Portsmouth CITY COUNCIL

Public Document Pack

NOTICE OF MEETING

HEALTH AND WELLBEING BOARD

WEDNESDAY, 22 JUNE 2016 AT 10.00 AM

THE EXECUTIVE MEETING ROOM - THIRD FLOOR, THE GUILDHALL (PLEASE NOTE CHANGE FROM USUAL VENUE)

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

Health and Wellbeing Board Members
Councillors Luke Stubbs (Joint Chair), Donna Jones, Gerald Vernon-Jackson, Ryan Brent and John Ferrett
Dr James Hogan (Joint Chair), Dr Janet Maxwell, Innes Richens, Ruth Williams, Healthwatch Portsmouth, Dianne Sherlock, Sue Harriman, Jackie Powell and Tim Powell

Plus one other PCCG Executive Member: Dr Linda Collie , Dr Elizabeth Fellows , Dr Dapo Alalade and Dr Tim Wilkinson

Portsmouth Councillor Standing Deputies:
Councillor Colin Galloway

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

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

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

A G E N D A

1 Welcome, apologies for absence and declaration of members' interests

2 Minutes of previous meeting - 2 December 2015 and Matters Arising
(Pages 1 - 8)

Members are asked to approve the minutes of the previous meeting and to raise any matters arising from these.

RECOMMENDED that the minutes of the previous meeting held on 2 December 2015 be approved as a correct record.

3 PCC Membership Update (for information)

To note that at the Portsmouth City Council Cabinet meeting on 9th June, the following Portsmouth City Council member appointments to the Health and Wellbeing Board were confirmed:

Councillor Donna Jones, Leader of the Council

Councillor Luke Stubbs, Cabinet Member for Adult Social Care and Public Health

Councillor Ryan Brent, Cabinet Member for Children's Social Care

Councillor Gerald Vernon-Jackson, Leader of the Opposition

Councillor John Ferrett, Leader of the Labour Group (co-opted member - subject to HWB approval)

Councillor Colin Galloway was confirmed as the Standing Deputy

4 Special Educational Needs & Disabilities (SEND) Strategy (Pages 9 - 14)

The information report by Julia Katherine is to update the Board on the refreshed Special Educational Needs and Disabilities (SEND) Strategy for Portsmouth and the implications of this for the Health and Wellbeing Board.

(As this is an update the appendix documents referred to are not included but can be sourced on line as these are sizeable documents)

5 Public Health Annual Report (Information Report) (Pages 15 - 46)

This information report is to note that the Director of Public Health is publishing her statutory Annual Report, 2015. The topic of this year's report is the recent Ipsos MORI survey of the health and wellbeing of adults aged 16+ years (which is also on this agenda).

The Annual Public Health Report 2015 summarises key findings, considers implications for action and makes recommendations.

6 Childrens Health Visiting Service (Information Report) (Pages 47 - 52)

This information report by Kate Lees is to update the Health and Wellbeing Board on public health services for 0-5 year olds, (including health visiting service); plans for financial savings and potential impact.

7 Portsmouth Health & Lifestyle Survey of Adults (Pages 53 - 120)

Information report from Public Health, to note that Public Health Directorate commissioned Ipsos MORI to conduct a survey of the health and wellbeing of adults aged 16+ years.

The survey report is attached - for noting. Implications for action and recommendations are set out in the statutory Director of Public Health's Annual Report, 2015 ("Portsmouth How Are You"), which is also on this agenda.

8 Shared Director of Public Health Arrangements

There will be a verbal update by David Williams PCC Chief Executive.

9 Update on Information Sharing Protocols (Information report) (Pages 121 - 168)

This information report by Joanna Kerr is to inform the Board that Portsmouth's multi-agency Information Sharing Framework has recently been revised.

10 Date of next meeting (information item)

Members are asked to note in diaries that the next scheduled meeting of the Health & Wellbeing Board will be held on Wednesday 21 September 2016 at 10am.

Members of the public are now permitted to use both audio visual recording devices and social media during this meeting, on the understanding that it neither disrupts the meeting or records those stating explicitly that they do not wish to be recorded. Guidance on the use of devices at meetings open to the public is available on the Council's website and posters on the wall of the meeting's venue.

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HEALTH AND WELLBEING BOARD

MINUTES OF THE MEETING of the Health and Wellbeing Board held on Wednesday, 2 December 2015 at 9.00 am in Conference Room A, Civic Offices, Portsmouth.

Present

Dr James Hogan (in the Chair)

Councillor Donna Jones
Councillor Gerald Vernon-Jackson

Dr Janet Maxwell
Innes Richens
Di Smith
Rob Watt
Patrick Fowler Healthwatch Portsmouth
Dianne Sherlock
Sue Harriman
Ursula Ward
Jackie Powell

Officers Present

David Williams
Matt Gummerson
Reg Hooke
Rachael Roberts
Lee Loveless
Mary Shek

34. Welcome, apologies for absence and declarations of members' interests (AI 1)

The Chair, Dr Jim Hogan, welcomed everyone and asked for introductions around the table. Apologies for absence had been received from Cllr Luke Stubbs, Cllr Neill Young and Ruth Williams.

There were no declarations of members' interests.

35. Minutes of previous meeting - 16 September 2015 - and Matters Arising (AI 2)

RESOLVED: The minutes of the meeting held on 16 September 2015 were approved as a correct record.

The following matters arose regarding minute 30 'A Proposal for Portsmouth: A Blueprint for Health and Care in Portsmouth'

(i) The joint PCC/CCG/PHT and Solent letter to the secretary of State - Matt Gummerson confirmed that this had been sent and a response had been chased.

(ii) Ursula Ward had fed back into this process having discussed this with the PHT Board.

It was noted that the Blueprint was later on this meeting's agenda for a progress update.

36. The Blueprint for Health and Care in Portsmouth (AI 3)

The report by Innes Richens and David Williams had been circulated to members the day before. Copies were available at the meeting and on the website. David Williams presented the paper which was for noting as this was to advise on the development of thinking for the way forward for the integration. He stressed the importance of the whole spectrum of activity (as evidenced in the diagrams within the report). So far progress was in line with government and the King's Fund guidance, and had been commented on within the Chancellor's autumn statement the previous week. Pages 3 to 4 of the report set out how implementation was taking place with investigation of the powers invested to the boards and to see how much progress Health & Wellbeing Board can make without the need for external permission. The governance arrangements at PCC and the CCG were also being looked at as well and the role of the Health & Wellbeing Board.

David Williams further reported that:

- There would be a series of steps for each organisation to ratify.
- There are areas of commissioning currently reserved to NHS England or Public Health England.
- There will need to be a decision made regarding accelerating the process and how the role of the Health & Wellbeing Board can be strengthened.

Innes Richens drew attention to page 11 of the report which set out how the changes would be delivered, such as:

- How PCC/CCG undertake commissioning together an how the funding for this could be joined up.
- The scope of the Health & Wellbeing Board.
- Looking at commitment to a single provision for a frontline delivery and regarding the impact on the organisations.
- Discussions were taking place on backroom support functions such as HR.

It was noted that all the organisations had pressures around the finances so this should not be decided in isolation but should be planned together.

Questions were raised by members regarding the legal and financial implications and how influence could be placed on the council's social care budgets but it was confirmed that Health & Wellbeing Board could express views to the council but authority on the actual budget lay with the council.

Councillor Donna Jones wished to record her disappointment that she had not been involved in consultations on this paper, so she was pleased it was an information and not decision item at this stage. As Leader of PCC she welcomed the direction of travel for the Blueprint and asked that she and her Cabinet Member for Health & Social Care were kept involved in the process. In response David Williams apologised for the late delivery and stressed that the report was for noting and this was part of a long journey for which members would be kept involved and there would be papers brought back to the Health & Wellbeing Board, with each of the organisations having the opportunity to be appropriately briefed before decisions were taken.

In response to other questions it was noted that the autumn budget had put more pressure on the budgets of the member organisations involved but each area should still develop its proposals. With regard to the ring-fencing of monies for adult social care, Councillor Donna Jones as Leader reported that PCC had launched an online consultation regarding a proposed extra 2% on the Council Tax to ensure protection of services. The government were not provided extra funding for the implications of the living social wage which could mean £1.5-2 million which was not funded by the government and was for the local authority to find.

Dr Hogan as Chair stressed that the papers were for noting and there were lessons learned in taking partners forward and being briefed appropriately. This area would continue to be developed with reports being brought back to the Health & Wellbeing Board (as well as the Cabinet and CCG Board).

37. Portsmouth Safeguarding Adults Board Annual (PSAB) Report (AI 4)

This report was presented by Rachael Roberts, from PCC Adult Social Care, who went through the headlines from the report. The PSAB was preparing for the implementation of the implications of the Care Act and met on a regular basis, as did the sub-groups, to working on their priorities. There was also close work with Hampshire County Council for a pan-Hampshire approach e.g. on fire safety, workforce development etc.

There had been a couple of adult safeguarding reviews, the main themes emerging from these were regarding communication, with the action plans being taken forward on these. The reviews were published on the PSAB website which also set out its policies and procedures. There were approximately 1,300 referrals each year with a higher proportion of these needing a greater response, including those concerning financial abuse, physical harm and neglectful care by providers.

In response to questions it was noted that the number of referrals was comparable with similar sized boards and there was more awareness leading to increased referrals and these were then signposted appropriately and the multi-agency "MASH" in Portsmouth (under the Safer Portsmouth Partnership) was helpful in improving communication. It was noted that there was member training on safeguarding awareness which was combined for children and adults. This was welcomed by the councillors present and it was felt it was particularly important for the spokespersons and group leaders to have this training.

Discussion took place regarding the possible cuts to domestic violence funding within the council's budget although it was noted that other schemes such as the Iris scheme in primary care would be continuing and the work of the police whose budgets had been more protected by the Chancellor. Councillor Jones reported that a letter would be going from Councillor New (as Cabinet Member for Environment & Community Safety) to the Police Commissioner to ask for funding and she stressed that the cuts to domestic violence were at the moment for 2017/18 and with efforts to secure future funding.

Rachael was thanked for her report which was noted.

38. Portsmouth Safeguarding Children's Board (PSCB) Annual Report (AI 5)

Reg Hooke presented this report as chair of the PSCB and reiterated the functions of the board to protect children by holding agencies to account, holding training sessions for professionals and upholding the standards by review. There was integration with the Safer Portsmouth Partnership, the Children's Trust and the Health & Wellbeing Board. There were also links with the Tackling Poverty strategy and the Mental Health strategy.

Priorities: Page 3 of the report set out the four strategic priorities for 2014-17: firstly to ensure that the voice of the child was heard, tackling neglect and the risk of neglect, improving communication between bodies and lastly the board to challenge itself and scrutinise its own effectiveness. An emerging theme for the city was the tackling of child sexual exploitation. Reg Hooke was pleased to report that the Ofsted inspection findings as set out in the report had given a "good" result for the PSCB. There were a number of areas of challenges which included female genital mutilation, tackling radicalisation, supporting care leavers and mental health provision. There was also the scrutinising of restructuring around less budget provision.

Questions and matters arising from the report:

- It was asked which areas would be helpful to have further funding if it were available? In response Reg Hooke felt that the analytical capability was crucial for the accessing of multi-agency information and the capacity of officers to develop this as well as the capturing of the voice of the child.
- It was noted that the report showed that all partners were involved and agencies were participating within the audit process.

- Cllr Jones stated that the council budget savings of £11 million did not target adult and children's social care but they were asked to come within their previous cash limits.
- It was reported that the radicalisation of young people was being tackled through the Prevent programme and future funding for this would be through the Home Office's support rather than from the city council. There was a strong involvement via schools in Portsmouth in the Prevent agenda.
- It was also noted that the schools councils were being encouraged to engage and schools were participating in the 'capturing of voices'.
- It was also reported that the Child Death Overview Panel was now having a more local arrangement for Portsmouth but they were still sharing annual data from across Hampshire.

Reg Hooke was thanked for his presentation.

RESOLVED Members of the Health and Wellbeing Board received the Portsmouth Safeguarding Children Board Annual Report and noted areas of progress and challenges identified in the context of services being planned and commissioned.

39. JSNA - annual summary and progress with outcomes in JHWS (AI 6)

Dr Janet Maxwell as the Director of Public Health gave a presentation on the JSNA annual summary, identifying areas in which there were improvements or where things had worsened in the city. She displayed maps profiling the deprivation levels by wards; those in the 1% highest deprivation areas would be where work would be targeted. The displayed graphs illustrated the diseases that were linked to preventable deaths, the highest being circulatory followed by cancer, respiratory and digestive (see page 11 of the JSNA report).

Trends: There was improvement in childhood obesity, teenage conception, new cases of TB and infant mortality. However there were worsening trends for alcohol related hospital stays and hip fractures. It was noted that road injuries was a big issue for Public Health and there were more efforts being made to influence road safety.

Dr Maxwell reported on the work of City Deal funded programmes to support those with health issues maintain their employability, early years work, integrating health visitors and the importance of the Portsmouth Together volunteering work. The chosen areas concentrate on strong community links were Fratton and Somerstown.

Public health officers were also involved in the refresh of the Portsmouth Plan looking at the economic development and infrastructure changes to promote walkability and breathability in Portsmouth and were working closely with the University of Portsmouth and making a national bid for 'urban living' funding.

Questions: In response to questions from Health and Wellbeing Board members, the following extra information was given:

- It was noted that female mortality rates had previously been better than male mortality rates.

- **Housing** There were other issues that were affecting the most deprived wards such as social housing. It was noted that more people were going into the private rented sector. Councillor Vernon-Jackson reported on the building of fewer council houses in the Hampshire area. Councillor Jones felt that lead developments would be mostly outside of Portsmouth, and developers in Portsmouth would say it was not viable for social housing to be provided within the city although the major developments outside of Portsmouth in the Solent PUSH area would have a large proportion of social housing. Janet Maxwell stressed the integration with the housing services and with those visiting the vulnerable to do risk assessments.

- **Training on JSNA** It was suggested that online training be given to group leaders and any other interested parties by Joanne Kerr (the Head of Public Health Intelligence) to show how to get the greatest value from the online tools that form part of the JSNA.

40. Mental Health and Wellbeing Strategy (AI 7)

Lee Loveless presented this report which requested the adoption of the Mental Health and Wellbeing Strategy 2016-2021 which had been brought together by a multi-agency group, setting out 11 pledges through the topic 'experts'. In consultation with each of these a pledge group had been formed. Once the strategy was adopted by the HWB there would be the developing of an action plan which would be brought back to HWB for approval in June 2016.

Janet Maxwell stressed there was a new approach for mental wellbeing being seen as an integrated part of people's lives and it was felt that Portsmouth were leading the way in this cultural shift. Councillor Jones was interested in the pledge to change and challenge attitudes and behaviour in turn reduce the stigma and isolation. Councillor Jones stressed that that the city council as a whole was very interested in the subject of mental health and had recently passed a cross-party Notice of Motion on the subject.

The action plan should be in place by the 1st April and would be reported back to the Health and Wellbeing Board after that.

The Chair thanked Lee Loveless and Matt Smith for this report.

RESOLVED that the Board adopted the proposed Mental Health and Wellbeing Strategy 2016-2021.

41. Progress of the Wellbeing Service (AI 8)

Mary Shek presented this report which gave an update to the Health and Wellbeing Board on the progress since the previous report in June and the launch of the Service on 1st October. The Service was to give support to residents on alcohol, smoking and diet advice for their wellbeing, taking a holistic approach working with Housing and other departments. There had been a smooth handover of clients in the transition and there had been a quiet launch so they would not be overwhelmed by requests initially but there would be the use of national branding from March. A majority of staff were in place (see paragraph 4.4 of the report) and she was pleased to report that this included apprentices. Of the 419 referrals, half of these were from GPs.

Training was taking place for staff regarding safeguarding and it was hoped there be a migration to a single IT system that was also used by the GPs.

In response to questions Mary Shek gave additional information:

- Staff going into homes already received safeguarding training.
- Dialogue was taking place with other services to try and ensure there was not duplication - there were locality teams sharing information and there was liaison with the Children's Centres.
- It was hoped that there would be demonstrable outcomes by April.

Dianne Sherlock appreciated working with Mary Shek from the voluntary sector angle. It was noted that Mary had been approached to give advice by other local authorities.

Mary was thanked for her report and it was asked that all partners feedback to her in relation to the capability and capacity of the Wellbeing Service e.g. referrals, waiting times and any barriers.

The HWB noted:

(1) the progress of the new integrated wellbeing service

(2) the role and strategic priorities of the Wellbeing Service within the wider health & social care system.

42. Dementia - HWB Priority Update (information report) (AI 9)

Matt Gummerson reported this was a regular item and any questions could be forwarded to Preeti Sheth. This report was noted.

43. Public Health Annual Report (AI 10)

Janet Maxwell presented this report. She reported on the refresh of the Portsmouth Plan which is an underpinning document for development in the city. It includes chapters dealing with transport and health, for which there was involvement in various issues such as:

- The Hard redevelopment
- The Park and Ride to reduce congestion and increase safety
- The bid for Urban Living.

- Sustainability and Health were also included within work on flood defences and the food economy.

Dr Maxwell was working with other directorates such as Housing and Education regarding employment for mental health support for people to keep them in work and also regarding the Healthy City Team to bring in funding.

The information report was noted.

44. Future work programme of HWB for 2016 (AI 11)

Matt Gummerson reported that during the year the workstreams had shaped the work programme and now a lot of work was taking place on the Blueprint and so future items would be brought back relating to this. There would continue to be the statutory annual reports and the intention was to share the work programme before the next meeting of the 17th February.

45. Date of next meeting (AI 12)

It was noted that the next meeting would take place on the 17th February at 10 am.

Additional business was raised in that:-

(1) It was Matt Gummerson's last meeting, so the Chair thanked him on behalf of the HWB for his help and support in establishing and progressing the work of the Board. Councillor Jones extended her good wishes to him in his new position working with Health and the University.

(2) In response to a question regarding the publicity for these meetings it was noted that these are public meetings and information was on the Portsmouth City Council's website and the HWB newsletter.

The meeting concluded at 11.00 am.

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Dr James Hogan
Chair

Portsmouth CITY COUNCIL

THIS ITEM IS FOR INFORMATION ONLY

Title of meeting:	Health and Wellbeing Board
Subject:	Special Educational Needs and Disabilities (SEND) Strategy
Date of meeting:	22nd June 2016
Report from:	Alison Jeffery, Director of Children's Services
Report by:	Julia Katherine, Head of Inclusion
Wards affected:	All

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1. Requested by

1.1 Portsmouth Health and Wellbeing Board have requested 6 monthly updates on the SEND Strategy and Portsmouth's readiness for local area SEND inspection.

2. Purpose

2.1 To update the Board on the refreshed Special Educational Needs and Disabilities (SEND) Strategy for Portsmouth and the implications of this for the Health and Wellbeing Board.

3. Background

3.1 Portsmouth has had a strategic plan for children and families since 2004. It is currently known as the Children's Trust Plan (some areas retain the original language of Children and Young People's Plan).

3.2 The Trust Board agreed on 7th June 2016 to refresh the priorities within the Plan to ensure that the Plan continues to reflect the important issues in the city and provides a coherent strategic framework for governance and planning.

3.3 The Portsmouth SEND Strategy is now one of 4 priorities within the Children's Trust Plan, as set out below:

THIS ITEM IS FOR INFORMATION ONLY

Priority 1	Stronger Futures: Affordable and (even) better A transformation programme to improve safeguarding, resilience, health, wellbeing and success of families
Priority 2	Improve education outcomes for children and young people [working title]
Priority 3	Improve outcomes for Looked After Children and Care Leavers
Priority 4	Special Educational Needs and Disability (SEND) Strategy: A strategy to promote inclusion and improve outcomes for children and young people with SEND and their families

3.4 The SEND Strategy has been refreshed to cover the period 2016 to 2019.

3.5 The overall aim of the strategy remains the same: to promote inclusion and improve the outcomes for Portsmouth children and young people aged 0-25 years with SEND and their families.

3.6 The outcomes that this strategy is aiming to improve are: to increase the percentages of children and young people with SEND who are able to:

- Be included within their local community,
- Lead healthy lives and achieve wellbeing,
- Learn and make progress,
- Make and maintain positive relationships within their family and community
- Participate in education and training post-16 and prepare for employment

3.7 There are six strands of the SEND Strategy:

Strand A: Promote good inclusive practice to improve outcomes
Strand B: Successful implementation of the SEND reforms
Strand C: Effective joint commissioning to improve outcomes
Strand D: Co-production, embedded as a way of working with children, young people and their parents and carers
Strand E: Early identification and early support for children with SEND and their families
Strand F: Effective preparation for adulthood and smooth transitions to adult services

3.7 The detailed strategy and delivery plans under each of these strands are included in Appendix A.

THIS ITEM IS FOR INFORMATION ONLY

3.8 The governance arrangements for the SEND Strategy are represented diagrammatically on page 15 of the strategy document (see Appendix A).

3.9 Statutory accountability is retained by the Health and Wellbeing Board.

3.10 The effectiveness of these arrangements will be assessed by the Local Area SEND Inspection which will take place within the next 5 years. This is a joint inspection by Ofsted and the Care Quality Commission.

3.11 The SEND Inspection framework states that *'Inspectors will assess the quality and impact of joint commissioning arrangements between partners, including through the local strategic needs assessment and well-being strategies. In assessing partners' work, inspectors will review how efficient, effective and sustainable this is in improving outcomes for children and young people'* Local area SEND Inspection handbook, page 22)

3.12 Key achievements to date have included:

3.12.1 Moving from consultation to co-production with service-users i.e. working in partnership with children and young people with SEND and their parents and carers to review and co-design the services that best meet their needs and improve outcomes. Parent/carer representatives sit on all workstreams of the SEND Strategy and co-chair the SEND Board. The Dynamite young people's co-production group have carried out the 'Big Bang' young people's survey and have launched the Young Inspectors programme whereby young people with SEND will inspect all of the services included within the Local Offer.

3.12.2 Rolling out the new multi-agency statutory education, health and care assessment process for the 2-3% of 0-25 year olds with the most complex needs who require the highest level of additional support over and above what is 'ordinarily available'. Around 1,000 0-25 years olds will require a transfer assessment from statements of special educational needs to Education Health and Care Plans by 2018, with an additional 100+ new assessments each year. We have had external validation of the quality of our EHC Plans, and the vast majority are now being completed within the statutory timescale.

3.12.3 Expanding and remodelling the range of additionally resourced provision available within mainstream schools, with two new secondary Inclusion Centres opening; for children with sensory impairment at St Edmunds and for children with communication and interaction difficulties (including Autism) at Trafalgar school. Two new Inclusion Centres for primary aged children with communication and interaction difficulties (including Autism) will open at Portsdown Primary and Devonshire Infants from September 2017.

3.13 Key priorities for the next 12 months will include:

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3.13.1 Clarifying the continuum of support available for children and young people with social emotional and mental health (SEMH) difficulties across education, health and care services, linking with the wellbeing strategy and Future in Mind.

3.13.2 Remodelling the special school provision at Cliffdale and Redwood Park special schools to enable them to meet the increasingly complex needs of children requiring special school placement, in order to enable us to achieve a better balance of children with SEND in mainstream and special schools to ensure that resources are focused on those requiring the highest level of support.

3.13.3 Reviewing the eligibility criteria for all services to ensure that they support the inclusion agenda.

3.14 The progress and impact of this strategy will continue to be monitored by the SEND Board and Children's Trust Board. A further update will be provided to the Health and Wellbeing Board in 6 months.

……
Signed by (Director)

THIS ITEM IS FOR INFORMATION ONLY

Appendices:

A - SEND Strategy 2016-2019 (Portsmouth Children's Trust Priority 4)

B - Local area SEND inspection framework, Published April 2016

https://www.gov.uk/government/publications/local-area-send-inspection-framework

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

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

Title of document	Location

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

……
Signed by:

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

Portsmouth CITY COUNCIL

Title of meeting:	Health and Wellbeing Board
Subject:	Portsmouth How Are You? Public Health Annual Report, 2015
Date of meeting:	22 June 2016
Report by:	Director of Public Health
Wards affected:	All

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1. Purpose

To note that the Director of Public Health is publishing her statutory Annual Report, 2015. The topic of this year's report is the recent Ipsos MORI survey of the health and wellbeing of adults aged 16+ years (which is also on this agenda).

The Annual Public Health Report 2015 summarises key findings, considers implications for action and makes recommendations.

2. Information Requested

None

……
Signed by (Director)

Appendices:

Public Health Annual Report, 2015

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

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

Title of document	Location

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Acknowledgements

Contributors from Portsmouth Public Health and Communications and Graphics Teams

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Sam Hibberd	Mary Shek
Joanna Kerr	Jenna Smith
Denyse King	Dr Matt Smith
Alan Knobel	Dan Williams
Dominique Le Touze	Andrea Wright

Portsmouth Health and Lifestyle Survey conducted by Ipsos MORI

Portsmouth Public Health acknowledge, with thanks, the help and advice from Ipsos MORI, and their permission to use their survey report as the basis of this year's Annual Public Health Report.

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

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We would be pleased to receive your comments about this report.
Email: **janet.maxwell@portsmouthcc.gov.uk**

Contents

Introduction

Good health starts in the home; in our schools, colleges, and university, in workplaces; in playgrounds and open spaces; in the air we breathe and the water we drink. My Annual Public Health Report in 2014[1] focused on the importance of these so-called "wider determinants of health" in supporting, strengthening and improving the health and wellbeing of the people of Portsmouth. About **half** of overall health and wellbeing derives from the impact these factors have on individuals and communities.

But we also know that about **one third** of overall health and wellbeing derives from our lifestyles. So in 2015 we commissioned Ipsos MORI to survey adults living in the city about their lifestyles, health and wellbeing. This year's report focuses on the survey findings and implications.

The findings show the extent of people's willingness to change (eg 77% of smokers say they would like to quit) and of their success in achieving change by themselves (eg 71% of ex-smokers say they gave up without any help or support). And now, for the first time, we have more information about the cumulative adverse impact of people adopting several unhealthy behaviours (eg smoking *and* drinking alcohol to excess), and about the impact of this on long-term health conditions; about the interactions between mental and physical ill health; and about the health problems facing middle-aged adults.

Helping individuals and communities achieve and maintain changes in their lifestyles is complicated. Against a backdrop of severe budget cuts there are difficult decisions to be made about how, and the extent to which, we use public resources to help communities and individuals make changes. But we live in a city of inequalities where males in the most deprived areas die about eight years earlier than males in the least deprived areas. The diseases that contribute to this gap in life expectancy are closely related to lifestyles. It is too simplistic to say that people should just stop smoking or be more physically active. Differences in health status reflect, and are caused by, social and economic inequalities in society. My reports for 2014 and 2015 complement each other and provide evidence for our actions to promote a healthy city.

It is more important than ever that we use the funding we have in the most effective, evidence-based ways, working in partnership with individuals, communities and others, on a large-scale, to achieve population-level behaviour change.

This report includes some of the survey findings; you can read the full survey report at: http://data.hampshirehub.net/def/concept/folders/themes/jsna/portsmouth-jsna/the-people-of-portsmouth

I commend this report - and in particular the recommendations which set a realistic agenda for improving public health over the next five years. I hope you find this report interesting and useful, and I will be pleased to receive any comments.

Dr Janet Maxwell Director of Public Health

[1] Portsmouth City Council. Building a healthier city: Public Health Annual Report 2014. http://data.hampshirehub.net/data/building-a-healthier-city---public-health-annual-report-2014 Accessed 14 April 2016

1 Executive summary and recommendations

1 The Public Health Annual Reports for 2014 and 2015 are complementary. The 2014 report focussed on the "wider determinants of health" (eg the environment, education, employment). About **half** of overall health and wellbeing derives from these factors. About **one third** of overall health and wellbeing derives from our lifestyles, so we commissioned Ipsos MORI to survey adults about their lifestyles, health and wellbeing. This 2015 report focuses on the survey findings and implications.

2 Between September and November 2015, Ipsos MORI conducted a postal survey of adults aged 16 years and over about their lifestyles, health and wellbeing. They surveyed 5,000 households with a final overall response rate of 22%. More information about the survey methodology and a copy of the survey questionnaire are in Ipsos MORI's report.

3 The survey results come at an opportune time as health, social care and voluntary sector decision makers across Hampshire and the Isle of Wight are making radical plans to achieve better health. Current trends of ill health and demand for services are financially unsustainable. Encouraging people to live healthier lifestyles, and to help themselves achieve better health, are key elements in the Sustainability and Transformation Plan, Portsmouth Blueprint, Better Care plan and plans to work even more closely with Southampton. The survey results provide evidence of the scale of issues and opportunities in Portsmouth.

4 For the first time we looked at clusters of unhealthy behaviours: smoking, drinking, eating unhealthily and being physically inactive. Fifty-seven per cent of residents exhibit at least two unhealthy behaviours and 18% show either three or four. Healthy (and unhealthy) behaviours are, to some extent, self-reinforcing eg 42% of drinkers who are at "high risk" of developing an alcohol use disorder also smoke compared to 10% of non-drinkers or low risk drinkers. There are clear differences in health behaviours along socio-economic lines eg 15% of those living in council/social housing exhibited all four unhealthy behaviours compared with 5% of all residents. Those with health conditions are also more likely to show unhealthy behaviours: 13% of those with a limiting long-term disability or health condition exhibited all four unhealthy behaviours compared with just 2% of those without any limiting disabilities or conditions.

5 The way residents *perceive* their own health is not necessarily fully commensurate with the way they actually *behave* eg 57% of residents who describe their diet as healthy do not eat the recommended five portions of fruit and vegetables a day. Most (88%) of residents feel well informed about how to look after their health. But the proportion of those who do not feel informed is significantly higher among those who, arguably, need the most advice and help to improve their health eg 27% of those who rate their health as bad, and 22% of those who have three or more health conditions, do not feel well informed. But people in Portsmouth are already taking action themselves to achieve healthier lifestyles eg of those who had given up smoking, 71% said they gave up without any help or support.

6 Feeling connected to the local community is an important factor for mental wellbeing. Those who agree they can ask neighbours for advice or help have higher mean score for satisfaction with life (7.38 compared with 6.89 for all residents). Unsurprisingly, people who rent from private sector

landlords, with possibly weaker ties to the local community, are less likely to agree that they could ask neighbours for advice or help (17% compared with 35% of all residents).

7 Younger adults (16-34 years) are generally physically fit. Most are not overweight so they appear healthy. But 44% are at "increasing risk" of developing an alcohol use disorder (compared with 33% overall).

8 Many middle-aged (35-64 years) adults urgently need to prepare for a healthier older age. Compared to other age groups they are more likely to be obese, smoke tobacco, be at "high risk" of developing an alcohol use disorder and exhibit three or more unhealthy behaviours.

9 For the current cohort of over 65s, physical health conditions or disabilities have a greater negative impact on their wellbeing rather than diet, alcohol or smoking. This gives a good base for building on positive behaviours.

10 Lower levels of mental wellbeing were linked with unhealthy behaviours and with physical ill health eg 32% of those in bad/very bad health had the lowest level of mental wellbeing compared with 5% of those with higher levels of mental wellbeing. Those with the lowest levels of mental wellbeing (compared with those with the highest levels) are more likely to be physically unfit/very unfit, have an unhealthy diet, smoke tobacco, and to drink alcohol putting themselves at "high risk" of developing an alcohol use disorder (9% compared with 3%). However, the widespread acceptance of drinking alcohol at a level of "increasing risk" of developing an alcohol use disorder means that there is little difference in this level of intake between those with the lowest and the highest levels of mental wellbeing (10% and 9% respectively).

11 Physical activity and healthy eating are the keys to maintaining a healthy weight. The lifestyle survey found that 46% of residents have a healthy weight, 34% are overweight and 19% are obese.

12 While most respondents are physically active, they are more likely to undertake moderate (88%) rather than vigorous exercise (50%). Fifty seven per cent would like to do more exercise than the current level but the most common barriers are lack of time (47%) and the financial cost of exercise (21%).

13 Sixty-five per cent of residents are more likely to agree than disagree that they have a healthy diet. However, even though 98% eat at least some fruit and vegetables a day, only a third (33%) meet or exceed the recommended daily minimum of five portions. In common with the barriers to physical activity, lack of time is the most frequent barrier to cooking healthy food (24%). This followed by a lack of willpower (20%) and cost of healthy food (19%).

14 Most people in Portsmouth drink alcohol in moderation. However, a minority drink at levels which could harm their health. Thirty-three per cent of residents are drinking at levels putting them at "increasing risk" of developing an alcohol use disorder, with a further 12% drinking at "high risk" levels. There was some evidence of the "alcohol harm paradox" with people from lower socio-economic groups not necessarily drinking 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 highest rates of negative impacts of alcohol were in Central locality.

15 Sixteen per cent of adults say they currently smoke or use tobacco (excluding e-cigarettes). In line with national findings, higher proportions of people in the most deprived fifth of neighbourhoods smoke compared with the least deprived fifth (28% compared to 8% respectively). The adverse health effects of smoking are also evident: 44% of tobacco smokers say their health is bad/very bad compared with 10% of those whose health is good/very good. Encouragingly, three quarters of smokers (77%) say they would like to stop smoking.

16 Seventy-five per cent of adults say they visit the dentist at least once a year. Only 7% say they never visit the dentist. But among the groups least likely to have visited the dentist in the previous year are those living in Central locality (70%), those living in the most deprived quintile of neighbourhoods (66%) and social housing tenants (56%) as well as 56% of adults of Black and Minority Ethnicity compared with 76% of adults of White ethnicity.

17 Recommendations

17.1 We should continue to promote Portsmouth as a healthy city.

17.2 We will ensure that the information in the lifestyle survey and in this report inform strategic decisions by, among others, the Sustainability and Transformation Plan, Portsmouth Blueprint and Better Care to improve health and wellbeing in Portsmouth.

17.3 We will promote self-help as the first port of call for information and support on healthy behaviours. We need to do this on a larger scale, working cost-effectively with partners across Hampshire and the Isle of Wight.

17.4 The survey did not explore the use of online health and wellbeing resources and applications. We need to find out which online resources are most effective at promoting behaviour change, and how can we provide the same sort of support to people who cannot access the internet.

17.5 We need to ensure that information about how to live a healthier life and how to access relevant services is readily available to everyone (but particularly to "high risk" groups) in a format that is easily understandable.

17.6 We should scale-up Making Every Contact Count (MECC). We need to work with partners across the city so that MECC philosophy, knowledge and skills are embedded and routinely practiced.

17.7 We should continue to monitor the uptake and outcomes of the Wellbeing Service. We need to ensure that access and use of the service is fair and focuses on those most in need.

17.8 We should continue to build and act on the findings in the Rapid Participatory Appraisals and continue to establish an ongoing relationship between local communities and service providers.

17.9 Portsmouth should continue to be part of Cities of Service. Through the 'Portsmouth Together' partnership, we will seek to promote and extend volunteering across Portsmouth, showing the impact that volunteering can make in our communities (eg the community sign-posters associated with the Wellbeing Service, and the community connectors linked to the Independence and Wellbeing Team). We will continue to promote the 'Portsmouth Together' website.

17.10 We will continue to work with other council directorates, including City Development and Transport, so that improving health and wellbeing is considered in all planning decisions.

17.11 We will continue to support the Mental Health Alliance, Food Portsmouth, the Tobacco Control Alliance and Safer Portsmouth Partnership. With partners, we will implement the Mental Health Strategy, the Physical Activity and Healthy Weight Strategies, and the Smokefree Portsmouth: Tobacco Control Strategy.

17.12 In addition to Safer Portsmouth Partnership's action plan in relation to tackling alcohol misuse, we should:

- deliver "Brief Advice" on a larger scale as evidence shows this is an effective means of reducing alcohol consumption amongst increasing and "high risk" drinkers
- include additional off-licenced premises cumulative impact areas, within Central locality, in the council's forthcoming Statement of Licensing Policy, recognising that current national and local licensing policy does not necessarily consider health related harm
- with partners, lobby local MPs and national government to support health as a licensing objective and the introduction of a national minimum price per unit of alcohol.

17.13 We will support workplace health initiatives through the Workplace Wellbeing Charter.

17.14 We will continue to implement NICE guidance about mid-life approaches to delay or prevent onset of dementia, disability and frailty.

17.15 We will continue to commission NHS Health Checks.

17.16 We will continue to use the survey results to investigate areas of concern and inform actions, for example at locality level.

Please read the survey report for full findings including information about sexual health and substance misuse.

2 Background

Context

The survey results come at an opportune time as health, social care and voluntary sector decision makers across Hampshire and the Isle of Wight are making radical plans to achieve better health, transformed quality of care, and sustainable finances (via the Sustainability and Transformation Plan (STP) which accelerates implementation of the NHS's plan "Five Year Forward View"). The STP must be built around the needs of local populations and address key challenges of increasing demand for services, the complex needs of people with multiple health conditions, the unwarranted variability in quality, outcomes and performance of local providers, and of severe budget constraints[2].

At the same time, Portsmouth's Health and Wellbeing Board is overseeing the implementation of the Portsmouth Blueprint. The Blueprint aims to shift resources from acute care to prevention, early intervention, primary and community care and maximises the contribution of the voluntary and community sector[3].

Better Care in Portsmouth aims to join up health and social care support for older or vulnerable people in Portsmouth, enabling people to live as independently as they can for as long as possible, and reduce the number of people who need to be admitted to hospital as an emergency[4].

Public health departments in Hampshire and the Isle of Wight already work closely together in a number of areas, for example commissioning sexual health services across Hampshire. The departments in Portsmouth and Southampton face many issues in common and will look to forge still closer links in future.

Encouraging people to live healthier lifestyles, and to help themselves achieve better health, are key elements in the success of each of these plans. Current trends of ill health and demand for services are financially unsustainable. The survey results provide evidence of both the scale of issues and of the opportunities to tackle them in Portsmouth.

The survey

Portsmouth's Health and Wellbeing Board sets the city's strategy to improve health and wellbeing[5] and the Board needs local intelligence to identify current health and lifestyle issues and monitor trends. Lifestyle surveys are one means of collecting population statistics of the individual behaviours that impact on health. The Public Health department had previously conducted lifestyle

[2] NHS England. NHS Shared planning guidance. www.england.nhs.uk/ourwork/futurenhs/deliver-forward-view/ Accessed 24 May 2016

[3] Portsmouth Health and Wellbeing Board. Agenda and minutes, 16 September 2015. http://democracy.portsmouth.gov.uk/ieListDocuments.aspx?CId=150&MId=3259&Ver=4 Accessed 24 May 2016

[4] Portsmouth City Council and NHS Portsmouth Clinical Commissioning Group. Better care in Portsmouth. www.portsmouth.gov.uk/ext/health-and-care/socialcare/better-care-in-portsmouth.aspx Accessed 24 May 2016

[5] Portsmouth City Council and NHS Portsmouth Clinical Commissioning Group. Joint Health and Wellbeing Strategy 2014-2017. www.portsmouth.gov.uk/ext/health-and-care/health/joint-strategic-needs-assessment.aspx Accessed 14 April 2016

surveys in 1993, 1999 and 2005. We need local intelligence to determine whether, and where, to take appropriate action, and to measure improvements.

On behalf of Portsmouth City Council and NHS Portsmouth Clinical Commissioning Group, Public Health Portsmouth commissioned Ipsos MORI to survey adults aged 16 years and over about their health and wellbeing. Between September and November 2015, Ipsos MORI posted survey forms to 5,000 households - surveying more households in the city's more deprived areas in anticipation that response rates in these areas might be disproportionately lower than the city average. The final overall response rate was 22%. More information about the survey methodology, and a copy of the survey questionnaire, are in Ipsos MORI's report.

3 Clustering of unhealthy behaviours

Survey findings

For the first time, we have information about the cumulative adverse effects of people having more than one unhealthy behaviour. The unhealthy behaviours we looked at were:

- smoking
- drinking alcohol to a risky level
- not doing the recommended amount of moderate or vigorous physical activity
- not eating the recommended five portions of fruit and vegetables each day.

Info graphic to show % single and multiple behaviours "Only one in ten Portsmouth residents (10%) exhibit *none* of these behaviours. Most exhibit at least two of them (57%), and one in six (18%) show either three or four. The mean number of unhealthy behaviours residents have is 2.17 (out of four)."

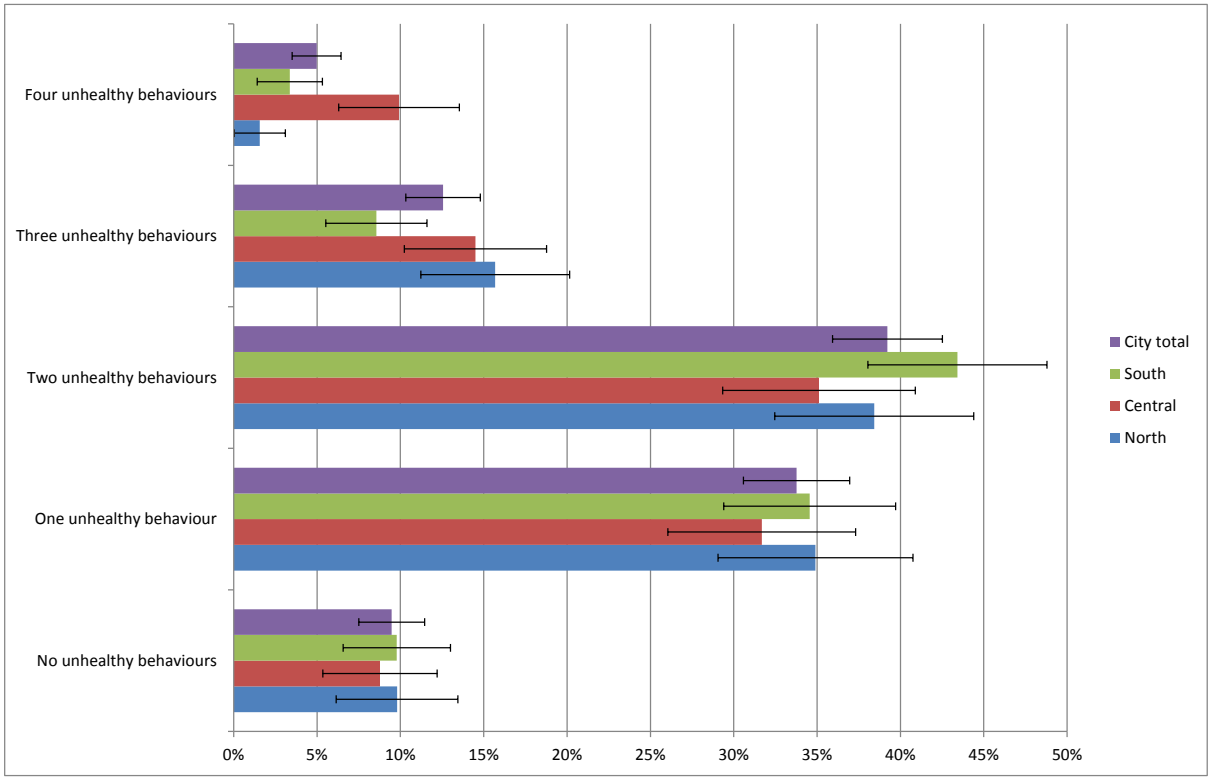
The survey found that healthy (and unhealthy) behaviours are, to some extent, self-reinforcing. For example, not meeting the recommended amount of physical activity is more common amongst people who smoke (48%) compared to those who had never smoked (34%), and among those who do not eat a healthy diet (40% of those who do not eat the recommended amount of fruit and vegetables compared with 28% of those who do).

Research shows that the adverse impact of multiple unhealthy behaviours contributes to health inequalities. The King's Fund[6] found that, in England between 2003 and 2008, the proportion of the whole population engaging in three or four of these unhealthy behaviours significantly declined. However, it was mainly people in the higher socio-economic and educational groups who had adopted the healthy behaviours. Between 2003 and 2008 the 'behaviour gap' actually widened so that by 2008, people with no qualifications were more than five times as likely as those with higher education to engage all four unhealthy behaviours, compared with three times as likely in 2003. The King's Fund starkly points out that "The health of the overall population will improve as a result of

[6] The King's Fund. 2012. Clustering of unhealthy behaviours over time. www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/clustering-of-unhealthy-behaviours-over-time-aug-2012.pdf Accessed 28 April 2016

the improvement in these behaviours, but the poorest and those with least education will benefit least, leading to widening inequalities and avoidable pressure on the NHS".

The survey 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%). The chart 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.



Those with health conditions are also more likely to show unhealthy behaviours: 13% of those with a limiting long-term disability or health condition exhibited all four unhealthy behaviours compared with just 2% of those without any limiting disabilities or conditions.

The relationships between issues such as deprivation or disabilities and lifestyle behaviours are complex. Tackling the root cause of why someone drinks to excess and smokes means taking a holistic view of circumstances, motivation and other factors.

The King's Fund recommends "moving beyond siloed approaches to public health behaviour policies, in which the focus is on renewing strategies on individual lifestyle risks one at a time, as this ignores how behaviours are actually distributed in the population".

What we are doing to help people lead healthier lifestyles

Side-bar: This chapter focuses on Wellbeing Services and Making Every Contact Count. Following chapters present information about other ways we help people to lead healthier lifestyles.

Public Health Portsmouth set up the Wellbeing Service in October 2015. It is a one-stop service offering support and advice to residents aged 18+ years on giving up smoking, reducing alcohol consumption and maintaining a healthy weight.

The Wellbeing Service replaced the services which offered support on single lifestyle behaviours (the alcohol intervention team, smoking cessation services and health trainers). The new service takes a holistic approach in assisting clients with wider issues, as we know that some people use unhealthy behaviours to deal with life issues, and these unhealthy behaviours can affect other areas such as housing, employment and managing money.

The service works in partnership with, among others, GPs, pharmacies, Probation, Job Centre Plus, libraries, community and voluntary groups to identify clients in need of support to address lifestyle risk factors. It targets the most socio-economically deprived areas of the city. It is based in community offices in North, South and Central localities, and at Queen Alexandra Hospital, to make the service easily accessible for local residents.[7]

Text in side bar about how to contact Wellbeing Service

"You can contact the Wellbeing Service on 023 9229 4001.

Email: wellbeing@portsmouthcc.gov.uk

Or ask your GP to refer you."

The Service is proving very popular but the lifestyle survey shows that tens of thousands of residents would benefit from changing their lifestyles. One service can never meet this level of need.

Everyone who comes into contact with members of the public has the opportunity to have a conversation to improve health and wellbeing. 'Making Every Contact Count' (MECC) encourages conversations based on behaviour change methodologies (ranging from 'Brief Advice' (see page x), to more advanced behaviour change techniques) to empower healthier lifestyle choices and explore the wider social determinants that influence health[8]. MECC is one of the council's priorities within workforce development and Public Health because it is a cost-effective way of preventing ill health. Many professionals beyond the Public Health department are jointly responsible for addressing public health issues by identifying cues from their clients to take action and suggest the appropriate way forward in their practice. Over the past three years, we have trained 276 people in local statutory and voluntary agencies in our MECC training programme.

What should we do?

- We should continue to monitor the uptake and outcomes of the Wellbeing Service - in particular, to look at the lifestyle issues people would like information and advice about, and how this varies by gender, age, disability and socio-economic factors. We need to ensure that access and use of the service is fair and focuses on those most in need.

[7] Find out about Portsmouth Wellbeing Service at: www.portsmouth.gov.uk/ext/health-and-care/health/portsmouth-wellbeing-service.aspx Accessed 28 April 2016
[8] Making Every Contact Count. www.makingeverycontactcount.co.uk/

- We should scale-up MECC. We need to work with partners across the city so that MECC philosophy, knowledge and skills are embedded and routinely practiced.

4 Being self-aware and informed

Survey findings

The survey found that the way residents *perceive* their own health is not necessarily fully commensurate with the way they actually *behave*. For example, 57% of residents who describe their diet as healthy do not eat the recommended five portions of fruit and vegetables a day.
Although perceived fitness levels do correlate markedly with actual levels of activity, there are some residents who overestimate their level of fitness. Of those who say they are fit/very fit, one in eight (12%) are actually doing less than the recommended amount of physical activity a week. Of those who describe themselves as already doing enough exercise, 12% do less than the recommended amount.

The great majority (88%) of residents feel well informed about how to look after their health. But there are important differences in that the proportion of those who do not feel informed is significantly higher among those who, arguably, need the most advice and help to improve their health. The people most likely to feel badly informed include those who rate their health as bad (27% feel not well informed) and those who have three or more health conditions (22% feel not well informed).

We also found that people in Portsmouth are already helping themselves achieve healthier lifestyles eg of those who had given up smoking, 71% said they gave up without any help or support.

What we are doing to help people lead healthier lifestyles

As well as providing one-to-one support and advice through the Wellbeing Service, the Public Health team in Portsmouth supports the national health marketing campaigns led by Public Health England. We complement national activity by distributing campaign messages and resources in the city, targeting populations who would benefit most. Examples of the national campaigns include Stoptober, Sugar Swaps, 10 Minute Shake up and Dry January. National campaign activity aims to enable the public to adopt healthier habits using the advice and resources it provides. Locally, these campaigns also provide a platform for local services to engage with those who require additional one-to-one or group support. For example, we used the Stoptober campaign to launch the Portsmouth Wellbeing Service.

Increasingly there are more sophisticated, easy to use digital tools which enable individuals and families to motivate themselves to make positive choices and monitor lifestyle behaviours. The Sugar Smart[9] mobile application can be used to scan food and drink barcodes to identify the amount of sugar in the product. Social media, such as the Facebook Smokefree[10] page, is also used as a tool

[9] Public Health England. Sugar Smart. www.nhs.uk/change4life-beta/campaigns/sugar-smart/home
[10] Public Health England. Smokefree www.nhs.uk/smokefree

to bring people together to support and motivate each other. The OneYou[11] campaign uses an online questionnaire[12] to help identify the most appropriate online tools to help the user, and uses direct communications with the individual to support long term improvements. OneYou gives information and advice about good mental health as well as smoking, eating healthily, and being more physically active.

The Wellbeing Service recruits and trains local people to be 'community sign-posters'. The sign-posters help cascade health messages within the community, and signpost individuals to relevant support services. The Service works with volunteers from partner organisations and other council directorates - for example, with the 'community connectors' who are volunteers working with the council's Independence and Wellbeing service who provide support to vulnerable people and are important for maintaining their mental wellbeing. The Wellbeing Service also works in tandem with local voluntary groups such as Age UK, and the volunteer partnership 'Portsmouth Together'.

What should we do?

- We will promote self-help as the first port of call for information and support on healthy behaviours. We need to do this on a larger scale, working cost-effectively with partners across Hampshire and the Isle of Wight (supporting the health promotion and prevention of ill health elements of the STP).
- The survey did not explore the use of online health and wellbeing resources and applications. We need to find out which online resources are most effective at promoting behaviour change, and how can we provide the same sort of support to people who cannot access the internet.
- Continue to train volunteers so they can signpost to services, and support others in their neighbourhoods.
- We need to ensure that information about how to live a healthier life and how to access relevant services is readily available to everyone (but particularly to "high risk" groups) in a format that is easily understandable.

5 Portsmouth communities

Survey findings

Appendix 1 summarises key findings for North, Central and South localities.

The survey showed that feeling connected to the local community is an important factor for mental wellbeing. Those who agree they can ask neighbours for advice or help have higher mean score for satisfaction with life (7.38 compared with 6.89 for all residents).

Adults are fairly evenly split as to whether they could ask someone in their neighbourhood for practical help or advice (35% agreed they could, 32% said they could not). Unsurprisingly, people who rent from private sector landlords, with possibly weaker ties to the local community, are less likely to agree that they could ask neighbours for advice or help (17% compared with 35% of all

[11] Public Health England. One You. www.nhs.uk/oneyou
[12] Public Health England. How are you quiz. www.nhs.uk/oneyou/hay

residents). As an age group which overlaps with those privately renting, younger people aged 16-34 years are less likely to agree they could ask for advice or help (24% compared with 35% of all residents).

The survey asked about some types of unpaid or voluntary work. The list included informal activities (such as baby-sitting, or doing a quick favour for an elderly neighbour) as well as more formal activities for groups, clubs or organisations. One fifth of residents could be described as regular volunteers, ie they have done formal voluntary work with a group, club or organisation at least once a month in the last year. There is some variation across demographic groups with, for example, women more likely to provide personal care to someone who is frail or sick (10% compared with 4% for men) while people aged 65+ years are more likely to keep in touch with someone who has difficulty getting out and about (37% compared with 28% of all residents).

The survey found that 72% of resident had volunteered (formally or informally) but an even greater proportion (82%) would be willing to do at least one of the activities in the future. For each activity, the proportion willing to do the activity is greater than the number who currently report doing it. Of the activities listed, babysitting/child care is the most frequent activity currently undertaken (30% of all residents) but doing a quick favour for an elderly neighbour is the activity most would be willing to do (44% of all residents).

What we are doing to help people lead healthier lifestyles

Co-production approaches underpin public health policy, interventions and approaches and are key in developing sustainable and effective outcomes for our communities. Co-production delivers ''public services in an equal and reciprocal relationship between professionals, people using services, their families and their neighbours"[13].

To support co-production, Public Health Portsmouth has undertaken a number of Rapid Participatory Appraisals (RPAs) in Paulsgrove, Fratton and Charles Dickens wards. The RPAs aim to:

- gain an insight into a community's own perspective of its main needs (and so are complementary to the statistical findings from the lifestyle survey)
- translate these findings into action
- establish an ongoing relationship between service providers and local communities.

Another strand of this work involves volunteering. The survey listed activities covering formal and informal community involvement but many people would not think of occasional acts of kindness, such as helping a neighbour, as 'volunteering'. That being said, we wish to encourage more people to help other people, rather than relying or depending on public services.

Portsmouth is a member of Cities of Service, an international coalition of cities which engage citizens to make a difference in the face of pressing issues. We set up Portsmouth Together with specific goals to:

- enhance mentoring programmes for young people in schools

[13] Boyle D and Harries H, 2009. Cited in New Economics Foundation. In this together website: www.neweconomics.org/publications/entry/in-this-together Accessed 23 May 2016

- recruit volunteers to support people in improving their confidence in using maths
- encourage local street communities' projects
- increase opportunities for people to volunteer.

The Portsmouth Together website has more than 150 organisations and charities looking for volunteers: www.volunteer.portsmouth.gov.uk . The website will also be used as a repository for advice and guidance on volunteering.

What should we do?

- We should continue to be a member of Cities of Service.
- We should continue to build and act on the findings in the RPAs and continue to establish an ongoing relationship between local communities and service providers.
- Through the 'Portsmouth Together' partnership, we will seek to promote and extend volunteering across Portsmouth, showing the impact that volunteering can make in our communities. We will continue to promote the partnership website.

6 Keeping well throughout our lives

Survey findings

Appendix 2 summarises key findings for different age groups.

Unsurprisingly young adults aged 16 to 34 years report that they have the best quality of health, and are the most physically active, and have a healthy weight. But the picture is not all rosy. Young adults are more likely than other residents to:

- say that barriers to healthy eating are lack of time to prepare or cook healthy food (40% compared to 24% overall) and the perceived higher cost of healthy food (27% compared to 19% overall)
- not eat the recommended daily fruit and vegetable intake (71% of 16-34 year olds compared to 62% of 65+ year olds)
- be at "increasing risk" of developing an alcohol use disorder (44% compared to 33% overall)
- have used illegal drugs or new psychoactive substances[14] in the last 12 months (14% compared to 9% of all adults)
- have close friends who have used illegal drugs or new psychoactive substances in the last 12 months (25% compared to 15% of all adults).

Younger adults may consider themselves somehow 'immune' from poor health. Physically, they consider themselves to be fit; and indeed, they have higher rates of physical activity. The majority are not overweight so they appear healthy. But by drinking alcohol to excess, they are putting themselves at "increasing risk" of developing an alcohol misuse disorder; they are storing up trouble ahead.

[14] The survey was conducted before the Psychoactive Substances Act came into force on 26 May 2016.

The survey was of adult lifestyles but the health of children and teenagers is highly dependent on the behaviours of the adults caring for them. Those who are younger than 35 years are in the age group that is likely to be the parents of pre- and school-age children. As the city's Healthy Weight Strategy says: "…breaking the pattern of lifestyle behaviours that reinforce weight gain is crucial as once established, it is notoriously difficult to treat. The focus needs to be on prevention and early intervention within families if a reversal of the rising tide of obesity is to be achieved". Helping parents overcome barriers of time and cost - showing people how to cook healthy meals on a tight budget - is an important intervention.

We have some information about the interactions between parents and teenagers (for example, we know from our annual survey of secondary school pupils that, of those pupils who had drunk a whole alcoholic drink, 45% obtained alcohol from their parents[15]). We need more information about lifestyle behaviours in the households which include children and teenagers.

The findings for Portsmouth's middle-aged adults are concerning. Those aged 35-64 years consistently rate aspects of their life and their mental wellbeing less positively than either younger adults or those aged over 65. They are more likely than over 65s to have unhealthy behaviours. For example:

- 25% of 35-64 year olds are obese compared with 11% of 16-34 year olds or 19% of 65+ year olds
- one fifth of 35-64 year olds smoke tobacco compared with 14% of 16-34 year olds or 10% of over 65s
- 27% of the younger middle-aged drinkers (aged 35-44 years) are at "high risk" of developing an alcohol misuse disorder compared with 14% of those aged 55-64 years and 11% of those aged 16-34 years
- middle-aged adults are also more likely to exhibit multiple unhealthy behaviours (23% exhibit three or more, compared with 18% overall).

We found some evidence of the so-called 'sandwich generation' of middle-aged adults who care for children and for older adults. For those aged 35-64 years, nearly one-third of adults had children aged under 17 years living in their household (compared to 25% of all adults); 24% of this age group gave unpaid care to other adults (compared to 21% of all adults). Within this age group, 29% of those aged 55-64 years provide unpaid care.

Many people in this age group urgently need to prepare for a healthy older age. Making it easier for people to stop smoking, be more physically active, reduce alcohol consumption, adopt a healthy diet and achieve and/or maintain a healthy weight will reduce the risk of dementia, disability and frailty[16]. Making healthy changes can reduce the risk of a number of diseases including type 2 diabetes, cardiovascular disease, some cancers and dementia. Risks for these conditions develop over the course of a lifetime but health gains can be made by changing behaviours in mid-life.

[15] Portsmouth City Council. 2015. 'You say' secondary schools health survey. http://data.hampshirehub.net/data/portsmouth-secondary-schools-health-survey-2015---you-say Accessed 28 April 2016

[16] NICE, 2015. NICE guideline NG8. Dementia, disability and frailty in later life - mid-life approaches to delay or prevent onset. www.nice.org.uk/guidance/NG16/chapter/1-Recommendations Accessed 29 April 2016

Several studies have found links between "successful ageing"[17] and not smoking (or having quit), exercising regularly, eating fruit and vegetables daily and drinking a moderate amount of alcohol.

There are about 30,600 people aged 65+ years living in the city. Perhaps unsurprisingly, compared to those aged 16-34 years and 35-64 years, older residents are:

- less likely to rate their health as good or very good (58% compared with 81% and 70% respectively)
- less physically active than most (44% meet recommended levels for physical activity compared with 71% and 57% respectively)
- more likely to have a health condition or disability that limits daily activities a little or a lot (53% compared with 14% and 34%)
- more likely to be overweight than the other age groups (41% compared with 26% and 36%).

However, compared to other age groups, older people have a better quality of diet both in terms of the way they view their own diet (71% say they have a healthy diet compared to 69% of 16-34 year olds and 59% of 35-64 year olds), and in eating the recommended healthy amounts of fruit and vegetables (38% compared with 30% and 33%). They are less likely to exhibit unhealthy behaviours such as smoking (11% smoke daily or occasionally compared with 16% and 21%) and risky drinking (23% are at increasing or "high risk" of developing an alcohol use disorder compared with 53% and 48% respectively).

For the current cohort of over 65s, it appears that it is physical health conditions or disabilities that have greater negative impact on their wellbeing, rather than their diet, or alcohol or smoking. This gives a good base for building on positive behaviours.

What we are doing to help people lead healthier lifestyles

The national Public Health campaign OneYou[18] specifically targets middle-aged adults. This age group often has other people relying on them (and relying on them to stay healthy). The message is that they need to look after their own health because "There's only One You."

We also commission NHS Health Checks. People aged 40 to 70 years can have a free health check from their GP or at a pharmacy. In 2015, uptake of the local service increased from 30% to 42% of those invited.

Workplace health is an important area for public health: "Improving the health of the working age population is critically important for everyone, in order to secure both higher economic growth and increased social justice."[19] The council's workplace health team supports employers to achieve the Workplace Wellbeing Charter, which gives them access to training for line managers, staff and

[17] Successful ageing is defined as "Survival to an advanced age while maintaining physical and cognitive function, functional independence and a full and active life. Ill health and disability are compressed into a relatively short period before death." (Fries et al. 2011). From www.nice.org.uk/guidance/NG16/chapter/7-Glossary#successful-ageing

[18] Public Health England. One You. www.nhs.uk/oneyou

[19] Department for Work and Pensions, 2008. Working for a healthier tomorrow: Dame Carol Black's review of the health of Britain's working age population. www.gov.uk/government/publications/working-for-a-healthier-tomorrow-work-and-health-in-britain Accessed 25 May 2016

wellbeing champions. Twenty workplace champions are currently engaged across the city, while ten businesses have been accredited against the Charter - and each has seen a reduction in employee sickness absence rates.

A healthy workforce is good for business and this sort of sustainable workplace wellbeing programme is a proven and effective way of promoting employee health and producing economic benefits. The potential economic return on investment for a UK business that invests in workplace health initiatives is £4.17 for every £1 spent[20].

What should we do?

- We will continue to implement NICE guidance about mid-life approaches to delay or prevent onset of dementia, disability and frailty.
- We will continue to promote national and local behaviour change initiatives for different age groups.
- We will continue to commission NHS Health Checks.
- We will support workplace health initiatives through the Workplace Wellbeing Charter.

7 Good mental health

Survey findings

This survey asked people to evaluate their mental health through answering questions in the shortened form of the Warwick and Edinburgh Mental Wellbeing Scale. Overall, the dimensions of good mental wellbeing which the highest proportion of residents most frequently experienced were being able to make up their mind about things (77% agreed they experienced this "all the time" or "often" over the previous two weeks), thinking clearly (69%) and feeling close to other people (61%). The dimensions adults least experienced were feeling optimistic about the future (49%) and feeling relaxed (43%).

Lower levels of mental wellbeing were linked with unhealthy behaviours and with physical ill health. Reporting being in bad/very bad health was more common in people with the lowest level of mental wellbeing (32% compared with 5% for those with higher levels of mental wellbeing); as was having a condition that limits daily activities a little/a lot (62% compared with 26% of those with medium levels of mental wellbeing and 21% of those with the highest levels).

Those with the lowest levels of mental wellbeing (compared with those with the highest levels) are more likely to be physically unfit/very unfit (32% compared with 8%); less likely to agree that they had a healthy diet (8% compared with 15%); to smoke tobacco (16% compared to 9%), and to drink alcohol putting themselves at "high risk" of developing an alcohol use disorder (9% compared with 3%). However, the widespread acceptance of drinking alcohol at a level of "increasing risk" of developing an alcohol use disorder means that there is little difference in this level of intake

[20] British Heart Foundation. Health and work - business case infographics. www.bhf.org.uk/publications/health-at-work/health-at-work---business-case-infographics Accessed 29 April 2016

between those with the lowest and the highest levels of mental wellbeing (10% and 9% respectively).

The survey also found that poorer mental health was more likely for people who are carers (19% compared with 9% for non-carers).

What we are doing to help people lead healthier lifestyles

In 2015 we set up the Mental Health Alliance. In 2016, after consultation with service users, carers and partners, the Alliance launched the five year strategy 'Improving Mental Health and Wellbeing in Portsmouth 2016 to 2021'. The strategy has 11 pledges addressing, among other issues, culture, building resilience, the prevention of mental ill health and joining up mental and physical health[21].

What should we do

- We will continue to work with the Mental Health Alliance to implement the pledges in the Mental Health Strategy to improve mental health, and develop and implement the action plan.

8 Healthy weight

Survey findings

Physical activity and healthy eating are the keys to maintaining a healthy weight. The lifestyle survey found that 46% of residents have a healthy weight, 34% are overweight and 19% are obese.

While most respondents are physically active, they are more likely to undertake moderate (88%) rather than vigorous exercise (50%). Fifty seven per cent would like to do more exercise than the current level but the most common barriers are lack of time (47%) and the financial cost of exercise (21%). Men are more likely than women to consider themselves fit/very fit (37% compared with 23%), and they are twice as likely (28%) as women (14%) to do more than 75 minutes of vigorous exercise a week. Encouragingly, over 60% of women say they would like to do more exercise.

Sixty-five per cent of residents are more likely to agree than disagree that they have a healthy diet. However, even though 98% eat at least some fruit and vegetables a day, only a third (33%) meet or exceed the recommended daily minimum of five portions. Ninety-four per cent say that they eat home-cooked meals made from scratch once a week and 66% do so at least four times a week. In common with the barriers to physical activity, lack of time is the most frequent barrier to cooking healthy food (24%). This followed by a lack of willpower (20%) and cost of healthy food (19%).

What we are doing to help people lead healthier lifestyles

[21] Portsmouth City Council, 2016. Improving mental health and wellbeing in Portsmouth 2016-2021. www.portsmouth.gov.uk/ext/documents-external/hlth-mental-health-strategy-2016-2021.pdf Accessed 24 May 2016

People are more likely to succeed in leading healthier lifestyles when activities or actions become part of everyday routines[22]. The environment around us (eg making it easy and pleasurable to walk or cycle around the city instead of driving, or having opportunities to be healthy in our workplaces) contributes to our ability to embed physical activity in our everyday lives[23].

Last year's Public Health Annual Report focused on a series of city seminars on the ways our built urban environment impacts on health[24]. As a result of that work, Public Health is working with partners inside (eg Transport and City Development directorates) and outside the council (eg University of Portsmouth) on shared priorities in these areas. Evidence reviews for the city's Air Quality Strategy, the refresh of the Transport Strategy, the Placemaking Strategy and the Portsmouth Plan will inform council policy.

Public Health is also part of Food Portsmouth, a local network bringing together a wide range of organisations and people from various backgrounds (growing, production, preparing and cooking, buying and providing) with food as the central theme, as part of our sustainable food city initiative. In last year's Annual Report recommendations, Public Health committed to strengthening the local food economy and links with local food growers across the region to improve markets for access to local seasonal produce; supporting people to grow their own food where possible through allotments and private and community growing space; promoting reduction in waste including food waste, unnecessary packaging by buying loose produce or using reusable bags; buying fruit and vegetables in season and where possible buying locally grown produce. Food Portsmouth supports these aims through its work with businesses, public, private and voluntary sectors and local communities.

For individual clients, the Wellbeing Service helps clients experiencing complex needs to change behaviours so they achieve a healthy weight eg to develop their own individual physical activity plans and work out ways to achieve them through embedding them in daily routines (which is free) and signposting clients to local physical activities (which are free or low cost). Some clients receive additional practical support in learning the basics of preparing healthy, low-cost meals.

Public Health also supports the activities provided by Adult Social Care's Independence and Wellbeing Team. One activity is "Healthy Walks" which offers free guided short or medium length walks across the city for people to enjoy fresh air, exercise and social contact. The scheme is open to everyone but is particularly used by older residents. In addition, other initiatives such as falls prevention and over 55s activity clubs are targeted at supporting people entering older life to remain as active and independent as possible.

What should we do?

[22] Public Health England. November 2014. Everybody active, every day: an evidence-based approach to physical activity. And Everybody active, every day: what works, the evidence. www.gov.uk/government/publications/everybody-active-every-day-a-framework-to-embed-physical-activity-into-daily-life Accessed 13 May 2016

[23] NICE. January 2008. NICE guideline PH8. Physical activity and the environment. www.nice.org.uk/guidance/ph8/chapter/Introduction Accessed 11 May 2016

[24] Portsmouth City Council, 2015. Building a healthier city: Public Health Annual Report 2014. Ibid

- We will continue to work with other council directorates, including City Development and Transport, so that improving health and wellbeing is considered in all planning decisions.
- We will continue to support Food Portsmouth.
- We will implement the Physical Activity and Healthy Weight Strategies.

9 Alcohol

Survey findings

Most people in Portsmouth drink alcohol in moderation. However, a minority drink at levels which could harm their health.

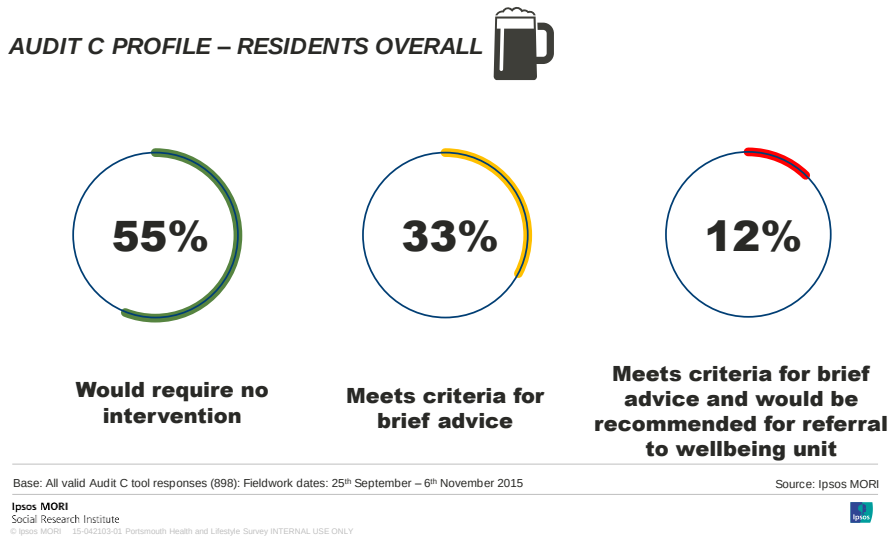
The survey shows that the percentage of residents drinking at levels which may harm their health is higher than previous estimates. Previously we thought about 25% of residents were drinking at either increasing (more than the government's previous guidelines) or "high risk" levels (ie 35 plus units per week for a woman or 50 plus units for a man - typically, a large glass of wine or a pint of premium larger contains three units of alcohol). This survey suggests that 33% of residents are drinking at levels putting them at "increasing risk" of developing an alcohol use disorder, with a further 12% drinking at "high risk" levels - giving a total of 45% of residents drinking to levels which puts their health at risk.

Re-do MORI graphic below with % and estimated numbers of people. And with nicer graphics

93,600 adults (55%) don't drink or drink in moderation = no intervention

55,500 adults (33%) at "increasing risk" of developing an alcohol use disorder = meet criteria for Brief Advice

21,000 adults (12%) at "high risk" of developing an alcohol use disorder = meet criteria for Brief Advice and would be recommended for referral to wellbeing unit



This survey results go some way to explaining why Portsmouth has among the highest alcohol-related mortality rates in the country, with high rates of liver disease and deaths. We know from last year's liver health needs assessment that liver disease is largely preventable. It is affected by physical activity, diet, tobacco smoking and alcohol as well as by Hepatitis B and C viruses. Liver disease is often silent in nature, which means that it goes undetected until major complications develop as a result of chronic liver damage[25].

However, the lifestyle survey also highlights that alcohol consumption on its own is not necessarily linked to other unhealthy lifestyles and poor health. For example, the survey shows that alcohol consumption was highest amongst people who undertook regular physical activity (although this is partly explained by the fact that this group had a high proportion of under 65s, who as well as exercising, also drank the most).

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. This is known as the "alcohol harm paradox"[26]. The paradox is demonstrated in the survey with "high risk" drinking being more common among drinkers who smoke or are overweight (35% and 27% respectively, compared with 15% of drinkers overall).

The survey showed that a minority of drinkers are suffering negative impacts from drinking. One in 10 of drinkers reported failing to do something expected of them due to drinking. Additionally 11% of all drinkers (but 22% of "high risk" drinkers) have either injured themselves, or someone else, due to their drinking. In all, 9% of all drinkers (but 35% of "high risk" drinkers) had a relative, friend or health worker suggest they reduce their alcohol consumption. Problems associated with drinking (failure to do things normally expected, injuries to themselves or others, and concern from family/friends) are more concentrated in areas with high levels of social housing and tenants of private landlords.

The highest rates for negative impacts were in Central locality. The data highlighted in the survey shows some association with analysis in the Safer Portsmouth Partnership's annual Strategic Assessment, when looking at violence and other negative alcohol-related impacts. The survey found that people in Central locality experience the highest negative impact of alcohol and we know that this area also has a high density of off-licenced premises and rate of alcohol-related hospital admissions. There appears to be a clear cumulative adverse impact of alcohol, related to density of licenced premises, consumption, negative impacts and health issues linked to alcohol in these neighbourhoods - and it is most likely this is exacerbated by alcohol sales in off-licenced premises (rather than public houses or restaurants).

What we are doing to help people lead healthier lifestyles

[25] Portsmouth City Council, 2015. Liver health needs assessment. http://data.hampshirehub.net/data/liver-health---needs-assessment-june-2015 Accessed 11 May 2016

[26] Institute of Alcohol Studies, 2014. Alcohol, health inequalities and the harm paradox: why some groups face greater problems despite consuming less alcohol. www.ias.org.uk/uploads/pdf/IAS%20reports/IAS%20report%20Alcohol%20and%20health%20inequalities%20FULL.pdf Accessed 25 May 2016

Alcohol, along with drug misuse, is a priority of the strategic Safer Portsmouth Partnership (SPP). The SPP already has plans in place to address alcohol misuse linked to the most problematic drinking and associated crime and disorder. These are contained in the SPP's Partnership Plan, available at www.saferportsmouth.org.uk.

The SPP works strategically so that agencies work together to tackle alcohol misuse from prevention to provision of support services. Examples are:

- working with Licensing Officers to implement licensing policy so that it meets current national licensing objectives (eg that a new alcohol outlet is not harmful to children and young people)
- enforcement to locate and destroy illegal imports of alcohol
- encouraging local businesses to sign up to the voluntary agreement to adopt the "Reducing the strength" scheme to remove super-strength beer and cider from sale[27]
- monitoring the price of alcohol - especially the very low cost of some ciders.

The Wellbeing Service offers alcohol interventions and support to clients. The service also takes referrals from the Probation Service for offenders who need alcohol support.

What should we do?

Side bar: Brief Advice is a short session of structured Brief Advice to help someone reduce their alcohol consumption. The advice can be given by non-alcohol specialists. It comprises:

F Feedback on the client's risk of having alcohol problems

R Responsibility - change is the client's responsibility

A Advice - give clear advice when requested

M Menu - what are the options for change?

E Empathy - an approach that is warm, reflective and understanding

S Self-efficacy - optimism about the behaviour change

In addition to the SPP's action plan, we should:

- deliver Brief Advice on a larger scale as evidence[28] shows this is an effective means of reducing alcohol consumption amongst "increasing" and "high risk" drinkers. It would be far too costly to develop a service to see the number of adult drinkers (estimated at between 61,300 and 76,200) who are at risk. However, in most cases these people do come into contact with frontline health, social care or other professionals who could ask a few basic questions and deliver Brief Advice (ie a MECC approach)

[27] Portsmouth City Council. Reducing the strength www.saferportsmouth.org.uk/alcohol/alcohol-campaigns/reducing-the-strength Accessed 18 May 2016

[28] NICE. June 2010 Public Health guideline PH24. Alcohol-use disorders: prevention. www.nice.org.uk/guidance/ph24 Accessed 15 April 2016

- include additional off-licenced premises cumulative impact areas, within Central locality, in the council's forthcoming Statement of Licensing Policy, recognising that current national and local licensing policy does not necessarily consider health-related harm
- with partners, lobby local MPs and national government to support health as a licensing objective and the introduction of a national minimum price per unit of alcohol.

10 Smoking

Survey findings

Sixteen per cent of adults say they currently smoke or use tobacco (excluding e-cigarettes). Seventy-two per cent of tobacco users smoke at least five times a day, 45% smoke between five and 15 times a day and 23% smoke more than 15 times each day. In line with national findings, higher proportions of people in the most deprived fifth of neighbourhoods smoke compared with the least deprived fifth (28% compared to 8% respectively).

Smoking and drinking alcohol to excess (ie those at 'high' risk of developing alcohol use disorders) are linked (42% of "high risk" drinkers also smoke, compared to 10% of non-drinkers or "low-risk" drinkers). The adverse health effects of smoking are also evident: 44% of tobacco smokers say their health is bad/very bad compared with 10% of those whose health is good/very good.

We see the adverse impact of smoking in the city's significantly high rates of death from diseases that are related to smoking: in deaths from lung cancer, from chronic obstructive pulmonary disease, and in overall mortality attributable to smoking.[29] Between 1995 and 2014, the city's female lung cancer mortality rate increased from 51 deaths per 100,000 females of all ages to 62 such deaths. Deaths associated with smoking are preventable.

Encouragingly, three quarters of smokers (77%) say they would like to stop smoking. Of those who had given up smoking, 71% said they gave up without any help or support.

What we are doing to help people lead healthier lifestyles

In 2015 we set up the Tobacco Control Alliance and have recently agreed the Smoke-free Portsmouth: Tobacco Control Strategy 2016-2020. The strategy aims to reduce ill health and preventable premature death by reducing the prevalence of smoking in the people of Portsmouth. The actions in the plan move Portsmouth towards best practice in tobacco control and are aligned with national recommendations.

Half of all current tobacco smokers started to smoke when they were younger than 16 years. Public Health works in the city's secondary schools, giving advice to year groups about not smoking, and to individuals about giving up. We conduct an annual survey of substance misuse for secondary school pupils to monitor trends.

Of all reasons for referral to the Wellbeing Service, most are referred for help in giving up smoking. The service offers drop-in sessions and one-to-one support for smoking cessation. Residents are also encouraged to use their local pharmacies for smoking cessation support.

[29] Public Health England. Tobacco Control Profile. www.tobaccoprofiles.info/ Accessed 3 May 2016

The city's rate of women who continue to smoke during pregnancy is significantly higher than the England average elsewhere (14.7% compared to 11.4% in 2014/15). The Wellbeing Service is working with midwives on plans to support women in smoking cessation.

What should we do?

- With partners on the Tobacco Control Alliance, we should implement the recently agreed Smoke-free Portsmouth: Tobacco Control Strategy 2016-2020.
- We will work with local communities to seek commitment for creating a tobacco-free generation. We want to take an asset-based approach by identifying and building on local assets (such as key individuals, groups or facilities) to help achieve our aims.

11 Good oral health

Survey findings

Good oral health is important for general health and wellbeing. Poor oral health can affect someone's ability to eat, speak, smile and socialise (for example, due to pain or social embarrassment at loss of teeth). It is important to visit the dentist regularly so s/he can assess and treat any oral health problems such as gum disease, tooth decay or oral cancer[30]. Dental decay is a preventable disease that can be arrested and even reversed in its early stages of development[31].

Seventy-five per cent of adults say they visit the dentist at least once a year - slightly fewer (68%) had actually visited the dentist within the previous 12 months. Only 7% say they never visit the dentist.

The greatest burden of poor oral health is demonstrated in the most vulnerable and disadvantaged population groups[32]. Among the groups least likely to have visited the dentist in the previous year are those living in Central locality (70%), those living in the most deprived quintile of neighbourhoods (66%) and social housing tenants (56%).The survey found that 76% of adults of White ethnicity visited the dentist at least one a year compared with 56% of adults of Black and Minority Ethnicity (BAME). Children of BAME parents generally have higher than average levels of tooth decay in their first teeth, even after adjusting for socioeconomic status[33]. Belonging to a family in which the mother speaks little English is a factor associated with severe tooth decay[34].

Smoking and drinking alcohol to excess are lifestyle risk factors linked to the majority (over 90%) of oral cancer cases[35]. Over 70% of current tobacco users, and over 70% of adults who drink alcohol at

[30] NICE. October 2014. Public Health guideline PH55. Oral health: local authorities and partners. www.nice.org.uk/guidance/ph55 Accessed 4 May 2016
[31] Fisher-Owens et al (2007), Pediatrics, vol. 120 no. 3 September 01, 2007.
[32] Department of Health. Early Years High Impact Area 5 – Managing minor illness and reducing accidents (hospital attendance/admissions). Commissioning of public health services for children. 1 July 2014.
[33] Marshman Z, Rodd H, Stern M et al. An evaluation of the Child Perceptions Questionnaire in the UK. Community Dent Health 2005; 22: 151–155.
[34] Rayner et al (2003) cited in: www.nice.org.uk/guidance/NG30/documents/oral-health-promotion-approaches-for-dental-health-practitioners-final-scope2 Accessed 26 May 2016
[35] NICE. Improving outcomes in head and neck cancers: Evidence Update May 2012.

levels putting themselves at "increasing risk" or at "high risk" of developing alcohol-use disorders, all visit the dentist at least once a year. Consequently, dentists are ideally placed to give people information about smoking cessation, Brief Advice about reducing their alcohol consumption, and can refer to specialist services if necessary.

Of all ages, those of middle age (35-64 years) were more likely to visit the dentist at least once a year (80%) and those aged 65+ years the least (71%). People with no disabilities were more likely than those with three or more conditions to visit the dentist (77% compared with 69%). Older people and people with disabilities present challenges for oral health promotion as their co-morbidities can make dental treatment more difficult. Some physical conditions or reduced manual dexterity can make oral health self-care a challenge for some older people.

Some people with dementia are dependent on carers for their health needs, while supporting their wishes and dignity. This survey was of adults living in their own homes, not in communal settings. Those in care or nursing homes are dependent on carers employed in these institutions for their oral health care. Any or all of these factors may result in oral health falling down the list of priorities, particularly when knowledge of oral health, and/or of dental services, is low. Prompt investigation into ways in which this can be rectified is recommended.

What we are doing to help people lead healthier lifestyles

The council is statutorily responsible for commissioning oral health promotion programmes to improve the health of the local population.

To encourage better oral health we:

- work in partnership with the University of Portsmouth Dental Academy to deliver the Brush Up and the Fluoride Varnish Programmes
- commission/deliver health promotion training and start up resources for schools
- commission triage sessions for young adults and people who find it difficult to maintain good oral health and/or access services for various reasons eg older people, people who are homeless and other vulnerable people in our communities. There is a plan to build in monthly mobile emergency dental care (as well as maintaining the ongoing oral health messages, screening and advice) from September 2016
- deliver oral health promotion messages and sign posting to relevant services such as NHS dentists
- are reviewing overall oral health to ensure that the health promotion we are offering is best matched to the oral health needs of Portsmouth residents.

What should we do

- Ensure that Portsmouth residents are able to access NHS dentists. We need to make sure that the information about oral health and where and how to access dental surgeries is readily available to everyone (but particularly high risk groups) in a format that is easily understandable.
- Engage dentists in MECC.

12 Summary of recommendations

1 We should continue to promote Portsmouth as a healthy city.

2 We will ensure that the information in the lifestyle survey and in this report inform strategic decisions by, among others, the Sustainability and Transformation Plan, Portsmouth Blueprint and Better Care to improve health and wellbeing in Portsmouth.

3 We will promote self-help as the first port of call for information and support on healthy behaviours. We need to do this on a larger scale, working cost-effectively with partners across Hampshire and the Isle of Wight.

4 The survey did not explore the use of online health and wellbeing resources and applications. We need to find out which online resources are most effective at promoting behaviour change; and how can we provide the same sort of support to people who cannot access the internet.

5 We need to ensure that information about how to live a healthier life and how to access relevant services is readily available to everyone (but particularly to high risk groups) in a format that is easily understandable.

6 We should scale-up Making Every Contact Count (MECC). We need to work with partners across the city so that MECC philosophy, knowledge and skills are embedded and routinely practiced.

7 We should continue to monitor the uptake and outcomes of the Wellbeing Service. We need to ensure that access and use of the service is fair and focuses on those most in need.

8 We should continue to build and act on the findings in the RPAs and continue to establish an ongoing relationship between local communities and service providers.

9 We should continue to be a member of Cities of Service. Through the 'Portsmouth Together' partnership, we will seek to promote and extend volunteering across Portsmouth, showing the impact that volunteering can make in our communities (eg the community sign-posters associated with the Wellbeing Service, and the community connectors linked to the Independence and Wellbeing Team). We will continue to promote the 'Portsmouth Together' website.

10 We will continue to work with other council directorates, including City Development and Transport, so that improving health and wellbeing is considered in all planning decisions.

11 We will continue to support the Mental Health Alliance, Food Portsmouth, the Tobacco Control Alliance and Safer Portsmouth Partnership. With partners, we will implement the Mental Health Strategy, the Physical Activity and Healthy Weight Strategies, and the Smokefree Portsmouth: Tobacco Control Strategy.

12 In addition to the SPP's action plan in relation to tackling alcohol misuse, we should:

- deliver Brief Advice on a larger scale as evidence shows this is an effective means of reducing alcohol consumption amongst increasing and "high risk" drinkers

- include additional off-licenced premises cumulative impact areas, within Central locality, in the Council's forthcoming Statement of Licensing Policy, recognising that current national and local licensing policy does not necessarily consider health related harm
- with partners, lobby local MPs and national government to support health as a licensing objective and the introduction of a national minimum price per unit of alcohol.

13 We will support workplace health initiatives through the Workplace Wellbeing Charter.

14 We will continue to implement NICE guidance about mid-life approaches to delay or prevent onset of dementia, disability and frailty.

15 We will continue to commission NHS Health Checks.

16 We will continue to use the survey results to investigate areas of concern and inform actions, for example at locality level.

Appendix 1

Key findings for North, Central and South localities

Behaviour	Percentage					Margin of error (plus or minus)			
	North	Central	South	All adults		North	Central	South	All adults
No unhealthy behaviours	9.8%	8.8%	9.8%	9.5%		3.6%	3.4%	3.2%	2.0%
One unhealthy behaviour	34.9%	31.7%	34.6%	33.8%		5.9%	5.6%	5.2%	3.2%
Two unhealthy behaviours	38.4%	35.1%	43.4%	39.2%		6.0%	5.8%	5.4%	3.3%
Three unhealthy behaviours	15.7%	14.5%	8.6%	12.6%		4.5%	4.3%	3.0%	2.2%
Four unhealthy behaviours	1.6%	9.9%	3.4%	5.0%		1.5%	3.6%	2.0%	1.5%
Low satisfaction with life nowadays	36.7%	38.0%	31.8%	35.1%		5.3%	5.3%	4.4%	2.9%
Medium satisfaction with life nowadays	42.8%	38.6%	44.7%	42.2%		5.5%	5.3%	4.7%	3.0%
High satisfaction with life nowadays	20.8%	23.5%	23.5%	22.8%		4.5%	4.6%	4.1%	2.5%
Low mental wellbeing	12.5%	12.7%	10.7%	11.8%		3.7%	3.7%	3.0%	2.0%
Medium mental wellbeing	73.5%	72.5%	72.7%	72.8%		4.9%	5.0%	4.3%	2.7%
High mental wellbeing	12.5%	10.5%	13.3%	12.2%		3.7%	3.4%	3.3%	2.0%
Being in "Very good" or "Good health"	67.5%	71.2%	75.1%	71.7%		5.2%	5.0%	4.1%	2.7%
Being in "Very bad" or "Bad health"	6.4%	10.3%	7.9%	8.2%		2.7%	3.4%	2.6%	1.7%
Underweight	1.1%	1.4%	2.3%	1.7%		1.2%	1.4%	1.5%	0.8%
Healthy weight	33.2%	45.1%	55.6%	46.0%		5.5%	5.9%	4.9%	3.2%
Overweight	43.8%	32.1%	27.2%	33.5%		5.8%	5.5%	4.4%	3.0%
Obese	21.9%	21.7%	14.6%	18.8%		4.8%	4.9%	3.5%	2.5%
						0.0%			
Meet 5+ portions of fruit or veg each day	34.1%	28.2%	35.1%	32.7%		5.3%	5.0%	4.7%	2.9%
Meet physical activity guidelines for moderate and/or vigorous activity each week	54.7%	54.0%	66.0%	59.1%		5.5%	5.4%	4.5%	3.0%
Alcohol drinking levels for all residents									
All residents - No risk	59.6%	58.4%	48.9%	55.0%		5.7%	5.7%	5.1%	3.2%
At "increasing risk" of developing an alcohol misuse disorder	31.1%	29.2%	36.3%	32.6%		5.4%	5.2%	4.9%	3.0%
At "high risk" of developing an alcohol misuse disorder	9.6%	12.4%	14.8%	12.4%		3.5%	3.8%	3.6%	2.1%
Alcohol drinking levels for those who drink									
Audit C score completed and no risk	50.6%	43.7%	38.9%	43.9%		6.4%	6.6%	5.5%	3.5%
Audit C score completed and "increasing risk"	37.7%	39.5%	43.5%	40.7%		6.2%	6.5%	5.6%	3.5%
Audit C score completed and "high risk"	11.7%	16.7%	17.6%	15.4%		4.1%	5.0%	4.3%	2.6%
Smoke daily or occasionally	16.5%	22.6%	13.2%	17.1%		4.1%	4.5%	3.3%	2.3%
Tobacco use	15.2%	20.9%	11.8%	15.6%		4.0%	4.4%	3.1%	2.2%
Give unpaid to help others because of either long-term physical or mental ill-health, disability or problems relating to old age	27.3%	15.4%	21.6%	21.4%		5.0%	4.0%	4.0%	2.5%

Appendix 2

Key findings for different age groups

Behaviour	Percentage					Margin of error (plus or minus)			
	16-34	35-64	65+	All adults		16-34	35-64	65+	All adults
No unhealthy behaviours	7.7%	9.5%	12.5%	9.5%		3.0%	2.9%	5.7%	2.0%
One unhealthy behaviour	34.8%	32.1%	35.9%	33.8%		5.3%	4.6%	8.3%	3.2%
Two unhealthy behaviours	43.9%	35.8%	39.1%	39.2%		5.5%	4.7%	8.5%	3.3%
Three unhealthy behaviours	8.7%	16.8%	9.4%	12.6%		3.1%	3.7%	5.0%	2.2%
Four unhealthy behaviours	5.8%	5.8%	2.3%	5.0%		2.6%	2.3%	2.6%	1.5%
Low satisfaction with life nowadays	34.2%	36.6%	33.8%	35.1%		4.9%	4.3%	6.6%	2.9%
Medium satisfaction with life nowadays	43.3%	44.7%	33.8%	42.2%		5.1%	4.4%	6.6%	3.0%
High satisfaction with life nowadays	22.5%	18.7%	32.3%	22.8%		4.3%	3.4%	6.6%	2.5%
Low mental wellbeing	11.9%	13.2%	8.2%	11.8%		3.4%	3.0%	4.0%	2.0%
Medium mental wellbeing	74.4%	75.0%	64.6%	72.8%		4.6%	3.9%	7.0%	2.7%
High mental wellbeing	11.7%	10.2%	18.5%	12.2%		3.3%	2.7%	5.7%	2.0%
Being in "Very good" or "Good health"	81.1%	70.3%	58.4%	71.7%		4.1%	4.1%	7.1%	2.7%
Being in "Very bad" or "Bad health"	4.2%	11.7%	7.0%	8.2%		2.1%	2.8%	3.7%	1.7%
Underweight	2.5%	0.9%	1.8%	1.7%		1.7%	0.9%	2.0%	0.8%
Healthy weight	60.7%	39.0%	38.1%	46.0%		5.3%	4.5%	7.3%	3.2%
Overweight	26.3%	35.9%	41.1%	33.5%		4.8%	4.4%	7.4%	3.0%
Obese	10.5%	24.5%	18.5%	18.8%		3.3%	4.0%	5.9%	2.5%
						0.0%			
Meet 5+ portions of fruit or veg each day	29.4%	32.8%	38.3%	32.7%		4.7%	4.2%	7.1%	2.9%
Meet physical activity guidelines for moderate and/or vigorous activity each week	70.6%	56.7%	44.2%	59.1%		4.7%	4.4%	6.9%	3.0%
Alcohol drinking levels for all residents									
All residents - No risk	46.9%	52.1%	77.2%	55.0%		5.4%	4.6%	6.5%	3.2%
At "increasing risk" of developing an alcohol misuse disorder	43.5%	29.8%	19.6%	32.6%		5.4%	4.2%	6.2%	3.0%
At "high risk" of developing an alcohol misuse disorder	9.3%	18.1%	3.2%	12.4%		3.2%	3.6%	2.7%	2.1%
Alcohol drinking levels for those who drink									
Audit C score completed and no risk	38.9%	41.4%	65.0%	43.9%		5.7%	5.1%	9.3%	3.5%
Audit C score completed and "increasing risk"	50.4%	36.4%	31.0%	40.7%		5.9%	4.9%	9.1%	3.5%
Audit C score completed and "high risk"	10.7%	22.2%	5.0%	15.4%		3.6%	4.3%	4.3%	2.6%
Smoke daily or occasionally	15.8%	20.7%	11.3%	17.1%		3.8%	3.6%	4.4%	2.3%
Tobacco use	13.8%	19.6%	9.7%	15.6%		3.6%	3.5%	4.2%	2.2%
Give unpaid to help others because of either long-term physical or mental ill-health, disability or problems relating to old age	17.9%	23.7%	20.9%	21.4%		4.0%	3.8%	5.8%	2.5%

Agenda Item 6

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Agenda item:

Title of meeting:	Health and Wellbeing Board
Subject:	Update on public health services for children 0-5 years, including health visiting
Date of meeting:	22 June 2016
Report by:	Director of Public Health, Portsmouth City Council
Wards affected:	All

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1. Requested by Chair of Health and Wellbeing Board

2. Purpose

To update the Health and Wellbeing Board on public health services for 0-5 year olds, (including health visiting service); plans for financial savings and potential impact.

3. Background

3.1 Responsibility for commissioning 0-5's public health services moved from NHS England to Local Authorities in October 2015. Local Authorities are now responsible for commissioning the whole 0-19 years Healthy Child Programme. The 5-19 programme, which has been commissioned by the Local Authority since April 2013, is delivered by the school nursing and young people's public health delivery teams.

3.2 Public health 0-5 services include health visiting (universal and targeted services) and Family Nurse Partnership (targeted service for teenage mothers).

3.3 Evidence shows that the first thousand days of life are crucial to a child's development. In response to this, the Government launched the 'call to action' in 2011 to increase investment in heath visiting services, aiming to increase HV numbers by 4,200 nationally over the course of its implementation..

4. Health visiting service

4.1 Health Visitors lead the local delivery of the Healthy Child Programme for 0-5 year olds, providing all families with crucial evidence-based support, expert advice and intervention in the first years of life. The Healthy Child Programme (HCP) is a prevention and early intervention public health programme offered to all families that lies at the heart of the universal service for children and families. It aims to support parents, promote child development, reducing inequalities and thus contribute to

improved child health outcomes and health and wellbeing, and ensure that families at risk are identified at the earliest opportunity.

4.2 As part of the transfer, some universal health visitor reviews, which form part of the 0 to 5 Healthy Child Programme, are legally mandated until March 2017. The 5 checks include following antenatal, new birth, 6-8 weeks, 12 months and 2 year check.

4.3 The health visiting service model works at 4 levels; Community, Universal, Universal Plus and Universal Partnership Plus, with the service provided increasing across differing levels of family need.

4.4 The Health Visiting service focuses on 6 High Impact Areas, based on national evidence prioritising areas of most significance in terms of children's health, and most effective interventions.

- Transition to parenthood
- Early weeks maternal mental health
- Breastfeeding
- Healthy weight and healthy nutrition
- Managing minor illnesses and reducing accidents
- Health, wellbeing and development of the child aged 2

4.5 Portsmouth also has a specialist health visiting service for children with disabilities and an infant feeding team.

5. Family Nurse Partnership

5.1 The Family Nurse Partnership programme (FNP) is an evidence-based, preventive public health home visiting programme for vulnerable first time young mothers aged 19 and under. Structured home visits, delivered by specially trained family nurses, are offered from early pregnancy until the child is two.

5.2 Portsmouth FNP is considered to be one of the best in the country and is part of a national programme to pilot new criteria and new ways of working.

6. Public Health services for 5-19 year olds

6.1 Public health services for 5-19 year olds in Portsmouth are provided by the school nursing and young people's public health delivery team. Investment in this age group is low compared to other areas, resulting in 2 small teams which are unsustainable individually going forward. The teams are working together to integrate and ensure delivery of a cohesive Healthy Child Programme for 5-19 year olds as part of Multi-Agency Teams.

7. Financial considerations

7.1 Public health services for children and young people form a significant proportion of the spending within the public health ring-fenced grant, as indicated in the following graph:

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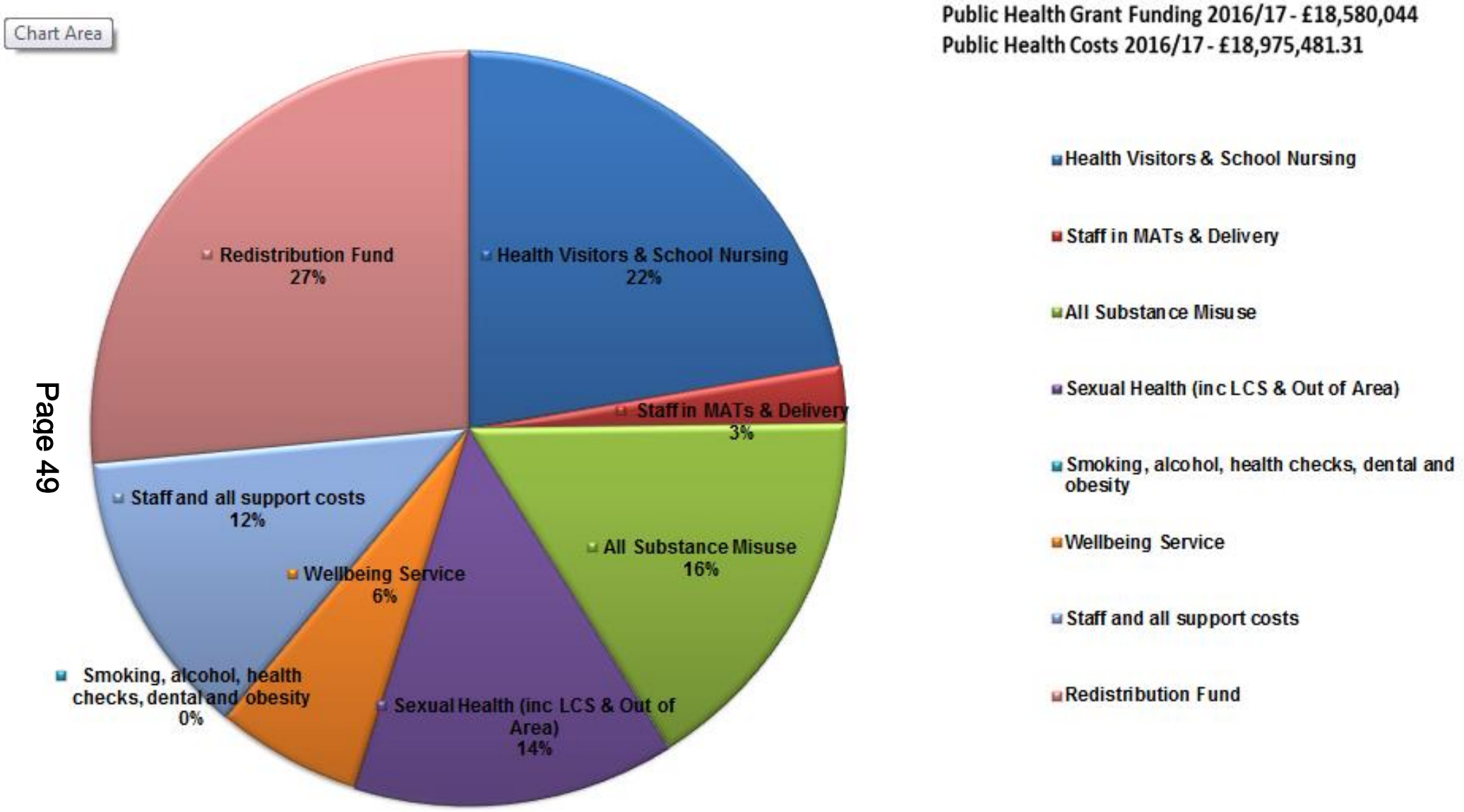

7.2 Other significant areas of spend in the public health budget include sexual health, substance misuse and lifestyle services. All these areas have either been remodelled, or are in the process of remodelling/retendering to make savings. This leaves very little opportunity for further savings. Future reductions in the public health grant post financial year 2017/18 will need to look to public health children's services.

Summary of Public Health Income				
	2016/17	2017/18	2018/19	2019/20
Grant Reduction 16/17 (2.2%)	417,956.00	417,956.00	417,956.00	417,956.00
Grant Reduction 17/18 (2.5%)		464,501.00	460,000.00	460,000.00
Grant Reduction 18/19 (2.6%)			471,004.00	473,000.00
Grant Reduction 19/20 (2.6.%)				458,758.00
Total Reduction	**417,956.00**	**882,457.00**	**1,348,960.00**	**1,809,714.00**
PHE Allocation (Grant)	**18,580,044.00**	**18,115,543.00**	**17,644,539.00**	**17,253,000.00**
PCC Savings Targets (indicative for 17/18 onwards)	1,448,600.00	601,800.00	817,800.00	705,100.00
Cumulative savings	3,405,450.00	4,854,050.00	5,455,850.00	6,273,650.00
Total cumulative savings to be redistributed	**4,854,050.00**	**5,455,850.00**	**6,273,650.00**	**6,978,750.00**
Total remaining recurrent budget	**13,725,994.00**	**12,659,693.00**	**11,370,889.00**	**10,274,250.00**

7.3 Most of the health visiting and FNP service budget is staff related, so further savings reductions will have an impact on staffing numbers.

8. Changes to date

8.1 The health visiting service have reviewed skillmix in order to meet the 2016/17 savings requirements (approx 7%). 16 qualified NHS band 6 Health Visitors are being replaced with band 5 community staff nurses, over the course of the year. These nurses will work under the supervision of health visitors to continue the safe and effective delivery of the universal mandated elements of the Healthy Child Programme to low risk families.

8.2 Temporarily there is reduced capacity in the health visiting service whilst the new community staff nurses are being recruited and trained. During this time, antenatal checks for non-first time, non-vulnerable mothers will be offered through groups and the 12 month review will be delivered as a home visit for first time, and vulnerable parents only. Other families will be offered the choice of a child health clinic, phone or email contact for their 12 month review.

9. Future plans

9.1 The Children's Trust Board's priority “Stronger Futures” programme, includes the development of a single investment strategy for children and young people. This work is the responsibility of the Joint Investment Group and the Director of Public Health is a member.

9.2 The Joint Investment Group has identified potential key strands of work for the next few years, designed to ensure effective management of demand against the background of reduced overall investment. This includes a review of the current balance between universal and targeted coverage for standard development reviews for children from pre-natal to 2/2.5 years and the potential to redeploy resources away from low risk universal coverage.

9.3 The Joint Investment Group is currently identifying principles for budget decisions, risks and challenges, and a more detailed action plan.

……
Signed by Director of Public Health

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

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

Title of document	Location

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

Portsmouth CITY COUNCIL

Title of meeting:	Health and Wellbeing Board
Subject:	Portsmouth Health and Lifestyle Survey of Adults
Date of meeting:	22 June 2016
Report by:	Director of Public Health
Wards affected:	All

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1. Purpose

To note that Public Health Directorate commissioned Ipsos MORI to conduct a survey of the health and wellbeing of adults aged 16+ years.
The survey report is attached - for noting.

Implications for action and recommendations are set out in the statutory Director of Public Health's Annual Report, 2015 ("Portsmouth How Are You"), which is also on this agenda.

2. Information Requested

None

……
Signed by (Director)

Appendices:

Ipsos MORI, 2015. Portsmouth Health and Lifestyle Survey: Summary report of findings.

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

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

Title of document	Location

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Portsmouth Health and Lifestyle Survey 2015

Summary report of findings – FINAL






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Summary of key findings

1 Summary of key findings

1.1 Introduction

This report summarises the key findings and statistically significant sub-group differences from a postal self-completion survey (with an online completion option) of 1,075 Portsmouth residents conducted between 25 September and 6 November 2015, by independent researchers Ipsos MORI on behalf of the Portsmouth Health and Wellbeing Board (PHWB). The research aims to provide an up-to-date picture of the health and wellbeing of local residents aged 16+ years across a range of measures: their physical and mental wellbeing; their diet and eating habits; the prevalence of drinking, smoking and drug use; sexual health; and, community involvement. The term "residents" in this report refers to Portsmouth resident adults aged 16+ years.

1.2 Overall health and wellbeing

- The great majority of Portsmouth residents (72%) rate their health as good/very good, compared with only a small number (eight per cent) who say it is bad/very bad. This, indicatively speaking, is only slightly below the England average of 76%[1].

- Three in ten residents (31%) report having a disability or health condition that limits their daily activities in some way; one in ten (10%) have one that limits them a lot.

- Over half of residents say they have a health condition of some kind (56%) and one in eight (13%) have a combination of at least three different types of condition, the most common individual conditions being high-blood pressure (16%) and arthritis or long-term joint problems (16%), followed by long-term back problems (14%). The survey results show that lifestyle factors and behaviours are closely linked to having a health condition, with overweight and obese residents, along with smokers, more likely to have multiple health conditions.

- PHWB wanted to know the prevalence of four key unhealthy behaviours (tobacco use, drinking to a risky level[2], not doing the recommended amount of moderate or vigorous physical activity[3], and not having the recommended five portions of fruit and vegetables a day). Only one in ten Portsmouth residents (10%) exhibit *none* of

[1] 2013 Health Survey for England, conducted face-to-face through a random probability selection method.
[2] A score of 5+ on the Audit C scale - see section 2.3.2
[3] Either doing less than 150 minutes' worth of moderate physical activity a week or its equivalent in vigorous activity.

these behaviours. Most exhibit at least two of them (57%), and one in six (18%) show either three or four. The mean number of unhealthy behaviours residents have is 2.17 (out of four).

- When asked about their recent state of mind[4], residents most frequently say they have been able to "make up their own mind about things" (77%) and have been "thinking clearly" (69%). Conversely, just under half (49%) feel "optimistic about the future" or "relaxed" (43%).

1.3 Physical activity

- Residents are fairly evenly split when asked about their level of fitness. Three in ten (29%) believe they are fit/very fit, compared with one in five (21%) who see themselves as unfit/very unfit. Half (50%) perceive their level of fitness to be about average. Perceived levels of fitness do correlate with actual levels of activity; the great majority of those who feel fit/very fit meet the recommended level of physical activity (86%, compared with 23% of those who feel unfit/very unfit).

- Residents are also evenly divided on the amount of exercise they do - almost half (45%) perceive that they currently exercise enough already, while half (50%) accept they do not exercise enough. When it comes to appetite for doing more exercise, the PHWB can perhaps be encouraged that a majority (57%) would like to do more exercise than they currently undertake.

- During an average week, the great majority of residents are physically active, but they are more likely to undertake activity which is moderate[5] (88%) rather than vigorous[6] (55%). Three in five (59%) meet the recommended weekly minimum of either 150 minutes of moderate activity or its equivalent in vigorous activity, which is in line with the average for Portsmouth (61%) and England overall (57%)[7] (noting that this is an indicative comparator only). Only nine per cent of respondents in Portsmouth are sedentary (i.e. do no moderate or vigorous activity).

- Residents cited "lack of time" as the most common single obstacle making it hard to do more exercise (47%). The next most common obstacle is the financial cost of exercise (cited by 21%).

[4] The questions asked are taken from the shortened version of the Warwick and Edinburgh Mental Wellbeing Scale (SWEMWBS)
[5] Defined as activity that raises the heart rate and makes respondents feel warmer.
[6] Defined as activity that makes respondents breathe harder and also makes it hard to talk without pausing for breath.
[7] 57% of adults across England report undertaking the weekly minimum of 150 minutes of moderate physical activity and/or 75 minutes of vigorous activity a week. The figure for Portsmouth is 61%. (Active People Survey, Sport England, 2014 reported in the Public Health Outcomes Framework, Public Health England, as at December 2015) .

1.4 Diet and healthy eating

- Portsmouth residents are far more likely to agree than disagree that they have a healthy diet overall (65% compared with 12%).

- However, in reality, far fewer have a healthy diet. Although almost all residents (98%) say they eat at least some fruit or vegetables a day, only one in three (33%) meet or exceed the recommended daily minimum of five portions. That said, almost all residents say they eat home-cooked meals made from scratch at least once a week (94%), and most do so at least four times a week (66%).

- Residents cite lack of time to prepare or cook food as the top reason for not eating more healthily (cited by 24%), closely followed by "lack of willpower" (20%) and the expense of healthy food (19%).

- Fewer than half of residents have a healthy weight (46%), based on the figures for their height and weight that they report. One in three (34%) are overweight, and one in five (19%) are obese. The proportion of obese residents is slightly higher than latest findings from the Active People Survey for Portsmouth (17%) and England (15%)[8].

1.5 Alcohol use

- The great majority of Portsmouth residents (82%) say they drink alcohol at least occasionally. One in three (35%) residents says they drink alcohol at least two or three times a week, with a further one in seven (14%) drinking four or more times a week. Among those who do drink, around one in four (23%) are drinking to unhealthy levels, consuming at least seven units in a typical day when drinking.

- Whilst the majority of residents (55%) are not seen to be at risk of developing an alcohol use disorder[9] from drinking alcohol, more than two-fifths (45%) are at such risk. Overall, one-third of residents (33%) could be described as being at 'increasing risk', meaning they meet the criteria for receiving "brief advice" from a health worker about how best to reduce their alcohol consumption. A further one in eight (12%) could be described as 'high risk'.

- When data are examined just for those who drink alcohol, over half of drinkers in Portsmouth (56%) are at some risk of developing an

[8] Data comes from the Active People Survey for 2012-14. Data are unadjusted, and so are somewhat different from the results listed in the Public Health Outcomes Framework, Public Health England, as at December 2015.
[9] As determined by three questions taken from the Audit C Tool. The tool uses response data for the frequency and quantity of alcohol drinking to score each participant on a scale between 0 (the lowest risk of developing an alcohol use disorder) and 12 (the highest risk of developing an alcohol use disorder).

alcohol use disorder: two in five (41%) are at 'increasing risk' and one in seven (15%) at 'high risk'.

- The adverse impact that drinking has on behaviour appears to be greater for those residents most at risk of developing an alcohol use disorder. For example, those drinkers seen to be at 'high risk' are more likely than drinkers overall to say that, at least once in the last 12 months, alcohol has made them unable to do what was expected of them, and that their drinking has caused them to injure themselves or someone else.

1.6 Smoking

- One in six Portsmouth residents (16%) say they currently smoke or use tobacco (excluding e-cigarettes). Although the comparison can only be indicative (for example, this survey is for those aged 16+ years), prevalence of smoking is in line with the England average for adults aged 18+ years (18%); however, it is lower than the prevalence for Portsmouth (22%) from the national Integrated Household Survey [10]. Additionally, more than one in four residents (28%) say that they have smoked or used tobacco or nicotine at some point in their lives, but no longer do so.

- The majority of tobacco users in Portsmouth smoke at least five times a day (72%). Half of them smoke between five to 15 times a day (48%), while one in four (24%) smoke more than 15 times a day.

- Three in four tobacco users in Portsmouth (77%) say they would like to stop smoking.

- Most tobacco users are aware of the various stop-smoking services available to them, the best known being those stop-smoking services provided by local healthcare providers such as GP surgeries and pharmacies. It appears medical providers may form the most trusted and effective form of delivering stop-smoking services as well. In thinking about how to support smokers to quit, it is worth reflecting that of the 28% of survey participants who are former smokers, seven in ten (71%) said that they gave up smoking without any help or support.

1.7 Drug use

- The great majority of residents (93%) say they have not taken any kind of illegal drug or 'legal high' in the last 12 months, but seven per cent indicate they have, which equates to almost 12,000 residents

[10] Reported in Public Health Outcomes Framework, Public Health England, using data from 2014. The source is the Integrated Household Survey (carried out by ONS) analysed by Public Health England

aged 16+ years in Portsmouth[11]. Drug use is slightly more prevalent when participants are asked about drug use among people they know. Nine per cent of residents say at least one of their close relatives uses drugs or 'legal highs', and one in seven (15%) say at least one of their close friends does so.

- Cannabis is the most frequently used substance among those who have used drugs in the last 12 months (81%). This is followed by ecstasy/ MDMA and cocaine powder (24% in both cases), 'legal highs' such as herbal incense (17%) and amphetamines (12%).

- Of those who have used drugs in the last 12 months, most (74%) say they have sometimes or always been able to control their actions when taking drugs, although one in five (20%) have not.

1.8 Sexual health

- Seven in ten residents (69%) have had a sexual partner in the last 12 months. Overall, a small proportion (seven per cent) have had more than one sexual partner, but this is more marked among young residents aged 25-34 years (where it is 18%).
- Of those who have had a sexual partner in the last 12 months, two in five (43%) say they themselves use contraception and a similar proportion (39%) say their partners use it.
- For those not using contraception, the main reasons are that it is their personal preference (19%), or because they are trying for a baby or are currently pregnant (18%).

- Awareness of sexually transmitted diseases appears to be having some influence on residents' sexual behaviour. While most sexually active residents see it as less relevant due to them being in a long-term exclusive relationship (74%), one in six (18%) say it has prompted them to make sure they use a condom, and almost as many say it has prompted them to have tests for sexually transmitted diseases when they change partners (15%).

1.9 Health and the community

- Almost all Portsmouth residents (98%) have personally used at least one of a range of specific local health services in the last 12 months. Use of healthcare services is greater among residents with physical and mental ill health, and those who are older.

[11] Based on percentage of total population aged 16+ from ONS mid-year population estimates 2014

- In terms of health service use, almost all residents who took part in the survey (99%) say they are registered with a local GP. Three in four visit the dentist at least once a year (75%).
- The great majority of residents (88%) feel well informed about how to look after their health. One in ten (11%) feel badly informed. However, the proportion who do not feel informed is significantly higher among those groups of residents who may need the most help to improve their health (those in self-reported bad/very bad health or who have a condition that limits daily activities a little/lot).
- One in five residents (21%) provides unpaid care and support to someone else because of a long-term health condition, disability or problems related to old age. For one in twenty (five per cent) residents, this consists of 20 or more hours of unpaid care a week.
- One in five residents (20%) in Portsmouth could be described as being a regular volunteer – i.e. they did formal voluntary work with a group, club or organisation at least once a month in the last year. This is lower than the England average of 27%[12], although this comparison is only indicative.

1.10 Measuring attitudes vs. behaviours

The findings suggest that the way residents *perceive* their own health is not necessarily fully commensurate with the way they actually *behave*. For example, a majority of residents who describe their diet as healthy do *not* eat the recommended five portions of fruit and vegetables a day (57%). Although perceived fitness levels do correlate markedly with actual levels of activity, there are some residents who overestimate their level of fitness. Of those who say they are fit/very fit, one in eight (12%) are actually doing less than the recommended amount of physical activity a week. Of those who describe themselves as already doing enough exercise, one in eight (12%) does less than the recommended amount.

1.11 Clustering of healthy behaviours

The clustering of unhealthy behaviours has received attention in recent years, for example through David Buck's 2012 research for the King's Fund [13]. The survey shows that healthy (and unhealthy) behaviours are, to an extent, self-reinforcing. As an example, having an unhealthy diet corresponds with other unhealthy behaviours; one in eight residents overall say they have an unhealthy diet (12%), but this figure is greater among those who are physically sedentary (24%), those who feel unfit (20%), obese residents (20%) and smokers (19%). Put another way, residents who

[12] Community Life Survey 2014-15, conducted with a random probability face-to-face method
[13] Clustering of unhealthy behaviours over time, King's Fund (2012) http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/clustering-of-unhealthy-behaviours-over-time-aug-2012.pdf

are obese are far more likely not to exercise (65% say they do not exercise enough compared with 46% of those with a healthy weight). Not meeting the weekly level of physical activity is also more common among smokers (48% compared with 34% of those who have never smoked) and those with a less healthy diet (40% of those who do not eat the recommended amount of fruit and vegetables compared with 28% of those who do).

Alcohol, and to some extent drug-taking, appears to be an exception. It is interesting to note that drinking – and drinking *beyond* safe limits (as measured via the Audit C profile) - is greater among healthier, fitter groups of residents (as determined by their other behaviours). It is those residents who, for all intents and purposes appear to be 'healthy', who are more likely to drink and drink to excess. For example, physically active residents are more likely to have a 'high risk' Audit C score (23% of those who undertake at least 75 minutes of vigorous exercise a week, compared with only six per cent of those who do not undertake vigorous exercise). Conversely, those who are more likely to exhibit unhealthy behaviours in relation to exercise are actually *less* likely to consume excessive amounts of alcohol.

The relationship between doing vigorous activity and being a 'high risk' drinker is possibly partly explained by age; 'high risk' drinking is least common among drinkers aged 65+ years, who are also the least likely to do vigorous activity.

1.12 The importance of healthy living to wellbeing

The survey findings reinforce the notion that healthy behaviours are important determinants of wider wellbeing. Unhealthy behaviours – particularly not doing exercise and smoking – have strong links to physical health, with residents who exhibit these behaviours being more likely to describe their general health as bad/very bad.

It is the same for mental health. For example, those with a low level of mental wellbeing[14] are particularly likely to be sedentary (27% compared with nine per cent of residents overall). Worryingly, having a disability appears to play a large role too, with one in four (25%) residents with a condition that limits daily activities a little/a lot having low levels of mental wellbeing, compared with only six per cent of those without such a condition.

1.13 How do results vary by sub-groups?

Results vary significantly between various groups of residents. For example, the patterns of behaviour vary quite considerably between age groups:

[14] As measured through the shortened Warwick and Edinburgh Mental Wellbeing Scale (SWEMWBS)

- Older residents aged 65+ years are less likely to rate their health as good/very good, are more likely to have a health condition or disability that limits daily activities a little/a lot and are less physically active than most. However, they have consistently higher levels of mental wellbeing, and have a better quality of diet both in terms of the way they view their own diet, and in eating the recommended healthy amounts of fruit and vegetables. They are also less likely to exhibit unhealthy behaviours such as smoking and risky drinking.
- Those of middle age (aged 45-64 years) are more negative across a wide range of measures. They are more likely to report having bad/very bad health, and their mental wellbeing and satisfaction with life is consistently lower than for other age groups. This is also reflected in their behaviours as these age groups are more likely to exhibit unhealthy behaviours, such as smoking and heavy drinking. However, it may also reflect pressures in their personal lives; for example, those aged 55-64 years are more likely than residents overall to be unpaid carers.
- As might be expected, younger residents aged 16-34 years have the best quality of health and are the most physically active. They are also more likely than residents overall to have had several sexual partners or to have used drugs or 'legal highs' in the last 12 months.

Healthy behaviour also varies strongly by **socio-economic status**, with housing tenure, qualifications and deprivation (used here as proxy measures of socio-economic status) being particular defining factors. For example, council/social housing tenants and those in the most deprived neighbourhoods in Portsmouth are more likely to self-define their health as bad/very bad and to exhibit a greater range of unhealthy behaviours. They also have lower levels of mental wellbeing and life satisfaction.

Those residents who are **veterans** of the Armed Forces or Reserve Armed Forces have a similar pattern of behaviour to older residents aged 65+ years, which reflects the overlap between the two groups. For example, veterans are less likely than residents overall to rate their health as good/very good (62% compared with 72%), as are residents aged 65+ years (59%). However, veterans' levels of mental wellbeing and satisfaction with life are in line with the average for residents across Portsmouth, and in line with the average for all residents aged 65+ years. Also, it is notable that veterans have a higher mean satisfaction score when it comes to their finances (7.29 compared with 6.54 for residents overall).

Results vary to some extent by gender, with men more likely than women to see themselves as fit/very fit (37% compared with 23%) and to be physically active (28% do more than 75 minutes of vigorous activity a week, compared with 14% of women). On the other hand, men are more unhealthy in several respects, as more of them are overweight or obese (57% compared with 47% of women) and are high-risk drinkers (20% compared with six per cent

of women). Men are also more likely than women to have taken drugs in the last 12 months (10% compared with four per cent).

There is generally little variation between the different localities of Portsmouth (see map of localities at Appendix 2). However, residents in Central Portsmouth are more likely to exhibit all four unhealthy behaviours (10% compared with five per cent across the city as a whole). Those in South Portsmouth are more positive in several respects; compared with those in the other parts of the city, they are more likely to regard themselves as fit/very fit (35% compared with 25%) and to rate their diet as healthy (72% compared with 60%). However, they are also more likely to have taken drugs in the last 12 months (10% compared with seven per cent of all residents) and to have close friends who take drugs (21% compared with 15% overall).

Main report

2 Overview of approach

1,075

residents aged 16 years and over took part in the 2015 survey

2.1 Introduction

This report summarises key findings from a postal self-completion survey of 1,075 Portsmouth residents conducted by independent researchers Ipsos MORI on behalf of Portsmouth Health and Wellbeing Board (PHWB), which brings together representatives of various organisations including Portsmouth City Council and NHS Portsmouth Clinical Commissioning Group. The research aimed to gather information on the health and wellbeing of Portsmouth residents aged 16 years and over across a wide range of measures: their physical and mental wellbeing; their diet and eating habits; the prevalence of drinking, smoking and drug use; sexual health; and, community involvement.

The survey follows three previous lifestyle surveys conducted in 1993, 1999 and 2005. The 2015 findings provide an up-to-date picture of healthy lifestyles across the Portsmouth population, as well as a more detailed understanding of how lifestyles differ across different community groups and across different localities in the city.

Specifically, the findings are intended to form a key component of Portsmouth's Joint Strategic Needs Assessment which aims to inform planning across the city to ensure service interventions can be targeted accordingly. It also provides a reliable baseline measure from which to track and monitor changes in lifestyle and health status across areas and over time.

More specifically, the 2015 survey looked at:

- **General quality of health**, as well as the incidence of health conditions and the use of local health services.
- Residents' **mental wellbeing**, based on a series of questions about their state of mind over the preceding two weeks, as well as questions about attitudes to various aspects of life.
- The amount and types of **physical activity** that residents undertake in the average week, barriers to doing more exercise, and the types of activity they do.
- Residents' perception of the quality of their own **diet,** the extent to which they have a healthy diet, and barriers that may prevent them from eating more healthily.
- Levels of **alcohol consumption**, how much and how frequently residents drink, and incidence of problems caused by drinking alcohol.

- Prevalence of smoking, residents' **smoking habits,** and awareness and appetite for using local Stop Smoking Support services.
- Prevalence of **drug taking**, the types of drugs taken and the effect of drug taking on levels of self-control.
- **Sexual health**, including the number of recent sexual partners residents have had and their use of contraception.
- Involvement in the **local community**, and local voluntary work, along with individuals' caring responsibilities.
- **Feeling informed** about keeping healthy and attitudes towards the quality of local healthcare information.

A number of **demographic questions** were also asked so as to understand the views and behaviours of different community groups.

2.2 Methodology

The methodology comprised a postal self-completion survey of 1,075 residents aged 16+ years, with a parallel online option. This was similar to the methodology taken in previous surveys.

Ipsos MORI drew a random sample of 5,000 Portsmouth addresses from the Royal Mail Postal Address File (PAF). The PAF is used by Royal Mail and is updated every three months, giving access to a comprehensive and up-to-date list of addresses from which to sample. A disproportionately higher number of households were sampled in Portsmouth's more deprived Lower Super Output Areas (LSOAs) and those with a higher Black, Asian and Minority Ethnic (BAME) population[15]; this was a form of stratification which was undertaken in anticipation that response rates in deprived areas and among ethnic minorities would be disproportionately lower than average.

A 16-page questionnaire was sent out to each address in the sample. The covering letter asked for the questionnaire to be completed by anyone living at the address aged 16+ years. A reminder mailing was sent out to all non-responders mid-way through the fieldwork period. A unique online link was provided on the paper questionnaire so those participants who wished to do so could complete the survey online. The questionnaire is at Appendix 3.

Fieldwork ran from 25 September until 6 November 2015. The overall response rate was 22%. This consisted of 1,044 responses via the paper questionnaire and 31 responses via the online questionnaire.

[15] Lower Super Output Areas are small geographical areas used for the analysis of Census data and were brought in after the 2001 Census. There are 125 LSOAs in the Portsmouth local authority area.

Data are weighted back to the known population profile of Portsmouth to counteract non-response bias. Data are weighted by age within gender, work status, and then by the distribution of the Portsmouth population according to LSOA. The weighting profile was based on the latest available population statistics (2014 Population Mid-Year Estimates for age and gender, and 2011 Census for work status).

All data was obtained, processed, analysed and stored confidentially by Ipsos MORI.

2.3 Analysis models used

To give further insight into the findings for physical and mental wellbeing, this report uses several analytical models that group residents' responses into broader categories.

2.3.1 Unhealthy behaviours

Four unhealthy behaviours have been identified from questions in the survey, and results are analysed according to the number of these behaviours that residents show. These four behaviours are:

- Current tobacco smoking.
- Drinking to a risky level (score of 5+ on the Audit C scale - see section 2.3.2).
- Doing less than the recommended weekly level of physical activity (fewer than 150 minutes of moderate physical activity a week or fewer than 75 minutes of vigorous activity).
- Eating fewer than five portions of fruit and vegetables a day.

Participants who either said 'don't know' or who gave no response to these questions in the survey were excluded from the analytical model.

2.3.2 Audit C Tool

AUDIT (Alcohol Use Disorders Identification Test) is a set of ten questions devised by the World Health Organisation and used internationally as a way to measure alcohol consumption. The Audit-C Tool is a subset of three of the questions that identify 'risky' levels of drinking. This analysis method assigns all participants a score of 0 to12 based on their responses to the three Audit-C Tool questions.

- How often do you have a drink containing alcohol?
- How many units of alcohol do you have on a typical day when drinking?

- How often have you had eight or more units (if male)/ six or more units (if female) on a single occasion in the last year?

For this particular analysis, the scores from Audit C were used to group participants into three bands: 'low risk' respondents have a score of 0-4 and are classed as either non-drinkers or residents who drink moderately; 'increasing risk' respondents have a score of 5-8 and are classed as drinking beyond safe levels although they are thought only to need advice to help them; and, 'high risk' respondents who have a score of 9-12 and are classed as needing not only advice but possible referral to a specialist service. The 'risk' refers to the risk of developing an alcohol use disorder.

Participants who either said 'don't know' or who gave no answer to any of the three Audit C questions were excluded from the analytical model.

2.3.3 Shortened WEMWBS series

The survey has used a shortened form of the Warwick-Edinburgh Mental Well-being Scale (WEMWBS)[16], which uses responses to a series of questions about people's recent state of mind to form a measure of mental wellbeing. The Warwick-Edinburgh Mental Well-being Scale was funded by the Scottish Executive National Programme for improving mental health and wellbeing, commissioned by NHS Health Scotland, developed by the University of Warwick and the University of Edinburgh, and is jointly owned by NHS Health Scotland, the University of Warwick and the University of Edinburgh.

Instead of the full list of 14 questions, this survey uses a recognised shorter form of seven questions. In this survey, residents were asked how often they have been:

- feeling optimistic about the future
- feeling useful
- feeling relaxed
- dealing with problems well
- thinking clearly
- feeling close to other people, and
- able to make up their own mind about things.

Using the value assigned to each five-point answer scale, participants who gave an answer to each of these seven questions were assigned a score of

[16] The Warwick-Edinburgh Mental Well-being Scale (WEMWBS) is a scale of 14 positively worded statements, and participants are asked on a five-point scale how often they have felt or done these things in the preceding few weeks. The data can be used to show a population´s mental wellbeing. Warwick and Edinburgh Universities were commissioned to develop this tool in 2006.

between 7 (the lowest level of mental wellbeing) and 35 (the highest). Those who did not answer all of the questions were excluded from the analysis.

Purely for the purposes of this survey, a score of 7-19 has been selected to describe individuals with a 'low' level of mental wellbeing, a score of between 20 and 30 a 'medium' level, and a score of between 31 and 35 a 'high' level[17].

2.3.4 Socio-economic status

Throughout this report, reference is made to results by socio-economic status. Socio-economic status could not be calculated for each respondent, so a series of proxy measures were used instead: respondents' housing tenure, level of qualification and the level of deprivation of the neighbourhoods in which they lived.

To provide this analysis by neighbourhood deprivation, all 1,075 **participants** were ranked according to the deprivation score for the LSOA in which their address was situated. The term 'deprivation' used in this report is equivalent to the latest Index of Multiple Deprivation (IMD) rank of the score from the English Indices of deprivation[18], released in September 2015. Once participants had been ranked by the level of deprivation, they were then grouped into five groups, or quintiles, with roughly equal numbers of residents in each one. These ranged from the most deprived quintile of residents to the least deprived quintile.

Another way to have performed the deprivation analysis would have been to rank all of Portsmouth's **LSOAs** (not participants) by their level of deprivation, divide the LSOAs into quintiles and then assign each participant to a quintile according to where they live. The problem with this is that response rates are much lower in deprived areas. As such, the most deprived quintile of LSOAs would have had very few respondents, and the least deprived quintile of LSOAs would have had a great many. In contrast, the method of ranking and dividing respondents (not LSOAs) into quintiles ensures that each quintile has about 200 respondents and results are comparable.

2.4 Comparator data

At various points in the report, reference is made to comparator data from other sources, in order to provide context to Portsmouth's own results. These include:

- **Active People Survey 2013-2014** - this is a survey conducted on behalf of Sport England with a large number of residents in England

[17] The choice of ranges is an arbitrary selection agreed with Portsmouth City Council based on previous research undertaken by Ipsos MORI.
[18] English indices of deprivation 2015, Department for Communities and Local Government

surveyed by telephone each month (500 in each local authority area each year). While the survey collects information on sports participation, it also collects public health information (including, height, weight, and consumption of fruit and vegetables). The survey methodology has shifted to an online, self-completion method in 2015.

- Community Life Survey 2014-15 - the Community Life Survey is held annually to track trends and developments in areas that encourage social action and empower communities. The Cabinet Office commissioned the first Community Life Survey in 2012 to look at the latest trends in areas such as volunteering, charitable giving, local action and networks and well-being. The survey uses a random probability method and is conducted face-to-face with a nationally representative sample of adults aged 16 years and over in England. A total of 2,022 adults were surveyed across England between 2014 and 2015. The Community Life Survey incorporates key measures and replicates the main methodology from the Citizenship Survey (run by the Department for Communities and Local Government between 2001 and 2010-11). The survey year for 2014-15 covers data from July 2014 to April 2015.

- Health Survey for England 2013 - this is a major monitoring tool looking at the nation's health. It is used by the Government to plan health services and make important policy decisions. It covers health, social care, and lifestyles and is an annual survey carried out since 1991. The survey also adopts a random probability survey, which is interviewer administered. The latest available data is for 2013, with 8,795 adults interviewed nationally this year (2,185 children were also interviewed).

- Public Health Profiles - these are produced by Public Health England and provide a snapshot of health and wellbeing across each local authority in England. They draw on several data sources (e.g. the indices of deprivation, national statistics, and neighbourhood statistics), and while the sources are from differing years, all are recent. The profiles contain data on a range of indicators for local populations such as adult smoking rates, levels of child and adult obesity, hospital stays and early mortality. Public Health Profiles have been published annually since 2007.

- Public Health Outcomes Framework for England - Public Health England collates and publishes a wide range of indicators on the Public Health Outcomes Framework. The framework focuses on increased healthy life expectancy and reduced differences in life expectancy and healthy life expectancy between communities. There are four domains: (1) improving the wider determinants of health; (2)

health improvement; (3) health protection; and, (4) healthcare, public health and preventing premature mortality.

Comparator data is provided on an indicative basis given that results are not strictly comparable to the 2015 Portsmouth Health and Lifestyle Survey. This is because of differing methodologies including different time periods, question phrasing, survey methodology and sampling approach.

The report has also deliberately avoided comparing the 2015 data with previous waves of the Portsmouth Health and Lifestyle surveys due to the significant period of time elapsed since previous surveys were conducted, and the inevitable change in population profile, making like-for-like comparisons less reliable.

2.5 Technical note

Where figures in this report do not add up to 100%, this is the result of computer rounding or multiple responses. An asterisk (*) indicates a score less than 0.5%, but greater than zero. Unless otherwise indicated, results are based on all participants who gave an answer (all valid responses). Thus, base sizes may be different for some questions, and not all base sizes will consist of all 1,075 participants. Please treat answers with a base size of less than 100 with caution.

It is important to note that the results presented here are based on participants' answers to the questions. We cannot control for any under- or over-reporting of behaviours as they relate to people's health, since we are relying on participants to give an honest appraisal.

Results are subject to statistical tolerances. Not all differences between the overall Portsmouth results and those for individual sub-groups will be significant. The descriptive sections of this report aim to highlight where findings between different sub-groups of residents are statistically significant. A guide to statistical reliability is provided in Appendix 1.

Throughout this report, reference is also made to localities of the city as categorised by the council. These are: North, Central and South. Further details about these localities can be found in Appendix 2. A full copy of the questionnaire can be found in Appendix 3.

2.6 Acknowledgements

Ipsos MORI would like to thank the 1,075 Portsmouth residents who gave up their time to take part in the survey. We would also like to thank Joanna Kerr and James Hawkins, Public Health Directorate, Portsmouth City Council for their assistance in terms of the survey and questionnaire design.

2.7 Publication of data

This research has been conducted in accordance with the ISO 20252 market research standard that Ipsos MORI is accredited to. As Portsmouth City Council has engaged Ipsos MORI to undertake an objective programme of research, it is important to protect the organisation's interests by ensuring that it is accurately reflected in any press release or publication of the findings. As part of our standard terms and conditions, the publication of the findings of this report is, therefore, subject to the advance approval of Ipsos MORI. Such approval will only be refused on the grounds of inaccuracy or misrepresentation.

3 Overall health and wellbeing

72%

of residents rate their overall health as 'good'/'very good' compared with just eight per cent who rate it as 'bad'/'very bad'

3.1 Clustering of unhealthy behaviours

When looking at the combination of four key unhealthy behaviours identified by the PHWB (tobacco smoking, drinking to a risky level[19], not doing the recommended amount of moderate or vigorous physical activity[20], and not having the recommended five portions of fruit and vegetables a day) only one in ten (10%) Portsmouth residents exhibit *none* of these behaviours. Most exhibit at least two of them (57%), and one in six (18%) show either three or four. The mean number of unhealthy behaviours residents have is 2.17 (out of four).

More deprived socio-economic groups are distinctly more likely to have unhealthy lifestyles; the proportion who exhibit all four unhealthy behaviours is higher among council/social housing tenants and those in the most deprived quintile of neighbourhoods (15% and 13% respectively, compared with five per cent of residents overall). The figure is also higher in Central Portsmouth (10% compared with five per cent overall), which may well reflect the greater concentration of council/social housing tenants in this part of the city[21].

Men exhibit more unhealthy behaviours (eight per cent exhibit all four, compared with three per cent of women). So do residents aged 35-64 years (23% exhibit three or more, compared with 18% overall).

Those with medical problems are also more likely to show unhealthy behaviours; the proportion who exhibit all four is greater among those with a limiting disability or health condition (13% compared with only two per cent of those without any limiting disabilities or conditions).

3.2 Self-reported health

3.2.1 Overall quality of health

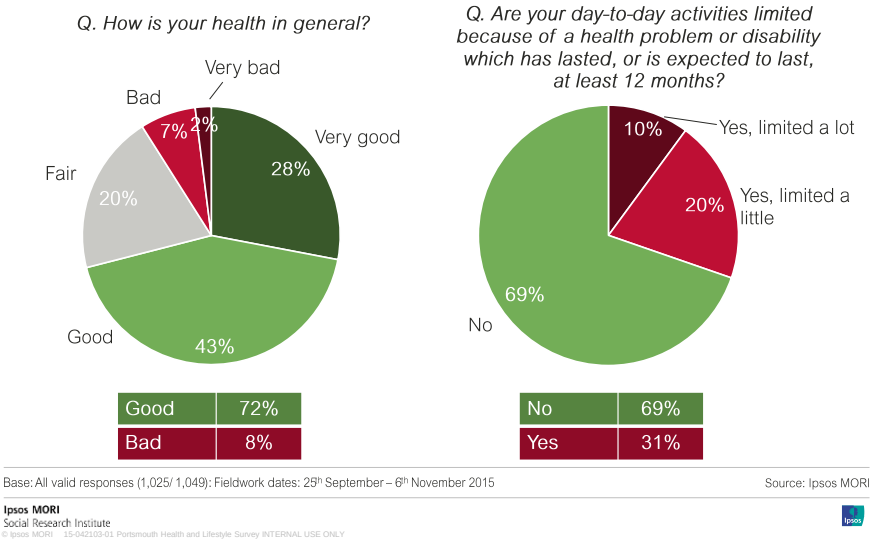
Most residents (72%) rate their health as good/very good (see Figure 3.1), compared with only a small number (just eight per cent) who rate their health as bad/very bad. The proportion of residents who rate their health positively is only slightly below the latest national average of 76%, as taken from the 2013 Health Survey for England, although this comparison should

[19] A score of 5+ on the Audit C scale - see section 2.3.2.
[20] Either doing less than 150 minutes of moderate physical activity a week or its equivalent in vigorous activity.
[21] 26% of respondents in Central Portsmouth are council/social housing tenants, compared with 16 per cent of all respondents to the survey.

be treated only as indicative because of the differing methodologies used between the surveys[22].

Three in ten residents (31%) report having a disability or health condition that limits their daily activities in some way; one in ten (10%) have one that limits them a lot (see Figure 3.1). The local proportion with a long-term condition limiting activities in some way is greater than the average for England as whole (20%), although caution must be exercised because of differences of question wording and survey methodology[23].

Figure 3.1 – Self-assessed health and limiting disabilities



As might be expected, age plays a big factor in how residents perceive their health, with older residents aged 65+ years less likely to report good/very good health (59% compared with 81% of younger residents aged 16-34 years). However, as Figure 3.2 shows, it is those in middle age who have the worst health - just seven per cent of those aged 65+ years actually say their health is bad/very bad, whereas amongst those aged 45-54 years and 55-64 years it is 14% and 13% respectively. This is not an isolated finding – more negative findings can be seen for middle aged residents when it comes to a range of health factors, including mental wellbeing, satisfaction with life and unhealthy behaviour.

Bad/very bad health is also more likely to be an issue for residents with a limiting disability or condition (26% compared with less than one per cent of residents without a limiting disability or condition). More deprived socio-economic groups also report poorer health, for example, council/social housing tenants (23% report their health as bad/very bad compared with

31%

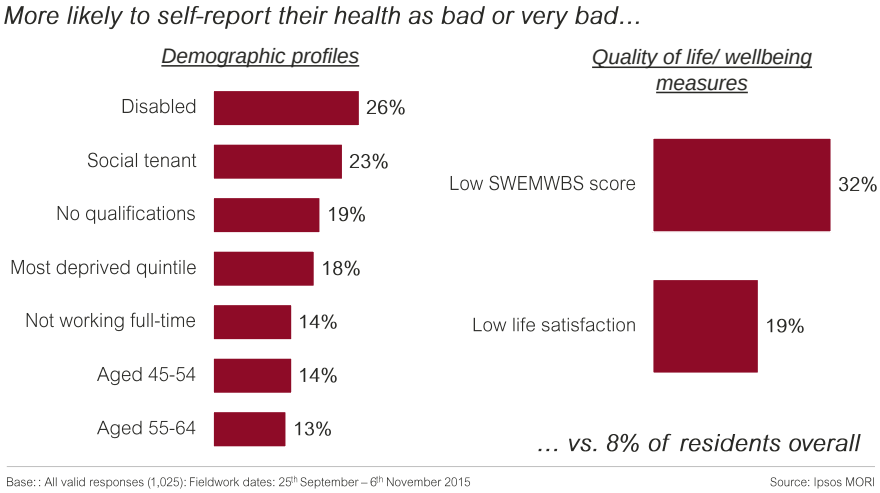
report having a health condition or disability that limits their day-to-day activities a little or a lot

[22] The Health Survey for England uses a random probability face-to-face method so is not strictly comparable to the Portsmouth survey which used a self-completion method.
[23] 20 per cent of adults in England had a limiting long-term condition in 2013, and 36 per cent had a long-term condition, whether limiting or not (Opinions and Lifestyle Survey, a random probability omnibus survey for the Office of National Statistics, 2013).

eight per cent of residents overall), and those living in the most deprived quintile of neighbourhoods (18% compared with only four per cent in the least deprived quintile).

There is also a marked correlation between overall self-assessed health status and mental wellbeing. Residents with a low SWEMWBS[24] mental wellbeing score are more likely to report bad/very bad health (32% compared with five per cent of those who have a higher score). Bad/very bad health is also reported more often by those with a low score for life satisfaction (19% compared with only one per cent of those with a high score for life satisfaction)[25].

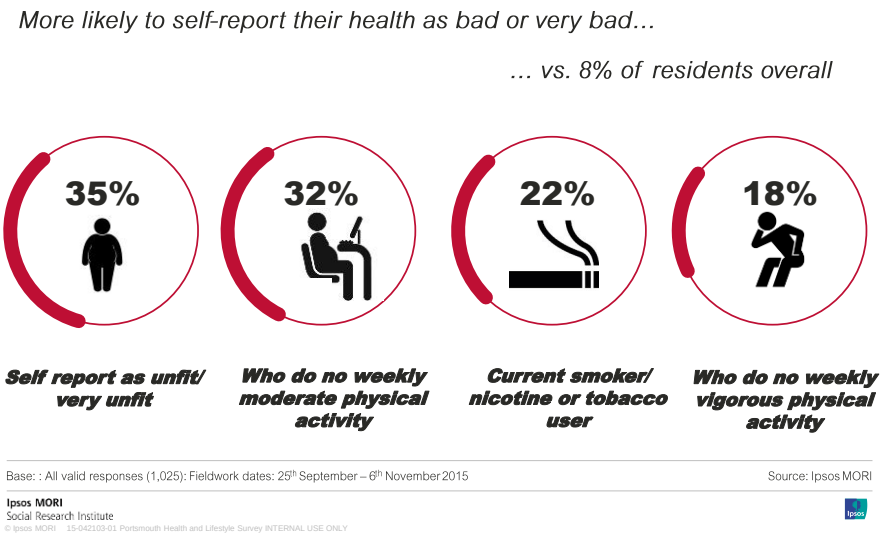
Figure 3.2 – Variations in quality of health



Self-reported health and healthy behaviours are also clearly linked – those who report unhealthy behaviours such as smoking or lack of exercise, and who see themselves as unfit, are far more likely to report their general health as bad/very bad compared with the wider population, as Figure 3.3 shows.

[24] This is a shortened form of the Warwick-Edinburgh Mental Well-being Scale, which uses responses to a series of questions about people's recent state of mind to form a measure of mental wellbeing.
[25] A low score for satisfaction with life is taken as one between 0 and 6 on a scale from 0 (lowest satisfaction) to 10 (highest). High satisfaction is taken to be a score of either 9 or 10.

Figure 3.3 – Variations in quality of health by lifestyle

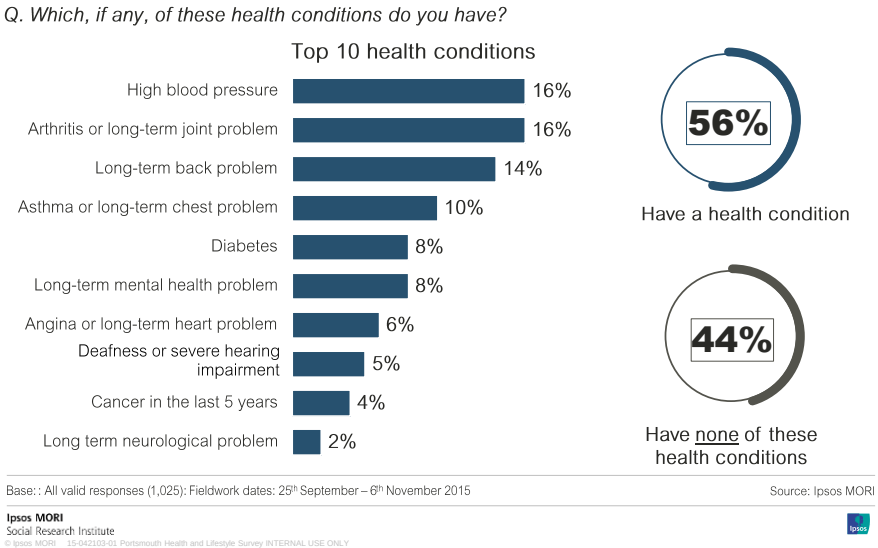


3.2.2 Prevalence of health conditions

Over half of residents say they have a health condition of some kind (56%) and one in eight (13%) have a combination of at least three different types of condition. This is in the context of increasing multi-morbidity across the UK population, with the numbers who have three or more conditions expected to increase from 1.9 million in 2008 to 2.9 million by 2018[26].

As Figure 3.4 shows, the most common single conditions among residents are high-blood pressure (16%) and arthritis or long-term joint problems (16%), followed by long-term back problems (14%).

Figure 3.4 – Prevalence of health conditions



56%

report having at least one health condition

[26] Long Term Conditions Compendium of Information, Department of Health 2012: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216528/dh_134486.pdf

The clearest trend is for prevalence of conditions to increase with age; the proportion with at least one condition rises from 30% of those aged 16-34 years to 83% of those aged 65+ years. As with general levels of health, prevalence also varies by housing tenure, with council/social housing tenants more likely to have at least one health condition (73% compared with 55% of housing owner-occupiers and 43% of private-sector tenants).

The results suggest that lifestyle factors and behaviour are closely linked to having a health condition. For instance, overweight and obese residents are more likely to have a high co-morbidity of three or more health conditions (18% compared with seven per cent of those with a healthy weight). So too are those who smoke (20% compared with eight per cent of non-smokers). Also, the proportion of residents with at least one health condition is greater among those who do not currently exercise enough (63% compared with 45% of those who do exercise enough) and those with an unhealthy diet (68% of residents who do not believe they have a healthy diet compared with 49% who do).

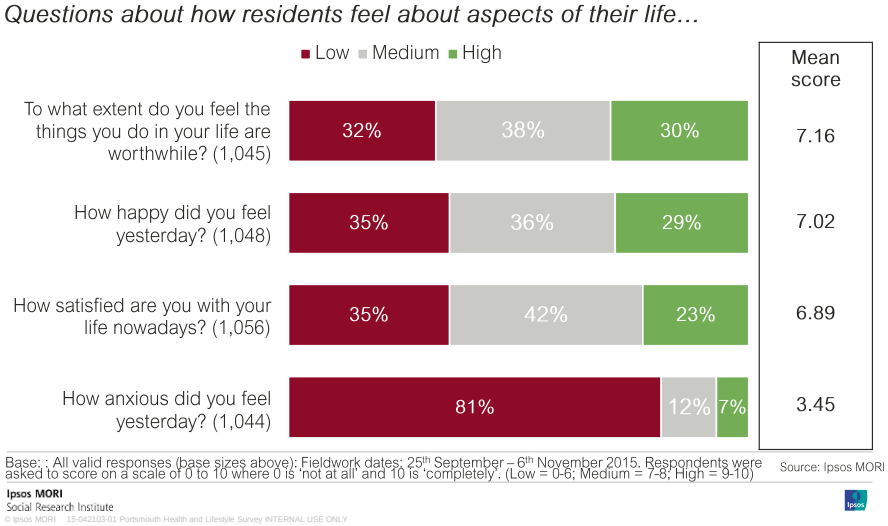
35%

of residents have low levels of satisfaction when it comes to their life overall

3.3 Life satisfaction

When asked about specific aspects of life satisfaction, residents are likely to feel the least negative about their level of anxiety [27] - as Figure 3.5 illustrates, residents who report high levels of anxiety are in a small minority (just seven per cent). However, around a third of residents report negative wellbeing when it comes to feeling that the things they do in life are worthwhile (32%), that they feel happy (35%), and that they are satisfied with their life nowadays (35%).

Figure 3.5 – Sentiments about aspects of life

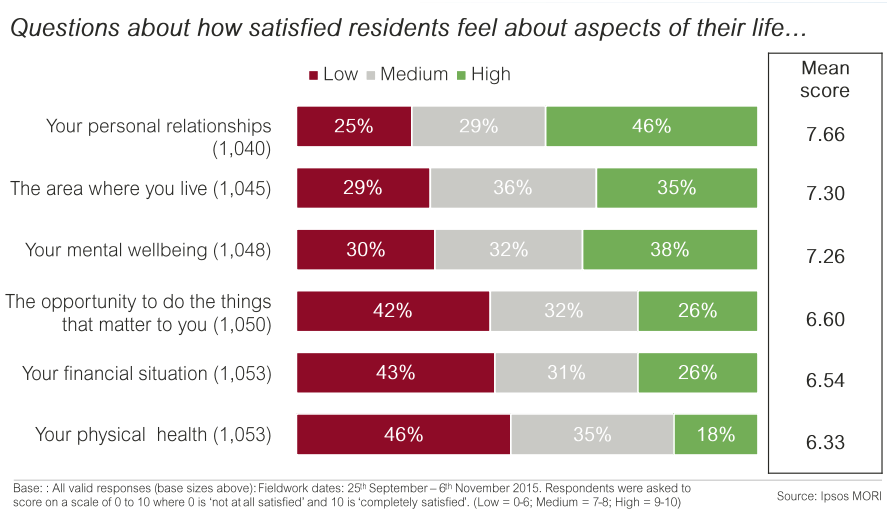


[27] Participants were asked to score each of the questions in Figure 3.5 on a scale of 1 to 10 where 0 is 'not at all' and 10 is 'completely'. A mean score is also shown, which represents the average score given across participants answering each question.

As shown in Figure 3.6, when asked about satisfaction with specific aspects of their day-to-day lives[28], residents are most likely to feel negative about their physical health (where 46% report low levels of satisfaction, compared with 18% who report high levels, with a mean score of 6.33), followed closely by their financial situation and the opportunity to do the things that matter to them (43% and 42% respectively exhibiting low levels of satisfaction).

Conversely, residents are most positive about their personal relationships (where 46% report high levels of satisfaction, compared with 25% who report low levels, and which has the highest mean score of 7.66). Positive feelings about the local area and their own mental wellbeing also outstrip negative sentiment.

Figure 3.6 – Satisfaction with various aspects of life



Across the range of questions about aspects of life, a number of trends emerge when looking at sub-group analysis:

- **Age:** Despite the fact that older residents (aged 65+ years) are less likely to report being in good/very good health, and are more likely to have a health condition, it is those aged 35-64 years who consistently rate aspects of their life less positively. For example, the mean score for "satisfaction with life nowadays" is lower among those aged 35-64 years (6.59) than those aged 65+ years (7.21). So too is the score for satisfaction with personal relationships (7.40 for those aged 35-64 years compared with 8.09 for those aged 65+ years). These lower ratings might be partly explained by those aged 35-64 years being more likely than those aged 65+ years to show unhealthy behaviours (for example in relation to smoking and drinking), and to report

[28] Participants were asked to score each of the questions in Figure 3.6 on a scale of 1 to 10 where 0 is 'not at all satisfied' and 10 is 'completely satisfied'. A mean score is also shown, which represents the average score given across participants answering each question.

bad/very bad health - factors which are correlated with lower mental wellbeing.

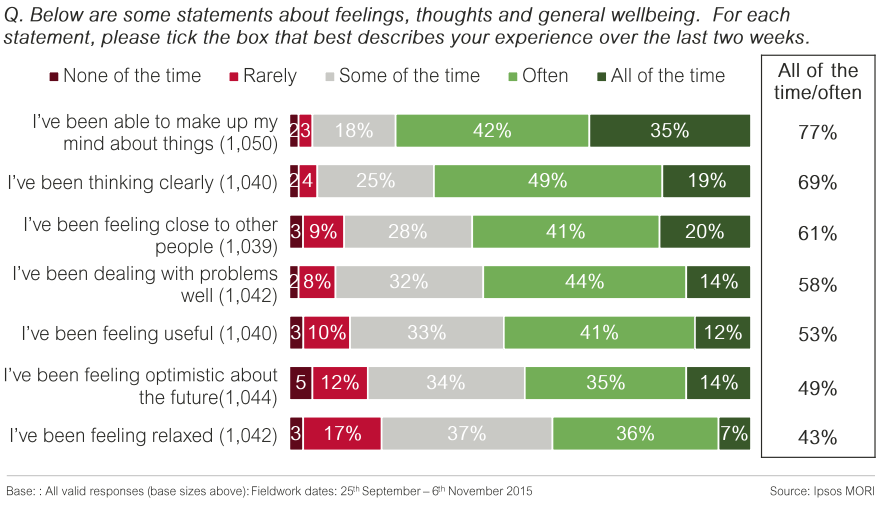
- Socio-economic status: As with their general health, residents from more deprived backgrounds generally rate life satisfaction less well. For instance, the mean score for levels of happiness is lower among council/social housing tenants (6.03 compared with 7.02 overall), as it is for those in the most deprived quintile of neighbourhoods (6.45 compared with 7.23 in the least deprived quintile).

- Health and lifestyle factors: Residents' quality of health and their lifestyles also play a big factor, with the mean satisfaction score for mental wellbeing a good deal lower among those with a limiting disability or health condition (6.14) compared with those with no disabilities or health conditions (7.74). It is similarly lower among those who undertake no moderate physical activity in a typical week (6.04 compared with 7.51 for those who do more than 150 minutes) and those with an unhealthy diet (6.35 for those who disagree they have a healthy diet compared with 7.57 who agree they do).

3.4 Mental wellbeing

When asked about their recent mental wellbeing[29], residents most frequently say they have had clarity of mind (measured in terms of often or always being able to make up their mind) (77%) and thinking clearly (69%). As Figure 3.7 shows, the majority of residents also say they have often or always felt close to other people (61%) and able to deal with problems (58%). On other hand, just under half have often or always felt optimistic about the future (49%) or relaxed (43%).

Figure 3.7 – Recent mental wellbeing (SWEMWBS)



[29] The questions are taken from the shortened version of the Warwick and Edinburgh Mental Wellbeing Scale (SWEMWBS)

The aggregated responses to these mental wellbeing questions are used to produce a score for each participant on a scale between 7 (the lowest level of mental wellbeing) and 35 (the highest). The mean score across all residents is 25.3, but this varies widely across various groups of residents. Mental wellbeing is lower among the following:

- **Those in middle age:** Those aged 35-64 years (mean score of 24.8) are more likely to have lower levels of mental wellbeing compared with older residents aged 65+ years (26.0).
- **Those from more deprived socio-economic backgrounds:** Specifically, council/social housing tenants (23.2 - compared with 25.9 for housing owner-occupiers and 25.3 for private sector tenants) and those in the most deprived quintile of neighbourhoods (23.7 compared with 26.0 in the least deprived).
- **Residents with a limiting disability or health condition:** 22.8 compared with 26.3 for those without any conditions.
- **Residents exhibiting less healthy lifestyles:** Especially smokers (23.9 compared with 25.6 of those who have never smoked) and those who do no moderate physical activity in the typical week (22.9 compared with 25.6 for those who do more than 150 minutes of it a week).

3.5 Contact with other people

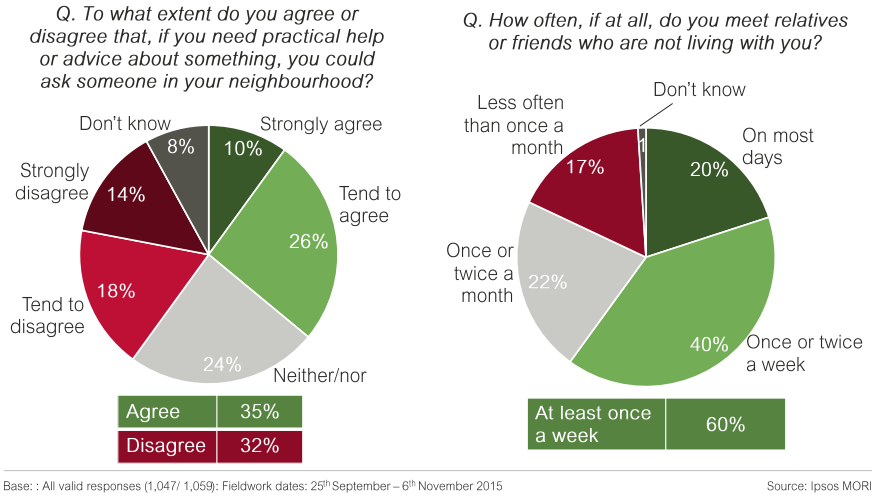
Portsmouth residents are evenly split as to whether they could ask someone in their neighbourhood for practical help or advice – as Figure 3.8 shows, one in three (35%) agree they could do so, but almost as many (32%) disagree.

Most residents are sociable though, with three in five (60%) saying that, at least once a week, they see friends and relatives who do not live with them. However, about one in six (17%) say they barely mix with people they do not live with (less often than once a month).

35%

of residents agree they could go to someone in their neighbourhood for help if they needed to – but a similar proportion disagree

Figure 3.8 – Seeking help and advice from neighbours, and contact with relatives and friends



Generally, it is those renting private sector housing and younger residents who have weaker social connections to the area. Private sector renters are more likely to *disagree* that they could ask for advice or help from neighbours (44% compared with 32% of residents overall) and fewer of them see friends or relatives at least once a week (48% compared with 60% overall). Meanwhile, younger residents aged 16-34 years are less likely to *agree* they could ask for advice or help locally (24% compared with 35% of residents overall). There is considerable overlap between these two groups[30], which suggests private sector renters in Portsmouth, especially younger ones, are a group with weaker ties to the local community.

A lack of connection to the local community is an important factor when it comes to feelings of wellbeing, and this is borne out in the data: feeling able to ask neighbours for help and advice is connected with a more positive state of mind. For example, those who agree they can ask for help have a higher mean score for satisfaction with life (7.38 compared with 6.89 for residents overall) and a higher mean score for mental wellbeing (26.4 compared with 25.3 overall).

[30] Forty-five per cent of participants aged 16-34 years are private renters, compared with 23 per cent overall.

4 Physical activity

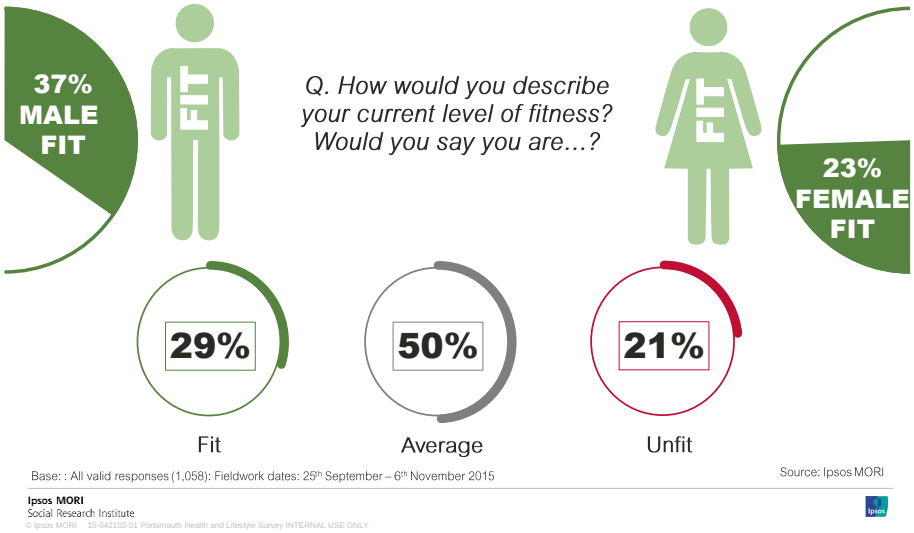
29%

of residents class themselves as fit/very fit vs. 21% who are unfit/very unfit

4.1 Fitness and exercise: perceptions

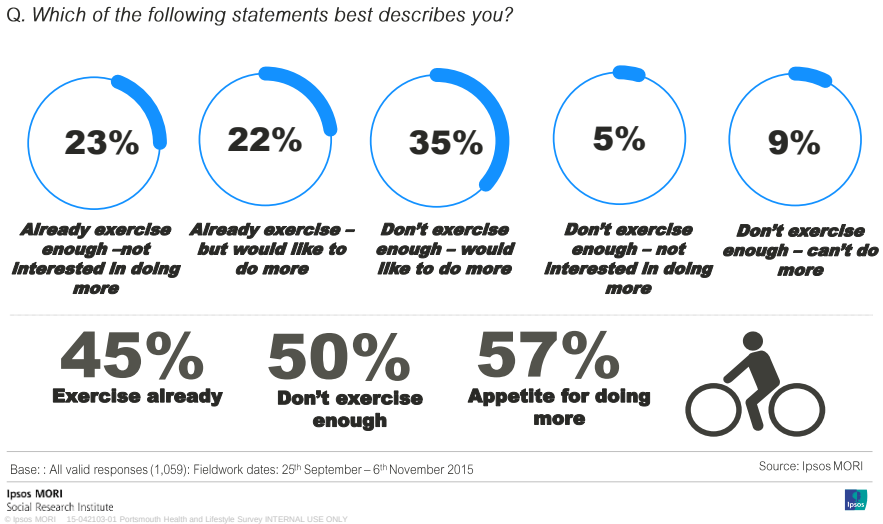
Residents are evenly split when asked about their level of fitness. As Figure 4.1 illustrates, three in ten (29%) believe they are fit/very fit, compared with one in five (21%) who see themselves as unfit/very unfit. Half (50%) perceive their level of fitness to be about average.

Figure 4.1 – Self-assessed levels of fitness



Residents are also evenly divided on the amount of exercise they do, as seen in Figure 4.2. Almost half (45%) perceive that they currently exercise enough already, while half (50%) accept they do not exercise enough.

Figure 4.2 – Perceptions of the amount of exercise currently done



When it comes to doing more exercise, the PHWB can perhaps be encouraged that there is appetite amongst a majority (57%) to do more exercise than they currently manage, leaving just one in seven residents (15%) who are not interested in doing more or who cannot do more.

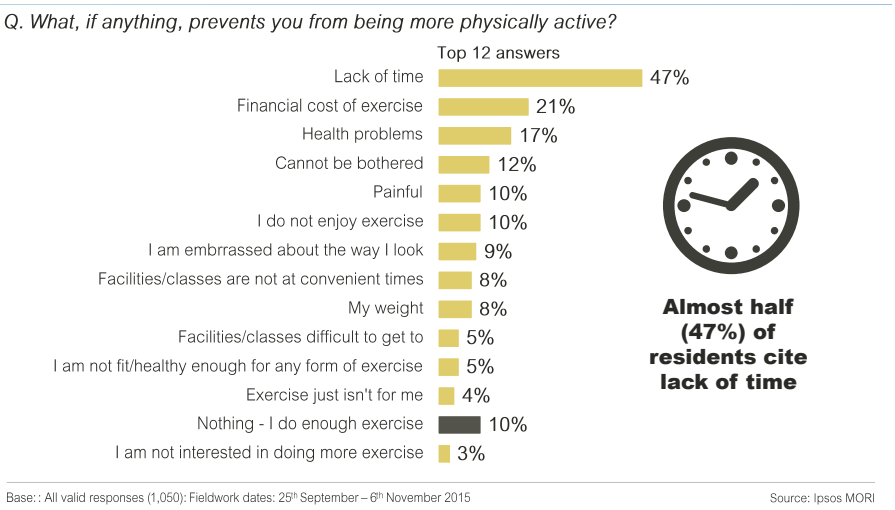
47%

Say lack of time is a key barrier to them doing more exercise

4.2 Barriers to doing more exercise

The most common single obstacle residents cite that makes it hard to do more exercise is a lack of time (47%). The financial cost of exercise is also a big factor (cited by 21%). Health problems and not being bothered enough to do more are other factors (mentioned by 17% and 12% respectively) – as shown in Figure 4.3.

Figure 4.3 – Barriers to taking further exercise



Reasons for not doing exercise vary according to a number of demographic sub-groups, with age being a key defining factor - older residents aged 65+ years are most likely to mention physical obstacles such as health problems (28% compared with 17% of residents overall) and the pain involved (14% compared with 10%), while younger residents are more likely to mention a lack of time (70% of those aged 16-34 years compared with 47% of residents overall) or simply not being bothered (24% compared with 12% overall).

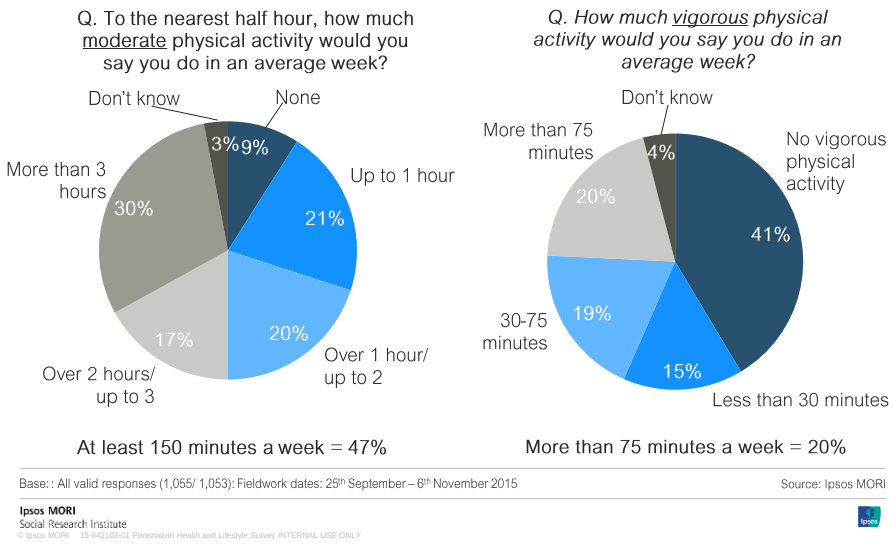
4.3 Exercise levels: actual reported

4.3.1 Amount of exercise done

Most residents are physically active during the average week, but they are more likely to undertake activity which is moderate[31] (88%) rather than vigorous[32] (55%), as shown in Figure 4.4.

[31] Defined as activity that raises the heart rate and makes respondents feel warmer.

Figure 4.4 – Amount of moderate and vigorous activity

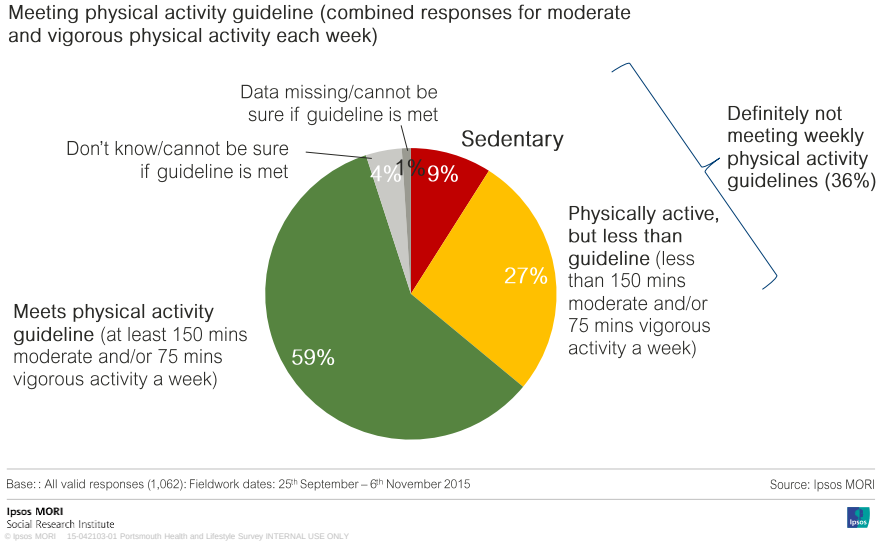


59%

undertake at least the recommended weekly amount of physical activity

The recommended weekly level of physical activity is either at least 150 minutes of moderate activity or its equivalent in vigorous activity (at least 75 minutes a week) of residents (59%) meet this recommend level of activity, which is closely in line with the findings from the national Active People's Survey for England (57%)[33] and Portsmouth (61%), noting that this is an indicative comparator only.

Figure 4.5 – Meeting the recommended level of physical activity



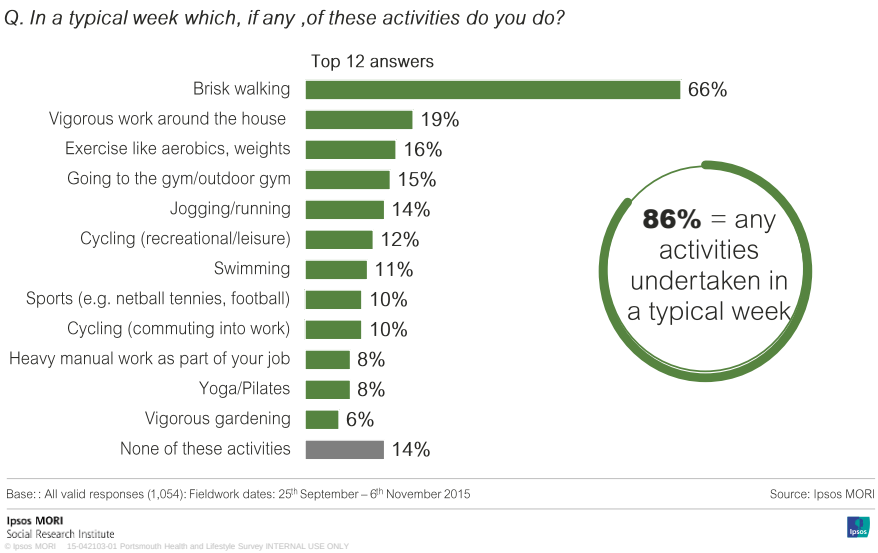
[32] Defined as activity that makes respondents breathe harder and also makes it hard to talk without pausing for breath.
[33] 57% of adults across England report undertaking the weekly minimum of 150 minutes of moderate physical activity and/or its equivalent in vigorous activity a week. The figure for Portsmouth is 61%. (Active People Survey, Sport England, 2014 reported in the Public Health Outcomes Framework, Public Health England, as at December 2015) .

Around one-third of survey respondents (36%) do less than the recommended amount of activity, although only a small proportion (nine per cent) are actually sedentary.

4.3.2 Types of physical activity done

When it comes to physical activities undertaken in a typical week, by far the most common activity is brisk walking (mentioned by 66% of residents). As shown in Figure 4.6, the next most common forms are vigorous work around the house, such as DIY (19%), exercise such as aerobics or with weights (16%), going to the gym (15%) and jogging or running (14%). The vast majority (86%) of residents do some kind of physical activity in a typical week.

Figure 4.6 – Types of physical activity currently done



4.4 Who are the fitter residents?

The groups of residents who are more favourable about their general health are also more likely to be fit and active, and to undertake the recommended levels of exercise:

- Age: The proportion who meet the weekly activity guideline is greatest among those aged 16-34 years (71% compared with 59% overall) and then falls sharply to half among those aged 35-44 years (50%). It is slightly higher among those aged 45-64 years (59%), but then falls again to its lowest level among those aged 65+ years (44%).

  Younger residents aged 25-34 years are also more likely to report being fit/very fit (40% compared with 24% of those aged 65+ years), and to say they do enough exercise (55% compared with 41% of those aged 35-64 years). The range of activities undertaken is also higher amongst younger residents (the proportion aged 16-34 years

who do one or more activities is much higher at 96% compared with 64% of those aged 65+ years).

- Socio-economic status: Council/social housing tenants are less active than residents of other types of housing tenures (19% are sedentary, compared with only seven per cent of housing owner-occupiers and 11% of privately-rented tenants). Meanwhile, housing owner-occupiers are more likely than average to report feeling fit/very fit (33% compared with 29% of residents) and to say they exercise enough (49% compared with 45%). Similarly, those in the most deprived quintile of neighbourhoods are more likely to be sedentary (17% compared with nine per cent overall). In terms of specific activities, the proportion who do one or more activities a week is lower among council/social housing tenants (69%) and those in the most deprived quintile (78%) than residents overall (86%).

- Gender: There is a big difference in fitness levels between men and women, as can be seen in Figure 4.1. Men are more likely than women to consider themselves fit/very fit (37% compared with 23%) and to say they already do enough exercise (51% compared with 40%). Men are also twice as likely as women to do more than 75 minutes of vigorous activity a week (28% compared with 14%). Women are more likely than men to have an appetite for doing more exercise (62% compared with 52% of men), reflecting their current comparatively lower physical activity levels.

Exercise has clear links to other healthy behaviours, suggesting healthy behaviours are, to an extent, self-reinforcing. For example, residents who are obese are far more likely not to exercise (65% say they do not exercise enough compared with 46% of residents with a healthy weight). Seventy-two per cent of residents who have three or more unhealthy behaviours say they do not exercise enough compared with 41% of those who exhibit only one unhealthy behaviour. Not meeting the recommended weekly level of physical activity is also more common among smokers (48% compared with 34% of non-smokers) and those who do not have the recommended five portions of fruit and vegetables a day (40% compared with 28% of those who do).

The data also suggests that self-assessed fitness levels are generally correlated to actual levels of exercise taken. For example, of those residents who self-report that they already exercise enough, the great majority (84%) are actually meeting the weekly recommended level of activity. However, there are also some residents who overestimate their level of fitness. Of those who say they are fit/very fit, one in eight (12%) are actually doing less than the recommended weekly level of activity. Of those who say they already do enough exercise, one in eight (12%) also do the recommended weekly amount.

Further to this, it is those residents who are already quite active and healthy (although not necessarily always the fittest) who have the appetite for doing *more* exercise. To illustrate, residents who already consider themselves to be in good/very good health are more likely to have an appetite for doing more exercise than those who are in bad/very bad health (64% compared with 24%). Similarly, those who already do some form of exercise have a greater appetite for doing more compared with those who are inactive (60% of those who do the minimum recommended amount of activity a week, compared with 32% of those who are sedentary). The survey also shows a correlation between exercise and mental health; those with a low SWEMWBS mental wellbeing score [34] are more likely than average to be sedentary (27% compared with nine per cent of residents overall).

[34] A SWEMWBS score of 7 - 19

5 Diet and healthy eating

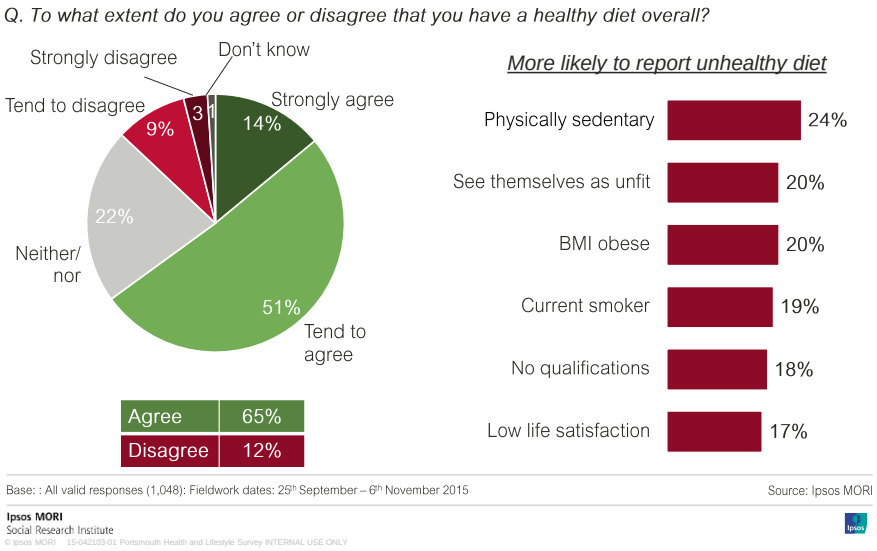
65%

Of residents perceive themselves as having a healthy diet

5.1 Healthy eating: perceptions

Portsmouth residents are far more likely to agree than disagree that they have a healthy diet overall (65% compared with 12%), although one in five (22%) have no opinion either way – as shown in Figure 5.1.

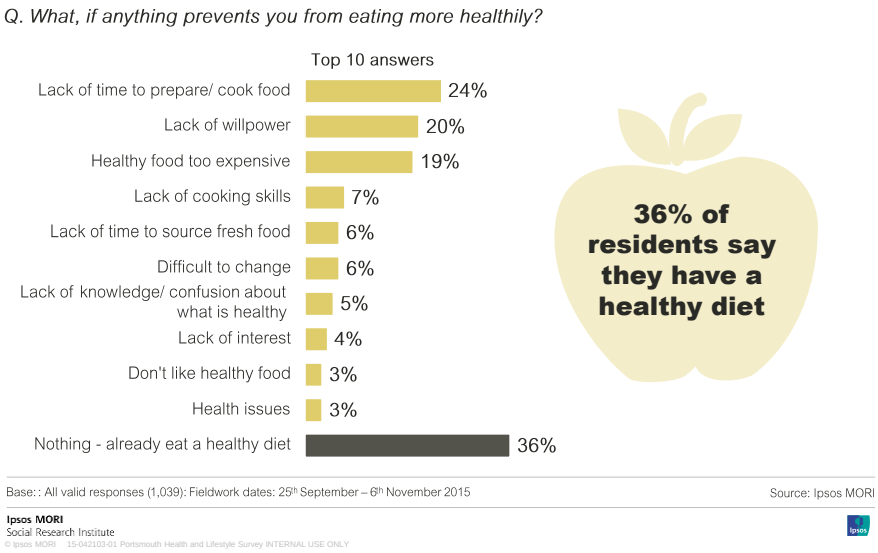
Figure 5.1 – Perceptions about the quality of diet



5.2 Barriers to healthy eating

Lack of time to prepare or cook healthy food is cited as the top reason for residents not eating more healthily (cited by 24%). (Lack of time is also the most common reason residents give for not being more physically active.) As shown in Figure 5.2, this is closely followed by a lack of willpower (20%) and the cost of healthy food (19%). However, around a third of residents (36%) do not perceive there to be any barriers - they already eat healthily enough.

Figure 5.2 – Perceived barriers to healthy eating



33%

Just one in three meet or exceed the recommended daily intake for fruit and vegetables

The types of barriers residents face differ according to the different sub-groups. For example:

- Those most likely to say a lack of time to prepare or cook healthy food is an obstacle are younger residents aged 16-34 years (40% compared with 24% of residents overall) as well as those who do not meet the recommended daily minimum of at least five portions of fruit and vegetables a day (29% compared with 17% of those who do).
- The perceived increased cost of healthy food is also mentioned more often by younger residents aged 16-34 years (27% compared with 19% of residents overall), as well as residents living in the most deprived quintile of neighbourhoods (30% compared with only nine per cent in the least deprived quintile).
- The groups who do *not* encounter any obstacles to eating more healthily are most often those who rate their diet as healthy **or** who meet the recommended minimum for fruit and vegetables consumption already (5-a-day). For example, not encountering obstacles is more common among those aged 55+ years (55% compared with 36% of residents overall), those in the least deprived quintile of neighbourhoods (50%) and among housing owner-occupiers (42%).

5.3 Healthy eating (fruit and vegetable intake): actual reported

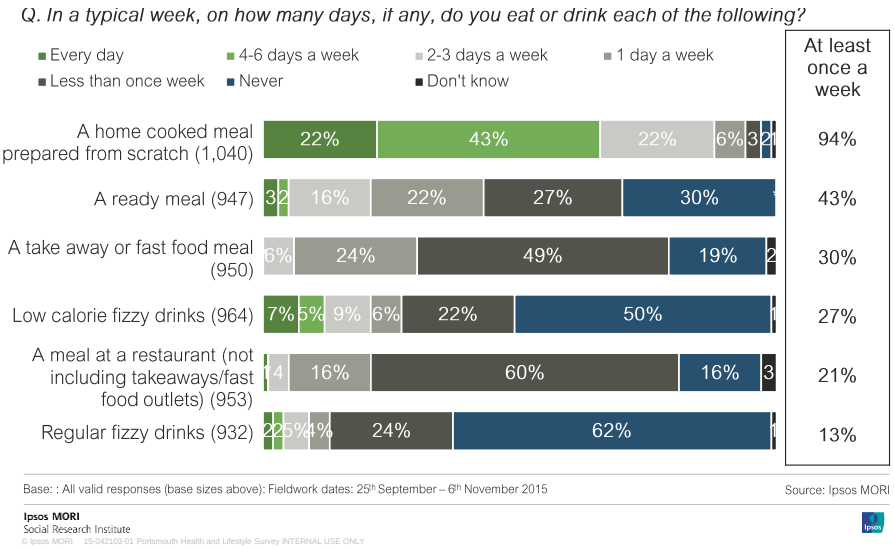
Even though most residents think positively about the diet they have, they are actually less likely to eat healthily. Although almost all residents (98%) say they eat at least some fruit or vegetables a day, only one in three (33%) meet or exceed the recommended daily minimum of five portions. The proportion who meet the guidelines is somewhat below the figure for

Portsmouth recorded by the Active People Survey in 2013/14 (48%), although this comparison can only be seen as indicative because of the differing survey methodologies involved[35].

5.4 Consumption of various type of food and drink

Of all types or sources of meal asked about, Portsmouth residents eat home-cooked meals the most regularly. As shown in Figure 5.3, almost all say they eat home-cooked meals made from scratch at least once a week (94%), and most do so at least four times a week (66%). They are less likely to eat pre-prepared food at least once a week. This includes ready meals (43%), take-away food (30%) and visits to restaurants (21%). Only a minority of residents say they drink fizzy drinks on a weekly basis, although they are more likely to drink low-calorie drinks at least once a week (27%) rather than regular fizzy drinks (i.e. not sugar free, 13%).

Figure 5.3 – Consumption of various types of food and drink



5.5 BMI

Nearly half of residents (46%) have a healthy weight based on body mass index (BMI) data from their reported height and weight. Just over half (52%) have an unhealthy weight, and one in five (19%) are actually obese. The proportion of obese residents is slightly higher than the latest findings from the Active People Survey for Portsmouth (17%) and England (15%), although differing data collection methods mean this comparison should only be considered indicative[36].

[35] Public Health Outcomes Framework for Portsmouth and England, taken from the Active People Survey, 2014. The Active People Survey is conducted by telephone.
[36] Data comes from the Active People Survey for 2012-14. Data are unadjusted, and so are somewhat different from the results listed in the Public Health Outcomes Framework, Public Health England, as at December 2015.

BMI results vary markedly by age, with the proportion of obese residents increasing from 11% of those aged 16-34 years to 35% of those aged 55-64 years, before falling to 19% of those aged 65+ years. Men are also more likely to be overweight or obese (57% compared with 47% of women).

BMI data vary according to self-reported health status, with a greater proportion of overweight and obese residents among those with bad/very bad health (69% compared with 47% of those in good/very good health) or who have a limiting disability or condition (60% compared with 49% of those who do not).

As might be expected, unhealthy behaviour is also a factor. Those who say they do not exercise enough are more likely to be obese (25% are obese compared with 13% obesity for those who feel they do exercise enough). Similarly, 'high risk' drinkers are more likely to be overweight or obese (66% compared with 50% of those at low risk), as are former smokers (64% compared with 47% of those who have never smoked).

5.6 Who are the healthier eaters?

The residents who rate their general health as good or very good are more likely to have a healthy diet, and in turn to eat the recommended intake of fruit and vegetables:

- Age: Older residents are more likely to report having a healthy diet (71% of those aged 65+ years compared with 65% of residents overall), and are more likely to eat the recommended daily fruit and vegetable intake (39% of residents aged 55+ years have at least five portions of fruit or vegetables a day compared with 22% of those aged 25-34 years). However, the picture is slightly different among the middle age groups, where 57% of 45-54 year olds would describe their diet as healthy (compared with 65% of residents overall). This corresponds with the higher proportion in this age band who rate their health as bad/very bad and who have poorer mental wellbeing.
- Socio-economic status: As with other health measures, it is those from more deprived backgrounds who are more likely to describe their diet as unhealthy. Once again, council/social housing tenants exhibit unhealthier behaviours (53% say their diet is healthy compared with 69% of housing owner-occupiers; eight per cent of council/social housing tenants report eating no fruit and vegetables compared with just two per cent of residents overall). The same is true for deprivation, where residents living in the most deprived quintile of neighbourhoods are more likely to describe their diet as unhealthy (17% compared with only six per cent in the least deprived quintile).

- **Locality:** Residents in South Portsmouth are particularly likely to say their diet is healthy compared with North Portsmouth and Central Portsmouth (72% compared with 60% and 59% respectively).

As shown in Figure 5.1, those who exhibit other unhealthy behaviours are also more likely to have an unhealthy diet. The proportion with an unhealthy diet is greater among:

- Residents who are physically sedentary (24% compared with eight per cent of those meeting weekly recommended activity guidelines)
- Those who see themselves as unfit (20% compared with four per cent of those who feel fit)
- Those who are obese (20% compared with seven per cent of those with a healthy weight)
- Current smokers (19% compared with eight per cent of those who have never smoked)

There is also a strong correlation between having a healthy diet and higher (good) mental wellbeing; the proportion of residents who eat a meal made from scratch every day is greater among those with a higher (good) mental wellbeing score[37] (41% compared with 22% of residents overall).

There is also a correlation between diet and other healthy behaviours. Eating the recommended amount of fruit and vegetables a day is much more common among those who show only one unhealthy behaviour or none at all (56% compared with 12% of those who exhibit two or more unhealthy behaviours). Conversely, having take-away food at least once a week is more common among those who show at least two forms of unhealthy behaviour (36% compared with 22% of those who show only one or none at all), and those who are overweight (37% compared 26% of those with a healthy weight).

As with exercise, the data also suggests that self-assessed healthy diet is to an extent correlated to actual behaviours (i.e. consuming the recommended intake of fruit and vegetables). For example, residents who describe their diet as healthy are more likely to report eating at least five portions of fruit and vegetables a day (42% compared with only four per cent of those who describe their diet as unhealthy). However, this finding also indicates there are widespread misperceptions among residents; there is a significant proportion of residents who *think* their diet is healthy even though they do not eat the recommended amount of fruit and vegetables (as high as 57%).

[37] A SWEMWBS score of 31-35

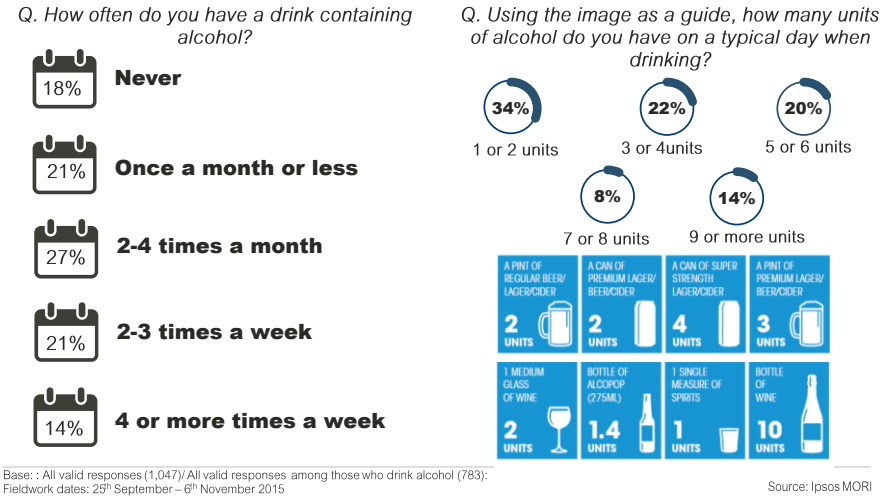
6 Alcohol use

6.1 Alcohol consumption: reported

The great majority of Portsmouth residents (82%) say they drink alcohol at least occasionally, although the frequency of drinking varies quite widely. As Figure 6.1 shows, one in three (35%) residents say they drink alcohol at least two or three times a week, with one in seven (14%) drinking four or more times a week.

Among those who do drink alcohol, residents are most likely to say they have either one or two units on a typical day (34%). However, one in five (22%) are drinking to unhealthy levels, consuming at least seven units in a typical day when drinking.[38]

Figure 6.1 – Overall alcohol consumption



Base: : All valid responses (1,047)/ All valid responses among those who drink alcohol (783): Fieldwork dates: 25th September – 6th November 2015

Source: Ipsos MORI

6.2 Audit C profile

The survey used the three questions in the Audit C Tool[39] as a way to measure the risk of developing an alcohol use disorder. The tool uses response data for the frequency and quantity of alcohol drinking to give each participant a score on a scale between 0 (the lowest risk of developing an alcohol use disorder) and 12 (the highest). The model includes those who answer the relevant questions, drinkers and non-drinkers alike.

[38] Respondents were prompted with an image in the questionnaire that showed various alcoholic, typical measures of them (e.g. 1 pint) and the units associated with that measure. Please see Figure 6.1 and Q18 in the questionnaire in Appendix 3.

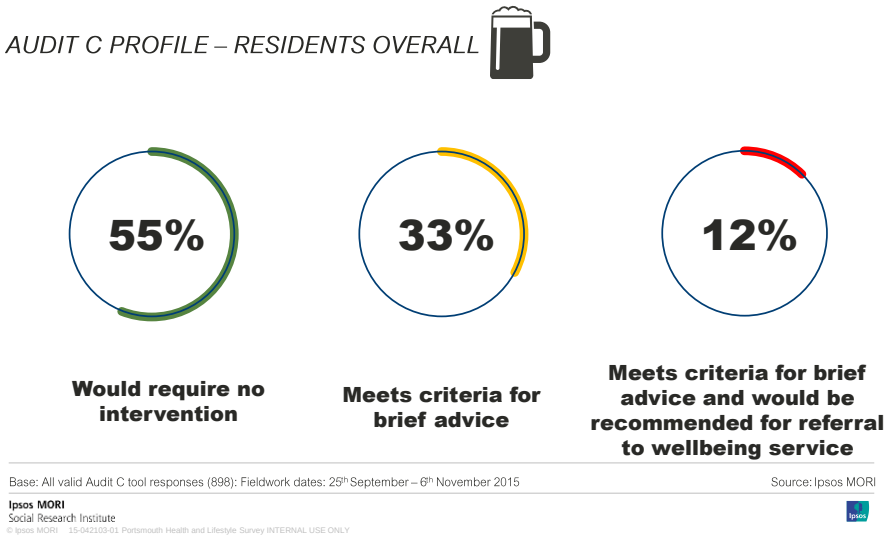
[39] Audit C is an assessment screening tool that identifies high-risk drinking. The survey included responses to three Audit C questions about how frequently people drink alcohol and how much they drink when they do so. It allocates all participants a score of 0-12. Non-drinkers have a score of 0, low-risk drinkers a score of 1-4, and high-risk drinkers a score of 5 or higher.

Figure 6.2 shows that just over half of residents (55%) are not at risk (a score of 0-4), either because they are non-drinkers or drink moderately. However, one in three (33%) have an 'increasing risk' score between 5 and 8, meaning they meet the criteria for receiving brief advice about reducing their alcohol consumption. A further one in eight residents (12%) has a 'high risk' score of between 9 and 12, which makes them priority for such advice and for referral to a wellbeing service.

56%

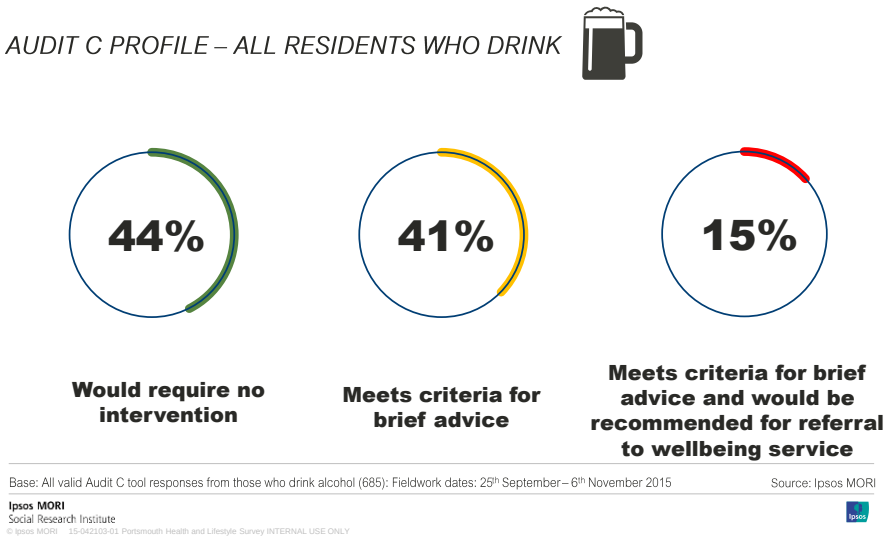
of residents who drink alcohol are at risk of developing an alcohol use disorder and meet criteria for receiving advice about reducing their alcohol consumption

Figure 6.2 – Audit C scores for levels of drinking risk (all residents)



If the data is examined just for residents who drink alcohol, it shows that just over half (56%) are at some risk of developing an alcohol use disorder. This breaks down into two in five who are at an 'increasing risk' (41%) and meet the criteria for brief advice, and one in seven drinkers who are at 'high risk' (15%) and who are a priority for referral to a wellbeing service.

Figure 6.3 – Audit C scores for levels of drinking risk (drinkers only)



6.3 Problems caused by drinking alcohol

Only a minority of residents who drink alcohol report problems as a result of the amount they drink. As shown in Table 6.1, just one in ten (11%) say that, at least once in the last 12 months, their drinking has made them unable to do what is normally expected of them. The same proportion (11%) say either they themselves or somebody else has been injured at some point because of their drinking. Slightly fewer (nine per cent) say a relative, friend or health worker has suggested they cut down on what they drink.

However, those drinkers with a 'high risk' Audit C score are more likely than average to say that, at least once in the last 12 months, alcohol has made them unable to do what was expected of them (27% compared with 11% of all drinkers) and that their drinking has resulted in either an injury to themselves or an injury to someone else (22% compared with 11% of all drinkers). One in three 'high risk' drinkers (35%) say someone else has suggested to them that they cut back on what they drink, compared with less than one per cent of 'low risk' drinkers.

Table 6.1 – Audit C vs. impact of drinking alcohol

	Failed to do what is normally expected because of drinking (803)	Ever injured themselves or someone else because of drinking (805)	Relative, friend or health worker has suggested reduced drinking (804)
All drinkers	11%	11%	9%
Low risk drinkers (1-4)	4%	4%	*
Increasing risk drinkers (score 5-8)	14%	17%	10%
High-risk drinkers (score 9-12)	27%	22%	35%

Base: Portsmouth residents who drink alcohol (variable base size).

6.4 Who drinks the highest levels of alcohol?

Age is an important factor in the level of risky drinking in Portsmouth. The proportion at 'high risk' of developing an alcohol misuse disorder peaks among middle-aged drinkers aged 35-54 years (25%). It is lower among younger drinkers aged 16-34 years (11%) and older drinkers aged 55-64 years (14%) or 65+ years (five per cent).

It is more active residents who are physically 'healthy' but who are more likely to drink, and drink to excess; the proportion of 'high risk' drinkers is greater among those who do more than 75 minutes of vigorous activity a week (25% compared with 12% of drinkers who do less or none). Male drinkers, who are more likely to do vigorous exercise, are also more likely to be 'high risk' drinkers (23% compared with eight per cent of female drinkers). This suggests a significant 'perception' gap' amongst many residents in terms of what constitutes healthy drinking behaviour.

In part, this relationship between heavy drinking and being vigorously active is a result of age, because 'high risk' drinking is lowest among drinkers aged 65+ and this age group is the least vigorously active.[40] Vigorously active, 'high-risk' drinkers are therefore likely to be younger than 65 years. They are most likely of all to be aged 35-54 years (rather than 16-34 years) because this age group has the highest incidence of 'high-risk' drinking.

However, tackling drinking in those residents at higher risk of developing an alcohol use disorder is not without its challenges when we consider that, at the other end of the scale, having a 'high risk' score overlaps with other unhealthy behaviours. High risk drinking is more common among drinkers who smoke or are overweight (35% and 27% respectively, compared with 15% of drinkers overall). Furthermore, the incidence of drinking problems increases sharply with the number of unhealthy behaviours that residents have. For example, one in four (27%) of those who show three or four unhealthy behaviours report that someone has shown concern about their drinking or has suggested they drink less. This contrasts with only five per cent of those who show one unhealthy behaviour or none at all.

The results also show that drinking problems are concentrated more strongly in Central Portsmouth. Drinkers there are more likely to have caused themselves or someone else an injury because of their drinking (17% compared with 11% overall). They are also more likely to have been advised by someone else to drink less (15% compared with nine per cent). Such problems are also more frequently reported by those in rented housing. So, for example, causing an injury to themselves or someone else is more likely to be reported by tenants renting from a private landlord and by council/social housing tenants than housing owner-occupiers (22% and 17% respectively, compared with just five per cent).

[40] Only 11% of residents aged 65+ years do more than 75 minutes of vigorous activity a week, compared with 23% of those aged 16-34 years and 22% of those aged 35-64 years

7 Smoking

7.1 Incidence of smoking and tobacco use

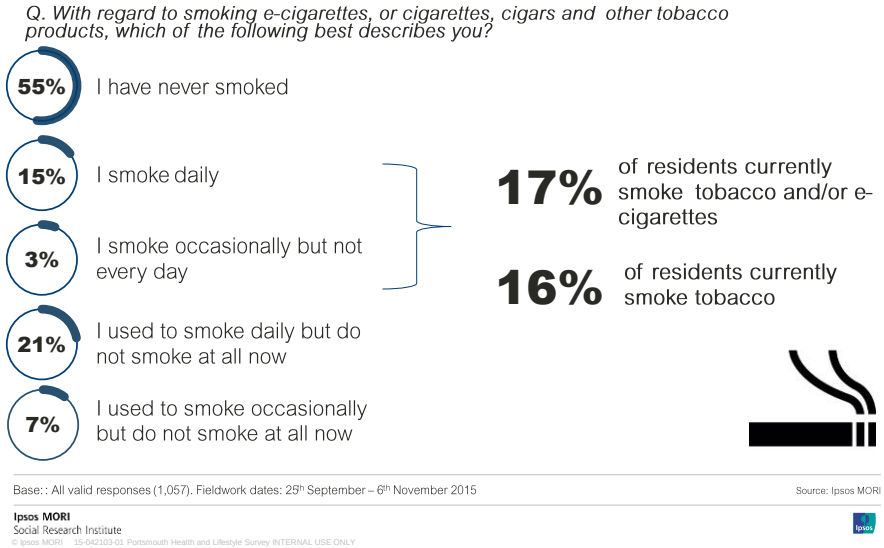
7.1.1 Smoking and tobacco use

One in six Portsmouth residents (17%) currently smoke tobacco or e-cigarettes. Once the handful who **only** use e-cigarettes are removed from calculations, it shows 16% of residents currently smoke tobacco[41].

Overall, one in seven (15%) smoke tobacco or e-cigarettes at least once a day, as illustrated in Figure 7.1. Additionally, approaching three in ten (28%) say that they have done so at some point in their lives, but no longer do so. This means almost half of Portsmouth residents (45%) have smoked tobacco or nicotine products at some point in their lives.

Although the comparison can only be indicative (for example, this survey is for aged 16+ years), prevalence of smoking is in line with the England average for adults aged 18+ years (18%); but lower than Portsmouth (22%) from findings from the national Integrated Household Survey.

Figure 7.1 – Prevalence of smoking



Among current **tobacco** smokers, cigarettes are the most commonly used tobacco product, with over half (55%) using pre-rolled cigarettes and just under half (47%) using roll-up cigarettes. One in seven (14%) tobacco smokers also use e-cigarettes with nicotine. Other products such as pipes, e-cigarettes without nicotine and cigars are used by very small numbers of people.

One in six (17%) Portsmouth residents say they currently smoke or use tobacco or nicotine, in line with the England average.

[41] There are handful of respondents (16 in total) who only use e-cigarettes with or without nicotine and who do not use any type of tobacco product.

Smoking tobacco is more common among those aged 35-64 (20%) than those aged 16-34 years (14%) or 65+ years (10%). It also increases with the level of deprivation; one in five residents in the most deprived quintile of neighbourhoods smokes tobacco (28%), compared with only eight per cent of those in the least deprived quintile. Linked to this, tobacco smoking is much more common among council/social housing tenants, and among those without any qualifications (41% and 24% respectively, compared with 16% overall).

Smoking tobacco also appears to correlate strongly with other unhealthy behaviours, and with poorer health status. For example, smoking and drinking unhealthy amounts of alcohol appear to be linked – two in five 'high risk' drinkers (42%) also smoke tobacco, compared with 10 per cent of non-drinkers or 'low risk' drinkers. Similarly, tobacco smoking is more common among residents who rate their health as bad/very bad (44% smoke tobacco compared with 10% of those who rate their health as good/very good) and among those with a disability or health condition limiting daily activities a little or a lot (29% compared with nine per cent of those with no such condition).

7.1.2 Frequency and length of smoking

The majority of tobacco smokers in Portsmouth smoke at least five times a day (72%). Almost half smoke between five to 15 times a day (48%), while one in four (24%) smoke more than this.

Residents who smoke tobacco generally started smoking at a young age. Half (50%) began when they were younger than 16 years, and one in four (24%) started between the ages of 16 and 17 years.

7.2 Giving up smoking

7.2.1 Giving up smoking among current smokers

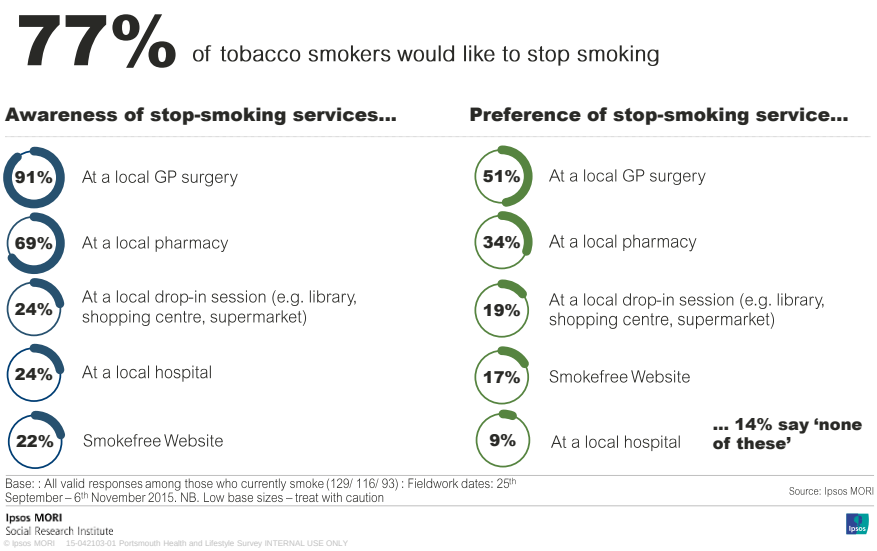
Almost four in five tobacco smokers in Portsmouth (77%) say they would like to stop smoking.

Most tobacco smokers in the city are aware of the various stop-smoking services available to them; just four per cent have never heard of them. The best known stop-smoking services are those provided by local healthcare providers such as GPs (91% of tobacco smokers are aware of availability of these services) and pharmacies (69%).

It appears health providers may form the most trusted and effective form of delivering stop-smoking services as well, since when asked about which services tobacco smokers would most likely use if they wanted to stop smoking, half (51%) say they would approach their GP, and a third (34%) their local pharmacy – as shown in Figure 7.2. One in five would also be likely to use a local drop-in centre, and a similar proportion would use the

Smokefree website to receive support in quitting (19% and 17% respectively). It is worth noting that one in seven (14%) say they would not be likely to use a stop-smoking service at all, if they were considering quitting.

Figure 7.2 – Giving up smoking: willingness to do so and attitudes towards stop-smoking services



7.2.2 Services and products used to help former smokers quit

It is worth reflecting that of the 28% of participants who are former smokers, seven in ten (71%) said that they gave up smoking without any help or support. The most popular sources of support that have been used are nicotine replacement products without prescription (seven per cent), followed by nicotine replacement products prescribed by a GP or nurse (six per cent). Just six per cent saw an NHS stop-smoking adviser or counsellor over a few weeks, and two per cent were given a voucher for nicotine replacement by an NHS stop-smoking adviser.

51%

Smokers are most likely to go to their GP for help to stop smoking

8 Drug use

8.1 Prevalence of drug use

8.1.1 Personal drug use

Most residents (93%) say they have not taken any kind of illegal drug or 'legal high' in the last 12 months. Seven per cent indicate they have, and two per cent have done so more than once a month. While the proportion of residents who say they take drugs appears relatively low, it equates to almost 12,000 residents aged 16+ years in Portsmouth taking recreational drugs[42].

Drug use is more common among men than women (10% compared with four per cent) and is concentrated among those aged 16-34 years (14% compared with three per cent across all other age groups). It is also above the city average in South Portsmouth (10% compared with seven per cent overall).

While it is important to be cautious when looking at the figures[43], given the relatively small number of people who said they had used an illegal drug or 'legal high' in the last 12 months, the results point to some patterns in terms of drug use and wider healthy behaviours. Drug taking is apparently greater among smokers and 'high risk drinkers' (18% and 29% respectively have used illegal drugs or 'legal highs' in the last 12 months, compared with seven per cent overall). Drug taking is also higher among the most physically active (and presumably younger) residents (13% of those who do more than 75 minutes of vigorous activity a week compared with four per cent of those who do none).

Cannabis is the most frequently used substance among drug users in the last 12 months (81%). This is followed by ecstasy/ MDMA and cocaine powder (24% in both cases), 'legal highs' such as herbal incense (17%) and amphetamines (12%). It is difficult to draw out any demographic patterns in terms of the types of drugs taken due to the small base sizes for this question.

8.1.2 Drug use among family and friends

Use of drugs or "legal highs" is more prevalent when participants are asked about close family or friends who use illegal drugs or 'legal highs': 15 per cent of residents say there is drug use or use of "legal highs" among their close friends, and nine per cent within their close family.

7%

Residents have taken illegal drugs or 'legal highs' in last 12 months

[42] Based on percentage of total population aged 16+ from ONS mid-year population estimates 2014
[43] The unweighted number of drug users is very small (25)

Use of drugs or "legal highs" among friends and relatives is most common among groups with higher rates of personal drug use. So, for example, use of drugs or "legal highs" among close friends is reported more often by those aged 16-34 years or who live in in South Portsmouth locality (25% and 21% respectively compared with 15% overall). It is also reported more often by those who smoke or are 'high risk' drinkers (25% and 41% respectively).

8.2 Effect of drug use on behaviour

Of those who have used drugs or "legal highs" in the last 12 months, most (74%) say they have 'sometimes' or 'always' been able to control their actions when they have been taking drugs. However, one in five (20%) say they have been unable to do so. It is not possible to draw out any demographic patterns in terms of drug users' behaviour when taking drugs due to the small base sizes for this question.

9 Sexual health

9.1 Number of sexual partners

Seven in ten residents (69%) have had a sexual partner in the last 12 months. Seven per cent have had more than one sexual partner.

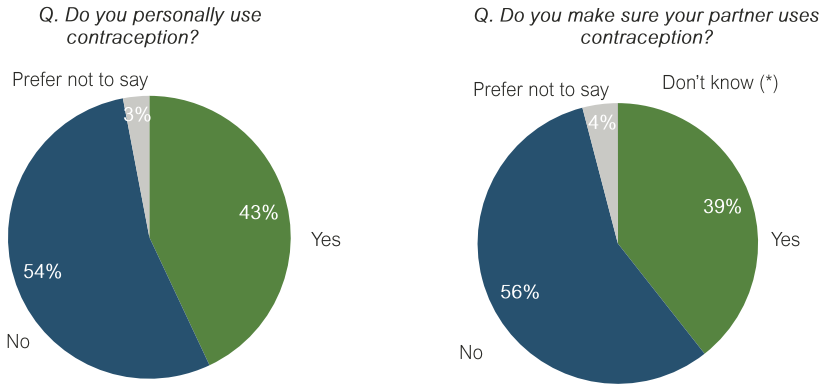
Having a sexual partner in the last 12 months is much more common for younger residents (86% of those aged 18-34 years compared with 32% of those aged 65+ years) and those without any limiting disabilities or healthy conditions (78% compared with 49% of those who do have one).

The proportion of residents who have had more than one sexual partner varies relatively little across various sub-groups of residents (e.g. age, sex, locality, housing tenure). However, it is more marked among young residents aged 25-34 years (18% compared with seven per cent overall).

9.2 Contraception

Of those have had a sexual partner in the last 12 months, two in five (43%) say they themselves use contraception and a similar proportion (39%) say they make sure their partner uses contraception, as shown in Figure 9.1.

Figure 9.1 – Use of contraception



Base:: All valid responses among those who have had one or more sexual partners in the last 12 months (527/ 524): Fieldwork dates: 25th September – 6th November 2015

Source: Ipsos MORI

Ipsos MORI
Social Research Institute

Use of contraception varies most by age, with those aged 16-34 years more likely than average to use it themselves (64% compared with 43% overall) or to have a partner who does so (58% compared with 39% overall). Women are also more likely than men to say they have personally used contraception (51% compared with 33%).

Those who use contraception, or whose partner does so, are most likely to say they get it from a GP surgery (35%) or a local pharmacy (34%). This is

followed by a supermarket or convenience store (29%) and a local sexual health service (17%). There is little variation between different demographic groups of residents.

Among those who do not use contraception, the most common reason for not doing so is that it is their personal preference (19%). This is followed by trying to get pregnant or being currently pregnant (18%), having already been sterilised or had a vasectomy (16%), being too old for contraception to be necessary (14%), and it being their partner's preference (13%). Reasons for not using contraception vary little between sub-groups of residents, except that men are more likely to say this is their partner's preference (18% compared with seven per cent of women), whereas women are more likely to mention the menopause as a reason why either they or their partner does not use contraception (11% compared with one per cent of men).

9.3 Awareness of sexually transmitted diseases

Residents who have had a sexual partner in the last 12 months were asked what influence awareness of sexually transmitted diseases has had on their sexual behaviour. Most say it is not relevant because they are already in a long-term, exclusive relationship (74%). However, one in six (18%) say awareness of sexually transmitted diseases has prompted them to make sure they use a condom, and almost as many say it has prompted them to have tests for sexually transmitted diseases when they change partners (15%). Just seven per cent say it has not influenced them at all.

Again, the main differences are by age group. Those aged 16-34 years are more likely than average to say they feel prompted to make sure they use a condom (30% compared with 18% of sexually active residents overall) and to have tests for sexually transmitted diseases (25% compared with 15%). Older residents aged 55+ years are more likely to say they have not changed their behaviour because they are already in a committed, long-term relationship (86% compared with 74% overall).

10 Health and the community

10.1 Contact with local health services

Almost all Portsmouth residents (98%) have personally used at least one of a range of local health services in the last 12 months. As shown in Table 10.1, they are most likely to have gone to a GP or health centre (86%), followed by a dentist (69%) or a pharmacy (67%). Two in five have also gone to an optician (41%) or to hospital as an in-patient or out-patient (41%).

Table 10.1 – Use of healthcare services in Portsmouth in last 12 months

	% who use service
A GP, family doctor or health centre	86%
A dentist	69%
A pharmacy	67%
An optician	41%
Hospital (in-patient or out-patient)	41%
Walk-in centre (e.g. St Mary's/Guildhall Walk Healthcare Centre)	20%
Treatment centre (e.g. St Mary's)	19%
NHS 111 service	13%
A hospital (A & E)	13%
None of these	2%
Don't know	*

Base: All valid responses (1,055)

It is those aged 55-64 years who have used the widest range of health services in the last 12 months; they are more likely than average to have visited a dentist (80% compared with 69%), a pharmacy (82% compared with 67%), an optician (52% compared with 41%) and a hospital as an in-patient or out-patient (48% compared with 41%). This may reflect the finding they have worse health than most residents (13% of them have bad/very bad health, compared with eight per cent of residents overall).

As might be expected, use of healthcare services is greater among residents with poorer physical and mental wellbeing. So, for example, visiting a hospital as an in-patient or out-patient is more common among residents with bad/very bad health (73% compared with 34% of those in good/very good health), those with a limiting disability or health condition (61% compared with 32% of those without such a condition) and residents with a low SWEMWBS mental wellbeing score (74% compared with 36% of those with a higher score).

Almost all residents who took part in the survey (99%) say they are registered with a local GP.

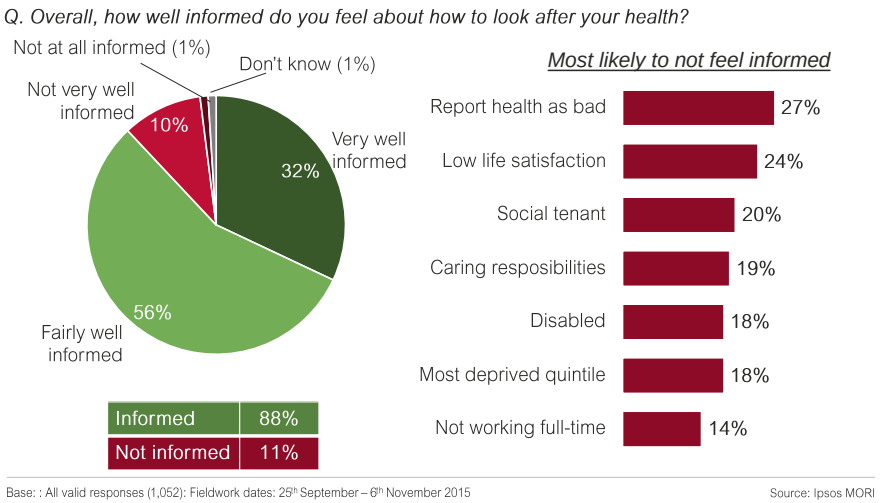
The majority of residents (75%) also say they visit the dentist at least once a year. Only a small number (seven per cent) say they never visit the dentist. The residents most likely to have visited the dentist in the last year are those who live in the least deprived quintile of neighbourhoods (84%), housing owner-occupiers (82%) and those aged 55-64 years (81%).

10.2 Information about healthcare

10.2.1 Feeling informed about looking after health

The great majority of residents (88%) feel well informed about how to look after their health. One in ten (11%) feel badly informed.

Figure 10.1 – Feeling informed about how to look after your health



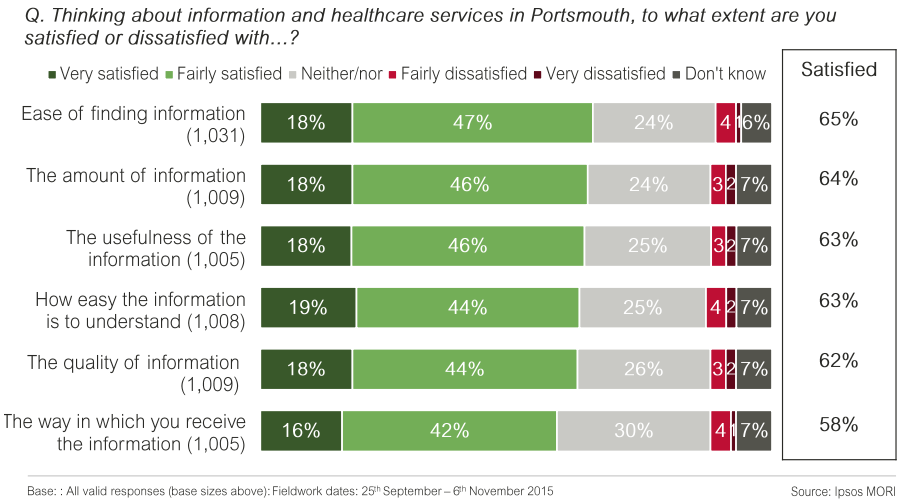
However, as Figure 10.1 shows, the proportion of residents who do not feel informed about how to look after their health is significantly higher among those groups who may need the most help to improve their health. Those groups most likely to feel badly informed about how to live healthily include those who rate their health as bad (27% feel uninformed) or who have a long term condition or disability (18%). It also includes residents with low levels of life satisfaction, poor mental wellbeing, council/social housing tenants, and those in the most deprived quintile of neighbourhoods.

Across other groups, feeling informed about how to live healthily is below average among younger residents aged 16-34 years and those without qualifications (76% and 79% respectively, compared with 88% overall).

10.2.2 Attitudes towards information about local healthcare services

When it comes to information about healthcare services in the city, residents are generally positive, although significant numbers are neutral. As shown in Figure 10.2, satisfaction is highest with how easy it is to find information (65% are satisfied with this) and with how much healthcare information is available (64%). Almost as many residents are satisfied with how easy it is to understand the information (63%), how useful it is (63%) and the overall quality of the information (62%). They are least satisfied with the way in which they receive the information (58%). However, across all of these measures, active dissatisfaction is very low.

Figure 10.2 – Satisfaction with local healthcare information



Results generally vary little across the various groups of residents. However, residents aged 55-64 years are more dissatisfied than average with each of the six aspects of local healthcare information the survey asked about, particularly with the way they get information (15% are dissatisfied compared with six per cent of residents overall), how easy it is to find information (13% compared with five per cent) and how easy it is to understand (13% compared with five per cent). The significance of this is that residents aged 55-64 years are particularly active users of local healthcare services, and many are also unpaid carers who are likely to be in a position to give information to the people they care for. Whilst generally speaking they are positive about the healthcare information available, a significant minority of them do have some concerns about aspects of local healthcare information, such as ease of finding it and understanding it.

10.3 Caring in the community

One in five residents (21%) provides unpaid care and support to someone else because of a long-term health condition, disability or problems related to old age. For one in twenty (five per cent) of residents, this consists of 20 or more hours of unpaid care a week.

Being a carer is more common among council/social housing tenants (36%) and those aged 55-64 years (29%). Carers are also likely to have lower levels of life satisfaction and poorer mental wellbeing. This may reflect their greater tendency to be council/social housing tenants or aged 55-64 years, as these two groups also have lower levels of mental wellbeing.

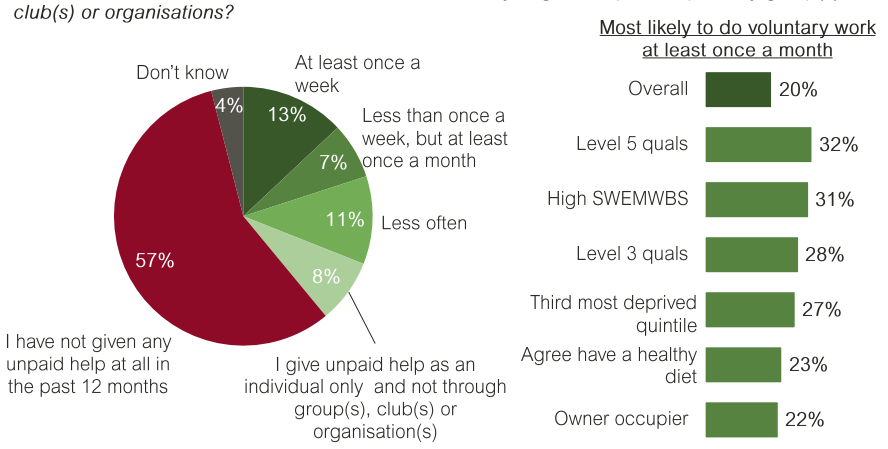
In fact, other survey evidence suggests carers generally tend to have lower physical and mental wellbeing than people without caring responsibilities [44]. Carers who took part in this survey are less likely than non-carers to say they have good health (62% compared with 75%) and are more likely than non-carers to have a low SWEMWBS mental wellbeing score (19% compared with nine per cent) and to be smokers (25% compared with 14%).

10.4 Volunteering in the community

One in five residents (20%) in Portsmouth could be described as being a regular volunteer – i.e. they have done formal voluntary work with a group, club or organisation at least once a month in the last year. This is lower than the England average of 27%[45], although this comparison can only be indicative because of the differing data collection methods.

Figure 10.3 – Regular formal voluntary work

Q. Overall, in the last 12 months, about how often have you given unpaid help to any group(s), club(s) or organisations?



Base: : All valid responses (1,042): Fieldwork dates: 25th September – 6th November 2015 Source: Ipsos MORI

[44] See 2012 Ipsos MORI research on carers for people with cancer: https://www.ipsos-mori.com/Assets/Docs/Publications/sri-ipsos-mori-macmillan-more-than-a-million-2012.pdf
[45] Community Life Survey 2014-15, conducted face-to-face through random probability surveying.

There is relatively little variation across demographic sub-groups of residents when it comes to volunteering, but there is an indication that it tends to be less disadvantaged groups of residents who are engaged in these activities - housing owner-occupiers and residents with a degree/Level 5 qualification (22% and 32% respectively volunteer once a month, compared with 20% of residents overall).

When it comes to various forms of formal and informal volunteering – see Table 10.2 - most residents (72%) say they have undertaken at least one activity in the last 12 months. The type of voluntary work most often currently being carried out is babysitting or childcare (30% of residents say they have done some of this in the last 12 months), followed by keeping in touch with someone who finds it hard to get around the local area (28%) and doing a quick favour for an elderly neighbour (27%).

However, even greater proportions of residents (82%) would be willing to do at least one of these volunteering activities in the future. In each case, the number willing to do a specific form of voluntary work is greater than the number who currently report doing it. The most popular form of activity would be doing a quick favour for an elderly neighbour with 44% saying they would be willing to do this.

When looking at individual activities, as opposed to volunteering in the round, there are some clear demographic differences. For example, women are far more likely to look after children (38% compared with 20% of men) or provide personal care to someone who is frail or sick (10% compared with four per cent). Older residents aged 55+ years are more likely to keep in touch with someone who has difficulty getting out and about (36% compared with 28% of residents overall), or do a quick favour for an elderly neighbour (33% compared with 27% overall). Residents from a white ethnic background are also more likely to keep in touch with someone compared with residents from a minority ethnic background (29% compared with 11%). Young adults (those aged 25-34 years) are far more likely to say they do none of the activities on the list (at Question 41 of the survey at Appendix 3) (43% compared with 27% of residents overall).

Readiness to do voluntary work in the future varies by key sub-groups as well. Willingness to do at least one of the activities listed is greater among housing owner-occupiers (84% compared with 71% of council/social housing tenants), and it is lower among those aged 25-34 years (73% compared with 85% of those aged 35+ years).

Table 10.2 – Doing voluntary currently and in the future

	Done in last 12 months	Willing to do in future
Babysit or care for children	30%	34%
Keep in touch with someone who has difficulty getting out and about	28%	37%
Do a quick favour or chore for an elderly neighbour	27%	44%
Volunteer for a local charity or other local organisation	17%	29%
Help keep your local area clean and tidy	13%	22%
Help to organise fund raising for a community facility or group	11%	15%
Help out at a local church, mosque, synagogue, temple or other faith organisation	9%	14%
Provide personal care (e.g. washing, dressing) to someone who is sick or frail	8%	13%
Help to run or manage a youth group	6%	12%
Take part in a pressure group/campaigning organisation to change things in your local area	5%	11%
Join a local residents group e.g. Neighbourhood Watch	5%	12%
Sometimes get involved in public services in your local area	4%	16%
Often get involved in public services in your local area	2%	8%
Other	9%	7%
None of these	27%	16%
Don't know	2%	2%

Base: All valid responses (888/ 742)

Appendices

Appendix 1: Guide to statistical reliability

The residents who took part in the survey are only a sample of the total 'population' of residents in Portsmouth, so we cannot be certain that the figures obtained are exactly those that would have been reached had everyone responded (the 'true' values). We can, however, predict the variation between the sample results and the 'true' values from knowledge of the size of the samples on which the results to each question is based, and the number of times a particular answer is given. The confidence with which we can make this prediction is usually chosen to be 95% - that is, the chances are 95 in 100 that the 'true' value will fall within a specified range. The following illustrates the predicted ranges for different sample sizes and percentage results at the '95% confidence interval':

Size of sample on which survey result is based	Approximate sampling tolerances applicable to percentages at or near these levels		
	10% or 90% ±	30% or 70% ±	50% ±
100 responses	6	9	10
200 responses	4	6	7
500 responses	3	4	4
1,075 responses	2	3	3

For example, with a sample size of 1,075 where 50% give a particular answer, the chances are, 19 in 20 that the 'true' value (i.e. the one which would have been obtained if all residents of Portsmouth had been interviewed) will fall within the range of +3 percentage points from the survey result (i.e. between 47% and 53%).

When results are compared between separate groups within a sample (e.g. men versus women) different results may be obtained. The difference may be 'real', or it may occur by chance (because not everyone in the population has been interviewed). To test if the difference is a real one - i.e. if it is 'statistically significant' - we again have to know the size of the samples, the percentage giving a certain answer and the degree of confidence chosen. If we once again assume a '95% confidence interval', the differences between the results of two separate groups must be greater than the values given in the following table:

Size of sample on which survey result is based	Differences required for significance at or near these percentage levels		
	10% or 90% ±	30% or 70% ±	50% ±
100 vs. 100	8	13	14
200 vs. 200	6	9	10
500 vs. 500	4	6	6

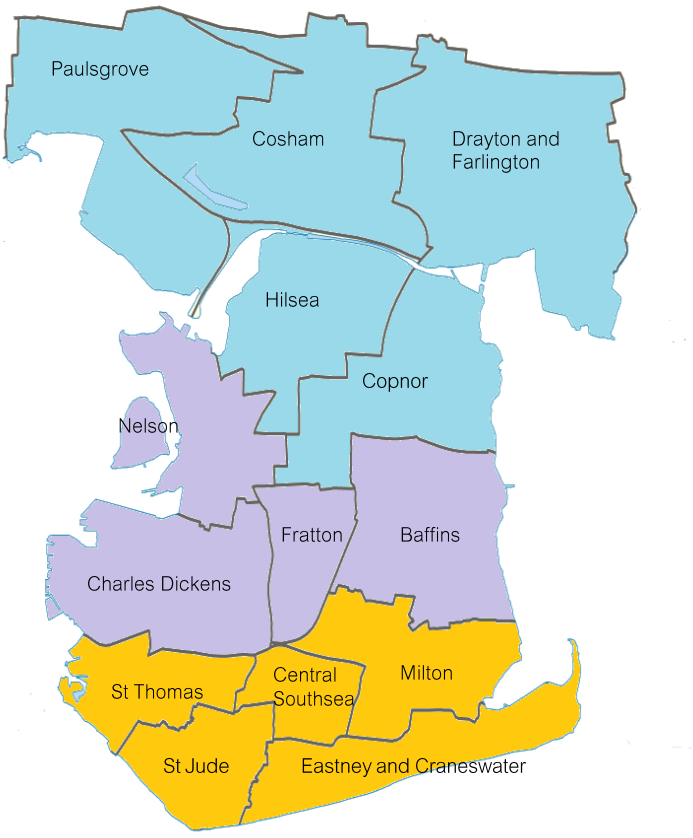
For example, if 46% of male residents give a particular answer compared with 54% of female residents, (both with a sub-sample size of about 500), then the chances are 19 in 20 that this eight point difference is significant (as the difference is more than six percentage points)

It is important to note that, strictly speaking, the above confidence interval calculations relate only to samples that have been selected using strict probability sampling methods. However, in practice it is reasonable to assume that these calculations provide a good indication of the confidence intervals relating to this survey.

Appendix 2: Portsmouth localities

For purposes of analysis, the wards of Portsmouth have been divided into three roughly co-equal localities. These are North, Central and South.

Ward	Locality
Copnor	North
Cosham	North
Drayton and Farlington	North
Hilsea	North
Paulsgrove	North
Baffins	Central
Charles Dickens	Central
Fratton	Central
Nelson	Central
Central Southsea	South
Eastney and Craneswater	South
Milton	South
St Jude	South
St Thomas	South



Appendix 3: Questionnaire

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

Portsmouth CITY COUNCIL

Title of meeting:	Health and Wellbeing Board
Subject:	Information Sharing Framework
Date of meeting:	22 June 2016
Report by:	Director of Public Health
Wards affected:	All

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1. Purpose

1. To inform the Board that Portsmouth's multi-agency Information Sharing Framework has recently been revised. The Framework provides:

    - Commitment to compliance with the law, good practice and the justifiable sharing of information for the delivery of public services
    - Clarity on definitions
    - Clarity on responsibilities
    - Clear summaries of the legislation
    - Examples of good and effective practice
    - Guidance on legal gateways for sharing information
    - An agreed suite of pro-formas and exemplar documentation – notably, a framework for Specific Information Sharing Protocols

2. The framework 'sits on top' of the necessary operational information sharing protocols and agreements which allows the appropriate, safe and secure sharing of information between public sector bodies.

3 The revised version has already been considered and approved by the Children's Trust and Safer Portsmouth Partnership. They were asked to:

a) Approve continued sign-up to the Portsmouth Information Sharing Framework following revisions in January 2016.

b) Agree that Board minutes reflect the Board's agreement (negating the need for individual members sign-up).

These recommendations were taken forward. As the same organisations are represented on Health and Wellbeing Board, the Framework is presented here for noting.

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

Portsmouth CITY COUNCIL

Information Requested

None

……
Signed by (Director)

Appendices:

Link to 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

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

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

Title of document	Location

Contents

Version Control

Version	Date amended	Brief description of changes
15	15 May 2014	Version control section - added Summary - added Appendix 1 - sentence added to make it clear PIA is an example. Appendix 1 - Previous PIA from Portsmouth City Council now updated Appendix 11 - new
	10 Nov 2015	List of relevant legislation updated
	10 Nov 2015	New Appendix 5 - Caldicott Principles
	19 Jan 2016	Clarifications in Appendix 2 - Example of operational agreement esp Privacy Impact Assessment,Legal justification for sharing and Fair Processing Information sections
	29 Jan 2016	12.2.4 Government Protective Marking Scheme now called Government Security Classification Policy – wording of this section amended. The addition of a flowchart as Section 18 to inform use of the document by non-IG specialists looking to put in place an operational agreement. Current appendices 1 (Example of Privacy Impact Assessment) & 2 (Example of operational agreement for data sharing between agencies) combined into a single appendix with a part A and a part B. Legal justifications for sharing added to the relevant field in part A of appendix 1. Appendix listing useful websites & guidance added. Glossary added as a penultimate appendix.
	09 Feb 2016	New paragraph at 1.4 re integrated multi-disciplinary services, digital technology, and the framework keeping pace with change.

Summary

Organisations in Portsmouth need to share personal and non-personal information so they can work effectively together to achieve better outcomes. Effective and structured information sharing between partners:

- informs decisions about plans to improve the city
- allow us to understand trends and patterns of activity so we can allocate resources more effectively
- enables us to respond to emergencies and disasters appropriately
- helps us to intervene and support the lives and safety of individuals, families and communities, and
- prevents and detects crime, apprehends and prosecutes offenders, protects life and property and preserves order and fulfils any duty or responsibility arising from common or statute law.

This Information Sharing Framework outlines the principles and standards of expected conduct and practice of the signatories and their staff and applies to all sharing of personal and non-personal data. The Framework establishes the organisation's intentions and commitment to data sharing and promotes good practice when sharing personal data. It also contains the legislative standards with which that all types of personal data sharing must comply.

This is the overarching Framework setting out the principles for using and sharing personal data amongst agencies working in Portsmouth. It includes templates for privacy impact assessments and information sharing operational agreements which agencies can use in specific circumstances or projects.

1 Foreword

1.1 Portsmouth has a long history of partnership working.[1] Partner agencies work together to deliver better outcomes for our citizens, employees and employers.

1.2 This 'Information Sharing Framework' ('the Framework'), sets out the information sharing requirements which need to be addressed when sharing personal information so that agencies can work effectively together. As a city, we have considerable challenges to overcome and if we want to work together to achieve our agreed outcomes for our citizens, it necessitates the structured sharing of information between all partners. Broadly speaking, effective and structured sharing of information between partners has the ability to:

- inform decisions about plans to improve the city
- allow us to understand trends and patterns of activity
- respond to emergencies and disasters appropriately
- intervene and support the lives and safety of individuals, families and communities, and
- prevent and detect crime, apprehend and prosecute offenders, protect life and property and preserve order and any duty or responsibility arising from common or statute law.

[1] The Vision for Portsmouth (April 2008). Portsmouth Local Strategic Partnership. http://www.portsmouth.gov.uk/yourcouncil/12142.html Accessed 30 October 2013

1.3 In a world of increased information gathering and recording, we have a moral and statutory responsibility to share it carefully and responsibly. Effective use of information will support us in achieving all the ambitions and aspirations we have for our city.

1.4 As integrated multidisciplinary services become an increasingly common model of public service delivery, and organisations embrace digital technology, information sharing will become both more widespread and more easily achievable. The information sharing framework must keep pace with these changes while ensuring that data is always shared in a legally justifiable way that safeguards the individual.

1.5 Within this Framework, justifiable purposes for sharing personal information between the partner agencies include to:

- develop evidence-led policies
- plan and commission more efficient, easier to access services
- improve existing and new services
- manage, report and benchmark performance
- promote accountability to customers, stakeholders, local residents and Government
- ensure that vulnerable children, young people and adults are given the protection they need
- allow organisations to cooperate so they can deliver the care and services that those people with complex needs rely on
- avoid duplication of data gathering
- monitor and protect public health and well being
- audit accounts
- analyse statistics for research and teaching
- prevent and detect crime and promote community cohesion and safety
- investigate complaints or actual/potential legal claims
- plan for and respond to emergencies and civil contingencies across the city
- obtain civil orders for breach of tenancy obligations
- comply with legal responsibilities eg court orders.

1.6 Organisations represented on the Portsmouth Children's Trust, Safer Portsmouth Partnership, the Health and Wellbeing Board as well as individual organisations working in Portsmouth are signed-up to this Framework. Statutory responsibilities remain, as always, with each organisation, but collectively this represents our commitment to sharing data.

1.7 This document is based on Protocols drawn-up by Coventry's Local Strategic Partnership. The template for individual information sharing agreements was drawn up by a pan-Hampshire group of health and social care organisations. We acknowledge, with thanks, the willingness of Coventry LSP and the pan-Hampshire group to help us formulate our Framework and Agreements and their approval for us to use their documents.

2 Introduction

2.1 This overarching Framework sets out the principles for using and sharing personal data among agencies working in Portsmouth.

2.2 Organisations involved in providing services to the public have a legal responsibility to ensure that their use of personal data is lawful, properly controlled and that an individual's rights are respected. This balance between the need to share data to provide quality services and protection of confidentiality can be a difficult one to achieve.

2.3 Uncertainty over the legal position may lead to data not being readily available to those who have a genuine need to know in order for them to do their job properly and provide the services required.

3 Structure

3.1 The Information Sharing Framework has been developed in a two-level framework. There is an overarching Information Sharing Framework (this document) and agencies who 'sign up' to the Framework will agree individual Information Sharing Agreements for specific projects or in particular circumstances.

3.2 The Information Sharing Framework outlines the principles and standards of expected conduct and practice of the signatories and their staff and applies to all sharing of personal and non-personal data. The Framework establishes the organisation's intentions and commitment to data sharing and promotes good practice when sharing personal data. It also contains the legislative standards with which that all types of personal data sharing must comply.

3.3 Specific Information Sharing Agreements set out the detail of what data is to be shared, how it will be shared, how it will be kept secure and who it will be given to. These Information Sharing Agreements also set out the limits to any data sharing and the extent to which it may be passed on to a third party without recourse to the originator of the data. All individual Information Sharing Agreements developed by the participating agencies comply with the principles set down in the overarching Information Sharing Framework. Appendix 1 part B provides model good practice of a specific information sharing agreement.

4 Aims and objectives of this Framework

4.1 The purpose of this overarching document is to set out a framework for partner organisations to manage and share data on a lawful basis with the purpose of enabling them to meet both their statutory obligations and the needs and expectations of the people they serve.

4.2 Specifically, this Framework aims to support appropriate and necessary data sharing between organisations within Portsmouth and includes:

- the general principles of data sharing
- the legal basis for sharing data

- when it is acceptable to share without consent
- the common purposes for holding and sharing data
- broadly, how data will be stored and kept safe.

4.3 It is expected that specific information sharing agreements will be developed separately. These will specify precisely what data is to be shared, how it will be shared and stored and to whom that data will be given for a particular area of activity. Responsibility for producing these specific data sharing agreements rests with the relevant senior managers.

5 What does the Framework cover?

5.1 The Framework applies to the following types of data:

5.1.1 Personal data

"'Personal data' means data which relate to a living individual who can be identified

(a) from those data, or

(b) from those data and other information which is in the possession of, or is likely to come into the possession of, the data controller,

and includes any expression of opinion about the individual and any indication of the intentions of the data controller or any other person in respect of the individual".

The term 'personal' data refers to any data held either as manual and/or electronic records, or records held by means of audio and /or visual technology, about a living individual who can be personally identified from that data.

Certain types of personal data have been classified as **sensitive data,** where additional conditions must be met for that data to be used and disclosed lawfully. The term 'sensitive' personal data means personal data consisting of data as to

(a) the racial or ethnic origin of the data subject,

(b) his political opinions,

(c) his religious beliefs or other beliefs of a similar nature,

(d) whether he is a member of a trade union (within the meaning of the Trade Union and Labour Relations (Consolidation) Act 1992),

(e) his physical or mental health or condition,

(f) his sexual life,

(g) the commission or alleged commission by him of any offence, or

(h) any proceedings for any offence committed or alleged to have been committed by him, the disposal of such proceedings or the sentence of any court in such proceedings."

5.1.2 Anonymised data

Anonymised data is that from which the individual cannot be identified by the recipient of the data. Broadly, data in this category is data about people that has been aggregated or tabulated in ways that, in effect, anonymise the details of individuals. This sort of data can be shared without the consent of the individuals involved. However, care should be taken to ensure that it should not be possible to identify individuals either directly or in summation. This can happen when anonymised data is combined with other data from different agencies, where the aggregated results produce small numbers in a sample, or where traceable reference numbers are used.

5.2. There is a general presumption and expectation that anonymised and non-personal information will be shared, unless there are exceptional reasons for this. These may include:

- commercial confidentiality (Section 43 Freedom of Information Act);
- policy formulation (to inform commissioning decisions about services / where a policy is under development and circulation would prejudice its development) (Section 36 Freedom of Information Act);
- legal prejudice (Section 42 Freedom of Information Act); and
- where information is marked protectively under HMG's Protective Marking Scheme and disclosure is not deemed appropriate (refer to your organisation's standards for information classification for further details).

5.3 This Framework applies to elected members, non-executive members, trustees and all employees of partner organisations who agree to be bound by it.

5.4 It also applies to any organisation or agency which has been commissioned to deliver services on behalf of any organisation party to this Framework where permission has been given to the third party organisation to disclose data. This requirement will be included in commissioning agreements, contracts or service level agreements etc.

5.5 The Framework is intended to complement any existing professional Codes of Practice that apply to any relevant profession working within any organisation, and does not constitute legal advice.

6 Legal responsibility to share

6.1 The legal framework within which public sector data sharing takes place is complex and overlapping and there is no single source of law that regulates public sector data sharing.

6.2 The purpose here therefore, is to highlight the legal framework that affects all types of personal data sharing, rather than serve as a definitive legal reference point.

6.3 The principal laws, guidance and regulations concerning the protection and use of personal data are listed below:

- Information Commissioner's Data Sharing Code of Practice (May 2011)
- the Children Act 1989 and 2004
- the Data Protection Act 1998
- the Human Rights Act 1998
- the Crime and Disorder Act 1998
- the Freedom of Information Act 2000
- the Health and Social Care Act 2012
- the Health and Social Care Act (Quality and Safety) 2015
- the Care Act 2014
- the Children and Families Act 2014
- No secrets, Department of Health 2000
- Regulatory Investigatory Powers Act 2000
- Police Reform Act 2002
- Criminal Justice Act 2003
- Civil Contingencies Act 2004
- Safeguarding Adults, Association of Directors of Social Services 2005
- Housing Act 1989
- Police and Justice Act 2006
- Guidance on the Management of Police Information 2010
- Working Together to Safeguard Children 2015 Statutory guidance
- Local Government & Public Involvement in Health Act 2007
- the Common Law Duty of Confidence
- Children and Young Persons Act 2008.

6.4 Section 11.7 includes a list of legislation which permits sharing of data without consent. There will also be specific legal bases enabling data sharing to support community safety and safeguarding work.

7 Purposes for which data will be shared

7.1 Data will only be shared for lawful purposes. The specific range of purposes will be identified within the separate and specific information sharing agreements.

7.2 Where the provision of anonymised or pseudonymised data is adequate practitioners must use these as a preferred method.

7.3 The partner organisations will ensure that data is shared or requested on the principle that it will be made available only on a justifiable 'need to know' basis. This means that staff will have access to data only if the function they are required to fulfil in relation to a particular service user cannot be achieved without access to the data in question. It may not be necessary to disclose all data held regarding a service user and only such data as is relevant for the purpose for which it is disclosed should be passed under the sharing arrangement to the recipient(s).

7.4 Privacy Impact Assessments will be used when considering the risks to individuals in the collection, use, sharing and disclosure of personal information. An example of a template used for Privacy Impact Assessments is at **Appendix 1 part A**. A Privacy Impact Assessment should be completed before using the Operational Agreement at **Appendix 1 part B**.

8 Principles underpinning this Framework

8.1 Seven Golden Rules about data sharing about individuals are at **Appendix 2**. Seven Golden Rules about systematic data sharing are at **Appendix 3**. The Caldicott Principles are at **Appendix 4**. The Health and Social Care Information Centre has also published a Code of Practice[2] and a Guide to confidentiality for handling confidential health and care information[3].

8.2 The partner organisations will:

- share data with each other where it is lawful
- comply with the requirements of the Data Protection Act 1998 and in particular with the eight Data Protection Principles. For more information, please see **Appendix 5**
- inform individuals when and how data is recorded about them and how their data may be used;
- ensure that adequate technical and non-technical security measures are applied to the personal data they hold and transfer;
- develop local Information Sharing Operational Agreements
- promote staff awareness of the Framework;
- promote awareness of the need for data sharing through appropriate communications media.

9 Consent

9.1 Introduction

9.1.1 All consent should be informed. Informed consent can be either explicit or implied.

a) Informed consent

The individual giving consent needs to understand why information needs to be shared, what will be shared, who will see their information, the purpose to which it will be put and the implications of sharing that information. This would include using their information for non-healthcare purposes in an anonymised format. Fair processing notices should be in place (see example at **Appendix 6**).

b) Explicit consent

[2] Health and Social Care Information Centre, 2014. Code of practice on confidential information. http://systems.hscic.gov.uk/infogov/codes/cop/code.pdf Accessed 10 November 2015

[3] Health and Social Care Information Centre. 2013. A guide to confidentiality in health and social care: treating confidential information with respect. http://www.hscic.gov.uk/media/12822/Guide-to-confidentiality-in-health-and-social-care/pdf/HSCIC-guide-to-confidentiality.pdf Accessed 10 November 2015

Consent to share information should be obtained from the individual at the start of the involvement and covers all of the agencies within a multi-agency service but there would be a need to seek additional explicit consent for sharing with practitioners or agencies outside of the service. Obtaining explicit consent for information sharing is best practice and can be expressed either verbally or in writing although written consent is preferable since that reduces the scope for subsequent dispute.

c) Implied consent

Consent can legitimately be implied if the context is such that information sharing is intrinsic to the activity or service and especially if that has been explained or agreed at the outset. Consent could be implied, for example, when a GP refers a patient to a hospital specialist and the patient agrees to the referral. In this situation the GP can assume that the patient has given implicit consent to share Information with the hospital specialist. However, the patient's explicit consent would be required to share information outside the bounds of the original service or setting. Consent can also legitimately be implied in individuals have been fully informed about the nature and purpose of information sharing and that they have a right to object to it, but have not done so.

9.1.2 Individual organisations may have their own procedures for dealing with issues of implicit/explicit consent to allow it to meet its lawful obligations. Please refer to your organisation's procedures.

9.1.3 To give informed consent, the person needs to understand why their information needs to be shared, what type of information may be involved, who that information may be shared with and the possible consequences if it is not shared (if relevant).

9.1.4 The person should also be advised of their rights with regard to their information (Principle 6 of the Data Protection Act. See **Appendix 5**). Additionally the individual has the right to

- withhold their consent
- place restrictions on the use of their information
- withdraw their consent at any time.

9.1.5 In general, once a person has given consent, that consent may remain valid for an indefinite duration unless the person subsequently withdraws that consent. However, it is good practice for practitioners to review this as a minimum annually.

9.1.6 If a person makes a voluntary and informed decision to refuse consent for their personal information to be shared, this decision must be respected unless there are sound legal grounds for disclosing without consent. The consequences of not providing consent should be explained – eg such as not receiving the right service/amount of support.

9.1.7 Consideration should be given as to whether consent needs to be updated if there are significant changes to the data held or shared.

9.2 Young Persons

9.2.1 Section 8 of the Family Law Reform Act entitles young people aged 16 or 17 years, having capacity, to give informed consent.

9.2.2 The courts have held that young people (below the age of 16 years) who have sufficient understanding and intelligence to enable them to understand fully what is involved will also have capacity to consent. This is augmented by the Gillick Competency. Signatory organisations should refer to their own procedures to determine the age at which competency is deemed to be acknowledged.

9.2.3 It should be seen as good practice to involve the parent(s) or guardian/representative of the young person in the consent process, unless this is against the wishes of the young person.

9.2.4 In the case where the wishes of a young person, who is deemed competent to give consent, are opposed to those of their parent/carer, then the young person's wishes should take precedent.

9.3 Recording consent

9.3.1 Wherever possible, all agencies should have in place a means by which an individual, or their guardian/representative, can record their explicit consent to personal information being disclosed and any limitations, if any, they wish to place on that disclosure.

9.3.2 An example of permission to share personal data is at **Appendix 7**.

9.3.3 Wherever possible, the individual or their guardian/representative, having signed the consent, should be given a copy for their retention.

9.3.4 The consent form should be securely retained on the individual's file/record and relevant information should be recorded on any electronic systems used, in order to ensure that other members of staff are made aware of the consent and any limitations.

10 Sharing with consent

10.1 Following best practice, partner organisations should seek to gain informed explicit consent from the individual concerned before sharing his/her personal data in accordance with this Framework - unless there is a specific reason for this not being possible, or where doing this would undermine the purpose of sharing that data.

10.2 Through Privacy Notices (see example at **Appendix 6**) and gaining individual consent, individuals will be made fully aware of the nature of the data that it may be necessary to share, who the data may be shared with, the purposes for which the data will be used, the benefits to the individual and others and any other relevant details including their right to access, withhold or withdraw consent.

10.3 All partner agencies will ensure that the details, including any conditions, surrounding consent (or refused consent) are clearly recorded on the individual's

manual record and/or electronic system in accordance with their agency's policies and procedures.

10.4 An example of a flowchart of sharing data, including obtaining consent, is at **Appendix 8.**

11 Sharing without consent

11.1 The Data Protection Act 1998 recognises that in certain circumstances the public interest requires the disclosure of personal data without consent. These are:

- disclosures required by law or in connection with legal proceedings or on production of a court order.
- disclosures required for the prevention or detection of serious crime
- disclosures required to protect the vital interests of the individual concerned
- where there is an overriding public interest.

11.2 The decision to disclose under these circumstances must be documented and include the reason for the decision, who made the decision, who the data was disclosed to and the date. A decision not to share data must also be recorded.

11.3 Where data needs to be shared in order to fulfil statutory requirements, but does not comply with the Data Protection Act, these requests will be considered and approved by the appropriate Caldicott Guardians or Senior Information Risk Officers (SIROs) of the partner organisations.

11.4 If you are unsure about whether it is lawful to disclose data without consent, contact your organisation's Data Protection Officer, or seek legal advice.

11.5 An example of a template Record of Disclosure for an individual's record is at **Appendix 9**.

11.6 In deciding whether or not disclosure of information given in confidence is justified it is necessary to weigh the harm that would result from breach of confidence against the harm that might result if you fail to disclose the information.

11.7 Legislation which permits the sharing of data without consent includes:

- NHS (Venereal Diseases) Regulations 1974
- Notifications of Births and Deaths Regulations 1982
- Codes of Practice, Mental Health Act 1983, s 1.3 – 1.13 and s 14
- Police and Criminal Evidence Act 1984
- Public Health Act 1984
- Public Health (Infectious Diseases) Regulations 1998
- Children's Act 1989 s 47
- Abortion Regulations 1991
- Finance Act 1994
- VAT Act 1994, s 91
- Criminal Procedure Investigation Act 1996
- Social Security Administration (Fraud) Act 1997

- Audit Commission Act 1998
- Crime and Disorder Act 1998, s 115
- Data Protection Act 1998, schedule 2 and schedule 3
- Terrorism Act 2000 s 19
- Civil Contingencies Act 2004.

11.8 All agencies should designate a person(s) who has the knowledge and authority to take responsibility for making decisions on disclosure without consent. This person(s) should hold sufficient seniority within the agency with influence on policies and procedures. Within health and social care agencies it expected that this person will be the Caldicott Guardian.

11.9 If information is disclosed without consent, then full details will be recorded about the information disclosed, the reasons why the decision to disclose was taken, the person who authorised the disclosure and the person(s) to whom it was disclosed.

11.10 A record of the disclosure will be made in the service user's case file and the service user must be informed if they have the capacity to understand, or if they do not have the capacity then any person acting on their behalf must be informed. See **Appendix 9**.

11.11 If information is disclosed without consent, there may be some exceptional circumstances (particularly in the context of police investigations or child protection/adult safeguarding work) where it may not be appropriate to inform the service user of the disclosure of information.

11.12 This situation could arise where the safety of a child/adult, would be jeopardized by informing the service user of such disclosure. In many such situations it will not be a case of never informing the individual., but rather delaying informing them until further enquiries have been made. Any decision not to inform, or to delay informing, should be recorded on the individual's case file, clearly stating the reasons for the decision, and the person making that decision.

12 Organisational and Individual Responsibilities

12.1 Organisations who sign-up to this Framework are responsible for embedding this Framework within their own processes relating to information sharing.

12.2 A number of safeguards are necessary in order to ensure a balance between maintaining confidentiality and sharing data appropriately. Organisations who share data under this Framework will adhere to the following:

12.2.1 Ensure staff are aware of and comply with:

- their responsibilities and obligations with regard to the confidentiality of personal data about people who are in contact with their agency
- know who to contact, and processes to follow, in the event of a breach of confidentiality
- the commitment of the organisation to share data legally and within the terms of an agreed specific information sharing agreement

- ♦ the commitment that data will only be shared on a need-to-know basis
- ♦ the understanding that disclosure of personal data which cannot be justified, whether intentionally or unintentionally will be subject to disciplinary action, and maybe subject to legal sanctions.

12.2.2 Ensure information disclosed is recorded appropriately by:

- ♦ ensuring that all personal information that has been disclosed to them under an agreement is recorded accurately on that individual's manual or electronic record in accordance with the agency's policies and procedures
- ♦ putting in place procedures to record the details of the information shared, the provider and who received the information.

12.2.3 Data security

Party agencies shall have appropriate technical and organisational measures in place to protect the confidentiality, integrity and availability of the data during all stages of processing. It is envisaged that each party will adhere to common standards for data security. Each party shall have formal procedures to:

- ▪ Ensure the security of personal data before, during and after data sharing takes place.
- ▪ Deal with breaches or suspected breaches of legislation or other duty, stated or implied, relating to the confidentiality of personal data, including measures for co-operation between the parties to the Framework.

12.2.4 Where organisations use a security classification scheme (such as the Government Security Classificaton Policy), it is the responsibility of those organisations to apply the appropriate level of security when they are sharing information.

Applying a classification to an information asset expresses the sensitivity of that asset and the impact of disclosure/compromise to unauthorised recipients or users without need-to-know.

Information assets can be any possible format of information carrier, paper and electronic; and when an organisation uses Protective Marking, it should be applied to **all** information assets.

The classification of an information asset:

- defines the protective measures we need to take in the protection of that information asset
- advises on handling, storing, transmitting, processing and destroying the information asset.

Users of this agreement should refer to local guidance on GPMS if they require further guidance.

12.2.5 Data quality

Data shared should be of a good quality and it is recommended that the data shared follows either the Audit Commission's six principles of data quality, or other appropriate guidance used by the organisations sharing the data. The six data quality principles are:

- accuracy
- validity
- reliability
- timeliness
- relevance, and
- completeness.

Further information about these principles can be found in the Audit Commission document entitled "Improving information to support decision making: standards for better quality of data".

12.3 Organisations must ensure that individuals are aware of their personal responsibilities with regard to sharing personal data, and who individuals should contact if queries arise.

13 Access to data

This document is an overarching framework that identifies the guidelines and principles under which sharing of information between signatory organisations will be undertaken, this will ensure that data is managed in accordance with the currently available best practice guidance on the protection and use of confidential information.

Individual Information Sharing Agreements (as at **Appendix 1 part B**) will provide more detail of information/data items to be shared and the associated controls around their use and management.

14 Sharing with organisations who are not signatories to this Framework

If it is necessary to share data with an organisation who is not party to this overarching Framework, consideration should be given on a case by case basis as to whether or not a specific information sharing protocol should be put in place for that information flow.

15 Monitoring and review

15.1 The Joint Strategic Needs Assessment Strategy Group will, in conjunction with partner organisations, review this overarching Framework three yearly unless new or revised legislation necessitates an earlier review.

15.2 Each partner organisation will be individually responsible for monitoring and reviewing the implementation of the Framework and any individual Information Sharing Agreements they may have.

16 Breaches

16.1 All agencies who are party to this Framework will have in place appropriate measures to investigate and deal with the inappropriate or unauthorised access to, or use of, personal data whether intentional or unintentional.

16.2 In the event that personal data shared under this Framework is or may have been compromised, whether accidental or intentional, the organisation making the discovery will, without delay:

- take appropriate steps, where possible, to mitigate any impacts;
- inform the organisation who provided the data of the details;
- take steps to investigate the cause;
- take disciplinary action against the person(s) responsible, if appropriate;
- take appropriate steps to avoid a repetition.

16.3 On being notified of a breach, the original data provider along with the organisation responsible for the breach, and others as appropriate, will assess the potential implications for the individual whose data has been compromised, and if necessary will:

- notify the individual(s) concerned;
- advise the individual(s) of their rights; and
- provide the individual(s) with appropriate support.

16.4 Where a breach is identified as serious, it may have to be reported to the Information Commissioner's Office. The original data provider, along with the breaching organisation and others as appropriate, will assess the potential implications, identify and agree appropriate action.

17 Complaints

17.1 Partner organisations must have in place procedures to address complaints relating to the disclosure of data. The partner organisations agree to cooperate in any complaint investigation where they have data that is relevant to the investigation. Partners must also ensure that their complaints procedures are well publicised.

17.2 If the complaint affects more than one partner organisation it should be brought to the attention of the appropriate complaints officers who should liaise to investigate the complaint.

18 Flowchart - setting up operational information sharing agreements / protocols

Staff of partner organisations wishing to put in place a new operational agreement should follow the steps indicated in the following flowchart:

Flowchart - setting up operational information sharing agreements/protocols

As early as possible, contact your organisation's Information Governance (IG) lead to check whether there is an existing protocol/agreement you could use. If not, seek advice and/or help with the process. Ensure that the same discussion is taking place at the agency with which your organisation needs to share data.

⇩

Establish your legal justification for sharing this data (see section 7 and appendix 1 of this document).

⇩

Complete the two-part form in appendix 1 (Example of combined Privacy Impact Assessment (PIA) and Operational Agreement (OA) for data sharing between agencies), asking your IG lead for advice and to review.

⇩

Forward the draft PIA/OA to the organisation/agency with whom you wish to share data to check and ensure that they and their IG lead are happy with the assessment and agreement.

⇩

Each organisation must have the PIA/OA document ratified and signed by an authorised signatory – usually a senior manager with responsibility for IG e.g. the Caldicott Guardian or Senior Information Risk Owner (SIRO)

⇩

You are now able to share data between organisations/agencies for the specific purpose(s) you have specified in the PIA/OA.

⇩

Please send a copy of the combined PIA/OA to joanna.kerr@portsmouthcc.gov.uk so that we have a complete, up-to-date record of agreements being used across Portsmouth.

⇩

All Privacy Impact Assessments/Operational Agreements should be subject to regular review.

Example of a combined Privacy Impact Assessment and operational agreement for data sharing between agencies

PLEASE USE RELEVANT PRIVACY IMPACT ASSESSMENT AND OPERATIONAL AGREEMENT TEMPLATE FROM YOUR OWN ORGANISATION AS APPLICABLE

Adapted with minor amendments from Portsmouth City Council (2014)

PART A

INFORMATION GOVERNANCE IMPACT ASSESSMENT QUESTIONAIRE

Please use black ink and CAPITAL letters if you are not completing this form electronically.

Data systems and/or external processes this piece of work links to			
		To be completed by Project Manager	
	Data system/external process	Separate IA Completed	Known Risks Y/N
1			
2			
3			

To be completed by Project owner			
Date received	All information provided (Y/N)	Risk Score	Signed off by Project Owner (Date and name)

To be completed by IG Administration			
Date received	All information provided (Y/N)	Risk Score	Signed off by IG Team (Date and name)

Work package details			
Project		Point of contact for this work (name, role, phone, email)	
Specific area concerned (e.g. which pilot)			
Project summary			
Brief description of overall activity			
Has anything similar been undertaken before			
Is there a reason why an			

Impact Assessment is not required for this piece of work			
Stakeholder(s) / Organisation(s) involved			
Sponsor (e.g. Project Board)		Activity period	

Information

What information will be collected – be specific (Person Identifiable Data (PID), Corporate, Sensitive etc)		
Why is information being collected		
How information is being collected	Verbal ☐ Paper questionnaire ☐ Other ☐→	Electronic form ☐ Electronic (automated) ☐
How information is to be stored	Paper ☐ Other ☐→	Electronic ☐
Where information will be stored (including back ups and copies)		
How information is to be edited or deleted		
How data is to be quality checked		
Who is responsible for the information		
What are the benefits to the individual and professional		
Is the use of Cloud technology being considered either by PCC or 3rd party supplier?	CLOUD ICO Questions_MASTERCC	

Sharing and access

What information is shared	
Who are you sharing with	
How information is to be transported	
Which roles will have access? Is there any restrictions based on different roles	
How is it accessed	
How access is to be monitored (audit, logs)	
What security measures will be in	

place	
What information sharing protocols and operational agreements will be in place	
What training is planned to support this piece of work	
What is the process for obtaining and recording consent/dissent (how, where, when, by whom)	
What is the legal justification for sharing? (See relevant section of part B)	
Will reports be generated from this information? If yes, will the information be identifiable or anonymous (will the reports be used for research)	
How can the individual access the information	
Retention	
How long data is to be retained	
What is the process for start-up and closing down this piece of work	
If the organisation/service ceases what will happen to the information	
Risks, issues and activities	
Any known risks or issues	
Any known activities that will have a direct affect on this piece of work	

Comments from Information Governance	
Comment	**Date/author**

Part B - Example of operational agreement for data sharing between agencies

Scope and Purpose

This is an Operational Agreement (OA) for data sharing between signatories of the Portsmouth Information Sharing Framework. As signatories to the Framework, the participating partner organisations agree to operate within a framework of data sharing that accords with best practice guidance set out in the Framework.

This OA is supplementary to the Framework and has been agreed between the participating partner organisations to support the regular sharing of personal data for the purpose of [Insert details here].

This OA covers the exchange of data between [Insert a brief description of the partner organisations]

It supports the data sharing partner organisations involved and the people it impacts upon. It details the specific purposes for sharing and the personal data being shared, the required operational procedures, consent processes, and legal justification that underpins the disclosure/exchange of data.

Partners may only use the data disclosed to them under this OA for the specific purpose(s) set out in this document.

Privacy Impact Assessment

[Select one of the following:]

A Privacy Impact Assessment has been completed to determine if this new process poses any new or emergent privacy concerns. Any privacy risks identified have been addressed in this Operational Agreement. [The information from the PIA should be used to populate the sections of this agreement]
OR
This Operational Agreement describes the formalisation of a pre-existing and lawful process and presents no additional privacy concerns to necessitate a privacy impact assessment. It has been determined in this case that the Operational Agreement addresses the privacy points.

Objectives

The objectives of sharing the data covered by this agreement are

- [Insert details here in bullet point form of the objectives of the data sharing covered under this agreement.]

Individuals Impacted by this OA

The residents/clients/service users and/or carers which this OA relates to include:

- [Insert details of the residents in bullet point form here].

The benefits to the people include:

- [Insert details here in bullet point form of how the ISP will benefit residents].

Legal Justification for Sharing

Please note: Staff should not hesitate to share personal data in order to prevent abuse or serious harm, in an emergency or in life-or-death situations. If there are concerns relating to child or adult protection issues, the relevant organisational procedures must be followed.

Data Protection Act, 1998 Principle 1 – Lawful Conditions

Processing, therefore sharing, of any personal data must be necessary for one or more condition of Schedule 2 of the Data Protection Act 1998. The relevant conditions are as follows:

[Complete the appropriate paragraph below and delete the one that does not apply]

- **Consent**: The sharing of personal data covered by this OA is based on informed consent from the data subject or carer. [Continue by describing the form of consent (explicit/implied) and how obtained and recorded; e.g. client signs consent form, implied consent assumed on referral, verbal consent given etc
- **Contract**: Where the agreement between data controller and data subject.
- **Legal obligation**: Where the sharing is mandated by the rule of law, for example, a Court Order.
- **Vital Interests** of the Data Subject: The sharing is necessary to prevent "life and limb" harm to the data subject, considered to be risk to life or immediate risk of serious harm.– i.e. severe or fatal.
- **Administration of justice:** Where the sharing is necessary for the functioning of the judiciary, for example the trial, finding and sentencing.
- **Legal gateway** The sharing of personal data under this protocol [is not / is not always] carried out with informed consent. In the absence of consent the legal justification for sharing is [Describe other legal or statutory basis which allows sharing, implicitly or explicitly]:
    - o
- **For a public duty in the public interest** – where the individual's right to confidentiality is outweighed by the public interest in sharing the information for the public good if there is a risk of harm. To make this assessment a Public Interest Test must be carried out on a case by case basis. Where all alternatives have been considered the public interest balance should be considered and approved by a senior officer.
- **Legitimate interests** of any party. Where the disclosure is necessary and compatible with legitimate aims of the information sharing partners to xxxxx; and where this is not unwarranted in any particular case by reason of prejudice to the rights and freedoms, or legitimate interest of the data subject. It is anticipated that disclosure will be warranted should xxxxx.

Where the Sensitive personal data will be shared under this agreement, the sharing must satisfy one or more of the following conditions of schedule 3 of the Data Protection Act. This list is not exhaustive, but the relevant conditions are as follows.
[Complete the appropriate paragraph below and delete the one that does not apply]

- No sensitive personal data will be shared under this arrangement
- Explicit and informed consent of the data subject has been obtained. The data subject must be fully aware of the scope of what they are consenting to.

- To protect the vital interests of the data subject or another person, where consent cannot reasonably be obtained or has been withheld unreasonably where the vital interests of a third party are at stake.
- The sharing is necessary for the purpose of, or in connection with, legal proceedings – (these must be directly compatible with a common law purpose to prevent public authorities acting *ultra vires*).
- The sharing of the information is necessary for:
    - the administration of justice
    - the exercise of any functions conferred on any person by or under an enactment
- The processing is necessary for medical purposes – specifically when it is necessary for the provision of care and treatment and the management of health care services
- The sharing of the information is necessary for the exercise of any functions conferred on a constable by any rule of law – this covers the use of common law powers to meet the policing purpose.

Data provided by partner organisations will not be released to any third party without the permission of the owning partner organisation.

Data to be Shared

Only the **minimum necessary** personal data consistent with the purposes set out in this document must be shared.

The data to be shared consists of [Describe or list data to be shared. [If possible include a full list of data items to be shared here or enclose as an appendix to the agreement]

Data Controller

The responsibility of Data Controller for the data subject to this agreement is held by [insert appropriate details here]:

> [Explain who is/are the data controller(s) for the data disclosed/exchanged. The responsibility may be shared (data controllers in common) or passed from one organisation to another in line with the flow of data.]

Data Quality

Personal data will only be collected using approved collection methods, ensuring the required data is complete and up-to-date.

All reasonable steps must be taken to ensure that anyone who has received data is notified of any relevant changes and if any inaccuracies are found the necessary amendments will be made.

Fair Processing Information

The Data Protection Act requires the fair processing of information unless an exemption applies. In particular, fairness involves being open with people about who is processing their data and how their data is being used. Put simply, a data subject should not be 'surprised' by their information being shared between the signatories.

Therefore so that individuals are not deceived or misled partners to this agreement should issue whenever possible a fair processing notice, either in writing or verbally. In some cases, it is in our interest to be open as to how data is shared.

[If existing fair processing notices do not adequately cover this information sharing arrangement additional measures will need to be taken and should be detailed in this section. If appropriate refer to specific leaflets etc that provide the information.]

Principle 2 – Secondary Processing

Data provided by partner organisations will not be released to any third party without the permission of the owning partner organisation.

Principle 3 – Adequate, relevant, not excessive

Only the **minimum necessary** personal data consistent with the purposes set out in this document must be shared.

The data to be shared consists of:

[Describe or list data to be shared. [If possible include a full list of data items to be shared here or enclose as an appendix to the agreement]

Principle 4 - Adequate, relevant, not excessive

Personal data will only be collected using approved collection methods, ensuring the required data is complete and up-to-date.

All reasonable steps must be taken to ensure that anyone who has received data is notified of any relevant changes and if any inaccuracies are found the necessary amendments will be made.

Principle 5 - Retention and Disposal

Personal data disclosed under this agreement will not be held for longer than necessary to fulfil the purpose for which it was collected and will be disposed of securely in accordance with national guidance and each organisation's local information retention and disposal policy.

[If it is possible to agree a set retention period for information shared under this agreement insert the details in this section.]

Principle 6 - Subject Access and Freedom of Information

If a party to this agreement receives a subject access application under section 7 of the Data Protection Act 1998 and personal data is identified as having originated from another signatory partner, it will be the responsibility of the receiving agency to contact that partner to determine whether the latter wishes to advise use of any statutory exemption under the provisions of the Data Protection Act 1998, or to consider further sharing on live matters. Disputes as to accuracy, damage or distress relating to the data processing will be passed promptly to the relevant Data Controller to resolve.

Participating partner organisations acknowledge a duty to assist one another in meeting their individual responsibilities under the Data Protection Act 1998 and the Freedom of Information Act 2000 to provide information subject to this agreement in response to formal requests.

Principle 7 – Technical and Organisational Security

Partners agree to ensure the reliability their employees through appropriate training around principle 7. As a bare minimum this should involve making staff aware of the processes outlined within this sharing agreement.

The information must be stored securely and is the responsibility of all partners to ensure that adequate security arrangements are in place in order to protect the integrity and confidentiality of information shared.

Each party agrees to apply appropriate security measures, to meet the requirements of principle 7 of the Data Protection Act to the data. That is, to make accidental compromise, loss or damage unlikely during storage, handling, use, processing, communication, transmission or transport; deter deliberate compromise or opportunist attack, and promote discretion in order to avoid unauthorised access. Any loss of data by a recipient partner must be notified to the originating partner at the earliest opportunity.

Only nominated representatives can access, request information, and make disclosure decisions and they should adhere to the 'need to know' principle when obtaining or disclosing information.

Principle 8 – Transfer outside of the EEA

Personal data supplied under the agreement will not be transferred outside the EEA.

Operational Procedures for Sharing

[Describe in this section the detailed procedures to be followed to allow data to be shared. This may be a simple as providing access to staff in one organisation to an existing information system hosted in another organisation or a more defined data transfer process. Consider the following questions if appropriate:

- Will data be requested or is an automatic data flow being set up?
- If data is being requested what is the procedure to do this?
- What will be the frequency of the data exchange?
- If setting up an automatic data flow how will data be transferred?
- If setting up an automatic data flow what are the security arrangements for the data in transit?
- Who is authorised to view/use the shared data and how?
- What systems are involved in the extraction, transfer and storage of the data?
- Could the data to be shared be transferred using the safe haven arrangements already in place in partner organisations?
- Do any arrangements need to be agreed for the return of data at the end of a contract term or agreed period of service provision?

Consider if the inclusion of a diagram or flow chart describing the sharing process will aid clarity.]

Retention and Disposal

11. Personal data disclosed under this agreement will not be held for longer than necessary to fulfil the purpose for which it was collected and will be disposed of securely in accordance with national guidance and each organisation's local information retention and disposal policy. [If it is possible to agree a set retention period for information shared under this agreement insert the details in this section.]

Subject Access and Freedom of Information

12. Participating partner organisations acknowledge a duty to assist one another in meeting their individual responsibilities under the Data Protection Act 1998 and the Freedom of Information Act 2000 to provide information subject to this agreement in response to formal requests.

Breach of Agreement

13. Any breach of this agreement should be reported and investigated in line with each partner organisation's incident reporting and management procedure and any relevant statutory guidance.

Complaints

14. Each partner organisation has a formal procedure by which individuals can direct, their complaints regarding the application of this OA.

Contacts

15. The primary contact for matters relating to the operation and management of this OA are:

Data Sharing Partner Organisations	Responsible Person
[Insert organisation details here]	[Insert job title and contact details here]
[Insert organisation details here]	[Insert job title and contact details here]
Insert rows below as necessary	

Review

16. This OA will be subject to local approval and reviewed [Insert agreed date for review here] or sooner if appropriate.

Authorised Signatories

In signing the document each signature is an undertaking to adopt the Agreement on behalf of their organisation

Signed on behalf of: .....

Signature: ..... Date: .....

Designation: ..... Role: .....

Name: ..... Title: .....

Signed on behalf of: .....

Signature: ..... Date: .....

Name: ..... Title: .....

[Add additional signature blocks as required]

Appendix 2

Seven Golden Rules of data sharing on an individual basis

1. Remember that the Data Protection Act is not a barrier to sharing data but provides a framework to ensure that personal data about living persons is shared appropriately

2. Be open and honest with the person (and/or their family where appropriate) from the outset about why, what, how and with whom data will, or could be shared, and seek their agreement, unless it is unsafe or inappropriate to do so.

3. Seek advice if you are in any doubt, without disclosing the identity of the person where possible.

4. Share with consent where appropriate and, where possible, respect the wishes of those who do not consent to share confidential data. You may still share data without consent if, in your judgement, that lack of consent can be overridden in the public interest. You will need to base your judgment on the facts of the case.

5. Consider safety and well-being: Base your data sharing decisions on considerations of the safety and wellbeing of the person and others who may be affected by their actions.

6. Necessary, proportionate, relevant, accurate, timely and secure: Ensure that the data you share is necessary for the purpose for which you are sharing it, is shared only with those people who need to have it, is accurate and up-to-date, is shared in a timely fashion, and is shared securely.

7. Keep a record of your decision and the reasons for it - whether it is to share data or not. If you decide to share, then record what you have shared, with whom and for what purpose.

Source: Guidance for Practitioners and Managers, 2008. Department for Children, Families and Schools

Appendix 3

Seven Golden Rules of data sharing on a systematic basis

1 Remember that the Data Protection Act is not a barrier to sharing data but provides a framework to ensure that personal data about living persons is shared appropriately

2 Assess the potential benefits and risks to individuals and/or society of sharing or not sharing.

3 Keep a record of your decision and the reasons for it - whether it is to share data or not. If you decide to share, then record what you have shared, with whom and for what purpose.

4 Necessary, proportionate, relevant, accurate, timely and secure: Ensure that the data you share is necessary for the purpose for which you are sharing it, is shared only with those people who need to have it, is accurate and up-to-date, is shared in a timely fashion, and is shared securely.

5 Is there a legal obligation to share data (for example a statutory requirement or a court order.

6 Share with consent where appropriate and, where possible, respect the wishes of those who do not consent to share confidential data. You may still share data without consent if, in your judgement, that lack of consent can be overridden in the public interest. You will need to base your judgment on the facts of the case.

7 Agree common retention periods and process for secure deletion of the data.

Source: ICO Guidance: Data Sharing checklist – systematic data sharing

Appendix 4

The Caldicott Principles

1. Justify the purpose(s)

Every proposed use or transfer of personal confidential data within or from an organisation should be clearly defined, scrutinised and documented, with continuing uses regularly reviewed, by an appropriate guardian.

2. Don't use personal confidential data unless it is absolutely necessary

Personal confidential data should not be included unless it is essential for the specified purpose(s) of that flow. The need for patients to be identified should be considered at each stage of satisfying the purpose(s).

3. Use the minimum necessary personal confidential data

Where use of personal confidential data is considered to be essential, the inclusion of each individual item of data should be considered and justified so that the minimum amount of personal confidential data transferred or accessible as is necessary for a given function to be carried out.

4. Access to personal confidential data should be on a strict need-to-know basis

Only those individuals who need access to personal confidential data should have access to it, and they should only have access to the data items that they need to see. This may mean introducing access controls or splitting data flows where one data flow is used for several purposes.

5. Everyone with access to personal confidential data should be aware of their responsibilities

Action should be taken to ensure that those handling personal confidential data – both clinical and non-clinical staff – are made fully aware of their responsibilities and obligations to respect patient confidentiality.

6. Comply with the law

Every use of personal confidential data must be lawful. Someone in each organisation handling personal confidential data should be responsible for ensuring that the organisation complies with legal requirements.

7. The duty to share information can be as important as the duty to protect patient confidentiality

Health and social care professionals should have the confidence to share information in the best interests of their patients within the framework set out by these principles. They should be supported by the policies of their employers, regulators and professional bodies.

Source: Department of Health: Information: To Share or Not to Share – Government Response to the Caldicott Review – September 2013

Appendix 5
Eight Data Protection Principles

The Data Protection Act 1998 governs the protection and use of personal data. It sets out standards which must be satisfied when obtaining, recording, holding, using or disposing of personal data. These are summarised by the eight Data Protection Principles. Under the key principles of the Act, personal data must be:

Principle 1 - processed fairly and lawfully. There should be no surprises – data subjects should be informed about why data about them is being collected, what it will be used for and who it may be shared with.

Principle 2 - obtained and processed for specified purposes. Only use personal data for the purpose(s) for which it was obtained and ensure it is not processed in any other manner that would be incompatible with that purpose(s).

Principle 3 - adequate, relevant and not excessive. Only collect and keep the data you require. It is not acceptable to collect data that you do not need. Do not collect data 'just in case it might be useful one day'.

Principle 4 - accurate and kept up to date. Have in place mechanisms for ensuring that data is accurate and up to date. Take care when inputting to ensure accuracy and have local procedures in place to manage requests for data to be amended.

Principle 5 - not kept for longer than is necessary. The legislation within which area you are working in, will often state how long documents should be kept. Data should be disposed of in accordance to your organisation's disposal policy.

Principle 6 - processed in accordance with the rights of the data subject under the Act. These rights include the right to:

- Make subject access requests
- Prevent the processing of data which is likely to cause them substantial
- damage or substantial distress
- Prevent processing for the purposes of direct marketing
- Be informed about automated decision making processes that affect them
- Prevent significant decisions that affect them from being made solely by automated processes
- Seek compensation if they suffer damage or distress through contravention of the Act
- Take action to require the rectification, blocking, erasure or destruction of inaccurate data
- Request an assessment by the Information Commissioner of the legality of any processing that is occurring.

Principle 7 - protected by appropriate security. This can be broken down into two elements:

- Practical – for example:
  - Internal and external postal arrangements
  - Verbal communications (phone, meetings etc)

- Electronic mail – such as what personal data can and cannot be sent via electronic mail, secure destruction of electronic mail
- Ensuring the confidentiality of faxes by using Safe Haven /secure faxes,
- Keeping confidential papers locked away,
- Ensuring confidential conversations cannot be overheard
- Ensuring data is transported securely
- Having procedures for access by their employees and others to personal data held in manual or electronic systems, and to ensure that access to such data is controlled and restricted to those who have a legitimate need to have access
- Storage of portable media
- Having procedures for the retention and disposal of records containing personal data
- Clear desk policies if appropriate

♦ Organisational (not an exhaustive list) – all organisations should have their own security policies:
- good information management practices
- guidelines on IT security
- procedure for access to personal data
- a retention and disposal policy for confidential data.

Principle 8 - not transferred to a country or territory outside the EEA without an adequate protection. If sending data outside the EEA, ensure consent is obtained and it is adequately protected. Consider carefully what is posted on websites or sent via email. Where appropriate, obtain approval from the data controller.

Appendix 6
Example of Privacy/Fair Processing Notice
Source: Based on NHS Hampshire Privacy Notice, May 2012

Privacy notice.

How we use your information
This privacy notice tells you what to expect when (Name of organisation) collects personal information. It applies to information we collect about:

- visitors to our websites
- complainants and other individuals in relation to a data protection or freedom of information complaint or enquiry
- people who use our services, e.g. application for additional healthcare funding or a specialist service.
- job applicants and our current and former employees

Visitors to our websites
When someone visits (website) we collect standard internet log information and details of visitor behaviour patterns. We do this to find out things such as the number of visitors to the various parts of the site. We collect this information in a way which does not identify anyone. We collect identifiable information from visitors to our website who register in order to comment on forum threads or to receive further information on specific topics. This information is held securely and only used for the purposes provided.

We do not make any other attempt to find out the identities of those visiting our website. We will not associate any data gathered from this site with any personally identifying information from any source. If we do want to collect personally identifiable information through our website, we will be up front about this. We will make it clear when we collect personal information and will explain what we intend to do with it.

YouTube cookies
We embed videos from YouTube channels using YouTube's privacy-enhanced mode.

People who make a complaint to us
When we receive a complaint from a person we make up a file containing the details of the complaint. This normally contains the identity of the complainant and any other individuals involved in the complaint.

We will only use the personal information we collect to process the complaint and to check on the level of service we provide. We do compile and publish statistics showing information like the number of complaints we receive, but not in a form which identifies anyone.

We usually have to disclose the complainant's identity to whoever the complaint is about. This is inevitable where, for example, the accuracy of a person's record is in dispute. If a complainant doesn't want information identifying him or her to be disclosed, we will try to respect that. However, it may not be possible to handle a complaint on an anonymous basis.

Appendix 6 continued

We will keep personal information contained in complaint files in line with our retention policy. This means that information relating to a complaint will be retained for 6 years from closure. It will be retained in a secure environment and access to it will be restricted according to the 'need to know' principle.

Similarly, where enquiries are submitted to us we will only use the information supplied to us to deal with the enquiry and any subsequent issues and to check on the level of service we provide.

People who use our services
(Name of organisation) offers various services to the public. For example, we send out publications and decide on requests for healthcare funding.

We have to hold the details of the people who have requested a service in order to provide it. However, we only use these details to provide the service the person has requested and for other closely related purposes. For example, we might use information about people who have requested a publication to carry out a survey to find out if they are happy with the level of service they received. When people do subscribe to our services, they can cancel their subscription at any time and are given an easy way of doing this.

Job applicants, current and former employees
When individuals apply to work at (Name of organisation), we will only use the information they supply to us to process their application and to monitor recruitment statistics. Where we want to disclose information to a third party, for example where we want to take up a reference or obtain a 'disclosure' from the Criminal Records Bureau we will not do so without informing them beforehand unless the disclosure is required by law.

Personal information about unsuccessful candidates will be held for 12 months after the recruitment exercise has been completed, it will then be destroyed or deleted. We retain de-personalised statistical information about applicants to help inform our recruitment activities, but no individuals are identifiable from that data.

Once a person has taken up employment with us, we will compile a file relating to their employment. The information contained in this will be kept secure and will only be used for purposes directly relevant to that person's employment. Once their employment with (Name of organisation) has ended, we will retain the file in accordance with the requirements of our retention schedule and then delete it.

Complaints or queries
(Name of organisation) tries to meet the highest standards when collecting and using personal information. For this reason, we take any complaints we receive about this very seriously. We encourage people to bring it to our attention if they think that our collection or use of information is unfair, misleading or inappropriate. We would also welcome any suggestions for improving our procedures.

This privacy notice does not provide exhaustive detail of all aspects of (Name of organisation) collection and use of personal information. However, we are happy to provide any additional information or explanation needed. Any requests for this should be sent to the address below.

Appendix 6 continued

Access to personal information
(Name of organisation) tries to be as open as it can be in terms of giving people access to their personal information. Individuals can find out if we hold any personal information by making a 'subject access request' under the Data Protection Act 1998. If we do hold information about you we will:

- give you a description of it;
- tell you why we are holding it;
- tell you who it could be disclosed to; and
- let you have a copy of the information in an intelligible form.

To make a request to (Name of organisation) for any personal information we may hold you need to put the request in writing addressing it to the Information Governance Manager, writing to the address provided below.

If we do hold information about you, you can ask us to correct any mistakes by, once again, contacting the Information Governance Manager.

Disclosure of personal information
In many circumstances we will not disclose personal data without consent. However when we investigate a complaint, for example, we will need to share personal information with the service concerned and with other relevant bodies.

You can also get further information on:

- agreements we have with other organisations for sharing information;
- circumstances where we can pass on personal data without consent for example, to prevent and detect crime and to produce anonymised statistics;
- how we check that the information we hold is accurate and up to date.

Links to other websites
This privacy notice does not cover the links within this site linking to other websites. We encourage you to read the privacy statements on the other websites you visit.

Changes to this privacy notice
We keep our privacy notice under regular review. This privacy notice was last updated on 12 October 2011.

How to contact us
Requests for information can be emailed to (the relevant person)
or by writing to:

The Information Governance Manager
Etc
Etc

Appendix 7 - Example of permission to share personal data

[Insert name/logo of organization]

Private and Confidential
Permission to View and Share

Name:	**DOB/Gender:**
Address:	**Telephone:**
Email Address:	**NHS Number:** **Paris Number**

Collecting, Viewing and Sharing Information

By recording information we aim to offer you a service that is right for you at the right time to meet your needs.

This information will be stored electronically on computer and possibly on paper. It will:

- Help us to understand what's happening in your own life and in your family.
- Tell us, about what services you are already receiving.
- Give you the opportunity to share anything you consider to be useful for us to know.

We aim to work with as many organisations as possible to be effective in our provision of services. This will be done in accordance to the Data Protection Act 1998.

In an emergency, safeguarding, or life threatening situation, there may be circumstances when we need to view and share information about you, without your consent, for the safety of yourself and others.

It is your choice who your information is shared with. You should let us know if you wish to review or change your consent and this can be updated and recorded at any time.

Are you willing for us to share your information with:

Personal

Immediate Family	**Yes/No**
Guardian	**Yes/No**
Next of Kin	**Yes/No**
Do any of these have lasting or Enduring power of attorney?	**Yes/No**

Carer	**Yes/No**
Appointee	**Yes/No**
Advocates	**Yes/No**
Religious Leader	**Yes/No**

Which of these is your preferred contact? .....

Who else would you like? .....

Care Worker / Personal Assistant

Employed/paid carer	**Yes /No**
Care agency	**Yes /No**
Supported Living Worker	**Yes/No**
Other	**Yes/No**

Who else supports you? .....

GP Surgery **Yes/No**

Anyone involved in my treatment and care

Hospital

Anyone involved in my treatment and care **Yes/No**

Community Health

Anyone involved in my treatment and care **Yes/No**
eg District Nurse, Dentist

Health & Social Care Team

Anyone involved in my treatment or care **Yes/No**

Mental Health Services

Anyone involved in my treatment and care **Yes/No**

Other Organisations

Housing Department/ Association	**Yes/No**
Private Health providers	**Yes/No**
Independent Providers	**Yes/No**
DWP - Department of Work and Pensions	**Yes/No**
Legal professionals	**Yes/No**
School/ Education	**Yes/No**
Employment Services	**Yes/No**
Blue Badge Service	**Yes/No**

Please list any others not on this list that are important to you

.....

.....

Emergency Services

Fire	**Yes/No**
Police - Local / International/Coast Guard	**Yes/No**
Ambulance Service	**Yes/No**

DO NOT SHARE WITH (please list)

....

.....

Declaration of Permission to Share Information

"I understand that information about me will be stored on computer and possibly paper. This will only be used in accordance with the Data Protection Act (1998). I agree to information about me being viewed and shared as indicated above where this is necessary in order to assess my needs and arrange and provide services."

Signed: ……..…… Date: ...…….....

Print Name: ……..……

<u>If signing on behalf of someone</u>

Signed: ……..…… Date: ...…….....

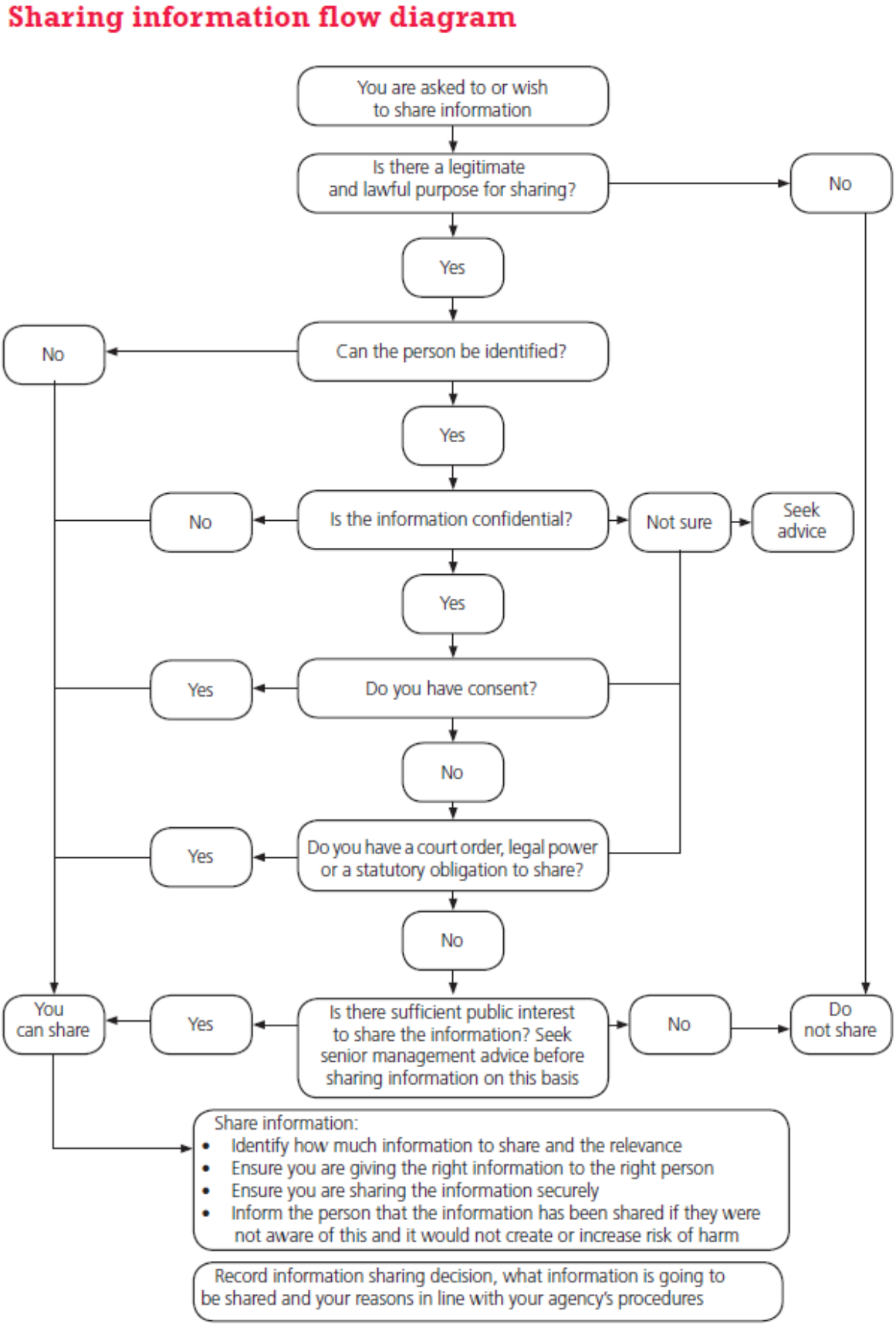
Print Name: ……..……

<u>Witnessed by</u>

Signed: ……..…… Date: ...…….....

Print Name: ……..……

Appendix 8 – Example of a sharing information flow diagram



Appendix 9 - Example of a Record of Disclosure formConfidential Record of Disclosure

Service user name	
Service user date of birth	
Local record identifier	
NHS number (if relevant)	
Description of data disclosed	
Reason for disclosure	
Recipient(s) of the data	
If disclosure is made without	
consent, please state reasons	
Reasons for refusal/limited	
disclosure (if appropriate)	
Disclosing organisation	
Disclosed by	
Authorised by	
Date of disclosure	

A copy of this disclosure record should be retained on the service user's file.

Appendix 10 – Useful websites and guidance

Data Protection Act 1998
http://www.legislation.gov.uk/ukpga/1998/29/contents

Health and Social Care (Safety and Quality) Act 2015
http://www.legislation.gov.uk/ukpga/2015/28/contents/enacted

Health & Social Care Information Centre – Information sharing
http://systems.hscic.gov.uk/infogov/iga/resources/infosharing
Includes a guide to The Health and Social Care (Safety and Quality) Act 2015 and other guidance to support sharing.

Health & Social Care Information Centre – Information Governance support and guidance
http://systems.hscic.gov.uk/infogov

Information Commissioner's Office – guidance for organisations
https://ico.org.uk/for-organisations/

Information Commissioner's Office – key definitions
https://ico.org.uk/for-organisations/guide-to-data-protection/key-definitions/

Information Governance Alliance – *Enabling information sharing: a user's map for health and social care* (Draft for consultation, Oct 2015)
http://systems.hscic.gov.uk/infogov/iga/consultations/nhsenframework.pdf

Information: To share or not to share - The Independent Information Governance Oversight Panel's report to the Secretary of State for Health (Jan 2015)
https://www.gov.uk/government/publications/iigop-annual-report-2014
This is the first annual report of the Independent Information Governance Oversight Panel, chaired by Dame Fiona Caldicott. It looks at whether health and social care organisations are sharing information wisely and preventing improper disclosure of personal data.

Information: To share or not to share? The information governance review (2013)
https://www.gov.uk/government/publications/the-information-governance-review
Dame Fiona Caldicott's independent review of information sharing, aimed at ensuring that there is an appropriate balance between the protection of patient information and the use and sharing of information to improve patient care.

Appendix 11 - Glossary

Anonymised data – information from which in practice the data subject cannot be identified by the recipient of the information, and where the theoretical probability of the data subject's identity being discovered is extremely small

Aggregated data – data which has been reduced to such an extent that it is no longer possible, by any means, to identify any individual. Typically this will include information for statistical returns at both local and national level.

Caldicott Guardian – is the representative responsible for agreeing and reviewing internal protocols governing the protection and use of patient-identifiable information by the staff in their organisation.

Confidentiality – respect for the privacy of information - one of the principles that underpin all health and social care practice. Information about a person is generally held under legal and ethical obligations of confidentiality. With certain important exceptions, information provided in confidence must not be used or disclosed in a form that might identify the person concerned without their consent.

Common law duty of confidentiality – a common law duty of confidentiality is owed to individuals who have been told that a matter will be dealt with in confidence or have discussed a matter under circumstances in which they might reasonably expect that it would remain confidential. This duty can only be broken if the public interest requires it. Statutory provisions on disclosure override common law provisions.

Consent – is one of the lawful bases for processing patient data. As long as you have given patients a fair choice that they understand (called informed consent) about how you will use their data if they say "yes", then it is a solid base to support the use of data. Consent is applicable to the Data Protection Act as well as the common duty of confidentiality. Remember, consent cannot be overridden in most instances (you cannot give people a choice then say "we have found a basis in law and are going to do it anyway") and can be withdrawn. Explaining to patients the benefits and consequence of both consent (saying "yes") and dissent (saying "no") is crucial.

Explicit consent – can be given in writing or orally (and then recorded) agreeing that information can be used purposes described.

Implied consent – is where the person has been informed about the information to be shared, the purpose for sharing and that they have the right to object; their agreement to sharing has subsequently been signalled by their behaviour rather than orally or in writing.

Data – is information recorded in a form in which it can be processed automatically in response to instructions; information recorded as part of a relevant filing system or an accessible record.

Data controller – a person who (alone, jointly or in common with other persons) determines the purposes for which and the manner in which personal data is processed.

Data Protection Act 1998 – the main UK legislation which governs the handling and protection of information relating to living people.

Data sharing – the disclosure of data from one or more organisations to a third party organisation(s), or the sharing of data within an organisation. Sharing can take the form of systematic, routine data sharing where the same data sets are shared between the same organisations for an established purpose; and exceptional, one off decisions to share data for a range of purposes.

Data (personal) – anything which is capable of identifying a living individual, e.g. name, address, CCTV image, telephone call recording, e-mail address, postcode, photograph etc.

Sensitive personal data – information about:

- racial and ethnic origin
- political opinions
- religious beliefs
- physical and mental health
- sexual life
- trade union membership
- criminal convictions and proceedings.

De-personalised data – is data about an individual from which all personally identifying information has been removed, including any unique identifiers such as a computer reference number.

Data processing – this has a very broad definition and includes:

- obtaining, recording or holding information or data
- organisation, adaptation or alteration of data
- retrieval, consultation or use of data
- disclosure of data
- alignment, combination, blocking, erasure or destruction of data

Data subject – a person who is the subject of personal data:

- they must be a living individual
- they need not be a UK national or resident
- organisations cannot be data subjects

Disclosure – this is the divulging or provision of access to data.

Duty of confidentiality – everyone has a duty under common law to safeguard personal information.

Fair processing – is a term that comes from the Data Protection Act. The first requirement of the Act is being fair and lawful in our use of patient data. That means telling them who we are and what we are doing with their data. We have to do this in a way that they understand. The Information Commissioner's Office (ICO), see below, refers to this process as 'Privacy Notices' but the concepts are rooted in the same law. Patient Notification (not patient communication) is a subtly different concept that relates to Section 251 applications (and the Regulations which permit the lawful flow of data when the Secretary of State approves).

Fair Processing Notice (also called Privacy Notice) – this is issued to children, young people, adults and their families to inform them what information is being collected and recorded about them, the reasons for doing so, under what circumstances it might be shared and why, and their right of access to the data.

Information Commissioner – the independent public official who reports to Parliament and whose principal duty is to enforce DPA 1998 and to educate organisations, businesses and individuals about the legislation.

Information Commissioner's Office (ICO) – is the regulator (they judge whether organisations are meeting both the letter and the spirit of the law) for Data Protection and Freedom of Information. They provide useful guidance on understanding the Data Protection Act and implementing Fair Processing or Privacy Notification as they call it. Remember, while the ICO have a view of "lawful" processing, this focuses on the Data Protection Act and they are not the ombudsman for the common law duty of confidentiality (there isn't one). The ICO will take account of the requirements of the Human Rights Act (HRA) and the Common Law duty of confidentiality, when determining what is lawful and fair.

Lawful basis – in order to use patient data (both the confidential data and that without a duty of confidentiality) organisations must have a lawful basis. For health data the standard is set by the Data Protection Act (statute), the common law duty of confidentiality (set by precedent and expectations) and the Human Rights Act (statute). This same standard will also often apply to social care data. For health and social care, this is a high standard for using patients' data. Using patient information well starts at the point where patients give us their information and what we tell them, at that time, about how we'll use it.

Need to know – sharing of information should only be with those who need to know and, even then, only the information that is actually required to provide any appropriate service.

Privacy impact assessment (PIA) – is a comprehensive process for determining the privacy, confidentiality and security risks associated with the collection, use and disclosure of personal data.

Public Interest – is the interest of the community as a whole, a group within the community, or an individual other than the data subject.

Purpose – the use / reason for which information is stored or processed.

Recipient – the person(s) to whom the data is disclosed.
Definitions have been drawn from the draft Information Governance Alliance guidance *Enabling information sharing: a user's map for health and social care* (http://systems.hscic.gov.uk/infogov/iga/consultations/nhsenframework.pdf; consulted upon in October 2015 and due to be published this year), and Essex Partnership's *Information Sharing Protocol Standard No 8 - Glossary of Terms* (http://www.essexpartnershipportal.org/content/information-sharing-protocol-standard-no-8-glossary-terms).

Appendix 12

Organisations signed up to this Framework as at 9th February 2016

Organisation	Information governance generic contact points
Portsmouth City Council	foi@portsmouthcc.gov.uk
NHS Portsmouth Clinical Commissioning Group	SOUTHCSU.IG-Enquiries@nhs.net
University of Portsmouth	Adrian Parry, Director of Corporate Governance
Hampshire Constabulary	Information.management@hampshire.pnn.police.uk
Portsmouth Hospitals NHS Trust	James Taylor, Information Governance Manager
Solent NHS Trust	SNHS.SolentIGTeam@nhs.net

Organisations intending to sign up to this Framework as at 9th February 2016

National Probation Service	Sarah Beattie
Purple Futures (Hampshire Community Rehabilitation Company)	Barbara Swyer