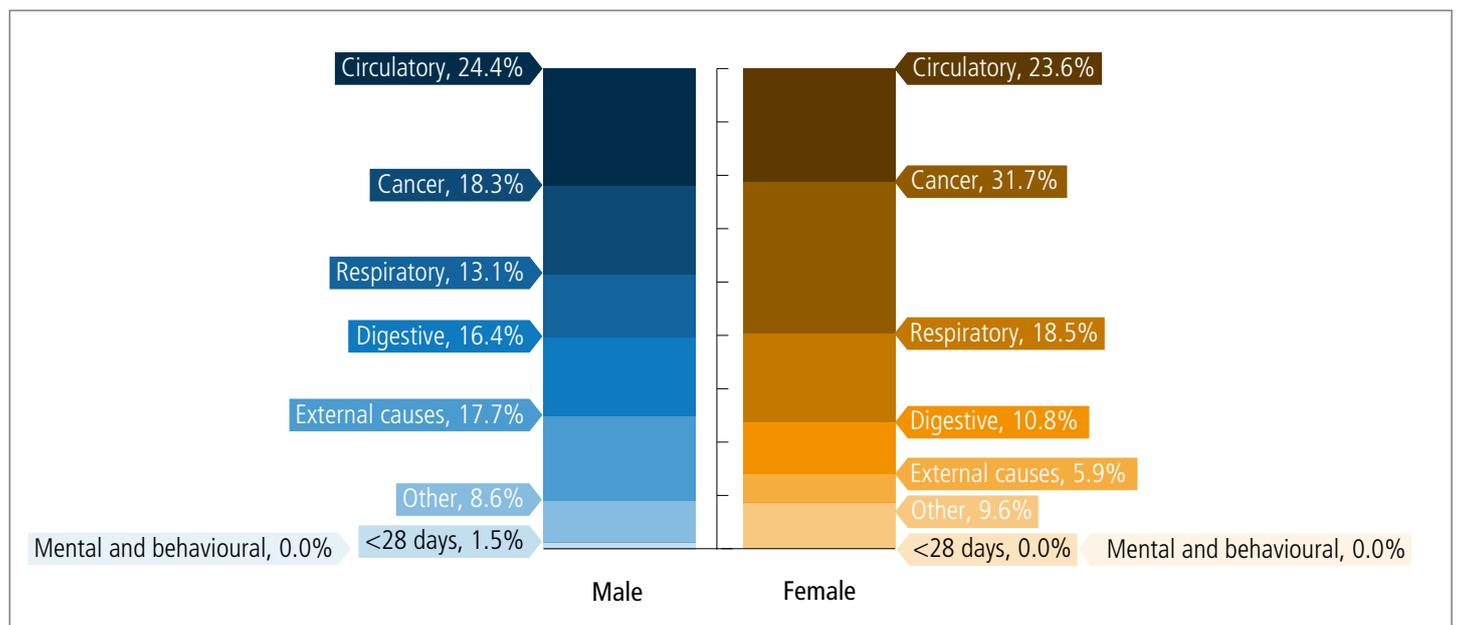
—+— England (non-resident deaths excluded)
—*— Portsmouth UA

Males in Portsmouth can expect to live 62.3 years in a state of 'Good' health. Females in Portsmouth can expect to live 63.0 years in a state of 'Good' health¹³.

Showing the impact of poorer physical and mental health outcomes, males in Portsmouth's most deprived areas die 9.5 years earlier than males in Portsmouth's least deprived areas. For females living in the most compared to least deprived areas, the gap in life expectancy is 6.0 years. Figure 5 shows the relative contribution made by different diseases/conditions to this gap in life expectancy eg circulatory diseases contribute 24% of the gap for males and for females; cancers contribute 18% of the gap for males and 32% of the gap for females¹⁴.

Figure 5 Causes of the life expectancy gap between the most deprived quintile and the least deprived quintile in Portsmouth, 2012-14

Source: Public Health England. Segment tool¹⁵



The data is stark. Between 2012 and 2014, comparing deaths in Portsmouth's most deprived areas compared to the least deprived areas there were:

- 78 more male deaths and 49 more female deaths from circulatory disease (including coronary heart disease and stroke)
- 19 more male deaths and 28 more female deaths from lung cancer
- 38 more male deaths and 25 more female deaths from chronic obstructive pulmonary disease
- 26 more male deaths and four more female deaths from chronic liver disease (including cirrhosis)
- Male suicide caused 14 additional deaths¹⁶

- ¹³ Public Health England. Public Health Outcomes Framework. Overarching indicators. www.phoutcomes.info/public-health-outcomes-framework#page/0/gid/1000049/pat/6/par/E12000008/ati/102/are/E06000044 Accessed 18 August 2016
- ¹⁴ Public Health England. Segment tool. <http://fingertips.phe.org.uk/profile/segment> Accessed 28 July 2016
- ¹⁵ Public Health England. Segment tool. Ibid
- ¹⁶ London Health Observatory. Segment tool: segmenting life expectancy gaps by cause of death. www.lho.org.uk/LHO_Topics/Analytic_Tools/Segment/Documents/LA_E06000044.pdf Accessed 3 September 2015

5.2 Male life expectancy

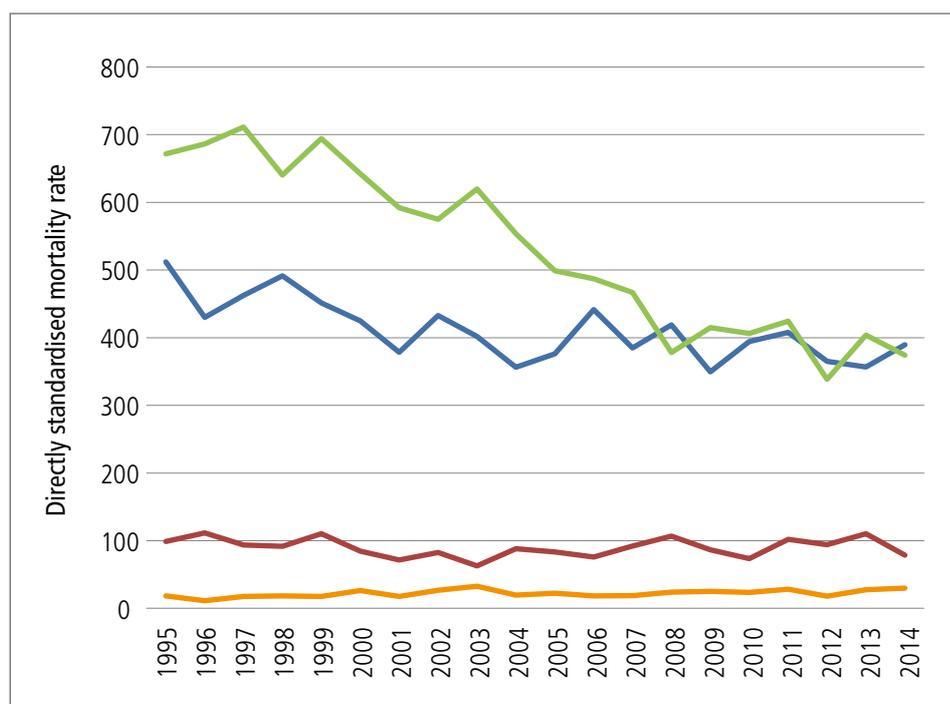
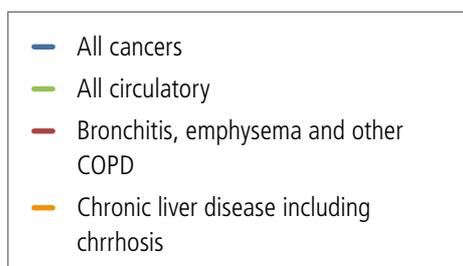
Male life expectancy in Portsmouth has been significantly shorter than the England average for over ten rolling three year periods. Some of the reasons for this were examined in the Director of Public Health's Annual Report, 2012¹⁷.

Local mortality data (2013-15) shows that males in Central locality have the shortest life expectancy (75.8 years) compared to South locality (77.8 years) and North locality (79.5 years).

Looking at the main contributors to local male mortality from 1995 onwards, mortality rates from circulatory diseases have shown greatest improvement (this is also the case nationally) – declining locally from 671 deaths per 100,000 males of all ages in 1995 to 374 deaths per 100,000 males of all ages in 2014. Over this period, deaths due to all cancers declined from 512 deaths per 100,000 males of all ages to 389 deaths per 100,000 males of all ages. Male deaths due to circulatory disease are now at a lower rate than deaths due to cancer.

Conversely, between 1995 and 2014, the male mortality rate for chronic liver disease increased from 18 deaths per 100,000 males of all ages to 30 deaths per 100,000 males of all ages.

Figure 6 Selected causes of male mortality, all ages, Portsmouth, 1995 to 2014



¹⁷ Director of Public Health, Portsmouth City Council, 2012. Public Health Annual Report: The health of men in Portsmouth. <http://data.hampshirehub.net/data/jsna/portsmouth-jsna/the-people-of-portsmouth/public-health-annual-reports/the-health-of-men-in-portsmouth-public-health-annual-report-2012> Accessed 23 October 2015

¹⁸ External causes include deaths from injury, poisoning and suicide – see below for more information about deaths due to suicide and undetermined intent.

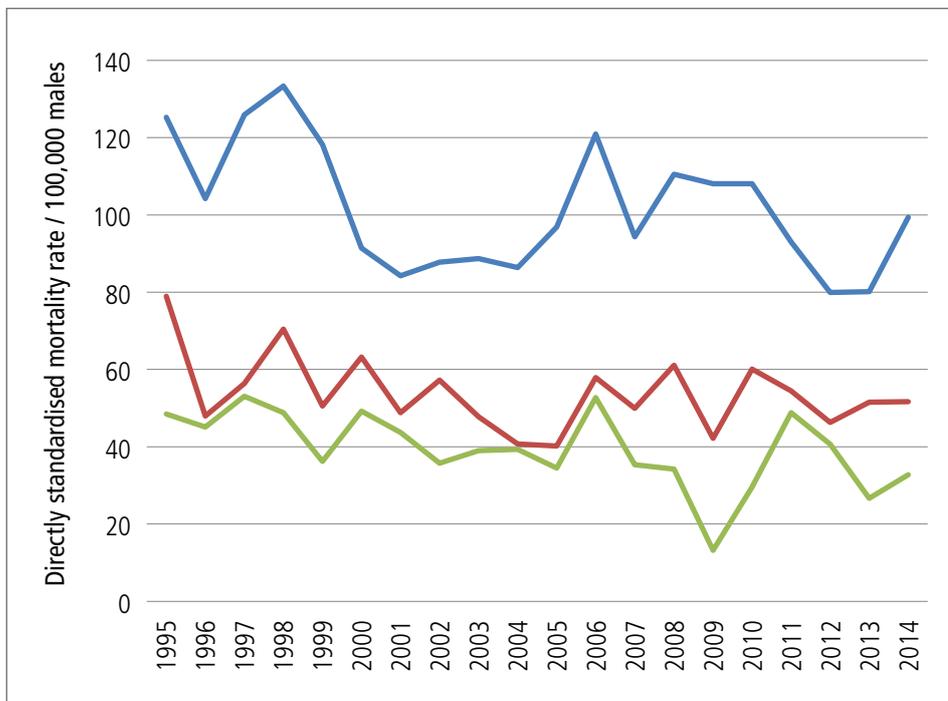
Within the city, Figure 5 shows that it is circulatory disease (includes coronary heart disease and stroke, 24% contribution), cancer and “external causes”¹⁸ (18% each) and digestive diseases (16%) that make the greatest

contributions to the gap in life expectancy between males living in the most deprived areas of the city compared to the least deprived.

For cancers, between 1995 and 2014, local mortality rates for males of all ages due to lung, prostate and colorectal cancers declined. However, between the most recent years 2013 to 2014, the mortality rates for lung cancer and colorectal cancer increased (for lung cancer from 80 deaths per 100,000 males of all ages to 99 deaths per 100,000 males of all ages; for colorectal cancer from 27 deaths per 100,000 to 33 deaths per 100,000). (Figure 7)

At 2012-14, Portsmouth’s overall cancer mortality rate for males aged under 75 years remains significantly higher than that of England (178 deaths per 100,000 males aged under 75 years compared to 158 such deaths). However, at 2011-13 and 2012-14, the local male premature mortality rate for cancers with elements that are considered preventable (eg through adopting healthy lifestyles, engaging with preventive, screening and other health services promptly) is similar to the England level, having previously been significantly higher than England for the past three rolling three year periods¹⁹.

Figure 7 Mortality due to certain cancers. Portsmouth males, all ages, 1995 to 2014



- Lung
- Colorectal
- Prostate

Source: HSCIC. NCHOD

Digestive diseases include alcohol-related conditions such as chronic liver disease and cirrhosis. More information about the impact of liver disease and excess alcohol consumption is in Chapter 7.

¹⁹ Public Health England. Public Health Outcomes Framework. Healthcare and premature mortality. Indicators 4.05i to 4.05ii www.phoutcomes.info/public-health-outcomes-framework#gid/1000049 Accessed 17 August 2016

Alcohol remains a priority area for improving public health. The strategy and action plans for tackling alcohol misuse are the responsibility of the Safer Portsmouth Partnership.

5.3 Female life expectancy

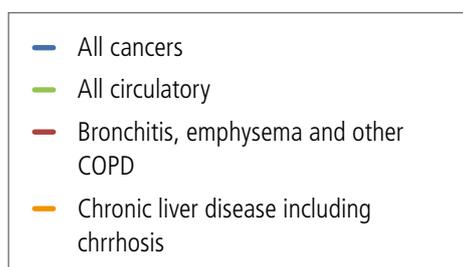
Portsmouth's female life expectancy is now (in 2011-13 and 2012-14) significantly shorter than the England female average. The last time local female life expectancy was significantly shorter than the England female average was in 2000-02 and 2001-03.

Showing the same pattern as male life expectancy, local data (2013-15) shows that females in Central locality have the shortest life expectancy (80.4 years) compared to South locality (82.9 years) and North locality (83.3 years).

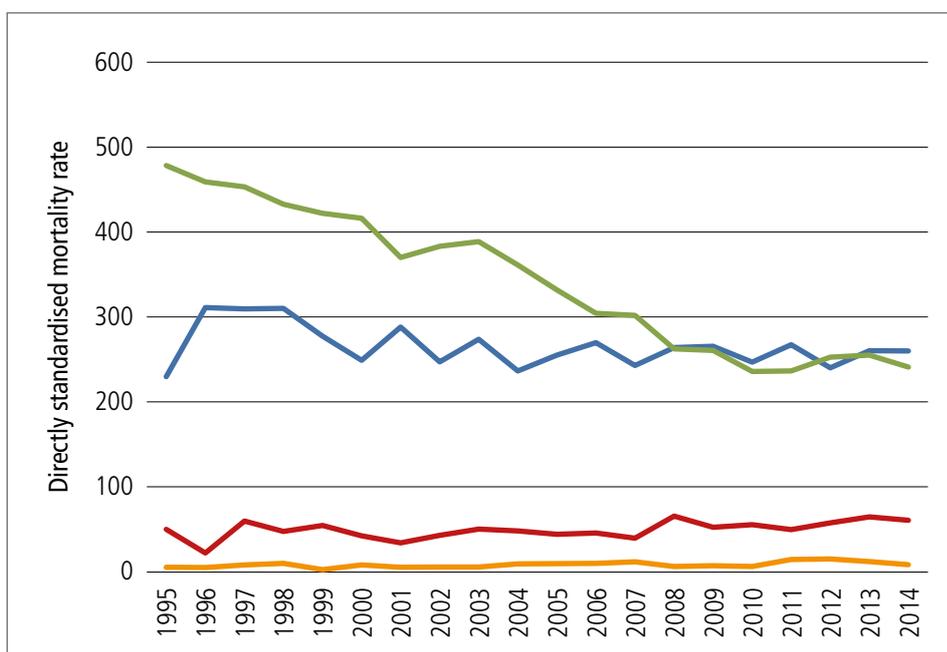
Within the city, Figure 5 shows that it is cancer (32% contribution), circulatory diseases (23%) and respiratory diseases (19%) that make the greatest contributions to the gap in life expectancy between females living in the most deprived compared to the least deprived areas of the city.

Looking at the main contributors to local female mortality from 1995 onwards, mortality rates from circulatory disease have shown greatest improvement (this is also the case nationally). But between 1995 and 2014, the female cancer mortality rate increased from 230 deaths per 100,000 females of all ages to 260 such deaths, and that for bronchitis, emphysema and COPD, increased from 50 deaths per 100,000 females of all ages to 61 such deaths. (Figure 8)

Figure 8 Selected causes of female mortality, all ages, Portsmouth 1995 to 2014



Source: HSCIC, Compendium of population health indicators²⁰



²⁰ HSCIC, Compendium of population health indicators. <https://indicators.hscic.gov.uk/webview/> Accessed 28 July 2016

Between 1995 and 2013, the female mortality rate for chronic liver disease increased from 5.7 deaths per 100,000 females of all ages to 12.7 such deaths, but decreased to 8.5 such deaths in 2014²¹. One contributor to chronic liver disease is alcohol. Between 2006-08 and 2011-13, Portsmouth's female alcohol-specific mortality rate increased from 9.1 deaths per 100,000 females of all ages to 15.7 such deaths, but decreased to 11.2 such deaths in 2012-14. However, the local rate has been significantly higher than the England rate for the last four rolling three year periods²². Chapter 7 includes more information about the impact of the liver disease and excess alcohol consumption.

For 2012-14, Portsmouth's female premature mortality rate (ie females dying before they reach 75 years of age), is significantly higher than England for cardiovascular diseases, cancers and liver disease. Of these, the local female premature mortality rate for cardiovascular diseases worsened between 2008-10 and 2012-14 (from 53.6 deaths per 100,000 females aged under 75 years to 64.1 such deaths)²³.

For 2012-14, local female premature mortality rates for cardiovascular disease, cancers, respiratory disease and liver disease with contributing factors which could have prevented early mortality (eg through adopting healthy lifestyles, engaging with preventive, screening and other health services promptly) are also all significantly worse than England²⁴.

Within cancers, the most common female cancers are breast, lung and colorectal cancers. Locally, of these, lung cancer has the highest mortality rate. The encouraging decreases in the female lung cancer mortality rate seen in late 1990s/early 2000s were not sustained and the local lung cancer mortality rate is now at 62 deaths per 100,000 females of all ages. Comparing 1995 and 2014, the breast cancer mortality rate has decreased from 39 deaths per 100,000 females of all ages to 31 such deaths; however, the colorectal cancer mortality rate has increased from 19 deaths per 100,000 females of all ages to 25 such deaths. (**Figure 9**)

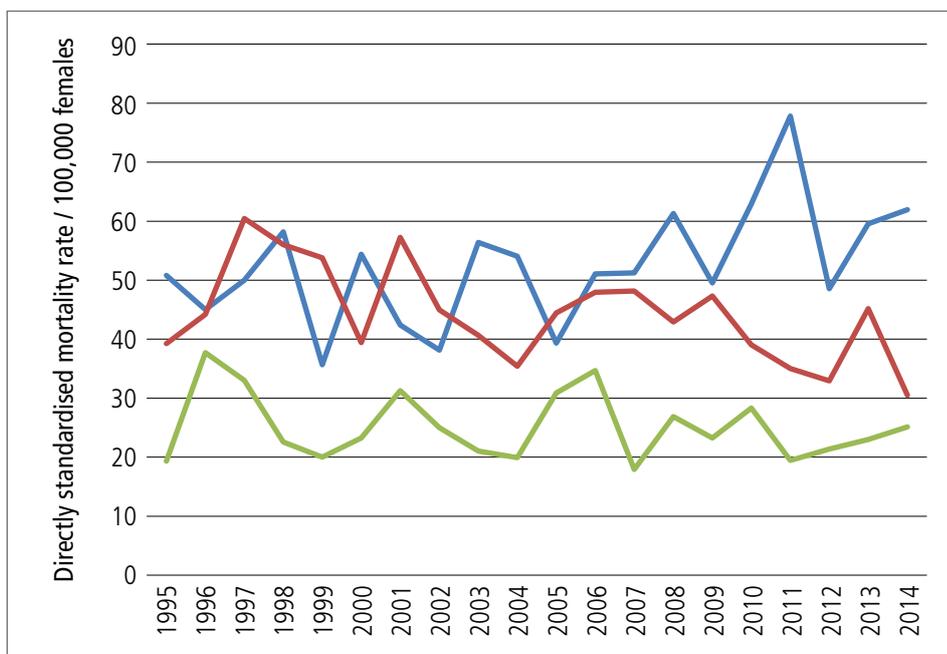
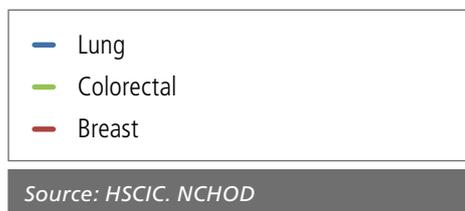
21 HSCIC, Compendium of population health indicators. Ibid

22 Public Health England. Local alcohol profiles for England. <http://fingertips.phe.org.uk/profile/local-alcohol-profiles> Accessed 28 July 2016

23 Public Health England. Public Health Outcomes Framework. Healthcare public health and preventing premature mortality www.phoutcomes.info/ Accessed 28 July 2016

24 Public Health England. Public Health Outcomes Framework. Healthcare public health and preventing premature mortality. Ibid

Figure 9 Mortality due to certain cancers, females of all ages, Portsmouth 1995 to 2014



As at March 2015, compared to England, significantly lower percentages of eligible Portsmouth females attended for breast screening (70.6% attended) or for cervical screening (69.6%). The local coverage levels for both screening opportunities have been significantly lower than England since 2010²⁵.

²⁵ Public Health England. Public Health Outcomes Framework. Health improvement www.phoutcomes.info/ Accessed 28 July 2016

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



Recent research

- Evidence for interventions which encourage pregnant women to stop smoking
- “Is there any evidence for the effectiveness of promoting breastfeeding at primary or secondary school? What age would be best, and which method of promoting breastfeeding is most effective?”
- Updated North, Central and South locality profiles – particularly to support development of the Multi-agency Teams working with children and their families in each locality²⁶
- Review of home to school transport and access to primary school places (Education, Children and Young People Scrutiny Panel)²⁷
- “What evidence is there linking healthy schools to better attainment, attendance and behaviour?”
- “Have there been any holistic health interventions with measured beginning and endpoints for primary school children (ideally aged 9-10 years, but 7-11 years also of interest), whether effective or ineffective? The interventions should have included three or more priorities from the following list: physical activity, healthy eating, healthy relationships, emotional resilience, oral health or drugs/medicines. Outcomes should ideally include raised levels of health literacy/knowledge, but any are of interest.”
- Needs assessment for children and young people with special educational needs and disabilities (SEND)²⁸
- “Promoting resilience, prevention and early intervention – we want to commission a lower level threshold service (early intervention) ie a universal service open to young people who do not meet the threshold for CAMHS. Is there any best practice guidance/literature?”
- “What evidence is there for peer-led interventions for the promotion of mental and emotional well-being in secondary school children?”
- “Is there a validated tool to assess health literacy of children in year 5?”
- Annual ‘You say’ survey of secondary school age pupils, 2016 (in press)
- Survey of parents whose children had received Personal, Social and Health Education (PSHE) lessons in school
- Destinations of Portsmouth school leavers (Year 11), 2015²⁹
- Support services for people aged 16-25 years living in isolation (Housing and Social Care Scrutiny Panel)³⁰
- Research to support revised strategy ‘Achieving excellence in education – a strategy for improving outcomes in Portsmouth’

²⁶ Hampshire County Council for Portsmouth City Council. Locality profiles for multi-agency teams. <http://data.hampshirehub.net/def/concept/folders/themes/jsna/portsmouth-jsna/jsna-and-ward-summaries-and-outcome-frameworks/electoral-ward-summaries> Accessed 27 September 2016

²⁷ Portsmouth City Council Cabinet meeting, 9 June 2016. Report of the Education, Children and Young People Scrutiny Panel: Home to school transport and access to primary school places

²⁸ Portsmouth City Council, 2016. Special educational needs and disabilities (SEND) a needs assessment for Portsmouth. <http://data.hampshirehub.net/def/concept/folders/themes/jsna/portsmouth-jsna/children-and-young-people/health-and-wellbeing/special-educational-needs-and-disabilities> Accessed 27 September 2016

²⁹ Portsmouth City Council, Autumn 2015. Year 11 activity survey, Portsmouth. <http://data.hampshirehub.net/data/destinations-of-portsmouth-school-leavers-year-11-2015-report> Accessed 22 September 2016

³⁰ Portsmouth City Council, Housing and Social Care Scrutiny Panel. Meeting 24 March 2016. Agenda item 4 <http://democracy.portsmouth.gov.uk/iListDocuments.aspx?CId=153&MIId=3414&Ver=4> Accessed 27 September 2016

Current research

- Summary strategic assessment of children and young people
- Ante-natal and post-natal depression
- The mental health of children and young people in Portsmouth – a needs assessment
- “In the context of an integrated approach to children’s health and social care and with a view to introducing a pre-birth to 19 (or 25) service, what are the most effective models for the delivery of the services currently provided by health visitors and school nurses? Could the five mandatory health checks be undertaken differently?”
- Child sexual exploitation (Education, Children and Young People Scrutiny Panel)
- School profiles

Planned research

- Widening access to extra-curricular activities in schools (Education, Children and Young People Scrutiny Panel)
- Bullying in schools with a particular focus on how to combat online bullying (Education, Children and Young People Scrutiny Panel)
- Safer routes to schools (Education, Children and Young People Scrutiny Panel)

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

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

The key outcome measures for this workstream are smoking in pregnancy, breastfeeding, and achievement in two elements of the Early Years Foundation Stage. Progress against the outcome measures, including those for localities, is at Appendix 4.

The city’s overall trend for under 5s is improving and is comparatively better than England for:

- Percentage of mothers starting to breastfeed within 48 hrs of baby’s birth
- Achieving at least the expected level in Early Years Foundation Stage in Communication and Language



- Achieving at least the expected level in Early Years Foundation Stage in Personal, social, emotional development

Although the trend for smoking in pregnancy is improving, the city value remains significantly higher than England.

Outcome measures in other public health profiles show that over the last three years, Portsmouth's position has improved and is now better or not significantly different to England for:

Measure	Source
Teenage conceptions under 18s	Public Health Outcomes, Children and Young People's (C&YP) Health Benchmarking Tool ³¹
Teenage conceptions under 16s	Public Health Outcomes, C&YP Health Benchmarking Tool
Teenage mothers aged under 18 years	Breastfeeding Profiles, C&YP Health Benchmarking Tool
Under 18s birth rate	Teenage Pregnancy, Sexual and Reproductive Health Profiles ³²
Admissions of under 1s for gastrointestinal or respiratory conditions	Breastfeeding Profiles, C&YP Health Benchmarking Tool
Hospital admissions for accidental and deliberate injuries in 0-4s	Public Health Outcomes, C&YP Health Benchmarking Tool

However, the overall positive picture hides inequalities affecting certain groups of under 5s in the city, for example:

- Children with special educational needs and disabilities (SEN)
 - » In 2015, the proportion of local children with SEN achieving a Good Level of Development in the Early Years Foundation Profile fell below the national average. The fall means that the local achievement gap between pupils with SEN and other pupils is now wider than the same gap nationally³³
- Children living in deprived areas
 - » In 2009-13, 31% of all low birth weight babies were born to mothers from the most deprived 20% of areas. A significantly higher percentage of the babies born to mothers resident in the most deprived quintile had a low birth weight compared to those born in the least deprived quintile (8.3% compared to 4.9%)³⁴
- Boys
 - » The percentage of local boys achieving at least expected level in these elements of the Early Years Foundation Stage is lower than the national average for boys³⁵
 - » 70% of active involvements via the Early Years Panel for special educational needs relate to boys

³¹ Public Health England. Children and Young People's Health Benchmarking Tool. <http://fingertips.phe.org.uk/profile/cyphof> Accessed 30 September 2016

³² Public Health England, Sexual and Reproductive Health Profiles. <http://fingertips.phe.org.uk/profile/sexualhealth> Accessed 30 September 2016

³³ Portsmouth City Council. SEND needs assessment, 2016 <http://data.hampshirehub.net/data/special-education-needs-sen---a-needs-assessment-for-portsmouth> Accessed 30 September 2016

³⁴ Portsmouth City Council. SEND needs assessment, 2016

³⁵ Portsmouth City Council. SEND needs assessment, 2016

-
- Children living in South locality
 - » Achievement in the Early Years Foundation Stage South locality is below England whereas that in North and Central localities is in line, or above, the England average

We need more information about:

- The reasons behind differential outcomes for different ethnic communities, for boys compared to girls, for children with SEN compared to other children
- Most effective ways to promote breastfeeding

There are quality issues with the data about breastfeeding prevalence at 6-8 weeks.

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

The key outcome measures for this workstream are pupil absence, achievement in making at least expected levels of progress between Key Stage 1 and Key Stage 2, Key Stage 2 results, progress between Key Stage 2 and Key Stage 4, and GCSE results. Progress against the outcome measures, including those for localities, is at Appendix 4.

After overall high attainment at the Early Years Foundation Stage, educational attainment in Portsmouth declines relative to other areas. The progress children make between Key Stage 1 and Key Stage 2 is not as good as nationally, and by GCSE level (Key Stage 4), Portsmouth pupils have some of the lowest outcomes in England.

English and mathematics are assessed at Key Stage 2 (ages 8-11 years). Although the trend is improving, both boys and girls in Portsmouth are currently achieving below the national average at Key Stage 2 (for achievement of Level 4+ in Reading/Writing/Maths: 78% nationally compared to 74% locally for boys, and 83% compared to 81% for girls). Again, nationally and locally girls out-perform boys. North locality had the highest Key Stage 2 results (82.4% achieving level 4+ in these subjects) and Central the lowest (72.2%).

The national standard is that all pupils should achieve at least five GCSEs graded A* to C, including English and mathematics. Portsmouth pupils have never achieved the national average. In 2015, local achievement for both boys (46.4%) and girls (55.1%) was significantly lower than the national average (52.7% and 62.1% respectively). North and South localities had the highest gold standard GCSE results (51.9% in each) and Central the lowest (48.6%).

In December 2015, the council recognised that local progress in improving educational outcomes was not "rapid or decisive enough", and agreed a revised strategy 'Achieving excellence in education – a strategy for

improving outcomes in Portsmouth³⁶. Research to develop the strategy showed that breaking the link between economic disadvantage and educational achievement is particularly important in Portsmouth's context where:

- there is a high proportion of White British pupils, with boys being particularly at risk of underachievement. The strategy will particularly focus on closing the gaps between white British disadvantaged pupils and other pupils in making at least their expected level of progress between Key Stage 2 and Key Stage 4
- there are particular areas where there are higher levels of economic disadvantage and where fewer children have reached age expectation at age 5 years – for example in Paulsgrove ward, where only half of all children reach age expectation
- at the end of their primary education, the gap for disadvantaged pupils is narrow, but not closing rapidly enough in all subjects. Furthermore, there are differences in the gap across geographical areas of the city
- compared to national outcomes for SEN pupils, Portsmouth has poorer educational outcomes for children with SEN in (amongst other areas):
 - » Attaining a Good Level of Development in the Early Years Foundation Stage Profile
 - » Making progress between Key Stage 1 and Key Stage 2 in Reading, Writing and Maths, and making progress between Key Stage 2 and Key Stage 4 in English and Maths
 - » Obtaining 5+ GCSEs graded A*-C, including English and Maths
 - » Achievement of a Level 2 or Level 3 qualification by age 19 years
- outcomes in 2014 indicated that the gap in attainment for all pupils has narrowed compared with national outcomes at age 16 years, but it remains too wide, especially in English

The new strategy will also target absenteeism. Too many Portsmouth children and young people do not attend school regularly leaving them vulnerable to risks which can reduce their chances in life. Research to develop the strategy showed that those who do not attend school regularly are more likely to:

- leave school without any qualifications
- become not in education, employment or training (NEET)
- leave themselves at risk to other poor outcomes eg offending behaviour
- be at increased risk of mental ill-health

36 Portsmouth City Council. Cabinet Member for Children and Education Decision Meeting. 10 December 2015. Agenda item 42. Achieving Excellence in Education: a strategy for improving outcomes in Portsmouth. <http://democracy.portsmouth.gov.uk/ieListDocuments.aspx?Cid=127&Mid=3185> Accessed 22 August 2016

Those children and young people who are absent from school in Portsmouth are most likely to:

- be White British
- be eligible for free school meals (as a proxy indicator for low income)
- have special educational needs. Local pupils with special educational needs and disabilities (SEND) are about four times as likely to become 'persistently absent' compared to those without SEN. Fifty-one per cent of young people with SEN who were persistently absent had 'Social, Emotional and Mental Health' (SEMH) as their primary area of need. 62% of SEN pupils who received a fixed period exclusion had a SEN primary need of SEMH
- have a history of absence from school
- have more absences as they get older

The local levels of absence for vulnerable groups are disproportionately represented compared to their peers.

The new Education Strategy focuses on three major areas for improvement:

- Narrowing the gaps in the achievement of disadvantaged pupils
- Improving standards overall
- Improving attendance

The new Education Strategy summary outcome measures are:

- a. reduce the number of schools in a category of concern to the local authority
- b. increase the number of schools in Portsmouth judged to be Outstanding
- c. increase the proportion of pupils attending schools judged to be good or better
- d. no secondary school to be below the Progress 8 floor target
- e. no school outcomes at the end of KS2 to be below the 65% in Summer 2016

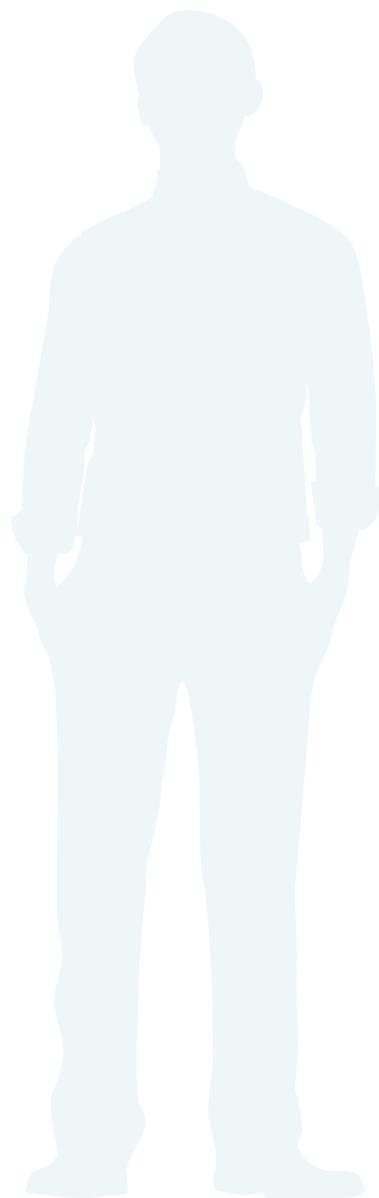
Priority 1c Understand more about the emotional wellbeing of children and young people

The child and adolescent mental health needs assessment is in preparation and will be reported to the Mental Health Alliance, Children's Trust and Portsmouth Safeguarding Children Board. The needs assessment will inform the implementation of 'Future in Mind'.

The key outcome measures for this workstream will be set by the Mental Health Alliance. However, research (mainly for the SEND and for the child and adolescent mental health needs assessments) identified where the city

is an outlier on national outcome measures. In summary, the main findings are:

- Estimated prevalence shows that children aged 11 to 16 years are more likely (11.5%) than those aged 5 to 10 years (7.7%) to experience mental health problems
- Estimated prevalence also shows that boys are more likely (11.4%) to have experienced or be experiencing a mental health problem than girls (7.8%). However, there are gender differences in the different types of problems or disorders being experienced
- In Portsmouth, about 6,300 young people aged 16-24 years are estimated to have any common mental health disorder. Young people with mental health disorders are at increased risk of self-harm. About 3,200 young people aged 16-24 year olds are estimated to have self-harmed in their lifetime
- Estimated level of need for mental health services varies with the model used. An estimated 4,120 to 6,180 children in Portsmouth are in need of Tier 1 services, falling to between 30 and 190 in need of Tier 4 services
- Some Portsmouth children and young people live in households experiencing adverse situations can increase the risk of poor mental health. Examples include:
 - » 18% of secondary school pupils worry a little or a lot about their parent/guardian's use of alcohol and 11% worry a little or a lot about their parent/guardian's use of drugs
 - » There are 800 to 1,200 children aged under 16 years where one or both parents have serious drug problems
 - » Domestic abuse remains the largest category of violence in the city
- About 1,400 local children and young people are predicted to have disabilities or physical ill health – both of which are risk factors for mental health problems
- Portsmouth has seven areas where the volume of pupils with particular primary (main) education or health needs is above national and statistical neighbour averages. Three of these areas (Speech, language and communication [includes autism spectrum conditions], Social, emotional and mental health difficulties [could also include autism spectrum conditions] and Severe learning difficulty) are related to mental health. Social, emotional and mental health difficulties was the most common primary need for those with SEN support
- 51% of local secondary school pupils report they had had a whole alcoholic drink. Forty-five per cent report that their parents provide them with alcohol
- Over 91% have never tried drugs (including solvents)



- Nearly half (45%) of looked-after children are predicted to meet the criteria for a psychiatric disorder – a predicted 144 of 319 looked-after children locally
- Compared to England, Portsmouth has a significantly higher rate of children in need: 175 children had a recorded disability

Preventative and therapeutic support for children and adolescents with mental health problems is provided by a wide range of statutory and voluntary services.

Attendances at emergency departments for mental health, poisoning and deliberate self-harm are one measure of the scale of mental distress in the community. Between April 2014 and March 2015, for Portsmouth's children and young people aged 0-24 years:

1. There were 987 attendances at Emergency Departments (predominantly at QAH) with 46% (n452) of these for teenagers aged 15-19 years
2. Overall, twice as many females as males attended (651 females compared to 336 males)
3. There was a significant increase in attendances between age groups 10-14 years and 15-19 years – particularly for females
4. Attendances by fewer than ten children and young people accounted for 19% (n188) of all attendances
5. However, 105 children and young people had more than one attendance for mental health-related reasons at an emergency department

In 2014/15 the local rate of hospital admissions by 0-17 year olds for mental health reasons (but excluding intentional self-harm), is now significantly lower than the England rate (51 admissions per 100,000 children aged 0-17 years compared to 87 such admissions nationally). The reasons for these admissions include anxiety, stress, depression as well as severe mental health conditions and admissions due to use of substances and alcohol.

Looking at other specific reasons for young persons' hospital admissions, for 2011/12-2013/14 and 2012/13-2014/15, hospital admissions for local young people aged 15-24 years for substance misuse were significantly higher than England (latterly, 116 admissions per 100,000 15-24 year olds compared to 89 such admissions nationally). Conversely, for 2012/13-2014/15, the rate of Portsmouth hospital admissions for alcohol for 0-17 year olds was in line with that of England at 37 per 100,000 young people aged 0-17 years)³⁷.

One way of expressing mental distress is self-harm. One of the 11 pledges in the Mental Health Strategy is to:

“Strive to reduce the number of people using self-harming behaviours as a coping strategy by supporting people to improve their resilience. We will also aim to improve the experience and outcome for those who self-harm.”³⁸

³⁷ Public Health England. CHIMAT. Child health profile. Ibid

³⁸ Portsmouth City Council. Mental Health Strategy 2016-2021. www.portsmouth.gov.uk/ext/documents-external/hlth-mental-health-strategy-2016-2021.pdf Accessed 18 August 2016

Definitions of self-harm vary. For example NHS Choices describes self-harm as: “when somebody intentionally damages or injures their body. It’s usually a way of coping with or expressing overwhelming emotional distress”³⁹. It could be argued that people may not know why they are, for example, drinking alcohol to excess but the end result is a form of self-harm.

NICE describes self-harm as ‘self-poisoning or self-injury, irrespective of the apparent purpose of the act’⁴⁰. The definitions are important because quantifying NHS actions to help children and adolescents who self-harm is dependent upon those actions (A&E attendances, hospital admissions or outpatient appointments) being identified and subsequently coded in medical records.

At population level, levels of self-harm reflect wider community as well as personal issues. The use of alcohol or drugs is strongly associated with suicide in the general population and in sub-groups such as young men and people who self-harm⁴¹. Self-harm hospital admission rates also reflect variability in the type, ease of access to and availability of appropriate mental and physical health services.

Local analysis found that between April 2013 and March 2016, attendances at emergency departments by 0-18 year olds for deliberate self-harm increased from an average of seven per month to 18 per month. In 2015/16, there were 219 attendances – 75% by 15-18 year olds. Between April 2013 and May 2016, 46% of attendances for deliberate self-harm were due to ‘Poisoning including overdose’ (221 attendances), with the next highest reasons being ‘Laceration’ (16%, n77) and ‘Psychiatric conditions’ (12%, n57). The emergency department dataset does not give more details about the drugs involved but this information is available for those who were admitted to hospital.

The national outcome indicators relate to hospital admissions where the first diagnostic code that represents an external cause lies between X60 and X84 (intentional self-harm). Portsmouth’s national outcome measure for those aged 10-24 years admitted as a result of self-harm shows an increasing trend and has been significantly higher than England for the past three financial years. In 2014/15 this local rate is ranked 139th of 150 county/unitary authorities, and is significantly higher than all other local authorities in the south east⁴². Similarly, for people of all ages, for the last three financial years, Portsmouth has had a significantly higher rate than England of people of all ages admitted to hospital as emergencies for self-harm⁴³.

For England, between 2004/05 and 2013/14, hospital admissions for self-harm for young people aged 10-14 years increased by 67%, and for young people aged 15-19 years by 60%. It has been suggested that these large increases may be attributed to improved data collection⁴⁴. However, the large volume of local emergency department attendances for reasons relating to mental health and self-harm suggests that the local hospital admission issue is not solely due to improved record-keeping.

39 NHS Choices Self Harm www.nhs.uk/conditions/Self-injury/Pages/Introduction.aspx Accessed 03 May 2016

40 National Institute for Clinical Excellence, 2004. Self-harm – the short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care. Clinical Guideline 16. www.nice.org.uk/Guidance/CG16 Accessed 30 September 2016

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

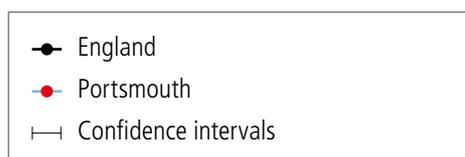
42 Public Health England. CHIMAT. Child health profile <http://fingertips.phe.org.uk/profile/child-health-profiles/data> Accessed 13 October 2016

43 Public Health England. Suicide prevention profile. <https://fingertips.phe.org.uk/profile-group/mental-health/profile/suicide/data#page/0/gid/1938132834/pat/6/par/E12000008/ati/102/are/E06000044/iid/21001/age/1/sex/4> Accessed 13 October 2016

44 Portsmouth City Council and NHS Portsmouth CCG. JSNA Annual Summary 2015 refers to HM Government 2015. Preventing suicide in England: Two years on. Second annual report on the cross-government outcomes strategy to save lives. www.gov.uk/government/uploads/system/uploads/attachment_data/file/405407/Annual_Report_acc.pdf Accessed 29 September 2015

Local analysis of Intentional self-harm (X60-X84) hospital admissions for 0-18 year olds found that, between 2013/14 and 2016/17 (part year), the average number of admissions increased from 10.8 per month to 13.5 per month. In line with the reasons for attending Emergency departments for self-harm, the majority of self-harm admissions related to 'Poisoning by drugs, medicaments and biological substances' (368 such admissions of 439 self-harm admissions, 84%). Of these, 40% (n175) were attributable to 4-Aminophenol derivatives (or Paracetamol).

Figure 10 Hospital admissions for self-harm, young people aged 10-24 years, Portsmouth and England, 2011/12 to 2014/15



Source: PHE Child Health Profile

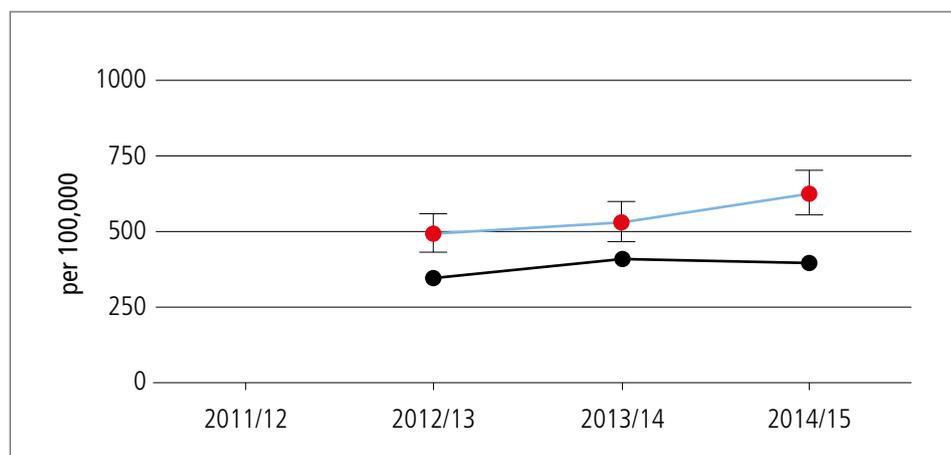
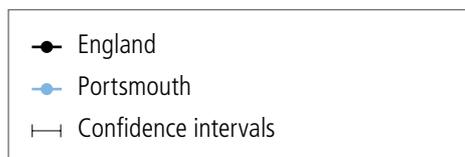
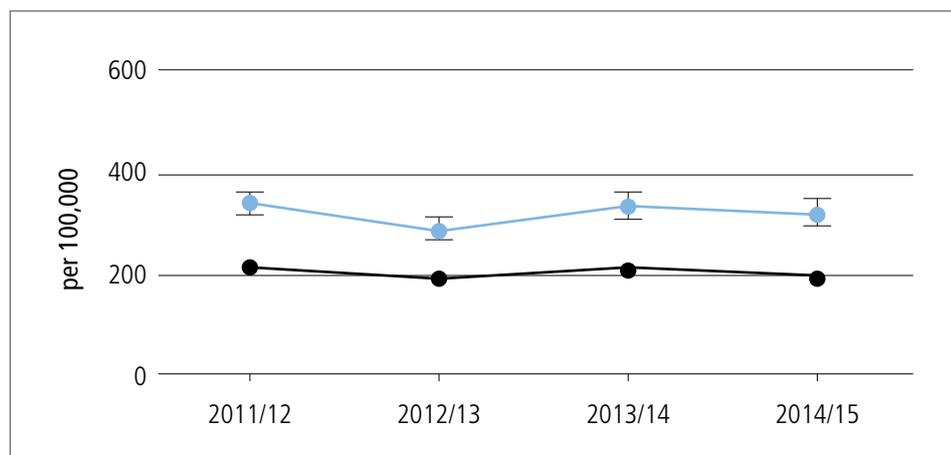


Figure 11 Hospital stays for self-harm, people of all ages, Portsmouth and England, 2011/12 to 2014/15



Source: PHE Suicide Prevention Profile



The research report into children's and young people's mental health needs describes the services available including support from education, primary care, the voluntary sector, community health and community mental health services, and general and specialist inpatient services. Current issues around waiting times, service capacity, attendances and repeat attendances at emergency departments are being examined. The plans to improve services

are in the Future in Mind work programme, which includes the current commissioning of early help services for mental health.

In addition to planned research, it is recommended that further research is needed into:

- the reasons for children and young people with SEND being more likely than other children to be absent from school, excluded from school and have poorer educational attainment, and what are the most effective ways to improve outcomes for children and young people with SEND
- the most effective ways to support teenagers to improve resilience





7

Priority 2: Promoting prevention

Recent research

- Air quality Briefing Note
- Evidence to support Active travel elements of the LTP4 (Transport Strategy), the development of the City Plan, Public Realm Strategy etc
- Update to the South Hampshire Strategic Housing Market Assessment, June 2016⁴⁵
- Rapid participatory appraisal of health and wellbeing in Fratton (in press)
- Rapid participatory appraisal of health and wellbeing in Paulsgrove and Wymering (in press)
- Rapid participatory appraisal of health and wellbeing in Charles Dickens (in press)
- Community Safety Survey, 2016⁴⁶
- Annual crime and anti-social behaviour strategic assessment (in press)
- Health and lifestyle survey of adults aged 16+ years, 2015 (Ipsos Mori)⁴⁷
- Portsmouth 'How are you? – Director of Public Health Report, 2015⁴⁸
- Annual 'You say' survey of secondary school age pupils, 2016 (in press)
- Confidential audit into deaths by suicide in 2013 and 2014
- Confidential audit into deaths by suicide in January to September 2015
- "What is the best practice level of effect in terms of interventions intended to reduce drinking at increasing or high risks level, as measured by the Alcohol Use Disorders Test (AUDIT)?"
- Portsmouth Alcohol Summit, November 2015⁴⁹
- Healthy weight strategy development

Current research

- Survey of Veterans' health, 2015 (Company of Makers)
- Health as a licensing objective (HALO) – Portsmouth is a pilot site for Public Health England's research
- Impact of the Reducing the Strength initiative (University of Southampton)
- Housing need and empty properties in Portsmouth and the impact of government policy (Housing and Social Care Scrutiny Panel)

Planned research

- Rapid participatory appraisals summary and implications, Director of Public Health Report, 2016
- Review of parking and transportation (Traffic, Environment and Community Safety Scrutiny Panel)

⁴⁵ GL Hearn for Partnership for Urban South Hampshire. South Hampshire Strategic Housing Market Assessment – objectively assessed housing need update, March 2016. www.push.gov.uk/strategic_housing_market_assessment.htm Accessed 21 September 2016

⁴⁶ Safer Portsmouth Partnership, 2016. Community Safety Survey www.saferportsmouth.org.uk/images/PDF/CSS_2016_report_-_FINAL_VERSION.pdf Accessed 27 July 2016

⁴⁷ Ipsos Mori for Portsmouth City Council, 2015. Health and lifestyle survey of adults. <http://data.hampshirehub.net/def/concept/folders/themes/jsna/portsmouth-jsna/lifestyles> Accessed 27 July 2016

⁴⁸ Portsmouth City Council. "Portsmouth: how are you?" – Public Health Report 2015 <http://data.hampshirehub.net/data/portsmouth-how-are-you---public-health-annual-report-2015> Accessed 27 July 2016

⁴⁹ Portsmouth City Council, November 2015. Presentations from the Portsmouth Alcohol Summit. <http://data.hampshirehub.net/data/portsmouth-alcohol-summit-november-2015> Accessed 27 September 2016

- Smart City agenda (Economic Development, Culture and Leisure Scrutiny Panel)
- Housing allocations (Housing and Social Care Scrutiny Panel)
- Veterans health needs assessment
- Research into self-harm
- Confidential audit into deaths by suicide in October to December 2015
- Research to support Safer Portsmouth Partnership strategies and plans

Priority 2a Create sustainable healthy environments

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

Initially, the workstream is focusing on how the physical environment can be improved to encourage “active travel” ie lessening our dependence on motorised transport, particularly the car. The city has a “Travel Active Portsmouth” strategy⁵⁰ and one key measure is that walking and cycling become the travel ‘norm’ for short trips. Baseline data to set and monitor the Strategy outcome measure is not yet available but will be collected in conjunction with the University of Portsmouth.

In the meantime, Census 2011 found that 50% of commuters in North and South localities travel fewer than 5km for work but 58% of commuters in the North use a car compared to 45% in the South. Walking and cycling to work is more common in Central and South localities (combined 27% for both in each locality, compared with 16% in North)⁵¹.

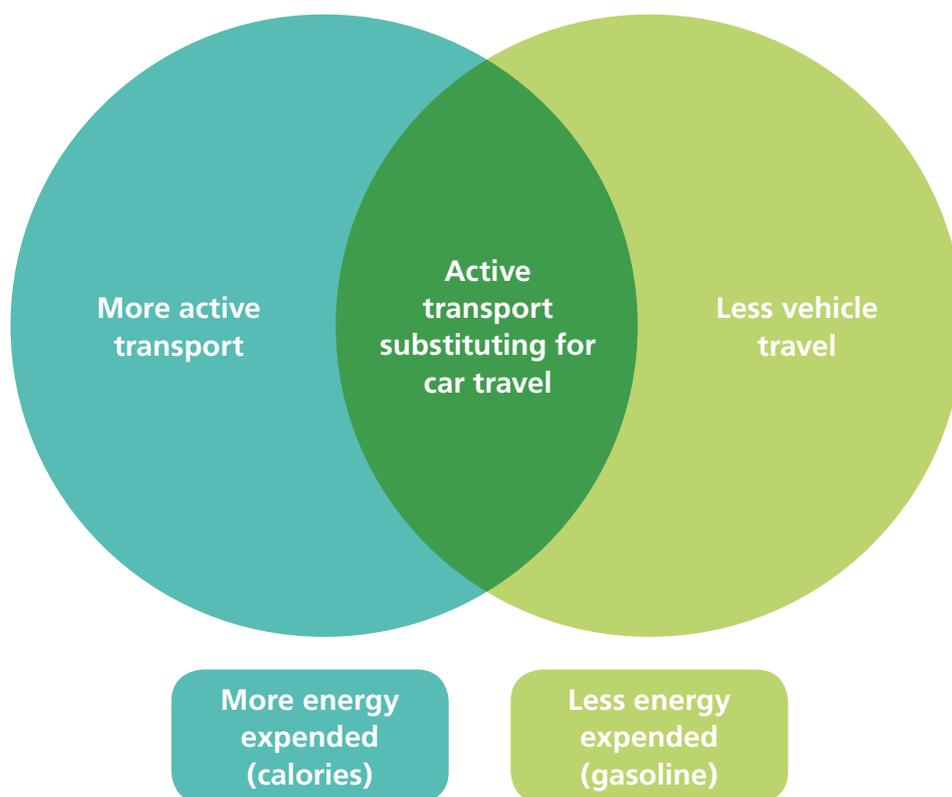
Recent local research looked at active travel in the context of increasing rates of physical inactivity and the adverse impact this has on physical and mental health. The local health and lifestyle survey found 47% of people in Portsmouth said that the most common barrier to exercise is not having enough time. Other time and access related barriers were “classes at wrong time for me” (8%), “classes too difficult to get to” (5%). “Financial cost of exercise” was also a factor (cited by 21%) with others stating that they “don’t like exercise” (10%) and 4% that “exercise is not for me”⁵². Making it easier for people to choose and use active travel options is one example of an approach that benefits the economy, the environment as well as societal and personal health.

⁵⁰ Portsmouth City Council. Travel Active Portsmouth: A walking and cycling strategy for 2013 to 2023 <http://www.hants.gov.uk/pccjsna/ActiveTravelStrategy.pdf> Accessed 15 July 2014

⁵¹ Hampshire County Council for Portsmouth City Council, 2015. Profile of Central locality MAT. <http://data.hampshirehub.net/data/central-mat>; Profile of North locality MAT. <http://data.hampshirehub.net/data/north-mat>; Profile of South locality MAT. <http://data.hampshirehub.net/data/south-mat> Accessed 24 August 2016

⁵² Portsmouth City Council, 2015. Health and lifestyle survey of adults. Ibid

Figure 12 The benefits of active travel compared to sedentary modes of travel⁵³



Social and health benefits	Environmental benefits	Economic benefits
Increased physical activity	Decreased congestion and delays	Increased connectivity and footfall and consequently growth for businesses
Contributes to healthy weight	Improved air quality/reduced carbon emissions	Cheaper travel options which reduces inequalities
Improved mental wellbeing	Reduced accidents/noise	Reduces the cost associated with car use estimated at £38-49 bn per year for the UK
Safer and more appealing environment	Safer more appealing environment	
Opportunity for social interaction		

Road injuries and deaths, all ages

The most recent national comparative outcome measure covers 2012 to 2014 when an average of 112 Portsmouth residents of all ages were killed or seriously injured (KSI) each year (54 persons per 100,000 population over the three years, significantly higher than the England rate of 39 persons per 100,000 population).

Previous research (JSNA Annual Summary 2015) found that between 2010 and 2014, car drivers and passengers made up the greatest proportion of all people who were killed, or seriously or slightly injured in Portsmouth (45% of all casualties). However, for KSI casualties, higher proportions were more

⁵³ Department for Transport, November 2014. Claiming the health dividend: a summary and discussion of value for money estimates from studies of investment in walking and cycling. www.gov.uk/government/uploads/system/uploads/attachment_data/file/371096/claiming_the_health_dividend.pdf Accessed 26 September 2016 (Page 14) and Evidence to support Active travel elements of the LTP4 (Transport Strategy), the development of the City Plan, Public Realm Strategy etc

vulnerable road users (29% of all KSI casualties were pedal cyclists and 27% were pedestrians)⁵⁴.

Local research by Hampshire Constabulary of trends between 2011 and 2015 found:

- An overall decline in the number of reported road casualties with slight injuries, and in those with serious or fatal injuries (although between 2014 and 2015, the number of serious or fatal casualties increased by 13)
- 43% of casualties were car occupants
- 26% of casualties were pedal cyclists, and the number of pedal cyclists sustaining slight injuries is increasing
- Since 2013, the number of seriously or fatally injured motorcycle casualties (riding 50cc-125cc or over 5cc motorbikes) has increased year-on-year
- The greatest proportion of all road casualties is aged 15-29 years. But the year-on-year increase has been in those aged 50-64 years
- Collisions in Portsmouth mostly occur during evening commuting times
- In the single year 2015, 28% of all road casualties in Portsmouth were pedal cyclists.

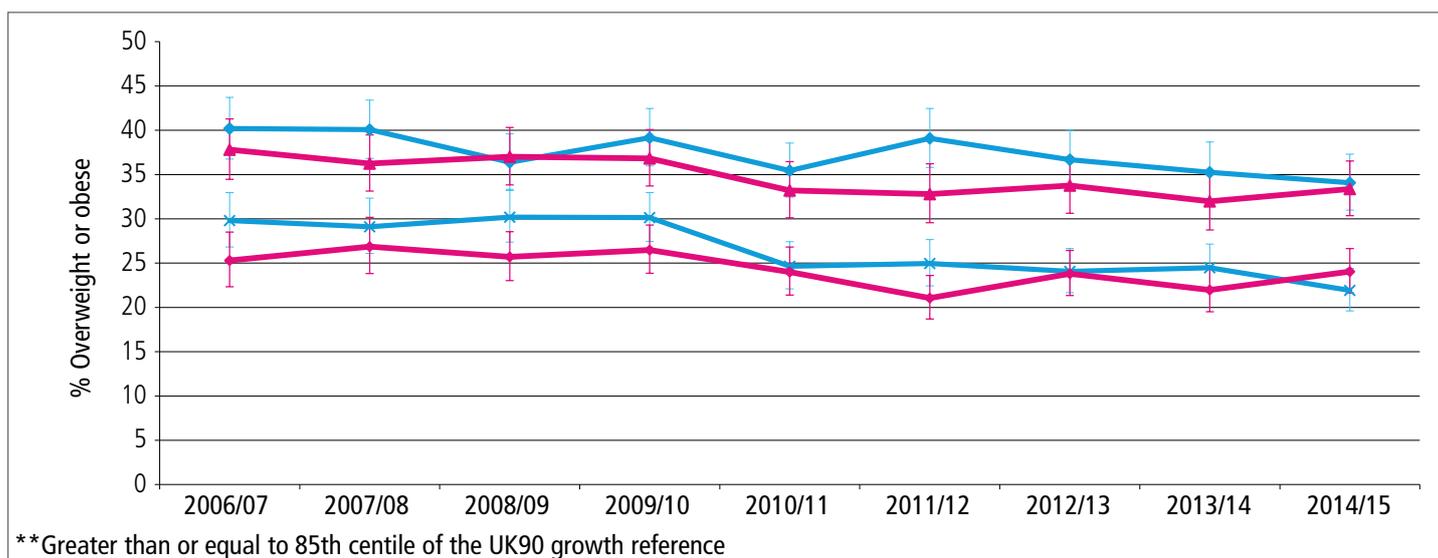
Healthy weight in childhood

Several current strategies place healthy weight within the context of the 'wider determinants' of health (ie how people's health can be supported by the city's environment – its built environment, and infrastructure such as housing, schools, roads and leisure opportunities; and the natural environment in terms of access to green open spaces and water). For example, the Travel Active Portsmouth strategy explicitly associates active travel with other measures to promote healthy weight. Childhood obesity measures (taken in Reception Year and in Year 6 of primary school) are key indicators of physical activity and of nutrition. Children of these ages are reliant on the adults around them for their nutritional needs. Overweight or obese children are of particular concern because habits learned in childhood of eating unhealthy food and being inactive can lead to a lifetime of obesity.

In 2014/15, 23.0% of Year R pupils in Portsmouth schools were overweight including obese – the local trend has not changed significantly since 2010/11. By Year 6, the prevalence of overweight including obese pupils in Portsmouth schools had increased to 33.7%. Figure 13 shows that, for both genders, the prevalence of excess weight increases while at primary school. The prevalence of excess weight in Year 6 boys has however, declined since 2011/12 while that of Year 6 girls has remained fairly static.

⁵⁴ Hampshire Constabulary, September 2015. Reported road casualties, Portsmouth 2010-2014. <http://data.hampshirehub.net/data/reported-road-casualties-portsmouth-2010-2014> Accessed 12 October 2015

Figure 13 Boys and girls aged 4-5 years (Year R) and 10-11 years (year 6) % overweight and obese with 95% confidence intervals. Portsmouth, 2006/07 to 2014/15



**Greater than or equal to 85th centile of the UK90 growth reference

- x Portsmouth Yr R Boys %
- ▲ Portsmouth Yr R Girls %
- Portsmouth Yr 6 Boys %
- Portsmouth Yr 6 Girls %

Source: 2006/07 to 2012/13 – National Obesity Observatory (NOO), PHE;
 *2013/14 to 2014/15: NCMP enhanced dataset, NHS Digital.

Comparative data about childhood obesity (for Portsmouth resident children attending Portsmouth schools) within localities is at Appendix 4. Central locality has higher proportions of overweight including obese Year R (25.4%) and Year 6 (38.9%) resident children compared to North (23.7% and 32.1% respectively) and South (20.4% and 31.3% respectively) localities.

Priority 2b Improve mental health and wellbeing

Improving mental health and wellbeing, and understanding more about emotional wellbeing of children and young people are workstreams within the Joint Health and Wellbeing Strategy. Improving mental health are the remits of both the Children’s Trust and the Mental Health Alliance. The Safeguarding Boards for children and adults also have parts to play.

The Mental Health Alliance has produced the mental health strategy and action plan. We know that Portsmouth has significantly higher rates of factors which are risks for mental ill health (eg relative deprivation, alcohol misuse and violent crime) but lower recorded rates than the national average of, for example, depression⁵⁵. Appendix 4 shows that an additional 1,662 patients would have to be diagnosed with depression for Portsmouth to have the same prevalence of recognised depression as the England average (2014/15).

The Mental Health Alliance has agreed 11 pledges to improve mental health and will also identify and monitor outcome measures. One of the 11 pledges in the mental health strategy is to: “work to reduce the number of suicides in the city and provide support for those bereaved by suicide”⁵⁶.

⁵⁵ Public Health England. Common Mental Health Disorders Profile. <http://fingertips.phe.org.uk/profile-group/mental-health/profile/common-mental-disorders> Accessed 24 August 2016

⁵⁶ Portsmouth City Council. Mental health strategy 2016-2021. www.portsmouth.gov.uk/ext/documents-external/hlth-mental-health-strategy-2016-2021.pdf Accessed 18 August 2016

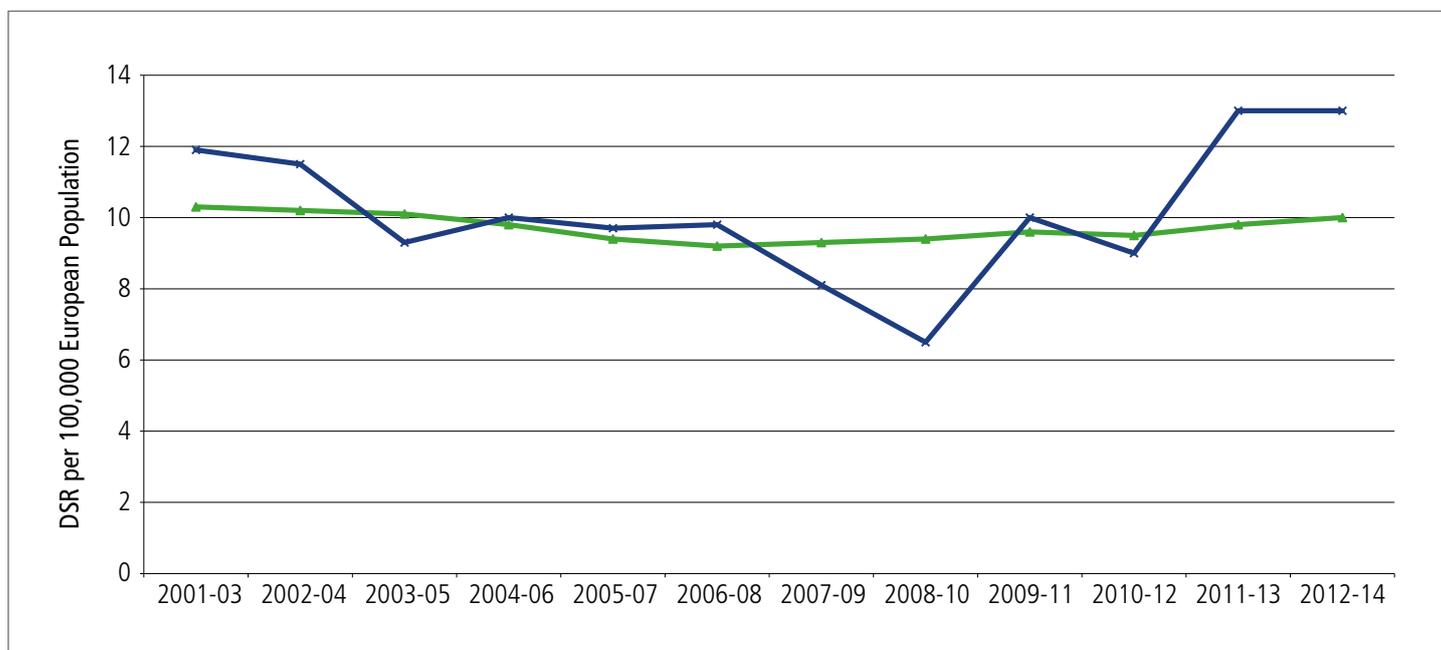
Compared to England, the risk factors section of Public Health England's suicide profile illustrates that Portsmouth has lower rates of people with long-term health problems and of long-term unemployment, but has higher rates of people who are separated or divorced, people living alone, children who are looked after, children leaving care, children in the youth justice system and estimated prevalence of opiates or crack cocaine. Portsmouth also has a higher than national rates of mental health clients receiving services from adult social care, of adult carers who have as much social contact as they would like, and of clients receiving specialist alcohol and drug services. Compared to England a higher percentage of Portsmouth opiate users successfully completed drug treatment (ie do not re-present within six months) but a lower percentage of people receiving treatment for alcohol misuse successfully completed treatment⁵⁷.

There has been a change to the definition of suicide and injury of undetermined intent used in the key Public Health indicator sets to bring it in line with that used by the Office for National Statistics. The national definition includes deaths given an underlying cause of intentional self-harm or an injury/poisoning of undetermined intent but only in those of people aged 15 years and over. The figures below reflect the revised definition (and will therefore differ from those presented in the JSNA Annual Summary, 2015).

For 2012/14, Portsmouth's suicide rate for persons continues to be significantly higher than the England rate (13.0 per 100,000 persons compared with 10.0 such deaths in England). This is the highest local rate since 2001-03. (**Figure 14**)

⁵⁷ Public Health England. Suicide prevention profile. Related risk factors and related service contacts sections. Ibid

Figure 14 Mortality from suicide and injury of undetermined intent, persons, Portsmouth and England 2001-03 to 2012-14



—△— England
—x— Portsmouth

Source: Health and Social Care Information Centre. © Crown Copyright. Compendium of Population Health Indicators (indicator.ic.nhs.uk) and National Statistics.

Locally, for 2012-14, the male rate of deaths due to suicide or injuries of undetermined intent was 22.0 deaths per 100,000 males compared to a very low (undisclosed) rate for females⁵⁸. However, the number of deaths fluctuates each year. The most recent local audit of suicide deaths found equal numbers of male and female deaths in the first nine months of 2015: consequently, the rate of female deaths due to suicide or injuries of undetermined intent is predicted to increase for the next national reporting period of 2013-15.

The results of the confidential suicide audits have been presented to the mental health leads. Recommendations demonstrate the multi-faceted nature of tackling mental ill health:

1. Re-convene the Suicide Action Group so that it can consider and implement actions to tackle issues identified in this audit.
2. Consider how the Suicide Action Group and the Adult Safeguarding Board can most effectively work together on common issues to protect vulnerable adults.
3. Research and implement the evidence base for any gender-specific population-level interventions which improve mental health for males and for females. Mental health care providers should ensure they provide any specific evidence-based interventions for males and females. The recommendations of the Public Health Annual Report, 2012 "The health of men in Portsmouth" should continue to be implemented.

⁵⁸ Public Health England, Suicide prevention profile, Suicide data. <http://fingertips.phe.org.uk/profile-group/mental-health/profile/suicide>
Accessed 12 September 2016

4. Health care providers should investigate suicide events in a timely manner and send their reports into Serious Incidents to the Coroner so that the findings and recommendations are considered at the Inquest.
5. The CCG should send the recommendations/action plans (from the health care provider Serious Incident reports) to Public Health for inclusion in future audits.
6. "...all health and social care professionals should ask patients about financial difficulties in routine assessments. Secondly, where debt is reported, primary care professionals should routinely assess for depression and other common mental disorders. Thirdly, these actions depend upon health and social care professionals having the time, knowledge and confidence to ask about patient finance. ...Professionals should receive basic 'debt first aid' training: knowing how to talk with patients about debt; knowing how to refer to, and support, debt counsellors, but without being expected to become 'debt experts' themselves."⁵⁹ (These national recommendations in the Foresight Review are reflected in the city's Tackling Poverty Strategy⁶⁰).
7. All agencies should contribute to achieving the actions in the city's Tackling Poverty Strategy. The Mental Health Strategy should link to the Tackling Poverty Strategy for activities linking mental health, health, money advice and creditor organisations.
8. The Suicide Action Group should continue to work with other organisations (eg Network Rail/South West Trains, University of Portsmouth) on evidence-based interventions to reduce the risk of death.

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

The key outcome measures relate to reducing the prevalence of smoking and drinking alcohol among young people, reducing the prevalence of smoking in adults, and reducing alcohol-related hospital admissions. Achieving these outcome measures is linked to the development of the Wellbeing Service (Joint Health and Wellbeing Strategy Priority 3b – Explore and develop lifestyle hubs).

The Health and Lifestyle Survey of adults aged 16+ years found, in relation to smoking, drinking alcohol to a risky level, unhealthy diet and not being sufficiently physically active:

- 57% of adults exhibit at least two unhealthy behaviours
- 18% show either three or four unhealthy behaviours
- Distinct differences along socio-economic lines eg 15% of those living in council/social housing exhibited all four unhealthy behaviours compared with 5% of all adults

⁵⁹ HM Government Foresight Review of Mental Capital and Wellbeing summarised in Jenkins R et al, 2009. Ibid

⁶⁰ Portsmouth City Council. Tackling Poverty Strategy 2015-2020. <http://data.hampshirehub.net/data/tackling-poverty-strategy-2015-2020> Accessed 9 March 2016

- Those with long-term health conditions are also more likely to show unhealthy behaviours eg 13% of those with a limiting long-term disability or condition exhibited all four unhealthy behaviours compared with 2% of those without any limiting disabilities or conditions
- Central locality has significantly higher percentage of adults with four unhealthy behaviours⁶¹

Smoking

Smoking remains the main reason for the gap in life expectancy between rich and poor. The Local Tobacco Control Profiles⁶² show that compared to England, Portsmouth has significantly higher rates of:

Measure	Portsmouth	England
Prevalence of current smokers in 15 year olds, 2014/15	10.9%	8.2%
Prevalence of regular smokers in 15 year olds, 2014/15	8.2%	5.5%
Smoking prevalence in adults, 2015	19.8%	16.9%
Pregnant women smoking at time of delivery, 2014/15	14.7%	11.4%
Smoking attributable mortality, 2012/14	333 deaths per 100,000 persons aged 35+ years	275 deaths per 100,000 persons aged 35+ years

The national Tobacco Control Plan for England states "...nicotine addiction for most people starts in adolescence. In England, almost two-thirds of current and ex-smokers say that they started smoking regularly before they were 18 years old.... Very few people start smoking for the first time after the age of 25"⁶³. The local Health and Lifestyle Survey found that 49% of all current tobacco smokers started to smoke when they were younger than 16 years, 24% between 16 and 17 years of age and 20% between 18 and 24 years of age⁶⁴.

The most recent local 'You say' survey of secondary school pupils encouragingly found an increase in pupils who had never tried tobacco from 78% in 2015 to 85.7% in 2016⁶⁵.

The local Health and Lifestyle Survey of adults found the highest levels of adults smoking daily or occasionally in Central locality (21% compared to 16% in North and 11% in South localities). Those with the lowest levels of mental wellbeing were more likely to smoke tobacco than those with the highest levels of mental wellbeing (16% compared to 9%). Seventy-seven per cent of local smokers say they would like to stop smoking. Of those who had given up smoking, 71% said they gave up without any help or support⁶⁶.

The Tobacco Control Alliance has recently agreed 'Smoke-free Portsmouth: Tobacco Control Strategy 2016-2020'.

⁶¹ Ipsos Mori for Portsmouth City Council. Portsmouth Health and Lifestyle Survey 2015. <http://data.hampshirehub.net/data/portsmouth-health-and-lifestyle-survey-2015-report-and-findings> Accessed 25 August 2016

⁶² Public Health England. Local Tobacco Control Profiles. www.tobaccoprofiles.info/ Accessed 25 August 2016

⁶³ HM Government, 2011. Healthy lives, healthy people: A tobacco control plan for England. www.gov.uk/government/uploads/system/uploads/attachment_data/file/213757/dh_124960.pdf Accessed 25 August 2016

⁶⁴ Ipsos Mori for Portsmouth City Council. Portsmouth Health and Lifestyle Survey 2015. Ibid

⁶⁵ Portsmouth City Council, 2016. 'You say' survey of secondary school pupils. In press

⁶⁶ Ipsos Mori for Portsmouth City Council. Portsmouth Health and Lifestyle Survey 2015. Ibid

Alcohol

Figure 5 shows that digestive conditions including chronic liver disease and cirrhosis contribute to the comparatively shorter life expectancy of males and females in the most deprived compared to the least deprived areas of the city. Liver disease is affected by physical activity, diet, tobacco smoking and alcohol as well as by Hepatitis B and C viruses: it is a largely preventable disease.

The Liver Disease Profiles⁶⁷ and the Local Alcohol Profiles⁶⁸ for England show that Portsmouth has significantly higher rates than England across for:

- Claimants of benefits due to alcoholism, 2015
- People admitted to hospital for alcohol-specific conditions, 2014/15
- Admission episodes for males aged 40-64 years, 2014/15
- Admission episodes for mental and behavioural disorders due to use of alcohol condition (broad definition) for males and for females, 2014/15
- Admission episodes for mental and behavioural disorders due to use of alcohol condition (narrow definition) for males 2014/15
- Admission episodes for intentional self-poisoning by and, exposure to, alcohol condition for males and for females, 2014/15
- Alcohol-specific mortality for males and for females, 2012/14
- Alcohol-related mortality for males, 2014
- Mortality from chronic liver disease for males and for females, 2014
- Premature mortality rate from liver disease for males and for females, 2012-14
- Premature mortality rate from alcoholic liver disease for males, 2012-14

The local Health and Lifestyle Survey found that 33% of adults are drinking alcohol at levels that put them at 'increasing risk' of developing an alcohol use disorder, with a further 12% drinking at 'high risk' levels. People from lower socio-economic groups do not necessarily drink more alcohol than people from other groups, but they do suffer disproportionately from alcohol-related illness due to the adverse impact of other lifestyle and socio-economic factors (the 'alcohol harm paradox'⁶⁹⁷⁰).

The survey also found the highest rates of negative impacts of drinking alcohol to excess were reported in Central locality. A significantly higher proportion of people aged 16-34 years are at 'increasing risk' of developing an alcohol use disorder (44%) compared to 35-64 year olds (30%) or 65+ years (20%). A significantly higher proportion of 35-64 year olds are at 'high risk' of developing an alcohol use disorder (18%) compared to 16-34 year olds (9%) and 65+ year olds (3%).

⁶⁷ Public Health England. Liver Disease Profiles. <http://fingertips.phe.org.uk/profile/liver-disease> Accessed 17 August 2016

⁶⁸ Public Health England. Local Alcohol Profiles for England. <http://fingertips.phe.org.uk/profile/local-alcohol-profiles> Accessed 17 August 2016

⁶⁹ Alcohol Research UK, 4 March 2015. Understanding the alcohol harm paradox. <http://alcoholresearchuk.org/alcohol-insights/understanding-the-alcohol-harm-paradox-2/> Accessed 25 August 2016

⁷⁰ Portsmouth City Council, 2015. Portsmouth How are you? Public Health Annual Report. Ibid

Alcohol remains a priority area for improving public health. The strategy and action plans for tackling alcohol misuse are the responsibility of the Safer Portsmouth Partnership.

The Joint Health and Wellbeing Strategy set four measures to monitor progress:

- a. Secondary school pupils reporting that they had drunk a whole alcoholic drink, not just a sip

The outcome measure is obtained from the annual 'You Say' survey of secondary school pupils. Encouragingly, between 2014 and 2016, the proportion of pupils reporting they have drunk a whole alcoholic drink, not just a sip, has fallen from 53% to 42%. The 2016 survey found the highest rates of pupils who reported that they had drunk a whole alcoholic drink were in North locality (47.6%) compared with 41.0% in Central locality and 34.1% in South locality⁷¹. (**Appendix 4**)

- b. Drinking alcohol to excess – reduction in the combined percentage of adults meeting the criteria for receiving brief advice, and of adults meeting the criteria for receiving brief advice plus being recommended for referral to the Wellbeing Service.

The baseline measure has now been obtained from the Health and Lifestyle Survey. Forty-five per cent of Portsmouth adults drink alcohol at these risky levels. The highest locality level is in South locality where 10% fewer adults should drink at these risky levels to fall to the city average.

- c. Alcohol-related hospital admissions – 'broad' definition

The 'broad' measure provides a more realistic measure than the 'narrow' measure of the total burden that alcohol has on community and health services. It looks at admissions where the main diagnosis or any secondary diagnosis was attributable to alcohol⁷². Using the broad measure, the local rate of alcohol-related hospital admission episodes has continued to decline and is now (2014/15) significantly lower than the national rate (2021 episodes per 100,000 persons of all ages compared to 2139 episodes per 100,000 persons of all ages)⁷³. (**Figure 15**)

However, in 2014/15 the complementary indicator of persons admitted to hospital for alcohol-related conditions (broad definition) remains significantly higher than the national rate (1324 persons per 100,000 persons of all ages locally compared with 1258 persons per 100,000 persons of all ages nationally)⁷⁴.

The difference between the two measures is that hospital episodes relate to the numbers of blocks of time (episodes) a patient spends in the continuous care of a consultant in hospital⁷⁵, whereas the second measure looks at the number of persons admitted. One person may have several hospital

71 Portsmouth City Council, 2016. 'You say' survey of secondary school pupils. Ibid

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

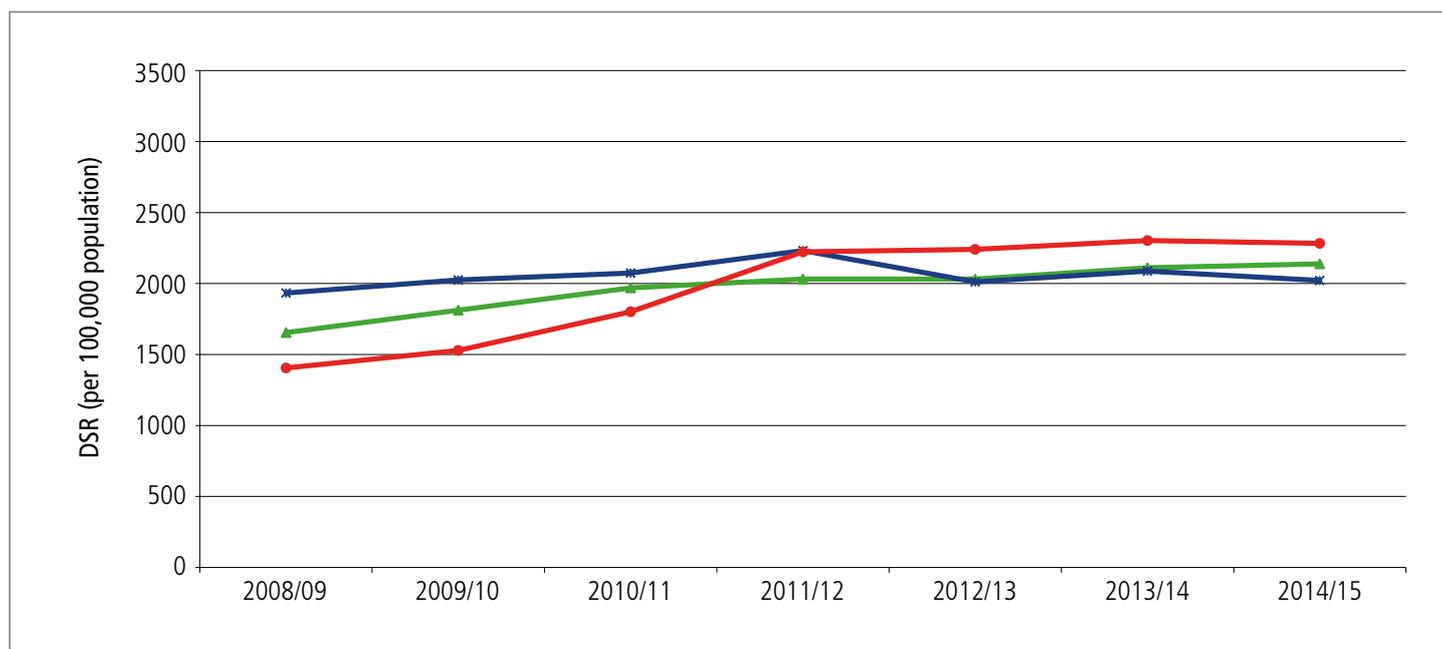
73 Public Health England. Local Alcohol Profiles for England. Hospital admissions. <http://fingertips.phe.org.uk/profile/local-alcohol-profiles/data> Accessed 31 August 2016

74 Public Health England. Local Alcohol Profiles for England. Hospital admissions. Ibid

75 Definition of Consultant Episode, NHS Data Dictionary. [www.datadictionary.nhs.uk/data_dictionary/nhs_business_definitions/c/consultant_episode_\(hospital_provider\)_de.asp?shownav=1](http://www.datadictionary.nhs.uk/data_dictionary/nhs_business_definitions/c/consultant_episode_(hospital_provider)_de.asp?shownav=1) Accessed 31 August 2016

episodes during one year. In general, it appears that locally a higher number of city patients are admitted for fewer episodes compared to nationally.

Figure 15 Admission episodes for alcohol related conditions (Broad): Persons, all ages. Portsmouth and comparators, 2008/09-2014/15.



d. Alcohol-related hospital admissions – ‘narrow’ definition

The ‘narrow’ measure of admissions is a better measure than the ‘broad’ measure when looking at the effectiveness of local actions directly on alcohol. The narrow measure looks at admissions to hospital where the main diagnosis is attributable to alcohol or where a secondary diagnosis is an alcohol-related ‘external’ cause (eg accidents, assault or intentional self-harm).

Using the narrow measure, the local rate of alcohol-related hospital admission has also continued to decline since 2011/12 and is now (2014/15) significantly lower than the England rate (599 admission episodes per 100,000 persons of all ages compared to 641 episodes per 100,000 persons of all ages)⁷⁶. (Figure 16)

Again, there is a difference in the picture presented by hospital episodes compared to number of people admitted. The local rate of persons admitted for alcohol-related conditions (narrow) has declined since 2011/12 but remains significantly higher than the England rate (481 persons per 100,000 people of all ages compared with 438 persons per 100,000 people of all ages)⁷⁷.

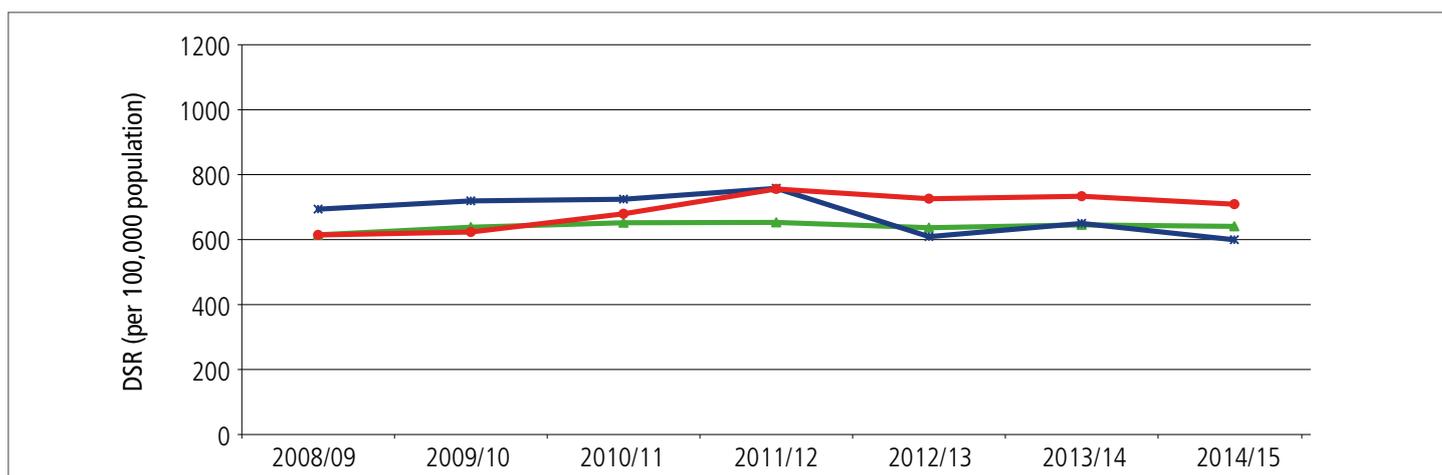


Source: LAPE, Knowledge & Intelligence Team (North West), Public Health England.

⁷⁶ Public Health England. Local Alcohol Profiles for England. Hospital admissions. Ibid

⁷⁷ Public Health England. Local Alcohol Profiles for England. Hospital admissions. Ibid

Figure 16 Admission episodes for alcohol-related conditions (Narrow): Persons, all ages. Portsmouth and comparators, 2002/03-2014/15



Source: LAPE, Knowledge & Intelligence Team (North West), Public Health England.

Portsmouth’s hospital alcohol-related admission rates on both broad and narrow measures are higher for males compared to females.

The Safer Portsmouth Partnership has lead responsibility for tackling alcohol misuse. Back in 2008 it identified alcohol misuse as a significant driver for violent crime and this continues to be a top priority for the Partnership. The SPP leads a programme to address the priorities identified by detailed analysis in the SPP Strategic Assessment and Plan⁷⁸.

The local Alcohol needs assessment 2012⁷⁹, the Liver health needs assessment 2015⁸⁰, the Health and Lifestyle Survey and the Public Health Annual Report 2015 all reiterate the importance of promoting healthier lifestyles (including alcohol, diet and smoking), good mental health and resilience, and addressing the prevention of transmission and treatment of viral hepatitis B and C. “Lifestyle change in multiple behaviours needs to be person-centred and there is a need to improve the general knowledge base around dietary behaviours to promote health. Motivation is a key barrier to behaviour change, therefore developing a greater understanding around ways to address this is an important finding.” (Liver health needs assessment. Page 3) The Wellbeing Service was established to provide holistic interventions to promote healthier lifestyles. See Chapter 8.

The Director of Public Health’s Annual Report 2015 pointed out that public sector services are not resourced to provide one-to-one support to everyone who currently smokes, drinks to risky levels, and/or is overweight or obese. We need to promote self-help on a larger scale, working cost-effectively with partners across Hampshire and the Isle of Wight. We also need to find out which online resources are most effective at promoting behaviour change, and how we can provide the same sort of support to people who cannot access the internet.

⁷⁸ See Safer Portsmouth Partnership website for more information including Strategic Assessment and Plan. www.saferportsmouth.org.uk/ Accessed 30 September 2016

⁷⁹ Portsmouth City Council, 2012. Alcohol needs assessment. <http://data.hampshirehub.net/data/jsna/portsmouth-jsna/lifestyles/alcohol-consumption/alcohol-needs-assessment-2012> Accessed 16 August 2016

⁸⁰ Portsmouth City Council, 2015. Liver health needs assessment. <http://data.hampshirehub.net/data/liver-health---needs-assessment-june-2015> Accessed 16 August 2016

Priority 3: Supporting independence



Recent research

Better Care Plan population needs and demand profiling

Health and lifestyle survey of adults aged 16+ years⁸¹

Current research

Better Care Plan population needs and demand profiling

Rapid Participatory Needs Appraisals to inform the development of the Wellbeing Service, and community development in Paulsgrove and Wymering, Fratton and Charles Dickens

Planned research

Research to support the Hampshire and Isle of Wight Sustainability and Transformation Plan and the local Health and Care Plan

Public Health Annual Report, 2016 – results and implications of the rapid participatory appraisals of wellbeing in three areas of the city

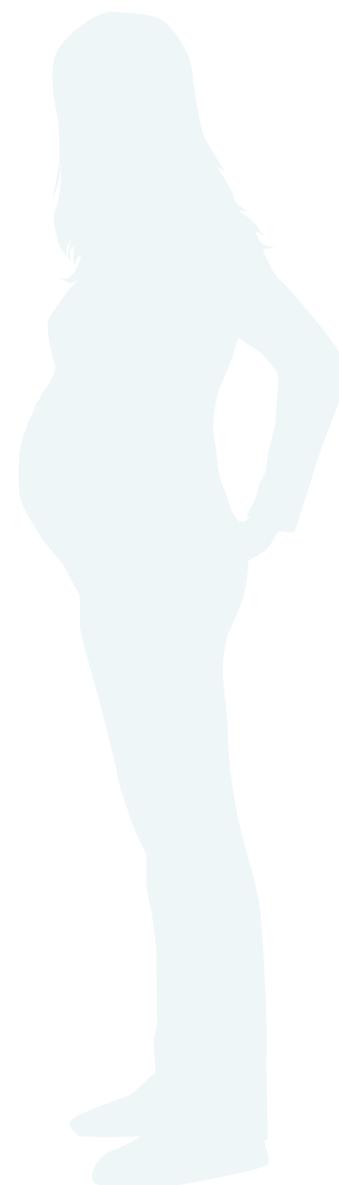
The priorities for this workstream are to develop and implement the Better Care Plan, to explore and develop the Wellbeing Service, and to implement the City of Service model of high impact volunteering (“Portsmouth Together”). The outcome measures for each of these priorities is in Appendix 4.

Priority 3a Develop and implement the Better Care Plan

The city’s Better Care Plan 2016/17, submitted to NHS England in May 2016, was ratified by the Cabinet Member for Adult Social Care and Public Health Decision Meeting on 29 June 2016⁸².

A single health and social care system is using the Better Care Fund to provide integrated care. Focussing initially on older people, this includes the following schemes: establishing fully integrated locality-based health and social care community teams, and reviewing current bed-based provision and reablement services. The key outcome measures cover nationally and locally defined measures, which are reported quarterly to NHS England:

- Proportion of adult social care users that have as much social contact as they like
- Reduction in total general and acute non-elective hospital admissions
- Increase in proportion of older people still at home 91 days after discharge from hospital into rehabilitation services
- Delayed transfer of care from hospital
- Permanent admissions of older people to residential and nursing care



The local Better Care Plan 2016/17 summarises key successes and challenges:

- By March 2015, achieved agreement on the Section 75 and pooled fund arrangements
- Progress for 2015/16 started well with key projects such as the Living Well Service, Integrated Personal Commissioning and the Acute Visiting Service being mobilised or well underway
- Reviews for reablement and community bed work-streams completed. Recommendations from both reports suggested significant changes into the way both services are commissioned and delivered in future, with planned implementation over the coming months.
- Some key schemes (the prevention scheme and integrated localities scheme) experienced some challenging delays due to IT and estates related issues
- Capacity shortages in key services throughout 2015/16 led to a decision to delay the co-location of the teams. A number of associated key milestones have been significantly delayed
- Emergency hospital admissions increased during 2015/16 with the Portsmouth Hospitals NHS Trust contract over performing against plan
- During 2015/16, the previously good “delayed transfer of care (DTC) from hospital” measure also deteriorated with an 87% increase in DTC days delayed
- Evaluation of the plans through the year and as part of the overall assessment and evaluation process of Better Care in quarter 3, 2015/16 has confirmed the need to continue with these key schemes into 2016/17. Milestones have been re-evaluated and delivery and project management arrangements strengthened to better support front line staff through the changes and enable partners to better hold each other to account
- A wider transformation programme, Health and Care Portsmouth Transformation Programme (HCP), has been established to improve outcomes and deliver a more sustainable health and care system

One of the Better Care workstreams is the Prevention Programme which aims to identify those cohorts of patients with high health resource use and having an increased risk of admission in order to commission interventions which will reduce service use and costs. Research was undertaken of anonymised data to measure the morbidity burden of the population based on disease patterns, age and gender. The key findings are:

- Costs increase significantly with each additional chronic condition a patient has
- The top 5% of most expensive patients account for about 40% of the total budget

81 Ipsos Mori for Portsmouth City Council. Portsmouth Health and Lifestyle Survey 2015. Ibid

82 Portsmouth City Council, NHS Portsmouth Clinical Commissioning Group. Cabinet Member for Adult Social Care and Public Health Decision Meeting, Agenda item 4. 29 June 2016 <http://democracy.portsmouth.gov.uk/ieListDocuments.aspx?CId=448&MId=3456&Ver=4> Accessed 12 September 2016

-
- There is wide case mix variation between GP practices
 - Costs are driven more by multimorbidity than age (ie older people are not necessarily 'using' health resources more than younger people)
 - Emergency admission rates, Accident and Emergency attendances and risk of emergency admission are also driven more by multimorbidity than by age
 - Risk of emergency admission varied by chronic condition

Subsequent research examined the impact of diabetes. Key findings are:

- Half of people with diabetes have at least two other chronic conditions
- There is a wide variation of people with multiple chronic conditions and resource use across GP practices
- Approximately 70% of patients with diabetes also have hyperlipidaemia and hypertension and 37% depression
- Patients with diabetes who are in the very high resource utilisation band have between three and four times the cost, number of Accident and Emergency attendances, emergency admissions and risk of emergency admission when compared to all patients with diabetes

A continuing research need is to understand how the needs of people with complex needs can escalate and what interventions are most effective in reducing future demand for services. This applies to both adults and children (Transformation Plan and Stronger Futures).

Priority 3b Explore and develop Wellbeing Service

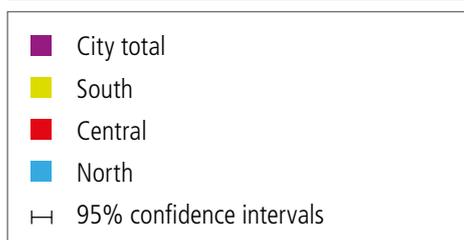
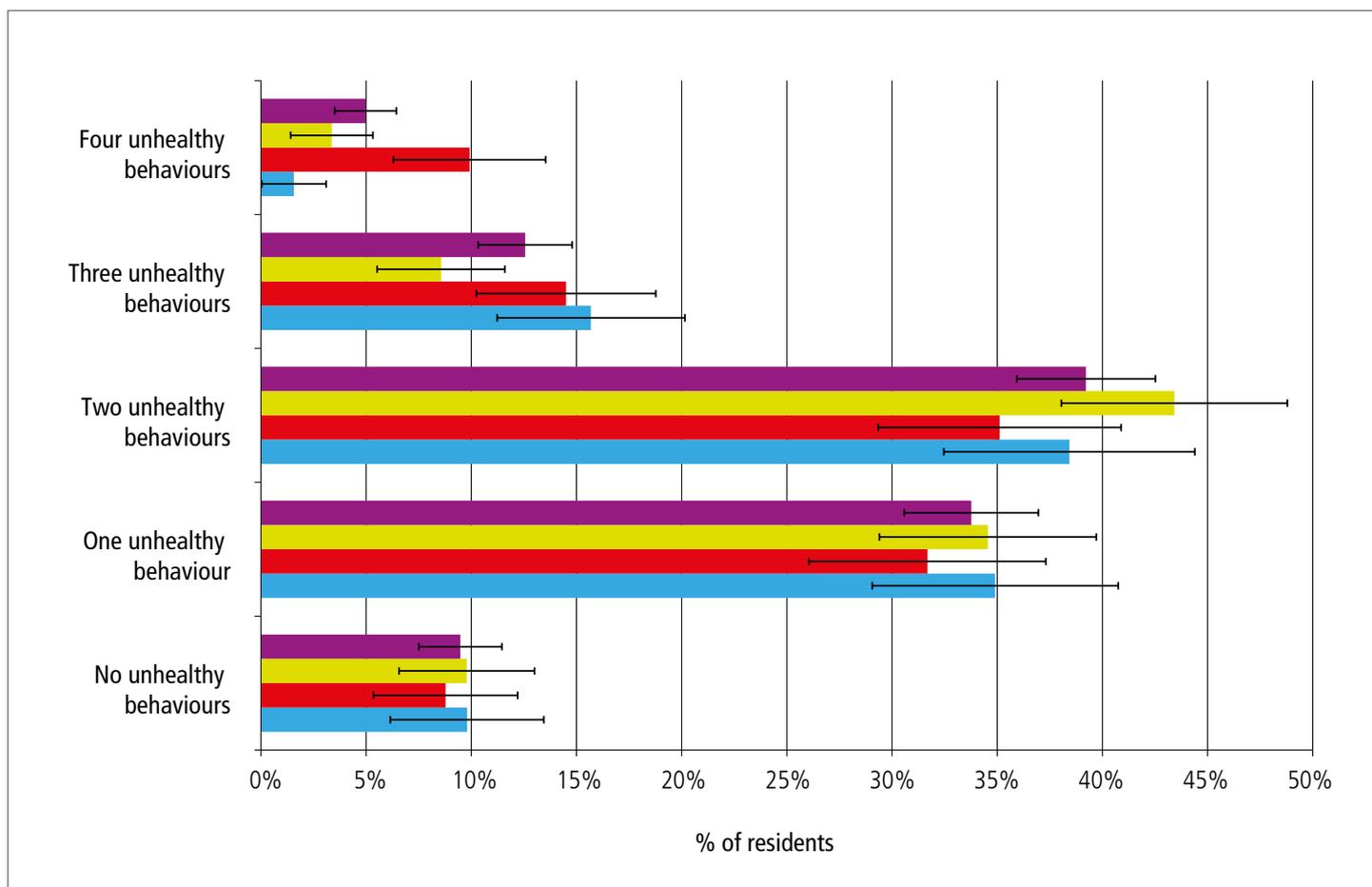
Public Health Portsmouth's Wellbeing Service, where local people can find information, advice and support to help lead healthier lifestyles, was set up in October 2015. At a population level, the outcome measures relate to increasing the prevalence of people having a healthy lifestyle – healthy diet, being physically active, not smoking and reducing alcohol misuse – as well as improvements in wider issues affecting wellbeing such as getting a job or getting out of debt.

Reflecting the aim to tackle multiple lifestyle behaviours, the key baseline measure is the reduction in the percentage of adults with two or more unhealthy behaviours: in 2015, 57% of Portsmouth adults have two or more unhealthy behaviours.

The adult health and lifestyle survey also found higher proportions of residents exhibiting all four unhealthy behaviours among those in council/ social housing (15% compared to 5% of all residents) and those living in the most deprived quintile of neighbourhoods (13%). Figure 17 shows that, compared to South or North localities, Central locality has a significantly higher percentage of adults with four unhealthy behaviours compared to South or North localities.



Figure 17 Percentage of adults with unhealthy behaviours, by locality, 2015



A key role of the Wellbeing Service will be to work with communities to identify needs and aspirations. The Rapid Participatory Appraisals in Paulsgrove and Wymering, Fratton and Charles Dickens include action plans to address community needs (in press).

Relevant outcome measures are described under other workstreams but tackling inequalities will necessarily mean improving the health and wellbeing of males of all ages, of Black and Minority Ethnic groups etc. Over time, different hubs are likely to have different outcomes reflecting the needs of their local communities, local assets etc.

Priority 3c Implement high impact volunteering – Portsmouth Together

When the Joint Health and Wellbeing Strategy was initiated, Portsmouth Together was a City of Service model of high impact volunteering which enabled local people and communities to tackle some of the city’s key challenges. In June 2016 the grant funding for Cities of Service UK came to

an end. In Portsmouth, the members of the Portsmouth Together Steering Group agreed to form the Portsmouth Together Partnership whose vision is:

“A city in which volunteering is encouraged, promoted, valued and supported because it has the power to enhance quality of life, reduce inequality or improve outcomes in health, public health and social care.”

The Partnership includes senior management representation from the city council, NHS Portsmouth CCG, Solent NHS Trust, the University of Portsmouth, the University of Portsmouth Students Union, Royal Navy, Action Portsmouth, Shaping Portsmouth, Portsmouth Youth Voice and Portsmouth Voluntary and Community Network (PVCN).

The workstream has its own metrics for performance. The three main projects are:

‘Activate’ mentoring project

This project aims to improve GCSE attainment by mentored pupils. Pupils, who are nominated by the school, all receive pupil premium. The initiative is managed by Education Business Partnership and in 2015/16 it ran in King Richard School, Paulsgrove. The results from cohorts in 2014/15 and 2016/17 showed that the mentored pupils not only outperformed the rest of the cohort of pupils receiving the pupil premium, but also matched the results of the school average. (Next year it will run in three Portsmouth schools – again including King Richard School.)

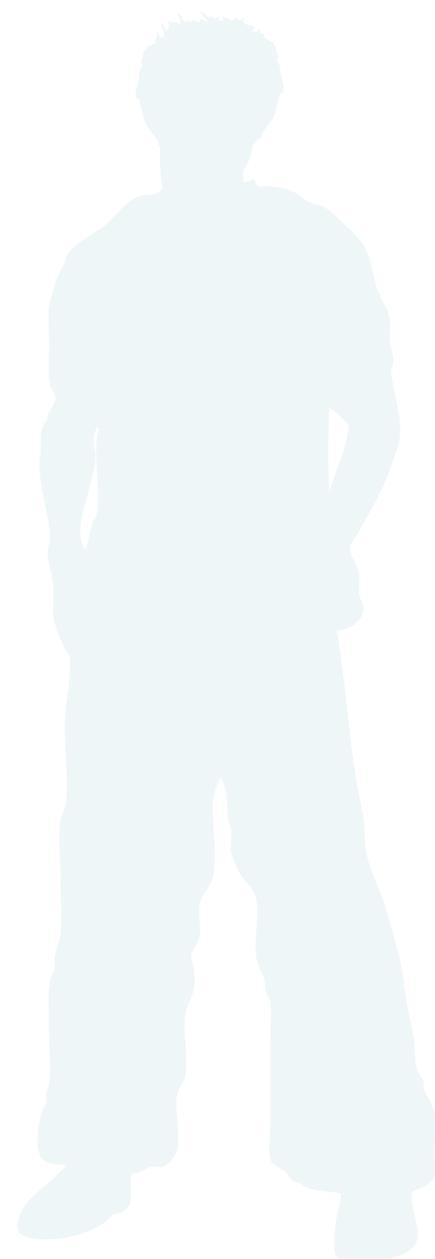
‘Love your street’

The project aim is to encourage more residents to engage in voluntary activities in their neighbourhood. Baseline measures were obtained in the Health and Lifestyle Survey which found that 20% of adults give unpaid help to any group, club or organisation at least once a month. The highest percentage (23%) was in South locality.

To date, 31 grants have been awarded (£15,287). Twelve projects have completed, reporting 407 volunteers doing 3,037 volunteer hours with 5,726 beneficiaries.

‘Numeracy project’

The project aimed to improve numeracy skills in adults of working age through working with a volunteer ‘Challenge Coach’. However, the project was abandoned as it was not delivering any impact.





9

Priority 4: Intervening earlier

Completed research

- Safeguarding reviews and investigations for children's and adults' safeguarding boards
- Better Care population needs and demand profiling

Current research

- Better Care population needs and demand profiling
- How community safety partners can work together to reduce demand and cost for intensive specialist services currently supporting individuals with complex needs

Planned research

- Research to support the Hampshire and Isle of Wight Sustainability and Transformation Plan and the local Health and Care Plan to be defined
- Development of intelligence to support Portsmouth Adult Safeguarding Board

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

Portsmouth's boards for safeguarding children and adults are responsible for scrutinising and challenging safeguarding arrangements. Some outcomes are not quantifiable and some may not be solely influenced by the workstream's actions (eg increases in the number of incidents of harm may be due to increased public awareness and reporting). The Annual Reports of Portsmouth Safeguarding Adults and Safeguarding Children Boards were reported to the Health and Wellbeing Board in December 2015 (agenda items 4 and 5)⁸³.

Priority 4b Deliver NHS Portsmouth CCG strategic priorities

NHS Portsmouth CCG strategic priorities are reported to the CCG Board.

Priority 4c Improve the quality of dementia services and care

Dementia continues to be a national and local priority. Key aims of the workstream are to increase the proportion of people identified with dementia and provide the right support at the right time. The key outcome measure is, by March 2015, to increase the diagnosis rate to 80% of the population predicted to have dementia. As a proxy for this measure, between 2012/13 and 2014/15, the prevalence of local people with diagnosed dementia increased from 0.68% of all registered patients to 0.71% of all registered patients. The local rate of diagnosed dementia is increasing but at a slower rate than that of England. ([Appendix 4](#))

Priority 5: Reduce inequality



Completed research:

- Destinations of Portsmouth school leavers (Year 11), 2015⁸⁴
- Confidential audits of death by suicide, 2013-2015(part)

Current research

- Rapid Participatory Needs Appraisals to inform the development of the Wellbeing Service, and community development in Paulsgrove and Wymering, Fratton and Charles Dickens

Planned research

- Confidential audit into suicide deaths in October to December 2015
- Creative industries in the city (Economic Development, Culture and Leisure Scrutiny Panel)
- Rapid participatory appraisals summary and implications, Director of Public Health Report, 2016

Priority 5a Implement 'Tackling Poverty Strategy'

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

The Tackling Poverty Needs Assessment was refreshed in January 2015 in the light of the recession and changes in the welfare system. The needs assessment identifies the multiple factors which adversely and positively affect poverty including educational outcomes, employment and low-pay employment, financial exclusion and debt and the way services are organised to respond to people in crisis⁸⁵. The Tackling Poverty Strategy sets out its own direct and indirect outcome measures⁸⁶.

The Joint Health and Wellbeing Strategy baseline outcome measures look at poverty experienced by children, working-age adults and older people. (**Appendix 4**)

The Acting Tackling Poverty Co-ordinator is responsible for the delivery of the Tackling Poverty Strategy Action Plan, with support from the Tackling Poverty Steering Group. The Group meets quarterly, with each meeting looking at a theme from the Action Plan. The July 2016 meeting focussed on employment; in October the group will focus on financial resilience (including the role of digital inclusion).

Current priorities for the Action Plan include re-commissioning a social welfare advice service for Portsmouth (Advice Portsmouth's contract expires in March 2017); responding to welfare reform (including the introduction of Universal Credit and the reduced Household Benefit Cap); and supporting access to resources for people in financial hardship, following the closure of the Local Welfare Assistance Scheme.

⁸³ Health and Wellbeing Board Agenda papers, 2 December 2015. <http://democracy.portsmouth.gov.uk/ieListDocuments.aspx?CId=150&MIId=3326&Ver=4> Accessed 15 September 2016

Austerity presents significant challenges to tackling poverty. Research by the Centre for Regional Economic and Social Research found that by 2020/21, the programme of welfare reforms implemented since 2010 will have led to a reduction of income in Portsmouth of £95 million per year, equivalent to £670 per year for every working age adult. The research also identified the uneven impact of welfare reform across England, which is reflected in Portsmouth, where the greatest adverse impact is in the areas of highest deprivation⁸⁷.

The confidential audits of deaths by suicide 2013-2015(part) identified potentially adverse life events affecting individuals before their death – bearing in mind that individual cases are complex and it is impossible to reduce suicide events to a single cause. Many people experienced more than one potentially adverse life event. The audits found that 39% of males and 25% of females were unemployed or were worried about employment, and 24% of males and 26% of females had finance worries. The audit cited a Royal College of Psychiatrists’ report on the relationship between debt and mental health: people in debt are more likely to have mental health problems, and people with mental health problems are more likely to be in debt. One in two adults with debts has a mental health problem; and one in four people with a mental health problem is in debt⁸⁸. However, the relationship between mental health and debt is complex and one does not inevitably lead to the other. Jenkins et al (2009) make recommendations about all agencies’ “Making Every Contact Count”, and co-ordinated activity across health, money advice and creditor organisations⁸⁹:

“Firstly, all health and social care professionals should ask patients about financial difficulties in routine assessments. Secondly, where debt is reported, primary care professionals should routinely assess for depression and other common mental disorders. Thirdly, these actions depend upon health and social care professionals having the time, knowledge and confidence to ask about patient finance. ... Professionals should receive basic ‘debt first aid’ training: knowing how to talk with patients about debt; knowing how to refer to, and support, debt counsellors, but without being expected to become ‘debt experts’ themselves.”⁹⁰ These national recommendations are reflected in the city’s Tackling Poverty Strategy⁹¹.

The audit recommended that all agencies should contribute to achieving the actions in the city’s Tackling Poverty Strategy. The Mental Health Strategy should link to the Tackling Poverty Strategy for activities linking mental health, health, money advice and creditor organisations.

The focus of the welfare reforms has been to increase employment, and number of people claiming Jobseekers Allowance has dropped significantly, since their peak following the 2008 financial crisis and subsequent recession. However, this masks those who have exited the welfare system due to increased conditionality, and rising levels of in-work poverty, caused by low pay, insecure work, and under-employment, where people cannot get

⁸⁴ Portsmouth City Council, Autumn 2015. Year 11 activity survey, Portsmouth. <http://data.hampshirehub.net/data/destinations-of-portsmouth-school-leavers-year-11-2015-report> Accessed 22 September 2016

⁸⁵ Portsmouth City Council, 2015. Tackling poverty needs assessment. <http://data.hampshirehub.net/data/jsna/portsmouth-jsna/social-and-environmental-context/poverty-and-deprivation/tackling-poverty-needs-assessment> Accessed 26 October 2015

⁸⁶ Portsmouth City Council. Tackling poverty strategy 2015-2020. <http://data.hampshirehub.net/data/tackling-poverty-strategy-2015-2020> Accessed 26 October 2015

enough hours of work to meet their needs. The National Living Wage (the increased minimum wage for over 25s) was a policy to address the issue of low pay. However, in-work poverty is an area where there is a lack of data at a local level. Further understanding is required on pay, hours and progression for residents in low paid work.

Some groups are more vulnerable to low pay and poverty, and further research is required to understand how Portsmouth residents are affected, and how they can be assisted. This includes self-employed people, people with health and care plans or disabilities and black, minority ethnic and refugee communities.

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

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

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

Priority 5c Address issues raised in the Public Health Annual Report

This workstream picks up issues raised by the Director of Public Health’s statutory Annual Report. The 2012 Report focused on men’s health⁹². The report recommended that improving men’s health should be a specific strategic aim for the Health and Wellbeing Board as well as for all city-wide strategic decisions.

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

The local Health and Lifestyle Survey found that men are more likely than women to:

- see themselves as fit/very fit (37% compared to 23% of women)
- be physically active (28% do more than 75 minutes of vigorous activity a week, compared to 14% of women)

87 Sheffield Hallam University Centre for Regional Economic and Social Research (for Oxfam and the Joseph Rowntree Foundation), March 2016. The uneven impact of welfare reform: The financial losses to people and places. www4.shu.ac.uk/research/crest/sites/shu.ac.uk/files/welfare-reform-2016.pdf Accessed 15 September 2016

88 Royal College of Psychiatrists. Health advice, debt and mental health. www.rcpsych.ac.uk/healthadvice/problemsdisorders/debtandmentalhealth.aspx Accessed 2 March 2016

89 Jenkins R, Fitch C, Hurlston M, Walker F. Recession, debt and mental health: challenges and solutions. *Mental health in family medicine* 2009 Jun; 6(2): 85-90 www.ncbi.nlm.nih.gov/pmc/articles/PMC2777607/ Accessed 2 March 2016

90 HM Government Foresight Review of Mental Capital and Wellbeing summarised in Jenkins R et al, 2009. Ibid

91 Portsmouth City Council. Tackling Poverty Strategy 2015-2020. <http://data.hampshirehub.net/data/tackling-poverty-strategy-2015-2020> Accessed 9 March 2016

-
- be overweight or obese (57% compared to 47% of women)
 - smoke (20% compared to 15% of women)
 - be high-risk drinkers (20% compared to six per cent of women)
 - have taken drugs in the last 12 months (10% compared to four per cent of women)

Since the 2012 Report, life expectancy levels for both males and females are significantly shorter than the national average.

Impact of selected Joint Health and Wellbeing Strategy outcomes



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



12

Developing the new Joint Health and Wellbeing Strategy

The current Joint Health and Wellbeing Strategy will end in 2017. The Health and Wellbeing Board will need to consider how best to develop a new strategy including how best to take account of stakeholder and community views.

12.1 Key issues

There has been much research activity over the past four years. Key issues for health and social care from the Joint Strategic Needs Assessment are:

Child, adolescent and adult mental health (including social isolation)

- ensuring that multi-factorial research uncovers the 'causes of the causes' of mental ill health, as it affects different age groups, genders and people living in different areas of the city

Adult lifestyles

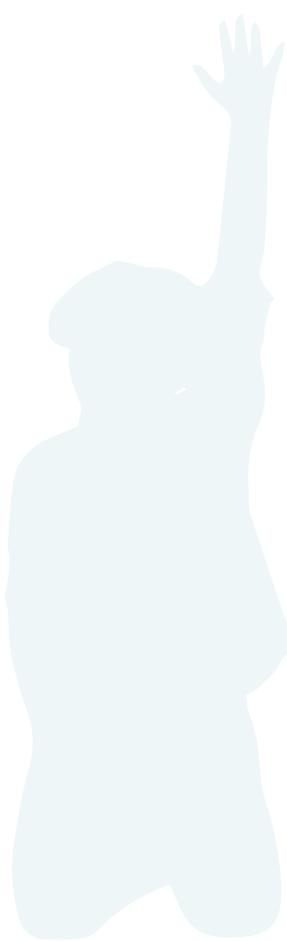
- particularly physical inactivity, unhealthy diets, drinking alcohol to excess, smoking – with a significant proportion of adults exhibiting more than one unhealthy behaviour
- ... which adversely contributes to the health inequalities of those living in Portsmouth's more deprived areas
- ... and affects the predicted poor long-term health of those currently of middle age (35 to 64 years) living anywhere in the city
- ... especially where adult behaviours impact negatively on children from pregnancy onwards (eg smoking in pregnancy, offering unhealthy food, snacks and drinks, not taking children to dental and other health appointments, experiencing or witnessing domestic abuse)

The economy

- improving attendance at school and improving education outcomes will give young adults more options for continuing their education, training or finding a job
- helping people with physical and/or mental health conditions into employment, or back into employment will reduce inequalities
- implementing the Tackling Poverty strategy and action plan will reduce inequalities and improve wellbeing by taking individuals and families out of poverty

The environment

- taking advantage of the development of the City Plan and Public Realm Strategy as means of promoting physical activity through increased walking and cycling, public spaces to facilitate community cohesion etc



A cross-cutting theme is:

Parenting – how to support parents and foster parents was the key research question from the Knowledge Summits. However, momentum was lost and it was not sufficiently explored in subsequent pieces of research

12.2 Recommendations

The research function

We need 'research' to be better co-ordinated – two actions in the Portsmouth Blueprint are “Single approach to planning and commissioning” and “Joint approach to business and public health intelligence”⁹³.

To inform these two workstreams, organisations should work together to develop a research programme, which defining research topics and questions (focussing on 'causes of the causes' rather than single issues) and agree how multi-agency resources (people, software) can be most efficiently and effectively allocated

Research problems

To support implementation of the Portsmouth Health and Care Plan, it is recommended that the Health and Wellbeing Board prioritises resolution of how anonymised or pseudonymised data can legally be shared between local health providers, the CCG, the Commissioning Support Unit and various departments in the local authority. (See page 5)

Recommendations for research topics from this year's Annual Summary

In addition to the proposed planned research (Appendix 2), it is recommended that further research is needed into the:

- The reasons behind differential education outcomes for different ethnic communities, for boys compared to girls, for children with SEN compared to other children (See pages 21 – 22 and Appendix 4)
- Most effective ways to promote breastfeeding (See pages 21 – 22 and Appendix 4)
- Reasons for children and young people with SEND being more likely than other children to be absent from school, excluded from school and have poorer educational attainment, and what are the most effective ways to improve outcomes for children and young people with SEND (See pages 22 – 24)
- Most effective ways to support teenagers to improve resilience (See pages 24 – 29)

We also need to find out which online resources are most effective at promoting behaviour change, and how we can provide the same sort of support to people who cannot access the internet. (See page 42)

Continuing research need is to understand how the needs of people with complex needs can escalate and what interventions are most effective in reducing future demand for services. This applies to both adults and children (Transformation Plan and Stronger Futures). (See pages 43 – 45)

Some groups are more vulnerable to low pay and poverty, and further research is required to understand how Portsmouth residents are affected, and how they can be assisted. This includes self-employed people, people with health and care plans or disabilities and black, minority ethnic and refugee communities. (See pages 49 – 51)

93 Portsmouth City Council. Health and Wellbeing Board, 2 December 2015. Developing the Portsmouth Blueprint. <http://democracy.portsmouth.gov.uk/documents/s9578/Blueprint%20for%20HWB.pdf> Accessed 27 September 2016

Appendix 1: Research to implement the Joint Health and Wellbeing Strategy, 2013/14 to 2014/5



Overall

“Knowledge Summits” held in January, February, November 2014. Identified ‘Parenting’ as key cross-cutting issue for Health and Wellbeing, Children’s Trust and Safer Portsmouth Partnership⁹⁴

Intelligence to support Equality and Diversity Strategy⁹⁵

Profiles of North, Central and South localities, and of electoral wards⁹⁶

Index of Multiple Deprivation 2015 – resources updated on JSNA website

Refresh of Portsmouth Information Sharing Framework⁹⁷ – agreed by Children’s Trust, Safer Portsmouth Partnership and Joint Health and Wellbeing Board

Priority 1 – Best start

Annual ‘You Say’ surveys of pupils in secondary schools⁹⁸

Portsmouth survey of children and young people: Measuring their wellbeing (Children’s Society)⁹⁹

Health and wellbeing needs of looked after children (also subject of review by Education, Children and Young People’s Scrutiny Panel)¹⁰⁰

Health and wellbeing needs of young offenders

Profile of children with speech, language and communication needs¹⁰¹

“Are there effective peer-led interventions aimed at primary school aged children and / or evidence of peer-led intervention for the promotion of mental and emotional well-being?”

Evidence review to show where guidance is supportive of Occupational Therapy Sensory Integration in children with Special Educational Needs (SEN)

Review of home to school transport and access to primary school places (Education, Children and Young People Scrutiny Panel)¹⁰²

“What are the most effective interventions for weight management targeting children who are currently or likely to be obese (ie overweight) either at the time of the universal health checks aged 1 year and 2 ½ years, or more generally before the age of 5? Do these interventions suggest a best practice delivery method (1-2-1, group, drop-in etc) or which professionals are best placed to deliver them? What should be our key messages to parents of children aged 0-5?”

Evidence for interventions which encourage pregnant women to stop smoking

Review of school nursing service

- 94 Portsmouth City Council Knowledge Summit, February 2014. <http://data.hampshirehub.net/data/jsna/portsmouth-jsna/presentations/partnership-boards-priorities-update-linked-research-programme> Accessed 30 September 2016
- 95 Portsmouth City Council. Equality and Diversity. www.portsmouth.gov.uk/ext/community-and-environment/community/equality-and-diversity.aspx Accessed 20 September 2016
- 96 Hampshire County Council and Portsmouth City Council. Locality profiles and electoral ward summaries: <http://data.hampshirehub.net/def/concept/folders/themes/jsna/portsmouth-jsna/jsna-and-ward-summaries-and-outcome-frameworks/electoral-ward-summaries> Accessed 20 September 2016
- 97 Portsmouth City Council. Information sharing framework, revised February 2016. <http://data.hampshirehub.net/def/concept/folders/themes/jsna/portsmouth-jsna/jsna-background-information-sharing-framework-and-technical-information/information-sharing-framework> Accessed 27 July 2016
- 98 Portsmouth City Council. You say survey of secondary school pupils, 2015. <http://data.hampshirehub.net/def/concept/folders/themes/jsna/portsmouth-jsna/children-and-young-people/lifestyles> Accessed 20 September 2016
- 99 Children's Society for Portsmouth City Council. Survey of children and young people: measuring their wellbeing, 2014. <http://data.hampshirehub.net/def/concept/folders/themes/jsna/portsmouth-jsna/children-and-young-people/lifestyles> Accessed 20 September 2016
- 100 JSNA website Children and young people: Health and wellbeing: Looked after children. <http://data.hampshirehub.net/def/concept/folders/themes/jsna/portsmouth-jsna/children-and-young-people/health-and-wellbeing/looked-after-children> Accessed 20 September 2016
- 101 Portsmouth City Council, 2013. Speech, language and communication health needs assessment for children and young people. <http://data.hampshirehub.net/def/concept/folders/themes/jsna/portsmouth-jsna/children-and-young-people/health-and-wellbeing/speech-language-and-communication> Accessed 20 September 2016
- 102 Portsmouth City Council Cabinet meeting papers, 9 June 2016. <http://democracy.portsmouth.gov.uk/ieListDocuments.aspx?Cid=126&Mid=3402&Ver=4>

Priority 2 – Promoting prevention

Series of seminars 'Building a healthier city', autumn 2014¹⁰³

Annual Public Health Report 2014: Building a healthier city¹⁰⁴

Consideration of options for, and improvements and variations to, Portsmouth's public transport system (Traffic, Environment and Community Safety Scrutiny Panel)

Safer Portsmouth Partnership annual crime and anti-social behaviour assessments and associated research¹⁰⁵

Profile of fires in dwellings, Hampshire, 2013¹⁰⁶

"What key or interesting research is there linking housing and health from a public health point of view?"

South Hampshire Strategic Housing Market Assessments¹⁰⁷

Research to support Travel Active Portsmouth: A walking and cycling strategy, 2013 to 2023¹⁰⁸

Scoping project – health and wellbeing needs of city council housing tenants

Promoting integration of recent migrant communities from non-EU countries (EU-funded Gateway project)¹⁰⁹

Reported road casualties, 2010-2014¹¹⁰

Road safety around schools – investigation by the Traffic, Environment and Community Safety Scrutiny Panel¹¹¹

Profiles of neighbourhoods especially Somerstown, Paulsgrove and Wymering, Portsea, Fratton to inform development of the Wellbeing Service

Health needs of people who are homeless¹¹²

Review of health services for people who are homeless

Portsmouth Food System Review¹¹³

Intelligence to support development of Healthy Weight Strategy¹¹⁴

Healthy Walks programme – social return on investment¹¹⁵

“Which interventions (in particular, those targeting physical activity) for substance misuse have the most lasting impact on physical and mental health outcomes, and best avoid relapse?”

Research into cumulative impact zones to inform Licensing Policy

“Are there any papers on alcohol minimum pricing per unit, from both a health and ethical/moral perspective?”

Alcohol licensing – is there a correlation / detrimental cumulative impact between the density of premises licensed to sell alcohol and consumption? What is the effectiveness of Cumulative Impact Zones?

Liver health in Portsmouth¹¹⁶

“What are the best practice models for (a) the non-weight-bearing pathway; (b) community nursing service?”

Sexual health needs assessment¹¹⁷ to inform Sexual health and wellbeing strategy 2014-19¹¹⁸

Pharmaceutical needs assessment, 2015 (statutory)¹¹⁹

How the unscheduled care system deals with people with mental health, alcohol and substance misuse problems

Priority 3 – Supporting independence

Better Care population needs and demand profiling

Review of carers’ services in Portsmouth, 2013¹²⁰

Intelligence to support development of the Carers’ Strategy, 2015-2020¹²¹

“What interventions are found in high performing frail elderly care systems, including strategies for case management and risk stratification?”

“What are the most effective models of care for older people’s mental health?”

Review of continence services

Additional analysis of reasons behind Portsmouth’s comparatively high rate of older people falling¹²²

“With reference to people with long-term conditions (particularly diabetes and COPD), what self-care/self-management/peer support interventions are effective for issues relating to mental well-being? What other lower-level support has been shown to be effective before those issues become more pronounced and counselling via IAPT becomes an option? Are there examples of best practice / accessible models of care elsewhere in the country?”

Advancing the use of technology in ASC (Telecare and Telehealth) (Housing and Social Care Scrutiny Panel)¹²³

103 Portsmouth City Council. All ‘Building a healthier city’ presentations accessed via Slideshare. www.slideshare.net/JoannaKerr/

104 Director of Public Health, Portsmouth City Council and NHS Portsmouth CCG. Building a healthier city, Public Health Annual Report, 2014 <http://data.hampshirehub.net/data/building-a-healthier-city--public-health-annual-report-2014> Accessed 20 September 2016

105 Safer Portsmouth Partnership. www.saferportsmouth.org.uk/home/our-research/ Accessed 20 September 2016

106 Hampshire Fire and Rescue Service, 2013. Profile of fires in dwellings, Hampshire. <http://data.hampshirehub.net/data/jsna/portsmouth-jsna/social-and-environmental-context/community-safety/profile-of-fires-in-dwellings-hampshire-2013> Accessed 20 September 2016

107 Partnership for Urban South Hampshire. South Hampshire Strategic Housing Market Assessments. www.push.gov.uk/work/housing-and-planning/strategic_housing_market_assessment.htm Accessed 20 September 2016

108 Portsmouth City Council. Travel active Portsmouth: a walking and cycling strategy, 2013-2023. <http://data.hampshirehub.net/data/jsna/portsmouth-jsna/social-and-environmental-context/transport/travel-active-portsmouth-a-walking-and-cycling-strategy-2013-to-2023> Accessed 20 September 2016

109 Prof G Lister for Portsmouth City Council, 2013. European Integration Fund Gateway Baseline review, literature review, interim evaluation report, social return on investment tool. <http://data.hampshirehub.net/def/concept/folders/themes/jsna/portsmouth-jsna/the-people-of-portsmouth/ethnicity> . Blog at: <http://portsmouthgateway.wordpress.com/> Accessed 20 September 2016

110 Hampshire Constabulary. Reported road casualties, Portsmouth 2010-2014. <http://data.hampshirehub.net/data/reported-road-casualties-portsmouth-2010-2014> Accessed 20 September 2016

111 Portsmouth City Council, 2015. Road safety around schools: a review by the Traffic, Environment and Community Safety Scrutiny Panel. <http://data.hampshirehub.net/data/reported-road-casualties-portsmouth-2010-2014> Accessed 20 September 2016

112 Portsmouth City Council, 2015. Health needs assessment of homeless people. <http://data.hampshirehub.net/data/health-needs-assessment-of-homeless-people> Accessed 20 September 2016

113 Food Matters for Portsmouth City Council, 2015. Portsmouth Food system review. <http://data.hampshirehub.net/data/portsmouth-food-system-review-april-2015> Accessed 20 September 2016

- 114** Portsmouth City Council. Healthy weight strategy for Portsmouth, 2014-2024. <http://data.hampshirehub.net/data/healthy-weight-strategy-for-portsmouth-2014-2024> Accessed 20 September 2016
- 115** Portsmouth City Council, 2015. Portsmouth healthy walks – social return on investment. <http://data.hampshirehub.net/data/healthy-walks-programme---social-return-on-investment> Accessed 22 September 2016
- 116** Portsmouth City Council, June 2015. Liver health in Portsmouth: a health needs assessment. <http://data.hampshirehub.net/data/liver-health---needs-assessment-june-2015> Accessed 21 September 2016
- 117** Portsmouth City Council, NHS Portsmouth CCG, March 2015. Sexual health needs assessment for Portsmouth city. <http://data.hampshirehub.net/data/1-sexual-health-needs-assessment-2014> Accessed 21 September 2016
- 118** Portsmouth City Council, Sexual health and wellbeing strategy, 2014-2019. <http://data.hampshirehub.net/data/1-sexual-health-strategy-2014-2019><http://data.hampshirehub.net/data/1-sexual-health-strategy-2014-2019> Accessed 21 September 2016
- 119** Portsmouth City Council, 2015. Pharmaceutical needs assessment. <http://data.hampshirehub.net/def/concept/folders/themes/jsna/portsmouth-jsna/services/pharmacies> Accessed 21 September 2016
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- 123** Portsmouth City Council. Cabinet, 7 October 2013. Agenda item 5. Housing and Social Care Scrutiny Panel. Advancing the use of technology in adult social care (Telecare and Telehealth). <http://democracy.portsmouth.gov.uk/ieListDocuments.aspx?Cid=126&MID=2212> Accessed 21 September 2016

Hospital discharge arrangements (Housing and Social Care Scrutiny Panel)¹²⁴

Priority 4 – Intervening earlier

Assessment of the progress made following Portsmouth's review of domestic abuse (Traffic, Environment and Community Safety Scrutiny Panel)¹²⁵

Annual reports of the Portsmouth Safeguarding Children Board

Annual reports of the Portsmouth Safeguarding Adults Board

Priority 5 – Reducing inequality

Tackling poverty needs assessment 2015 to inform Tackling poverty strategy 2015-2020¹²⁶

Pathways into work for young people (Economic development, Culture and Leisure Scrutiny Panel)¹²⁷

Revitalising Portsmouth's local high streets and secondary shopping areas (Economic development, Culture and Leisure Scrutiny Panel)¹²⁸

Solent Local Enterprise Partnership (LEP) economic outlook¹²⁹

Solent LEP skills strategy evidence base, skills strategy and strategy interim evaluation¹³⁰

Economic impact report of Great South Run on Portsmouth and Southsea¹³¹

“Please find national but preferably local ‘evidence’ about positive or negative impact of employment on health and wellbeing and vice versa including benefits from employer point of view, and benefits from employee point of view.”

Widening student opportunities in the city (Economic Development, Culture and Leisure Scrutiny Panel)¹³²

Appendix 2: Planned research



Includes proposed work programme of Scrutiny Panels agreed by Scrutiny Management Panel, 8 July 2016 <http://democracy.portsmouth.gov.uk/documents/s11812/MIS2815July2016.pdf>

Priority 1 – Best start

- Widening access to extra-curricular activities in schools (Education, Children and Young People Scrutiny Panel)
- Bullying in schools with a particular focus on how to combat online bullying (Education, Children and Young People Scrutiny Panel)
- Safer routes to schools (Education, Children and Young People Scrutiny Panel)

Priority 2 – Promoting prevention

- Rapid participatory appraisals summary and implications, Director of Public Health Report, 2016
- Review of parking and transportation (Traffic, Environment and Community Safety Scrutiny Panel)
- Smart City agenda (Economic Development, Culture and Leisure Scrutiny Panel)
- Housing allocations (Housing and Social Care Scrutiny Panel)
- Veterans health needs assessment
- Research into self-harm
- Confidential audit into deaths by suicide in October to December 2015
- Research to support Safer Portsmouth Partnership strategies and plans

Priority 3 – Supporting independence

- Research to support the Hampshire and Isle of Wight Sustainability and Transformation Plan and the local Health and Care Plan
- Public Health Annual Report, 2016 – results and implications of the rapid participatory appraisals of wellbeing in three areas of the city
- Independent living (Housing and Social Care Scrutiny Panel)

Priority 4 – Intervening earlier

- Research to support the Hampshire and Isle of Wight Sustainability and Transformation Plan and the local Health and Care Plan to be defined
- Development of intelligence to support Portsmouth Adult Safeguarding Board

Priority 5 – Reducing inequality

- Confidential audit into suicide deaths in October to December 2015
- Creative industries in the city (Economic Development, Culture and Leisure Scrutiny Panel)
- Rapid participatory appraisals summary and implications, Director of Public Health Report, 2016

- 124** Portsmouth City Council. Hospital discharge arrangements, Housing and Social Care Scrutiny Panel, December 2014 and response. <http://data.hampshirehub.net/def/concept/folders/themes/jsna/portsmouth-jsna/services/hospital-care> Accessed 21 September 2016
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- 126** Portsmouth City Council. Tackling poverty needs assessment and Tackling poverty strategy 2015-2020. <http://data.hampshirehub.net/def/concept/folders/themes/jsna/portsmouth-jsna/social-and-environmental-context/poverty-and-deprivation> Accessed 22 September 2016
- 127** Portsmouth City Council Economic development, culture and leisure scrutiny panel, 1 April 2014. Agenda item 15. A review of pathways into work for young people, April 2014. <http://democracy.portsmouth.gov.uk/documents/s3558/Pathways%20into%20work%20for%20young%20people%20final%20version.pdf> Accessed 21 September 2016
- 128** Portsmouth City Council, Economic development, Culture and Leisure Scrutiny Panel. Revitalising local high streets and secondary shopping areas in the city, 2015. And Director's Response to the Report. <http://data.hampshirehub.net/def/concept/folders/themes/jsna/portsmouth-jsna/social-and-environmental-context/the-economy-and-employment> Accessed 22 September 2016
- 129** Oxford Economics for Solent LEP, March 2014. Solent LEP economic outlook. http://solentlep.org.uk/uploads/documents/OE_Solent_LEP_report_March_2014.pdf Accessed 22 September 2016
- 130** Solent LEP. Skills for growth webpage http://solentlep.org.uk/strategic_priorities/skills_for_growth Accessed 22 September 2016
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- 132** Portsmouth City Council Cabinet meeting, 9 June 2016. Report of the Economic development, Culture and Leisure Scrutiny Panel: Widening student opportunities in the city. <http://democracy.portsmouth.gov.uk/documents/s11281/EDCL%20Widening%20Student%20Opportunities%20panel%20report.pdf> Accessed 21 September 2016

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Appendix 3: Health profiles of Portsmouth and CIPFA nearest neighbours compared to England, ranked in descending order of deprivation

Indicator	Period	England	Nottingham	Salford	Bolton	Newcastle upon Tyne	Coventry
Deprivation score (IMD 2015)	2015	–	36.9	33.0	28.4	28.3	28.1
Children in low income families (under 16s)	2013	18.6	32.7	26.0	22.4	27.0	23.5
Statutory homelessness	2014/15	0.9	0.3	3.3	0.2	4.8	1.5
GCSEs achieved	2014/15	57.3	42.0	49.2	55.9	56.9	51.2
Violent crime (violence offences)	2014/15	13.5	22.4	12.2	15.0	13.9	13.1
Long term unemployment	2015	4.6	11.1	5.1	7.3	6.5	5.6
Smoking status at time of delivery	2014/15	11.4*	*	14.8	15.1	14.3	12.3
Breastfeeding initiation	2014/15	74.3	71.1	61.8	67.1	68.4	76.9
Obese children (Year 6)	2014/15	19.1	22.5	21.3	19.6	24.2	21.1
Alcohol-specific hospital stays (under 18)	2012/13–14/15	36.6	34.9	72.0	43.1	29.5	42.0
Under 18 conceptions	2014	22.8	32.8	31.3	23.8	34.7	33.8
Smoking Prevalence in adults	2015	16.9	24.0	22.3	18.5	18.6	16.6
Percentage of physically active adults	2015	57.0	55.0	49.5	55.2	55.7	55.8
Excess weight in adults	2012–14	64.6	62.3	65.2	63.2	61.3	62.4
Cancer diagnosed at early stage	2014	50.7	49.6	46.3	51.5	52.8	49.4
Hospital stays for self-harm	2014/15	191.4	225.2	390.5	265.5	225.8	264.3
Hospital stays for alcohol-related harm	2014/15	641	928	924	693	831	767
Recorded diabetes	2014/15	6.4	5.4	6.0	7.9	5.8	6.5
Incidence of TB	2012–14	13.5	18.1	11.1	19.3	14.8	32.5
New sexually transmitted infections (STI)	2015	815	1040	889	590	1023	927
Hip fractures in people aged 65 and over	2014/15	571	640	681	588	655	590
Life expectancy at birth (Male)	2012–14	79.5	77.1	76.7	78.0	77.9	78.6
Life expectancy at birth (Female)	2012–14	83.2	81.6	80.7	81.6	81.9	82.3
Infant mortality	2012–14	4.0	5.7	3.8	4.3	4.1	4.1
Killed and seriously injured on roads	2012–14	39.3	38.6	29.4	28.3	28.2	34.7
Suicide rate	2012–14	10.0	11.1	10.1	10.6	11.8	10.1
Deaths from drug misuse	2012–14	3.4	*	3.8	4.6	6.8	4.0
Smoking related deaths	2012–14	274.8	346.1	393.2	336.7	361.8	285.4
Under 75 mortality rate: cardiovascular	2012–14	75.7	109.5	114.8	98.2	97.8	88.7
Under 75 mortality rate: cancer	2012–14	141.5	170.5	188.8	143.7	175.1	156.7
Excess winter deaths	Aug 2011–Jul 2014	15.6	21.8	9.1	17.9	13.7	16.8

■ Better
 ■ Worse
■ Similar
 Not compared

Source: Public Health England, Health Profiles, 2016

Derby	Sheffield	Bristol	Portsmouth	Southampton	Plymouth	Southend-on-Sea	Brighton and Hove	Medway	North Tyneside	Swindon
27.8	27.6	27.2	27.1	26.9	26.6	24.5	23.4	22.3	21.3	17.9
22.9	23.5	22.6	22.5	22.7	20.1	20.6	17.0	20.8	18.3	15.6
1.7	1.9	0.5	0.5	*	0.3	0.1	2.4	4.4	1.1	0.4
57.6	54.2	51.9	51.1	51.1	49.3	57.6	61.4	56.0	62.2	54.1
15.0	10.4	19.3	23.6	23.5	21.2	17.9	18.8	19.6	8.3	15.3
3.9	8.3	4.0	3.9	2.7	4.0	4.0	2.8	6.0	5.4	2.2
14.4	15.1	11.1	14.7	14.7	10.2	*	6.4	17.9	12.7	12.7
70.2	80.1	82.2	74.6	73.2	70.5	*	87.9	69.1	67.4	76.3
20.8	19.5	20.4	19.1	20.8	18.0	17.0	13.3	19.8	19.1	19.7
36.9	22.1	35.7	37.3	78.0	53.9	36.9	60.0	26.4	61.0	43.1
26.1	27.9	22.1	22.6	29.0	29.6	28.8	28.2	33.2	22.3	20.0
18.7	18.3	18.1	19.8	20.5	20.6	18.8	20.9	22.3	18.0	18.7
58.3	54.2	62.2	60.5	54.2	56.2	56.3	68.4	53.3	53.6	56.4
64.8	63.2	56.9	63.2	62.2	62.4	66.8	52.4	66.8	67.4	69.5
43.0	49.3	54.8	53.8	46.1	51.2	53.5	47.3	44.6	49.4	52.9
263.6	176.8	292.3	319.8	329.5	246.8	216.5	288.0	110.5	296.1	352.3
774	699	776	599	709	671	600	613	434	1028	674
7.1	6.2	5.0	5.6	5.5	6.0	6.3	4.1	6.9	6.8	6.9
13.9	16.1	21.6	8.3	14.9	5.7	7.6	8.3	6.4	4.9	10.1
713	594	1024	851	1013	1146	699	1507	712	695	765
478	610	527	611	656	542	640	624	607	663	551
78.3	78.9	78.4	78.2	78.2	78.5	79.6	79.0	78.7	77.8	79.5
82.7	82.5	82.9	82.2	83.1	82.5	83.1	83.5	82.2	82.7	83.0
5.0	4.4	3.4	2.9	2.8	4.6	4.0	4.3	3.4	3.6	2.6
34.9	31.8	28.4	54.0	49.1	27.0	37.9	55.5	20.2	24.1	33.2
10.4	9.8	11.7	13.0	14.8	12.7	9.0	13.4	11.4	12.3	12.0
5.3	4.6	5.0	7.1	4.4	4.9	4.7	7.2	5.2	*	3.9
295.3	291.4	290.6	332.9	321.1	310.8	286.5	305.0	319.1	345.7	284.4
84.9	83.7	85.4	103.4	92.8	86.2	85.6	72.1	77.2	80.9	81.9
148.1	154.9	153.6	163.2	158.8	155.4	140.8	152.6	161.5	172.1	142.2
20.4	11.8	13.2	21.9	14.5	12.8	15.9	14.0	15.7	11.2	9.6

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Appendix 4: Outcome measures in the Joint Health and Wellbeing Strategy

Workstreams	Outcome measure	Portsmouth Strategy baseline (Yr)	Latest England	Latest Portsmouth	Latest Portsmouth compared to England	City trend	Yearly city action to match England average
	Increasing life expectancy for males	78.2 yrs (2010/12)	79.5 yrs	78.2 yrs	Significantly shorter than England	Static	
Overall priority							
	Increasing life expectancy for females	82.6 yrs (2010/12)	83.2 yrs	82.2 yrs	Significantly shorter than England	Static	
1 Give children and young people the best start(*)							
	Smoking in pregnancy (% of women giving birth who have smoked throughout pregnancy)	15.4 (2013/14)	10.6%	12.7%	Significantly higher	Improving	56 fewer women smoking during pregnancy
	Breastfeeding within 48 hrs of baby's birth	66.0% (2013/14)	74.3%	74.6%	Higher	Improving	Need to maintain high level
	Breastfeeding at 6-8 weeks (% of women breastfeeding at the time of the baby's 6-8 week check)	38.9% (2013/14)	43.8%	38.9%	Cannot compare – different methodologies	No change	Need to improve 6-8 wk rate. Baseline to be set.
1a. Improve outcomes for the pre-birth to 5 years age group							
	Early Years Foundation Stage: Meeting at least Expected Level in Communication and language – overall	75% (2013)	80%	81%	Higher	Improving	Achievement continues to be higher than England average – need to maintain level
	Boys	67% (2013)	75%	74%	Lower	Improving	4 more boys to match England average
	Girls	82% (2013)	86%	88%	Higher	Improving	Achievement continues to be higher than England average – need to maintain level
	Early Years Foundation Stage: Meeting at least Expected Level in Personal, social, emotional development – overall	80% (2013)	84%	85%	Higher	Improving	Achievement continues to be higher than England average – need to maintain level

NB Values in this table are as calculated. Rounded values shown in JSNA Summary text

(*) Reported to Children's Trust

(**) Reported to Safer Portsmouth Partnership

(***) Reported to NHS Portsmouth Clinical Commissioning Group. Although the measures for the CCG specific Workstream concern adult age groups, CCG priorities concerning children and young people are reflected in other Workstreams

Locality values			Actions or issues			Specific issues	Source
North	Central	South	North	Central	South		
79.5 yrs (2013-15)	75.8 yrs (2013-15)	77.8 yrs (2013-15)	Decrease compared to 2012-14 (but not significantly)	Central significantly shorter life expectancy at birth than North and South. Decrease compared to 2012-14 (but not significantly)	Decrease compared to 2012-14 (but not significantly)	Males in most deprived 10% of LSOAs live 10.2 yrs fewer than males in least deprived (0.7 yrs higher than 2011-13)	National and city data: ONS. 2012/14 Locality data: Primary Care Mortality Database via Public Health Mortality File, 2013-15
83.3 yrs (2013-15)	80.4 yrs (2013-15)	82.9 yrs (2013-15)	Static compared to 2012-14	Central significantly shorter life expectancy at birth than North and South. Decrease compared to 2012-14 (but not significantly)	Increase compared to 2012-14 (but not significantly)	Females in most deprived 10% of LSOAs live 5.8 yrs fewer than females in least deprived (0.2 yrs lower than 2011-13).	
		Not yet available at locality level				Teenage mothers have higher rates of smoking during pregnancy 4% of Portsmouth women had an 'Unknown' smoking status"	HSCIC. 2015/16
		Not available at locality level				Lower rates for mothers from lower socio-economic status groups	HSCIC. For CCG localities. 2014/15
		Not available at locality level				Lower rates for mothers from lower socio-economic status groups Data for breastfeeding prevalence at 6-8 weeks did not meet validation criteria in 2013/14 and 2014/15; criteria includes breastfeeding status' not known' must be below 5%. Recommended that provider improves data quality.	HSCIC. For CCG localities. 2014/15
83.4%	81.0%	79.7%	Achievement above England average – need to maintain level		3 more pupils to match England average		
76.6%	75.1%	73.1%	Achievement above England average – need to maintain level	Achievement in line with England average – need to maintain level	5 more boys to match England average	Gender differences – boys have lower outcomes than girls. Gap widened between 2014 and 2015.	DfE Statistical First Release 2015 and Education Information Services GIS Analysis
90.0%	87.4%	87.0%	Achievement above England average – need to maintain level				
86.9%	85.1%	81.8%	Achievement above England average – need to maintain level		12 more pupils to match England average		

Workstreams	Outcome measure	Portsmouth Strategy baseline (Yr)	Latest England	Latest Portsmouth	Latest Portsmouth compared to England	City trend	Yearly city action to match England average
continued.... 1a. Improve outcomes for the pre-birth to 5 years age group	Early Years Foundation Stage: Meeting at least Expected Level in Personal, social, emotional development – overall	80% (2013)	84%	85%	Higher	Improving	Achievement continues to be higher than England average – need to maintain level
	Boys	73% (2013)	78%	77%	Lower	Worsened since 2014 but still higher than 2013	13 more boys to match England average
	Girls	87% (2013)	89%	92%	Higher	Improving	Achievement continues to be higher than England average – need to maintain level
1b. Support delivery of 'Effective Learning for every Pupil Strategy'	Pupil absence: Overall absence - % sessions missed	"5.3% (2013/14)"	4.6%	5.3%	Worse	Static	
	Pupil absence: Persistent absentees – % PA enrolments (old methodology 15% absence – pupil is PA if they miss 56 or more sessions)	5.3% (2013/14)	3.7%	5.0%	Worse	Improving	302 fewer PA pupils to match England average
	Pupil absence: Persistent absentees – % PA enrolments (new methodology 10% absence – pupil is PA if they miss 10% or more of their own possible sessions)	14.4% (2014/15)	11.0%	14.4%	Worse	N/A	785 fewer PA pupils to match England average
	Reading – % pupils making at least expected levels of progress between Key Stage 1 and Key Stage 2	82% (2013)	91%	87%	Lower	Worsened since 2014 but still higher than 2013	70 more pupils making at least expected progress
	Writing – % pupils making at least expected levels of progress between Key Stage 1 and Key Stage 2	88% (2013)	94%	93%	Lower	Improving	16 more pupils making at least expected progress
	Maths – % pupils making at least expected levels of progress between Key Stage 1 and Key Stage 2	84% (2013)	90%	88%	Lower	Improved 2009-2015 (although remained same 2012-2013)	42 more pupils making at least expected progress
	KS 2 results (Level 4+ in Reading/Writing/Maths) – overall	69.8% (2013)	80%	78%	Lower	Improving	44 more pupils achieving Level 4+ Reading/Writing/Maths
	Boys	66% (2013)	78%	74%	Lower		35 more boys achieving Level 4+ Reading/Writing/Maths
	Girls	74% (2013)	83%	81%	Lower	Improving	20 more girls achieving Level 4+ Reading/Writing/Maths
	English – % pupils making at least expected levels of progress between Key Stage 2 and Key Stage 4	65.3% (2014)	71.3%	65.7%	Lower	Improving	93 more pupils making at least expected progress
	Maths – % pupils making at least expected levels of progress between Key Stage 2 and Key Stage 4	59.6% (2014)	67.0%	62.4%	Lower	Improving	78 more pupils making at least expected progress
	5 GCSE A* to C grades incl English and Maths – all pupils	50.8% (2014)	57.3%	50.7%	Lower	Static	112 more pupils achieving 5+ A*-C including English and Maths
	Boys	47.5% (2014)	52.7%	46.4%	Lower	Improving	54 more boys achieving 5+ A*-C including English and Maths
Girls	54.3% (2014)	62.1%	55.1%	Lower	Worsening	58 more girls achieving 5+ A*-C including English and Maths	
1c. Understand more about emotional wellbeing of children and young people	Outcome measures to be determined within Mental Health Strategy (Workstream 2b)						

2 Promoting prevention

Locality values			Actions or issues			Specific issues	Source
North	Central	South	North	Central	South		
86.9%	85.1%	81.8%	Achievement above England average – need to maintain level		12 more pupils to match England average	Gender differences – boys have lower outcomes than girls. Gap widened between 2014 and 2015.	DfE Statistical First Release 2015 and Education Information Services GIS Analysis
79.2%	78.4%	74.9%	Achievement above England average – need to maintain level		11 more boys to match England average		
94.5%	92.2%	89.4%	Achievement above England average – need to maintain level		Achievement in line with England Average – need to maintain level		
Not yet available at locality level							
Not yet available at locality level						Some pupils may be counted more than once (if they moved schools during the academic year or are registered in more than one school)	DfE Statistical First Release 2015 and Education Information Services Analysis
Not yet available at locality level							
87.9%	85.1%	90.3%	23 more pupils to match England average	38 more pupils to match England average	3 more pupils to match England average	Inequalities in outcomes experienced by pupils with SEND. See SEND Needs Assessment for more information	DfE Statistical First Release 2015 and Education Information Services GIS Analysis
93.5%	91.6%	95.1%	4 more pupils to match England average	15 more pupils to match England average	Achievement above England average – need to maintain level		
88.1%	87.1%	88.3%	15 more pupils to match England average	19 more pupils to match England average	8 more pupils to match England average		
82.4%	72.2%	77.7%	Achievement above England average – need to maintain level	52 more pupils to match England average	11 more pupils to match England average	Gender differences – boys have lower outcomes than girls Inequalities in outcomes experienced by pupils with SEND. See SEND Needs Assessment for more information	DfE Statistical First Release 2015 and Education Information Services GIS Analysis
78.2%	67.5%	77.4%	Achievement in line with England average – need to maintain level	35 more boys to match England average	1 more boy to match England average		
86.4%	76.8%	77.9%	Achievement in line with England average – need to maintain level	21 more girls to match England average	13 more girls to match England average		
64.6%	66.0%	67.8%	43 more pupils to match England average	33 more pupils to match England average	13 more pupils to match England average	Inequalities in outcomes experienced by pupils with SEND. See SEND Needs Assessment for more information	DfE Statistical First Release 2015 and Education Information Services GIS Analysis
69.3%	57.5%	59.0%	Achievement above England average – need to maintain level	59 more pupils to match England average	29 more pupils to match England average		
51.9%	48.6%	51.9%	35 more pupils to match England average	56 more pupils to match England average	20 more pupils to match England average	Gender differences – boys have lower outcomes than girls, gap has widened between 2014 and 2015. Also, inequalities in outcomes experienced by pupils with SEND. See SEND Needs Assessment for more information	DfE Statistical First Release and Education Information Services GIS Analysis
45.1%	47.2%	46.7%	26 more boys to match England average	18 more boys to match England average	11 more boys to match England average		
59.7%	50.0%	56.9%	7 more girls to match England average	39 more girls to match England average	10 more girls to match England average		
Measures to be determined by Mental Health Alliance							

Workstreams	Outcome measure	Portsmouth Strategy baseline (Yr)	Latest England	Latest Portsmouth	Latest Portsmouth compared to England	City trend	Yearly city action to match England average
	Walking and cycling becoming the travel 'norm' for short trips Walking and cycling to work	23.4	12.6	N/A	N/A	N/A	Already higher than England
	Childhood obesity – Year R (% resident children who are overweight including obese)	23.8% (2010/11-2012/13)	22.2%	23.4%	Higher	Improving	26 fewer children of excess weight
2a. Create sustainable healthy communities	Boys (% resident boys equal to or above 85th centile of UK90 growth reference)	24.1% (2012/13)	22.6%	21.9%	Lower	Improving	
	Girls (% resident girls equal to or above 85th centile of UK90 growth reference)"	23.8% (2012/13)	21.2%	24.1%	Higher	Worsening	
	Childhood obesity – Year 6 (% resident children who are overweight including obese)	35.3% (2010/11-2012/13)	33.4%	34.1%	Higher	Improving	13 fewer children of excess weight
	Boys (% resident boys equal to or above 85th centile of UK90 growth reference)	36.7% (2012/13)	34.9%	34.1%	Lower	Improving	
	Girls (% resident girls equal to or above 85th centile of UK90 growth reference)"	33.7% (2012/13)	31.5%	33.4%	Higher	Worsening	

Locality values			Actions or issues			Specific issues	Source
North	Central	South	North	Central	South		
16%	27%	27%	Additional 7.4% of people required to walk or cycle to work	Already higher than England and city rates	Already higher than England and city rates	Census 2011 used pending results of University of Portsmouth study	Census, 2011
23.7% (22.8% in 2011/12 to 2013/14)	25.4% (26.0% in 2011/12 to 2013/14)	20.4% (20.5% in 2011/12 to 2013/14)	About 10 fewer children of excess weight per year to meet England level (North locality is about the same as the Portsmouth average)	About 25 fewer children of excess weight per year to meet England level About 15 fewer 4-5 year olds of excess weight per year to meet Portsmouth average.	Already below England and city averages		England and Portsmouth: National Child Measurement Programme (NCMP) 2012/13 to 2014/15 (three years pooled) via Public Health Outcomes Framework, Public Health England (PHE). Localities: NCMP 2012/13 to 2014/15 (three years pooled) via NCMP enhanced dataset, NHS Digital (Note: Portsmouth State schools only).
22.0%	23.0%	21.1%	Better, but not significantly, than previous year (2013/14)	Better, but not significantly, than previous year (2013/14)	Worse, but not significantly, than previous year (2013/14)		National Child Measurement Programme Enhanced Dataset, Health and Social Care Information Centre. 2014/15 NB Data for boys and girls relates to one year
24.4%	25.2%	21.7%	Worse, but not significantly, than previous year (2013/14)	Worse, but not significantly, than previous year (2013/14)	Worse, but not significantly, than previous year (2013/14)		
32.1% (33.8% in 2011/12 to 2013/14)	38.9% (38.1% in 2011/12 to 2013/14)	31.3% (33.4% in 2011/12 to 2013/14)	Already below England and city averages	About 30 fewer children of excess weight per year to meet England level About 25 fewer 4-5 year olds of excess weight per year to meet Portsmouth average.	Already below England and city averages		England and Portsmouth: National Child Measurement Programme (NCMP) 2012/13 to 2014/15 (three years pooled) via Public Health Outcomes Framework, Public Health England (PHE). Localities: NCMP 2012/13 to 2014/15 (three years pooled) via NCMP enhanced dataset, NHS Digital (Note: Portsmouth State schools only).
30.7%	37.3%	33.5%	Better, but not significantly, than previous year (2013/14)	Worse, but not significantly, than previous year (2013/14)	Worse, but not significantly, than previous year (2013/14)		National Child Measurement Programme Enhanced Dataset, Health and Social Care Information Centre. 2014/15 NB Data for boys and girls relates to one year
32.5%	37.5%	29.2%	The same as the previous year (2013/14)	Worse, but not significantly, than previous year (2013/14)	Worse, but not significantly, than previous year (2013/14)		

Workstreams	Outcome measure	Portsmouth Strategy baseline (Yr)	Latest England	Latest Portsmouth	Latest Portsmouth compared to England	City trend	Yearly city action to match England average
Mental Health Alliance outcomes							
2b. Improve mental health and wellbeing	Prevalence of registered patients aged 18+ yrs, diagnosed and recorded since 2006 as having depression in GP Practices(Prev year data for localities)	5.5% (2012/13)	7.3%	6.4%	Lower	Increasing	Additional 1,662 patients diagnosed with depression – possible under-recognition
	People with mental health conditions in settled accommodation (% of adults in contact with secondary mental health services to live in stable and appropriate accommodation)	57.4% (2013/14)	59.7%	69.6%	Higher	Improving	N/A
2c. Tackle issues relating to smoking, alcohol and substance misuse	Secondary school pupils report never having tried tobacco	82% (2014)	N/A	85.7%	N/A	Improving	N/A
	Secondary school pupils report they have drunk a whole alcoholic drink	53% (2014)	N/A	42%	N/A	Improving	N/A
	Adult smoking prevalence (18+ years)**(*new data source so revised baseline)	24.1% (2012)	16.9% (2015)	19.8% (2015)	Significantly higher	Improving	4,821 fewer adults smoking
	Adult smoking prevalence (smoke daily or occasionally, aged 16+ years)	17.1% (2015)	N/A	N/A	N/A	N/A	N/A
	Drinking alcohol to excess – Reduction in % adults meeting criteria for receiving brief advice or brief advice plus recommended for referral to Wellbeing Service	45% (2015)	N/A	45.0%	N/A	N/A	N/A
	Alcohol misuse – broad measure (**)(Hospital admission episodes for alcohol-related conditions per 100,000 population)	2,012 admissions per 100,000 population (2012/13)	2,139 admissions per 100,000 population	2,021 admissions per 100,000 population	Lower	Improving	N/A
Alcohol misuse – narrow measure (**)(Hospital admission episodes for alcohol-related conditions per 100,000 population)	609 admissions per 100,000 population (2012/13)	641 admissions per 100,000 population	599 admissions per 100,000 population	Lower	Improving	N/A	
3 Supporting independence							
3a. Better Care	Proportion of adult social care users that have as much social contact as they like	41.5% (2013/14)	44.8%	44.5%	Lower	Improving	Already lower than England. Local metric is to increase to 47% in 2015/16 (as this level not achieved in 2014/15)
	Reduction in total general and acute non-elective hospital admissions	19,635 admissions (2013/14)	N/A	19,052 (2015/16)	N/A	Reducing	N/A
	Increase in proportion of older people still at home 91 days after discharge from hospital into rehab services	81.8% (2013/14)	82.1%	76.2%	Lower	Improving	Already lower than England. Local metric is to increase to 83%
	Delayed transfer of care from hospital for 18+ adults per 100,000 population	3.2 per 100,000 population aged 18+ yrs (2013/14)	12.3 per 100,000 people	4.7 per 100,000 people	Lower	Generally increasing trend	Already lower than England. Local metric is to increase to 83%
3b. Explore and develop the Wellbeing Service	Permanent admissions of older people to residential and nursing care per 100,000 population aged 65+ years	747.9 per 100,000 people aged 65+ years (2013/14)	668.8 adults per 100,000 people aged 65+ years	736.3 per 100,000 people aged 65+ years	Higher	Increasing in year	
	Reduction in % of adults with two or more unhealthy behaviours	56.8%	N/A	56.8%	N/A	N/A	N/A

Locality values			Actions or issues			Specific issues	Source
North	Central	South	North	Central	South		
Measures to be determined by Alliance							
5.3% (4.7%)	6.6% (5.8%)	7.0% (6.2%)	Additional 990 patients diagnosed to match England average prevalence Additional 517 patients diagnosed to match Portsmouth average	Additional 434 patients diagnosed to match England average prevalence 94 fewer patients diagnosed to match the Portsmouth average	Additional 238 patients with recorded depression to match England average 422 fewer patients with recorded depression to match Portsmouth average	Portsmouth prevalence likely to reflect under-diagnosis or under-recording in GP Practices	Health and Social Care Information Centre. QOF. For CCG Localities 2014/15
Not yet available at locality level							ASCOF 1H. PHOF 1.06ii Health and Social Care Information Centre. 2014/15 http://ascof.hscic.gov.uk/Outcome
84.9%	84.3%	88.9%	0.8 % points below city average	1.4 % points below city average	Already above city average. Need to maintain		Portsmouth City Council. Secondary school pupil substance misuse survey, 2016
47.6%	41.0%	34.1%	6% points higher than city average	Already below city average. Need to maintain	Already below city average. Need to maintain		Annual Population Survey (APS) via Tobacco Control Profiles. 2016
N/A							Portsmouth Health and Lifestyle Survey of adults, 2015
16.5%	22.6%	13.2%	Already below city average. Need to maintain	5.5% points less	Already below city average. Need to maintain		Portsmouth Health and Lifestyle Survey of adults, 2015
42.0%	41.6%	51.1%	Already below city average. Need to maintain	Already below city average. Need to maintain	10.1% points less		Portsmouth Health and Lifestyle Survey of adults, 2015
Not available at locality level							Local Alcohol Profiles 2016 (data period 2014/15) PHOF 9.01 and 10.01
Not available at locality level							
Not yet available at locality level							ASCOF 1I(1), 2014/15
Not yet available at locality level							Better Care
Not yet available at locality level							ASCOF 2B(i). BCF measure. 2014/15 http://ascof.hscic.gov.uk/Outcome
Not yet available at locality level							ASCOF 2C(1), 2015/16 https://www.england.nhs.uk/statistics/statistical-work-areas/delayed-transfers-of-care/
Not yet available at locality level							ASCOF 2A(2) 2014/15
55.7%	59.5%	55.4%	Already below city average	3% points fewer adults with two or more unhealthy behaviours	Already below city average	Wellbeing Service established October 2014	Portsmouth Health and Lifestyle Survey of adults, 2015

Workstreams	Outcome measure	Portsmouth Strategy baseline (Yr)	Latest England	Latest Portsmouth	Latest Portsmouth compared to England	City trend	Yearly city action to match England average
3c. Implement the City of Service model of high impact volunteering	GCSE attainment – average points scored (See Workstream 1b for GCSE Gold Standard attainment)	335.9 average point score all pupils (2015)	369.5 average point score all pupils (2015)	337 average point score for Portsmouth Together mentored students (279 for other Pupil Premium students, 333 for non-Pupil Premium students)	Lower		
	Adult numeracy skills (% of working age adults with numeracy skills at Entry Level 3 or below)	47.7%	49.2%	47.7%	Better	N/A	Already better than England
	Love Your Street Residents give unpaid help to any group, club or organisation at least once a month	20% (2015)	N/A	N/A	N/A	N/A	N/A
	Satisfaction with area where you live	71% (2015)	N/A	N/A	N/A	N/A	N/A
4 Intervening earlier							
4a. Safeguard the welfare of children, young people and adults (**)							
4b. Deliver CCG strategic priorities (***)							
4c. Improve the quality of dementia services and care	Increasing diagnosis rate for people with dementia (% recorded dementia per registered patients of all ages)	0.68% (2012/13)	0.74%	0.71%	Lower but statistically similar	Increasing, but at a slower rate than the England average	70 more patients diagnosed to meet England rate.
5 Reducing inequality							
	Indices of Multiple Deprivation	76th worst of 326 local authorities (2010)	N/A	63rd worst of 326 local authorities		Comparatively worse in ranking	
5a. Implement refreshed Tackling Poverty Strategy	Children aged 0-19 yrs in low income families	22.3% 9,330 children (2012)	19.9%	23.3% 9,925 children	Higher	Worsening	Approximately 1,455 fewer children
	Index of Multiple Deprivation – Older People	18.1% IMD 2010	15.8%	19.0%	Worse	Now 63rd highest of 152 LAs	

Locality values			Actions or issues			Specific issues	Source
North	Central	South	North	Central	South		
						The 'Activate' mentoring project is managed by the Education Business Partnership. The project continues to run in King Richard school (two schools previously)	Portsmouth Together Provisional 2015 KS4 results (Education Team, PCC)
49.5%	53.4%	42.3%	131 more adults obtaining Level 1 and above to meet England average 839 more adults obtaining Level 1 and above to meet Portsmouth average	1,510 more adults obtaining Level 1 and above to meet England average 2,049 more adults obtaining level 1 and above to meet Portsmouth average	Numeracy skills better than England average	Project abandoned as not delivering any impact	Adult Skills Survey 2010 numeracy skills at Entry Level 3 or below – pending measure of outcomes set by participants in the Challenge
19%	17%	23%	1% more	3% more	Already above city average – need to maintain	Total of £15,287 in grants given to 31 projects. Twelve projects have completed, reporting 407 volunteers (3,037 volunteer hours) with 5,726 beneficiaries	Portsmouth Together
76%	65%	71%	Already above city average – need to maintain	6% improvement	Already in line with city average – need to maintain		Portsmouth Health and Lifestyle Survey for adults, 2015 Responses to Question 37. Those reporting medium to high satisfaction ie rating 7/10 to 10/10
Reported by Safeguarding Boards							
Measures reported to CCG Board							
0.82% (0.70% in 2012/13)	0.61% (0.58% in 2012/13)	0.70% (0.74% in 2012/13)	Already higher than England and city rates	95 more patients diagnosed to meet England rate. 70 more patients diagnosed to meet city rate	30 more patients diagnosed to meet England rate. Same as city rate.	Use this measure until data available to measure diagnosis of expected prevalence. Locality caution: These are CCG GP practice community based localities therefore not necessarily resident to the localities.	Prevalence of recorded dementia by GP Practices, QOF 2014/15, NHS Digital (HSCIC).
Data to be refined at locality level							Indices of Multiple Deprivation 2015 (data from 2012/13)
19.1% 3,095 children (17.0% in 2013: 2,750 children)	29.8% 4,545 children (27.1% in 2013: 4,090 children)	20.6% 2,290 children (19.8% in 2013: 2,185 children)	Already below England and city levels, but increasing (as is England and Portsmouth). Highest rate in Paulsgrove 31.2%, 1,225 children (in 2013, it was 28.1%, 1,090 children)	1,510 fewer children to meet England level. 990 fewer children to meet city level. Highest rate in Charles Dickens 47%, 2,035 children (in 2013 it was 42.7%, 1,765 children)	80 fewer children to meet England level. Already below city level. Increasing rate. Highest rate in St Thomas: 36%, 870 children (in 2013 it was 31.9%, 760 children)		Children in low income families local measure, 2014. HMRC, 30 September 2016 https://www.gov.uk/government/statistics/personal-tax-credits-children-in-low-income-families-local-measure-2014-snapshot-as-at-31-august-2014-30-september-2016
14.3%	26.7%	17.8%					Indices of Multiple Deprivation (IDAOPI) 2015 for LSOAs aggregated to ward level

Workstreams	Outcome measure	Portsmouth Strategy baseline (Yr)	Latest England	Latest Portsmouth	Latest Portsmouth compared to England	City trend	Yearly city action to match England average
5b. Tackle health-related barriers to accessing and sustaining employment	Reduce long-term unemployment (people claiming for more than 12 months per 1,000 working age population)	6.45 per 1,000 working age population (July 2014)	3.7 per 1,000 working age population	2.82 per 1,000 working age population	Lower	Improving	Already better than England
	NEW: Claimant counts (the number of people claiming benefit principally for the reason of being unemployed)	15.3 per 1,000 working age population (July 2015)	17.8 per 1,000 working age population	13.4 per 1,000 working age population	Lower	Improving	Already lower than England
	Gap in employment between those in contact with secondary mental health services and the overall employment rate (% point difference)	68.1 (2012/13)	66.1	65.1	Lower	Worsening	N/A
	Employment rate of people with a learning disability known to Adult Social Care	9.6%	6.0%	8.0%	Higher	Worsening	Already better than England
	Young people aged 16-18 yrs not in education, training or employment	330 young people 5.6% of 16-18 yr olds known to PCC (2015)	4.5% of 16-18 yr olds known to all LAs (June 2016)	308 young people ie 5.2% of 16-18 yr olds known to PCC (June 2016)	Higher	Improving	60 fewer NEET young people Aim is for no young person to be NEET"
5c. Address issues identified in "Men's health – Annual Public Health Report, 2012"	Narrowing of gap in life expectancy for males in least/most deprived areas						

Locality values			Actions or issues			Specific issues	Source
North	Central	South	North	Central	South		
2.0 per 1,000	3.7 per 1,000	2.6 per 1,000	Already below England and city averages	About the same as the England rate; but need approximately 40 fewer claimants to meet Portsmouth rate	Already below England and city averages		NOMIS JSA Claimants as at July 2016. Hampshire County Council Small Area population forecasts. England ONS mid-yr estimates.
10.7 per 1,000 working age population	18.3 per 1,000 working age population	11.9 per 1,000 working age population	Already below England and city averages	About 50 fewer to meet England level; but need approximately 215 fewer claimants to meet Portsmouth rate	Already below England and city averages		NOMIS Claimant count as at July 2016 (both existing JSA claimants and new unemployed Universal Credit claimants). Denominator for rates: Hampshire County Council Small Area population forecasts and England ONS mid-yr estimates.
Not available at locality level							PHOF 1.08 iii 2014/15
Not available at locality level							ASCOF 1E. 2014/15 http://ascof.hscic.gov.uk/Outcome
120 young people	132 young people	62 young people	4.8% of 16-18 YP resident in the North of the City	6.3% of 16-18 YP resident in the Centre of the City	4.5% of 16-18 YP resident in the South of the City	The data provided is based on 3 month average (Nov 20-15-Jan 2016) as per DfE guidelines	NEET per LA, 2015. Dept for Education
See overall priority above							

NB Values in this table are as calculated. Rounded values shown in JSNA Summary text

(*) Reported to Children's Trust

(**) Reported to Safer Portsmouth Partnership

(***) Reported to NHS Portsmouth Clinical Commissioning Group. Although the measures for the CCG specific Workstream concern adult age groups, CCG priorities concerning children and young people are reflected in other Workstreams



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