Portsmouth CITY COUNCIL

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NOTICE OF MEETING

HEALTH AND WELLBEING BOARD

WEDNESDAY, 21 FEBRUARY 2018 AT 10.00 AM

CONFERENCE ROOM A - CIVIC OFFICES - FLOOR 2

Telephone enquiries to Joanne Wildsmith, Democratic Services Tel: (023) 9283 4057
Email: joanne.wildsmith@portsmouthcc.gov.uk

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

Health and Wellbeing Board Members
Councillors Luke Stubbs (Joint Chair), Donna Jones, Gerald Vernon-Jackson CBE, Ryan Brent, Jennie Brent and Leo Madden
Innes Richens, Dr Jason Horsley, Mark Cubbon, Dr Linda Collie (Joint Chair), Dr N Moore, Ruth Williams, Dianne Sherlock, Sue Harriman, Patrick Fowler, Alison Jeffery and Andy Silvester

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

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

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

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

A G E N D A

1 Welcome by Dr Collie, Apologies for Absence and Introductions

2 Declaration of Members Interests

3 Minutes of the previous meeting - 29 November 2017 (Pages 5 - 12)

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

4 Pharmaceutical Needs Assessment (Pages 13 - 144)

The report of the Director of Public Health is attached.

The Health and Wellbeing Board has a statutory responsibility to publish a statement of the needs for pharmaceutical services of the population in its area, referred to as a Pharmaceutical Needs Assessment (PNA). It must be published every three years with the next PNA due to be published on 1st April 2018. A paper was brought to the Health and Wellbeing Board (HWB) on 20th August 2017 where the draft PNA was approved for consultation.

The regulations state that the HWB must undertake a consultation on the content of the PNA and it must run for minimum of 60 days. The consultation took place from 23rd October to 27th December 2017. Consultation findings (appendix 1) have been considered and have not changed the conclusion of the PNA. This paper presents the final Portsmouth PNA 2018 (appendix 2) and seeks approval of the report for publication on 1st April 2018.

RECOMMENDED the Health and Wellbeing Board is asked to approve the final Portsmouth Pharmaceutical Needs Assessment (PNA) 2018 for publication on 1st April 2018.

5 Health and Wellbeing Strategy - Refresh 2018-2021 (Pages 145 - 182)

The purpose of the report by the Director of Public Health is to present to the Health and Wellbeing Board the Health and Wellbeing Strategy for 2018-2021 for approval.

RECOMMENDED that the Health and Wellbeing Board:

a. **Approve the Health and Wellbeing Strategy attached at Appendix 1.**

b. **Recommend that partner organisations adopt the strategy through their own governance arrangements, as set out on paragraph 6.1**

c. **Consider the approach to progressing the strategy as set out in section 6, and propose areas for HWB consideration.**

6 Portsmouth Suicide Prevention Plan

Amy McCullough to present. Report and plan to follow.

RECOMMENDED: **That the Health and Wellbeing Board approve the Portsmouth Suicide Prevention Plan.**

7 Date of next meeting

It is proposed that the next meeting takes place on Wednesday 20th June at 11am.

And the following meetings are suggested:

Weds 3rd October & 28th November 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, 29 November 2017 at 10.00 am in Conference Room A, Civic Offices, Portsmouth.

Present

Dr Linda Collie (in the Chair)

Councillor Donna Jones
Councillor Gerald Vernon-Jackson CBE

Innes Richens
Dr N Moore
Patrick Fowler
Dianne Sherlock
Sue Harriman
Alison Jeffery
Andy Silvester

Officers Present

Kelly Nash
David Williams

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

Dr Collie, as chair, welcomed everyone and gave fire evacuation instructions, before inviting introductions of those present.

Apologies for absence had been sent by Councillors Ryan Brent (due to work commitments), Jennie Brent and Luke Stubbs (both of whom were on other council business) and Councillor Donna Jones apologised for her late arrival as she had been at another meeting.

23. Declarations of Members Interests (AI 2)

There were no declarations of interests.

24. Membership Change (information item) (AI 3)

Dr Collie, as Chair, welcomed Andy Silvester to his first meeting of the Health & Wellbeing Board as the new Portsmouth CCG Lay Member. She also asked that Jackie Powell be thanked for her good service to the board over her years of membership.

25. Minutes of previous meeting - 20 September 2017 (AI 4)

RESOLVED that the minutes of the Health & Wellbeing Board held on 20 September 2017 were approved as a correct record, subject to the inclusion of Dr N Moore in the list of attendees.

26. Portsmouth Safeguarding Adults Board - Annual Report (AI 5)

Robert Templeton, Independent Chair of the Portsmouth Safeguarding Adults Board (PSAB), presented their annual report, which was an overview of last year's activities and the priorities going forward. One of the biggest challenges was to keep people safe with the capacity to do so and ensure that shortcuts are not taken which would increase risks. The PSAB sought to use a partnership approach effectively. Mr Templeton had also become Chair of the Southampton Safeguarding Adults Board, so worked across Hampshire, but saw the different priorities for Portsmouth to other parts of the county. There were peer reviews between the local authority areas. One of the priorities was to ensure that the data is right to help identify where problems are.

Questions were raised by members of the Health & Wellbeing Board which included:

- The level of concern raised by the 303 enquiries that were identified as needing further input - The PSAB Chair responded that some areas had been worrying; some inquires reflect where it is already known that the system is under pressure through the work of the CQC and hospital trusts. One area receiving further inspection was the referrals from hospital.
- What was being done to address domiciliary care staff shortages and pressures - The PSAB Chair responded that there are workforce offers across Hampshire for safeguarding which are free to the providers, with discussions taking place with the Assistant Director of Adult Social Care and it was essential that care workers are well supported.
- Modern day slavery and work with the Police & Crime Commissioners Office on this - work was taking place with partners to raise awareness of what to do when suspicions are raised.
- Section 42 Enquiries - the high level of "unknown to individual" sources of abuse - this could be a data recording error which was being looked at with the health services involved.

The PSAB annual report was accepted and Robert Templeton was thanked for his presentation of it.

27. SEND Strategy and Self-Evaluation (Information report) (AI 6)

Dr Julia Katherine, Head of Inclusion, presented her report which was a six monthly update as well as providing information on the self-evaluation, in readiness for local area SEND inspection. Key to this process will be the views of the service users and their families. The report identified areas of strength and areas for further development. Dr Katherine will report back on

the results of the peer review taking place on 30th November by colleagues from Reading.

In response to questions on the timescale of the SEND reforms implementation work-strand it was reported that the deadline for transfers from SEN statements to Education Health and Care Plans is 31st March 2018, although the SEND reforms in their totality have been described nationally as a 10-year transformation programme. The Implementation group has been refocused on Performance in recognition that we are moving on from the implementation phase to the embedding phase of the reforms. The Performance group will take the lead in monitoring the performance indicators, demonstrating the impact of this work.

It was noted that there would be further revisions to update the documents.

Dr Collie, as Chair, thanked Julia Katherine and her team for their work and the Health and Wellbeing Board noted the progress.

28. Future in Mind Update (Information item) (AI 7)

Stuart McDowell and Andrea Havey gave an update and circulated an A3 update of the Future in Mind Vision 'We want all children and young people in Portsmouth to enjoy good emotional wellbeing and mental health', and highlighted the achievements over the last 12 months and looking at the year ahead. He reported that the city was 2 years into a 5 year programme and had developed a Transformation Plan to attract £400k funding. There had been improvements in working better together as partner organisations and there was more targeted counselling and support. The listed achievements included the work undertaken by Sarah Christopher to ensure the sharing of good practice in schools and colleges.

Priorities to be tackled in the next 12 months included completion of the Social Emotional and Mental Health Needs Assessment which was vital to targeting and identifying interventions. There was also the need to ensure a better set of measures to see how well the CAMHS team were performing, as whilst in Portsmouth the waiting times were lower than for our regional counterparts, there were still concerns caused by delays. Alison Jeffery, Director for Children's Services, stressed the importance of meeting the needs of care leavers with mental health issues; Amy McCullough from Public Health would link with Alison on this. Discussion took place on how the waiting times for referrals could be reduced, and Sue Harriman (on behalf of Solent NHS Trust) reported that the full risk assessments are undertaken and patients are sign-posted to get support and Dr Moore (for PCCG) reported that GPs will made same day referrals. Amy McCullough reported that a needs assessment for self-harm had been undertaken over the summer to look at the links to suicide prevention.

Councillor Jones felt that there was not a consistency in approach to dealing with young persons' mental health issues in schools and colleges. Alison Jeffery reported that the anti-bullying resources were being refreshed and the

Restorative Practice programme was making a difference. The need to further promote the services available was raised.

The update was noted and officers thanked for the work that had been undertaken.

29. Pharmacy Consolidation Application Response Procedure and application for Pharmacy Consolidation (AI 8)

Claire Currie, representing the Director of Public Health, presented these reports.

a) **Pharmacy Consolidation Application Response Procedure**

Claire Currie explained the statutory requirement for applications for mergers of pharmacies received by NHS England to be notified to the Health & Wellbeing Board (HWB) and the need to respond within 45 days. Therefore as applications would need to be dealt with outside the quarterly meetings of HWB a procedure was needed for responding in a timely way. The report set out the proposed ways of dealing with consolidation applications if they were non-contentious and those that were potentially contentious, the latter would be referred to a sub-committee of HWB, which would have delegated authority to make a response to NHS England and decide if there would be a gap in service provision for this response.

The sub-committee composition would be:

- Both of the Joint Chairs of the Health and Wellbeing Board
- The Director of Public Health, PCC (or senior delegate)
- The Chief Operating Officer, NHS PCCG (or senior delegate)
- A senior Healthwatch Portsmouth representative (non-voting)

Patrick Fowler, explained the role of Healthwatch Portsmouth was to be independent and to act as a link for the public so whilst they wished to be involved they did not feel it appropriate to be part of the voting process.

Councillor Vernon-Jackson asked that the Members' Information Service (MIS) was used to inform councillors of these applications, which Claire Currie was happy to implement, and this would invite comments from ward councillors.

During discussion some members raised their concerns at their role in intervening in the possible closures of pharmacies, which could also prevent competition of other pharmacies opening on these sites, and thereby remove choice for customers. In response Claire reiterated the need to consider

whether a gap in pharmaceutical provision was caused for local residents. Councillor Jones suggested that the national legislation could be looked at to see if members wished to lobby for changes to the process. Councillor Vernon-Jackson felt that at a time when patients were encouraged to speak to pharmacists it was not beneficial to look at the closure of these sites. Dianne Sherlock reported on her survey of community transport which had highlighted delays and the social isolation caused by lack of access to health services.

It was also felt that both Joint Chairs of HWB should be involved in the consultation as to whether an application is considered contentious or not.

The Health and Wellbeing Board approved the procedure for responding to pharmacy consolidation applications, as amended to reflect the composition of sub-committee set out above, and with the use of the Members Information Service weekly bulletin to inform councillors of applications.

b) An Application for Pharmacy Consolidation - Rowlands Pharmacy 129 Eastney Road (continuing site) and 117 Winter Road (closing site)

Claire Currie explained that due to the timescale this application had been brought to the attention of the Health & Wellbeing Board for noting as the response to NHS England had been due by 24 November. The Health & Wellbeing Board was asked to make a response as to whether or not a gap in provision would be created should this consolidation application be approved.

Consultation had taken place and ward councillors notified to invite comment. The opening hours were not dissimilar between sites, with a half hour variation over lunchtime and closing. In the response, it was requested that NHS England clarify hearing loop provision at the continuing site. Claire noted that all services currently provided by the continuing and closing site would continue to be provided by the continuing site.

Councillor Vernon-Jackson stated that he had been unaware of the application and he felt that it was very contentious, so he wished to oppose it as a removal of choice for residents. Claire Currie responded that the current Pharmaceutical Needs Assessment for Portsmouth showed a good provision for the city so a detrimental effect was not anticipated. Dr Collie confirmed that HWB members had been contacted by email on 9 November to request comments in respect of this application.

It was therefore put to the vote, and whilst some members either voted against, or abstained, by majority the Health and Wellbeing Board agreed that:

1. The proposed consolidation of two pharmacies would not create a gap in pharmaceutical services that could be met by a routine application to meet a current or future need for pharmaceutical services.

2. The proposed consolidation of two pharmacies would not create a gap in pharmaceutical services that could be met by a routine application to secure improvements, or better access, to pharmaceutical services.

30. Suicide Prevention Plan update (AI 9)

Amy McCullough, on behalf of the Director of Public Health, presented this information report as an update before a final version of the Suicide Prevention Plan would be brought to the Health & Wellbeing Board for sign-off in February 2018. This is both a national and local key priority and it is expected that the plan will need to be submitted next year. In Portsmouth the level of suicides is approximately 24 per year and the premise of the plan is that these are preventable, with the aim to reduce these by 10% over the next 3 years (the report set out the 7 key areas for action). The multi-agency Portsmouth Suicide Prevention Partnership would oversee the development of the plan. This had been brought to this meeting for engagement of the HWB members and their organisations. Amy stressed the importance of mental health training packages, which were being targeted to those dealing with the high risk group of middle-age men, such as debt advisers, and if funding could be secured mental health first aid would be taken into schools.

Dianne Sherlock indicated that Age UK would be happy to be involved with work with veterans, and it was noted that ex-servicemen were another key group to target. Councillor Jones suggested that there be a similar treatment of ex-servicemen as for the local authority's care leavers. Amy reported that there is an Armed Forces Needs Assessment, and this would help inform this workstream. The profiles of those who had taken their lives were being investigated, and there were often a combination of factors involved. Alison Jeffery also suggested that foster carers and workers in residential children's homes receive this training.

The update report was noted, with a further paper being considered at the next meeting.

31. Health and Wellbeing Strategy (AI 10)

Kelly Nash, Corporate Performance Manager, circulated a designed version of the strategy, which would come back in its final form in February 2018. The document was more proactive on the promotion of mental health wellbeing (and would reflect Future in Mind) and there would be public consultation via the PCC website inviting an electronic return, with Healthwatch assisting with the completion of other methods of return (the wording for this would need to be agreed). Final amendments could be raised by HWB members.

Councillor Vernon-Jackson referred to the annual Public Health report which contained clear graphics; the strategy design would reflect that they were in the same family of documents.

The Health & Wellbeing Board:

(1) Approved the document for consultation (Appendix A) subject to the amendments suggested at the meeting;

(2) Agreed the proposals for consultation (set out in Section 6).

32. Date of Future Meeting (AI 11)

The date of the next meeting was agreed as Wednesday 21st February 2018 at 10am. (Councillor Vernon-Jackson offered his apologies for absence in advance.)

The next agenda would include an item on Adults with Complex Needs.

The meeting concluded at 12.00 pm.

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Dr Linda Collie
Chair

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Portsmouth CITY COUNCIL

Title of meeting:	Health and Wellbeing Board
Date of meeting:	21st February 2018
Subject:	Pharmaceutical Needs Assessment: For approval
Report by:	Director of Public Health
Wards affected:	All
Key decision:	No
Full Council decision:	No

1. Purpose of report

1.1 The Health and Wellbeing Board has a statutory responsibility to publish a statement of the needs for pharmaceutical services of the population in its area, referred to as a Pharmaceutical Needs Assessment (PNA). It must be published every three years with the next PNA due to be published on 1st April 2018. A paper was brought to the Health and Wellbeing Board (HWB) on 20th August 2017 where the draft PNA was approved for consultation.

1.2 The regulations state that the HWB must undertake a consultation on the content of the PNA and it must run for minimum of 60 days. The consultation took place from 23rd October to 27th December 2017. Consultation findings (appendix 1) have been considered and have not changed the conclusion of the PNA. This paper presents the final Portsmouth PNA 2018 (appendix 2) and seeks approval of the report for publication on 1st April 2018.

2. Recommendations

2.1 The Health and Wellbeing Board is asked to:

1. Approve the final Portsmouth Pharmaceutical Needs Assessment (PNA) 2018 for publication on 1st April 2018.

3. Background

3.1 The PNA is a report on the local needs for pharmaceutical services. It is used to identify gaps in current services or improvements that could be made to current or future service provision. The specific content of the PNA is set out in schedule 1 of the NHS (Pharmaceutical & Local Pharmaceutical Services) Regulations 2013. It is a statutory requirement for the Health and Wellbeing Board to publish a revised assessment within three years of its previous PNA. The refreshed Portsmouth PNA must be published by 1st April 2018.

3.2 There is a regulatory duty (NHS (Pharmaceutical & Local Pharmaceutical Services) Regulations 2013 No 349: Part 2: Reg 8) to have a 60 day consultation about the contents

of the assessment it is making and to consult with those specified. As part of the Portsmouth PNA refresh, the consultation ran from Monday 23rd October to Wednesday 27th December 2017.

3.3 The draft Portsmouth PNA 2018 which underwent consultation concludes that there are 41 community pharmacies, one distance selling pharmacy and one dispensing appliance contractor. The location, number, distribution and choice of pharmaceutical services serving the Portsmouth residents meets the needs of the population. There is currently no identified need for improvements and better access to pharmaceutical services in Portsmouth.

4. Reasons for recommendations

4.1 Summary

Consultation findings showed satisfaction with the PNA. Consultation findings have been considered but there will be no notable changes to the document before formal publication on 1st April 2018. A full report on the consultation findings is enclosed with this paper (appendix 1).

4.2 How was the consultation undertaken?

4.2.1 Consultation questions

The set of six questions used for the consultation of the Portsmouth PNA 2015 was used (with minor amendments). For each question a response was asked for and an opportunity given for respondents to add free text comments.

4.2.2 Consultation with professional stakeholders

All professional stakeholders as specified in the Regulations were contacted by email by Monday 23rd October 2017. All contractor pharmacies within the city were contacted by a message on PharmOutcomes (software system used by pharmacies) and by email on 23rd October 2017 giving details of the consultation process. A letter was also posted to each community pharmacy on the same date.

4.2.3 Consultation with the public

The public consultation was supported by the Portsmouth City Council (PCC), Healthwatch Portsmouth and NHS Portsmouth Clinical Commissioning Group (CCG). Further detail is given in the consultation report (appendix 1).

4.3 Summary of consultation findings

4.3.1 Response

Seventy-eight responses to the consultation were received; eight responses from professional stakeholders and 62 responses from members of the public. Overall responses to the consultation questions were as follows:

4.3.1.1 Has the purpose of the PNA been explained clearly?

- 100% (8/8) of professional stakeholders strongly agreed or agreed that the purpose of the PNA had been clearly explained.
- 85.5% (53/62) members of the public who responded strongly agreed, agreed or were neutral that the purpose of the PNA had been clearly explained (one disagreed and eight chose not to respond).

4.3.1.2 Do you know of any relevant information that we have not included that may affect the conclusion of this document?

- 100% (8/8) of professional stakeholders did not know of any further relevant information that should have been included that would affect the document's conclusions.
- 69.4% (43/62) members of the public who responded did not know of any further relevant information that should have been included that would affect the document's conclusions (16 chose not to respond). The three respondents to the survey who stated there was further relevant information provided a further rationale but none of which were considered to have a bearing on the conclusion of the PNA.

4.3.1.3 From the information in the pharmaceutical needs assessment and my personal experience, I believe the pharmaceutical needs of myself (or my patients and/or the people I represent) are being met.

- 100% (8/8) of professional stakeholders strongly agreed, agreed or were neutral that the pharmaceutical needs of local residents were being met.
- 46.8% (29/62) members of the public who responded strongly agreed, agreed or were neutral that the pharmaceutical needs of local residents were being met (10 (16.1%) disagreed and another 23 (37.1%) chose not to respond).

4.3.1.4 From the information in the pharmaceutical needs assessment and my personal experience, I believe that my future pharmaceutical needs for myself (or my patients and/or the people I represent) for the next four years will be met.

- 87.5% (7/8) of professional stakeholders strongly agreed, agreed or were neutral that the pharmaceutical needs of local residents are likely to be met over the next four years (one chose not to respond).
- No members of the public responded to this question.

4.3.1.5 Do you think there is a need for additional pharmacy sites within Portsmouth?

- 62.5% (5/8) of professional stakeholders disagreed or were neutral that there is a need for additional pharmacy sites in Portsmouth. Two indicated there is a need and one chose not to respond. Of the two respondents stating there is a need, only one comment was given to provide further explanation stating that more patients are being prescribed medicines on a daily basis.
- 43.5% (27/62) members of the public disagreed or were neutral that there is a need for additional pharmacy sites in Portsmouth. Nine (14.5%) respondents to the public survey considered there to be a need for additional pharmacy sites (26 (41.9%) chose not to respond). There were twenty-one written comments from members of the public with 14 indicating sufficient pharmacy sites, six indicating a need for more and one comment being unsure of what the general experience of pharmacy provision by other residents in the city is.

4.3.1.6 Do you have any further comments you would like to make about pharmaceutical services in Portsmouth? This can include good or bad experiences, any concerns, questions or just general comments you might have.

- There were a small number of additional comments from professional stakeholders. Additional comments from members of the public could be broadly themed into

issues relating to access and quality of service. The comments given are not considered to have a bearing on the conclusion of the PNA.

5. Equality impact assessment

5.1 An equality impact assessment has been conducted (appendix 3).

6. Legal implications

6.1 There is a statutory duty requiring the Health and Wellbeing Board to undertake and publish this needs assessment under section 128A of the National Health Service Act 2006 and regulations made under that section, namely the National Health Service (Pharmaceutical & Local Pharmaceutical Services) Regulations 2013 ("the 2013 Regulations")

6.2 Regulations 3 to 9 and Schedule 1 of the 2013 Regulations set out the detailed requirements as to the content of needs assessments and the manner in which the assessment is to be made and published.

6.3 Regulation 8 of the 2013 Regulations, in particular, prescribes those specified persons who must be consulted about the content of the assessment and the manner in which they must be consulted about specified matters.

7. Director of Finance's comments

7.1 The PNA report has been reviewed and there are no financial implications to note.

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Signed by: Dr Jason Horsley, Director of Public Health

Appendices:

Appendix 1: Consultation report
Appendix 2: Portsmouth Pharmaceutical Needs Assessment Report 2018
Appendix 3: Equality Impact Assessment

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:

Portsmouth Pharmaceutical Needs Assessment 2018
Consultation report

Consultation Requirements

The NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 sets out detailed requirements for the consultation process including a specified list of stakeholders that must be consulted at least once.

Publication of draft PNA

The draft PNA and the associated questionnaires were published on the Portsmouth City Council website. Printed copies were available on request.

Consultation period

There is a minimum requirement of 60 days for consultation process. Local formal consultation started on Monday 23rd October 2017 and closed on Monday 27th December 2017.

Consultation Activities

Consultation questions

The short set of questions used for the consultation of the Portsmouth PNA 2015 was used (with minor amendments). For each question there was an opportunity for respondents to add free text comments to expand on their views.

Consultation with professional stakeholders

All professional stakeholders as specified in the Regulations were contacted by email by Monday 23rd October 2017. 'Read' receipts of these emails have been retained.

All contractor pharmacies within the city were contacted by a message on PharmOutcomes (software system used by pharmacies) and by email on 23rd October 2017 giving details of the consultation process. A letter was also posted to each community pharmacy on the same date.

Consultation with the public

The public consultation was supported by the Portsmouth City Council (PCC), Healthwatch Portsmouth and NHS Portsmouth Clinical Commissioning Group (CCG).

The PCC communications team used social media Twitter and Facebook to promote the consultation. The PNA consultation for Portsmouth was included in the November issue of Flagship magazine which is distributed to 93,000 Portsmouth residents. The consultation was publicised to the citizen panel (where around 1000 people had the opportunity to respond) and in the volunteer newsletter.

The CCG publicised the consultation, in October, on its Intranet news page for local staff and GPs and their practice staff. The consultation was publicised at the CCG Patients Participation forums held on 6th September 2017 and 6th November 2017. The consultation was also discussed as part of the Practice Managers forum on 18th October 2017.

Healthwatch Portsmouth publicised the consultation via e-mail to a variety of community and voluntary sector groups.

Response

The HWB appreciates the time given by members of the public and professional stakeholders to complete this consultation exercise.

Seventy-eight responses to the consultation were made - there were eight responses included from professional stakeholders (there were another eight responses where no responses had been given and so have been excluded) and 62 responses from members of the public.

Summary
Consultation findings showed satisfaction with the PNA. Comments will be addressed in the PNA but there will be no notable changes to the document before formal publication on 1st April 2018.

Responses
The summary of the responses to each question are listed below. Comments relating to specific pharmacies are outside the scope of the PNA but will be followed up as considered appropriate by relevant members of the group who led this work.

1. **Has the purpose of the pharmaceutical needs assessment been explained clearly?**

100% (8/8) of professional stakeholders strongly agreed or agreed that the purpose of the PNA had been clearly explained. 85.5% (53/62) members of the public who responded strongly agreed, agreed or were neutral that the purpose of the PNA had been clearly explained (one disagreed and eight chose not to respond). There were no additional comments given in response to this question.

Table 1. Summary of responses to consultation question one

	Strongly agree	Agree	Neither agree or disagree	Disagree	Strongly disagree	Did not respond	Total
Public	13	32	8	1		8	62
Professional	4	4					8

2. **Do you know of any relevant information that we have not included that may affect the conclusion of this document?**

100% (8/8) of professional stakeholders did not know of any further relevant information that should have been included that would affect the document's conclusions. There were no comments from professional stakeholders. 69.4% (43/62) members of the public who responded did not know of any further relevant information that should have been included that would affect the document's conclusions (16 chose not to respond). The three respondents to the survey who stated there was further relevant information provided a further rationale.

Comment
One comment pointed to the expected development of Forty Acres, Bedhampton as one which may impact on GP and Pharmacies within the Drayton area.
Response
Thank you for noting this. Forty Acres is a proposed site for development of approximately 300 homes. Future residents of this development are likely to use pharmacies in Portsmouth, as well as those in Bedhampton, Havant, and other surrounding areas. If occupied during the lifetime of this PNA, we anticipate any additional demand placed upon pharmacy services from this development would be met within existing capacity.

Comment
One comment stated that another pharmacy site is needed along Commercial Road in order to provide an additional facility as there is only a Boots pharmacy on that road.
Response
There is one pharmacy along Commercial road. There is also a further two pharmacies within 500 metres of this site (Lalys and Berry (RJ) Ltd) and seven further pharmacies within 1km. It is considered that current provision should adequately meet the pharmaceutical needs for the population.

Comment
One comment raised general concerns about whether individual pharmacists can dispense emergency hormonal contraception (EHC) on 'conscience grounds'.
Response
This is outside the scope of the PNA but a response is offered here to provide clarification on an important issue. General Pharmaceutical Council guidance[1] clarifies that while a pharmacist may be unwilling to provide a particular service, they should take steps to make sure the person asking for care is at the centre of their decision-making, so they can access the service they need in a timely manner.

Table 2. Summary of responses to consultation question two

	Yes	No	Did not respond	Total
Public	3	43	16	62
Professional		8		8

3. From the information in the pharmaceutical needs assessment and my personal experience, I believe the pharmaceutical needs of myself (or my patients and/or the people I represent) are being met.

100% (8/8) of professional stakeholders strongly agreed, agreed or were neutral that the pharmaceutical needs of local residents were being met. 46.8% (29/62) members of the public who responded strongly agreed, agreed or were neutral that the pharmaceutical needs of local residents were being met (10 (16.1%) disagreed and another 23 (37.1%) chose not to respond). There were no additional comments from either professional stakeholders or members of the public.

Table 3. Summary of responses to consultation question three

	Yes*	Neither agree or disagree	No**	Did not respond	Total
Public	24	5	10	23	62
Professional	6	2			8

***For professional stakeholder survey these were strongly agree or agree responses
****For professional stakeholder survey these were strongly disagree or disagree responses

4. From the information in the pharmaceutical needs assessment and my personal experience, I believe that my future pharmaceutical needs for myself (or my patients and/or the people I represent) for the next four years are being met.

87.5% (7/8) of professional stakeholders strongly agreed, agreed or were neutral that the pharmaceutical needs of local residents are likely to be met over the next four years (one chose not to respond). There were no written comments from professional stakeholders. No members of the public responded to this question, however, six comments were provided.

Comment
Three comments related to quality of service at specific pharmacies.
Response
These comments highlighted areas outside the remit of the PNA but will be followed up appropriately.

[1] General Pharmaceutical Council; In practice: Guidance on religion, personal values and beliefs (June 2017) https://www.pharmacyregulation.org/sites/default/files/in_practice-_guidance_on_religion_personal_values_and_beliefs.pdf

Comment
Two comments related to opening hours of pharmacies. One stating that there needs to be more 100 hour pharmacies available and one highlighting that there are no pharmacies open on Sundays in the south locality of Portsmouth.

Response
These comments are responded to in question 6 under the theme 'access'.

Comment
One respondent commented that pharmacists are not available for consultations for conditions that do not require a doctor.

Response
A pharmacist will be present at an NHS pharmacy when there is provision of NHS services. While not explicit, this comment may highlight the issue of staffing capacity within pharmacies to enable pharmacists to provide advice on minor ailments. It is positive that pharmacies are being recognised as having a role in easing pressure on GPs. Staffing levels are for individual pharmacies to determine.

Table 4. Summary of responses to consultation question four

	Yes*	Neither agree or disagree	No**	Did not respond	Total
Public				62	62
Professional	5	2		1	8

*****For both surveys these were strongly agree or agree responses
******For both surveys these were strongly disagree or disagree responses

5. Do you think there is a need for additional pharmacy sites within Portsmouth?

62.5% (5/8) of professional stakeholders disagreed or were neutral that there is a need for additional pharmacy sites in Portsmouth. Two agreed there is a need and one chose not to respond. Of the two respondents stating there is a need, only one comment was given to provide further explanation.

Comment
The rationale given in this comment was that more patients are being prescribed medicines on a daily basis.

Response
It is recognised that dispensing workload is increasing locally and nationally. However, this does not provide a sufficient basis to deem there to be gaps in provision within Portsmouth. Across England, the average prescription items dispensed per month per community pharmacy has increased each year (2007/08 to 2016/17)[2]. The Portsmouth PNA considered the average dispensing workload of pharmacies in Portsmouth compared to Wessex and England (section 7.2.1), showing the average numbers of prescription items dispensed each month per pharmacy was similar to Wessex and slightly higher than the England average.

43.5% (27/62) members of the public disagreed or were neutral that there is a need for additional pharmacy sites in Portsmouth. Nine (14.5%) respondents to the public survey considered there to be a need for additional pharmacy sites (26 (41.9%) chose not to respond). There were twenty-one written comments from members of the public with 14 indicating sufficient pharmacy sites, six indicating a need for more and one comment being unsure of what the general experience of pharmacy provision by other residents in the city is.

[2] NHS Digital; General Pharmaceutical Services; England 2007/08 to 2016/17 (published November 2017)

Comments
Of the six comments indicating a need for more pharmacy sites, the rationale given was:
- Acknowledgement that for those that do not have a car access may be more difficult (2 comments)
- Positive experience the value of pharmaceutical service provision (1 comment)
- Issues relating to 'capacity' of existing pharmacies (3 comments)

Response
For a response to issues about 'access', please see the response in question 6 under this theme. The comment highlighting the benefits of pharmaceutical provision stated that, 'they help the community and provide a great primary care service, checking on my medication and offering advice around care for my condition'.

Regarding capacity, while it was not clear about the precise issue, one comment related to a specific pharmacy. This will be followed up appropriately. One comment concerned the growing population (see response above which mentions this issue) and one comment stated: ' To save time at the doctors more people are going to the pharmacist first. This then creates a queue in the pharmacy '. See the response in question 4 relating to capacity.

Table 5. Summary of responses to consultation question five

	Strongly agree	Agree	Neither agree or disagree	Disagree	Strongly disagree	Did not respond	Total
Public	3	6	10	11	6	26	62
Professional	1	1	2	1	2	1	8

6. Do you have any further comments you would like to make about pharmaceutical services in Portsmouth? This can include good or bad experiences, any concerns, questions or just general comments you might have.

Five comments were from professional stakeholders.

Comment
We could not identify from the needs assessment whether there are plans to widen the availability of naloxone for overdoses caused by heroin and other opiates

Response
A project has been approved to make naloxone available through a small number of pharmacies in Portsmouth. This will start during 2018 and will be monitored to assess success.

Comment
We do not agree that the number of Distance Selling Pharmacies (DSPs) will, or should, increase. There is already sufficient provision to housebound patients as many pharmacies provide a delivery service - this is not a pharmaceutical service, so should not be a part of this assessment, but we feel it is an important point.

Response
In the 2013 Regulations, DSPs are the only exemption category from the current market entry regulations. Therefore, the use of the PNA for market entry does not apply to distance selling pharmacies. Acknowledgement of DSPs has been included in the PNA as they contribute to overall pharmaceutical provision (although, as has recognised in the comment made, activity is not solely located to the area in which a DSP is based). The PNA acknowledges that Portsmouth residents may choose to have their prescriptions dispensed from any pharmacy across the country including distance selling pharmacies. Across England, the number of distance selling pharmacies has increased year on year, from 56 in 2008/09 to 321 in 2016/17[2].

Comment
We also challenge the assertion that there is no need for Independent Prescribers in Community Pharmacy as this would develop the service above and beyond that which can be provided by pharmacists in GP surgeries.
Response
Thank you for this comment. The wording in the PNA will be rephrased.

Comment
The PNA needs to acknowledge that Hampshire residents may use services in Portsmouth in particular Out of Hours
Response
The wording will be amended to explicitly recognise that Hampshire residents can choose to use pharmacies located in Portsmouth.

Comment
One comment requested to bring back the weight management service which has previously been run through pharmacies in Portsmouth.
Response
There are currently no plans to reinstate the weight management service run through community pharmacies. This was an innovative, local service, rather than a pharmaceutical service. It is acknowledged that this service was well received and will be kept under review should there be an appropriate opportunity.

There were fourteen written comments from members of the public to this question. Other relevant comments in questions above (two comments given in response to question four, and two comments given in response to question five, all on the theme of 'access', giving a total of 18 comments) have also been considered here. These have been categorised into themes of access and quality of service. One comment concluded the respondent was satisfied with the spread of pharmacies and length of opening hours.

Access
There were eight comments which related to access. Six comments placed importance on longer opening hours. Two of the comments commended a particular '100 hour' pharmacy including noting that it relieves pressure from local GP practices, two respondents commented generally that further late night or 100 hour pharmacies would be helpful. One comment suggested it would be useful to have a late night pharmacy in the Palmerston Road area of Southsea and one comment highlighting that there are no pharmacies open on Sundays in the south locality of Portsmouth. The final two comments acknowledged that it is easier to access a pharmacy if an individual has access to a car.

The PNA mapped opening hours of pharmacies (section 7.1). It is recognised that access is more limited outside of core working hours, particularly in evening and on Sundays; however, the pharmaceutical services at these times are considered satisfactory in Portsmouth. A pharmacy normally has 40 core contractual hours (or 100 for those that have opened under the former exemption from the control of entry test). If a pharmacy wants to open for longer, a pharmacy can give notice to NHS England. Opening hours are therefore driven by individual pharmacies.

There is one pharmacy in the South locality (Boots at Gunwharf Quays) which is open for Sunday trading hours, although it is recognised this may not provide easy access to all in the south locality. Across Portsmouth, there are nine pharmacies in total providing Sunday access. Opening is more limited on Sundays than at other times during the week. However, provision is considered satisfactory.

It is acknowledged that journey times to a pharmacy may be longer if an individual does not have access to a car. While not suitable for all residents, over 99% of the population can reach a

pharmacy in Portsmouth within a 20 minute walk (section 7.1.9). This is considered to provide good access to pharmacies in Portsmouth.

Quality
There were nine comments relating to quality of service.

Two comments raised individual issues experienced with specific pharmacies. One of these responses included an indication that the individual now use a different pharmacy as a consequence where they are much happier with the service. One comment highlighted that, while being otherwise satisfied with service at a specific pharmacy, there is often a delay in the delivery of prescriptions from the GP practice to the pharmacy. Another comment was a general comment indicating pharmacies 'could be better and more organised'. These comments highlighted areas outside the remit of the PNA and will be followed up appropriately. NHS Portsmouth CCG is actively providing support to pharmacies (as well as GP practices) to share good practice in the use of electronic repeat dispensing services. This feedback is helpful to inform understanding of how this scheme is working.

One comment related to medicines being out of stock which resulted in repeat trips. With a huge number of prescription items dispensed, there will be some occasions when medicines are unavailable which can either be due to a national supply issue or to pharmacy stock levels and ordering processes. The CCG continues to work with GP practices and pharmacies to improve communication with patients and to ensure an alternative medicine is made available when appropriate.

One further comment suggested that pharmacies could do more to promote their services and another comment suggested that more staff in pharmacies may be beneficial, but recognised challenges to pharmacy funding to facilitate this. See response to question 4 which addresses staffing.

A further two comments related to market entry of and promotion of distance selling pharmacy services. While this is outside the scope of the PNA, a guidance document published by the General Pharmaceutical Council may provide useful information on registering and providing DSP services[3].

[3] General Pharmaceutical Council; Guidance for registered pharmacies providing pharmacy services at a distance, including on the Internet (2015)
https://www.pharmacyregulation.org/sites/default/files/guidance_for_registered_pharmacies_providing_pharmacy_services_at_a_distance_including_on_the_internet_april_2015.pdf

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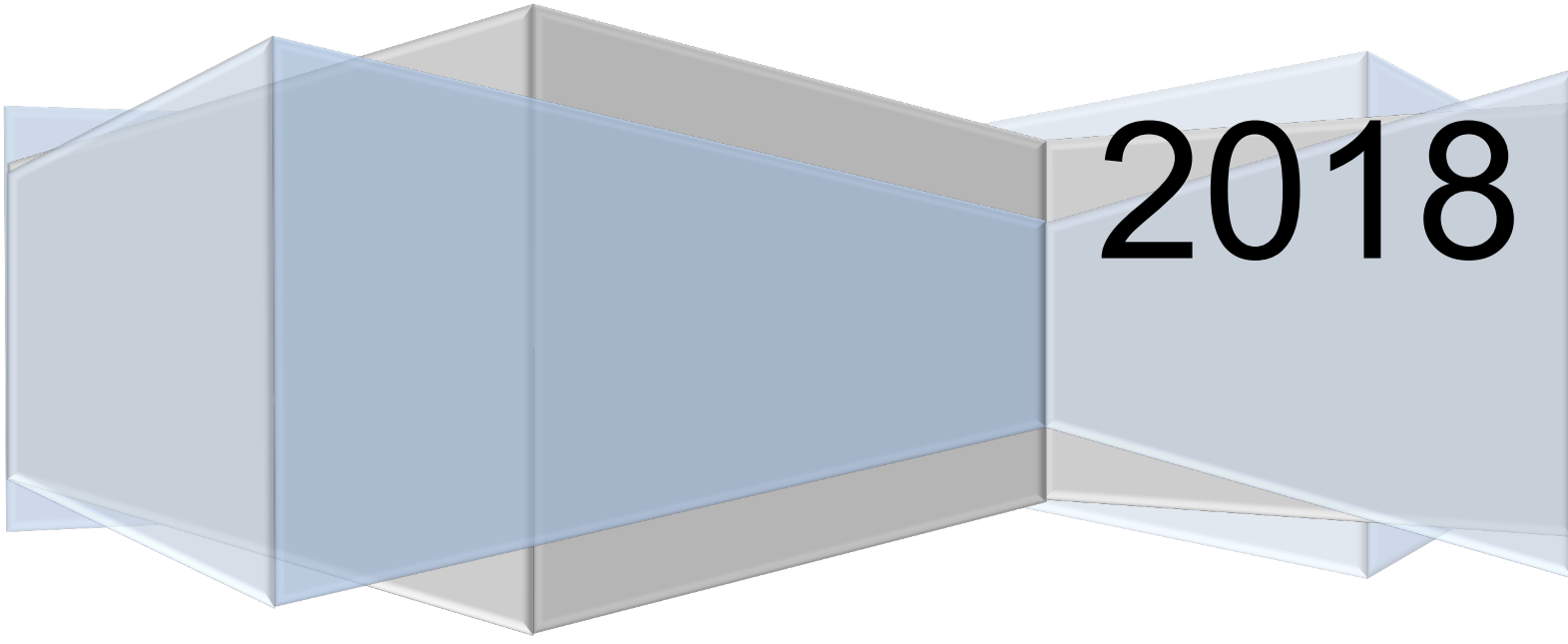
Portsmouth Pharmaceutical Needs Assessment



2 Executive Summary

The statutory Pharmaceutical Needs Assessment (PNA) is a statement of current pharmaceutical services provided in the local area, assesses whether or not the pharmaceutical services provision is satisfactory for the local population and identifies any perceived gaps in the provision.

In Portsmouth there are 41 community pharmacies, one distance selling pharmacy and one dispensing appliance contractor.

The Health and Wellbeing Board consider the location, number, distribution and choice of pharmaceutical services serving the Portsmouth residents to meet the needs of the population. The Health and Wellbeing Board also consider that there is currently no identified need for improvements and better access to pharmaceutical services in Portsmouth.

In particular, this is based on:

- The total Portsmouth population is within a 1.6km straight line distance of a community pharmacy (section 7.1.9.1).
- A good geographical spread of community pharmacies across all three localities in the city (section 6.7) and within communities experiencing greatest deprivation (section 9.2).
- There being 19 community pharmacies per 100,000 Portsmouth population, which is the same as the average for Wessex and is broadly in line with national averages (section 7.2.1).
- Over 99% of the Portsmouth population are within a 20 minute walk of a community pharmacy (section 7.1.9.5).
- Nearly nine in every 10 (87.5%) respondents to a public survey said it took 15 minutes or less to get to a community pharmacy (section 8).
- Good access demonstrated by opening hours from early morning, through lunchtimes and late into the evening as well as weekend opening (section 7.1.1).
- A distance selling pharmacy, five 100 hour pharmacies, supplementary hours in other Portsmouth community pharmacies as well as provision in a neighbouring Health and Wellbeing Board area provide improvements and better access which meets the needs of Portsmouth residents (section 6.7).
- All pharmacies provide the full range of essential pharmaceutical services (section 7.2).
- Good provision of advanced services across the city (section 7.3).
- A range of enhanced and locally commissioned services delivered in the city (section 7.4). Pharmacies accredited to deliver these services have good geographical spread across the localities within Portsmouth.
- A large proportion of community pharmacies providing a delivery service to residents, including housebound patients (section 7.1.10).
- There will not be substantial changes in population areas, nor major development, which can be anticipated during the three-year lifespan of this PNA, which would warrant the need for additional pharmaceutical services. Smaller changes would be managed by existing providers. (Section 9.5 and 10).

3 Introduction

3.1 Definition and purpose of the PNA

The statutory Pharmaceutical Needs Assessment (PNA) is a statement of current pharmaceutical services provided in the local area, assesses whether or not the pharmaceutical services provision is satisfactory for the local population and identifies any gaps in the provision. A revised assessment is required to be published three years after the previous PNA.

It is a key commissioning tool that will be used to inform and support the future commissioning of pharmaceutical services in Portsmouth. If a person (a pharmacist, a dispenser of appliances or in some circumstances and normally in rural areas, a General Medical Practitioner (GP)) wants to provide pharmaceutical services, they are required to apply to the NHS to be included on the pharmaceutical list. The PNA will be used by NHS England, as a basis for making decisions, when applications are received to enter or amend the entry on the list of pharmaceutical service providers within the Health and Well Being Board area. This includes to;-

- Determine market entry of new NHS pharmaceutical service providers
- Determine relocation or change of business premises of existing pharmaceutical service providers.
- Determine changes of pharmaceutical services provided by any current individual pharmaceutical services provider. It may also be used by Portsmouth City Council and NHS Portsmouth Clinical Commissioning Group (CCG) to inform local commissioning decisions.

3.2 Historical and Legal Background

The Health Act 2009[1] sets out the minimum standards for PNAs and the use of PNAs as the basis for determining market entry to NHS pharmaceutical services provision. The Regulations came into force in May 2010 and required Primary Care Trusts (PCTs) to develop and publish their first PNA under these Regulations by 1 February 2011.

Portsmouth City Teaching PCT developed and published its first PNA[2] under the new regulations in 2011.

The Health and Social Care Act 2012[3] brought about major reforms to the NHS. From April 2013, PCTs were abolished and their duties transferred to other organisations. Responsibility for developing, updating and publishing a local PNA was transferred to Health and Wellbeing Boards. In addition this Act also transferred

[1] National Health Service Act 2009 available at http://www.legislation.gov.uk/ukpga/2009/21/contents

[2] Portsmouth Pharmaceutical Needs Assessment 2011 available at http://www.hants.gov.uk/pccjsna/API_STR_JSNA_SERV_PHARM_PharmNeedsAx2010.pdf

[3] Health and Social Care Act 2012 available at http://www.legislation.gov.uk/ukpga/2012/7/contents/enacted

the responsibility of using the PNA as the basis for determining market entry to a pharmaceutical list and dispensing doctor list from the PCT to NHS England.

The NHS (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013[4] set out the legislative basis for developing and updating PNAs. The National Health Service (Pharmaceutical and Local Pharmaceutical Services (Amendment and Transitional Provision) Regulations 2014[5] have been published to amend these regulations following a report published by the Joint Committee on statutory instruments. More recently, The NHS (Pharmaceutical and Local Pharmaceutical Services) (Amendment) Regulations 2016 were published.

The first PNA to be produced by the Portsmouth Health and Wellbeing Board was published on 1st April 2015 to comply with these regulations. The regulations state that each Health and Wellbeing Board must publish a revised statement within three years of it previous publications and this document has been produced to satisfy this requirement.

4 Process for producing the Pharmaceutical Needs Assessment

The PNA has been undertaken in line with the requirements of the NHS (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013 under the guidance of the PNA steering group.

The Portsmouth PNA published in 2015 has been used as the basis for the Portsmouth PNA 2018 and the work from its authors is gratefully acknowledged. The Portsmouth PNA 2018 has been in development from April 2017 until its official publication on April 1st 2018. The process has had many steps; the key stages are outlined below.

Stage 1: Formation of a steering group

A joint steering group formed to oversee the development of each of the PNAs for Portsmouth and Southampton cities.

The group has representation from key stakeholders, is hosted by Public Health Portsmouth, and reports to the Joint Director of Public Health for Southampton City Council and Portsmouth City Council.

The group oversees the development of the PNA and ensures that the PNA conforms to the relevant regulation and statutory requirements on behalf of the Health and Wellbeing Board.

[4] The NHS (Pharmaceutical Services and Local Pharmaceutical Regulations) 2013 available at http://www.legislation.gov.uk/uksi/2013/349/contents/made

[5] The National Health Service (Pharmaceutical and Local Pharmaceutical Services) (Amendment and Transitional Provision) Regulations available at http://www.legislation.gov.uk/uksi/2014/417/contents/made

Key stakeholders include representation from Public Health Portsmouth, NHS Portsmouth CCG, NHS England Wessex Area Team, Local Pharmaceutical Committee and Healthwatch Portsmouth.

Stage 2: Collation of information and data

The Joint Strategic Needs Assessment for Portsmouth has been extensively used to give an overview of major health and wellbeing needs of the local population.

Every existing community pharmacy in Portsmouth was invited to complete a detailed questionnaire about their services to inform the development of the PNA. This survey was open from 7th June until 14th August 2017. Data held by NHS England Wessex Area Team was also used to inform the Portsmouth picture of local pharmaceutical provision, including data on delivery of advanced services. National and locally held statistics have been examined to determine levels of activity in delivering current services.

A public survey was open for responses from 7th June until 28th July 2017 to gather views about pharmaceutical services in the city. This survey was hosted on Portsmouth City Council's website and promoted through various local channels including through Healthwatch networks. The survey received 224 responses. This was based on and acknowledges the survey used to inform the Southampton PNA in 2015.

Expertise and advice has also been sought from Portsmouth City Council Planning and Communications departments.

Stage 3: Analysis

Analysis of the information collated to identify any gaps of pharmaceutical provision within the locality. Draft consultation document completed in line with national guidance and approved by the steering group and Director of Public Health.

Stage 4: Draft PNA

Draft PNA shared with the Health and Wellbeing Board in September 2017 prior to consultation.

Stage 5: Consultation

A stakeholder consultation to meet the stated requirements will be held from 23rd October 2017 to 27th December 2017.

Stage 6: Review of consultation responses

The steering group considered the comments received in response to the consultation. A report on the information gathered in the consultation can be found in Appendix E. Minor amendments have been made in light of the consultation.

Stage 7: Publication

The final PNA will be published on 1st April 2018.

5 Introduction to Portsmouth

Portsmouth is located on the south coast of England. In 2018, it is estimated that approximately 215,900 people will be resident in Portsmouth[6].

Portsmouth is a compact city covering 40 square kilometres—75% of the population lives on Portsea Island. The city continues to be the most densely populated local authority area outside London (5,396 people per square kilometre).

5.1 Localities

This PNA considers Portsmouth in three localities:

North encompassing five electoral wards of Drayton and Farlington, Cosham, Paulsgrove, Hilsea and Copnor.

Central encompassing four electoral wards of Charles Dickens, Nelson, Baffins and Fratton wards.

South encompassing five electoral wards of St Thomas, St Jude, Central Southsea, Milton and Eastney and Craneswater.

These localities are electoral ward based and reflect the divisions used by the local authority in other departments such as children's services. Similar size populations are resident in each locality. Using an electoral ward base approach facilitates the use of statistics and other public health information held within the local authority. This method of division is familiar to Councillors and local authority staff. NHS Portsmouth CCG is also looking to commission community services on a locality basis, North, Central and South.

5.2 North Locality Profile

The North locality comprises of five wards; three north of Hilsea moat - Paulsgrove, Cosham and Drayton and Farlington; and the two northern-most wards on Portsea Island - Hilsea and Copnor.

The M27 bisects this locality. All three road routes, which provide the on/off access to Portsea Island, plus the railway line, are in the North.

Population

In 2018, it is estimated that 68,400 people live in the North locality, but is estimated to decrease slightly to 68,100 residents by 2021 (Hampshire County Environment Department's 2011 Census, 2016-based Small Area Population Forecasts). See demography and needs section for more information on the population.

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

Employment

The large employers in this area include Portsmouth Hospitals NHS Trust (Queen Alexandra Hospital), Highbury College, IBM, Alenia Marconi and the businesses located at Lakeside North Harbour Business Park. There are light industrial estates and business areas at Anchorage Park, Port Solent, and O'Jays industrial parks and in Fitzherbert Road and Broad Oak areas.

Large retail outlets are at Port Solent, Ocean Park and Anchorage Park, with shopping centres in Cosham and North End and smaller centres in Paulsgrove, Hilsea and Drayton. There are three superstores in the area, Sainsbury's, Tesco and Morrison's.

NHS services

The CCG member practices in this locality are Portsdown Practice (one site in Cosham and one in Paulsgrove); Drayton Surgery and its Wootton Street surgery branch; North Harbour Medical Group Practice; Kirklands and branch surgeries of Hanway Group Practice and Copnor Road Surgery.

Queen Alexandra Hospital, provided by Portsmouth Hospitals NHS Trust, is located in the North of the city. This is the main acute hospital for the area supporting residents in Portsmouth City and also areas of Fareham and Gosport and South East Hampshire. This hospital hosts the local major Accident and Emergency department. The current GP out-of-hours provider operates a primary care centre at Queen Alexandra Hospital.

There are eleven dental practices providing NHS dental services and five opticians located in the North locality.

The Paulsgrove and Wymering Healthy Living centre is located in Paulsgrove and provides information about health care and local health services.

There are 15 community pharmacies in the area (including one distance selling pharmacy) - two pharmacies located in major supermarkets, four in the Cosham shopping area, one in Paulsgrove and two in the Drayton shopping area. In the Portsea Island wards of Hilsea and Copnor there are three pharmacies in the Copnor area; two at Anchorage Park (one located within the supermarket and the other is distance selling); and one in the Hilsea area.

Two of these pharmacies are '100' hour pharmacies providing evening and weekend services. A further three pharmacies routinely open on Sunday.

The legend in Figure 1 relates to the locality maps given in Figures 2, 3 and 4.

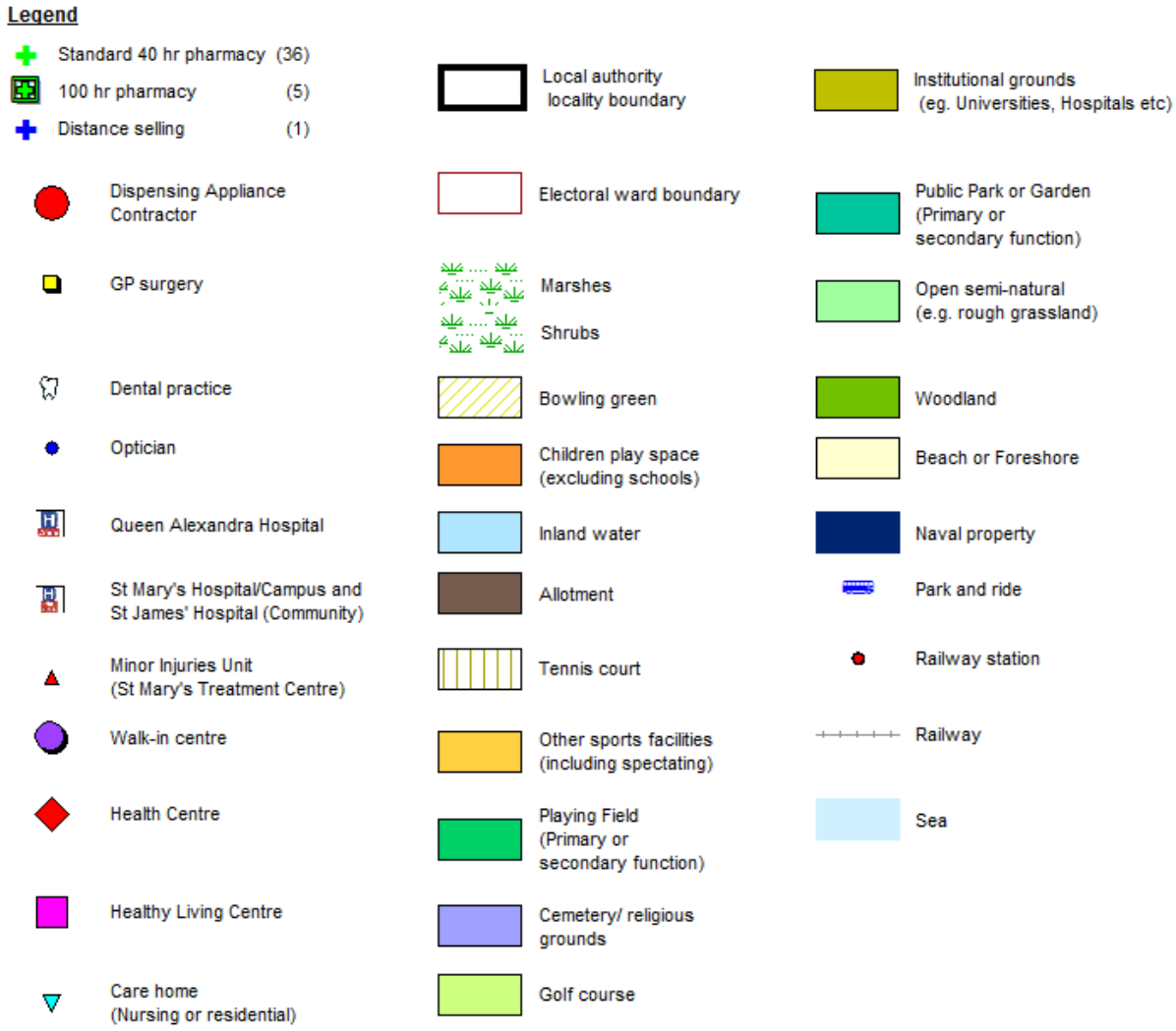
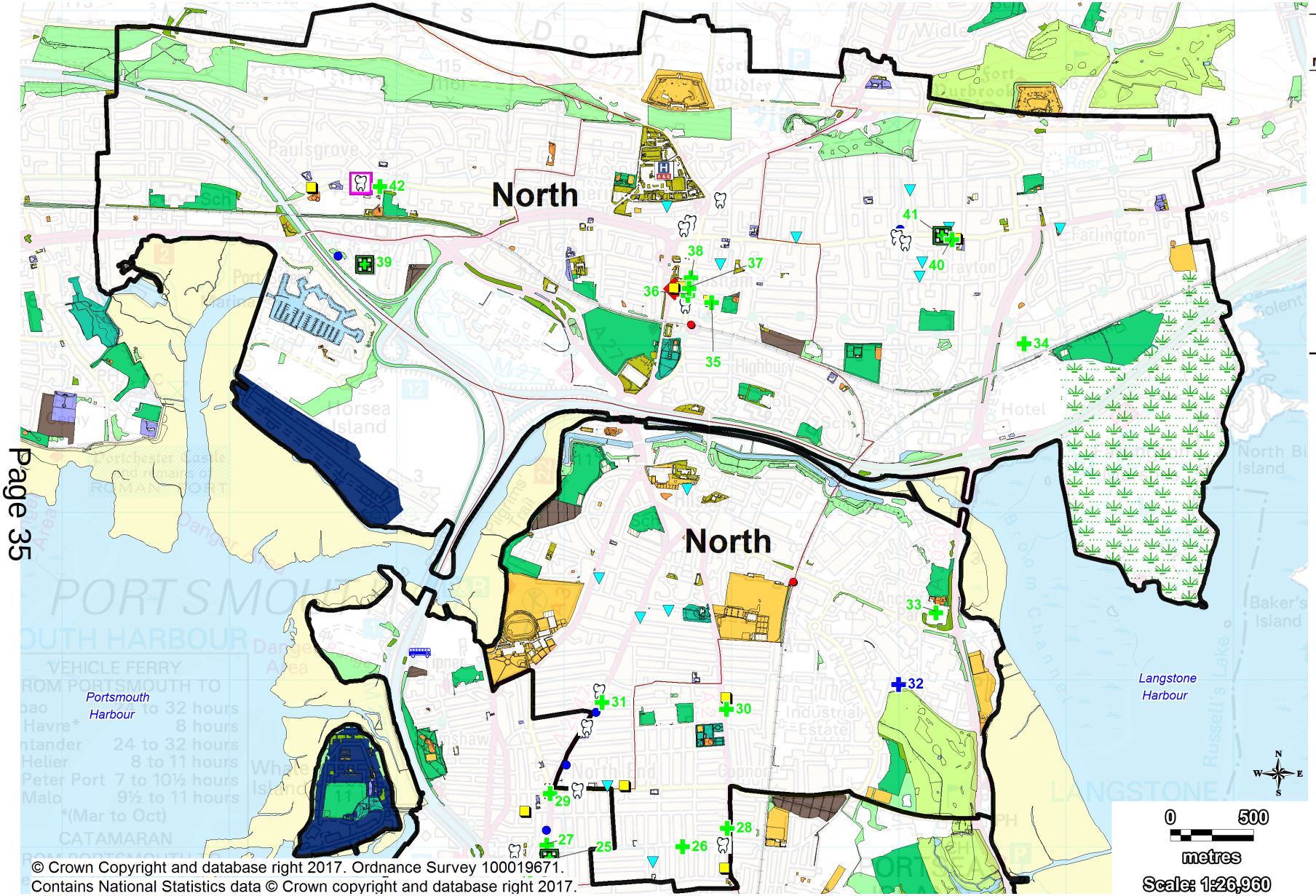


Figure 1. Legend of the locality maps of Portsmouth showing the location of pharmacies and other key sites, as at July 2017.



Map ID	Pharmacies in the North locality (sorted by left to right on the map)
39	Tesco Instore Pharmacy
42	Rowlands Pharmacy
31	Rowlands Pharmacy
26	The Pharmacy
36	H J Everett
37	Lloyds Pharmacy
38	Boots The Chemists
35	Lloyds Pharmacy
30	Copnor Pharmacy
28	Rowlands Pharmacy
32	Victory Internet Pharmacy
33	Morrisons Pharmacy
41	Drayton Community Pharmacy
40	Rowlands Pharmacy
34	Lloyds Pharmacy in Sainsburys

Figure 2. Map of the North locality of Portsmouth showing the location of pharmacies and other key sites, as at July 2017.

5.3 Central Area Locality Profile

The Central locality comprises of four electoral wards crossing the centre of Portsea Island: - Nelson, Charles Dickens, Fratton and Baffins.

Population

In 2018, it is estimated that 67,600 people live in the Central locality, but is estimated to increase to 68,900 residents by 2021 (Hampshire County Environment Department's 2011 Census, 2016-based Small Area Population Forecasts). See demography and needs section for more information on the population.

Employment

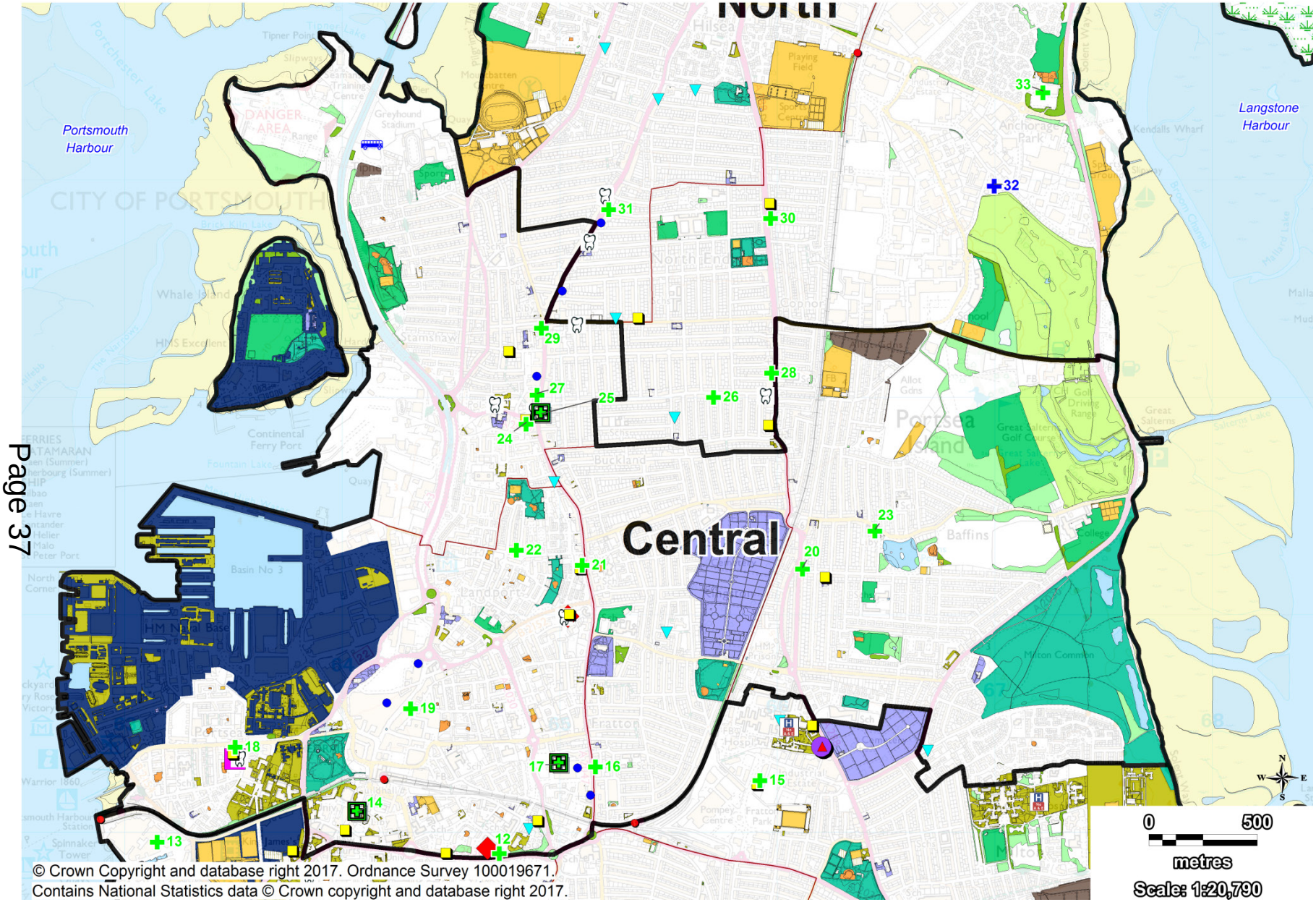
The larger employers based in this area are Portsmouth City Council, University of Portsmouth, Royal Navy, the international ferry port and the historic dockyards, plus the major retail employers for the Commercial Road shopping area. Other shopping areas include North End and Fratton Road. There are small business and light industrial estates e.g. Victory Business Centre.

NHS services

The CCG member practices are Lake Road Practice, Hanway Group Practice, Derby Road Practice, East Shore Partnership (Baffins Surgery), John Pounds Surgery, two Portsdown Group Practice surgeries (Somerstown Central Health Centre and Kingston Crescent Surgery), Southsea Medical Centre and Guildhall Walk Healthcare.

There are five dental practices providing NHS dental services and there are six opticians located in the Central locality.

There are 14 community pharmacies in the area. Three of these pharmacies are '100' hour pharmacies providing evening and weekend services. A further three pharmacies routinely open on Sunday.



Map ID	Pharmacies in the Central locality (sorted by left to right on the map)
18	H Merali Dispensing Chemist
14	Lalys Pharmacy
19	Boots The Chemists
12	Lloyds Pharmacy
22	R J Berry Chemist
24	Rowlands Pharmacy
27	Boots The Chemists
29	City Pharmacy
25	Lalys Pharmacy
17	Asda Pharmacy
21	Lalys Chemist
16	Rowlands Pharmacy
20	Lloyds Pharmacy
23	Bobat Pharmacy

Figure 3. Map of the Central locality of Portsmouth showing the location of pharmacies and other key sites, as at July 2017.

5.4 South Area Locality Profile

The South locality comprises of five electoral wards crossing the southern part of Portsea Island:-St Thomas, St Jude, Central Southsea, Eastney and Craneswater and Milton.

Population

In 2018, it is estimated that 75,600 people live in the South locality but is estimated to increase to 76,500 residents by 2021 (Hampshire County Environment Department's 2011 Census, 2016-based Small Area Population Forecasts). See demography and needs section for more information on the population.

Employment

The larger employers in this area are in retail, leisure and NHS. Retail areas include Gunwharf Quays, Palmerston Road, Albert Road/Highland Road areas and the Fratton Park retail area. The NHS has two major sites at St Marys Community Campus and St James Hospital. The South has several major hotels along the seafront as well many smaller hotels and bed and breakfast establishments.

There are several small business and light industrial estates e.g. Warren Avenue, Pompey Centre.

NHS services

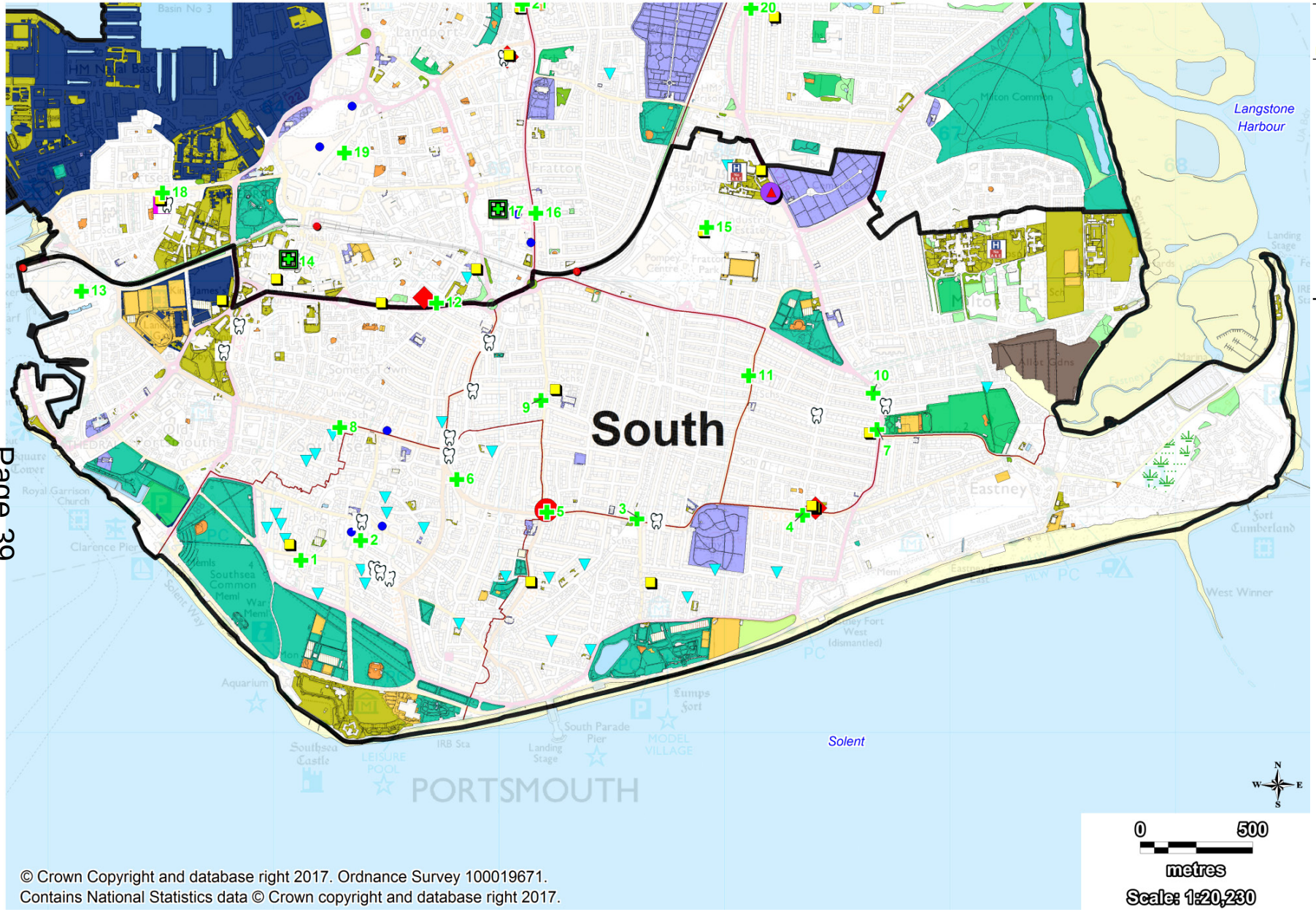
The CCG member practices are Sunnyside Surgery, Portsdown Practice (Heyward Surgery), Trafalgar Medical Group (2 sites), University Surgery, Craneswater Group Practice (2 sites), Eastney Practice, Devonshire Practice, East Shore Partnership (Milton Park Practice).

There are 13 dental practices providing NHS dental services and located in the South locality. This includes the University of Portsmouth Dental Academy which provides patient services. There are also three opticians in the South locality.

The NHS St Marys Treatment Centre is located in the east of this region providing treatment for minor illness and injuries plus a range of diagnostic services. The St Marys hospital campus provides many community based services including integrated sexual health service, imaging services and community assessment services.

St James' hospital is also located in this area. It is home to some of the adult mental health services provided by Solent NHS Trust.

There are 13 community pharmacies in the area. One pharmacy routinely opens on Sunday. Though there are no 100 hour pharmacies in this area, there are two located close to the southern boundary of the Central locality which are easily accessible.



Map ID	Pharmacies in the South locality (sorted by left to right on the map)
13	Boots The Chemists
1	Rowlands Pharmacy
8	Rowlands Pharmacy
2	Boots The Chemists
6	Rowlands Pharmacy
9	Lalys Chemist
5	Goldchem Pharmacy
3	Rowlands Pharmacy
15	Lloyds Pharmacy
11	Rowlands Pharmacy
4	Lloyds Pharmacy
10	Rowlands Pharmacy
7	Rowlands Pharmacy

Figure 4. Map of the South locality of Portsmouth showing the location of pharmacies and other key sites, as at July 2017.

6. Current Pharmaceutical Services

NHS Act 2006[7] sets out the definition for pharmaceutical services.

6.1 Community Pharmacy

Portsmouth has 41 community pharmacies providing NHS services. The pharmacies are distributed across the city in primary, secondary and tertiary shopping areas and are part of the makeup of varied retail areas within the city. These pharmacies can be divided into pharmacies providing a minimum of 40 hours of NHS pharmaceutical services each week and those providing 100 hours of NHS pharmaceutical services per week.

There are 36 pharmacies providing '40 core hours' of service and 5 pharmacies providing '100 core hours' of service. The majority of 40 hour pharmacies choose to open for longer and these additional hours are referred to as supplementary hours.

6.2 Distance Selling Pharmacies

Portsmouth has one distance-selling pharmacy which opened in August 2016. Distance selling pharmacies provide services solely to customers who do not attend the premises, for example internet services only. However, Portsmouth residents may choose to have their prescriptions dispensed from any pharmacy across the country including distance selling pharmacies. This trend is anticipated to increase, in line with other internet shopping trends, particularly as more electronic prescriptions are produced by prescribers.

6.3 Dispensing Doctor

None of the GP practices in Portsmouth are on a dispensing doctor list. GP practices can only apply for consent to dispense in rural areas. This facility is available to patients who live at a distance of more than one mile from pharmacy premises. Portsmouth is a totally urban area and the conditions for such an application would not arise.

6.4 Local Pharmaceutical Services Scheme

Portsmouth has no Local Pharmaceutical Services pharmacies (LPS). These are pharmacies that provide a service tailored to specific local requirements. A typical example would be for very rural areas where a pharmacy opening to provide pharmaceutical services would not be financially viable without this type of arrangement. Again due to the urban nature of Portsmouth with a wide distribution of pharmacies the conditions for this type of application to the pharmaceutical list cannot be identified.

6.5 Dispensing Appliance Contractor

Portsmouth has one dispensing appliance contractor (DAC). This type of contractor only supplies appliances e.g. stoma care products (rather than medicines). Many prescriptions for specialist appliances are dispensed by specialist appliance contractors, located across the country and provide delivery services. All pharmacies within the city are also able to dispense appliances.

[7] http://www.legislation.gov.uk/ukpga/2006/41/contents

6.6 Pharmacies close to Portsmouth boundaries

Consideration has been taken of pharmacies providing pharmaceutical services just outside the Portsmouth City boundary. Most of the city is located on an island and so the only land border is on its northern edge. There is the natural geographical feature of the South Downs running along this border and a major motorway M27 running just inside this boundary. The nearest retail areas are; - in west direction Portchester and then Fareham; east direction Bedhampton and Havant; in north direction Purbrook and Waterlooville. Examining dispensing data shows that some prescriptions prescribed by Portsmouth GPs are dispensed in these localities but they are not large in number (see section 8.2.1).

One pharmacy in Crookhorn, two miles north of the Portsmouth city boundary, dispenses a number of prescriptions, generated by a Portsmouth member practice. This is because this GP practice is located at multiple sites, mainly in Portsmouth but with one surgery in Crookhorn. The pharmaceutical needs of some patients accessing medical services at the Crookhorn surgery are likely to be being met by the pharmacy located in Crookhorn, which is within Hampshire HWB area.

Generally these pharmacies located on the boundaries are providing additional choice for people residing in Portsmouth but they do not provide additional pharmaceutical services, e.g. a greater range of opening hours or services, compared to Portsmouth located pharmacies. Hampshire residents may also choose to use pharmacies located within Portsmouth.

6.7 Pharmaceutical Needs assessment map

The PNA requires a map that shows all current pharmaceutical service providers. Figure 5 is the designated map as required by paragraph 7 of Schedule 1 of the 2013 Regulations. This map will be updated, during the lifetime of this PNA, when pharmacy premises open, close or relocate. This map shows the locations of the 41 community pharmacies, one distance selling pharmacy and one dispensing appliance contractor.

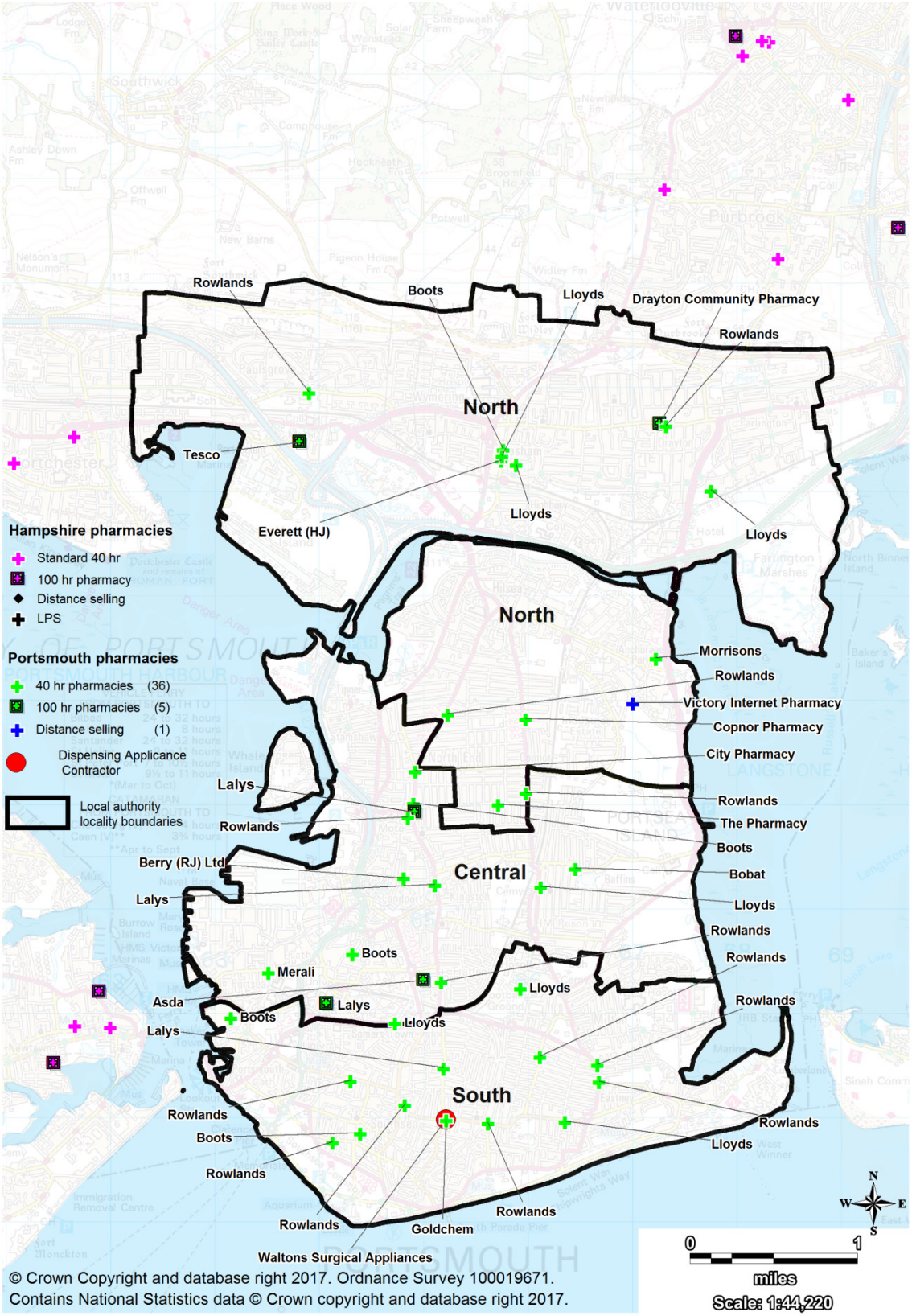


Figure 5. The map detailing the location of Pharmaceutical Service providers in Portsmouth; and the nearest providers outside the city

7. NHS Pharmaceutical Services

The PNA has considered the general accessibility to all pharmaceutical services.

The NHS regulations have split Pharmaceutical services into Essential Services, Advanced Services and Enhanced Services. The delivery and access to each of these services levels is considered within this PNA.

7.1 Access to Pharmaceutical Services[8]

7.1.1 Opening hours

The opening hours used in this section are based on the total opening hours (both 'core' and 'supplementary' hours) as held by NHS England for July 2017. Details of individual pharmacy opening times can be found on the NHS Choices website[9].

Many pharmacies that provide a minimum of '40 core hours' of NHS pharmaceutical service also extend these hours of service, opening into the evening and/ or opening on Saturday afternoon and Sunday. This gives a broad range of opening hours for the pharmacies located across the city.

The following maps relating to week days have been drawn based on Monday opening hours. This, in general, is the same opening hours for all weekdays, however, Copnor Pharmacy in the North locality closes at 1pm on a Wednesday.

7.1.2 100 hour core hour of service pharmacies

There are five '100 hour pharmacies' in the city which opened using the 'necessary or expedient' test under the 2005 exemptions to the market entry system. These pharmacies provide 100 core hours per week of pharmaceutical services. They have given Portsmouth residents greater access to pharmaceutical services by extending opening hours both in the morning and late into the evening plus extended weekend coverage. These pharmacies meet an identified need for pharmaceutical services for both 'out of hours' dispensing services and for the general population who wish to seek professional help for health and lifestyle advice, treating minor ailments and conditions that may be managed by self-care.

[8] Public Health data held following PNA questionnaire/ data collection from Portsmouth pharmacies June 2014

[9] NHS Choices website - available at http://www.nhs.uk/Pages/HomePage.aspx

7.1.3 Opening hours Morning

For early morning access fifteen pharmacies open before 9am on weekdays. Eight of these located in the Central locality with six in the North and one in the South.

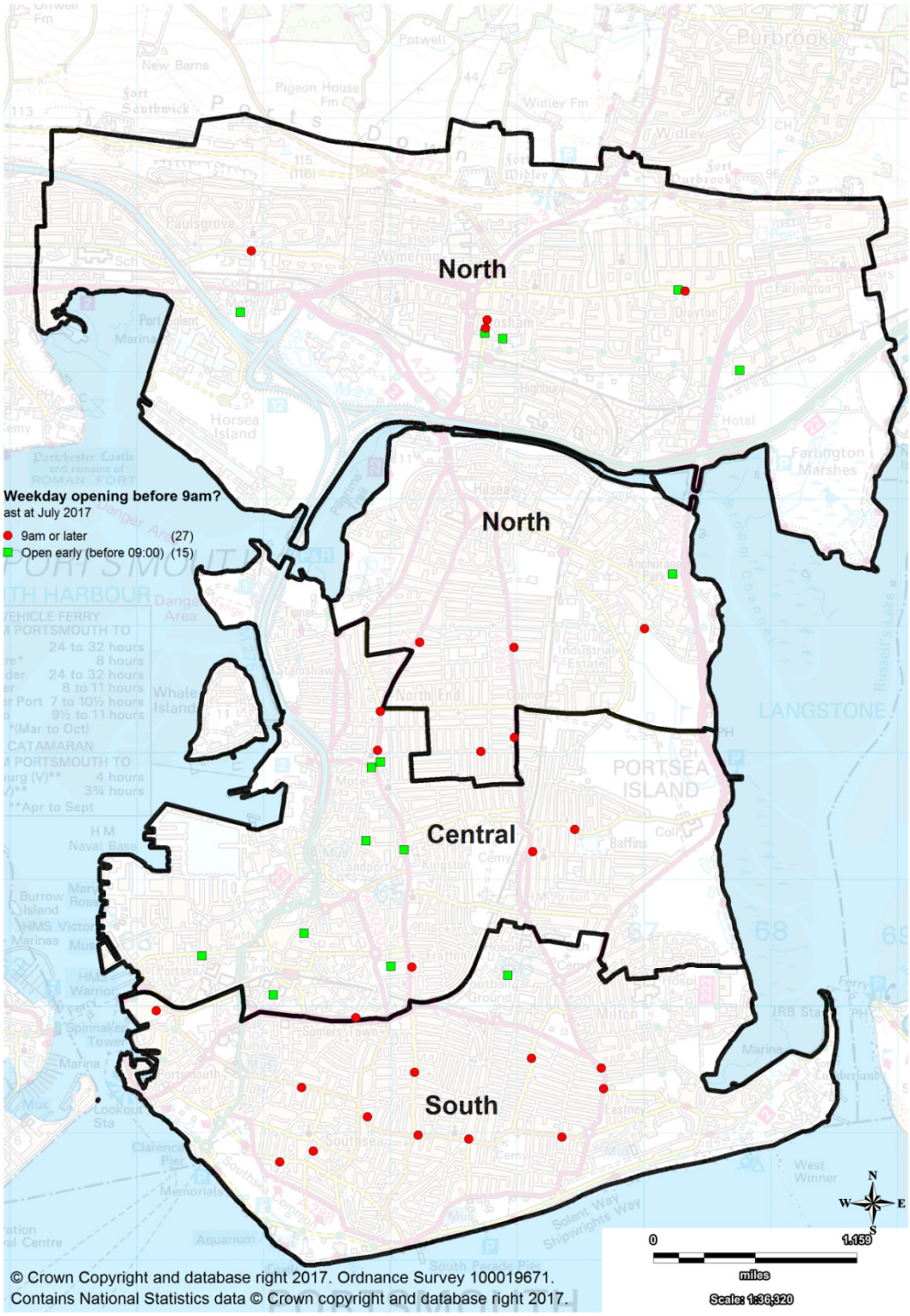


Figure 6. Map of weekday morning opening times for community pharmacies in Portsmouth, as at July 2017

7.1.4 Opening Hours Lunchtime

There is access to NHS pharmaceutical services throughout the lunch period (12pm to 3pm) in nineteen local pharmacies. Sixteen pharmacies are closed for one hour during lunch, and a further one pharmacy for up to an hour and 15 minutes. The remaining six pharmacies are closed for 30 minutes or less.

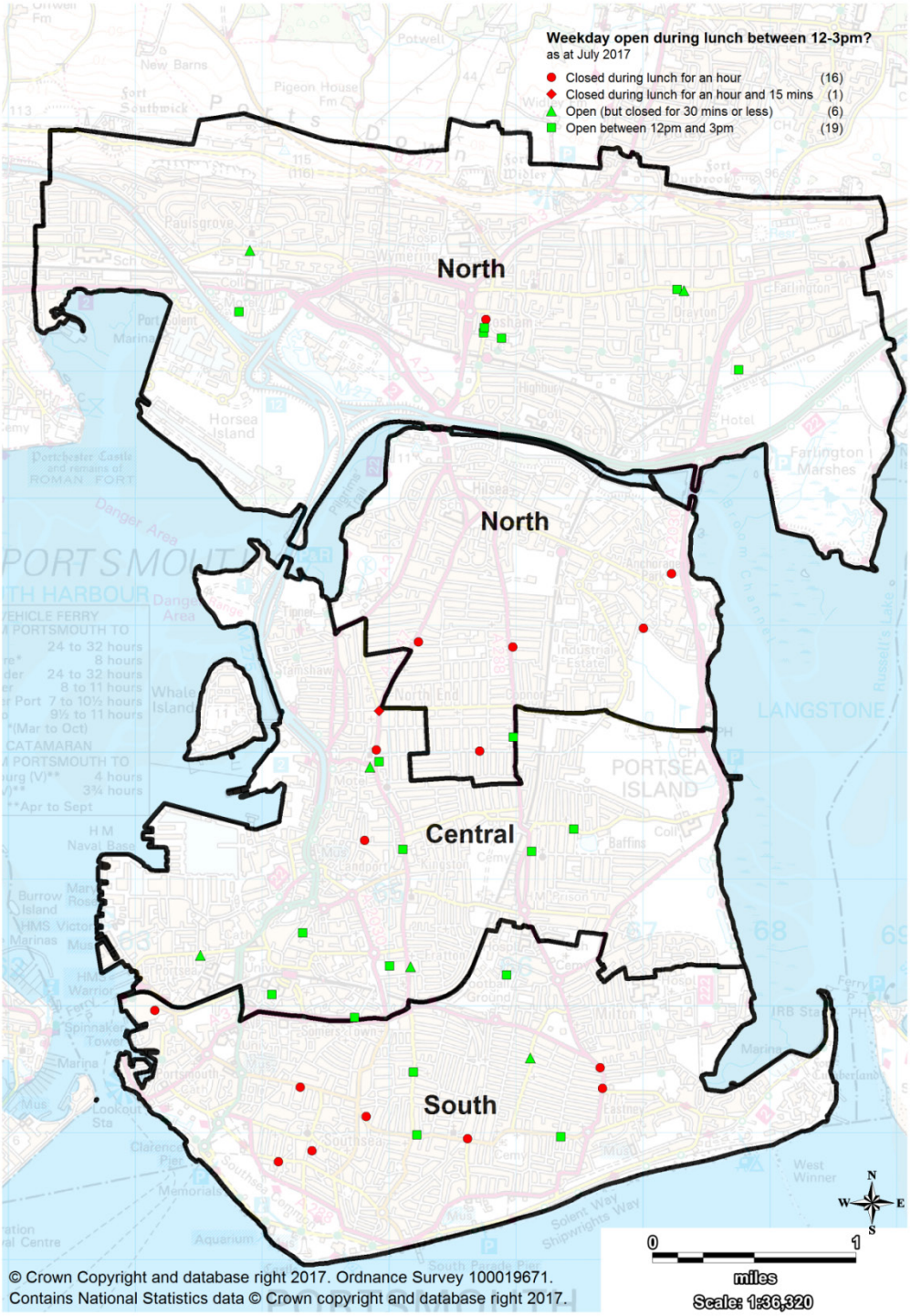


Figure 7. Map of weekday lunchtime opening times for community pharmacies in Portsmouth, as at July 2017

7.1.5 Opening Hours Evening

Six pharmacies are open late in the evening between 8pm and 11pm. Another six pharmacies are open between 6.30pm and 8pm. The remaining twenty-eight are closed by 6.30pm.

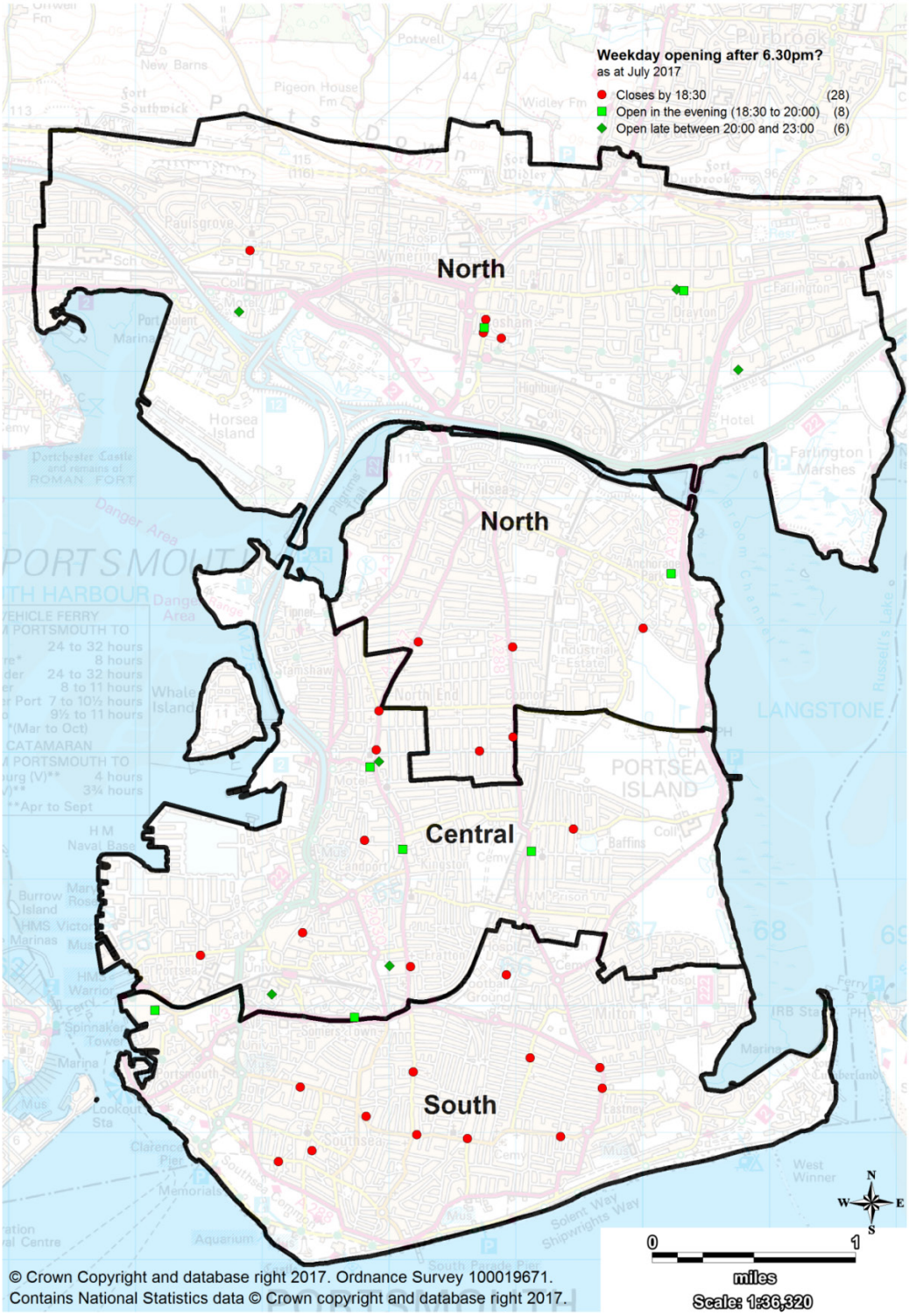


Figure 8. Map of weekday evening opening times for community pharmacies in Portsmouth, as at July 2017

7.1.6 Saturday opening

The majority of pharmacies are open for at least a part of the day on a Saturday with only two pharmacies closed all day. Twenty-three pharmacies close at 2pm or before, ten are open during the hours of 2pm to 6.30pm and seven are open after 6.30pm.

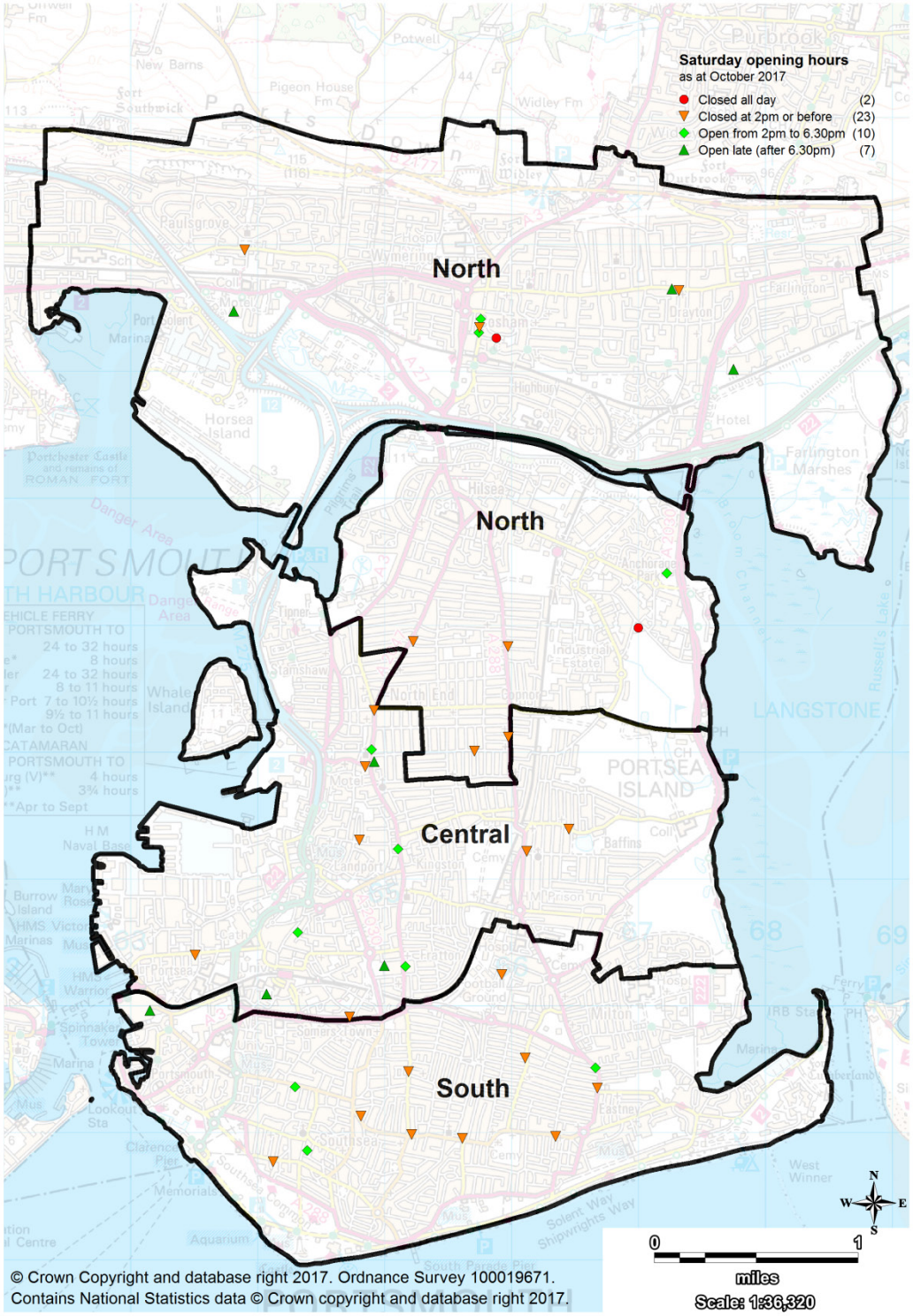


Figure 9. Map of Saturday opening times for community pharmacies in Portsmouth, as at 9th October 2017 (Notification of amendment to the Pharmaceutical list from NHS England South - Wessex)

7.1.7 Sunday opening

Nine pharmacies are open regularly on a Sunday. For six of these pharmacies the Sunday trading laws limit opening times to six hours only with typical closing times being 4pm, 4.30pm or 5pm. The remaining three pharmacies are open before 10am to after 5pm.

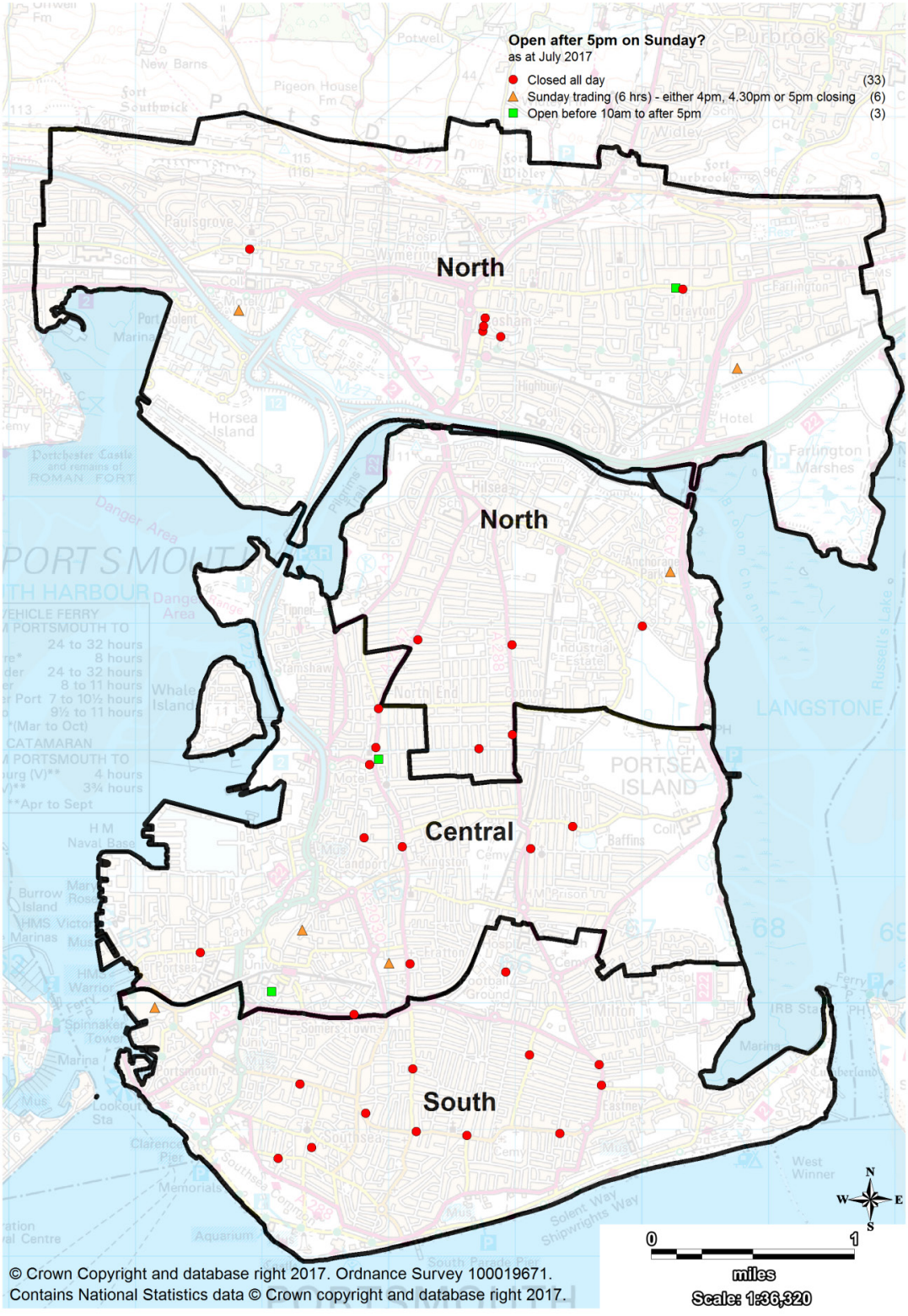


Figure 10. Map of Sunday opening times for community pharmacies in Portsmouth, as at July 2017

7.1.8 Bank Holidays

Community pharmacies are not required to open on bank holidays. However for the majority of the bank holidays historically, some have opened on a voluntary basis.

For major bank holiday such as Christmas Day and Easter Sunday, voluntary opening by one or two pharmacies has ensured sufficient pharmaceutical services for the city to enable urgent prescriptions to be dispensed and self-care remedies to be purchased. NHS England can direct pharmacies to open on bank holidays if required.

Details of opening times for these holidays are published on the NHS Choices website and are usually available on the NHS Portsmouth CCG website.

7.1.9 Access Distance

7.1.9.1 Pharmacies with buffer zone of 1.6km

All pharmacy locations within Portsmouth with a buffer zone of 1.6km Euclidean distance (straight line) demonstrates that the population of Portsmouth can access a pharmacy (excluding distance selling) within 1.6km (approximately one mile) or less from all parts of Portsmouth (assuming it's possible to travel in a straight line) (Figure 11).

7.1.9.2 Driving

In 'rush hour' in Portsmouth (normal speed limits but taking into account junctions, crossings and traffic lights with the additional congestion data and road density analysis), a pharmacy in Portsmouth should still be accessible within a four minute drive for most parts of the city, with only a few small areas with low residential density being an eight minute drive or more from a pharmacy (Figure 12).

7.1.9.3 Cycling

Eighty-five percent of the Portsmouth population are within a four minute cycle ride of a pharmacy (excluding distance selling); and over 99% of the population are within an eight minute cycle ride - this assumes a cycle speed of 15km per hour (kph) or 9.3 miles per hour (mph). This of course assumes all people have access to a bike and can ride a bike; nevertheless for those that do have access and can ride a bike it assumes that cycling to a pharmacy is a reasonable option.

7.1.9.4 Public Transport

Residential areas of Portsmouth are well covered by bus stops and bus routes; therefore access to pharmacies in Portsmouth are well served. There are also two railway stations in the North locality (Hilsea and Cosham stations) and three on the border of the Central and South localities (Fratton; Portsmouth and Southsea; and Portsmouth Harbour stations) and over 99% of the Portsmouth population are within a 20 minute rail journey of a pharmacy (excluding distance selling). In addition, Portsmouth is well served with 24 hour taxi services at prices not too dissimilar to bus and rail prices.

7.1.9.5 Walking

Over 99% of the population can reach a pharmacy in Portsmouth (excluding distance selling) within a 20 minute walk (assuming the average walking speed is 3.1 mph) and this is especially the case in the more densely populated areas of Portsmouth. Over 50% of the

Portsmouth population is within a four minute walk of a pharmacy, which is especially the case in the South and Central localities of the city; and Portsea Island is relatively flat with few hills/inclines which might make walking a realistic alternative to public transport or car use. The total Portsmouth population is within a 25 minute walk of a pharmacy (Figure 13).

7.1.9.6 Proximity to GP Practices

The location of GP surgeries along with the shortest straight line distance to a community pharmacy is given in Figure 14. Locations of GP surgeries are all within 500m straight line distance of a community pharmacy.

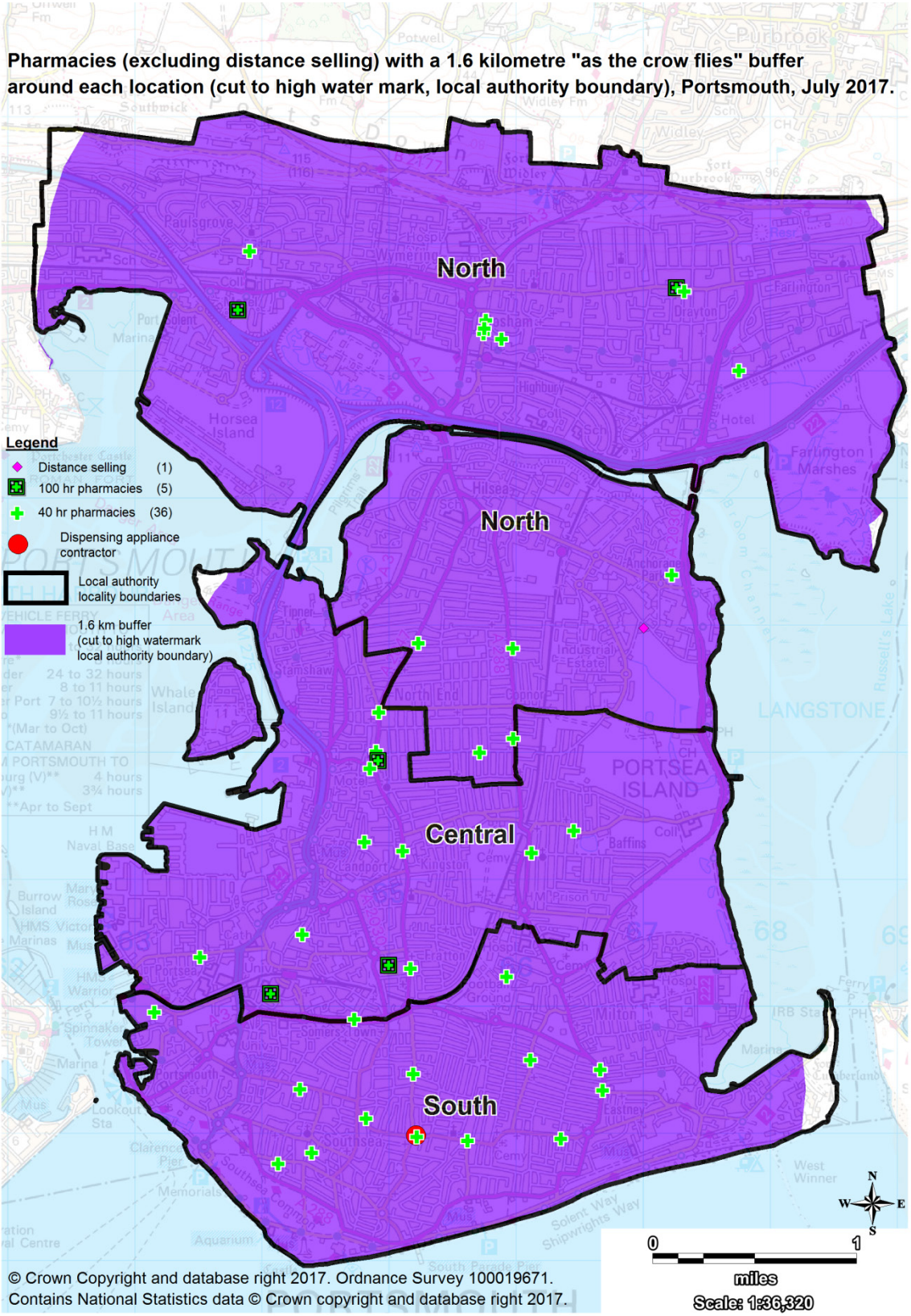


Figure 11. Map of pharmacies with a 1.6km straight line buffer zone (purple), Portsmouth.

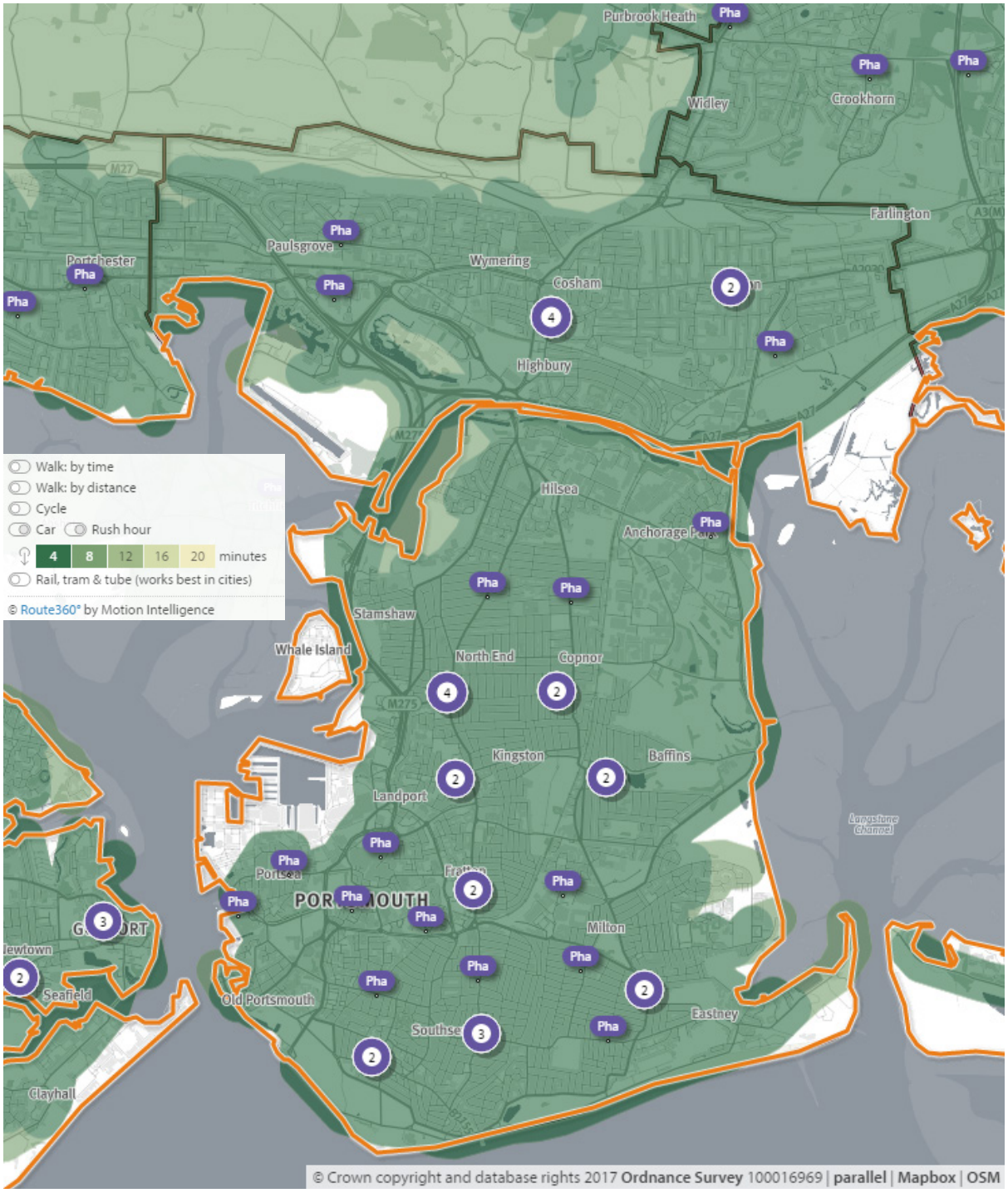


Figure 12. Map of drive times in rush hour from pharmacies (excluding distance selling) in Portsmouth and outside of the local authority boundary. Source: SHAPE place, Public Health England.

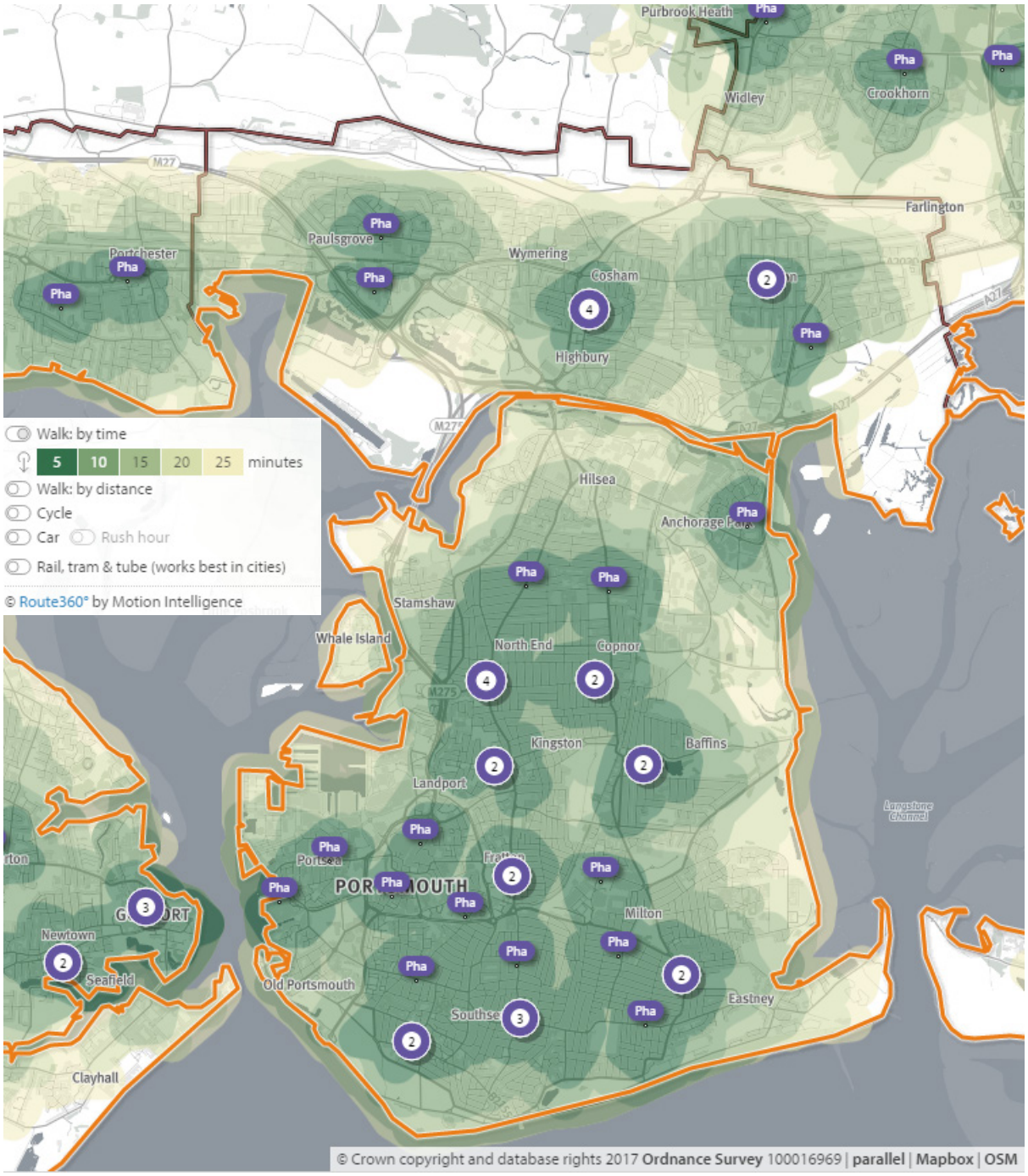


Figure 13. Map of walking times (5-25 minutes) from pharmacies in Portsmouth (excluding distance selling) and outside of the local authority boundary. Source: SHAPE place, Public Health England.

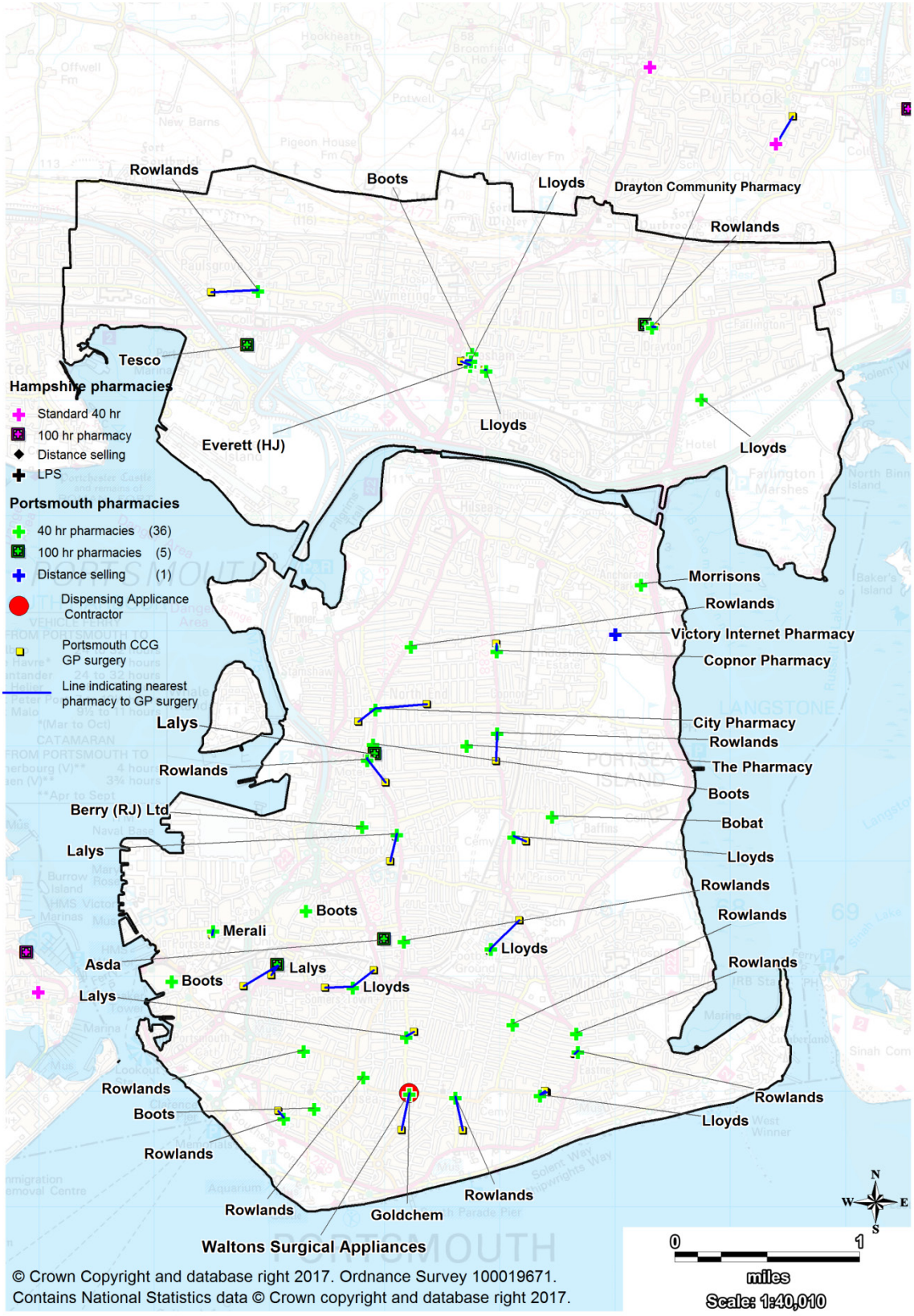


Figure 14. Map of the Euclidean (straight line) distance from a GP surgery to the nearest pharmacy in Portsmouth.

7.1.10 Access for residents with additional needs

The contractor questionnaire was issued to all 41 community pharmacies and one DAC in Portsmouth. This resulted in 30 responses.

Housebound

The survey of pharmacies indicated that all 30 pharmacies who responded will collect prescriptions from GP practices across the city. The majority of these pharmacies (29, 93.3%) stated they provide a delivery service to residents, including housebound patients, free of charge to both patients and the NHS.

All pharmacies can give telephone advice to housebound and other residents.

Equality Act

Businesses and health care professionals have responsibility under the Equality Act to make reasonable adjustment to their services to facilitate access by people affected by disability. For pharmacy this is part of their terms of service. Typical examples of adjustments for premises adjustments include wheelchair/ buggy ramps, doors sufficiently wide to allow wheel chairs, consultation rooms with wheelchair access and hearing aid loops. Typical examples of amendments to services include collection of prescriptions; home delivery of prescriptions and other goods from pharmacy; adding easy opening lids to medicine bottles; large print labels; provision of compliance charts and other aids to help use eye drops and inhalers.

Access Languages

The pharmacy workforce in Portsmouth embraces a range of nationalities and cultural backgrounds. The recent survey showed that 29 different languages were spoken from amongst Portsmouth staff. It is not unusual for residents who are from other countries and cultures to seek out services from a pharmacy that speaks their native language.

These were the languages identified from individual pharmacies:

Afrikaans	German	Mandarin	Swahili
Amharic	Greek	Persian	Thai
Arabic	Gujarati	Polish	Tigrinya
Bengali	Hindi	Portuguese	Turkish
Chinese	Hungarian	Punjabi	Urdu
English	Italian	Romanian	
Farsi	Latvian	Russian	
French	Malay	Spanish	

7.2 Essential Services

Essential Pharmaceutical services are provided by all community pharmacies and cover those services that any member of the public would anticipate receiving from a community pharmacy on the high street. They include:

- dispensing prescription medicines and appliances
- repeat dispensing and electronic prescribing services
- disposal of unwanted medicines
- providing support for self-care
- promoting healthy lifestyles
- signposting
- clinical governance.

7.2.1 Dispensing NHS prescriptions

A range of nationally[10] and locally available statistics[11] has been researched to determine whether there is sufficient capacity within Portsmouth pharmacies to dispense prescriptions generated within the city.

In 2016-2017 there were 3,722,960 items prescribed by Portsmouth GPs dispensed across the country (an increase from 3,470,266 items dispensed in 2013-2014). More than 99% of these prescription items are dispensed through less than 100 sites. Further analysis of these 100 sites shows that:

- 87.5% of these prescriptions are dispensed within Portsmouth community pharmacies;
- 5% are dispensed in Crookhorn, Havant and Waterlooville area (this is mainly due to the location of the Crookhorn surgery where the three nearest pharmacies account for 3.8% of this 5% total);
- 2 % are personally administered items, which are bought in and used by the GP practice e.g. vaccinations;
- 1% dispensed by specialist appliance suppliers;
- 2.5% dispensed by distance selling pharmacies (this has increased from 1% in 2013-2014 reported in the previous Portsmouth PNA);
- 1% dispensed by Fareham and Portchester pharmacies;
- 1% dispensed elsewhere.

In turn Portsmouth pharmacies dispense many prescriptions generated from outside the Portsmouth area. This will typically be from workers, tourists and students, who are registered with GPs outside the area, as well as some care home provision.

[10] NHS Business services
[11] Epact data held by NHS Portsmouth CCG for April 2016-March2017

Density of pharmacies

Table 1 shows that Portsmouth has the same number of pharmacies per 100,000 of the population compared to Wessex and slightly fewer than the rest of England. For the average number of prescription item dispensed each month per pharmacy, this is slightly higher for Portsmouth than for Wessex and England. Overall, the number of pharmacies and their dispensing work load is broadly in line with national averages.

	Number of community pharmacies	Prescription items dispensed per month	Population Mid 2015 [12]	Pharmacies per 100,000 population	Average number of dispensed items per pharmacy per month
ENGLAND	11,688	82,940,000	54,786,327	21	7,096
WESSEX	511	3,752,000	2,762,546	19	7,342
Portsmouth (CCG)	41	310,250	211,758	19	7,567

Table 1. Community pharmacies on a pharmaceutical list at 31 March, prescription items dispensed per month and population by NHS England Region 2015-16[13]

7.2.2 Repeat Prescribing and Electronic Prescription Service

All GP practices and pharmacies are enabled to deliver NHS Electronic Prescription Service and participate in this national programme. NHS Portsmouth CCG has actively encouraged the uptake of both electronic repeat prescribing and electronic prescribing services by providing specialist support to GP practices and pharmacies. These services can be beneficial to patients by reducing the number of visits they make to their GP practice to collect routine prescriptions for long term conditions.

The latest statistics from NHS England demonstrate the success of these programmes (Table 2).

January – March 2017 Percentage of all items prescribed as electronic prescribing as a proportion of all prescription items.[i]	
England	53.86%
Portsmouth	59.37%
April 2016 – March 2017 Percentage of all electronic prescription service items prescribed as electronic repeat dispensing	
England	12.18%
Portsmouth	26.33%

Table 2. Items prescribed as electronic prescribing items in Portsmouth and England

Other Essential Services including disposal of unwanted medicines; providing support for self-care; promotion of healthy lifestyles; signposting and clinical governance are provided by all pharmacies in the city.

[12] Source: ONS Mid-2015 Population Estimates for Clinical Commissioning Groups in England, by single year of age, Persons (National Statistics)

[13] Sources: NHS Prescription Services part of the NHS Business Services Authority

4 Population data - Office of National Statistics (2011 mid-year Estimates based on 2011 census)

7.3 Advanced Services

There are six advanced services that may be provided by any community pharmacy as long as they meet the necessary requirement to deliver the service and are on the pharmaceutical list.

- Medicines Use Review (MUR)
- New Medicine Service (NMS)
- Appliance Use Reviews (AUR)
- Stoma Appliance Customisation (SAC)
- Flu Vaccination Service
- NHS Urgent Medicine Supply Advanced Service (NUMSAS)

7.3.1 Medicine Use Reviews

Medicine Use Review (MUR) and prescription intervention service allows accredited pharmacists to undertake structured adherence review with patients on multiple medicines, particular for those receiving medicines for long term conditions. The service helps patients understand their therapy, the best time to take the medicine, discussion about side-effects and adherence with the prescribed regimen, which may identify any problems the patient is experiencing along with possible solutions. The number of MURs is capped at 400 per pharmacy.

NHS England data show all 41 pharmacies in Portsmouth were accredited to deliver the MUR service for April 2016 - March 2017. The average for the city was 331 MURs per pharmacy at a rate of 3.6 MURs per 1000 items dispensed.

7.3.2 New Medicine Service

The service provides support for people, with long-term conditions and who have newly been prescribed a medicine. The aim of the services is to help improve medicines adherence; it is initially focused on particular patient groups and conditions; asthma and COPD, diabetes (Type 2), antiplatelet /anticoagulant therapy and hypertension.

NHS England data show 38 of the 41 pharmacies (93%) were accredited to deliver the New Medicine Service for April 2016 - March 2017 for these patient groups providing 3,101 provisions of service. The average for the city was 74 per pharmacy.

7.3.3 Appliance Use Reviews

Appliance Use Reviews (AURs) can be carried out by a pharmacist or a specialist nurse in the pharmacy or at the patient's home. AURs should improve the patient's knowledge and use of any listed appliances that include stoma care products.

Nationally, NHS England data shows little activity is recorded for this service. The contractor questionnaire issued to all 41 community pharmacies and one DAC in Portsmouth had 30 responses. Two of these responses reported the pharmacy to provide the AUR service and two reported they would soon be providing the service. Only a very small number of patients would have need to access the AUR service. Locally many GP practices have provided targeted information or signposted patients to specialist nurse services that allow similar reviews to be carried out in the patients home. Patients have good access to these services.

7.3.4 Stoma Customisation Services

Stoma customisation services aim to ensure proper use and comfortable fitting of the stoma appliance and to improve the duration of usage, thereby reducing waste. This service is for a very limited number of patients, many of whom may access this service from specialist appliance contractors located outside the city, who operate a mail order service. Patients have a good choice of providers for this specialised service. These patients may also access specialist nurse services.

NHS England data show twelve pharmacies were accredited to provide this service in the city for April 2016 - March 2017.

7.3.5 Flu Vaccination Service

The seasonal influenza vaccination programme aims to protect those who are most at risk of serious illness or death should they develop influenza, by offering protection against the most prevalent strains of influenza virus. This advanced service aims to support an effective vaccination programme in England by building capacity of community pharmacies as an alternative to general practice and improving convenience for eligible patients to access flu vaccinations.

NHS England data show 36 of the 41 pharmacies (93%) were accredited to deliver flu vaccinations for April 2016 - March 2017 giving a total of 4,745 vaccinations. The average number of flu vaccinations for the city was 113 per pharmacy.

7.3.6 NHS Urgent Medicine Supply Advanced Service

The NHS Urgent Medicine Supply Advanced Service (NUMSAS) is running in some areas of the country as a pilot service until end September 2018. This service has been operational in Portsmouth since 8th January 2018. It is a service that manages a referral from NHS 111 to a community pharmacy because they need urgent access to a medicine or appliance that they have been previously prescribed on an NHS prescription, enabling access to medicines or appliances out of hours.

7.4 Enhanced and other locally commissioned services

Enhanced services are listed in the Pharmaceutical Services (Advanced and Enhanced Services) (England) Directions 2013 [14] and the provision in Portsmouth is summarised below.

Service	How this need is met
No specifically commissioned service	
Anticoagulant Monitoring	This service is provided by Portsmouth Hospitals Trust.
Care Home service	This service is directly provided by Portsmouth CCG staff.
Disease specific medicines management service	Training opportunities to increase knowledge about local clinical pathways is provided through a varied range of educational and information resources for all health staff within the locality.
Gluten free food supply service	Available via GP prescription.
Independent prescribing service	A number of nurses and employed CCG pharmacists are able to provide this service.
Home delivery service	There is a widespread voluntary service provided by local community pharmacies which meets this need.
Language access service	NHS Portsmouth CCG commissions professional language service when required. However it is recognised that a wide variety of languages are spoken within Portsmouth pharmacies and residents may choose to use a particular pharmacy for that reason.
Medication review service	The MUR service meets the need for medication reviews at this time.
On demand availability of specialist drugs	Palliative care drugs are usually available from major pharmacies. Additional capacity is not required at this time.
Out of hours service	Voluntary opening by one or two pharmacies has ensured sufficient pharmaceutical services for major bank holidays.
Prescriber support service	Provided in house by NHS Portsmouth CCG staff. Pharmacists working in GP practices are an emerging role nationally.
Schools service	This service is not required at this time from community pharmacies.
Supplementary Prescribing Service	The majority of prescribing is met by GPs.
Service commissioned by NHS England Wessex Area Team	
Emergency supply	Pharmacy Urgent Repeat Medicine Service (PURMs) is commissioned by NHS England Wessex Area Team. In addition, see detail in the previous section regarding the NHS Urgent Medicine Supply Advanced Service (NUMSAS).
Service commissioned by NHS Portsmouth CCG	
Medicines assessment and compliance support	Commissioned by NHS Portsmouth CCG. See detail below.
Minor ailment service	Commissioned by NHS Portsmouth CCG. See detail below.
Service commissioned by Portsmouth City Council, Public Health	
Needle and Syringe Exchange Service	Commissioned by Portsmouth City Council, Public Health. See detail below.
Patient Group Direction service (not related to public	Emergency Hormonal Contraception (via a PGD) is commissioned by Portsmouth City Council, Public Health. See

[14] Pharmaceutical Services (Advanced and Enhanced Services) (England) Directions 2013 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/193012/2013-03-12_-_Advanced_and_Enhanced_Directions_2013_e-sig.pdf

health services)	detail below.
Screening Service	NHS Health Checks are commissioned by Portsmouth City Council, Public Health. See detail below.
Stop Smoking Service	Commissioned by Portsmouth City Council, Public Health. See detail below.
Other service not named in the Regulations	A supervised consumption service is commissioned by Portsmouth City Council, Public Health. See detail below.
Other service not named in the Regulations	An Alcohol Brief Intervention service is commissioned by Portsmouth City Council, Public Health. See detail below.

7.4.1 Medicines assessment and compliance support

Good compliance with medicine can prevent disease progression and hospital admission. Poor medication compliance can lead to an increase in financial costs related to greater health treatment costs and a probable reduction in quality of life for the patient.

In 2008 Portsmouth PCT set up an Intermediate Care Pharmacy service to support medicine taking for the most vulnerable people. This has now been renamed as Medicines Advice at Home service. Though there are no age constraints on patients referred to this service, more than 90% of referrals are for elderly patients. This pharmacy team has a spectrum of support for any individual with problems taking their medicines. This ranges from medication review, synchronizing medicines, auditing medicines taken with GP held records, compliance cards and one off aids. Regular ongoing support from local community pharmacy has often been identified as the best option for many scenarios. If the required support is outside of the pharmacies responsibilities required under their NHS terms of service then funding is available for items such as Medication Recording charts and monitored dosage systems. In the last few years a successful pilot to use digital technology to improve medicine compliance has been carried out. There is now a commissioned digital technology service for dispensed medicines available for up to 50 patients in the city.

7.4.2 Minor ailment service - Pharmacy First

Minor ailments are defined as common or self-limiting or uncomplicated conditions which can be managed without medical intervention. The management of patients with minor self-limiting conditions, impacts significantly upon GP workload. The situation is most acute where patients do not pay prescription charges and may not have the resources to seek alternatives to a prescription from their GP. It is estimated that one in five GP consultations are for minor ailments and by reducing the time spent managing these conditions would enable them to focus on more complex cases.

A minor ailments scheme has been in place within Portsmouth, since 2005. In 2014 this service was redesigned and renamed as Pharmacy First. The scope of the service both in geography and range of conditions has been expanded and pharmacies now make use of web based technology to facilitate the scheme. The service is available in all areas of the city and now covers 26 conditions. Thirty four pharmacies actively took part in the scheme in 2016/17, delivering over 3,500 consultations.

7.4.3 Needle and Syringe Exchange Service

Needle Exchange services for injecting drug users are a crucial component in providing a comprehensive harm reduction programme. These schemes prevent blood born viral infections within the illicit drug addiction community.

27 pharmacies have a contract to provide Needle Exchange services in 2017/18 (Figure 35). The following map also notes the pharmacies which offer supervised consumption for which further detail is given in a later section.

7.4.4 Emergency Hormonal Contraception

The supply of Emergency Hormonal Contraception is available free through 37 of the community pharmacies with contracts in Portsmouth in 2017/18 Figure 36. This service is available to all women of child bearing age to lessen the demand on GP practices, A&E and Out Of Hours services.

7.4.5 NHS Health Checks

NHS Health Checks were launched as a national programme in April 2009. The check is offered to residents who are aged between the ages of 40 and 74, once every five years, to assess risk of heart disease, stroke, kidney disease and diabetes and will be given support and advice to help them reduce or manage that risk. Those who have already been diagnosed with these conditions will not be invited.

Ten pharmacies have a contract to offer this service alongside most GP practices in the city in 2017/18 (Figure 37). Having a pharmacy service offers residents more choice and access.

7.4.6 Stop Smoking Service

The service offers one to one support and advice, plus nicotine replacement therapy to any individual who wants to stop smoking. Community Pharmacy has consistently contributed to the achievement of successful ‘4 week’ quitters in addition to stop smoking support offered by the Wellbeing Service (a Portsmouth City Council Service). Thirty-eight community pharmacies have contracts to provide this service in 2017/18 (Figure 38).

7.4.7 Supervised consumption

Methadone and buprenorphine (oral formulations), using flexible dosing regimens, are used for maintenance therapy in the management of opioid dependence, as part of a programme of supportive care. To aid compliance, administration of these medications can be supervised which also provides routine and structure for the client in helping to promote a move away from chaotic and risky behaviour.

The current supervised scheme is contracted to run through 25 pharmacies in 2017/18. Refer to Figure 35 for the locations of these pharmacies.

7.4.8 Alcohol Brief Intervention

This service is in two parts. The first is aimed at all adults and asks those to complete a simple scratch card which will highlight whether they should be concerned about their levels of alcohol consumption. This simple analysis results in either congratulating the client that their alcohol consumption is within recognised agreed national limits; or highlights a moderate problem that can be easily addressed by making a small change e.g. introducing alcohol free days to the week, reducing strength of alcoholic beverages; interspersing

alcohol with soft drinks or highlights a more serious concern – this can be followed up by a more detailed questions and support and/ or direct referral to the council based Wellbeing Service.

Thirty-four community pharmacies have contracts to provide this service in 2017/18 (Figure 39).

7.4.9 Pharmacy Urgent Repeat Medicine Service

This is a locally commissioned service available at weekends and bank holidays, that allows participating pharmacies to make emergency supplies (which are usually private transactions) at NHS expense. Normal prescription charges apply unless the patient is exempt in accordance with the NHS Charges for Drugs and Appliances Regulations. The pharmacist will only make a supply where they deem that the patient has immediate need for the medicine and that it is impractical to obtain a prescription without undue delay. Thirty-seven community pharmacies are accredited to provide this service in 2017/18 (Figure 40).

5.5 Healthy Living Pharmacies

The Healthy Living Pharmacy (HLP) framework is a tiered commissioning framework aimed at achieving consistent delivery of a broad range of high quality services through community pharmacies to meet local need, improving the health and wellbeing of the local population and helping to reduce health inequalities[15].

The Department of Health (DH) introduced a Quality Payments Scheme as part of the Community Pharmacy Contractual Framework in 2017/18. HLP status is included in this scheme.

The 30 respondents to the contractor questionnaire identified whether they were regarded as a Healthy Living Pharmacy (HLP). Over half (53.3%) reported having achieved HLP status with the remainder working towards HLP status (Table 3).

Healthy Living Pharmacy	Total
Yes	16 (53.3%)
Working towards HLP status which will be achieved by 1st April 2018	12 (40.0%)
Working towards HLP status but will not be achieved by 1st April 2018	2 (6.7%)

Table 3. Healthy Living Pharmacy status reported by community pharmacies in Portsmouth, at July 2017

Further information about the award winning Portsmouth Healthy Living Pharmacy initiative is given in appendix B - 'Portsmouth Community Pharmacy Local Services - pioneers of Healthy Living Pharmacy'.

[15] PSNC; Healthy Living Pharmacies accessed via http://psnc.org.uk/services-commissioning/locally-commissioned-services/healthy-living-pharmacies/

8. Public engagement

The public survey which gathered views about pharmaceutical services in the city received 224 responses. Of the total, 168 had complete responses (i.e. all questions were seen although answers may have been skipped for some) for which the results are presented here.

Residents from all areas of the city were represented in the survey with a small number of respondents living in a PO7, PO8 or PO9 postcode (11 responses in total).

The age profile of respondents is given in Table 4. Seven in every ten of the respondents (70.8%) were 45 years of age and over. Three-quarters of respondents were female (76.2%).

Table 4. Age profile of respondents to the public survey

Age	Number of respondents
Under 16	0
16-24 years	2
25-34 years	18
35-44 years	26
45-54 years	44
55-64 years	46
65 years and over	29
Unknown	3
Total	168

Other respondent information included:

- Nine in every ten respondents (89%) identified themselves to be White British.
- Just over one in every five (22%) of respondents identified themselves to be retired and over four in every ten respondents (45%) were in full-time employment.
- 12 (7%) respondents identified themselves to be registered as disabled and a further 20 (12%) identified themselves to be disabled but unregistered.
- While the majority of responses were blank, nearly one in five (17.3%) respondents identified themselves to be a formal or informal carer.

Most respondents (88.7%) reported using the same pharmacy all or most of the time. The reason and frequency given for using a pharmacy is shown in Figure 15. Of those who indicated how frequently they get a prescription for themselves, almost half (44.6% of 166) stated using pharmacies at least once a month. Of those who indicated how frequently they get a prescription for someone else, one in every four (26.0%) stated using pharmacies for this reason at least once a month.

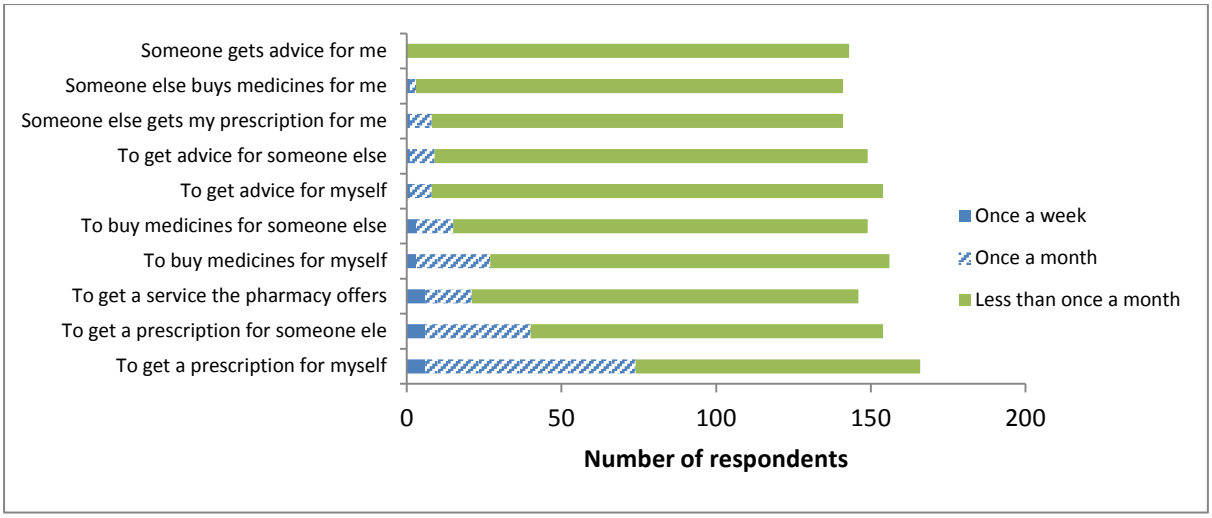


Figure 15. Reason and frequency given by survey respondents for using a community pharmacy

When asked if there is a more convenient or closer pharmacy that for some reason they didn't use, 58 (35%) responses said 'Yes', citing the following as the reasons for not doing so (respondents were able to select more than one reason):

- The service is too slow (19 responses)
- I have had a bad experience in the past (16 responses)
- It is not easy to park (15 responses)
- It is not open when I need it (11 responses)
- There is not enough privacy (10 responses)
- They don't have what I need in stock (9 responses)
- It is not wheelchair / buggy friendly (0 responses)

When accessing the pharmacy themselves, 65 respondents (38.7%) said it took less than five minutes with 82 respondents (48.8%) reporting it took between 5 and 15 minutes. Overall, getting to a pharmacy was deemed easy by three-quarters of respondents (76.2%) and difficult by only a small number. Six in every ten (59.9%) respondents reported walking to the pharmacy with almost another third (31.8%) using a car and only 7% using a bus. Use of bikes and taxis were reported infrequently (0.6% of respondents for each).

The most convenient time for the respondents to use a phamacy is during standard working hours of 9am to 5pm. The evening period until 8pm is also popular with a lesser number of people identifying late evening and early morning (before 9am) as convenient. Respondents were invited to select all the time slots which were most convenient for them Table 5.

	Normal weekday	Saturday	Sunday	Total respondents
Before 9am	55.1%	26.5%	18.4%	
	54	26	18	98
Between 9am	30.6%	42.5%	26.9%	
and noon	67	93	59	219
Between noon	36.5%	37.1%	26.3%	
and 2pm	61	62	44	167
Between 2pm	37.8%	35.7%	26.5%	
and 5pm	70	66	49	185
Between 5pm	52.6%	27.3%	20.1%	
and 8pm	81	42	31	154
After 8pm	47.8%	28.9%	23.3%	
	43	26	21	90

Table 5. Times reported as being convenient to se a community pharmacy by survey respondents

When seven in ten respondents could not access their usual pharmacy (70.3% of 111 who responded to the question) they went to another. The majority of the remainder waited until that pharmacy was open (26.1%). In order to access information on the pharmacy, such as opening times and services, searching the Internet was reported as the most common source.

The knowledge of respondents in respect of services offered by community pharmacies varied, with the availability of stop smoking help the most widely recognsied (71.2% of 156 who responded to the question) Table 6. Over half of those who responded to the question were aware that home delivery (58.2% of 158) and flu vaccination services (51.3% of 156) were available. A comparatively small proportion had used these services. The services used by the respondents were the flu vaccination service (7.1% of 156), medicines reviews (6.5% of 153) and minor ailments (6.0% of 151).

	I know they offer this service	I didn't know this service was on offer	I have used this service	Total
Stop smoking help	71.2%	26.9%	1.9%	156
Alcohol advice	46.7%	51.3%	0.7%	152
Heart health check ups	37.7%	60.3%	1.3%	154
Cholesterol check ups	36.4%	60.9%	0.7%	151
Morning after pill	44.7%	51.3%	2.0%	150
Medicine reviews	42.5%	50.0%	6.5%	153
Treatment for minor ailments	47.0%	45.5%	6.0%	151
Disposal of injecting equipment	29.0%	64.1%	2.1%	145
Flu vaccination	51.3%	41.7%	7.1%	156
Home delivery	58.2%	36.5%	5.7%	158

Table 6. Knowledge of services offered by community pharmacies reported by survey respondents

Nearly six in every ten (57.7%) respondents felt the pharmacy they visit offered information on heatlhy living Table 7. The term 'Healthy Living Pharmacy' seemed to be less familiar to respondents with 87.0% not knowing whether the pharmacy they visit was accredited.

	Yes	No	Don't know	Total
Is information on healthy living offered at the pharmacy?	57.7% (94)	2.5% (4)	39.9% (65)	163
Is the pharmacy Healthy Living Pharmacy accredited?	10.5% (17)	2.5% (4)	87.0% (141)	162

Table 7. Information on healthy living being offered by community pharmacies and Heatlhy Living Pharmacy status as reported by survey respondents

9. Portsmouth City demography and health needs

9.1 Demography

In 2018, approximately 215,900 people are estimated to be resident in Portsmouth - an increase of about 1,500 (0.7%) compared to 2017.[16] As at 1st April 2017, nearly 227,800 people were registered with Portsmouth City GP Practices[17]—although the vast majority are resident to Portsmouth, not all registered patients live in Portsmouth and the Portsdown Group GP practice has one of its surgeries (Crookhorn surgery) located outside of Portsmouth, which increases the registered population. The workday population at the time of the 2011 census was 217,960 (ie either in employment in Portsmouth, or not in employment but living in Portsmouth). The workplace population at the time of the 2011 census was 109,456 (residents aged 16 to 74 years in employment in Portsmouth a week before the census).

Portsmouth is a compact city covering 40 square kilometres—75% of the population lives on Portsea Island. The city continues to be the most densely populated local authority area outside London (5,396 people per square kilometre).

Where possible this section has also has taken account of the localities North, Central and South, when describing the health needs of the city.

[16] SNPP Z1: 2014-based Subnational Population Projections. Local Authorities in England, mid-2014 to mid-2039, Office for National Statistics (ONS) via Portsmouth Joint Strategic Needs Assessment (JSNA) webpage: http://data.hampshirehub.net/data/jsna/portsmouth-jsna/the-people-of-portsmouth/demography-general/population-mid-year-estimates-and-projections-ons-and-hcc-and-census-2011 [accessed 24 May 2017]

[17] Number of Patients Registered with a GP Practice, NHS Digital http://content.digital.nhs.uk Accessed 20 April 2017

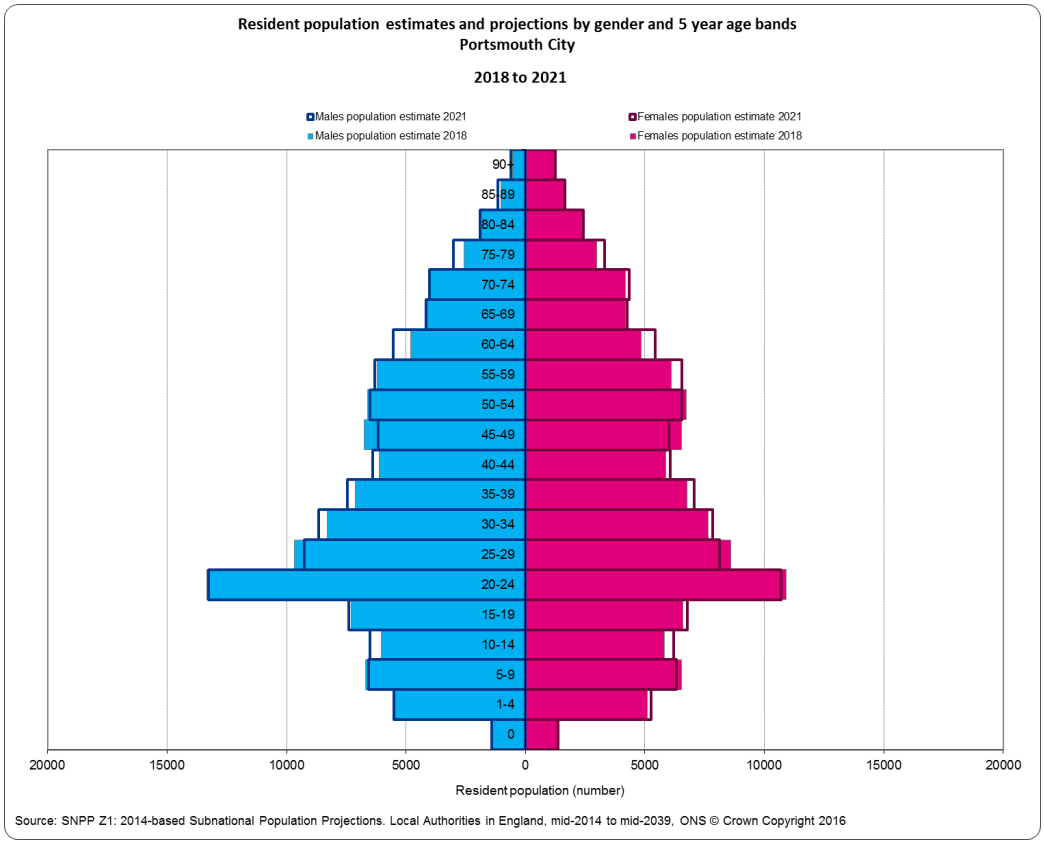


Figure 16. Resident population estimates and projections by gender and 5 year age bands, Portsmouth City, 2018 estimate compared to 2021 estimate.

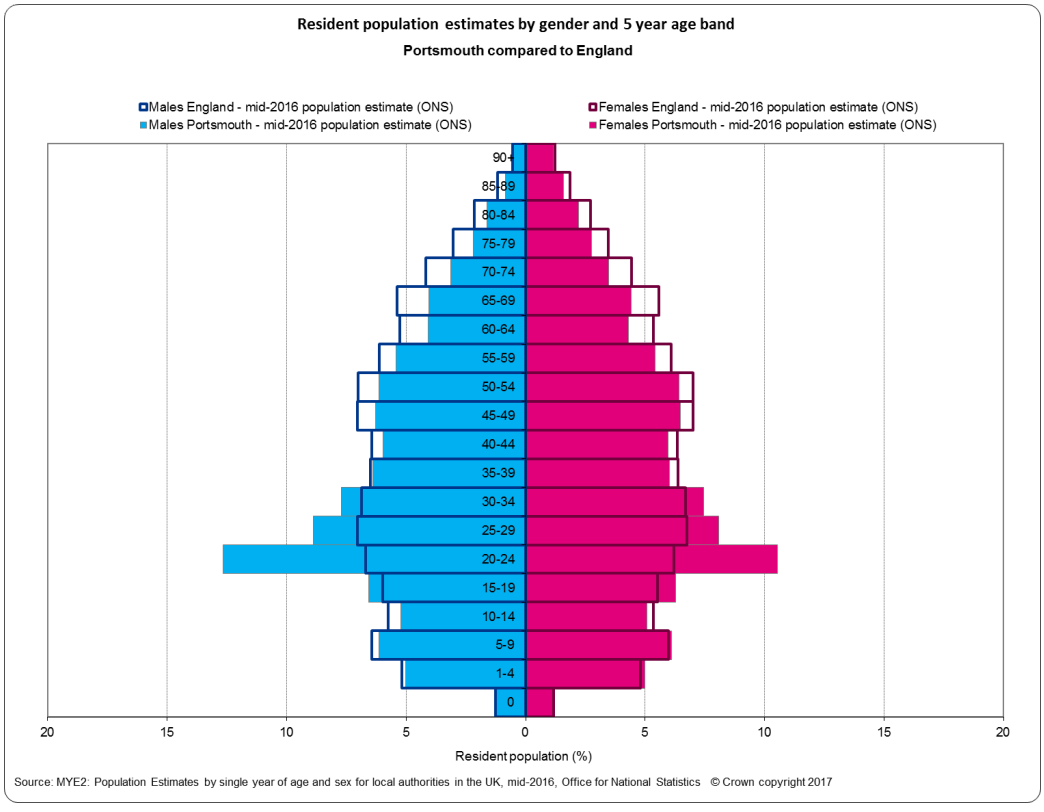


Figure 17. ONS mid-2016 resident population estimate by gender and 5 year age bands, Portsmouth City compared to England

Portsmouth has a comparatively high proportion of young people aged 20-24 years, compared to England, due to the city's University and colleges (11.6% of Portsmouth's total population compared with 6.4% nationally). (Figure 17)

The total Portsmouth population is predicted to increase by roughly 3,300 from 2018 to 2021; and increase by nearly 19,000 between 2018 to 2033. (Table 8 and Figure 18)

Table 8. Long term population projections for Portsmouth, 2014 to 2039

	Year							
Age group	**2014**	**2018**	**2021**	**2024**	**2027**	**2030**	**2033**	**2039**
0-15	38761	40432	41476	41769	41690	41723	41954	42399
16-64	140853	144726	145609	146735	148504	149620	150282	152588
65+	29471	30699	32058	34267	36950	39851	42462	46181
All ages	**209085**	**215856**	**219143**	**222771**	**227144**	**231195**	**234699**	**241168**
75+ only	*13806*	*14222*	*15280*	*17224*	*18244*	*19310*	*20784*	*24719*

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

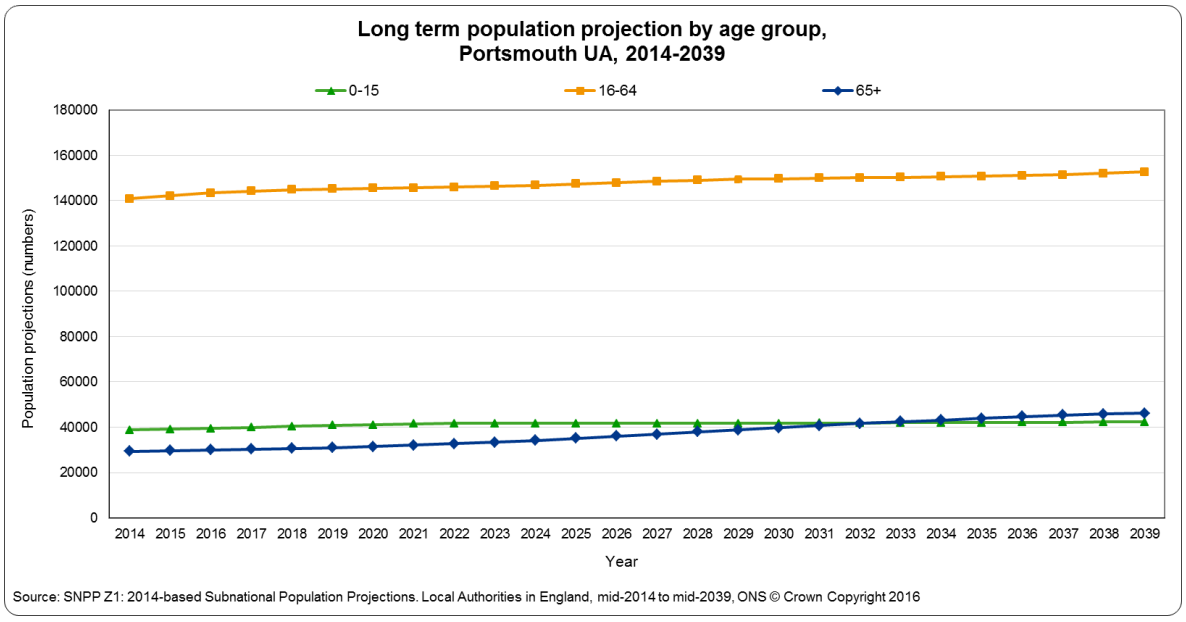


Figure 18. Long term population projection by broad age group, Portsmouth UA, 2014-2039.

In 2018, the North locality of the city is estimated to have a more even spread of residents across age bands than the Portsmouth average. The North is estimated to have a greater proportion than the Portsmouth average in residents aged 45 years and over, but less than average in ages 15-29 years (Figure 19). However, by 2021, the population in the North is

forecast to increase the most for those aged 35-39 years, aged 60-64 years and males in particular aged 75 years and over; whilst, the population is predicted to decrease the most in ages 45-54 years (Figure 20).

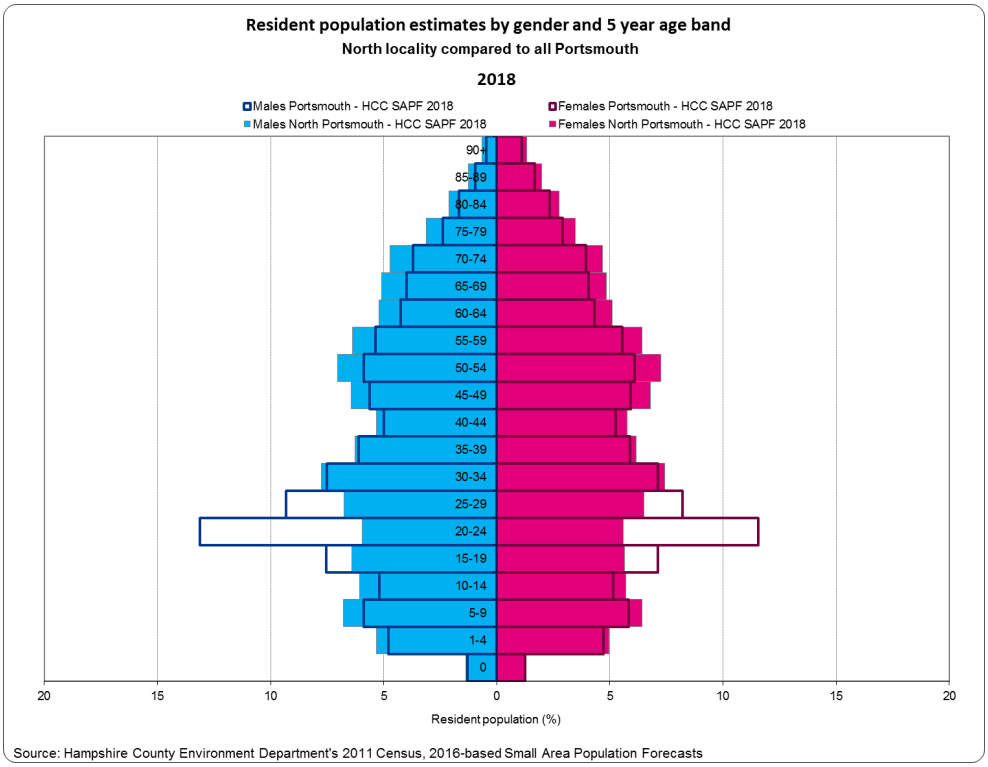


Figure 19. Resident population estimates by gender and 5 year age band, North locality compared to all Portsmouth, 2018.

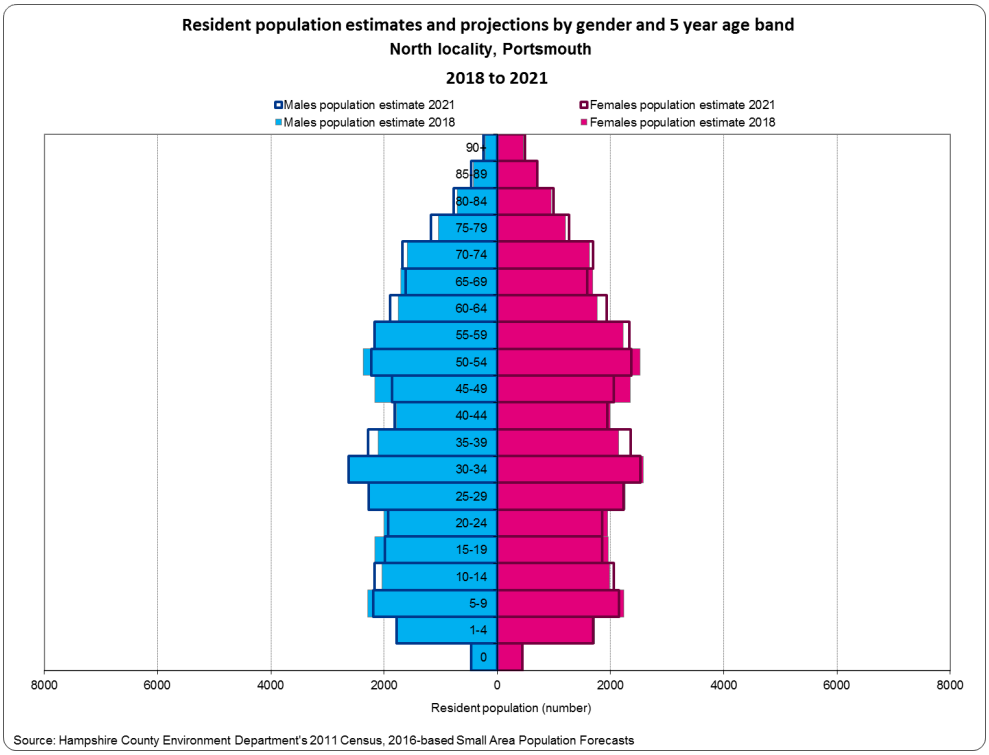


Figure 20. Resident population estimates and projections by gender and 5 year age band, North locality, 2018 compared to forecasted 2021.

In 2018, the Central locality of the city is estimated to have a similar pattern across all age groups compared to the Portsmouth average. However, the Central locality is estimated to have a greater proportion than the Portsmouth average in residents aged 0-19 years and in under 40 years in general (except the aged 20-24 years group for females) (Figure 21). By 2021, the population in the Central locality is forecast to increase the most for those aged 10-14 years, aged 55-64 years and aged 75-79 years (in particular for males); whilst, the population is forecast to decrease the most in ages 5-9 years and 45-54 years (Figure 22).

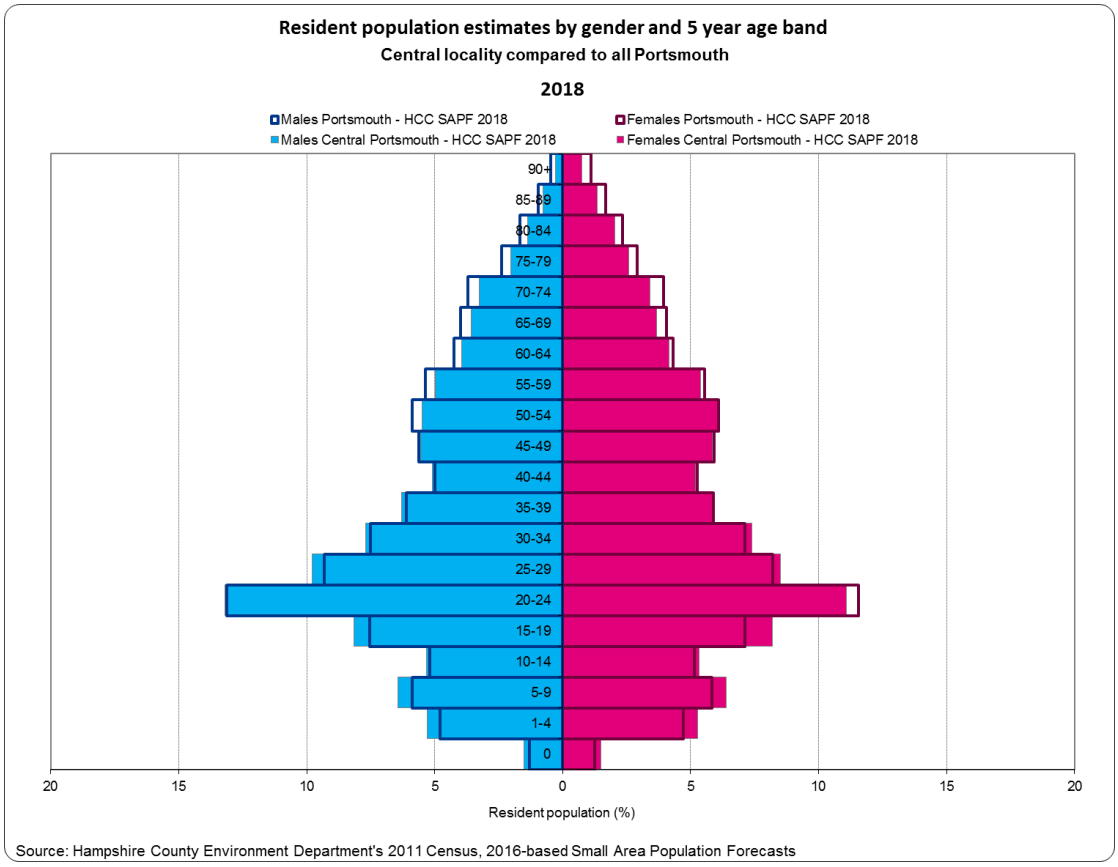


Figure 21. Resident population estimates by gender and 5 year age band, Central locality compared to all Portsmouth, 2018.

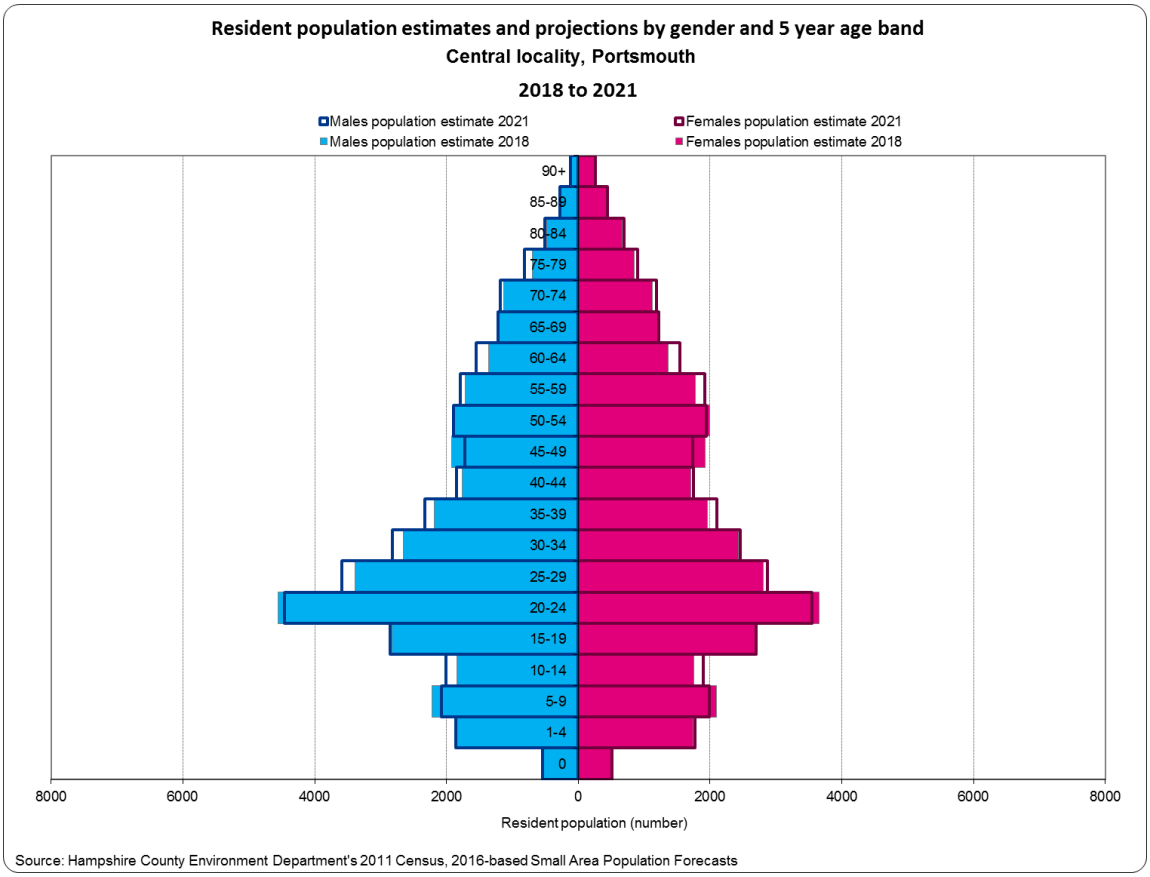


Figure 22. Resident population estimates and projections by gender and 5 year age band, Central locality, 2018 compared to forecasted 2021.

In 2018, the South locality of the city is estimated to proportionally have a much larger population of young persons aged 15-29 years compared to the Portsmouth average, with the 20-24 years age group being principally larger than the Portsmouth average, primarily due to the vast majority of students being located in the South. The South is also estimated to have a lower proportion of age 0-14 years and 30-84 years (45-69 years in particular) than the Portsmouth average (Figure 23). However, by 2021, the population in the South is forecast to increase the most for those aged 30-39 years, aged 60-64 years and aged 70-79 years; whereas, the population is predicted to decrease the most in aged 45-54 years and aged 65-69 years (Figure 24).

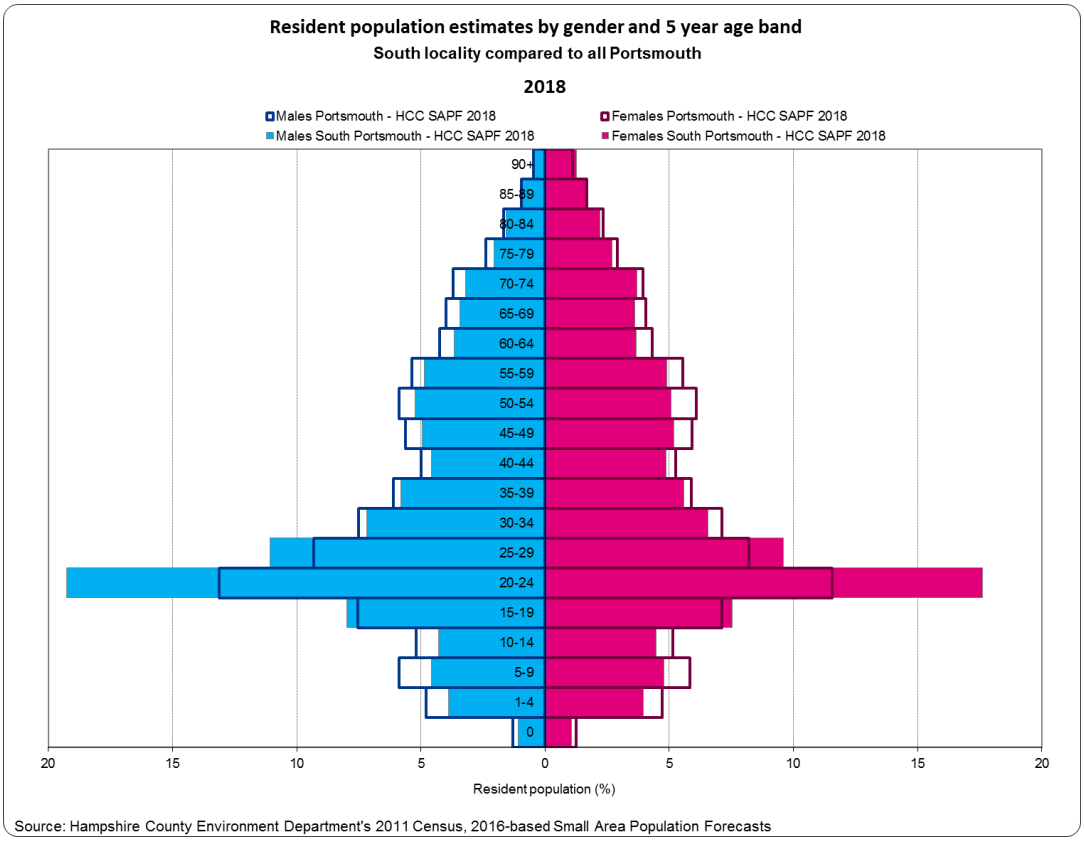


Figure 23. Resident population estimates by gender and 5 year age band, South locality compared to all Portsmouth, 2018.

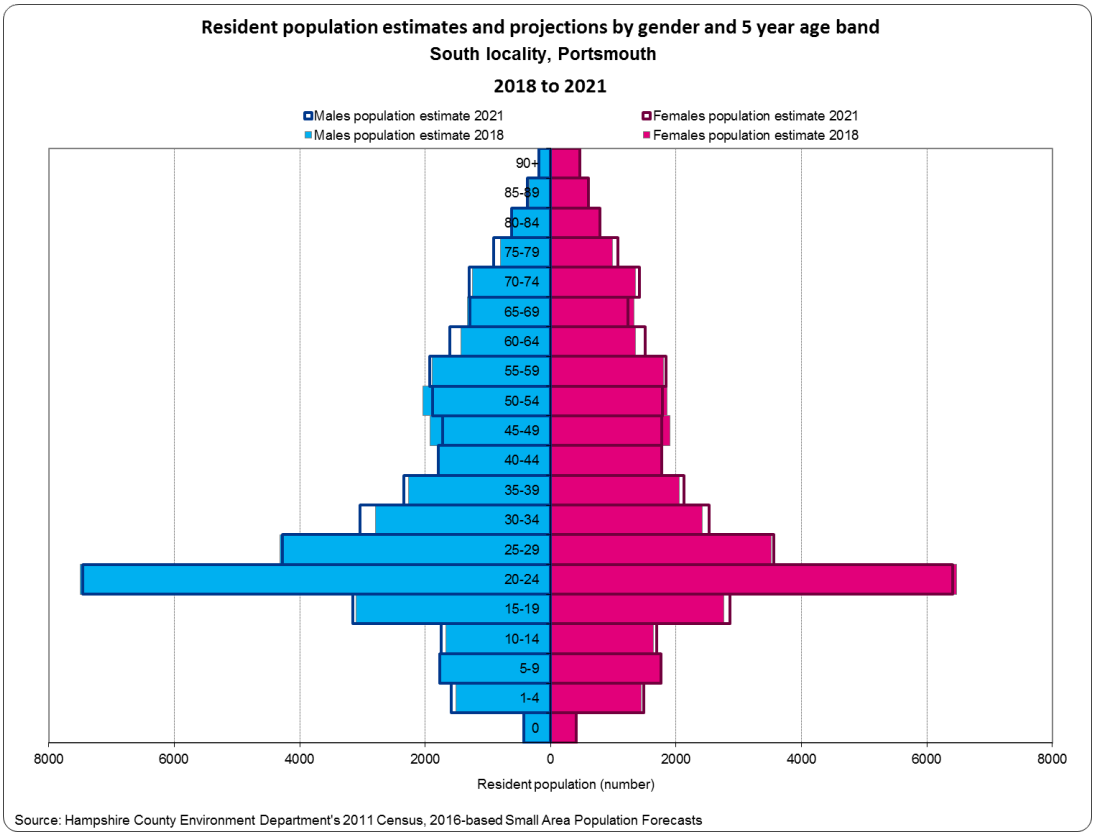


Figure 24. Resident population estimates and projections by gender and 5 year age band, South locality, 2018 compared to forecasted 2021.

Important themes are:

- An ageing society. Between 2018 and 2033 the population aged 65+ years is estimated to increase by 38% and those aged 75+ years by 46%. The "traditional" working age population (16–64 years) is estimated to increase by 4%, and those aged under 16 years are expected to increase by 4%.
- At the time of the 2011 Census, Portsmouth had a lower percentage of residents from Black and minority ethnic (BME) communities (people identifying with an ethnicity other than White English/Welsh/Scottish/Northern Irish/British) compared to in England (16% compared to 20%). However, 32,800 residents make Portsmouth a diverse multi-ethnic community. All BME groups (except Mixed) have a larger proportion of their group of working age than the White British group (Figure 25). Of the localities in Portsmouth, the South is the most ethnically diverse with 22% of the population belonging to BME groups, compared to 16% of the Portsmouth population (Figure 26)[18]. Children and young people have a different ethnic profile with 20% of school-age children being of non-White British ethnicity in 2015 compared to 15% in 2011. Of the localities, the South remains the most ethnically diverse with 28% of school children of non-White British ethnicity; 22% and 11% of school children living in the Central and North localities, respectively, are of non-White British ethnicity.

[18] Portsmouth City Council and NHS Portsmouth CCG JSNA webpage. Ethnic group by broad age group (2011 Census) http://data.hampshirehub.net/data/jsna/portsmouth-jsna/the-people-ofportsmouth/ethnicity/ethnic-groups-by-electoralward-2011-and-2001-census [Accessed 27 September 2016]

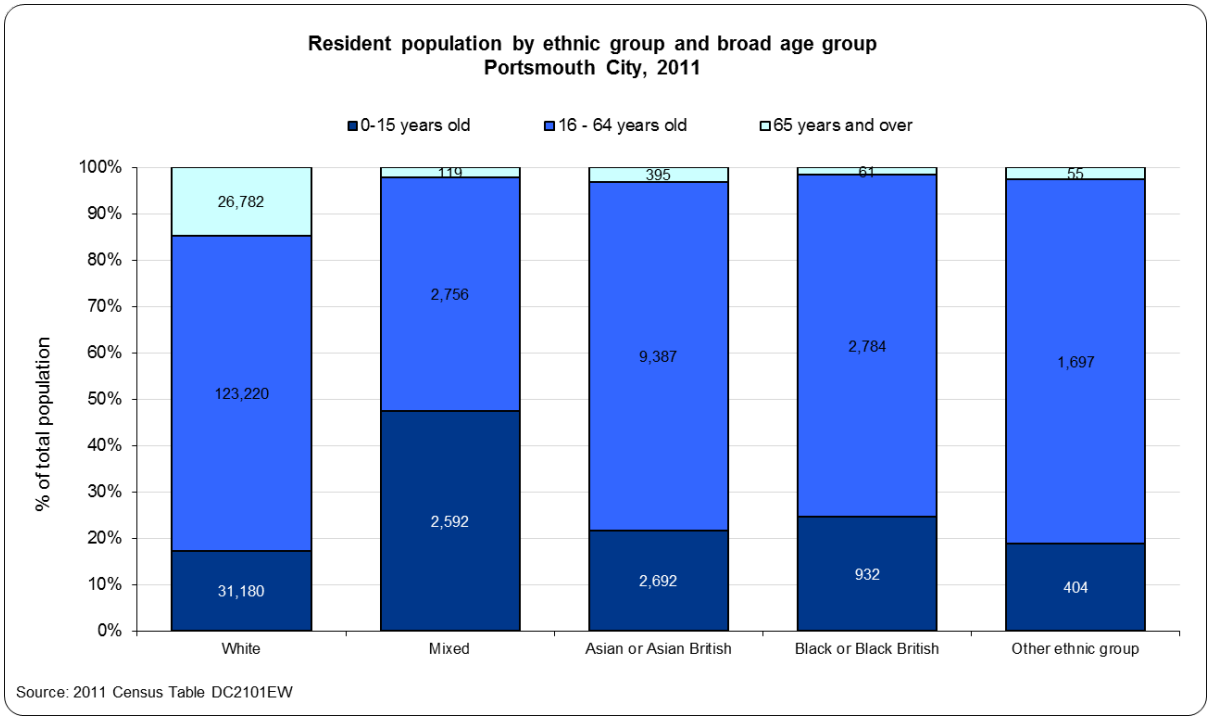


Figure 25. Proportion of population by ethnic group and broad age group, Portsmouth UA, 2011.

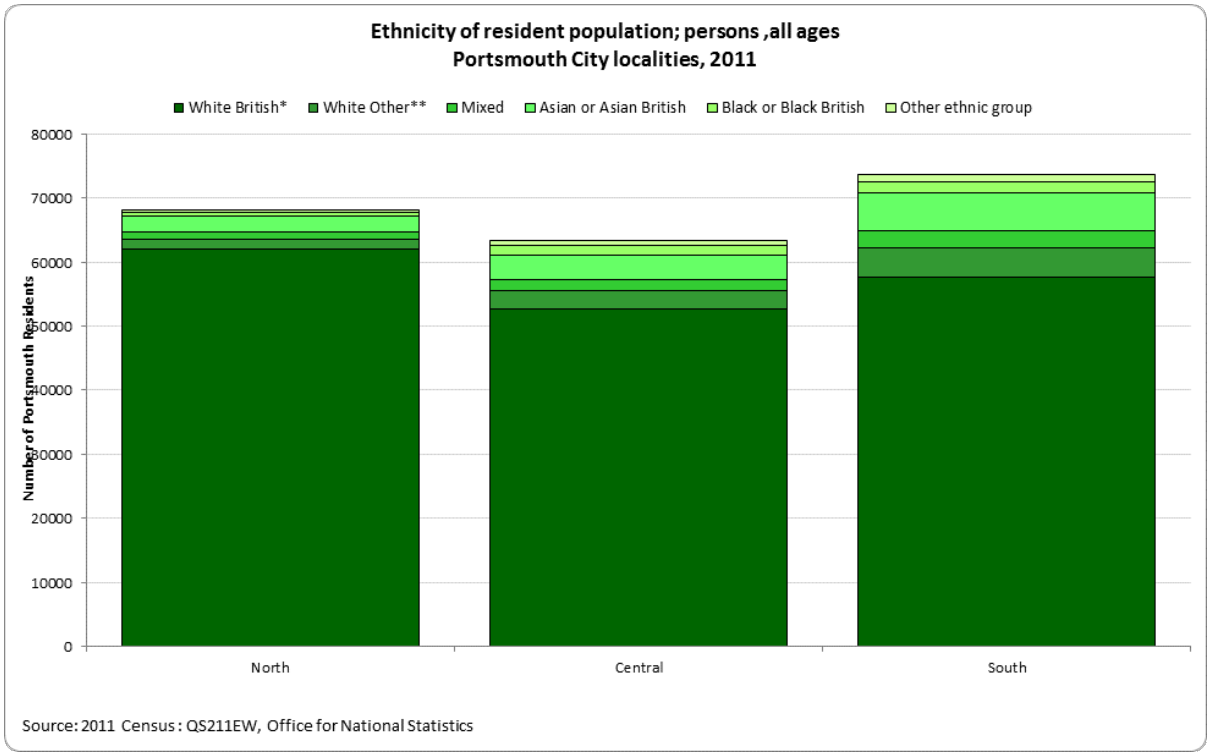


Figure 26. Number of people by ethnicity and locality, Portsmouth UA, 2011.

9.2 Socio-economic

Portsmouth is ranked 63rd of 326 local authorities (excluding counties; and where a ranking of first is the most deprived) in terms of the average index of multiple deprivation (IMD) score in 2015 (a rank of 1 is the most deprived). Deprivation can be experienced in several forms: the IMD comprises seven domains: income; employment; health deprivation and disability; education, skills and training; barriers to housing and services; crime; and living environment. The IMD is assigned to Census derived small administrative areas of about 1500 people named Lower Super Output Areas (LSOAs) of which there are 125 LSOAs in Portsmouth as at 2011 Census. Twenty-eight of 125 LSOAs in Portsmouth are in the 20% most deprived in England. Of these 28 LSOAs (in the most deprived 20% in England), 8 (of 44) LSOAs are in the North locality; 16 (of 39) in Central locality; and four (of 42) are in the South[19]. (Figure 27)

[19] English Indices of Deprivation, 2015. Department of Communities and Local Government. https://www.gov.uk/government/statistics/english-indices-of-deprivation-2015 [Accessed 6 October 2015]

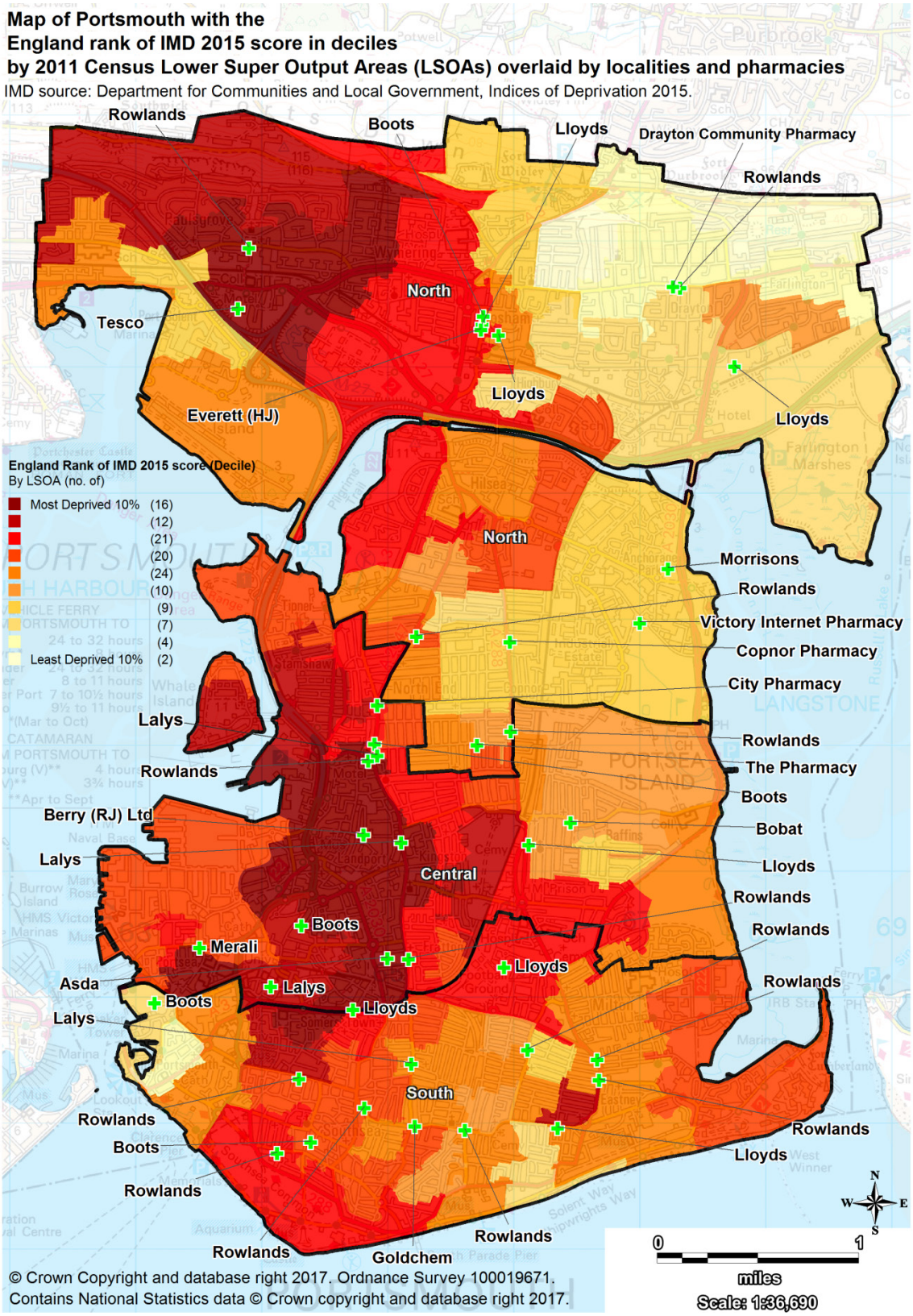


Figure 27. Map of Portsmouth with the England Rank of IMD 2015 score in deciles by 2011 Census LSOAs overlaid by localities and pharmacies.

The most commonly used threshold for income poverty is below 60% of median income. The latest data from 2013/14 estimates that approximately 21,000 households in Portsmouth are below 60% of the median income *after* housing costs (25% of households) or approximately 13,100 households in Portsmouth are below 60% of the median income *before* housing costs (15% of households). There is greater variation in income poverty at smaller geographies in the City. In the North locality of the City, it's estimated that Paulsgrove and Wymering Middle Super Output Areas (MSOAs) have roughly 30% of households below the after housing cost (AHC) threshold compared to 13% of households in Cosham Junction MSOA. In the Central locality, it's estimated that the City Centre and Buckland MSOAs have roughly 45% of households below the after housing cost (AHC) threshold compared to 16% of households in Baffins MSOA. In the South locality, it's estimated that the Somerstown MSOA*[20] have roughly 44% of households below the after housing cost (AHC) threshold, compared to 17% of households in Prince Albert MSOA.[21]

Childhood poverty is a major challenge - just under a quarter of children aged under 16 years in the city live in low-income families (24%, in 2014); the highest proportion of children aged under 16 years in low-income families are in the Central locality (30.6%), followed by the South (20.9%) and then the North (19.8%). However, there are wide variations of income and children in low-income families in small areas (Lower Super Output Areas) within these localities—in the North locality, the LSOA with the highest proportion of children aged under 16 years in low-income families is in the Central Paulsgrove area (44.3%); the LSOA in the Central locality with the highest proportion is Landport (61.5%); and the LSOA in the South locality with the highest proportion is the Sackville Street area (49.0%).[22]

Based on data from 2012, the Income Deprivation Affecting Older People Index (IDAOPI) (a sub-domain of IMD 2015) estimate that 19% of Portsmouth residents (about 7,100 people) aged 60 years and over in the City lived in income-deprivation (14.3%, 26.7% and 17.8% in the North, Central and South localities respectively).

The most recent Annual Population Survey, for the period April 2015 to March 2016, show that Portsmouth's employment rate at 71.7% was the highest rolling annual quarterly rate since April 2013 to March 2014 (also 71.7%); however this is not statistically significantly

[20]*Somerstown MSOA are not coterminous with the South Locality and North Somerstown is part of the Central locality; however, both the north and south of somerstown have similar levels of deprivation therefore the proportion of households below 60% of the median income is likely to be similar.
[21] Households in Poverty estimates for middle layer super output areas, England & Wales, 2013/14. Office for National Statistics.
[22] Children in low-income families local measure: 2014, HM Revenue & Customs via Portsmouth JSNA: www.jsna.portsmouth.gov.uk

different to any of the previous periods.[23] In 2015/16, Portsmouth's employment rate is significantly lower than the South East region; and lower but not significantly than England.[24]

As at March 2017, unemployment Claimant Count rates were highest in three of the electoral wards in the Central locality: Charles Dickens (3.6% of working age population), Nelson (2.3%), and Fratton (2.0%); and Paulsgrove (2.0%) in the North locality. [25]

The percentage of Portsmouth's young people obtaining five or more GCSEs (including English and Maths) at grades C or above was 53.2% in 2015/16, which was an increase on the previous year (51.1%). The percentage achieving these grades in 2015/16 was still considerably lower than the percentages for England (57.8%) and the South East region (60.3%).[26]

In 2015, the percentage of Portsmouth young people aged 16-18 years not in education, employment or training (NEET) was 5.5%. This is higher than England (4.2%), the South East region (3.9%) and four of Portsmouth's eleven closest ONS Business and Education Centre group statistical comparators. [27]

9.3 Crime and disorder

Overall, levels of recorded crime and anti-social behaviour increased in Portsmouth during 2016/17 (17% and 7% respectively compared to the previous year). The increase in recorded crime in Portsmouth is higher than the average increase seen nationally (10%). It has been largely driven by higher levels of recorded violent crime, although there have been rises in most types of crime. This is thought to be largely due to changes in recording practices since the Her Majesty's Inspectorate of Constabulary (HMIC) Data Integrity Report in 2014, but it is likely that there were 'real' increases in crime during 2016/17 which is supported by calls to Hampshire 101 and 999 increasing by 1.3% and 6.7% respectively.

Domestic abuse continues to be the largest category of violence, accounting for over 29% of assaults (including assaults by spouse/partner not flagged as domestic), rising to 38% when all types of flagged family violence is included. 14.5% of assaults took place in the designated night time economy areas or at licenced premises.

[23] NOMIS. ONS Crown Copyright Reserved. https://www.nomisweb.co.uk accessed 31 May 2017.
[24] Public Health Outcomes Framework (PHOF), Public Health England. http://www.phoutcomes.info
[25] Health Profiles for England. http://fingertips.phe.org.uk/profile/health-profiles [accessed 10 July 2017]
[26] Hampshire County Council. Claimant Ward Reports. http://www3.hants.gov.uk/factsandfigures/figures-economics/hants_labour_market.htm [accessed 31 May 2017]
[27] Public Health Outcomes Framework (PHOF), Public Health England. http://www.phoutcomes.info

9.4 Economy

Portsmouth has over 6,000 businesses within its boundaries. The city has a broad employment base with the largest sectors being engineering, manufacturing, tourism, retail and leisure, business services and public administration.

Like many urban areas, Portsmouth has a net influx of workers commuting into the city. The city a has a strong tourist industry linked to its seaside location, international ferry port, historic dockyard and commercial districts - notably the areas of Commercial Road, Port Solent and Gunwharf Quays.

Portsmouth is an employment hub for the wider region, attracting more commuters in, than sending out – particularly from Havant. However, Portsmouth residents still contribute a significant amount to other local economies, with Portsmouth residents holding 21% of Havant's workplace jobs. There is a similar pattern with commuting flows to Gosport. Collectively, residents from the neighbouring authorities of Havant, Fareham and Gosport constitute 24% of Portsmouth's workforce. Portsmouth is the second largest employment area for Havant, Fareham and Chichester residents, with a quarter of Havant's employed residents working in Portsmouth. In-commuters are over represented in the workplace in the mainland wards.

Portsmouth is home to just over 40% of the working age population of the South East Hampshire area but provides nearly 50% of its jobs. Portsmouth has a strong influence and inter-dependence with the surrounding area, most notably on the economies of Havant and Gosport.

Further analysis indicates that Portsmouth is importing a large proportion of its workforce for more senior occupations from outside of Portsmouth. This goes some way to explain the disparity between higher workplace wages to lower resident wages.

The sectors representing the largest proportion of employment in Portsmouth are: 'Health' (15.1%, 15,000 employees) and 'Public administration' (14.4%, 14,400 employees). Portsmouth has a specialisation in 'information and communication', although this is in line with the South East generally. Portsmouth also has a disproportionately large 'manufacturing' sector compared to comparator cities, although it is in line with the national average. Portsmouth has a small but massively over represented 'aerospace and defence' industry. The same is also true to a certain extent for the 'advanced engineering' and

'marine' sector, which are responsible for a disproportionately large amount of employment in Portsmouth compared to the national average. The voluntary and community sector is vital to the prosperity and well-being of Portsmouth, making a valuable contribution to the economic and social regeneration of the city. The creative, cultural and leisure sector provides significant direct and indirect employment and acts as a catalyst for enhancing employment prospects, urban regeneration and investment in the city. Portsmouth's cultural life is one of the key factors in drawing people to live in and visit the city. [28]

9.5 Major regeneration projects

Major regeneration projects have been identified in several areas of Portsmouth, including The Hard, Somerstown, the City Centre and Tipner. In addition, new student accommodation is planned and is currently being developed in the city centre which is likely to change the distribution of the student population around the city, as well as freeing up existing housing for other groups. This issue will be considered further by the Council as part of the production of the new Local Plan for Portsmouth. The council is undertaking a consultation on Issues and Options for the Local Plan in August and September 2017, following which, further work will be undertaken to arrive at a development strategy for the city.

Further details on developing Portsmouth and regeneration can be found on the Portsmouth City Council website: https://www.portsmouth.gov.uk/ext/development-and-planning/planning/the-local-plan.aspx and https://www.portsmouth.gov.uk/ext/development-and-planning/regeneration/developing-portsmouth.aspx

9.6 Students

In the last academic year (2016/17), the University of Portsmouth had over 24,000 registered students — 75% came from the UK, 4% from China and 2% from Nigeria. There are registered students from 140 other nationalities (these separately accounted for 1% or less of the total student population).

[28] Executive summary - Portsmouth Local Economic Assessment (produced for Portsmouth City Council by the University of Portsmouth's CEAP), Portsmouth JSNA: http://www.hants.gov.uk/pccjsna/API_STR_JSNA_SEC_EMP_ECON_AREA_AX2012_SUMMARY.pdf Accessed 18 July 2014

9.7 Lifestyle and behaviour

9.7.1 Smoking

Estimated prevalence for 2016 is that 20.1% of Portsmouth adults (aged 18+ years) smoke - significantly higher than the estimated prevalence for England and the South East region. The prevalence in Portsmouth had estimated to have decreased from 2010-2015 and the latest 2016 estimate is the first increase; but there is no statistical significance difference between years.[29] However, the most recent (2015) Portsmouth Health and Lifestyle Survey (H&LS) found that 16% of adults (aged 16+ years) smoke tobacco. The Portsmouth H&LS, 2015 found higher proportions of people in the most deprived fifth of neighbourhoods smoke compared to the least deprived fifth (28% compared to 8% respectively). 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). In terms of localities, the Portsmouth H&LS found the highest prevalence of adults smoking daily or occasionally is in the Central locality (22.6%, compared to 16.5% in North locality and 13.2% in South locality).[30]

There is a strong association between deprivation, socio-economic classification and smoking. In 2016, smoking prevalence amongst adults (aged 18+ years) in the 'routine and manual group' (a national statistics socio-economic classification) in Portsmouth (25.3%), is lower but not significantly than the prevalence in this group in England (26.5%).[31]

In 2016/17, the percentage of women registered with a Portsmouth City GP smoking at time of delivery (% SATOD) was 12.4% - lower percentage compared with Southampton (13.8%); but higher than the Wessex Area (regional area of CCGs) (10.7%) and England (10.5%).[32] For 2016/17, for all the geographies mentioned, the % SATOD is the lowest annual percentage recorded.

High smoking attributable admission rates are indicative of poor population health and high smoking prevalence. In 2015/16, the rate of smoking attributable hospital admissions for Portsmouth residents (aged 35+ years) was lower (but not significantly) than England but higher than the South East region.

[29] Annual Population Survey via Local Tobacco Control Profile, Public Health England
[30] Ipsos MORI for Portsmouth City Council. Health and Lifestyle Survey, 2015.
[31] Annual Population Survey via Local Tobacco Control Profile, Public Health England
[32] The Health and Social Care Information Centre, Lifestyle Statistics / Omnibus. Accessed 22 June 2017.

In 2013-15, Portsmouth had a significantly higher rate of smoking-attributable deaths in persons aged 35+ years compared to England. Also, compared to England, Portsmouth had significantly higher rates of deaths from lung cancer (2013-15), deaths from chronic pulmonary disease (2013-15) and lung cancer registrations (2003-15).[33]

9.7.2 Alcohol

The local Health and Lifestyle Survey (2015) found Portsmouth residents aged 16+ years (82%) say they drink alcohol at least occasionally, although the frequency of drinking varies quite widely - one in three (35%) residents says they drink alcohol at least two or three times a week (with one in seven (14%) drinking four or more times a week).
The Portsmouth Health and Lifestyle Survey (2015) found that among those who do drink, around one in five (22%) are drinking to unhealthy levels, consuming at least seven units in a typical day when drinking. Fifty-six per cent 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.
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).

The Portsmouth Health and Lifestyle Survey (2015) findings 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.

Data from the Health Survey for England allows for comparisons to be made with statistical neighbours and in 2011-2014, Portsmouth had a higher percentage of adults (aged 18 years and over) binge drinking on the heaviest day in the last week (20.8%) compared to England (16.5%), the South East (15.5%) and Southampton (9.2%), although Portsmouth is not statistically significantly higher than these areas. Chief Medical Officer guidelines advises that that in order to keep to a low level of risk of alcohol-related harm, adults should drink no more than 14 units of alcohol a week - in 2011-2014, Portsmouth had a lower (but not significantly) percentage drinking more than 14 units of alcohol a week (19.2%) than England (25.7%) and the South East region (26.7%).

[33] Tobacco Control Profiles, Public Health England.

The gender specific alcohol-related admissions measure indicates those adversely affected by alcohol. The broad measure (better than the narrow measure for measuring the burden on community and health services) of the directly aged-standardised rate (DSR) of alcohol-related hospital admissions of all ages in 2015/16 for Portsmouth males was significantly lower than the rate for England; and Portsmouth females was lower, but not significantly, compared to England. However, in 2015/16, the alcohol-specific (admissions wholly attributable to alcohol) admission rate for Portsmouth males and females was significantly higher than the England rate.

In 2013/15, Portsmouth's alcohol-specific mortality rate for males and females was significantly higher than the rates for England.

9.7.3 Excess weight and physical activity

In 2015/16, 23.5% of Year R pupils (aged 4-5 years) and 35.1% of Year 6 pupils (aged 10-11 years) attending a state school in Portsmouth were overweight, including obese. The percentage overweight, including obese for Year R pupils attending Portsmouth schools is higher than England. The percentage overweight, including obese for Year R pupils attending Portsmouth schools is higher (although not significantly higher) than England and the South East region.

The percentage overweight, including obese for Year 6 pupils attending Portsmouth schools is significantly higher than the South East region and higher (although not significantly higher) than England. Since 2006/07, the percentage for overweight, including obese for both age groups attending Portsmouth schools improved.[34]

The national Active People Survey estimates that 24.3% of adults (aged 16 and over) in Portsmouth were obese in 2013-15 —lower, but not significantly than the percentage obese in England. Portsmouth also has a lower (but not significantly) 'excess weight' (overweight, including obese) prevalence than England and the South East. Additionally, of the 2011 ONS Business & Education centre comparators, Brighton & Hove, and Bristol are the only unitary authorities with significantly lower obesity prevalence than Portsmouth. Portsmouth's obesity and 'excess weight' prevalence is similar to Southampton.[35]

[34] National Child Measurement Programme, Health & Social Care Information Centre.
[35] Adjusted BMI from the Active People's Survey via National Obesity Observatory, Public Health England.

The local Portsmouth Health and Lifestyle Survey 2015 (H&LS 2015) of adults (aged 16 years and over) found (by using a similar adjusted BMI method to the Active People Survey) that an estimated 40% of Portsmouth adults are overweight and 27% obese - the adjusted BMI also showed that the North and Central localities had a higher percentage of obese adults (34% and 29% respectively) compared to the South locality (21% obese).

The Active People Survey found that in 2015, 50% of Portsmouth adults meet the recommended '5-a-day' on a 'usual day' - in line with the percentage for England but significantly lower than the South East region.[36]

The Portsmouth Health and Lifestyle Survey of Adults 2015 found that only 33% met or exceeded the recommended daily minimum of five portions. Barriers to healthy eating were lack of time to prepare or cook food (24%), 'lack of willpower' (20%) and the cost of healthy food (19%). 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). [37]

In 2015, the Active People Survey found 60.5% of Portsmouth adults (aged 16 years and over) were physically active[38], which is higher (but not significantly) than England (57.0%) and significantly higher than Portsmouth's ONS Business Centre comparator group (54.2%). The same survey found 25.7% of Portsmouth adults (aged 16 years and over) were physically inactive[39], which is lower (but not significantly) than England (28.7%) and significantly lower than Portsmouth's ONS Business Centre comparator group (31.4%).[40]

The Portsmouth Health and Lifestyle Survey of Adults 2015 (H&LS 2015) found three in five (59%) Portsmouth adults (aged 16 years and over) meet the recommended weekly minimum of either 150 minutes of moderate activity or its equivalent in vigorous activity. The local survey found that the South locality had a significantly higher proportion meeting the recommended weekly minimum physical activity guideline, than the North and Central

[36] Public Health Outcomes Framework, www.phoutcomes.info Accessed 31 January 2017
[37] Ipsos MORI for Portsmouth City Council. Health and Lifestyle Survey, 2015. http://data.hampshirehub.net/data/portsmouth-health-and-lifestyle-survey-2015-report-and-findings Accessed 4 October 2016
[38] Defined as adults doing at least 150 “equivalent” minutes of at least moderate intensity physical activity per week in bouts of 10 minutes or more in the previous 28 days.
[39] Defined as adults less than 30 “equivalent” minutes of at least moderate intensity physical activity per week in bouts of 10 minutes or more in the previous 28 days.
[40] Public Health Outcomes Framework, www.phoutcomes.info

localities (and the Portsmouth average) - 66% in the South compared to 55% and 54% in North and Central.[41]

9.7.4 Substance misuse

When comparisons were possible using the Tell Us Survey, higher percentages of young people aged 10-15 years in Portsmouth (12.8% in 2009/10) reported frequently misusing substances including alcohol, illegal drugs and volatile substances compared with England and the South East region (9.8% for both). The Tell Us Survey was discontinued; but Portsmouth City Council conducted its own Health ('You Say') survey (including substance misuse) amongst Year 8 and Year 10 secondary school age pupils each year from 2010 to 2016 (2014 was part of a wider 'measuring wellbeing survey'). Key findings from the 2016 survey include:

- Ninety-two percent of pupils have never tried drugs (including solvents)
- Cannabis is the most frequently tried drug—16% of pupils have been offered cannabis (9% in Year 8 and 26% in Year 10) but only 8% of pupils have tried it at least once (2% in Year 8 and 10% in Year 10)
- Friends are the most common source of drugs
- The perception that no one of their own age takes drugs was the lowest percentage for Year 10 pupils (6%) since 2012, including significantly lower than 2014 survey (15%).

Year 10 pupils were significantly more likely than Year 8 pupils to:

- perceive half or most of peers take drugs;
- have been offered and used cannabis;

Year 8 pupils were significantly more likely than Year 10 pupils to:

- perceive none of peers take drugs. [42]

The latest estimate from 2011/12 for the number of opiate and/or crack cocaine users (OCUs) is 1,549 (or between 1,291 and 1,917 users) - as a crude rate this is 10.9 per 1,000 population aged 15-64 years, which is estimated to be higher than England, the South East and Southampton. The 2011/12 estimates that 588 (or between 470 to 716) Portsmouth residents inject opiate and/or crack cocaine.[43]

[41] Ipsos MORI for Portsmouth City Council. Health and Lifestyle Survey, 2015.
[42] Portsmouth City Council, 2016. 'You Say' Survey Secondary Schools. http://data.hampshirehub.net/data/portsmouth-secondary-schools-health-survey-2016--you-say
[43] National Treatment Agency, Public Health England. http://www.nta.nhs.uk/facts-prevalence.aspx [Accessed 14 July 2017]

Persons who inject drugs are at increased risk of contracting hepatitis B and C injections. In 2014/15, of Portsmouth residents entering substance misuse treatment, 227 were eligible for a Hep B vaccination, but 4.4% (n=10) of these completed a course of Hep B vaccination, which is significantly lower than the England average (8.7%). However, in 2014/15, of Portsmouth residents entering substance misuse treatment who inject drugs, 563 were eligible for Hep C test of which 510 received a Hep C test (90.6%) - significantly higher than the England average (81.5%).[44]

In 2015, there were 708 clients resident to Portsmouth in treatment for opiate use. Portsmouth's percentage of successful completion of drug treatment for opiate users (ie the percentage who do not re-present within 6 months) was 8.8% (n=62), significantly higher than England (6.7%), and higher but not significantly so than the South East Region (7.2%) and Southampton (5.8%). In 2015, 37.4% (n=67) of Portsmouth's residents receiving treatment for non-opiate drug use was successful which was similar to England (37.3%), lower but not significantly so than the rate for the South East region (37.7%) and significantly higher than the rate for Southampton (23.8%).[45]

In 2015/16, 33.7% of Portsmouth adults with substance misuse treatment need successfully engaged in community-based structured treatment following release from prison. This was higher but not significantly so than the rates for England (30.3%) and the South East region (29.4%), and lower but not significantly so than Southampton (36.5%).[46]

9.8 Sexual health

In Portsmouth, there has been a year-on-year decrease in Chlamydia screening from 2012 to 2016 (46% of people aged 15 to 24 years in 2012 compared to 22% in 2016). In 2016, the percentage aged 15-24 screened in Portsmouth was significantly lower than the rate for Southampton (our geographically nearest statistical neighbour) and significantly higher than the rate for England and the South East. Figure 28 shows a close relationship nationally between the proportion screened for Chlamydia and the Chlamydia detection rate, aged 15-24 years.

[44] Health Protection Profile, Public Health England. http://fingertips.phe.org.uk/health-protection [Accessed 14 July 2017]
[45] Public Health Outcomes Framework Public Health England www.phoutcomes.info Accessed 23 February 2017
[46] Public Health Outcomes Framework Public Health England www.phoutcomes.info Accessed 23 February 2017

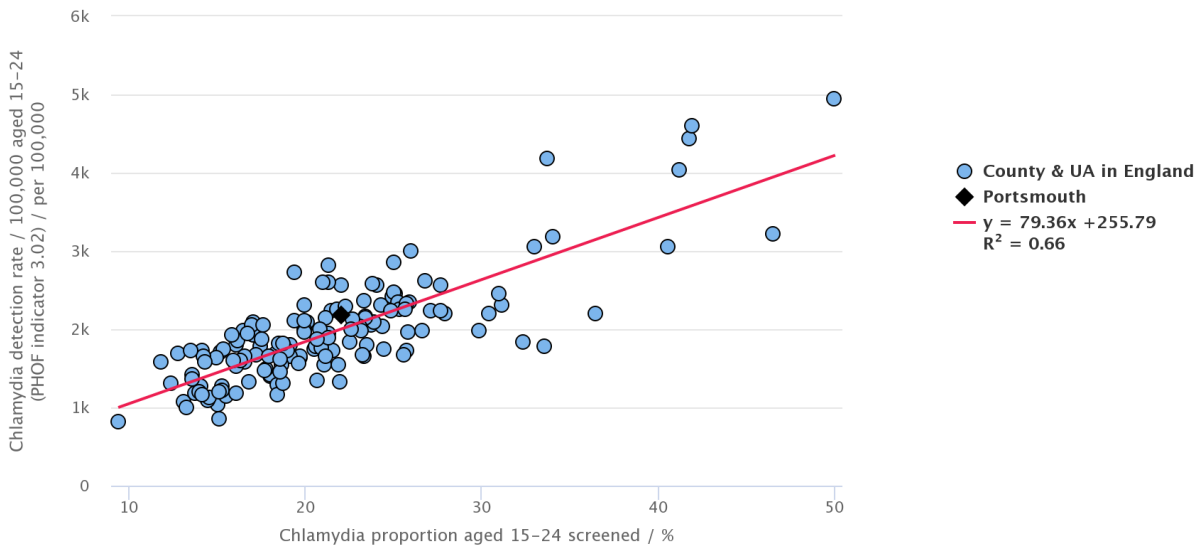


Figure 28. Proportion of aged 15-24 population screened for Chlamydia, 2016 compared to Chlamydia detection rate per 100,000 young people aged 15-24, 2016, by Unitary Authorities. Source: Sexual and Reproductive Health Profiles, Public Health England.

In line with national and regional trends, Portsmouth's coverage of cervical screening in women aged 25-64 years has declined since 2010. Measured on 31 March each year; in 2016, Portsmouth's rate was 68.1% - significantly lower than both the national and regional rates—a 1.5 percentage point decrease from 2015. [47]

In 2016, Portsmouth had a significantly higher rate of all new STIs compared to England (977 per 100,000 population, all ages compared to 750 per 100,000 population, all ages). In 2016, the Portsmouth rate for new STI diagnoses excluding Chlamydia aged under 25 years was higher, but not significantly than England (836 per 100,000 population, aged 15-64 years compared to 795 per 100,000 population, aged 15-64 years). Perhaps unsurprisingly, Figure 29 shows the new STI diagnoses rate is strongly correlated with the STI testing rate - in 2016, Portsmouth had a significantly higher STI testing rate than England; but has a similar testing rate compared to the following local authorities in the same ONS Business & Education Centre comparator group: Southampton, Nottingham, Newcastle and Kingston Upon Thames. Of these local authorities, in 2016, Portsmouth had a significantly lower new STI diagnosis rate (excluding Chlamydia aged under 25 years) per 100,000 population aged 15-64 years than Southampton, Newcastle and Kingston Upon Thames; but a similar rate compared to Nottingham. In 2016, Portsmouth and Nottingham also have the lowest STI testing positivity rate (3.6%) in the ONS Business & Education Centre group.

[47] Public Health England. Public Health Outcomes Framework. Indicator 2.201i Accessed 24 March 2017

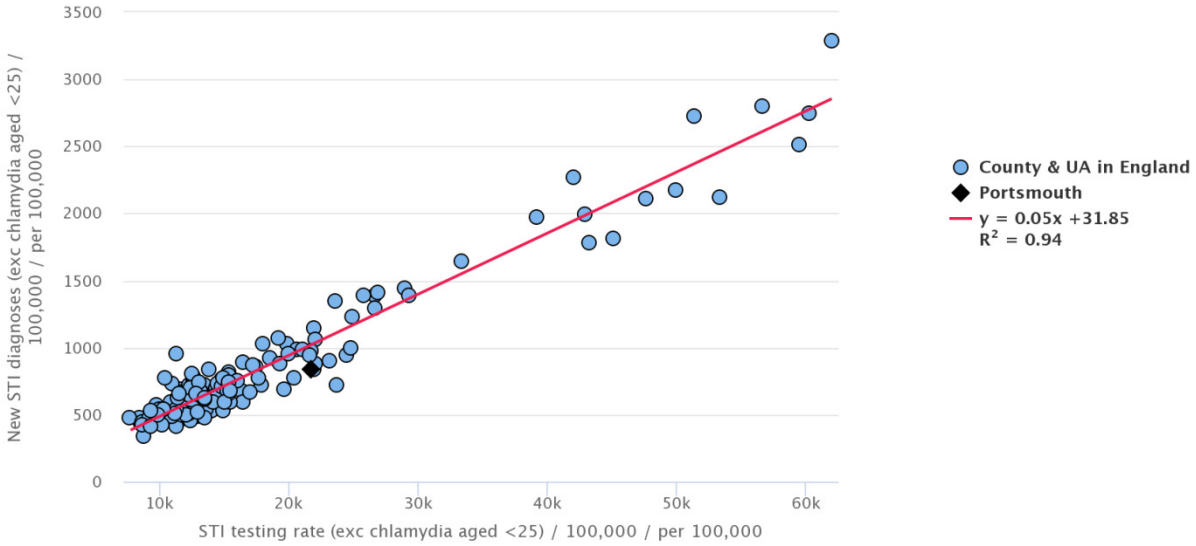


Figure 29. New STI diagnoses (exc chlamydia aged <25) per 100,000 aged 15-64 years, 2016 compared to STI testing rate (exc chlamydia aged <25) aged 15-64 years, 2016; by Unitary Authorities. Source: Sexual and Reproductive Health Profiles, Public Health England.

In 2016, Portsmouth residents aged 15-24 years had a significantly higher rate of diagnoses of Chlamydia (2,187 per 100,000 persons aged 15-24 years) than England and the ONS Business & Education Centre group; but a significantly lower rate than Southampton. In 2016, Portsmouth also had a similar Chlamydia diagnoses rate (aged 15-24 yrs) compared to some local authorities with a similar proportion screened for Chlamydia in the ONS Business & Education Centre group: Manchester, Salford, Nottingham; however, Leeds had a significantly higher detection rate; but Kingston Upon Thames had a significantly lower detection rate than Portsmouth. Portsmouth's rate remains lower than PHE's recommended detection rate of at least 2,300 per 100,000 population aged 15-24 years.

Common STIs in Portsmouth are anogenital warts (163 persons diagnosed per 100,000 persons of all ages, in 2016), herpes (71 persons diagnosed per 100,000 persons of all ages, in 2016), gonorrhoea (56 persons diagnosed per 100,000 persons of all ages, in 2016) and syphilis (12 persons diagnosed per 100,000 persons of all ages, in 2016).

In 2016, Portsmouth had higher rates of anogenital warts and herpes in persons of all ages compared to England, South East region and Southampton. Portsmouth had lower rates (but not significantly) of gonorrhoea than England and Southampton. Portsmouth had higher rates (but not significantly) of syphilis than England, the South East region and Southampton.

Between 2013 and 2015, the rate of anogenital wart diagnoses had decreased in Portsmouth (following national and regional trends), but the rate of anogenital wart diagnoses in 2016 is similar to 2015 rates. Between 2013 and 2016, herpes diagnoses decreased in Portsmouth; but remained significantly higher than England and SE region. Between 2013 and 2015, the rate of gonorrhoea diagnoses had increased nationally, regionally and in Portsmouth since 2009; but in 2016 there was a non-significant decrease in those areas. Syphilis numbers have increased again in Portsmouth in 2016, but the numbers remain relatively small (<20); however, the rate has been increasing nationally and regionally, especially since 2014. [48]

The local rate of people aged 15-59 years diagnosed with human immunodeficiency virus (HIV) has been lower than the regional and national rates since 2005. Prevalence of HIV in Portsmouth in 2015 was 1.82 per 1,000 persons aged 15-59 years (slightly lower than England and Southampton). In 2015, the new HIV diagnosis rate in Portsmouth was 8.6 per 100,000 population aged 15 years and over - lower (but not significantly) than England. In Portsmouth, for 2013-15, 39.6% of such viruses were diagnosed late for aged 15 years and over (lower but not significantly than England, Southampton and the South East region). In 2013-15, the percentage of those diagnosed late was lower (but not significantly) than the nationally set target (50%) - previous years the percentage had been higher. [49]

9.8.1 Teenage conception and abortions

In 2015, the teenage conception rate, aged under 18 years, in Portsmouth increased to 25.2 per 1,000 females aged 15-17 years (n=81). In 2015, the Portsmouth under 18 years conception rate was higher than England (20.8 per 1,000 females aged 15-17 years) and the South East (17.1 per 1,000 females aged 15-17 years); but was lower than Southampton (n=99; 29.0 per 1,000 females aged 15-17 years). The 2013-15 (three-year pooled) under 18 years conception rate for Portsmouth (24.2 per 1,000 females aged 15-17 years) was significantly lower than Southampton; but significantly higher than the South East region; and higher (but not significantly) than England.

The three-year pooled trend in the under 16 years conception rate for Portsmouth continues to decrease (5.7 per 1,000 females aged 13-15 years in 2013-15, compared to 7.0 in 2012-14) and remains lower than Southampton (7.5 per 1,000 females aged 13-15), but higher

[48] Sexual and Reproductive Health Profiles, PHE Fingertips. Accessed July 2017.
[49] Public Health England Sexual and Reproductive Health Profiles. Accessed August 2016.

than England (4.3 per 1,000 females aged 13-15) and the South East region (3.4 per 1,000 females aged 13-15) in 2013-15. [50]

There are electoral wards in each locality which have significantly higher under 18 year old conception rates than England—Paulsgrove ward, in the North of the City; Charles Dickens, in the Central locality; and St.Thomas ward in the South locality, all have higher rates than England, in 2012-14. (Figure 30)

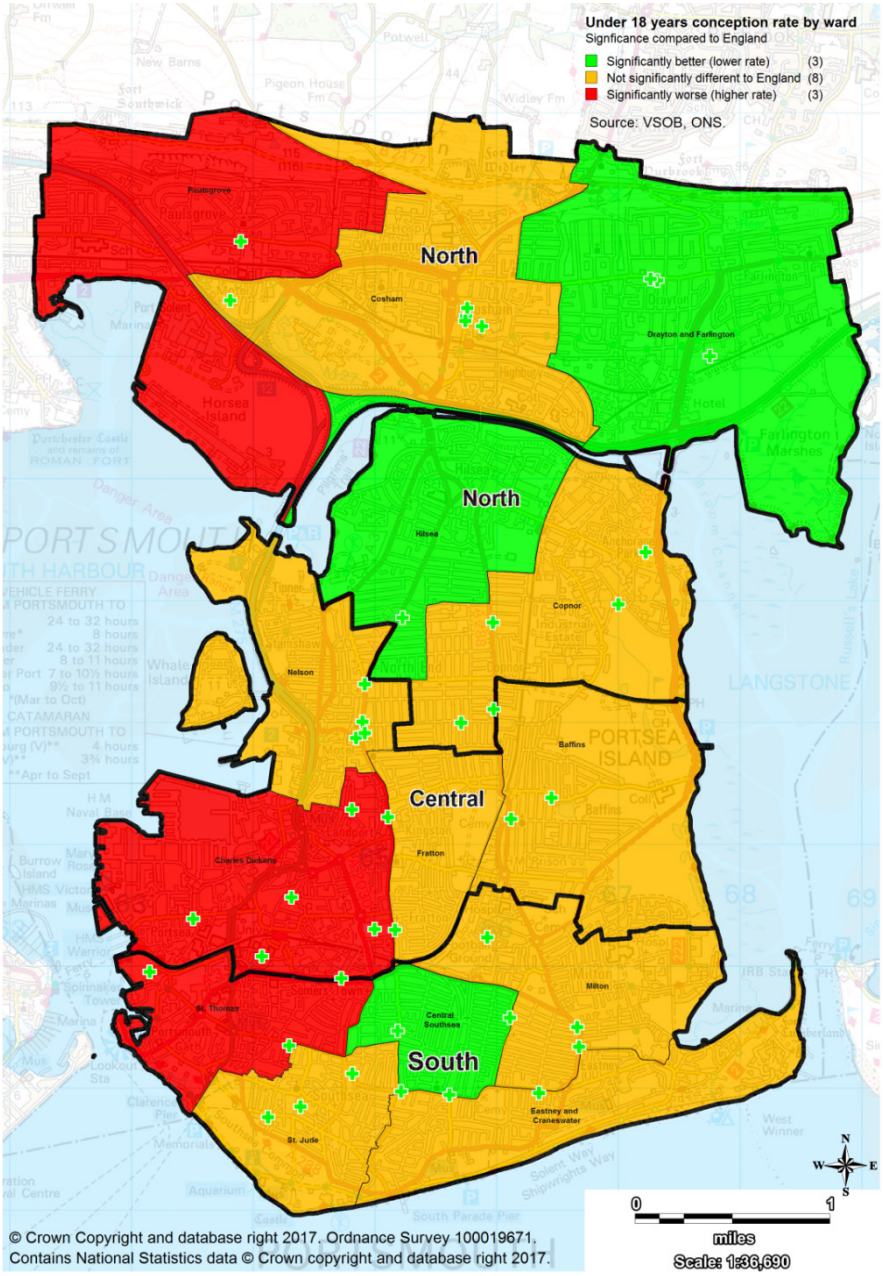


Figure 30. Map of Portsmouth comparing the electoral ward under 18 years conception rate to England, 2012-14, overlaid by localities and pharmacies.

[50] Table 7, VSOB, Office for National Statistics © Crown Copyright via Portsmouth JSNA: www.jsna.portsmouth.gov.uk

The abortion rate is one measure of unwanted pregnancies. In 2013-15, 56.6% of conceptions to under 16 year olds in Portsmouth led to abortion—a lower percentage than England and the South East region; but higher than Southampton. The percentage of conceptions leading to abortion in Portsmouth in 2013-15 was the highest since 2008/10. [51]

In 2015, Portsmouth's abortion rate in females aged under 18 years is 12.1 per 1,000 females aged 15-17 years. The local abortion rate for females aged under 18 years was lower than Southampton; but higher than England and the South East. However, single year abortion rates are subject to fluctuation: in 2012, Portsmouth's rate was higher than England, the South East and Southampton. In 2015, 48.1% of conceptions to Portsmouth women aged under 18 year olds led to abortion—a lower percentage than England and the South East region. [52]

In 2016, for women of all ages, the age-standardised abortion rate in Portsmouth was 18.0 abortions per 1,000 women aged 15-44 years. This is significantly higher than England, the South East and Southampton. Abortions are safer when carried out in early pregnancy—before 10 weeks. [53] Since 2004, over 70% of NHS-funded abortions to women from Portsmouth have been carried out before 10 weeks (86% in 2016 – higher than the rates for the Wessex region and Southampton). [54] In 2016, of the Portsmouth women aged under 25 years having an abortion, 23.3% had had a previous abortion; and of the Portsmouth women aged 25 years and over having an abortion, 50% had had a previous abortion. [55]

9.9 Skin cancer

In 2012-14, Portsmouth's incidence of malignant melanoma was 33 registrations per 100,000 persons of all ages; and there was no significant difference between males and females for Portsmouth CCG. The Portsmouth incidence rate is significantly higher than the rate for England; but not significantly different to Southampton CCG nor Brighton & Hove CCG for persons, males and females. [56]

[51] Table 7, VSOB, Office for National Statistics © Crown Copyright via Portsmouth JSNA: www.jsna.portsmouth.gov.uk
[52] Table 6, VSOB, Office for National Statistics © Crown Copyright via Portsmouth JSNA: www.jsna.portsmouth.gov.uk
[53] DH Abortion Statistics © Crown Copyright. Table 10d via Portsmouth JSNA: www.jsna.portsmouth.gov.uk
[54] DH Abortion Statistics © Crown Copyright. Table 11a via Portsmouth JSNA: www.jsna.portsmouth.gov.uk
[55] DH Abortion Statistics © Crown Copyright. Table 11b.
[56] CancerData, Public Health England and NHS England. https://www.cancerdata.nhs.uk [accessed 19 Jun 2017].

9.10 Tuberculosis (TB)

In 2013-15, Portsmouth's rate of new TB notifications was 7.5 per 100,000 persons of all ages (47 new cases). The rate has been decreasing since 2008-10. The Portsmouth incidence rate is significantly lower than the England rate (12 per 100,000 persons of all ages); however, Portsmouth's TB incidence rate is amongst the top 50th percentile of upper tier local authorities.[57] Nationally, in 2015, 7.4% of TB cases had first line drug resistance which was predominantly the drug Isoniazid (6.9% of TB cases). [58]

9.11 Antibiotic prescribing

Reductions in antibiotic consumption is a well-recognised target in Antimicrobial Resistance (AMR) policies across PHE, the NHS, DH and internationally, including the WHO. In 2016, Portsmouth's adjusted rate of antibiotic prescribing in primary care was 1.07 per STAR-PU (Specific Therapeutic group Age-sex weightings Related Prescribing Unit), which is significantly better (lower) than the England rate in 2016; and is also better than the benchmarked England 2013/14 mean prescribing rate of 1.161.[59] A target of antibiotic prescribing is to reduce the proportion of broad spectrum antibiotics (cephalosporin, quinolone and co-amoxiclav class) consumed— the Portsmouth twelve month rolling percentage of these broad spectrum antibiotics was 8.6% as at March 2017, which is similar to the England average (although the percentage has not been adjusted for the confounding effects of age and sex).

Uncomplicated urine infections are normally treated empirically within the community with the recommended first line drugs, trimethoprim or nitrofurantoin. Nitrofurantoin is the recommended first line treatment for urinary tract infections in adults in primary care. As at March 2017 for Portsmouth, 67% of trimethoprim and nitrofurantoin items prescribed were for trimethoprim (twelve month rolling proportion). This has been decreasing monthly since January 2015. As at March 2017, Portsmouth is above the target of 95% for the percentage of E.coli urine specimens with antimicrobial susceptibility tests for both trimethoprim and nitrofurantoin (97% and 96%, respectively).

[57] Public Health Outcomes Framework, Indicator 3.05ii, Public Health England. http://www.phoutcomes.info Accessed 7 September 2017.
[58] TB case notifications with drug resistance, England, 2005 to 2015, Public Health England. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/554426/TB_case_notifications_with_drug_resistance__England__2000_to_2015.pdf Accessed 7 September 2017.
[59] Public Health Outcomes Framework, Indicator 3.08, Public Health England. http://www.phoutcomes.info Accessed 7 September 2017.

As at March 2017, 33.4% (n=135) of specimens (first identified patient E. coli or coliform urine specimens, which were taken in a community setting) which have been tested for susceptibility to trimethoprim were found to be resistant for patients in Portsmouth CCG. This percentage of E. coli urine specimens non-susceptible to trimethoprim is higher than the England average.

As at March 2017, 2.7% (n=11) of specimens (first identified patient E. coli or coliform urine specimens, which were taken in a community setting) which have been tested for susceptibility to nitrofurantoin were found to be resistant for patients in Portsmouth CCG. This percentage of E. coli urine specimens non-susceptible to nitrofurantoin is similar to the England average.[60]

9.12 Healthcare associated infections (HCAI)

In 2016/17, Portsmouth CCG's (Portsmouth CCG registered patients or resident to Portsmouth) rate of Clostridium difficile infections was 17 per 100,000 persons aged 2+ years (36 cases), which is lower than the England rate.

In 2016/17, there were three cases of Meticillin Resistant Staphylococcus aureus (MRSA) infections attributed to Portsmouth CCG patients (Portsmouth CCG registered patients or resident to Portsmouth) —1.4 per 100,000 persons of all ages, which is similar to the England rate. [61]

9.13 Screening and protection

In 2015/16, Portsmouth's immunisation coverage of children aged 1 year for Pneumococcal disease (PCV) (96.0%); Diphtheria Tetanus, pertussis, polio and Haemophilus influenzae type b (DTaP/IPV/Hib) (96.2%) were higher than the England rate. Portsmouth's coverage rate for Meningococcal group C (MenC) was 97.6% in 2015/16, but could not be compared to the England average due to data quality reasons nationally. Portsmouth met the national target of 95% coverage for all vaccinations for children aged 1 year.

[60] AMR local indicators, Public Health England. https://fingertips.phe.org.uk/profile/amr-local-indicators/ Accessed 7 September 2017.
[61] AMR local indicators, Public Health England. https://fingertips.phe.org.uk/profile/amr-local-indicators/ Accessed 7 September 2017.

In 2015/16, Portsmouth's immunisation coverage of children aged 2 years for PCV booster vaccine (95.9%); first dose of Measles, Mumps and Rubella (MMR) vaccine (95.6%); the combined Haemophilus influenza type b and meningitis C (Hib/menC) booster vaccine (95.7%); and DTaP/IPV/Hib (97.6%) were all higher than the England rate and all met the national target of 95% coverage.

In 2015/16, Portsmouth's immunisation coverage for children at their fifth birthday completing MMR (1st and 2nd dose) (89.3% receiving both doses, although 96.1% received at least the 1st dose); receiving a fourth dose of Diphtheria, Tetanus, Polio and Pertussis (DTaP/IPV) vaccine (booster) (85.7%); Hib/menC (92%) were all lower than the national target of 95% coverage (except first dose of MMR (MMR1)) and only MMR1 was a significantly higher coverage rate than England. [62]

Immunisation against the human papillomavirus (which causes 70% of cases of cervical cancer) was introduced in 2008/09 and was initially a three dose programme and is offered through educational establishments. In 2015/16, Portsmouth's vaccination coverage for one dose of human papillomavirus (HPV) for girls aged 12-13 years (Year 8) was 94.2% - a decrease on the previous year and remains above the 90% target; however, coverage rates for both years were significantly higher than England and South East region rates. [63]

In 2016/17, the Portsmouth 'seasonal flu' vaccine coverage rate in the population aged 65+ years was 72.8%, which is lower than the national target of 75% (a continued decrease since 2013/14). The rate for Portsmouth in 2016/17 was higher than the coverage rates for England and the South East region. [64]

In 2016/17, the Portsmouth 'at-risk individuals' vaccine coverage rate in the population aged 6 months to under 65 years (at risk individuals from age six months to under 65 years, excluding otherwise 'healthy' pregnant women and carers) was 49.5%, which is lower than the national target of 55% (an increase from 2015/16, but lower than 2014/15). The rate for Portsmouth in 2016/17 was higher than the coverage rate for the South East region and England.

[62] HSCIC: NHS Immunisation Statistics, England - 2015-16. http://content.digital.nhs.uk/catalogue/PUB21651 Accessed 18th May 2017 Portsmouth JSNA: www.jsna.portsmouth.gov.uk
[63] Public Health England, Annual HPV Vaccine Coverage in England Annual report. https://www.gov.uk/government/statistics/annual-hpv-vaccine-coverage-2015-to-2016-by-local-authority-and-area-team [Accessed 16 December 2016] via Portsmouth JSNA: www.jsna.portsmouth.gov.uk
[64] Public Health Outcomes Framework, Public Health England via Portsmouth JSNA: www.jsna.portsmouth.gov.uk [Accessed 1 August 2017]

In 2013-14, a new childhood influenza vaccine programme was started. In 2016/17, the Portsmouth 'aged 2-4 year old' vaccine coverage rate was 40.2%, which is within the minimum expected range of above 40%, but lower than the national target of 65% (an increase from 2015/16). The rate for Portsmouth in 2016/17 was higher than the coverage rate for England; but similar to the South East region. [65]

In addition to cervical cytology screening and chlamydia screening mentioned in the Sexual health section, there are other screening programmes including a number of antenatal and new-born screenings, and other young people and adult screening programmes: diabetic retinopathy, breast cancer screening, bowel cancer screening and Abdominal Aortic Aneurysm (AAA) screening. Although not strictly a screening programme, the NHS Health Checks programme is offered to people aged 40-74 years aiming to help prevent heart disease, stroke, diabetes and kidney disease for those not already diagnosed.

As at March 2016, Portsmouth's coverage of breast screening for female residents aged 53 to 70 years was 72.2%. Portsmouth's coverage continued to be significantly lower than the rates for the South East (77.1%) and England (75.5%); but higher than the ONS Business Centres comparator group (71.4%). Portsmouth's coverage as at March 2016 is the highest percentage coverage since March 2013. [66]

In 2016, the bowel cancer screening coverage rate (% of residents screened adequately within the previous two and a half years, out of those eligible for bowel screening) for 60-74 year olds in Portsmouth (57.2%) was lower than the coverage rate for England (57.9%) but higher than the ONS Business Centres comparator group (53.1%). [67]

In 2015/16, the Abdominal Aortic Aneurysm (AAA) screening coverage rate for males aged 65 years old in Portsmouth (81.6%) was similar to the England rate (79.9%) but higher than the ONS Business Centres comparator group (75.7%). [68]

[65] Public Health Outcomes Framework, Public Health England via Portsmouth JSNA: www.jsna.portsmouth.gov.uk [Accessed 1 August 2017]
[66] Public Health Outcomes Framework, Public Health England www.phoutcomes.info via Portsmouth JSNA: www.jsna.portsmouth.gov.uk [Accessed 24 July 2017]
[67] Public Health Outcomes Framework (Indicator 2.20iii) http://www.phoutcomes.info/ via Portsmouth JSNA: www.jsna.portsmouth.gov.uk [Accessed 25 July 2017]
[68] Public Health Outcomes Framework (Indicator 2.20iv) http://www.phoutcomes.info/ [Accessed 25 July 2017]

In 2015/16, 85.8% of Portsmouth CCG registered patients with diabetes aged 12+ years, had retinal screening (as a proportion of those offered screening)—this is higher than the proportion for England (82.8%). [69]

In 2015/16, the newborn blood spot screening coverage rate in Portsmouth (99.7%) was higher than the rates for England (95.6%) and the South East region (97.1%). The newborn hearing screening coverage rate in Portsmouth (99.0%) was higher than the rates for England (98.7%) and the South East region (98.7%). [70]

The cumulative percentage of eligible population aged 40-74 years offered an NHS Health Check who received an NHS Health Check (in the five years period 2013/14 to 2017/18) was 31.7%—this is significantly worse than the proportion for England (48.6%). [71]

9.14 Lesbian, gay, bisexual and transgender community

Official statistics on lesbian, gay, transgender (LGBT) communities have not been routinely collected nationally (e.g. Censuses) or locally; and the survey findings have been mixed. In 2015, the Office for National Statistics (ONS) estimated that 1.7% of the UK population identified themselves as lesbian, gay or bi-sexual (LGB)[72]—however, this could be a low estimate due to the telephone and face-to-face survey methodology used[73]. The ONS estimate is much lower than the preceding UK government estimate that 5% to 7% of the UK population are lesbian, gay or bi-sexual. Portsmouth City Council Equality & Diversity strategy 2014-17 estimates the LGBT community to be several thousand people in Portsmouth[74]. Applying national estimates (5-7%) roughly to the Portsmouth population aged 16 years and over gives an estimated population of 8,600 to 12,200 (rounded to the nearest 50).

[69] Diabetic eye screening services, Public Health England. https://www.gov.uk/government/publications/diabetic-eye-screening-2015-to-2016-data Accessed 25 July 2017.
[70] Public Health Outcomes Framework (Indicators 2.20xi and 2.20xii) http://www.phoutcomes.info/ [Accessed 25 July 2017]
[71] Public Health Outcomes Framework (Indicators 2.22iv) http://www.phoutcomes.info/ [Accessed 25 July 2017]
[72] Office for National Statistics. Annual Population Survey: January 2015 to December 2015 (Experimental Statistics).
[73] Producing estimates of the size of the LGB population of England: Technical Report 2 - methodology for synthesis, Public Health England. https://www.gov.uk/government/publications/producing-estimates-of-the-size-of-the-lgb-population-of-england [Accessed 3 February 2017]

[74] Portsmouth City Council Equality & Diversity strategy 2014-17. http://democracy.portsmouth.gov.uk/documents/s1749/Appendix%20B%20-%20Equality%20Diversity%20Strategy.pdf Accessed 25 July 2014.

Alternatively, Portsmouth City carried out a Health & Lifestyle postal and online Survey in late 2015 (H&LS 2015) and one of the questions asked was: "How would you describe your sexual orientation?" The survey found 4% described themselves as LGB (or 6% male and 2% female) which does not include those stating 'I prefer not to say' nor 'none of these', so the prevalence could be higher (up to 9.5% persons: 11% male and 8% female, if included). In the South locality, 7% described themselves as LGB, which is significantly higher than the North locality and City average. [75] Applying the 4% LGB estimates from the H&LS 2015 to the ONS 2014-based subnational population projection for 2018 suggests that roughly 7,050 of adults aged 16 and over identify themselves as LGB (5,350 male and 1,700 female) rounded to the nearest 50; but including those stating 'I prefer not to say' and 'none of these' as potentially LBT (although not identified as so) then there could be roughly 16,700 LGB adults in Portsmouth aged 16 and over (9,800 male and 6,900 female). Comparing this to the GP patient survey (also a postal and online survey) results for Portsmouth CCG in 2017 (coterminous, but not all CCG patients are resident to Portsmouth); the estimates are quite similar, but 3% LBT (persons) with 5% 'prefer not to say' and 1% stating 'other'.

The EU LGBT 2012 survey found that 44% of UK respondents felt discriminated against or harassed in the 12 months preceding, on the grounds of sexual orientation. Fourteen per cent of UK respondents felt discriminated against, because of being LGBT, by healthcare personnel (of these 18% of bisexual, 19% of lesbian and 26% of transgender respondents felt discriminated against). Five per cent of respondents experienced difficulty in gaining access to healthcare and 8% felt they had received unequal treatment when dealing with medical staff—significantly higher amongst transgender respondents (25% and 21% respectively). [76]

9.15 Long term conditions

At the time of the 2011 Census, 11.6% of Portsmouth residents aged 16-64 years (working age) and 54.9% of Portsmouth residents aged 65 years and over declared a long-term health problem or disability that limits their day-to-day activity a lot or a little. The highest percentage for both working age (13.9%) and aged 65+ years (59%) is in the Central locality of the city (Figure 31 and Figure 32) with Charles Dickens ward having almost 1 in 5 working age adults with a limiting long term illness (LLTI). The North of the city has the second

[75] Ipsos MORI for Portsmouth City Council. Health and Lifestyle Survey, 2015.
[76] Portsmouth City Council Equality & Diversity strategy 2014-17. Ibid.

highest percentage reported LLTI for working age people (12.1%); although the South has the second highest percentage reported LLTI for aged 65+ years (54.2%).

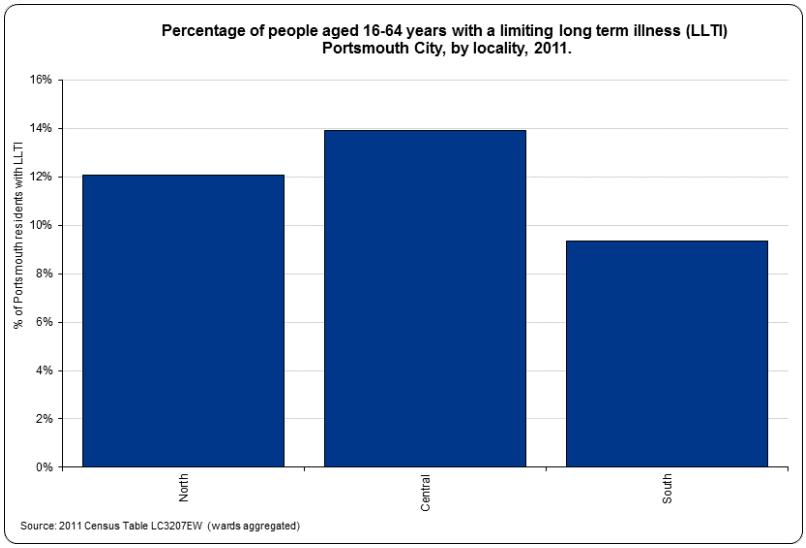


Figure 31. Percentage of people aged 16-64 years with a limiting long term illness (LLTI), Portsmouth City, by locality, 2011.

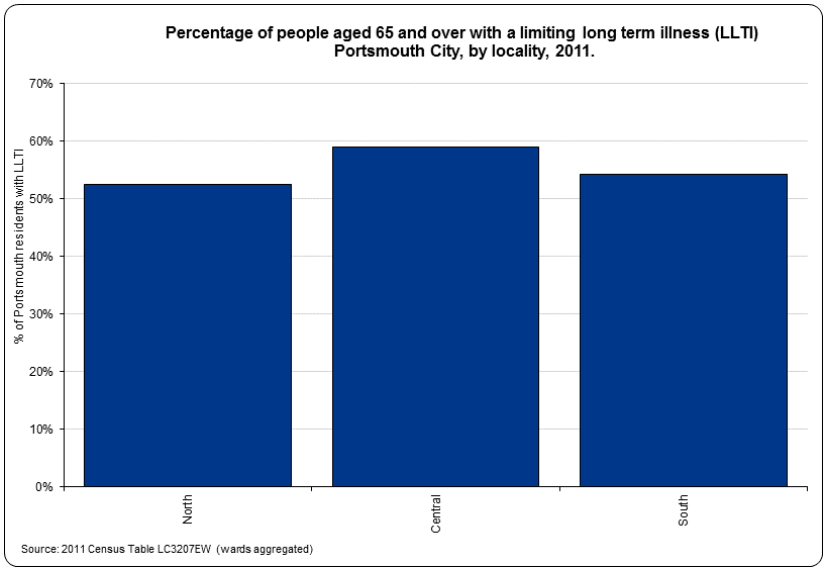


Figure 32. Percentage of people aged 65 and over with a limiting long term illness (LLTI), Portsmouth City, by locality, 2011.

The more recent Portsmouth Health & Lifestyle Survey 2015 found over half of adult residents aged 16 and over 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 single conditions among residents are high-blood pressure (16%) and arthritis or long-term joint problems (16%), followed by long-term back problems (14%). 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). [77]

Poor health in childhood and adolescence can have a significant impact on overall life chances, with certain unhealthy behaviours having medium to long-term impacts on health. The national What About YOUth (WAY) survey, 2014/15 found that 16.8% of 15 year olds in Portsmouth responded that they had a long-term illness, disability or medical condition diagnosed by a doctor—this is higher than the proportion for England (14.1%).[78]

9.15.1 Prevalence and modelled prevalence of long term conditions

There are major differences between modelled prevalence (taking into account various risk factors such as age, sex, ethnicity, smoking status and deprivation) and locally recorded prevalence for many long-term conditions (NB the information below does not reflect co-morbidities):

9.15.1.1 Hypertension

In 2015/16, hypertension is the most common condition on GP registers with 26,448 patients or 11.9% of registered patients of all ages, on hypertension registers. The range at practice level was from 20.5% at Northern Road Surgery to Sunnyside Medical Centre at 9.7% (excluding Guildhall Walk and the University Practice prevalence rates). Portsmouth CCG recorded prevalence is lower than the prevalence figures for England (13.8%). However, this is likely to be an underestimate of the prevalence of hypertension in Portsmouth. Modelled prevalence based on self-reported responses from the Health Survey for England

[77] Ipsos MORI for Portsmouth City Council. Health and Lifestyle Survey, 2015 via Portsmouth JSNA.
[78] What About YOUth (WAY) survey,Health behaviours in young people Profile, Public Health England. http://fingertips.phe.org.uk/child-health-behaviours [Accessed 01 August 2017]

estimates that in 2015, 17.2% of Portsmouth residents aged 16 years and over have been diagnosed with hypertension (based on survey respondents stating they were told by a nurse or doctor they had high blood pressure) and a further 10.9% of Portsmouth residents aged 16+ years are estimated to also have hypertension but undiagnosed (derived from those respondents that, first, were considered uncontrolled or untreated hypertensive and second, they did not report having been diagnosed high blood pressure) —roughly 30,000 residents aged 16 years and over expected to be diagnosed with hypertension and there may be roughly, a further 18,800 residents aged 16+ years undiagnosed with hypertension.[79]

9.15.1.2 Diabetes

In 2015/16, 10,453 people aged 17+ years (5.8% of people aged 17+ years registered with Portsmouth City GP Practices) are on GP registers either Type 1 or Type 2 diabetes - lower than England (6.5%). Portsmouth's recorded prevalence of diabetes has increased annually from 4.9% in 2010/11. [80]

However, modelled prevalence of diagnosed and undiagnosed diabetes (taking into account age, sex, ethnicity and deprivation) suggests that in 2016 there may be approximately 12,450 Portsmouth residents aged 16+ years or 13,400 Portsmouth CCG registered patients aged 16+ years with diabetes in the city[81] (compared with 10,453 registered patients aged 17+ years on the diabetes register in 2015/16, 5.8% prevalence[82]) - the modelled prevalence suggests that there may be roughly 3,000 Portsmouth CCG registered patients undiagnosed/ not on the diabetes register.

Modelled prevalence is predicted to increase from 7.2% to 8.1% between 2015 and 2035 but assumes no change in the age, sex and ethnicity; and also assumes no change in the proportion of people who are overweight or obese[83]. However, Public Health England have provided scenarios on the potential impact of changing obesity levels on diabetes prevalence in the city (note: it also assumes there to be no change in age, sex and ethnicity):

[79] Disease and risk factor prevalence, Public Health England https://fingertips.phe.org.uk/profile/prevalence via Portsmouth JSNA: www.jsna.portsmouth.gov.uk [Accessed 04 August 2017]
[80] Quality and Outcomes Framework (QOF) prevalence. PHE Diabetes Profile http://fingertips.phe.org.uk/diabetes Accessed 5 October 2016
[81] Diabetes prevalence model for local authorities and CCGs. PHE. https://www.gov.uk/government/publications/diabetes-prevalence-estimates-for-local-populations Accessed 08 August 2017
[82] Quality and Outcomes Framework (QOF) prevalence, NHS Digital. http://www.content.digital.nhs.uk/catalogue/PUB22266 Accessed 28 October 2016.
[83] PHE. Diabetes prevalence model for local authorities and CCGs. https://www.gov.uk/government/publications/diabetes-prevalence-estimates-for-local-populations Accessed 08 August 2017

Scenario: the 2015 level of obesity *increases by 5%* every 5 years –it is estimated there would be 13,350 (7.6%) Portsmouth residents aged 16+ years with diabetes in 2020. This represents an additional 300 people with diabetes compared to if obesity levels remained unchanged. By 2035, it is estimated that there would be 17,100 (8.8%) people with diabetes if obesity levels continued to increase at the same rate. This represents an additional 1,450 residents aged 16+ years.

Scenario: the 2015 level of obesity *decreases by 5%* every 5 years – it is estimated there would be 12,800 (7.3%) Portsmouth residents aged 16+ years with diabetes in 2020. This represents 300 fewer people with diabetes compared to if obesity levels remained unchanged. By 2035, if obesity levels continued to decline at the same rate, it is estimated that there would be 14,400 (7.4%) residents with diabetes. This represents 1,250 fewer residents aged 16+ years. [84]

Non-diabetic hyperglycaemia, also known as pre-diabetes or impaired glucose regulation, refers to raised blood glucose levels, but not in the diabetic range. People with non-diabetic hyperglycaemia are at increased risk of developing Type 2 diabetes. They are also at increased risk of other cardiovascular conditions. PHE modelled estimates for Portsmouth in 2015 suggest the prevalence of non-diabetic hyperglycaemia to be 9.4% (16,250 people) of the population aged 16 years and over - Portsmouth has a lower estimated prevalence than average due to a lower elderly population than average. [85]

9.15.1.3 Coronary heart disease

In 2015/16, there were 6,167 patients on the coronary heart disease (CHD) register (2.8% of registered patients of all ages compared with 3.2% in England). The range at GP practice level was from 4.2% of registered patients of all ages at Northern Road surgery to 2.4% at the Derby Road practice (excluding Guildhall Walk Healthcare Centre and the University Practice). [86]

[84] Estimating the impact of obesity on diabetes prevalence. https://www.gov.uk/government/publications/diabetes-prevalence-estimates-for-local-populations Accessed 08 August 2017

[85] NHS Diabetes Prevention Programme (NHS DPP): Non-diabetic hyperglycaemia analysis, Public Health England. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/456149/Non_diabetic_hyperglycaemia.pdf [Accessed 25 July 2017].

[86] Disease and risk factor prevalence, Public Health England https://fingertips.phe.org.uk/profile/prevalence [Accessed 04 August 2017]

Modelled prevalence of CHD was derived from various sources including self-reporting; definite angina, hospitalisation or death from CHD, abnormal ECGs, medication or other treatment for CHD. In 2015, the estimated prevalence for CHD is 8.2% of Portsmouth residents aged 55-79 years[87] —roughly 3,400 people (applying the prevalence rate to the ONS 2014-based subnational population estimates). Assuming the CHD prevalence remains the same in future years, the ageing population in Portsmouth would indicate a greater number of residents aged 55-79 years with CHD—roughly 4,100 people aged 55-79 years by 2025 (applying the prevalence rate to the ONS 2014-based subnational population estimates). However, CHD prevalence is also modelled on various risk factors which are likely to change over time such as prevalence of diabetes, smoking, hypertension, obesity, physical activity, dyslipidaemia (high total cholesterol, low high density lipoproteins (HDL), and high low density lipoproteins (LDL), deprivation, Chronic Kidney Disease (CKD). [88]

Between 2014 and 2016, coronary heart disease (also known as ischaemic heart disease) was the second most frequent broad cause of death for Portsmouth residents of all ages (537 deaths, 10% of all deaths).[89]

9.15.1.4 Chronic obstructive pulmonary disease

In 2015/16, there were 4,493 registered patients of all ages recorded with COPD on GP practice registers (2.01% of all registered patients) compared to 1.85% nationally. The range at GP practice level was from 4.7% of registered patients at Northern Road surgery to 1.3% at Trafalgar Medical Group Practice (excluding Guildhall Walk Healthcare Centre and University practice).[90] Portsmouth's prevalence of COPD is increasing (1.6% in 2010/11; 1.7% in 2011/12; 1.8% in 2012/13; 1.9% in 2013/14, 2.0% in 2014/15).

Modelled prevalence of COPD was derived from various sources including Clinical Practice Research Datalink (CPRD) recorded COPD based on agreed Read Code lists; Hospital Episode Statistics (HES) linked record of admission for COPD; and on inferred COPD based on symptoms and prescribing. In 2015, the estimated prevalence for COPD was 2.8% of

[87] Disease and risk factor prevalence, Public Health England https://fingertips.phe.org.uk/profile/prevalence [Accessed 04 August 2017]
[88] CHD prevalence model technical document, Disease and risk factor prevalence, Public Health England https://fingertips.phe.org.uk/profile/prevalence [Accessed 04 August 2017]
[89] Public Health Mortality Files, ONS via Primary Care Mortality Database (PCMD), Copyright ©2017, re-used with the permission of HSCIC. All rights reserved.
[90] Quality and Outcomes Framework (QOF) prevalence, NHS Digital. http://www.content.digital.nhs.uk/catalogue/PUB22266 Accessed 28 October 2016.

Portsmouth residents of all ages[91] —roughly 6,000 people (applying the prevalence rate to the ONS 2014-based subnational population estimates). However, the actual COPD prevalence is expected to be higher than both GP recorded prevalence and the modelled estimate for 2015 which was limited by data access issues including researchers unable to identify patients who are likely to have COPD but do not have a diagnosis from any source. The Imperial College London estimate that the actual COPD prevalence is at least double the England modelled prevalence of 2.4% and expect COPD prevalence to be least 6% nationally[92]. Therefore, considering the Portsmouth modelled prevalence is 0.4 percentage points higher than the England estimate, a rough estimate of 6.4% of Portsmouth residents with COPD—roughly 13,700 people (applying the prevalence rate to the ONS 2014-based subnational population estimates) estimated to have COPD. Estimating future prevalence might also be affected by an ageing population, smoking prevalence and deprivation.

In 2014/16, chronic lower respiratory disease (which includes COPD) was the third most frequent broad cause of death (361 deaths, 7% of all deaths) to Portsmouth residents of all ages.[93]

9.15.1.5 Asthma

In 2015/16, there were 13,981 registered patients of all ages (6.3% of all registered patients) on GP Practice asthma registers. The national prevalence was 5.9% of all registered patients. Portsmouth's prevalence of asthma is not dissimilar between years; (6.4% in 2011/12; 6.4% in 2012/13; 6.2% in 2013/14, 6.3% in 2014/15). [94]

9.15.1.6 Stroke

In 2015/16, there were 3,332 patients on the Stroke or Transient Ischaemic Attacks registers in primary care (1.5% of registered patients of all ages compared with 1.7% in England). The range at GP practice level was from 2.3% at Craneswater Group Practice to 1.3% at

[91] Disease and risk factor prevalence, Public Health England https://fingertips.phe.org.uk/profile/prevalence [Accessed 04 August 2017]
[92] COPD prevalence model technical document v1.2, Imperial College London for Public Health England, PHE https://fingertips.phe.org.uk/profile/prevalence [Accessed 04 August 2017]
[93] Public Health Mortality Files, ONS via Primary Care Mortality Database (PCMD), Copyright ©2017, re-used with the permission of HSCIC. All rights reserved.
[94] Quality and Outcomes Framework (QOF) prevalence, NHS Digital. http://www.content.digital.nhs.uk/catalogue/PUB22266 Accessed 28 October 2016.

Baffins Surgery and Derby Road Practice (excluding Guildhall Walk and the University Practice prevalence rates). [95]

Modelled prevalence of stroke was derived from a combination of patients self-reporting being told by a nurse or doctor that they had stroke; a clinical record of stroke/TIA; or mortality from stroke. In 2015, the estimated prevalence for stroke is 3.8% of Portsmouth residents aged 55-79 years[96] —roughly 1,600 people (applying the prevalence rate to the ONS 2014-based subnational population estimates). Assuming the stroke prevalence remains the same in future years, the ageing population in Portsmouth would indicate a greater number of residents aged 55-79 years with stroke—roughly 2,000 people by 2025 (applying the prevalence rate to the ONS 2014-based subnational population estimates). However, stroke prevalence is modelled on various risk factors which are likely to change over time such as prevalence of diabetes, smoking, hypertension, obesity, physical activity, dyslipidaemia (high total cholesterol, low high density lipoproteins (HDL), and high low density lipoproteins (LDL)), deprivation, Chronic Kidney Disease (CKD).[97]

In 2014/16, stroke was the fourth most frequent broad cause of death for Portsmouth residents (330 deaths, 6% of all deaths).[98]

9.16 Physical disability

Registration for physical disabilities is good from Adult Social Care as part of the Assessment of Social Care Services, but poor outside of this system.

At 31 March 2015, 3,672 adults were registered with physical disabilities by Portsmouth Adults Social Care services (this includes patients registered with NHS Portsmouth Clinical Commissioning Group who live outside Portsmouth). At electoral ward level, the highest registration crude rates for residents aged 18+ years were in Charles Dickens (36 registrations per 1,000 residents), Paulsgrove (33 registrations per 1,000 residents) and

[95] Disease and risk factor prevalence, Public Health England https://fingertips.phe.org.uk/profile/prevalence [Accessed 04 August 2017]
[96] Disease and risk factor prevalence, Public Health England https://fingertips.phe.org.uk/profile/prevalence [Accessed 04 August 2017]
[97] Stroke prevalence model technical document, Disease and risk factor prevalence, Public Health England https://fingertips.phe.org.uk/profile/prevalence [Accessed 04 August 2017]
[98] Public Health Mortality Files, ONS via Primary Care Mortality Database (PCMD), Copyright ©2017, re-used with the permission of HSCIC. All rights reserved.

Nelson (24 per 1,000 residents). Charles Dickens and Nelson wards are in the Central locality and Paulsgrove ward is in the North locality. [99]

In 2014/15, 3,785 adults aged 18+ years with physical disabilities received a service from Adult Social Care and 3,410 received a service in the community from Adult Social Care. Of those receiving a service in the community, where the location and/or age was known, 608 clients were aged 18-64 years (0.5% of all residents in this age group) and 2,644 were aged 65+ years (8.3% of all residents in this age group). The highest prevalence of all adult clients receiving a service for physical disabilities lived in Charles Dickens (3.1% of adult residents). [100]

9.17 Life expectancy

Life expectancy is a frequently used indicator of the overall health of a population: a longer life expectancy is generally a reflection of better health. Reducing the differences in life expectancy is a key part of reducing health inequalities. Life expectancy at birth for an area is an estimate of how long, on average, babies born today may live if she or he experienced that area's age-specific mortality rates for that time period throughout her or his life.

In 2013/15, male life expectancy at birth in Portsmouth (77.7 years) decreased for the first time (but not statistically significantly) since available records (2001-03) and is statistically significantly longer than in 2006-08; however, it continues to be significantly shorter than England (79.5 years in 2013/15). In 2013/15, female life expectancy at birth in Portsmouth (82.2 years) is significantly worse than England (83.1 years). Whilst life expectancy for females across England has improved, female life expectancy at birth in Portsmouth is static. [101]

Life expectancy at birth (2013/15) for males in Portsmouth's most deprived 10% of Lower Super Output Areas (LSOAs) is 9.8 years shorter than males in Portsmouth's least deprived 10% of LSOAs. Life expectancy at birth (2013/15) for females in Portsmouth's most deprived 10% of LSOAs is 6.0 years shorter than females in Portsmouth's least deprived

[99] Adult Social Care databases, Portsmouth City Council via Portsmouth JSNA: www.jsna.portsmouth.gov.uk.
[100] Adult Social Care databases, Portsmouth City Council via Portsmouth JSNA: www.jsna.portsmouth.gov.uk.
[101] ONS Life expectancy at birth and at age 65 by local areas in UK, 2013 to 2015 https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthandlifeexpectancies/datasets/lifeexpectancyatbirthandatage65bylocalareasuk (Accessed 29 November 2016)

10% of LSOAs (the slope index of inequality in life expectancy at birth for males and females). [102]

In 2013/15, the healthy life expectancy (HLE) at birth in Portsmouth is significantly shorter than England for both males and females. [103] Portsmouth males and females have a similar HLE at birth (61.5 years and 61.3 years respectively); but as a result of longer life expectancies at birth, females in Portsmouth (and nationally) would be expected to have a smaller proportion of life in "good" health than males. However, there are inequalities in HLE by deprivation (within Middle Super Output Areas). In 2009-2013, Portsmouth has a slope index of inequality of 15.1 years of HLE for males and 14.2 years of HLE for females (the range in years of HLE from the most and least deprived). [104]

9.18 Mortality

Between 2014 and 2016, the three most frequent (broad) causes of death have been dementia and Alzheimer's disease; ischaemic heart diseases; and chronic lower respiratory diseases (Table 9).

Table 9. Leading causes of death: number of deaths; persons, all ages, resident in Portsmouth, 2014-2016.

Rank by Number of Deaths	Rank by Number of Deaths compared to 2013-15	Underlying Cause of death (ICD-10)	Number of Deaths in 2014-16	Percentage of all deaths, in 2014-16
1	⬌	Dementia and Alzheimer's disease (F01, F03, G30)	670	13%
2	⬌	Ischaemic heart diseases (I20–I25)	537	10%
3	⬌	Chronic lower respiratory diseases (J40–J47)	361	7%
4	⬆	Cerebrovascular diseases (I60–I69)	330	6%
5	⬇	Malignant neoplasm of trachea, bronchus and lung (C33, C34)	309	6%
6	⬌	Influenza and pneumonia (J09-J18)	209	4%
7	⬆	Malignant neoplasm of colon, sigmoid, rectum and anus (C18–C21)	132	3%
8	⬇	Accidents (V01–X59)	130	3%
9	⬇	Malignant neoplasms of lymphoid, haematopoietic and related tissue (C81–C96)	113	2%
10	⬆	Malignant neoplasms of breast (C50)	99	2%
		Other causes	2283	44%
		All Deaths 2014-16	**5173**	**100%**

[102] Public Health Outcomes framework Indicators 0.2iii - Slope index of inequality in life expectancy at birth within English local authorities, based on local deprivation deciles: the range in years of life expectancy across the social gradient within each local authority, from most to least deprived, 2010/12-2013/15, Public Health England. http://www.phoutcomes.info/public-health-outcomes-framework#page/4/gid/1000049/pat/6/par/E12000008/ati/102/are/E06000044/iid/92901/age/1/sex/1 Accessed 29 August 2017.

[103] Public Health Outcomes Framework. Indicator 0.1i - Healthy life expectancy at birth, Male and female http://www.phoutcomes.info/public-health-outcomes-framework#page/3/gid/1000049/pat/10039/par/cat-39-4/ati/102/are/E06000044/iid/90362/age/1/sex/1 Accessed 29 August 2017.

[104] Slope index of inequality (SII) in healthy life expectancy (HLE) at birth by sex for Upper Tier Local Authorities (UTLAs) in England, 2009 to 2013, Office for National Statistics. *http://www.ons.gov.uk/ons/rel/disability-and-health-measurement/health-expectancies-at-birth-by-middle-layer-super-output-areas--england/inequality-in-health-expectancies-using-imd-2015-small-area-deprivation-scores--2009-13/index.html* Accessed 20 November 2015.

9.19 Mental health

Common mental health disorders (CMD) are mental health conditions that cause marked emotional distress and interfere with daily function but do not usually affect insight or cognition– including different types of depression and anxiety, and include obsessive compulsive disorder. The Adult Psychiatric Morbidity Survey 2014 (APMS 2014) categorises the following as types of CMD: generalised anxiety disorder; depression; all phobias; obsessive compulsive disorder; panic disorder; and CMD not otherwise specified. The APMS 2014 found that since the last survey (2007), increases in CMD have been evident among late midlife men and women (aged 55 to 64 years), and approached significance in young women (aged 16 to 24 years). CMDs were more prevalent in certain groups of the population. These included Black women, adults under the age of 60 who lived alone, women who lived in large households, adults not in employment, those in receipt of benefits and those who smoked cigarettes. These associations are in keeping with increased social disadvantage and poverty being associated with higher risk of CMD. Most people identified by the CIS-R with a CMD also perceived themselves to have a CMD. This was not the case for most of the other disorders assessed in the APMS. [105]

The APMS 2014 found prevalence of common mental health disorders is higher in females compared to males of all ages, nationally - 20.7% of females compared to 13.2% of males. [106] Using the overall prevalence rates identified in the Adult Psychiatric Morbidity Survey 2014, about 27,350 Portsmouth residents aged 16-64 years are predicted to be affected by common mental disorders in 2018, increasing to 27,500 by 2021 (assuming the prevalence rate remains the same). [107] [108]

In 2015/16, about 14,232 people aged 18+ years (7.9%) were recorded by GPs as having depression with the range at GP practice level from 17.3% to 3.1% - lower than the prevalence for England (8.3%).[109] There were 2,303 new cases of depression in 2015/16—

[105] Stansfeld S, Clark C, Bebbington P, King M, Jenkins R, Hinchliffe S. 'Chapter 2: Common mental disorders' in McManus S, Bebbington P, Jenkins R, Brugha T. (eds) (2016) Mental health and wellbeing in England: Adult Psychiatric Morbidity Survey 2014. Leeds: NHS Digital.
[106] NHS Digital. Adult Psychiatric Morbidity Survey, 2014 (Table 2) and ONS 2014 sub-national populations projections
[107] NHS Digital. Adult Psychiatric Morbidity Survey, 2014 (Table 2)
[108] Note: these are projections are crude estimates based on national estimated prevalence and have not been adjusted for local population differences in age structure, ethnicity, etc.
[109] QOF 2015/16, Quality Management and Analysis System via Health and Social Care Information Centre Compendium of Population Health Indicators centre www.qof.hscic.gov.uk 3 February 2017

1.3% of the GP practice register aged 18+ years and this is significantly lower than the England incidence rate (1.4%). [110]

However, the recorded prevalence by GPs is likely to be an underestimate of the prevalence of depression in Portsmouth. Modelled prevalence based on self-reported responses from the Health Survey for England estimates that in 2015, 15.4% of Portsmouth residents of all ages have been diagnosed with depression (based on survey respondents stating they were told by a health professional that they had depression)[111]. This also correlates closely to the 2015/16 estimated prevalence of depression and anxiety from the self-reported GP patient survey (15.3% of NHS Portsmouth patients aged 18+ years)[112] —using the 15.4% modelled prevalence, then approximately 33,250 residents of all ages would be expected to have depression in 2018 (applying the prevalence rate to the ONS 2014-based subnational population estimates). Assuming the depression prevalence remains the same in future years, the ageing population in Portsmouth would indicate a greater number of residents of all ages with depression—roughly 34,550 people by 2025 (again, applying the prevalence rate to the ONS 2014-based subnational population estimates). However, depression prevalence is also modelled on various risk factors which are likely to change over time such as prevalence of obesity and physical activity; ageing population; ethnicity; educational levels; socio-economic status; marital status; alcohol and drug abuse; limiting long-lasting illness; anxiety; and sleep disorders. [113]

In 2015/16, compared to England, Portsmouth CCG had a similar prevalence of people with schizophrenia, bipolar affective disorder and other psychoses (locally about 2,000 people – 0.90% of people of all ages, in line with 0.90% in England).[114] Using the prevalence from the Adult Psychiatric Morbidity Survey (APMS) 2014, it is estimated that in 2017, 860 adults aged 16-64 years had a psychotic disorder in the past year (assuming the prevalence rate from APMS does not change, this is projected to increase to 900 adults by 2030). [115] [116]

[110] QOF via Public Health England. Mental Health Dementia and Neurology Profiles: Common Mental Health Disorders. Accessed 30 August 2017.
[111] Disease and risk factor prevalence, Public Health England https://fingertips.phe.org.uk/profile/prevalence via Portsmouth JSNA: www.jsna.portsmouth.gov.uk [Accessed 31 August 2017]
[112] Mental Health Dementia and Neurology Profiles: Common Mental Health Disorders, Public Health England https://fingertips.phe.org.uk/profile-group/mental-health/profile/common-mental-disorders [Accessed 31 August 2017]
[113] Depression prevalence model technical document v1.1, Imperial College London for Public Health England, PHE https://fingertips.phe.org.uk/profile/prevalence [Accessed 30 August 2017]
[114] QOF, 2015/16. HSCIC.
[115] NHS Digital. Adult Psychiatric Morbidity Survey, 2014 (Table 5)
[116] Note: these are projections are crude estimates based on national estimated prevalence and have not been adjusted for local population differences in age structure, ethnicity, etc.

In 2015/16, Portsmouth had a significantly higher rate of emergency hospital admissions for intentional self-harm compared to England and the South East region. [117]

In 2014/15, Adult Social Care provided services for mental health problems to 1,032 clients aged 18+ years (877 clients in 2013/14). In 2014/15, Adult Social Care provided services in the community for mental health problems to 236 clients aged 18-64 years (1.7 clients per 1,000 residents aged 18-64 years) and to 88 clients aged 65+ years (2.9 clients per 1,000 residents aged 65+ years). In total, Adult Social Care provided services in the community for mental health problems to 324 adults aged 18+ years. Where rates could be calculated, the highest crude rates were in the Central locality: Charles Dickens (57 clients, 3.7 clients per 1,000 population) and Nelson (26 clients, 2.4 clients per 1,000 population) wards.

In 2014/15, 235 people caring for someone with a mental health problem received a needs assessment, review or advice and information. [118]

In 2013/15, Portsmouth's suicide and mortality from injury of undetermined intent directly age standardised rate (DSR) aged 10 years and over (14.1 per 100,000 population) was significantly higher than England (10.1 per 100,000 persons aged 10+ years) and the South East region (10.2 per 100,000 persons aged 10+ years).[119]

9.20 Armed Forces personnel and veterans

The Ministry of Defence has a number of establishments in this area, with roughly 6,400 military personnel registered to Portsmouth (97% in Royal Navy/Royal Marines), as at July 2017. [120]

At the time of the 2011 Census, there were 2,396 members of the Armed Forces aged 16 years and over resident to Portsmouth: 80% were male; 203 (8%) persons identified themselves as BME (not White English/Welsh/Scottish/Northern Irish/British); 20% were aged 16-24 years, 36% aged 25-34 years, 38% aged 35-49 years and 5% aged 50+ years. However, there were 4,611 members of the Armed Forces aged 16+ years whose workplace

[117] Public Health Outcomes Framework (2.10ii), Public Health England http://www.phoutcomes.info Accessed 16 May 2017
[118] Short- and Long-Term Support (SALT) database, Portsmouth City Council via Portsmouth JSNA: www.jsna.portsmouth.gov.uk.
[119] Public Health Outcomes Framework (4.10), Public Health England http://www.phoutcomes.info Accessed 30 August 2017
[120] Quarterly Locations Report, 1 July 2017 Edition, Defence Statistics (Tri Service). https://www.gov.uk/government/statistics/location-of-uk-regular-service-and-civilian-personnel-quarterly-statistics-2017 Accessed 30 August 2017.

was Portsmouth. There were 1,251 associated people (i.e. a spouse, same-sex civil partner, partner, child or stepchild) of a member of the Armed Forces aged 16+ years resident to Portsmouth—20% of the associated people were economically inactive.[121]

The most robust estimates of the national veteran population are obtained from survey data from the Office for National Statistics (ONS) Annual Population Survey (APS). The APS 2015 estimates approximately 2.56 million veterans residing in Great Britain (GB) (5% of the GB adult population)—89.5% of whom are male. [122] APS 2015 found UK Armed Forces veterans residing in GB aged 16-34 and 50-64 were more likely to have ever smoked. Working age (16-64) veterans who had ever smoked were significantly more likely to report suffering from respiratory and mental illness health conditions compared to non-smokers. They were also more likely to report that their general health was bad and that their health concerns limited their day to day activities.[123]

Locally, the Portsmouth Health & Lifestyle 2015 found that there was an estimated 11% of the adult population aged 16+ years are veterans (of the Armed Forces or Reserve Armed Forces)—roughly 17,500 residents aged 16+ years (applying the prevalence rate to the ONS 2014-based subnational population estimates) of which approximately 84% are estimated to be aged 45 years and over (roughly 14,500 residents).[124] The local H&LS 2015 found 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 all 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).[125]

[121] 2011 Census: AF001, AF003, AF004, AF005. Office for National Statistics © Crown Copyright 2014
[122] Annual Population Survey: Annual Great British Veteran Report, 2015 reference tables. Defence Statistics (Health), Ministry of Defence https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/572961/20161125_APS_Excel_Tables_2015_Update_.xlsx Accessed 31 August 2017
[123] Annual Population Survey: UK Armed Forces Veterans residing in Great Britain, 2015 bulletin. Ministry of Defence https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/559369/20161013_APS_Official_Statistic_final.pdf Accessed 31 August 2017
[124] Portsmouth Health & Lifestyle Survey 2015, Ipsos MORI for Portsmouth City Council.
[125] Ipsos MORI Summary Report of findings for Portsmouth City Council. Health and Lifestyle Survey, 2015 via Portsmouth JSNA.

9.21 Prison health

Since the closure of HMP Kingston in 2013, there are now no prisons in Portsmouth.

9.22 Adults with autistic spectrum conditions

A local estimate of the prevalence of autistic spectrum disorders (ASD) in adults in Portsmouth was produced using national prevalence estimates derived from the Adult Psychiatric Morbidity Survey (APMS) 2014, which combined data from APMS 2014 with data from the previous APMS 2007. APMS 2014 found that ASD was associated with level of educational qualification, with rates being higher among people with no qualifications; and People with ASD appeared to be no more likely than other adults to make use of treatment or services for mental or emotional problems[126]. The APMS 2014 found 1.5% of males and 0.2% of females, averaged for all ages, are estimated to have ASD. However, prevalence of ASD is estimated to be higher in younger adults aged 16-34 for both males and females (2.6% and 0.6% respectively). By applying these national adult age and gender specific ASD prevalence estimates crudely to the estimated adult population in Portsmouth, it is estimated that in 2017 between 670 and 4,190 adults in Portsmouth have ASD and that by 2030 this will increase to between 740 and 4,680 people. (Table 10). [127]

Table 10. Estimated number of adults with autism-spectrum disorders, Portsmouth, 2017 to 2030.

Estimated number of adults with autism spectrum disorders (ASD) Portsmouth, 2017, 2025 and 2030									
	2017			2025			2030		
Age band (years)	Estimated no.	Lower estimate	Upper estimate	Estimated no.	Lower estimate	Upper estimate	Estimated no.	Lower estimate	Upper estimate
16-34	1,180	480	2,880	1,200	490	2,920	1,240	520	3,100
35-54	70	20	280	70	20	270	70	20	290
55-74	380	170	840	420	180	930	440	190	960
75+	40	10	190	60	10	260	70	20	330
Total	1,670	670	4,190	1,740	700	4,380	1,810	740	4,680

Sources:
(1) Table 6.2: Estimated national prevalence of ASD (combined Adult Psychiatric Morbidity Survey (APMS) 2007 and 2014), by age and sex, Adult Psychiatric Morbidity Survey (APMS) 2014, NHS Digital
(2) SNPP Z1: 2014-based Subnational Population Projections. Local Authorities in England, mid-2014 to mid-2039, ONS.

[126] Brugha T, Cooper SA, Gullon-Scott FJ, Fuller E, Ilic N, Ashtarikiani A, Morgan Z. (2016) 'Chapter 6: Autism' in McManus S, Bebbington P, Jenkins R, Brugha T. (eds.) Mental health and wellbeing in England: Adult Psychiatric Morbidity Survey 2014. Leeds: NHS Digital.
[127] Note: these local estimates are based on crude national prevalence rates and have not been adjusted for local differences in additional risk factors e.g. educational attainment

9.23 Dementia

In 2015/16, there were 1,516 patients on the dementia register (0.68% of registered patients of all ages compared with 0.76% in England). The range at Practice level was from 1.3% of patients registered with Craneswater Group practice to 0.4% at Sunnyside Medical Practice (excluding the University Practice). [128] Portsmouth's prevalence of dementia has not changed significantly between years (0.6% in 2010/11; 0.6% in 2011/12; 0.7% in 2012/13; 0.7% in 2013/14; 0.7% in 2014/15).

In 2015/16, Portsmouth's crude rate of newly diagnosed dementia registrations is 10.7 per 1,000 patients registered aged 65+ years (341 patients newly diagnosed with dementia) is significantly lower than the England rate (12.7 per 1,000 patients registered aged 65+ years).[129]

Modelled prevalence suggests that in 2017, it is estimated that approximately 2,190 people[130] aged 65+ years have dementia in Portsmouth. With an ageing population, by 2026 and 2032 the number of people aged 65+ years with dementia is predicted to increase by 21% (about an additional 450 people (2,640 in total)) and 45% (approximately an additional 990 people (3,180 in total)), respectively. [131]

There are about 700 fewer people on GP dementia registers than is predicted by the above modelled national prevalence estimates for our registered population. However, most Practices have registered numbers of patients sufficient to almost equal the numbers predicted to have moderate or severe dementia. Part of the national Dementia Strategy is to encourage people to seek early diagnosis when experiencing the signs of mild dementia.

Between 2014 and 2016, dementia and alzheimer's disease was the most frequent broad cause of death for Portsmouth residents of all ages (670 deaths, 13% of all deaths).[132]

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[128] Quality and Outcomes Framework. 2015/16. NHS Digital. http://www.content.digital.nhs.uk/catalogue/PUB22266 Accessed 10 January 2017.

[129] Dementia Profile, Public Health England. https://fingertips.phe.org.uk/profile-group/mental-health/profile/dementia Accessed 1 September 2017

[130] Please note that these are very rough estimate of simply applying the national prevalence estimates to the estimated population for those age groups. It does not take into effect other possible risk factors which might impact on the estimated prevalence.

[131] Projecting Older People Population Information System. www.POPPI.org.uk accessed 16 November 2016 and SNPP Z1: 2014-based Subnational Population Projections. Local Authorities in England, mid-2014 to mid-2039, ONS via Portsmouth JSNA: www.jsna.portsmouth.gov.uk.

[132] Public Health Mortality Files, ONS via Primary Care Mortality Database (PCMD), Copyright ©2017, re-used with the permission of HSCIC. All rights reserved.

9.24 Learning disabilities

In 2015/16, Portsmouth GPs recorded that they were aware of 865 people of all ages with a learning disability on GP registers (0.39% of registered patients of all ages compared to 0.46% in England). [133]

People with learning disabilities are at increased risk of social exclusion. Two national priorities aim to reduce this risk by improving their outcomes in terms of settled accommodation and employment. In 2015/16, 81% (79% in 2014/15) of Portsmouth adults aged 18+ years with a learning disability known to Adult Social Care were in settled accommodation (higher than the percentage for England and the South east region). Also, the employment rate of Portsmouth adults aged 18+ years with a learning disability known to Adult Social Care was 7.2% (higher than the percentage for England and the South east region). [134]

In 2015/16, the percentage point gap in the employment rate of Portsmouth adults aged 18+ years with a learning disability known to Adult Social Care and the overall employment rate had increased to 64% (62% in 2012/13, 2013/14 and 2014/15). Nationally this gap has increased annually over the same period. [135] Recent local data shows for 2014/15, 8% of adults aged 18+ years with a learning disability known to Adult Social Care were in employment - slight decrease on 2013/14. [136]

In 2014/15, Adult Social Care provided a service to 523 people aged 18+ years relating to learning disability (decrease of forty-three clients compared to 2013/14).[137]

In 2014/15, Adult Social Care provided a service in the community for 432 people with a learning disability aged 18+ years (2.6 per 1,000 residents aged 18+ years). The highest number and rate of clients receiving services in the community were in Hilsea ward (5.7 clients per 1,000 resident population aged 18+ years) in the North locality, followed by Eastney and Craneswater (3.5 clients per 1,000 resident population aged 18+ years) in the

[133] QOF, Quality and Outcomes Framework, 2015/16 via Health and Social Care Information Centre (HSCIC) . © Crown Copyright Accessed 3 February 2017 via Portsmouth JSNA: www.jsna.portsmouth.gov.uk.
[134] HSCIC Adult Social Care Outcomes 2015/16 http://www.content.digital.nhs.uk/catalogue/PUB21900 1E Accessed 16 May 2017 via Portsmouth JSNA: www.jsna.portsmouth.gov.uk.
[135] Public Health Outcomes Framework Public Health England www.phoutcomes.info Accessed 16 May 2017
[136] Short- and Long-Term Support (SALT) database, Portsmouth City Council via Portsmouth JSNA: www.jsna.portsmouth.gov.uk.
[137] Short- and Long-Term Support (SALT) database, Portsmouth City Council via Portsmouth JSNA: www.jsna.portsmouth.gov.uk.

South locality and Fratton (also 3.5 clients per 1,000 resident population aged 18+ years) in the Central locality. [138]

9.25 Carers

At the time of the 2011 Census, over 17,000 people of all ages (8.4% of total population) stated that they provided unpaid care—over 4,000 provided 50 or more hours of unpaid care per week. [139] About 1 in 10 people (n=6,644) in the North of the city are unpaid carers and over 1,600 people provide 50 hours or more of unpaid care. The Central and South localities had 8.3% and 7.1%, respectively, of residents providing unpaid care. (Figure 33)

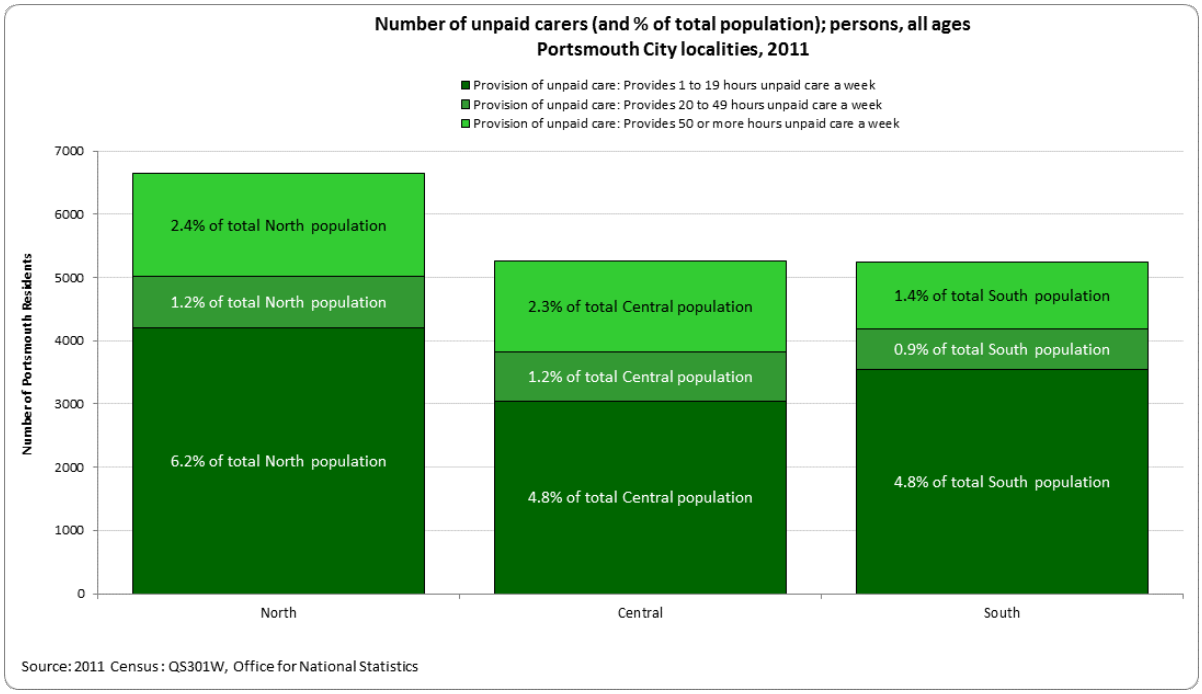

Figure 33. Number of unpaid carers (and percentage of total population); persons, all ages, Portsmouth City UA localities, 2011 Census.

The Portsmouth Health & Lifestyle Survey 2015 found that 21% of residents provide unpaid care (27% in the North locality which is significantly higher than the Central locality - 16%) 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

[138] Short- and Long-Term Support (SALT) database, Portsmouth City Council via Portsmouth JSNA: www.jsna.portsmouth.gov.uk.
[139] 2011 Census: QS301EW, Office for National Statistics.

council/social housing tenants or aged 55-64 years, as these two groups also have lower levels of mental wellbeing. 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 9%) and to be smokers (25% compared with 14%).[140]

In February 2017, 2,493 (155 more than in February 2016) residents of working age claimed Carer's Allowance. This equates to 17.5 per 1,000 residents of working age compared with 16.6 per 1,000 residents of working age in 2016. The highest number of claimants are in Paulsgrove Middle Super Output Area (MSOA) (269 claimants, 55.6 per 1,000 residents of working age), which is in the North locality, followed by the City Centre MSOA (267 claimants, 23.9 per 1,000 residents of working age), which is in the Central locality. [141]

In 2014/15, Adult Social Care carried out a needs assessment, review or gave advice and information to 1,727 carers (55% more than in 2013/14). People caring for someone with physical disabilities accounted for 58% of such carer interventions; people caring for someone for learning disabilities or mental health was 4% and 14% (or 68 and 235 people), respectively. For all carers, the highest Adult Social Care activity rates were in Cosham ward (14 such carer interventions per 1,000 residents) and Paulsgrove (13 such carer interventions per 1,000); but the highest number of carers aged 18-64 receiving a needs assessment was in Charles Dickens (102 clients), followed by Paulsgrove (95 clients) and Cosham (92 clients). [142]

The national survey of carers is carried out biennially. The 2014-15 postal survey of local carers aged 18+ years receiving services from Social Services was carried out in October/November 2014. The carers' survey found that, locally, 70% of people being cared for were aged 65+ years. The three main reasons for caring for someone were physical disabilities (54%), problems related to ageing (40%) and long-standing illness (37%). Sight or hearing loss and dementia each accounted for 34%. High levels of the person being cared for had not accessed available services eg short-notice respite (85% not accessed) , sitting service (74% not accessed), personal assistant (90%), day centres (79%), lunch club (97%), meals services (93%). Home adaptations (49% accessed) was most likely to have

[140] Ipsos MORI Summary Report of findings for Portsmouth City Council. Health and Lifestyle Survey, 2015 via Portsmouth JSNA.
[141] Department for Work and Pensions, Feb 2017. https://stat-xplore.dwp.gov.uk (Claimant numbers) Accessed 1 September 2017. Rates calculated using Hampshire County Environment Department's 2016 based Small Area Population Forecasts.
[142] Short- and Long-Term Support (SALT) database, Portsmouth City Council via Portsmouth JSNA: www.jsna.portsmouth.gov.uk.

been accessed. Over half of all carers themselves had some sort of physical or mental health problem. 42% of local carers had some social contact but said it was not enough; 11% felt socially isolated. [143]

9.26 People threatened with homelessness

In 2015/16, Portsmouth had a significantly higher rate of statutorily homeless households compared to England that are accepted as being owed a duty by their local authority under homelessness legislation as a result of being eligible for assistance, unintentionally homeless and in priority need—that is 498 households (5.6 acceptances per 1,000 households).[144]

In addition, there are households and individuals that are eligible but not in priority need or are in temporary accommodation which can have greater public health needs than the population as a whole. In 2015/16, Portsmouth had a significantly lower rate of statutory eligible homeless people deemed not to be in priority need compared to England—0.6 homeless people per 1,000 households (52 homeless people). Portsmouth also had a significantly lower rate of households in temporary accommodation provided under the homelessness legislation compared to England—1 per 1,000 households (60 households).[145]

9.27 Gypsies and travellers

At the time of the 2011 Census, there were 85 people identifying themselves as White: Gypsy or Irish Traveller (less than 1% of the total population). [146] Also, the latest ethnicity data from the January 2016 school pupil census, identifies 38 pupils as 'White: Gypsy/Roma' resident to Portsmouth.[147]

Although not necessarily ethnic gypsies and travellers, as at January 2017, there were neither authorised nor unauthorised traveller caravans in Portsmouth.[148]

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[143] Personal Social Services Survey of Adult Carers in England, 2014-15. NHS Digital. http://content.digital.nhs.uk/catalogue/PUB18423 Accessed 12 October 2016
[144] Public Health Profiles, Public Health England. http://fingertips.phe.org.uk Accessed 4 September 2017.
[145] Public Health Outcomes Framework. Public Health England. Indicator 1.15i and 1.15ii http://www.phoutcomes.info/ Accessed 4 September 2017.
[146] 2011 Census: QS211EW, Office for National Statistics.
[147] Department for Education Statistical First Release Schools, Pupils and their Characteristics: January 2016. © Crown Copyright via Portsmouth JSNA: www.jsna.portsmouth.gov.uk.
[148] Tables 1 and 3: Traveller caravan count, Department for Communities and Local Government. https://www.gov.uk/government/statistics/traveller-caravan-count-january-2017 Accessed 4 September 2017

However, it is acknowledged that Portsmouth continues to lack useful data on gypsy and traveller communities. [149]

The 2006 Hampshire Gypsy & Traveller Accommodation Assessment reported that travellers on authorised sites were less likely to be registered with a GP[150]; however, since then access for unregistered people has been improved with the opening of the Guildhall Walk Healthcare Centre.

[149] Portsmouth City Council Equality & Diversity strategy 2014-17. Ibid.
[150] Gypsies & Travellers and Travelling Show people strategy, 2009, Portsmouth City Council. https://www.portsmouth.gov.uk/ext/documents-external/pln-local-dev-housing-gypsy-traveller-strategy.pdf

10 Potential future need

10.1 Major developments

As discussed in an early section, there are identified major redevelopment projects within the city. The Council is undertaking a consultation on issues and options for the Local Plan in August and September 2017, following which further work will be undertaken to arrive at a development strategy for the city. Should this identify large developments not currently anticipated, which will place substantial demand on pharmaceutical services the PNA will need to be reviewed.

A part of this is increasing provision of student accommodation. Figure 34 shows the sites and number of accommodation units which have been identified and which have permission for student halls of residence in the city until 2021. While development is anticipated, the larger of the new sites are situated in the central locality where there is existing good pharmaceutical provision. The potential increase in pharmaceutical services is expected to be met within existing provision.

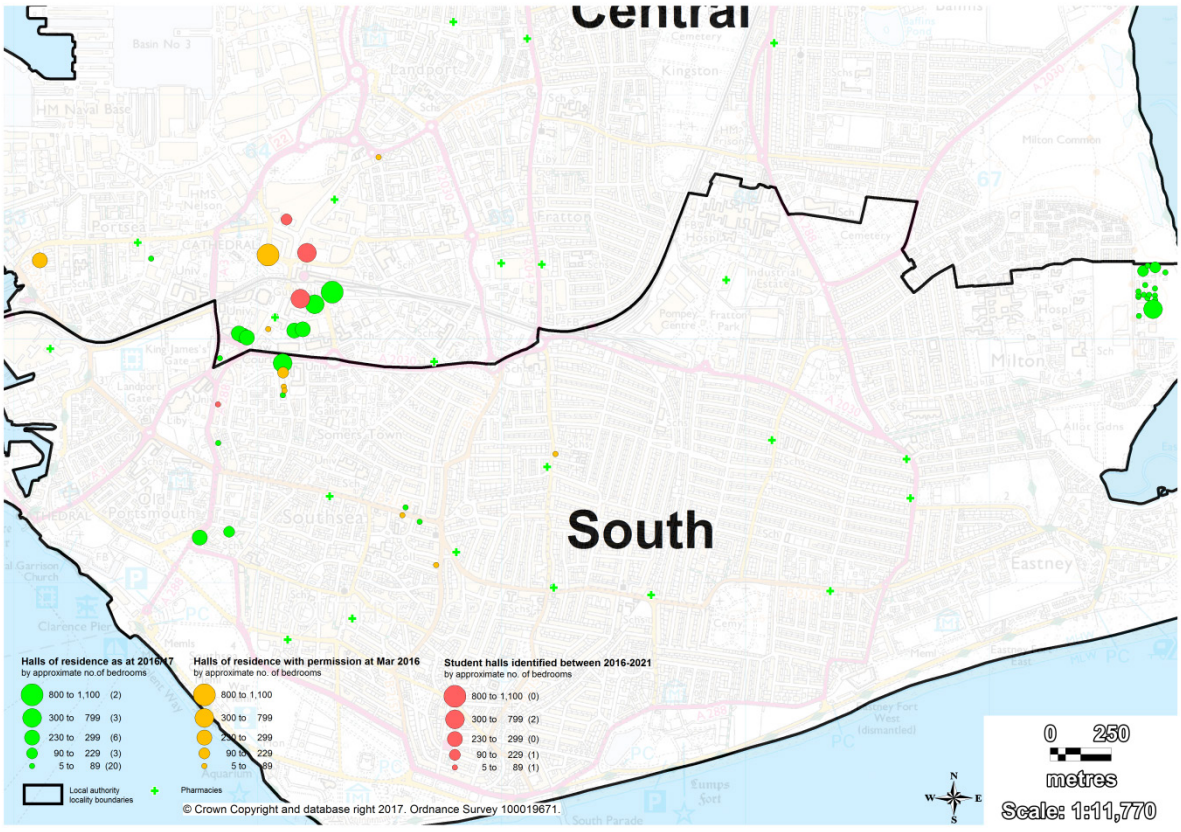

Figure 34. Map of current sites and number of accommodation units identified and which have permission for student halls of residence in Portsmouth, 2016-2021 (source Portsmouth City Council)

10.2 GP extended opening

Plans are being implemented within the city to improve access to GPs. This is likely to include opening weekday evenings as well as some Saturday and Sunday opening. Some GP practices are already offering a range of opening hours. Many GP consultations result in a prescription being issued. Community pharmacies within Portsmouth offer good access through supplementary hours, five 100 hour pharmacies and a distance selling pharmacy.

Therefore, any potential increase in demand for pharmaceutical services as a consequence of extended GP opening is expected to be met within existing provision.

11. Gaps in provision

13.1 Necessary services

The Health and Wellbeing Board consider the location, number, distribution and choice of pharmaceutical services serving the Portsmouth residents to meet the needs of the population.

In particular, this is based on:

- The total Portsmouth population is within a 1.6km straight line distance of a community pharmacy.
- A good geographical spread of community pharmacies across all three localities in the city and within communities experiencing greatest deprivation.
- There being 19 community pharmacies per 100,000 Portsmouth population, which is the same as the average for Wessex and is broadly in line with national averages.
- Over 99% of the Portsmouth population are within a 20 minute walk of a community pharmacy.
- Nearly nine in every 10 (87.5%) respondents to a public survey said it took 15 minutes or less to get to a community pharmacy.
- Good access through opening hours from early morning, through lunchtimes and late into the evening as well as weekend opening.
- All pharmacies provide the full range of essential pharmaceutical services
- There is good provision of advanced services across the city.
- A large proportion of community pharmacies providing a delivery service to residents, including housebound patients.
- There will not be substantial changes in population areas, nor major development, which can be anticipated during the three-year lifespan of this PNA, which would warrant the need for additional pharmaceutical services. Smaller changes would be managed by existing providers.

13.2 Improvements and better access

The Health and Wellbeing Board consider that there is currently no identified need for improvements and better access to pharmaceutical services in Portsmouth.

In particular, this is based on:

- A distance selling pharmacy, five 100 hour pharmacies, supplementary hours in other Portsmouth community pharmacies as well as provision in a neighbouring Health and Wellbeing Board area provide improvements and better access which meets the needs of Portsmouth residents.

- This current provision is expected to continue to meet any increase in need as a result of further increase in extended hours of opening by GP practices or known planned developments.
- There is good provision of advanced services across the city.
- There are a range of enhanced and locally commissioned services delivered in the city. Pharmacies accredited to deliver these services have good geographical spread across the localities within Portsmouth.

14 Conclusion

The Health and Wellbeing Board has considered the city's' demography and health needs (section 9), how the public use pharmaceutical services (section 8) and pharmaceutical provision (section 7) in Portsmouth and concludes:

- The current need for pharmaceutical services is met by the existing providers on the pharmaceutical list.
- There will not be substantial changes in population areas, nor major development, during the three-year lifespan of this PNA, which would warrant the need for additional pharmaceutical services. Smaller changes would be managed by existing providers.
- Improvements and better access to pharmaceutical services have been made during the last three years by the entry of a distance selling pharmacy which has given local residents and others further afield greater choice and access.
- There is good coverage across the city of Advanced, Enhanced and locally commissioned services in place.
- That there are no identified specific improvements or better access that could be met by an additional pharmaceutical services provider at this time.
- Future improvements or better access will be met by the current pharmaceutical service providers.

15 Appendix A: Maps showing provision of enhanced and locally commissioned services

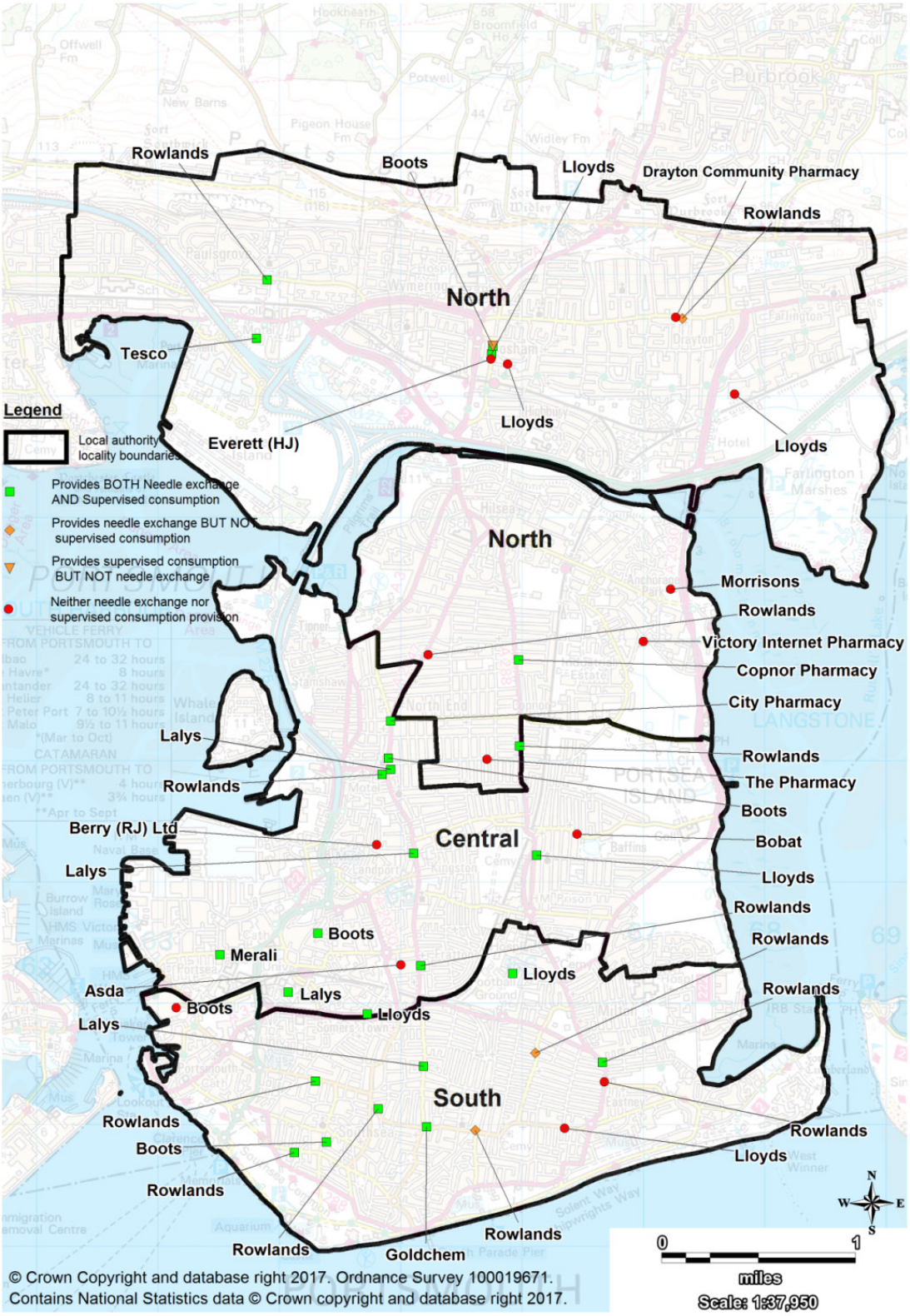

Figure 35. Map of pharmacies which have a contract to provide Needle Exchange and Supervised Consumption services in Portsmouth for 2017/18 (source Portsmouth City Council, Public Health)

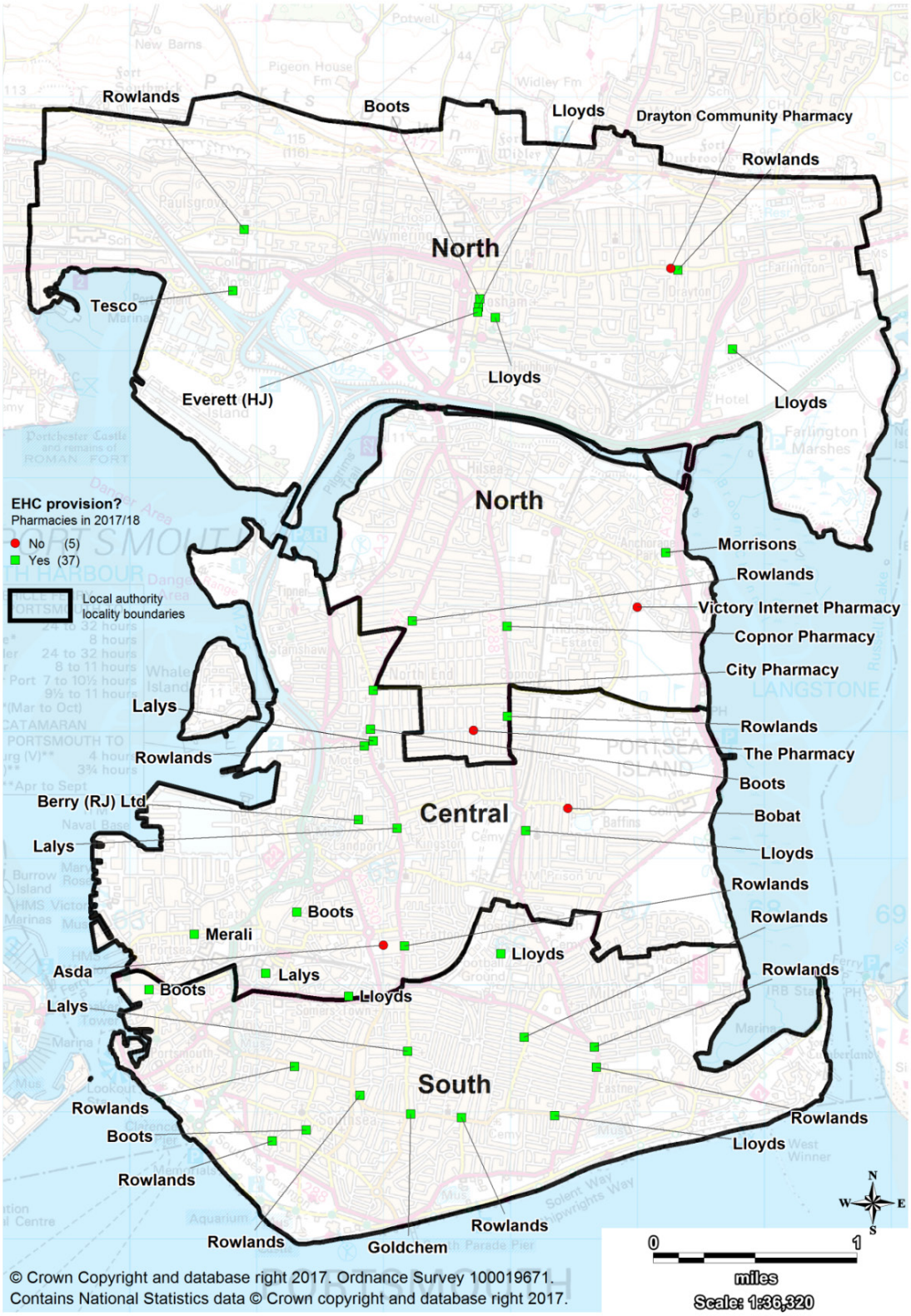

Figure 36. Map of pharmacies which have a contract to provide Emergency Hormonal Contraception in Portsmouth for 2017/18 (source Portsmouth City Council, Public Health)

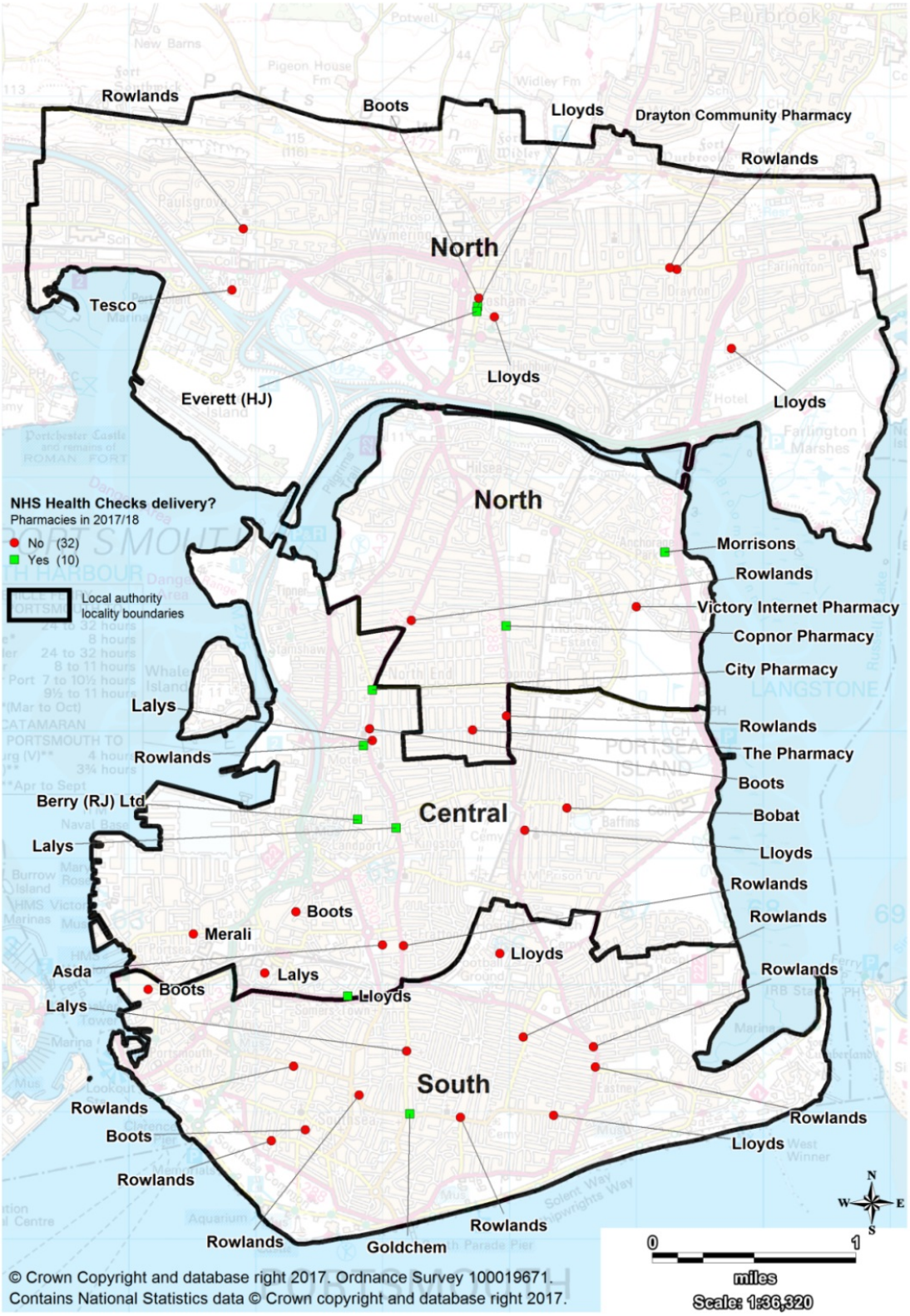

Figure 37 Map of pharmacies which have a contract to provide NHS Health Checks in Portsmouth for 2017/18 (source Portsmouth City Council, Public Health)

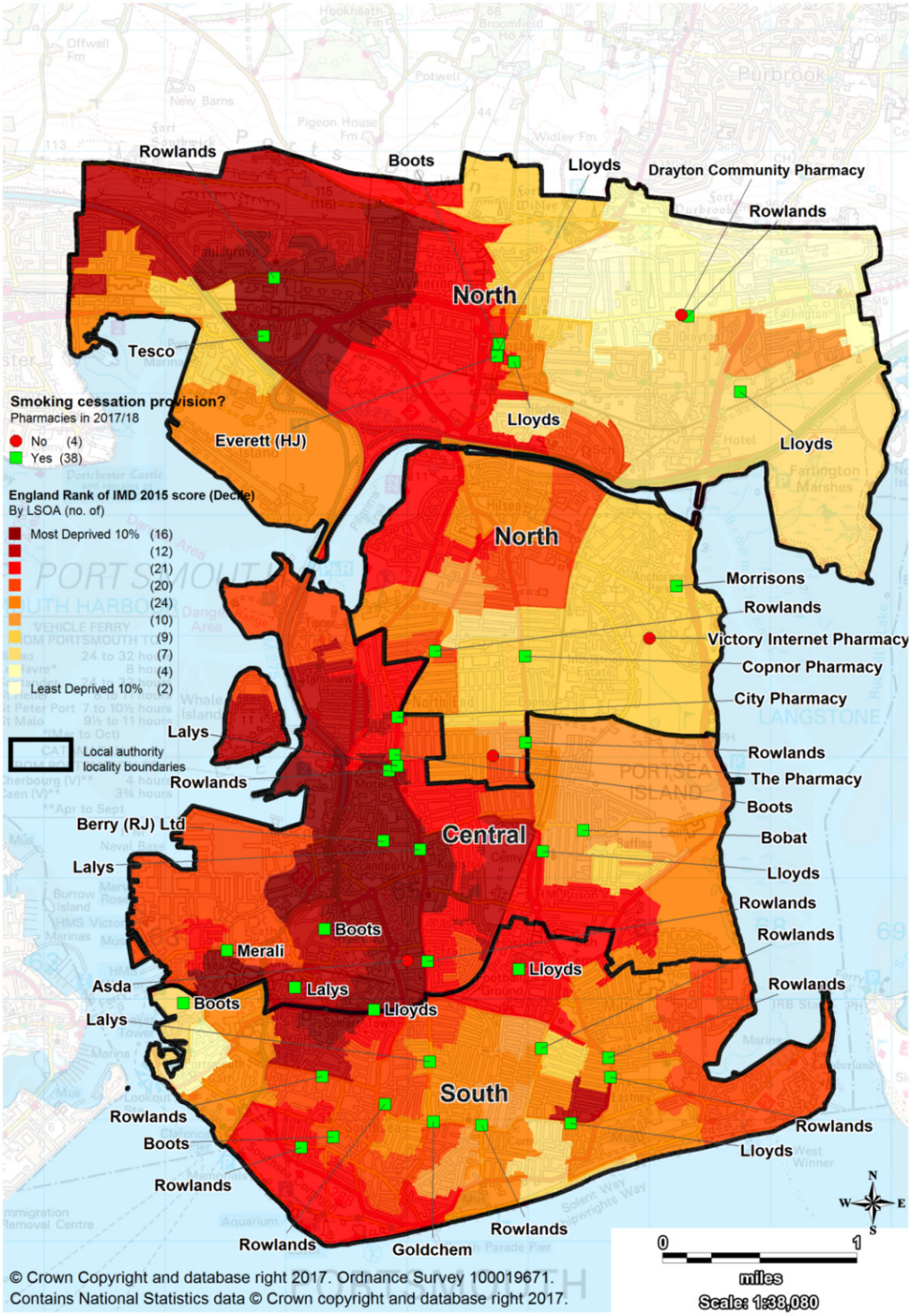

Figure 38 Map of pharmacies which have a contract to provide the Stop Smoking Service in Portsmouth for 2017/18 (source Portsmouth City Council, Public Health)

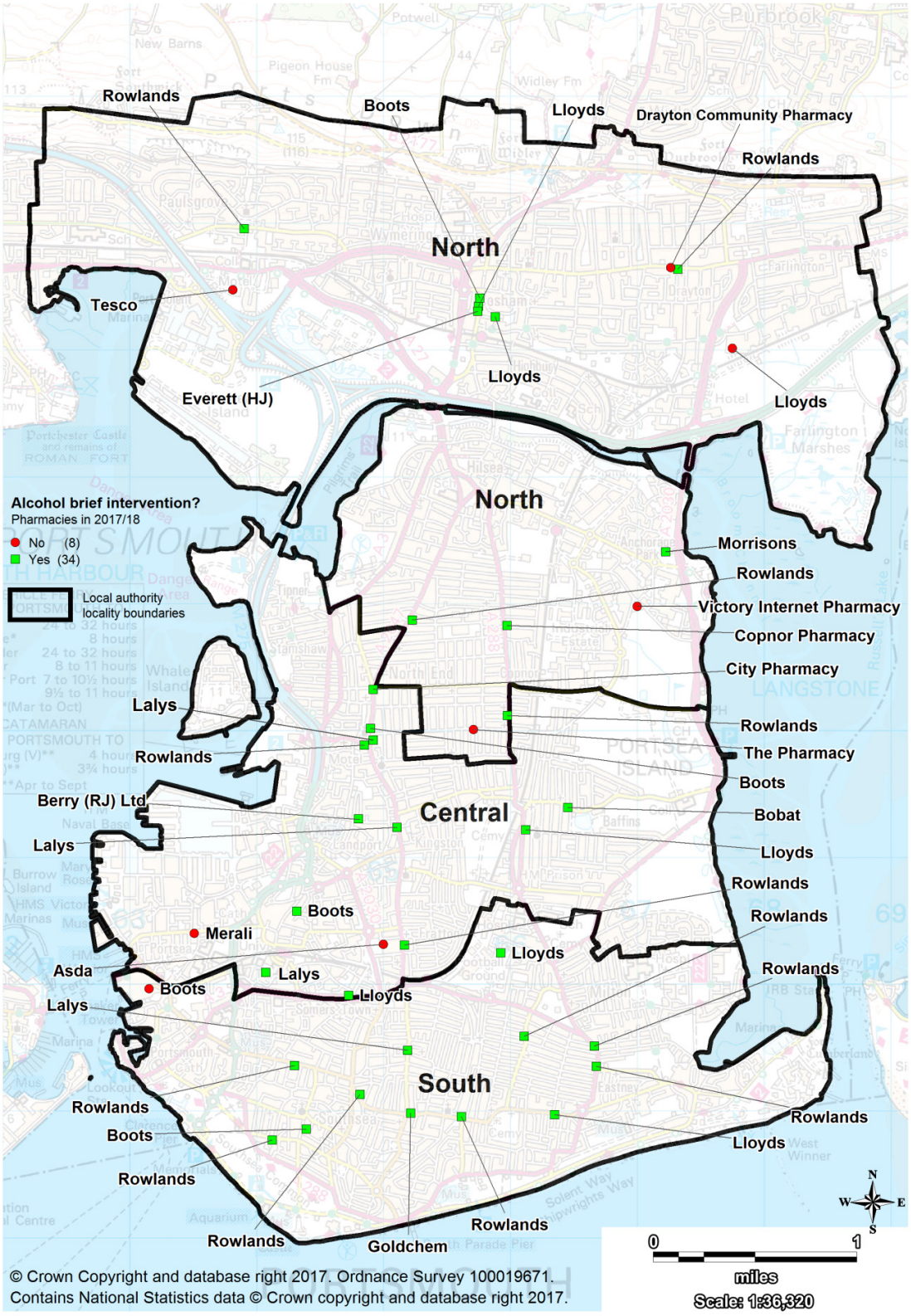

Figure 39. Map of pharmacies which have a contract to provide Alcohol Brief Intervention in Portsmouth for 2017/18 (source Portsmouth City Council, Public Health)

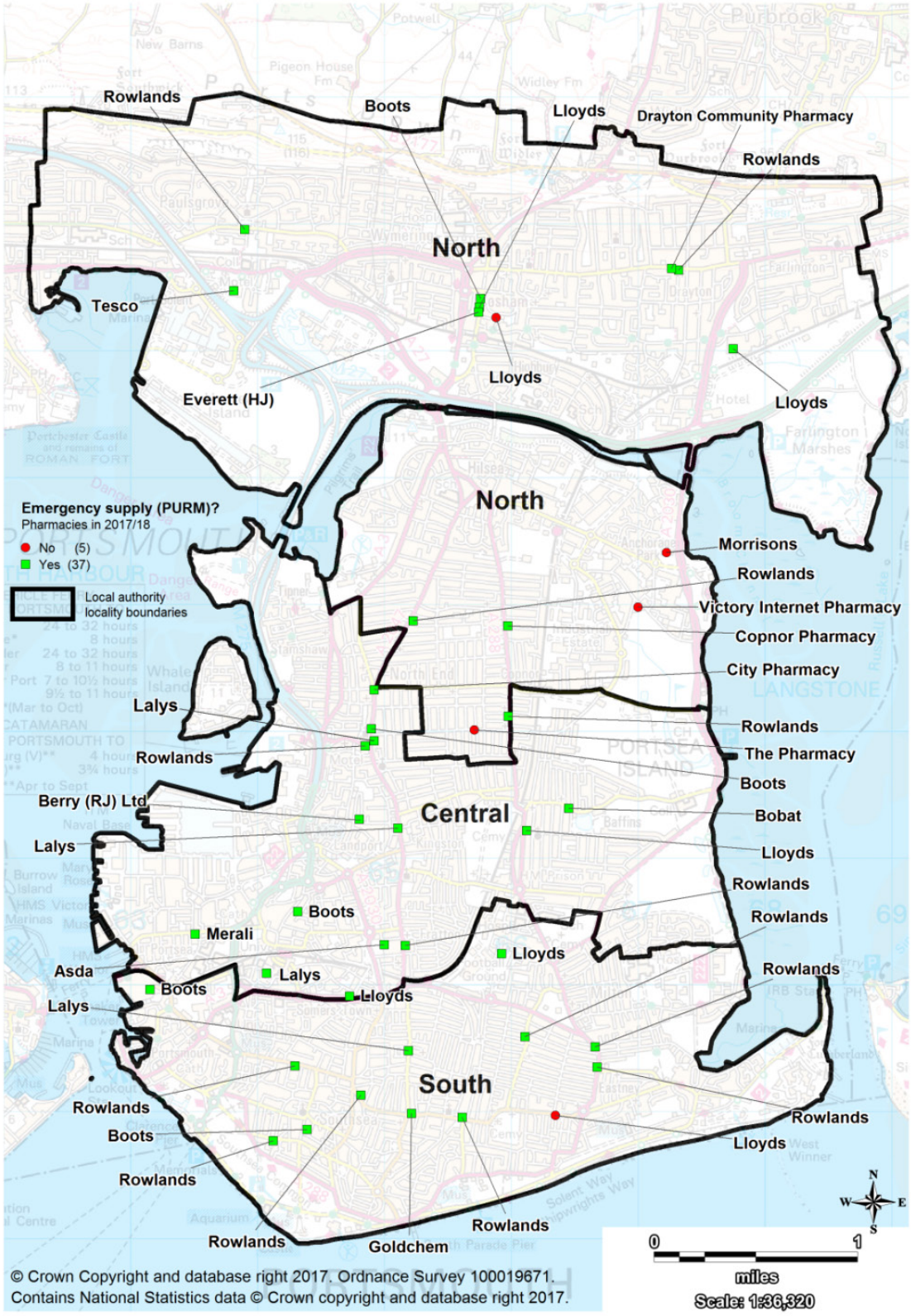

Figure 40. Map of pharmacies accredited to provide the Pharmacy Urgent Repeat Medicine Service in Portsmouth for 2017/18 (source NHS England Wessex Area Team)

16 Appendix B: Terms of Reference

Pharmaceutical Needs Assessment Steering Group

Terms of Reference

The Pharmaceutical Needs Assessment (PNA) is a legal duty of the Health and Wellbeing Board (HWB). The HWB is required to publish the revised PNA for its area by 1st April 2018. The PNA is used by NHS England to make decisions on which NHS funded pharmaceutical services need to be provided in the local area. Failure to publish a robust PNA, which has been produced in line with requirements of the NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 could lead to legal challenges, particularly as the local PNA is central to making decisions about new pharmacy openings. The steering group is preparing this document on behalf of the Director of Public Health for presentation to the HWB.

Purpose:
The steering group will:-

- Oversee the development and publication of a separate PNA for Portsmouth City Council (PCC) and Southampton City Council (SCC)
- Agree a project plan and timetable for the development of the PNAs and ensure representation of the full range of stakeholders
- Agree the format and content of the PNAs
- Ensure that the PNAs reflects any future needs for, or improvement or better access to, pharmaceutical services as will be required by the local population
- Ensure the PNAs meets the requirements of the NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013
- Ensure the PNAs fulfils its statutory duties for consultation for the PNA
- Ensure publication of the PNAs within the required timescale
- Ensure the PNAs comply with requirements of each local authority to ensure authorisation by the respective HWB.

Membership
The membership of the steering group is as follows:-

Portsmouth City Council

Claire Currie (Chair)	Public Health Consultant (on behalf of PCC and SCC)
James Hawkins	Specialist Public Health Intelligence Analyst
Janet Byng	Public Health Team Administrator

Southampton City Council

Dan King	Service Lead – Intelligence and Strategic Analysis

NHS Portsmouth Clinical Commissioning Group

Janet Bowhill	Pharmaceutical Adviser

NHS Southampton City Clinical Commissioning Group

Sue Lawton	Locality Lead Pharmacist for West / Community Pharmacy Development Manager

Hampshire and Isle of White Local Pharmaceutical Committee

Paul Bennett (until June 2017)	Chief Officer
Debby Crockford (from July 2017)	

NHS England Wessex Local Area team

Leslie Riggs	Interim Contracts Manager (Pharmacy and Optometry), NHS England (Wessex)

Healthwatch representatives

Siobhain McCurrach (Portsmouth)	Project Manager, Healthwatch Portsmouth
Rob Kurn (Southampton)	Healthwatch Southampton Manager

An agreed deputy may be used where the named member of the group is unable to attend.

Other staff members/stakeholders may be invited to attend meetings for the purpose of providing advice and/or clarification to the group.

Where there are discussions in the steering group specific to one City Council, only those members representing the City in question may take part.

Declarations of interest

Members must declare any pecuniary or personal interest in any business on the agenda for it to be formally recorded in the minutes of the meeting.

Meetings

All meetings will have an agenda and minutes. The frequency of the meetings will be determined by the chair of the group in line with the development of the PNA.

Accountability and reporting

The PNA steering group will be accountable to the Southampton Health and Wellbeing Board and separately to the Portsmouth Health and Wellbeing Board for the PNA being developed for the respective areas. The PNA steering group will report on progress on a three monthly frequency or as required by the Health and Wellbeing Board.

The pre-consultation drafts and the final draft PNAs will be presented to their respective Health and Wellbeing Board for approval.

17 Appendix C: Policy context

Pharmacies have a major role to play in helping improve the public's health, with 1.6 million people visiting a pharmacy each day[151]. There were approximately 12,000 community pharmacies in England (2016) and 79% of people have visited a pharmacy at least once in the last 12 months.

Pharmacists are experts in the use of medicines to treat disease and are an appropriate first point of contact for dealing with an array of health concerns. Pharmacists work within a code of ethics that requires them to continuously develop their professional knowledge and competence relevant to their field of practice. Pharmacists are responsible for the supply of most medicines available to the public. They advise the public and other professionals on the safe and effective selection and use of medicines and other health-related matters. Pharmacies provide a range of services in the heart of neighbourhood communities where they are within reach of the people who need them most – poorer people, older people and people with a disability or chronic condition.

The role of community pharmacy is evolving. Distance selling pharmacies are providing greater choice and accessibility for the public to pharmaceutical services. They are also changing the community pharmacy provision from the traditional high street provision.

Published in April 2016, the General Practice Forward View set out a vision to improve patient care and access, and invest in new ways of providing primary care. The General Practice Forward View committed to over £100m of investment to support an extra 1,500 pharmacists to work in general practice by 2020/21. This is in addition to over 490 pharmacists already working across approximately 650 GP practices as part of a pilot, launched in July 2015.

Pharmacists working as part of the general practice team aim to resolve day-to-day medicine issues and consult with and treat patients directly. This includes providing extra help to manage long-term conditions, provide advice for those on multiple medications, improving the quality of care and ensuring patient safety.

In August 2016 the Community Pharmacy Forward View was published by PSNC and Pharmacy Voice, with the support of the RPS English Pharmacy Board which set out the ambition for the sector. It focused on three key roles:

- As the facilitator of personalised care for people with long-term conditions;
- As the trusted, convenient first port of call for episodic healthcare advice and treatment; and
- As the neighbourhood health and wellbeing hub.

For 2017/18, The Department of Health (DH) introduced a Quality Payments Scheme as part of the Community Pharmacy Contractual Framework. This scheme involves payments being made to community pharmacy contractors meeting certain gateway and quality criteria. Achieving Healthy Living Pharmacy status is included in these criteria.

[151] Local Government Association; The community pharmacy offer for improving the public's health https://www.local.gov.uk/sites/default/files/documents/community-pharmacy-offer--9b3.pdf

18 Appendix D: Portsmouth Community Pharmacy – Pioneers of Healthy Living Pharmacy

The Healthy Living Pharmacy concept was developed by NHS Portsmouth. It recognised the significant role community pharmacies could pay in helping reduce health inequalities by delivering consistent and high quality health and wellbeing services, promoting health and providing proactive health advice and interventions.

A Healthy Living Pharmacy consistently delivers a range of health and wellbeing services to a high quality and has achieved defined quality criteria requirements and met productivity targets linked to local health needs. The pharmacy team proactively promotes health and wellbeing and proactively offers brief advice on a range of health issues such as smoking, activity, sexual health, healthy eating and alcohol.

To become accredited as an HLP all staff have had to undertake additional training for all levels of staff, improve their consultation facilities and their health promotion areas as well as proactively deliver local services that are targeted at improving residents' healthy lifestyle. Behaviour change training has been offered to all levels of staff.

The programme has achieved a number of accolades, nominations for awards and citations in academic research. Following the success of HLPs in Portsmouth, the Minister for Pharmacy, Lord Howe asked whether the results in Portsmouth could be replicated in other areas with differing demography to Portsmouth. A national Pathfinder Support Group was established enabling roll out to 20 areas of the country and a comprehensive and independent academic evaluation of the scheme.

The evaluation[152] (2013), which included data from Portsmouth demonstrated that;

- The HLP concept was consistent with increased service delivery and improved quality measures and outcomes;
- 21% of people surveyed wouldn't have done anything if they hadn't accessed a service or support in the HLP so would have missed out on the benefit of getting advice to improve their health and wellbeing;
- 60% of peopled surveyed would have otherwise gone to a GP;
- Public feedback was positive with 98% saying they would recommend the service to others and 99% were comfortable to receive the service in the pharmacy;

The HLP programme has the support of Public Health England and has spread across the country. The Department of Health (DH) introduced a Quality Payments Scheme as part of the Community Pharmacy Contractual Framework in 2017/18. Achieving HLP status is included in this scheme.

[152] Evaluation of the Healthy Living Pharmacy work programme available at http://psnc.org.uk/wp-content/uploads/2013/08/HLP-evaluation.pdf

19 Appendix E: Consultation report

Appended as a separate document.

20 Appendix F: Equality Impact Assessment

Appended as a separate document.

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Equality Impact Assessment

Full assessment form v5 / 2013

www.portsmouth.gov.uk

Directorate: Director of Public health

Function e.g. HR, IS, carers: Public Health

Title of policy, service, function, project or strategy (new or old):

Portsmouth Pharmaceutical Needs Assessment 2018 (revised from 2015 version)

Type of policy, service, function, project or strategy:

- ☐ New / proposed
- ☐ Changed
- ★ Existing

Lead officer Claire Currie, Consultant in Public Health

People involved with completing the EIA: James Hawkins, Specialist Public Health Intelligence Analyst

Introductory information (Optional)

Step 1 - Make sure you have clear aims and objectives

What is the aim of your policy, service, function, project or strategy?

A Pharmaceutical Needs Assessment (PNA) is a statement of current pharmaceutical services provided in the local area. It also assesses whether or not the pharmaceutical services provision is satisfactory for the local population and identifies any perceived gaps in the provision.

The NHS (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013 set out the legislative basis for developing and updating PNAs. It is a statutory requirement for the Health and Wellbeing Board to publish a revised assessment within three years of its previous PNA. The refreshed Portsmouth PNA must be published by 1st April 2018.

Who is the policy, service, function, project or strategy going to benefit or have a detrimental effect on and how?

The PNA reflects the current and future needs for pharmaceutical services. This affects the residents of Portsmouth, people who work and study in the city and partner NHS organisations including NHS Portsmouth Clinical Commissioning Group, Portsmouth Hospital Trust, GP practices and the existing community pharmacy network.

Access to high quality pharmaceutical services is particularly relevant for those taking medicines, typically people suffering from long term conditions and disproportionately affects those in ill-health and older adults.

What outcomes do you want to achieve?

Effective provision of pharmaceutical services, that meet the needs of people living and working in Portsmouth. The services need to be available across the city by all people who need them.

What barriers are there to achieving these outcomes?

Community pharmacies are businesses and provision of desired pharmaceutical services have to be commercially viable. The public may express a desire for more pharmacies and extended hours but this has to be balanced against financial viability for local commissioning organisations.

Step 2 - Collecting your information

What existing information / data do you have? (Local or national data) If you don't have any data contact the Equalities and diversity team for some ideas

Extensive data has been collated from a number of sources, including:
- Joint Strategic Needs Assessment
- Data from Portsmouth City Council Planning regarding anticipated developments
- Data held by NHS England of current pharmaceutical provision
- Questionnaire of community pharmacy contractors describing current provision
- Public survey to inform understanding of how current pharmaceutical services are used
- Public and professional stakeholder consultation on the draft PNA report

Using your existing data, what does it tell you?

In Portsmouth there are 41 community pharmacies, one distance selling pharmacy and one dispensing appliance contractor.

The Health and Wellbeing Board consider the location, number, distribution and choice of pharmaceutical services serving the Portsmouth residents to meet the needs of the population. The Health and Wellbeing Board also consider that there is currently no identified need for improvements and better access to pharmaceutical services in Portsmouth.

In particular, this is based on:
• The total Portsmouth population is within a 1.6km straight line distance of a community pharmacy.
• A good geographical spread of community pharmacies across all three localities in the city and within communities experiencing greatest deprivation.
• There being 19 community pharmacies per 100,000 Portsmouth population, which is the same as the average for Wessex and is broadly in line with national averages.
• Over 99% of the Portsmouth population are within a 20 minute walk of a community pharmacy.
• Nearly nine in every 10 (87.5%) respondents to a public survey said it took 15 minutes or less to get to a community pharmacy.
• Good access demonstrated by opening hours from early morning, through lunchtimes and late into the evening as well as weekend opening.
• A distance selling pharmacy, five 100 hour pharmacies, supplementary hours in other Portsmouth community pharmacies as well as provision in a neighbouring Health and Wellbeing Board area provide improvements and better access which meets the needs of Portsmouth residents.
• All pharmacies provide the full range of essential pharmaceutical services
• Good provision of advanced services across the city.
• A range of enhanced and locally commissioned services delivered in the city. Pharmacies accredited to deliver these services have good geographical spread across the localities within Portsmouth.
• A large proportion of community pharmacies providing a delivery service to residents, including housebound patients.
• There will not be substantial changes in population areas, nor major development, which can be anticipated during the three-year lifespan of this PNA, which would warrant the need for additional pharmaceutical services. Smaller changes would be managed by existing providers.

Step 3 - Now you need to consult!

Who have you consulted with?	If you haven't consulted yet please list who you are going to consult with
There is a regulatory duty (NHS (Pharmaceutical & Local Pharmaceutical Services) Regulations 2013 No 349: Part 2: Reg 8) to have a 60 day consultation about the contents of the assessment it is making. The consultation ran from 23rd October 2017 to 27th December 2017. The public consultation was supported by the Portsmouth City Council, Healthwatch Portsmouth and NHS Portsmouth Clinical Commissioning Group. According to the Regulations, the following were consulted: • Local Pharmaceutical Committee • Local Medical Committee • Any persons on the pharmaceutical lists and any dispensing doctors list for its area; • Any local pharmaceutical service pharmacy in its area with whom the NHS England has made arrangements for the provision of any local pharmaceutical services; • Healthwatch and any other patient, consumer or communtiy group in its area which has an interest in the provision of pharmaceutical services in its area • Any NHS Trust or NHS Foundation Trust in the area • NHS England and the local CCG • Neighbouring Health & Wellbeing Boards There were eight responses from professional stakeholders and 62 from members of the public.	

Please give examples of how you have or are going to consult with specific groups or communities e.g. meetings, surveys

The draft PNA report and the consultation questionnaire were hosted on the 'consultations' page on the Portsmouth City Council website. Hard copies were available upon request. The short set of questions used for the consultation of the Portsmouth PNA 2015 was used (with minor amendments). For each question there was an opportunity for respondents to add free text comments to expand on their views.

All professional stakeholders as specified in the Regulations were contacted by email by Monday 23rd October 2017.

All contractor pharmacies within the city were contacted by a message on PharmOutcomes (software system used by pharmacies) and by email on 23rd October 2017 giving details of the consultation process. A letter was also posted to each community pharmacy on the same date.

The PCC communications team used social media Twitter and Facebook to promote the consultation. The PNA consultation for Portsmouth was included in the November issue of Flagship magazine which is distributed to 93,000 Portsmouth residents. The consultation was publicised to the citizen panel (where around 1000 people had the opportunity to respond) and in the volunteer newsletter.

The CCG publicised the consultation, in October, on its Intranet news page for local staff and GPs and their practice staff. The consultation was publicised at the CCG Patients Participation forums held on 6th September 2017 and 6th November 2017. The consultation was also discussed as part of the Practice Managers forum on 18th October 2017.

Healthwatch Portsmouth publicised the consultation via e-mail to a variety of community and voluntary sector groups.

Step 4 - What's the impact?

Is there an impact on some groups in the community? (think about race, gender, disability, age, transgender, religion or belief, sexual orientation, pregnancy and maternity and other socially excluded communities or groups)

Generic information that covers all equality strands (Optional)

There is no specific impact on any one group. Everyone may need access to pharmaceutical services in the city. The PNA has made specific reference to a range of groups.

Ethnicity or race

Higher prevalence of some health conditions is associated with particular ethnic groups. No specific impact on a particular group has been identified from this PNA. Questions were asked about languages spoken by pharmacy staff which has been summarised in the PNA.

Gender including transgender

Life expectancy of men is lower than that for women both in Portsmouth and nationally. No specific impact for either men or women has been identified from the recommendations of this report.

Age

Medicines use increases with age. The majority of older adults will be taking at least one regular prescription medicine. All pharmacy contractors were asked about their services that would support this age group. These services include prescription collection and home delivery of medicines. The distance selling pharmacy in Portsmouth, as well as others outside of Portsmouth, also provide additional choice and increases accessibility to older adults who may have limited mobility. Adjustments to the dispensing process includes easy open containers and large print labels.

Disability

All pharmaceutical contractors were asked to describe adjustments they make in their service for disabled service users. This included wheelchair access into premises and consulting rooms and access by housebound patients. During the data collection process it was confirmed that the majority of pharmacies in the city offer a free prescription collection and home delivery service for those patients finding difficulty in getting to a pharmacy. The distance selling pharmacy in Portsmouth, as well as others outside of Portsmouth, also provide additional choice and increases accessibility to individuals with disabilities who may have limited mobility.

Religion or belief

No specific impact has been identified as part of this assessment. The General Pharmaceutical Council has published guidance to clarify that while a pharmacist may be unwilling to provide a particular service due to religious reasons or personal values and beliefs, they should take steps to make sure the person asking for care is at the centre of their decision-making, so that they are able to access the service they need in a timely manner.

Sexual orientation

No specific impact has been identified.

Pregnancy and maternity

Community pharmacy can provide an important source of advice for minor ailments for conditions such as constipation which can commonly occur in pregnancy. For women planning pregnancy, access to a community pharmacy for advice can also be important. As this PNA indicates there is satisfactory pharmaceutical provision across Portsmouth, no specific impact on this group has been identified.

Other socially excluded groups or communities e.g. carers, areas of deprivation, low literacy skills

Reference to services beneficial to carers have been made within the document. Areas of deprivation have been identified alongside pharmaceutical provision have been described within the assessment. As this PNA indicates there is satisfactory pharmaceutical provision across Portsmouth, no specific impact on these groups have been identified.

Health Impact

Have you referred to the Joint Needs Assessment (www.jsna.portsmouth.gov.uk) to identify any associated health and well-being needs?

★ **Yes** ☐ **No**

What are the health impacts, positive and / or negative? For example, is there a positive impact on enabling healthier lifestyles or promoting positive mental health? Could it prevent spread of infection or disease? Will it reduce any inequalities in health and well-being experienced by some localities, groups, ages etc? On the other hand, could it restrict opportunities for health and well-being?

The PNA describes provision of locally commissioned services and their role in promoting health and wellbeing of the people of Portsmouth.

The PNA has been developed to ensure a range of good quality pharmaceutical services may be accessed by the local population of Portsmouth. Many services have been identified and their beneficial impact on health and wellbeing described.

Health inequalities are strongly associated with deprivation and income inequalities in the city. Have you referred to Portsmouth's Tackling Poverty Needs Assessment and strategy (available on the JSNA website above), which identifies those groups or geographical areas that are vulnerable to poverty? Does this have a disproportionately negative impact, on any of these groups and if so how? Are there any positive impacts?, if so what are they?

The PNA profiles and references deprivation and the associated poor health and wellbeing in the city. The PNA describes pharmaceutical provision and highlights the areas of greatest need where services can have the most impact.

Step 5 - What are the differences?

Are any groups affected in a different way to others as a result of your policy, service, function, project or strategy?

There is no intention to affect any specific group in a different way due to this assessment.

Does your policy, service, function, project or strategy either directly or indirectly discriminate?

☐ Yes ★ No

If you are either directly or indirectly discriminating, how are you going to change this or mitigate the negative impact?

N/A

Step 6 - Make a recommendation based on steps 2 - 5

If you are in a position to make a recommendation to change or introduce the policy, service, project or strategy clearly show how it was decided on

The recommendation is that the PNA be approved by the Portsmouth Health and Wellbeing Board on 21st February 2018 and published by 1st April 2018.

What changes or benefits have been highlighted as a result of your consultation?

Once published, the PNA will be used as reference by NHS England to determine market entry of applications for new NHS pharmaceutical service providers and in responding to consolidation applications. In addition, the final PNA may be used by local commissioning organisations to inform commissioning decisions.

If you are not in a position to go ahead what actions are you going to take?
(Please complete the fields below)

Action	Timescale	Responsible officer

How are you going to review the policy, service, project or strategy, how often and who will be responsible?

Under current legislation, it is a statutory requirement for the Health and Wellbeing Board to publish a revised assessment within three years of its previous PNA. This PNA will be published by 1st April 2018.

Step 7 - Now just publish your results

This EIA has been approved by: Dr Jason Horsley

Contact number: 023 9284 1779

Date: 26/01/2018

Please email a copy of your completed EIA to the Equality and diversity team. We will contact you with any comments or queries about your full EIA.

Telephone: 023 9283 4789

Email: equalities@portsmouthcc.gov.uk

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Portsmouth CITY COUNCIL

Title of meeting:	Health and Wellbeing Board
Date of meeting:	21st February 2018
Subject:	Health and Wellbeing Strategy refresh, 2018-2021
Report by:	Jason Horsley, Director of Public Health
Wards affected:	n/a
Key decision:	No
Full Council decision:	No

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1. Purpose of report

1.1 To present to the Health and Wellbeing Board the Health and Wellbeing Strategy for 2018-2021 for approval.

2. Recommendations

2.1 The Health and Wellbeing Board is recommended to:

a. Approve the Health and Wellbeing Strategy attached at Appendix 1.
b. Recommend that partner organisations adopt the strategy through their own governance arrangements, as set out on paragraph 6.1
c. Consider the approach to progressing the strategy as set out in section 6, and propose areas for HWB consideration.

3. Background

3.1 There is statutory duty on local Health and Wellbeing Boards to produce a strategy for the Health and Wellbeing of their population. Portsmouth's current strategy runs from 2014-2017. At the last meeting of the Board, a draft document was approved for consultation until 31st January 2018.

4. Reasons for recommendations

4.1 The Health and Wellbeing Strategy needs to focus on the highest impact issues for the city, and the areas where the work of the Health and Wellbeing Board can add maximum value. The proposals set out in the consultation document approved at the last meeting represented early suggestions to be developed through the consultation process.

4.2 The consultation document reflected previous decisions that:

- our overarching aims should be to improve healthy life expectancy in the city; and reduce inequality by improving the areas with lowest expectancy fastest
- we do this by working to principles around promoting prevention, supporting independence and intervening earlier
- that the strategy needs to work on all dimensions of the city in a whole systems approach
- that broad themes are supporting physical good health, supporting social, emotional and mental health, working to improve outcomes for marginalised groups fastest; and improving access to services.

5. Feedback from consultation

5.1 Over 80 responses were received in response to consultation. Most responses were made by individuals rather than on behalf of organisations. Organisations represented include:

- Healthwatch
- Portsmouth College
- Portsmouth Hospitals Trust - maternity
- North End Baptist Church
- Safer Portsmouth Partnership
- NHS Property
- Portsmouth CCG (ICS)
- Wessex Cancer Trust
- Adult Social Care, PCC
- Stroke Association
- Milton Neighbourhood Forum
- Home of Comfort Nursing Home
- The Roberts Centre
- The Society of St James
- Portsdown U3A
- Regeneration Directorate, PCC
- Public Health, PCC
- Vivid Housing
- Tackling Poverty Steering Group

5.2 Most respondents were female, and there were very few responses from people under 25.

5.3 There was strong agreement that the four priorities that had been identified felt correct for Portsmouth's strategy. Key comments in relation to the general priorities were that:

- There needs to be a greater reflection of the importance of economic good health because it is so important for overall wellbeing

- We need to come alongside communities, with their skills and aspirations, and look at 'what is strong rather than what is wrong'.
- Look at how the voluntary and community sector can work alongside the statutory services and organisations to deliver services and build better understanding.
- Ensure the wider determinants of health are integrated into commissioning plans - 'somewhere to live, someone to love and something meaningful to do.'

5.4 In relation to Priority 1 - Physical Health, there was strong agreement that this is an important priority, and agreement about the themes of preventing the harms from tobacco and increasing physical activity. However, there was also a sense that the overarching theme needed to be "reducing obesity" or "encouraging healthy weight" with physical activity and diet/nutrition as the enablers to that aim. There was also feedback about the importance of starting early with support to children and families.

5.5 Commentary around Priority 2 - Social, emotional and mental good health suggested that there was strong support that the right priorities had been identified, althought the question was posed if issues related to addiction (including substance misuse) would sit better linked to tobacco and physical health. Many respondents picked up on the issues that mental wellbeing is influenced by a huge range of factors and that preventing matters arising in the first instance (such as abuse, loneliness and lack of opportunities) is critical t any approach.

5.6 In considering vulnerable groups, there was broad agreement that the right groups had been identified but that more needed to be done to reflect issues of homelessness.

5.7 In response to the feedback, a number of amendments have been made to the draft document, including:

- Inclusion of reference to the children's physical health strategy
- More emphasis on the issue of homeless as a cause and effect of marginalisation
- More consideration of issues relating to diet and healthy weight
- Recognition of the importance of the surrounding environment, picking up issues such as air quality and quality of the public realm

5.8 Detailed anonymised summary of feedback can be made available on request.

6. Proposed work programme to progress the Health and Wellbeing Strategy

6.1 Subject to approval of the draft text attached at Appendix 1, it is recommended that this is incorporated into an accessible designed version (as with the consultation document) and that partner organisations progress the document for adoption through their governance structures as required.

6.2 In terms of progressing the areas of concern identified in the HWB strategy, it is recognised that many of the areas are being taken forward through other

partnerships, but that there would be value in the HWB Board inviting discussion on progress and where the HWB Board could support moving further and faster.

6.3 It is also recognised that for some areas, there are looser oversight arrangements (for example, around physical activity healthy weight) and the HWB Board could add some value in drawing work together. It is recommended that the Director of Public Health is tasked with bringing discussion items on this work to the HWB Board, along with any other elements that the HWB would welcome discussion on.

6.4 There are thematic issues arising from the development of the Strategy that could benefit from further discussion. Chief among these is the idea of tackling loneliness and isolation in the city, and tapping into the strong community assets that exist in the city. This could be an area where the HWB Board could add considerable value and comment is requested on how this could be progressed in support of the strategy.

6.5 Finally, there were examples of good practice highlighted, particularly from voluntary sector partners, and it may be that HWB Board would wish to invite discussion of some of these schemes and consider what learning could be taken from them. This could be as part of a wider discussion around the concepts of social isolation and building on community assets.

7. Equality impact assessment

7.1 A preliminary EIA was completed for the document and concluded that there will be no negative impact on any of the protected characteristics arising from the development of a refreshed Health and Wellbeing Strategy. Any individual projects or measures arising from the strategic approach outlined will be subject to impact assessments in their own right. The preliminary EIA is attached as Annex 2.

8. Legal implications

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

9. Director of Finance's comments

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

……
Signed by:

Appendices:
Draft Health and Wellbeing Strategy for consultation

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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Portsmouth's Health and Wellbeing Strategy 2018-2021

Introduction

Developing the draft Health and Wellbeing Strategy

There is a statutory duty on local Health and Wellbeing Boards to produce a strategy for the Health and Wellbeing of their populations. The strategy should inform work that is done to improve health and wellbeing in local areas.

Portsmouth's previous strategy (2014-2017) is wide-ranging and provided a comprehensive overview of health and wellbeing matters in the city. In refreshing this for 2018-2021, we are focusing on the relationships to other work in the city, and on the areas of work that will have the highest impact in the context of the wider system.

We have sought to identify priorities based on the strong evidence we have about the city and the huge range of stakeholder information and feedback that members of the Board have access to. We remain committed to the reduction of health inequalities, by improving outcomes for those in the worst position fastest. We recognise that inequalities can be identified according to where people live, and that this is particularly true in some areas where there are high levels of deprivation and need; but there are also inequalities between genders, ethnicities, ages and abilities that we need to tackle.

In developing the document we have taken account of:

- the most up to date evidence of what is happening around health and wellbeing outcomes in Portsmouth, as summarised in our Joint Strategic Needs Assessment
- an assessment of our progress against the previous strategy
- latest relevant national guidance, strategies and plans
- local strategies and plans
- insight from local residents and communities, including through an open consultation on the draft document.

The strategy will be a critical piece of documentation for:

- Underpinning commissioning decisions: setting a framework for commissioning plans across the NHS, local authority and other agencies in the city
- Influencing decisions: providing a source of evidence and direction for policy and decision making in a wide range of areas across the city, such as development, community safety and education.
- Holding leaders of organisations across the city to account for improving outcomes: the strategy will be reviewed each year and provide a basis for conversations about where we are improving outcomes, and where more needs to be done.

We are consulting on our draft strategy, and the responses to this will be used to shape the final document. We will consult in detail with lead agencies and partnerships to ensure that the work programmes proposed in the strategy are complementary to programmes already underway, and consider where the Health and Wellbeing Board can add additional value to those programmes.

The Health and Wellbeing Board works alongside other partnerships in the city, looking at a range of issues that affect people's lives. Portsmouth's Children's Trust Board will take the lead on issues relating to children and families and education. Similarly, the Safer Portsmouth Partnership will lead on issues relating to violent crime. However, there are some issues with a very specific health and care emphasis, and that cut across areas of work, and these are reflected in the Health and Wellbeing Strategy.

We have some significant challenges to address, but we are confident that by working together we can really make a difference over the next three years.

Health and Wellbeing Board Portsmouth

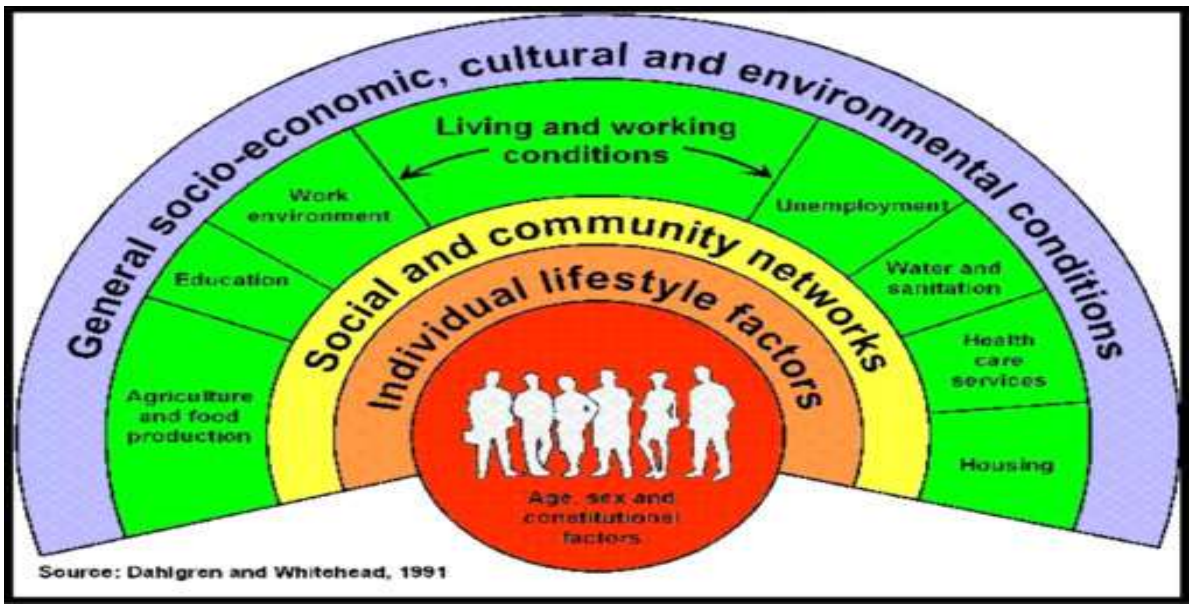
Portsmouth - in a nutshell and the case for change

Portsmouth is a great waterfront city, home to over 200,000 people, with all the diversity, opportunities and challenges that come with that.

The city has great assets and potential. We have an extraordinary natural environment, world-leading status in industries including marine technology, aerospace and defence, and a vibrant cultural sector. Our university is thriving and respected and we have plans for regeneration of the city, including the development of thousands of homes on the Tipner site to the west of the city.

Despite this, the most recent summary of the Joint Strategic Needs assessment for the city showed that life expectancy in the city is lower than the national averages for both men and women. Main areas of concern for Portsmouth, when considering health and wellbeing data, are educational achievement at 16, high levels of recorded violence against the person (including domestic abuse), premature mortality from cancer, high levels of death from drug misuse and deaths from suicide.

We believe that if the city is to unlock its potential, we need to tackle these issues - and other areas where Portsmouth may be making improvements but is still in a poor position relative to other areas of the country, such as smoking prevalence and smoking-related deaths, and premature mortality from heart disease and stroke. We know that outcomes in health are more than about managing health problems and that the wider determinants of health are critical:



Put simply, people who have good quality and secure jobs and housing in the areas and communities where they have families and social networks stay healthier, feel happier and live longer. In order for them to secure work, homes and relationships, they need a good start in life, support when they have problems, and care when they need it. When these conditions exist, areas are attractive to investors and visitors, creating more opportunities for residents, and more resources that can be directed to support the most vulnerable.

The case for improving health and wellbeing in Portsmouth is clear - unlocking the potential of the city and securing the prosperity it can generate depends on it.

Our vision and approach

We want to improve healthy life expectancy in the city; and reduce inequality by improving the areas with the lowest expectancy fastest. We will do this by working to principles around:

- Promoting prevention
- Supporting independence
- Intervening earlier

We know that we want to give people the best possible start in life, empower them to live healthy lives and enjoy a healthy older age. In order to do this we will:

- Empower people to take care of their physical health
- Empower people to take care of their social, emotional and mental health
- Work with marginalised groups to make improvements for them fastest
- Improve access to health and social care support in the community

Themes	Priority	What we will do
Improve healthy life expectancy in the city; and reduce inequality by improving the areas with the lowest expectancy fastest		
Support physical good health	Reduce the harms from tobacco and other substances	- Implement the Smoke-Free Portsmouth Tobacco control strategy - Tackle the causes of substance and alcohol misuse and work with the Safer Portsmouth Partnership to reduce the harms from substance misuse.
	Reduce the harms from physical inactivity and poor diets	- Ensure wider environmental measures such as open space protection and transport infrastructure are taken to support better quality environments - Implement our citywide approach to physical activity - Implement the wider Healthy Weight strategy, including a focus on education, diet and nutrition.
	Focus on good physical health in children and young people	- Implement the Children's Trust strategy to support the physical health of children, including supporting families and communities.
Support social, emotional, mental and economic health	Promote positive mental wellbeing across Portsmouth	- Develop opportunities to ensure people feel connected to the wider community - Continue to implement the Future in Mind Strategy to transform the approach to child and adolescent mental health
	Reduce the drivers of isolation and exclusion	- Develop and implement the suicide prevention plan - Progress the priorities of the Tackling Poverty Strategy, including providing good quality, sustainable employment opportunities that enable a reasonable standard of living for residents; helping residents to be financially resilient and shaping wider policies and decisions so they reduce the risk of poverty.
Make improvements for marginalised groups fastest	People with complex needs	- Progress programme of activity around complex needs - Develop and implement citywide strategy for street sleeping
	People in the armed forces community	- Complete a detailed needs assessment by Spring 2018.
	Children and people with special educational needs and disabilities, and their families	- Implement the six priorities in the SEND strategy - Implement the four priorities in the Carers' Strategy
	Looked after children and care leavers	- Increase placement stability - Improved educational outcomes - More care leavers in education, employment and training - Improved emotional health and resilience.
Improve access to health and social care support in the community	Implementation of the Portsmouth Blueprint for health and care	- development of the Stronger Futures programme for integrating care services for children, and supporting earlier intervention through a restorative approach - developing integrated locality teams for adults services - developing a multi-speciality community provider model for services in the city - developing a programme for workforce development across the city.

How we will deliver and monitor the strategy

Our approach will consider the complete environment in which people live, and the whole range of influences on their lives:

In our work with individuals, we will:

- ensure that people are empowered to take responsibility for their own well-being, transferring responsibility to them wherever possible to self-care and self-manage, to opt for personal budgets and to have a full say in designing and shaping the policies, services and plans that will affect them.
- Ensure we see the whole person and their whole set of issues, consider how these link together and support them to tackle problems holisitically.

In our work with communities, we will:

- Take an asset-based approach, recognising the many strengths that already exist in our cities and communities
- Consider community-based ideas and solutions to tackle problems, building on schemes such as community connectors.

In our work with each other, we will:

- Continue to work together on commissioning and delivering services, so that organisational structures and boundaries don't stand in the way of delivering the best solutions, and residents don't experience difficulty in access and navigating services
- Hold each other to account respectfully and supportively for delivering on the objectives in the Health and Wellbeing Strategy.
- Support key partnerships to identify local priorities and deliver long-term sustainable changes to the way we work.

Much of the detailed information underpinning this strategy, and the supporting work programmes, are contained in documents referenced throughout. The Health and Wellbeing Board will work

alongside other partnerships and groups in the city groups, and will support discussion on these key areas to understand where we can go further and faster in securing the improvements in health and wellbeing that we need to see in the city.

Progress against the areas set out in the strategy will be tracked through the annual reports presented by the Director of Public Health setting out progress against the Public Health Outcomes Framework. The Board will also invite colleagues to celebrate successes and share challenges regularly so that all partners with an interest in health and wellbeing in Portsmouth can come together to build a common understanding of the challenges and opportunities, and can tackle them together.

Theme 1: Support good physical health

Lifestyles, particularly physical inactivity, unhealthy diets, drinking alcohol to excess, and smoking are challenges in Portsmouth, with a significant proportion of adults exhibiting more than one unhealthy behaviour, which adversely contributes to the health inequalities of those living in Portsmouth's more deprived areas, and affects the predicted poor long-term health of those currently of middle age (35 to 64 years) living anywhere in the city. There is also a real challenge that many of these behavioural issues in adults impact negatively on children from pregnancy onwards (eg smoking in pregnancy, offering unhealthy food, snacks and drinks, not taking children to dental and other health appointments).

Creating the conditions for improvement

The choices people make about things that affect their physical health and wellbeing are often influenced by the environments they live, work and relax in. We need to make sure that these wider environments are supporting people to take care of their own physical health.

This includes making sure that we tackle issues around air quality, which is known to contribute to premature deaths. We also need to make sure that environments support people to undertake physical activity, for example, by making sure that our transport infrastructure supports active travel. This is important because the more we can encourage people to use more active travel methods, the greater the opportunities for reducing traffic and improving the air we breathe.

We also need to ensure we protect our open spaces, which is particularly important in a very densely built city like Portsmouth, and make them nice places to be and to use. The city benefits hugely from the unique natural environment created by the waterfront, but people need to be able to feel confident and safe using their environments and making the most of the opportunities they present.

Priority 1a: Reduce the harms from tobacco and other substances

Why is this a priority?

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

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

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

The most recent local 'You say' survey of secondary school pupils encouragingly found an increase in pupils who had never tried tobacco from 78% in 2015 to 85.7% in 2016.

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

The Tobacco Control Alliance has recently agreed 'Smoke-free Portsmouth: Tobacco Control Strategy 2016-2020'. This four-year strategy covers all aspects of smoking and tobacco control to improve the health and wellbeing of the people of Portsmouth by reducing inequalities and by nurturing a tobacco free generation. Creating a smokefree generation is a key priority for us and we will ensure that we focus on preventing young people from starting to smoke to help achieve this.

This will be achieved through a reduction in the prevalence of smoking consistent with national targets and by addressing the wider tobacco control agenda.

We aim to:
i. Reduce smoking prevalence in Portsmouth, both overall and in identified target groups
ii. Support local communities to create a tobacco-free culture for Portsmouth

The strategy focus on the three important areas of protection, prevention, and cessation; with our key priorities for achieving a Smoke-Free Portsmouth being to:
1. Promote smokefree environments across the city
2. Motivate and assist every smoker to stop
3. Deliver effective communications and campaigns around the tobacco agenda
4. Provide leadership to create a smokefree city
5. Develop a workforce confident and competent to help reduce the harms of smoking
6. Improve health outcomes and reduce smoking related inequalities targeting young people, pregnant women, adults in routine and manual occupations and adults with mental health disorders.

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

The Liver Disease Profiles and the Local Alcohol Profiles for England show that Portsmouth has significantly higher rates than England across for:
- Claimants of benefits due to alcoholism, 2015
- People admitted to hospital for alcohol-specific conditions, 2014/15
- Admission episodes for males aged 40-64 years, 2014/15

• Admission episodes for mental and behavioural disorders due to use of alcohol condition (broad definition) for males and for females, 2014/15
• Admission episodes for mental and behavioural disorders due to use of alcohol condition (narrow definition) for males 2014/15
• Admission episodes for intentional self-poisoning by and, exposure to, alcohol condition for males and for females, 2014/15
• Alcohol-specific mortality for males and for females, 2012/14
• Alcohol-related mortality for males, 2014
• Mortality from chronic liver disease for males and for females, 2014
• Premature mortality rate from liver disease for males and for females, 2012-14
• Premature mortality rate from alcoholic liver disease for males, 2012-14

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

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

The use of alcohol or drugs is strongly associated with suicide in the general population and in sub-groups such as young men and people who self-harm. Although substance misuse affects fewer people, its effects are particularly severe, on physical health, mental health, employment prospects and on those around the person. Alcohol and drugs misuse is also closely associated with crime and offending. The strategy to reduce harms caused is overseen by the Safer Portsmouth Partnership.

Smoking, alcohol and substance misuse are all issues that feature strongly in the Public Health Outcomes Framework, and we will use these indicators to track the effectiveness of work in these areas.

Priority 1b: Reduce the harms from physical inactivity and poor diets

Why is this a priority?

The list of benefits of regular and adequate levels of physical activity is huge; some of the main ones were highlighted by the World Health Organisation:

- improve muscular and cardiorespiratory fitness;
- improve bone and functional health;
- reduce the risk of hypertension, coronary heart disease, stroke, diabetes, breast and colon cancer and depression;
- reduce the risk of falls as well as hip or vertebral fractures; and
- fundamental to energy balance and weight control.

Being physically active improves the health of everyone, regardless of age, sex, ethnicity, disability, wealth or waist size. Various pieces of research and analysis have concluded that:

- persuading inactive people to become active could prevent one in six premature deaths
- physical inactivity is the 4th largest cause of disease and disability in the UK
- in children aged 0-5 years, lower levels of physical activity are associated with increased levels of obesity

As measured by the Active Lives Survey 64.5% of the Portsmouth population are classed as active. This is in line with the national averages but below that of the region and Hampshire. 22.8% of Portsmouth residents achieve less than 30 minutes per week of moderate intensity activity.

The Portsmouth Health and Lifestyle survey found that the South locality had a significantly higher proportion meeting the recommended weekly minimum physical activity guideline, than the North and Central localities (and Portsmouth average) - 66% in the South compared to 55% and 54% in North and Central. The local 2015 survey also found that the proportion who meet the weekly activity guideline is greatest amongst those aged 16-34 years, and then falls sharply to half among those aged 35-44 years. It is slightly higher again among those aged 45-64, but then falls again to its lowest level among those aged 65+. The survey also found that 9% of respondents in Portsmouth are sedentary (i.e. do not do regular moderate or vigorous activity). Those in the most deprived quintile of neighbourhoods are more likely to be sedentary.

The overall aim in the city is to ensure that everyone meets the recommendations for physical activity. However, targeting those who are the most inactive to become more active will produce the greatest reduction in chronic disease.

Therefore, we will aim to:

1. **Create Active Environments**
   Engineering activity back into daily life through infrastructure, transport, housing, workplaces and open space. Influence how people live their lives and choose being active

2. **Enable Active starts**

Creating positive attitudes and behaviour amongst all children and young people. Ensuring that positive habits are resilient into adulthood and through periods of change.

3. **Support Active Lives**
   Engage and empower individuals, families and communities to be active every day. Build a culture of activity throughout every corner of daily life.

4. **Practice Active Medicine**
   Valuing and utilising physical activity to prevent and treat health conditions. Activity is viewed as a key component for physical and mental health and wellbeing.

This is an area where there is strong data available about levels of activity undertaken in the city (often commissioned by outside agencies) and around areas that we know are linked to activity, including healthy weight data. Therefore, we will propose to track progress against the following indicators:

1. Increase physical activity levels amongst children and young people
2. Reduce the number of physically inactive adults
3. Retain levels of activity through the life course
4. Reduce inequalities of activity levels amongst females, people with a disability, some ethnic groups and people living in Portsmouth's most deprived communities

Physical activity is commonly linked with obesity and healthy weight and whilst activity is an essential component in maintaining a healthy weight it should be regarded as a health priority in itself. The health benefits of physical activity extend beyond weight loss and are just as important for those overweight, underweight or at the correct weight.

Equally, physical activity is not the only element to maintaining a healthy weight. 'Healthy weight' is the terms used to describe an individual whose height and weight is proportional and falls within defined parameters where the risk of ill-health due to weight is at its lowest. Those individuals above (overweight or obese) or below (underweight) a healthy weight are at increased risk of adverse effects on their health and wellbeing.

Nationally, it is estimated that 64% of the adult population (16+) is above a healthy weight, with a further 1.8% underweight, meaning that only 36.5% of the population falls within the healthy weight range. The most recent estimates for Portsmouth suggest that around 98,000 residents are above normal weight. In Portsmouth, the prevalence of childhood obesity is higher in the most deprived areas compared to the least deprived, which follows the links between deprivation and childhood obesity seen nationally. Similar associations exist around adult obesity, highlighting that the most significant predictor of childhood obesity is parental obesity.

In order to tackle these issues, we need to create a culture where healthy eating becomes the norm alongside physical activity, through developing supportive environments, ensuring healthy food options are easily accessible and readily affordable, and that support is available to help individuals

achieve a healthy weight. We need also to remember that diet doesn't only impact on weight - it is known to contribute to conditions such as type 2 diabetes, hypertension and certain cancers.

Work on promoting physical activity is led through the Physical Activity Alliance, supported by Public Health Portsmouth who also lead efforts to promote healthy eating and good nutrition. The impact of the Health and Wellbeing Board's work on promoting physical activity will be measured through the Public Health Outcomes Framework.

Priority 1c: Support the physical good health of children and young people in Portsmouth

Why is this a priority?

For Portsmouth, our children's health and wellbeing is doing well in some aspects, but there are a range of areas where we are lagging behind how England is doing as a whole. For example:

- Smoking prevalence at age 15 (current smokers) is significantly higher than for England (10.9% v 8.2% in 2014/15).

- A&E attendances per 1,000 are significantly higher than the national average for 5-9 year olds, 10-14 year olds, 15-17 year olds and 15-19 year olds based on 2015/16 data, although are lower than the national average for 0-4 year olds

In order to address the particular physical health issues that affect children and young people in the city, and to ensure they get the best possible start, a strategy is in place to tackle the key issues. This has three strategic themes:

1: Supporting young people - risky behaviours are those that expose young people to harm, or significant risk of harm and may result in unintended or undesirable consequences. Some risky behaviour can be considered a part of growing up but there is a distinction to behaviour that could escalate to a harmful stage. So we will work together to reduce these, including focusing on alcohol and substance misuse amongst young people.

2: Supporting families - the family environment and the circumstances a child grows up in has a huge impact on health and wellbeing of children and young people. Early, secure attachment is crucial for healthy, early development as well as contributes to social and educational outcomes in later life, and children need to grow up in safe, supportive environments. We will work to ensure that support to families incorporates both healthcare approaches and also addresses social concerns, through joining up commissioning of young people's services and continuing to promote good health to families and schools.

3: Supporting communities - children and young people are influenced by their surrounding that they grow up in, including where they learn and play. Services working with families as well as the built environment shapes all have a role. Examples of services include primary care, community and acute services and services outside health such as children's centres, nurseries and schools, play and youth services. We will work together to deliver seamless healthcare in the community, ensure the role of education settings in heath is recognised, and support the development of healthy environments for children.

The Public Health Outcomes Framework includes many indicators of child and family health and we will track progress according to our direction of travel on these indicators.

Theme 2: Support social, emotional, mental and economic health

We know that Portsmouth has significantly higher rates of factors which are risks for mental ill health but lower recorded rates than the national average of, for example, depression.

Priority 2a: Promote positive mental wellbeing across Portsmouth

Stigma and discrimination often means that mental health problems are not openly talked about. However, illnesses linked to mental health account for a third of GP consultations, and research shows mental health issues are closely associated with poorer outcomes for employment, personal relationships and physical health.

By promoting wellbeing and building emotionally resilient communities we can reduce the number of people going on to experience a mental health problem. In addition, supporting early identification and intervention we can reduce the impact for individuals experiencing a mental health problem.

This means ensuring that mental health becomes a part of everyday conversation and is something that everybody is aware of and cares about. Whether it is a midwife supporting a mother through the birth of a child, a school nurse helping children to develop emotional literacy, or a member of our new integrated community health and social care teams.

We will continue to promote better physical and mental health through using the "five ways to wellbeing" model:

- Connecting with the people around you
- Being active - exercise makes you feel good
- Taking Notice - be aware of the world around you and what you are feeling
- Keep learning - learning new things builds confidence and is fun
- Giving - do something nice for a friend or stranger - seeing yourself, and your happiness linked to the wider community can be incredibly rewarding and create connections.

The evidence also shows that people have different levels of "mental capital" throughout their lives, and this is something that planning needs to take into account. A particularly critical time, including for building resilience, is in childhood and adolescence.

Future in Mind is a five-year strategy to transform children's mental health and wellbeing provision, so that by 2020 England could lead the world in improving outcomes for children and young people with mental health problems. We want all children and young people in Portsmouth to enjoy good emotional wellbeing and mental health. Our Local Transformation Plan sets out that the way in which we will achieve this vision is by:

- Establishing a clearly understood needs-led model of support for children and young people with Social Emotional Mental Health difficulties which will provide access to the right help at the right time through all stages of their emotional and mental health development.
- Ensuring that every child and young person has access to early help in supporting their emotional wellbeing and mental health needs which will prevent difficulties escalating and requiring specialist mental health services.
- Supporting professionals working with children and young people to have a shared understanding of Social Emotional Mental Health and to promote resilience and emotional wellbeing in their work.

The Strategy is overseen by the Health and Wellbeing Board.

We know that building emotional resilience, and improving the life experiences of people with mental health issues is not something that can be managed in isolation. Instead, we must work with other health and social care agencies, the voluntary sector, patients, carers and the public, to look at services needed to enable people to live stable and happier lives, where they feel supported and in control of their own mental wellbeing.

Priority 2b: Reduce poverty and other drivers of isolation and exclusion

Why is this a priority?

Compared to England, the risk factors section of Public Health England's suicide profile illustrates that Portsmouth has lower rates of people with long-term health problems and of long-term unemployment, but has higher rates of people who are separated or divorced, people living alone, children who are looked after, children leaving care, children in the youth justice system and estimated prevalence of opiates or crack cocaine. Portsmouth also has a higher than national rates of mental health clients receiving services from adult social care, of adult carers who have as much social contact as they would like, and of clients receiving specialist alcohol and drug services. Isolation is also a recognised driver of mental ill health. Mapping from Age UK shows that the most deprived communities in the city also have the highest risk of loneliness in those aged 65 and over.

For overall deprivation, Portsmouth is now ranked 63rd worst of 326 local authorities (where one is the most deprived, previously ranked 76th worst of 326 local authorities). The Tackling Poverty Needs Assessment was refreshed in January 2015 in the light of the recession and changes in the welfare system. The needs assessment identifies the multiple factors which adversely and positively affect poverty including educational outcomes, employment and low-pay employment, financial exclusion and debt and the way services are organised to respond to people in crisis. Current priorities for the Action Plan include re-commissioning a social welfare advice service for Portsmouth (Advice Portsmouth's contract expires in March 2017); responding to welfare reform (including the introduction of Universal Credit and the reduced Household Benefit Cap); and supporting access to resources for people in financial hardship, following the closure of the Local Welfare Assistance Scheme.

The confidential audits of deaths by suicide 2013-2015 identified potentially adverse life events affecting individuals before their death – bearing in mind that individual cases are complex and it is impossible to reduce suicide events to a single cause. Many people experienced more than one potentially adverse life event. The audits found that 39% of males and 25% of females were unemployed or were worried about employment, and 24% of males and 26% of females had finance worries. The audit cited a Royal College of Psychiatrists' report on the relationship between debt and mental health: people in debt are more likely to have mental health problems, and people with mental health problems are more likely to be in debt. One in two adults with debts has a mental health problem; and one in four people with a mental health problem is in debt. However, the relationship between mental health and debt is complex and one does not inevitably lead to the other.

Some groups are more vulnerable to low pay and poverty, leading to social isolation, and further research is required to understand how Portsmouth residents are affected, and how they can be assisted. This includes self-employed people, people with health and care plans or disabilities and black, minority ethnic and refugee communities. However, there is a much broader issue about the importance of good quality work for people for people in the city, and the importance of supporting people dealing with challenging issues such as low pay, zero hours contracts, forced self-

employment, and insecure work. In Portsmouth, there is a particular issue around seasonal and short-term work driven by the visitor economy.

We will work together to ensure that there are support mechanisms in place for people who need them. Much work to address this is being led through the Tackling Poverty Strategy Steering Group. The Tackling Poverty Strategy 2015-2020 has six priority areas for action:

- Improving our children's futures
- Providing good quality, sustainable employment opportunities that enable a reasonable standard of living for residents
- Helping residents to be financially resilient
- Helping people to move out of immediate crisis, but also helping them to solve their problems in the longer term
- Improving residents' lives by recognising the links between poverty and health inequalities
- Shaping wider policies and decisions so they reduce the risk of poverty.

The Health and Wellbeing Board will support the Tackling Poverty Steering Group wherever it is able to do so.

Theme 3: Make improvements for marginalised groups fastest, including our most vulnerable children, young people and adults.

Creating the conditions for helping marginalised people

There are certain things that many of us take as a given in day to day life - that we have enough money to take care of our basic needs, somewhere to live, people to love and connect with and things to do that give us purpose.

But for a variety of reasons, not everyone has some or all of those things, and experience some level of marginalisation. The strategy has already addressed the importance of tackling poverty, and identified the link between poor quality employment and physical and mental health. There is increasing recognition of the prevalence and significance of loneliness too - and in the context of Portsmouth, the issue of urban loneliness is critical. More and more, we are understanding that even in a densely populated and vibrant city, it is possible for people to feel isolated and unsupported.

We also recognise that some of the symptoms of a marginalised life aren't always obvious. We understand that health conditions are sometimes not visible - particularly in the case of mental health issues - but other social issues can be difficult to detect too. For example, it is sometimes not obvious if people are living with poor housing conditions, in housing where their tenure is insecure, or whether people are part of the "hidden homeless", sleeping on sofas or a succession of temporary accommodation.

The Health and Wellbeing Board will support existing work, led through the strategic group on homelessness and rough sleeping to ensure that services and support are in place to support people who are struggling, with a principle of preventing situations escalating, and intervening as early as possible.

Priority 3a: People with complex needs

Why is this a priority?

There is growing national and local evidence that a small cohort of adults in our communities are likely to experience 'severe and multiple deprivation' (SMD cohort), including substance misuse, homelessness, offending and mental health problems. They are likely to have ineffective contact with services that are often designed to deal with one problem at a time, and so regularly and persistently 'fall between the cracks' that open up between services.

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

Services have a range of processes, pathways, panels and interventions in place to support adults with a variety of complex needs. Services have in the main been commissioned or directly provided

to meet a defined individual need - often successfully - but generally not designed to address composite and compounding needs e.g. homeless/mental health/substance misuse/criminal justice.

Similarly, individual assessments of need by statutory services tend to focus on the presenting issue and there are different eligibility thresholds for accessing services that do not necessarily take into account complexity of needs and associate behaviour, the nature of 'recovery'.

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

It is clear from the case studies that valuable work is already being undertaken. There are some successes in supporting people to achieve positive outcomes, and there are examples of good practice in effective collaborative working. However, customers, advocates and professionals have questioned the consistency of the effectiveness, efficiency and value of current approaches, particularly for those service users present with the most complex needs.

Recent research has also shown that adverse childhood experiences (ACEs), including witnessing domestic abuse for example, increase the likelihood of 'health harming behaviours' in adulthood, so it's also important to act early when these risk factors are present to 'turn off the tap', reducing the numbers of people in this cohort in future years.

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

Priority 3b: People in the armed forces community, including veterans

Why is this a priority?

The armed forces community is made up of anyone who is or has served for at least 1 day in the armed forces (regular or reserve, including national service) as well as Merchant Navy Seafarers and fisherman who have served in a vessel that was operated to facilitate military operations by the armed forces. The armed forces community also includes spouses, civil partners and dependent children of those who currently are or have served for at least 1 day, even if the serving person is now deceased.

National estimates suggest 4.9% of adult population of England are Veterans. Pension data demonstrates more veterans live in the south east of England than anywhere else, however not all veterans get a pension, and the community is far larger than veterans. On 1st April 2016 140,450 Regular service personnel were stationed in the United Kingdom, the majority located in the South East and South West of England. Portsmouth's military significance makes it likely that a higher concentration of service personnel are based in the area. Locally, the Portsmouth Health and Lifestyle Survey 2015 found that there was an estimated 11% of the adult population aged 16+ years who are veterans (of the Armed Forces or Reserve Armed Forces) - roughly 17,000 residents, of

which approximately 84% are estimated to be aged 45 years or over. There is no way of fully knowing how many dependants, spouses and civil partners currently reside in Portsmouth.

National research suggests that the vast majority of this community have needs in line with the general population. However age, service undertaken and position within the Armed Forces community brings with it specific issues. For example Older Veterans are known to experience more hearing, skin and musculoskeletal issues than the general population, and a small yet significant number of people who leave service early experience mental health and substance misuse issues. Little is known about the health and wellbeing needs of reservists and their families, however the limited research that has been undertaken suggests family stress and mental health are emerging issues.

A needs assessment for the sub-Solent area is currently underway, and therefore a better picture of need and gaps in support will be available in Spring 2018.

Priority 3c: People with special educational need or disabilities , and their families

Why is this a priority?

Portsmouth Children's Trust publishes a strategic children's needs assessment as part of the city's Joint Strategic Needs Assessment (JSNA) process. In 2016, a detailed Special Educational Needs and Disability Needs Analysis was undertaken as part of this process. The key findings are:

1. There is a wide range of potential disabilities or conditions which could start to affect someone from conception or during pregnancy, during labour, as a baby or as a child or young person. Understanding the cause of some disabilities is necessary to support multi-agency health promotion and early identification and intervention.
2. Overall prevalence of a child or young person having any special educational need has decreased by 38% since 2009 - mostly due to a fall in pupils identified as needing SEN Support (from 23.9% to 13.4%). Portsmouth has seen a steeper decrease than nationally with the overall percentage of SEN in Portsmouth now only 1 percentage point above national, having previously been much higher. This substantial decrease is considered to be due to the more accurate identification of those with SEN following implementation of the SEND reforms.
3. Between 2010 and 2015, there was a 13% increase in the number of children with statements of SEN or an Education, Health and Care Plan (EHCP) issued and maintained by Portsmouth LA. However, the proportion of the total population of young people identified as having a statement of SEN or EHCP has stayed fairly static throughout this time both nationally (2.8%) and within Portsmouth (3.1%).
4. There are gender differences in the prevalence of SEN, with twice the proportion of Portsmouth boys (17.4%) being SEN Support compared to girls (9.5%). Five per cent of boys have either a Statement of SEN or EHCP compared to 1.9% of girls. This reflects the national picture.

   Compared to national outcomes for SEN pupils, Portsmouth has poorer education outcomes for children with SEN in the following areas:

   - Attaining a Good Level of Development in the Early Years Foundation Stage Profile
   - Making progress between Key Stage 1 and Key Stage 2 in Reading, Writing and Maths
   - Key Stage 2 attainment of Reading, Writing and Maths (combined)
   - Making progress between Key Stage 2 and Key Stage 4 in English and Maths
   - 5+ GCSEs graded A*-C, including English and Maths
   - Achievement of a Level 2 or Level 3 qualification by age 19

5. The local survey of children and young people aged 7 to 18 years found that children who say they are disabled, or who have difficulties with learning, had significantly lower than average wellbeing compared to other children. SEN is over-represented in groups including looked after children, and the care leaving population. 65% of the average Youth Offending Team (YOT) caseload have SEN. National prevalence rates predict that 60-90% of them will have a communication disorder.
6. Overall, children with SEN are about four times as likely to be persistently absent from school than those without SEN. Nine per cent of all pupils with SEN Support were persistently absent; 11% of those with a statement of SEN or EHC plan were persistently absent.

7. Pupils with SEN were more than eight times as likely to receive fixed period exclusions than those without SEN. Compared to non-SEN pupils, higher percentages of children with SEN were excluded from school with no alternative provision for education being made.
8. The proportion of 16 and 17 year olds with SEN participating in education and training is slightly higher in Portsmouth than nationally and is lower for those with SEN than those without SEN, reflecting the national picture. However, the proportion of learners with SEN who progressed to education or employment/training is considerably lower in Portsmouth than nationally at the end of both Key Stage 4 and Key Stage 5.
9. Higher rates of disability prevalence are found in the most disadvantaged socio-economic groups nationally. Pupils with SEN in Portsmouth are twice as likely to be eligible for free school meals than those without SEN (26% compared to 13%). Children aged 0-15 years with a long-term health problem or disability, are almost twice as likely to be living in socially rented homes in Portsmouth than children with no limiting long-term health problem or disability.
10. The Dynamite Survey of young people with SEND found that Health and Employment were the areas that are most important to them, and that Employment was the area on which they found it most difficult to find out about choices and support.

The aim of the special educational needs and disability (SEND) strategy is to promote inclusion and improve the outcomes for Portsmouth children and young people aged 0-25 years with SEND and their families. Delivery of this strategy is overseen by the Children's Trust Board.

In order to improve outcomes, we aim to ensure that there are in place a range of high quality support services that contribute to removing the barriers to achievement for all Portsmouth children and young people, in particular those with special educational needs and disabilities. This includes enabling children and young people to lead healthy lives and achieve wellbeing; to benefit from education or training, with support, if necessary, to ensure that they can make progress in their learning; to build and maintain positive social and family relationships; to develop emotional resilience and make successful transitions to employment, higher education and independent living.

For adults living with disabilities and long-term conditions, we need to ensure that there are a range of support and opportunities in place, and that barriers to people living the life they want to live in the way that they want to live it are removed wherever possible. This means considering how we can ensure there is a range of accommodation available, how we ensure that there are opportunities for employment and meaningful activity, and support people in participating in the community.

Finally, we cannot forget the importance of supporting those who are providing care to people living with an additional need, illness or disability. The city has a Carers' Strategy, with four main priority areas:

1. Identification and recognition Carers will be respected as expert partners, and identified at an early stage to secure comprehensive, personalised services to support them in their caring role.
2. Realising and releasing potential - Making sure that a carer is not disadvantaged by their caring status.
3. A life alongside caring - Personalised support both for carers and those they support, enabling them to have a family and community life.
4. Supporting carers to stay healthy - Supporting carers to stay mentally and physically well.

The Strategy includes local commitments to ensure that we provide the best possible support for those people looking after a family member or friend.

Priority 3d: Looked after children and care leavers

Children and young people are in care either by a court order or with the agreement of their parent(s) or guardian(s). A child or young person may come into care as a result of temporary or permanent problems facing their parents, as a result of abuse, neglect or some other difficulties.

Children and young people in care are individuals - they come from all walks of life and have different aspirations, ambitions and cultural identities. Many looked after children and care leavers are at greater risk of social exclusion than their peers, both because of their experiences prior to coming into care, and by virtue of the fact that they are in care.

At the end of March 2017, there were 358 children in the care of Portsmouth City Council, including 49 unaccompanied asylum seeking children. This is a slightly higher rate of care that our statistical neighbour group, and higher than the national average.

47% of the children in our care live in the local authority are, and 77% live with foster families. The majority of children who live out of the city are in our neighbouring authorities. A lower percentage of children live in children's homes than is found nationally.

The composition of the looked after children population has changed over the last year, and we now have a higher proportion of 14-17 year old children looked after. There are more boys than girls in local authority care.

We know that the educational attainment of looked after children needs to be improved, particularly at KS4. GCSE results improved slightly in 2016 with 30% of Portsmouth's looked after children achieving five or more GCSEs grade A*-C including English and Maths. Only 78% of looked after 16 and 17 year olds are in education, employment and training, and among our ove-18 care leavers, only 56% were in education, employment or training. These early outcomes have a massive impact on the life chances of these young people. If children and young people are to have a positive and supportive experience of being in care, and fulfil their potential as adults, these outcomes must get better.

A Corporate Parenting Strategy is in place to lead improvement, overseen by the Children's Trust Board. There are four main priorities:

- Increase placement stability
- Improved educational outcomes
- More care leavers in education, employment and training
- Improved emotional health and resilience.

Theme 4: Improve access to health and social care support in the community.

Priority 4a: Implement the Portsmouth Blueprint for Health and Care in Portsmouth

Why is this a priority?

208,900 people live in the City and 217,562 people are registered with a Portsmouth GP. We know there are significant health and care challenges in Portsmouth. Too many people have poorer health and wellbeing than in other similar cities. Demand for our health and care services is increasing and more people tell us that what matters to them is ease of access and joined up services. The Blueprint for Health and Care in Portsmouth is now well-established as the set of guiding principles that set out how the key health and care organisations in the city will work together, with an overarching goal *where everyone is supported to live healthy, safe and independent lives by health and social care services that are joined up around the needs of individuals and are provided in the right place at the right time.*

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

There is a great deal of work underway in all organisations and services, as business as usual, inorder to achieve savings and efficiencies, and in order to achieve more transformational change as envisaged in the Blueprint. This landscape is increasingly complex as work also develops across a wider Portsmouth and South East Hampshire geography around an accountable care system, as well as responding to the county-wide STP footprint. Portsmouth is also increasing links with Southampton via the public health agenda.

Health and care systems across Hampshire and Isle of Wight (HIOW) have come together in partnership to develop a strategic transformation plan (STP), setting out the strategic aims and objectives for transformation across the county. The key aims and objectives of the Portsmouth Blueprint are reflected within this wider system plan. It has been agreed that delivery of the STP needs to take place at local level, within local delivery systems. The City of Portsmouth forms part of the Portsmouth and South East Hampshire (PSEH) delivery system. Health and care partners in PSEH have come together to form an accountable care system (ACS) as a vehicle for delivering the New Models of Care set out in the NHS 5 Year Forward View publication. Once again the aims and objectives and key work programmes to deliver the Blueprint are reflected in the ACS plans.

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

Projects include:

- development of the Stronger Futures programme for integrating care services for children, and supporting earlier intervention through a restorative approach
- developing integrated locality teams for adults services
- developing a multi-speciality community provider model for services in the city
- developing a programme for workforce development across the city.

Equality Impact Assessment

Preliminary assessment form v5 / 2013

www.portsmouth.gov.uk

The preliminary impact assessment is a quick and easy screening process. It should:

- identify those policies, projects, services, functions or strategies which require a full EIA by looking at:
  - negative, positive or no impact on any of the equality groups
  - opportunity to promote equality for the equality groups
  - data / feedback
- prioritise if and when a full EIA should be completed
- justify reasons for why a full EIA is not going to be completed

Directorate: Director of Public health

Function e.g. HR, IS, carers: Strategy

Title of policy, service, function, project or strategy (new or old) :

Health and Wellbeing Strategy refresh 2018-2021

Type of policy, service, function, project or strategy:

- ☐ Existing
- ★ New / proposed
- ☐ Changed

Q1 - What is the aim of your policy, service, function, project or strategy?

There is statutory duty on local Health and Wellbeing Boards to produce a strategy for the Health and Wellbeing of their population. Portsmouth's current strategy runs from 2014-2017, so it is now necessary to consider how this needs to be refreshed.

The next Health and Wellbeing Strategy needs to focus on the highest impact issues for the city, and the areas where the work of the Health and Wellbeing Board can add maximum value. The proposals above set out early suggestions that will be developed through the drafting process, and through wider consultation.

Q2 - Who is this policy, service, function, project or strategy going to benefit or have a detrimental effect on and how?

The strategy should have a beneficial effect on the population of the city, by bringing about improved healthy life expectancy and reduced health inequality by improving the areas with lowest expectancy fastest. We do this by working to principles around:
- promoting prevention,
- supporting independence
- intervening earlier

We know we want to give people the best start in life, empower them to live healthy lives, and enjoy a healthy older age. In order to do this, we need to:
o Empower people to take care of their physical health
o Empower people to take care of their social, emotional and mental health
o Work with marginalised groups to make improvements for them fastest (including income deprived households).

Q3 - Thinking about each group below, does, or could the policy, service, function, project or strategy have a negative impact on members of the equality groups below?

Group	Negative	Positive / no impact	Unclear
Age	☐	★	☐
Disability	☐	★	☐
Race	☐	★	☐
Gender	☐	★	☐

Transgender		★	
Sexual orientation		★	
Religion or belief		★	
Pregnancy and maternity		★	
Other excluded groups		★	

If the answer is "negative" or "unclear" consider doing a full EIA

Q4 - Does, or could the policy, service, function, project or strategy help to promote equality for members of the equality groups?

Group	Yes	No	Unclear
Age			★
Disability			★
Race			★
Gender			★
Transgender			★
Sexual orientation			★
Religion or belief			★
Pregnancy or maternity			★
Other excluded groups			★

If the answer is "no" or "unclear" consider doing a full EIA

Q5 - Do you have any feedback data from the equality groups that influences, affects or shapes this policy, service, function, project or strategy?

Group	Yes	No	Unclear
Age			★

Disability	☐	☐	★
Race	☐	☐	★
Gender	☐	☐	★
Transgender	☐	☐	★
Sexual orientation	☐	☐	★
Religion or belief	☐	☐	★
Pregnancy and maternity	☐	☐	★
Other excluded groups	☐	☐	★

If the answer is "no" or "unclear" consider doing a full EIA

Q6 - Using the assessments in questions 3, 4 and 5 should a full assessment be carried out on this policy, service, function or strategy?

☐ yes ★ No

Q7 - How have you come to this decision?

This is a high-level strategic framework. At this stage, there are no identified negative impacts for the protected groups, and a number of positive direct and indirect impacts, particularly around age, gender and income expected, given the purpose of the Health and Wellbeing Strategy. It is expected that as individual plans are developed in support of the strategy, these plans will be subject to individual equalities impacts assessments to ensure that there are no negative impacts, and indeed that positive impacts are maximised.

If you have to complete a full EIA please contact the Equalities and diversity team if you require help Tel: 023 9283 4789 or email:equalities@portsmouthcc.gov.uk

Q8 - Who was involved in the EIA?

Kelly Nash, Corporate Performance Manager, PCC

This EIA has been approved by: Jason Horsley

Contact number:	023 9243 7685
Date:	7th February 2018

Please email a copy of your completed EIA to the Equality and diversity team. We will contact you with any comments or queries about your preliminary EIA.

Telephone: 023 9283 4789

Email: equalities@portsmouthcc.gov.uk

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